

Treatment Record Documentation

In accordance with your Participation Agreement, you are required to maintain high quality medical, financial and administrative records 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.

In order to perform required utilization management and quality improvement activities, CHIPA may request access to such records, including claims records. The federal, state and local government or accrediting agencies may also request such information necessary to comply with accreditation standards, laws or regulations applicable to CHIPA and its customers, Clinicians, and facilities. The HIPAA Privacy Rule permits the exchange between covered entities, such as your office and CHIPA, of protected health information (PHI) to be used for purposes that relate to treatment, payment or health care operations. The exchange of PHI for such purposes does not require the member's written permission

CHIPA may request copies of your records be submitted to CHIPA or may review them during a scheduled On-site Audit. An On-site Audit and/or Treatment Record Review can occur for a number of reasons, including:

- Pre-credentialing review of potential high-volume Clinicians
- Reviews of facilities without national accreditation
- Audits of high-volume Clinicians
- Routine random audits for quality of care or claims
- Audits concerning quality of care issues identified by CHIPA or brought to CHIPA's attention by members, family members or their representatives

The audits focus on the completeness and quality of documentation within treatment records. CHIPA has established a passing performance goal of 80% for both the Treatment Record Review and On-site Audit. On-site Audit or Treatment Record Review scores under 80% result in the requirement of submission of a written Corrective Action Plan, or a signed attestation statement. Scores under 70% require submission of a written Corrective Action Plan and a re-audit within six months of the initial audit.

Treatment Record — Content Standards

CHIPA expects that all treatment records are written legibly in blue or black ink, and at a minimum include:

- 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
- Treatment record entries that include the date of service and the responsible Clinician's name, professional degree, license, and relevant identification number
- Treatment records should be made contemporaneously with treatment description and dated with the date of entry; if records are not contemporaneously made with treatment, then the date of service should be noted along with date of 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 known allergies, history of adverse reactions or relevant medical conditions, this should be prominently noted

- Clear and uniform medication tracking that provides a clear picture of all medications taken by the patient from the onset of care through discharge, and includes standing, P.R.N. and STAT orders for all prescription and over-the-counter medications; each record should indicate the date medications are prescribed along with the dosage and informed member consent for medication, including the member's understanding of the potential benefits and risks of the medications; changes in medication and/or dosage should be clearly documented along with the clinical rationale for the changes; discharge notes should specify all medications and 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 of special status situations, when present, such as imminent risk of harm, suicidal ideation or elopement potential, including revisions as appropriate; it is also important to document the absence of such conditions
- A medical and psychiatric history including previous treatment dates, Clinician identification, therapeutic interventions and responses, sources of clinical data, and relevant family information; 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 cigarettes or alcohol, as well as illicit, prescribed or over-the-counter medications
- Documentation of a DSM-IV diagnosis, including all five axes, consistent with the presenting problem(s), history, mental status examination, and other assessment data
- Treatment plans that:
 - Specify symptoms and problems
 - Prioritize the critical problems that will be the focus of this episode of care
 - Relate the recommended level of care to the level of impairment
 - Include the member in treatment planning and document participation
 - Focus on the Axis I diagnosis of the treatment episode
 - Have specific, behavioral, and measurable treatment goals
 - Identify progress on previously established goals
 - Provide the rationale for the estimated length of the treatment episode
- Progress notes that describe member strengths and limitations in achieving treatment plan goals and objectives, and reflect treatment interventions that are consistent with those goals and objectives; documented dates for follow-up visits or complete termination summaries
- Documentation of continuity and coordination of care activities between the primary Clinician and group, consultants, other behavioral health or medical Clinicians, and health care institutions; this includes communications that are clinically appropriate which occur in the course of care, including timely communications at discharge to ensure proper member care and safety across the continuum; if the member refuses to allow you to communicate with other treating Clinicians and facilities, this must be documented; the member's reason for refusal should also be noted
- Documentation of referrals to other Clinicians, services, community resources, and/or wellness and prevention programs

- Separate treatment records for each identified and diagnosed member of a family when care involves more than one family member; billing records should reflect the primary plan participant who was treated and the modality of care

Guidelines for Storing Member Records

Below are additional guidelines for completing and maintaining treatment records for members.

- Practice sites must have an organized system of filing information in treatment records
- Treatment records must be stored in a secure area and the practice site must have an established procedure to maintain the confidentiality of treatment records in accordance with any applicable laws and regulations
- The practice site must have a process in place to ensure that records are available to qualified professionals if the treating Clinician is absent
- Treatment records are required to be maintained for seven years from the date of service, or in accordance with state or federal laws or regulations, whichever is longer; termination of the Participation Agreement has no bearing on this requirement
- Financial records concerning covered services rendered are required to be maintained from the date of service for 10 years, or the period required by applicable state or federal law, whichever is longer; termination of the Participation Agreement has no bearing on this requirement

Member Access to Medical/Mental Health Records

A member, upon written request and with proper identification, may access his/her records that are in the possession of CHIPA. Before a member is granted access to his/her records, the record will first be reviewed to ensure that it contains only information about the member. Confidential information about other family members that is in the record will be excised.