



Elements of a Service Note

Service Notes

- Progress note required for each treatment encounter
- Includes billable and non-billable sessions
- Any time there is contact with a client or entity that is clinically relevant
 - For example, Primary Care Physician, hospital social worker, school counselor

(reference Clinical Coverage Policy (CCP) 8C
7.3.5 Service Notes and Progress Notes)

Service Notes

- Service Definitions may have additional specific requirements
 - Exception to service note policy is documentation required for medical providers offering medication management and billing E/M codes
 - Medical provider must document chosen E/M code with all necessary elements as outlined in the current edition of the American Medical Association Current Procedural Terminology manual

(reference Clinical Coverage Policy (CCP) 8C
7.3.5 Service Notes and Progress Notes)

Service Notes

- General Documentation Requirements found in the Records Management and Documentation Manual (APSM 45-2) should also be followed
- The following requirements are considered best practice and protects you as well as the client

(reference Clinical Coverage Policy (CCP) 8C
7.3.5 Service Notes and Progress Notes)

Service Notes

- Service notes must include:
 - Actual and relevant activities that occurred during the service event
 - Important issues discussed
 - Interventions and treatment provided
 - Effectiveness of interventions and treatment provided and individual's response
 - Relevant observations and updates that occurred and were specific to the service delivery provided that day

Service Notes

- Documentation must be specific and individualized and must accurately reflect the service provided per session
- Each service note requires its own newly-composed evidence of the service provided

Required Elements

- There are a total of nine service note required elements according to CCP 8C and APISM 45-2

Required Elements

- Date of Service
 - The date that the treatment takes place
 - If billing an assessment that takes place over the course of multiple days you must document all days, but the date of service (DOS) for billing purposes is the final day that you saw the identified client face-to-face

Required Elements

- Name of Service Provided
 - Include procedural code (ex. 90837)
 - Examples include Outpatient Therapy Individual, Family Therapy, etc.

Required Elements

- Type of Contact
 - Face-to-face
 - Non face-to-face services are not covered or reimbursable
 - Services provided in accordance with clinical coverage policy 1H, Telemedicine and Telepsychiatry, are considered as face-to-face services. Refer to www.ncdhhs.gov/dma/mp/
 - Collateral
 - Phone call

Required Elements

- Description of the Treatment or Interventions Utilized
 - Includes the active engagement of the consumer
 - Interventions must relate back to the goals and strategies within the treatment plan
 - Evidenced Based Interventions considered best practice.
 - Interventions should describe the actions that provider took during the session

Required Elements

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 - Includes the active engagement of the consumer
 - Interventions must relate back to the goals and strategies within the treatment plan
 - Evidenced Based Interventions considered best practice.
 - Interventions should describe the actions that provider took during the session

Required Elements

- Effectiveness
 - Individual's response to interventions used
 - Examples: “Janey actively engaged in....”
or “Intervention was ineffective due to...”
 - Individuals progress towards the treatment plan goals

Required Elements

- Duration
 - Document the exact time that spent with the consumer or legally responsible person
 - Must be documented in minutes
 - Must correspond to appropriate CPT code that was billed
 - Example: 56 minutes documented for an individual therapy session – billed CPT 90837

Required Elements

- Signature to Authenticate Note
 - Signature includes date signed and credentials (degree, licensure)
 - Handwritten note requires handwritten signature and handwritten date
 - Credentials, degree and licensure may be typed printed or stamped
 - Signatures cannot be an ink stamp

Required Elements

- Signature to Authenticate Note
 - EMRs and electronic signatures (APSM 45-2)
 - An electronic medical record, or EMR, is a digital version of a person's paper record
 - An electronic system that contains medical and treatment information on individuals seen by provider
 - Completing a note in Microsoft Word or other similar program NOT considered an electronic medical record system

Required Elements

- Signature to Authenticate Note
 - EMRs and electronic signatures (APSM 45-2)
 - NC DHHS follows guidelines set by federal and state law governing what constitutes an electronic signature and who may use them
 - Currently only “digital signatures” meet the standards

Required Elements

- Group Therapy Notes
 - Full service note required for every person in the group receiving the service
 - Each note must contain required elements outlined in the previous slides, CCP 8C and APSM 45-2
 - While the interventions for members of the group may be similar the staff person writing the note must also indicate any individual interventions provided as well

Required Elements

- Group Therapy Notes
 - Purpose of the contact should be based on the specific goals in the individual's service plan, with an individualized description of his or her response to the treatment

Required Elements

- Billable Versus Non-billable Notes
 - Treatment record should contain documentation of all clinically relevant interactions with the client as well as other coordinating providers
 - Some interventions such as coordination of care are not billable separately, but should still be documented in the service record

Timelines for Service Notes

- For most MH/IDD/SU services, service notes (and grids when permitted) required to be written or dictated within 24 hours of day that service is provided
 - Weekends and holidays not counted in terms of writing a note within 24 hours of the date of service unless agency operates on weekends and holidays

(per Medical Records and Documentation Manual (APSM 45-2))

Timelines for Service Notes

- If service note is written or dictated after 24 hours of date of service or close of service period, it is classified as a late entry
 - All late entries must be marked as such and must include a dated signature

(per Medical Records and Documentation Manual (APSM 45-2))

Timelines for Service Notes

- Service notes expected to be written or dictated within the seven-day time frame
 - To meet reimbursement requirements and to ensure accurate description of service provided
 - Should be rare for a service note to be written or dictated after the seven-day time frame, as the possibility for the accuracy and detail depicted in the note to be compromised increases with time

(per Medical Records and Documentation Manual (APSM 45-2))

Timelines for Service Notes

- Service notes expected to be written or dictated within the seven-day time frame
 - When a service note is written or dictated after the seven-day time frame, it is classified as a late entry
 - Must be indicated as a late entry
 - Dated signature required
 - May not be billed

(per Medical Records and Documentation Manual (APSM 45-2))

To Consider

- Service notes must be written to provide substance, efficacy and value
- Interventions, treatment and supports must all address the goal(s) listed in the plan
- Must be written in a meaningful way so the notes collectively outline the beneficiary's response to treatment, interventions and supports in a sequential, logical, and easy-to-follow manner over the course of service

To Consider

- All notes must include the Service Record Number and Medicaid Number (APSM 45-2)

Timelines for Service Notes

- When a service note is written or dictated after the seven-day time frame has lapsed, it is classified as a late entry, must be indicated as such, and a dated signature is required, but it may not be billed

(per Medical Records and Documentation Manual (APSM 45-2))

References

- APISM 45-2 Records Management and Documentation Manual
- DMA CCP 8C