Section 19

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 the care, the quality of the 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:

<u>General Requirements</u>

- Each record includes the member's identification and demographic information, including but not limited to 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 the member has an Advanced Directive.
- Each record includes an individual bio-psychosocial assessment (e.g., presenting problems; medical history, physical health status, and relevant medical conditions; identified strengths; relevant psychological, emotional, behavioral, vocational, cultural and social conditions affecting the member and family; 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 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, active target interventions, frequencies and modalities, results of the Primary Care Physician (PCP)/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Assessment 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 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. Discharge 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 provider and revised as necessary, or when a major change in the member's condition or service needs occurs, or monthly for members involuntarily receiving services pursuant to Section 27-10-101 *et seq*., CRS.
  - 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 progress notes for each encounter, which describe the member's efforts in achieving treatment/service plan goals and objectives, and reflect treatment interventions that are consistent with those goals and objectives, including the date(s) and type(s) of service(s) along with clear reference to the duration/length of the session (e.g., a 50 minute individual session).
- Case management notes reflect 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.

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.