

# Clinical Documentation Training

Dr. Martin Lazoritz,  
Psychiatrist

# Objectives of Training

At the end of the training, attendees will be able to:

- Identify the function of a medical record
- Be aware of what and how to document
- Identify critical events in a medical record
- Define the purpose of a treatment plan
- Construct a detailed progress note

# This information will be helpful to

- Psychiatrists
- Nurses
- Therapists
- Case Managers
- Psychosocial Rehabilitation Counselors
- Anyone responsible for charting



If You Didn't Write It,  
It Didn't Happen

# The Medical Record



# The Functions of the Medical Record

1. A readily Accessible Repository of Up-To-Date Information About the Patient
2. An Adjunct to the Memory of the Treating Physician
3. An Accurate Reflection About What is Actually Taking Place In Treatment
4. A Record of the Development and Testing Of Clinical Hypotheses
5. A source of Information for Research Purposes
6. A Tool For Quality Assurance
7. An Accurate Legal Document
8. A tool for Utilization Review

## Who Relies on Documentation?

- Client's families
- Physicians/Psychiatrists
- Mental Health Professionals
- Referrals Sources (PCP, DCF)
- Managed Care Companies
- Licensing and Accreditation Agencies

*The Overall Goal is Coordinated Care*



# What To Chart

1. Justify the need for continued inpatient care
2. Progress being made toward goals
3. Response to treatment
4. Side effects (to medication and other treatment)
5. Changes in the treatment plan including aftercare
6. Demonstrate that active treatment is taking place
7. Participation in the treatment team

*TCMs need to attend medical appointments with client*



# Details to Include in Chart

1. Address abnormal labs and physical findings
2. Interpretation of variance between notes of various staff members
3. Length of time (on unit and) with patient
4. Date and time
5. Interval history
6. Mental status (to support diagnosis)



# How to Chart

## 1. Data

- History
- Exam
- Lab
- Response to treatment
  - Effects and side effects

## 2. Assessment

- Formulation “you don’t have to be right, just thoughtful”

## 3. Plan

- What are you planning and why
- What are the expected outcomes

*DAP format is a common progress note format*

# Appropriate Action Words

Accessed	Facilitated	Provided Information
Arranged	Informed	Reassessed
Assessed	Intervened	Referred
Attended	Linked	Relayed on behalf of client
Located	Reported	Obtained
Collaborated	Monitored (not Meds)	
Secured	Completed	Submitted
Contacted	Notified	Updated
Coordinated	Observed	Ensured



# Introduction to medical decision making

- Process of diagnosis and treatment planning
- Quest for perfection?
- Testing of clinical hypotheses

# CASE STUDY

Use a spare piece of paper to  
write a brief DAP note.

# Another note format

- SOAP
  - Subjective
    - Patient complaints
    - Patient history
  - Objective
    - Clinician observation
    - Test Results
    - Vital Signs



- Assessment

- Mental Status information
- Differential diagnosis based on 'S' and 'O'

- Plan

- Further testing or procedures needed
- Further treatment needed
- Goals for next visit/session/discharge

# How to Chart

- Must be legible
- Must have identifying data
- Must have providers name and signature
- Must have date and time
  - For timed services the length of time

# Back to Basics...

- Do not use White-out
- Do not use pencil
- Black ink is preferred
- Do not write over a mistake
- Do not leave blank spaces between entries.

*That implies that something was left out or will be added later.*

# Treatment Planning

# Treatment Plans

- The treatment plan must reflect the steps to be taken to render the patient no longer in need of care at a particular level
  - Who is to do what
  - How often
  - What are the likely results
  - If a form is used, it must be completed
  - The physician is responsible



## • Goals

- What will let the psychiatrist and treatment team (and any reviewer) know that the patient has changed either positively or negatively
  - Psychosis cleared to the point that patient does not need 24 hour/day nursing care
  - Patients suicidal ruminations cleared
- Not
  - Improved self esteem
  - Decreased depression

# Writing Objective Goals

- Subject + verb + frequency + duration + monitor

Ex. Mary will take all medication as prescribed by Dr. Lee daily for a month as monitored by sister/ALF/CM by way of medication sorter

# Treatment Plans

- Target symptoms
  - Concrete
  - Observable
  - Countable
  - Able to be graphed
  - Meaningful
- Correlate interventions to the change in target symptoms
- Try to do make one change at a time

# Treatment Team (or its equivalent)

- Multidisciplinary
- Integrate treatment plan
  - Behavioral, medical, psychiatric, psychological etc.
  - Medication Management, Case Management, Outpatient Therapy, Psychosocial Rehabilitation
- Discuss response to treatment
  - Effects and side effects
- Assign tasks
- Reflects decision making



# Problem Areas

- Other staff notes need to be commented upon
  - Often the nursing notes will give a different picture
  - In case of CMHCs, read psychiatrist's notes or therapist's notes
- Physical problems must be addressed
- Always write down what you are doing and why as well as what you are not doing and why
- Document unexpected results
- Document risks
- Informed Consent



# Release of Information

For HIPAA guidelines, it is important to have a Release of Information (ROI) for every person or agency with whom your patient is involved. This will allow a constant flow of communication (Verbal or written) and coordinated care.

# Problem Areas

- Justification for Seclusion and restraint
- Justification for Emergency treatment orders
- Justification for polypharmacy and off label use
  - Rational polypharmacy
  - Drug interactions
- Write legibly

# Problem Areas

- PRN orders
  - Response
  - Length of order
  - Is it made routine?

# Abbreviations

- Each agency or organization has an approved abbreviation list
- Stay updated on rules for abbreviations, especially medication rules
  - ie



# Joint Commission of Healthcare Administration Organization(JCAHO)

Since 1971, the Joint Commission has been evaluating organizations that provide mental health, chemical dependency, mental retardation/developmental disabilities services, and other psychosocial services

# JCAHO

## National Patient Safety Goals

*relating to  
behavioral health*

**Goal 1:** Improve the accuracy of patient identification

**Goal 2:** Improve the effectiveness and communication among care givers

**Goal 3:** Improve the safety of medications

**Goal 8:** Accurately and completely reconcile medications across the continuum of care

**Goal 13:** Encourage patients' active involvement in their own care as a patient safety strategy

# JCAHO “Do Not Use” List

<u>Do Not Use</u>	<u>Potential Problem</u>	<u>Use Instead</u>
U(unit)	Mistaken for zero, the number 4 or cc	Write “unit”
IU(international unit)	Mistaken for IV or the number ten	Write it out
QD, qd, Q.D., q.d.	Mistaken for each other	Write out daily
QOD, qod, Q.O.D., q.o.d.	Period after q mistaken for I	Write out every other day
Trailing zero (x.o mg)	Decimal point is missed	Write X mg
Lack of leading zero (.x mg)	Decimal point is missed	Write o.X mg
MS	Can mean morphine sulfate or magnesium sulfate	Write it out

For accreditation purposes, the official “do not use” list applies, at a minimum, to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

# Reviewers Will...

- Judge by what you wrote- not what you did
- Try to look at process, outcome, and intent
- Look for variance from quality standards

# Reviewing Documentation

# CMS

- Evaluation and Management Services (E/M)
  - History
  - Examination
  - Medical decision making
  - Counseling
  - Coordination of care
  - Nature of presenting problem
  - Time

# First Coast Advantage follows Medicaid Guidelines



# First Coast Advantage

## Behavioral Health Clinical Record Review

### Audit Tool

Provider: \_\_\_\_\_ Location: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Medicaid# \_\_\_\_\_ Date of Service: \_\_\_\_\_

Required Components	Documented	Not Documented	Comments
<b>Demographic Information</b>			
1. Member's identifying information consisting of: <ul style="list-style-type: none"> <li>• Name (on all pages)</li> <li>• Identification/Medicaid Number (on all pages)</li> <li>• Date of Birth</li> <li>• Gender</li> <li>• Legal Guardianship (if applicable)</li> <li>• Address and phone number</li> <li>• Member's Primary Physician</li> <li>• Confidentiality Statement signed by Member or Legal Guardian</li> </ul>			
<b>Clinical Information</b>			
2. Axis I-V Diagnosis Code			
3. ICD- 9 Diagnosis Code			
4. Date of Service Provided			
5. An evaluation or assessment conducted by a licensed practitioner of the healing arts for diagnostic and treatment planning purposes.			
6. Identification of the setting in which the service was rendered.			
7. Identification of the specific problem, behavior, or skill deficit for which the service is being provided.			
8. Identification of the type of service rendered, including the specific intervention.			
9. Presenting problem and mental status (includes the members affect, speech, mood, thought content, judgment, insight, attention/concentration, memory and impulse control)			

Required Components	Documented	Not Documented	Comments
10. Progress notes reflecting the Members progress towards meeting goals and objectives identified in the Treatment Plan.			
11. Current medication list, with dosages listed			
12. All entries must include the name, credential (e.g. ) and profession of practitioner rendering services including signature or initials.			
<b>Treatment Plan</b>			
13. The Treatment Plan appears to be consistent with the diagnosis.			
14. Evidence that the member is involved in the development of their treatment plan. (Did they sign the treatment plan)			
15. Does the Treatment Plan have measurable goals and objectives, estimated time frames for goal attainment or problem resolution?			
16. Treatment intervention is consistent with the treatment plan goals and interventions.			
17. Does the Plan reflect inclusion of the member's cultural strengths within the intervention?			
18. Description of the member's strengths and limitations in achieving treatment plan goals are documented.			
<b>Progress Notes</b>			
19. Progress Notes reflect services that are sensitive to age, developmental level and functional level of the member.			
20. Start and end times for procedures with specified minimum time frames and procedures billed on a per unit basis.			
21. Documentation of all emergency behavioral encounters; appropriate follow-up.			
22. Documentation of all referral services.			
23. Documentation reflects that completed comprehensive assessments were reviewed and used for treatment planning for members.			
24. Compliance to treatment is addressed in Progress notes.			
<b>Coordination of Care and Management</b>			
25. Documentation reflects that services include the participation of others involved in the member's life as appropriate. (E.g. Care givers, family support etc.)			
26. Does the documentation reflect coordination of care?			
27. Documentation of court ordered mental health evaluation of member.			
28. Documentation for members that missed a scheduled appointment reflecting attempts to contact the individual.			

Chart reviewed by:

Date:

Required Components	Documented	Not Documented	Comments
29. Psychiatric Advance Directive is offered when indicated.			
30. Communication barriers are identified.			
31. Documentation of appointments.			
32. Documentation that the PCP was notified of hospitalization/ treatment/medication.			
<b>Clinical Reports and Assessments</b>			
33. Psychology Evaluation			
34. Psychosocial Assessments			
35. Mental Status Exam			
36. Psychiatric Evaluation			
37. Brief Behavioral Health Status Examination			
38. In-Depth Assessment			
39. FARS/CFARS			
40. Evidence of Treatment Plan reviews			
41. Evidence of Medication monitoring			
42. Documentation of a Developmental History if the member is an adolescent or child.			
43. Record of Consultation Reports			
44. Documentation of Denial of Services			
<b>Discharge Planning</b>			
45. Documentation that the Member agrees/and supports the discharge plans. (Signed by Member)			
46. Does the documentation of transfers or discharges indicate individualized information related to the member's condition, current living situation, and community resources?			

# Florida Medicaid Provider General Handbook

## **Record Keeping Requirements**

Medical records must state the necessity for and the extent of services provided.

- Description of what was done during the visit
- History
- Physical assessment
- Chief complaint on each visit
- Diagnostic tests and results
- Diagnosis
- Treatment plan, including prescriptions

# Medicaid Record Keeping Requirements Continued

- Medications, supplies, scheduling frequency for follow-up or other services;
- Progress reports, treatment rendered;
- The author of each (medical record) entry must be identified and must authenticate his or her entry by signature, written initials or computer entry;
- Dates of service; and
- Referrals to other services.

Note: See the service-specific Coverage and Limitations Handbook for record keeping requirements that are specific to a particular service.



# Incomplete Records

Providers who are not in compliance with the Medicaid documentation and record retention policies may be subject to administrative sanctions and recoupment of Medicaid payments. Medicaid payments for services that lack required documentation or appropriate signatures will be recouped.

# Bottom Line

If You Didn't Write It, It Didn't  
Happen and You Won't Get  
Paid or You May Have to Pay  
the Money Back



## Mental Health Targeted Case Management Coverage and Limitations Handbook

In addition to the general Medicaid record keeping requirements and the specific documentation requirements listed, the following documentation requirements described apply to all mental health targeted case management services.

# The Case Management record

Must contain

- the recipient's certification form
- assessment
- service plan
- service plan review(s)
- documentation of the home visit

# For Each CM Activity

- Case manager's name, signature, title, and date  
*Photocopied signatures, stamped signatures, or signatures of anyone other than the person rendering the service are not acceptable*
- Recipient's name
- Service provided
- Date of the service
- Services beginning and ending time on the clock
- Units for each service billed
- Location of the service

# Be sure to include

Updates when the recipient...

- changes residence
- enters or is discharged from an inpatient hospital or state mental hospital
- experiences a significant change in mental status
- experiences a significant change that impacts his/her life and support system
- changes custody
- changes educational placement
- changes employment

# Case Management Notes

1. Clearly reflect how the case manager's efforts are linked to the services and goals in the recipient's service plan
2. Describe the recipient's progress or lack of progress relative to the service plan
3. If a substitute case manager provided the service, explain the circumstances requiring the provision of services by a substitute case manager.

**If more than one contact with a recipient is made in a day, all contacts should be summarized in one case note.**



# What does FCA want?

## Inpatient

The reason for admission must be clearly documented as stated by the patient and or others significantly involved.

# FCA Continued Stay

- Primary Mental Health Diagnosis
- Reason for Admission
- Current Treatment Interventions
- Medications (including dosages)
- How many days requested and why?

# FCA Requirements Continued

Each patient must receive a psychiatric evaluation that must contain

- Chief complaint
- Past history of any psychiatric problems and treatment
- Past family, educational, vocational, occupational, and social history
- Within the evaluation does one find the specific signs and symptoms, and other factors that justify the diagnosis?



# FCA Requirements Continued

- Include a medical history
- Contain a record of mental status
  - Must describe the appearance and behavior, emotional response, verbalization, thought content, and cognition of the patient
- Note the onset of illness and the circumstances leading to the admission to unit



# FCA Requirements Continued

- Describe attitudes and behavior
- Estimate intellectual functioning, memory and orientation
- Include an inventory of the patient's assets in descriptive, not interpretive fashion



# FCA Requirements Continued

Each patient must have an individual comprehensive treatment plan

1. The plan based on an inventory of patient strengths and disabilities
2. Patient specific
3. Goals appropriate to length of stay
  1. Measurable
  2. Observable
  3. Discharge criteria
4. Specific treatment modalities

# Outpatient Requirements

1. The chief complaint and/or reason for the encounter and relevant history, physical findings, and prior diagnostic tests
2. Assessment, clinical impression or diagnosis
3. Plan for care
4. Date length of time and a verifiable legible identity of the health care professional who provided the service

## Outpatient Requirements Continued

5. The patient's progress, response to and changes in treatment, planned follow-up care and instructions and diagnosis should be documented
6. The CPT and ICD-9-CM codes reported on the health insurance claim form should be supported by the documentation in the medical record
7. A service should be documented during, or as soon as practicable after it is provided



# Summary/Anecdotes

# References

- <http://www.cfs.purdue.edu/mft/Forms/Student/Resource/Casenote.PDF>
- Medicaid handbooks
  - Community Behavioral Health
  - Targeted Case Management
  - Provider General Handbook
  - AHCA Training

**Please be sure to complete an evaluation  
of this program and return to the table.  
Your certificate will be available today.**

Thank you!