Section: Clinical Practices	Procedure Name: **Clinical Documentation**	Procedure #: **P12.11.01**
Overarching Policy: **12.11 Clinical Documentation**		
Owner: **Manager of UM & Call Center**	Reviewed By: **Elizabeth Guisinger, LPC, CAADC** **Alena Lacey, MA, LPC**	Total Pages: **5**
Required By: ☐ **BBA** ☐ **MDHHS** ☐ **NCQA** ☐ **Other (please specify):** _____	Final Approval By: Beth Guisinger (Jun 7, 2024 16:23 EDT) Alena Lacey	Date Approved: Jun 7, 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: **4/20/2017**

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: This procedure outlines the requirements of Southwest Michigan Behavioral Health (SWMBH) staff to ensure professional, complete, accurate and timely documentation of work produced within the scope of organization's normal business. Appropriate documentation promotes a high standard of clinical care, improved communication, and dissemination of information between and across providers, as well as an accurate account of treatment, intervention and care planning.

Scope: Provides clinical staff with guidelines for documenting interactions with customers, providers, and stakeholders in SWMBH's Managed Care Information System (MCIS), including, but not limited to: clinical/medical necessity documentation, care coordination, case review, and correspondence regarding customer care. Additionally, this outlines the requirements for documentation surrounding the preparation and distribution of meeting agendas and minutes for Integrative Care Team (ICT) meetings organized by SWMBH.

Responsibilities: All SWMBH staff will appropriately document information in the MCIS in accordance with

the timelines as outlined in this procedure. Documentation will be comprehensive, clear, complete, accurate, and supportive of all decisions made.

Definitions: None

Procedure:

A. Clinical Documentation: SWMBH health professionals are to record, in the customer's care management record, all significant events/contacts. This includes all level of care screenings, comprehensive assessments, care coordination, and referrals that occur within the scope of treatment recommended, determined and/or requested. All documentation shall follow the guidelines below.

1. Comprehensive, Clear, and Complete
    a. Entries must demonstrate a complete depiction of what had occurred, information provided and given, and any follow-up steps discussed and agreed upon.
    b. Information must be factual, accurate, and true.
    c. Language should be customer focused, non-judgmental and representative and reflective of professional observations.
    d. Wording used shall distinguish between what was observed/heard directly, what was reported by others and/or professional opinion.
    e. The entry must be clear, structured and detailed to enable others to understand the clinical information and allow for ongoing service at any time by another health professional.
    f. Only standard abbreviations are to be used in the customer's record. Should circumstances dictate the use of non-standard abbreviations, they must be identified with their first use in the record.
2. Accurate
    a. Documentation must be entered into the correct customer's care management record. Staff must confirm the record type prior to entering clinical information with at least two of the following ID sources: customer's name, date of birth, and social security number.
    b. The customer's record cannot contain identifiable information regarding another customer. Documents that have been faxed, and include more than one customer's information, must be scanned into separate documents before being uploaded into a customer record.
    c. Uploaded or scanned records must be named according to the appropriate type of document naming convention.
3. Supportive of Decisions
    a. Documentation of an eligibility determination shall demonstrate appropriate use of level of care tools and specific medical necessity criteria used in making the determination.
    b. Any determination resulting in a denial decision made by a peer reviewer (i.e. Medical Director, Consulting physician/psychiatrist) must be clearly documented in the authorization request determination.
    c. Referrals to other services/agencies must be supported by identifiable reasons indicated by the screening/assessment.

d. Any breech of personal health information to authorities, following a situation that has been deemed as meeting the definition of "duty to warn", shall be clearly documented by: clear detailed of all information presented by the customer that initiated the breech, any consultation with peers and/or senior leaders, as well as specific information that was given to law enforcement.

4. Organized and Timely
   a. Information documented during or immediately after care is provided or an event has occurred is a more reliable and accurate record of care or an event than information recorded later, based on memory.
   b. Chronological entries present a clear picture and sequence of events or care provided over time and facilitate better communication among and between care providers. Late entries should be appropriately recorded as soon as possible to rectify the absence.
   c. Documentation that does not occur at the time of the event, shall clearly indicate in the narrative the date and time the event took place. This includes attempts to reach a customer without success.
   d. Timeframes for completion of documentation is based on event type.
      i. Contact Notes: Must be completed and signed by the end of the business day on which the event(s) occurred.
      ii. American Society of Addiction Medicine (ASAM) Screenings: Must be completed and signed within one (1) business day from the date of the screening.
      iii. Level of Care Utilization System (LOCUS) Screenings: Must be completed and signed within one (1) business day from date of the screening.
      iv. Inpatient Psychiatric/Partial Hospitalization/Crisis Residential Continued Stay Reviews: Must be completed and signed by the end of the business day that the review was requested, unless the request and accompanying clinical information was provided after 4:30 PM. In that case, the review event must be completed and signed within 24 hours of the continued stay request.
      v. Correspondence from Customers: Any written communication received from a customer must be uploaded into the customer's record within three (3) business days.
      vi. Clinical Documentation from Providers: Any written clinical documentation (Pre-Admission Screens, Assessments, Treatment Plans, Urine Drug Screen results, etc.) that has been faxed to SWMBH, and was not uploaded by the provider into the customer's record, must be uploaded into the customer's record within two (2) business days.
      vii. Release of Information: Must be uploaded to the customer's record by the end of the day the release is received.
      viii. Appeal/Fair Hearing Determinations: The determination on the appeal request must be entered into the customer's record in the form of a 'Contact Note' within one (1) business day from the disposition of the determination. Written documentation of the proceedings, when applicable, must be uploaded to the customer's record within two (2) business days of receipt.

B. Meeting Agendas and Minutes
   1. ICT Meeting Agendas

a. Agendas for regularly scheduled ICT meetings shall be made available to all meeting participants no less than five (5) business days from the meeting date, unless the Medicaid Health Plan involved has not confirmed and/or agreed upon selected customers to review.
b. All meeting agendas must be in format approved by senior leadership.
c. Materials that will be discussed shall be provided to participants prior to the meeting date, when available to the organizer.

2. ICT Meeting Minutes
   a. Minutes for ICT meetings shall be made available to all meeting participants no more than seven (7) business days following the meeting.
   b. Are required to be written in a format that has been approved by senior leadership.
   c. Must reflect the substance of a meeting and be a clear and accurate record of the proceedings.
   d. Identifies follow-up action items and who is responsible for said action.
   e. Accurately records attendance of all meeting participants and their method of attendance (i.e. in person, phone).
   f. Discussions that occur during the meet regarding specific customers symptoms, treatment coordination and outcomes, shall be entered into the customer's record in SWMBH's MCIS.

Effectiveness Criteria: All previously listed documentation will be completed in standards in accordance with this procedure.

References: Standard Abbreviation List

Attachments: None

Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
Initial	6/10/2019	Transferred to updated template	Added Responsibilities and Effectiveness Criteria	E. Guisinger
1	6/15/2020	NA	Annual Review	E. Guisinger
2	5/16/2022	Effective Date	Updated effective date to 4/20/17 due to it being incorrectly reflected when moved to the update template	E. Guisinger
3	6/3/2024	Policy & Procedure	Removed NCQA and reference to Level IIs and Care Coordination Plans – all things related to previous MI Health Link Clinical Documentation	E. Guisinger

P12.11.01 Clinical Documentation

Final Audit Report 2024-06-08

Created:	2024-06-07
By:	Megan O'Dea (megan.odea@swmbh.org)
Status:	Signed
Transaction ID:	CBJCHBCAABAA4o7qls26jERscVjMs45oKjyAvI8KzrPV

"P12.11.01 Clinical Documentation" History

Document created by Megan O'Dea (megan.odea@swmbh.org)
2024-06-07 - 7:10:00 PM GMT- IP address: 50.124.41.78

Document emailed to Beth Guisinger (beth.guisinger@swmbh.org) for signature
2024-06-07 - 7:10:29 PM GMT

Email viewed by Beth Guisinger (beth.guisinger@swmbh.org)
2024-06-07 - 8:22:41 PM GMT- IP address: 104.47.56.126

Document e-signed by Beth Guisinger (beth.guisinger@swmbh.org)
Signature Date: 2024-06-07 - 8:23:42 PM GMT - Time Source: server- IP address: 174.210.228.7

Document emailed to Alena Lacey (alena.lacey@swmbh.org) for signature
2024-06-07 - 8:23:44 PM GMT

Email viewed by Alena Lacey (alena.lacey@swmbh.org)
2024-06-08 - 1:54:03 AM GMT- IP address: 172.225.132.76

Document e-signed by Alena Lacey (alena.lacey@swmbh.org)
Signature Date: 2024-06-08 - 1:54:23 AM GMT - Time Source: server- IP address: 174.210.224.187

Agreement completed.
2024-06-08 - 1:54:23 AM GMT