CLINICAL RECORD DOCUMENTATION TIPS

September 2017

What is documentation and why is it important?

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's medical history, treatment and outcomes. The medical record chronologically documents the treatment of the member and is an important element contribution to high quality care. The medical record facilitates:

- the ability of the counselor and other healthcare professionals to evaluate and plan the member's immediate treatment, and to monitor his/her outcomes over time;
- communication and continuity of care among counselors and other health care professionals involved in the member's care;
- accurate and timely claims review and payment;
- appropriate utilization review and quality of care evaluations; and
- collection of data that may be useful for research and education.

An appropriately documented medical record can reduce many of the logistical issues associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

Every activity must have a start and stop time, including residential activities used to meet AAPS standards requirements.

For example:

- Start time: 2:00 p.m. Stop time: 3:00 p.m. Billed 4 units (15 minute increments)

The service code must match the documentation in the chart. The clinical practice should be within scope.

For example:

- Called to set up doctor's appointment, psych meds and housing consultation for member. Called member to let her know the appointment dates and times. Billed case management or PCCM (depending on funding source).
- NOTE: Urine Analyses (UAs) are not billable as a separate service.
- The focus of treatment should be on the diagnosis.

Documentation in the KCPC should match documentation in the member's chart.

For example:

The clinical record says the member is doing well in group and has a positive attitude and the KCPC notes say the same thing or give a reason why there is a difference.

Notes should provide enough detail for the reviewer to be able to determine what service was billed.

- Individualize each progress note; provide detail for the member who attended. For example, "Tonight the group shared their treatment goals. John attended group and gave good input. He and his wife are having a child and he discussed how this has affected his determination to stay clean. He took part in a role-playing activity and appeared attentive. He also provided feedback to one of his peers struggling with anger issues. Over the next week, John will document his triggers and his response to each of the triggers."

Notes should document that the member was present for the entire time for which services are billed. The units paid should match the documentation in the clinical record.

For Example:

- A one hour group started 15 minutes late so it lasted 45 minutes, only 3 units billed.
- Member was a no show, no services billed.
- Member had a seizure during group, only the time the member was in the group is billed. The start and stop time in the chart accurately reflects the time the member was present in the group
- The member was on a 2 day pass, no services billed.
- Reconcile the overlapping time issue. The member cannot be in the inpatient group and an outpatient from 2:45-3:00.

The following chart should help limit rounding errors for services provided in 15 minute increments:

- Bill 1 unit if a member is seen between 8 minutes to 22 minutes.
- Bill 2 units if a member is seen between 23 minutes to 37 minutes.
- Bill 3 units if a member is seen between 38 minutes to 52 minutes.
- Bill 4 units if a member is seen between 53 minutes to 67 minutes.
- Bill 5 units if a member is seen between 68 minutes to 82 minutes.
- Bill 6 units if a member is seen between 83 minutes to 97 minutes.
- Bill 7 units if a member is seen between 98 minutes to 112 minutes.
- Bill 8 units if a member is seen between 113 minutes to 127 minutes.

Notes should be signed with a complete signature by an AAPS credentialed counselor as required by the service being performed as follows:

For example:

- Sign each individual entry
- If there are multiple entries on a page, sign each entry
- Use full names in the signature

- Type the person's full name and electronically sign the document using AAPS approved software for electronic signatures
- If the person signing each entry is not AAPS credentialed, have the supervising AAPS credentialed person sign the daily entries.

Additional Tips

- All entries in the record should be in blue or black ink, not pencil.
- The record should not contain any white out. If corrections must be made use a single line to strike through what was written in error so it is still visible.
- Documents must be bound in the record, not on post-it-notes or loose paper.
- Residential records need to include a daily log of activities to demonstrate how the member received the required 40 hours/week or 10 hours/week of structured activities as defined by the regulations. Each entry should include a start and stop time if it is to be counted toward reimbursement.
- Each piece of paper should document a way to identify the client. For example John Doe or Chart number: 0015232