Documentation Requirements

Rev 12/18/21

Diagnostic Assessment Report:

90791 needs a DA report, not just a regular PN. To be completed prior to the third session.

DA must include the following elements:

- ✓ Presenting problems/ justification of DSM diagnosis
- ✓ Family history
- ✓ Chemical health history
- ✓ Medical and psychiatric history
- ✓ Appropriate psychiatric referral (adherence to DHS guidelines for psychiatric referral)
- ✓ Acknowledgment of other practitioners
- ✓ Note if client declined or consented for PCP collaboration
- ✓ Relevant social conditions
- ✓ Mental status
- ✓ Risk assessment (i.e. suicidality, homicidality, self-injurious behavior, substance abuse/dependence, physical/sexual abuse, child/elder neglect or eating disorder)
- ✓ Patient's strengths and limitations
- ✓ DSM 5 codes
- ✓ Clinical plan
- ✓ Explained informed consent
    - Place of service (for teletherapy)*

Medical necessity

Document the medical necessity for psychotherapy in the diagnostic assessment.

Treatment Plan:

- ✓ To be completed prior to the fourth session
- ✓ Reviewed and updated every 180 days or if major diagnosis change.

Must address the following:

- ✓ Diagnosis
- ✓ Measurable goals (Includes baseline data and desired outcome. Goals are stated with frequencies, percentages, or a Likert scale that can objectively indicate progress.)
- ✓ Estimated time frames for treatment goals
- ✓ Discharge planning
- ✓ Special status situations (if any risks are identified in the diagnostic assessment, they need to be addressed in the treatment plan.)

Must include:

- ✓ Signatures (Includes patient's signature once a year, provider's signature on each treatment plan and review, and supervisor's signature when applicable.)

- ✓ Document in the individualized treatment plan (ITP) the specific interventions with measurable goals and objectives (including start and stop time) describing how the mental health professional will use psychotherapy to treat the member's mental illness.

Progress Notes:

- ✓ Present & signed for each date of service billed
- ✓ Each progress note must include:
- ✓ Type of service
- ✓ Date of service
- ✓ Place of service (for teletherapy)*
- ✓ Session start and stop times
- ✓ Scope of service (nature of interventions or contacts including treatment modalities, phone contacts, etc.)
- ✓ Client's progress (or lack of) to overall treatment plan goals and objectives
- ✓ Treatment or intervention activity & Client's response or reaction to treatment intervention(s)
- ✓ Client provided information (verbal and non-verbal information the client provided)
- ✓ Formal or informal assessment of the member's mental health status (current functioning and issues)
- ✓ Name and title of person who gave the service
- ✓ Date documentation was made in the member's record
- ✓ Action plan
- ✓ Type of service rendered (CPT code or name and duration of service)
- ✓ Date and responsible clinician's name (present on all entries)
- ✓ Required clinical supervision (when applicable, supervision is documented)
- ✓ Current risk factors the member may be experiencing
- ✓ Emergency interventions
- ✓ Consultations with or referrals to other professionals
- ✓ Summary of effectiveness of treatment, prognosis, discharge planning, etc.
- ✓ Test results and medications
- ✓ Symptoms

Discharge Documentation

Describes the termination and/or transition of services. It provides closure for a service episode and referrals, as appropriate. There are two (2) types of clinical discharge documentation:

• Discharge Progress Note: This is used when the final session is a closing session that is a final billable service with the client present. Progress Note to indicate that the case is closed, per the Minimum Requirements below.

• Discharge Summary: A comprehensive document that is clinically necessary in order to provide continuity of care for the next service provider, per the Minimum Requirements below.

Timeliness of Discharge Summary & Discharge Note

Cases/episodes must be closed within 90 days (3 months) after the client's last service, unless the rationale for maintaining an open case is written in the clinical record.

A quarterly written rationale must be provided if the case will be kept open during continued noncontact.
Discharge documentation must be entered into the clinical record within one (1) working day of the discharge decision, but prior to closing the episode, and must be clearly labeled as either “Discharge Summary” or “Discharge Note”.

Minimum Requirements include documentation of the following:
a. Reason for discharge/transfer.
b. Date of discharge/transfer.
c. Referrals made, if applicable.
d. Follow-up care plan.
e. Treatment provided.
f. Overall efficacy of interventions
g. Progress made toward the mental health goals/objectives.
h. Clinical decisions/interventions:
- ✓ Treatment planning recommendations for future services relevant to the final Client Plan; and
- ✓ Any referral(s) for aftercare services/community support services.

*Wording for place of service for teletherapy:

This visit was performed via telemedicine using two-way synchronous audio and video. Prior to initiating the services, informed consent for telemedicine was obtained from the client.

Verification of patient identity was established with the patient.
Originating Site (client's location): Home
Distant Site (provider's location): Office