Section: **Clinical Practices**	Policy Name: **Clinical Documentation**	Policy Number: **12.11**
Owner: **Director of Clinical and Quality Outcomes**	Reviewed By: **Alena Lacey, MA, LPC** **Elizabeth Guisinger, LPC, CAADC**	Total Pages: **7**
Required By: ☐ **BBA** ☒ **MDHHS** ☐ **NCQA** ☐ **Other (please specify):** _____	Final Approval By: Alena Lacey Beth Guisinger (Jul 2, 2024 14:09 EDT)	Date Approved: Jul 2, 2024 Jul 2, 2024
Application: ☒ **SWMBH Staff/Ops** ☒ **Participant CMHSPs** ☒ **SUD Providers** ☒ **MH/IDD Providers** ☐ **Other (please specify):** _____	Line of Business: ☒ **Medicaid** ☒ **Healthy Michigan** ☒ **SUD Block Grant** ☒ **SUD Medicaid** ☐ **Other (please specify):** _____	Effective Date: **7/29/2014**

Policy: It shall be the policy of Southwest Michigan Behavioral Health (SWMBH) to provide/assure that clinical documentation including progress notes, meets the contractual and regulatory requirements of the Michigan Department of Health and Human Services (MDHHS) contract, Center for Medicare and Medicaid Services (CMS), Code of Federal Regulations (CFR), and the Public Health Code. This will be demonstrated by each service containing all required elements.

Purpose: To ensure all clinical documentation accurately represents services provided and supports the medical necessity of services delivered. Clinical Documentation and progress notes are considered an integral part of supporting medical necessity treatment and as such the documentation must be completed within acceptable timelines based on contractual obligations.

Scope: To describe a clear method for ensuring that all clinical documentation is completed thoroughly and timely.

Responsibilities:

SWMBH and Community Mental Health Service Providers (CMHSP) shall follow the guidelines set forth in this policy regarding completing all clinical documentation in a timely manner to comply with federal and state standards.

Definitions: **Psychotherapy notes -** Notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation

during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the customer's medical record.

Standards and Guidelines:

A. Assessments

Clinical assessments will be completed as contractually required based on population of service—Substance Use Disorder (SUD), youth with Severe Emotional Disturbance (SED), Intellectual and Developmental Disabilities (I/DD), Mental Illness Adult (MIA)—and shall include all levels of clinical assessment. Standardized assessment tools shall be administered by qualified trained staff only. All initial and annual assessments shall be accessible and available within 30 days of the date of service billed for the assessment.

1. Primary Assessments shall be completed within 14 days of referral to the service provider.
2. SUD assessments shall include ASAM placement criteria and shall be updated annually, or if resuming services after more than six months out of service.
3. ASAM placement criteria shall be updated when new authorization requests are submitted, and at a minimum of six-month intervals.
4. MIA assessments shall include the LOCUS. The LOCUS shall be updated at least annually and when there is significant change in individual's status.
5. SED assessments shall include the Child and Adolescent Functional Assessment Scale (CAFAS) for children ages seven through seventeen years (7-17) and Preschool and Early Childhood Functional Assessment Scale (PECFAS) for ages four through seven (4-7). The CAFAS and PECFAS shall be updated every 3 months and at the time of discharge.
6. Biopsychosocial assessments shall be updated at least annually and when requested and/or when there is significant change in individual's status.
7. I/DD initial assessments shall include information from intellectual assessments completed.
8. Assessments specific to Autism benefits shall be administered according to Medicaid Provider Manual Requirements.
9. Standardized functional assessment tools shall be administered by qualified trained staff only.
10. All Initial and annual assessments shall be accessible and available within 30 days of the date of service billed for the assessment unless otherwise specified in assessment.
11. All functional assessment tools completed by the Community Mental Health Service Provider (CMHSP) or provider shall be submitted to the SWMBH Data Warehouse in a structured data format within 14 days of completion.

B. Treatment Record Documentation

SWMBH's documentation requirements ensure compliance with contractual and regulatory requirements. SWMBH believes that consistent, current and complete documentation in the treatment record is an essential component of quality member care. All entries into the treatment record are dated and include the responsible clinician/staff's name who provided the

service, professional degree, and relevant identification number if applicable. Any handwritten documents must be legible to persons other than the writer. Any changes to a written record must be corrected by drawing a single line through the error and marked as an error or dated and initialed or an addendum must be completed to reflect any changes. The member's name, or identification number, must be present at the top of each page of clinical documents. SWMBH requires the following content to be present in the treatment record, as applicable:

1. Member's name
2. Member's date of birth
3. Gender
4. Presenting problems, along with relevant and social conditions affecting the member's medical and psychiatric status and the results of a mental status exam
5. A medical and psychiatric history, including previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data and relevant family information.
    a. For members 12 and older, documentation should also include past and present use of alcohol and cigarettes, as well as illicit, prescribed and over the counter drugs.
    b. For child and adolescent members, documentation should contain prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic).

C. Treatment Planning

Treatment planning must occur according to the Michigan Medicaid Provider Manual and MDHHS Primary Care Physician (PCP) Guideline for every Member receiving Medicaid funded services on at least an annual basis. It is imperative that all persons charged with implementing Individualized Plans of Service (IPOS) and subsequent addendums are promptly and adequately trained when Plans are developed and when there is a change to the IPOS.

D. Progress Note Documentation

Progress note documentation must correspond to the member's IPOS/plan of care, including current status, progress toward specific goals and objectives addressed during the encounter, and interventions offered by the clinician/staff during the encounter and shall include these mandatory elements:

1. Required content
    a. Customer's Legal Name
    b. Diagnosis
2. Service Data
    a. Service Provided
    b. Clinician/staff member providing the service
    c. Clinician/staff member licensure/credentials
    d. Other persons present during the service (exclusion names of other customers)
    e. Location or method of delivery (office, home, community, school, long term care facility, hospital, telephone)
    f. Date of service
    g. Start and stop time of the encounter (duration)

3. Description of Service
    a. Presenting problems, treatment modality, customer response to treatment
    b. Goal(s) and/or objectives of the IPOS addressed
    c. Member's strengths and limitations in achieving treatment plan goals and objectives
    d. Treatment interventions that reflect consistency with those goals and objectives
    e. Progress toward desired outcome or lack thereof
    f. Current status of the customer
    g. Future treatment recommendations
    h. Continuity and coordination of care activities as appropriate
    i. Dates of follow up appointments or, as applicable, discharge plans are noted
    j. Specific clinician/staff interventions offered during the service contact
4. Excluded Content
    a. Progress notes for psychotherapy should not include psychotherapy notes as defined under Health Insurance Portability and Accountability Act (HIPAA) in 45 CFR Part 164, subpart E, section 501
    b. Content from psychotherapy notes that can be included in the record are limited to the following:
        i. Medication prescription and monitoring
        ii. Counseling session start and stop times
        iii. The modality and frequency of treatment provided
        iv. Results of clinical tests
        v. Summary of any of the following: diagnoses, functional status, treatment plan, symptoms, prognosis, and/or progress to date
5. Service documentation or progress notes must be completed and be part of the customer record within a reasonable time period after the delivery of the service, and prior to the submission of the claim or encounter.

References:

Medicaid Provider Manual

MDHHS Person Centered Planning Policy

MDHHS Behavioral Health Code Charts and Provider Qualifications

MDHHS Site Review Protocols

MDHHS Access Standards

45CFR Part 164, Subpart E, Section 501

Prepaid Inpatient Health Plan (PIHP)/Provider contract

Affordable Care Act Section 2402(a) Guidance for Implementing Standards for Person Centered Planning and Self Direction in Home and Community Based Services Programs

Home and Community Based Services (HCBS) Medicaid Program and Community Based Setting Requirements for Community first Choice and HCBS Waivers, 79 FR 2947 January 16, 2014

Attachments: None.

Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
Initial	10/26/21	Scope and Responsibility. Moved to new template.	Added Scope and Responsibilities	L. Mitchell
1	12/7/2022	Lines of Business and References	Removed MHL and Medicare references	E. Guisinger
2	3/28/2024	Throughout	Updated for changes to MHL and SIS language	DeLeon