PerformCARE®	Policy and Procedure
Name of Policy:	Documentation Standards for Providers
Policy Number:	QI-049
Contracts:	☒ All counties ☐ Capital Area ☐ Franklin / Fulton
Primary Stakeholder:	Quality Improvement Department
Related Stakeholder(s):	All Departments
Applies to:	Associates
Original Effective Date:	10/30/19
Last Revision Date:	01/21/25
Last Review Date:	03/28/25
OMHSAS Approval Date:	03/28/25
Next Review Date:	03/01/26

Policy: PerformCare has established standards for clinical documentation that encompasses accuracy, timeliness, accessibility, legibility, completeness, and is chronological in structure.

Purpose: To establish network standards for documentation of clinical information for PerformCare Member records.

Definitions: **Business Processes:** PerformCare defines business process as related to this policy as: QOCC, complaints, grievances, authorization requests and any other necessary tasks that require review of Member records.

Acronyms:
DHS: Department of Human Services
DOB: Date of Birth
DSM: Diagnostic Statistical Manual
EBP: Evidence-Based Practice
EVS: Electronic Verification System
ICD: International Statistical Classification of Diseases and Related Health Problems
OMHSAS: Office of Mental Health and Substance Abuse Services
PCP: Primary Care Physician
QOCC: Quality of Care Council
SI/HI: Suicidal Ideation/Homicidal Ideation

Procedure:
1. All Member treatment record documentation must contain specific data elements that are current, detailed, legible, organized, comprehensive, promote effective care, facilitate quality review, and are readily retrievable. The Member treatment record documentation will conform

to the standards of the Commonwealth of Pennsylvania Medical Assistance Manual.

1.1. Providers must store treatment records securely, allow access by authorized personnel only, and adhere to all applicable federal and state confidentiality regulations for treatment records.

1.2. By provider contract, Member treatment records must be made available for review by PerformCare for quality improvement purposes.

1.3. Providers will maintain medical records of Members in accordance with applicable DHS regulations, as set forth in 55 Pa. Code 1101.53(e), and any other applicable laws and regulation, customary professional medical practice, and in a manner that shall permit timely and effective quality assurance review. This includes practitioners posting documentation in a timely manner, as well as making records available for review upon reasonable notice during normal business hours as outlined in the PerformCare Provider Agreement.

2. The following standards are to be maintained by and apply to all PerformCare providers who create or add to a Member's treatment record:

2.1. The PerformCare Member's name and a second unique identifier is on each page of paper documentation and on every entry of electronic records.

2.2. The PerformCare Member's identifying information and demographics include:

2.2.1. Name

2.2.2. Current age and DOB

2.2.3. Street address and county of residence

2.2.4. Home and work telephone number(s) and/or method of contact

2.2.5. Name and contact information of employer or school

2.2.6. Marital status

2.2.7. Legal status

2.2.8. Parent/Guardian Name (for children and non-adjudicated adolescents)

2.2.9. Name and contact information for PCP

2.3. All entries in the Member medical record are dated, author of documentation is identified by name, title, credentials and signature (paper) or key identifier (electronic).

2.4. Written documentation is legible to someone other than writer or affiliated staff/colleagues. Legibility is determined through review/audit by PerformCare staff.

2.5. Allergies, to include medication allergies and adverse reactions.

2.6. All abbreviations are taken from an acceptable list of acronyms.

2.7. Risk Assessment/Risk screening on admission, and with each subsequent therapeutic/1:1 contact. Risk should include

SI/HI/psychosis and any other known risky behaviors, such as self-injurious behaviors. If risk behaviors are identified, a crisis plan should be developed *(see 2.25 below)*. Providers should consider using EBP assessment tools and modalities when assessing and treating risk behaviors.

2.8. Medical information
2.9. Developmental History – (for children and adolescents)
2.10. History of behavioral health interventions/treatment, to include dates and duration of services, level of care, behavioral health symptoms treated, information on Member compliance with treatment and treatment success.
2.11. Screening for trauma, and if trauma is identified, ensuring Member is offered appropriate treatment options.
2.12. DSM/ICD diagnoses (current version)
2.13. Medication information to include medication name, frequency, dosage, effectiveness of treatment regime and any known side effects for:
  2.13.1. Past psychotropic medications
  2.13.2. All current medications
  2.13.3. Evidence that current medication has been consistently provided as prescribed and reevaluated as necessary
  2.13.4. Changes in medication, dosage and reason for change
  2.13.5. Name of prescribing physician
  2.13.6. Record of administration of any injection as ordered by physician
2.14. Screening for tobacco use, and cessation information when appropriate.
2.15. Screening for drug and alcohol use utilizing a formal screening format.
2.16. History of and current use of alcohol/substance use to include kind, type, frequency and amount.
2.17. Screening for cultural considerations that may impact treatment.
2.18. Consultations, referrals and specialists' reports, to include laboratory results, psychological evaluations, summaries, screenings and reviews as applicable.
2.19. Coordination with Member's PCP to include notification upon admission, change in level of care or treatment, and upon discharge with Member's written permission.
2.20. Assistance in obtaining PCP for Members who do not have a PCP.
2.21. Discharge summaries
2.22. Individualized treatment plan, signed by both the Member and Provider, within the required number of days, as specified by applicable DHS and OMHSAS licensing regulations.
2.23. Treatment plan updates completed timely in accordance with regulations for treatment being provided.
  2.23.1. Individualized Treatment Plan to include:

2.23.1.1. Specific and measurable goals and objectives with measurable baseline information.
2.23.1.2. Measurable discharge criteria to move to lower level of care and/or natural community recovery supports, and clear aftercare plan.
2.23.1.3. Therapeutic interventions/modalities with clear identification of who is responsible for each intervention.
2.23.1.4. Individualized and specific target dates for each goal and objective.
2.23.1.5. Response to treatment/ progress towards goal achievement.
2.23.1.6. Treatment plan developed, reviewed and agreed upon by PerformCare Member.
2.23.1.7. Documentation of efforts related to Member strengths, natural supports, and focus on recovery / resiliency.

2.24. Documentation of all treatment/interventions provided and results of treatment/interventions.
2.25. Upon completing the risk assessment *(see 2.7 above)*, if clinically appropriate and/or required, a crisis plan should be developed *(see PerformCare Provider Manual)*. Crisis plans, to include components as per *PerformCare Provider Manual*, and updated following any crisis that occur during treatment.
2.26. Documentation of team members involved in the multi-disciplinary team of PerformCare Member needing specialty care and resolution to specialty needs.
2.27. Documentation of behavioral health and physical health integration to include:
2.27.1. Screening for behavioral health conditions which may be affecting physical health.
2.27.2. Screening for physical health conditions which may be affecting behavioral health.
2.27.3. Screening and referral to PCP when appropriate.
2.28. Documentation of PCP referral to PerformCare provider.
2.29. Documentation of reason for termination of treatment.
2.30. Documentation/progress note of all dates and types of treatment sessions/visits by clinician.
2.31. Documentation of regular EVS eligibility verification checks (or evidence of provider's EVS process demonstrated).
2.32. Authorization requests
2.33. Authorization/denial documentation from PerformCare.

3. Review of Treatment Records
3.1. Documentation standards will be reviewed through treatment record reviews (as per *QI-026 Provider Treatment/Service Record Reviews*) and during other business processes that require review of records.

Related Policies: *QI-026 Provider Treatment/Service Record Reviews*

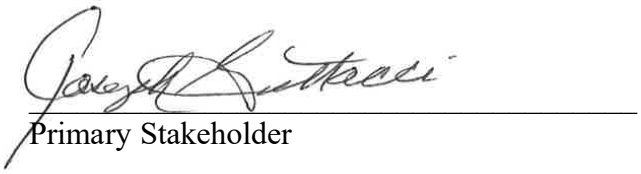
Related Reports: None

Source Documents and References:
Commonwealth of Pennsylvania medical assistance manual
PerformCare Provider Manual
PA Code 1101.51
MAB 29-02-03, 33-02-03, 41-02 Documentation and Record-Keeping Requirements
PerformCare Provider Memo: AD 10 006 Billable Reportable Time
MH-TCM Documentation Requirement-OMHSAS Bulletin 12-03
OMHSAS Policy Clarification 08-13-02 Record Retention

Superseded Policies and/or Procedures: *CM-006 Documentation Standards for Providers*

Attachments: None

Approved by:



Primary Stakeholder