Treatment Record Documentation Requirements

Introduction

In accordance with your Participation Agreement, you are required to maintain high quality medical, financial and administrative records (including appointment or scheduling books) related to the behavioral health services you provide. These records must be maintained in a manner consistent with the standards of the community and conform to all applicable laws and regulations including, state licensing, Centers for Medicare and Medicaid Services (CMS) and/or national certification board standards.

In order to perform required utilization management, practice management, payment and quality improvement activities, we may request access to claims records and treatment record documentation.

- You are permitted under HIPAA Treatment, Payment or Healthcare Operations to provide requested records as contractually required. In accordance with HIPAA and the definition of Treatment, Payment or Healthcare Operations, you must provide such records upon request.
- Federal, state and local government or accrediting agencies may also request such information as necessary to comply with accreditation standards, laws or regulations applicable to Optum and its payors, customers, clinicians and facilities.

Onsite Audits

We may review your records during a scheduled onsite audit or may ask you to submit copies of the records to Optum for review. An onsite audit or treatment record review may occur for a number of reasons, including, but not limited to:

- Reviews of facilities and agencies without national accreditation such as The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF) or other agencies approved by Optum
- Audits of services and programs including, but not limited to, Applied Behavioral Analysis (ABA), services delivered through telehealth platforms, and Peer Support Services
- Audits of high-volume providers
- Routine audits
- Audits related to claims coding or billing issues
- Audits concerning quality of care issues
- Audits concerning potential practice or billing patterns

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Audit Results
Routine, standard monitoring and quality of care audits may focus on the physical environment (including safety issues), policies and procedures, and/or thoroughness and quality of documentation within treatment records and/or accuracy of billing and coding.

- We have established a passing performance goal of 85% for both the treatment record review and onsite audit.
- Onsite audit or treatment record review scores under 85% will require a written Corrective Action Plan.
- Scores under 80% require submission of a written Corrective Action Plan and a re-audit within 6 months following implementation of the plan. However, in some cases, a requesting committee may require a Corrective Action Plan and/or re-audit regardless of the scores on the audit tools.

Treatment Record – Content Standards

When billing services for more than one family member, separate treatment records must be maintained.

Optum requires that all non-electronic treatment records are written legibly in blue or black ink. All treatment records must include the following:

- The member's name or identification number on each page of the record.
- The member's address; employer or school; home and work telephone numbers, including emergency contacts; marital or legal status; appropriate consent forms; and guardianship information.
- The date of service, either start and stop time or total time in session (for time-based services), the Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS)/Revenue (REV) code billed, notation of session attendees, the rendering clinician's name, professional degree, license and relevant identification number as applicable.
- Treatment record entries should be made on the date services are rendered and include the date of service. If an entry is made more than 24 hours after the service was rendered, the entry should include the date of service, date of the entry and a notation that it is a late entry.
- Clear and uniform modifications. Any error is to be lined through so that it can still be read, then dated and initialed by the person making the change.
- Clear documentation of medication allergies, adverse reactions and relevant medical conditions. If the member has no relevant medical history, this should be prominently noted.
- Clear and uniform medication tracking that provides a comprehensive summary of all medications taken by the member from the onset of care through discharge, including the following applicable for all prescribers:
  - Standing, as needed (PRN) and immediate (STAT) orders for all prescription and over-the-counter medications.
  - The date medications are prescribed along with the dosage and frequency.

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    - Informed member consent for medication, including the member's understanding of the potential benefits, risks, side effects and alternatives to the medications.
    - Changes or rationale for lack of changes in medication and/or dosage should be clearly documented along with the clinical rationale for the changes.
    - Discharge summaries should specify all medications/dosages at the time of discharge.

- A clear summary of presenting problems, the results of mental status exam(s), relevant psychological and social conditions affecting the member's medical and psychiatric status, and the source of such information.

- Prominent documentation (assessment and reassessment) of special status situations, when present, including, but not limited to, imminent risk of harm, suicidal or homicidal ideation, self-injurious behaviors, or elopement potential (for all overnight levels of care). It is also important to document the absence of such conditions.

- A medical and psychiatric history including previous treatment dates, clinician or facility identification, therapeutic interventions and responses, sources of clinical data and relevant family information.

- The behavioral health history includes an assessment of any history of abuse the member has experienced.

- For adolescents, the assessment documents a sexual behavior history.

- For children and adolescents, past medical and psychiatric history should include prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic).

- For members 12 years of age and older, documentation includes past and present use of nicotine or alcohol, as well as illicit drugs, prescribed or over-the-counter medications.

- Documentation of a DSM diagnosis consistent with the presenting problem(s), history, mental status examination and other assessment data.

- Medical conditions, psychosocial and environmental factors and functional impairment(s) that support understanding of mental health condition.

- Treatment plan documentation needs to include the following elements:
    - Specific symptoms and problems related to the identified diagnosis of the treatment episode
    - Critical problems that will be the focus of this episode of care are prioritized; any additional problems that are deferred should be noted as such
    - Relates the recommended level of care to the level of impairment
    - Member (and, when indicated, family) involvement in treatment planning
    - Treatment goals must be specific, behavioral, measurable and realistic
    - Treatment goals must include a time frame for goal attainment
    - Progress or lack of progress towards treatment goals
    - Rationale for the estimated length of the treatment episode
    - Updates to the treatment plan whenever goals are achieved or new problems are identified
    - If the member is not progressing towards specified goals, the treatment plan should be re-evaluated to address the lack of progress and modify goals and interventions as needed

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- Progress notes include:
  - Signature of the practitioner rendering services
  - The date of service
  - If provided through telehealth, documentation of the use of this technology
  - Member strengths and limitations in achieving treatment plan goals and objectives
  - Treatment interventions that are consistent with those goals and objectives noted in the treatment plan
  - Dates of follow up visits
  - Documentation of missed appointments, including efforts made to outreach the member
  - For time-based services only, either start and stop time or total time in session
- Documentation of on-going discharge planning (beginning at the initiation of treatment) includes the following elements:
  - Criteria for discharge
  - Identification of barriers to completion of treatment and interventions to address them
  - Identification of support systems or lack of support systems
- A discharge summary is completed at the end of the treatment episode that includes the following elements:
  - Reason for treatment episode
  - Summary of the treatment goals that were achieved or reasons the goals were not achieved
  - Specific follow up activities/aftercare plan
- Documentation of coordination of care activities between the treating clinician or facility and other behavioral health or medical clinicians, facilities or consultants. If the member refuses to allow coordination of care to occur, this refusal and the reason for the refusal must be documented. Coordination of care should occur:
  - At the time of intake
  - During treatment
  - At the time of discharge or termination of care
  - At the point of transition between levels of care, and
  - At any other point in treatment that may be appropriate
- Documentation of referrals to other clinicians, services, community resources, and/or wellness and prevention programs
- Telehealth Services: If the service is being provided virtually, this must be noted in the treatment record. Many states have specific documentation requirements for telehealth services. Please review the telehealth regulations in the states in which you are licensed to practice.
- Billing records should reflect all applicable fields as required for completion of the Form 1500 claim form or UB-04 claim form.
- The **Fraud, Waste, Abuse, Error and Payment Integrity** information page on the *Provider Express* website includes additional resources to support documentation requirements.

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