Behavioral Health Medical Record Documentation Standards

Standard	Explanation
1. General Information	• Patient's identification (full name or ID number) on all pages • Patient's personal and biographical data (address, home/work telephone, date of birth, marital status) • Name, relationship, address, and telephone number of next of kin or other responsible person **For pediatric patients, please include all of the information above, plus:** • The name, address, and phone number of a parent, guardian, or other responsible adult, and that person's relationship to the patient *Please note:* All medical record entries must be dated and in sequential order. All records must be legible. All documentation must follow Centers for Medicare and Medicaid (CMS) documentation guidelines, which can be found in the CMS NCDs and LCDs.
2. 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.
3. The provider's note states the presenting problem and history.	The note includes the following documentation (at a minimum): • The presenting problem • 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

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4. 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 and should state who prescribes the medication.
5. 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
6. Authorization to release patient information to primary care physician and other treating providers as needed 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.
7. Substance use disorder 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 and non-prescription drugs and other chemicals, or "none."

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8. Past medical history and family history is documented.	Past medical history is documented and includes: • Significant medical illnesses • Operations and/or injuries • Family medical and psychiatric history Past medical history may be located on the progress notes, an initial exam form, hospital discharge summary, or on a separate form.
9. 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
10. 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
11. 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.

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12. There is a complete list of DSM V diagnoses, supported by the clinical assessment.	• There is specific documentation of DSM V diagnoses and also includes information regarding medical conditions, social determinants of health and assessment of functioning.
13. A treatment plan addresses the DSM V diagnoses and care plan.	There is specific documentation of: • Therapeutic intervention recommended • Short- and long-term goals/expected outcome
14. 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
15. 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.
16. There is documentation of attempted communication with 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

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	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 required. These are part of a well-articulated treatment planning process.
3. There is documentation for visits that require use the Interactive Psychotherapy Complexity Code 90785 that appropriately support the complexity.	The progress notes includes the following documentation: • Reflects the CPT code definitions of 90785
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.