SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Licensed Independent Practitioners (LIP) Provider Training

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Training Objectives

- Outline the quality assurance (QA) review process
- Identify common trends leading to deficiencies
- Share industry examples of supporting documentation

Purpose and Scope of a QA Review

- Evaluate and improve health care and services
- Monitor and assess providers and processes
- Provide key findings
- Implement action plans

Overview of the QA Review Process

- Notification letter sent to provider
  - Letter sent to provider via secure email
  - Documentation request
  - Period under review (PUR)
    - Supporting documentation outside of PUR
- Provider response – submission deadlines
  - Submit documents via the SCDHHS secure Dropfile system
- Additional documentation requests
  - Missing documents

Overview of the QA Review Process *(cont.)*

- QA review tool
  - Criteria corresponds to manual requirements
  - Met/not met/not applicable
- Summary of findings letter
  - Compilation of findings noted during the QA review of the documentation provided
- Corrective action plan
  - Provider required to respond to “not met” findings

LIP QA Review 2024

- LIP Rehabilitative Services Provider Manual
  - Effective July 1, 2022
- PUR
  - July 1-Dec. 31, 2022
- Claims data
  - Corresponding documentation

Client Information and Authorization

Highlights of QA Review Tool Criteria

Client Information and Authorizations (Section 2): Consent for Treatment Form (Section 2.1)

A consent form dated and signed by the Healthy Connections Medicaid member, parent, legal guardian or primary caregiver (in cases of a minor) or legal representative must be obtained at the onset of treatment from all Medicaid members and placed in the Medicaid member's file. If the Medicaid member, parent/guardian or legal representative cannot sign the consent form due to a crisis and the Medicaid member is accompanied by next of kin or a responsible party, that individual may sign the consent form.

Document Example: Consent for Treatment Form

Licensed Independent Practitioners

Consent for Treatment Form

****Example**

Consent for Treatment Form

HIPAA Privacy Rule of Patient Authorization Agreement for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my mental health care, **Licensed Independent Practitioners LLC** originate and maintain mental health records describing my health and medical history, symptoms, clinical assessment, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

· a basis for planning my care and treatment;

· a means of communication among the mental health and medical professionals who may contribute to my health care;

· a source of information for applying my diagnosis and procedure information to my bill;

· a means by which a third-party payer can verify that services billed were actually provided;

· a tool for routine mental health care operations such as assessing quality and reviewing the competence of mental health care professionals.

Document Example: Consent for Treatment Form *(cont.)*

I have been offered a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

Privacy Rule of Patient Consent Agreement to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

· I have the right to review **Licensed Independent Practitioners LLC** Notice of Information practices prior to signing this consent. I authorize the disclosure of my Protected Health Information (PHI) as specified below for the purposes and to the parties designated by me.

· **Licensed Independent Practitioners LLC** reserve the right to change the notice and practices and that prior to implementation will mail or email a copy of any notice to the address I have provided, if requested;

· I have the right to object to the use of my health information for directory purposes;

· I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that **Licensed Independent Practitioners LLC** are not required by law to agree to the restrictions requested;

I may revoke this consent in writing at any time, except to the extent that **Licensed Independent Practitioners LLC** have already taken action in reliance thereon.

Document Example: Consent for Treatment Form *(cont.)*

Licensed Independent Practitioners

Consent for Treatment Form

****Example**

Consumer Rights & Responsibilities

· Consumer has the right to be treated with personal dignity and respect.

· Consumer has the right to care that is considerate and respects member's personal values and belief system.

· Consumer has the right to personal privacy and confidentiality of information.

· Consumer has the right to receive information about managed care company's services, practitioners, clinical guidelines, and consumer rights and responsibilities.

· Consumer has the right to reasonable access to care, regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability.

· Consumer has the right to participate in an informed way in the decision-making process regarding their treatment planning.

· Consumer has the right to discuss with their providers the medically necessary treatment options for their condition regardless of cost or benefit coverage.

· Consumer has the right for consumer's family to participate in treatment planning as well as the right of consumers over 12 years old to participate in such planning.

Document Example: Consent for Treatment Form *(cont.)*

· Consumer has the right to individualized treatment, including:

o Adequate and humane services regardless of the source(s) of financial support,

o Provision of services within the least restrictive environment possible,

o An individualized treatment or program plan,

o Periodic review of the treatment or program plan, and

o An adequate number of competent, qualified, and experienced professional clinical staff to supervise and carry out the treatment or program plan.

· Consumer has the right to participate in the consideration of ethical issues that arise in the provision of care and services, including:

o Resolving conflict,

o Withholding resuscitative services,

o Forgoing or withdrawing life-sustaining treatment, and

o Participating in investigational studies or clinical trials.

***LIP Consent for Treatment Example* 2

Document Example: Consent for Treatment Form *(cont.)*

Licensed Independent Practitioners

Consent for Treatment Form

****Example**

· Consumer has the right to designate a surrogate decision-maker if the member is incapable of understanding a proposed treatment or procedure or is unable to communicate his or her wishes regarding care.

· Consumer and their families have the right to be informed of their rights in a language they understand.

· Consumer has the right to voice complaints or appeals about managed care company or the care provider.

· Consumer has the right to make recommendations regarding managed care company rights and responsibilities policies.

· Consumer has the right to be informed of rules and regulations concerning consumer's conduct.

· Consumer has the responsibility to give their provider and managed care company information needed in order to receive care.

· Consumer has the responsibility to follow their agreed upon treatment plan and instructions for care.

· Consumer has the responsibility to participate, to the degree possible, in understanding their behavioral health problems and developing, with the provider, mutually agreed upon treatment goals.

I understand my rights and responsibilities.

Document Example: Consent for Treatment Form *(cont.)*

Client Name (print): Magnolia Rose **Date:** May 1, 2024

Client Signature:
****Parent / Legal Guardian** Magnolia Rose **Date:** May 1, 2024

Provider: Name (print) Candy Lane **Date:** May 1, 2024

Signature / Credentials: Candy Lane, MA, LPC **Date:** May 1, 2024

Provider: Electronic Signature / Credentials **Date:** May 1, 2024

Candy Lane, MA, LPC

****LIP Consent for Treatment Example*** 3

Clinical Assessment

Highlights of QA Review Tool Criteria

Comprehensive Assessment: Initial and Follow-up Clinical Assessment (Section 4)

Section 4.2

The components of an assessment include the LIP's name, professional title/credentials, signature and date listed on the assessment to confirm medical necessity.

Highlights of QA Review Criteria *(cont.)*

Comprehensive Assessment: Initial and Follow-up Clinical Assessment (Section 4)

The purpose of an initial comprehensive assessment is to determine the need for services by establishing medical necessity, establish and/or confirm a diagnosis and provide the basis for development of an effective course of treatment. The initial comprehensive assessment may include but is not limited to, psychological assessment/testing to determine accurate diagnosis or differential diagnosis. The diagnostic assessment must be completed within 14 calendar days of admission to the practice.

Highlights of QA Review Criteria *(cont.)*

Program Overview
Clinical Assessment (Section 4)

Section 4.4

Services must be determined medically necessary to be eligible for Medicaid reimbursement and some services must be authorized prior to service delivery. Medical necessity means the necessary treatment services are justified to diagnose, treat, cure or prevent an illness, or that which may reasonably be expected to relieve pain, improve and preserve health or be essential to life.

Highlights of QA Review Criteria *(cont.)*

Clinical Assessment (Section 4)
Section 4.7

The comprehensive assessment includes the following 17 components.

- Medicaid member name
- Date of birth
- Medicaid member identification
- Referring state agency or physician (if applicable)
- Date of assessment
- Medicaid member demographic information
- Presenting complaint, source of distress
- Medical history and medications
- Family history

Highlights of QA Review Criteria *(cont.)*

- Psychological and/or psychiatric treatment history including previous psychological assessment/testing reports, etc.
- Substance use history
- Mental status
- Current edition Diagnostic and Statistical Manual of Mental Disorders or International Statistical Classification of Diseases diagnosis
- Medicaid member and/or family strengths and support system
- Exposure to physical abuse, sexual abuse, anti-social behavior or other traumatic events
- Recommendations for additional services, support or treatment based on medical necessity criteria, including specific rehabilitative services
- LIP's name, professional title/credentials, signature and date

Document Example: Clinical Assessment

Licensed Independent Practitioners

Comprehensive Assessment

****Example****

Client Name: Goldie Loxe
Medicaid ID Number: 1111111111
Date of Birth: 01/10/2012

Date: 5/1/24

Client Name: Goldie Loxe

Medicaid ID Number: 1111111111

Date of Birth: 01/10/2012

Providers Name: Candy Lane

Place of Service (11-Office): 11

Service Rendered: 90791

Start Time:
01:00 PM

End Time:
02:00 PM

Document Example: Clinical Assessment *(cont.)*

Beneficiary Demographic Information: (Address, Age, Phone Number, Occupation, Sex)
Address: 111 Magnolia Lane, Magnolia, SC
Age: 12 y/o
Phone: 111-111-1111
Occupation: n/a
Sex: Female

Presenting Complaint (Source of Stress):

School counselor recommended client engage in counseling due to client's parent's divorce, trouble falling asleep (averages 6 hours per night), difficulty concentrating, sporadic excessive energy, guilt, delusions (hears her name being called however no-one else is in the client's presence), irritability, loss of interest, panic attacks, racing thoughts, suspiciousness.

Onset of Presenting Complaint(s):
Trouble falling asleep: since 2021 difficulty concentrating: started 1 year ago
excessive energy bursts: since February 2021.
Delusions: started "a long time ago"

Document Example: Clinical Assessment *(cont.)*

Licensed Independent Practitioners

Comprehensive Assessment

****Example****

Client Name: Goldie Loxe
Medicaid ID Number: 1111111111
Date of Birth: 01/10/2012

Irritability: Since 2018
Loss of interest: Since March 2022
Panic attacks: Started summer of 2021

Psychological and/or Psychiatric Treatment History (Facility name and address, Provider name, Treatment dates, Treatment information): None

Mental Status Exam

Inappropriate for situation

Mood:
Apprehensive

Thought Process:
Mutism

Speech:
Hesitant

Behavior:
Awkward

Document Example: Clinical Assessment *(cont.)*

Oriented to (Person, Place, Time, Situation):

Delusions:

Reports suspiciousness

Hallucinogens:

Reported audible

Suicidal Ideation:

Reported in the past

Homicidal Ideation:

None reported

Release Signed to Coordinate Care? If NO, EXPLAIN REASON.:
No coordination of care requested

Medical History & Medications (Illnesses, Hospitalizations, Injuries, Allergies): Illnesses: None reported.

***LIP Clinical Assessment Example** 2

Document Example: Clinical Assessment *(cont.)*

Licensed Independent Practitioners

Comprehensive Assessment

****Example****

Client Name: Goldie Loxe
Medicaid ID Number: 1111111111
Date of Birth: 01/10/2012

Hospitalizations: Injuries: Allergies: None reported.

Medications & Dosage Amount: No medications are currently taken.

Family History (Biological, Psychological, Social):
BIO: Sister has diagnosis of depression.

PSYCH: None reported SOCIAL: None Reported

Pre/Post-Natal Care/Delivery: N/A

Substance Abuse History (Substance, Quantity, Frequency, Duration, Symptioms): No history of substance abuse.

Document Example: Clinical Assessment *(cont.)*

Understanding and Communicating:

Within Normal Limits

Mobility:

Within Normal Limits

Self-Care:

Spending time on her phone

Getting along with others:

Reports she has 3 close friends and states "a lot of kids don't like me"

Life activities:

None reported

Participation in society:

None reported

Exposure to Physical Abuse, Sexual Abuse, Anti-Social, Behavior, or Other Traumatic Events: None Reported

Physical: none Sexual: None

Emotional: Rude to classmates

Document Example: Clinical Assessment *(cont.)*

Licensed Independent Practitioners

Comprehensive Assessment

****Example****

Client Name: Goldie Loxe
Medicaid ID Number: 1111111111
Date of Birth: 01/10/2012

Recommendations for additional services, support, or treatment based on medical necessity criteria, including specific rehabilitative services:

Weekly counseling focuses on coping skills, managing mental health diagnosis symptoms, explore family relational concerns, and build a positive support system. Client may require a referral to a psychologist for an assessment.

Discharge planning (Include proposed discharge plan, supports needed for discharge including needs for therapy, seeing Psychiatrist/Psychologist, barriers to discharge and how they would be addressed):

Achieve a level of functioning and respect to treatment plan goals and objectives. Achieve stabilization through medication management options.

Age-appropriate Functional Assessment

Document Example: Clinical Assessment *(cont.)*

Current Edition DSM or ICD Diagnosis:

Client meets criteria for adjustment disorder with mixed anxiety and depressed mood 309.28 (F43.23) and Disruption of Family by Separation or Divorce V61.03 (Z63.5)

Has MEDICAL NECESSITY been established? (Clinically significant symptoms/behaviors that need evidence-based treatment to improve quality of living. Treatment services are necessary to diagnose, treatment, cure or prevent illness.):

Differential diagnosis reviewed. Bipolar disorder ruled out due to presence of delusions and hallucinations symptoms. Schizophrenia and disorder ruled out due to the unknown family history variables and the client's age. Presenting symptoms are clinically significant.

Provider Name (print): Candy Lane — **Date:** May 1, 2024
Provider Signature / Credentials: *Candy Lane, MBA, LPC/A* — **Date:** May 1, 2024
****Electronic Signature:** *Candy Lane, MBA, LPC/A* — **Date:** May 1, 2024

Supervisor: Name (print): Bright Starr — **Date:** May 1, 2024
Supervisor Signature / Credentials: *Bright Starr, MBA/ LPC/S* — **Date:** May 1, 2024
****Electronic Signature:** *Bright Starr, MBA/ LPC/S* — **Date:** May 1, 2024

Individual Plan of Care

Highlights of QA Review Criteria

Individual Plan of Care (IPOC) – (Section 5)
Section 5.1

An IPOC must be present in the Medicaid member's record.

- The Medicaid member must be given the opportunity to determine the direction of his or her treatment and must sign the IPOC indicating they have been involved in the planning process and have been offered a copy of the IPOC.
- If the Medicaid member does not sign the IPOC or if it is not considered appropriate for the Medicaid member to sign the IPOC, the reason the Medicaid member did not sign the IPOC must be documented on the IPOC and clinical record.

Highlights of QA Review Criteria *(cont.)*

IPOC (Section 5)
Section 5.2

The IPOC must be signed, dated and contain the title of the LIP that confirms the appropriateness of care.

Highlights of QA Review Criteria *(cont.)*

IPOC (Section 5)
Section 5.3

- The Medicaid member must be given the opportunity to determine the direction of his or her treatment and must sign the IPOC indicating they have been involved in the planning process and have been offered a copy of the IPOC.
- If the Medicaid member does not sign the IPOC or if it is not considered appropriate for the Medicaid member to sign the IPOC, the reason the Medicaid member did not sign the IPOC must be documented on the IPOC and clinical record.

Highlights of QA Review Criteria *(cont.)*

IPOC (Section 5)
Section 5.4

A new IPOC must be developed at least every 12 months.

Highlights of QA Review Criteria *(cont.)*

IPOC (Section 5)
Section 5.5

All required components of the IPOC must be present and address the following.

- Goals and objectives of treatment
- Types of interventions
- Planned frequency of service delivery
- Criteria for achievement
- Estimated duration of treatment
- Long-term or discharge goals

Document Example: IPOC

Licensed Independent Practitioners

Individual Plan of Care (IPOC)

****Example****

Date: May 1, 2024

Client: Amber Blue

DOB: 01/10/2019

Client / Medicaid ID: 1111111111

Provider: Candy Lane

License: LPC / LPC/S

Appointment: Individual Appointment Time: May 1, 2024

9:00 am – 9:30 am / 30 minutes

Diagnosis: F91.9 – Conduct, unspecified

Document Example: IPOC *(cont.)*

Type of sessions:

- **Individual**
- **Family**

Frequency of sessions: Weekly

ICD-10 Diagnosis: F41.1

DSM-V Diagnosis: 300.02

Symptoms: Fearful, sensory overwhelm, intense tantrums, noises make her very nervous, easily scared.

Any Risks Identified? None

***LIP Individual Plan of Care (IPOC) Example 1*

Document Example: IPOC *(cont.)*

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Individual Plan of Care (IPOC)

****Example****

Client Name: Amber Blue
Medicaid ID Number: 1111111111
Date of Birth: 01/10/2019

Strengths of client: Kind, helpful, talkative

Weaknesses of client: Easily overwhelmed

How will parent/guardian be involved with client's care? If not, why? Parent agrees to attend family therapy to assist client with managing emotions.

GOALS AND OBJECTIVES

Goal 1:

Amber is struggling to regulate her emotions when she is overwhelmed or scared.

Objective 1a:

Amber will learn diaphragmatic breathing, PMR and grounding *coping* skills to *assist* with anxiety reduction.

Document Example: IPOC *(cont.)*

Objective 1b:

Amber will have O tantrums per week.

Objective 1c:

Amber's parents will learn coregulation skills to assist Amber with emotional regulation and will use co regulation skills 7 out of 7 days per week.

Interventions needed to achieve Goal 1:

- **Play Therapy**
- **Family Therapy with client**
- **Family Therapy without client**
- **PCIT**

Service type and amount:

- **Individual Therapy 1 x per week**
- **Family Therapy 1 x per week**

****LIP Individual Plan of Care (IPOC) Example 2***

Document Example: IPOC *(cont.)*

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Individual Plan of Care (IPOC)

****Example****

Client Name: Amber Blue
Medicaid ID Number: 1111111111
Date of Birth: 01/10/2019

Goal 1 Target Date:

09/13/2024

Any Agencies involved in client /other providers involved with client care? If so, what services are they providing?

None noted

Discharge Criteria: levels of change in order to discharge from therapy
Amber will be discharged when she has O tantrums per week and can regulate emotions with parents assistance.

Document Example: IPOC *(cont.)*

Client Name (print): Amber Blue **Date:** May 1, 2024

***Client Signature:** Mama Blue **Date:** May 1, 2024

***Parent / Legal Guardian (if minor)**

Provider Name (print): Candy Lane **Date:** May 1, 2024

Provider Signature / Credentials: Candy Lane, MBA, LPC/A **Date:** May 1, 2024

****Electronic Signature:** Candy Lane, MBA, LPC/A **Date:** May 1, 2024

Supervisor: Name (print): Bright Starr **Date:** May 1, 2024

Supervisor Signature / Credentials: Bright Starr, MBA, LPC/S **Date:** May 1, 2024

****Electronic Signature:** Bright Starr, MBA, LPC/S **Date:** May 1, 2024

Clinical Service Notes

Highlights of QA Review Criteria

Clinical Service Notes (CSN) – (Section 6)
Section 6.1

A CSN must be present within the Medicaid member's record for each submitted claim during the PUR.

General Requirements

All services must be documented in CSNs upon the delivery of services and filed in the Medicaid member'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 Medicaid member'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.

Highlights of QA Review Criteria *(cont.)*

CSN (Section 6)
Section 6.2

All CSNs must be signed or co-signed, dated (month/date/year) and contain the title of the LIP responsible for the provision of services. The signature verifies the services are provided in accordance with standards in the LIP Rehabilitative Services Manual.

Highlights of QA Review Criteria *(cont.)*

CSN (Section 6)
Section 6.3

The following requirements must be met for a LIP to be compliant with the Medicaid documentation policy for services. Alls CSNs must include the following.

- Medicaid member's name and Medicaid identification
- Date of service
- Name of the service provided (psychotherapy, family psychotherapy, group psychotherapy, etc.)
- Place of service
- Duration of service (start and end time for each service delivered)

Highlights of QA Review Criteria *(cont.)*

CSN (Section 6)
Section 6.3

The following requirements must be met for a LIP to be compliant with the Medicaid documentation policy for services. Alls CSNs must include the following. *(cont.)*

- Separate document for siblings
- Documentation must be legible and abbreviations decipherable. If abbreviations are used, the provider must maintain a list of abbreviations and their meanings. This list must be made available to SCDHHS.
- Be typed or handwritten using only black or blue ink
- Be legible and kept in chronological order
- Reference individuals by full name, title and agency/provider affiliation at least once in each note
- Be signed, dated (month/date/year) and include the title of the LIP responsible for the provision of services; The signature verifies the services are provided in accordance with standards in the LIP Rehabilitative Services Manual.
- Be completed and placed in the clinical record following service delivery, but no later than five business days from date of service

Highlights of QA Review Criteria *(cont.)*

CSN (Section 6)
Section 6.4

All documentation supports the number of units billed.

- Content of services reflects what was billed

Highlights of QA Review Criteria *(cont.)*

CSN (Section 6)
Section 6.5

Units/time billed on the claim matches the units/time identified on CSN

- Duration of service (start and end time for each service delivered)

Highlights of QA Review Criteria *(cont.)*

CSN (Section 6)
Section 6.7

All services are provided by staff with the required credentials

Provider Qualifications

LIP providers must fulfill all 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. Licensed professionals must maintain a current license from the appropriate authority to practice in South Carolina and must be operating within their scope of practice.

Document Example: CSN

Licensed Independent Practitioners

Clinical Service Note

****Example****

Client Name: Cynda Joy

Medicaid ID Number: 1111111111

Date of Birth: 01/10/1990

Provider: Candy Lane

Provider License: LPC

Appointment:

- **Date: May 1, 2024**
- **Time: 6:30 pm – 7:30 pm**

Billing code: 90837 - Psychotherapy, 60 min

Diagnosis: F43.23 - Adjustment disorder with mixed anxiety and depressed mood

Document Example: CSN *(cont.)*

Diagnosis: F43.23 – Adjustment disorder with mixed anxiety and depressed mood

Location:
Telehealth (02) / Other Location

Office Location:
111 Candy Lane Avenue, Anytown, SC

Participants: None

Observations:
Cognitive Functioning: Oriented / Alert **Affect:** Appropriate
Mood: Overwhelmed
Interpersonal: Interactive
Functional Status: Intact

Risk Factors: None
Medications:
See Medication List in chart

Document Example: CSN *(cont.)*

Licensed Independent Practitioner

Clinical Service Note

****Example****

Client Name: Cynda Joy
Medicaid ID Number: 1111111111
Date of Birth: 01/10/1990

Current Functioning, Symptoms, or Impairments:

Cynda's affective and emotional state appeared: exhausted and feeling overwhelmed.

Focus of Session:

Discussed expressing feelings effectively and utilizing coping skills.

Content or Topics/Themes Discussed:

Cynda and counselor processed Cynda's current stressors. Together they explored ways she can implement self-care despite her hectic schedule. Discussed effectively balancing roles to create a more peaceful life.

Themes of the Session:

The main themes of the session were: interpersonal difficulties with spouse/partner; exploration of family life; exploration of effectively expressing feelings of anger and frustration; expression of stressful experiences; exploration and working through of inner self-criticism, self-punishment and self-denial; adjustment to new demands in life situation; management and coping with daily life; identifying obstacles to mental and emotional wellbeing; and awareness and exploration of tendency to push others away in response to anxiety.

Document Example: CSN *(cont.)*

Therapeutic Intervention:

The main therapeutic interventions consisted of supportive techniques; an emphasis on coping with current life difficulties; an emphasis on strengthening self-care and self-preservation; unconditional positive regard; genuineness; empathetic understanding; exploring fears and anxieties; and discussion and establishment of plans and goals for better self-care.

Developments, Treatment Plan, Ongoing Issues:

The ongoing treatment plan includes continued support of the client's self-exploration and understanding; support of the client's capacity for thought and reflection; continued exploration of current life difficulties; and helping the client gain greater awareness, understanding, and expression of underlying emotions.

Interventions:

- **Exploration of Coping Patterns**
- **Exploration of Emotions**
- **Client Centered Therapy**
- **Individual Therapy**

***LIP Clinical Service Note Example** **2**

Document Example: CSN *(cont.)*

Licensed Independent Practitioner

Clinical Service Note

****Example****

Client Name: Cynda Joy
Medicaid ID Number: 1111111111
Date of Birth: 01/10/1990

Client Response to Interventions:

Client displayed gained insight.

INDIVIDUAL PLAN OF CARE PROGRESS (REFER TO CLIENT'S IPOC FOR DETAILS ON EACH GOAL/OBJECTIVE)

IPOC Objectives Addressed in this session:

Learn and implement stress management and relaxation techniques to reduce fatigue, anxiety, and depressive symptoms. Describe role and responsibilities associated with work and family and related thoughts, feelings, and behaviors.

Generate a list of self-care activities and make a commitment to regularly participate in such activities.

Progress on IPOC Goals:

Maintained

Document Example: CSN *(cont.)*

Plan:

Client to return in two weeks.

Recommendation:

Continue Current Therapeutic Focus

Provider Name (print): Candy Lane **Date:** May 1, 2024

Provider Signature / Credentials: Candy Lane, MBA, LPC/A **Date:** May 1, 2024

****Electronic Signature:** Candy Lane, MBA, LPC/A **Date:** May 1, 2024

Supervisor: Name (print): Bright Starr **Date:** May 1, 2024

Supervisor Signature / Credentials: Bright Starr, MBA, LPC/S **Date:** May 1, 2024

****Electronic Signature:** Bright Starr, MBA, LPC/S **Date:** May 1, 2024

Treatment Progress and Process

Highlights of QA Review Criteria

Treatment Progress and Process (Section 7)
Section 7.1

The record contains a progress summary covering the PUR.

Progress Summary

The 90-day progress summary is a periodic evaluation of a Medicaid member's progress toward the treatment objectives, appropriateness of the services being furnished and need for the Medicaid member's continued participation in treatment.

The progress summary of the Medicaid member's participation in services will be conducted at least every 90 calendar days from the signature date on the IPOC and, at a minimum, each 90 days thereafter.

Highlights of QA Review Criteria *(cont.)*

Treatment Progress and Process (Section 7)
Section 7.2

The progress summary is documented on the IPOC by the LIP and identified as the progress summary.

Highlights of QA Review Criteria *(cont.)*

Treatment Progress and Process (Section 7)
Section 7.3

The progress summary reflects progress toward the treatment objectives, appropriateness of the services being furnished and need for the Medicaid member's continued participation in treatment.

- The LIP will review the following areas.
  - The Medicaid member’s progress toward treatment objectives and goals.
  - The appropriateness of the services provided and their frequency.
  - The need for continued treatment.

Document Example: Progress Summary

Licensed Independent Practitioners
Progress Summary
****Example****

Progress Summary (90 Days)		
Place Of Service:		
Client's Name	Medicaid #	Review Period
Myrtle Lacey	11111111111	1/1/2024 – 3/31/2024
Outcoming Rating Scale: (What is the overall progress client has made)		Some
Check all Services Received during this Quarter		Assessment / Ind. Tx
Client's Goal		
Per client "To feel better and to not feel on edge all the time".		
Objective(s)		
Client will identify at least one skill to manage anxiety and use skill successfully for 5 out of 7 days each week. Client will identify and communicate emotions with a reduction of anger successfully for 3 out of 7 days each week.		

Document Example: Progress Summary *(cont.)*

Progress		
During the past 3 months, Client has made some progress. Some of the improvements Client has made has been developed skills to manage their anxiety. Client has made some progress with managing her anxiety. Much of her distress reported is regarding her relationship issues with her BF. Her supports are limited so she struggles to make decisions about whether to stay or leave this relationship. Some areas client continues to grow is making decisions about her life. Client gets stuck in the cycle of her relationship, reporting bf can be impulsive, moody, and unsupportive of her. She contemplates leaving but struggles to move into action phase. She has expressed a desire to return to North Carolina but struggles due to her contemplation about her relationship with her bf. Recommendations for the upcoming quarter is continue current goal(s). This Counselor recommends Client continues being seen for indtx 1xwk.		
Provider's Signature and Credentialing: All LPC/A will need Supervisor's review and signature		
Provider Name (print): Candy Lane		Date: May 1, 2024
Provider Signature / Credentials: *Candy Lane, MBA, LPC/A*		Date: May 1, 2024
**Electronic Signature: *Candy Lane, MBA, LPC/A*		Date: May 1, 2024
Supervisor: Name (print): Bright Starr		Date: May 1, 2024
Supervisor Signature / Credentials: Bright Starr, MBA, LPC/S		Date: May 1, 2024
**Electronic Signature: Bright Starr, MBA, LPC/S		Date: May 1, 2024
***If applicable*		

Discharge and Transition Plan

Highlights of QA Review Criteria

Discharge and Transition Plan (Section 9)
Section 9.1

Transitioned and discharged participants have met appropriate criteria.

Transition and Discharge

The authorizing entity is responsible for determining the duration of treatment based on the individual needs of the Medicaid member. Medicaid members should be considered for discharge from treatment when they meet the following criteria.

- Level of functioning has significantly improved with respect to the goals established in the IPOC
- Medicaid member requests discharge (and is not imminently dangerous to self or others)
- Medicaid member requires a higher level of care (i.e., inpatient hospitalization or a psychiatric residential treatment facility)

Document Example: Discharge Plan

Licensed Independent Practitioners

Discharge Plan

****Example****

Discharge Summary

Date: May 1, 2024

Client: Gracie Belle

DOB: 1/1/2012

Client / Medicaid ID: 111111111111

Diagnosis: Adjustment Disorder with Depression

Treatment Duration: Gracie participated in counseling for a total of 10 sessions over a span of five months.

Presenting Issues: Initially presented with adjustment difficulties stemming from her parents' separation, notably her father's nonattendance. These challenges manifested as increased anger, suicidal ideation, and depressive symptoms. Gracie also reported decreased interest in previously enjoyed activities, such as baseball.

Document Example: Discharge Plan *(cont.)*

Intervention and Progress:

The therapeutic approach included cognitive-behavioral strategies. Magnolia's treatment focused on developing coping skills, improving emotional regulation, and addressing the impact of the family transition on her well-being. Progress was observed in Magnolia's ability to express her emotions, a reduction in suicidal statements, and the identification of protective factors, such as her interests in fishing, dirt biking, and spending time with friends.

Achievements:

- **Improved emotional regulation and expression of feelings.**
- **Reduction in the frequency of suicidal statements.**
- **Identification and engagement in protective activities.**
- **Reconnection with some friends and participation in school activities.**

Discharge Recommendations: Gracie has made significant progress during the counseling process. Continued family communication and involvement are recommended to maintain positive changes.

***LIP Discharge Plan Example** 1

Document Example: Discharge Plan *(cont.)*

Licensed Independent Practitioners

Discharge Plan

****Example****

Client Name: Gracie Belle
Medicaid ID Number: 1111111111
Date of Birth: 01/10/2012

Provider Name (print): Candy Lane **Date: May 1, 2024**
Provider Signature / Credentials: *Candy Lane, MBA, LPC/A* **Date: May 1, 2024**
****Electronic Signature:** *Candy Lane, MBA, LPC/A* **Date: May 1, 2024**

Supervisor: Name (print): Bright Starr **Date: May 1, 2024**
Supervisor Signature / Credentials: *Bright Starr, MBA, LPC/S* **Date: May 1, 2024**
****Electronic Signature:** *Bright Starr, MBA, LPC/S* **Date: May 1, 2024**

Questions

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DUM SPIRO SPERO
SPES