BAY ARENAC BEHAVIORAL HEALTH

Documentation Requirements for Direct Service Professionals & Behavior Technicians

(Version 6; 05/20/21)[1]

- The Medicaid Provider Manual requires that documentation must be legible. Write or print clearly. Use of black ink is recommended by BABHA as some other ink colors do not scan as legibly as black ink.
- Use only an approved abbreviation or write out the word.
- When multiple staff document on one note, documentation must be completed in the order services occurred (i.e., notes for a service provided at 3:00 pm should not be recorded before a note for a service provided at 8:00 am)
- All documentation should be completed and signed by staff before they leave work for the day, unless otherwise directed by the BABH compliance office or provider managers/directors.

	Do's	Don'ts
Name of the person served	▪ BABH strongly recommends inclusion of the full first and last name ▪ For some services providers may also be asked to include the person's Medicaid ID #, birthdate or other secondary identifier	▪ BABH does not endorse the use of partial names, nicknames and initials as they may not be accepted by state Medicaid officials in an audit
Date of service	▪ Include the month, date and year ▪ If a service takes more than one day, use the date the service was started as the date of service, unless otherwise directed	▪ BABH does not endorse the use of partial dates as they may not be accepted by state Medicaid officials in an audit
Start and stop time	▪ The start and stop time of the service should include am/pm	
Contact type, attendance and location of service	▪ For licensed professionals this info is usually included in the service documentation ▪ For technician/aide services, this info is usually added by office/finance staff when the service is billed.	

Description of the service provided	▪ The description should match the services in the plan. For example:
	  ▪ If personal care service is in the plan, personal care must be the service provided, and service documentation should describe assistance with bathing, eating, etc.
	  ▪ If behavioral technician services 3-4 times a week are authorized in the plan, there should be documentation 3-4 times per week for tech services.
	▪ **See additional information below for special considerations for technician/ aide services provided for people at end-of-life or with significant physical limitations.**
		▪ Do not leave narrative sections completely blank or fail to mark required checkboxes
		▪ The description should prove that a service was provided.
		  ▪ BABH does not endorse the use of blanket statements with no additional description of the service, such as 'enjoyed meal', 'IPOS followed' or 'watched TV'.
		  ▪ Such statements may or may not be accepted by state Medicaid officials in an audit

[1] Only revision was the name of the document; revised to support creation of a separate version for clinicians.

	Do's	Don'ts
Signature	▪ BABH strongly recommends inclusion of the full first and last name of the person who provided the service ▪ For some services providers may also be required to include the person's Medicaid ID #, birthdate or other secondary identifier	▪ BABH does not endorse the use of partial names, nicknames and initials as they may or may not be accepted by state Medicaid officials
Date of Signature	▪ Include the month, date and year ▪ If a service takes more than one day, use the date the service documentation was signed	▪ BABH does not endorse the use of partial dates as they may not be accepted by state Medicaid officials in an audit

Narrative Examples Using CLS	"Do's"	"Don'ts"
Objective: Increase independence in laundry and housekeeping so he can live in an apartment Authorization: CLS	• "Joe washed his laundry but needed more help than usual; seemed tired" OR • Joe chose not to clean his room; prompted per plan; got upset"	• No mention of any type of activity OR • Only mention an unrelated service like personal care OR • "Had a bad day"
Objective: Participate in community activities to develop a network of natural supports Authorization: CLS	• "Staff took Joe to play baseball; Joe got frustrated; prompted per plan" OR • "Joe chose not to go out; played catch at home with instead"	• "Watched TV" OR • "Sat in chair"
Objective: Strengthen arms to improve ability to transfer from bed to wheelchair Authorization: CLS	• "Joe completed his arm exercises then went to bed; did better today."	• "Good day" • "Did plan; In bed"

Special Considerations for Documentation of Technician/Aide Services for Individuals Who Are at End-Of-Life or Have Significant Physical Limitations

- Since the level of activity of people who are on hospice or who are significantly physically challenged may be limited, it can be more difficult to document CLS services.
- **IMPORTANT:** Service documentation must show active CLS services to justify billing and avoid problems during an audit.
- The following are CLS services that are often provided to such individuals to support their continued community living:
  - Preserving health and safety, in the form of checking in with the person to ensure they are safe, see if they require the attention of their nurse or doctor, and if they are as physically comfortable as possible.
  - Personal care skills training, in the form of encouraging participation in personal care and other self-care as tolerated
  - Relationship building, in the form of social interaction with staff, family and friends for purposes of emotional support and perhaps bereavement
  - Other care (non-medical), such as spiritual support, encouraging engagement with the environment by making small choices, and ensuring they have the comforts of home such as a favorite blanket or possession.

Protocol for Correcting Errors in Documentation in a Compliant Manner

Do's

- Supervisory personnel should check documentation regularly so errors can be corrected right away.
- The original document containing an error should be retained in the record.
- To correct a wrong entry in the original document (if you have been given the authority to do so, and if you were present at the time the service was provided and/or have evidence of what occurred):
  - Draw a line through the error (making sure the original text is still visible)
  - Write 'error' or the corrected information above the line drawn
  - The person who made the correction signs the change with their full name and date of signature.

- To fill a gap in the information on the original documentation (if you have been given the authority to do so, and if you were present at the time the service was provided and/or have evidence of what occurred):
  - Write in the correct information in the blank space that was left incomplete
  - The person who made the correction signs the change with their full name and date of signature.

Don'ts

- Do not use white-out or erasers.
- Do not remove or destroy documentation with an error from the record.
- Don't create documentation today for a previous service date and backdate the date of the service or the signature
- Don't copy old documentation and change the date, time or other information for today or another service date

Don't fix an error in completed documentation if you have not been granted the authority to so, if you were not present at the time the note was completed and/or do not have evidence of what occurred.