Record Management and Documentation Manual

for

Providers of Publicly Funded Mental Health, Intellectual or Developmental Disabilities, Traumatic Brain Injury, and Substance Use Services

and

Local Management Entities / Managed Care Organizations

North Carolina

Department of Health and Human Services

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

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Preface and Scope

Recordkeeping is a fundamental and necessary component of service delivery for healthcare providers and managed care organizations. Record-keeping practices for documenting service provision during the entire course of treatment is required. While the predominant focus is to address the documentation requirements of an individual's service record, there are other requirements that extend beyond this. The broader requirements undergird the service delivery system. Such administrative and reporting requirements must also be in place to ensure compliance with all the applicable rules, regulations, policies, and standards of care.

For the purpose of this manual, a service record may be paper-based, electronically based, or a hybrid which contains both paper-based records and electronically based records. An electronically-based service record is a digitized version of a member's or recipient's record that resides in a system specifically designed to support authorized users by providing accessibility to complete and accurate data, clinical support systems, and links to other sources that help ensure the total integrated care of an individual's treatment. Integrated care focuses on improving a member/recipient's experience and achieving greater efficiency and value from health and behavioral health delivery systems.

The requirements outlined in this resource reflect current policy unless superseded by subsequent changes in Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS) or Division of Health Benefits (DHB) policies, requirements in the specific service definitions, Communication Bulletins, other related Department of Health and Human Services (DHHS) policies, procedures, rules, or North Carolina General Statutes (NCGS). Entities are responsible for keeping abreast of all rules, policy changes, and other communications to the provider network and stakeholders through regular reference to the DMH/DD/SUS and DHB (NC Medicaid) websites as well as applicable state and federal requirements.

The requirements and guidelines addressed in this resource have incorporated Medicaid and State-funded standards, DMH/DD/SUS rules, policies, and procedures, as well as other applicable regulations, such as the Health and Insurance Portability and Accountability Act (HIPAA), etc. The standards identified apply to mental health, intellectual or developmental disabilities, traumatic brain injury, and/or substance use services (MH/IDD/TBI/SUS) provided by an entity which is defined as follows: individual practitioner or agency, behavioral health/managed care organizations to include Local Management Entity - Managed Care Organizations (LME-MCOs), Pre-Paid Health Plans (PHPs) such as the Standard Plans (SP)/Tailored Plans (TP)/Child and Family Specialty Plan (CFSP), and Pre-Paid Inpatient Health Plans (Medicaid Direct).

In addition, some of the requirements in this manual are also 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.

Overall, the following are excluded from the guidance provided in this manual, but entities are responsible for ensuring a review of the manual to determine if there are any exceptions that apply:

- Hospital providers specific to inpatient and emergency services;
- State-operated facilities;
- Intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs); and

- Advanced Medical Home Plus (AMH+), and Care Management Agencies (CMAs) providing Tailored Care Management.

Additional Guidance

- For any information obtained from an electronic health record (EHR), in printed form, entities must ensure all information requested is provided and reflects actual date of entry (recognizing that printed materials can misrepresent in terms of date authentication).
- When auditing EHRs any printed document/material from an EHR that appears to be missing elements/content must be verified within the EHR system before being scored as out of compliance/not met. An auditor must verify information within the EHR using an auditor login when available, or through a designated entity staff logging into the system so that information can be visually verified by the auditor.
- The Records Management and Documentation Manual (RMDM) is designed to serve as a resource/supplemental guide for entities in the provision of MH/IDD/TBI/SU services. However, the RMDM is not a standalone primary source document. The RMDM is incorporated by reference or imbedded in applicable Medicaid and State-funded Clinical Coverage Policy (CCP), DHHS approved alternative service definitions/in-lieu of definitions, as well as contracts between entities and will continue as guidance to assist entities in ensuring consistent, quality documentation of services provided for individuals receiving MH/IDD/TBI/SU services.
- In the event of a conflict between the RMDM and higher authorities, including federal regulations, Medicaid CCP's, State-funded service definition policies, approved alternative/in-lieu-of service definitions, applicable NC Administrative Rules, and NC General Statutes, the applicable policies, rules, and statutes shall take precedence. The RMDM serves as supplemental guidance and is subordinate to these sources unless otherwise specified through written communication by the Department.
- State-funded includes local and county funds only if the payor entity is administering the management of these funds, otherwise the municipality is responsible and will follow applicable record management practices in accordance with Department of Natural and Cultural Resources (DNCR), the Division of Archives and Records.
- Entities are obligated to meet all contractual requirements.
- In circumstances where Federal law(s) are applicable as well as state law(s) to a given area/topic, the more restrictive regulatory authority is recognized.

Entities are responsible for implementing and maintaining a well-managed record-keeping and reporting system within their organizations in order to verify compliance. Documentation in a member or recipient's record must describe the Individual's response to the planned treatment provided over time and support the measurement of progress toward goals and assess the effectiveness of the planned course of treatment on an ongoing basis. In addition, records must be made available for continuity of care, monitoring and auditing purposes to provide documented evidence of accountability for all services rendered. Entities are obligated to document all information required to meet service requirements.

Administrative Requirements

Administrative Record Management

Administrative functions are required per applicable contracts that result in the formation and maintenance of administrative record(s). There are no required formats. Administrative records shall be retained until DHHS provides authorization, upon request by the designated entity, for destruction. Additionally, this is also applicable between entities and providers. Administrative requirements, at a minimum, include the personnel record, evidence of compliance with policies governing the retention and destruction of records, an index of individual's served, and the assignment of a unique identifier (if the entity - issued service record number is not being utilized). The entity must maintain a policy/procedure that ensures for the identification and retrieval of individual service records.

Screening, Triage and Referral

Documentation and Coordination of Standardized Processes for Screening, Triage, and Referral, Registration, Admission, and Discharge is to be documented for any individual that enters the service system through an entity's access unit. This information will be included as part of the administrative record, unless the individual is enrolled in services, and at that time this information becomes part of the full service record.

Personnel Records

Entities must maintain personnel information that identify and verify the required education, licensure, credentials, and other qualifications of those performing the service as specified in the DHHS Clinical Coverage Policies and/or other regulatory authority. This includes evidence and documentation to establish identity and employment eligibility including but not limited to a valid picture identification as well as required criminal background checks and criminal record disclosures as applicable per rule, statute, and evidence. In addition, any sanctions from professional boards and/or the North Carolina Health Care Personnel Registry must be reviewed, when applicable. Personnel information also includes, position descriptions, records of continuing education and training, clinical or administrative supervision, and documentation of supervision plans and activities when supervision is required. These records must be retained according to the records retention schedules.

Record Retention and Disposition

Each entity owns the records that they generate and bears an inherent responsibility for the maintenance and retention of those records at their own expense and in accordance with all applicable federal and state requirements. 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).

Entitles are required to follow the most stringent schedule. Requirements include, but are not limited to:

- APSM 10-6 DHHS Records Retention and Disposition Schedule – DMH/DD/SAS Local Management Entity (LME);
- APSM 10-5 DHHS Records Retention and Disposition Schedule – DMH/DD/SAS Provider Agency;
- North Carolina DHHS Records Retention and Disposition Schedule for Grants;
- DHHS Record Retention Policy;
- Final Rule - 42 CFR Part 2;
- Records Retention and Disposition Schedule – General Records Schedule for Local Government Agencies – NC Department of Natural and Culture Resources – Division of Archives and Records;
- N.C.G.S. § 90-21.5;
- N.C.G.S. § 132;
- 45 CFR Part 164;
- 42 C.F.R. § 438.208(b)(5)
- According to G.S.§121-5 and G.S. §132-8, state and local governmental entities may only destroy public records with the consent of the Department of Natural and Cultural Resources (DNCR), the Division of Archives and Records; and
- For information specific to disposition schedules, a records management analyst through the NC Department of Cultural Resources is available as a designated point of contact.

Record Abandonment

The abandonment of records, or any failure of a designated entity to safeguard the privacy, security, retention, and disposition of records, is a violation of state and federal laws and is subject to legal sanctions and penalties. Appropriate action must be taken, by the designated entity, upon notification of any situation where records have been abandoned, exposed, or susceptible to a privacy or security breach inclusive of an investigation to determine that a violation of health information privacy/security rights has occurred. If a violation is confirmed a formal complaint shall be filed with the Office of Civil Rights (OCR) as mandated by 45 CFR Part 160, Part 162 and Part 164 (HIPAA Privacy and Security Rule) and by Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), P.L. 111-5 of the Health Information Technology for Economic and Clinical Health Act (HITECH Act), and 42 CFR 2.4(a). In the case of violations by an opioid treatment program, 42 CFR 2.4(b), a report is to also be directed to the Substance Abuse and Mental Health Services Administration (SAMHSA)

If determination is made that records have been abandoned, the appropriate entity that serves as the payor for the member/recipient shall take possession of the abandoned records and ensure notification of appropriate authorities to include but not be limited to the relevant national accrediting organization and all DHHS state agencies involved with the associated provider.

Destruction of Records Not Listed in a Schedule

Authorization from DMH/DD/SUS and the Division of Archives and Records shall be secured for destruction of records not listed in a schedule. To obtain authorization for disposal, a "Request for Disposal of Unscheduled Records" form must be completed which can be found in the *Records Retention and Disposition Schedule – General Records Schedule for Local Government Agencies – NC Department of Natural and Culture Resources – Division of Archives and Records.* The North Carolina Department of Natural and Cultural Resources is the only governing authority for the destruction of all records including substance use disorder records.

Transfer of Records when an Entity Dissolves, Merges or Consolidates

Entities are responsible for treatment and safeguarding of all types of service records in the same manner as the original source record. Specifically, all records are to be protected against unauthorized deletions, additions, alterations or destruction. When a payor entity dissolves, the successor organization is obligated to assume responsibility for the dissolved entity's records, electronic/digitized/paper, for the duration of the applicable retention schedule. Key elements of the HIPAA Privacy and Security Rule are applicable. Substance use records are protected by 42 CFR Part 2.

When a service entity within a Network ceases operation, the entity must meet contractual obligations related to a record retention plan that includes storage, custodial responsibility and contact information or copies of records when applicable. This information must be submitted to the payor source.

Data Reporting Requirements

As a function of the contractual relationship of a provider with a payor entity, certain information must be submitted to the payor entity including all pertinent information about each member's entry into, progress within, and exit from the service system. The provider has responsibility of notifying the entity of any changes or updates made, and the entity has responsibility for verifying the accuracy of the information submitted, especially as it relates to the integrity of billing and reimbursement and the submission of such data to the State for federal and state compliance reporting.

Entities are required to submit certain statistical data and information required by DHHS, the General Assembly, and federally funded programs. Specifics are referenced in contracts between entities and DMH/DD/SUS and NC Medicaid.

Consumer Data Warehouse Reporting by Entity

The Consumer Data Warehouse (CDW) is a secure server-based data warehouse owned by DMH/DD/SUS and maintained by NC Department of Information Technology (NCDIT). that contains demographic, clinical, outcome, and satisfaction data regarding individuals receiving mental health, intellectual and developmental disabilities, or substance use services. The data stored in the CDW is used for the planning and evaluation of services as well as meeting the reporting requirements of the Mental Health Block Grant (MHBG) and the Substance Use Prevention, Treatment and Recovery Services Block Grant (SUPTRS). Specific references for CDW include:

- CDW LME-MCO Reporting Requirements, July 1, 2015, Version 2.1; and
- CDW Data Dictionary – Effective 07/01/15 – Version 2.1

The *Consumer Data Warehouse Data Dictionary* is a guide to the technical aspects of the data. Refer to the Reporting Requirements publication as the correct source of requirement information. The dictionary is a reference source only.

CDW requires that the payor entity terminate or discharge the member from CDW after 60 consecutive dates of no billable services.

CDW Enrollment

CDW enrollment is required as follows:

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

The listing above includes the following categories of members/recipients who are served or coordinated through an entity:

- Individuals who are supported through an entity and are provided services directly or through contracted services, DMH/DD/SUS regular funding, single stream funding, waiver entity, or other specialized funding, and for which claims are submitted through NC Tracks, accounted for through Financial Status Reports (FSRs), supported through Non-UCR (Unit Cost Reimbursement) or settlement mechanisms, or other forms of reimbursement, financial assistance, purchase of service, or procurement;
- Individuals who are supported through NC Innovations funding, or those supported through community ICF-IID Program funding;
- Individuals who are admitted to and discharged from DSOHF facilities, including State Hospitals, Alcohol and Drug Abuse Treatment Centers (ADATCs), Developmental Centers, Neuro-Medical Treatment Centers and other state-operated facilities for which the entity has care coordination responsibilities;
- Individuals admitted to and discharged from local community hospital inpatient units (including Three-Way Contracts) and hospital emergency departments for behavioral health services, walk-in crisis services, psychiatric aftercare, mobile crisis management teams, facility-based crisis

centers, withdrawal management (detoxification) facilities, START Teams, respite and crisis respite for which the entity has consumer care coordination responsibilities;

- Individuals who are admitted to and discharged from jails, detention centers, prisons, and other Department of Public Safety correctional facilities, and facilities under the jurisdiction of the Juvenile Justice Section, including Detention Centers and Youth Developmental Centers, and for whom the entity has care coordination responsibilities;
- Individuals served through specialized DMH/DD/SUS resources, such as Traumatic Brain Injury (TBI) funds, Deaf and Hard of Hearing funds, and Homeless funds;
- Individuals served through the DMH/DD/SUS Treatment Accountability for Safer Communities (TASC) Program and the Juvenile Justice SA/MH Partnership Initiative (JJSAMHP, formerly MAJORS Program);
- Individuals served through approved DMH/DD/SUS Alternative Services;
- Individuals served through DMH/DD/SUS Cross Area Service Programs (CASPs); and
- Individuals who are served in licensed Opioid Treatment Programs (OTPs) with services that are funded through Medicaid or other public funds.

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

CDW Enrollment Not Required as Follows

- Individuals served only in non-DMH/DD/SUS, non-NC Medicaid, and non-DSOHF federal, state, regional entity, county or local government-funded or supported services, except for those listed above in the required categories of admission;
- Individuals receiving services supported through Medicaid, and other federal or state funds, or funds expended under a waiver, or other capitated plan, and who are not receiving one or more of the services listed in the previous section under numbers 1-8;
- Individuals receiving non-enhanced services by licensed professionals who are directly enrolled as a Medicaid provider, Medicare, Tricare, or another third-party payer is billed for the service received;
- Individuals served only through Employee Assistance Program (EAP) services that are directed at individuals who do not require treatment for substance use. Such programs are aimed at educating and counseling individuals on substance use providing for designated non-treatment activities to reduce the risk of substance use;
- Individuals served through DMH/DD/SUS Driving While Impaired (DWI), Alcohol and Drug Education Traffic School (ADETS), and Drug Education School (DES) services only, that are exclusively privately supported, covered by private insurance, or self-pay;
- Individuals or family members served only through the DMH/DD/SUS-funded Problem Gambling Program;
- Individuals or family members served only in DMH/DD/SUS-supported HIV Early Intervention Services (EIS);
- Individuals served only in private licensed opioid treatment program services and that are privately supported, covered by private insurance, or self-pay;
- Individuals served indirectly through consultative services only to other providers or caregivers, such as DMH/DD/SUS Health Education and Aging Resource Team (HEART), also known as Gero Teams;

- Individuals served only through arrangements for the delivery of services within other host agencies such as local school districts, local health departments, and primary care physician practices;
- Individuals served only through privately supported sources, covered by private insurance, or self-pay;
- Individuals served only through substance use, mental health, or intellectual or developmental disabilities primary prevention, education, and training sources; and
- Individuals supported only through non-governmental, foundation, business, religious, charitable, fraternal, or other private groups and organization through grants, donations, and other forms of funding or resources.

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Mental Health, Developmental Disabilities and Substance Use Services

Chapter 2: Administration and Management of Clinical Service Records

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.

The service record is the only documented evidence of the quality of care delivered by an entity to a member/recipient. The service record is the legal business record for an entity providing mental health, intellectual/developmental disabilities, traumatic brain injury, or substance use services, and it must be maintained in a manner that follows all applicable regulations, accreditation standards, professional practice standards, and legal standards. As a component of integrated care, all involved service providers must collaborate to ensure continuity of care.

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

A service record may be paper-based, electronically based or a hybrid which contains both paper-based and electronically based records. An electronically based service record is a digitized version of an individual's service record that resides in a system specifically designed to support authorized users by providing accessibility to complete and accurate data, clinical support systems, and links to other sources that help ensure the total integrated care of an individual's treatment. In addition to these resources, electronic record systems track data over time and provide alerts, reminders, and other aids.

Electronic Health Records (EHR) facilitate the sharing of information across authorized users in real time. If any entity utilizes an EHR system, The HITECH Act (The Health Information Technology for Economics and Clinical Health Act) outlines the necessary requirements and expectations. The Centers for Medicaid and Medicare Services (CMS), and the Office of the National Coordinator for Health Information Technology (ONC) have established standards for certifying bona fide EHR systems. ONC maintains a list of EHR technology products that have been tested and found to meet their standards. Medicaid and State-funded entities are responsible for adherence to N.C.G.S. § 90, Article 29B – Statewide Health Information Exchange Act and any appropriate subsequent legislation.

Entities must maintain an accounting, manually or electronically, of a comprehensive list of individuals served inclusive of a unique identifier to facilitate the retrieval of service records as warranted. Entities must have a policy and procedure of this process.

All pertinent information contained in the service record must be clear, concise, timely, comprehensive and accurate. Clinical documentation of physical and behavioral health includes:

- Full accounting of the provision and continuity of services;

- Documented 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;
- Communication among all providers contributing to the individual's care;
- Information used in examining and reviewing the quality of services provided and in promoting recommended or evidence-based services;
- Information to substantiate treatment and services for the reimbursement of services provided;
- Documented evidence of the involvement of the individual to whom the service plan belongs and, when appropriate, the involvement of family members in the individual's treatment/services/supports;
- Assistance in protecting the legal interests of the individual, the entity, and the service practitioner;
- Promotion of compliance with existing rules, regulations, and service delivery requirements;
- Data for research; and
- Data for use in internal training, continuing education, quality assurance, utilization review, and quality improvement.

Auditing the EHR

For any information obtained from an EHR, in printed form, entities must ensure all information requested is provided and reflects actual date of entry (recognizing that printed materials can misrepresent in terms of date authentication).

When auditing EHRs any printed document/material from the EHR that appears to be missing elements/content must be verified within the EHR system before being scored as out of compliance/not met.

An auditor must verify information within the EHR using an auditor login when available or through a designated entity staff logging into the system so that information can be visually verified by the auditor.

Electronic Signatures

According to HIPAA standards an electronic signature is the attribute affixed to an electronic document to bind it to a particular party. No specific technology is mandated by HIPAA. Specific citation is NCGS Chapter 66, Article 40 of The Uniform Electronic Transactions Act (UETA) of 2000.

The NC Department of Health and Human Services follows the guidelines set by federal and state law that pertain to electronic signatures. These regulations govern what constitutes an electronic signature and who may use them. Determinations by the Secretary of State's office can be found on their specific web page.

Policies and procedures, at a minimum, must include:

- Safeguards against unauthorized use of electronic signatures. The policy shall also address sanctions for improper or unauthorized use of electronic signatures;
- Address procedures that must be followed if the application is unavailable;
- Address procedures for the entity to follow when the responsible author is not available to sign documents electronically; and
- Must follow authentication (e.g. signature/date stamp) requirements.

Electronic signature standards are subject to revision based upon state law and/or HIPAA requirements. Entities are responsible for compliance with all such standards and requirements.

Types of Clinical Service Records

There are three distinct types of clinical service records: pending records, modified records, and full clinical service records. However, all service records are subject to the full protections, privacy, and safeguarding practices.

Pending Records

For some services, especially at the point of service entry, the initial documentation is typically maintained in a pending record. 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. A pending record is created when an individual presents for screening for possible services, or when there is insufficient, partial, or incomplete information available, and a full-service record cannot be established. A pending record may be used when there may have been some intervention, such as an initial screening, but the individual is not subsequently enrolled in active mental health, intellectual or developmental disabilities, and substance use services.

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

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

Modified Records

A modified record is a clinical service record that has requirements that are either different from those usually associated with a full clinical service record, or one which contains only certain components of a full-service record. The use of modified records is limited to specific services, and only if there are no other services being provided. When an individual receives additional services, then a full-service record shall be opened, using the same record number, and the modified service record documentation shall be merged into the full-service record.

Full Clinical Service Records

A full clinical service record is one that is used to document the provision of physical and behavioral health 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.

The clinical service record for all MH/IDD/TBI/SU services must include the following information or items as applicable, as well as any other relevant information that would contribute to or address the quality of care for the member:

- Consents:
    - Informed written consent for the entity to provide treatment;
    - Informed written consent or agreement for proposed treatment and plan development – required on the individual's person-centered plan (PCP) or service plan, or a written

statement; stating why such consent could not be obtained (10A NCAC 27G .0205(d)(6));
    - Informed written consent for planned use of restrictive intervention (10A NCAC 27D .0303(b));
    - Written consent granting permission to seek emergency care from a hospital or physician;
    - Acknowledgement of receipt of HIPAA notice of privacy practices;
    - Third-party release (to include private insurance carrier, public benefits and entitlements);
    - Informed written consent for participation in research projects; and
    - Written consent to release information (10A NCAC 26B .0202 and .0203).
- Demographic Information / In Case of Emergency / Advance Directives:
    - Member or Recipient's name (must be on all pages in the service record that are generated by the entity);
    - Service record number, with Medicaid Identification Number (MID), and/or unique identifier if created by the entity;
    - Demographic information in the service record including, but not limited to, the individual's full name (first, middle, last, maiden), contact information, service record number/MID number/unique identifier, if applicable, date of birth, race, gender, address and phone number; marital status, admission date, parent or guardian, if under eighteen (18) or adjudicated incompetent and discharge date when services end;
    - Emergency information which shall include the name, address, and telephone number of the person to be contacted in case of sudden illness or accident; the name, address, and telephone number of the individual's preferred physician; and hospital preference;
    - Advance directives;
    - Health history, risk factors;
    - Documentation of history of mental illness, intellectual or developmental disability, or substance use disorder, according to the DSM-5-TR or any subsequent edition, and the ICD-10-CM or any subsequent edition; and
    - Documentation of medication allergies, other known allergies, and adverse reactions, as well as the absence of known allergies.
- Medications and Lab Documents:
    - Documentation of medications, dosages, medication administration, medication errors in a Medication Administration Record (MAR), per 10A NCAC 27G .0209 Medication Requirements and Publication APSM 30-1, Rules for MH/DD/SA Facilities and Services; including:
        - Medication orders, including orders to self-medicate, as applicable;
        - Requirements for medication review and medication education;
        - Requirements for documenting medication errors; and
        - When applicable, orders for, and copies of lab tests.
- Notification of Rights:
    - Evidence of a written summary of the member/recipient's rights given to the individual/legally responsible person, according to 10A NCAC 27D .0201, and as specified in N.C. G. S. § 122C, Article 3; and
    - Documentation that the member/recipient's rights were explained to the individual/legally responsible person.
- Restrictive Interventions:

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

    - Discharge plans; and
    - Discharge summaries.
- Referral information (sent or received);
- Service notes or grids;
- Incidents: Documentation of incidents, including description of the event, action taken on behalf of the individual, and the individual's condition following the event (NOTE: Completed incident reports are to be filed separately from the service record.)
- Release/disclosure of information including releases received from external entities;
    - 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;
    - Documentation that persons receiving substance use treatment received a written (paper/electronic) summary of federal law and regulations that protect confidentiality of substance use disorder patient records, in accordance with Final Rule 42 CFR 2.22; and
    - Accounting of releases and disclosures of confidential information.
- Legal information and relevant legal documents such as:
    - Letter of guardianship/legally responsible person designation;
    - Healthcare power of attorney;
    - Other correspondence such as:
        - Incoming and outgoing correspondence; and
        - Inclusive of all letters relating to services provided that do not fit into the other mentioned categories.

Service authorizations and reauthorizations are not required to be maintained in the clinical record; however, should be available for audit purposes if requested.

Behavioral Health/IDD Service Array and Documentation Requirements

State service definitions and clinical coverage policies often contain documentation requirements that are specific to individual services. The appropriate reference must be reviewed to ensure compliance with the documentation requirements that may be specific to that service definition/policy.

A complete listing of the State-funded service array for behavioral health/IDD services is posted on the NCDHHS-DMH/IDD/TBI/SU State Funded Service Definitions.

Detailed information regarding the requirements for the array of Medicaid-funded behavioral health/IDD/TBI services are posted on the NCDHHS-NC Medicaid/DHB Program Specific Clinical Coverage Policy webpage.

Forms and Formats

In general, the elements for documenting a particular service are defined by the type of service being provided or within the service definition/policy. Unless specific formats are prescribed, the CCP/service definition policy's documentation requirements may be documented in any format if the essential elements are present.

Abbreviations

To ensure information contained in service records is readily understood by all parties, entities shall develop policy and procedures and/or standard operating practices regarding the development, use, and maintenance of an abbreviation list. Only symbols and abbreviations contained in the entity's abbreviation

list, or abbreviations listed in a standard dictionary and referenced in policy, may be used when entering information in the service record.

Informed Consent

Informed written consent is required per North Carolina General Statutes including, but not limited to consent for treatment, and release of information, as well as other treatment measures. Any consent must be included in the service record of the member.

References for Consent for Treatment as Applicable for Entity Types:

- 10A NCAC 27D.0303 (a) – Informed Consent
- NCGS §122C – 57(a) – Right to Treatment and Consent to Treatment
- 10A NCAC 27G .0205(d)(6) – Written Consent or Agreement to Proposed Treatment Plan
- 10A NCAC 27G .0206 (a)(6) – Emergency Care Written consent to provide (authorized) treatment is obtained prior to treatment services and shall be signed by the individual and/or legally responsible person.
- 10A NCAC 27D .0303(b) Planned Interventions or Other Procedures
- NCGS § Chapter 90-Article 1A – Treatment of Minors

Consent for Research

Research is regulated through the following 10 NCAC 26C 0200 10A NCAC 27G. 0210. For research purposes, written consent, signed by the individual or legally responsible person, shall be obtained to authorize the person's participation as a subject in a research project. The consent shall reflect that the individual or legally responsible person (LRP) has been informed of any potential dangers that may exist, that the conditions of participation are understood, and that the individual has been informed of the right to terminate participation without prejudicing the treatment that is being received. Reference: NC General Statute § 122C-56 – Exceptions; research and planning.

Individualized and Integrated Planning

Person-centered and individualized planning is the foundation for individualized and integrated care. The plan is driven by an individual's Comprehensive Clinical Assessment, that includes preferences, strengths, and needs. Requirements inclusive of specific elements for plans are outlined in State-funded service definitions, Medicaid CCP's, the Person-Centered Planning Instruction Manual as well as 10A NCAC 27G.0205. Additional information for person-centered planning can be found at NCDHHS Person-Centered Planning.

For children and adolescents, there are often special provisions and requirements, and providers are responsible to ensure compliance as applicable.

Discharge Planning

Discharge planning begins at the time of admission for all physical and behavioral health services. The goal of discharge planning focuses on treatment or interventions required to facilitate continued progress of the member.

Service-specific discharge or transition planning requirements are delineated in Clinical Coverage Policies, applicable service definitions, and in statute.

Discharge Summary

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

- The reason for admission;
- Course and progress of the member/recipient in relation to the goals and strategies in the individual PCP or service plan;
- Condition of the individual at discharge;
- Recommendations and arrangements for further services or treatment;
- Final diagnoses; and
- Dated signatures, as appropriate.

When an assigned clinician leaves an organization without completing discharge information, and when closure of the record is warranted, the clinician's supervisor has the sole responsibility of completing the discharge requirements.

The discharge summary shall be completed within 30 days following discharge of the individual. The discharge summary is to be filed in the client service record.

Closure of Records

An open clinical service record is any record where there is some degree of expectation that the member/recipient is currently receiving or may be returning to treatment. Closure of the service record is not the same as discharge reporting to the Consumer Data Warehouse. Entities must adhere to CDW requirements. The clinical service record should be considered closed in the case of death of a member/recipient. Closure should also be considered for individuals who have permanently moved out of state. There is no state requirement that stipulates when or under what conditions a clinical service record must be closed or terminated.

Administrative Closure of Clinical Service Records

Administrative closure of a service record is completed when an assigned clinician has left the employment of an entity/provider and has not completed required discharge documentation for individuals(s) that have met requirements for discharge. There must be documentation in the service record addressing the administrative closure.

In these situations, the supervisor of the former employee has the responsibility for processing the discharge. Each record that is administratively closed must be audited in accordance with the entity's written policies or practices to ensure that all services that were billed were properly documented. If a subsequent 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 in accordance with 42 CFR 401.305.

Privacy and Security of Records

Entities 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 entity's responsibility to follow the most stringent requirements, including the code of ethics of professional licensure. It is the entity'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 member.

Entities shall develop policies and procedures to ensure the privacy and security of service records. Such policies and procedures should address various aspects of health information management, including, but not limited to, how information will be recorded, stored, retrieved, and disseminated, as well as how such information will be protected against loss, theft, destruction, unauthorized access (breach), and natural disasters. The ensuing policies and procedures shall identify the safeguards that have been implemented to mitigate any potential loss or compromise of the integrity of pertinent clinical, service, and non-clinical information (e.g., financial data and personnel records) necessary to document and support service delivery.

All entities subject to the Health Insurance Portability and Accountability Act regulations are responsible for developing policies and procedures to comply with HIPAA Privacy and Security regulations and the Omnibus HIPAA final rule. These regulations are designed to improve the efficiency and effectiveness of the healthcare system by standardizing the interchange of electronic data for specified administrative and financial transactions and implementing provisions from the HITECH and American Recovery and Reinvestment Act (ARRA).

Safeguards

Entities must ensure maintenance of security standards consistent with Federal and State personal health information protected health information (PHI) security standards. In addition, there must be established policies and procedures to reasonably protect against unauthorized uses and disclosures of member and recipient identifying information and to protect against reasonably anticipated threats or hazards to the security of identifying information. These formal policies and procedures must also address areas identified in 42 CFR § 2.16 - Security for Records. Entities must, at minimum be in compliance with the Health Insurance Portability and Accountability Act of 1996, P.L. No.104-191, 110 Stat. 1938 ("HIPAA"), as amended by title All of Division A and title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), P. L. 111-5, the Health Information Technology for Economic and Clinical Health Act (HITECH Act), 45 CFR Parts 160, 162 and 164 (HIPAA Privacy and Security Rule), and N.C.G.S. 122C-52 through 122C-56.

Additional policies and procedures required include, but are not limited to:

- Faxing of confidential information;
- Electronic mail;

- Voice messaging;
- Usage of Electronic Health Records; and
- Short message service (SMS) language, e.g. messaging, text speak, text language, instant messaging, etc.

Confidentiality

Entities are required to comply with all applicable state and federal confidentiality laws, rules and regulations. In addition, entities must have policies and procedure in accordance with The Omnibus HIPAA final rule, in particular Parts 160, 162, and 164, and the state confidentiality laws applicable to mental health, intellectual/developmental disabilities, and substance use service providers' addresses protection of information, release and disclosure of information.

Confidential information will also be protected as follows:

- N.C.G.S. § 122C-51 through 122C-56 and the Confidentiality Rules, codified in 10A NCAC 26B (Division publication APSM 45-1, updated 1/1/05 (and any subsequent revisions);
- 42 CFR, Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records;
- 42 U.S.C. §290dd-2 – Confidentiality of Records;
- Information relative to individuals with AIDS or related conditions – G.S. § 130A-143; and
- The Health Information Technology for Economics and Clinical Health Act.

Special Situations Regarding Disclosure of Information

Care Coordination

Coordination of care requires seamless transition for the member/recipient and is the responsibility of the service providers involved. Except for substance use disorder information, the Omnibus HIPAA final rule and the state confidentiality law permit the sharing of individual's service information for purposes of coordinating care and treatment without the member/recipient's written consent or authorization. Under the Omnibus HIPAA final rule, a covered entity may use or disclose protected health information (PHI) for its own treatment activities or the treatment activities of another health care provider. Authorization is not needed when sharing information for these purposes' however, requirements of N.C.G.S. § 122C-55(a)7 apply (See 164.506(c)(1) and (2) and HIPAA definition of "treatment" to understand the scope of activities subject to this rule). Under N.C.G.S. § 122C, mental health, developmental disabilities, or substance use service programs that are operated by or are under contract with an entity or are a part of a state-operated facility, may share confidential information regarding program service to members/recipients when necessary to coordinate appropriate and effective care, treatment, or habilitation of the individual. Consent of the individual receiving service is not needed for this information exchange (N.C.G.S. § 122C-3(14) and 122C-55(a)), however, requirements of N.C.G.S. § 122C-55(a)7 apply.

Juvenile Justice

Multiple-party Consents for Release and Exchange of Information are available through the Department of Public Safety and Juvenile Justice Section website, Juvenile Justice - Behavioral Health Consent for Release of Information | NC DPS. Information regarding the documents can also be found in North Carolina Juvenile Justice – Behavioral Health Information Sharing Guide on the UNC School of Government's website.

Substance Use Information

The federal law governing substance use disorder treatment information requires the individual's written authorization before an entity, covered under the law may disclose information to other treatment providers.

In the absence of written consent, court order or other allowable exceptions sufficient to comply with 42 CFR Part 2 (Confidentiality of Alcohol and Drug Abuse Patient Records), entities must redact all identifying information from records involving alcohol or drug abuse when sharing with other entities, etc. Please see 42 CFR Part 2 for further guidance.

Payers/Insurers

Service entities may without the member's consent, exchange confidential information regarding its service recipients with the entity when necessary to conduct payment activities (Refer to G.S. § 122C-55(a2)(a3).

A mental health, intellectual or developmental disabilities, traumatic brain injury, and substance use service provider, or entity must obtain the member's written authorization to disclose substance use service recipient identifying information to a third party.

Special Circumstances

Certain disclosures are allowed where there may be a need to avert a serious threat to the health and safety of the person or the public. Reference applicable state and federal laws and DHHS policy.

Documentation Requirements when Disclosing Information

The following rules regarding consent or authorization to disclose information apply to the information governed by all three confidentiality laws (see Confidentiality section).

- The authorization must be in writing;
- The member's authorization must be *voluntary*;
- The member'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;
- An authorization to disclose confidential information *permits*, but does not require, the covered entity to disclose the information. (Disclosure is mandatory only when the individual requests disclosure to an attorney. See N.C.G.S. § 122C-53(i).);
- When a covered entity obtains or receives an authorization for the disclosure of information, any disclosure must be consistent with the authorization. This means that covered entities are bound by the statements provided in the authorization; and
- A member may revoke the authorization at any time except to the extent that the covered entity has taken action in reliance on the authorization.

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

- Verify the identity of the person requesting PHI as required in the DHHS Privacy Manual 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;
- Obtain any documentation, statements, or representations that are required by the Omnibus HIPAA final rules from the person requesting the PHI;

- Make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request (164.502(b)); and
- An accounting of disclosures must be maintained for a minimum of six years, and member/recipients may request a copy. At a minimum, entities must keep an accounting of releases and disclosures 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; and
    - Name of person disclosing the information (not required but recommended).

- Release/disclosure of information from external entities must be contained in the individual's service record to demonstrate disclosure of requested information.

All disclosures or re-disclosures of substance use disorder treatment information must be made in accordance with 42 CFR Part 2.RE-DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Re-disclosure of protected health information is prohibited, except as provided by N.C.G.S. § 122C-53 through N.C.G.S. § 122C-56.

Individual Access to Service Records

North Carolina General Statutes and the Department of Health and Human Services make provisions for the individual and the legally responsible person to access the information contained in one's own service record. However, there are certain circumstances where access to the service record may be limited. When an individual or his or her LRP is granted limited access to the record, proper justification for restricting access to the complete record must be clearly indicated in the service record. Individuals and their legally responsible person have the right to appeal such a determination. Refer to Article 3, Part 1 (Client Rights), Omnibus HIPAA Final Rule, DHHS Policy and Procedure Manual (Privacy and Security) and other statutory/rules as applicable.

Transporting Records

Service records shall only be transported by individuals designated by the entity. This includes any type of record, including but not limited to hard copy, USB, Tablets, CPU, etc. When original service records are removed from the premises, meaningful efforts shall be made to ensure the security of records. When service records are transported, they shall be secured in a locked compartment, and in a manner to protect the service record from unauthorized access. Policies and procedures shall be developed by the appropriate entity, that includes, at a minimum, what occurs if information is lost or stolen and circumstances of transport.

Storage and Maintenance of Service Records

Service records shall be stored and maintained in a manner consistent with the principles and rules of privacy and security in accordance with applicable laws and rules. *Managing Public Records Produced by Information Technology Systems*, developed by the Government Records Section (part of the Division of Archives and Records, NC Department of Natural and Cultural Resources), contains guidelines regarding the development and monitoring of electronic records. All entities that maintain electronic

records should conduct a self-warranty process. Information can be accessed through the NC State Archives website.

Chapter 4: Clinical Assessments and Evaluations

A Comprehensive Clinical Assessment (CCA) by a licensed professional is required prior to service delivery except when there is a current CCA on file, and there has not been a substantive change in the individual's condition since the last CCA was completed, or in situations when this prerequisite would impede access to crisis or other emergency services. The purpose of a CCA is to provide necessary and relevant clinical data, and recommendations that are utilized in the development of the PCP or service plan. Upon completion of the CCA, when services other than outpatient treatment/medication management only are recommended, the clinician should work directly with other involved service providers to identify goals and needed services, natural supports, and planning crisis prevention strategies. Requirements for clinical evaluations and assessments, including re-assessments are outlined in Medicaid clinical coverage policies and State-funded service definition policies.

Required Elements of a Comprehensive Clinical Assessment

The format of a CCA is determined by the individual provider, based on the clinical presentation. Although a CCA does not have a designated format, the assessment (or collective assessments) used must contain all the following elements:

- Description of the presenting problems, including source of distress, precipitating events, and associated problems or symptoms;
- Chronological general health, past trauma history and behavioral health history (consisting of mental health and substance (including tobacco use) of the individual's symptoms, treatment, and treatment response;
- Current medications for medical, psychiatric, and substance use disorder treatment; including identification of past medications that were ineffective or caused significant side effects or adverse reactions;
- A review of biological, psychological, familial, social, developmental, and environmental dimensions to identify strengths, needs, and risks in each area;
- Evidence of beneficiary and legally responsible person's (if applicable) participation in the assessment;
- Analysis and interpretation of the assessment information with an appropriate case formulation, consisting of a determination of the American Society or Addiction Medicine (ASAM) level of care when a substance use disorder is present;
- Diagnoses using the DSM-5-TR, or any subsequent editions of this reference material, consisting of mental health, substance use disorders, or intellectual and developmental disabilities, as well as physical health conditions and functional impairment;
- Recommendations for additional assessments, services, support, or treatment based on the results of the CCA; and
- The CCA must be signed and dated by the licensed professional completing the assessment.

Emergency Situations

As outlined in DHB Clinical Coverage Policy 8-C and the DMH/DD/SUS State-funded Outpatient Behavioral Health Services, in cases of emergency (psychotherapy for crisis), or during the first six (6) outpatient therapy sessions delivered by entities of integrated medical and behavioral health services, or when medical providers are billing E/M codes for medication management, the following domains must be included in the health record until a CCA is completed:

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

Age and Disability-Specific Guidelines for the Comprehensive Clinical Assessment

As part of the CCA, entities are required to utilize tools/assessments that are recognized as clinical best practice. Further, as indicated, any tools/assessments, as approved by the State of NC, must be utilized in accordance with the service.

Services for Children and Youth

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

- Address the prior existence and effort of the Child and Family Team, (when applicable);
- If the family is new to services, or if the child is referred to an enhanced service, a recommendation to convene a Child and Family Team meeting with the family and qualified professional;
- Assess the strengths of the child or youth and family members, preferably utilizing a strengths-based assessment tool; and
- Utilize information such as reports from previous psychological testing and/or Individual Education Plans (IEPs), if available.

Adult Mental Health Services

In addition, the assessment should address the following life domains:

- Employment/education history and current pursuits;
- Trauma history;
- Cultural/religious/spiritual considerations; and
- Hobbies and other special interests.

The assessment should incorporate principles of psychoeducation, wellness and recovery, and empowerment in developing a collaborative partnership with the individual during the diagnostic process.

Intellectual, Developmental Disability, or Traumatic Brain Injury Services

Intellectual, developmental disability, and moderate to severe traumatic brain injury are life-long conditions often with complex profiles that require the focus of the assessment be on identifying the

person's current functioning status and the supports needed to achieve and maintain maximum independence.

Assessments that may be warranted include, but are not limited to:

- Intellectual functioning
- Psychiatric
- Current level of adaptive functioning
- Physical examination
- Educational/vocational
- Physical therapy
- Occupational therapy
- Speech language/augmentative communication

Reassessment must occur as indicated by an individual's need or in accordance with standard operating practices of the designated entities.

The North Carolina Support Needs Assessment Profile (NC-SNAP) and the Supports Intensity Scale® (SIS) are two tools used to assess the level of services and supports needed by an individual based on their level of functioning.

Substance Use Services

The information gathered in the CCA or Diagnostic Assessment (DA) should be utilized to determine the appropriate level of care using the current edition of ASAM Criteria – Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. A determination of ASAM level of care when a substance use disorder is present is required for both the CCA and DA for children/adolescents and adults.

Service Specific Considerations and other Required Instruments for Assessments

Driving While Impaired (DWI) Assessment

DWI-related assessments must be conducted by service providers who are authorized to provide DWI services by DMH/DD/SUS, pursuant to N.C.G.S. § 122C-142.1.

Specific documentation for DWI-related assessments include:

- Standardized test from the approved list maintained by DMH/DD/SUS;
- Clinical, multidimensional, face-to-face interview;
- Review of individual's complete driving history from the Department of Motor Vehicles (DMV);
- Blood alcohol content verification;
- Diagnosis according to DMS-5 (or any subsequent edition);
- ASAM criteria;
- Written consent for release of information;
- Notice of provider choice;
- Notice of Recommendations and Requirements for driver's license reinstatement; and

- DMH/DD/SUS Certificate of Completion 508 form submission via web-based E508 system.

Alcohol and Drug Education Traffic School (ADETS)

Documentation for Alcohol and Drug Education Traffic School records includes:

- Evidence of orientation and review of information regarding the initial assessment to determine eligibility to attend school, including driving record, documentation of blood/breath alcohol concentration (BAC), and review of diagnostic criteria according to the DSM-5-TR or any subsequent edition of this reference material;
- The appropriateness of the referral to a treatment resource (if applicable);
- A copy of the E508, Certificate of Completion Form;
- A service agreement explaining the requirements for reinstatement of the driver's license, including duration of course work and fees, attendance policy, student contacts and other relevant transactions, i.e., referrals, and/or non-compliance issues and outcomes;
- Evidence of 16 hours of participation in the DMH/DD/SUS approved program, in sequential order, indicating the dates/times of class participation; receipt of a workbook;
- Pre-test and post-test scores; and
- A copy of a signed authorization for release of information, giving the facility permission to report the student's progress to DMH/DD/SUS, Division of Motor Vehicles, and other agencies, as needed.

Record Retention for DWI and ADETS

All assessment and clinical records for DWI Services should be maintained by the agency for 11 years following discharge – 10A NCAC 13B .3903. However, the agency shall retain a copy of the 508-R form for a minimum period of at least 5 years – 10A NCAC 27G .3811.

Withdrawal Management (Detoxification) Services

Detoxification rating scale tables, e.g., Clinical Institute Withdrawal Assessment for Alcohol, Revised (CIWA-Are), and flow sheets, which include tabulation of vital signs, are to be used as needed, or any other nationally normed scale.

Drug Education School (DES)

Documentation for school records in Drug Education Schools shall include:

- Documentation of an initial assessment completed by a person who is authorized to provide substance use assessments by their licensing agency;
- Information regarding the initial assessment to determine eligibility to attend school;
- Determination of appropriateness of the referral to a treatment resource (if applicable);
- Copy of Form DMH-4401, Drug Education School Completion form;
- Documentation of other relevant transactions and student contacts, i.e., referral to another county and/or non-compliance issues and outcomes;
- Copies of pre and post-tests; and
- Homework assignments, if any.

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

recipient. Once a student becomes a treatment service recipient, a service record shall be opened, and the staff will incorporate the DES record into the service record. Refer to the appropriate DHHS webpage(s) and the North Carolina Drug Education School Program webpage.

Juvenile Justice Behavioral Health Partnership Initiative

Various standardized assessments are available for persons working with youth who enter the juvenile justice system in order to determine the presence of a substance use, mental health, or co-occurring disorders. Examples of standardized assessment tools are listed on the Division of Public Safety's (DPS's) website. Entities/providers should confirm with the individual's home entity that the assessment tools listed on the DPS website will suffice as a Comprehensive Clinical Assessment.

NC-SNAP for Individuals with Intellectual or Developmental Disabilities

The North Carolina Support Needs Assessment Profile (NC-SNAP) is a protocol used to assess the level of intensity of services and supports needed by a person with intellectual or developmental disabilities. Either the NC-SNAP or the SIS is required for all individuals with intellectual or developmental disabilities, regardless of whether the services they are receiving are Medicaid or Non -Medicaid. The NC-SNAP is not a diagnostic tool. 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, refer to NCDHHS– NC SNAP website (NC Support Needs Assessment Profile).

Supports Intensity Scale® (SIS) for Individuals with Intellectual or Developmental Disabilities

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

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

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

For more detailed information and resources related to the SIS, refer to NCDHHS NC Innovations Supports Intensity Scale website.

North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS)

NC-TOPPS is the program by which DHHS measures outcomes and performance. It must be completed in a face-to-face interview by the qualified professional responsible for the development and implementation of the Person-Centered Plan/service plan with the individual receiving a qualifying mental health or substance use service. NC-TOPPS is administered as a regular part of developing and updating an individual's PCP to capture key information on a member/recipient'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 entities in their responsibility for monitoring treatment services. Support materials and data entry can be found on the NC DHHS NC Treatment Outcomes and Program Performance System (NC-TOPPS) web page.

Treatment Accountability for Safer Communities (TASC)

TASC's role and function include assessing for substance use disorders and screening for mental health issues in the criminal justice population, matching offenders to appropriate services, ensuring placement, and monitoring, and reporting on all progress. The procedures and guidelines specified in the *TASC Standard Operating Procedures Manual*, revised June 30, 2007, shall be followed regarding additional documentation requirements.

The assessment process for TASC includes a structured interview and a standardized instrument. The entity cannot bill for court-ordered assessments that require the consumer to pay. The information collected and documented includes demographics, employment, education, legal issues, drug/alcohol use, family/social relationships, family history, medical status, psychiatric status, mental health screening, diagnostic impression according to the DSM-5 or any subsequent edition, ASAM American Society for Addition Medicine) Criteria, assessment outcome, and staff signature and credentials.

Work First /Child Protective Service (CPS) Substance Use Initiative

The Alcohol Use Disorders Identification Test (AUDIT) and Drug Abuse Screening Test (DAST-10) shall be used for screening alcohol and drug use disorders for all adult Work First applicants/recipients by the Department of Social Services (DSS) worker only. An assessment for substance use disorders is required for all Work First applicants/recipients who are found to be high risk on the AUDIT screening and is administered by a Qualified Professional in Substance Abuse (QPSA). An assessment for substance use disorders for all Food and Nutrition Services (FNS) applicants who have had a Class H, or I Controlled Substance Felony since 1996 is required and is administered by a QPSA. The assessment utilized by the QPSA should be a comprehensive clinical assessment (CCA) unless the QPSA is not credentialed to do so. In the case that the QPSA lacks the credential to complete a CCA, then the current version of the Substance Use Disorders Diagnostic Schedule (SUDDS), or other standardized assessment tool designated or approved by DMH/DD/SUS, is used for this population. If treatment is indicated as a result of the CCA or the assessment tool used, the QPSA refers the individual to treatment. The QPSA is responsible for tracking and communicating with DSS, the individual's participation in treatment with corresponding releases of information. An overview of the Work First/CPS SU Initiative can be found on the Work First/CPS Substance Use Initiative webpage.

Individuals the QPSA provides services to under this Initiative, shall have a modified record. Components of the modified record shall include a CCA, when applicable. It shall also include:

- Referral information, sent or received;
- Service notes or grids: authenticated by the person who provided the service, which include interventions, treatment, effectiveness, progress toward goals, service coordination and other case management activities, and other related information;
- Incidents: documentation of incidents, including description of the event, action taken on behalf of the individual, and the individual's condition following the event (NOTE: completed incident reports are to be filed separately from the modified service record);
- Release/disclosure of information;
    - Documentation of written notice given to the individual/legally responsible person upon admission that disclosure may be made of pertinent confidential information without his or her expressed consent, in accordance with G. S. §122C-52 through 122C-56;

- Documentation that persons receiving substance use disorder treatment received a written (paper/electronic) summary of federal law and regulations that protect confidentiality of substance use disorder patient records, in accordance with Final Rule 42 CFR 2.22; and
- Log of releases and disclosures of confidential information.

Screening for mental health issues is voluntary. The Emotional Health Inventory (EHI™) is the screening tool used to identify mental health issues. When it is completed through this program, it also becomes part of the record in addition to required tracking of the individual's engagement in treatment. Additional documentation shall include any barriers to services.

Medical Review of the Comprehensive Clinical Assessment

Reference should be made to (Session 2007 - *House Bill 2436, Section 10.15.(w)*) requires that a comprehensive clinical assessment be completed by a licensed clinician prior to service delivery except where this requirement would impede access to crisis or other emergency service.

Written authentication by the licensed professional who signs the service order verifying medical necessity, indicating whether or not he or she:

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

The entity shall notify the licensed professional's occupational licensing board when the licensed professional fails to comply with specified requirements.

Re-Assessments

Re-assessments should occur whenever the need for an update is clinically indicated and is not limited to:

- New behavioral concerns identified;
- Changed or unmet service or treatment needs; and
- Annual review of the individual's service plan.

The current assessment remains valid as long as there has not been a substantive change in the member's clinical profile unless otherwise indicated in the service definition.

When a reassessment results in a change of diagnosis a written report is required. If the re-assessment results in a refinement in the diagnostic formulation based on additional information or observations made which do not result in a change in diagnosis, a clinical note is sufficient.

Individualized and Integrated Person-Centered Planning

Person-centered planning is the foundation for individualized and integrated care. The plan (e.g. ISP, PCP, service plan) is driven by the comprehensive clinical assessment (as appropriate) as well as the preferences, strengths, and needs of the individual. Requirements inclusive of specific elements for plans are outlined in service definitions, clinical coverage policies and the DHHS Person Centered Planning Guidance Document as well as 10A NCAC 27G.0205. Medication Management does not require a service plan/person-centered plan.

Medical Necessity

Medical necessity is established by an assessment of the member's needs by a professional who is licensed or certified to diagnose mental health, intellectual and developmental disabilities, and/or substance use issues, based on diagnostic criteria for services and established best practice and clinical practice guidelines.

For a service to be eligible for reimbursement by Medicaid or State funds, medical necessity must be met in accordance with applicable Medicaid and State-funded policies found on NC Medicaid's Behavioral Health Clinical Coverage Policies webpage and/or DHHS DMH/DD/SUS State-funded Service Definitions web page.

Service Orders

Requirements for service orders are located within the Medicaid funded policies on the NC Medicaid's Behavioral Health Clinical Coverage webpage or NC DHHS Services Definitions web page for State-funded services. In addition, entities must ensure compliance with any applicable federal, state, and local regulations.

There is no standardized form for service orders. Entities and licensed independent practitioner's (LIP) must have a written policy indicating what constitutes a service order and validation of medical necessity when ordering services. Providers of Medicaid and State-funded covered outpatient treatment services must also follow the specific requirements outlined in policy.

Whenever the situation presents the need for a verbal order, there are procedures that must be followed for the verbal order to be valid. Treatment may proceed based on a verbal order by the appropriate professional as long as the verbal order is documented in the individual's service record 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.

Psychological Testing

Psychological testing involves the culturally and linguistically appropriate administration of standardized tests to assess a member/recipient's psychological or cognitive functioning. Testing results shall be utilized to guide treatment selection and treatment planning. For more detailed information on the policy governing psychological testing, refer to either Clinical Coverage Policy 8C, NC Medicaid or the State-funded Outpatient Behavioral Health Services policy.

Service Authorization

When required by State-funded service definition policy, Medicaid clinical coverage policy, or the authorizing entities utilization management policy, requests for authorization are required prior to the initiation of service or for continuation of the service beyond the initial authorization. The service authorization process establishes the provision of a service related to the scope, amount, and duration of a service, based on documented medical necessity. Some limitations regarding service provision are reflected in the State-funded service definitions or Medicaid clinical coverage policies and must be referenced. The process/protocol for authorizations, reauthorizations and end-date reporting for providers, is the responsibility of the authorizing entity.

End-date reporting is service-specific and may occur at any time throughout the course of treatment. When a service is authorized, it covers a specific period. The end-date is the last date service is provided for which a reimbursement claim can be submitted. For Medicaid and State-funded services, providers are required to notify the entity responsible for conducting the utilization review and service authorization when an individual changes providers or ends a service that the entity has authorized. Providers must follow the reporting requirements and protocol specified by the entity for end-dating services.

Medicaid and State-funded Appeals

Medicaid and State-funded service member/recipients have appeal rights when a service has been denied, reduced, suspended, or terminated. Member/recipients are ensured timely and adequate notice, detailed reasons for the decision, and an opportunity to appeal or request a review of the decision. References include: DHHS website (Medicaid) – Right to Appeal Denial of Benefits; State-funded Appeal Process 10A NCAC 27I.600; and Appeals Regarding Utilization Review Decisions for State-funded Services -10A NCAC 27G.7004.

Special Considerations for Admission Requirements

Medical Examinations

There are services for which a medical examination is required for admission. Medical examinations can be performed by a physician or a physician extender. According to N.C.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.” This examination assures that the individual is able to participate in the program. The exam must include the physician’s directions regarding management of the individual’s medical condition(s), if the individual has specific medical issues. The medical examination shall also note the presence of any communicable disease(s) or condition(s) that may present a significant risk for transmission within the program, except as provided in N.C.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 N.C.G.S. §130A-152 (Public Health Statutes: “Immunization Required”). Documentation of such examinations shall become part of the individual’s service record, as well as the physician’s direction regarding management of any identified condition.

Service-specific admission requirements are delineated in Clinical Coverage Policies, applicable service definitions, licensure rules and statute.

Tuberculosis (TB) Screening for Individuals Participating in Substance Use Disorder Treatment Funded by Block Grants

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

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

Based upon an individual's positive responses to symptoms in the screening tool, a referral must be made to the local county health department or the individual's medical practitioner for follow-up testing and care. The completed screening and any required follow up must be documented in the service record.

Child and Adolescent Residential Treatment – Level III & Level IV

Prior to admission to Level III or Level IV residential treatment, there must be a discharge/transition plan developed by the Child and Family Team. This discharge/transition plan must be updated and submitted to the payor entity with each request for service authorization. Child and Adolescent Residential Treatment providers are required to document collaboration with the payor entity and the System of Care (SOC) Coordinator throughout the youth's stay in the residential treatment facility. SOC Coordinators may be required to sign off on the discharge plan.

Psychiatric Residential Treatment Facilities (PRTF)

Federal regulations require the completion of a Certification of Need [CON] form prior to admission to a PRTF facility. The last dated signature on the CON determines the effective date of the CON and authorization for payment and must be maintained in the record. Specific requirements are contained in *NC Medicaid Clinical Coverage Policy 8 -D-1.*

Service notes serve as supporting evidence of individual outcomes. Service notes document the individual's ongoing progress and response to interventions, treatments, and supports progress, or lack thereof. Evidence that an individual has achieved their service/treatment outcomes as indicated in the plan (e.g. who, what, when, where, why and how), and interventions that support those outcomes. Service notes also reflect significant events that occur in the individual's life that may affect progress during the course of services. This would include coordination and case management activities, for both Medicaid and State-funded services that may occur on behalf of an individual. The descriptions of the interventions, treatment, and supports provided must address the goal(s) listed in the service plan, however, there may be situations that necessitate a note where support/service was rendered that addressed an immediate/urgent need to avoid/avert a crisis.

Documentation and service notes are based on separate and unique events, and/or interventions that must be specific and individualized. Service notes must accurately reflect the service provided per session, and each note requires its own newly composed evidence of the service provided. Documentation that has been photocopied from an earlier service date or from another person's service record with a new date put in its place, or handwritten exactly, or almost exactly, as an earlier service note, or from what appears verbatim another person's service record, is not acceptable as an individualized service note.

If reference is made to another individual in the record, the other person may be referenced by using his or her initials, record number, letters/numbers, or role in the person's life etc.

The use of the names of non-service member/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 if the extent and type of relationship and specific influence are also included. When non-service member/recipient names are included, such information should be reviewed prior to release to determine whether the information should be disclosed or redacted.

Specific to Medicaid and State-funded services, in the case of conflict between Medicaid CCP/State Service Definition Policy, Administrative Rule, Records Management and Documentation (RMDM), etc., the guidance in the CCP/State Service Definition will be the primary point of reference unless further communication has been issued by the Department.

General Documentation Do's and Don'ts

Do enter information that is:

- Accurate – Document the facts as observed or reported.
- Timely – Record significant information at the time of the event, since delays may result in inaccurate or incomplete information.

- Objective – Avoid drawing conclusions. When a professional opinion is expressed, it must be phrased to indicate clearly that it is the view of the recorder.
- Specific, Concise, and Descriptive – Record in detail rather than in general terms; be brief and meaningful without sacrificing essential facts. Thoroughly describe observations and other pertinent information.
- Consistent – Explain any contradictions and give the reason for the contradiction.
- Comprehensive, Logical, and Reflective of Thought Processes – Record significant information relative to an individual's condition and course of treatment or habilitation.
- Clear – Record meaningful information and write in non-technical terms when possible.
- Inclusive of follow-up care, calls, or contacts, ensuring that unresolved problems from previous contacts are subsequently addressed, and recording plans for next contact (date/time), etc.
- Person-centered – Use person first language when describing individuals, behavioral characteristics, treatment, events, and all other information that produces a picture of this person, unless the person has communicated a preference otherwise.

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

Don't enter information that:

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

Timelines for Service Documentation

For facility-based services, i.e. all licensed services, when an individual receives a service in a licensed site, the person who provided the service shall document at the time of service or within one standard business day (not to exceed 24 hours) of the staff delivering the service.

For community-based outpatient services, when an individual receives a service, the person who provided the service shall document at the time of service or within three standard business days (not to exceed 72 hours) of the staff delivering the service.

When an individual receives a community-based habilitative services, i.e., encompasses any service that does not occur in a licensed facility, the person providing the service shall document at the time of service or within two standard business days (not to exceed 48 hours) of delivering the service.

Certain categories of services that do not require a daily service note, e.g. weekly, monthly, quarterly notes, are to be written/dictated at the close of a designated service period, or within three standard business days of the service period. These services are denoted in the individual service definition.

Late Entries

Late entries are defined as those that are entered after the required time for documentation has expired and must be reflected as such. All late entries must be marked as such and must include a dated signature. Entries that exceed the established timeline for documentation can only be billed up to seven business days beyond the service date. When a service note or grid is documented after the seven-day period has lapsed, it is not billable and must not be submitted for reimbursement by the payor.

Contents of a Full Service Note

A service note, at a minimum, must include:

- Name of the individual receiving the service;
- Either the service record number of the individual issued by the payor along with the Medicaid Identification Number (as applicable), or unique identifier issued by the entity;
- Full date the service was provided (month/day/year);
- Name of the service provided;
- Type of contact (in person, telehealth, telephonic, collateral);
- Place of service;
- Purpose of the contact (tied to the specific goals in the plan);
- Description of the interventions, treatment, and support provided;
- Duration: the total amount of time spent performing the service that must include active engagement of the individual as it relates to the goals and strategies. It must accurately reflect treatment for all time indicated for the service unless the service is event and/or per diem basis. For services billed/reimbursed as event and/or per diem basis, the total amount of time spent completing the services is not required. The duration of service, as submitted for billing purposes, must match what is reflected on the service grid/ note. An entity can opt to reflect time in/out for services billed on an event/per diem basis, but it is not required. The interventions described in the service grid/note, must accurately reflect and support the treatment provided for the event/per diem. All services must meet requirements outlined in the relevant Medicaid Clinical Coverage Policy, Medicaid State Plan, or State-funded MH/IDD/TBI/SU service definitions;
- Effectiveness of the intervention(s), treatment, or support provided, and the individual's response/progress toward goal(s);
- Electronic service note authentication (e.g., electronic signature date stamp and credentials) is required by the person who provided the service and must be reflected on the date the person authenticates the document. The use of a cursive font in a Microsoft Word document is not a valid electronic signature. All service notes must be in accordance with relevant Medicaid Clinical Coverage Policy, Medicaid State Plan, or State-funded MH/IDD/TBI/SU service definitions. All entities utilizing an EHR system must develop a standard operating procedure on the use of electronic records, and ensure compliance with the North Carolina Health Information Exchange Authority (NC HIEA) called the NC Health Connex; and
- Additional service note requirements as outlined by Medicaid clinical coverage policy or State-funded service definition must be followed.

Program, Intervention, and Evaluation (PIE) elements are part of the full service note, but all required elements, reflected in this section, must be included for billing and audit purposes. For paper records, handwritten signatures require a handwritten date by the signatory.

Service Notes When Providing Group Therapy

Services provided to a group of individuals requires a full service note for every person in the group receiving the service and must contain all the required elements. Description of the interventions for a group may be the same for all group members; however, the effectiveness and member's response must be addressed individually in the note.

Service Notes When Provided by a Team

When the same discrete service or intervention is provided to an individual by more than one staff at the same time, only one of the team members who provided the service is required to document the service note. The service note must document the interdisciplinary team's review and discussion of assessment as well as include the names and title/position of the other participating staff members.

Service Notes Provided by Multiple Practitioners

For services where multiple team members or practitioners provide different types of treatment to an individual, each service provider shall document a separate note in the service record for each discrete service, treatment, or intervention provided.

Shift Notes

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

- Due to the nature of twenty-four-hour services, there may be a shift when an intervention does not occur (e.g., individual asleep or at school). In those situations, a shift note should reflect the care, oversight, support and non-treatment events that occur during the shift; and
- When more than one staff person is providing services for a shift only one staff person is required to document and sign the shift note. The note must identify the names of other staff persons present to reflect staff ratios are met.

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 a mental illness, intellectual or developmental disability, or substance-related issue, as defined in APSM 30-1, *Rules for MD/DD/SA Facilities and Services, 10A North Carolina Administrative Code 27G,* and as outlined in the service definition requirements and/or Clinical Coverage Policy. For all periodic services, the frequency requirements for entering service notes is per date of service, when the service is provided. Due to continued service changes within the system, **the list below may not be all inclusive**; however, the entity is responsible for ensuring documentation requirements are met for any services that meet the definition of a periodic service such as:

- Intensive In-Home Services;
- Community Support Team;
- Mobile Crisis Management;
- Multi-Systemic Therapy;
- Peer Support Services;
- Outpatient Opioid Treatment (see Service Specific Considerations);

- Research-Based Behavioral Health Treatment (RH-BHT);
- Crisis Services – (NC Innovations);
- Community Navigator – (NC Innovations);
- Community Networking – (NC Innovations);
- Individual Directed Goods and Services – (NC Innovations);
- Natural Supports Education – (NC Innovations); and
- Specialized Consultative Services – (NC Innovations);

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 30-01, Rules for MH/DD/SUS – 10A North Carolina Administrative Code 27G*) and as outlined in the service definition requirements and/or Clinical Coverage Policy. Due to continued service changes within the system **the list below may not be all inclusive**; however, the entity is responsible for ensuring documentation requirements are met for any services that meet the definition of a day/night service.

The date(s) of attendance shall also be documented in the record for day/night services that includes member name, date, and indicates daily attendance in hours or units. In addition to a full service note unless the service is specified as allowing a modified note and/or grid when documenting day/night services:

- The following day/night services shall be documented <u>per date of service</u>:
    - Child and Adolescent Day Treatment;
    - Community Living and Support - (NC Innovations);
    - Day Supports (State-funded);
    - Day Supports (NC Innovations);
    - Substance Abuse Intensive Outpatient Program; and
    - Substance Abuse Comprehensive Outpatient Treatment;
    - Supported Employment – (NC Innovations); and
    - Supported Living – (NC Innovations);
- Psychosocial Rehabilitation and Partial Hospitalization shall be documented on a <u>weekly</u> basis.
- The following day/night services shall be documented on a <u>quarterly</u> basis:
    - Adult Developmental Vocational Program (ADVP) (State-funded);
    - Community Rehabilitation Program (State-funded);
    - Day/Evening Activity (State-funded);
    - Developmental Day (including Before/After School and Summered Day) (State-funded);
    - Long-Term Vocational Support Services (Extended Services) (State-funded); and
    - I/DD Supported Employment – (State-funded).

For day/night services requiring a date of service (DOS)/weekly/monthly/quarterly note, but billed in 15-minute increments, the total amount of time spent performing the service per day must be documented in the service record. For each date of service note, the total time is to be in the note. For weekly and quarterly notes, this information may be indicated with the attendance information or included in the notes.

If the duration of services is less than the above noted frequency, a service note shall be documented for the period that the member received the service. A daily note is not required.

Twenty-Four Hour Services

A twenty-four-hour service is a service provided to an individual on a twenty-four-hour continuous basis, as defined in *APSM 30-1, Rules for MH/DD/SA Facilities and Services, 10A North Carolina Administrative Code 27G* as outlined in the service definition requirements and/or Clinical Coverage Policy. Due to continued service changes within the system, the list below, may not be all inclusive; however, the entity is responsible for ensuring documentation requirements are met for any services that meet the definition of a twenty-four service.

The following twenty-four-hour services shall be documented according to the minimum frequency requirements as specified below in a full-service note, unless otherwise specified:

- Child and Adolescent Residential Treatment – Level I/Family Type: Daily;
- Child and Adolescent Residential Treatment – Level II, Family Type (also known as Therapeutic Foster Care): Per date of service; *(may use service note or grid)*;
- Child and Adolescent Residential Treatment – Level II, Program Type: Daily;
- Child and Adolescent Residential Treatment – Level III, including wilderness camp: Per shift;
- Child and Adolescent Residential Treatment – Level IV: Per shift;
- Family Living: Monthly, or duration of stay if less than a month; a daily note is not required;
- Facility Based Crisis – Medicaid – at a minimum, a full service note per shift by nursing staff and a full service note per intervention per date of service;
- Professional Treatment Service in Facility-Based Crisis Program – (Non- Medicaid) – Minimum of a service note per shift;
- Group Living: Monthly, or duration of stay if less than a month; a daily note is not required;
- Independent Living: Monthly, or duration of stay if less than a month; a daily note is note required;
- Inpatient Behavioral Health Services (State-funded): Shift note for every eight (8) hours of service provided;
- SA Medically Monitored Community Residential Treatment; Daily service note;
- Ambulatory Withdrawal Management without Extended Oversight and Medically Monitored Inpatient Withdrawal Management: Per date of service; includes additional elements for documentation as outlined in the service definition;
- Professional Treatment Services in a Facility-Based Crisis Program: Daily service note per shift;
- Psychiatric Residential Treatment Facility (PRTF): Per shift;
- Residential Supports (State-funded): Monthly, or duration of stay if less than a month; a daily note is not required;
- Residential Supports (NC Innovations): Grid must be completed daily or per activity to the service provided;
- Residential Treatment/Rehabilitation for Individuals with Substance Use Disorders: Per shift; and requires additional documentation elements as outlined in the service definition;
- Respite: (NC Innovations and State-funded): Per date of service, which may be documented on a modified service note, a service grid, or a combination of the two. If using a modified service note, or a combination of a modified note and a service grid, documentation frequency is per date of service, if the duration of the service was no longer than a day. If longer than a day documentation shall be for the duration of the event, but not less than weekly. Institutional Respite is documented per State Developmental Center documentation requirements;
- Social Setting Detoxification: Shift note for every eight (8) hours of service provided;
- Social Setting Detoxification requires additional elements for documentation as outlined in the service definition;

- Substance Abuse Halfway House: Per date of service (daily service note); and
- Supervised Living: Monthly, or duration of stay if less than a month; a daily note is not required.

Significant events in a member/recipient's life that require additional activities or interventions shall be documented over and above the minimum frequency requirements. **Medicaid clinical coverage policies and State-funded service definitions should be consulted for any additional or revised documentation requirements.**

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

- The note shall be identified as a late entry; it shall include the date the documentation was made and the date that the documentation should have been entered, i.e., closing date of service period. For example, “Late Entry made on 4/3/24 for service provided on 3/30/24.”
- The late entry service note requires a dated signature.

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

Services Utilizing a Modified Service Note

When allowable in the Medicaid Clinical Coverage Policy/State-funded Service Definition Policy, a modified service note may be used in lieu of a full-service note as described below. However, use of a modified service note for documenting certain services does not release the entity from the responsibility of documenting any unusual or significant responses related to the individual, situation, or including other pertinent updated information.

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

- Name of the individual on each service note page;
- Either the service record number of the individual issued by the payor along with the Medicaid identification number (as applicable), or unique identifier issued by the entity;
- Service provided;
- Date of service - total amount of time spent performing the service that must include active engagement of the individual as it relates to the goals and strategies. It must accurately reflect treatment for all time indicated for the service unless the service is event and/or per diem basis. For services billed/reimbursed as event and/or per diem basis, the total amount of time spent completing the services is not required. The duration of service, as submitted for billing purposes, must match what is reflected on the service grid. An entity can opt to reflect time in/out for services billed on an event/per diem basis, but it is not required. The interventions described in the service note, must accurately reflect/support the treatment for the event/per diem. All services must meet requirements outlined in the relevant Medicaid Clinical Coverage Policy, Medicaid State Plan, or State-funded MH/IDD/TBI/SU Service Definitions;
- Duration of service;
- Goal addressed/tasks performed; and

- Full dated signature and credentials, or initials, if the full signature is included on the page when the use of a grid, attendance log, or checklist is allowed for documenting the service in accordance with record keeping practices/systems.

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

- Opioid Treatment: (see Service Specific Specifications).
- Personal Assistance;
- Personal Care Services: This service may be documented using a modified service note, a service grid, or a combination of a grid/checklist and a modified service note, unless provided by a home care agency that is following the home care licensure rules;
- Respite: This service may be documented using a modified service note, a service grid, or a combination of a grid/checklist and modified service note; or
- Community Respite.

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Service Grids

Specific services outlined below may utilize a service grid. At a minimum, a grid is documented per event, containing the following components:

- Name of the individual on each service note page;
- Either the service record number of the member issued by the payor along with the Medicaid identification number (as applicable), or unique identifier issued by the entity;
- Service provided;
- Date of service;
- Duration of service: Total amount of time spent performing the service that must include active engagement of the member as it relates to the goals and strategies. It must accurately reflect treatment for all time indicated for the service (time in and time out) unless the service is event and/or per diem basis. For services billed/reimbursed as event and/or per diem basis, the total amount of time spent completing the service is not required. The duration of service, as submitted for billing purposes, must match what is reflected on the service grid. An entity can opt to reflect time in/out for services billed on an event/per diem basis, but it is not required. The interventions described in the service note, must accurately reflect/support the treatment for the event/per diem. All services must meet requirements outlined in the relevant Medicaid Clinical Coverage Policy, Medicaid State Plan, State-funded Enhanced Mental Health and Substance Abuse Services, or State-funded MH/IDD/TBI/SU Service Definitions;
- Goals addressed/tasks performed/interventions;
- Full dated signature and credentials (or initials, if the full signature is included on the page when the use of a grid is allowed for documenting the service in accordance with record keeping practices/systems; and
- Any other items required by CCP or service definition and may include effectiveness or assessment of progress with accompanying keys when utilized.

For NC Innovations, a grid includes three additional components:

- A number or letter as specified in the appropriate key that reflects the intervention, activities, and/or tasks performed;
- A number/letter/symbol as specified in the appropriate key that reflects the assessment of the member's progress toward goals; and
- A comment section for entering additional or clarifying information, e.g., to further explain the interventions/activities provided, or to further describe the individual's response to the

interventions provided and progress toward goals. Each entry in the comment section must be dated. If an electronic health record is used, the system must be set up to clearly associate a comment with the correlating goal. Each entry shall have a date associated with it.

For Respite only: comments should be included about any behaviors and special instructions followed.

Services Utilizing a Grid

A grid may only be used for the following services:

- Adult Developmental Vocational Program (ADVP);
- Behavioral Health Prevention Education Services in Selective and Indicated Populations;
- Community Living and Support (NC Innovations);
- Community Networking (NC Innovations);
- Day/Evening Activity;
- Day Supports (NC Innovations and State-funded);
- Drop-In Center;
- Financial Supports
- Individual Supports
- Long-Term Vocational Support Services (extended IDD);
- Residential Supports (NC Innovations and State-funded);
- Respite – all categories including Community Respite, (b)(3) and Innovations except for Institutional Respite, which shall follow the state Developmental Centers' documentation requirements;
- Supported Employment services (NC Innovations, (b)(3), and State-funded) unless noted changes with employment that require a modified note; and
- Supported Living, Supported Living Periodic and Supported Living Transition (NC Innovations)
- Child and Adolescent Residential Treatment – Level II, Family Type (also known as Therapeutic Foster Care): Per date of service.

Transmission of Service Notes

It is permissible to fax or email service notes, in accordance with an entity's established policy and procedure, provided that reasonable administrative, technical and physical privacy precautions and safeguards are securely in place to protect the information from inappropriate use or disclosure. In addition, the entity must ensure compliance with *45 CFR § 164.530(c)* and established processes in accordance with applicable regulatory authority to follow in the event of a breach.

Alterations to Service Documentation

Changes or modifications to original documentation for corrective purposes is permitted at any time and shall be in accordance with the service provider's operating processes. Alterations/changes to entries that exceed seven business days beyond the service date are not billable. Minimally, the following must be included in the service provider's procedure guidelines:

- Original entry must not be deleted or altered in such a manner that it is not clearly legible in its original context;
- Corrections, as possible, must be made by the person who initially authored the entry with explanation of the correction, however if this is not possible, the person updating the documentation must reflect needed change and the rationale for such;

- Any change must be signed and dated; and
- The revised/corrected entry must be in proximity to/at or near the original entry as possible.

The above guidelines may be met when an entity utilizes an EHR system that incorporates tracked changes and timestamps.

Authenticating Service Documentation

All entries must be validated via a signature, through EHR or paper copy, and must contain the signature date, appropriate credentials, degree, licensure, and/or title of the person entering information in the service record.

- The use of initials in lieu of a full signature is only permitted when an entry is being updated/corrected, or for notations entered on a service grid. However, a full signature must be noted on the grid signifying appropriate initials;
- When any individual has a documented reason per the Americans with Disabilities Act (ADA) for not being able to sign, then another means for providing the signature is required and acceptable; and
- Accommodations will only be utilized for medical/physical reasons in accordance with ADA guidelines. The process for such must be incorporated in the service providers standard operating practices/policy.

For individuals, parents, LRPs, and other collaterals, providers must ensure standard operating practices/policy that ensures the authentication of the appropriate party. Collateral signature must include date, title and/or relationship to the service recipient.

If the original author for any service entry is no longer available to sign or amend a service entry, a notation reflecting this shall be documented in the service record and signed/dated by the appropriate party.

Pre- or post-dating signatures in any form or circumstance is prohibited.

Utilization of countersignatures must comport to an entities policy/standard operating practice.

Use of Rubber Stamps

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

Special Situations

There are circumstances that occur in the provision of MH/IDD/TBI/SU services that require additional guidance as noted below:

Sex Offender Treatment

When applicable, documentation must include the specific goals of sex offender treatment, and the updated discharge/transition plan.

Therapeutic Leave

Therapeutic Leave as permitted must follow applicable Medicaid Clinical Coverage Policies and/or State-funded Service Definitions.

- Documentation shall reflect the number of days of leave and include verification of the specific therapeutic leave days;
- Documentation related to the therapeutic leave shall include:
    - The length of time for the leave;
    - Justification for each therapeutic leave episode; and
    - A statement regarding the member's condition prior to and after return from the leave;
- Therapeutic leave must be documented in the PCP for residential care; and authorized, as required, by the payor entity. Entities shall keep a cumulative record, which can be a log, of therapeutic leave days taken by each individual for reference and audit purposes.

Documentation of Suspected/Observed Abuse/Neglect/Exploitation

Whenever abuse/neglect/exploitation of an individual is observed, suspected, or reported, relevant facts shall be documented in the service record, including reports made by the individual and actions taken by staff. This does not preclude completion of an incident report and adherence to state law reporting requirements:

- Per G.S. § 7B-301, any person or institution has the duty to report abuse, neglect, dependency, or death due to maltreatment of any juvenile to the Child Protective Services division of the Department of Social Services in the county where the juvenile resides or is found;
- Per G.S. § 108A-102, any person having reasonable cause to believe that a disabled adult is in need of protective services shall report such information to the Adult Protective Services division of the Department of Social Services in the county in which the person resides or is present;
- Per 10A NCAC 27G .0604, Category A and B providers shall submit an incident report to the entity responsible for the catchment area where services are provided, and DMH/DD/SUS (as appropriate for the level of incident) whenever there is an allegation of abuse, neglect, or exploitation of an individual in accordance with the timeframes for submitting the incident report; and
- Per 10A NCAC 27G .0504(c), the entity's Client Rights Committee shall oversee the implementation of client rights protections through a review procedure of cases of alleged abuse, neglect, or exploitation.

Incident Reporting

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. All incident reports must be maintained by the service provider in accordance with the Records Retention and Disposition Schedule, General Records Schedule for Local Government Agencies, NC Department of Natural and Culture Resources, and Division of Archives and Records.

Service providers shall comply with the Death Reporting Requirements specified in 10A NCAC 27G .0201(a)(7)(G) Incident Response, Reporting, and Documentation requirements specified in 10A NCAC 27G.0601, Restrictive Intervention documentation specified in 10A NCAC 27E .0104(e)(9), Client Rights Rules in Community Mental Health, Developmental Disabilities and Substance Abuse Services, APSM 95-2, and General Statute(s) inclusive of 122C-66.

Reports of incidents, including the use of restrictive interventions and deaths, shall be submitted as required above through the web-based North Carolina Incident Response Improvement System (NC-IRIS). The incident submission site, the Incident Response and Reporting Manual, the IRIS Technical Manual, as well as required forms and other information, are available electronically, and can be accessed through DHHS's website.

In Loco Parentis and Consent for Minors

"In loco parentis" refers to an individual who assumes long-term parental status and responsibilities for a minor child without formally obtaining legal recognition of that relationship. Chapter 122C-3(20) of the General Statutes defines a legally responsible person to include a person standing "in loco parentis," meaning someone who is acting on behalf of, or in the role of, a parent. If the person standing "in loco parentis" has documentation of this status, it must be included in the member/recipient's record. However, if there is no recorded documentation, the entity has an obligation to record, in the individual's service record, the stated relationship/role to the minor child.

An individual that acts in a parental role may/will be able to make decisions for the minor child. Service providers are charged with provision of explanation in the service record specific to the responsibility of the person acting "in loco parentis" to include situations where custodial parent(s) are unable to sign required documents.

Individuals acting "in loco parentis" must sign required documents as the legally responsible person on behalf of the child indicating their identify and their relationship to the child.

Signatures of Minors

These laws serve as the policy documents for the issue of the signature of a minor:

- N.C.G.S. § 90-21.5 Minor's consent sufficient for certain medical health services. A 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;
- N.C.G.S "§ 90-21.10B. Parental consent for treatment. (a) Except as otherwise provided in this Article or by court order, a health care practitioner shall not provide, solicit, or arrange treatment for a minor child without first obtaining written or documented consent from that minor child's parent. (b) Except as otherwise provided in this Article or by court order, a health care facility shall not allow treatment to be performed on a minor child in its facility without first obtaining written or documented consent from that minor child's parent. (c) This section does not apply to services provided by a clinical laboratory unless the services are delivered through a direct encounter with the minor child at the clinical laboratory facility.
- N.C.G.S. § 122C-223. Emergency admission to a 24-hour facility. For minors receiving services for a substance use disorder in a non-emergency admission to a twenty-four-hour facility, both the legally responsible person and the minor are required to sign the plan; and
- 42 CFR Part 2 - 2.14. Minor seeking and/or receiving SUD treatment.

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

Service-Specific Considerations

Prevention Education Services for Children and Adolescents in Selective, Indicated and Universal Populations

Providers of Prevention Education Services are required to follow documentation and upload requirements outlined by the state and as required for upload in the Ecco System (Ecco is an online reporting system substance use prevention providers are required to use to report on the progress of state approved community-level strategies).

Additionally, administrative records must be maintained and retained for five years to meet documentation requirements unless there are pending audits or litigation. Additionally, if a Medicaid service has been rendered then the minimum Medicaid retention period would apply. Documentation requirements for the administrative file for parenting and/or youth prevention education includes the following minimum requirements to meet federal funding requirements for SAMHSA:

- Attendance record for each class with date and duration;
- A record of the sessions completed;
- Pre-Test and Post-Test scores, if applicable/available; and
- Curriculum fidelity checklist which contains: Documentation of the sessions completed including number of sessions and the content of the program (what was delivered) that identifies the educational curriculum, and any modifications made per class.

For Parenting Education, the following must be documented: Parent recruitment/retention plan to address ten parents/participants per curriculum be recruited.

If an individual begins to receive other services, a full clinical record must be opened. Prevention documentation would remain in the administrative file versus becoming part of the full clinical record.

Projects for Assistance in Transition from Homelessness (PATH) Program

Modified records for PATH Program must include the following:

- PATH Eligibility Verification form (which also serves as the initial service note);
- Clinical assessment or other documentation listing the diagnosis;
- PATH service plan;
- Full-service notes by individual providing intervention;
- Any referrals made inclusive of date/time/location for next contact;
- Release of Information / Statement of Confidentiality, and NCHMIS release;
- NCHMIS PATH Entry Form;
- PATH Eligibility Verification form (which also serves as the initial service note);
- PATH Discharge Summary form (which also serves as the final service note);
- Security Deposits Assistance (rent/utilities);
- Lease Agreement, when obtained; and
- Utility company letter indicating the amount the individual requires for utility deposits.

Information about the PATH Program and documentation requirements is provided to the PATH Provider Agencies by the NC State PATH Contact.

Opioid Treatment Services

For this service, a full-service note is required for documenting all counseling or therapy sessions, case management activities, health education and for any other significant activities or events, changes in status, or situations outside the scope of medication administration for each contact or intervention for each date of service, written and signed by the person who provided the service is required.

A Medication Administration Record (MAR) or electronic Medication Administration Record (eMAR) shall be used to document each administration of methadone, buprenorphine, naltrexone, or other medication ordered for the treatment of an Opioid Use Disorder (OUD). In addition, this service requires a record of all take-home doses ordered by a program physician, physician assistant or nurse practitioner and prepared for the beneficiary, and each Opioid Treatment Program (OTP) Exception Request and Record of Justification submitted to the State Opioid Treatment Authority and Center for Substance Abuse Treatment under 42CFR § 8.11 (h).

Any of the following occurrences is considered a clinical event and is required to be documented in a full-service note, a modified service note, the MAR with appropriate justification, or physician order:

- A change in medication or medication dose;
- A medication error;
- An adverse reaction to medication;
- A caution or advisory regarding a potential medication interaction;
- An OTP Exception Request and Record of Justification;
- A take-home level change;
- A positive alcohol or drug screening result including non-prescribed medications;
- Outcome of a bottle call-back or pill count;
- Any findings for the individual from an OTP query of the NC Controlled Substance Reporting System or other state prescription monitoring program;
- A report of possible medication diversion;
- A concern regarding safe medication storage;
- An event related to instability or non-compliance with program requirements, including required program attendance and adherence with behavioral expectations in the clinic setting;
- Change in medical status; and
- Provision of naloxone rescue kit and education.

Any findings, service/support rendered, changes in the individual’s condition, and response to treatment/interventions/habilitation.