In accordance with your Agreement, you are required to maintain high quality medical, financial and administrative records (including appointment or scheduling books) related to the behavioral health services you provide. These records must be maintained in a manner consistent with the standards of the community, and conform to all applicable laws and regulations including, but not limited to, state licensing, Centers for Medicare and Medicaid Services (CMS) and/or national certification board standards.

In order to perform required utilization management, practice management, payment and quality improvement activities, we may request access to such records, including, but not limited to, claims records and treatment record documentation. You are permitted under HIPAA Treatment, Payment or Healthcare Operations to provide requested records as contractually required. In accordance with HIPAA and the definition of Treatment, Payment or Healthcare Operations, you must provide such records upon request. Federal, state and local government or accrediting agencies may also request such information as necessary to comply with accreditation standards, laws or regulations applicable to Optum and its Payors, Customers, Clinicians, and Facilities.

We may review your records during a scheduled On-Site Audit or may ask you to submit copies of the records to Optum for review. An On-Site Audit and/or Treatment Record Review may occur for a number of reasons, including, but not limited to:

- Reviews of facilities and agencies without national accreditation such as The Joint Commission, CARF or other agencies approved by Optum
- Audits of services and programs including, but not limited to, Applied Behavioral Analysis (ABA), Supervisory Protocol and Peer Support Services
- Audits of high-volume Providers
- Routine audits
- Audits related to claims, coding or billing issues
- Audits concerning quality of care issues

The audits may focus on the physical environment (including safety issues), policies and procedures, and/or thoroughness and quality of documentation within treatment records and/or accuracy of billing and coding. We have established a passing performance goal of 85% for both the Treatment Record Review and On-Site Audit. On-Site Audit or Treatment Record Review scores under 85% will require a written Corrective Action Plan (CAP). Scores under 80% require submission of a written CAP and a re-audit within six months of
the implementation of the CAP. However, in some cases, a requesting committee may require a CAP and/or re-audit regardless of the scores on the audit tools. Billing records should reflect all applicable fields as required for completion of the 1500 claim form or UB-04 claim form.

**Treatment Record - Content Standards**

When billing services for more than one family member, separate treatment records must be maintained.

Optum requires that all non-electronic treatment records are written legibly in blue or black ink. All treatment records must include the following:

- The Member’s name or identification number on each page of the record
- The Member’s address; employer or school; home and work telephone numbers, including emergency contacts; marital or legal status; appropriate consent forms; and guardianship information
- The date of service, either start and stop time or total time in session (for time based services), the Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS)/Revenue (REV) code billed, notation of session attendees, the rendering Clinician’s name, professional degree, license, and relevant identification number as applicable
- Treatment record entries should be made on the date services are rendered and include the date of service; if an entry is made more than 24 hours after the service was rendered, the entry should include the date of service, date of the entry, and a notation that this is a late entry
- Clear and uniform modifications; any error is to be lined through so that it can still be read, then dated and initialed by the person making the change
- Clear documentation of medication allergies, adverse reactions and relevant medical conditions; if the Member has no relevant medical history, this should be prominently noted
- Clear and uniform medication tracking that provides a comprehensive summary of all medications taken by the patient from the onset of care through discharge includes the following (applicable for all prescribers):
  - Standing, P.R.N. and STAT orders for all prescription and over-the-counter medications
  - The date medications are prescribed along with the dosage and frequency
  - Informed Member consent for medication, including the Member’s understanding of the potential benefits, risks, side effects, and alternatives to the medications
  - Changes or rationale for lack of changes in medication and/or dosage should be clearly documented along with the clinical rationale for the changes

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January 2017
• Discharge summaries should specify all medications and dosages at the time of discharge

• A clear summary of presenting problems, the results of mental status exam(s), relevant psychological and social conditions affecting the Member’s medical and psychiatric status, and the source of such information

• Prominent documentation (assessment and reassessment) of special status situations, when present, including, but not limited to, imminent risk of harm, suicidal or homicidal ideation, self-injurious behaviors, or elopement potential (for all overnight levels of care). It is also important to document the absence of such conditions

• A medical and psychiatric history including previous treatment dates, Clinician or Facility identification, therapeutic interventions and responses, sources of clinical data, and relevant family information

• The behavioral health history includes an assessment of any history of abuse the Member has experienced

• For adolescents, the assessment documents a sexual behavior history

• For children and adolescents, past medical and psychiatric history should include prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual, and academic)

• For Members 12 years of age and older, documentation includes past and present use of nicotine or alcohol, as well as illicit drugs, prescribed or over-the-counter medications

• Documentation of a DSM diagnosis consistent with the presenting problem(s), history, mental status examination, and other assessment data

• Continue to list medical conditions, psychosocial and environmental factors and functional impairment(s) that support understanding of mental health condition

• Treatment plan documentation needs to include the following elements:
  • Specific symptoms and problems related to the identified diagnosis of the treatment episode
  • Critical problems that will be the focus of this episode of care are prioritized; any additional problems that are deferred should be noted as such
  • Relates the recommended level of care to the level of impairment
  • Member (and, when indicated, family) involvement in treatment planning
  • Treatment goals must be specific, behavioral, measurable, and realistic
  • Treatment goals must include a time frame for goal attainment
  • Progress or lack of progress towards treatment goals
- Rationale for the estimated length of the treatment episode

- Updates to the treatment plan whenever goals are achieved or new problems are identified

- If the Member is not progressing towards specified goals, the treatment plan should be re-evaluated to address the lack of progress and modify goals and interventions as needed

- Progress notes include:
  - Signature of the practitioner rendering services
  - The date of service
  - Member strengths and limitations in achieving treatment plan goals and objectives
  - Treatment interventions that are consistent with those goals and objectives noted in the treatment plan
  - Dates of follow up visits
  - Documentation of missed appointments, including efforts made to outreach the Member
  - For time based services only, either start and stop time or total time in session

- Documentation of on-going discharge planning (beginning at the initiation of treatment) includes the following elements:
  - Criteria for discharge
  - Identification of barriers to completion of treatment and interventions to address those barriers
  - Identification of support systems or lack of support systems

- A discharge summary is completed at the end of the treatment episode that includes the following elements:
  - Reason for treatment episode
  - Summary of the treatment goals that were achieved or reasons the goals were not achieved
  - Specific follow up activities/aftercare plan

- Documentation of coordination of care activities between the treating Clinician or Facility and other behavioral health or medical Clinicians, Facilities, or consultants. If the Member refuses to allow coordination of care to occur, this refusal and the reason for the refusal must be documented. Coordination of care should occur:
  - At the initiation of treatment
• Throughout treatment as clinically indicated
• At the time of transfer to another treating Clinician, Facility, or program
• At the conclusion of treatment
• Documentation of referrals to other Clinicians, services, community resources, and/or wellness and prevention programs
• Records related to billing must include all data elements required for submission of the claim

The Fraud, Waste, Abuse, Error and Payment Integrity information page on Provider Express includes additional resources to support documentation requirements.

Guidelines for Storing Member Records

Below are additional guidelines for completing and maintaining treatment records for Members:
• Practice sites and Facilities must have an organized system of filing information in treatment records
• Treatment records must be stored in a secure area and the site must have an established procedure to maintain the confidentiality of treatment records in accordance with any applicable laws and regulations, including HIPAA
• The site must have a process in place to ensure that records are available to qualified professionals if the treating Clinician is absent
• Treatment records are required to be maintained for a minimum period of seven years from the date of service, or in accordance with applicable state or federal law, whichever is longer. Termination of the Agreement has no bearing on this requirement
• Financial records concerning covered services rendered are required to be maintained from the date of service for 10 years, or the period required by applicable state or federal law, whichever is longer. Termination of the Agreement has no bearing on this requirement
• Providers with Electronic Health Records must have an established procedure to maintain a backup copy of all electronic health records

Member Access to Medical/Mental Health Records

A Member, upon written request and with proper identification, may access his/her records that are in the possession of Optum. Before a Member is granted access to his/her records, the record will first be reviewed to ensure that it contains only information about the Member. Confidential information about other family Members that is in the record will be redacted.