

Documentation Standards for Mental Health Outpatient Providers

Mental Health Outpatient (MHOP) services provide much needed support to many Community Behavioral Health (CBH) Members while affording them the opportunity to remain in their communities. Recently, the Commonwealth updated regulations that govern many aspects of care for facilities licensed as Mental Health Outpatient Clinics. These updates provided an excellent opportunity for CBH to finalize documentation requirements for these same clinics.

The standards presented here will be used by CBH Compliance audit teams to, in part, determine if sufficient care has been documented to substantiate billing and/or payment for mental health outpatient services. Additionally, we are asking Providers who also deliver ambulatory mental health care to our Members to also adhere to these requirements. Examples of Providers deliver ambulatory mental health care may include, but are not limited to, independent practitioners and group practice Members. Specific information about who should follow this are detailed in the guidelines.

The guidelines are below and will be included in Section 7.1 Clinical Documentation Guidelines of the [CBH Provider Manual](#). These guidelines will be updated as needed. As such, please ensure that you bookmark the CBH Provider Manual and not specific versions of the Guidelines or Provider Manual to ensure that you have the most current version.

Please direct any questions about this Bulletin to CBH.ComplianceContact@phila.gov.

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Expectations presented in this document apply to services provided in facilities licensed as MHOP clinics. Individual practitioners and those in group practices providing MHOP care are also strongly encouraged to follow these guidelines as well when possible. Individual practitioners are required to follow the documentation guidelines presented separately and available in the [CBH Provider Manual](#).

MHOP Providers 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.

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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.
- ➔ Record should be in its 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 record must have some form of identification of the person receiving services.
- ➔ Records should not include names of other individuals.
- ➔ 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 and date the change, then enter correct material. (Note: only original authors may make corrections).
- ➔ 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.

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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 of 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 may not be billed. Progress notes should be written in a standardized format (e.g. - DAP, SOAP, BIRP) and should include the following:

- ➔ The date with start and end clock times of the service, including AM/PM designation or using military time

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- ➔ Type of service rendered
- ➔ Assessment of the individual's current clinical presentation
- ➔ Interventions utilized by a practitioner and the individual's response to said intervention
- ➔ Treatment goals and the individual's progress towards each stated goal
- ➔ Collateral information (with consent from the person receiving a service or services)
- ➔ Unresolved issues from previous contacts
- ➔ Plans, next steps, and/or clinical decisions
- ➔ Signature of rendering practitioner

Treatment Planning

Providers can find specific requirements for treatment plans, including required participants/signatures, timeframes for initial and plan updates, and regulatory basis in the Treatment Planning Guide and in the CBH Provider Manual. We encourage all individuals providing care to the Member to participate in the planning session and note their participation by signing treatment plans and/or updates.

While changes in MHOP settings may be incremental in nature, care should be given to ensure that treatment plans and updates are not duplicated across periods. Significant reuse of content in treatment plans may result in compliance action.

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 regularly. Individuals should be discharged from care consistent with agency policy. Discharge documentation should include, at minimum, the following:

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- ➔ Type of discharge (e.g., successful completion of treatment, transfer, AMA)
- ➔ Name of next level of care 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 (triggers, warning signs, coping strategies)
- ➔ Signature of the person receiving service AND clinician (in general if over age 14)
- ➔ Signature of the parent/guardian AND clinician (in general if under age 14)

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

SPECIAL MHOP CONSIDERATIONS

Providers are reminded that there is no CBH requirement that ‘therapy’ services are needed to receive medication management services. In fact, for many individuals for whom medications management has helped afford stability, medication management sessions alone may be clinically indicated.

MHOP Providers treating Members with medication management-only services are reminded that Medicaid regulations § 1153.42. Ongoing responsibilities of Providers require treatment plans for Members receiving these services.

Some Providers have advised Members that they must receive both individual and group therapies to participate in outpatient mental health services. This is not a CBH or Medicaid requirement.

Some Providers are conducting annual Comprehensive Biopsychosocial Evaluations or Re- Evaluations or psychiatric evaluations, listing a reason for the evaluation as “Annual

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Evaluation.” This is also not a CBH requirement, nor is this a sound clinical rationale for conducting an evaluation.

Members do not need to receive an annual evaluation to continue receiving outpatient mental health services. These practices contradict the importance of Member choice and may also represent waste if not clinically necessary. CBH expects Providers to consult best practices, medical necessity, and Member choice when determining course of treatment, including whether a Member should receive individual and/ or group therapy along with medication, or whether medication only is sufficient. In every instance, the level of services provided must be guided solely by clinical need.

CBH will continue to monitor network Providers for overuse and medically unnecessary services and will recoup payments for services not clearly demonstrated as medically necessary.

MHOP Providers utilizing group therapy as a component of care adhere to requirements for group therapy services. These requirements include, but are not limited to:

- ➔ Therapeutic in nature only, psycho-educational groups are not a billable service in MHOP
- ➔ The maximum group size is 12
- ➔ The number of participants must be documented in the record
- ➔ Individual response to the group must be documented

Additional information specific to group services may be found elsewhere in the [CBH Provider Manual](#).