

## Massachusetts Behavioral Health Partnership/BeHealthy Partnership Health Records Guidebook: Core Health Record Documentation Standards

The purpose of this guidebook is to specify MBHP/BeHealthy Partnership core health record documentation standards for all MBHP/BeHealthy Partnership providers. MBHP/BeHealthy Partnership believes that quality documentation promotes quality clinical practice. The MBHP/BeHealthy Partnership health record documentation standards are available to facilitate provider quality documentation practices.

### MBHP/BeHealthy Partnership Core Health Record Keeping Standards for All Covered Services

<b>Standard 1: Comprehensive Assessment</b>
<b>Standard 2: Individualized Action Plan</b>
<b>Standard 3: Coordination/Monitoring of Treatment</b>
<b>Standard 4: Outcome Measurement</b>
<b>Standard 5: Progress Notes – Medical Necessity Criteria</b>
<b>Standard 6: Discharge Summary</b>
<b>Standard 7: Documentation of Paid Services</b>

The standard-specific criteria listed below will be used by MBHP/BeHealthy Partnership in its review of providers’ health records. As such, providers may consider the record-keeping criteria as guidelines that can be used for a self-assessment of their own record-keeping practices.

**Notation of referral date/date of first visit**

MBHP/BeHealthy Partnership now reviews the date of referral and date of first visit by the Member to the provider’s services. Please ensure that these important dates are easily identifiable in the Member record.

**1. Comprehensive Assessment**

- i. *Core Standard:* Sufficient and necessary information is collected for the purpose of assessing the Member’s treatment needs and strengths in support of treatment. The assessment information is interpreted and evaluated to determine the Member’s assessed needs for behavioral health services and

- treatment recommendations. Quality treatment depends upon a comprehensive assessment of the Member's bio-psycho-social functioning and should include how the presenting concerns are affecting the Member's life functioning, how the strengths of the Member can be incorporated into the treatment process, and a diagnostic determination.
- ii. Providers should have an established assessment protocol appropriate to the level of treatment.
  - iii. A clinical formulation is a synthesis of the clinician's impression of the Member's need areas for behavioral health treatment, the factors that lead to the needs, and the plan to address them. The clinical formulation is a critical step to develop the individualized action plan.
  - iv. Child and Adolescent Needs and Strengths (CANS) administration must augment the comprehensive assessment process and should be integrated in the final comprehensive assessment document.
  - v. Outcome measurement for applicable levels of care should integrate findings in the final comprehensive assessment document.
- b. *Comprehensive Assessment Criteria*
- i. Presenting concerns
  - ii. Medical history
  - iii. Psychiatric history
  - iv. Substance use history
  - v. Developmental history (children and adolescents)
  - vi. Allergies/adverse reactions
  - vii. Medications
  - viii. Risk assessment
  - ix. Mental status exam
  - x. Member strengths
  - xi. Clinical formulation
  - xii. Clinical formulation validated by clinical data
  - xiii. DSM-5, axis I-V diagnosis
  - xiv. DSM-5, diagnosis validated by clinical data
  - xv. CANS administered and integrated (under 21)
  - xvi. Outcome tool administered and integrated, as applicable

## 2. **Individualized Action Plan**

- a. *Core Standard:* This standard ensures that a comprehensive and individualized action plan is linked to the Member's assessed needs and identifies goals, objectives, and interventions for each assessed need. The plan is developed with the participation of the Member.
- i. The goal of an individualized action plan is to guide the clinician and the Member in the pursuit of treatment goals that are meaningful and important to the Member, as the Member defines his/her needs.
  - ii. For each assessed need identified through the assessment process, an individualized action plan is formulated and written in non-technical language

that is understandable to the Member.

- iii. Members should participate in the development of the individualized action plan and should concur with the final plan. A notation of Member involvement should be made on the plan.
- iv. MBHP/BeHealthy Partnership review of the individualized action plan is based on the most current plan.

b. *Individualized Action Plan Criteria*

- i. Goal identified for each assessed need
- ii. Objective/s identified for each assessed need
- iii. Interventions identified for each objective
- iv. Timelines for attainment are identified
- v. Agencies/supports/resources
- vi. Consultation with outside psychiatric/medical care indicated, as relevant
- vii. Medications prescribed
- viii. Member strengths identified
- ix. Member/guardian participation in individualized action plan development
- x. Plan is appropriate to diagnosis and current presentation
- xi. Plan is appropriate to treatment goals

3. **Coordination and Monitoring of Treatment**

- a. *Core Standard:* This standard requires both coordination and monitoring of services. The coordination of treatment enhances the clinical effectiveness of all health care providers. The monitoring of treatment reviews the Member's progress in achieving the treatment goals.
- b. *General Guidelines*
  - i. The health record should provide evidence of the periodic review of the Member's progress in achieving the treatment goal(s), including: the reformulation of the goals; the date of goal achievement; and the inclusion of new goals.
  - ii. The health record should provide evidence of the coordination of treatment with other health care providers, including the Member's primary care clinician.
- c. *Coordination and Monitoring of Treatment Criteria*
  - i. Individualized action plan is current
  - ii. Individualized action plan revised as appropriate
  - iii. Consultation with primary therapist (if medication only)
  - iv. Routine laboratory tests are requested as appropriate
  - v. Routine laboratory tests have been reviewed
  - vi. Member/guardian requested to sign authorization for use/disclosure of health information for collateral contacts
  - vii. Member/guardian requested to sign authorization for use/disclosure of health information for primary care clinician
  - viii. Primary care clinician release of information sent by the fourth session
  - ix. Consent refusal documented for communication with primary care clinician

- x. Multi-disciplinary team action items document resolution\*
  - xi. Multi-disciplinary team includes questions/recommendations/comments\*
  - xii. Multi-disciplinary team includes requires signatures\*
- \* not required for individual practitioners/group practices

#### 4. **Outcome Measurement**

- a. *Core Standard:* This standard ensures that the administration of an outcome assessment and reassessment is integrated in the comprehensive assessment/individualized action plan processes.
- b. *General Guidelines*
  - i. CANS is required for all Members under the age of 21 if enrolled in treatment after November 2008.
  - ii. Outcome measurement for adults is not required for Members who have not given consent for outcome measurement.
- c. *Outcome Measurement Criteria*
  - i. CANS review current, within three months of review date, under the age of 21
  - ii. Outcome reassessment current, within one year for adults
  - iii. If reassessment is current, reassessment results included in treatment planning process
  - iv. If reassessment is current, risk issues identified are addressed appropriately

#### 5. **Progress Notes - Medical Necessity Criteria**

- a. *Core Standard:* This standard requires that the individualized action plan is implemented, progress notes address the goals of the plan, and Member progress is appropriately documented.
- b. *General Guidelines*
  - i. Progress notes are sequential narratives that describe the progress of the Member by direct reference to the individualized action plan.
  - ii. When new issues are documented in a note (not linked to the individualized action plan), a revision of the individualized action plan should be made if the new issue will become a focus of treatment, e.g., new or changed diagnosis, loss of employment, etc.
  - iii. One or more progress notes are subject to recovery of payment if the record is found to fail to meet one or more of the criteria list below.
- c. *Progress Notes-Medical Necessity Criteria*
  - i. Notes are relevant to the individualized action plan
  - ii. Notes assess symptomatic progress
  - iii. Notes assess functional progress
  - iv. Notes assess risk, as applicable
  - v. Notes identify what the clinician did in the session

#### 6. **Discharge Summary**

- a. *Core Standard:* This standard ensures that discharge from treatment is a planned and documented process.

b. *General Guidelines*

- i. A discharge plan should be given to the Member upon discharge and should be written in non-technical language that is understandable to the Member.
- ii. The treatment summary should be a concise summation of the Member's treatment.
- iii. This standard is not reviewed if the Member is not discharged.

c. *Discharge Summary Criteria*

- i. Summary of services provided
- ii. Status toward meeting goals
- iii. Axis I-V (at time of discharge)
- iv. Reason for discharge
- v. Medications prescribed
- vi. Referrals documented
- vii. Aftercare options identified

**7. Documentation of Paid Services**

a. *Core Standard:* This standard requires that all paid services are documented appropriately.

b. *General Guidelines*

- i. An audit of paid claims matches paid services to the documented service in the Member's record.
- ii. Four criteria are subject to recovery of payment for each standard element that is not met (see asterisks below).

c. *Documentation of Paid Services Criteria*

- i. All entries are legible.\*
- ii. All paid services match service provided and modality/date/duration.\*
- iii. All entries are signed/authenticated with clinician's name/credentials.\*
- iv. All progress notes are documented.\*
- v. All entries indicate the date of next session.
- vi. All entries indicate the plan for next session, as appropriate.
- vii. Cancelled/missed appointments are indicated on the document plan for the next session.