BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
POLICIES AND PROCEDURES MANUAL

Chapter: 4	**Care and Treatment Services**		
Section: 10	**Clinical Record**		
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Policy

It is the policy of Bay-Arenac Behavioral Health Authority (BABHA) to be fully committed to carrying out its services in a manner consistent with its Mission, Vision, Values and Strategic Plan, and to include standards of care and regulations regarding clinical documentation in a medical record.

Purpose

This policy and procedure was established to ensure that appropriate and legible clinical information is maintained in the medical record.

Education Applies to

☐ All BABHA Staff
☒ Selected BABHA Staff, as follows: All Clinical, Clinical Support, Clinical Provider Supervisors, Agency Nurses-Clinical and Agency Nurses-Residential
☐ All Contracted Providers: ☐ Policy Only ☐ Policy and Procedure
☒ Selected Contracted Providers, as follows: Primary Care Providers
☐ Policy Only ☒ Policy and Procedure
☐ Other:

Definitions

Contracted Primary Behavioral Health Provider: A contracted primary behavioral health care provider is a behavioral health treatment provider contracted by BABHA to provide the full cycle of care (service intake, treatment planning, service delivery and discharge planning), including any coordination of care. Such providers assume responsibility for complying with State and Federal requirements for education, notification of due process rights and Person-Centered Planning with the person served.

Procedure

A. General Documentation Requirements

1. As part of its compliance efforts, BABHA staff and contracted primary behavioral health care providers are responsible for using reasonable "good faith" efforts to comply with this policy on clinical documentation and legibility.
2. BABHA will work in coordination with its contracted primary behavioral health care providers to effectuate this policy.

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3. Clinical records will contain the following information, as applicable (See C13-S01-T20 Designated Record Set for more information about what documents officially comprise BABHA's medical/clinical record):
    a. Name, address, and birth date,
    b. Date of each visit,
    c. Begin time and end time if service is time specific according to procedure code provided,
    d. Presenting symptoms, condition, and diagnosis,
    e. Individual history, progress notes, and consultation reports,
    f. Results of examination(s),
    g. Records of medications, drugs, assistive devices or appliances, therapies, tests and treatments which are prescribed, ordered or rendered,
    h. A description of observations made by the clinical provider,
    i. Orders for tests,
    j. Written interpretations of tests,
    k. Test methodology,
    l. Strength, dosage, and quantity of drug,
    m. Level and type of service,
    n. Name and signature of prescribing and/or referring physician
    o. Individual/Family Plan of Service (POS), including the individual's dreams, desires and/or goals and their strengths, needs and abilities,
    p. Responses to, or outcomes from, medications or the POS.
4. The following information will be readily available in the person's medical record for the appropriate health care professionals who are involved with the medication management system. The person's:
    a. Gender identification,
    b. Past medication use,

c. Drug and alcohol use and abuse,

d. Allergies and past sensitivities,

e. Height and weight, and

f. Pregnancy and lactation status, if appropriate.

5. BABHA staff and contracted primary behavioral health care providers shall only document information in the clinical record that is truthful, valid, legible, and accurate.
   a. When use of ink is required on a document for the clinical record, black ink is recommended as other colors are not as legible when scanned.
6. All entries in the clinical record shall be signed and dated by the author, in writing, unless otherwise directed; and in addition, for BABHA direct operated programs:
   a. The assigned supervisor will co-sign each person's IPOS, Clinical Assessments, Periodic Reviews and Discharge Summaries.
   b. The assigned supervisor will also co-sign clinical documentation completed by BABHA employees with limited licensure who are receiving the required hours of supervisor to achieve full licensure and BABHA student interns.
   c. Nurse Medication Reviews conducted in clinic setting require physician co-signature.
7. See C04-S10-02 Signatures for information about acceptable means of obtaining signatures.
8. Service documentation must include the following information about the service rendered:
   a. First and last name of the person served. Partial names, nicknames and initials should not be used.
   b. Month, date and year that the service was provided. If a service takes more than one day, use the date the service was started as the date of service, unless otherwise directed. Partial dates should not be used.
   c. Start and stop time of the service (including am and pm), unless otherwise directed.
   d. The type of contact, who attended and the location in which the service was provided.

e. Description of the service provided and the person's response to the service.

i. Services delivered must be consistent with the person's plan of service and authorized through the BABHA EHR.

ii. The service description must be within the constraints outlined by Medicaid, Medicare or other payers for the service to be delivered.

iii. Each service which will be billed to a payer based on the documentation must be individually identifiable in the service description.

9. BABHA employees and contracted primary behavioral health care providers are responsible for organizing the records in a uniform manner so that similar information will be found in the same place from case record to case record.

B. Timeliness of Completion of Records

1. All records received that require scanning into the electronic health record will be scanned within (2) business days of receipt.

2. Clinical documentation should generally be completed and signed within (1) business day, unless otherwise directed by supervisory staff. It is understood plans of service and clinical assessments may require more than one business day to complete. Crisis Contacts, pre-admission screens, and access screens need to be done in 24 hours with the exception of pre-admission screens that have to wait to be signed due to waiting for acceptance at a hospital.

3. Transcribed records should be entered into the EHR within 7 days.

4. Upon termination of services, the clinical record will be completed no more than 30 days after discharge.

C. Assessments

1. See C04-S04-T46 General Intake/Primary Care Services for general requirements regarding clinical assessments.

2. Each person's medical record should indicate the specific findings or results of diagnostic or therapeutic procedures. Abbreviations, symbols or other "marks" used will be standard and widely accepted health care terminology and not on the prohibited abbreviation list (see BABHA Agency Manual, Policies and Procedures, C04-S09-T13 - Dangerous or Prohibited Abbreviations/Symbols/Acronyms, Dose Designations).

3. All persons served must receive an intake (and annual update) of a bio-psychosocial assessment that addresses the person's eligibility and medical necessity for specialty behavioral health services. This includes individuals receiving limited services, such just psychotropic medications or respite services, unless otherwise specified in BABHA policies and procedures.
4. As required by federal Medicaid managed care regulations, reassessment must be completed at least every twelve (12) months or when the person served's needs change significantly, or at the request of the person served.

D. Individual Plan of Service (IPOS)and Person-Centered Planning (PCP) Meeting Documentation

1. In order for services to be covered by Medicaid, certain requirements must be met including that the services are provided according to an individual written plan of service that has been developed using the PCP process.
2. The Michigan Mental Health Code (MMHC) provides that individuals serviced by BABHA have the right to have an individual plan of service that has been developed through a PCP process.
3. See section 5 of Chapter 4 of the BABHA policy and procedure manual for more information about person centered planning.
4. According to Medicaid requirements, BABHA staff and contracted primary behavioral health care providers, as applicable, are required to develop an Initial/Interim 30 day written plan of service within seven (7) days of commencement of services.
    a. Interim Plans of Service are valid for 45 days and are not intended to be a replacement for Individual/Family Plans of Service, or Plan of Service Addendums. Use of consecutive Interim Plans of Service may be needed in limited circumstances to ensure continuity of care for the person served. In absence of such justification, use of repeated Interim Plans is not endorsed by BABHA and may not be accepted in an audit/investigation or may be subject to Recipient Rights review.
5. An Individual/Family Plan of Service shall:
    a. Include a treatment plan, a support plan, or both,
    b. Establish meaningful and measurable goals and objectives with the person served and be written in language the person understands,

i. The plan will name the services to be provided to support the person in achieving their goals and objectives, including the amount, scope and duration of each service, the relevant service authorizations, and the expected date each service is expected to commence.

ii. Generally, services will be authorized through a plan of service or plan of service addendum. The workflow for some services, such as enhanced CLS or psychiatric clinic service may require the authorization of services using stand-alone authorization screens in the EHR. Workflows which require the completion of service authorizations outside of the plan of service must be sanctioned by the responsible Director of Integrated Healthcare Services.

c. Address, as either desired or required by the person, the person's need for food, shelter, clothing, health care, employment opportunities, legal services, transportation and recreation,

d. The person's dreams, desires and goals will be identified, addressed and documented as well as the person's strengths, needs and abilities, cultural background and safety and health issues,

e. Any available natural support to assist the individual to achieve his or her desired outcomes should be evaluated, identified, and utilized,

f. BABHA employees and contracted primary behavioral health care providers will make efforts to allow each person to provide ongoing opportunities to express his or her dreams, desires, and goals and to make choices regarding support and treatment options,

g. In some instances, a person's dreams, desires, support or treatment choices pose issues of health or safety or exceed reasonable expectations of resource consumption or are not allowable. Efforts will be made to negotiate toward a mutually acceptable alternative that meets the outcomes intended.

h. BABHA employees and contracted primary behavioral health care providers are responsible for clearly reflecting this information in the clinical record.

6. BABHA employees and contracted primary behavioral health care providers will strive to inform the person of their rights to a PCP process and associated appeal options, The IPOS will be current and modified, when applicable. The following requirements must be documented in the IPOS when a specific health or safety warrants a restriction,

limitation or modification:

a. The specific and individualized assessed health or safety need.

b. The positive interventions and supports used prior to any modifications, restrictions or intrusive techniques.

c. Documentation of less intrusive methods that have been implemented without success.

d. A clear description of the condition that is directly proportionate to the specific health or safety need.

e. Regular collection and review of data to measure ongoing effectiveness of the modification.

f. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

g. Informed consent of the individual to the proposed modification.

h. An assurance that the modification will not cause harm to the individual.

7. BABHA staff and contracted primary behavioral health care providers, as applicable, will use the PCP process in developing a person's written individual/family plan of service and ensure that efforts are used to fully document this process.

8. BABHA staff and contracted primary behavioral health care providers shall use reasonable efforts to review at regular intervals the effectiveness of, and the provision of, services under, an individual/family plan of service.

   a. Plans of service must be kept current and modified when needed based on changes in the needs of the person served and their preferences for support.

   b. A person served may request and review the plan at any time.

   c. As required by the MDHHS/CMHSP Person Centered Planning Best Practice Guidelines, formal review of the plan must occur no less than annually to review progress toward goals and objectives and to assess satisfaction of the person served.

9. BABHA staff and contracted primary behavioral health care providers are also responsible for fully reviewing and using “good faith” efforts to follow the PCP Best Practice Guideline and the MDHHS/BHDDA Person Centered Planning Policy.

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10. Persons served must receive a copy of their plan of service within fifteen (15) business days of the plan of service meeting date.

E. Progress Notes

1. A progress note will be generated for all contacts with the person served, activities conducted on the person's behalf, and for any other significant activity that occurs related to the person's treatment or support plan.
2. Since progress notes include a Service Activity Log (SAL) for billing, Contact Notes, which do not include a SAL, should only be used to document cancellations, no-shows, family/friend contacts without the person served, or a contact with the person served is not significant enough for a progress note.
3. If two services were provided by a staff person on the same day for a person served, such as treatment planning and physical therapy, there must be either:
    a. Separate progress notes for each service; OR
    b. A single document where the two services are clearly distinguishable. The start and stop times must be specified for each service; and the description of the services provided must clearly reflect the delivery of each separate service and the results.
4. If one service is provided by more than one staff for a person or group of people, there must be either:
    a. Separate progress notes for each staff, with the non-billing staff coding their note as consultation/support so it is not billed; OR
    b. A single progress note signed by both staff.
5. Emails or text messages may not be used as a substitute for progress notes. Emails and text messages should not be scanned or uploaded into the EHR to become part of the record of services for the person served.
6. See attachment to this procedure for guidance regarding documentation requirements geared to direct service professionals and behavior technicians.

F. Updating Documents

1. Completed documents in the clinical record can be copied forward for updating where appropriate using the ‘copy forward’ functionality of the EHR.

2. The EHR also permits limited use of 'quick phrases' to assist with completion of clinical documentation.
3. The EHR functionality permits some cutting and pasting of text to facilitate record completion in a timely manner.
    a. If cut and pasted, text must be customized for the person to whose record the content is being added, consistent with the MDHHS and BABHA person centered planning, recovery and self-direction requirements.
    b. Cutting and pasting old documentation and changing the date, time and signature to create new documentation is prohibited.

G. Correcting Errors in Completed Documentation

1. If documentation is not legible or is an unacceptable or dangerous abbreviation, acronym, or symbol, the documentation must be clarified and re-written.
2. With limited exceptions, an error in an EHR document should be corrected by the author of the document using the change signed document function, unless an administrative change is authorized.
    a. The Manager and Supervisor of the Access/Emergency Services program are authorized to make changes to Access/ES related documents or Phoenix screens authored by other Access/ES staff if necessary to ensure needed service delivery for persons served. Examples are such changes are modifications to continuing stay reviews, pre-admission screenings (including MCG), BH-TEDS records, etc. Permission does not need to be obtained for these situations.
    b. For other BABHA direct operated programs, the Corporate Compliance Officer, Chief Financial Officer, or Chief Executive Officer, may authorize administrative changes. Examples of such changes are Authorizing a supervisor or EHR Administrator correct an overt error in documentation, (i.e., code, name, time or date) that was identified during supervisory, quality, finance or compliance review or authorizing an EHR Administrator to make system level coding or authorization modifications.
    c. See also C09-S05-T06 Access Controls – Electronic Signature and Error Corrections.
3. When an error in paper documents is needed, draw a line through the error (making sure

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the original text is still visible) and write 'error' or the corrected information above the line drawn, or insert the correct information into a blank field. Sign/date the correction. Use of white-out and erasers is not endorsed.

Attachments

Documentation Requirements for Direct Service Professionals and Behavior Technicians.

Related Forms

N/A

Related Materials

N/A

References/Legal Authority

1. Michigan Mental Health Code, MCLA 330.1700(g), 330.1141 and 330.1712
2. MDHHS/CMHSP Managed Specialty Supports and Services Contract Agreement
3. MDHHS/CMHSP Person Centered Planning Best Practice Guidelines
4. MDHHS Medicaid Provider Manual, General Information for Providers and Behavioral Health and Intellectual and Developmental Disability Supports and Services.
5. Michigan Administrative Code, Sections 330.7199 and 330.2814
6. 42 CFR Managed Care Rules 438.208(c)(2) & 438.208(c)(3)(v)

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SUBMISSION FORM

AUTHOR/ REVIEWER	APPROVING BODY/ COMMITTEE/ SUPERVISOR	APPROVAL / REVIEW DATE	ACTION (Deletion, New, No Changes, Replacement or Revision)	REASON FOR ACTION - If replacement list policy to be replaced
G. Lesley	CLT	03/17/11	Revision	Establish standard of practice for scanned documents to ensure that all electronic medical records are complete, accurate, and up to date
B. Roszatycki E. Albrecht	PNLT	05/31/12	Revision	Updated include BABHA record review process, updated language and more specific timeline requirements for scanning documents into the EMR
E. Albrecht	E. Albrecht	09/19/13	Revision	Updated with Person First Language. Added CARF language "strengths, needs and abilities." Renumbered – was 4-10-10.
K. Amon	K. Amon	09/30/14	Revision	Changes in EHR and in Record Review process
S. Holsinger K. Amon	K. Amon	11/6/18	Revision	Triennial Review-Changes to reflect current Record Review process.
K. Amon	K. Amon	5/13/2021	Revision	Triennial review-updated to current policy
J. Pinter, w. K. Amon	Corp Comp Comm & Prov. Network Ops & Quality Mgt Comm	09/21/21; 10/14/21	Revision	Incorporate additional documentation compliance requirements; attach documentation guide for CLS staff.