Select Health of South Carolina

Healthy Connections

Guidelines for Evaluation of Behavioral Health Medical Records

1. Each Licensed Independent Practitioner (LIP) shall maintain a clinical record for each Select Health eligible member that fully describes the extent of the treatment services provided. The beneficiary's name and Medicaid number should be on all clinical documentation and billing records. The clinical record must contain documentation sufficient to justify Medicaid reimbursement and should allow an individual not familiar with the beneficiary to evaluate the course of treatment.	Federal regulations at 42 CFR Part 431, Subpart F, and South Carolina Code of State Regulations at Chapter 126, Article 1, Subarticle 4, require that certain information concerning Medicaid applicants and beneficiaries be protected. Beneficiary information that must be protected includes, but is not limited to, the following: • Name and address • Medical services provided • Social and economic circumstances • Medical data, including diagnosis and past history of disease or disability • Any information involving the identification of legally liable third-party resources • Any information verifying income eligibility and the amount of medical assistance payments The record must be legible to someone other than the writer. A provider record, or any part thereof, will be considered illegible if at least three medical or other professionals who perform reviews are unable to read the record or determine the extent of services provided. • Handwritten entries must be legible to a reader other than the author. • Content of records must be presented in a standard format that allows a reader other than the author to review without the use of a separate legend/key. • If abbreviations are used, the provider must maintain and provide a list of abbreviations and their meanings. Information, spelling, and grammar in clinical documents should be error-free. Documentation of medical encounters must be entered in the record as follows: • Diagnostic assessment (DA) – within 14 days of admission to the practice. • Individual plan of care (IPOC) – within 45 days of the completion of the DA. • Clinical service note (CSN) – within five business days of the service date. • All services provided and billed to Medicaid must be recorded on a CSN.

2. A consent form dated and signed by the beneficiary, parent, legal guardian or primary caregiver (in cases of a minor), or legal representative must be obtained from all beneficiaries at the onset of treatment and placed in the beneficiary's file.	The DA must be completed within 14 calendar days of the patient's admission to the practice.
3. The beneficiary's clinical record must include, at a minimum, the following documentation: • A comprehensive DA, that establishes medical necessity. • A signed/titled and dated individual plan of care (IPOC), progress summaries, and reformulations. • Signed releases, consents, and confidentiality assurances for treatment. • Signed/titled and dated clinical service note (CSN). • Court orders, if applicable. • Copies of any evaluations and/or tests, if applicable. • Physician orders, laboratory results, lists of medications and prescriptions (when performed or ordered), if applicable. • Copies of all written reports and any other documents relevant to the care and treatment of the beneficiary.	All services must be documented in CSNs upon the delivery of services and filed in the beneficiary's record. Each discrete service should have its own CSN capturing service and bill time. The purpose of the CSN is to record the nature of the beneficiary's treatment; any changes in treatment; discharge; crisis interventions; and any changes in medical, behavioral, or psychiatric status. Documentation must justify the amount of reimbursement claimed to Medicaid. Medicaid requires that the LIP attest to the accuracy of the diagnoses, treatment modalities, and claims submitted for all Medicaid beneficiaries.
4. LIPs must fulfill all the requirements for South Carolina licensure and appropriate standards of conduct by means of evaluation, education, examination, and disciplinary action regarding the laws and standards of their profession as promulgated by the South Carolina Code of Laws and established and enforced by the South Carolina Department of Labor, Licensing and Regulation (LLR).	Services may be provided by the following people: • An unlicensed person who is on track to gain licensure as a psychologist and is supervised by a licensed psychologist. • A Licensed Professional Counselor — Associate (LPC-A) who is supervised by a Licensed Professional Counselor — Supervisor (LPC-S). • A Licensed Marriage and Family Therapy — Associate (LMFT-A) who is supervised by a Licensed Marriage and Family Therapy — Supervisor (LMFT-S). • A Licensed Master Social Worker (LMSW) who is supervised by a Licensed Independent Social Worker — Clinical Practice (LISW-CP) who is an approved supervisor through the South Carolina licensing board.

5. Direct supervision means that the psychologist, LPC-S, LMFT-S, Licensed Psychoeducational Specialist — Supervisor (LPES-S), or LISW-CP must provide services at the same location (out of the same office) as the supervisee and be immediately accessible by phone or other electronic device when the services being billed are provided.	Supervisors and associates must work within Medicaid guidelines: • All required documentation and contracts for supervision must be submitted to the appropriate board prior to service delivery by the associate or LMSW. • Supervisors must supervise no more than six full-time associates or LMSWs in order to bill Medicaid. • Supervisors must cosign all clinical notes completed by the supervisee interns or practicum students working toward an advanced degree who are providing psychotherapy services. Psychotherapy services completed by interns or practicum students under the direct guidance of an LIP should be identified in notes but should not sign notes for Medicaid reimbursement.
6. Claims for Medicaid reimbursement submitted under a Medicaid ID number or NPI number other than that of the ordering, referring, or rendering provider may be audited and may result in a program integrity investigation and/or recoupment of the Medicaid payment.	• LIP applicants must complete the following steps to become enrolled as a Medicaid provider: 1. Obtain an NPI number. 2. Register for the Pre-enrollment Orientation. 3. Complete the online Provider Enrollment application. • Once enrolled in Medicaid, please review the Select Health of South Carolina credentialing requirements, which are described in pages 6 – 15 of the Select Health of South Carolina Provider Manual. Contact your Account Executive for more information. • Providers are not allowed to bill for services rendered to a beneficiary covered by a specific managed care organization (MCO) unless the provider is credentialed with that MCO.
7. All Medicaid enrolled groups must maintain a file substantiating each practitioner's qualifications and training. Individual LIPs or group providers are responsible for ensuring that all professionals rendering services must maintain current licensure and appropriate standards of conduct.	The group must maintain a signature sheet that identifies all professionals providing services by name, signature, and initial. The following documents are required for each practitioner who provides services: • A completed employment application form. • Copies of advanced degrees. • A copy of all applicable licenses. • Letters or other proof of previous employment, pro bono, or volunteer work to document experience with the population to be served. • A criminal record check form from an appropriate law enforcement agency, updated annually. • Verification must be updated annually from the child abuse registry that there are no findings of abuse or neglect against the individual. Verification from the state and national sex offender registries, updated annually.

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<td>8. A comprehensive DA is completed, signed, and signature dated by the LIP and the licensed associate (LPC-A, LMFT-A, Licensed Psychoeducational Specialist — Associate [LPES-A], or LMSW) or unlicensed psychologist who completed the DA, if applicable. Any assessments must include face-to-face time with the beneficiary.

For medical review purposes, Medicaid requires that services provided/ordered be authenticated by the author.

Initial assessments should be completed in one day. If additional time is needed to complete a thorough assessment, billing should occur on another day through the follow-up assessment code.</td>
<td>DAs must:
• Establish one or more diagnoses, including co-occurring substance use or dependence if present in accordance with the current edition of the International Classification of Diseases (ICD).
• Determine the appropriateness of treatment services, including the need for integrated treatment of co-occurring disorders.
• Upon periodic review, determine progress toward goals and justify continuation of treatment.
• Confirm medical and/or psychiatric necessity of treatment.

If the beneficiary has not received services for 45 consecutive calendar days, a follow-up assessment is completed.

All assessments, initial and follow-up, include the following components:
• Beneficiary name.
• Date of birth.
• Medicaid ID.
• Referral source.
• Beneficiary demographic information.
• Presenting problem that represents the source of distress or the reason for seeking services.
• Medical history and medications.
• Family history.
• Psychological/psychiatric treatment history to include previous psychological assessment and testing reports.
• Substance use history.
• Mental status exam.
• Current Diagnostic and Statistical Manual of Mental Disorders (DSM)/ICD diagnosis.
• Beneficiary and family strengths.
• Beneficiary support system.
• Exposure to trauma, abuse, and loss.
• Service recommendations and frequencies, both within the provider agency and external services.
• Statement of Medical Necessity.</td>
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9. A current IPOC and subsequent progress summaries are in the chart.	The IPOC must be developed every 12 months. Any discontinued services are explained, and the reason for discontinuing treatment is stated. IPOCs, whether initial or reformulated, include the service date, the signature, title, and signature date of the LIP. Using information from the DA, the IPOC records: • Short- and long-term goals and objectives of treatment that are specific, measurable, achievable, relevant, and time bound. • Services to be provided. • Interventions to be used that are evidence-based practices and emerging best practices. • Planned frequency of service delivery appropriate to the needs of the client. • Criteria for achievement stating how progress will be demonstrated and the desired outcome of treatment. • Estimated duration of treatment with dates that reflect incremental change and do not uniformly reflect the IPOC expiration date. • Long-term or discharge goals to include estimated discharge date, expected progress, and any recommended aftercare needs. • Signature of the beneficiary and/or the parent/guardian who participated in goal determination. The progress summary is completed at least every 90 calendar days from the signature date on the IPOC. Completed by the LIP, it is documented on the IPOC. There is identification that names the progress summary, differentiating it from the previously developed IPOC. Progress summaries record: • Progress or barriers to progress toward goals. • Appropriateness of services and their frequencies. • Why services were not provided. • The clinical/medical need for continued treatment. • Recommendations for continued specific services.

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<td>10. The CSN's purpose is to record each instance of the beneficiary's treatment; any changes in, discharge of, or termination of services; crisis interventions; and any changes in the beneficiary's environment, progress, or concept of personal experience. Documentation must justify the amount of reimbursement claimed to Medicaid.

All services must be documented in CSNs upon the delivery of services and filed in the beneficiary's record. Each discrete service should have its own CSN that captures service and bill time.</td>
<td colspan="2">Psychotherapy services documentation requirements:
The structured activities of the beneficiary in the session.
The specific intervention(s) used.
The beneficiary's response to the intervention/treatment.
The beneficiary's progress or lack of progress made in treatment; specific recommendations; and plans for follow-up activities, homework, referrals, or any other activities to describe the next steps in treatment.
Service duration — start and end time.</td>
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<td>11. The requirements in the right cell must be met in order for an LIP to be in compliance with Medicaid documentation policy for services.</td>
<td>All CSNs must include the:
Beneficiary's name and Medicaid ID.
Date of service.
Name of the service provided.
Psychotherapy.
Family Psychotherapy.
Group Psychotherapy.
Place of service that agrees with the location code billed.
Duration of service reported in real time, at the exact time, to reflect the actual time the session took place.
Separate documentation for siblings.
Documentation must be legible and abbreviations decipherable.
Abbreviations are supported by a list of abbreviations and meanings provided to Select Health of South Carolina.</td>
<td>All CSNs should:
Be recorded using an electronic medical record (EMR) or be typed or handwritten using only black or blue ink.
Be legible to people other than the author.
Be kept in chronological order.
State the full name, title, and agency/provider-affiliation of anyone who participated in the service, at least once in each note.
Be signed, titled, and signature dated by the LIP who is responsible for the provision of services.
Be completed and placed in the clinical record following service delivery no later than five business days from the date of service.</td>
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12. Billing practices are observed. The South Carolina Medicaid program utilizes National Correct Coding Initiative (NCCI) edits and its related coding policy to control improper coding.	Remember, as a Medicaid provider: • You have agreed, when credentialed with Select Health of South Carolina, to accept payment from Select Health as payment in full. You can never balance bill a beneficiary receiving Medicaid-covered services for anything other than the Medicaid copayment. • Billing for appointments scheduled in the future or for holding appointment blocks is not allowed. • Broken or missed appointments cannot be billed, and the beneficiary cannot be charged.

Reference List

SC DHHS Licensed Independent Practitioner's (LIP) Rehabilitative Services Provider Manual

SC DHHS South Carolina Healthy Connections (Medicaid), Provider Manual Supplement, Third Party Liability

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