Behavioral Health Medical Record Review: Documentation Overview

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This resource provides general documentation requirements and common audit findings.

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- Why we do it
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Rationale for Behavioral Health Record Reviews: Why We Do It

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- **Contractual agreement**
  Agreement between the State and the Health Plan requires periodic provider record audits.

- **Preparation for State audits**
  The State has the right to audit providers' records with little notice. Our audits provide feedback to assist providers in passing State audits.

- **Quality of Care**
  Audits help to identify and resolve Quality of Care issues. This directly influences the quality of care our members receive.

- **Industry standard**
  Audits help providers meet industry and community standards for documentation.

WellCare Medical Record Review Audit Tools

The WellCare Medical Record Review audit tools are designed to:

- Measure adherence to State and Federal guidelines
- Promote best practices

The audit tools are provided to you prior to the audit and are available upon request at any time.

Main areas of focus for an audit

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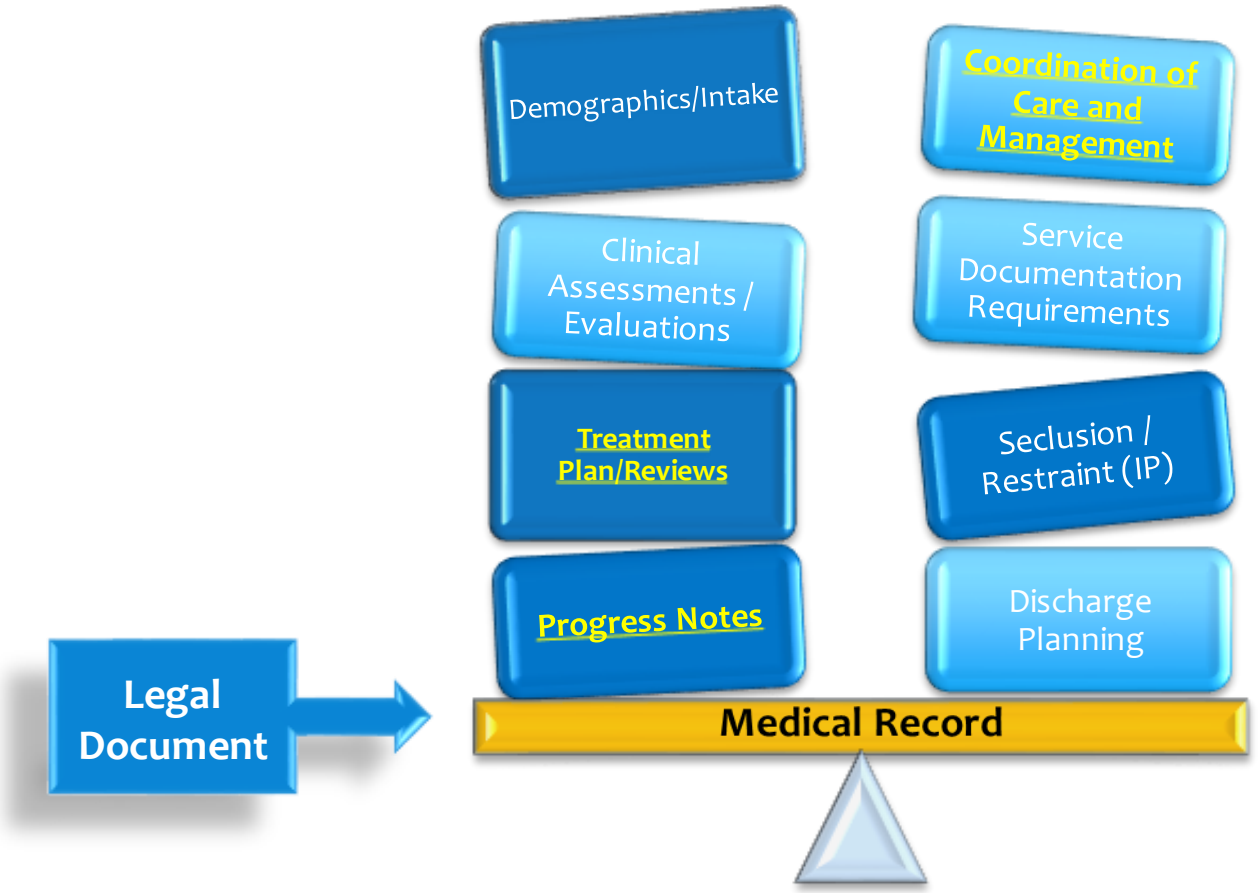
Focus of Audit: Snapshot



*Yellow highlighted areas have the most deficiencies and will be addressed separately

Demographics

At a minimum, the following data should be collected:

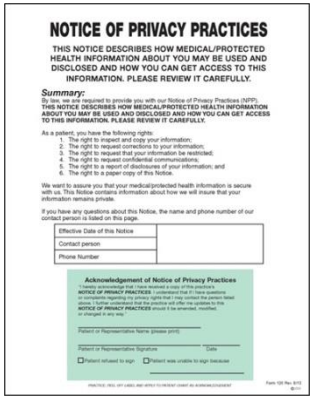
- Full name
- Date of birth and **age**
- **Gender**
- Address and **phone number**
- **Primary language spoken**
- **Legal guardianship,** if applicable
- Marital status (adults only)
- Race or ethnicity
- Name and phone number of emergency contact
- Name of employer or school

NOTE: Highlighted items are commonly absent from the records

Intake Documents

Initial, legal paperwork is important and should include the following documents:

- Signed and dated consent for treatment
- **Signed and dated evidence that the member was apprised of Notice of Privacy Practices/HIPAA**
- Evidence that the member was apprised of Rights & Responsibilities
- **Inpatient records should also include documentation supporting the legal status of the member (i.e., voluntary/involuntary admission)**
- **Any releases of information (e.g., PCP; other treating providers)**


NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

NOTE: Highlighted items are commonly absent from the records

Clinical Assessment/Evaluations

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Outpatient

Psychosocial assessments:

- Should be completed within 30 days of the start of services
- Should be reviewed and updated at least annually

Psychiatric Evaluations:

- Should be reviewed and updated annually

Inpatient

Psychiatric evaluations:

- Should be completed within 24 hours of admission

Psychosocial assessments:

- Should be completed if the admission is longer than 72 hours

Service Documentation

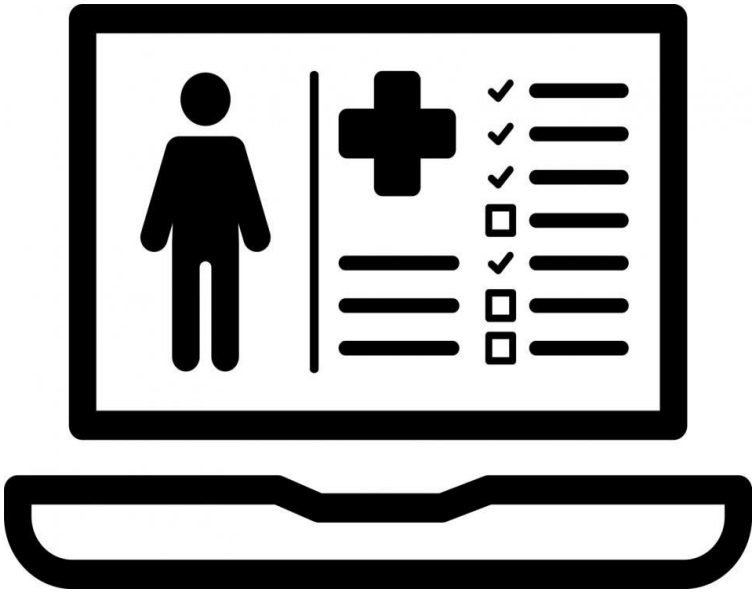
All records, whether hardcopy or electronic, are legal documents and should:

- Be individualized!
- Include the member's name and/or ID on every page of the clinical record
- Be legible to the reviewer
- Include the date the service occurred
- Include legible signatures with credentials and/or title of person performing the service

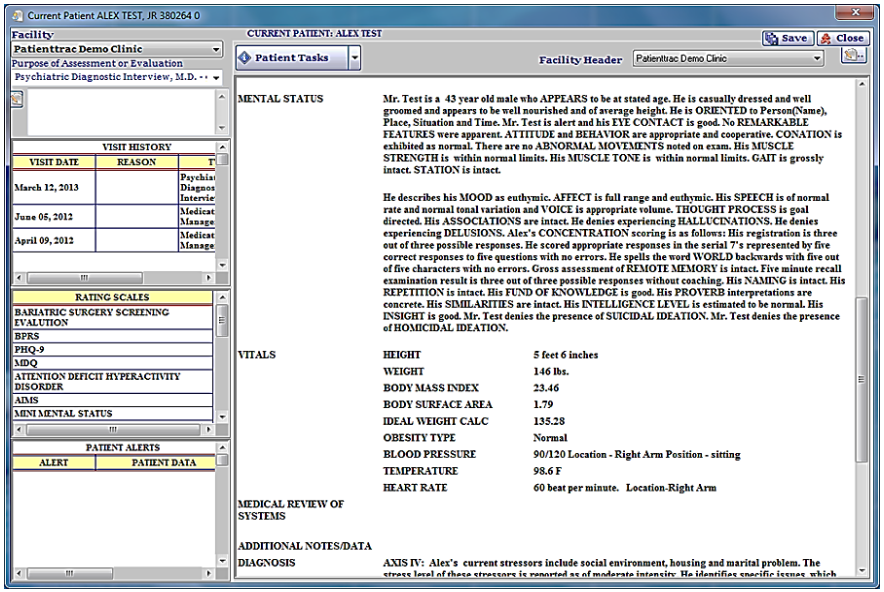
  *Tips: Print name below signature; use a signature stamp along with signature; IP – use a signature sheet

Electronic Medical Record (EMR) Tip

When developing and using EMR, be sure to make the record as individualized as possible. Extensive use of checklists and checkboxes often does not present a clear picture of the member and may be inadequate for the utilization review process.



vs.



Service Documentation

Members who pose a risk to themselves or others should have a crisis/safety plan

Sample Safety Plan

SAFETY PLAN

Step 1: Warning signs:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place _____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5:Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Local Urgent Care Services _____
   Urgent Care Services Address_____
   Urgent Care Services Phone _____
5. Suicide Prevention Hotline Phone: 1-800-273-TALK (8255), push 1 to reach a Mental Health Provider

Discharge planning: Why is it important?

- Discharging to a lower level of care, or ending a therapeutic relationship, is a critical time for a member. It is imperative that appropriate supports and / or follow-up appointments are in place.

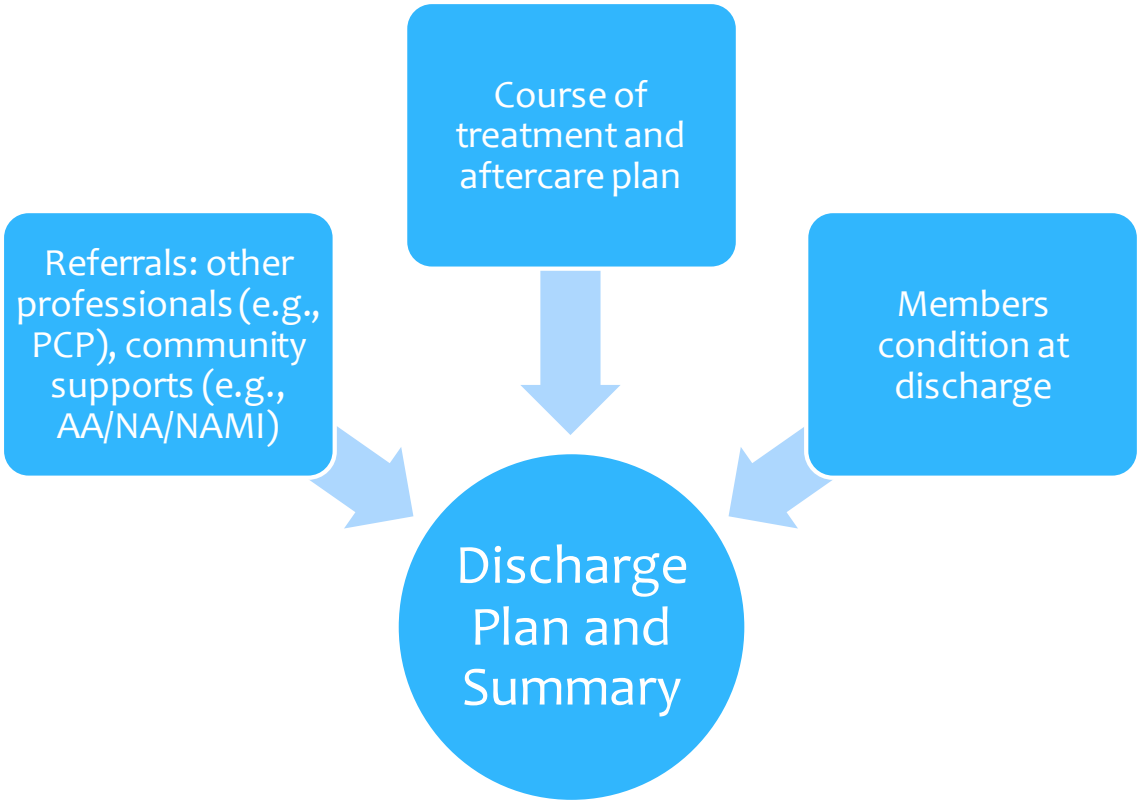
- The member should be provided with resources in the event that problematic symptoms reoccur.

- Risks associated with discharge from an inpatient setting include rapid readmission due to poor support system, no access to medications, increased risk of suicidality.

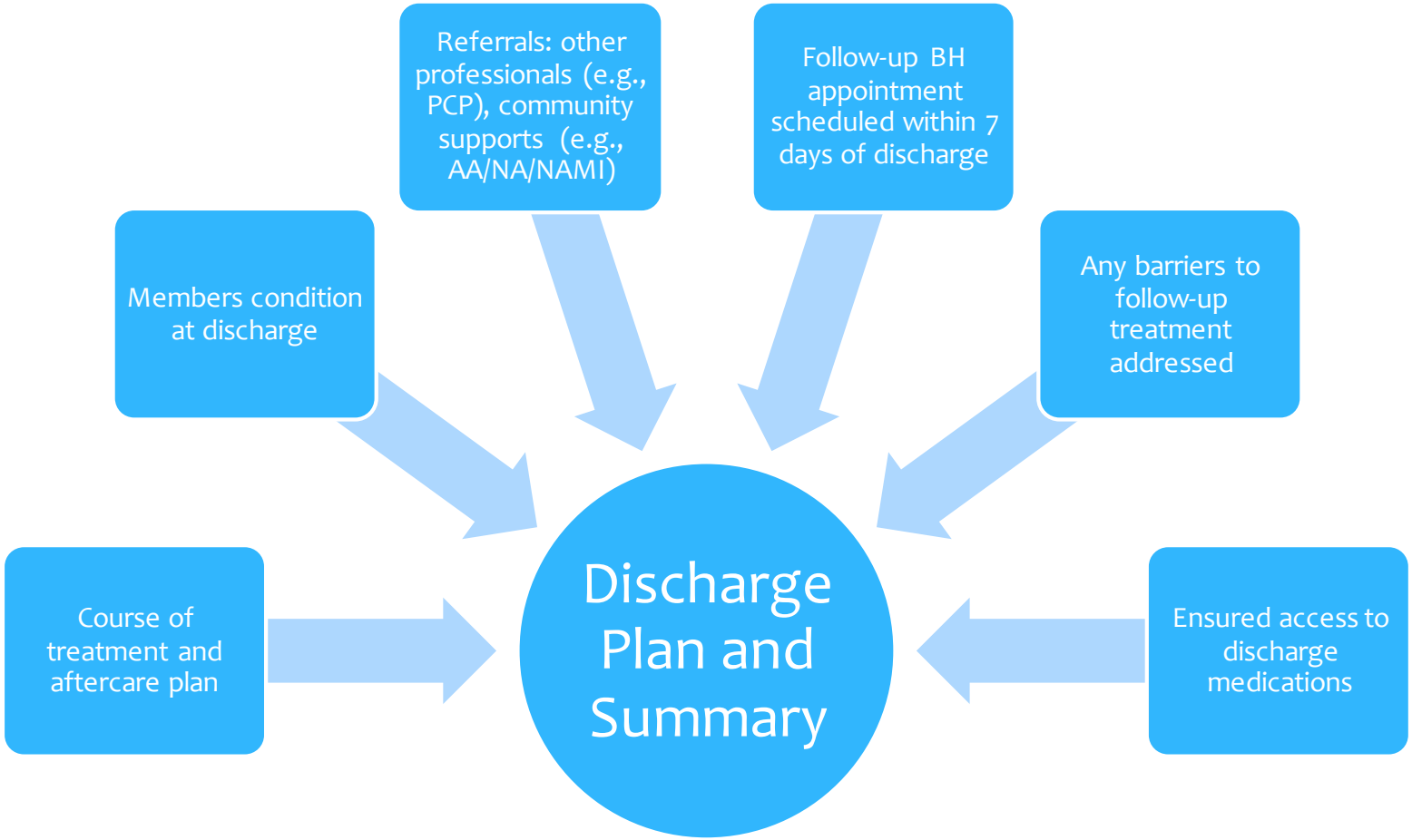
- The member should agree with the discharge plan in order to maximize treatment outcomes. The member's dated signature signifies agreement.

- **Discharge planning should begin at the onset of treatment.**

Discharge planning (Outpatient)



Discharge planning (Inpatient)



Areas of Opportunity

- Treatment Plans
- Treatment Plan Reviews

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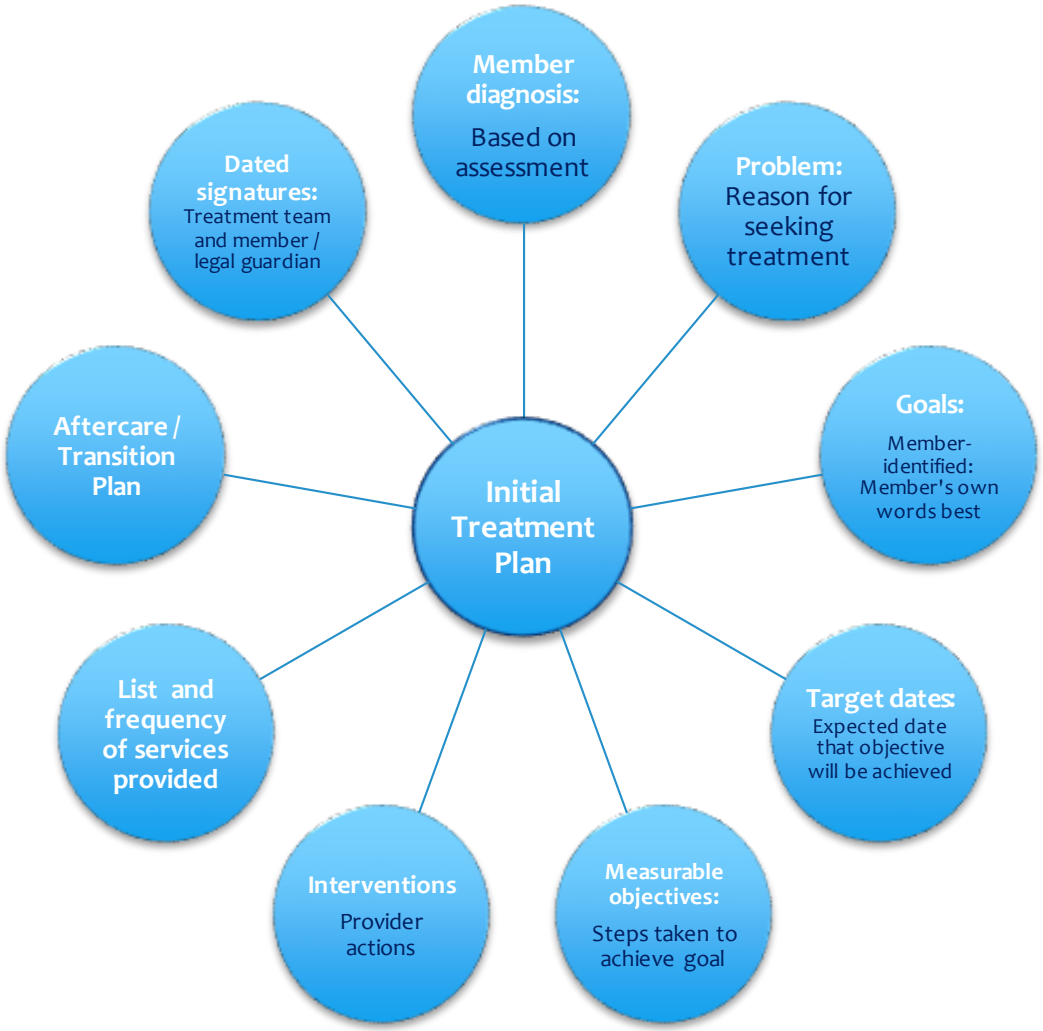
Treatment Plans

- A treatment plan is an individualized, structured, and goal-oriented schedule of services, with measurable objectives, that promotes symptom reduction; and, addresses the primary diagnosis identified by the assessment.
- Treatment plans should be completed within 30 days of service initiation (outpatient), or, 24 hours of admission (inpatient) and after the assessment.
- Treatment Plans are the blueprint that guides treatment and are always required.
- Treatment Plans are "living documents," always changing and adapting to the member.
- Treatment Plans are the most frequently omitted document from medical records.
- Treatment Plans provide a complete view from beginning of treatment through termination or transition to alternate level of care.

Treatment Plan Components



Treatment Plan Reviews

- Best practice is to review Outpatient Treatment Plans at least every 6 months or when there is a change in treatment (e.g., adding group therapy).
- It is also best practice to review Residential Treatment Plans every 3 months.
- Treatment Plan Reviews should include findings, recommendations, and progress towards Goals, as well as rationale for changing any Objective or Goal (e.g., Member completes Goal and new Goal is added).
- It is best if the Treatment Plan Reviews are separate documents from the Initial Treatment Plan.
- All Treatment Plan Reviews should be signed and dated by the treatment team members and the Member.

Common Treatment Plan Findings

Providers may confuse Treatment Plan Goals, Objectives, and Interventions

NOTE: Targeted Case Management is *not* an intervention, it is a separate service

Goals

- Have preferred outcomes
- Are general, rather than specific
- Do not need to be measurable

Objectives

- Steps member takes to achieve goal
- Are measureable
- Have Target Dates - Projected date of completion (OP); or, anticipated discharge date (IP)

Interventions

- Actions and techniques the service provider utilizes to support the member in achieving goal and objectives
- Can include multiple providers (i.e., psychiatrist, therapist, community support, etc.) with their own intervention

Common Treatment Plan Findings

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Other missing components

Services:
What?
When?
Who?

- **What?** A list of services provided
- **When?** Frequency of service
- **Who?** List who will provide the service

Example:

1. Medication management 1x/month to be provided by MD
2. Individual therapy every 2 weeks to be provided by LPHA
3. Group therapy 1x/week to be provided by LPHA

Aftercare / Transition Plan

The criteria for discharge/transition to lower level of care

Example: Client will be discharged from services when he has reached his treatment goals. It is recommended that he continue to follow up with his psychiatrist and PCP on a regular basis to maintain optimal health.

Dated Signatures

- The treatment plan and treatment plan review(s) must be signed and dated by the treatment team AND the member/legal guardian
- Supervisors of unlicensed staff must also sign and date

Sample Outpatient Treatment Plan: Goal, Objectives, Interventions

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- Member-identified Goal: *"I don't want to feel so sad and lonely"*

- Objectives:
  - Member will take medication as prescribed and report any side effects to psychiatrist
    - Target date: (date within 6 months of objective initiation)
  - Member will identify 3 triggers of depressed mood
    - Target date: (date within 3 months of objective initiation)
  - Member will call at least 1 friend weekly
    - Target date: (date within 6 months of objective initiation)

- Interventions:
  - Psychiatrist will review medication effectiveness and adherence at each visit
  - Therapist will utilize CBT to address mood disorder
  - Therapist will administer PHQ-9 every 3 months

Sample Outpatient Treatment Plan: Services and Aftercare Plan

- List of Services
  - Individual therapy 2x/month for 45 minutes; service provided by licensed practitioner
  - Group therapy weekly for 1 hour; service performed by registered intern with supervision by licensed practitioner
  - Medication management once/month; service performed by psychiatrist or psychiatric nurse practitioner

- Aftercare/Transition Plan
  - Member will be discharged from services when:
    - All Goals are met
    - Member requests to discontinue services
    - Member is transitioned to lower level of care (IOP to individual therapy)
  - Member will continue medication management through PCP

Sample Inpatient Treatment Plan: Goal, Objectives, Interventions

- Member-identified Goal: *"I don't want to feel so bad that I want to kill myself"*

- Objectives:
  - Member will take medication as prescribed and report any side effects to psychiatrist
    - Target date: Prior to discharge (list anticipated discharge date)
  - Member will identify 3 triggers of depressed mood
    - Target date: Prior to discharge (list anticipated discharge date)
  - Member will identify 3 positive coping skills to address depressed mood
    - Target date: Prior to discharge (list anticipated discharge date)

- Interventions:
  - Psychiatrist will review medication effectiveness and adherence daily
  - Therapist will utilize CBT to address mood disorder in group
  - One family session will occur prior to discharge
  - Social Worker will set up appropriate discharge referrals

Sample Inpatient Treatment Plan: Services and Aftercare Plan

- List of Services
  - Daily nursing assessment
  - Group therapy 3 times per day; service performed by social work and nursing staff
  - Medication management daily; service performed by psychiatrist or psychiatric nurse practitioner

- Aftercare/Transition Plan
  - Member will be discharged from facility when:
    - All Goals are met
    - Member is no longer a safety risk
    - Member is at baseline
  - Member will follow-up with current OP providers

Areas of Opportunity

- Progress Notes

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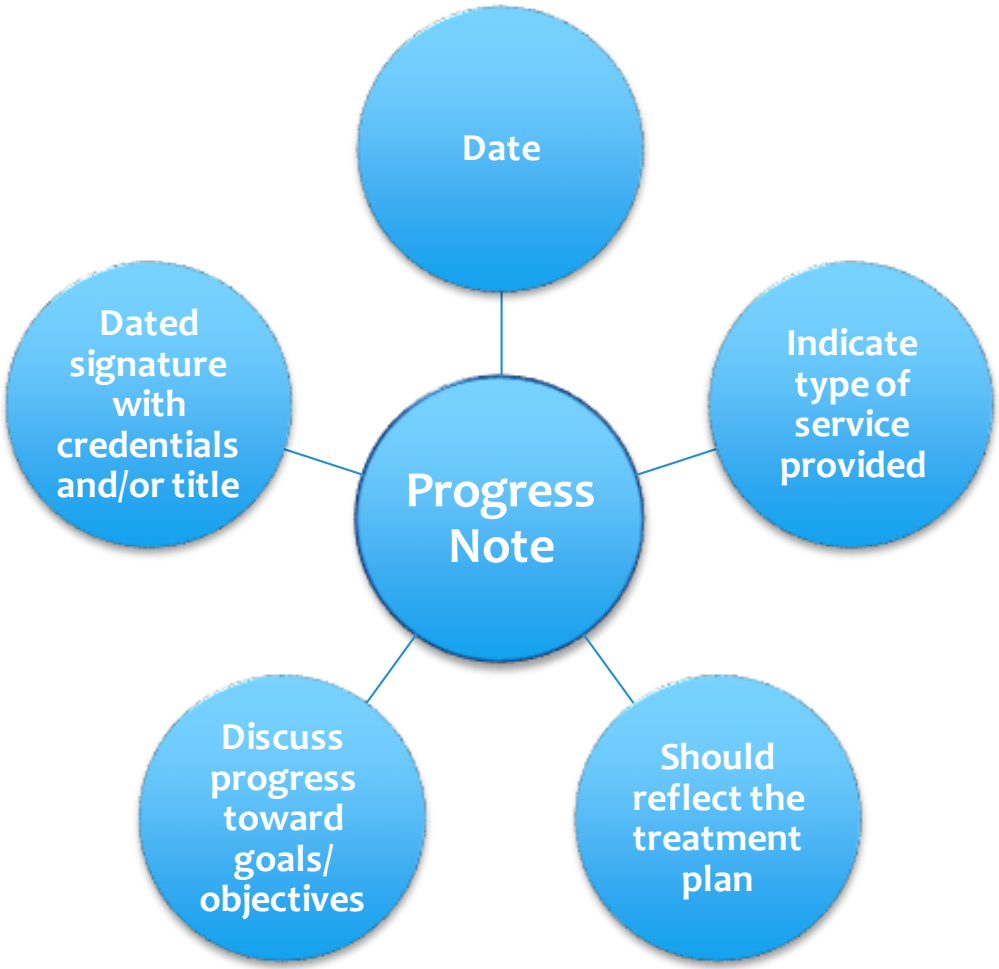
Key Elements for Progress Notes: Outpatient

Key Elements for Progress Notes: Inpatient



Let's talk about handwriting

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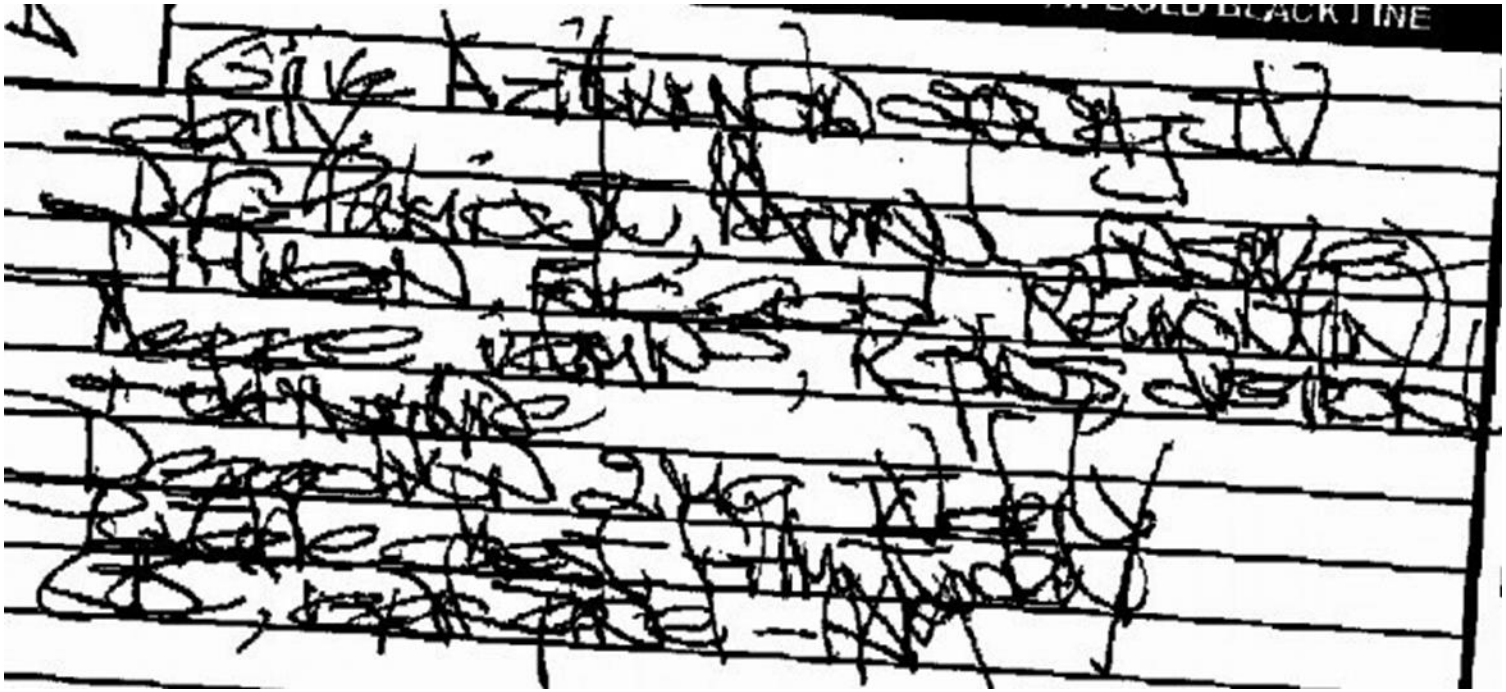
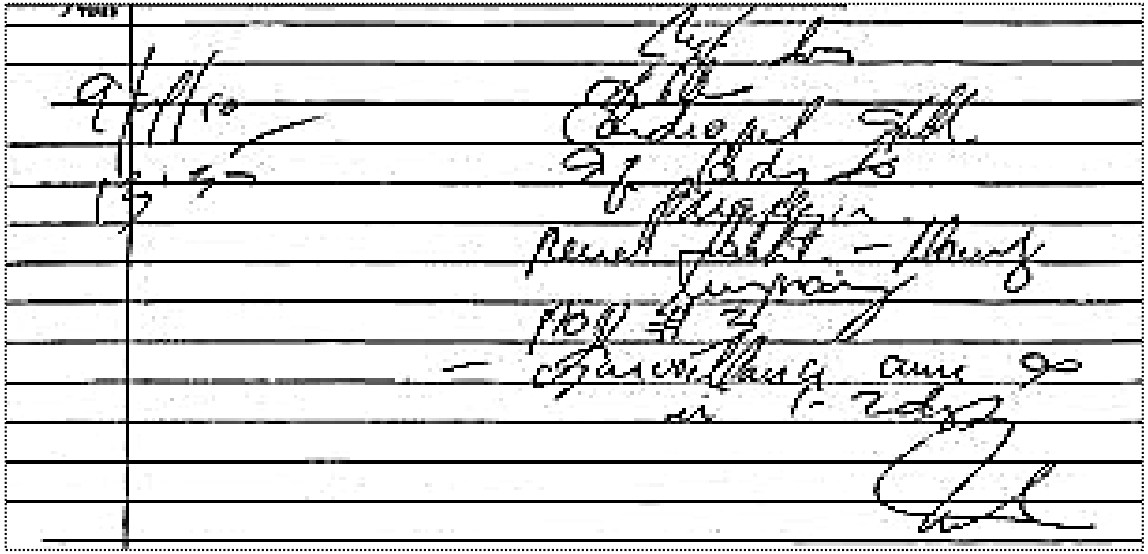


Let's talk about handwriting

Audit tool definitions:

- **Met** = The documentation in the record is legible by the reviewer
- **Not Met** = If significant information in the record is illegible (i.e., cannot be read by reviewer)

Let's talk about handwriting

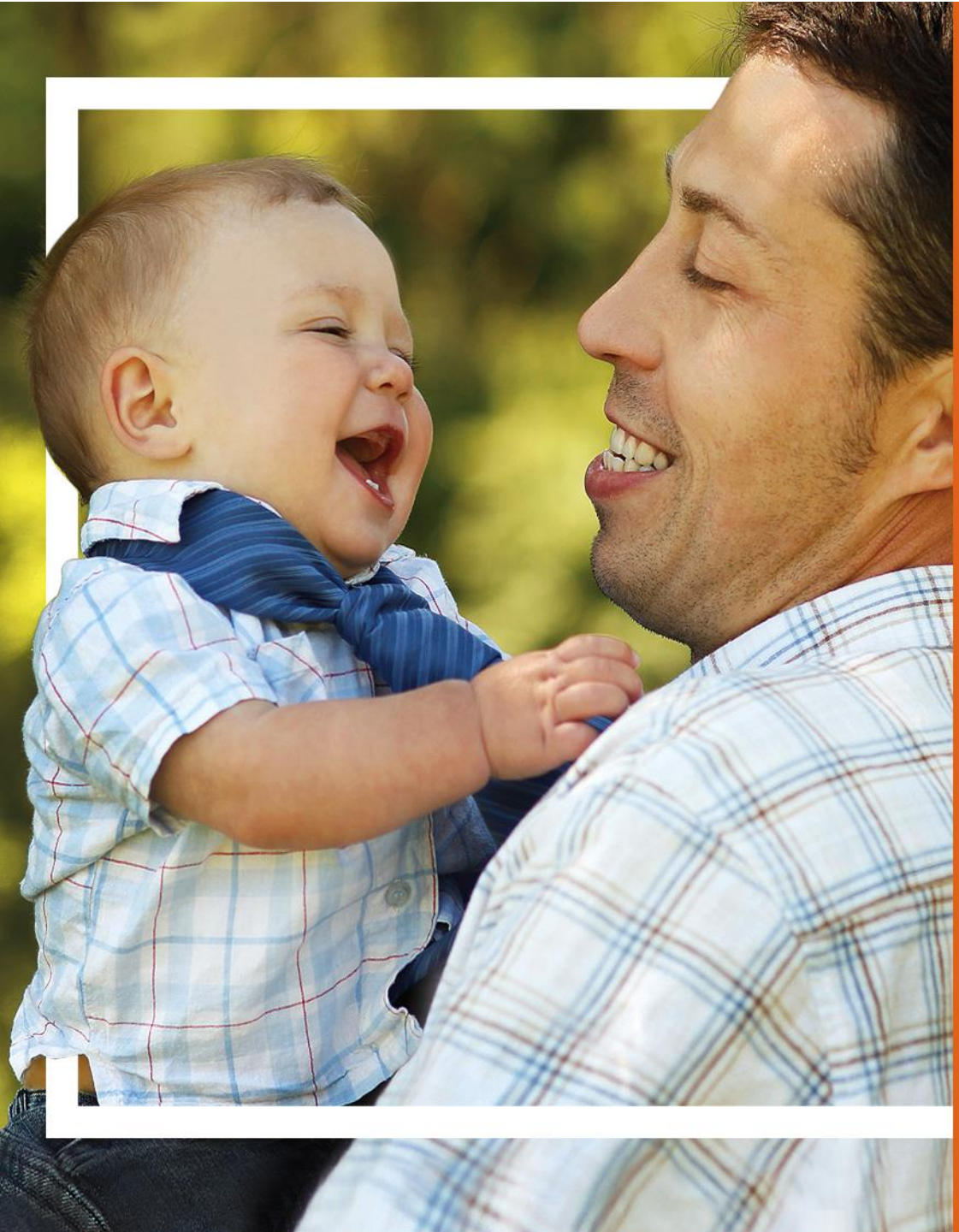


Signatures are to be legible with credentials and title

* *Best practice:*

  If you do not have a legible signature, use a stamp along with your signature; include a signature sheet in the record; or legibly print your name under your signature

  NOTE: Electronic signatures should be dated and time-stamped



Areas of Opportunity

- Coordination of Care

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PCP Coordination of Care

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Why is Coordination of Care with PCPs Essential?

According to the Agency for Healthcare Research and Quality (AHRQ), *"The main goal of care coordination is to meet patients' needs and preferences in the delivery of high-quality, high-value health care* ***to achieve safer and more effective care."***

PCP Coordination of Care

- WellCare of Kentucky requires that behavioral health providers communicate and coordinate care with the Member's PCP at initiation of services and at least every 90 days thereafter. *(see WellCare of Kentucky Provider Manual)*

- It is best practice to reach out to a Member's PCP in order to inform the PCP that the Member is receiving services, *especially* if the PCP is prescribing psychotropic medication and/or the member has a chronic medical condition.

Consent to communicate with other Providers

When healthcare providers collaborate on a member, good quality care takes place and the member benefits. Some examples of useful information that can be obtained are:

- Member's baseline
- Key information that the member neglected to share with all providers during current treatment that could affect the outcome, such as substance abuse, non-adherence to prior treatment, etc.

Therefore, it is best practice to obtain as much collateral information as possible.

Consent to treat with medication

Some states require a signed informed consent *prior* to administering psychotropic medication. It is **best practice** for all prescribers to obtain written consent.

Preparing to Submit Medical Records

- Checklists

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Documentation Checklists

When sending out the Medical Record Review confirmation letters, WellCare includes a general checklist to aid the provider in ensuring that all required documents are submitted. The checklists are not an exhaustive list of all required documentation. We recommend checking the audit tool for State-specific requirements.

Documentation Checklists

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✓ **Member demographics**

Intake Form (updated annually)

- Date of birth and age
- Gender
- Marital status
- Primary language
- Race or ethnicity
- Emergency contact
- Legal guardianship

✓ **Legal Documents, signed by member or legal guardian**

- Rights & Responsibilities
- Confidentiality/HIPAA statement
- Releases of information
- Legal status documentation (IP – voluntary/involuntary)
- Psychiatric advanced directive documentation (IP)

Documentation Checklists

✓ Coordination with Primary Care Practitioner (PCP)

- Attempts to collect PCP contact information
- Attempts to obtain consent for communication with PCP
- Communication with PCP (should occur after **intake, significant events,** and **discharge** from service)

✓ Consents, signed by member or guardian

- General - to receive behavioral health services
- Informed consent to treat with psychotropic medication, if applicable

Documentation Checklists

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✓ Clinical assessments and Treatment Plans

- Initial Psychiatric, Medical, and Psychosocial Assessments, Needs assessments
- Annually updated assessments
- Initial Treatment Plans and Treatment Plan Reviews, Service Plans and Service Plan Reviews

✓ Treatment

- Progress notes, physician orders, copies of prescriptions, lab/test results, current medications, and medication management notes

✓ Coordination of Care

- Documentation of coordination of care with current/previous treatment providers if applicable; contacts with other treatment team members, family members, school personnel, etc. (all with appropriate consents in the record)

How to Submit Medical Records

- Options

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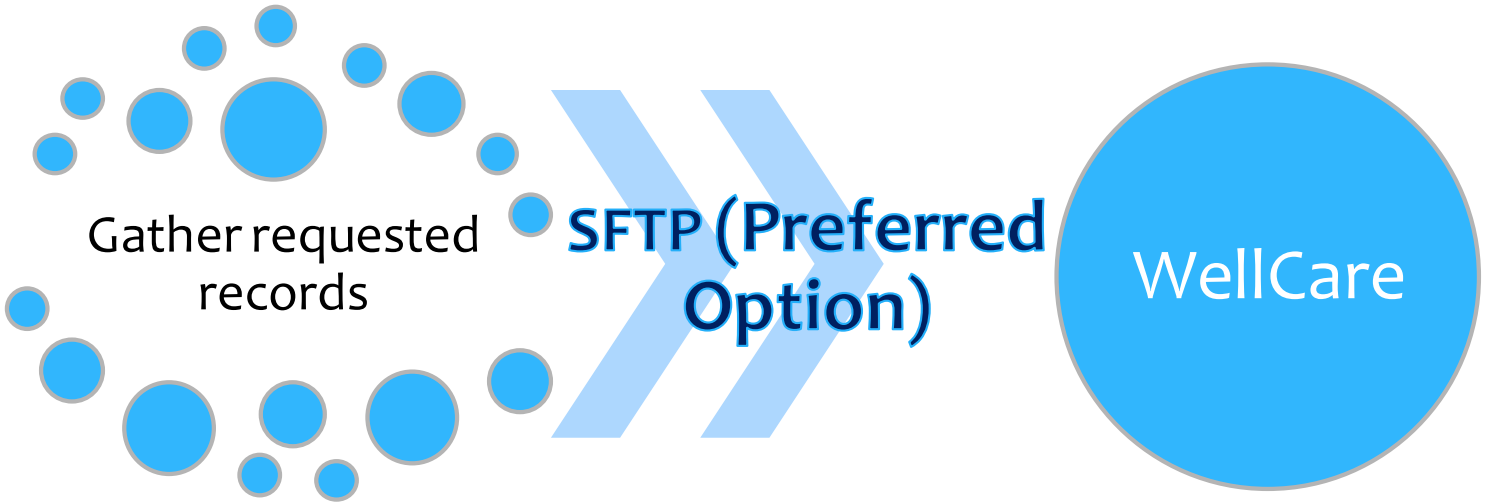
Record submission options: Secure File Transfer Protocol (SFTP)



SECURE electronic submission directly to WellCare

NO COST!

Record submission options: Tracked Mail

Gather requested records

Certified (USPS) or tracked mail (FedEx/UPS)

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The requestor's name MUST be directly on the package(s), not just the tracking slip

Your cost

Resources and References

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Resources

- WellCare Provider Manual: https://www.wellcare.com/ → Select State → Select "Providers" → Select "Overview" → Select "Medicaid" or "Medicare" → Select "Download" next to Provider Manual → Select "Open"
- Mary Ellen Cleary – Director, Quality Improvement; (813) 206-5508; MaryEllen.Cleary@wellcare.com
- Carl McLean – Manager, Quality Improvement; (813) 206-3694; Carl.McLean@wellcare.com
- Joanne Varadi, LCSW – Clinical Quality Specialist; (813) 206-1952; Joanne.Varadi@wellcare.com
- Market audit tool elements & definitions