



Licensed Independent Practitioner

Collaborative Webinar

August 9, 2018 12-1pm

Agenda

Introductions

Maria Ballard LCSW, Provider Network Account Specialist

Credentialing Update

Fielding Yelverton- Credentialing Team Supervisor

Perception of Care/Echo Survey Results

Tamikka Woods, MBA/HCM QM Supervisor

Integrated Care: Physical health/preventive appointment goals

Jennifer Greene MA LPC, Integrated Care Project Manager

System of Care Grant Update

Lachelle Freeman MA, SAMHSA Grant, Project Manager

Multi-Systemic Therapy Service, Family Centered Treatment, & Intensive

In Home Service Definitions

Martin Cox LPC, LCAS, MHSU Care Manager

Program Integrity: Documentation for Reimbursement

Teresa Shirley AHFI, Program Integrity Lead Auditor

Next Webinar: November 8, 2018, 12-1 pm

Contacts for the LIP Collaborative Webinar:

Maria Ballard, PN Account Specialist mballard@partnersbhm.org

Roanna Newton, PN Development Specialist rnewton@partnersbhm.org



Odds & Ends about the webinar:

- ▶ Maria Ballard, Provider Network Account Specialist, is your moderator for today's webinar.
- ▶ The audience is in "listen only mode" unless you received an audio control pin. If you did not receive this pin code when you registered, then you can only hear us talking, but you can't talk with us through the phone in an interactive way.
- ▶ You may submit questions from today's webinar to:
questions@partnersbhm.org



State update:

LME-MCO Communication Bulletin J298

Date: July 24, 2018 **KODY H. KINSLEY** • Interim Senior Director

To: Local Management Entities/Managed Care Organizations (LME-MCOs)

From: Deb Goda, Behavioral Health Unit Manager, DMA,
Lisa Haire, Associate Director, Quality Management and Operations,
DMH/DD/SAS

Subject: Medicaid and Health Choice Provider Enrollment Screening Changes

Effective July 1, 2018, Session Law 2018-5 made changes to Medicaid and Health Choice Provider Screenings. The provider types listed below have been moved from moderate or high categorical risk to limited categorical risk.

- Behavioral health and intellectual and developmental disability provider agencies that are nationally accredited by an entity approved by the Secretary; and
- Licensed outpatient behavioral health providers.

If you have questions, please contact NC Medicaid Provider Services at 919-855-4050, or Deborah Goda at 919-855-4297 or Deborah.goda@dhhs.nc.gov.

Previous bulletins can be accessed at: <https://www.ncdhhs.gov/divisions/mhddsas/joint-communication-bulletins>.



Acorn Outcome Tool Providers:

- ▶ Please do **NOT** fax your Acorn surveys to Clinical Informatics!! This incurs an additional cost to Partners BHM above and beyond our contracted agreement with Clinical Informatics. Partners BHM has paid this surplus fee, but **WILL NOT** continue to do so.
- ▶ Any providers that continue to fax surveys will be financially responsible for the cost associated with Clinical Informatics processing fees.



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Credentialing Update Fielding Yelverton, Credentialing Manager

LIP FAQs

- ▶ All applicants must ensure that their CAQH information is up-to-date
 - You **must** complete *and upload* a state release/authorization specific to Partners in CAQH
 - This form can be found in CAQH
- ▶ We receive a number of questions that fall into two categories, which will be the focus of the remainder of this presentation:
 - Insurance
 - National Plan and Provider Enumeration System (NPPES)



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Insurance Requirements

- ▶ Partners must be the **Certificate Holder** on all required insurance policies.
 - It is not necessary for Partners to be listed as an additional insured on these policies for LIPs.



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Insurance Requirements (cont)

- ▶ You must complete the *Partners Behavioral Health Management Insurance Affidavit for Contracted Providers* form if:
 - 1-You do not transport consumers (waiver of automobile coverage)
 - 2-Your number of employees exempts you from the requirement of carrying Workers Compensation coverage (Workers Compensation waiver)
 - 3-You rent your office space and your landlord holds the General Liability policy covering the property (General Liability coverage waiver)
 - Please note: you **must** be able to produce a copy of this policy/certificate of insurance (COI)
 - As this policy is not held by the applicant, the coverage limits (\$1mil occurrence/\$3mil aggregate) do not apply
- ▶ You can obtain this form by contacting Partners' Credentialing Department at CredentialingTeam@partnersbhm.org or (704) 842-6483



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NPPES

- ▶ Addresses, taxonomies, NPI numbers must all match in:
 - NC Tracks
 - NPPES
 - Alpha
- ▶ Inconsistencies among these databases will not stop your credentialing application from being processed but **will** prevent you from billing
- ▶ For practices with multiple site addresses:
 - Partners staff can only see the first site address in NPPES.
 - You will need to print screen shots for all other site addresses and submit them along with your application materials



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NPPES – Do I need an organizational NPI?

- ▶ If you contract with Partners using a Tax ID other than your Social Security Number:
 - The practice/agency/organization associated with that Tax ID **must** have an organizational NPI number
 - The organizational NPI number **must** be enrolled in NC Tracks.



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NPPES – Making Changes to Information

- ▶ How to make changes to information in NPPES:
 - For **individual** NPI numbers:
 - Call: **800-465-3203**
 - Ask for “**role request**” to gain access to NPI information
 - For **organization** NPI numbers:
 - Call **866-484-8049**
 - Select the option called “**Identity & Access**” (I&A)
 - Ask for guidance in processing a “**role request**” to gain access to organization NPI information
 - For all changes related to the organization NPI, you will likely need to have your W-9 handy when you call.
 - Partners cannot process your credentialing application until your current practice site address (associated with your organizational NPI) is entered in NPPES



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Questions?

- ▶ Fielding Yelverton, Credentialing Supervisor
 - (704) 884-2505
 - fyelverton@partnersbhm.org
- ▶ Credentialing Department
 - (704) 842-6483
 - CredentialingTeam@partnersbhm.org



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Next up: Quality Management

The ECHO/Perception of Care Survey

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Tamikka Woods QA/QI Section Manager

- ▶ Allows the North Carolinas Department of Health and Human Services (DHHS) and LME/MCO's to identify key opportunities for improving members' experiences
- ▶ Helps identifying strengths and weaknesses in quality of care and services
- ▶ Provides data necessary to assess where resources can best be allocated
- ▶ Provides a way to see the effects of improvement efforts over time

PURPOSE



Experience of Care and Health Outcomes Survey (ECHO)

- ▶ Survey administered directly to consumers by the Carolina Center for Medical Excellence, a contracted agency with DMA
- ▶ The survey types include:
 - Child
 - Adult



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Mental Health/Substance Abuse Consumer Perception of Care Survey

- ▶ Is the perception of individuals and families who received MH and/or SU services
- ▶ Administered by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services and distributed by LME/MCO's annually
- ▶ Survey-type:
 - Adult
 - Youth
 - Child Family-Parents of children under 11 years of age



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How did we do?



Results of ECHO Survey

- ▶ Child Domains has 4 Composites
 - Getting Treatment Quickly- 61.8%
 - How Well Clinicians Communicate- 91.8%
 - Getting Treatment and Information from the Plan- 43.6%
 - Perceived Improvement- 63.7%
- ▶ Adult Domains has 5 Composites
 - Getting Treatment Quickly- 65.6%
 - How Well Clinicians Communicate- 82.3%
 - Getting Treatment Information from the Plan- 29.7%
 - Perceived Improvement- 54.4%
 - Information about Treatment Options- 55.2%

Results for Perception of Care Survey

- ▶ 8 Perception of Care Domains regarding consumers' services:
 - Access to Services
 - Quality and Appropriateness
 - Outcomes
 - Treatment Planning
 - General Satisfaction
 - Social Connectedness
 - Functioning
 - Cultural Sensitivity



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Summation/Key Strengths

- ▶ Partners' highest domain scores were Quality and Appropriateness for Adult Survey, and Cultural Sensitivity for the Youth and Child Family Survey.
- ▶ There were no domain scores that below 60% for all three survey types.
- ▶ Partners' lowest domain scores across all three(3) surveys was for the Outcome domain.
- ▶ Quality Appropriateness
 - Adult- 95%
- ▶ General Satisfaction
 - Adult- 91%
- ▶ Cultural Sensitivity
 - Youth- 90%
 - Child Family- 96%
- ▶ First Service within timeframe that met needs
 - Child Family- 91%



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Opportunities

► Outcomes

- Better at handling daily life- 66%
- Getting along better with family- 67%
- Better able to cope when things go wrong- 59%
- Getting along better with friends, others- 65%
- Satisfied with family life- 55%

► LME/MCO Network

- Received Consumer Handbook in 14days- 46%
- Knows how to make a complaint- 60%
- Given choice of providers- 64%

► Adult Physical Health

- Received routine physical exam in past year- 61%
- Received dental care in past year- 40%
- Smokes or use tobacco/nicotine products every/some days- 64%



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In Conclusion...

- Partners' is invested in overall continued quality improvement.
- The ECHO and Perception of Care Survey results data serve as tools to assess both the network and LME/MCO functions in an effort to providing high quality customer service and services to consumers and families.
- We need your feedback about strategies to address the areas of opportunity identified in addition to continuation of improving in the areas of strength.

Tamikka Woods, MBA/HCM
twoods@partnersbhm.org
 (704) 884-2568



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What's New in Integrated Care?



WPIC Initiative for LIP Provider Webinar



Whole Person
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**Presented by Jennifer R Greene, MA LPC,
Integrated Care Project Manager**

Objectives

- ▶ Explore current health integration practices
- ▶ Highlight current efforts in the region
- ▶ Introduce integration initiative for 2018-2019 fiscal year



Whole Person Integrated Care

Integration of medical, behavioral, and public health approaches to care for the whole person.

- ▶ WPIC expands integrated care beyond the health care sector to include the social determinants of health, or the conditions in the places where people live, learn, work, and play.
- ▶ By tackling all the conditions that impact an individual's overall health, we can:
 - improve population health,
 - reduce health disparities,
 - advance health equity,
 - and optimize public and private resources.
- ▶ Ultimately, WPIC helps achieve the best care for the whole population at the lowest cost.



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WHOLE PERSON INTEGRATED CARE THEORY OF CHANGE

Health Homes that implement the WPIC model,

....integrating the following EBPs and Best Practices:

- Promotion, Prevention
- (modified) Collaborative Care Model
- Peer engagement & support
- Attention to/addressing SDOH
- Human Services community & Health Home Partnership & moving to a community Health Network via the Collective Impact Model

...are more likely to have consumers/patients that:

- are engaged in their health care,
- are satisfied that it is relevant to their everyday lives,
- can access the health services needed,
- experience improvements in their health through effective quality services, and
- have a sense of self-agency and hope regarding their ability to achieve and maintain wellness

...and advance / generate outcomes that:

- Lower costs; improve care, clinical outcomes and consumer satisfaction; lower rates of ED visits, increase use of preventative care, increase rates of treatment initiation and completion;
- Increase patient/member and practitioner satisfaction, improve quality of life;
- Decrease social isolation, improve community participation, reduce Social Determinants of Health barriers to wellness;
- Advance an enhanced health delivery system promoting wellness, and increases community capacity to address key factors influencing outcomes



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Progress to date

- Five Integrated Care Centers now operational
- Increased partnerships between behavioral health and physical health providers
- 32 partnerships with community resources to strengthen health in SAMHSA's 8 areas of wellness



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A Look at the Coming Year

- Partners' provider network offers a variety of strengths and treatment options
- The Integrated Care department believes that a variety of health integration strategies are currently in place in our network
- We are looking to highlight current efforts and educate those interested in adopting practices



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Partners' Integrated Care Department Goal

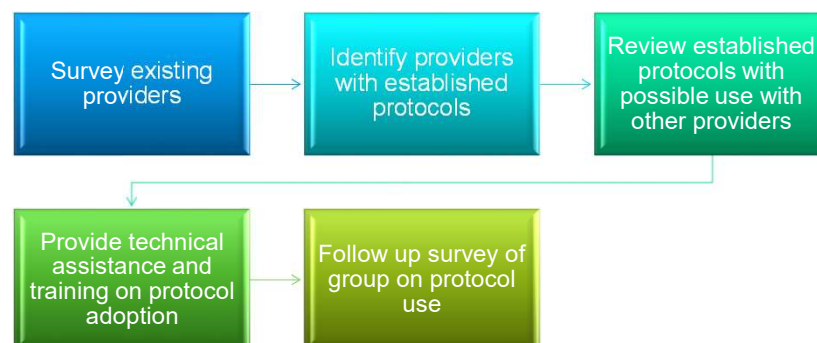
To add 60 providers (from the existing providers) to the Provider Network who have adopted protocols to obtain preventive physical care and annual physical data for behavioral health consumers by 6/30/2019



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Action Plan



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Next Steps

- **Be on the look out for the Physical Health Integration Protocol Survey to be released this month**
- **Please complete survey even if you are not interested in adopting protocols at this time**



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Questions?

Please contact Jennifer Greene, Integrated Care Project Manager with any questions or if you want to serve on the workgroup for this project.

jgreene@partnersbhm.org

828-323-8086



You can also direct questions to Jennifer through your account specialist.



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System of Care

SAMHSA Grant Update

Lachelle Freeman SAMHSA Grant

Project Director

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Brief Overview of Partners NC System of Care Expansion Grant

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Partners' SOC Expansion Grant builds upon two Partners' initiatives

- System of Care, a nationally-known program that brings child and family serving agencies together with the family to develop and implement services in the child's best interest; and
- Partners' innovative Whole Person Integrated Care model, which combines behavioral care, physical care, and peer support in one setting



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Promotion, Prevention & Intervention

- ▶ Address SDOH
- ▶ Sustainable Plan
- ▶ Comprehensive Services
- ▶ Family and Youth Voice
- ▶ Improved Service Integration
- ▶ Successful Engagement

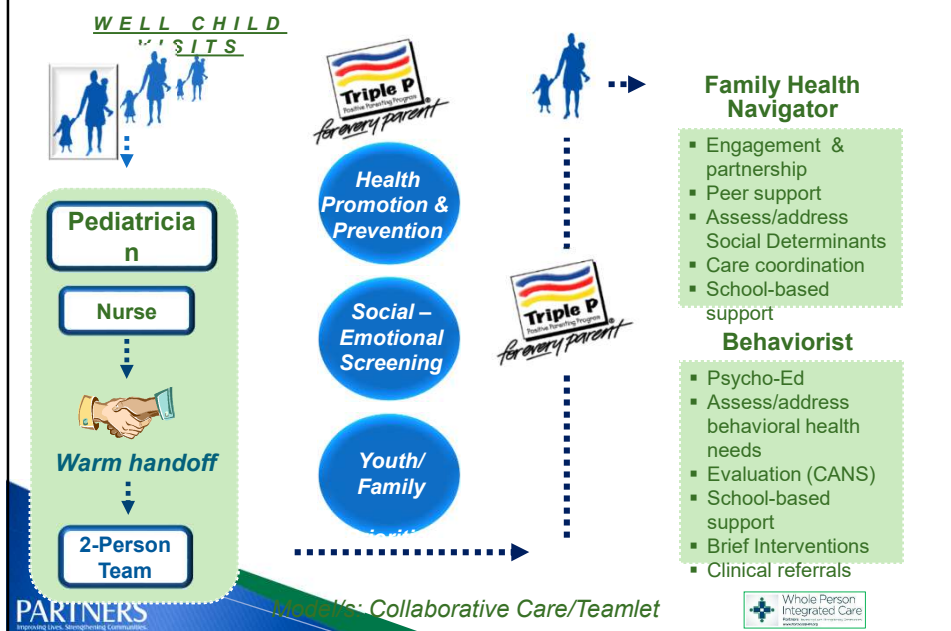


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Population to be Served

Age Range	Diagnostic Criteria	Additional Criteria	Severity
Children and youth ages birth to 21, and their families	Criteria #1a: - Emotional, socio-emotional, behavioral, or mental disorder - diagnosable under the current DSM-4 or the ICD-9 equivalents or the DC: 0-3R if under age three OR Criteria 1b: is experiencing/at serious risk of first episode psychosis (FEP).	Criteria #2a -TWO or MORE of the following <u>additional criteria</u> : (1) trauma history (abuse, neglect, trafficking), (2) co-occurring substance use disorder, (3) Autism Spectrum Disorder; (4) two or more MH/SA hospitalizations; (5) an episode of care in a psychiatric residential facility; (6)currently involved with child welfare (e.g. in foster care); or, (7) currently involved with the Department of Juvenile Justice.	Criteria #2b: The combination and severity of additional criteria is assessed at high, medium or low severity: - If Criteria #1a OR #1b is YES, the Child and Adolescent Needs & Strengths tool (CANS) is administered with a clinical interview. - The results of this screening and assessment process are determined to be high, moderate or low severity in total (per CANS process)

Flow of Care in PCP



Flow of Care - continued

Behaviorist provides Child and Adolescent Needs Assessment/CANS to identify level of care needed

- **Level 1 highest level of care:** High Fidelity Wraparound with access to all interventions available in the community • WPIC services to support the family and address social determinants, o continued healthcare access, o MH/SA individualized services from a whole person/whole family perspective, o linkage to a Medical Home of choice, • Triple P parenting training and support • Buffering Toxic Stress training, Transition to Independence (older youth)

STEP DOWN TO LEVEL 2

- **Level 2 > high risk:** WPIC, o linkage to a Medical Home, • Triple P • Care Management • Triple P Level 3 services to support the parents on targeted behavioral issues • Care Coordination and access to all community resources • Buffering Toxic Stress training, • Transition to Independence (older youth)

STEP DOWN TO LEVEL 3

- **Level 3 at risk:** • normal targeted array of services delivered with a strengths-based focus, honoring youth and parent priorities, with access to • Buffering Toxic Stress training • Transition to Independence (older youth)

All children/youth are continuously monitored for potential change in need that may elevate them to

Levels 1 or 2.



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Table 4. Number of Children/Youth/ to be Served by Site, Tier and Year, Adjusted for County Population

County	Year 1			Year 2			Year 3			Year 4			Total
	T1	T2	T3	T1	T2	T3	T1	T2	T3	T1	T2	T3	
Gaston	7	16	35	15	35	70	20	40	70	20	40	70	438
Lincoln	5	12	25	10	25	50	10	25	50	10	25	50	297
Burke							10	25	50	10	25	50	170
Iredell							10	25	50	15	35	60	195
Tier Totals													
Annual Total	12	28	60	25	60	120	50	115	220	55	125	230	1,100
	100			205			385			410			



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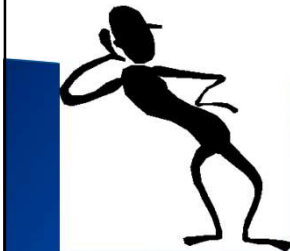
Community Resources & Support

Each participating PCP is supported through their county's Community Collaborative, to assist with:

- Access to community partners
- Assistance in accessing resources
- An array of child/youth/family services



**Now let's hear about
service definitions:**





IIH/FCT/MST

Martin Cox, LPC, LCAS

Intensive In-Home(IIH) Service is:

IIH is a **team** approach to address the identified needs of children/adolescents who, due to **serious** and **chronic** symptoms of an emotional, behavioral or substance use (SU) disorder, are unable to maintain stability in the community without intensive intervention. *IIH is a time-limited, intensive child and **family** intervention.*

- IIH operates 24/7/365.
- IIH provides are **first responders** for crisis situations.
- IIH is predominately home-based.



IIH Eligibility/Entrance Criteria

- Consumers from ages 3 through 20 years for *Medicaid* and ages 3 through 17 for *State* funding *and*
- Current/past history of symptoms or behaviors indicating the need for crisis intervention: suicidal or homicidal behaviors, physical aggression toward others, self-injurious behaviors, serious risk taking as evidenced by running away, sexual aggression, sexually reactive behavior or substance abuse; *and*
- Symptoms and behaviors are unmanageable at home, school or community setting due to youth's mental health or substance use disorder and intensive and coordinated clinical intervention is required; *and*
- Youth is at imminent risk of out-of-home placement based on mental health or substance use disorder clinical symptomatology or the youth is current in an out-of-home placement and a return home is imminent; *and*
- There is no evidence that alternative intervention would be equally or more effective based on NC community practice standards: Best Practice Guidelines of American Academy of Child and Adolescent Psychiatry, American Psychiatric Association and American Society of Addiction Medicine.



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IIH Evidence Based Practices

Make sure that the EBP applies to the age group:

- Cognitive Behavioral Therapy (CBT) with an outcome measure
- Eco-systemic Family Therapy
- Feedback Informed Therapy
- Strategic Family Therapy with an outcome measure
- Strengthening Families with an outcome measure

These were decided by a IIH evidence based practice task force that was made up by providers.



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Family Centered Treatment

Family Centered Treatment (FCT) is an Evidence Based Model of intensive in-home services for at-risk youth and their families. The goal of FCT is to promote permanency by presenting an alternative to out-of-home placement or minimizing the length of stay for out-of-home placement.

The Difference:

FCT is a researched, viable alternative to residential placement, hospitalization, correctional facility placement and other community-based services.



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Family Centered Treatment

FCT is an **eco-structured** therapy and an emotionally focused therapy.

What is that?

Ecology is a science that, in this case, studies the patterns and relationships between youth and their environment. The focus is getting to the root of problem behaviors and internalizing change to reduce recidivism. All phases of treatment incorporate **trauma-focused** treatment.



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Family Centered Treatment

FCT therapist works with the youth, family and other stakeholders to develop an individualized plan to promote the following:

- Enhanced problem-solving
- Improve limit-setting
- Develop risk management techniques and safety plans
- Enhance communication
- Build skills to strengthen the family
- Advance therapeutic goals
- Improve ineffective patterns of interaction
- Identify and utilize natural and community resource to promote sustainability of treatment gains
- A FCT therapist is available 24/7 during each phase of FCT.



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Family Centered Therapy

Entrance Criteria:

- Child between the ages of 3 and 20 for Medicaid and 3 and 17 for IPRS when:
 - A. There is a mental health or substance abuse diagnosis (DSM-5) other than a sole diagnosis of intellectual and development disability
 - B. There is significant family functioning issues that have been assessed as benefiting from family systems work as **evidenced by one of the following:**



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Family Centered Treatment

Entrance Criteria cont'd:

- Step-down from higher level of care
- DSS involvement in the last year
- Juvenile Justice involvement in the last 6 months
- ER visit/hospitalization in the last 6 months
- Multiple school suspensions
- Crisis intervention in the last 6 months
- Physical abuse
- Verbal abuse
- Sexual abuse
- Physical neglect
- Emotional neglect
- Parent/caretaker that abuses substances
- Parent/caretaker that is the victim of domestic violence
- Parent/caretaker that has a mental health diagnosis
- Loss of parent or caretaker to divorce, abandonment or death
- Parent/caretaker is incarcerated
- A significant traumatic event has occurred



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Family Centered Treatment

The FCT Model consist of four stages:



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Multisystemic Therapy (MST)

- MST provides an intensive model of treatment based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions.
- The purpose of this program is to keep youth in the home by delivering an intensive therapy to the family within the home.
- Services are provided through a team approach to beneficiaries and their families.



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Multisystemic Therapy (MST)

MST is a program designed for youth between ages 7 and 17 who:

- Have antisocial, aggressive or violent behaviors
- Are at risk of out-of-home placement due to delinquency
- Adjudicated youth returning from out-of-home placement
- Chronic or violent juvenile offenders or
- Youth with serious emotional disturbances or a substance use disorder



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Multisystemic Therapy (MST)

Specialized therapeutic and rehabilitative intervention are available to address special areas:

- Substance use disorder
- Sexual abuse
- Sex offending and
- Domestic violence

Services occur in-home, at school, and in other community settings. MST involves families and other systems such as school, probation, extended families and community connections.



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Multisystemic Therapy (MST)

This team approach is structured face-to-face therapeutic intervention to provide support and guidance in all functional domains:

- Adaptive
- Communication
- Psychosocial
- Problems solving and
- Behavioral management

This service promotes the family's capacity to monitor and manage the beneficiary's behavior.



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Multisystemic Therapy (MST)

Entrance Criteria

A. There is a DSM 5 diagnosis present, other than a sole diagnosis of Developmental Disability.

AND

B. The youth should be between the ages of 7 through 17.

AND

C. The youth displays willful behavioral misconduct (e.g., theft, property destruction, assault, truancy or substance use/abuse or juvenile sex offense), when in conjunction with other adjudicated delinquent Behaviors



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Multisystemic Therapy (MST)

AND

D. The youth is at imminent risk of out-of-home placement or is currently in out-of-home placement due to delinquency and reunification is imminent within 30 days of referral.

AND

E. The youth has a caregiver who is willing to assume long term parenting role and is willing to participate with service providers for the duration of the treatment.



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PI has some important findings to share...



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Documentation for Reimbursement

LIP Collaborative Webinar, August 9, 2018
Teresa Shirley, Program Integrity Lead Auditor

Purpose of this training...

- ▶ To briefly discuss NC Medicaid and Health Choice Clinical Coverage 8C section 7.3.5: Service Note and Progress Notes requirements
- ▶ Records Management and Documentation Manual APSM 45-2 section 8-5: Service Notes and Service Grids
- ▶ To assure services are well documented to support paid claims



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Documentation and reimbursement in a clinical setting:

Regulatory issues and reimbursement mechanisms have an enormous impact on the quality of care, the introduction to the latest technology, utilization of products and services, patient access to care and the actual outcomes of care delivered.



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Service and Procedure Codes

Clinical Coverage Policy 8C § 7.3.5 Service Notes and Progress Notes:

There must be a progress note for each treatment encounter that documents the following information:

- ❑ Date of service;
- ❑ Name of the service provided (e.g., Outpatient Therapy – Individual);
- ❑ Type of contact (face-to-face, phone call, collateral)
- ❑ Purpose of the contact (tied to the specific goals in the plan);



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Service and Procedure Codes Cont.

- ❑ Description of the treatment or interventions performed. Treatment and interventions must include active engagement of the beneficiary and relate to the goals and strategies outlined on the beneficiary's plan;
- ❑ Effectiveness of the intervention(s) and the beneficiary's response or progress toward goal(s);
- ❑ The duration of the service (e.g., length of the assessment or treatment in minutes);
- ❑ Signature, with credentials, degree, and licensure of clinician who provided the service. A handwritten note requires a handwritten signature; however, the credentials, degree, and licensure may be typed, printed, or stamped; and
- ❑ Service notes must be written in such a way that there is substance, efficacy, and value. Interventions, treatment, and supports must all address the goal(s) listed in the plan. They must be written in a meaningful way so that the notes collectively outline the beneficiary's response to treatment, interventions, and supports in a sequential, logical, and easy-to-follow manner over the course of service.



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FYI

The provider submitting the claim is responsible for providing upon request all pertinent information and records needed to support the services billed.



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An accurate record of the services or event should be depicted...

- Be specific to the consumer
- Be specific to the situation at the time of the encounter
- Accurately reflect the service performed
- Support the necessity of the services
- Clearly identify who performed the services and assessments documented clearly



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Record Management and Documentation Manual APSM 45-2 § 8.5 Contents of a Service Note

While there are no specific required formats for the documentation of service delivery, all services which require a service note must contain certain required elements. Service notes shall include, but are not limited to the following on every service note page:

- ▶ Name of the individual receiving the service
- ▶ Service record number of the individual
- ▶ Medicaid Identification Number for services reimbursed by Medicaid



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Contents of a Service Note cont.:

- ▶ Medicaid Identification Number for services reimbursed by Medicaid [on every service note page]
- ▶ Full date the service was provided [month/day/year]
- ▶ Name of the service provided [e.g., Community Support – Individual]
- ▶ Type of Contact [face to face, phone call, collateral]
- ▶ Place of service [when required by the service definition]
- ▶ Purpose of the contact [tied to specific goal(s) in the service plan]



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Contents of a Service Note cont.:

- ▶ Description of the intervention(s)/treatment/support provided. Interventions must include active engagement of the individual and relate to the goals and strategies outlined on the individual's PCP or service plan. NOTE: The interventions described in the service note, whether for periodic, day/night, or twenty-four hour services, must accurately reflect treatment for the duration of time indicated.
- ▶ Total amount of time spent performing the service [required for periodic services, unless the periodic service is billed on a per event basis, and any other service as required by the service definition, Medicaid Clinical Coverage Policies, or the Medicaid State Plan]. Some of the services for which the provider must record the amount of time spent performing the interventions are listed on the Service Duration Table in Appendix F of APSM 45-2.



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Contents of a Service Note cont.:

- ▶ Effectiveness of the intervention(s) and the individual's response/progress toward goal(s).
- ▶ For professionals: Signature, with credentials, degree, or licensure of clinician who provided the service. For licensed professionals, the full signature denotes the clinician's licensure and/or certification; for non-licensed professionals, the full signature denotes the degree [e.g., BA, MSW] and should also include the individual's professional status [e.g., QP or AP], and any other certifications the person may hold [e.g., CSAC]. The signature must be handwritten; however, the credentials, degree, or licensure may be typed, printed or stamped.



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Finally...

The provider is responsible for staying abreast of the requirements for delivering the services that they are credentialed and contracted to provide in the Partners' closed Network.



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Helpful Links...

- ▶ Records Management and Documentation Manual:
<http://www.ncdhhs.gov/mhddsas/statspublications/Manuals/rmdmanual-final.pdf>
- ▶ DMA Clinical Coverage Policies:
<http://www.ncdhhs.gov/dma/mp/>
- ▶ DHSR Mental Health Licensure Section:
<http://www.ncdhhs.gov/dhsr/mhlcs/mhpage.html>



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This concludes the webinar....



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