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SECTION I: SERVICES DESCRIPTIONS AND INFORMATION

(SEE SECTION 2 OF MEDICAID MANUAL FOR DETAILS)

HTTPS://WWW.SCDHHS.GOV/INTERNET/PDF/MANUALS/CMH/SECTION%202.PDF
CRISIS INTERVENTION SERVICE (CI) H001

Documentation: (FIRSD)

- Focus of session or nature of crisis
- Content of the session
- Intervention(s) provided by staff
- Response of client to intervention(s) of the staff
- Status of the client at the end of the session
- Disposition of the client at the end of the session

General Purpose: To stabilize the client, identify the precipitants/causal events of the crisis, reduce immediate personal distress felt by the client, and reduce the chance of future crisis though preventative strategies.

Provided by: MHP or RN within their scope of practice

POC Requirement: Not required

Billing Restrictions: Not eligible in Inpatient or Forensic Settings

If listed: PRN frequency

Units: 15 mins

Maximum units/day: 20 face-to-face
Telephone: 4 units/day

MCO Prior Authorization: Never

Updated August 2016
MH ASSESSMENT BY NON-PHYSICIAN (ASSMT) H002

Documentation:

- Initial Clinical Assessment (CSN should reference documents)
- CSN which includes a mental status exam

General Purpose: Mental Health Assessment by a Non-Physician is a face-to-face clinical interaction between a client and an MHP that determines the following:

- The nature of the client’s problems
- Factors contributing to those problems
- The client’s strengths, abilities, and resources to help solve the problems
- One or more of the client’s diagnoses
- The basis upon which to develop a POC for a client

When a client is unable to supply the information detailed above, the MHP may use this service when securing information from collaterals who have reason to know information pertinent to the status of the client.

Provided by: MHP

POC Requirement: Not required  Billing Restrictions: Not with Initial PDA

If listed: PRN frequency

Units: 30 mins  Maximum units/day: 6

MCO Prior Authorization: Never

Updated August 2016
INDIVIDUAL THERAPY (IND TX) H003

Documentation: (FIRPP)

- Focus of session
- Intervention(s) of staff
- Response of client to intervention(s)
- Progress of the client in relation to the treatment goal objective(s)
- Plan for next session

General Purpose: Individual Psychotherapy involves face-to-face, planned therapeutic interventions. These interventions focus on the enhancement of a client’s capacity to manage his or her emotions and behaviors through effective decision making, developing and acquiring coping skills, making better choices and decisions regarding co-occurring substance abuse, achievement of personal goals, and development of self-confidence and self-esteem.

Provided by: MHP

POC Requirement: Required with planned frequency
Billing Restrictions: None

Units: Based on length of time of the session
Maximum units/day: 1 Encounter/day

MCO Prior Authorization: Never for SelectHealth and BlueChoice MCOs;
Prior to the 13th Therapy (Ind, Gp, and/or Fam) encounter for ATC/Cenpatico and WellCare;
Prior to the 25th Therapy (Ind, Gp, and/or Fam) encounter for Molina.
FAMILY THERAPY (FAM TX)

(CLIENT: PRESENT OR NOT PRESENT)

H004-001 WITH CLIENT PRESENT

H004-002 CLIENT NOT PRESENT

Documentation: (FIRPP)

- Focus of session
- Intervention(s) of staff
- Response of client/family to intervention(s)
- Progress of the client in relation to the treatment objective(s)
- Plan for next session

General Purpose: Family Psychotherapy includes interventions with the client’s family unit (i.e., immediate or extended family or significant others) with or on behalf of a client to restore, enhance, or maintain the function of the family unit.

Family Psychotherapy promotes and encourages the family support to facilitate a client’s improvement. Services include the identification and resolution of conflicts arising in the family environment – including conflicts that may relate to substance use or abuse on the part of the client or family members; and the promotion of the family understanding of the client’s mental disorder, its dynamics, and treatment. Services may also include addressing ways from mental illness and/or co-occurring substance use disorders. Family Psychotherapy may be rendered to family members of the identified client as long as the identified client is the focus of the session.

Must be face-to-face, planned therapeutic intervention with the client.

Provided by: MHP

POC Requirement: Required with planned frequency

Billing Restrictions: Not billed on same day Ind Tx (for medicare clients); Fam Tx w/client cannot be billed same day as Fam Tx w/o client.

Units: None

Maximum units/day: 1 Encounter/day

MCO Prior Authorization: Never for SelectHealth and BlueChoice MCOs;
Prior to the 13th Therapy (Ind, Gp, and/or Fam) encounter for ATC/Cenpatico and WellCare;
Prior to the 25th Therapy (Ind, Gp, and/or Fam) encounter for Molina.

Updated August 2016
GROUP THERAPY (GP TX) H005

Documentation: (FIRPP)

- Focus of group or activities in the group
- Intervention(s) of staff
- Response of client to intervention(s)
- Progress of the client in relation to the treatment objective(s)
- Plan for next session

General Purpose: Group Psychotherapy involves face-to-face, planned, therapeutic interventions directed toward the restoration, enhancement, or prevention of deterioration of role performance levels. Group Psychotherapy allows the therapist to address the needs of several clients at the same time and mobilize group support for the client. The group therapy process provides commonality of client therapy experience and utilizes a complex of client interaction under the guidance of a therapist. The participants benefit from a commonality of experiences, ideas, and group support and interaction. These services can be therapeutic, psychoeducational, or supportive in orientation.

Provided to all clients, adults and children as well as to family members in Multiple Family Groups (MFG).

Multiple Family Therapy Groups are rendered to clients along with family members of the identified client as long as the identified client is the focus of the session.

Ratio: 1:8; if MFG, 1 clinician and a minimum of 2 family units (a minimum of 4 individuals) and a maximum of up to eight individuals which includes the beneficiaries and their families.

Provided by: MHP

POC Requirement: Required with planned frequency

Billing Restrictions: Not billed on same day with ASSMT or Initial PDA

Units: None

Maximum units/day: 2 Encounters/day

MCO Prior Authorization: Never for SelectHealth and BlueChoice MCOs;
- Prior to the 13th Therapy (Ind, Gp, and/or Fam) encounter for ATC/Cenpatico and WellCare;
- Prior to the 25th Therapy (Ind, Gp, and/or Fam) encounter for Molina.

Updated August 2016
PSYCHIATRIC DIAGNOSTIC ASSESSMENT WITH MEDICAL SERVICES (PDA)

(FORMERLY KNOWN AS PMA/PMA-APRN)

H012/H013 INITIAL

H052/H053 SUBSEQUENT

**Documentation:** PSYCHIATRIC MEDICAL ORDERS (PMO) note with CSN to reference the PMO note

**General Purpose:** To assess and monitor the mental status and need for treatment, including co-occurring disorders; provide psychiatric diagnostic evaluation; specialized care, medications and referrals; diagnosis, treat and monitor chronic and acute health problems; plan treatment and assess the need for continued treatment.

**Medicaid:** Must receive this service at least once within the first 90 days form the admission date or the first service thereafter. Subsequent PMA's may be repeated as often as is medically necessary. Clients receiving psychotropic medications are encouraged to receive a PMA at least every six months at a minimum.

Clients who have not have a face-to-face treatment service during a 6 month period will require a new PMA completed by a MD or APRN within 90 calendar days.

**Medicare:** Initial PMA is done prior to the provision of covered services. Limit one Initial PDA/year. No other services (ASSMT, Ind Tx, Fm Tx, Gp Tx, SPD/IT, Med Mon, or Subsequent PDA) can be billed on the same day as Initial PDA. For Subsequent PDA, no ASSMT, Ind Tx or Initial PDA can be billed on the same day.

**Provided by:** MD (H012/H052) or Advanced Practice RN (H013/H053) or in a Telepsychiatry location

Limit H012/H013: Medicaid: one every 6 months; Medicare: one/year

**POC Requirement:** Not required (if listed, PRN frequency)               **Billing Restrictions:** For H012/H013 (See Medicare restrictions above) Initial PDA’s: Not billed on same day as Subsequent PDA Any services rendered after 90 calendar days from admission date and before the rendering of a PDA may not be billed. Once PDA completed, may bill.

**Units:** Based on time and complexity               **Maximum units/day:** 1 Encounter/day

MCO Prior Authorization: Never

Updated August 2016
NURSING SERVICE (NS) H021

Documentation:

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General Purpose: Offers a variety of face-to-face or telephonic interventions to the client. A holistic approach is used that addresses the medical, physical, and psychiatric needs of the client, recognizes the interaction of the two and prevents unnecessary psychiatric hospitalizations. Used for monitoring medication(s), promoting health, educating the client, and to provide follow up nursing care.

Provided face-to-face or telephonic with the client or on behalf of the client to assess the client’s physiological or psychological response to a medication order.

Provided by: RN, under supervision of MD or APRN

POC Requirement: Not required
If listed: PRN

Billing Restrictions: Telephonic: 2 units/day

Units: 15 mins

Maximum units/day: 7 units/day

MCO Prior Authorization: Never

Updated August 2016
INJECTABLE MEDICATION ADMINISTRATION (MED ADMIN)

H010 AND H016

Documentation:

- Medication Administered
- Dosage given (quantity and strength)
- The route (IM, ID, IV)
- The injection site
- Side effect(s) or adverse reaction(s)

General Purpose: Is the injection of a medication in response to the order of a licensed physician or APRN which is documented on a PMO. Used as an adjunctive treatment to restore, maintain or improve the client’s role performance or mental status.

Provided by: RN, MD, APRN, LPN

POC Requirement: Not required

Billing Restrictions: Don’t bill H010 if client provides/pays for medication. Bill when Center is providing medication.

If listed: PRN

Units: Billed per cost of medication

Maximum units/day: N/A

MCO Prior Authorization: Never

Updated August 2016
MH SERVICE PLAN DEVELOPMENT BY NON-PHYSICIAN (SPD) H017-03

Documentation:

- Focus of the staffing (one or more of the following):
  - Client’s treatment needs
  - Development, monitoring and/or review of POC
  - Diagnosis
  - Discharge plans
  - Treatment strategies
  - Types and frequencies of services
  - Confirmation of medical necessity
- The Physician’s recommendations

General Purpose: MH Service Plan Development by Non-Physician is a face-to-face or telephonic interaction between a physician and a Mental Health Professional (MHP) or Registered Nurse (RN) to jointly assess the client's mental and physical strengths, weaknesses, social history, and support systems. The purpose of this service is to develop an individualized plan of care for the beneficiary, based on the beneficiary’s needs, goals and objectives and identify appropriate treatment or services needed by the beneficiary to meet the goals.

Provided by: MHP or RN with Physician jointly

The MHP/RN and the Physician are required to sign and date the CSN corroborating the delivery of the service.

POC Requirement: Not required
Billing Restrictions: None

Units: 15 mins
Maximum units/day: 2 units/day

Note: as in any Service your documentation must reflect and support the time billed.

MCO Prior Authorization: Never

Updated August 2016
SERVICE PLAN DEVELOPMENT/INTERDISCIPLINARY TEAM (SPD/IT)

H060-001 (CLIENT PRESENT)

H060-002 (CLIENT NOT PRESENT)

Documentation:

- Focus of the staffing (one or more of the following):
  - Members of the interdisciplinary team present
  - Client’s treatment needs
  - Development, monitoring and/or review of POC
  - Diagnosis
  - Discharge plans
  - Treatment strategies
  - Types and frequencies of services
  - Confirmation of medical necessity

General Purpose: to allow the interdisciplinary team the opportunity to discuss and or review the beneficiary’s needs in collaboration and develop a plan of care. The interdisciplinary team will establish the beneficiary’s goals, objectives and identify appropriate treatment or services needed by the beneficiary to meet those goals.

An interdisciplinary team is typically composed of the client, his or her family members, treatment providers, care coordinators and/or multiple health and human service agencies. The client can either be present or not present during the interdisciplinary team meeting.

Venue: Multi-agency meetings may be face-to-face or telephonic

Provided by: MHP

POC Requirement: Not required

Billing Restrictions: SPD (H017), ASSMT, and PDA cannot be billed on the same day.

Units: Encounter

Maximum units/day: Encounter, 1/day

MCO Prior Authorization: Never

Updated August 2016
PSYCHOSOCIAL REHABILIATIVE SERVICES (PRS) H056

Documentation:

- Focus of the objectives of the activities.
- The nature of the activities in which the client participated.
- Intervention(s) and involvement of staff.
- Response of the client to these intervention(s) regarding the development of the psychosocial behavioral skills.
- The progress of the client in reference to the treatment objectives/goals and includes observations of their conditions/mental status.
- The plan for the next session.

General Purpose: The purpose of this face-to-face service is to enhance, restore and/or strengthen the skills needed to promote and sustain independence and stability within the beneficiary’s living, learning, social, and work environments. PRS is a skill building service, not a form of psychotherapy or counseling. PRS is intended to be time-limited. The intensity and frequency of services offered should reflect the scope of impairment. Services are generally more intensive and frequent at the beginning of treatment and are expected to decrease as the beneficiary’s skills develop. Services are based on medical necessity, shall be directly related to the beneficiary’s diagnostic and clinical needs and are expected to achieve the specific rehabilitative goals specified in the beneficiary’s POC.

PRS include activities that are necessary to achieve goals in the POC in the following areas:

- Independent living skills development related to increasing the beneficiary’s ability to manage his or her illness, illness, to improve his or her quality of life, and to live as actively and independently in the community as possible
- Personal living skills development in the understanding and practice of daily and healthy living habits and self-care skills
- Interpersonal skills training that enhances the beneficiary’s communication skills, ability to develop and maintain environmental supports, and ability to develop and maintain interpersonal relationships

Eligibility & Continued Stay Criteria: Admission to the time-limited PRS program for Adults or Children requires that several distinct clinical criteria be established. To determine if your client is eligible, refer to pages 2-100 through 2-104 of the SC DHHS Rehabilitative Behavioral Health Services Policy and Procedure manual at the link below:


Provided by: MHP

Ratio: Individually or in small groups of 1:8

POC Requirement: Required, must be implemented within 30 days or has to be re-authorized by physician in order to be reimbursed for service.

Billing Restrictions: only one RBHS Community Support Service (PRS, FS, BMod, CIS) can be billed on any date of service

Units: 15 mins; Maximum units/day: 24 units/day

MCO Prior Authorization: YES, for all MCOs

Updated August 2016
PEER SUPPORT SERVICES (PSS) H059

Documentation:

- Focus of the objectives of the activities.
- The nature of the activities in which the client participated.
- Intervention(s) and involvement of staff.
- Response of the client to these intervention(s) regarding the development of the psychosocial behavioral skills.
- The progress of the client in reference to the treatment objectives/goals and includes observations of their conditions/mental status.
- The plan for the next session.

General Purpose: to allow Medicaid beneficiaries over the age of 18 with similar life experiences to share their understanding with other beneficiaries to assist in their recovery from mental health and/or substance use disorders. The peer support specialist gives advice and guidance, provides insight, shares information on services and empowers the beneficiary to make healthy decisions. The unique relationship between the peer support specialist and the beneficiary fosters understanding and trust in beneficiaries who otherwise would be alienated from treatment. The beneficiary’s plan of care determines the focus of Peer Support Services (PSS).

PSS is person-centered with a recovery focus. Allows client’s to direct their own recovery and advocacy processes. Promotes skills for coping with and managing symptoms while facilitating the utilization of natural resources and the preservation and enhancement of community living skills. Services are multifaceted and emphasize the following:

- Personal Safety
- Self-worth
- Introspection
- Choice
- Confidence
- Growth

- Connection
- Boundary Setting
- Planning
- Self-advocacy
- Personal Fulfillment
- The Helper Principle

- Crisis Management
- Education
- Meaningful Activity and Work
- Effective Communication Skills

To reinforce and enhance the client’s ability to cope and function in the community and develop natural supports.

Eligibility & Continued Stay Criteria: Eligibility for PSS for Adults requires that several distinct clinical criteria be established. To determine if your client is eligible, refer to pages 2-135 through 2-136 of the SC DHHS Rehabilitative Behavioral Health Services Policy and Procedure manual at the link below:


Provided by: Certified Peer Support Specialist

POC Requirement: Required with specific frequency

Ratio: Individual or in small groups consisting of no more than 8 clients

Billing Restrictions: None

Units: 15 mins  Maximum units/day: 16 units/day

MCO Prior Authorization: YES, (SelectHealth, BlueChoice, ATC/Cenpatico, WellCare); No, (Molina)

Updated August 2016
MEDICAL MANAGEMENT ONLY (MMO)

(NOT A SERVICE BUT IS A LEVEL OF CARE)

Medical Management Only (MMO) is a level of care provided to clients due to their level of functioning and psychiatric stability do not require ongoing psychotherapeutic intervention. Clients that are eligible for MMO require only the prescription of appropriate medications and continued monitoring for side effects. Based on the judgment of the physician, these identified clients who can benefit from medical management to maintain therapeutic gains and emotional stabilization will be managed by medical staff with the exception of situations of crisis when the client may be seen by a MHP and if client is receiving Targeted Case Management (TCM) to be assisted in assessing resources to meet general needs.

The physician determines and authorizes (through a PDA) the appropriateness of the client for the program and prescribe a plan of care to be followed.

Annual Assessment:

All MMO clients must be assessed at least annually to determine ongoing appropriateness for program.

The APRN can conduct the annual psychiatric assessment and determine the treatment plan to be followed. The PMO should include the co-signature of the supervising physician.

Services are provided by: Physicians, Advanced Practice Registered Nurses (APRN’s), Registered Nurses (RN’s), Physician Assistants (PA’s), Licensed Practical Nurses (LPN’s)

Services allowed:

- Nursing Services (NS)
- Mental Health Service Plan Development by Non-Physician (SPD)
- Injectable Medication Administration (INJ ADM)
- Mental Health Assessment by a non-physician (ASSMT)
- Psychiatric Diagnostic Assessment (PMA)
- Psychiatric Diagnostic Assessment Advanced Practice Registered Nurse (PMA APRN)
- Crisis Intervention Services (CI) (NOTE: up to 2 contacts/year)

The client’s progress and any significant changes in the client’s treatment must be documented in the medical record every 90 days. Summary may be documented in the PMO or CSN. If the client has not been seen by physician, APRN, or RN during the preceding 90 day period and does not have sufficient clinical information a progress summary must be completed during the first contact thereafter.

At any time in treatment it is determined that the client needs additional community mental health services other than those allowed under MMO and/or the client no longer meets MMO criteria then MMO will be discontinued by physician/APRN and appropriate services to meet the needs of the client will be provided by appropriate clinical staff.

Updated August 2016
TARGETED CASE MANAGEMENT (TCM)

FOR INFORMATION ONLY

(This service is provided by care coordinator only and is separate from clinical services.)

Documentation:

- Purpose of contact(s)
- Who was contacted
- Component(s) of TCM utilized
- Results of contact(s)
- Plan for continued follow up

**General Purpose:** Activities which will assist clients in gaining access to needed medical, social, treatment, educational, and other services through:

- **Assessment:** taking individual history, identifying the needs, completing related documentation, and gathering information from other sources such as family members, medical providers, social workers, and educators as necessary to form a complete assessment of the client.
- **Care Plan:** development and periodic revision of a specific care plan based on the information collected through the assessment, that includes the following: goals and actions to address the needed services, activities such as ensuring the active participation of the client and working with the client and others to develop goals, and identifies a course of action to respond to the client’s assessed needs.
- **Referral and Linkage:** referral and related activities (such as scheduling appointments) to help the client obtain needed services, including activities that help link the client with services that are capable of providing services to address identified needs and achieve specified goals.
- **Monitoring and Follow-up:** activities and contacts that are necessary to ensure that the Care Plan is effectively implemented and adequately addresses the client’s needs. May be with the client, family members, service providers, or other entities or individuals. May be conducted as frequently as necessary and including at least one annual monitoring to help determine whether services are being furnished in accordance with the Care Plan, services in the Care plan are adequate to meet the client’s needs, and there are changes in the client’s needs or client’s status.

**TCM Activities:**

Documentation must support that the TCM billed includes at least one of the following: For a complete list of TCM activities see Section 2 of the Targeted Case Management Provider Manual.

- Assists the client in obtaining required educational, treatment, residential, medical, social, or other support services through accessing available services or advocating for service provision.

Updated August 2016
• Contacts with providers of social, health, and rehabilitation services to promote access to and appropriate use of services by the client, and coordination of service provision by multiple providers.
• Monitors client’s progress through the services accessed by the client and performs periodic reviews and reassessment of treatment needs.
• Arranges and monitors client access to health and/or behavioral/mental health care providers. Includes written correspondence sent to health and/or behavioral health care providers which gives a synopsis of care client is receiving.
• Coordinates and monitors other health care needs by arranging appointments for services.
• Contact with the client dealing with specific and identifiable problems of service access which requires the Care Coordinator to guide or advise the client in the solution of the problem of services access.
• Contacts with family, representatives of human service agencies, and other service providers to form a multidisciplinary team to develop a comprehensive and individualized service plan, which describes the client’s problems and corresponding needs, and details services to be accessed or procured to meet the client’s needs.
• Preparation of a written report which details the client’s psychiatric and/or functional status, history, treatment, or progress for service providers for physicians, other service providers, or agencies. (Note: not for legal or consultative purposes.)
• Accessing:
  • needs, access to services or client functioning
  • the medical and/or mental needs through review of evaluations completed by other providers of services
  • of physical needs, such as food and clothing
  • of social and/or emotional status
  • for housing, financial and/or physical environment needs
  • for familial and/or social support system
  • for independent living skills and/or abilities
• Ensuring the active participation of the client.
• Working with the client and others to develop goals.
• Identifying a course of action to respond to the client’s assessed needs.
• Linking clients with medical, social, educational, and/or other providers, programs, and services that are capable of providing the assessed needed services.
• Ensuring the Care Plan is implemented effectively and is adequately addressing the client’s needs.
• Staffings related to receiving consultation and supervision on a specific case to facilitate optimal case management. This includes recommending and facilitating movement from one program to another or from one agency to another.

Provided by: Care Coordinator who has successfully completed a SCDHHS approved training curricula.

Requirements:

• Freedom of Choice form(s)
• Needs Assessment
• CMP (Case Management Care Plan):
  • Developed within 14 working days of the TCM Needs Assessment.
    o Must be developed prior to billing for TCM services.
    o Reviewed and updated as needed.

Updated August 2016
Reformulated at a minimum of 180 calendar days (6 months) after the development of the initial CMP. If not reformulated by the 180th day TCM activities are not reimbursable from the 181st day until the date of the completion of a new CMP.

- Progress Summary: at least every 180 days (6 months) in consultation with the client.

Billing Restrictions:

- Only the Care Coordinator from the Freedom of Choice form shall bill for TCM services.
- Does not include the direct delivery of an underlying medical, educational, social, or other service to which a client has been referred.
- Persons with family relationships to the client may not provide TCM services to the client.
- Reimbursement for activities involved in trying to locate a client may be claimed for only the first 30 days.
- For specific non-billable activities see Section 2 of the Targeted Case Management Provider Manual.

Units: 15 mins
Maximum units/day: 16 units/day

Contact: face-to-face, telephone.

Frequency of Contact: Determined based on client’s individual needs.

- Must make contact with the client, parent, legal guardian, or representative, at least once every 180 calendar days (6 months) or more frequently as specified in the Care Plan.
- At least one face-to-face contact must be made in the client’s residential setting within the first 6 months (180 days) of service.
- Face-to-face or telephone contact with the client, family member, authorized representative, or provider at least every 60 days.
- At the request of the client.

Limitations: Does not include the direct delivery of an underlying medical, educational, social, or other service to which a client has been referred.
GENERAL MEDICAL RECORDS STANDARDS

- Each client shall have a medical record. Medical records are legal documents.
- Medical record shall include sufficient information to justify treatment and permit a clinician not familiar with the client to evaluate the course of treatment.
- Kept confidential in conformance with HIPAA regulations.
- Medical records must be current and meet documentation requirements.
- Medical records must contain:
  - Initial Clinical Assessment
  - PDA
  - All treatment plans, reviews, and addenda
  - Physician’s orders, lab results, lists of medications and prescriptions (when applicable)
  - Clinical Service Note (CSN)
  - Copies of any testing
  - Copies of all written reports
  - Consents and eligibility information
  - Any other documents relevant to client’s care
- **Consents:** A signed consent must be obtained from all clients at each admission. If the client refused to sign, the clinician should indicate why in a CSN. If client is unable to sign due to a crisis, a family member may sign, or if alone, the MHP and one other person can sign stating the client is unable to sign due to emergency situation. The client should sign the consent as soon as circumstances permit.
- **Abbreviations:** Only approved abbreviations of services and accepted abbreviations maintained by the service provider may be used.
- **Legibility:** All documents must be typed or legibly written in black or blue ink. Legible signature and credential of the person rendering the service must be present in all clinical documentation.
- **Error Correction (written documentation):** NEVER use white out or any type of correction tape in any documentation that will be placed in the client’s medical record. This can be interpreted as falsification of medical records. Never completely scratch through an error. This applies to “write-overs” as well. The proper way to correct an error is: Draw one line through the error/mistake: Write “ME” for “mistaken entry” or “ER” for error” to the side of the error in parenthesis (ME) (ER). Initial and date the mistake. Continue writing immediately following the mistake.
- **Late Entries:** Should only be used to correct a genuine error of omission or to add new information that was not discovered until a later date.
  - Written documentation: Identify the new entry as “late entry.” Enter the current date and time. Identify or refer to the date and incident for which the late entry is written. Sign and date the late entry. Document as soon as possible.
  - EMR: once a CSN is signed you may update the documentation my noting the reason for the update using the guidelines above. All prior documentation can be seen by viewing all forms when you click on that service note.
- **Physician Responsibility:** The physician must direct all treatment. A PDA is required for all clients within 90 days of admission. The physician must sign the POC within 90 days. The physician must approve any additions of service or change in frequency on the service plan. The physician must sign the rollover POC’s on, or no earlier than 30 days prior to, the due date (based on admission date).

Updated August 2016
SECTION 2: GUIDE FOR DETERMINING BILLABLE TIME

BILL TIME is direct face to face contact (with the client or caregiver) for all services except those that can be delivered “on behalf” of the client or over the telephone (See Service Descriptions). Billable time starts from the time you greet the client at the front door until you say goodbye at the front check-out window. As you are escorting the client to your office, you are making the critical first impressions on the mental status of the client.

Bill time is the actual amount of time spent with the client or on behalf of the client.

STAFF TIME must be less than or equal to Bill Time.

NO-CHARGE:

If a service is not to be charged, select the reason in the No Charge Indicator Box (drop-down box) of the CSN.

NON-BILLABLE ACTIVITIES:

There are some activities that are done for and on behalf of clients that are not allowed to be billed. The following list is not exhaustive and is intended as a guide.

- Travel time
- Attempted phone calls
- Attempted home visits
- Attempted face to face contacts

Updated August 2016
• Record reviews
• Completion of any specially requested information regarding clients from the State office or from other agencies for administrative purposes
• Services provided to institutionalized Medicaid clients (i.e. DJJ, prisons/jails, DMH hospitals, ICF, ICF/MR facilities, IMDs, long term hospitalization outside SC DMH, etc.)
• Recreation or socialization with a client. Professional judgment should be exercised in distinguishing between billable and non-billable activities
• Documentation of service notes
• Completion of MIS reports and monthly statistical reports
• Unstructured time with clients. Inactivity, free and unstructured time may be necessary for a client, but is not part of billable service
• Educational services provided by the public school system, such as home bound instruction, special education, or defined educational courses (GED, Adult Development). Tutorial services in relation to a defined education course are non-billable
• Filing and mailing of reports
• Medicaid eligibility determinations and redetermination
• Medicaid intake processing
• Prior authorization for Medicaid services
• Required Medicaid utilization review
• Early Periodic Screening, Diagnosis and Treatment (EPSDT) administration
• “Outreach” activities in which an agency or a provider attempt to contact potential Medicaid recipients
• Participation in job interviews
• The on-site instruction of specific employment tasks
• Staff supervision of actual employment services
• Assisting the client in obtaining job placement
• Assisting the client in filling out an application
• Assisting the client in performing the job or performing the job for the client
• Taking a specimen to the lab
• Visiting a client while he is in another mental health service program
• Assisting the client get medication kept at the CMHC
• Scheduling appointments with the physician, or any other clinician at the CMHC

BILLABLE ACTIVITIES:

See Service Descriptions and Section 2 of the Community Mental Health Services Medicaid Provider Manual.
WAYS OF ACCESSING SERVICES

- New clients access BCMHC services in a variety of ways. The center has Walk-in hours Mon-Fri 8:30a-2:30p during which a potential new client will be screened and possibly assessed to determine treatment needs. Clients may also call the Access/Mobile Crisis team to receive a phone screening to determine eligibility. Also, clients may access services through crisis contacts which may be initiated by family, friends, citizens or law enforcement
- Routine Admission to BCMHC Outpatient Services-Scheduled Appointment
- Emergency Admission to BCMHC Outpatient Services- Unscheduled Appointment

<table>
<thead>
<tr>
<th>Forms to Complete</th>
<th>Disposition of Forms</th>
</tr>
</thead>
<tbody>
<tr>
<td>If Applicable:</td>
<td>Emergency After hours</td>
</tr>
<tr>
<td>Initial Clinical Assessment Form (ICA) or ICA Update</td>
<td>EMR</td>
</tr>
<tr>
<td>Medical Assessment Form</td>
<td>EMR-Import</td>
</tr>
<tr>
<td>Crisis Management Form</td>
<td>EMR-Import</td>
</tr>
<tr>
<td>Copy of Commitment Papers</td>
<td>EMR-Import</td>
</tr>
<tr>
<td>Hospital Discharge Assessment</td>
<td>EMR-Import</td>
</tr>
<tr>
<td>Screen 8</td>
<td>Wall Divider-Mail Room</td>
</tr>
<tr>
<td>CSN</td>
<td>EMR</td>
</tr>
<tr>
<td>Discharge Data if closing case</td>
<td>Wall Divider-Mail Room</td>
</tr>
<tr>
<td>Trauma Assessment</td>
<td>Front Desk then EMR-Import</td>
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<tr>
<td>Satisfaction Survey</td>
<td>To QI for scoring.</td>
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See the next pages for codes to use in the Screen 8 form.
### GUIDE FOR COMPLETING CIS INFORMATION SCREEN 8 FORM

**REFERRAL SOURCE:**

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<thead>
<tr>
<th>Code</th>
<th>Referral Source</th>
<th>Code</th>
<th>Referral Source</th>
<th>Code</th>
<th>Referral Source</th>
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<td>Aiken - Barnwell MHC</td>
<td>FF</td>
<td>Family or Friend</td>
<td>MH</td>
<td>Private MH Professional</td>
</tr>
<tr>
<td>3H</td>
<td>AOP MHC</td>
<td>GH</td>
<td>General Hospital</td>
<td>PP</td>
<td>Pvt Physician/Psychiatrist</td>
</tr>
<tr>
<td>3J</td>
<td>Beckman MHC</td>
<td>3A</td>
<td>Greenville MHC</td>
<td>PH</td>
<td>Pvt Psychiatric Facility</td>
</tr>
<tr>
<td>3W</td>
<td>Berkeley MHC</td>
<td>47</td>
<td>Harris Hospital</td>
<td>3F</td>
<td>Santee-Wateree MHC</td>
</tr>
<tr>
<td>46</td>
<td>Bryan Hospital</td>
<td>HS</td>
<td>Health Service</td>
<td>SH</td>
<td>School/Special Class</td>
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<td>49</td>
<td>Byrnes Medical Center</td>
<td>LF</td>
<td>Law Enforcement</td>
<td>SF</td>
<td>Self</td>
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<td>Campbell Nursing Home</td>
<td>3T</td>
<td>Lexington MHC</td>
<td>SS</td>
<td>Social Services</td>
</tr>
<tr>
<td>3G</td>
<td>Catawba MHC</td>
<td>MR</td>
<td>Mental Retardation</td>
<td>41</td>
<td>State Hospital</td>
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<td>3B</td>
<td>Chas/Dor MHC</td>
<td>71</td>
<td>Morris Village</td>
<td>3C</td>
<td>Spartanburg MHC</td>
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<td>CL</td>
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<td>NH</td>
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<td>3N</td>
<td>Tri-County MHC</td>
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<td>3M</td>
<td>Coastal Empire MHC</td>
<td>3R</td>
<td>Orangeburg MHC</td>
<td>65</td>
<td>Tucker Center</td>
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<td>3D</td>
<td>Columbia Area MHC</td>
<td>OT</td>
<td>Other Referrals</td>
<td>VA</td>
<td>Veterans Administration</td>
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<td>CC</td>
<td>Community Care Home</td>
<td>MP</td>
<td>Other Med Professionals</td>
<td>VR</td>
<td>Vocational Rehabilitation</td>
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<td>CR</td>
<td>Courts</td>
<td>OS</td>
<td>Out of State</td>
<td>3P</td>
<td>Waccamaw MHC</td>
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<td>42</td>
<td>Crafts Farrow</td>
<td>3E</td>
<td>Pee Dee MHC</td>
<td>58</td>
<td>William S. Hall</td>
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<td>DA</td>
<td>Drug and Alcohol</td>
<td>3S</td>
<td>Piedmont MHC</td>
<td>YS</td>
<td>Youth Services</td>
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<td>44</td>
<td>DGNCC-Columbia</td>
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<td>DGNCC-Rock Hill</td>
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**PRESENTING PROBLEM:**

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<td>1</td>
<td>Substance</td>
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<tr>
<td>2</td>
<td>Psych/Substance</td>
</tr>
<tr>
<td>3</td>
<td>Psychiatric/MR</td>
</tr>
<tr>
<td>4</td>
<td>Psych/Substance/MR</td>
</tr>
<tr>
<td>5</td>
<td>Substance/MR</td>
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<tr>
<td>6</td>
<td>All Others</td>
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**TYPE OF COMMITMENT:**

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<td>01</td>
<td>Voluntary</td>
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<tr>
<td>02</td>
<td>Emergency</td>
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<tr>
<td>03</td>
<td>Judicial</td>
</tr>
<tr>
<td>04</td>
<td>Circuit/Criminal Court Order</td>
</tr>
<tr>
<td>05</td>
<td>Family Court</td>
</tr>
<tr>
<td>06</td>
<td>Medical Certification</td>
</tr>
<tr>
<td>07</td>
<td>Order of MH Commission</td>
</tr>
<tr>
<td>08</td>
<td>Court to Judicial</td>
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**TYPE OF PAPERS:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Type of Papers</th>
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<tbody>
<tr>
<td>01</td>
<td>Psychiatric</td>
</tr>
<tr>
<td>02</td>
<td>Alcohol/Drug</td>
</tr>
<tr>
<td>03</td>
<td>Nursing Home</td>
</tr>
<tr>
<td>04</td>
<td>Forensic</td>
</tr>
<tr>
<td>05</td>
<td>Court Order for Outpatient Treatment</td>
</tr>
<tr>
<td>Cat</td>
<td>Description</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------</td>
</tr>
<tr>
<td>01</td>
<td>Private Residence/Household</td>
</tr>
<tr>
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<td></td>
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</tr>
<tr>
<td>02</td>
<td>Homeless Shelter</td>
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<tr>
<td>03</td>
<td>On the Street</td>
</tr>
<tr>
<td>04</td>
<td>Jail or Correction Facility</td>
</tr>
<tr>
<td>05</td>
<td>Other Residential or Institutional Facility</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Updated August 2016
| 5D | Community Residential Care Facility- Standard-Type 1: Living in a community residential care facility offering room and board with minimal supervision in personal care as outlined in DEHEC licensure. |
| 5E | Community Residential Care Facility- Type 2: Living in a community residential care facility that provides a higher level of care and rehab services. The CRCF has contracted with DMH for enhanced services not provided for in a standard CRCF. |
| 5F | Community Residential Care Facility- Type 3: Living in a community residential care facility operated by DMH and provides a very structured and high level of personal care and rehabilitative services. |
| 5G | Group Home-Moderate: Living in a group home with level of supervision and intensity of program to manage and treat youth with moderate emotional and/or behavioral problems. Approved by DSS. |
| 5H | Group Home-High Management: Living in a group home with level of supervision and intensity of program to manage and treat youth with severe emotional and/or behavioral problems. Approved by DSS. |
| 5J | Residential Treatment Facility: Living in a highly structured and secure treatment environment with intensive professional multi-disciplinary focus for youth. Licensed by DHEC. |
| 5K | Resides in an inpatient setting in a facility such as a psychiatric hospital, a medical hospital, etc. but not a correctional unit. |
| 5L | Nursing home: Living in a facility providing comprehensive nursing care on a 24 hour basis. |

| 99 | Not Collected/Not Available |
| 9A | Not collected/Not Available/Unknown/Not reported. |

**OTHER QUESTIONS ABOUT LIVING ARRANGEMENTS WHEN SCREEN IS CHOSEN:**

- Does the consumer live in SCDMH housing?
  - (At present time the answer for Berkeley County consumers should be NO.)
- Is the consumer receiving a housing rent subsidy? (Check those that apply)

**HOUSEHOLD COMPOSITION:**

| 1 | Lives alone |
| 2 | Lives with family/relatives |
| 3 | Lives with significant other(s) |
| 4 | Group/Institutional Living |
| 5 | Not appropriate |

**COMPETENCY: (JAIL INMATES ONLY)**

| 01 | NGRI |
| 02 | Not Adjudicated |
| 03 | Guilty but Mentally Ill |
| 04 | Not competent to stand trial |
| 05 | Memo of Agreement/Mental |
| 06 | Examination to determine competency |

Updated August 2016
### PSYCHIATRIC ADMISSIONS:

<table>
<thead>
<tr>
<th>Inpatient:</th>
<th></th>
<th>Outpatient:</th>
</tr>
</thead>
<tbody>
<tr>
<td>46 Bryan Hospital</td>
<td>3K Aiken Barnwell MHC</td>
<td>3R Orangeburg MHC</td>
</tr>
<tr>
<td>42 Crafts Farrow</td>
<td>3H Anderson Oconee Pickens MHC</td>
<td>MP Other medical professional</td>
</tr>
<tr>
<td>GH General Hospital</td>
<td>3J Beckman MHC</td>
<td>3E Pee Dee MHC</td>
</tr>
<tr>
<td>47 Harris Hospital</td>
<td>3W Berkeley MHC</td>
<td>3S Piedmont MHC</td>
</tr>
<tr>
<td>NN None</td>
<td>3G Catawba MHC</td>
<td>MH Private MH professional</td>
</tr>
<tr>
<td>IP Other Inpt Hospital</td>
<td>3B Chas/Dor MHC</td>
<td>PP Private Physician/Psych</td>
</tr>
<tr>
<td>PH Private Psychiatric Hospital</td>
<td>3M Coastal Empire MHC</td>
<td>PH Pvt Psych Facility</td>
</tr>
<tr>
<td>41 SC State Hospital</td>
<td>3D Columbia MHC</td>
<td>3F Santee-Wateree MHC</td>
</tr>
<tr>
<td>UN Unknown</td>
<td>GH General Hospital</td>
<td>3C Spartanburg MHC</td>
</tr>
<tr>
<td>58 Wm S Hall Psych Inst</td>
<td>3A Greenville MHC</td>
<td>3N Tri-County MHC</td>
</tr>
<tr>
<td>71 Morris Village</td>
<td>3T Lexington MHC</td>
<td>UN Unknown</td>
</tr>
<tr>
<td>VA Veterans Admin</td>
<td>NN None</td>
<td>3P Waccamaw MHC</td>
</tr>
<tr>
<td>54 Wm S Hall Outpt Services</td>
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</tbody>
</table>

### GAF/CGAS CODES:

**GAF/CGAS has been replaced by DLA-20 score (mGAF) beginning November 2015.**

**Updated August 2016**
### EMPLOYMENT CODES:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanation</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0</td>
<td>Consumer Operated Business</td>
<td>Employed in a business operated by client(s).</td>
<td>01</td>
<td>Competitive</td>
</tr>
<tr>
<td>A1</td>
<td>Self-Employed</td>
<td>Owner of own business.</td>
<td>01</td>
<td>Competitive</td>
</tr>
<tr>
<td>B0</td>
<td>Employed Competitively</td>
<td>Employed in a competitive job situation—non consumer run business.</td>
<td>01</td>
<td>Competitive</td>
</tr>
<tr>
<td>B1</td>
<td>Active Military</td>
<td>On active duty in the US Military (Army, Navy, Air Force, Marines, Coast Guard, etc.)</td>
<td>01</td>
<td>Competitive</td>
</tr>
<tr>
<td>M1</td>
<td>Employed Informally</td>
<td>Day Laborer/Casual Labor</td>
<td>01</td>
<td>Competitive</td>
</tr>
<tr>
<td>C0</td>
<td>Supported Employment</td>
<td>Employed on a job that is not time limited with necessary support provided by a job coach</td>
<td>02</td>
<td>Supported Employment</td>
</tr>
<tr>
<td>D0</td>
<td>Time Limited Transitional</td>
<td>Employed in a time limited job with ongoing job support to maintain the worker role</td>
<td>02</td>
<td>Supported Employment</td>
</tr>
<tr>
<td>F0</td>
<td>Mobile Work Crew</td>
<td>Member of a supervised work crew in a MHC or similar community setting with job support from staff.</td>
<td>02</td>
<td>Supported Employment</td>
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<tr>
<td>G0</td>
<td>Enclave</td>
<td>Eight of fewer consumer employees in one location with continuous supervision and ongoing job support from staff.</td>
<td>02</td>
<td>Supported Employment</td>
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<tr>
<td>I0</td>
<td>Vocational Volunteer</td>
<td>Volunteers in a work setting to improve vocational skills.</td>
<td>03</td>
<td>Unemployed and desiring work</td>
</tr>
<tr>
<td>P1</td>
<td>Unemployed and seeking work</td>
<td>Currently unemployed-desiring and seeking employment.</td>
<td>03</td>
<td>Unemployed and desiring work</td>
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<tr>
<td>P2</td>
<td>Unemployed and not seeking work</td>
<td>Currently unemployed and desiring work but currently not seeking employment.</td>
<td>03</td>
<td>Unemployed and desiring work</td>
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<tr>
<td>H0</td>
<td>Unpaid family worker</td>
<td>Works in a family owned business and does not receive a salary.</td>
<td>04</td>
<td>Not in Work force and not seeking or desiring work</td>
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<tr>
<td>J0</td>
<td>Educational Placement and training</td>
<td>Enrolled in a specific educational program to increase abilities for competitive employment.</td>
<td>03</td>
<td>Unemployed and desiring work</td>
</tr>
<tr>
<td>J1</td>
<td>Student over 17 years old</td>
<td>Student over 17 in an educational program and currently not desiring/seeking work.</td>
<td>04</td>
<td>Not in Work force and not seeking or desiring work</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Explanation</td>
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<td></td>
</tr>
<tr>
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<td>-------------</td>
<td>-------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J2</td>
<td>Preschool</td>
<td>Children under age 5 that are not attending an educational program.</td>
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<tr>
<td>J3</td>
<td>Student under 18 years old</td>
<td>Student under 18 in an educational program.</td>
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<tr>
<td>K1</td>
<td>Homemaker/Caretaker</td>
<td>Maintains a household with or without family—does not work outside the home.</td>
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<tr>
<td>K2</td>
<td>Retired</td>
<td>Retired from the workforce and not desiring or seeking employment.</td>
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<td>Disabled</td>
<td>Currently on disability and currently unable to work.</td>
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<td>Z1</td>
<td>Other</td>
<td>Any employment status not listed above except unknown.</td>
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<tr>
<td>Z9</td>
<td>Unknown</td>
<td>Consumer’s employment status is unknown.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EMPLOYMENT LEVELS:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Full time</td>
<td>Working 35+ hours per week</td>
</tr>
<tr>
<td>02</td>
<td>Part time</td>
<td>Working &lt; 35 hours per week</td>
</tr>
<tr>
<td>03</td>
<td>Not employed</td>
<td>Unemployed</td>
</tr>
<tr>
<td>04</td>
<td>Not applicable</td>
<td>Not applicable or unemployment level unknown</td>
</tr>
</tbody>
</table>

**JOB CLASS:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Classification</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0</td>
<td>Professional</td>
<td>School teacher, physician, attorney, librarian, nurse, etc.</td>
</tr>
<tr>
<td>B0</td>
<td>Managerial</td>
<td>Sales manager, trade manager, public administration manager</td>
</tr>
<tr>
<td>C0</td>
<td>Technical</td>
<td>Engineer, analyst, lab technician, scientist, etc.</td>
</tr>
<tr>
<td>D0</td>
<td>Construction/Contractor</td>
<td>Plumber, carpenter, electrician, mechanic, carpet installer</td>
</tr>
<tr>
<td>E0</td>
<td>Clerical/sales</td>
<td>Secretary, file clerk, data entry, bookkeeper, cashier</td>
</tr>
<tr>
<td>F0</td>
<td>Service</td>
<td>Wait staff, preschool helper, hair dresser</td>
</tr>
<tr>
<td>G0</td>
<td>Other</td>
<td>-----------</td>
</tr>
</tbody>
</table>
OFFICE AND LOCATION CODES:

What do they mean? When do I use them?
We have tried to simplify the office/location codes.

B 27 - Used by Access Center for intake admissions. Code changes as they are assigned to clinicians.
B 35 - Used by all adult clients seen who are NOT in an emergency
B 45 - Used by HomeShare clients in all situations
B 48 - Used by IPS workers when working specifically on employment with clients
B 50 - Used for ACT (Like) clients at all times
B 54 - Used for children in treatment all diagnosis and circumstance except emergencies
B 71 - Crisis Diversion
B 72 - CRISP
B 87 - Proviso children
C 34 – DSS/Child Welfare Initiative-children seen by DSS worker
Q 56 – ICS: Children seen in ICS

SCHOOL OFFICE/LOCATION CODES

D 32  Whitesville Elementary
H 32  Goose Creek Primary
J 32  Sedgefield Elementary
K 32  Hanahan Elementary
L 32  Goose Creek High
P 32  Boulder Bluff Elementary
S 32  Sedgefield Middle
U 32  Sangaree Elementary
V 32  Sangaree Intermediate
X 32  St. Stephen Elementary
Y 32  Sangaree Middle
Z 32  Cross Elementary

CRISIS CODES: BY PHONE OR IN PERSON

B 70 - Crisis for adults during office hours MC office
B 80 - Crisis for Children during office hours MC office
G 70 - Crisis for adults after hours
G 80 - Crisis for children after hours

<table>
<thead>
<tr>
<th>Office and Location Codes</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>B 27</td>
<td>Intake and Triage/Assessment</td>
</tr>
<tr>
<td>B 35</td>
<td>Continuing Treatment and Support (Adults)</td>
</tr>
<tr>
<td>B 45</td>
<td>HomeShare</td>
</tr>
<tr>
<td>B 48</td>
<td>Employment-IPS</td>
</tr>
<tr>
<td>B 50</td>
<td>ACT-Like</td>
</tr>
<tr>
<td>B 54</td>
<td>Continuing Treatment and Support (CAF)</td>
</tr>
</tbody>
</table>

Updated August 2016
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B 70</td>
<td>Crisis Intervention-Office Hours-Adult</td>
</tr>
<tr>
<td>B 71</td>
<td>Crisis Diversion</td>
</tr>
<tr>
<td>B 72</td>
<td>CRISP</td>
</tr>
<tr>
<td>B 80</td>
<td>Crisis Intervention-Office Hours-CAF</td>
</tr>
<tr>
<td>B 87</td>
<td>Proviso</td>
</tr>
<tr>
<td>C 34</td>
<td>DSS/Child Welfare Initiative</td>
</tr>
<tr>
<td>G 70</td>
<td>Crisis Intervention-After Hours-Adult</td>
</tr>
<tr>
<td>G 80</td>
<td>Crisis Intervention-After Hours-CAF</td>
</tr>
<tr>
<td>Q 56</td>
<td>ICS-CAF</td>
</tr>
<tr>
<td>53</td>
<td>Inpatient Forensics</td>
</tr>
<tr>
<td>90</td>
<td>Duke Endowment</td>
</tr>
</tbody>
</table>
SECTION 4: EMR SERVICE TICKETS
HOW TO DOCUMENT A CLINICAL SERVICE NOTE (CSN) IN EMR

1. When your appointment is scheduled the following fields of your clinical service note/ticket (CSN) have already been selected for you. You are expected to review this information on your CSN and make any necessary changes.
   a. Location
   b. Office
   c. Start Time
   d. Service Code
   e. Place of Service
   f. Emergency After Hours

2. Select Clinical Notes tab.

3. You will see a list of clients for your scheduled appointments under the Heading of Appointment Info for Search Selection.

   In this section of the EMR you may also see Headings of:
   - Appointment Info over 24 Hours
   - Unsigned Forms
   - Signed Forms

4. To document your CSN choose the ticket you wish to document by selecting from the choices available:

   NOTE: If the service selected by the scheduler staff is not the service you provided that day YOU MUST change the service BEFORE selecting the ticket to document. For example if the staff who scheduled the appointment chose Ind Tx as the service but you actually provided an Assessment then YOU must change the Service from the Ind Tx to Assess BEFORE selecting the ticket to open for your documentation. There is a drop down box as below.

Updated August 2016
5. Once the CSN has been selected the following will appear on your screen:

Check to make sure the following are correct for your client and service providing.

**Location and Office Codes:** using the information provided in Section 3 above

**Place of service:**

- **11** - Office
- **12** - Home

Updated August 2016
- 21 - Inpatient Hospital
- 22 - Outpatient Hospital
- 23 - Emergency Room (Hospital)
- 51 - Inpatient Psych Facility
- 53 - Community MHC
- 99 - Other
- 03 - School (when not Medicaid)

**Time of Service Provided**

**Staff Time:** Enter the actual time during which a service was rendered. Time must be less than or equal to bill time.

6. You may ADD a staff who participated in the service being provided and enter the exact amount of time they participated and who is primary.

7. **Bill Time:** Enter the actual time during which a service was rendered. This is defaulted to the length of the scheduled appointment but it is up to YOU to enter the ACTUAL amount of time you spent with or on behalf of the client.

8. **Groups:** when you select the client by clicking on the square you will be given the choice as indicated below whether the client was present or not. Choose the correct one and document accordingly.

Updated August 2016
9. **Cancel/NS** field defaults to present therefore this **MUST** be changed if client is not present. Select the appropriate from the options in the drop down box.
10. **No Charge Indicator:**

   ![No Charge Indicator](image)

11. **Incarcerated: Defaults to N**

   ![Incarcerated](image)

12. **Problem:** Choose appropriate choice from drop down box. Indicates problem of particular session.

   ![Problem](image)

13. **Emerg/Afhrs:** Choose appropriate choice from drop down box.

   ![Emerg/Afhrs](image)

Updated August 2016
14. **Treatment Objective/Focus:** From the drop down box choose the objective that was addressed in the session.

15. **Document** as indicated and required for the service provided.

   **Nursing:** Med Admin and Inj Admin: Nurse enters information into the fields indicated for medication.

16. **Submit/Cancel:** Submit or cancel as needed. Heed the warning if you cancel ticket.

If submitted then save if you have not completed documentation or sign/save if documentation is complete.
17. Prompt to enter as indicated below. Enter your Signature ID and Password (NEVER give your Password to ANYONE). Submit or cancel. Once submitted your CSN is completed.

Signature id: 
Signature password: 
Submit  Cancel

If you encounter any difficulties or make an error please contact the Center’s EMR representative and/or QI Director as needed. NOTE: If there are other fields that need to be completed you will receive a message informing you of this and you will not be allowed to sign/save until the error has been corrected.

Updated August 2016
SECTION 5: FEE STATUS AND BILLING REQUIREMENTS

Clients at the Center are billed on their ability to pay based on income and the number of people dependent on that income. This is determined at the time of the first visit based on proof of income that the client must provide. The fee status is reviewed annually and whenever the client reports a change in any of the factors which determine fees. Completion of the forms for fee status changes or annual updates is the responsibility of the administrative and clinical staff. The initial fee sheet is the responsibility of the administrative staff member completing the ID Data sheet.

SPECIAL DOCUMENTATION REQUIREMENTS

1. The following services may be billed to Medicare, if the clinician is credentialed to provide them. All others must be billed to other payers.
   a. Individual Therapy
   b. Group Therapy (A maximum of 60 minutes is allowed without justification. If justification is included, 90 minutes may be billed.)
   c. Medication Monitoring
   d. Psychiatric Medical Assessment (PMA)

2. Services cannot be billed to MEDICARE if there is no physician on premises.

3. When a client has insurance, the client is expected to pay the co-pay for the service if it applies. The insurance company is billed first. Once remittance is received from the first insurance plan, the balance still due is transferred to the next payer source which could be another private insurance plan, Medicare, or Medicaid which are known as the secondary plan. After all payers have been billed and remittance received, the client is then billed for any remaining balance. The client is responsible for the co-pays and the deductible only if there is not a secondary insurance plan.

4. Payment (or non-payment) of fees is a treatment issue. Clinicians need to assist the client with accepting responsibility for their treatment which includes taking responsibility for payment of the fees for the services provided.

5. Clients who are incarcerated cannot be billed for any services. However, if they are out on bail, bond, or parole; they can be charged for services.

Updated August 2016
SECTION 6: CHANGE FORMS

Change forms are done at any time during treatment to update the client’s vital statistics, such as address, phone number, clinicians, etc. Some client information must be updated every 6 months for CIS.

The Change Form can be located on the Staff Resource Page, under Forms.
SECTION 7: BILLING ERROR CORRECTION PROCEDURES

1. Staff person identifying the billing discrepancy completes the BCMHC Internal Billing Discrepancy Form or sends an email with same to Supervisor and Quality Improvement Director.

2. The form, along with the medical record, is reviewed with the respective supervisor to review the nature of the discrepancy and/or documentation deficiencies that may be identified in the medical record. **EXCEPTION:** In the case that the discrepancy is identified by QI or UR staff, supervisory review is not necessary.

3. The Billing Discrepancy Form is forwarded to QI for further review and authorization for billing adjustments. Any additional notes may be added to assist billing staff in understanding the nature of the required billing adjustments. Authorized billing adjustments may include but are not limited to:
   a. No reviewing physician’s signature and date on POC to confirm medical necessity and appropriateness
   b. Discrepancy in service code or definition
   c. Discrepancy in bill time
   d. No record or documentation of service
   e. Clinical service notes do not substantiate that the service billed was rendered
   f. Billing for more frequent services than were ordered on the POC
   g. Service rendered is not listed on treatment plan
   h. Service rendered was added after the physician signed the POC and has not been authorized by doctor
   i. PMA not rendered within time limits on admission
   j. Voided tickets for any reason
   k. CSN documented late

4. QI forwards Billing Discrepancy Form to billing staff who adjusts accounts accordingly.

5. Once billing adjustments are made, total dollar adjustments are calculated and reported to QI. QI is responsible for routing this information to Executive Director, Supervisory Team, DMH Office of Quality Improvement/Performance and DHHS per department guidelines.
SECTION 8: MEDICAL RECORDS SIGNATURES AND INITIALS/LEGIBILITY

**Signatures** include name, title, and date. **Initials** when applicable include date.

**Signatures:** are necessary for any entry in the medical record. All forms and Clinical notes require the Clinician’s signature. Any addition to a note, POC, Progress Summary, etc., must be signed and dated by the clinician adding the entry which in the EMR you must provide a reason for an update to a form that has already been signed and saved.

**Titles:** In the interest of uniformity, titles should be listed as your educational degree and/or license.

Example: Jane Doe, M.Ed., LPC –or- Jon Doe, RN

Black or Blue ink is to be used for documentation unless otherwise specified for a particular situation.

All clinical documentation must be typed or legibly written. If you have a “distinctive” signature, **print** your name beside/under your signature.

Stamped, photocopied or computer generated signatures are not acceptable. *(Note: Your EMR signature is acceptable for EMR documentation. It is a protected signature requiring a password.)*

Signatures of anyone other than the person rendering the service and/or co-signature, when required, are not acceptable.
SECTION 9: MEDICAL RECORDS ORGANIZATION

Medical Records in the EMR are organized according to the standards required and implemented by the Department of Mental Health.

On March 7, 2011 Berkeley Community Mental Health converted to Electronic Medical Record.

See the Home Page of the EMR for the EMR Manual.

Clients who were admitted prior to March 7, 2011 will have both a hardcopy chart as well as EMR chart. Medical Records staff is in process of importing records from hardcopy to EMR.

Clients admitted after March 7, 2011 will have the current admission information in EMR.

FOR PAPER MEDICAL RECORDS: ALL SECTIONS ARE DESCRIBED FROM TOP TO BOTTOM.

SECTION I

1. Discharge Data (if closed)
2. CIS Facesheets
3. Fee Sheets
4. Financial information - copies of insurance info, etc.
5. Voters Reg. Form
6. Consent forms (audio/video, consent to treatment, consent to follow up, etc.)
7. Orientation page (Client signs for orientation package)
8. Proof of income, copies of insurance, driver’s license, etc

SECTION II

1. Accounting Log (M453)

Updated August 2016
2. Post Discharge follow-up letter (if closed)
3. Court Orders of Dismissal (should always remain on top if applicable)
4. Court Orders/Judgments (should always remain on top with identifier on front of chart)
5. Letter to Amend (M452) with Center response by date requested
6. Letter to Inspect/Copy (M451) by date requested
7. Desire for Treatment Letter
8. Correspondence ("Correspondence" chart divider if applicable) (all items in chronological order)
   a. Court Correspondence
   b. Desire For Treatment Letters
   c. Appointment Letters/No-show Follow-up Letters
   d. Authorization for release of information
   e. Business Correspondence
   f. School Reports
   g. Boarding Home/Nursing Home Notes
   h. Miscellaneous treatment information from outside sources
   i. *(Chart Divider for Conner's Forms) Children Only*
9. ("Hospital" chart divider)
   a. Hospital Summaries (and commitment papers)
   b. Hospital summaries and corresponding commitment papers must be filed together with no other information between them.

**SECTION III**

1. Confidential Information Sheet (Teal sheet, if applicable, with chart notifier on outside of chart)
2. Physicians Medical Assessment Notes
   (Medication Education/Consent Sheets Divider)
3. Neuroleptic Consents, Medication Information sheets
   ("AIMS" Chart divider)
4. Testing Materials and Results (AIMS Scale, etc.)
5. Weight Chart, if necessary
   ("Lab/X-Ray" chart divider)
6. Lab Results
   (Nurses notes divider)
7. Medication monitoring notes
   ("Injection Record" chart divider)*Only for clients receiving injection
8. Injection (MAR) Record
   ("Medications" chart Divider)
9. Prescription Copies mounted on prescription sheet in order

**SECTION IV**

1. Discharge Plan/ Summary (if closed)
2. POC with Progress Summaries- Transition plans if applicable
3. Outcomes Measures (Adult Outcomes Form, CBCL)

Updated August 2016
4. Care Plan (Boarding Home Patients only)
5. TCM section divider to include TMC Plan, progress summaries and CSNs.
   *IPS chart divider (if applicable)*
6. all assessments and material related to IPS program
   * (SCIMA chart divider, if applicable)*
7. Assessment tools for SCIMA-schizophrenia only
   *("Progress Notes" chart divider)*
8. Clinical Service Notes including generic notes in chronological order
   * (Crisis/Brief Assessment Divider)*
9. All crisis/brief assessment forms
   * (Divider for Assessment information)*
10. Hospital Discharge Assessment
11. Initial Clinical Assessment
12. Medical Assessment
13. Trauma Assessments
14. Intake Sheet

**SECTION V AND VI (ONLY FOR PRS)**

PRS notes to correspond to CSN in Part IV in chronological order (most recent on top).

At any place in the chart, a properly labeled "blank" chart divider may be included.

**SEPARATING CHARTS**

When a chart has gotten too thick to easily handle, or information is awkward and difficult to find, information was separated into another chart.

The following is a guide for your understanding of how this process was accomplished and where you should look for information once the chart has been divided. It is a logical process. The basic idea is that all information which is related to a particular POC moves with that POC.

1. A POC is closed for a guide in separating a chart.
2. The POC is removed and any information from the time period which it covers as indicated below. Unless otherwise indicated, move original documents to the new chart.
   a. **Clinical service notes** – (Keep the CSN’s in the chart with the correct POC.)
      i. It is determined whether it will be easier to remove CSN’s from the Data Mount Sheet which should go into the new chart or remain with the old chart.
      ii. Appropriate CSN’s are careful removed and placed on a new Data Mount Sheet.
      iii. Generic notes are written to place in both charts to indicate that CSN’s were moved in the process of thinning the chart, and indicates that the rest of the CSN’s may be found in another chart.
   b. Miscellaneous notes
   c. Weekly summaries
   d. Physician’s notes
   e. Injection record

Updated August 2016
f. The neuroleptic consent form

g. Prescription copies

h. Laboratory work reports

i. Correspondence, both in and out of the Center

j. Any change in diagnosis forms for the time period covered

k. The ID Data and Consent forms for the CURRENT admission

l. Any other information not specified above which is considered necessary for comprehensive care

m. The Clinical History & Evaluation for the CURRENT admission

For items b, c, d, e, and l it may be necessary to make copies to provide uninterrupted flow of information in both charts. This is accomplished by copying each page (front and back) of information which needs to be moved to a new chart and contains information which goes with a POC in the original chart. Copies are clearly marked as such. Copies and originals are placed in the charts in the manner which will best suit the POC.

Torn or weakened pages are strengthened with reinforcements or tape. Parts are filed in separate holding from the current chart.

In addition to the regular labels, multiple part charts need to have an additional label. It should be on both the original chart as well as any and all supplemental charts which are made. These are placed on the front of each chart on the upper right side.

**FOR EXAMPLE:**

<table>
<thead>
<tr>
<th>John Smith</th>
<th>John Smith</th>
</tr>
</thead>
<tbody>
<tr>
<td>00000</td>
<td>00000</td>
</tr>
<tr>
<td>PART I</td>
<td>PART II</td>
</tr>
<tr>
<td>1/1/81 - 7/1/87</td>
<td>7/2/87 –</td>
</tr>
</tbody>
</table>

Charts are maintained at the Center for at least 3 years after discharge. Then they are processed for transfer to DMH for scanning and storage as indicated in DMH directive. Once chart has been scanned the Center has accessibility via Informix. If a chart that has been sent to DMH has not been scanned, Center can contact DMH who will make chart available.

Updated August 2016
SECTION 10: CORRECTING DOCUMENTATION ERRORS IN THE MEDICAL RECORD

WRITTEN DOCUMENTATION:

1. **NEVER** use white out or any type of correction tape in any documentation that will be placed in the client’s medical record. This can be interpreted as falsification of medical records.
2. **Never** completely scratch through an error. This applies to “write-overs” as well.
3. The proper way to correct an error is:
   a. Draw one line through the error/mistake: Write “ME” for “mistaken entry” or “ER” for error” to the side of the error in parenthesis (ME) (ER).
   b. Initial and date the mistake.
   c. Continue writing immediately following the mistake.

EMR DOCUMENTATION:

You must provide a reason for the correction to an EMR generated document once you have signed it. The documentation from the previous entry can be viewed by choosing the View All Forms when you click on the CSN/form.
SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

Columbia, South Carolina

OFFICE OF THE STATE DIRECTOR OF MENTAL HEALTH

PRIVACY PRACTICES: DIRECTIVE NO. 837-03 (5-100)

TO: All Employees

SUBJECT: Privacy Practices

Purpose

This Directive describes DMH policy for the use and disclosure of DMH Consumer medical and payment Protected Health Information or "PHI" (see Notice for terms that begin with a capital letter) and Consumer rights related to access, control, accounting and amending of their PHI. This Directive incorporates DMH Form M-010, "NOTICE OF PRIVACY PRACTICES" ("Notice"), as well as other forms and procedures listed in the Appendix. Appendix components are identified in this Directive by quotes and caps (e.g. "AUTHORIZATION TO DISCLOSE SCDMH PROTECTED HEALTH INFORMATION"). This Directive includes future Notices, forms or procedures added to the Appendix, and adopted in accord with DMH policy and applicable law.

Each DMH employee, volunteer or other person (e.g., contract physician) incorporated in the DMH workforce ("workforce member" or "staff") and officials, must sign acknowledgement of receipt of, and agreement to comply with this Directive. The signed statement must be kept in the applicable personnel or other official folder. Each DMH component must ensure training of its staff consistent with this Directive and DMH Privacy Practices training. All DMH component policies or agreements must be consistent with this Directive.

Applicable Law

This Directive is to conform with, and is subject to, applicable federal and state law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Section 44-22-100 of the Code of Laws of South Carolina. Identifying information from alcohol and drug treatment programs is subject to additional restrictions and protections under federal law 42 CFR Part 2. If in doubt as to whether 42 CFR Part 2 applies to a DMH program, the applicable local director should consult with the DMH Office of General Counsel. In general, DMH is required by law to: follow the Notice requirements; keep Consumer information private; give Consumers the opportunity to review the Notice and request restrictions on PHI use or disclosure; not use or share PHI without Consumer Authorization except as described in the Notice; provide for Consumer rights involving control over his or her PHI; and a procedure for Consumer complaints about DMH privacy practices.

Additional requirements (e.g., for licensing, accreditation, etc.) may also apply to individual DMH components.

1) Notice

A copy of the current DMH Notice must be posted at each service site where persons seeking DMH services will be able to read it. When DMH changes the Notice, a current copy must be posted in like manner. A copy of the Notice must also be posted on the DMH Internet Web site. Consumers must have the opportunity to review the Notice and receive a paper copy at any time. DMH service sites must attempt to obtain a Consumer’s signed acknowledgement of receipt of the Notice at the Consumer’s next visit beginning April 14, 2003. This acknowledgment is to be recorded on DMH Form C-107 (revised March, 2003) "CONSENT TO

Updated August 2016
EXAMINATIONS AND TREATMENT” or an applicable intake or admission form, containing the statement (or an attached statement): “I have been provided a copy of the SCDMH Notice of Privacy Practices and an opportunity to review it and ask questions.” If not signed, staff must note on the signature line of the statement, why signed acknowledgement was not obtained (e.g., “refused a copy of the Notice”, “refused to sign”, etc.) Questions concerning the Notice, this Directive, or DMH Privacy Practices should be directed to the local Privacy Officer or the DMH Privacy Officer.

2) DMH Uses and Disclosures of PHI

After providing the Consumer with the opportunity to review the Notice, and object and/or request certain restrictions, staff may share PHI as described in the Notice. In an emergency or if the Consumer is incapacitated, without giving the Consumer the opportunity to review the Notice, object or request limitations, DMH may use and/or share PHI as permitted under the Notice. As soon as reasonable after the emergency or incapacity, the Consumer must be given those opportunities. When practical and when it will not compromise Treatment, DMH should accommodate a Consumer’s request to limit PHI use or disclosure. As described in the Notice, PHI may be disclosed pursuant to a Business Associate Agreement, approved by the DMH Contracts Office and the DMH Privacy Officer. DMH workforce members should limit use or disclosure of PHI to the Minimum Necessary to accomplish the purpose for the use or disclosure as described in the Notice.

For use and disclosure of PHI for Operation purposes, applicable component directors must identify employees who need access to PHI to carry out their DMH duties (see Notice); and the PHI categories to which access is needed and any limitations to such access. For types of disclosure of, or request for, PHI made on a routine and recurring basis, the component must implement protocols limiting the PHI disclosed or requested to the Minimum Necessary to achieve the purpose of the disclosure or request. Protocols must be reviewed and approved by the local Privacy Officer. For other PHI disclosures or requests (i.e., non-routine, non-recurring), the component must develop protocols to limit the PHI disclosed or requested to the Minimum Necessary and review all such requests for disclosure on a case by case basis to determine that the PHI information sought is limited to the Minimum Necessary to achieve the purpose of the specific disclosure or request.

3) Other Exceptions, Legal Proceedings, Notice of Privacy Law

Unless disclosure is otherwise permitted by the Notice, upon receipt of a subpoena or other request for PHI, a statement substantially similar to the “MODEL NOTICE OF PRIVACY LAW” must be sent to the requester. If required to provide testimony or other information containing PHI in a legal proceeding, staff must follow the procedure described in “DISCLOSURES IN LEGAL PROCEEDINGS”.

4) Authorizations

Unless permitted by the Notice, PHI may not be disclosed without a signed “AUTHORIZATION TO DISCLOSE SCDMH PROTECTED HEALTH INFORMATION”, to be kept in the Consumer’s medical record. Requests pursuant to an Authorization must be acknowledged within 15 days of receipt and completed within 60 days.

5) Re-Disclosure Notice

When PHI is authorized to be disclosed by the Notice (e.g. photocopies of a medical records sent to a non-DMH medical provider for Treatment), the disclosed copies of PHI must be accompanied by a notice cover sheet or other statement substantially similar to the “MODEL NOTICE PROHIBITING RE-DISCLOSURE.”

6) Consumer Privacy Rights

Updated August 2016
The Notice describes the following Consumer PHI privacy rights: receipt of a copy of the Notice and opportunity to review and ask questions; object and request restrictions on some PHI uses or disclosures; request confidential communication/notification; inspect and obtain copy of PHI; request amendment to PHI; receive an accounting of PHI disclosures; and the right to file a complaint with DMH, HHS and Office of Civil rights about DMH privacy practices. As described following, exercise of Consumer privacy rights concerning his or her PHI, may require that a Consumer complete a written request and follow the noted procedure. Formal Privacy Practice complaints may involve the Privacy Officer and the Consumer Advocate.

7) Consumer Access to His or Her Own PHI, Psychotherapy Notes

A Consumer has the right to request (“REQUEST TO INSPECT AND/OR COPY SCDMH PROTECTED HEALTH INFORMATION”) access and/or copies of his/her PHI as described in the Notice as long as DMH maintains the PHI. The applicable component must document and retain for 6 years, Designated Record Sets subject to Consumer access and titles of persons and/or offices responsible for processing access requests. The DMH component must act on a Consumer’s request as described in the Notice, but may deny access to some information including Psychotherapy Notes as described in the Notice. Note the narrow definition of Psychotherapy Notes in the Notice. All DMH Treatment and Payment information should be kept in the applicable DMH record. If a member of the DMH workforce keeps Psychotherapy Notes, he or she does so as an individual, and is therefore individually responsible for their content, control, protection, access and disclosure, including disclosure pursuant to a court order or as otherwise required by law.

As applicable, the DMH component must inform the Consumer that the request has been granted and provide access as requested (see “MODEL REPLY TO REQUEST TO INSPECT AND/OR COPY”). PHI should be provided in the format requested if readily reproducible or in readable hard copy or other format as agreed to by the Consumer, unless he or she agrees to a written summary as described in the Notice. If the same PHI is maintained in more than one Designated Record Set or at more than one location, the PHI may only be produced once. If the component does not maintain the requested PHI, but knows where it is maintained, the component must inform the individual where to direct the request.

If access is denied, the DMH component must provide a written denial within 15 days of the request (see “MODEL REPLY TO REQUEST TO INSPECT AND/OR COPY”). If the Consumer requests a review in writing, the component must designate a licensed health care professional who was not involved in the denial decision to review the denial. The designated person must give the Consumer written notice within 15 days of review request, the designated person’s decision, and take other action necessary to carry out the decision.

8) Consumer’s Right to Request Amendment to PHI

After a Consumer requests an amendment in writing (“REQUEST TO AMEND SCDMH PROTECTED HEALTH INFORMATION”) staff must act on the request in accord with the Notice timelines and procedures. The request must be forwarded to the component director with copy to the local Privacy Officer. The director must designate staff to review the request and take needed action documented on Page 2 of the “REQUEST” form. The request must be reviewed by the designated staff in conjunction with staff originally recording the PHI and by the staff’s supervisor(s), who must consult with other staff as needed to determine if an amendment is needed. Any conflict must be resolved by the director. The Consumer must be informed of the final decision by a letter substantially similar to the “MODEL REPLY TO REQUEST TO AMEND” with a copy of the original “REQUEST”, including Page 2 documenting the DMH component’s review and basis for its decision.

If the request for amendment is approved, after notifying the Consumer as noted above and obtaining the Consumer’s agreement with the proposed amendment, the amendment should be made, the record flagged to indicate the amendment and the amendment form filed in the record. Staff should also attempt to secure the Consumer’s permission to notify necessary relevant

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persons of the amendment. If the Consumer refuses, document the attempt to obtain permission in the record prior to giving needed notification.

A request for amendment may be denied if the PHI: was not created by DMH; is not in the Designated Record Set; or the PHI is accurate and complete. If the request is denied, the Consumer must be notified in writing as described above indicating: the basis for the denial; that the Consumer may submit a one-page written disagreement, stating the basis for disagreement; that the Consumer may request that future disclosures of the disputed PHI include the request and the denial; and how the Consumer may file a Complaint.

Records must be maintained identifying the PHI in the Designated Record Set that is the subject of the disputed amendment and appended or otherwise linked to the Consumer’s request for amendment, DMH denial, Consumer’s statement of disagreement, and any DMH rebuttal. If a Consumer submits a statement of disagreement following a denial, subsequent disclosures of the disputed PHI must include the above items.

9) Consumer’s Right to Request Accounting of Some PHI Disclosures

DMH components must log each applicable PHI disclosure using the “ACCOUNTING LOG OF PHI DISCLOSURES”. The accounting must include disclosures by DMH as well as disclosures to a DMH Business Associate. This accounting requirement does not include PHI used or shared before April 14, 2003 or other disclosures described in the Notice. The local Privacy Officer or designee must respond to a Consumer’s written request, and provide, a copy of the applicable accounting log as described in the Notice (see “MODEL REPLY TO REQUEST OF ACCOUNTING LOG”). However, a Consumer’s right to receive an accounting log must be suspended if a health oversight agency (HHS) or law enforcement official notifies DMH that providing an accounting would be reasonably likely to impede the health oversight or law enforcement agency’s activities and specifying the time for which the suspension is required. DMH must document that statement (including the identity of the agency or official) and temporarily suspend the Consumer’s right to an accounting for no longer than 30 days, unless a written statement is received from the applicable agency during that time.

10) Consumer Privacy Practice Complaints

Applicable DMH components must, in coordination with the local Privacy Officer and Consumer Advocate, have a process for Consumers to make a written complaint about DMH privacy practices or compliance with those practices (“SCDMH PRIVACY PRACTICES COMPLAINT”) and must document all complaints received and their disposition as described in the Notice. At any time, a Consumer has the right to file a complaint with DMH and/or HHS as described in the Notice. DMH must provide records and compliance reports, as required by HHS and otherwise permit access, as requested by HHS, to applicable facilities, records, and other sources of information, including PHI as needed for a HHS inquiry or investigation pursuant to a Complaint.

DMH component or staff may not intimidate, threaten, coerce, discriminate against, or retaliate against any person for the exercise of rights or participation in any process relating to this Directive, or against any person for filing a complaint with DMH, HHS or other privacy related investigation, compliance review, proceeding or hearing, or engaging in reasonable opposition to any act or practice that the person in good faith believes to be unlawful under HIPAA or state law as long as the action does not involve disclosure of PHI in violation of the regulations, nor require individuals to waive any of their rights under HIPAA or state law as a condition of Treatment or eligibility for DMH services.

11) DMH Privacy Officer

DMH must designate a DMH Privacy Officer responsible for the development and implementation of DMH privacy practices. Applicable DMH components must designate a local Privacy Officer and Privacy Practices workgroup that advise and support the local Privacy Officer and DMH Privacy Officer.

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13 Sanctions and Mitigation of Damages

DMH Human Resources office must document and each DMH component must apply, appropriate DMH employee disciplinary action, for employees who fail to comply with this Directive. Exceptions include disclosures made by employees as whistleblowers, for mandatory reporting or certain crime victims. Each DMH component must have a process to mitigate, to the extent practicable, any harmful effects of unauthorized uses or disclosures of PHI by the component or any of its Business Associates.

Each workforce member must receive this training within 30 days after joining the workforce. Each workforce member whose functions are impacted by a material change in this Directive, or by change in position or job description, must receive the training as described above within a reasonable time after the change becomes effective. All training must be documented and records maintained.

Updated August 2016

Number of Incidents and Penalties: 16

All violations of this directive must be reported to the applicable person's supervisor. DMH employees who make an unauthorized disclosure of PHI, or otherwise violate provisions of this Directive, are subject to disciplinary action in accordance with the DMH Employee Discipline Policy. Further, South Carolina law provides for penalties for unauthorized disclosures of PHI up to $250,000 and ten years imprisonment. Unauthorized use or disclosure of PHI may also subject the employee to additional civil or criminal liability.

As permitted by this Directive, PHI may be disclosed under the requirements and protocols described in "UNIDENTIFIABLE OR DEIDENTIFIED INFORMATION" or "LIMITED DATA SETS". Applicable DMH components must comply with "PRIVACY PRACTICES SECURITY" requirements.

Penalties for disclosures of PHI, or otherwise violate provisions of this Directive, are subject to disciplinary action in accordance with the DMH Employee Discipline Policy. Further, South Carolina law provides for penalties for unauthorized disclosures of PHI up to $250,000 and ten years imprisonment. Unauthorized use or disclosure of PHI may also subject the employee to additional civil or criminal liability.

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George D. Guttierez
State Director
PRIVACY PRACTICES SECURITY

Applicable DMH components must be assessed for security of PHI that it receives, creates, maintains or discloses, twice per year initially and annually thereafter by designated component staff. Problems identified during the assessment will be reported in writing and include a corrective action plan with a copy provided to the local Privacy Officer for follow up and resolution. Reasonable efforts will be made to mitigate and correct identified problems. Unresolved problems must be reported to the DMH Privacy Officer.

General Guide For Copying, Faxing Or E-Mail Of Protected Health Information

1. Information disclosed should generally be the minimum necessary to accomplish the intended permitted purpose. This usually means limiting the scope and content of information requested, used or disclosed. However, complete identifying information may be necessary for Treatment purposes.
2. For fax cover sheets and e-mail subject matter title and messages referring to a Consumer, unless essential for the understanding of the message (identifying detail may be needed for Treatment, if there is a likelihood of confusion, etc.), de-identify or otherwise limit the identity of the Consumer (e.g., “41 yr. old male admission last night”; strike through the name; Consumer’s first name and last initial only, “Ferris B.”, etc.).
3. Double check phone/addresses prior to sending faxes or e-mails.
4. Only send to DMH staff that need the information in doing their DMH job.
5. Do not leave PHI documents at the copy/fax machine once the information has been copied or faxed.
6. Do NOT email Protected Health Information to email addresses outside the SCDMH network.
7. Fax and e-mail communications or transmissions that include PHI should identify the intended recipient, the sender (with reply contact information) and include a notice statement substantially similar to the following:

PRIVACY NOTICE: THIS COMMUNICATION IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY TO WHICH IT IS ADDRESSED AND MAY CONTAIN SCDMH PATIENT OR OTHER INFORMATION, THAT IS PRIVATE AND PROTECTED FROM DISCLOSURE BY APPLICABLE FEDERAL AND/OR STATE LAW. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT OR RESPONSIBLE FOR DELIVERING THE MESSAGE TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION OR COPYING OF THIS COMMUNICATION OR THE INFORMATION CONTAINING WITHIN IT, IS STRICTLY PROHIBITED AND MAY SUBJECT THE VIOLATOR TO CIVIL AND/OR CRIMINAL PENALTIES. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE NOTIFY US IMMEDIATELY BY TELEPHONE, REPLY E-MAIL OR FAX USING THE PHONE NUMBER OR ADDRESS IDENTIFIED IN THIS COMMUNICATION AND DESTROY OR DELETE ALL COPIES OF THIS COMMUNICATION AND ALL ATTACHMENTS.

LIMITED DATA SETS

When using or disclosing PHI, a DMH component may use a limited data set if the component enters into a data use agreement with the limited data set recipient providing that a limited data set not include any of the following direct identifiers of the individual who is the subject of the PHI or of relatives, employers, or household members of the individual:

- Names; Postal address Information, other than town or city, State, and zip code;
- Telephone numbers or Fax numbers or Electronic mail addresses;
- Social security numbers or Medical record numbers;
- Health plan beneficiary numbers or Account numbers;
- Certificate/license numbers;
- Vehicle identifiers and serial numbers, including license plate numbers;
- Device identifiers and serial numbers;

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• Web Universal Resource Locators (URLs) or Internet Protocol (IP) address numbers;
• Biometric identifiers, including finger and voice prints; or
• Full face photographic images and any comparable images.

A DMH program area may use or disclose a limited data set only if it obtains satisfactory assurance, in a memorandum of agreement, that the limited data set recipient will only use or disclose the PHI for limited purposes. The memorandum of agreement must:

• Establish the permitted PHI uses and disclosures in the limited data set by the recipient;
• Establish who is permitted to use or receive the limited data set;
• Provide that the limited data set recipient will:
  • Not use or disclose the Information unless permitted by the agreement or as required by law;
  • Use appropriate safeguards to prevent improper uses or disclosures;
  • Report any known use or disclosure not provided for by its data use agreement;
  • Ensure that any agents, including subcontractors, to whom it provides the limited data set agrees to the same restrictions and conditions that apply to the recipient with respect to the PHI; and
  • Not attempt to identify or contact the individuals whose data are included in the limited data set.

A DMH program area may use or disclose a limited data set only for the purposes of research, public health, or health care Operations. If the limited data set is needed for research or projects that have a research component, DMH’s Institutional Review Board (see Research policy) must approve the research project.

The DMH program area that will use or disclose the requested limited data set must determine the purpose of the request. If the request is for research purposes or has a research component, DMH’s Institutional Review Board must first review the request. If the Institutional Review Board approves the research, the Institutional Review Board Administrator will inform the program area that it may proceed with the memorandum of agreement as described in this policy. If the purpose of the limited data set is for public health or health care Operations, then the DMH program area may proceed with the memorandum of agreement as described in this policy. The DMH Privacy Officer or his/her designee must approve the memorandum of agreement before the limited data set is provided to the requestor.

Updated August 2016
In reply to your subpoena or other request dated __________, pertaining to __________________:

Please take notice that Information identifying a patient or former patient of the South Carolina Department of Mental Health (SCDMH) or a person for whom civil commitment has been sought, is protected by §44-22-100, Code of Laws of South Carolina, as amended, and 45 CFR Part 160 (HIPAA). Such Information may not be disclosed (oral, written, or otherwise) except as authorized under HIPAA and §44-22-100, including written Authorization meeting requirements of those laws, or a South Carolina or federal court order pursuant to Section 44-22-100 (A)(2), finding that “disclosure is necessary for the conduct of proceedings before it and that failure to make the disclosure is contrary to public interest.” Individual patient Information may be further protected by other law, including alcohol and drug treatment records protected under 42 CFR Part 2. General authority to disclose Information including: subpoena for records or testimony; discovery order; workers’ compensation claim; foreign court order or general consent, is usually not sufficient to authorize disclosure of such information. Unauthorized disclosure is subject to civil and criminal penalty.

A copy of the SCDMH Authorization form is attached. When the applicable Authorization or court order is secured meeting requirements of Section 44-22-100 (A)(2), you may then send a copy with the request or subpoena for the release of the applicable information. If the Authorization is signed by a person other than the patient, also attach a copy of the document authorizing substitute consent (e.g., court appointment as guardian, personal representative, etc.)

If you believe that some other exception under the above noted laws otherwise permit or require disclosure, let us know. As applicable, should the attorney handling this case have any questions concerning the applicable law or court order, please contact the Office of General Counsel, South Carolina Department of Mental Health, P. O. Box 485, Columbia, South Carolina 29202; voice # 803.898.8557, fax # 803.898.8554.

Sincerely,

[Local Privacy Officer, Medical Records/HIS Director, etc. with contact info if not included in letterhead]
MODEL NOTICE PROHIBITING RE-DISCLOSURE

[LETTERHEAD]

[DATE]

[NAME]

[FAX/ADDRESS]

The attached or enclosed information is been disclosed to you from records whose privacy is protected from disclosure by federal and state law including, as applicable, 45 CFR Part 160 (HIPAA); 42 CFR Part 2, (alcohol and drug Treatment) and Section 44-22-100, Code of Laws of South Carolina. The applicable law or laws may prohibit you from making any further disclosure without the specific written authorization by the individual to whom it pertains or their authorized representative, or as otherwise permitted or required by law. A general authorization for release of information is not sufficient for this purpose unless it conforms to the specific requirements of the applicable law or laws. Further disclosure not in accordance with applicable federal and law may result in civil and/or criminal penalties.

Sincerely,

[Local Privacy Officer, Medical Records/HIS Director, etc. with contact info if not included in letterhead]
MODEL REPLY TO REQUEST TO INSPECT AND/OR COPY SCDMH PROCTECTED HEALTH INFORMATION

[LETTERHEAD]

[DATE]

[NAME]

[ADDRESS]

Dear Sir/Madam:

In reply to your request to inspect and/or copy your SCDMH protected health information dated___________:

☐ We have decided to grant your request.

☐ Your appointment to inspect the requested information is ____________________________.
☐ As the information is in multiple locations please contact me to arrange access.
☐ Copies, or if agreed to, the written summary of the information, will be available _________________.

The charge for copies/written summary is ___________, plus any applicable postage ____________.

☐ We do not maintain the requested PHI, please direct your request to ________________.

☐ We have decided to deny your request for parts of your Designated Record set because of the following:

☐ The request is for Psychotherapy Notes.
☐ The request is for information needed for a DMH legal proceeding.
☐ The request is for research information.
☐ The request is for information given in confidence and is likely to reveal the source of information.
☐ A DMH licensed health care professional determined that access is reasonably likely to endanger your or another person’s life or safety.
☐ Other ________________________________________________________________

If we denied your request, you may send us a written request for a review. We will designate a licensed health care professional who was not involved in the denial decision to review the denial. The designated person will then notify you in writing within 15 days of your review request, the decision, and take other action necessary to carry out the decision. You may also file a complaint with DMH and/or HHS as described in the SCDMH Notice of Privacy Practices. If needed, contact me at the address or phone number noted on our letterhead.

Sincerely,

Privacy Officer

Updated August 2016
MODEL REPLY TO REQUEST FOR ACCOUNTING LOG

[LETTERHEAD]

[DATE]

[NAME]

[ADDRESS]

Dear Sir/Madam:

In response to your written request dated __________, we have enclosed a copy of our disclosure accounting log pertaining to our disclosure of your protected health information. In accord with applicable law, the log does not include some information such as information used or shared for Treatment, Payment or Operations, or information shared to you or by your written authorization, information disclosed: for national security or intelligence; to correctional or other law enforcement facilities; or for notification purposes.

If this is other than your first request within a 12 month period, we have determined a reasonable charge for copying and mailing of $ _______. Please send this amount to me at the address noted on our letterhead.

If you have any questions, please call me at the number on our letterhead.

Sincerely,

Privacy Officer
MODEL REPLY TO REQUEST TO AMEND

[LETTERHEAD]

[DATE]

[NAME]

[ADDRESS]

Dear Sir/Madam:

In reply to your request to amend your SCDMH protected health information dated__________, based upon the attached review explaining the basis for our determination:

☐ After review, we have decided to grant your request and make the amendment as noted. Please sign below and indicate:

☐ I agree with the amendment as written on the review attached.

☐ I give my permission to notify necessary relevant persons of the amendment (Note that even without permission, SCDMH may have the authority to make such notification.)

_______________________________________________________________
Client’s Signature          Date

☐ After review, we have decided to deny your request because of the following:

☐ The information was not created by SCMDH

☐ The information is not part of a SCMDH Designated Record Set

☐ The information is accurate and complete

☐ Other_______________________________________________________________

If we have denied your request, you have the right to send us a one-page written disagreement with the denial, stating the basis for your disagreement. You may also request in writing that future disclosures of the disputed information include your request for amendment and the denial. You may also file a complaint with DMH and/or HHS as described in the SCDMH Notice of Privacy Practices. If needed, contact me at the address or phone number noted on our letterhead.

Sincerely,

Privacy Officer

Updated August 2016
Information regarding a DMH Consumer or a person for whom commitment has been sought is protected by applicable federal and state law and may be used or disclosed only under the conditions described in the DMH Privacy Practices Directive.

**Depositions:** If a DMH employee is subpoenaed to provide testimony and/or provide documents (i.e., "subpoena ducus tecum") in a civil deposition, send a reply “SCDMH NOTICE OF APPLICABLE PRIVACY LAW” to the attorney issuing the subpoena, notifying the attorney that such information cannot be provided without compliance with HIPAA and Section 44-22-100 of the Code of Laws of South Carolina. Unless excused by the attorney, the employee must go to the place designated, but should not provide information regarding the Consumer’s PHI unless a court order is provided or the Consumer has signed an Authorization giving authority for such disclosure, or other exception as described in the DMH Privacy Practices Directive.

**Other subpoenas or requests for documents:** If an employee is subpoenaed or receives a request from an attorney or other person or entity, to provide documents (i.e., "subpoena ducus tecum"), send a reply “SCDMH NOTICE OF APPLICABLE PRIVACY LAW” to the attorney issuing the subpoena, notifying the attorney that such information cannot be provided without compliance with HIPAA and Section 44-22-100 of the Code of Laws of South Carolina. Information regarding a Consumer should not be disclosed unless a court order is provided, or the Consumer has signed an Authorization giving authority for such disclosure, or other exception as described in the DMH Privacy Practices Directive.

Sending the reply “SCDMH NOTICE OF APPLICABLE PRIVACY LAW” notice will not excuse the employee from appearing at the date, time and location designated in the subpoena if the subpoena commands the employee’s presence. However, the letter will legally preserve the objection to producing the records, as well as place the attorney on notice of the applicable law and need for Authorization or court order.

**Court Testimony:** If an employee is subpoenaed to go to court for a court hearing or other legal proceeding, to provide testimony and/or provide PHI, the applicable employee must go (and take the record if so indicated). Upon taking the stand and being sworn, the employee will usually be asked preliminary questions (name, place of employment, education, etc.). When the preliminaries are finished and the questioning regarding the PHI begins, the employee should not provide such information, absent written Authorization, or prior court order, unless the judge takes notice of the applicable law and decides that disclosure is necessary. To get this determination on the court’s record of the proceeding, the employee should advise the judge as follows:

Your Honor, paragraph two (2) of South Carolina Code Section 44-22-100 will not allow me to disclose information about a patient or former of the Department of Mental Health or a person for who commitment has been sought, until the court “directs that disclosure is necessary for the conduct of the proceedings before it and that failure to make the disclosure is contrary to the public interest.”

If the judge then directs that the question be answered and/or documents provided, an employee should do so. If the employee feels that the testimony will do irreparable damage to treatment if released in open court, the employee may ask to confer with the judge in private to explain his or her concern. Such conferences in chambers and any ensuing actions by the court are matters within the judge's sole discretion.

**Copy of Record:** When an original record is taken to court, deposition or other proceeding, a copy of some or all of the record that will likely be needed for evidence should also be taken. Only copies should be surrendered for exhibits or other record to be retained by the court or other entity conducting the proceedings.

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Information may be disclosed, as determined by a person designated by DMH who has appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods that the applicable Information is not individually identifiable. The designated individual must apply such principles and methods necessary to determine that the risk is very small that the Information could be used, alone or in combination with other reasonably available Information, by any recipient to identify an individual who is a subject of the Information; and the designated individual documents the methods and results of analysis that justify the determination.

Unidentifiable or De-identified Information cannot contain:

- Names
- All geographic subdivisions smaller than a state, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for three digits of a zip code if, according to current publicly available data from the Bureau of the Census
- The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people
- The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people are changed to 000
- All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older
- Telephone numbers
- Fax numbers
- Electronic mail addresses
- Social security numbers
- Medical record numbers
- Health plan beneficiary numbers
- Account numbers
- Certificate/license numbers
- Vehicle identifiers and serial numbers, including license plate numbers
- Device identifiers and serial numbers
- Web Universal Resource Locators (URLs)
- Internet Protocol (IP) numbers
- Biometric identifiers, including finger and voice prints
- Full face photographic images and any comparable images
- Any other unique identifying number, characteristic, or code, unless no individual could be identified in any manner and the number or code is not derived from or related to Information about the individual. The designated person must attest, on behalf of DMH, to having no actual knowledge that the Information could be used alone or in combination to identify a subject of the Information.

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SECTION 12: BCMHC MEDICAL RECORDS SECURITY

In order to track the client’s paper medical record through the facility, it is necessary that all records be signed both in and out of the file room. The Bar Code system will be the preferred process. In instances when the system is down, they will be signed in and out by hand.

- Clinicians may request a chart via phone call or email to Medical Records or in person with a written request of the client’s name. Clinicians should return the chart as soon as they have finished with it and not wait until the end of the work day.
- Records should be signed out listing first and last name of client.
- If a previously closed chart is to be removed from the file room for any purpose by any staff member, it must be signed out.
- Charts being returned to the chart room should be received by the medical records clerk for checking in and refiling.
- Charts being signed out for physicians should be signed out for the particular physician requesting the chart. At that time, the chart may be taken to the physician’s wing and secured in the locked holding cabinet if physician is unavailable to receive the chart.
- Clinicians are not allowed in the Medical Records room. Access is limited to the door. A Medical Records clerk will be available to help at all times.
- When a chart is out of the Medical Records room it is the responsibility of the requesting staff to ensure the security of the chart and will be in a locked space when not in the possession of the requester.
- Charts are filed using the Alpha Random system.
- An area in the Medical Records room is designated as a holding area for charts that are waiting to be picked up.
- Staff members will have access to records during regular working hours each work day.
- At the end of the work day the file cabinets and the file room are locked.
- No charts are to be left in the clinician’s office. All charts are to be returned to the designated holding areas.

FILING CLOSED PAPER CHARTS:

- They are filed using the Alpha Random system, the same system used for the open files.
- Closed charts are kept for at least three years before sending to Columbia to be scanned. Records that have been scanned are readily available for clinician use by requesting from the QA/Medical Records office.
- Microfilm is kept in Columbia at DMH and needs to be requested for copying.

The Center began using the Department of Mental Health Electronic Medical Record on March 7, 2011 at which time all staff have access to the client’s record as needed to perform their job duties.

Staff should be aware of how their computer monitor can be viewed.

Computer monitors are password locked when staff leaves their office. Staff will only have the information of the client they are currently working with in view of the client.

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SECTION 13: ALLERGY WARNINGS

RED Allergy stickers were used on the exterior of paper charts to flag any known allergies of the client.

If a chart has multiple parts, the allergy sticker is necessary only on the part containing the current information. There is no need to place a sticker on the older part(s). However, you should not remove allergy stickers from the older parts of the chart if they are already present.

In the EMR, client’s allergies are noted in the client’s PMO, under the client’s Overview tab, under the client’s Medication tab and on the annual Emergency Contact Form. During the client’s PMA’s allergies are also reviewed. Allergies may be listed in the Alert section for the client’s EMR as well.

Allergies to medicines, bee stings, etc. should be listed. It is not necessary to list food allergies.

Overview Tab:

<table>
<thead>
<tr>
<th>Allergies:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Celebrex-rash</td>
</tr>
<tr>
<td>sulfas-issues</td>
</tr>
<tr>
<td>Augmentin-gi issues</td>
</tr>
<tr>
<td>Asprin-Gi issues</td>
</tr>
<tr>
<td>Nsaids-issues</td>
</tr>
<tr>
<td>Trilafon-anaphylactic shock</td>
</tr>
</tbody>
</table>

Updated August 2016
SECTION 14: BCMHC GUIDELINES FOR CLINICAL CARE

*IN 2016, DMH WILL IMPLEMENT A NEW LEVEL OF CARE SYSTEM. ONCE FINALIZED, IT WILL REPLACE THE CURRENT LOC MATRIX*

The following table is a set of guidelines for admission, discharge, continued stay, length of stay, services offered in each program, admission mGAF scores, Diagnosis, and risk assessment. Keep in mind that these are only guidelines and do not replace clinical judgment. Always a client’s best interest and the best way to meet that client’s need is of foremost consideration. The Center’s programs are listed from highest risk to lower risk assessment. These guidelines should be considered when placing a client in any program. The guidelines are not meant to exclude anyone from needed care.

Care Coordination may be provided at any level of care. In formulating this table, DMH regulations, CARF guidelines and other requirements were considered.

<table>
<thead>
<tr>
<th>Level I</th>
<th>Level II</th>
<th>Level III</th>
<th>Level IV</th>
<th>Level V</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Management Only (MMO)</td>
<td>Clients who have strengths and abilities to function in all domains. Regular psychotropic medication is needed to sustain these strengths and abilities. Ongoing reviews for potential discharge to primary care provider.</td>
<td>Client has strengths to address domains of functioning. Have implemented/demonstrated skills. POC objectives describe continuing enhancement and/or mastery of skills in some functional domain.</td>
<td>Client engaged in services to address POC goals/objectives. May be newly admitted client. May be longer term client with concrete problem in daily functioning or symptoms. This may be a recurrent or newly identified problem in a client who previously experienced a greater ability to function. May be a client with serious mental illness who requires frequent interventions to support functioning in multiple domains (e.g. ACT-Like)</td>
<td>Client’s psychiatric symptoms grossly impair functioning on all domains. Client needs interventions to stabilize acute symptoms. Client may express thoughts of harm to self or others. Clinical and medical staff evaluation to determine community and/or inpatient/ placement (CAF) interventions. Frequency of contact: Minimum = daily until stabilized Caseload Cap – N/A</td>
</tr>
<tr>
<td>Clients who adhere to prescribed medications and have been offered interventions to build skills and enhance functioning, but have refused such. Ongoing review of need for interventions to build/enhance skills.</td>
<td>Requires more than Medical Management Only. Ongoing reviews for potential move to MMO Frequency of contact: Minimum = 1q2 mos. Caseload Cap – 1RN:200</td>
<td>POC has been updated to reflect change/progress/achievement of goals identified at admission. Frequency of contact: Minimum = monthly Caseload Cap – 1MHP:120 adults 1MHP:80 adults 1MHP:60/children</td>
<td>POC objectives</td>
<td>Caseload Cap – 1MHP:35 adults 1MHP:35 children</td>
</tr>
<tr>
<td>Frequency of contact: Minimum = 1q3-4 mos. Caseload Cap – 1RN:200</td>
<td></td>
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</tr>
</tbody>
</table>

*Domains of functioning: ADLs, family/social, school, employment, housing

Updated August 2016
**It is recognized that some clinicians will serve clients from more than one level of care and/or may serve both children and adults. In those instances, the respective supervisor will decide the appropriate caseload size that will ensure the needs of those clients are met.**
SECTION 15: ASSESSMENT

Each client receives a comprehensive assessment as part of the admission process. The following forms give consideration to the kinds of information needed as part of this assessment. The Initial Clinical Assessment (ICA) needs to be completed within three non-emergency visits of the admission date.

Here are some general considerations when completing the forms.

- Do not leave blank spaces.
- If the client does not have the information or the answer is none, mark the space as such.

Follow the prompts for each area to be addressed. You have three non-emergency visits to complete the assessment form. Sources of information include the client, family, other providers, or any person willing to provide information, with consent from the client, of course.

The Medical Assessment is most often done by a nurse and is a part of the Initial Clinical Assessment. This should be done within 3 non-emergency visits from the time of admission, along with the ICA.

At the time of a significant change in status for the client, the update form may be used. This form mirrors the ICA and only needs to be updated with new information and current mental status information. Keep in mind that significant changes may indicate a need for update to the POC.

Discharge planning is essential and is initiated at the beginning of treatment. The client may be limited to projecting what things may look like for him/her, but it is important to begin the process of thinking toward completion of treatment. What behavioral signs will be present? How will current behavior/thinking be different?

If a client is readmitted to the Center within one year of the completion of the ICA, the update form may be used at the time of readmission. You will be updating the information received at the previous admission. If the form used for the ICA at the time of the previous admission is not the current form being used, complete the ICA currently being used.

The Hospital Discharge Assessment Form is used upon the first visit following discharge from a psychiatric hospitalization. This helps to capture some of the information needed to assess trauma experienced related to the client’s admission and treatment in an inpatient setting.
ICA FORM INSTRUCTIONS

The ICA to be completed as well as the ICA Update is in the EMR. Address all prompts thoroughly.

TOP OF FORM:

- **Source of Data:** check all that are used to complete the assessment.
- **Referred by:** click appropriate box. If Court ordered also enter the Type of Court Order (DJJ, Outpt. MH), **Other** could be parents, primary care physician, hospital ER, DSS, A&D, etc.

SECTION A: IDENTIFYING DATA:

- Name and demographic information will be populated.
- **Other Identifying Data:** (Space is limited.) May include information of notice and importance such as identifying characteristics, physical characteristics, hearing impaired, accessories like glasses or a cane, or any noteworthy mannerisms or gestures.

SECTION B: PERCEPTIONS AND HISTORY OF PRESENTING PROBLEM(S):

- Documentation should address the source of information for each question.
- Address each question and ask each source of information the same question.
- Remember to review the C-20 Intake/Referral Form and address issues identified on it.
- You are inquiring about the reason for coming in for treatment. Looking for issues/problems (Px), psychiatric, emotional, behavioral symptoms (Sx), history (Hx) of problems e.g. When did they start? How long? Intensity? And any stressors? Use quotation marks to indicate client’s exact responses. This is the start of determining the treatment plan. Needs to be more than “my momma said I had to come”. You would then ask something like: “what is/was going on that momma thinks you need to come to the center?”
- Ask each (client, family and collateral) what they think caused/triggered the problem.
- Ask each what area(s) of the client’s life and who if anyone else is affected by the client’s problem. How/Does the problem affect the client’s thoughts of him/herself, does this impact how the others think of the client? Possible areas: family relationships, work, marriage, friendships, school.
- Ask each what they think will help make it better. This gives an indication of what they want from the Center: medications, coping or relationship skills development, or anger management, etc. Ask if anything helped in the past, types of treatment, referrals, etc.

SECTION C: URGENT NEEDS/RISK ASSESSMENT:

- **Risks:** Ask about each area (suicidal, homicidal, self-mutilation and other risk taking behaviors). Check all that apply.
- **Comments:** address all blocks/issues that are checked (other than denies) in each risk area. History of suicidal and/or homicidal/assaultive acts would go here. Note if affected by substance use.

Updated August 2016
• **Steps taken to address urgent needs:** This is what is done at time of intake if urgent needs are identified. Example: Referred to physician for immediate evaluation, assessment stopped to deal with immediate safety issues, admitted to an inpatient facility, etc. You would also address safety plan for any possible urgent need/risk that may develop.

**SECTION D: HISTORY OF MENTAL HEALTH TREATMENT:**

• Check None if they deny having any prior Mental Health Treatment.
• If they have had treatment list any and all treatments that the client has received in order of occurrence with location, type, dates of treatment, diagnosis and how/why ended.
• **Family Mental Health History:** Check None if denies or List the relationship and type of mental health issues, treatment, and diagnoses if known as well as medication(s) used if known.

**SECTION E: TRAUMA HISTORY**

• Reference to the Trauma Assessment Form is done by checking the “See Trauma Assessment” box.
• **History of Trauma:** Check appropriate boxes.
• **Type of trauma:** Check appropriate boxes in the section to indicate the type trauma or check none if none indicated.
• **Client Was:** Check appropriate boxes
• **Describe issues identified:** If trauma is identified then describe the issues/difficulties they are experiencing.

**SECTION F: SUBSTANCE USE**

• Check denies if the client denies.
• If client reports substance use then complete the Check Boxes
• Address/ask about each substance, if used indicate the age started, frequency and quantity, method and last use. If admits to using some but not others fill in the info to the applicable ones and leave the others blank.
  • Example: Cannabis: 16 yo, 1-2 joints/per weekend, smoked, 3 days ago. : If denies any use check the “Denies” block and go to Family Hx of substance abuse.
• **History of Substance Use Treatment:** enter all treatment episodes with as much information as possible, such as date, location, type of treatment and how and why ended. Use N/A or None Reported if applicable
• **Substance Use Experiences:** Ask about each 1-5, if answer is yes, describe in the line beside the question.

**SECTION G: MEDICAL HISTORY AND CURRENT STATUS**

• We use The Medical Assessment Form, which is a nursing assessment form. If the Medical Assessment Form is completed this section does not have to be done. Refer to Medical Assessment form by checking the block. The form will need to be completed within 3 non-emergency visits. You may complete this section and also have the Medical Assessment done as a more thorough assessment by a nursing professional. If any blocks are checked for current or history they must be addressed in the comments section.
• Remember to ask for authorization to obtain medical information from hospitals and PCPs if applicable!
• Check the “C box” beside “No physical sx/problems” if they currently do not have any problems and leave the other “C” boxes blank but you may check the “H” Boxes since they could still have a history of certain ailments. The specify blocks, if applicable; information is to be entered in the comment section as applicable.

Updated August 2016
• **Significant Family History.** Either fill in the family history if any (indicating the relationship) or denies if none identified or does not know.

• **Medication:** List all medications prescribed and over the counter with corresponding dosage, frequency, purpose/effectiveness. Remember to ask about herbs and vitamins.

• **List Medication Allergies and Adverse Reactions to medications:** If none now click NKDA or enter allergies as reported.

• **Primary Care Physician, phone number and date last seen.** Who do they see for medical problems?

• **If client does not have a primary care physician, indicate if community resources were given to the client by checking yes or no.** If yes, list the type of resources given.

• **Example:** “Made referral to Care Coordinator”.

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**SECTION H: SOCIAL ECONOMIC AND CULTURAL**

• Ask and address all questions and prompts. **Do Not Leave Blanks** - use denies or unknown, none or N/A as appropriate.

  o **Where were you born and raised?**
  o **Family of origin:** who raised you, how many siblings, and quality of relationships then and now?
  o **Current family/significant relationships:** significant other, children, quality of relationships.
  o **Past significant relationships:** marriages, divorces, separations.
  o **Significant losses/separations:** through war, divorce, death, limbs, eye sight, pets, property, possessions, etc.
  o **Current housing situation:** house, mobile home, apartment, and who living w/ them. Make referral to care coordinator if needs identified in this area.
  o **Problems/changes/issues with sex/sexuality:** if yes describe.
  o **Current social involvement:** activities they enjoy with others.
  o **Current spiritual/religious involvement.** Attends church 3x week, Sunday school teacher, practicing Buddhist, or Atheist, etc.
  o **Educational background:** how far in school, tech school, college, special programs, highest level completed, performance in school, if quit school, why, etc.
  o **Current & Past employment:** length of employment, if unemployed - why, work history and reasons for quitting/being released from prior employment. Military Service? Type of work he/she would like to do.
  o **List any past & current legal issues:** pending court orders, charges, marital legal issues, custody issues, DJJ involvement, past arrests, convictions, etc. Is treatment court-ordered? –be sure to indicate on page 1

**SECTION I: STRENGTHS, NEEDS, ABILITIES, AND PREFERENCES (SNAP’S)**

• **Strengths:** Who or what gives your support? Support (family, spouse, social, spiritual), hobbies, neighbors, caregiver, employer, other agency, etc) and attitudes/things/people that have helped in the past. Desire to succeed, cooperative, motivated, receives guaranteed income, etc.

• **Needs:** emotional, physical, social, environmental. Hearing impaired, transportation, vocational training and/or placement, to complete education, recreational or social outlets, friends, on-going medical care for medical problems, housing, legal assistance, A&D treatment, etc. Make referral as needed to Care Coordinator.

• **Abilities:** ability to follow up with treatment, understand instructions, participate in treatment , can cook/clean & other ADLs, balance checkbook, driver’s license, can read & write, takes medication per instruction, abstains from ETOH/drug use, vocational & avocational skills, etc.

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*Updated August 2016*
• **Preferences**: appointments certain days or time of day, frequency, male vs. female therapist, medications vs. no medications, denominational, cultural, etc.
• Is client receiving services from other providers/agencies? If yes, specify.

**SECTION J: VIEW OF TREATMENT AND DISCHARGE**

• Documentation should include the source of the following: Check either Client and/or Family specifying relationship.
• **Expectations**: Enter both the client’s and family’s expectations: What client/family wants to happen; and what they expect from treatment; these are the foundation for the goals on the POC. Does client want the family to be involved in treatment? Does the family want to be involved? Name the family member(s) and relationship to client. Need referral to support group, NAMI, education regarding mental illness?
• **Commitment and Motivation to Treatment**: The motivation will give insight into the commitment to follow the treatment plan and medication compliance and indicative of the outcomes. Use the motivation and depth of commitment when developing the POC. Is the person willing to come to appointments as scheduled and participate in treatment process via working in sessions and doing outside assignments/homework (as applicable). Family’s commitment and motivation to treatment: How can they best help the client, indicates willingness to support the client and themselves to learn skills and/or behaviors to address the issues.
• **Discharge**: How will you know when you are ready to be discharged or transitioned to a lower level of care? What will be different or what must happen for you to no longer need Center services? Sometimes an individual may need continued support/services from the Center but to varying degrees therefore transitioned to lower level of care is the aim and can be achieved. Be specific about what needs to be different or how they will know and measure they are ready for discharge/transition, again this is the beginning of the development of the POC: “I can fall asleep and sleep all night 5 nights a week”. “My child will go from failing all subjects to making C’s.” “No more legal problems.” “I get a job.” “I stop crying for no reason.” “8 weeks without in school suspension or discipline notes”. These can be broken down into smaller objectives for the ITP. “Ask the person, what will your life/circumstances/sx look like when you are ready for transition to less frequent/intense services and/or discharge?” The family’s perspective is also very important here as well.

**SECTION K: MENTAL STATUS EXAM**

• Any blocks checked that are not normal range or response can be elaborated on in the comment section.
• **Appearance and Hygiene**: Check appropriate descriptor and include appropriate comments that address problem areas.
• **Motor Activity**: Check appropriate descriptor and include appropriate comments that address problem areas.
• **Attitude During The Interview**: Check appropriate descriptor and include appropriate comments that addresses problem areas.
• **Affect**: Check appropriate descriptor and include appropriate comments that address problem areas. Comments can include: “consistent with the content of the conversation and facial expressions”, “cried while discussing recent happy event and unable to explain why”.
• **Mood**: Check appropriate descriptor and include appropriate comments that address problem areas. How they feel most days. Note level of emotion, dysregulation & behaviors that indicated, ways the client has handled it.
• **Speech**: Check appropriate descriptor and include appropriate comments that address problem areas.
• **Thought Process**: Check appropriate descriptor and include appropriate comments that address problem areas.
• Difficult to understand line of reasoning, illogical thinking, grandiosity, magical thinking, perseveration, delusions, reports of experiences of depersonalization. Abstraction Skills: These are based on proverbs, sayings, similarities such as "How are a

Updated August 2016
______ and a ______ alike? Different?"; and giving both definitions for words that sound alike and have 2 different meanings such as "What are two different meanings for the words 'right,' 'bit,' and 'left?'". Examples of proverbs and sayings are: "What do people mean when they say... A rolling stone gathers no moss.; All that glitters is not gold; Don't count your chickens before they hatch; Don't put all your eggs in one basket; Strike while the iron is hot; Rome wasn't built in a day; When the cat's away the mice will play, A stitch in time saves nine." What would I mean if I said I am feeling blue? Seeing red? I have a chip on my shoulder? Or hot under the collar?

- **Thought Content**: Check appropriate descriptor and include appropriate comments that address problem areas. If suicidal/homicidal – see the risk assessment pg. 2. Describe, including plans and intent. Are there things that worry you a lot? Have you ever felt an intense fear or worry that something bad would happen to you? Are there specific things that frighten you? (Anxiety) Do you ever feel the need to do something over and over until it's perfect? Are there certain things you sometimes feel compelled to do over and over? Are there ever thoughts that you just can't get out of your head? (Compulsions and Obsessions)

- **Hallucinations**: Check appropriate descriptor and include appropriate comments that address problem areas.

- **Delusions**: Check appropriate descriptor and include appropriate comments that address problem areas if other than no evidence.

- **Orientation/Level of Consciousness**: Check appropriate descriptor and include appropriate comments that address problem areas.

- **Judgment**: Check appropriate descriptor and include appropriate comments that address problem areas.

- **Insight/Adjustment to Problems/Illness, Disabilities, Disorders**: Check appropriate descriptor and include appropriate comments that address problem areas.

- **Memory**: Check appropriate descriptor and include appropriate comments that address problem areas. Document the test to assess memory.
  - Intact or document incorrect responses which indicate difficulties with memory.
  - Recent Past: after ten minutes ask Client to repeat the name of the four objects, ask what they did yesterday (meals, activities, etc.)
  - Remote Past: ask birthday, dates of school attendance, marriage, birthdates of children, military discharge, other important chronological facts.
  - Immediate: (Registration and Recall) name four objects and ask Client to repeat them.

- **Concentration and Calculations**: Check appropriate descriptor and include appropriate comments that address problem areas. Document the test(s) in comments and result/answer. Ability to pay attention: does Client ask you to repeat questions? Based on Digit Span and attention to your questions, serial 7's or 3's in which they count backwards from 100 to 50 by 7s or 3s, naming the days of the week or months of the year in reverse order, spelling the word "world", their own last name, or the ABC's backwards.

- **Fund of knowledge**: Check appropriate descriptor and include appropriate comments that address problem areas. Document the test(s) and results/answers in comments. Problem-solving ability, estimate of general level of intellectual functioning, based on answers to questions like "Name last four presidents," "Who is the governor of the state," "What is the capitol of the state," "What direction does the sun set," etc...). Any results of testing and who did the testing: ie: IQ testing score and who did it, etc.

- **Other Pertinent Information**: complete as needed or N/A. Impulsivity (low medium, high, affected by substance use). Do you ever find yourself suddenly doing something before you have really had a chance to think about it? Do you ever do things you had decided not to do, and don't know why? Does money "burn a hole in your pocket"? Facial and emotional expressions (relaxed, tense, smiled, laughed, became insulting, yelled, happy, sad, alert, day-dreamy, angry, smiling, distrustful/suspicious, tearful when discussing such and such.

- **Sleep Patterns**: How are you sleeping? Do you have trouble falling asleep, staying asleep, waking up?
• **Appetite/Eating Patterns**: How is your appetite? Do you think your eating habits are unusual? What is your weight now? What is the most and least you’ve weighed? Are you concerned about your weight, purges, binges?

• **Energy Levels**: How is your energy level though the day; do you have enough energy to get things done? Have you ever had so much energy you couldn’t sit still? That you didn’t need to sleep for days at a time? *(Mania)*

• **Libido**: How is your libido, would you describe it as adequate, increased, or decreased?

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**SECTION L: DSM-5 DIAGNOSIS**

- Specify numerical code and name of disorder as appears in current DSM
  - If applicable, note severity/psychotic/remission/chronicity specifiers.
  - Ensure that diagnosis given meets DSM diagnostic criteria for that diagnosis and document all supporting symptoms that the client presents/reports.

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**SECTION M: INTERPRETIVE SUMMARY**

The blocks in the heading are to be checked when that information is included in the body of the summary. It is a way to ensure that it is included.

**INTERPRETIVE SUMMARY/CLINICIAN’S EXPECTATIONS:**

This is a narrative summary and interpretation of all pertinent assessment data gleaned from the assessment such as:

- demographic factors
- medical issues
- past treatment history,
- reason for seeking services
- mental status
- motivation
- support
- positive and negative factors
- levels of functioning
- co-occurring disorders.

This summary is the beginning of treatment, justifies the treatment/services rendered, and it is the foundation of the POC. Issues defined here are incorporated into the POC. Include the MHP’s recommendations for treatment and possible referrals. Include all factors that may impact the outcomes, both positive and negative.

Frequently, when a Client first enters our services they “just want to feel better” or “not go to the hospital anymore” or “behave and mind their parents and or teachers” they need us to guide them into setting obtainable goals and objectives. This summary will be the foundation to jointly plan their treatment and is the basis for the diagnosis.

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**SIGN AND SAVE YOUR DOCUMENT.**

Updated August 2016
NOTE:

The CAF ICA includes a section for Developmental History, School History, Behaviors, and Social Environment. Complete each section thoroughly.

ICA Update Form references the last ICA.
BERKELEY COMMUNITY MENTAL HEALTH CENTER HOSPITAL DISCHARGE ASSESSMENT FORM

Name: CID #:
Was BCMHC involved in admission? Yes No

Hospital Admission Date: Hospital Discharge Date:
Name of hospital consumer admitted to:
Did hospital send Discharge summary? Yes No

Diagnosis (current; was this changed in the hospital?):

Mental Status: (appearance, affect, mood, judgment, perceptual disorder, insight, etc)

Medications (name, dosage, etc; neuroleptic consent needed? Was the consumer given facts about meds while in hospital? What is the consumer’s understanding of why the meds were RX’d?):

Side Effects? (AIMS if needed)

Hospital experience (How was your hospital experience? Was it helpful? Did anything upsetting or frightening/scary happen? What? Include time from transport through discharge)

Rate the hospital experience 1-10 (1=worst experience of my life; 10=very helpful, positive experience):

Plan: (next appointment, Dr. appt., additions to treatment plan)

Clinician Signature/Date:

Updated August 2016
Plans of Care: in Brief

• Must be started 1st session after Assessment is done, but no later than 90-days.
• Ongoing, living document, should be revised throughout treatment.
• Expires 1 year after most recent MD signature new POC must be started.

Goals:

• What your Client wants.
• Must be in the Client's or Family's words.

Objectives:

• The small steps your client takes (behaviorally or cognitively) to accomplish the goal.
• How do you eat an Elephant? --take small Bites!
• Should make sense for the current Level of Care
• See SMART objectives section.
• Must incorporate the client’s SNAPs (Strengths, Needs, Abilities, Preferences)

Intervention:

• What the therapist does to help the client accomplish the Objectives (the therapy!)
• Should fit with the client's Level of Care. Higher level of care = more intensive interventions.

Services:

• Any or all of these MUST be Ordered (once) on the POC:
  • Ind Tx, Gp Tx, Fam Tx, PSS, PRS, FS, B-Mod.
  • These all require specific frequency: for example, 1xWeek, 4xMonth, etc.
  • Should reflect LoC: Higher LoC = more frequent and intensive services.

Signatures:

• Must be signed by the Client, the Counselor and the Physician.
The Plan of Care (POC) serves as the client’s roadmap to recovery. Keep in mind it must be a tool used to guide the client’s goals and justify the treatment according to diagnosis and promote recovery. The client must sign the document or you must justify why they were unwilling or unable to sign. Every client must have a treatment plan of care if they are to be in ongoing treatment. Clients that receive only emergency services and/or are closed within 90 days do not have to have a formal treatment plan.

The POC must be formulated, signed by the clinician, doctor, and client within 90 days of admission. There must be a yearly update of services/goals/objectives that will be signed and dated by the clinician, physician, and client. POCs may be updated at any time. Your POC reports and EMR will help you keep track of POC’s and Progress Summaries that need to be completed.

Any services that are required to be listed on the POC and are delivered after the 90 days from admission must be No-charged if they are not ordered on the POC at the time of delivery. Services required to be listed on the POC and delivered after renewal POC’s are due are to be No-charged. Only those services which are not required on the POC may be delivered and billed for. These services are: Crisis Intervention, PMA, Nursing Services, SPD, SPD/IT, Med Administration, and Assessment. Billing may resume once the physician signs the POC.

If services are added to the POC after the physician signs it, the physician must sign and date the POC to show medical necessity. If this does not happen, the service must be no-charged.

The following information is provided to help you with the documentation of your goals and objectives:

**GOALS AND OBJECTIVES**

**THREE TYPES OF GOALS:**

- **Life goals:** Include aspects of a person’s life where they have hopes for overall improvement and may include aspirations such as, “I want to be married” or “I want a job.”

- **Treatment goals:** Include the resolution of needs and concerns that are a barrier to discharge or transition from services. They are often linked to the reason the person/family sought help. “I don’t want to go to the hospital anymore” or “I want the sadness to go away” or “I want to be able to manage my life again.”

- **Quality of life enhancement goals:** Includes those other needs not immediately related to seeking services but typically reflect quality of life concerns for the individual or family. “I want to be able to travel more” or “I want more friends, a better job, live near the beach”, and so on. These goals are often very important to the person, but not as tightly linked to needs, challenges and barriers that result from mental health and addictive disorders that are the focus of the plan.

**LANGUAGE OF GOALS: GOALS SHOULD BE IN THE CLIENT OR FAMILY'S OWN WORDS, USE QUOTES**

**Criteria Possible Goals**

Provide a focus of engagement/life changes as a result of treatment

- “I want to get off drugs.”
- “I want a boyfriend/girlfriend”
- “I want to learn how to…….”
- “I want to be able to drive a car.”
- “I want to open my own bank account”
- “I want to work as ...........”

Are consistent with a desire for recovery, self-determination, and self-management.

Reflective of the person’s values, lifestyles and so on

Updated August 2016
Culturally relevant, in consultation with individuals & their families, appropriate to the individual’s needs, preferences, and abilities.

Based upon the individual’s strengths, needs, preferences, and abilities.

Written in positive terms, which embody hope not negative in focus

Appropriate to the stage of recovery

Alternative to current circumstances

How to elicit goals:

Ask questions like:

- What would you like to change in your life? How do you want your life to be in the future?
- What is important to you? What are your hopes and dreams?
- Tell me about your friends, hobbies, favorite activities.
- What kind of work would you like to do?
- What keeps you from doing the things you would like to do/used to do?
- If court ordered or just don’t feel they have any problems—What does the judge say has to change for your order to be dropped? What kinds of things does the judge/family identify as a problem for you?

KEEP IT SIMPLE:

One or two long term goals are plenty to work on. Make the objectives the short term things that the individual can be successful within a short amount of time. Each objective and its intervention should build on the individual’s strengths, and resources to address, relieve, and remove barriers to success that are immediately related to mental health and/or addictive disorders.

For example: The person identifies that they like to garden and they like to write. The goal is “I want to stop losing my temper with my family so much.”

An objective could be: Joe will use activities such as gardening and journaling to decrease his angry outbursts (screaming, throwing things, cursing, etc.) to no more than 3 times/wk.

Intervention: Therapist will assist Joe in developing skills to identify triggers that cause his angry outburst and identify healthier coping skills to decrease them.

Updated August 2016
OBJECTIVES:

Should be described in action words and should involve changes in behavior, thinking, understanding, insight, etc. Objectives should require the individual and family to master new skills and abilities that support them in developing more effective responses to their needs/challenges. As much as possible, objectives should reflect an increase in functioning and ability, along with the attainment of new skills, rather than merely a decrease in symptoms or attending appointments.

OBJECTIVES SHOULD GENERALLY SATISFY ALL OF THESE CRITERIA:

- Measurable
- Appropriate to the treatment setting
- Achievable
- Understandable
- Time-specific (don’t make this related to the duration of the Plan of Care, work with the client for reasonable time frames).
- Written in action-oriented and behavioral language
- Responsive to the individual’s unique needs, challenges, and recovery goals
- Appropriate to the age, development, and culture of the individual and family

Goals should be appropriate to where the client is in his/her life. Here are some stages of change that may help you and the client contemplate where they are and what they want to change.

STAGES OF CHANGE:

PRE-CONTEMPLATION

- Denial
- Unwillingness to change
- Unaware of having a disease, disorder, disability or deficit
- Unaware of the causes and consequences of the disease, disorder, disability, or deficit
- Unaware of the need for treatment and rehabilitation
- Lack of motivation to engage in treatment and rehabilitation

CONTEMPLATION

- Aware of their issues (problems)
- Know the need for change
- Not yet committed to change

PREPARATION

- Ready to change
- Need to set goals and priorities for future change
- Receptive to treatment plans that include specific focus of interventions, objectives, and intervention plans

Updated August 2016
ACTION

- Makes successful efforts to change
- Develop and implement strategies to overcome barriers
- Requires considerable self-effort
- Noticeable behavioral change takes place
- Target behaviors are under self-control, ranging from one day to six months

MAINTENANCE

- Meet discharge criteria
- Be discharged
- Maintain wellness and enhance functional status with minimum professional involvement
- Live in environment of choice
- Be empowered and hopeful
- Engage in self-determination through appropriate choice-making

EVALUATION

- Assess personal outcomes
- Obtain social validation and feedback from significant others

INTERVENTIONS:

The stage of change that the person is in helps to define the interventions that will be necessary to define and meet the objectives.

Interventions are the activities and services provided by the members of the team-including professional and/or peer providers, the individual and family themselves, or perhaps other sources of support within the community that help the individual achieve their goals and objectives. Interventions may be synonymous with treatment, care, services, therapy, support, medications, programs, and so on. They are different from objectives, but are closely linked. While an objective describes desired changes in status, abilities, skill, or behavior for the individual, the interventions detail the various steps taken by the team to help bring about the changes described in the objective.

EXAMPLE

Strengths: Supportive parents/grandparents
Abilities: Likes sports, music... “I like to fish with my Dad”
Preferences: after school appointments
Needs: “I need to stay out of trouble”

Goal: “I want to feel better by not getting in trouble all the time.”

Possible Objectives/Interventions:

Objective:

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John will tell people how he is feeling without aggressive (yelling, hitting) behaviors as evidenced by no more than 3 time outs in one week in the next 3 months.

**Intervention:**

Clinician will assist John in developing healthier anger management skills such as ‘Count to ten,’ Deep breathing, etc. to deal more effectively with his feelings.

Clinician will assist John’s parents in developing the use of consistent discipline and how to encourage John to express his feelings in an appropriate manner.

**Objective:**

John will be respectful in his communication with adults and peers in 3 out of 5 situations in the next 3 months as evidenced by parent/teacher reports.

**Intervention:**

Clinician will use play therapy and role play to assist John in developing respectful communication skills.

**Objective:**

John will use his coping skills to decrease aggressive behaviors and have no ISS or OSS incidents in the next 3 months.

**Interventions:**

Clinician will assist John in developing anger management skills he can use to help him deal more effectively.

Clinician will assist John and his parents about reward system for good behaviors and they will plan at least one activity per month based on John’s good behavior (no ISS or OSS).

**Objective:**

John will participate in an after school sports program to increase his sense of value through teamwork.

**Intervention:**

Clinician will explore with John the sports program he may be interested in and provide support for him to continue his participation.

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**Q-TIPS FOR POC DEVELOPMENT:**

First, the clinician assists the client to elicit relevant treatment goals. If the client is unable to state his/her own goals, then a family member or the clinician should establish the treatment goals.

Second, the clinician will work with the client to develop the objectives to reach the client goal(s).

*Keep in mind: “The objectives are the expected observable behaviors”.*

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Third, the clinician works with the client to establish the measures of the objectives, as these should be based on what the client believes h/she can do. The clinician helps the client make the measure realistic to foster success.

Fourth, the clinician includes the interventions to be used in assisting the client to reach the objectives, that is, to perform the expected behavior.

Keep in mind: Interventions are treatment methods, and activities, e.g. role-playing, supportive interventions, education, cognitive therapy, skills development, etc.
PROGRESS SUMMARIES/REVIEWS:

- Done every 90 days and at discharge.
- DLA-20 should be done with the client when present.
- Rate each objective. Rating scales as listed on the progress summary sheet.
  - 1 = None
  - 2 = Limited;
  - 3 = Some
  - 4 = Significant
  - 5 = Accomplished
- Narrative should include: Progress narrative on each objective. Clinical justification of need for continuing treatment by clearly stating how the services are necessary to treat the disorder or to prevent decompensation. Plan for future treatment or discharge. Include client and family feedback.
- Integration into community: What community activities have you encouraged or gotten the client to participate? How will this lessen his/her need for reliance on MHC?
- Are there any changes to the treatment plan?
- Review periods: Begin from the date of admission and every 90 days thereafter and at discharge. Can be done up to 14 days in advance. Begin the next review the day after the last one.
- Sign and date the Progress Summary
SECTION 17: CRISIS MANAGEMENT FORM AND SAFETY PLANS

This form is to be used by all clinical staff (office hours and after hours) to document the service of Crisis Intervention. It does not supplant the use of the Initial Clinical Assessment for routine clinical admissions. These forms are also used to help track monthly service data to report to DMH and Board of Directors.

Crisis Intervention is defined in the Medicaid Community Mental Health Services manual as an intensive, time limited service by a MHP face-to-face, on the phone, or on behalf following or during abrupt substantial changes in function and/or a marked increase in personal distress which results in an emergency situation for the client or the client’s environment.

This means the client may come in off schedule, call or may present for a scheduled appointment or a family member may call or come in seeking assistance with the above criteria. One of these forms should be completed for ALL clients receiving this service:

- For clients with an open BCMHC medical record, complete sections of Crisis Management form indicated on the attached example. On CSN reference Crisis Management form (e.g. “See Crisis Management Form dated this date”).
- For new admissions, complete entire form along with other admission paperwork, on CSN, reference Crisis Management form (e.g. “See Crisis Management Form dated this date”).
- CSN’s: “Emerg/Afhrs” and “Problem” need to reflect emergency and type of problem (e.g. psychiatric, A/D)
- Original form to be imported in the Medical Record and a copy the Access Center supervisor.

A Safety Plan should be put in place if the client has any tendency toward harmful behaviors to self or others. This plan should be put into place as soon as possible after admission if needed. It should address triggers toward the behaviors and preferences of the client as to how to resolve the thoughts or behaviors.
SECTION 18: DISCHARGE/TRANSITION PLANNING

- Discharge/transition planning begins at the time of initial assessment. (What do you want help with? How can we help? How will you know when you are ready to leave treatment?)
- The POC formulation process also speaks to Discharge/Transition criteria. (How will the client feel, behave, and recognize change?)
- During the treatment process and treatment reviews, discharge options should be considered. CSN’s should contain discussions regarding discharge/transition.

Example: John has accomplished his goal of decreasing depressive symptoms, he is sleeping, has gone back to work, his relationship with his wife has improved. He continues to have need of resolving his issues with his parents. We discussed his needs and informed him of several treatment options; a monthly medication monitoring group to address his need to follow on medication along with individual counseling. When he feels his need for counseling is done MMO will be considered. John is in full agreement with this plan.

- Discharge/Transition Form should wrap up a summary of treatment, SNAP’s and why the discharge/transition is taking place. The client should be involved in all phases of this planning.
- If the client is transitioned to other services, the receiving clinician will follow up to assure needs are being met. If the client leaves all service the standard discharge follow up will occur.

FOR A RECORD TO BE CONSIDERED CLOSED, THE PAPERWORK DESCRIBED BELOW MUST BE COMPLETED:

- CLIENT DISCHARGE FORM-SCDMH FORM PDR-2
  - Used only if client is discharged from the Center.
- REFERRAL/DISCHARGE/TRANSITION FORM
- PROGRESS SUMMARY/REVIEW
  - To close out treatment from time of previous review to the time of closure.

CLIENTS WHO HAVE BEEN ASSESSED EMERGENTLY OR AFTER-HOURS NOT MEETING CENTER ELIGIBILITY CRITERIA: NOT KNOWN TO CENTER:

- Crisis Management Form. Every block must be completed with appropriate information
  - A narrative must be included in the MHP CSN indicating disposition of the client and whether our intervention is complete or not. If no further care is indicated by our Center-complete the Discharge Summary portion of the form. The front desk will close the chart by the indicated space on the form.

CLIENTS WHO HAVE BEEN ASSESSED ROUTINELY AND ARE FOUND NOT APPROPRIATE FOR OUTPATIENT TREATMENT:

- Initial Clinical Assessment Form-See form for case disposition information
- PDR-2

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DISCHARGE/TRANSITION FORM INSTRUCTIONS

Client Name: Give client full name as indicated on the record.

CID: List the client’s CID listed on the record.

Date of Admission: See date on the face sheet.

Date of Discharge/Transition: The actual date you are closing/transitioning client.

Reason for Discharge/Transition: provide reason for the client’s discharge or transition. Include statements such as: Unable to engage client in treatment; Client has met his goals of ............ and now wishes to be on medication management; Client moved to Timbuktu and wishes to pursue his tx there; Unable to locate client have attempted phone calls, home visits, etc.; Attempted follow up with client and have not received any response as requested.

Diagnosis at Admission: List dx’s at admission from initial PMA or POC.

Diagnosis at Discharge/Transition: List current dx’s.

mGAF at Admission: List mGAF at admission from initial PMA or POC.

mGAF at Discharge/Transition: List current mGAF.

Strengths: List strengths that client has acquired during tx or what client reported in the beginning of tx.

Needs: See above

Abilities: See above

Preferences: List what client prefers at this point in their treatment.

Current Medications Section: If the client was on medication, please list the most recent medications prescribed with dosages and how they responded to the medications. Will the client be discharged/transitioned on medication? The answer should be no for most, if yes explain...it should be that they have moved and have a Rx for the interim period.

Presenting problems/symptoms: List the problems/symptoms that the client came to us with.

What Services were provided and what were the results of the services/progress on recovery at the time of Discharge/transition: include the following: What services provided? Were goals/objectives met? Progress in his/her recovery?

Date of Last Contact: provide the date of the last contact with the client whether face-to-face, over the phone, or in a letter.

Client Status at Last Contact: What was the status of the client at last contact?

Recommendations for Follow-up/Support: It is a given that if sx’s re-appear the client may return for evaluation and treatment as necessary therefore that is always the first one and is written for you. Any referrals list and provide contact name and number.

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Provide any other recommendations made. What will it take to keep them stable in the community? What agencies or support systems should they have? How do family help with this?

**Program Transfer Information:** Provide information as indicated.

**Persons Participating in Discharge/Transition Plan:** List all those who helped with this plan. If you know the client is moving or will be transferring you can do the plan ahead of time with the client’s input. Staffing with your supervisor as well and if doctor involved include their name.

**Staff Signature/Title/Date:** Sign and date.

**Client received a copy of the Discharge/Transition Plan:** Check the appropriate block. A copy can be mailed to the client if he/she is not present.
Before any information can be released about a client several things must happen:

1. A properly signed Release of Information (ROI) must be provided. This ROI will be in the Import Section of the EMR or may be under the Consent Tab: “Auth. To Disclose Protected Health Info.”
2. (See Section 11. Release of Information, for requirements).
3. A generic note must be completed stating exactly what information you sent and to whom.
4. If you send a summary letter, you must retain a copy in the Import Section of the EMR and reference that copy on the generic note documenting the disclosure.

Treatment Summary letter can be found on the Center’s HomePage.

VOCATIONAL REHABILITATION DISABILITY LETTERS AND OTHER VALID REQUESTS FOR TREATMENT RECORDS:

All requests from DDD will be processed through the medical records department to include:

1. Being logged
2. Checking the release for records to be an original
3. With the client or authorized person’s signature
4. Witnessed
5. Client’s date of birth
6. Client’s Social Security #
7. Dates of services requested

The Medical Records designated staff will copy the medical record for the requestor in accordance with the Policy Number 03-005.R7 of the CSS manual. The clinician and supervisor and/or QI Director must sign approval for the records to be sent to the entity requesting the records.

Medical Records staff will record the date they mail/deliver/fax the copied records to the requestor after receiving the approval to release from the clinician and supervisor and/or QI Director.

The request will be monitored and followed up by Medical Records staff to ensure the processing and forwarding of these records in a timely manner. Supervisors are involved as needed to speed up the processing of these records.

A bill is assessed for copying of records. The agency does provide other treatment providers and DDD copies without charge.

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The Standardized Abbreviation List is located on the EMR HomePage.
The EMR will have the latest version to the DSM and ICD codes available to staff.
SECTION 22: AUDITING FORMATS FOR DMH QUARTERLY AUDITS

In order to monitor compliance with Quality Assurance requirements for medical record documentation for all clinicians and supervisors, the Quality Assurance staff will provide consistent feedback to clinicians about the completeness and quality of documentation and treatment in the medical record. Audit results will also provide information on clinicians’ job performance in meeting quality assurance requirements and will be integrated into the annual EPMS process.

FEEDBACK TO CLINICIANS:

Review findings are forwarded to clinicians and supervisors for reviews and corrective actions when indicated. QA provides summary to clinicians, supervisors, and Leadership Team on a regular basis.

INTEGRATION WITH EPMS PROCESS:

Audit findings and information will be maintained for each clinician. This information is available to supervisors at the time of the clinician’s EPMS.
SECTION 23: STAFF CREDENTIALING

All staff who provide clinical services are credentialled and privileged using the SCDMH Credentialing and Privileging for CMHC’s systematic process.

It is a uniform and systematic process toward the privileging and credentialing of clinical staff at the SC DMH Community Mental Health in conformance with standards of the NCQA which serves as the basis for the standards of various accreditation bodies and insurers.

This process verifies professional competency to provide certain services as defined, and according to the required credentials of the South Carolina Department of Mental Health.

A credentialing file is maintained on site and at the Department level.

Credentialing requirements for each service are listed with the individual service description in Section 2 of the Medicaid Community Mental Health Manual and Section 2 of the Medicaid Rehabilitative Behavioral Health Services Manual.

MHP Privilege: The standards for qualification as Mental Health Professional (MHP) are defined as:

- **Psychiatrist**: A Doctor of Medicine or Doctor of Osteopathy who has successfully completed a recognized residency training program in psychiatry and is licensed to practice psychiatry in South Carolina. Psychiatric Nurse: A registered nurse who is licensed in SC and has a minimum of 1 years’ experience in the mental health field.
- **Advanced Practice Registered Nurse**: A registered nurse with a Master’s Degree and licensed in S.C. and is recognized by the State Board of Nursing and has national certification.
- **Physician**: A Doctor of medicine or Doctor of Osteopathy licensed to practice medicine in SC.
- **Social Worker**: A holder of a Master’s Degree in Social Work from an accredited university or college and licensed to practice in the state of SC.
- **Clinical Chaplain**: A holder of a Master of Divinity degree from an accredited theological seminary who has 2 years of pastoral experience as a priest, minister, rabbi and 1 year of Clinical Pastoral Education which includes provision of supervised clinical services.
- **Psychologist**: A holder of a doctorate from an accredited university or college who is licensed in the state of SC in the Clinical, School, or Counseling specialty areas.
- **Mental Health Counselor**: A holder of a master’s degree or doctorate from a program that is primarily psychological in nature (e.g., counseling, guidance, social science equivalent) from an accredited university or college.
- **Mental Health Professional Master’s Equivalent**: A holder of a master’s degree in a field that is related to bio-psychosocial treatment or treatment of the mental ill or a holder of a master’s degree in a reasonable related field that is augmented by graduate courses and experience in a closely related field. Also, those appropriate Ph.D. candidates who have by-passes the master’s degree but have enough hours to satisfy a master’s requirement and are actively pursuing a Ph.D.

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TO: ALL ORGANIZATIONAL COMPONENTS

SUBJECT: CENTRALIZED CREDENTIALING SERVICE

THE FOLLOWING DOCUMENT IS TO BE INTERPRETED CONSISTENT WITH SECTION 41-1-110, CODE OF LAWS OF SOUTH CAROLINA. NOTHING IN THIS DOCUMENT OR ANY SCDMH DIRECTIVE, EMPLOYEE HANDBOOK, MANUAL, POLICY, PROCEDURE, OR RELATED DOCUMENT CREATES AN EMPLOYMENT CONTRACT OR CONTRACTUAL RIGHTS OR ENTITLEMENTS. SCDMH RESERVES THE RIGHT TO REVISE THIS DOCUMENT AND ANY SCDMH DIRECTIVE, HANDBOOK, MANUAL, POLICY, PROCEDURE OR OTHER DOCUMENT. NO PROMISES OR ASSURANCES CONFLICTING WITH THIS STATEMENT CREATE AN EMPLOYMENT CONTRACT.

I. Purpose:
   The purpose of this directive is to maintain a centralized credentialing service within the South Carolina Department of Mental Health (SCDMH) - Human Resource Services - Central Credentialing (HRS-CC) and to describe the scope of responsibility for that service as it relates to the SCDMH’s facilities and centers.

II. Policy:
   It is the policy of the SCDMH to maintain a credentialing system that ensures that all members of its clinical staff, i.e. medical and behavioral health professionals are qualified in terms of current licensure; relevant training and experience; current competence; and to perform the privileges requested.

III. Objectives:
   a. To credential clinical staff only once to reduce the administrative burden on the facility/center and provide consistency across the system.
   b. To provide a central source within SCDMH of true and correct copies of the required credentialing information on the clinical staff to any/all credentialing committees that the professional serves in addition to the employing facility/center.

IV. Definitions:
   As used in this directive, the following definitions shall apply:
   a. **Appointment** is the process whereby a SCDMH inpatient facility or community mental health center authorizes a clinical professional to provide patient care services in or for the authorizing facility or center.
   b. **Centralized Credentialing (CC)** refers to the system-wide process of the employing facility/center supplying copies of the credentialing information for the clinical professional upon request by SCDMH inpatient facilities, community mental health centers, or the DMH Office of Quality Management and Compliance.
   c. **Credentialing** refers to the process of obtaining, verifying, and assessing the qualifications of a clinical professional to provide patient care services in or for a SCDMH inpatient facility or community mental health center.

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d. **Primary source verification** is the process in which an organization validates credentialing information from the organization that originally conferred or issued the credentialing element to the clinical professional.

e. **Privileging** is the process whereby a specific scope and content of patient care services are authorized for a healthcare professional by a healthcare organization based upon its evaluation of the individual’s credentials and performance.

f. **Employing facility/center** is the facility or center where the physician started current employment.

g. **Clinical staff** refers to all medical professionals (physician, nurse practitioner, physician assistant, dentist, and nurses) and behavioral health professionals (psychologists, social workers, counselors and other paraprofessional staff)

V. **Responsibility for Privileging Decisions:**

a. The SCDMH inpatient facility or community mental health center has primary responsibility for making the determination as to whether a clinical professional applying for employment in the medical or behavioral health professional staff is qualified and competent to provide care and professional services.

b. The Medical Staff Bylaws of the SCDMH inpatient facility or community mental health center and credentialing and privileging criterion of the respective accreditation bodies shall govern the decision process. In addition, each inpatient facility or mental health center of the SCDMH shall operate according to Federal Law, the statutes of the State of South Carolina and the rules, regulations and policies promulgated by the SCDMH. The centralized credentialing process does not alter the process except to the extent that HRS-CC will be responsible for filing the information from the National Professional Data Bank.

c. The SCDMH facilities and community mental health centers will ensure that the process of decision making in credentialing and privileging members of their clinical staff does not take into consideration the applicant’s gender, race, ethnicity, age or sexual orientation.

d. The Credentialing/Privileging Committee at the SCDMH facilities and community mental health centers is comprised, at a minimum, of the Medical Director or his/her designee, the Facility Director or his/her designee, the Quality Assurance or Credentialing Officer and other members of the Senior Management. The Committee shall meet no less than quarterly to review new applications and review renewals of privileges of their staff members unless otherwise necessary.

e. The Executive Director of each of SCDMH facilities and community mental health centers is responsible for the final review of credentialing and privileging applications and conformance of the process to the Medical Bylaws of the facility and community mental health center and the particular accreditation body.

VI. **Procedure:**

a. The Division of Inpatient Services (DIS) credentialing is responsible for assembling credentialing files on all active clinical staff for Bryan Psychiatric Hospital, William S. Hall Psychiatric Institute, and Morris Village.

b. Patrick B. Harris Psychiatric Hospital (Harris Hospital), C.M. Tucker, Jr., Nursing Care Center (Tucker Center), Richard M. Campbell Veterans’ Nursing Home (Campbell Nursing Home), Veterans’ Victory House, and individual Community Mental Health Centers (CMHCs) are responsible for assembling credentialing files for all active members of their clinical staff.

c. The credentialing liaisons for DIS, Harris Hospital, Tucker Center, Campbell Nursing Home, Veteran’s Victory House and the QA Coordinators at the CMHCs will provide HRS-CC with a copy of all credentialing files on all clinical staff members for their facility/center.

d. Due to the nature of the information submitted for credentialing and privileging, all documents submitted by an applicant must be kept confidential, in a secured manner by the appropriate staff. Documents shall be maintained in a file in a locked cabinet or cabinet room. If documents are maintained in an automated fashion, these should

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be password protected and only accessible to the QA Assurance Coordinator or the Credentialing/Privileging Officer.

e. The applicants should be notified of their right to review information submitted to support their application for correctness and of or discrepancies on of any information received to support their application and the specific time line to submit required information. They should also be informed of the status of their application upon request.

f. Professionals files will contain copies of all verified credentialing information as listed below which should be available to the Credentialing/Privileging Committee prior to its determination:

i. Completed credentialing application
ii. History of employment and clinical practices
iii. Areas of competencies reflecting the specific needs of the person served and clinical skills that are appropriate to the position
iv. Official transcript
v. Copy of Diploma or Certificate
vi. Current license to practice in South Carolina, as appropriate
vii. A valid Federal Drug Enforcement Agency (DEA) certificate, renewable every 3 years (Medical Professionals)
viii. SC Controlled Substance (DHEC) certificate, renewable each year (Medical professionals)
ix. Graduation from an accredited institution. Medical staff must be graduated from a professional school and/or residency or postdoctoral program [verified in the American Medical Association (AMA) Master Profile Report, or in other accepted source of verification based on the applicant’s professional degree]
x. Education commission for Foreign Medical Graduates (ECFMG) certificate, if appropriate (Medical staff only)
xi. Board certification, if appropriate (Medical staff only)
xii. Work history or current competence in the form of letters from authoritative sources on clinical performance, professional obligations, and ethical performance
xiii. Statement of malpractice insurance that states the dates and the amount of coverage, if an independent provider
xiv. The results of a check of the OIG List of Excluded Individuals/Entities
xv. Attestation by the applicant as to convictions, drug abuse, ethical qualifications, health status, reasons for any restrictions to perform the essential functions of the position, with or without accommodation, etc., necessary to provide healthcare service in or for the facility/center and which authorizes an evaluation of professional competence
xvi. History of professional liability claims that resulted in settlements or judgments paid by or on behalf of the professional, if an independent provider
xvii. The results of a check of the National Practitioner Data Bank (which must be done by each inpatient facility and community mental health center for each medical staff professional)
xviii. Criminal background checks

g. Once the credentialing and privileging process is completed, the applicant is to be informed of the decision of the Committee within the next ten (10) working days from the application for privileges. The Executive Director and/or Medical Director as appropriate, and the Supervisor and/or the QA Coordinator at the CMHCS or the Credentialing/Privileging Coordinator of the DIS facilities must sign the document. In the event that a Community Mental Health Center requests concurrence on the privileging from the SCDMH Division of Quality Management and Compliance, a copy of the final document should be given to the applicant as outlined in this paragraph.

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h. A master list of all credentialed professionals will be maintained in the office of HRS-CC and at each inpatient facility and community mental health center. Each medical and clinical staff should be listed with their respective credentials, to include professional title, type of license/certification, professional degree, education, training, board certification and specialty.

VII. Reappointments

a. The facility/center is primarily responsible for the recommendation for reappointment of the clinical staff.
b. All clinical staff must be reappointed every two (2) years
c. All licenses, FDEA and Controlled Substance Certificates must be updated on or before their expiration date
d. All applications must be updated at reappointment
e. HRS-CC will receive updated and reappointment documentation
f. HRS-CC will provide, upon request, to each facility or community mental health center that employs or contracts with a medical/clinical professional the following:
   i. A copy of the information in the centralized credentialing file within fifteen (15) days from the date of the request if all information is available
   ii. Each page of the file provided to the facility/center will be stamped with the location of the original verified document
   iii. The information transmitted to the facility/center will accurately represent the information gained in the verification process
   iv. Every effort will be made to assure that all credentialing information is transported and stored in as safe and confidential manner as possible
   v. The Joint Commission (TJC) has confirmed that a SCDMH centralized credentialing service, which completes and/or maintains primary source verification and maintains originals of documents needed for credentialing decisions is acceptable for survey purposes. Copies of primary source information, that have been certified to be true and correct copies of original documents, can be utilized by individual inpatient facilities, community mental health centers, and the credentialing office of DIS or HRS-CC
g. A copy of the credentialing files of currently active medical/clinical staff, stamped with the location of the original verified documents, will be retained by HRS-CC

h. The facility/center is responsible for the development and retention of information related to quality improvement, utilization review, drug utilization, administrative and documentation requirements, Continuing Medical Education (CME’s), Continued Education (CEUs), training hours, performance data, checks on the SCDHHS and OIG Sanctions List, and other pertinent information required for reappointment of clinical staff.
SECTION 24: OUTCOME MEASURES

DAILY LIVING ACTIVITIES – 20 (DLA-20)

In the Summer 2015, the Department of Mental Health standardized all client outcome measures for clients 6 years of age or older. (For children under 6 years of age, the Pediatric Symptoms Checklist is utilized) This tool is a nationally validated and reliable measure of human functioning in 20 domains. All clinicians of DMH who treat clients are required to receive training and become certified in the administration and interpretation of the DLA-20. The DLA can be accessed through EMR on the Outcomes Tab in a client’s record.

Certified Clinicians (Not certified trainers):

- Complete the initial 3.5 hours of training
- Complete 3 DLA-20 assessments satisfactorily
- Demonstrate proficiency in the use of the DLA-20
- Adhere to the standards of practice of the DLA-20
- Adhere to SC DMH Policy and written procedures on the use of the DLA-20
- Sign attestation form confirming proficiency in the use the DLA-20. The DLA-20 Certified Trainer shall endorse this form.

Procedures:

1. Effective July 1, 2015, clinicians of the SCDMH will periodically assess the level of functioning of their clients using the DLA-20.
2. Data will be collected on adults, children and adolescents and reported as one of the outcome measures of the SC DMH
3. The DLA-20 will be administered as follows:
   a. New clients - those admitted on or after July 1, 2015
      i. At onset of treatment and as part of the initial diagnostic assessment
      ii. Every 90 day thereafter at the time of the 90 day progress review
   b. Existing clients
      i. At the first 90 day progress review after July 1, 2015
      ii. Every 90 day thereafter at the time of the 90 day progress review
4. Clinicians properly trained and certified as having competency in the use of this tool will be responsible for administering the DLA-20 to their assigned clients
5. Clients who are in the Medication Management Only (MMO) level of care are excluded from this measure
6. Reporting measures on the DLA-20 is “not acceptable” only in the following situations:
   a. If at the time the scale is going to be administered the client presents with cognitive or perceptual distortions in a psychiatric crisis, or
   b. If at the time of the Progress Summary the client misses the scheduled appointment to complete the scale and in addition to that, the client has not been seen for the last 30 days.
      i. In these cases the DLA-20 should be administered at the next time the client is seen.
   c. If the client is discharged without being seen, the last known DLA-20 scores should be reported.
7. Data from the DLA-20 should be reflected in:

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a. Plans of Care as treatment goals and/or objectives and as determined by the client and the therapist at the beginning of treatment, at the 90 days progress reviews as necessary, and annually if the Plan of Care needs to be reformulated.

b. 90-day Progress Summary to indicate the client’s progress in an objective manner and to substantiate observations made by the therapist.

PRIOR TO NOVEMBER 2015, THE BCMHC EMPLOYED THE TOOLS IDENTIFIED BELOW FOR DETERMINING CLIENT OUTCOMES.

CHILD BEHAVIOR CHECKLIST (CBCL):

The CBCL is a tool used by a reliable clinician to measure how impaired a youth is in day to day functioning, secondary to behavioral, emotional, or substance use problems. It is used at intake, every 6 months thereafter, and at discharge to assess change while in treatment. It is meant to be used as measurement outcome and an active treatment planning tool with the youth and their families. Family members/caregivers fill out the form with help from the clinician if needed.

ADULT OUTCOME TOOLS:

Clinicians should rate adults with the Center Outcome Survey for Adults form. This should be accomplished at admission and every year thereafter. The form also asks for GAF scores. The GAF is required to be updated in CIS every 6 months.
SECTION 25: GENERAL GUIDELINES FOR DOCUMENTATION

DOCUMENTATION OF CLINICAL SERVICE NOTES (CSNS): THE FIRPP MODEL

Focus

- ...of the session: This *must* relate to the POC and *should* be one of the objectives from the POC.

Interventions

- What *you* did with the client. *The Therapy!*
- Processed, encouraged, validated, roleplayed, supported, etc.

Response

- What did the client do in reaction to your interventions?
- Participated, considered, ignored, agreed, refused, became guarded, appeared hopeful, etc.
- Should *not* be the bulk of the note.

Progress

- How does this session relate to the overall recovery of the client?
- Do other services/goals need to be added to the POC?
- Must indicate that symptoms or functioning are getting better, getting worse, or staying the same.
- "NA" is a No, no. One can always describe progress, even if this is your 1st session with the client.

Plan

- What *meaningful* work are you intending to complete next session.
- It will become the Focus of your next session.
CLINICAL SERVICE NOTES GUIDELINES:

THE FOLLOWING ARE SOME GUIDELINES/EXAMPLES TO HELP YOU WITH THIS DOCUMENTATION:

FOCUS OF THE SESSION:

The Focus of the session will be one of the objectives from the POC.

INTERVENTIONS:

counseled  consoled  directed  discussed  bolstered  assisted  
advocated  addressed  advised  avoided  encouraged  guided  
identified  instructed  interpreted  furnished  helped to..  confronted  
emphasized  commended  recommended  rejected  urged  offered  
suggested  reassured  upheld  shared  presented  provided  
supported  role-played  re-directed  consented  re-assessed  allowed  
referred  sustained  structured  oriented  reframed  empathized  demonstrated  
addressed issues of  praised  prodded  evaluated  set limits  elicited  compared  
met needs by..  used humor to..  helped client think through...  helped client consider.......  

RESPONSE OF CLIENT:

agreed  disagreed  evaluated  integrated  acknowledged  
blamed  listened  manipulated  adopted  established  
commented  refused  accepted  acted out  reflected  
ignored  clarified  chose to  focused  resolved  
thoughtful  angry  enlightened confused  denied  promised to think about  
optimistic  guarded  assertive  suspicious  agitated  
argumentative  reassured  preoccupied  withdrawn  introspective  

PROGRESS IN RELATION TO GOALS:

Continues to....  Achieved  Partial progress  Needs to...  Having problems with:  
Improved in the areas  Resolved  Change occurring  

Updated August 2016
WORDS THAT CONVEY TIME SPENT:

- Lengthy
- After ____ minutes...
- Stated/Restated____ times
- Explained until understood
- Reiterated Numerous times
- Eventually

Finally
- At length
- Several attempts
- Repeatedly
- Discussed in great detail

KNOW THAT THE MEDICAL RECORD IS A LEGAL DOCUMENT AND AS SUCH...

HERE ARE SOME DO’S AND DON’TS.

DO KNOW THAT:

**Fraud**: is knowingly and willfully executing, or attempting to execute, a scheme or deception to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program (SCDMH Corporate Compliance Plan-Definitions/Acronyms).

In other words, it is an intentional deception or misrepresentation made by someone knowing that it is false and could result in an unauthorized payment. Keep in mind the attempt itself is fraud, regardless of whether it is successful (www.cms.gov).

**Abuse**: refers to an activity that may result in direct or indirect unnecessary costs to any health care benefit program including improper payment or payment for items or services that fail to meet professionally recognized standards of care, or defined by the program as medically unnecessary. Abuse includes payment for items or services when there is no legal entitlement to payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment (SC DMH Corporate Compliance Plan – Definitions/Acronyms).

That is abuse involves actions that are inconsistent with accepted, sound medical, business, or fiscal practices. Abuse directly or indirectly results in an unnecessary cost to the program through improper payments.

The real difference between abuse and fraud is the person’s intent (www.cms.gov).

The standards of all the services are listed in Section 1 of this manual and in the third party payer Manuals. You are responsible for the appropriate coding of the services you provide. Know what the standards require and how the services are used.

**Bill** for the services provided and according to applicable standards.

Assure that the clinical documentation is in the medical record immediately after the service is provided. When this practice is not possible due to extraordinary circumstances, you have up to 10 business days for the documentation to be in the medical record. This is the rarity and not the practice. You are encouraged to use Concurrent Documentation with your client to assess his/her input and which provides the client with a review of the session, what the expectations are until next session, progress being made, plan for next session, and know of what is being documented in his/her medical record.

Updated August 2016
Refund payment or no charge are made for services not documented or for documentation not in the chart within 10 business days of the service rendered.

Assure that the client’s diagnosis is justified by the symptoms and behaviors presented by the client and/or reported by the client’s representative, friend, next of kin, parent, etc., during the clinical assessment and ongoing throughout treatment.

Justify medical necessity based on the symptoms, needs, and level of functioning of the client at least in the interpretive summary and Progress Summaries.

Know your clinical privileges and only provide services for which you are appropriately credentialed, privileged, and qualified to provide.

Question any requests to alter or amend existing documentation to meet audit requirements to justify payment, whether from a supervisor or another staff member.

DON’T !!

- Misrepresent diagnosis to justify payment.
- Bill for services not provided.
- Upcode or unbundled a service to bill at a higher rate.
- Alter or falsify certificates of medical necessity or other clinical documentation (clinical notes, Progress Summaries, etc.) to justify payments.
- Bill for or provide services you are not appropriately qualified and privileged to provide.
A CASE: FROM START TO FINISH

(Treatment completion)
INTAKE: Client walks-in, intake paperwork completed

Assessed by Access/Mobile Crisis. Referred to Program Supervisor for assignment to therapist. DLA-20 and Initial POC are developed. For School-Based (SB) the onsite therapist completes. Submit Screen 8 form.


Initial POC needs to be completed within 90-days of admission and requires client and physician signature.

Consider if any planned services will require Prior Authorization before delivery. Complete PA documents as needed.

Staff case with team, supervisor, and/or MD to review findings and further develop appropriate treatment plan. Document on SPD or Generic note in EMR. Utilization of services should be planned based on Level of Care (LoC).

Begin planned services (required on POC) as described on POC. Planned Services include: Ind Tx, Gp Tx, Fam Tx, PRS, PSS, FS, Beh Mod.

If enrolled in Rehabilitative Services (PSS, PRS, FS or Beh Mod) be sure client begins these within 30-days of POC order, otherwise must discontinue or have MD recertify on POC.

Consider referral to Care Coordinators for Targeted Case Management (TCM) services.

Review and amend POC as needed throughout treatment. Consult with Supervisor or Physician and document on generic of SPD when change in POC is warranted.

Complete a Progress Summary and DLA-20 every 90-days. Based on PS and DLA-20 score determine any revisions needed to POC and/or LoC.

Monitor attendance to treatment sessions; complete progress reports to referral sources/supervising agencies as needed.

Upon achieving tx goals, staff for discharge. Complete a Progress Summary and Discharge/Transfer summary in EMR. File CIS Discharge form. (see "What to do at Admission/Discharge" section)
WHAT TO DO: FIRST SESSION (ASSMT):

Pre-Session

- 60-min session will be scheduled for you by Central Scheduling.
- Review Initial Clinical Assessment (ICA), POC, and chart.
- Communicate any questions about ICA/POC findings to A/MC.

First Session (after ASSMT)

- Begin to develop rapport - introduce self, discuss program, answer questions.
- Review Assessment and POC with Client.
- Check ROIs to see if more are needed (DSS, Kennedy Center, etc.)
- Begin Transition Planning
- Collaboratively document your Ind Tx note in EMR.
- Schedule appointment for next session.

Post-Session

- Communicate with referral source regarding client's attendance, etc.
- Staff POC with Supervisor, team and/or Physician. Document as Generic/SPD where applicable.
WHAT TO DO THROUGHOUT TREATMENT:

Therapy Sessions (Ind, GP, Fam Tx)

- Review last service note before client/group arrives to determine what the intended plan for this session was.
- Greet client(s) at lobby.
- Briefly review last session's goal/progress (and current POC with client if Ind Tx session) to determine interventions for today's session.
- Update POC as necessary. Address treatment goals.
- Therapy/Counseling.
- Collaboratively document the session with your client.

Managing the Case

- CAF Clients: within first 30-90 days complete Trauma Screens and Symptoms Checklists (CPSS)
- Continue monitoring needs for Prior or Re-Authorization of planned services.
- Maintain communication with referral source/supervising agencies.
- Update POC and Level of Care (LoC) based on changes in symptoms and functioning.
- Complete a Progress Summary (PS) and DLA-20 every 90 days.
- Case Consultations/Staffings.

Updated August 2016
WHAT TO DO AT COMPLETION/DISCHARGE:

Pre-Discharge/Transfer

- Confirm achievement of all treatment goals.
- Confer with group counselor(s) and/or TCM Care Coordinators regarding progress.
- Must staff case with Supervisor, document.
- Discuss with client a completion date - a gradual transition from treatment is most appropriate (reduction in service dosage, intermittent Ind Tx, etc.) - "Transition from Care" becomes the new goal.

Final Session

- Complete Discharge/Transfer Summary and PS.
- Complete DLA-20
- Discuss how client can re-engage services if necessary.
- Termination Process

Post-Completion/Discharge

- Communicate Discharge/Completion to referral source/supervising agencies.
- Complete CIS Discharge Form and file in Mail room.

Client flow in Adult and CAF Services is similar, through there are nuanced differences. See your supervisor for specifics.
### National Correct Coding Initiative (NCCI)

<table>
<thead>
<tr>
<th>If you provide...</th>
<th>Then you cannot bill for these on the same day:</th>
<th>This only applies to clients with:</th>
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<tr>
<td><strong>Mental Health Assessment (by Non-physician) (ASSMT)</strong></td>
<td>IND TX</td>
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<tr>
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<td>any FM TX</td>
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<tr>
<td></td>
<td>GP TX</td>
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</tr>
<tr>
<td></td>
<td>Multi Fam Gp</td>
<td>x</td>
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<tr>
<td></td>
<td>Med Mon</td>
<td>x</td>
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<tr>
<td></td>
<td>any PMA</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>any SPD/IT (H060)</td>
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<td><strong>Initial PMA</strong></td>
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<tr>
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<td></td>
<td>subsequent PMA</td>
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<td>Service Plan Development/ Interdisciplinary Team (SPD/IT) (H060)</td>
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*SPD/IT w/ client cannot be billed same day as SPD/IT w/o client