

Community Mental Health Services
Provider Questions and Answers
August 12, 2010

1. What is the difference between Medicaid eligible and Bureau of Behavioral Health (BBH) eligible?

Medicaid eligible recipients have qualified for NH Medicaid and may receive services within the scope of coverage when medical necessity requirements have been met. BBH eligibility means that an individual is eligible to receive long term care services outlined in He-M 426. BBH eligibility is based on the severity of functional limitations resulting from severe mental illness or serious emotional disorder. BBH long-term care services are only available to individuals who meet BBH eligibility. For example, functional support services and case management are only available to individuals who meet BBH eligibility.

2. Does the intake require the Medical Doctor (MD) signature in order to bill for subsequent services?

Yes, pursuant to He-M 401.03 (f) which states, "For all persons applying, the Community Mental Health Provider (CMHP) shall identify the services it anticipates providing", and whereas He-M 408.06 (d) states, "Intake assessments that are completed to function as the initial ISP shall include the initial services to be provided and a physician's signature", the physicians signature shall be required on the intake in order to bill for subsequent services.

3. Does the doctor have to see the individual in order to sign the treatment plan?

Federal State Medicaid Manual (SMM) section 4221 requires the following:

B. Outpatient Program Entry.--An intake evaluation should be performed for each recipient being considered for entry into an outpatient psychiatric treatment program. This applies to any organized program or course of treatment that a recipient enters or attends to receive scheduled or planned outpatient psychiatric services. The evaluation is a written assessment that evaluates the recipient's mental condition and, based on the patient's diagnosis, determines whether treatment in the outpatient program would be appropriate.

The evaluation team should include, at a minimum, a physician and an individual experienced in diagnosis and treatment of mental illness (both criteria can be satisfied by the same individual, if appropriately qualified). For each recipient who enters the program, the assessment should include a certification by the evaluation team that the program is appropriate to meet the recipient's treatment needs. The assessment should be made a part of the patient records.

4. Does the doctor have to prescribe the intake in writing in order for the diagnostic evaluation to be billed to Medicaid?

Medicaid does not require that the doctor prescribe the intake.

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5. Where is it in the State He-M's that says that a non-licensed master's level clinician can do the initial eligibility determination while a Case Manager (CM) (who can do the annual review) cannot?

If you are conducting the eligibility determination as a part of the intake process, staff must meet the qualifications listed in 426.08 (h) – (i). Qualifications for completing eligibility are different. He-M 401.04 identifies those practitioners who can conduct an eligibility determination.

Pursuant to He-M 426.10 (b) Psychiatric diagnostic interview exam (intake) shall:

- (1) Be a covered CMHP service when conducted by staff meeting qualifications as outlined in He-M 426.08(h)-(i);

He-M 426.08 identifies who can conduct an intake:

Intake without supervision: Qualified intake staff include psychologists, psychiatrist, pastoral psychotherapists, Marriage and Family Therapist (MFT), Licensed Clinical Mental Health Counselor (LCMHC), Licensed Independent Clinical Social Worker (LICSW), Registered Nurse (RN) with masters in psychiatric nursing, Advanced Registered Nurse Practitioner (ARNP) with psychiatric mental health specialty.

Intake with requisite supervision: Master's degree in marriage and family therapy, psychology, social work, rehabilitation counseling or education/counseling from a college or university accredited by an accrediting agency recognized by the U.S. Department of Education **OR** Be a registered nurse with a certificate in mental health nursing from the American Nurse's Association.

Below is the current rule for your reference.

426.08 (h)-(i)

(h) For the purpose of providing psychotherapy without supervision, clinical staff of CMHP's or providers shall meet the applicable following minimum qualifications:

- (1) Psychiatrists shall meet the requirements of RSA 135-C: 2, XIII;
- (2) Psychologists shall be licensed in accordance with RSA 330-A: 16;
- (3) Pastoral psychotherapists shall be licensed in accordance with RSA 330-A: 17;
- (4) Marriage and family therapists shall be licensed in accordance with RSA 330-A: 21;

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(5) Clinical mental health counselors shall be licensed in accordance with RSA 330-A: 19;

(6) Clinical social workers shall be licensed in accordance with RSA 330-A:18; and

(7) Nurses shall be registered as required by RSA 326-B: 6 and have a master's degree in psychiatric nursing or be licensed as an advanced registered nurse practitioner (ARNP) with a psychiatric mental health specialty in accordance with RSA 326-B:11.

(i) Except as provided pursuant to (k) and (m) below, anyone providing psychotherapy services who does not meet the established standards as indicated in (h) above shall:

(1) Have completed at least one year of work in the field of psychiatric or mental health services under the supervision of a psychiatrist, doctoral level psychologist or a licensed mental health professional or person authorized pursuant to RSA 330-A: 34, I, (d); and

(2) Have at least a master's degree in marriage and family therapy, psychology, social work, rehabilitation counseling or education/counseling from a college or university accredited by an accrediting agency recognized by the U.S. Department of Education; or

(3) Be a registered nurse with a certificate in mental health nursing from the American Nurse's Association.

Below is the rule regarding who can conduct eligibility determinations;

He-M 401.04

(b) An eligibility determination shall be conducted by:

(1) A psychiatrist who meets the definition in RSA 135-C:2, XIII;

(2) A psychologist who is licensed in accordance with RSA 330-A:16, I;

(3) A pastoral psychotherapist who is certified in accordance with RSA 330-A:17;

(4) A clinical social worker who is licensed in accordance with RSA 330-A:18;

(5) A nurse who is registered as required by RSA 326-B and has a master's degree in psychiatric nursing or is certified as an advanced registered nurse practitioner with a psychiatric mental health specialty in accordance with RSA 326-B:10;

(6) A clinical mental health counselor licensed in accordance with RSA 330-A:19;

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(7) A registered nurse (RN-C) certified in psychiatric nursing by the American Nurses Association;

(8) A marriage and family therapist licensed in accordance with RSA 330-A:21; or

Staff who possesses the qualifications required below may do an eligibility determination that is signed off by other qualified staff pursuant to the rule below.

(9) Any of the following, provided that the eligibility determination is reviewed and cosigned by a professional identified in He-M 401.04 (b) (1) through (7):

a. A case manager, including staff members who possess a bachelors' degree and staff for whom a waiver to provide MIMS services has been granted pursuant to He-M 426.21; or

b. A master's level clinician.

(c) An eligibility determination shall be effective on the date that the determination is signed by the professional(s) making the determination.

(d) A redetermination shall be conducted and signed no later than 30 days after the expiration date of the previous determination. The person shall be deemed eligible during that 30 day period.

6. Do the State He-M's require that we complete a full intake assessment for individuals who are not found eligible if we do not use the Medicaid intake billing code?

Under nationally recognized clinical practice standards, an intake assessment should be completed for any person being seen for the first time. There are many sources that identify the elements of an intake and psychiatric diagnostic evaluation.

NH Medicaid requires that intakes for individuals who meet BBH eligibility standards meet all the documentation elements in He-M 400.

Current procedural coding (CPT) indicates that the psychiatric diagnostic interview (90801) includes:

- Communication with family/other sources
- Disposition
- History
- Mental status
- Ordering/interpretation of lab studies
- Ordering/interpretation of other medical diagnostic studies

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Medicare (National Heritage Insurance Company (NHIC) training 10/06/10) indicates that the psychiatric diagnostic interview includes:

- Elicitation of a complete medical and psychiatric history (including past, family and social),
- Completion of a comprehensive mental status exam,
- Establishment of a tentative diagnosis
- And an evaluation of the patient's ability and willingness to work to solve the patient's mental problem.

State Medicaid Manual (SMM) section 4221 which applies to all Medicaid recipients requires:

B. **Outpatient Program Entry.**--An intake evaluation should be performed for each recipient being considered for entry into an outpatient psychiatric treatment program. This applies to any organized program or course of treatment that a recipient enters or attends to receive scheduled or planned outpatient psychiatric services. The evaluation is a written assessment that evaluates the recipient's mental condition and, based on the patient's diagnosis, determines whether treatment in the outpatient program would be appropriate.

The evaluation team should include, at a minimum, a physician and an individual experienced in diagnosis and treatment of mental illness (both criteria can be satisfied by the same individual, if appropriately qualified). For each recipient who enters the program, the assessment should include a certification by the evaluation team that the program is appropriate to meet the recipient's treatment needs. The assessment should be made a part of the patient records.

7. **Do the State He-M's require that we complete a full intake assessment for individuals who are not found eligible if they do not have Medicaid?** Please see question 4. He-M's identify service and documentation requirements for individuals who meet BBH eligibility.
8. **Does a physician need to authorize an intake in advance of the service?** Not for Medicaid purposes. Other payers may have different requirements
9. **Can a Master of Arts (MA) level therapist intern bill for Intake assessment, if they are supervised by a licensed supervisor and intake is cosigned by licensed supervisor?** Currently the He-M rules do not allow for an intern to complete the intake. Please see response to question 3. Only those individuals meeting the requirements in He-M 426.08 (h)-(i) can conduct the intake assessment. Interns may do supervised psychotherapy is outside of 426.08 (k).
10. **Can a non-licensed master's level clinician bill for Intake assessment, if supervised as above?** (same question as above, but the person has a master's and is no longer an intern?) The individual must meet the requirements in He-M 426.08 (h)- (i).

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The following qualifications with requisite supervision: Master's degree in marriage and family therapy, psychology, social work, rehabilitation counseling or education/counseling from a college or university accredited by an accrediting agency recognized by the U.S. Department of Education **OR** Be a registered nurse with a certificate in mental health nursing from the American Nurse's Association.

11. **Can an intake be home-based or does it have to occur in an office? Can psychotherapy be home based or does it have to occur in the office?** There are no Medicaid restrictions on home-based intake or psychotherapy services for CMHC. As a contracted provider BBH expects you to make home-based services available as necessary. In order to maximize other revenue sources you should make every effort to comply with OI requirements. If other insurance requires office based visit there should be clinical justification for home-based intake or psychotherapy.
12. **When does the treatment plan become effective: at the treatment plan date or the MD signature date?** Both dates are required before the plan is effective. In recent years there have been a number of rule changes to make the requirements as clear as possible. The most recent rule change was effective 07/09/09.

He-M 408.08

- (d) The ISP shall include: (1) The effective date of the plan;
- (h) Prior to the implementation of the plan, a psychiatrist's signature shall be required to indicate the medical necessity of the services to be provided.
13. **What about the other signatures?** Required signatures must be in place prior to the plan being in effect.

In the case where someone doesn't return the signed plan, the record should reflect the plan was sent but not returned

401.11 (e) ...guardian shall have 15 days from the date notice was sent to respond, in writing, indicating approval or disapproval of the ISP. **Failure to respond within the time allowed shall constitute approval of the ISP**
and

401.11 (f) If the consumer or guardian refuses to sign the individual service plan, the dispute shall be resolved:

- (1) Through informal discussions with the CMHP;
- (2) By convening or reconvening a service planning meeting; or

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(3) By the individual, parent, or guardian filing an appeal with the division pursuant to He-M 202.

14. What is the difference between a preliminary treatment plan and individualized service plan according to State He-Ms?

BBH does not have any language that refers to a preliminary treatment plan. We do allow for an initial Individual Service Plan (ISP) to be done during the intake assessment. The services listed in the intake assessments may serve as the initial ISP until the full ISP process can be completed within required timeframes. The difference between the initial ISP and the completed ISP could include but not be limited to: consultation with the doctor to assist in the diagnostic formulation and treatment plan.; completion of the intake process which sometimes takes more than one visit.

Refer to He-M 401 for elements required in the full service planning process

“Intake assessments that are completed to function as the initial ISP shall include the initial services to be provided and a physician’s signature”.

15. Does a client need to sign the intake when it functions as the initial ISP, if the MD signs it, or do they just need to sign the final treatment plan?

He-M 408.05 Application and Demographic Data.

(a) Pursuant to He-M 401, an application for services shall be completed and signed by the consumer or guardian at or before the intake interview. This should be sufficient until the full ISP process is complete.

16. If the client has not signed the treatment plan, but there is evidence in the correspondence section that indicates a copy was sent to consumer for approval and no response is received, is that considered approval of treatment plan?

He-M 401.10 (m) The individual service plan shall include the signature of the consumer/guardian as indication of approval of the plan. If it is necessary to notify the consumer/guardian by mail, the consumer/guardian shall have 15 days from the date notice was sent to respond in writing, indicating approval or disapproval of the ISP. Failure to respond within the time allowed shall constitute approval of the ISP.

17. If the Annual date, effective date, and signature dates are not in sync is that an issue? On the surface this is not a compliance issue as long as all regulatory requirements are met. EVERY ENTRY into the record must be signed and dated. Documentation must be completed within the timeframes required in the rule. Streamlining the documentation so that it is all completed at the same time certainly creates administrative efficiencies. It could be a logistical challenge to manage different annual, ISP, eligibility and signature dates. This lends itself to high risk of not having the necessary signatures in place.

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18. **Is there a grace period for treatment plans as long as it is within the same month? Ex. 2009 treatment plan done 7/7 with 2010 treatment plan not done 7/23- does '09 treatment plan cover services until 2010 treatment plan done, or will billing be denied?** No. If there is no plan in effect you cannot bill for services. Services won't be denied but you are not authorized to bill for services without a plan in effect.
19. **If the client does not sign the treatment plan and we treat anyway, do we have a problem if there is a question about informed consent? Client rights notification?** If you are out of compliance with the regulatory requirements services would be subject to recovery.
20. **When documenting the service rendered in the record is it ok to have only the billing code of the service listed or is it necessary to write the service description in narrative?**
If the service provided is documented and can be identified using a billing crosswalk the billing code may be sufficient to identify which service was billed. Keep in mind that the record is intended to be written in language that the consumer can understand. Your notes must assure that the individual can understand the service received and progress towards goals/objectives when reviewing their record.

The following service documentation is required.

- (1) Progress notes shall be written for each therapeutic face-to-face encounter;
- (2) Progress notes shall be written for each contact related to a crisis or change in health status; and
- (3) Progress notes shall be written for each activity related to assessment, monitoring, or referral
- (4) Progress notes shall document
 - a. The therapeutic services provided;
 - b. The objective(s) in the ISP for which the service was provided;
 - c. The consumer's response to the service including progress towards objectives;
 - d. The date the service was provided;
 - e. The date of documentation

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- f. The start and stop time of the service provided; (start and duration is also allowed)
- g. The setting where the service was provided; and
 - a. The signature, credentials, and title of the person providing services.

21. For Crisis Intervention Services, is it ok to have 0 to 4 3 times per month on frequency, because we are predicting a potential need? While you must be specific for planned visits, it would be more appropriate to state (pro re nata) PRN (or as needed) for visits of an emergency or unplanned nature.

22. Can the crisis Intervention Plan order services?

If the crisis intervention plan is a component of the ISP and includes the physician signature then yes. If the crisis intervention plan is a stand-alone document it cannot order the services.

23. What should be done when a parent is absent Division of Children Youth and Families (DCYF) custody but the parent is still the guardian) and can not be found to sign the plan, or refuses to participate and treatment. Is still ordered by the court?

I consulted with Department of Health and Human Services (DHHS) legal staff on this question who responded below.

According to the attorney for DCYF, when the state is awarded custody under RSA 169-C, the award includes the responsibility to provide "ordinary" medical care. Although "ordinary" is not defined, the view of DCYF is that mental health treatment, and especially the provision of psychotropic medication, is not "ordinary" medical care. Therefore, if the parent refuses, or is unavailable, to provide consent, DCYF will seek a medical guardianship. That may be the path that this center needs to follow.

24. Does a current quarterly review need to be in place before billing can take place for the next quarter?

Yes

NH administrative rule He-M 408.10

- (b) For each consumer, the CMHP shall conduct and document a quarterly ISP review at least every 90 days from the effective date of the ISP.

State Medicaid Manual (federal manual) 4221

Periodic Review.--The evaluation team should periodically review the recipient's PoC in order to determine the recipient's progress toward the treatment objectives, the appropriateness of the services being furnished and the need for the recipient's continued participation in the program. The evaluation team should

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perform such reviews on a regular basis (i.e., at least every 90 days) and the reviews should be documented in detail in the patient records, kept on file and made available as requested for State or Federal assessment purposes.

ISP for medication monitoring only

He-M 408.08 (i) For consumers whose ISPs indicate “medication monitoring only” services, the physician shall enter in the ISP, at least quarterly, a comprehensive statement, indicating:

- (1) The continued medical necessity of “medication monitoring only” services; or
- (2) The need for additional services, and the initiation of the ISP planning processes as outlined in He-M 401.

He-M 408.10 (ISP Reviews)

(e) All signatures required in (d) above, shall be obtained within 90 days of the date of the completion of the quarterly review:

- (7) A statement and a dated, physician’s signature indicating participation in the quarterly review and the medical necessity of services to be provided;
- (8) The date the documentation was completed and the signature and title of the person documenting the review; and
- (9) Indication of consumer/family/guardian participation in the review including signatures and dates whenever possible.

25. Does the Doctor have to participate in the quarterly review?

The federal and state rules require that the evaluation team review the plan of care at least every 90 days. The team **MUST** include “a physician and an individual experienced in the diagnosis of mental illness, both criteria can be satisfied by the same individual if qualified.” The doctor must participate in that review. The 90-day time frame allows for paperwork to be completed and signatures to be gathered following the review. The doctor signature is acknowledgement of the Dr’s participation in the quarterly review process. Signing off on a plan without participation does not meet the intent of the requirement.

26. Is a quarterly review a review of the chart documentation during the quarter or of the client's entire problems/progress during the quarter?

408.10(C)

A quarterly review is a review of progress towards goals and objectives as well as documentation of continued need for services as evidence by the following:

Quarterly Review

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The quarterly review shall be based on the consumer's current status and progress, or lack thereof, in achieving the goals and objectives identified in the ISP, as documented in the progress notes for the reporting quarter.

Documentation of the quarterly review shall include:

- (1) The time period covered by the review;
 - (2) Description of the consumer's current functional impairments due to mental illness;
 - (3) Any other clinically relevant information regarding changes in status during the reporting quarter;
 - (4) Services received during the reporting quarter;
 - (5) The consumer's progress toward achieving ISP goals and objectives during the reporting quarter and the reasons for failure, if any, to meet the goals or objectives;
 - (6) Changes in the ISP during the reporting quarter;
 - (7) A statement and a dated, physician's signature indicating participation in the quarterly review and the medical necessity of services to be provided;
 - (8) The date the documentation was completed and the signature and title of the person documenting the review; and
 - (9) Indication of consumer/family/guardian participation in the review including signatures and dates whenever possible.
27. **Why is a signature by the client necessary?** Client signature is required by administrative rule. The intent is that the clients participate meaningfully in the planning process. This is their plan. The signature serves as evidence of the client's participation in the treatment planning process.
28. **Do staff other than the MD have to sign the quarterly?** Yes. The signature and title of the person who documented the review is required. Additionally, every entry into the record must be signed and dated by the person who entered it.
29. **What are the key elements of a successful expression of continued need for services?** I have outlined quarterly documentation elements and highlighted examples of key elements for a successful expression of continued need for services.

Documentation of the quarterly review shall include:

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- (1) The time period covered by the review;
- (2) Description of the consumer's current functional impairments due to mental illness;
- (3) Any other clinically relevant information regarding changes in status during the reporting quarter;
- (4) Services received during the reporting quarter;
- (5) The consumer's progress toward achieving ISP goals and objectives during the reporting quarter and the reasons for failure, if any, to meet the goals or objectives;
- (6) Changes in the ISP during the reporting quarter;
- (7) A statement and a dated, physician's signature indicating participation in the quarterly review and the medical necessity of services to be provided;
- (8) The date the documentation was completed and the signature and title of the person documenting the review; and
- (9) Indication of consumer/family/guardian participation in the review including signatures and dates whenever possible.

30. **Does the date of the annual review need to be the same as the effective date of the treatment plan, or before it?** It could be either, but it cannot be after. The date the annual review took place must be documented in the record. The effective date of the ISP is the date indicated on the ISP as "effective date".
31. **Does the date of this year's annual review need to be exactly the same as last year's annual review date, or do we adjust for weekends? If we adjust, how much leeway?** You do not adjust for weekends. The review must be on or before the date of the last years review. It can happen prior to 12 months but not after. Ideally it would happen so that logistically the clinician would have time to draft the agreed upon plan of care, review with the physician, finalize paperwork and get all necessary signatures prior to the effective date of the next ISP. Keep in mind that you may need to coordinate a series of signatures and you may need to mail the document out to the consumer. By indicating the ISP effective date and completing the process prior to that date you could be on the same cycle every year.
32. **If the annual review is not physically attached to the treatment plan will it need a separate MD signature and if so, what date will need to be on that signature?** Yes, every entry into the record must be signed and dated. Separate documents and entries would require separate signatures and dates. The signature

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must include the date it is entered and signed. The treatment plan may be effective on a future date, but the date it is entered in the record must also be documented.

He-M 408.03 (e) Each documentation in the clinical record of a CMHP service shall include:

- (1) The signature of the service provider;
- (2) The service provider's credentials;
- (3) The legible name of the service provider including a typed name, name stamp, or printed name within proximity of the credentials and signature of the service provider;
- (4) The date of service; and
- (5) The date of documentation.

33. If the annual plan review is not physically attached to the treatment plan will it need other staff and/or client to sign, and if so, what date will need to be on those signatures? The annual plan review is the fourth quarterly review. The quarterly review requires the signature of 1) the person completing the documentation, 2) the physician; as well as the 3) the consumer, family, or guardian whenever possible.

Every entry into the record must be signed and dated. The annual review will need to be signed and dated by the person who completed it.

He-M 408.03 (e)

(e) Each documentation in the clinical record of a CMHP service shall include:

- (1) The signature of the service provider;
- (2) The service provider's credentials;
- (3) The legible name of the service provider including a typed name, name stamp, or printed name within proximity of the credentials and signature of the service provider;
- (4) The date of service; and
- (5) The date of documentation.

34. In the symptoms section, should Diagnostic and Statistical Manual (DSM) language be used, or should we use the concepts from the DSM in the

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vernacular, quotes from client, that sort of thing? The language should be written in such a way that it is understandable by the consumer.

35. Must progress notes for eligible Medicaid recipients be written and signed on the date of the service according to State or Federal billing requirements?

They must be written and signed prior to being billed. In addition, every agency is required to have a medical records policy which indicates timeframes for completing service documentation, in compliance with state and federal regulations. (reference 408.03)

36. Can outpatient progress notes be signed on a date other than when it was written? No. Every entry into the record must be signed and dated to reflect the date it was entered into the record. (reference 408.03)

37. Must an outpatient progress note list the specific goals and objectives from the treatment plan worked on each progress note?

Documentation requirements for services to BBH eligible individuals regardless of insurance are:

(5) Progress notes shall document

- a. The therapeutic services provided;
- b. The objective(s) in the ISP for which the service was provided;
- c. The consumer's response to the service including progress towards objectives;
- d. The date the service was provided;
- e. The date of documentation
- f. The start and stop time of the service provided; (start and duration is also allowed)
- g. The setting where the service was provided; and

The signature, credentials, and title of the person providing services.

Service documentation for Medicaid recipient services, regardless of BBH eligibility are:

D. Documentation.--The outpatient program should develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. This documentation, at a minimum, should consist of material which includes:

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1. the specific services rendered;
2. the date and actual time the services were rendered;
3. who rendered the services;
4. the setting in which the services were rendered;
5. the amount of time it took to deliver the services;
6. the relationship of the services to the treatment regimen described in the PoC and
7. updates describing the patient's progress.

38. Are stop and start time as well as duration required to be listed on each and every progress note? Start and stop time is required for everything except Individualized resiliency and recovery oriented services (IROS) services which may have start and stop time or start and duration.

39. Can a Case Management (CM) note be signed on a date other than when it is written? All entries into the record must be documented pursuant to He-M 408.03. This requires that a signature be done with each entry.

He-M 408.03 (e) Each documentation in the clinical record of a CMHP service shall include:

- (1) The signature of the service provider;
- (2) The service provider's credentials;
- (3) The legible name of the service provider including a typed name, name stamp, or printed name within proximity of the credentials and signature of the service provider;
- (4) The date of service; and
- (5) The date of documentation.

40. Does a CM and or Functional Support Services (FSS) note need to be signed, or would supplying name and credentials of the provider be enough? The CM note must be signed see He-M 408.03 in question 36 above.

41. For a Non-Caid, Certified client is an entry "Non-Billable" required each month for case management? There is no longer "non-billable" case management. All allowable case management activities are included in the case management reimbursement rate. Case management is currently reimbursed on a

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monthly basis with the requirement that all contacts and case management activities are documented in the record.

42. **On the CM note, goal/objective numbers are referenced, but to what--the goal and objective on the treatment plan or the goals on the Care Plan?** The rule requires documentation of the progress towards objectives. The objective on the ISP should be related to the CM care plan. The specific activity must also be documented. Remember that the documentation must be written in such a way that it is understandable by the consumer. Also, because the record serves as a means of communication among providers, the consumer and any reviewers, it must be written in such a way that whoever is reviewing it can understand the service, the objectives and the outcome.
43. **Can an FSS note be signed on a date other than when it is written?** Every entry into the clinical record must be signed and dated in accordance with He-M 408.03.
44. **Does an FSS note need to be signed at all?** Yes. Every entry into the clinical record must be signed and dated in accordance with He-M 408.03.
45. **Does a physician need to authorize an emergency in advance of the service?**
No the physician doesn't need to authorize an emergency service.
(h) The consumer or guardian shall document informed consent for all planned services except as otherwise prohibited by law or where emergency treatment is indicated pursuant to RSA 135:21-b.
46. **When a quarterly or an annual is completed PRIOR to the certification date; does this change the actual certification date?** No, a quarterly or annual ISP review date does not change the BBH eligibility certification date.
47. **During an internal review of a record, found an error in the eligibility, for example Category Severe and Persistent Mental Illness (SPMI) and should have been Severe Mental Illness (SMI). How do we make these kinds of corrections?** Was this an administrative error such as a keying error? (f)
Documentation shall not be altered or changed by erasure or masking, such as through the use of liquid correction fluid. Corrections shall be made by drawing a line through the mistake. All corrections shall be signed and dated by the person making the change.
If you are doing an internal eligibility review audit and determine that the individual did not meet SPMI criteria you 1) should request a waiver from BBH to allow SMI eligibility as of the SPMI evaluation date, you will be required to adjust all of your claims or 2) request a waiver to allow the SPMI eligibility to stand and indicate effective date of SMI eligibility. If the individual is determined to have not met eligibility then you will be required to refund payment for services restricted to eligible or in excess of the cap unless you seek a waiver from BBH.

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48. Also if there is an error found on a treatment plan, outpatient service is listed instead of Individual Therapy. Is there a correct way to make changes?

He-M 408.03 (f) Documentation shall not be altered or changed by erasure or masking, such as through the use of liquid correction fluid. Corrections shall be made by drawing a line through the mistake. All corrections shall be signed and dated by the person making the change.