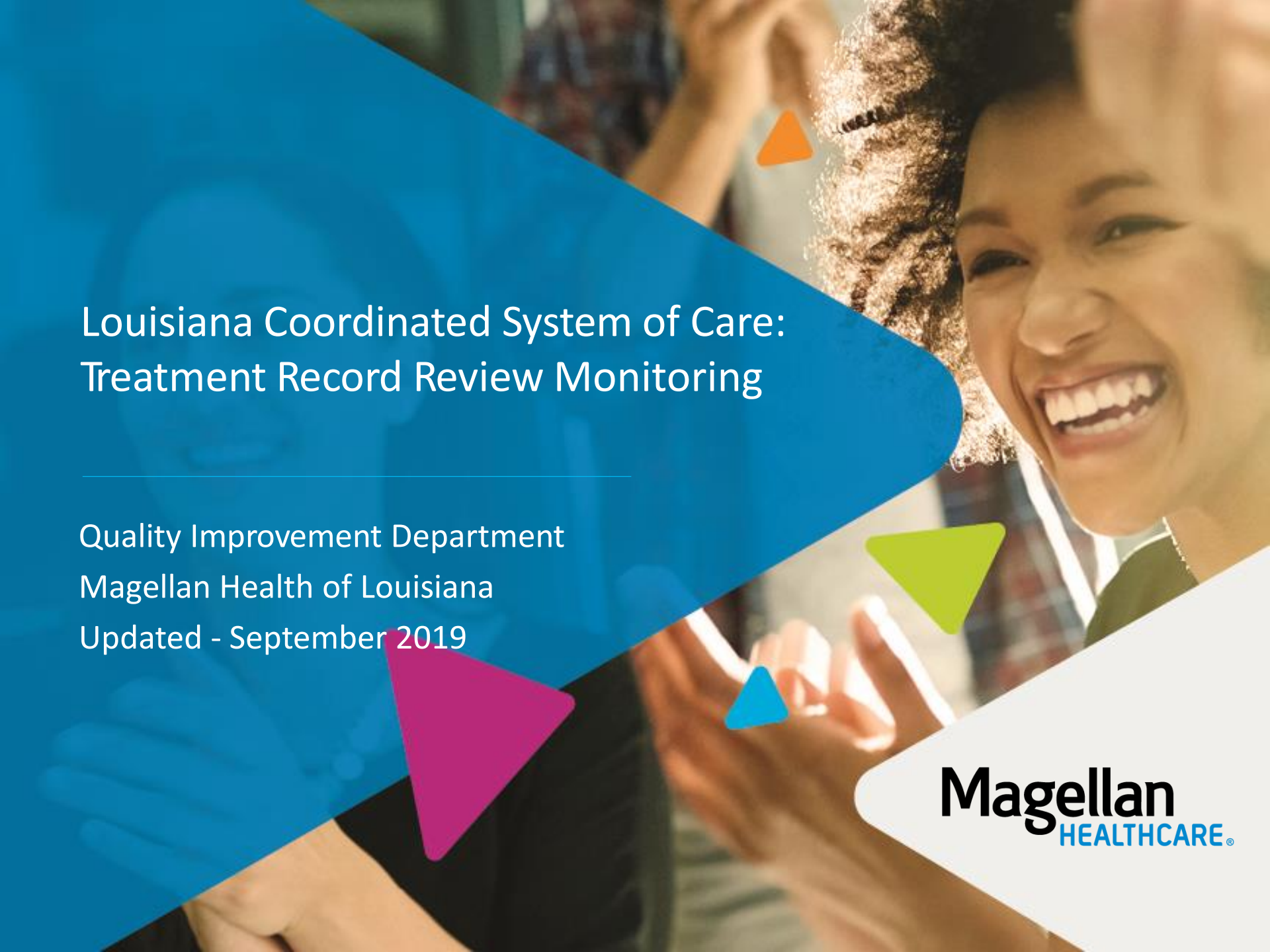


Louisiana Coordinated System of Care: Treatment Record Review Monitoring

Quality Improvement Department

Magellan Health of Louisiana

Updated - September 2019

Magellan HEALTHCARE®

Agenda

1. Purpose
2. The Basics
3. The Coordinated System of Care
4. Quality Assurance Activities

Magellan HEALTHCARE®

Purpose

Magellan HEALTHCARE®

Agenda One / Purpose

Why should you care about record keeping?

Magellan HEALTHCARE

Consequences of Poor Record Keeping

Errors

- Documents missing within record
- Omitted information
- Lack of detail
- Too much detail
- Failure to document important decisions
- Failure to document critical incidents

Poor Member Care

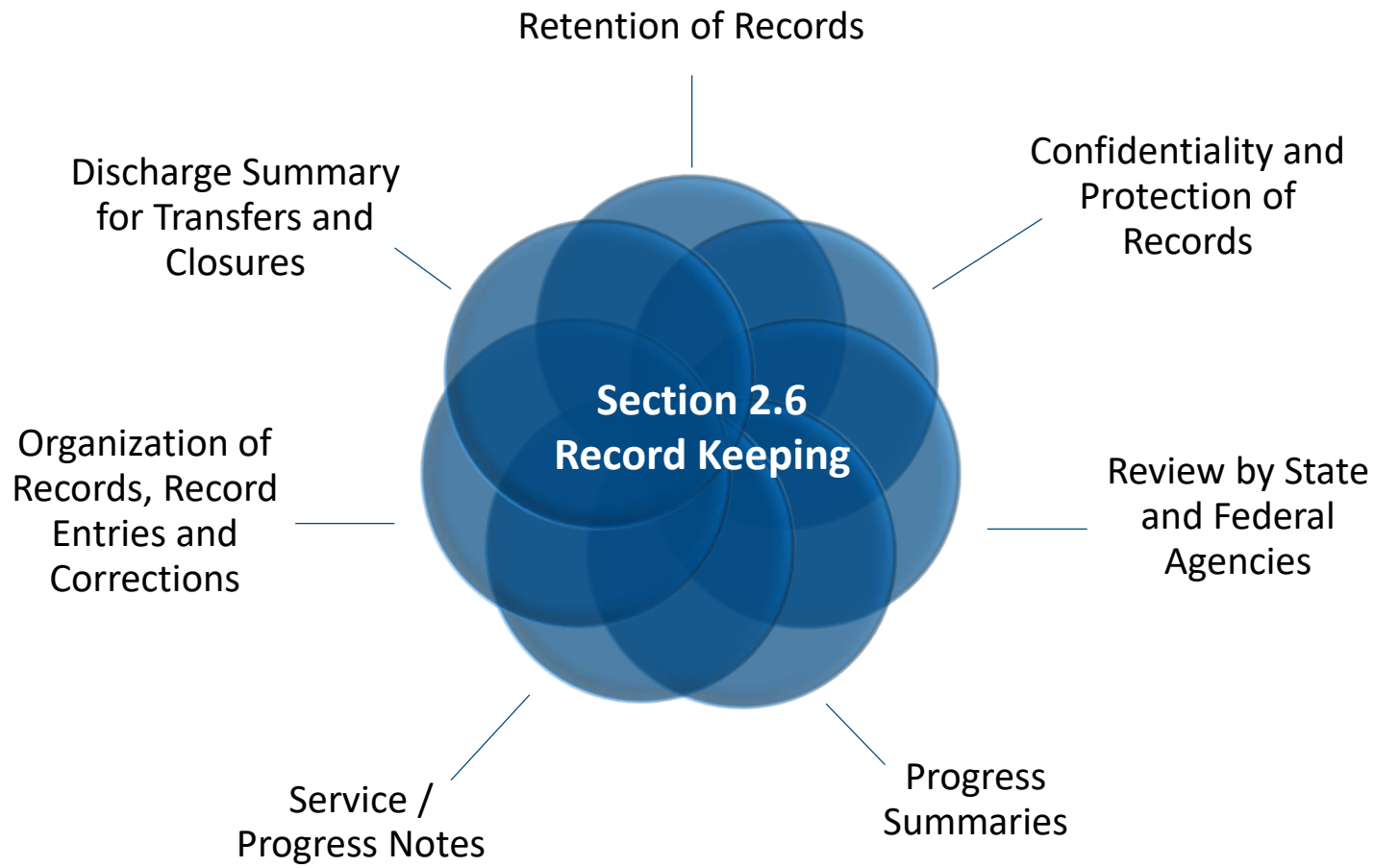
- Impaired quality of care
- Poor treatment engagement and retention
- Poor or uninformed treatment decisions
- Misdiagnosis
- Poor continuity of care
- Ethical and legal concerns
- Failure to assure insurance requirements

Third Party Payor Action

- Legal actions
- Recovery of payments
- Penalties - Corrective Action Plans or Performance Improvement Plans
- Hold on new referrals
- Termination of contract

Behavioral Health Services Provider Manual

All providers are responsible for knowing and complying with all requirements outlined in the manual. Section 2.6. specifically address record keeping. Please ***Appendix Four*** for the complete copy of the section.



Medicaid - Record Requirements

- Records must be maintained in an accessible, standardized order, and format
- Records must be sufficient to document compliance with LDH requirements for the recipient served and the provision of services.
- Records must support medical necessity for each billed service and fully document services for which payments have been made
- Records must be sufficient to verify that prior to payment each charge is due and proper.

The Basics

Informed Consent

- Demonstrates that the provider and member are in agreement with and consent to the treatment to be provided, including its potential benefits and limitations
- Treatment of minors (youth under the age of 18) requires the consent of the parent or guardian
- Should include the discussion of confidentiality, including potential limits
- If you are a prescriber, informed consent for medications should be documented separately.

Don’t forget to explain your obligations as a mandated reporter of suspected abuse, neglect and exploitation of children as part of your informed consent process.

Intake Assessment

General Requirements

- Contact information, including emergency and crisis contacts
- Current concerns
- Current and previous diagnoses
- Treatment history
- Response to and outcome of previous treatments
- Cultural needs (e.g., racial, gender, spirituality, sexuality, preferred language, etc.)
- History of trauma or abuse
- Guardianship and family history
- Educational background
- Risk factors (e.g., previous or recent suicidal and/or homicidal ideation, behavior or attempts)

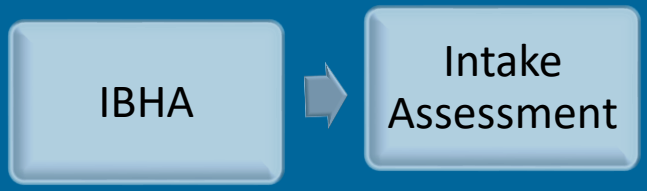
Heller RJ, Gilliam LS, Chenail RJ, Hall TL. Three Authors, One Client: A Qualitative Description of Marriage and Family Therapy Initial Case Documentation. Contemporary Family Therapy. 2010;32(4):363–374. doi:10.1007/s10591-010-9130-6.

Intake Assessment

- Using a structured intake process and standardized intake form, including screening tools, can help providers ensuring necessary information is gathered
- Intake assessment should be reviewed and updated on a continuous and ongoing basis - contact information, diagnosis or medications may change
- Once appropriate consent is obtained, providers should validate and clarify information with previous and current mental health providers

FAQ - Can the Independent Behavioral Health Assessment (IBHA) replace a provider intake assessment?

The IBHA is conducted by a Certified Provider every 180-days for eligibility determinations. It can inform a provider intake assessment; however, the IBHA should not replace the provider's intake assessment.



Authorized Uses and Disclosures

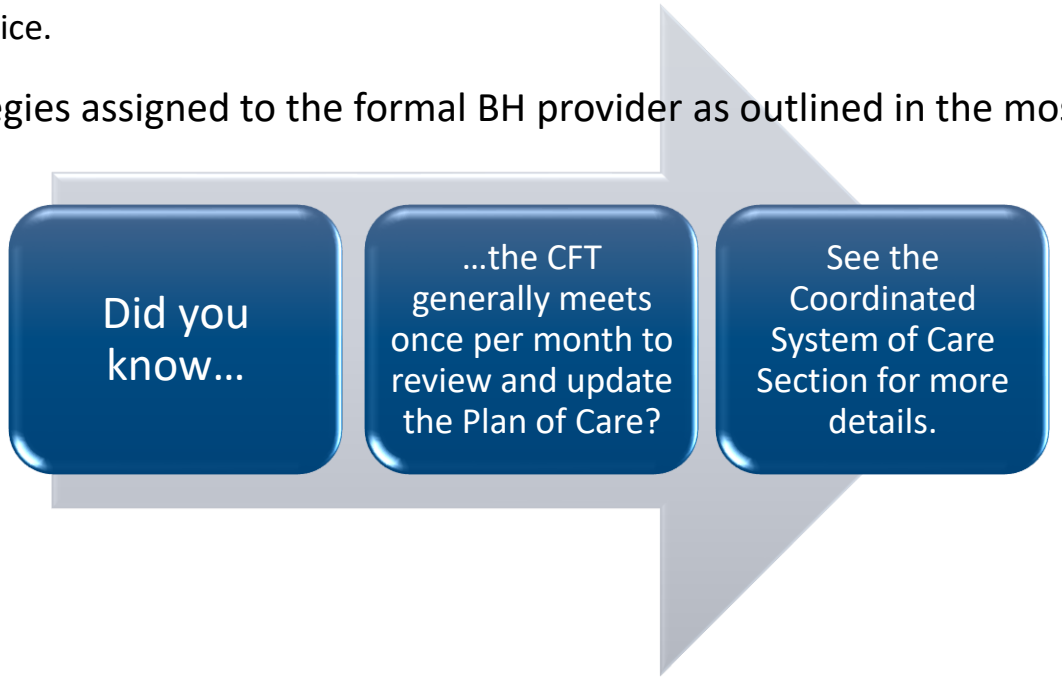
- Allows professionals to share information with others, both verbal and written.
- Necessary to support continuity of care -
  - → When clients have received previous services
  - → Concurrent services necessitate communication across providers
  - → When information need to be transferred to ensure continuity of treatment
- There are two types of releases of information (ROIs) -
  - → Release to obtain information
  - → Release to provide information to others

CSoC Specific Requirements

Providers must have ROIs to obtain and release information with the member's Wraparound Agency, PCP and other relevant BH providers (e.g., LMHP, psychiatrist, etc.).

Treatment Planning

- Treatment plans typically document diagnoses, symptoms to be treated, treatment goals, and treatment approach.
- Louisiana Medicaid requires treatment plans include at a minimum:
  - Goals and objectives, which are specific, measurable, action oriented, realistic and time-limited;
  - Specific interventions;
  - Service locations for each intervention;
  - Staff providing the intervention; and
  - Dates of service.
- Reflect the strategies assigned to the formal BH provider as outlined in the most recent Plan of Care.



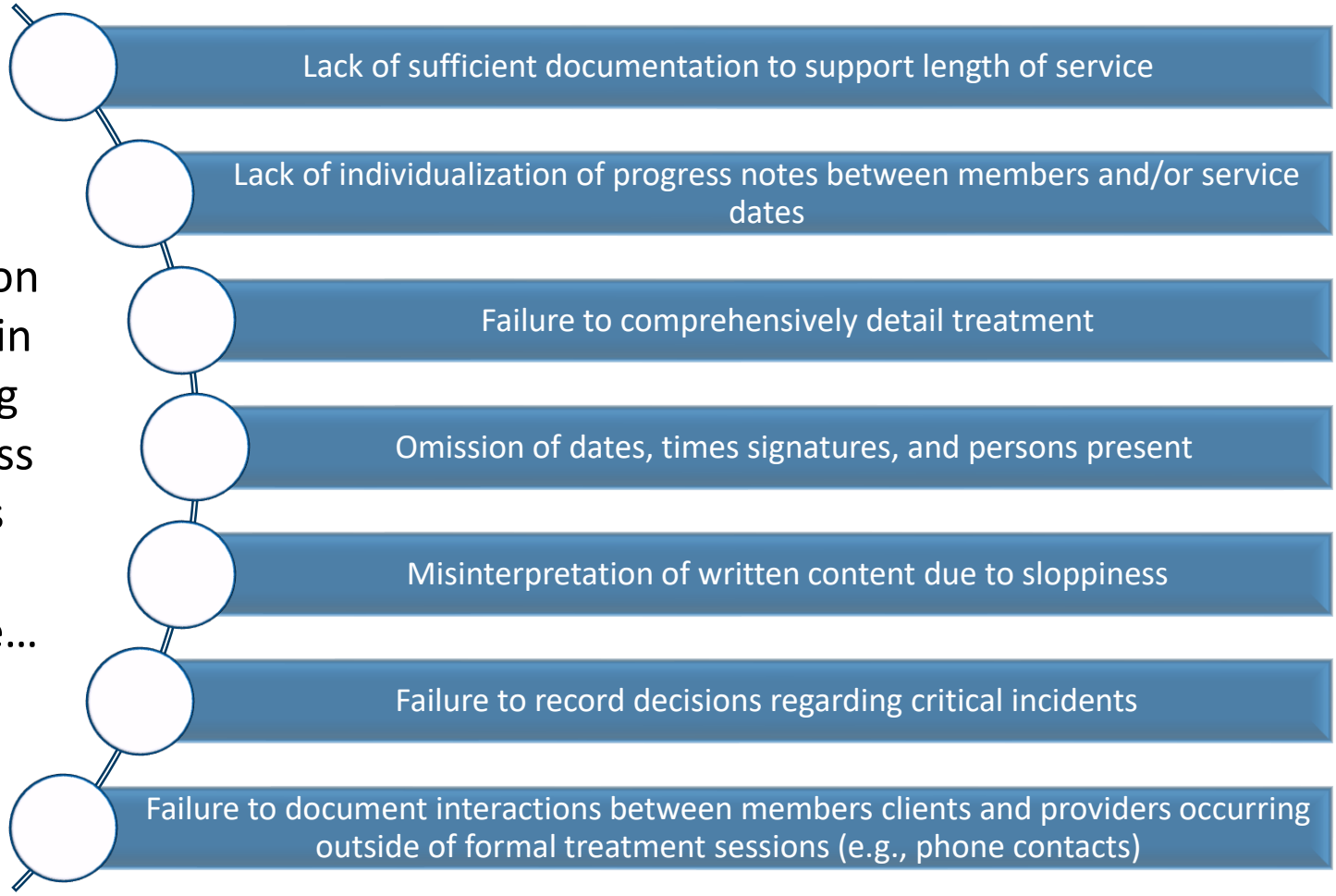
Progress Notes

Some of the Behavioral Health Services Provider Manual requirements:

- Include service location and start and end time
- Be documented in a narrative format that reflects delivery of each service and elaborates on the activity of the contact;
- Be of sufficient content to reflect descriptions of activities and cannot be so general that a complete picture of the services and progress cannot be easily determined from the content of the note
- Indicate how the recipient is progressing toward the personal outcomes in the treatment plan, as applicable;
- Document delivery of each service identified on the treatment plan, as applicable;
- Record any changes in the recipient's medical condition, behavior or home situation that may indicate a need for a reassessment and treatment plan change, as applicable;
- Be legible (including signature) and include the functional title of the person making the entry and date;
- Be complete and updated in the record in the time specified;
- Be complete and updated by the supervisor (if applicable) in the record as progress summary at the time specified;
- Be signed by the person providing the services; and
- Be entered in the recipient's record when a case is transferred or closed.

Progress Notes – Common Errors

Common errors in writing progress notes can include…



Progress Notes – Standardized Templates

Semi-standardized progress note formats can be a helpful mechanism to ensure relevant information is consistently documented, but they should be used with caution.

- **STIPS** (Symptoms, Topics of discussion, Interventions, Progress and plans, Special client issues)
- **DAP** (Data, Assessment, Plan)
- **SOAP** (Subjective, Objective, Assessment, Plan)

Strengths

→ Allows for the consistent documentation of key elements across members cases and provider staffs, and trainees

→ Supports providers with documenting and assessing clinical information to assist and validate therapeutic decisions

Weaknesses

→ Lead to the lack of individualization of content across clients within an agency or within a client's record

→ Increase difficulties when providers and/or supervisors try to identify important treatment information

Discharge Summary

- Discharge summary usually contains:
  - Overview of assessment results
  - Summary of problems evidenced prior to treatment implementation
  - Interventions implemented,
  - Member response to treatment
  - Future therapeutic plan
- Discharge from treatment occurs for various reasons, including successful completion of treatment program, disengagement of youth and/or family, relocation and provider changes.
  - Providers should have policies and procedures with specific criteria to trigger the completion of a discharge summary to ensure compliance.

.

Access to Records

Purpose: To guarantee information contained in member records remains confidential and secure.

- Providers are responsible for being knowledgeable of and complying with applicable laws and regulations regarding the retention of client records for mandated periods
- Must effectively manage obligations to ensure that any personnel who handle member records are familiar with confidentiality and methods to secure records.
- Policies should address both the management of paper and electronic records, including stipulation to keep records locked and secure at all times in locked cabinets within locked offices or storage rooms to protect them from damage, destruction, and improper access.

Clinical Practice Guidelines

Magellan develops or adopts clinical practice guidelines to assist providers in screening, assessing and treating common disorders.

- Intended to augment, not replace, sound clinical judgment.
- Developed using a multi-disciplinary panel—including board-certified psychiatrists and clinical staff— that examines relevant scientific literature and seeks input from network providers as well as consumers and community agencies.
- Reviewed at least every two years for continued applicability and updates guidelines as necessary.
- Magellan Health in Louisiana monitors provider adherence to clinical practice guidelines for:
  - Suicide Risk Assessment and Management
  - Attention Deficit Hyperactivity Disorder
  - Conduct Disorder
  - Trauma-informed Care
- Guidelines are accessible to providers at MagellanProvider.com.

The Coordinated System of Care

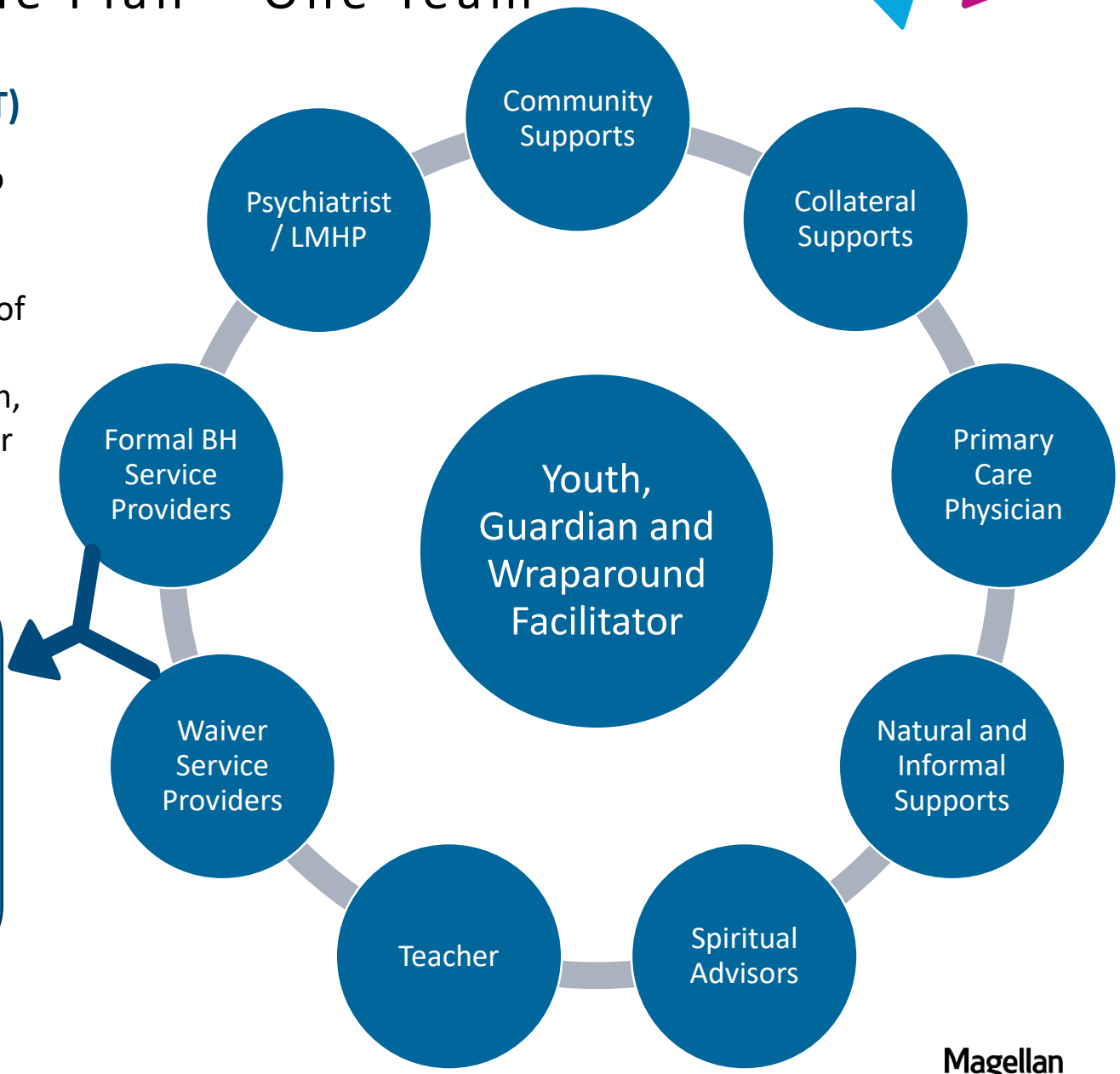
Magellan HEALTHCARE®

One Family – One Plan – One Team

Child and Family Team (CFT)

A diverse team of people who are relevant to the life of the child or youth collaboratively develop an individualized plan of care, implement this plan, monitor the efficacy of the plan, and work towards success over time.

The CFT typically includes formal BH and waiver service, including youth and parent supports, providers to build skills and meet youth and family needs.



Magellan HEALTHCARE

Participation in CFT Meetings

- The CFT generally meets at a minimum of once per month or more frequently as needed.
- It is best to attend in person so you can actively participate with the team, including:
  - Supporting youth and guardian
  - Brainstorming creative ways to meet complex needs
  - Celebrating accomplishments together
  - Tracking progress

Can't attend? Didn't get notification of the CFT?

Established a fixed date and time to talk with your youth's Wraparound Facilitator at least once per month. You can discuss:

- Progress toward goals – accomplishments, newly identified needs, worsening needs
- Barriers to treatment
- Effectiveness of interventions
- Any known risk factors
- Changes to medications (if applicable)
- Confirm the date and time of the next CFT meeting
- Issues with authorizations or missing documents – IBHA, POC, CANS

Core CSoC Documents

Core Documents

- Independent Behavioral Health Assessment (IBHA)
- Child and Adolescent Needs and Strengths (CANS) Comprehensive Plan of Care (POC)
- Plan of Care (POC)
- Crisis Plan
- Freedom of Choice form

Intake Assessments

- Diagnosis
- Youth and family strengths
- BH needs and risk areas
- Medical issues
- Family history
- Trauma history
- Previous treatment history
- Educational Needs

Treatment Planning

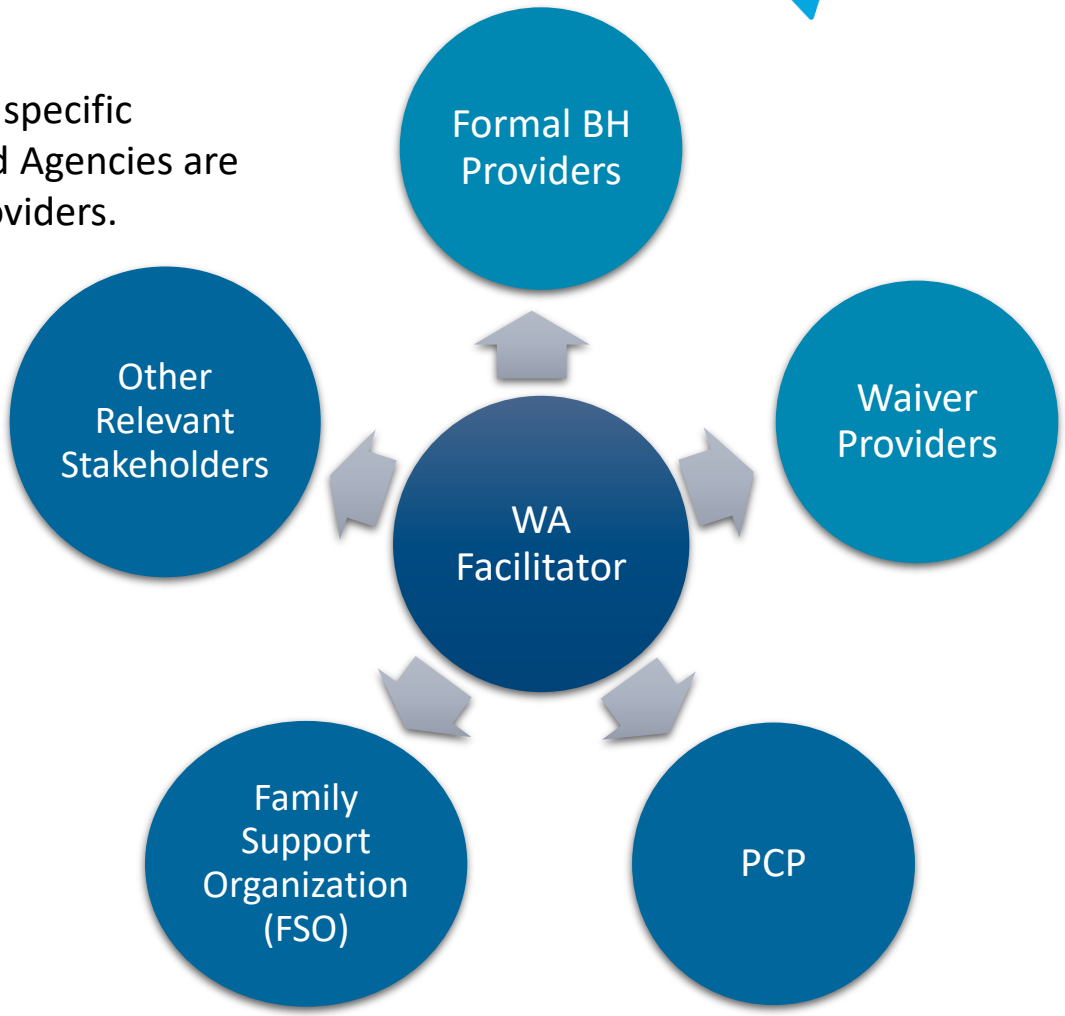
- Identify strategies to be address on treatment plan
- Provides the service authorization start and end date
- Specifies the type, frequency, duration and amount of services to be provided
- Other relevant BH providers working with youth

The Wraparound Facilitator is responsible for completing these core documents, which provide a wealth of information that can be used by formal providers to inform and guide treatment and/or service delivery.

Timeframes for Sharing Documents

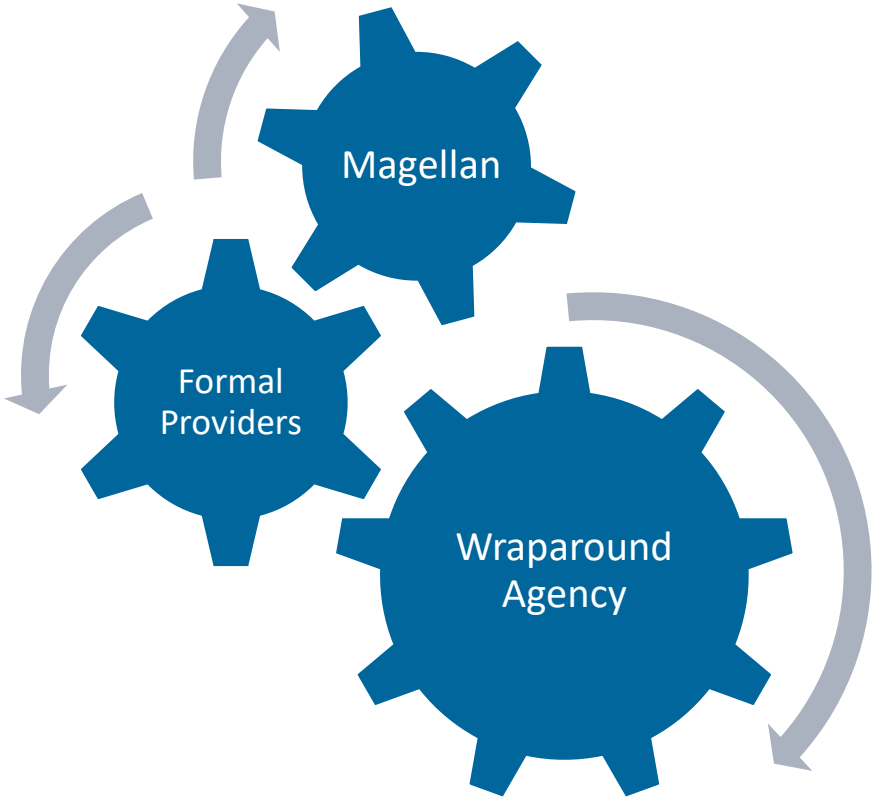
The **Standard Operating Procedure** provides specific requirements for when and how Wraparound Agencies are required to share documents with formal providers.

- Eligibility documents (i.e., IBHA, CANS and POC) every 180 days
- Notification of CFT meetings at least 7 calendar days prior to the meeting date and time
- Notification of updated CFT meeting date and time in the event of a cancelled and/or rescheduled CFT meeting
- Current POC to all formal providers listed on the CFT via secure email within 5 business days after each CFT meeting



Building a Hospitable System

- Magellan works together with the Wraparound Agencies and Formal Providers to support care coordination of CSoC Members.
- Implementation of an independent audit tool to assess the level of care coordination and document sharing completed by the WAAs as evidence in the formal provider and FSO records.
- It is NOT a measure of Formal Provider performance.
- Mechanism to collect quantitative data to examine care coordination between provider organizations.
- Results used to identify barriers and targeted interventions to improve coordination of care activities across the system of care.



Quality Assurance Activities

Treatment Record Reviews (TRR)

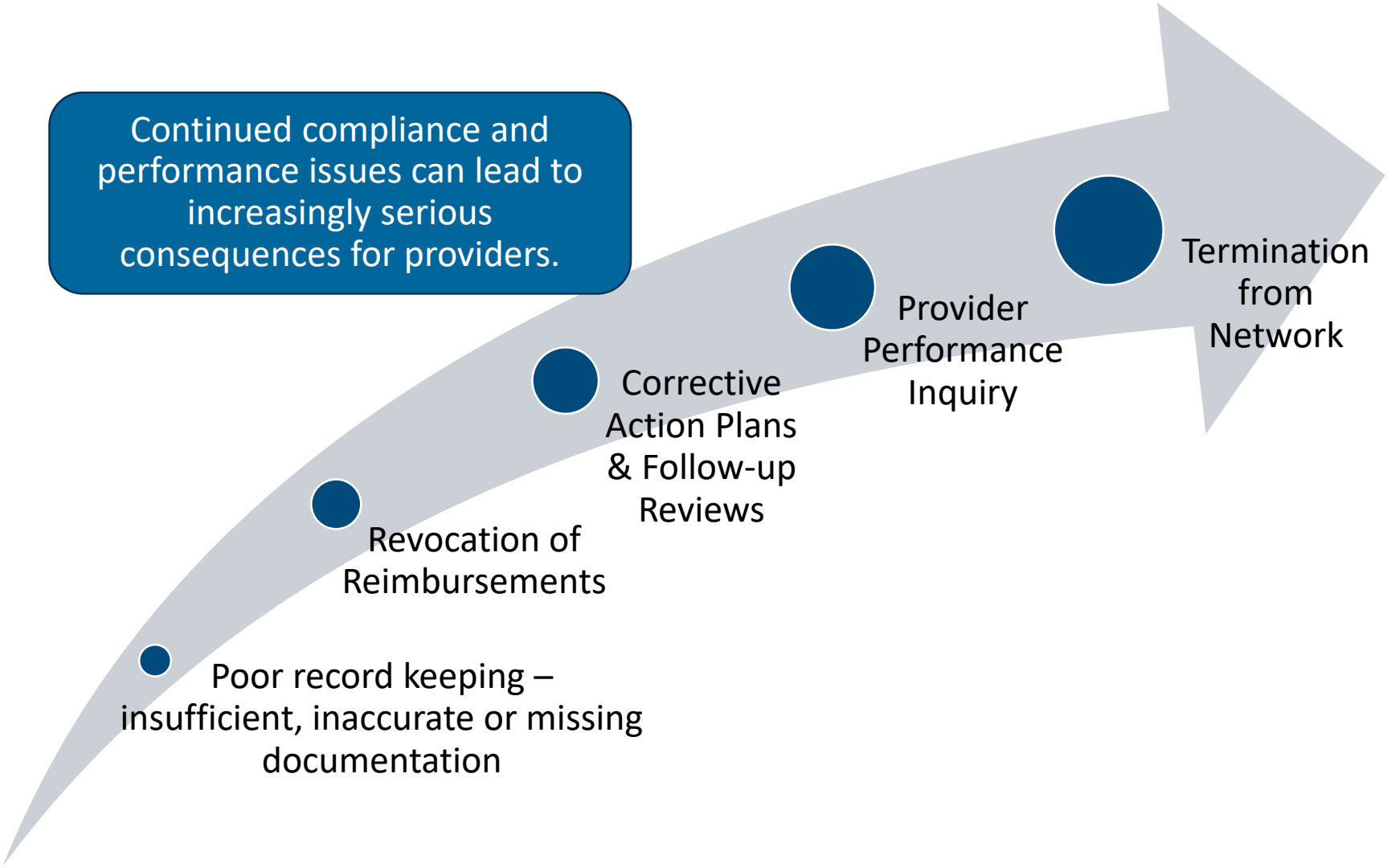
- Magellan is contractually required to conduct audits, or Treatment Record Reviews, to monitor providers record keeping practices to ensure compliance with:
  - Center for Medicare & Medicaid Services (CMMS) requirements and regulations
  - Louisiana Department of Health (LDH) standards
  - Magellan's practice standards : Medical Necessity Criteria and Clinical Practice Guidelines
- Provider participation is required.
  - **Section 2.5 of the Network Provider Contract** - Provider AGREES to cooperate and participate with all announced or unannounced internal and external quality assessment reviews, utilization review/management, and grievance procedures, or other similar programs established by Magellan and DHH-OBH, or its designee.
- All contracted providers are required to submit records without charges to Magellan.
  - **Section 8.1 of the Network Provider Contract -** If copies of Members' medical records are requested by Magellan or Payer for appeals or any utilization, grievance, claims payment or quality review, Facility AGREES to provide the medical records WITHOUT charges.

General Requirements

- Providers can be selected for review as part of quarterly random sampling or to investigate an incident, such as a quality of care concern, member grievance or adverse incident.
- Reviews are generally conducted remotely.
- If selected, a Clinical Reviewer will notify you by phone, confirm contact information, and provide an overview of the process. The notification will be followed up with an electronic request that includes the members selected for review, detailed procedures for the audit and a copy of the audit tool.
- When submitting records, ensure that all relevant documents are included to address questions.
- Records should be submitted in securely accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations.
- Performance Improvement Plans (PIPs) will be requested if areas of non-compliance or quality concerns are identified through the review process. Magellan will provide specific requirements and time frames for PIPs as needed.

Impact of Poor Performance

Continued compliance and performance issues can lead to increasingly serious consequences for providers.



Magellan HEALTHCARE

Protective Factors

- → Preventive actions may include changes in problematic forms, ongoing training, and protocol revisions
- → While corrective actions involve providing feedback and requiring corrections to be made for errors within a record

- → Should include detailed and specific guidelines
- → Ensure compliance with Federal and State regulations and third party payer requirements
- → Address initial and ongoing training protocols for staff

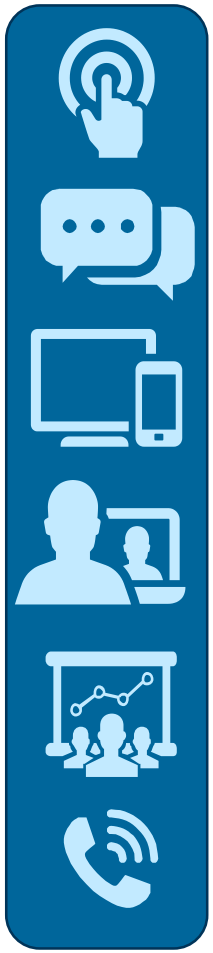
- → Audits should be conducted on a continuous and ongoing basis with a sufficient sample of records, stratified by staff and members
- → Utilize established criteria to determine the correctness of diagnoses and treatment planning
- → Ensure all documentation is complete and accurate

Resources and Appendices

Magellan HEALTHCARE®

Resources

- Quality Improvement and Outcomes page on the Magellan Health in Louisiana website has resources to help providers in record keeping practices, including:
- Sample Templates
  - Crisis Plan Template
  - Discharge Summary Template
  - Informed Consent for Medication Template
  - Member Rights and Responsibilities Template (Spanish and English)
- Information Sheets
  - Advance Psychiatric Directives
  - Initial Evaluations
  - Tips for Writing Progress Notes
  - Tips for Writing Treatment
- Contact one of Magellan's Clinical Reviewers any time if you have questions or concerns.
  - → Stephanie A Beck, LPC-S at sabeck@magellanhealth.com
  - → Britannia Jones, LPC-S at jonesb@magellanhealth.com



References

- Behavioral Health Services Provider Manual - https://www.lamedicaid.com/provweb1/providermanuals/manuals/bhs/bhs.pdf
- Bradshaw KM, Donohue B, Wilks C. A Review of Quality Assurance Methods to Assist Professional Record Keeping: Implications for Providers of Interpersonal Violence Treatment. Aggress Violent Behav. 2014 May;19(3):242-250.
- Center for Substance Abuse Treatment . Screening for Infectious Diseases Among Substance Abusers. Substance Abuse and Mental Health Services Administration; Rockville, MD: 1993. Treatment Improvement Protocol (TIP) Series, No. 6.
- Heller RJ, Gilliam LS, Chenail RJ, Hall TL. Three Authors, One Client: A Qualitative Description of Marriage and Family Therapy Initial Case Documentation. Contemporary Family Therapy. 2010;32(4):363–374. doi:10.1007/s10591-010-9130-6.
- Magellan Provider Clinical Practice Guidelines - websitehttps://www.magellanprovider.com/providing-care/clinical-guidelines/clinical-practice-guidelines.aspx
- Mary A, Cynthia A, Armand R, Galietta M, Sara J, Lally S, Lovejoy GD, et al. Record keeping guidelines. The American psychologist. 2007;62(9):993–1004. doi:10.1037/0003-066X.62.9.993.
- Piazza N, Baruth N. Client record guidelines. Journal of Counseling & Development. 1990;68(3):313.
- Pyle H. Auditing clinical data. Applied Clinical Trials. 2000;9(5):65.
- Standard Operating Procedure Manual: https://www.magellanoflouisiana.com/media/4281/csoc_sop_11-2018-final.pdf
- Tjeltveit AC, Gottlieb MC. Avoiding the road to ethical disaster: Overcoming vulnerabilities and developing resilience. Psychotherapy (Chicago, Ill.) 2010;47(1):98–110. doi:10.1037/a0018843.
- Whyte M. Computerized versus handwritten records. Pediatric Nursing. 2005;17(7):15–18.
- U.S. Department of Health and Hospitals: https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html

Magellan HEALTHCARE

Appendix 1

Common Errors in Record Keeping and Resulting Problems

Document	Common Errors	Examples of Resulting Problems
Informed Consent	Missing within record	Ethical and legal concerns
	Not administered	Poor rapport
		Premature termination
Intake Forms	Missing within record	Impaired quality of care
	Inaccurate information	Poor treatment engagement and retention
	Lack of information	Poor or uninformed treatment decisions
	Time inefficiencies	
	Poor continuity of care	
Release of Information	Missing within record	Ethical and legal concerns
	Not administered	Poor continuity of care
	Inaccurate completion	
Progress Note	Missing within record	Ethical and legal problems
	Omitted information	Failure to assure insurance requirements
	Lack of detail	Improper treatment
	Too much detail	Poor continuity of care
	Failure to document important decisions or critical incidents	
	Poor handwriting	
Treatment Plan	Missing within record	Rapport
	Poorly documented	Poor or uninformed treatment decisions
	Poor assessment of client symptoms or concerns	Failure to assure insurance requirements
	Vague or irrelevant goals	Misdiagnosis
Discharge Summary	Missing within record	Continuity of care
	Omitted information	Insurance requirements
	Lack of detail	Failure to document treatment progress or completion
	Too much detail	
Access to records	Breach of confidentiality	Ethical and legal concerns
	Failure to retain records for required time period	Poor continuity of care
	Inaccessible or lost records	

Appendix 2

Releases of Information - Resources

Fact Sheets related to handling mental health information under HIPAA

- HIPAA Privacy Rule and Sharing Information Related to Mental Health - PDF
- Additional FAQs on Sharing Information Related to Treatment for Mental Health or Substance Use Disorder—Including Opioid Abuse – PDF

Fact Sheets regarding the Substance Abuse Confidentiality Regulations

The protected health information of individuals who receive drug and alcohol abuse treatment in federally-funded programs is subject to additional privacy protections under 42 USC § 290dd-2 and 42 CFR § 2.11 (Part 2).

- Disclosure of Substance Use Disorder Patient Records: Does Part 2 Apply to Me?
- Disclosure of Substance Use Disorder Patient Records: How Do I Exchange Part 2 Data?

Fact Sheets for Youth and Minors

- When Your Child, Teenager, or Young Adult has Mental Illness: What Parents Need to Know about HIPAA - PDF
- Am I my child's personal representative under HIPAA? - PDF
- When may a mental health professional use professional judgment to decide whether to share a minor client's treatment information with a parent? - PDF
- When can parents access information about their minor child's mental health treatment? (Decision Chart) - PDF

Appendix 3

Core CSoC Document - Definitions

- **Standard Operating Procedure Manual**: Promulgated by LDH to provide guidance for conducting the day-to-day activities that are necessary in developing, implementing and sustaining the Coordinated System of Care (CSoC) in Louisiana. Guidance is provided in the areas of CSoC eligibility, referral, screening/assessment, enrollment, services, quality assurance and training requirements.
- **Child and Adolescent Needs and Strengths (CANS) Comprehensive:** Developed from a communication perspective to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices. Domains assessed include general symptomatology, risk behaviors, developmental functioning, personal/interpersonal functioning, and family functioning.
- **Independent Behavioral Health Assessment (IBHA):** Thorough, face-to-face assessment of the individual's most recent behavioral/mental status, any relevant history, including findings from the CANS Comprehensive, medical records, objective evaluation of functional ability, and any other available records.
- **Plan of Care (POC):** Includes a Crisis Plan and specifies the type, amount, frequency and duration of formal services the Child and Family Team deem appropriate. Magellan builds authorizations for services (generally in 180-day increments) based on the POC.

Appendix 4
Section 2.6 Record Keeping

This appendix is replication of **LDH's Behavioral Health Services Provider Manual, Chapter Two of the Medicaid Services Manual, Section 2.6: Record Keeping, Issued 06/29/18** (Replaced Version Issued on 04/20/18) retrieved on 09/04/2019. It is the responsibility of providers to monitor the Louisiana Medicaid Website for revisions to the manual on an ongoing basis.
Link - https://www.lamedicaid.com/provweb1/Providermanuals/manuals/BHS/BHS.pdf

Components of Record Keeping

All provider records must be maintained in an accessible, standardized order, and format, at the office site in the Louisiana Department of Health's (LDH) administrative region where the recipient resides. The provider must have sufficient space, facilities and supplies to ensure effective record keeping. The provider must keep sufficient records to document compliance with LDH requirements for the recipient served and the provision of services.

A separate record that supports medical necessity for each billed service and fully documents services for which payments have been made must be maintained on each recipient. The provider must maintain sufficient documentation to enable LDH, or its designee, to verify that prior to payment each charge is due and proper. The provider must make available all records that LDH or its designee finds necessary to determine compliance with all federal or state law, rule or regulation promulgated by LDH.

Retention of Records

Administrative, personnel and recipient records must be maintained for whichever of the following time frames is longer:

- Until records are audited and all audit questions are answered; or
- Six years from the date of the last payment period.

NOTE: Upon provider closure, all provider records must be maintained according to applicable laws, regulations and the above record retention requirements, and copies of the required documents transferred to the new agency.

Appendix 4
Section 2.6 Record Keeping

Confidentiality and Protection of Records
All records, including administrative and recipient records, must be the property of the provider and secured against loss, tampering, destruction or unauthorized use. Employees of the provider must not disclose or knowingly permit the disclosure of any information concerning the provider, the recipient or their families, directly or indirectly, to any unauthorized person. The provider must safeguard the confidentiality of any information that might identify the recipients or their families. The information may be released only under the following conditions:

- Court order;
- Recipient's written informed consent for release of information;
- Written consent of the individual to whom the recipient's rights have been devolved when the recipient has been declared legally incompetent; or
- Compliance with the Federal Confidentiality Law of Alcohol and Drug Abuse Patients Records (42 CFR, Part 2).

Upon request, a provider must make available information in the case records to the recipient or legally responsible representative. If, in the professional judgment of the administration of the agency, it is felt that information contained in the record would be damaging to the recipient, that information may be withheld from the recipient, except under court order. The provider may charge a reasonable fee for providing the above records. This fee cannot exceed the community's competitive copying rate.

A provider may use material from case records for teaching or research purposes, development of the governing body's understanding and knowledge of the provider's services, or similar educational purposes, if names are deleted and other similar identifying information is disguised or deleted. Any electronic communication containing recipient specific identifying information sent by the provider to another agency, or to LDH, must comply with regulations of the Health Insurance Portability and Accountability Act (HIPAA) and be sent securely via an encrypted messaging system. A system must be maintained that provides for the control and location of all recipient records.

NOTE: Under no circumstances should providers allow staff to take recipient's case records from the office**.**

Appendix 4
Section 2.6 Record Keeping

Review by State and Federal Agencies
Providers must make all administrative, personnel and recipient records available to LDH, or its designee, and appropriate state and federal personnel at all times. Providers must always safeguard the confidentiality of recipient information.

Member Records
Providers must have a separate written record for each recipient served by the provider. For the purposes of continuity of care/support and for adequate monitoring of progress toward outcomes and services received, service providers must have adequate documentation of services offered and provided to recipients they serve. This documentation is an on-going chronology of activities undertaken on behalf of the recipient.

Providers shall maintain case records that include, at a minimum:

- Name of the individual;
- Dates and time of service;
- Assessments;
- Copy of the treatment plans, which include at a minimum:
  - Goals and objectives, which are specific, measurable, action oriented,
  - realistic and time-limited;
  - Specific interventions;
  - Service locations for each intervention;
  - Staff providing the intervention; and
  - Dates of service;
- Progress notes;
- Units of services provided;
- Crisis plan;
- Discharge plan; and
- Advanced directive.

Appendix 4
Section 2.6 Record Keeping

Organization of Records, Record Entries and Corrections
Organization of individual recipient records and the location of documents within the record must be consistent among all records. Records must be appropriately thinned so that current material can be easily located in the record. All entries and forms completed by staff in recipient records must be legible, written in ink (not black) and include the following:

- The name of the person making the entry;
- The signature of the person making the entry;
- The functional title of the person making the entry;
- The full date of documentation; and
- Reviewed by the supervisor, if required.

Any error made by the staff in a recipient's record must be corrected using the legal method which is to draw a line through the incorrect information, write "error" by it and initial the correction**. Correction fluid must never be used in a recipient's records**.

Service/Progress Notes
Service/progress notes document the service/progress billed. Service/progress notes must reflect the service delivered and are the "paper trail" for services delivered. The following information is required to be entered in the service/progress notes to provide a clear audit trail and document claims:

- Name of recipient;
- Name of provider and employee providing the service(s);
- Service provider contact telephone number;
- Date of service contact;
- Start and stop time of service contact; and
- Content of each delivered service, including the reason for the contact describing
- the goals/objectives addressed during the service, specific intervention(s), progress
- made toward functional and clinical improvement.

Appendix 4
Section 2.6 Record Keeping

Service/progress notes must be reviewed by the supervisor (if applicable) to ensure that all activities are appropriate in terms of the nature and time, and that documentation is sufficient. The service/progress note must clearly document that the services provided are related to the recipient's goals, objectives and interventions in the treatment plan, and are deemed medically necessary and clinically appropriate; document what materials were used when teaching a skill and document the progress of the recipient with very specific information regarding response to the intervention and the plan for next time. Service/progress notes should include each recipient's response to the intervention, noting if progress is or is not being made. Effective documentation includes observed behaviors if applicable and a plan for the next scheduled contact with the recipient.

Progress Summaries

A progress summary is a synthesis of all activities and services for a specified period (at least every 90 days or more often if required by the managed care organization (MCO) or Coordinated System of Care (CSOC) contractor) which address each recipient's assessed needs, progress toward the recipient's desired personal outcomes, and changes in the recipient's progress and service needs. This summary must be of sufficient detail and analysis to allow for evaluation of the appropriateness of the recipient's treatment plan, sufficient information for use by supervisors, and evaluation of activities by program monitors. Progress summaries must:

- Document the time period summarized;
- Indicate who was contacted, where contact occurred and what activity occurred;
- Record activities and actions taken, by whom, and progress made;
- Indicate how the recipient is progressing toward the personal outcomes in the
- treatment plan, as applicable;
- Document delivery of each service identified on the treatment plan, as applicable;
- Document any deviation from the treatment plan;

Appendix 4
Section 2.6 Record Keeping

- Record any changes in the recipient's medical condition, behavior or home situation that may indicate a need for a reassessment and treatment plan change, as applicable;
- Be legible (including signature) and include the functional title of the person
- making the entry and date;
- Be complete and updated in the record in the time specified;
- Be complete and updated by the supervisor (if applicable) in the record as progress summary at the time specified;
- Be recorded more frequently when there is frequent activity or when significant changes occur in the recipient's service needs and progress;
- Be signed by the person providing the services; and
- Be entered in the recipient's record when a case is transferred or closed.

Progress summaries must be documented in a narrative format that reflects delivery of each service and elaborates on the activity of the contact. Progress summaries must be of sufficient content to reflect descriptions of activities and cannot be so general that a complete picture of the services and progress cannot be easily determined from the content of the note.

NOTE: General terms and phrases such as “called the recipient”, “supported recipient”, or “assisted recipient” are not sufficient and do not reflect adequate content. Check lists alone are not adequate documentation.

Discharge Summary for Transfers and Closures
A discharge summary details the recipient’s progress prior to a transfer or closure. A discharge summary must be completed within 14 calendar days following a recipient’s discharge.

Confidentiality statement

By receipt of this presentation, each recipient agrees that the information contained herein will be kept confidential and that the information will not be photocopied, reproduced, or distributed to or disclosed to others at any time without the prior written consent of Magellan Health, Inc.

The information contained in this presentation is intended for educational purposes only and is not intended to define a standard of care or exclusive course of treatment, nor be a substitute for treatment.

Magellan HEALTHCARE