Behavioral Health Medical Record Documentation Standards

Standard	Explanation
	Initial Note
1. All pages in the medical record contain patient identification.	• Patient's first and last name, or • Patient's first initial and last name, or • Patient's Social Security Number, or • Any physician office-generated number that remains unique to that patient
2. The medical record contains documentation of each patient's personal and biographical data.	There is a form or designated place in the record that contains but is not limited to the following non-medical information: • Date of birth • Address • Employer (if applicable) • Home/work telephone number (if applicable) • Marital status OR The same information is maintained in the computer and is available each time the patient is seen.
3. Name, relationship, address, and telephone number of next of kin or responsible person is noted in the chart.	The record includes the person's name, address, phone number (work, if applicable, and home) and relationship to patient of the person to contact in case of emergency. • For children to the age of 18, the name, relationship, address, and telephone number of the responsible person is to be documented in the medical record.
4. Notes are signed or initialed by provider.	All entries in the medical record contain author identification as follows: • Author initials and/or name/signature handwritten, stamped, or electronic, or • A number assigned to that physician or practitioner may be used.
5. All entries in the medical record are dated. *For prescribers only.*	Entries in the medical record are dated. The entries include any originating from personnel in the office/facility, including: a. Progress notes b. History c. Prescription requests or refill information d. Phone call forms Reports generated by separate agencies are not considered entries (e.g., psychological testing, laboratory reports, emergency encounter forms).

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6. The provider's note states the presenting complaint and history.	The note includes the following documentation (at a minimum): • The presenting complaint • Behavioral health history including prior hospitalizations, medications, outcomes • Precipitating events • A diagnosis • Any risk factors relevant to the treatment. • Documentation of a return visit • A treatment plan
7. Entries in the medical record are legible to someone other than the author.	• Entries in the medical record can be interpreted by another user.
8. There is a list of all current medications documented in the medical record.	There is specific documentation of all medications currently taken, including dosages OR documentation should state "no medication." List should include prescription and known OTC medications
9. The presence of known drug allergies and/or reactions to drugs is prominently displayed in a uniform location in all medical records. *For prescribers only.*	There is consistency in the location of documentation, such as: • The outside cover of the chart • The inside cover of the chart • Drug allergies handwritten in the medical record in a uniform place • A form in the record that addresses allergies and is filed in a uniform location • Computer field dedicated to documentation of allergies
10. Authorization to release patient information is dated and signed by patient.	Patient has signed a release of information form or "refused to sign" documented in medical record, giving permission to release information to a specific provider.
11. Substance use/abuse evaluation is present.	If present, there is documentation of the substance use history, including but not limited to age of onset, frequency of use, amount of use. Documentation of use or nonuse of alcohol or other substances, which includes but is not limited to alcohol/prescription drugs/street drugs and other chemicals, or "none."

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12. Past medical history is documented.	Past medical history is documented and includes: • Significant medical illnesses • Operations and/or injuries Past medical history may be located on the progress notes, an initial exam form, hospital discharge summary, or on a separate form.
13. Psychosocial history is documented.	Psychosocial history includes but is not limited to: • Developmental history for children and adolescents • Living situation, employment, relationships, social stressors • Cultural, language, spiritual issues • Strengths useful for treatment
14. Mental status evaluation is documented (within first visit).	There is documentation of current mental status that includes but is not limited to: • Appearance, thought process, thought content, perception, speech, motor activity, mood, affect, orientation, attention/concentration, judgment, insight, memory
15. There is documentation of risk assessment.	There is risk assessment documented that includes but is not limited to: • Severity and imminence of potential harm to self or others • History of suicidal gestures or attempts Information should be updated as clinically appropriate.
16. There is a complete list of DSM IV multi-axial diagnoses, supported by the clinical assessment.	There is specific documentation of five DSM IV diagnoses: • Principal and/or provisional diagnoses (Axis I and II) • General medical conditions (Axis III) • Psychosocial and environmental problems (Axis IV) • Global assessment of functioning (Axis V)
17. A treatment plan addresses the DSM IV diagnoses and care plan.	There is specific documentation of: • Therapeutic intervention recommended • Short- and long-term goals/expected outcome

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18. The medical record shows that appropriate adjunctive treatment referrals were made and resources utilized.	The medical record shows documentation of appropriate adjunctive treatment referrals and use of available community resources, including: • Information given to patient regarding specific referral to support groups (e.g., NAMI, AA, Alanon) • Discussion with patient regarding benefits of various groups, reason for referral, as related to diagnosis/problem list
19. There is documentation that the patient was informed of treatment plan.	There is documentation that patient has been informed of treatment plan. This is indicated either on a separate form in the medical record or referred to in provider's notes.
20. There is documentation of current medical providers.	There is documentation in the medical record that medical providers are to be involved and formally communicated with: • If none, so noted • If member refuses, so stated • Release of information signed and dated by member in medical record
	Subsequent Progress Notes
1. Subsequent progress notes reflect treatment and progress.	Visit notes reflect progress towards goals: • Review of current state • Update to treatment plan and revisions as appropriate to identify barriers to care • Evidence of member improvement or lack of • Documentation of referrals to other providers or services to address gaps in care • Evidence of member's involvement in treatment
2. There is documentation that the interventions are consistent with generally accepted Best Practice Standards for the member's diagnosis.	• Reference to Best Practice standards is encouraged. • Use of Standard Evaluation and Assessment tools is encouraged. These can be part of a well articulated treatment planning process
3. There is documentation for visits that require use	The progress notes includes the following documentation: • Reflects the CPT code definitions of 90785

Standard	Explanation
of the Interactive Psychotherapy Complexity Code 90785 that appropriately support the complexity.	
4. There is documentation for visits that require use of the 60-Minute Individual Psychotherapy Code 90837 and E/M Codes supports their use.	The progress notes should include the following documentation: • Reflects the CPT code definitions of 90837 and support at least a 53-minute visit. • E/M codes are documented per the CPT code definitions for the appropriate time, evaluation and management requirements.