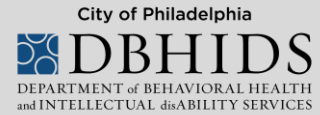




## Provider Bulletin 20-30 December 7, 2020



# Documentation Requirements – Independent Practitioner Guidelines

An independent practitioner is defined by Community Behavioral Health (CBH) as a sole practitioner or practitioner in a group practice providing services to CBH members, who possesses and is paid on their own tax identification number. This Bulletin provides guidance on the documentation requirements for clinical records maintained by independent practitioners.

CBH requires independent practitioners to complete and retain clinical records for each service provided to members and billed to CBH. CBH compliance audits include member chart reviews to ensure services are documented in accordance with the requirements outlined herein. CBH will recoup payments associated with documentation that is insufficient to substantiate the services billed.

The guidelines are below and included in Section 7.1 Clinical Documentation Guidelines of the [CBH Provider Manual](#). The guidelines were presented at the CBH Compliance Forum on November 5, 2020, and the presentation has been posted to the [CBH website](#). These guidelines will be updated as needed.

Please direct any questions about this Bulletin to [CBH.ComplianceContact@phila.gov](mailto:CBH.ComplianceContact@phila.gov).

## **Documentation Standards for Independent Practitioners**

An independent practitioner is defined by Community Behavioral Health (CBH) as a sole practitioner or practitioner in a group practice providing services to CBH members, who possesses and is paid on their own tax identification number.

Credentialing requirements for independent practitioners can be found in the [CBH Credentialing Manual](#). Documentation should be in alignment with the guidelines laid out in the [CBH Credentialing Handbook for Network Providers](#).

Independent practitioners are responsible for the completion and retention of clinical records for each service provided and billed to CBH. CBH may request records at any time to aid in coordination of care and investigations of quality or compliance concerns.

### **General Record Maintenance**

- Final and complete clinical notes must be entered into the clinical record within seven days of the date of service or prior to the submission of claims for payment for the service, whichever occurs first.
- Records should be in their original form, including signature.
- Records should be organized in a way that allows for ease of location and referencing.
- Records should be sequential, and date ordered.
- All entries within the record must be legible (including signature).
- Records should be typed, written, or printed only in ink.
- Every page in the records must have some form of identification of the person receiving services.
- Records should not include names of other individuals (may use initials or similar method to maintain confidentiality for group services).
- Records should be individualized to meet the needs of each person receiving services.
- Correcting errors: correction tape/fluid, scribble over, etc. should not be used. If there is an error, draw a single line through the error and initial, then enter correct material. (Note: only original authors may make alterations).
- Records should only contain universal and county-designated acronyms and abbreviations.
- Signatures must include the date signed, and those dates may not be pre-printed for paper-based records. The signature must reflect the date the note was signed.
- Each CBH member must sign either an encounter form or sign-in log that includes a signature date completed by the member, demonstrating that the member was present for the service and provide evidence of the duration of their attendance.

### **Storage, Retention, and Destruction of Records**

#### *Storage*

Clinical records contain Protected Health Information (PHI) covered by both state and federal laws. Providers are required to protect the record against loss, defacement, tampering, or use by unauthorized persons.

Clinical records should be “double locked” for storage (e.g. records placed in a locked filing cabinet within a locked office). Practitioners should have a safe and confidential filing system and retrieval system for access, accountability, and tracking.

Electronic records should be created and maintained in a way that is designed to protect their security, integrity, confidentiality, and appropriate access. Electronic records should be stored in a password-protected computer located within a locked room. Electronic records should also comply with applicable legal and ethical requirements.

#### *Retention/Destruction*

Full records should be retained for seven years after the last date of service delivery for adults and until one year after a minor reaches the age of majority, even if this requires the record to be retained longer than seven years. (49 Pa. Code § 16.95). Records should be retained beyond seven years if an audit involving those records is pending, until the audit findings are resolved and completed.

Records should be destroyed in a manner to preserve and assure confidentiality.

#### **Content of records**

##### *Progress Notes*

Progress notes are the evidence of services provided and relate to the individual’s progress in treatment. Progress notes are to be completed within seven days of the date of service or prior to the submission of claims, whichever occurs first. Missed appointments should also be documented within the clinical chart but should not be billed. Progress notes should be written in a standardized format (e.g. DAP, SOAP, BIRP) and should include the following:

- Date with start and end times of the service including a.m./p.m. designation or using military time
- Type of service rendered
- Assessment of individual’s current clinical presentation
- Interventions utilized by practitioner and individual’s response to said intervention
- Treatment goals and individual’s progress towards each stated goal
- Collateral information (with consent from person receiving service)
- Unresolved issues from previous contacts
- Plans, next steps, and/or clinical decisions
- Practitioner’s signature

Independent practitioners are not responsible for completing separate recovery/resilience plans with each person receiving service. However, elements of recovery/resilience plans should be contained within the progress notes. Goals, interventions, and the plan for the next session should be evident in each progress note. In addition, there needs to be a rationale for treatments, including medications, documented within the progress note. Simply documented plans such as “John will return in one week” will not be considered sufficient for documentation of on-going care planning.

### *Continuing Support Plans*

The continuing support process (previously referred to as the discharge planning process) should be initiated at the time an individual begins treatment. A timeline for transitioning out of care should be discussed during sessions. Individuals should be discharged from care consistent with practitioner policy. Discharge documentation should include, at minimum, the following:

- Type of discharge (e.g. successful completion of treatment, transfer, AMA)
- Name of next Level of Care (LOC) provider with date and time of appointment (if applicable)
- Supports needed (e.g. housing, case management, educational)
- Medications with dosages and date/time of next medication appointment (if applicable)
- Individualized crisis/safety plan (e.g. triggers, warning signs, coping strategies)
- Signature of person receiving service **and** independent practitioner (if over age 14)
- Signature of parent/guardian **and** independent practitioner (if under age 14)

Please note: Signature of the individual receiving service and/or parent/guardian is not required for unplanned discharges.