ADMINISTRATIVE POLICY STATEMENT
Georgia Medicaid

Policy Name & Number	Date Effective
Behavioral Health Service Record Documentation Standards-GA MCD-AD-1076	11/01/2024
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Behavioral Health Service Record Documentation Standards

B. Background

Medical record documentation is a fundamental element required to support medical necessity and is the foundation for coding and billing. Documentation relays important information such as (but not limited to) assessments completed, services provided, coordination of services, timeliness of care, plan of care/treatment, rationale for orders, health risk factors, member's progress towards goals of the treatment plan, and response to treatment. Chronological documentation of member care contributes to high quality care and allows other healthcare professionals to plan treatment, monitor wellness and interventions over time, and ensures continuity of care.

Medical record documentation serves as a legal document that verifies care provided to individuals. Information in the record may be used to validate place(s) of service, medical necessity and appropriateness of diagnostics and/or therapeutic services provided, or that services provided have been accurately reported. According to the rules of the Mental Health Parity and Addictions Equity Act (MHPAEA), coverage for the diagnosis and treatment of behavioral health (BH) conditions will not be subject to any limitations that are less favorable than limitations that apply to medical or surgical conditions as covered under this policy.

Specific documentation requirements for applied behavior analysis for the treatment of autism is covered in a separate policy, including standards for evaluations, reviews of medical necessity, treatment plans, and discharge criteria. The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) provides additional guidance on services and record requirements, including eligibility requirements, community service requirements, and general policies and procedures. Information from Georgia Department of Community Health (DCH) or DBHDD may be updated on a more frequent basis than this policy and supersedes information found in this policy. Information in this policy is provided as a courtesy only. For information specific to components not found in this guidance (eg, Positive Behavior Support Plan, individualized crisis intervention plan, medication assisted treatment), see service definition guidance in the *DBHDD Provider Manual*.

C. Definitions

- **Adult Needs and Strengths Assessment (ANSA)** – A tool developed for adult BH services to support decision making, including level of care and service planning, facilitating quality improvement, and monitoring outcomes of services while preventing duplicate assessments, decreasing unnecessary testing and informing case planning.
- **Behavioral Health (BH) –** As defined by Official Code of Georgia Annotated, a BH disorder is a mental or emotional illness, developmental disability or addictive disease as defined by the *Diagnostic and Statistical Manual of Mental Disorders.*

- **Child and Adolescent Needs and Strengths (CANS)** – A multi-purpose tool developed for children's services to support decision making (eg, level of care, service planning), facilitate quality improvement initiatives, and allow for the monitoring of outcomes of services.
- **Clinical Record** – A written record pertaining to an individual patient and including all medical records, progress notes, charts, admission and discharge data, and other information recorded by a facility pertaining to hospitalization and treatment. Such other information as may be required by rules and regulations of the board shall also be included.
- ***Diagnostic & Statistical Manual of Mental Disorders*** – The American Psychiatric Association's classification and diagnostic tool for behavioral health conditions. When the term *DSM* is referenced, it is specifically in reference to the current version of the manual.
- **Diversionary Activities** – Activities or time during which a therapeutic intervention tied to a goal on the IRP is not occurring.
- **Initial Engagement** – The first encounter with the member.
- **Mental Health Parity and Addictions Equity Act (MHPAEA)** – A 2008 federal law that generally prevents group health plans and health insurance issuers who provide mental health and substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations than on medical/surgical (M/S) coverage.
- **Mental Illness** – A disorder of thought or mood significantly impairing judgment, behavior, recognition of reality, or ability to cope with ordinary demands of life.
- **Secure Electronic Signature** – An electronic or digital signature, symbol, or process associated with a document which is created, transmitted, received, or stored by electronic means which requires or is
  - requires the application of a security procedure
  - capable of verification/authentication
  - adopted by a party with the intent to be bound or to authenticate a record
  - signed under penalty of perjury
  - unique to the person using it
  - under the sole control of the person using it
  - linked to data in such a manner that if the data is changed the electronic signature is invalidated
- **Substance Abuse and Mental Health Services Administration (SAMHSA)** – A the agency within the US Dept of Health and Human Services that leads public health efforts to advance the BH of the nation.
- **Supervision Documentation** – Described by O.C.G.A. § 43-10A-3 as, "a contemporaneous record of the date, duration, type (individual, paired, or group), and a brief summary of the pertinent activity for each supervision session."
- **TeleMental Health** – A term defined by Ga. Comp. R. & Regs. R. 135-11-01 applicable only to Licensed Social Workers, Professional Counselors and Marriage & Family Therapists when either practicing telehealth or providing telephonic intervention when allowable via DCH/DBHDD guidelines.

- **Verified Diagnosis** – A BH diagnosis provided following a face-to-face (including telemedicine) evaluation by a professional identified in O.C.G.A Practice Acts as qualified, including a Licensed Psychologist, a Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, a Licensed Professional Counselor, a Licensed Physician, or a Physician Assistant or APRN (NP and CNS-PMH) working in conjunction with a physician with an approved job description or protocol.

D. Policy

I. Overview or General Documentation Standards

Each record must include the practitioner's printed name as listed on the state license. Records must be organized, complete, current, meaningful, and succinct. All records will be managed in a manner that ensures individual confidentiality and security, while providing access and availability as appropriate.

A. Individual records must be maintained onsite (DBHDD-approved service locations) for review for a minimum of 90 days following the last date of service or discharge date as identified by the authorization for the individual served.

B. All signatures, and initials (where appropriate), must be original, belonging to the person creating the signature or initials and must be dated by the person signing or initialing to reflect the date on which the signature/initials occurred (eg, no backdating, no postdating) and must be legible.

C. Member information in the record must include the following:

1. name of member, precautions, allergies (or no known allergies) and "volume #x or #y" on the front of the record
2. identification and contact information
3. financial and insurance information
4. the following rights, consents, and legal information:
    a. consent for service, including telemedicine consent, if applicable
    b. release of information (ROI) documentation, including
        01. specific information to be released or obtained
        02. purpose for the authorization for ROI
        03. to whom the information may be released
        04. time period the ROI remains in effect (not to exceed a year)
        05. statement of ability for revocation at any time by the member to the extent that the provider has not already acted upon the ROI
    c. legal documentation establishing guardianship
    d. evidence that rights and responsibilities are reviewed at start of services and annually thereafter
    e. legal status as relating to Title 37
5. pertinent medical information
6. members who are deaf, deaf-blind, and hard of hearing, communication documentation must include:
    a. Communication Assessment Report (CAR) from the Office of Deaf Services (carries the weight of a Service Order) per Provider Procedures for Referral and Reporting of Individuals with Hearing Loss, 15-111

   b. action plan for implementing required communication accommodations from the CAR
   c. record of communication accommodations provided
7. evidence that the services billed are the services provided
8. any psychiatric/other advanced directive (or documentation of member denial of the existence of directive or declined to include it in the medical record)
9. records or reports from previous or other current providers
10. correspondence related to the member and the Individualized Recovery Plan
11. frequency and style of documentation should be appropriate to the frequency and intensity of services, supports, and treatment
12. documentation of contacts with persons involved in other aspects of member care, including but not limited to, internal or external referrals
13. documented process for communication between staff members working with the same members in different programs, activities, schedules or shifts
14. in keeping with standard release of information expectations upon requests, information must be shared in a timely and sufficient manner with other DBHDD provider agencies and/or supporting healthcare entities also serving the member to ensure the continuity, coordination, and efficacy of care received by the member from all involved healthcare professionals

D. Special requirements for paper versus electronic health/medical records (EHR/EMR) are as follows:
   1. For providers using paper records, all handwritten or typed content must be
      a. written in black or blue ink (red ink may denote allergies or precautions)
      b. readable, decipherable, and easily discernible to all readers
      c. documented in the following manner for changes or edits:
         01. corrections or alternations must be clearly visible
         02. no “white-out” products or unreadable cross-outs are allowed
         03. a single line is used to strike an entry with strike labeled “error,” initialed, and dated
         04. if the document contains a Secure Electronic Signature, it must be linked to data in such a manner that, if the data is changed, the electronic signature is invalidated
   2. For providers using EHR/EMR, provider platforms must be configured to allow DBHDD and proxies (eg, CareSource, other authorized external reviewing entities), full administrative access (view-only) to all components of the record. Access must include the following:
      a. ability to validate document creation date, time, and author
      b. time stamp of signatures
      c. dates, time stamps, and author(s) of any edits, amendments, or late entries
      d. ability to view original content prior to editing or amendments without deletions
      e. dates and time stamps for documents uploaded to the record

II. Assessment(s)
Individualized services, supports, care, and treatment determinations are made on the basis of an assessment of needs with the member who must be informed of the findings of assessments in a language the member can understand.
A. An initial ANSA/CANS assessment must be completed within the first 30 days of intake into all BH services types, excluding crisis service center (CSC), crisis stabilization unit (CSU), and mobile crisis response (MCR). Ongoing ANSA/CANS assessments must be completed as demanded by changes with an individual, as needed for reauthorization of services, and upon discharge.
B. Additional assessments may be related to any potential or changes to the member's services, supports, care, and treatment, such as preferences for treatments and review of legal concerns. See Part II, Section III-2 of the *Provider Manual for Community Behavioral Health Providers* for a more complete list.

III. Diagnosis
Specific to non-intensive outpatient services, any member newly presenting to a provider, a diagnostic impression is allowed for 30 days after the initial engagement to initiate timely provision of services. After 30 days, the member must have a verified diagnosis to justify planned services against the diagnostic criteria and to continue services. Specialty services generally require a verified diagnosis prior to admission. Diagnostic impressions may be provided by practitioners who are permitted by a scope of practice to do so.

The diagnosing professional may rely on assessment information provided by other professionals and collateral informants (as permitted by the member), but a face-to-face interaction must also occur, including telemedicine. A signature by such a person on documentation leading to or supporting a diagnostic impression does not meet this requirement for performing an assessment adequate to support assigning a behavioral health diagnosis. At a minimum, all diagnoses must be verified annually by a qualified practitioner. For any diagnoses that are valid less than one year, an assessment should be completed more often as indicated in the current *DSM*. If this requirement is not met due to member refusal or choice, documentation in the record should reflect member refusal or choice.

When diagnosing individuals who are deaf, deaf-blind, or hard of hearing, the professional must demonstrate training, supervision, and/or consultation with a qualified professional as approved by DBHDD Office of Deaf Services. When diagnosing children who are between the ages of 4 to 5 years old, providers may use the DC:0–5™ Manual. After appropriately using the tools in the DC:0-5 manual, professionals should use the Georgia Crosswalk of DC:0-5 Disorders with DSM-5 and ICD-10 guide to map the diagnosis to the *DSM-5-TR*.
A. Diagnostic documentation of the initial and annually verified diagnosis(es) must include the following:
1. clearly indicated diagnosis(es)

2. information about the diagnosing practitioner, including printed name as listed on the State license(s) and credential(s)
3. signature of the diagnosing practitioner
4. date of the diagnosis

B. Additional documentation requirements regarding diagnosis(-es):
   1. Providers approved to deliver the diagnostic assessment service, regardless of whether the service is actually billed, must adhere to the requirements above, as well as to all Diagnostic Assessment Service Guidelines in the *DBHDD Provider Manual*, and must have documentation of
      a. factors considered and justification used in determining the diagnosis(es)
      b. necessary information, including a summary of findings to support the diagnosis(-es)
      c. a face-to-face clinical assessment provided as part of the diagnostic process
   2. Specialty providers who have a diagnosing practitioner on staff rendering diagnoses for members must adhere to the requirements above, as well as provide documentation of a face-to-face clinical assessment (telemedicine may be used) but are not required to provide documentation of the factors considered and justification used in determining the diagnosis(es), a summary of findings, or any other supporting documentation related to the diagnosis(-es) or diagnostic assessment process.
   3. Specialty providers who must obtain diagnoses from external providers must adhere to the basic requirements above but are not required to provide documentation of a face-to-face clinical assessment, the factors considered and justification used in determining the diagnosis(-es), a summary of findings, or any other supporting documentation related to the diagnosis(-es) or diagnostic assessment process

IV. Order/Recommendation for Course of Treatment

All services must be ordered by a licensed physician or other appropriately licensed practitioner, and orders may exist across multiple authorizations. Each service to be provided must be specified on the order and will be reviewed and signed by the practitioner(s) on or before the initial date of service. When more than 1 physician is involved in treatment, there should be evidence that an RN or MD has reviewed all relevant information to assure no contradictions or inadvertent contraindications within the services and treatment orders or plan.

If the recommendation for treatment (order) crosses multiple pages in a paper record, the provider must ensure that the order is clear, that the additional pages are a continuation of the order. For example, in a 2-page order, page 2 must contain the name of the individual, a page number, and indication that the signature of the practitioner indicates authorization for services as noted on page 1. For a complete list of requirements regarding Orders and Recommendations see the *DBHDD Provider Manual.*

V. Individualized Recovery/Resiliency Planning (IRP)

IRP planning develops a plan that focuses on member hopes, dreams, and vision of a life well-lived. Every record must contain an IRP in accordance with content set forth by the Georgia DBHDD. IRPs must be reviewed and updated at least annually (more frequently as needed to reflect evolving needs and goals), which establishes services by integrating information gathered from the current assessment(s), status, functioning, and past treatment history into a clinically sound plan. IRPs are developed by the member who directs decisions with the guidance of an appropriate professional. Members with coexisting, complex and confounding needs should be involved in cross-disciplinary approaches to planning. With consent of the member, others should assist in the development of IRPs, including significant others, those involved in formal or informal support of the member, and others who deliver specific services, supports and treatment identified in the IRP. When services are provided to youth during school hours, the IRP should indicate how the intervention has been coordinated among family system, school, and provider.

A. IRP planning should encompass the following:
    1. identify and prioritize the needs of the member
    2. be fully explained to the member using language understandable and agreed to by the member
    3. be member-driven and focused on outcomes the member desires to achieve
    4. state goals honoring the achievement of stated hopes, choice, preferences, and desired outcomes of the member and/or family
    5. be indicative of desired changes in levels of functioning and quality of life to objectively measure progress
    6. define goals/objectives that are individualized, specific and measurable with achievable timeframes
    7. include a projected plan to modify or decrease the intensity of services, supports, and treatment as goals are achieved

B. Documents that may be relevant for incorporation by reference into an IRP could include, but are not limited to, the following:
    1. medical updates as indicated by physician orders or notes
    2. addenda as required when a portion of the plan necessitates reassessment
    3. personal safety/crisis plan
    4. Wellness Recovery Action Plan (WRAP), which should
        a. be discussed with the member and developed, if desired
        b. be completely voluntary and include a written statement to that effect (declining assistance should also be documented in a progress note along with assistance desired, including start and stop times for developmental activities)
        c. be developed with fidelity to WRAP Values and Ethics
        d. belong to the individual, who chooses where the WRAP will be kept and with whom it will be shared (location is the clinical record only if self-directed by the member for inclusion; if it is not to be included in the clinical record, documentation of assistance to the member and the fact

that the member chose to not include it in the record should be documented in a progress note)

e. be devoid of clinical language (ie, in the member's own language)

C. Modifications/additions to the IRP must be made by a practitioner authorized to do so as soon as possible following the clinical review and resulting recommendations. Justification for recommendations not adopted should be documented in a progress note. Reassessment of plans (or portions of) must occur with a member's changing needs, circumstance, and responses of the member, including, but not limited to, the following:

1. any life change potentially impacting goals, objectives or interventions in the plan or that would necessitate the new goals, objectives or interventions
2. any change in medical, behavioral, cognitive, and/or physical status potentially impacting goals, objectives or interventions in the plan or that would necessitate adding new goals, objectives or interventions
3. when either of the following events occur:
   a. provider refers the member to an acute level of BH care (eg, emergency dept for a psychiatric emergency, BH Clinical Consultation, CSU, psychiatric inpatient hospital, PRTF)
   b. within 7 business days of a member's discharge from an acute level of care (LOC) regardless of whether or not the member was enrolled with the provider prior to the acute service episode or the length of stay, the provider must complete the following:
      01. a licensed (independent or associate-level) or SUD-credentialled (certification level II or above) practitioner must conduct a clinical review of relevant clinical information to assess member needs, strengths, progress, antecedents for acute loc, post-acute/post-discharge treatment recommendations:
         (1) members being admitted/readmitted to the provider's services following discharge from acute loc: include review of the clinical record if previously enrolled with the provider, as well as documentation, including communications, from the acute care provider (eg, discharge plan or summary, treatment plan during acute care, any risk assessments, the CSSRS)
         (2) members being referred by the provider to an acute loc: include review of the clinical record (eg, progress notes, event notes, recent assessments), as well as communication with other practitioners or informal supports (eg, family, caregivers)
      02. Based on clinical review, the practitioner must document findings and recommendations in the record as an administrative citation and specifically include recommended modifications/additions to the IRP
4. when requested by the member
5. as required by a specific service definition
6. as required by a new or modified order
7. at least annually
8. when goals are not being met

D. IRP planning must
   1. support the member to develop goals/objectives that
      a. relate to assessment/reassessment
      b. designed to ameliorate, rectify, correct, reduce or manage symptoms
      c. support and utilize the member's strengths
   2. detail interventions to achieve outcomes noted in goals and objectives
   3. identify services and interventions of the right frequency, intensity and duration to best accomplish plan objectives (frequency of delivery, intensity of the service, and overall duration of the service will be based on what is realistic for the member, circumstances, and predicted to be necessary for achieving progress toward goals/objectives within a limited timeframe) NOTE: Crisis intervention is an exception in that the IRP may indicate that the crisis intervention service is provided as needed. If the service is part of the IRP, it is expected that an initial and brief crisis plan be developed and in place in order to direct the service. See the *DBHHD Provider Manual* for crisis plan standards.
   4. identify staff responsible for service delivery (can be broadly defined, such as "physician," "therapist," "paraprofessional," "PSR team")
   5. assure that goals and objectives are consistent with the service intent
   6. document by individual signature and/or, when applicable, guardian signature that member is an active participant in planning and process of services (to the degree that is possible). Changes to the plan should document individual and/or guardian signature via dated initials. If gaining signatures/initials (as applicable) is not possible, document the attempt and reason in the record.

VI. Discharge and Transition Planning

Discharge and transition planning should be documented at the onset of service delivery and include specific objectives to be met prior to decreasing the intensity of service or discharge. Discharge criteria should be defined and objectively measure progress by aligning with documented goals and objectives, desired changes in levels of functioning, and quality of life. Specific step-down service/activity/supports to meet individualized needs should be defined, and all aspects of planning should be measurable and include anticipated step-down/transition date(s).

Providers of community adult BH services will participate in hospital recovery planning team meetings for members enrolled in or being referred to community services by a psychiatric inpatient facility. Comprehensive Community Providers (CCP) and/or specialty providers are responsible and accountable for implementing *Follow-up for Individuals Discharged from the State Hospital, 01-508.* For a complete list of discharge/transition planning and summary documentation requirements, see section III-6, 7 of the *GA BHDD Provider Manual.*

VII. Progress Notes

Progress note documentation includes the actual implementation and outcome(s) of the designated services in a member's IRP. Content in progress note documentation

provides all the necessary supporting evidence to justify the need for services based on medical necessity criteria and support all requirements for billing and adjudication of service claims. Review of sequential progress notes should provide a snapshot of the member over a specified time frame. A physician or psychiatrist, physician assistant, or advanced practice nurse (APN) must see the member face-to-face daily during any residential stay and record a progress note for the session.

A. Progress note documentation must reflect the following:
    1. Linkage - Clear link between the IRP and intervention(s) provided.
    2. Consumer profile – Description of current status of member and may include member statements, shared information and quotes, observations and description of member affect, behaviors, symptoms, and level of functioning.
    3. Justification – Rationale for payment of services provided and utilization of resources as related to service definition(s) and member need(s).
    4. Specific services/intervention/modality provided – Detail of all provided activity(-ies) including date, time, frequency, duration, and location, including whether telemedicine or telephonic intervention was utilized and where the individual was physically located during the intervention.
    5. Member response to intervention(s) – Identification of how and in what manner the service, activity, and modality impacted the member (ie, what was the effect and how was this evidenced).
    6. Member's progress – Identification of member progress (or lack of) toward specific goals/objectives.
B. Progress note documentation should reflect the following:
    1. Purpose or goal of the services – Clarification of the reasons for member participation in services and the demonstrated value of services.
    2. Monitoring – Evidence that selected interventions are occurring and monitored for the expected and desired outcomes.
    3. Next steps – Targeted next steps to support progress toward goals.
    4. Reassessment and adjustment to plan – Review and acknowledgement as to the need to modify, amend or update the IRP, and if so, how.
    5. Standardized format – Providers are expected to follow best practices and select or create a prescribed narrative to be used consistently. Specific details regarding actual practice should be described in provider policies, procedures, training manuals and/or documentation instruction sheets. All formats require a clear link between the progress note, assessment, and service and planning data.
C. Progress note documentation must address and adhere to the following:
    1. Presence of note – For any claim or encounter submitted, a note must be present justifying the specific intervention. Other ancillary or non-billable services related to the well-being of the member must be included in the official medical record, as well.
    2. Service billed – All progress notes must contain the corresponding HCPCS/CPT code and any designated modifier. When documenting practitioner modifiers, the modifier must indicate the reimbursement level, which may differ from the practitioner level in certain cases.

3. Timeliness – All services provided are documented (written and filed) within the current individual record within a pre-established time frame set by provider policy not to exceed seven (7) calendar days. Best practice standards require progress notes to be written within 24 hours of the clinical or therapeutic activity. Notes entered retroactively into the record after an event or a shift must be identified as a “late entry”.
4. Conciseness and clarity – Clear language, grammar, syntax, and sentence structure is used to describe the activity and related information.
5. Activities dated – Documentation specifies the date/time of service.
6. Dated entries – All progress note entries are dated to reflect the date of signature of the individual providing the service (this date may differ from the actual date of service) may only be dated by the signer. In electronic records, the date of entry must reflect the date that the electronic signature was entered. Back-dating and post-dating are not permitted.
7. Duration of activities – Documentation of the duration must be noted for all services to include the number of units, times, and dates. For those services in which the unit/rate is based on time (not per contact/encounter), documentation must include time-in and time-out (start and stop times), including face-to-face and collateral contacts but excluding residential services. Residential services must follow specific guidelines in each residential code. Further instruction for the Psychosocial Rehabilitation Program and Peer Supports Program can be found in the *Service Guidelines*.
8. Rounding of units is to occur as follows:
    a. Time-based: Rounding of units is permitted when a service meeting the service definition is provided in less time than the unit increment requirement. Providers must have an internal policy regarding rounding. In order to bill a unit of service, at least 50% of the time required per unit must be provided and documented by “time-in, time-out” documentation.
    b. Cost-based: In this case, rounding of cents should follow standard mathematical rounding protocols (ie, .49 and less round down, .50 and higher round to the next dollar amount). Provider documentation and policy shall define provider internal controls regarding this expectation.
9. Location of intervention is documented as follows:
    a. For billed as occurring In-Clinic or Out-of-Clinic, notes must reflect the location as either In-Clinic or Out-of-Clinic (unless otherwise noted in *Service Guideline*).
        01. In-Clinic Interventions: No further specificity is required unless the intervention is delivered via telemedicine or telephonically. Specific delivery modality and the member’s physical location at the time of the intervention must be clearly stated.
        02. Out-of-Clinic Interventions: Notes must reflect specific locations of interventions (eg, “…at the member’s home,” “…at the grocery store”). “In the community” is not sufficient to describe a location.

03. At or During School: When services are provided to youth at or during school, documentation must indicate that the intervention is most effective when provided during school hours.

b. Out-of-Clinic Justification and Documentation
Out-of-Clinic services have an established U7 Out-of-Clinic modifier which may only be billed when the following exist:
01. travel by the practitioner is to a non-contiguous location
02. travel by the practitioner is to a facility not owned, leased, controlled, or named as a service site by the agency who is billing the service (excepting visits to Shelter Plus sites)
03. travel is to a facility owned, leased, or controlled by the agency billing the service, but
(1) no more than 6 individuals are being served in the course of that day by a single practitioner in non-group services
(2) no more than 24 individuals are being served in groups at that site in the course of a day
(3) One group and/or 6 individual sessions per practitioner could occur in a single day; however, if **either** of these productivity caps is exceeded, then the Out-of-Clinic rate may not be billed. In that case, none of the services provided at that location by the practitioner for that day qualify for Out-of-Clinic billing

If volume or infrastructure indicates that a location or site is regularly operating as a service site (eg, posted on websites as a clinic site, the site is a daily point of service for multiple practitioners, administrative staff are employed for that site) providers need to enroll/license it as a site. If the service does not qualify to be billed as Out-of-Clinic or if the U7 modifier utilization criteria above are not met, then the In-Clinic rate/modifier (U6) may still be billed.

c. The Place of Service (POS) code required on a progress note/claim may not seem to intuitively align with the In-Clinic and Out-of-Clinic modifier use. Modifiers must always reflect accurate accountability to the requirements above, whereas the POS code can be generalized and is not used for auditing/accountability purposes.

d. Claims - When multiple practitioners of the same U-level deliver a service for which the same procedure code and modifier would be billed, but service delivery occurs at 2 different times, the time would need to be aggregated into 1 claim. If a different POS code were applicable for each practitioner, only 1 should be selected and used on the aggregated claim.

10. Participation in intervention – Notes should reflect all participants in the treatment or support intervention and the specific interaction that occurred during the reported timeframe. Duplication of notes is not allowed.
11. Signature, printed staff name, qualifications and/or title – The documentation writer is designated by name, credentials/qualifications, and when required, degree and title. If a licensed practitioner, the printed name must match the State license. Original signatures are required. Printed name, qualifications,

and/or title may be recorded using a stamp or typing. Automated or electronic documentation must include a secure electronic signature.

12. Consistency – Documentation must follow a consistent, uniform format. If documentation crosses multiple pages in a paper record, clarity must be ensured that the additional pages are a continuation of previous documentation (eg, in a 2-page note, page 2 must contain the name of the individual, date of service, a page number, and indication that the signature of the practitioner or paraprofessional is related to the progress note on page 1).
13. Diversionary and non-billable activities are to be documented as follows:
    a. Providers may not bill for multiple services that are direct interventions with the same member during the same time period. If multiple services are determined to have been billed at the same or overlapping time period, billing for those services are subject to recoupment. Allowable exceptions include the following:
       01. a service provided without client present indicated with modifier "HS"
       02. a collateral contact as indicated by the modifier “UK”
       For example, a provider may bill Individual Counseling with the member while case management is being billed for a collateral contact. This is only allowable when at least 1 of the services do not require the member to be present and the progress note documents such.
    b. Non-billable activities are activities or administrative work not falling within a service definition (eg, confirming appointments, observation/monitoring, tutoring, transportation, completing paperwork, communication/ coordination between providers employed by the same agency). Billing for non-billable activities is subject to recoupment.
    c. Billing for services that do not fall within the respective service definition for the service is subject to recoupment.
    d. Diversionary activities billed are subject to recoupment.

VIII. Event Notes

In addition to progress notes that document intervention(s), records must also include event notes that document the following:

A. issues, situations or events occurring in the life of the individual
B. member’s response to the issues, situations or events
C. relationships and interactions with family and friends, if applicable
D. missed appointments, including
    1. documentation and result of follow-up (ie, reason for missed appointment, date of rescheduled appointment)
    2. strategies to avoid future missed appointments

IX. Documentation of Supervision for Individuals Working Toward Licensure

Documentation of supervision (see definition above) must be present and current in personnel records. The 3 specialties governed by the GA Composite Board (professional counseling, social work or marriage and family therapy) have different supervision requirements. It is the responsibility of the provider to ensure that the ion

requirements specified by the board for the specialty are met. Documentation standards for Certified Alcohol and Drug Counselor-Trainees and Certified Counselors in Training can be found in the *DBHDD Provider Manual*.

E. Conditions of Coverage

Submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service. The GT modifier is required as applicable and/or the use of either POS 02 or POS 10. The GQ modifier is still required as applicable. DCH provides additional guidance on the provision of telehealth, telemental health, and telemedicine services in the *Telehealth Guidance Manual* on the GAMMIS website.

Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis, subsequent medical review audits, recovery of overpayments identified, and provider prepayment review. Program Integrity will be engaged for an annual review of data.

F. Related Policies/Rules

I. CareSource Policies
   A. Applied Behavior Analysis for Autism Spectrum Disorders
   B. Medical Necessity Determinations
   C. Medical Record Documentation Standards for Practitioners

II. Other Applicable Documents or Rules
   A. Definitions, 37 U.S.C. § 101 (2021).
   B. Health Care Fraud, 18 U.S.C. § 1347 (2010).
   C. Security and Privacy, 45 C.F.R. Part 164 (2013).
   D. Sentence of Fine, 18 U.S.C. § 3571 (1987).
   E. Statutory Basis, Basic Rule, and Applicability, 42 C.F.R. § 438.600(a)(5) (2024).

G. Review/Revision History

	DATES	ACTION
Date Issued	4/28/2021	New Policy
Date Revised	05/11/2022 05/10/2023 06/19/2024	Removed Covid red box and DOB; updated references Added sec. II.C.4 on signed and dated progress notes; Updated references. Approved at Committee. Annual review. Added MHPAEA info. Definitions updated to GA Code. Section D rewritten based on GA DBHDD Provider Manual. Updated F and H. Approved at Committee.
Date Effective	11/01/2024	
Date Archived		

H. References

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10. Definitions, O.C.G.A. § 37-1-1 (2022).
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