SUMMIT POINTE POLICY AND PROCEDURE MANUAL

Section: Provision of Care	**Policy Name:** Clinical Documentation	**Policy Number:** 7.1.31
Owner: Clinical Director	**Applies To:** ☒Summit Pointe Staff ☒Summit Pointe Contract Providers ☒Summit Pointe CCBHC Services ☐Summit Pointe CCBHC DCO Providers	
Approved By: Joann Goodrich		
Version Number: 4	**Revised Date: 07/16/2024**	**First Effective Date: 11/01/2018**

I. PURPOSE:

To ensure all clinical documentation accurately represents services provided and supports the medical necessity of services delivered. Clinical Documentation and progress notes are considered an integral part of supporting medical necessity treatment for behavioral health services delivered by Summit Pointe and as such the documentation must be completed within acceptable timelines based on statutory and contractual obligations.

II. DEFINITIONS: Refer to the "Summit Pointe Policy and Procedures Definitions Glossary."

III. POLICY:

It shall be the policy of Summit Pointe to provide/assure that clinical documentation, including progress notes, meets the contractual and regulatory requirements of the Michigan Department of Health and Human Services (MDHHS) contract, Michigan Mental Health Code, Center for Medicare and Medicaid Services (CMS), Code of Federal Regulations (CFR), the Public Health Code, and accreditation guidelines and standards. This will be demonstrated by each document containing all required elements.

IV. PROCEDURE:

Screening shall be completed for people calling Summit Pointe for new services and as part of the request for service and brief assessment process. The screening shall consist of specific data elements as well as the population specific functional assessment tool; LOCUS for adults with a mental illness, CAFAS/PECFAS for youth with a SED and ASAM for substance use disorder service.

Clinical assessments will be completed as contractually required based on population of service (SUD, Youth with SED, I/DD, MIA) and shall include all levels of clinical assessment. Standardized assessment tools shall be administered by qualified trained staff only. Primary Assessments shall be completed and signed by the clinician.

SUD assessments shall include or be informed by a completed ASAM Continuum placement criterion and shall be updated annually or if resuming services after more than six months out of service.

ASAM Worksheet placement criteria shall be updated when new authorization requests are submitted, and at a minimum of six-month intervals.

MIA assessments shall include or be informed by a completed LOCUS. The LOCUS shall be updated annually within 365 days, when an annual update document is completed or when there is a change in level of care.

SED assessments shall include or be informed by a completed Child and Adolescent Functional Assessment Scale (CAFAS) for children ages seven through seventeen years (7-17) and Preschool and Early Childhood Functional Assessment Scale (PECFAS) for ages four through seven (4-7). The CAFAS and PECFAS shall be updated every 3 months and at the time of discharge.

Biopsychosocial assessments shall be updated annually within 365 days of the previous assessment.

The Supports Intensity Scale (SIS) for individuals with I/DD shall be handled according to MDHHS SIS Manual and AAIDD guidelines. The MDHHS SIS Manual indicates completion at least every 3 years. Biopsychosocial assessments for individuals with I/DD shall be updated annually.

I/DD initial assessments shall include information from intellectual assessments completed.

Assessments specific to Autism benefits shall be administered according to Medicaid Provider Manual Requirements.

Standardized functional assessment tools shall be administered by qualified trained staff only.

All Initial and annual assessments shall be accessible and available within 30 days of the date of service billed for the assessment unless otherwise specified in assessment-specific material such as MDHHS SIS Manual.

All PIHP reportable functional assessment tools shall be submitted to the SWMBH Data Warehouse in a structured data format within 14 days of completion.

Treatment Record Documentation:
Summit Pointe's documentation requirements ensure compliance with contractual and regulatory requirements, as well as accreditation guidelines. Summit Pointe believes that consistent, current and complete documentation in the treatment record is an essential component of quality member care. All entries into the treatment record are dated and include the responsible clinician/staff's name who provided the service, professional degree, and relevant identification number if applicable. Any handwritten documents must be legible to persons other than the writer. Any changes to a written record must be corrected by drawing a single line through the error and marked as an error, or dated and initialed or an addendum must be completed to reflect any changes. The member's name, or identification number, must be present at the top of each page of clinical documents. The following content is required to be present in the treatment record, as applicable:

- Customer's name.
- Customer's date of birth.
- Gender.
- Presenting problems, along with relevant and social conditions affecting the member's medical and psychiatric status and the results of a mental status exam.
- A medical and psychiatric history, including previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data and relevant family information.
    - For members 12 and older, documentation should also include past and present use of alcohol and cigarettes, as well as illicit, prescribed and over the counter drugs.
    - For child and adolescent members, documentation should contain prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic).

Treatment Planning:
All individuals receiving services from Summit Pointe must have a preliminary plan indicating next treatment steps completed as part of the interpretive summary in the primary assessment within 7 days of commencing services or if hospitalized, prior to discharge.

Medicaid:
Treatment planning must occur according to the Michigan Medicaid Provider Manual and MDHHS PCP Guideline for every Member receiving Medicaid funded services on at least an annual basis. It is imperative that all persons charged with implementing Individualized Plans of Service (IPOS) and subsequent addendums are promptly and adequately trained when Plans are developed and when there is a change to the IPOS.

Commercial/Third Party:
For individuals receiving services funded through a Commercial or 3rd Party payor, services must be based on an assessment and a written plan of care completed by Summit Pointe. The plan of care may be contained in a separate treatment plan document updated at least annually with specific goals and objectives or documented in progress notes on an ongoing basis in a specifically identified plan statement.

Progress Note Documentation:
Progress note documentation must correspond to the member's IPOS/plan of care, including current status, progress toward specific goals and objectives addressed during the encounter, and interventions offered by the clinician/staff during the encounter and shall include these mandatory elements:

- **Required Content:**
  - Customer's legal name.
  - Diagnosis.
- **Service Data:**
  - Service Provided.
  - Clinician/staff member providing the service.
  - Clinician/staff member licensure/credentials.
  - Other people who were present during the service (excluding names of other customers).
  - Location or method of delivery (office, home, community, school, long term care facility, hospital, telephone).
  - Date of service.
  - Start and stop time of the encounter (duration).
- **Description of Service:**
  - Presenting problems, treatment modality, customer response to treatment.
  - Goal(s) and/or objectives of the IPOS addressed.
  - Member's strengths and limitations in achieving treatment plan goals and objectives.
  - Treatment interventions that reflect consistency with those goals and objectives.
  - Progress toward desired outcome or lack thereof.
  - Current status of the customer.
  - Future treatment recommendations.
  - Continuity and coordination of care activities as appropriate.
  - Dates of follow up appointments, or, as applicable, discharge plans are noted.
  - Specific clinician/staff interventions offered during the service contract.
- **Excluded Content:**
  - Progress notes for psychotherapy should not include psychotherapy notes as defined under HIPAA in 45 CFR Part 164, Subpart E, Section 501.
  - Content from psychotherapy notes that can be included in the record are limited to the following:
    - Medication prescription and monitoring.
    - Counseling session start and stop times.
    - The modality and frequency of treatment provided.
    - Results of clinical tests.
    - Summary of any of the following: diagnoses, functional status, treatment.
    - Plan, symptoms, prognosis, and/or progress to date.

Service documentation or progress notes must be completed and be part of the customer record within a reasonable time period after the delivery of service, and prior to the submission of a claim or encounter.

- **Signatures:**
  - All documents must be signed by all professionals participating in the service.
  - If a session is facilitated by two professionals, one may write and sign a progress note for an individual customer, the other should sign off on the progress note documenting their participation in the service.
  - All signatures must include all professionals' credentials and the date.
- **Correcting Errors:**
  - ***Errors in hard-copy clinical documents must be corrected using one of the following methods:***
    - Prior to completion of a clinical document, the writer may destroy the document, the document with the error, and draft a new document.
    - Completed and signed clinical documents or clinical documents drafted by another professional should not be destroyed. Errors on these documents should be corrected with a single line through the error so that the original entry is still legible. The person correcting the error must initial and date the correction.
    - At no time should an error on a document be covered with correction fluid/paper or completely blacked out, so that the original entry is not legible.
  - ***Modifications to errors in the electronic medical record may be addressed as follows:***
    - If the document has not been electronically signed, the document is still "in progress" and the author can continue to make modifications as necessary.
    - If the document has been electronically signed, the author should follow Summit Pointe Policy 3.5.4: Correction/Deletion of Information from the EMR.
- **Change in Condition:**
  - A change in the customers' condition may require a change in the Individual Plan of Service. In these situations, the following processes should be followed:
  - An updated assessment or periodic review must be completed to document the clinical necessity for the change in service.
  - When applicable, the documentation should include the customer's new diagnosis and document the reason for the change in diagnosis.
  - The documentation must include service recommendations.
  - An updated Individual Plan of Service must be completed to document revisions to services recommended in the assessment.
- **Diagnosis Code Discrepancies:**
  - A clinical professional may disagree with a diagnosis assigned by another internal or external professional. In this situation, the clinical professional must document the reason for the change in diagnosis and support their decision.
  - ***Notation:*** Only those clinical professionals whose scope of practice and licensure allows for diagnostic formulation may change the diagnosis. Consultation will be held, and approval obtained, by an appropriately licensed clinical professional when diagnostic modifications are required.
- **Timeliness of Documentation:**
  - Routine paperwork (i.e. psychiatric evaluations, periodic reviews, progress notes, etc.) should be completed and signed within 72 hours (3 calendar days) of contact and/or service.
  - Treatment plans and addendums should be completed and signed within 72 hours (3 calendar days) of receipt of an authorizations determination whether the determination was made through utilization review or approved through the bundle.

- Any documentation related to crisis/urgent/emergent services (including pre-admission screenings) will be completed and signed before the clinical staff person leaves their work shift.

V. REFERENCES:

Summit Pointe Policy 3.5.4: Correction/Deletion of Information from the EMR.
Southwest Michigan Behavioral Health Policy 12.11: Clinical Documentation.
CARF Behavioral Health Standards Manual: Section 2.E.

VI. ATTACHMENTS:

None