NORTH Dakota Be Legendary.

Health & Human Services

1915(i) Records and Documentation

What is the “Golden Thread?”

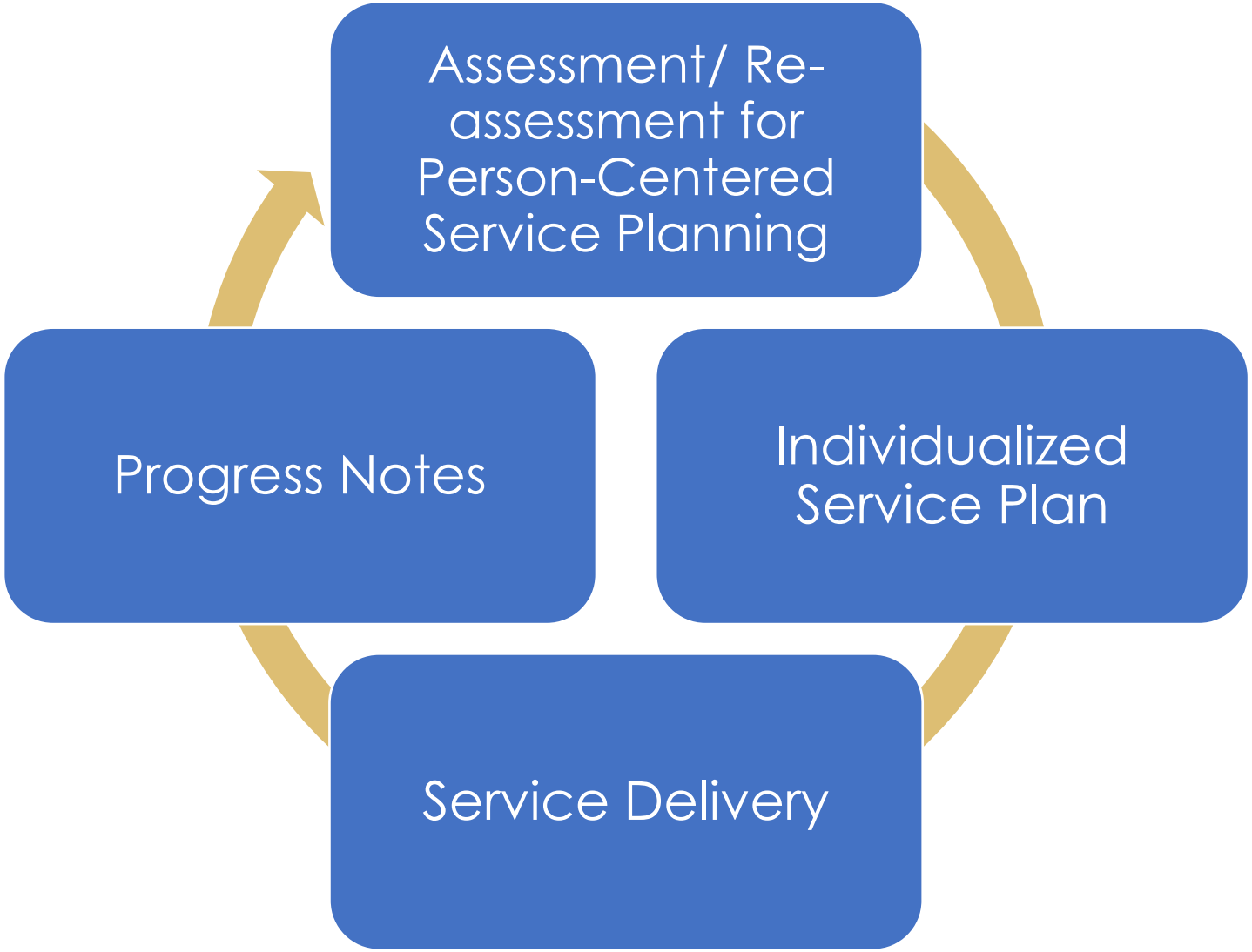
- "An idea or feature that is present in all parts of something, holds it together, gives it value" - Oxford Dictionary

- In Healthcare, it is defined as a way to consistently present relevant information throughout all documentation for a client, *tying together* a narrative of a client’s experience as evidence of medical necessity.

WHAT IS MEDICAL NECESSITY?

- Medical or remedial services or supplies required for treatment of illness, injury, diseased condition, or impairment
- Consistent with the recipient's diagnosis or symptoms
- Appropriate according to generally accepted standards of medical practice
- Not provided only as a convenience to the recipient or provider
- Not investigational, experimental, or unproven; clinically appropriate in terms of scope, duration, intensity, and site
- Provided at the most appropriate level of service that is safe and effective

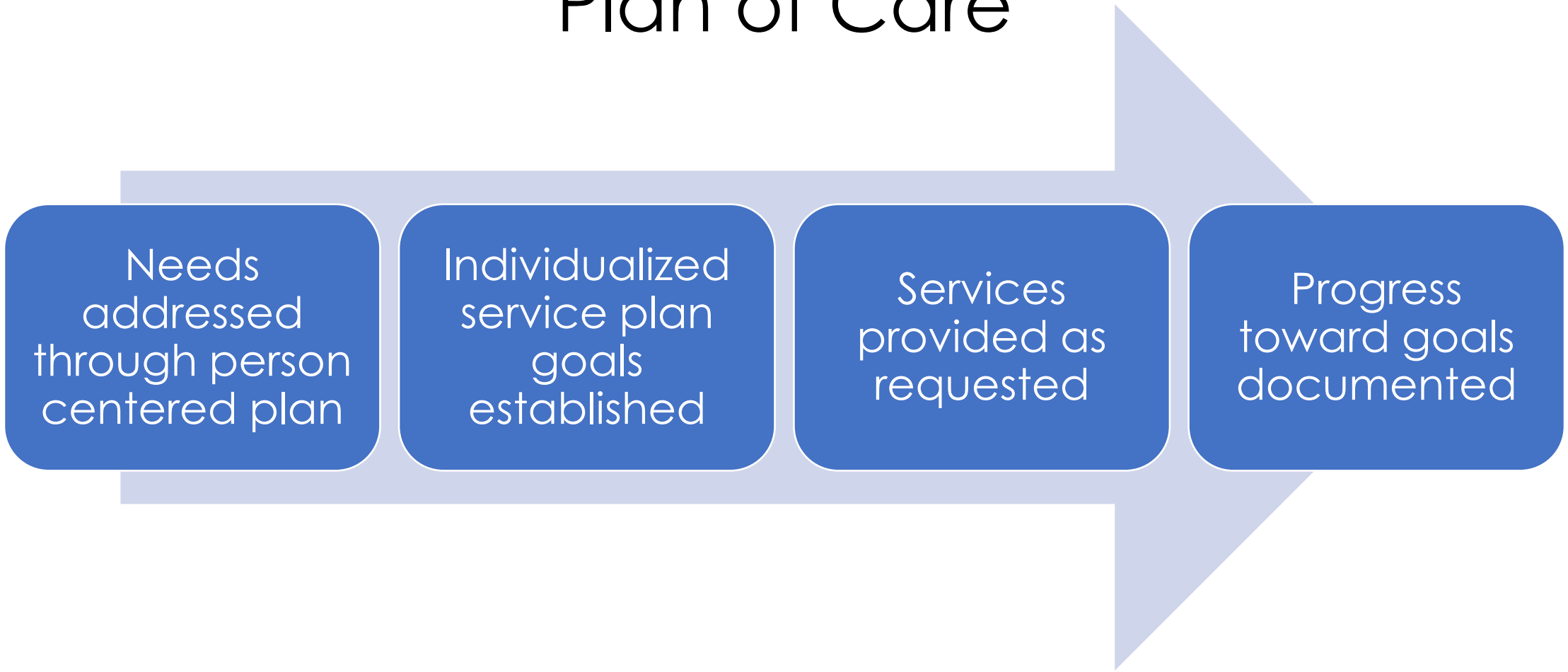
Golden Thread



An external reviewer (State) must be able to clearly track the thread of need for the services from the assessment (WHODAS), and then understand how these needs are translated into goals and activities for the client on the Plan of Care.

These proposed activities are turned into actions (service delivery) and tracked in progress notes.

Documentation: Connect back to needs and goals established on Person-Centered Plan of Care



Connecting The Note To The Goals

Diagnosis:

- **Social Anxiety Disorder**

WHODAS Assessment Domains with High Scores:

- **Participation**
- **Getting Along**

Person-Centered Plan of Care

- **Includes goal of community involvement, specifically attending a connect group at a local church once a week**

"Accompanied Joey to the connect group at the local church where members meet to discuss personal issues or struggles. During the group, participants shared their struggles with feeling anxious in public and how they overcome their fear as well as shared stories of recovery from drugs, alcohol, etc.

Joey will be attending this group weekly and has set a goal to verbally participate in the group sometime within the next 3 meetings."

Connecting The Note To The Goals

Diagnosis:

- **Major Depressive Disorder**

WHODAS Assessment Domains with High Scores:

- **Self Care**

Person-Centered Plan of Care

- **Includes goal of eating nutritious meals to improve mental health, specifically grocery shopping and preparation of healthy meals at least twice a week**

"Observed Joey had only junk food (chips, chocolate, soda, etc.) when conducting a home visit.

Accompanied Joey to the grocery store. During the trip, discussed several important items. First, the importance of buying healthy food for nutrition. Second, where to find healthy items in the grocery store. Third, provided resources for healthy meals."

Subjective	Objective
"The apartment was a mess."	"Writer observed food, garbage, clothing and papers blocking walkways and vents."
"Client was out of control and kicked out of the store."	"Client was experiencing active paranoia and persecutory thoughts. Client began to scream at other shoppers. Security was called and escorted client out."
"Client is doing much better living indoors."	"Client appeared calm, confident and in good health. Client showed writer how she stores her meds in her weekly pillbox. When asked how she is liking her new unit, client reported "I like this place, I mean I can't stop smiling. I love it. Especially the A/C unit."

Objective Writing:

- focus on the facts (what happened?)
- avoid being too subjective or opinionated
- write notes knowing that this is the legal medical record of the individual you support

Adding More Narrative

Documentation	Adding More Narrative
Joey and provider met at Joey's apartment this morning. Provider assisted Joey in some household chores. We then went to Hornbacher's for groceries before returning to Joey's apartment. After unloading everything, we made plans to meet on Wednesday.	Joey and provider met at Joey's apartment this morning. Provider assisted Joey in doing some household chores (what was the instruction given to Joey, how did Joey respond, what specific chores were performed). We then went to Hornbacher's for groceries (what happened at the grocery store, what instruction was given, what food was purchased, how did Joey respond) before returning to Joey's apartment. After unloading everything, we made plans to meet on Wednesday (what is going to happen on Wednesday, what will be worked on).

How do these activities relate to the goals in the POC?

Not everything is going to directly relate to a specific goal, but the overall activity or time spent does need to have that focus.

Document any progress made on the goals in the POC.

1915(i) Required Medical Record Information

- Individual's name and date of birth
- Date of service
- Begin time and end time of service (for services billed per 15-minute unit)
- Name and title of individual providing (rendering) the service
- Signature and date by the person providing the service
- Person-Centered Plan of Care
- Service authorization number(s)
- Claims, billings and records of Medicaid payments and amounts received from other payers for services provided to members
- Any other related medical or financial data that may include appointment schedules, account receivable ledgers and other financial information.

1915(i) Medical Records Policy

Additional Documentation Requirements

Services provided must connect back to the individual's goals and assessed needs identified on their plan of care while also staying within the scope of service. Documentation should describe the progress toward the individual's goals and assessed needs identified in their plan of care.

Documentation records must:

- Thoroughly document the extent of services rendered and billed. These records are used to decide necessity and correct billing. Be in their original or legally reproduced form. This may be electronic.
- Support the time spent rendering a service for all time-based codes.
- Be kept for a minimum of seven (7) years from the date of their creation or the date when they were last in effect, whichever is later. Note: state law may require a longer retention period for some provider types.
- Be signed by the ND Medicaid-enrolled provider rendering the service. Claims selected for an audit that don't have signed records shall be denied.
- Be legible, promptly completed, dated and timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided consistent with organization policy. Signatures must follow Medicare requirements.
- Be kept confidential.