Medical records and documentation provider training

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Medical records and documentation

For practitioners, helping patients is the top priority. Documenting each patient encounter accurately and efficiently is critical for practitioners to meet their patients' ongoing needs. Improperly documented records that are missing relevant information can yield insufficient services and unintended complications.

Federal laws, state laws and policies set forth by Amerigroup all mandate the proper documentation of medical services. These laws require practitioners to maintain the records necessary to fully disclose the extent of the services, care and supplies furnished to beneficiaries, as well as to support claims billed. Proper documentation helps to protect practitioners from challenges to furnished treatment and to avoid civil, criminal and administrative penalties and litigation.

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Medical record standards

- **Date and corroboration:** All entries must be dated and author-identified.
- **Patient identification information:** Each page or electronic file in the record must contain the patient's name or patient ID number.
- **Personal/biographical data:** The record must include the patient's age, sex, current address, employer, current home/cell telephone number, work telephone number and marital status.
- **Allergies**: Medication allergies and adverse reactions must be prominently noted on the record. Absence of allergies (no known allergies [NKA]) must be noted in an easily recognizable location.
- **Immunizations:** For pediatric records of members age 13 and younger, a completed immunization record or a notation of prior immunization must be recorded. This should include vaccines and their dates of administration when possible.

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Medical record standards (cont.)

- **Physical examination:** A record of physical examination(s) appropriate to the observation and treatment of presenting complaint or condition must be noted.
- **Smoking/alcohol/substance use**: A notation concerning cigarettes and alcohol use and substance use must be stated if present for patients age 12 and older – abbreviations and symbols may be appropriate.
- **Identification of current problems:** Significant illnesses, medical and behavioral health conditions, and health maintenance concerns must be identified in the medical record. A current problem list must be included in each patient record.
- **Diagnostic information:** Documentation of clinical findings and evaluation for each visit should be noted.
- **Medication information**: This notation includes medical information and instructions to the patient.

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Medical record standards (cont.)

- **Consultations, referrals and specialist reports:** Notes from any referrals and consultations must be in the patient's record. Consultation, lab and X-ray reports filed in the chart must have the ordering physician's initials or other documentation signifying review. Consultation and any abnormal lab and imaging study results must have an explicit notation in the record of follow-up plans.
- **Past medical history for patients seen three or more times:** Past medical history must be easily identified, including serious accidents, operations and illnesses. For children, the history must include prenatal care of the mother and birth.
- **Preventive services/risk screening**: The record must include consultation and provision of appropriate preventive health services and appropriate risk screening activities.
- **Instructions:** The record must include evidence that the patient was provided with basic teaching/instructions regarding physical/behavioral health condition.

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Medical record standards (cont.)

- **Documentation:** Documentation is required setting forth the results of medical, preventive and behavioral health screening and of all treatment provided and results of such treatment.
- **Emergencies:** All emergency care provided directly by the contracted provider or through an emergency room and the hospital discharge summaries for all hospital admissions while the patient is part of the PCP's panel must be noted.
- **Hospital discharge summaries:** Discharge summaries must be included as part of the medical record for all hospital admissions that occur while the patient is enrolled and for prior admissions as appropriate. Prior admissions pertaining to admissions that may have occurred prior to the patient being enrolled may be pertinent to the patient's current medical condition.
- **Advance directive:** Medical records of adult patients must document whether the individual has executed an advance directive. An advance directive is a written instruction, such as a living will or durable power of attorney, which directs healthcare decision-making for individuals who are incapacitated.

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Medical record standards (cont.)

- **Release of information**: Written procedures are required for the release of information and obtaining consent for treatment.
- **Security:** Providers must maintain a written policy to ensure that medical records are safeguarded against loss, destruction or unauthorized use. Physical safeguards require records to be stored in a secure manner that allows access for easy retrieval by authorized personnel only. Staff receives periodic training in member information confidentiality.
- **Multidisciplinary teams:** Documentation of the team members involved in the multidisciplinary team of a patient needing specialty care is required.
- **Legibility**: Each record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.

Medical record standards (cont.)

Integration of clinical care: Documentation of the integration of clinical care in both the physical and behavioral health records is required. Such documentation must include the following:

- Notation of screening for behavioral health conditions (including those that may be affecting physical healthcare and vice versa) and referral to behavioral health providers when problems are indicated
- Notation of screening and referral by behavioral health providers to PCPs when appropriate
- Notation of receipt of behavioral health referrals from physical medicine providers and the disposition and outcome of those referrals
- A summary (at least quarterly or more often if clinically indicated) of the status/progress from the behavioral health provider to the PCP

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Medical record standards (cont.)

Integration of clinical care: Documentation of the integration of clinical care in both the physical and behavioral health records is required. Such documentation must include the following:

- A written release of information that will permit specific information sharing between providers
- Documentation that behavioral health professionals are included in primary and specialty care service teams when a patient with disabilities, or chronic or complex physical or developmental conditions, has a co-occurring behavioral disorder

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Mental health targeted case management and rehabilitation documentation requirements

There are specific documentation requirements for some behavioral health services. According to Texas Medicaid, target case management has the following documentation requirements:

- A comprehensive diagnosis must be included in the person's medical record, including documentation of applicable diagnostic criteria according to the latest edition of the DSM, as well as the specific justification of need for services.
- Mental health targeted case management (MHTCM) services, including attempts to provide MHTCM services, must be documented in the person's medical record. For routine case management, the case manager must document the person's strengths, service needs, and assistance required to address the service needs as well as the steps that are necessary to accomplish the goals required to meet the person's service needs.

Mental health targeted case management and rehabilitation documentation requirements (cont.)

There are specific documentation requirements for some behavioral health services. According to Texas Medicaid, target case management has the following documentation requirements:

- For intensive case management, the assigned case manager must include the intensive case management treatment plan in the child's or youth's medical record and document steps taken to meet the child's or youth's goals and needs in the child's or youth's progress notes.
- As a result of the face-to-face meetings, assessments, and reassessments conducted, the case manager must document the person's identified strengths, service needs, and assistance given to address the identified need, and specific goals and actions to be accomplished.

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Mental health targeted case management and rehabilitation documentation requirements (cont.)

The case manager must document the following for all services provided:

- Event or behavior that occurs while providing the MHTCM service or the reason for the specific case management encounter
- Person, persons, or entity, including other case managers, with whom the encounter or contact occurred
- Recovery plan goal(s) that was the focus of the service, including the progress or lack of progress in achieving recovery plan goal(s)
- Timeline for obtaining the needed services
- Specific intervention that is being provided
- Date the MHTCM service was provided
- Collateral contacts, such as:
    - Contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the person access services and managing the person's care, including coordination with other case managers

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Mental health targeted case management and rehabilitation documentation requirements (cont.)

- The case manager must document the following for all services provided:
  - Start and end time of the MHTCM service
  - Location where the MHTCM service was provided and whether it was a face-to-face or telephone contact
  - Name of the provider agency and the signature of the employee providing the MHTCM service, including their credentials
  - Timeline for reevaluating the needed service
  - Provider must retain documentation in compliance with applicable records retention requirements in federal and state laws, rules and regulations.
  - If the person refuses MHTCM services:
    - The case manager must document the reason for the refusal in the most appropriate area of the person's medical record and request that the person sign a waiver of MHTCM services that is filed in the person's medical record.

Mental health targeted case management and rehabilitation documentation requirements (cont.)

According to Texas Medicaid, these are the documentation requirements for mental health rehabilitation services:

- All services require documentation to support the medical necessity of the service rendered. A licensed practitioner of healing arts (LPHA) must document in the person's medical record that mental health rehabilitative services are medically necessary when the services are authorized and reauthorized.
- Persons determined to need mental health rehabilitative services must have a treatment plan developed by the Medicaid enrolled provider of mental health rehabilitative services, that describes in writing the type, amount, and duration of mental health rehabilitative services determined to be medically necessary to meet the needs of the person.

Mental health targeted case management and rehabilitation documentation requirements (cont.)

A rehabilitative services provider must document the following for all mental health rehabilitative services:

- Name of the person to what the service was provided
- Type of service provided
- Specific goal or objective addressed, and the modality and method used to provide the service
- Date the service was provided
- Start and end time of the service
- Location where the service was provided
- Signature of the staff member providing the service and a notation of their credentials
- Any pertinent event or behavior relating to the person's treatment which occurs during the provision of the service
- Outcome or progress in achieving treatment plan goals

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Mental health targeted case management and rehabilitation documentation requirements (cont.)

In addition to the general requirements described previously, when providing crisis services, a provider must document the following information:

- Risk of suicide or homicide
- Substance use
- Trauma, abuse, or neglect
- Outcome of the crisis (for example: person in hospital, person with friend and scheduled to see doctor at 9 a.m. the following day)
- Actions (including rehabilitative interventions and referrals to other agencies) used by the provider to address the problems presented.
- Response of the person, and if appropriate, the response of the LAR and family members.
- Any pertinent event or behavior relating to the person's treatment that occurs during the provision of the service

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Mental health targeted case management and rehabilitation documentation requirements (cont.)

In addition to the general requirements described above, when providing crisis services, a provider must document the following information:

- Follow-up activities that may include referral to another provider.
- Documentation for day programs for acute needs must be made daily. Documentation must be made after each face-to-face contact occurs to provide the mental health rehabilitative service for all other services.
- LPHA must, within two business days after crisis intervention services are provided, determine whether the crisis intervention services met the definition of medical necessity.
- If medical necessity is met, then the LPHA must document the medical necessity. Services are subject to retrospective review and recoupment if documentation does not support the service billed.
- Provider must retain documentation in compliance with applicable federal and state laws, rules, and regulations.

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Medical documentation signature best practices

- **Orders** are your authorizations for tests, plans of care, and procedures, and are considered part of the overall medical record. You must validate orders with a timely signature.
- For certain unsigned test orders, submit progress notes showing intent to order the tests. The progress notes must be authenticated by your valid signature. If the orders and the progress notes are unsigned, a claims reviewer will disregard the order, and your facility or practice will be assessed an error, which may involve recouping an overpayment.
- You may not add late signatures to orders or medical records (beyond the short delay that occurs during the transcription process). Medicare does not accept retroactive orders.
- If your signature is missing from the medical record (other than an order), you may submit an attestation statement. Your contractor may offer specific guidance regarding signature attestation statements, including whether current laws or regulations allow attestation for missing signatures in certain situations.

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Medical documentation signature best practices (cont.)

- You or your organization may submit a signature log or attestation statement to support the identity of any illegible signatures. A printed signature below the illegible signature in the original record may be accepted.
- Please refer to CMS requirements for additional information: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/signature_requirements_fact_sheet_icn905364.pdf.

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Documentation opportunities for improvement

- Notes should not be duplicated across members and/or across service dates.
- Remember to note start and stop times.
- Remember to bill the correct number of units or the correct procedure code based on the start and stop time of the service.
- Remember the provider signature is required on all therapy notes.
- Physician orders should always be included in the medical record.
- Remember that all assessments and treatment plans must be in the medical record
- Document the place of service.
- Document the method of delivery for the service:
  - For example, you should note if the service is provided virtually by a telemedicine or a telehealth platform.

Documentation opportunities for improvement (cont.)

- Document the responses to treatment and progress or lack of progress in achieving treatment plan goals.
- Treatment plans must be individualized and specific for each member.
- Document and implement safety plans when the member's safety is at risk or the member reports a mental health or physical health crisis.
- Bill modifiers appropriately.
- Treatment plans must be signed and acknowledged by the patient or guardian if the patient is a minor.
- Always use appropriate procedure codes for the level of the provider.
- Remember to always document care coordination with the member's other service providers.

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Medical Records Additional Resources

- Access the provider manual: https://providers.amerigroup.com/TX
- *Texas Provider Procedures Manual Volume 2 Behavioral Health and Case Management*: https://www.tmhp.com/resources/provider-manuals/tmppm

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https://providers.amerigroup.com/TX