COMMUNITY FIRST HEALTH PLANS

BEHAVIORAL HEALTH MEDICAL RECORD DOCUMENTATION GUIDELINES

Community First has established guidelines for medical record documentation. Individual medical records for each family member are to be maintained. The medical records must be handled and maintained in a confidential manner and must be organized in such a manner that all progress notes, diagnostic tests, reports, letters, discharge summaries, and other pertinent medical information are readily accessible. In addition, each office should have a written policy in place to ensure that medical records are safeguarded against loss, destruction, or unauthorized use.

CRITERIA	REQUIREMENTS
A. DOCUMENTATION	
1. Patient identification	**Each page** of the medical record must include a unique identifier, which mayinclude patient ID number, medical record number, first and last name.
2. Personal data	Personal/biographical data including the age, sex, address, employer, home andwork telephone numbers, marital status of the patient, and emergency contacts must be included in the medical record.
3. Problem list	For patients seen three (3) or more times, a separate list of all the patient's chronic/significant problems must be **maintained**. A chronic problem is defined asone that is of long duration, shows little change or is of slow progression.
4. Medication list (P)	For patients seen three (3) or more times, maintenance/ongoing medications should be listed on a medication sheet and **updated as necessary** with dosage changes and the date the change was made. A separate medication sheet is recommended, but if a physician chooses to write out all current medications at each visit, this is acceptable. The medication list should include information/instruction to the Member.
5. Chart legible	Medical records must be legible to someone other than the author. A record that is deemed illegible by the reviewer should be evaluated by a second person.
6. Author signature	All entries in the medical record must be signed by the author/performing Provider.
7. Dated entries	Each and every entry must be accompanied by a date (month, day, & year).

CRITERIA	REQUIREMENTS
8. Start & stop time for counseling session	The start and stop time for every counseling sessions will be documented.
B. CONTINUITY OF CARE	
1. Past psychiatric history	During the initial visit, the past psychiatric history must be easily identified and include serious psychiatric incidents (to include hospitalizations, etc). For children and adolescents (18 years and younger), past psychiatric history may include special education.
2 Tobacco, alcohol, & other substance use	For patients **12 years and older**, assessment of tobacco, alcohol, and other substance use should be documented in the medical record.
3. Significant medical/physical history	During the initial visit, a history of significant medical history/information must be documented. For patients seen three (3) or more times, past medical history should be easily identified including serious accidents, operations, and illnesses. For children, past medical history relates to prenatal care and birth.
4. Significant developmental history	For all patients at the initial visit, a history of the developmental history must be documented.
5. Significant family psychiatric history	The psychiatric history of family members should be documented as it may relate to the patient's presenting problems to include both appropriate subjective and objective information.
6. Support systems	Admission and initial assessments must include current support system or lack thereof.
7. Risk factors	Factors that may put the patient at risk must be documented; examples include current abuse, current living situation, no family support, history of mental illness, danger to self or others, perceptual disorders, etc.
8. Evaluation for abuse/neglect or other socio-environmental factors	The medical record should reflect evidence that the Provider evaluates for signs / symptoms or behaviors associated with abuse / neglect or other significant socioenvironmental factors.

CRITERIA	REQUIREMENTS
9. Mental status	At each visit, the patient's current mental status is documented.
10. Presenting problems	Problems/symptoms identified by the patient and/or others that are presently occurring must be documented. This should be completed for each visit.
11. Diagnosis	The diagnosis identified during each visit should be documented and should be consistent with findings. ICD-9 code(s) may be used but must include the written description of the diagnosis.
12. Treatment plan/goals	Based on the chief complaint, exam findings and diagnosis, the treatment plan is clearly documented.
13. Teaching regarding BH issues	The Member is provided basic teaching/instructions regarding behavioral health conditions.
14. Depression screening	
15. Appropriate studies ordered	The laboratory and other studies ordered should be consistent with the treatment plan as related to the working diagnosis and should be documented at the time of the visit. Abnormal findings must have an explicit notation of follow-up plans.
16. Review of labs/studies	There must be evidence that the physician has reviewed the results of diagnostic studies. Methods can vary, but often the physician will initial the lab report or mention it in the progress notes.
17. Hospital/ER records (appropriate to behavioral health)	Pertinent inpatient records must be maintained in the office medical record.
18. 7-day follow up	LPC visit within 7 days after ER visit or Behavioral Health inpatient stay

CRITERIA	REQUIREMENTS
19. Change in behaviors/symptoms	At each subsequent visit, changes in the patient's behavioral health symptoms/behaviors are documented.
20. Coordination with BH/PCP	Evidence (at least quarterly, or more often if clinically indicated) that the patient's PCP is notified that his/her patient is receiving behavioral health services. This can be demonstrated through use of the Community First Health Plans form or a summary report of the patient's status/progress from the Behavior Health Provider to the PCP. A copy of the report should be maintained in the record.
21. Involvement of family (if patient is a minor)	If the patient is a minor, involvement of his/her parent/guardian is documented. If the minor is receiving services that allow for no involvement of the parent/guardian, this is also documented.
22. Follow-up if missed appointment	If the patient misses a scheduled appointment, documentation will reflect that follow-up contact was made. This can be done by letter or phone. If there is no response, this also should be documented.
23. Date of next visit	Encounter forms or notes should have a notation, when indicated, regarding follow-up care, calls, or visits. Specific time of return should be noted in weeks, months, or as needed.
24. Release of information	A signed release of information is obtained as indicated, which will permit specific information sharing between Providers.
25. Care coordination for Members with disabilities or Chronic/Complex Special Health Care Needs (CCSHCN)	The medical record should reflect evidence that all professionals are included in primary and specialty care service team for CCSHCN Members who may have co-occurring Behavioral Health disorders.
C. VALIDATION – FOR NON-COMPLIANCE	
1. Diagnosis validation	The record should reflect that the billing diagnosis is consistent with that of the chief complaint.

CRITERIA	REQUIREMENTS
2. Claims validation	The record should reflect the documented encounter is appropriate for the level of E/M services billed.

(P) Required by Psychiatrists ONLY. (Not within scope of practice for other types of Behavioral Health Providers)
Requirements obtained from NCQA, STAR contract, and Community First Health Plans Standards as appropriate.