PROVIDER TYPE: Licensed Psychiatrists, Licensed Clinical Social Workers, Licensed Psychologists, Licensed Marriage and Licensed Family Therapists, Licensed Professional Counselors, Behavioral Specialists, Licensed Behavioral Health Free-Standing Facilities*

SCOPE: Adult and Pediatric medical records in an inpatient and/or outpatient setting.

STANDARD: 84%

TARGET POPULATION: All Members

OUTCOME/PROCESS INDICATOR(S):

- Medical records are maintained in a legible, current, detailed, organized, and comprehensive manner which permits effective quality management review, and assessment of appropriate health management and continuity of care.

GUIDELINE:

- Behavioral health practitioners/organizational providers develop and maintain a system for the collection, processing, maintenance, storage, retrieval, and distribution of the members’ medical records in a current, detailed, and comprehensive manner that permits effective member management and quality review.

  Records must accurately reflect all aspects of members’ care, including ancillary services.

  Records shall be easily located and available at each member encounter

  Records must show evidence of appropriate member consent or informed refusal of tests and/or therapies.

  Records will be available within seven (7) days of receipt of request for medical records.

  Records and/or summaries will be transferred to a new behavioral healthcare practitioner at the member’s request. The records and/or summaries will be transferred within thirty (30) days of the member’s signed release or written request so as to not interfere or cause delay in the provision of services to the member.

- Except as required by law, all member’s records will be treated in a strictly confidential manner and will be reasonably protected from loss, tampering, alterations, destruction, and all unauthorized or inadvertent disclosure of information. The practitioners shall have in place appropriate administrative, technical, and physical safeguards to protect the privacy of
protected health information.

- All records shall be legible.

- The medical record must be capable of being read alone by anyone who has the need to understand the clinical information carried therein.

- Only standard abbreviations are to be used in the medical record. Should circumstances dictate the use of non-standard abbreviations, they must be identified with their first use in the medical record or a list of abbreviations used within the medical record must be maintained with the medical record.

- Personal/biographical data shall include: full name, date of birth, gender, address, employer, home and/or work telephone numbers, and marital or legal status and guardianship information if relevant.

- Consent or denial for release of information to Primary Care Physicians signed by member or legally authorized representative(s) shall be included in the medical records.

- The members’ medical records shall demonstrate conformity with standard professional practice and permit effective quality management review.

- At least the following information shall be entered in the medical record:
  
  - Chief complaint or purpose for referral/evaluation
  - A DSM-5 diagnosis is documented, consistent with chief complaint/presenting problems history, mental status evaluation and/or other relevant assessment data
  - A comprehensive bio-psychosocial history and needs assessment. For children and adolescents, prenatal and perinatal events along with a complete developmental history (physical, psychological, social, intellectual, and academic), as applicable to services required
  - Request for/documentation of a history and physical from a Primary Care Physician; and/or completion of a verbal or written health questionnaire by the member with documented review by the behavioral health practitioner by third visit
  - History and current use of tobacco, alcohol, drugs, to include but not limited to, prescribed, over-the-counter and herbal preparations for patients ages 12 and over
  - Dated documentation of presence or absence of medical and psychiatric history including previous treatment dates, provider information, therapeutic interventions and responses, sources of clinical data and relevant family information
  - A prominently displayed and dated list of currently used medications/allergies and adverse reactions to medications and other substances. If there are no known allergies, history of adverse reactions, or relevant medical conditions, this is prominently noted.
  - Each record indicates what medications have been prescribed, the dosages of each and the dates of initial prescription refills
  - Relevant medical conditions/special status situations are listed prominently, identified, and revised
- Documentation of presence or absence of history of physical/sexual abuse
- A systematic mental status examination to include, for example, appearance, mood, affect, sensorium, thought content and flow, speech, attention/concentration, insight and judgment, memory and impulse control
- Documentation of a determination of the degree of danger to self and others or elopement potential are prominently noted and revised in compliance with written protocol
- A social assessment (should include family history and spiritual orientation of member)
- For members receiving chemical recovery treatment medical record documentation will include:
  
  a) history of alcohol and/or drug abuse including substances used, duration, patterns, and consequences of use;
  b) presence or absence of a family history of alcohol or drug use;
  c) presence or absence of a history of physical problems associated with dependence;
  d) presence or absence of current and past psychiatric abnormalities (necessary to differentiate between dysfunctions related to alcohol/drug use and psychiatric disorder) - list DSM-5 psychiatric diagnosis
- All entries in the treatment record include the responsible practitioner’s name and professional degree. Author identification may be handwritten, unique electronic identifier or initials.
- All pages of the medical record should contain date, member’s name or ID number
- Documentation supporting the level of treatment.

- All behavioral health medical records shall include a written, comprehensive description of treatment plan, objectives, and definable goals, consistent with DSM-5 diagnosis including:

  - Significant illnesses, medical conditions, problems and needs are identified on a problem list.
  - Specific therapeutic treatment consistent with treatment plan goals and objectives
  - Documentation of member’s participation in development of treatment plan
  - Supervisor signature as evidence of oversight on documentation entered by ancillary staff.
  - Time frame for reassessment of plan and treatment; preliminary discharge plan, if applicable.
  - Evidence of reassessment of plan when major clinical changes, treatment methods, medications, or progress/regression occurs
  - If applicable, evidence of member informed consent, (education/instruction and member agreement), regarding newly prescribed medications/review of medications presently taken
  - If applicable, all diagnostic procedures/tests are reviewed and initialed by the physician, prior to being incorporated into the member’s record. If the report is presented electronically or by some other method, there is also representation of review by the ordering physician.
If applicable, documentation of communication with the client regarding care, treatment, and services (for example, telephone calls or e-mail)

All member-generated information (letters, e-mails, or information entered over the web or by any other means) must be entered into the medical record.

- Each treatment session with members shall include:
  - Presenting problems, along with relevant psychological and social condition affecting the medical and psychiatric status are documented
  - The practitioner’s analysis of and conclusions regarding the member’s current status to include a description of the strengths and limitations as related to ability to achieve treatment plan goals and objectives
  - Plan (strategies) reflecting the practitioner’s actions to be taken in light of the evaluation and indication of the direction of treatment
  - If applicable, a group note including a comment relative to member’s the response to participation in the group session
  - Signature, name and title of individual providing treatment
  - Length of session
  - Date of session

- Appropriate behavioral health management shall be clearly reflected in the medical record as evidenced by continuity and coordination of care between primary care physician, consultants, ancillary providers and health care institutions.

  Documentation of Primary Care Physician follow-up is evidenced by a copy of a letter or telephone conversation, provided that the member has granted permission, within thirty (30) days of initiation of treatment

Office/clinic notes document:

1. Date for return session
2. Plan for return session which includes focus for next session, suggested self-development between sessions
3. Problems from previous sessions addressed, if appropriate
4. Plan for discharge designed to provided continuity of care as evidenced by referral to but not limited to:
   - another agency (if indicated)
   - partial program
   - community program
   - inpatient hospitalization
   - self-help groups
   - personal support system
5. Discharge summary
Specifically, where appropriate, evidence of behavioral health management:

1. Lab and other studies are ordered as appropriate
2. Working diagnosis (es) is consistent with findings
3. Plans of action/treatment are consistent with diagnosis (es)
4. There is evidence of appropriate use of consultants
5. The care appears to be clinically appropriate
6. Preventive services are appropriately used

• All medical records shall be retained for at least seven (7) years from the date of the last service, or longer (particularly in the case of minors), if required by law.

• All notes about a member are recorded in a timely manner; e.g., as close as possible to the time of the encounter. Corrections can be made to the medical record when information has been entered erroneously or to clarify previous entries, provided the corrections or additions are clearly identified as subsequent entries by a date, time, initials, and or signature of person making the entry

NOTE: MRD Practice Guideline strives to remain consistent with the intent of directives from National Committee of Quality Assurance (NCQA), The Joint Commission and Centers for Medicare and Medicaid Services (CMS) documentation guidelines.

REFERENCES:


2006 NCQA Guidelines for Treatment Record Documentation – Behavioral Health

PA Department of Health Medical Record Documentation Standard.

49 PA Code Chapter 16, Subsection 16.95

49 PA Code Chapter 47, Subsection 47.78

49 PA Code Chapter 41, Subsection 41.57

55 PA Code Chapter 5200, Subsection 5200.41

55 PA Code Chapter, Subsection 5210, Subsection 5210.26

APPLICATION OF PRACTICE GUIDELINE:

This practice guideline applies to the following companies:

First Priority Life Insurance Company®
HMO of Northeastern Pennsylvania (d/b/a First Priority Health®)

APPROVAL:

Approved: Mental Health/Chemical Recovery
Quality Management Committee  02/17/93, 05/18/94, 11/21/96
Credentialing/Recredentialing Committee 11/16/99
Credentialing/Recredentialing Committee 11/20/01
Credentialing Committee (Format Changes) 09/17/02
Credentialing Committee 03/18/03
Credentialing Committee 03/30/04
Credentialing Committee 03/21/06
Credentialing Committee 01/16/07
Credentialing Committee 07/17/07
Credentialing Committee 01/15/08
Credentialing Committee (Format Changes) 03/16/10
Credentialing Committee 03/20/12
Credentialing Committee 10/16/12
Credentialing Committee 03/18/14