SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Rehabilitative Behavioral Health Services Clinical Standards – Clinical Service Notes

Division of Behavioral Health

Quality Assurance Team

2021

Disclaimer

- Materials presented today are not comprehensive. This training does not take the place of reading the provider policy and procedure manual. Prior to treatment, all beneficiaries must meet criteria for medical necessity for that service. All information in this presentation pertains to South Carolina Department of Health and Human Services Healthy Connections (SCDHHS) Medicaid beneficiaries.

Clinical Service Notes (CSNs)

- The purpose of the CSNs 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.
- A CSN is required for each contact or service, for each date of service, for each beneficiary (if service was rendered in a group setting) and must be written and signed by the qualified staff who provided the service.
- Each CSN must support both the type of service billed and the number of units billed.
- Every CSN must be individualized to reflect treatment/service and interventions with a specific beneficiary, for each date of service, for each service rendered to the beneficiary and/or family.
- The content of CSNs shall not be duplicated among the records of beneficiaries served by the provider and/or among dates of service for any one beneficiary served by the provider.
- If CSNs are not completed and maintained in accordance with the requirements in this manual, payments to the provider shall be subject to recoupment.

Purpose of the Orientation

- To act as a guide for Rehabilitative Behavioral Health Services (RBHS) providers who are learning about South Carolina Medicaid policy and procedures prior to rendering RBHS.
  - While this presentation is designed to enhance understanding of the Medicaid standards regarding the RBHS Policy Manual, all aspects and policy are not covered in this presentation. Please review the RBHS Manual and the Administrative and Billing Manual.
- To help providers avoid potential Medicaid recoupment.

Availability of Clinical Documentation

- CSNs and other service documentation should be completed and placed in the clinical record immediately following the delivery of a service, but no later than five business days from the date of service.
- Any documentation completed and placed in the clinical records for any billed activity after this deadline will be subject to recoupment.

Components of Clinical Service Notes

The CSN must include the following information:

- The beneficiary's name and Medicaid ID number.
- The date of service.
- The name of the rehabilitative service (or its approved abbreviation) and the corresponding procedure code.
- The number of units of service rendered.
- The date of service in a month, day and year format.
- Document the start time and end time for each service delivered. (Exclusion: Clubhouse program CSNs and foster parent CSNs are not required to reflect start and stop times.)
- Location where the service was rendered. (Refer to the Billable Code/Location of Service section of the RBHS manual for additional information.)
- The manner in which the service was delivered: individual or group; if the service is provided in a group setting, the number of beneficiaries must be identified on the CSN.

Components of Clinical Service Notes (Cont.)

The CSN must include the following information:

- Be typed and/or handwritten — documentation must be legible.
- Be kept in chronological order.
- Abbreviations must be decipherable — if abbreviations are used, the provider must maintain a list of abbreviations and their meanings and the list must be made available to SCDHHS upon request.
- Reference individuals by full name, title and agency or provider affiliation at least once in each note, as applicable.
- Identification of other beneficiaries by name shall not be included.
- Be signed, credentialed or titled, and signature dated (month/date/year) by the qualified staff who provided the service. The signature verifies that the services were provided in accordance with these standards.
- Billing modifiers must match the credentials of the individual rendering the service.
- Be completed and placed in the beneficiary's record immediately following the delivery of the service, but no later than five business days from the date of rendering the service.

CSNs Clinical Description (FIRPP – focus, intervention, response, progress, plan)

Each CSN must address the following items to provide a pertinent clinical description and to ensure that the rehabilitative service conforms to the service description and authenticates the charges:

- The focus and/or reason for the session or interventions which should be related to treatment objective(s) and/or goal(s) on the Individualized Plan of Care (IPOC), unless there is an unexpected event that needs to be addressed.
- The detailed summary of the interventions (e.g., action steps, tools used, techniques utilized, etc.) and involvement of qualified staff with the beneficiary and/or family during each contact or session/meeting (only time spent rendering the intervention or treatment can be billed — see the *Covered Services* section for additional information).
- The individualized response of the beneficiary and/or beneficiary's family, as applicable, to the interventions and/or treatment rendered at each contact or session/meeting.

CSNs Clinical Description cont'd. (FIRPP – focus, intervention, response, progress, plan)

Each CSN must address the following items to provide a pertinent clinical description and to ensure that the rehabilitative service conforms to the service description and authenticates the charges:

- The general progress of the beneficiary to include observations of their conditions/mental status. Progress should reflect detailed individualized information about the beneficiary over the course of treatment and shall not reflect general categories of progress or general statements of progress in treatment (e.g., phrases such as "moderate" or "not making progress", without providing detailed information to support the identification of these will not meet this standard).
- The future plan for working with the beneficiary and the beneficiary's family, as applicable. This should reflect the plan of action for the next and foreseeable future sessions/meetings with the beneficiary (e.g., statements such as "will continue to meet with person as per IPOC" will not meet this standard).

Clinical Service Notes

- The units/time billed must align with the units/time documented on the CSN.
- Staff-to-beneficiary ratio must be met for services rendered.
- Services must be provided by staff with the required credentials.
- Applicable services must be provided face-to-face.
- Services must be administered in a setting that is convenient for both the beneficiary and the professional that affords an adequate therapeutic environment and that protects the beneficiary's rights to privacy and confidentiality.


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