Section 17

MEDICAL RECORD DOCUMENTATION STANDARDS

ValueOptions has specific documentation standards that must be adhered to by all providers. These standards incorporate all federal and state Medicaid documentation requirements as well as good professional practice. They are intended to insure the highest quality of care, reduce medical errors, and achieve full compliance with federal, state, and ValueOptions audit requirements.

All providers must maintain a comprehensive medical record for each member served. At a minimum, the medical record substantiates the diagnosis, the medical necessity of care, the quality of care, the progress of care, and the claims submitted for reimbursement.

While network Community Mental Health Centers follow the applicable Division of Behavioral Health regulations regarding medical records (2 CCR 502-2 and 2 CCR 502-1), all ValueOptions providers must meet the following minimum standards for their own medical records:

General Requirements:

- Each record includes the member's identification including but not limited to: age, date of birth, gender, address, employer or school, home and work telephone numbers, emergency contacts, marital/legal status, and financial information.
- Each record includes appropriate consent forms and guardianship information.
- Each record contains a statement as to whether or not a member over age 18 has an Advanced Directive; and contains a statement that you provided AD information if requested.
- Each record contains a statement as to whether or not a member under age 21 has had a well-child exam (EPSDT) in the last year and results of the exam if related to the mental health condition, or a referral to a Primary Care Physician if no recent exam has occurred.
- Each record contains a copy of Medicaid client rights and responsibilities signed by the member.
- Each record contains a copy of the member's signed acknowledgement that s/he received your Notice of Privacy Practices.
- Each record contains a copy of your professional disclosure form signed by the client
- Each record contains a copy of any release of information (to PCP or other parties as indicated) signed by the member, or a statement that member refused to sign. Releases meet all HIPAA requirements,
- Each record contains an assessment of transportation needs and documentation that the provider helped to arrange transportation when necessary.
- Each record includes an individual bio-psychosocial assessment (e.g., presenting problems; medical history, physical health status, and relevant medical conditions. current medications, allergies, retardation or organic brain disorders; identified strengths; relevant psychological, emotional, behavioral, vocational, cultural and social conditions affecting the member and family; past or present history of abuse; legal involvement; psychiatric history; relevant family information; past and present use of alcohol and other substances).
    - For children and adolescents, the assessment includes a developmental history (e.g., physical, psychological, social, intellectual and academic).
    - For older adults, the assessment includes issues specific to that population, such as hearing and/or vision loss, strength, mobility and aging issues.

- Each record includes a mental status examination documenting the member's presentation/appearance, affect and mood, speech, cognitive/intellectual functioning, thought

content/process, judgment, insight, attention/concentration, memory, impulse control, and danger to self and others.

- Each record includes a current Diagnostic and Statistical Manual (DSM) diagnosis based on psychiatric, psychological or medical condition with sufficient description of the criteria per the current DSM to support the diagnosis and any subsequent changes in diagnosis.
- The documented diagnosis is consistent with the presenting problems, history, mental status examination and/or other assessment data in the record.

Service/Treatment Plan:

- Each record includes an individualized treatment/service plan containing behaviorally measurable goals and objectives, the desired discharge criteria, the provider's intended therapeutic interventions, frequencies and modalities, and estimated timelines for goal attainment/problem resolution.
    - The treatment/service plan is consistent with the member's diagnosis and needs as identified in the assessment.
    - There is documented evidence in a progress note that the member (and parent/guardian, if applicable) participates in the development of, understands, and agrees with the treatment/service plan and any significant revisions/updates.
    - The treatment/service plan must include specific criteria for discharging the member from treatment that are agreed upon by the member and provider. ischarge criteria may be modified as a member's circumstances change; modifications will be documented in the member's treatment plan.
    - The treatment/service plan is reviewed by the client and provider at least every 6 months or when a major change in the member's condition or service needs occurs. The plan is revised as necessary. For members involuntarily receiving services pursuant to Section 27-65- 101 *et seq*., CRS, the plan must be reviewed monthly.
    - The member or guardian must sign the treatment plan. If they refuse, this fact must be documented clearly in a progress note.

Progress Notes:

- Each record includes a progress note for each encounter which describes the goal/objective being addressed during the session, the member's efforts in achieving treatment/service plan goals/ objectives, and the treatment interventions used by the provider to assist the member.
- Each progress note includes information relevant to the claim for payment, including date, start time, duration or end time, CPT code, place of service, and persons present, and provider signature with credentials and date signed..
- Case management notes reflect the name and agency of person contacted and the content of each contact.
- Progress notes document an ongoing assessment of member safety (e.g., dangerous to self or others) and substance use/abuse issues, if applicable, and how these have been addressed.
- For members who become homicidal, suicidal or unable to conduct activities of daily living, the record documents prompt referral to the appropriate level of care.
- Each record documents attempts at outreach for persons who "no show" for scheduled appointments.

Miscellaneous

- As applicable, each record includes results of laboratory tests, psychological testing, and consultation reports.

- As applicable, each record indicates what medications have been prescribed, the dosages of each, the dates of initial prescription or refills, prescriber information, and informed consent for medication.
- Each record documents preventive and recovery-focused services as appropriate, such as relapse prevention, wellness programs, lifestyle changes, and referrals to community resources.
- Each record documents continuity and coordination of care between the Care Coordinator (Primary Clinician), consultants, ancillary providers and health care institution/providers, and other community services agencies.
- Each record documents the date(s) of follow-up appointments or, as appropriate, discharge plans and summary.
- All entries are dated.
- All entries include the legible identity of the rendering provider’s name, professional degree and identification number, if applicable.
- All entries are legible to someone other than the writer, and written/typed in black or blue ink.
- Each page contains the member's name and Medicaid ID.