Chapter Title	Chapter #		Subject #
Fiscal	F		281.1
Subject Title **Documentation**	Adopted 04/12/02	Last Revised 12/16/19	Reviewed 3/15/05;7/26/05; 9/5/06;4/23/10; 2/24/14;10/08/15; 3/17/17;11/27/17; 11/5/18; 12/16/19

PROCEDURE

Application

This procedure shall apply to the clinical services of The Right Door for Hope, Recovery and Wellness.

1.0 Contents of Clinical Records

1.1 Providers must maintain, in English and in a legible manner, written or electronic records necessary to fully disclose and document the extent of services provided to beneficiaries.

1.2 Clinical records shall be maintained in a manner that protects the confidentiality of the individual being served and complies with federal and state mandates.

1.3 Access to the contents of a clinical record shall be limited to those individuals authorized access to this information.

1.4 Contents of the clinical records shall be organized in a way that is clear, complete and concise.

1.5 All documents shall require full and legible electronic or hand signatures, or signature accompanied by printed name with the appropriate credentials indicated and shall include the date of signing.

1.6 Providers of Medicaid beneficiaries must document the following:

1.6.1 Name

1.6.2 Medicaid ID Number

1.6.3 Medicaid Record Number

1.6.4 Address, including zip code

1.6.5 Birth Date

1.6.6 Telephone number, if available

1.6.7 Any private health insurance information for the beneficiary, if available

1.6.8 Date of each visit

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1.6.9 Begin Time and End Time – Specific According to Procedure/Revenue Code billed

1.6.10 Presenting Symptom, Condition

1.6.11 Diagnosis

1.6.12 Patient Histories

1.6.13 Plans of Care

1.6.14 Progress Notes

1.6.14.1 Progress notes must be directly linked to the treatment plan, are required for every formal counseling session and service provided, and include date, staff signature, and staff credential.

1.6.15 Consultation Reports

1.6.16 Result of Exams

1.6.17 Records of Medications, Drugs, Assistive Devices or Appliances, Therapies, Tests, and Treatments that are ordered, prescribed, referred or rendered.

1.6.18 Physical Assessments and/or nursing activities that pertain to care provided and support the services rendered and billed

1.6.19 Orders for tests and test results.

1.6.20 Pictorial records or graphs and written interpretations of tests.

1.6.21 Test Methodology

1.6.22 Name, strength, dosage, quantity and route of drug, and time administered.

1.6.23 Ordering, prescribing or referring physician.

1.6.24 Transportation information other than ambulance.

1.6.25 All documents within the contents of the clinical record will be identified with case number and name or initials.

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1.7 Email

1.7.1 Emails should become a part of the clinical record when related to diagnosis and/or significant treatment issues.

1.7.2 The last response to an email, which includes the entire email correspondence should be included in the clinical record. Individual responses without any context should not be included in the clinical record.

1.7.3 The primary clinician will inform persons served and the supports of persons served that email is not to be used to communicate emergencies.

1.7.4 The primary clinician should obtain consent for email communication whenever possible using the agency Text/Email consent form.

1.7.5 Communication preferences should be clearly noted in the electronic health record.

1.7.6 Persons served may withdraw their consent verbally or in writing at any time by informing an agency employee. Medical Records must be notified and withdraw must be documented in the electronic medical record.

1.8 Text Messages

1.8.1 Text messages should become a part of the clinical record when related to diagnosis and/or significant treatment issues.

1.8.2 Text messages should be documented in a progress note. Individual responses without any context should not be included in the clinical record.

1.8.3 The primary clinician will inform persons served and the supports of persons served that texting is not to be used to communicate emergencies.

1.8.4 The primary clinician should obtain consent for text communication whenever possible using the agency Text/Email consent form.

1.8.5 Communication preferences should be clearly noted in the electronic health record.

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1.8.6 Persons served may withdraw their consent verbally or in writing at any time by informing an agency employee. Medical Records must be notified and withdraw must be documented in the electronic medical record.

2.0 Records Review

Peer Review of clinical records are completed at least quarterly on a pre-determined sample of all agency consumer clinical records. The reviews shall ensure that proper documentation and services are being provided based on the individual's identified goals, needs, medical necessity, and selection guidelines. Clinical record reviews are to be completed on the agency approved clinical record review form.

3.0 <u>Timelines</u>

3.1 Providers shall document services and submit said documentation to Medical Records within 0-3 business days of providing the service.

3.2 Medical Records staff shall ensure that all documents and reports are entered into the electronic filing system within 24-hours of receiving said documents and reports.

References:
Michigan Medicaid Manual Section 15: Record Keeping

Kerry L Possehn, Chief Executive Officer	Date		