Behavioral Health Medical Record Documentation Standards and Requirements:

Outpatient Level of Care

Standard	Explanation of Documentation
1. General information	• Member's full name (both legal name and preferred name) on all pages or ID number • Member's demographic information (address or lack thereof, contact number, date of birth, gender identity, sexual orientation, race, ethnicity, primary language) • Name, relationship, address, and contact number of next of kin or other responsible person • All medical record entries must be dated and in sequential order • All records must be legible • All documentation must follow Center for Medicare & Medicaid Services (CMS) documentation guidelines, which can be found in CMS National Criteria Determination (NCD) and Local Coverage Determinations (LCD) and state Medicaid entities • All documentation in medical record contain the provider's handwritten signature, unique electronic signature • If required, legible print name of supervisor • All billable encounters/sessions must have date of service, duration or start and stop times, based on applicable law, total unit(s), appropriate CPT/HCPCS or Revenue code, and place of service (POS)
2. Intake	• Date of initial contact • Date of intake • Documentation that Member received a copy of their rights, signed and dated BY CCA Member • Documentation of Member's consent to treatment is signed and dated • Signed Releases of Information for collaterals (PCP, prescriber (if different than PCP) Outpatient Mental Health or Substance Use provider, Recovery Coach, DMH OR DDS, other Community Support Provider, etc.)

3. Behavioral Health Clinical Assessment	• The Provider completes an initial, comprehensive, biopsychosocial assessment for all Members entering any level of care, which is documented in the Member’s medical record.
	• The assessment includes but is not limited to:
	  ○ Member’s description of the problem, and any additional information from other sources, including the referral source (if applicable)
	  ○ Member’s report of what brought them to seeking behavioral health treatment (i.e., chief complaints and symptoms
	  ○ History of behavioral health, substance use, medical, family, and social history, linguistic and cultural background
	  ○ Mental status examination
	  ○ Risk assessment of suicide, violence risk, and substance use
	  ○ Previous and current medications, and any allergies or adverse reactions to medications
	  ○ Member’s strengths and or barriers to treatment
	  ○ DSM-5 diagnosis and clinical formulation that are supported by the clinical data gathered, rationale for treatment, and treatment recommendations; name of CCA Care Partner and other key providers, Outcome tool administered and integrated into clinical formulation, as applicable, documentation, clinician’s signature, credentials, and date
	• When requested and/or as indicated by the Member’s clinical presentation, the provider conducts and documents in the Member’s health record a substance use assessment either directly or by linkage with a provider trained in substance use disorders
	• Provider creates initial treatment goals with Member that are documented in the assessment
	• Provider documents recommended treatment frequency that matches the behavioral health functioning and supports medical necessity for treatment

4: Treatment Plan(s) aka Individualized Action Plan (IAP)	• For Members, the initial outcome measurement is administered prior to or on the date of the comprehensive assessment completion to document that the clinical data was integrated into the initial assessment process • The provider completes individualized initial treatment plan based on the assessment and developed with the Member and/or guardian/caregiver, and, with consent of Member, the CCA Interdisciplinary Care Team (ICT), PCP,

	state agencies, recovery and peer support specialist or other involved providers and supports identified by the Member
	• The treatment plan is signed, dated, and documented in the Member's health record and includes but is not limited to:
	  ○ Realistic long-range goals, and a time frame for their achievement
	  ○ Short-term objectives that are attainable and problem resolution focused, and are linked to supporting Member accomplish long-range goals
	  ○ Objectives have realistic time frames that are short term and attainable for the Member (i.e., 3-6 months)
	  ○ The Member's strengths to support progress in treatment
	  ○ Links to primary care especially for Members with active co-occurring medical conditions
	  ○ If applicable, a plan to involve a state agency case manager when appropriate
	  ○ Treatment recommendations are consistent with the service plan of the relevant state agency if involved
	  ○ CCA believes quality treatment plan includes the reviewing the plan with the Member and requesting their signature on it, if the Member refuses to sign provider should document the Member's declination/refusal or document that the Member is not psychologically sound to sign the treatment plan
	• The time frames for the completion of the initial treatment plan are delineated in each of the service-specific performance specifications
	• The provider assigns a multi-disciplinary treatment team to each Member within the time frames delineated in each of the service- specific performance specifications. A multi-disciplinary treatment team meets to review the assessment and initial treatment plan and discharge plan within time frames delineated in each of the service-specific performance specifications
	• The treatment plan is implemented, reviewed, and revised throughout the course of treatment, based on the provider's continual reassessment of the Member and with the Member's participation (*minimum update requirement is annual, CCA's best clinical practice is every 6 months)
	• The medical record shows documentation of appropriate adjunctive treatment referrals and use of available community resources, including: • Information given to patient regarding specific referral to support groups (e.g., NAMI, AA, Al-Anon) • Discussion with the Member regarding benefits of various groups, reason for referral, as related to diagnosis/problem list
	• The provider ensures adequate follow-up when the Member misses appointments or drops out of treatment

	• The Member's progress in achieving the treatment goals is documented in progress notes and treatment plan updates in the Member's health record
5. Progress Notes	Progress notes are sequential narratives that describe the progress of the Member by direct reference to the treatment plan/individualized action plan. When a new issue are identified in progress notes (not linked to the treatment plan) a revision of the treatment plan should be made if the new issue will become a focus of treatment (i.e., diagnosis change, loss of loved one, etc.) Progress notes include, at minimum, the following documentation: • The presenting problem • Assessment of current symptoms and behaviors that are impacting the Member's functioning • List any prescribed medications, if applicable • Mental status exam • Assessment of risk, if applicable (i.e., SI, HI, substance use) • Interventions delivered by clinician in session and Member's response to them related to treatment plan • Member's progress in treatment plan goals • Next steps/plan between sessions (documentation of referrals to other providers or services to address gaps in care) • Clinician's signature, credentials, date
6: Care Coordination	The provider seeks informed consent from the Member in order to coordinate admissions, assessment, treatment/care planning, and discharge planning with the following collaterals, as appropriate to the level of care. The type and amount of information shared is appropriate to the purpose and the role of those to/from whom the information is being communicated/requested, including the following: • Caregivers/family/significant others/natural supports • CCA's Interdisciplinary Care Team (ICT) • Primary Care Physician (PCP) • Adult Community-Based Mobile Crisis Intervention (AMCI) aka Emergency Services Program (ESP) and Community Crisis Stabilization (CCS)

	• 24-hour levels of care, including psychiatric hospitals and or ASAM continuum of care (i.e., medical managed intensive inpatient services aka hospital-based detox, medically monitored intensive inpatient services aka Acute Treatment Services, and/or clinically managed high-intensity residential services aka Clinical Stabilization Services) • State agency involved teams, including DMH, DPH, DDS, MCB, MCDHH, EOEA and/or DTA • Police departments and local court systems if necessary and appropriate • Outpatient therapists, medication prescribers, and all other community supports including Community Support Programs (CSPs), and substance use programs

7. Discharge and/or transition planning	When a Member is discharged, the provider makes best attempt at ensuring the Member has a strong and appropriate plan for next steps in treatment.
	
	• Documentation of discharge summary should include:
	    ○ Summarize Member's treatment
	    ○ Recommendations for appropriate services following-up
	    ○ Brief summary of Member's condition and behavioral functioning upon discharge
	    ○ Dates of any scheduled appointments
	        ▪ For 24 hour/inpatient level of care providers this would include date and time of 7 & 30 day follow up after hospitalization for mental illness and 14-day medication appointment with prescriber; scheduled intake for Partial Hospitalization Program
	        ▪ For substance use facilities: scheduled intake appointment with MAT providers, intakes for Structured Outpatient Addiction Program (SOAP), Partial Hospitalization Program (PHP), or Intensive Outpatient Program (IOP)
	• Outpatient providers are expected to contact the CCA Care Team by calling CCA' s Provider Services at (866) 420-9332 (option #4) for all discharge and aftercare planning, transportation support and other service needs.
	• Inpatient and diversionary providers are expected to contact and collaborate with CCA Behavioral Health (BH) Transitions of Care (TOC) specialist at 866-610-2273. In addition, provide CCA with the finalized discharge plan within one business day of a Member's discharge. Providers can do this by either calling BH TOC or by faxing the discharge summary to 855-341-0720 within one business day of the Member's discharge. Timely receipt of this information is critical to CCA's ability to support the Member following through with their discharge plan.