Chapter Title	Chapter #		Subject #
Fiscal	F		281.1
Subject Title	Adopted	Last Revised	Reviewed
Documentation	04/12/02	11/14/2023	3/15/05;7/26/05; 9/5/06;4/23/10; 2/24/14;10/08/15; 3/17/17;11/27/17; 11/5/18; 12/16/19; 12/16/20; 12/20/21; 12/21/22; 11/14/23; 12/13/24

PROCEDURE

Application

This procedure shall apply to the clinical services of The Right Door for Hope, Recovery and Wellness.

1. Contents of Clinical Records

1.1. Providers must maintain, in English and in a legible manner, written or electronic records necessary to fully disclose and document the extent of services provided to beneficiaries.

1.2. Clinical records shall be maintained in a manner that protects the confidentiality of the individual being served and complies with federal and state mandates.

1.3. Access to the contents of a clinical record shall be limited to those individuals authorized access to this information.

1.4. Contents of the clinical records shall be organized in a way that is clear, complete, and concise.

1.5. All documents shall require full and legible electronic or hand signatures, or signature accompanied by printed name with the appropriate credentials indicated and shall include the date of signing.

1.6. The clinical record must be sufficiently detailed to allow reconstruction of what transpired for each service billed.

1.7. For services that are time-specific according to the procedure code billed, providers must indicate in the medical record the actual begin time and end time of the particular service.

1.8. The individual record includes:

Chapter Title	Chapter #		Subject #
Fiscal	F		281.1
Subject Title	Adopted	Last Revised	Reviewed
Documentation	04/12/02	11/14/2023	3/15/05;7/26/05; 9/5/06;4/23/10; 2/24/14;10/08/15; 3/17/17;11/27/17; 11/5/18; 12/16/19; 12/16/20; 12/20/21; 12/21/22; 11/14/23; 12/13/24

1.8.1. Contact information for the individual's personal representative, conservator, guardian, or representative payee, if any of these have been appointed.

1.8.2. Contact information for the person to notify in the event of an emergency.

1.8.3. Name of the person currently coordinating the services of the person served.

1.8.4. Location of any other records, if applicable.

1.8.5. Information about the primary care physician of the person served or similar medical practitioner.

1.8.6. Financial agreement with person served

1.8.7. Healthcare reimbursement information, if applicable.

1.8.8. Health history

1.8.9. current medications

1.8.10. Preadmission screening, when conducted.

1.8.11. Documentation of orientation.

1.8.12. Assessments

1.8.13. Risk assessments

1.8.14. Safety plans

1.8.15. Person-centered planning, including reviews, when applicable.

1.8.16. Transition plan

Chapter Title	Chapter #		Subject #
Fiscal	F		281.1
Subject Title	Adopted	Last Revised	Reviewed
Documentation	04/12/02	11/14/2023	3/15/05;7/26/05; 9/5/06;4/23/10; 2/24/14;10/08/15; 3/17/17;11/27/17; 11/5/18; 12/16/19; 12/16/20; 12/20/21; 12/21/22; 11/14/23; 12/13/24

1.8.17. Progress notes

1.8.18. Discharge summary

1.8.19. Correspondence pertinent to the person served

1.8.20. Authorization for release of information

1.8.21. Documentation of internal or external referrals, if applicable.

1.9. Providers of Medicaid beneficiaries must document the following:

1.9.1. Name

1.9.2. Medicaid ID Number

1.9.3. Medical Record Number

1.9.4. Address, including zip code

1.9.5. Birth Date

1.9.6. Telephone number, if available

1.9.7. Any private health insurance information for the beneficiary, if available

1.9.8. Date of each visit

1.9.9. Begin Time and End Time – if Service is Time-Specific according to the Procedure or Revenue code billed.

1.9.10. Presenting Symptom, Condition

1.9.11. Diagnosis

1.9.12. Patient Histories

Chapter Title	Chapter #		Subject #
Fiscal	F		281.1
Subject Title	Adopted	Last Revised	Reviewed
Documentation	04/12/02	11/14/2023	3/15/05;7/26/05; 9/5/06;4/23/10; 2/24/14;10/08/15; 3/17/17;11/27/17; 11/5/18; 12/16/19; 12/16/20; 12/20/21; 12/21/22; 11/14/23; 12/13/24

1.9.13. Plans of Care

1.9.14. Progress Notes: Progress notes must be directly linked to the treatment plan, are required for every formal counseling session and service provided, and include date, staff signature, and staff credential.

1.9.14.1. Progress notes document:

1.9.14.1.1. Progress toward achievement of identified objectives and goals.

1.9.14.1.2. Significant events or changes in the life of the person served.

1.9.14.1.3. The delivery and outcomes of specific interventions, modalities, and/or services that support the person centered plan.

1.9.14.1.4. Changes in frequency of services

1.9.14.1.5. Changes in levels of care.

1.9.14.2. Progress notes are signed and dated.

1.9.15. Consultation Reports

1.9.16. Result of Exams

1.9.17. Records of Medications, Drugs, Assistive Devices or Appliances, Therapies, Tests, and Treatments that are ordered, prescribed, referred, or rendered.

1.9.18. Physical Assessments and/or nursing activities that pertain to care provided and support the services rendered and billed.

1.9.19. Orders for tests and test results.

1.9.20. Pictorial records or graphs and written interpretations of tests.

Chapter Title	Chapter #		Subject #
Fiscal	F		281.1
Subject Title	Adopted	Last Revised	Reviewed
Documentation	04/12/02	11/14/2023	3/15/05;7/26/05; 9/5/06;4/23/10; 2/24/14;10/08/15; 3/17/17;11/27/17; 11/5/18; 12/16/19; 12/16/20; 12/20/21; 12/21/22; 11/14/23; 12/13/24

1.9.21. Test Methodology

1.9.22. Name, strength, dosage, quantity and route of drug, and time administered.

1.9.23. Ordering, prescribing, or referring physician.

1.9.24. Transportation information other than ambulance.

1.9.25. All documents within the contents of the clinical record will be identified with case number and name or initials.

1.10. Email

1.10.1. Emails should become a part of the clinical record when related to diagnosis and/or significant treatment issues.

1.10.2. The last response to an email, which includes the entire email correspondence should be included in the clinical record. Individual responses without any context should not be included in the clinical record.

1.10.3. The primary clinician will inform persons served and the supports of persons served that email is not to be used to communicate emergencies.

1.10.4. The primary clinician should obtain consent for email communication whenever possible using the agency Text/Email consent form.

1.10.5. Communication preferences should be clearly noted in the electronic health record.

1.10.6. Persons served may withdraw their consent verbally or in writing at any time by informing an agency employee. Medical Records must be notified and withdraw must be documented in the electronic medical record.

Chapter Title	Chapter #		Subject #
Fiscal	F		281.1
Subject Title	Adopted	Last Revised	Reviewed
Documentation	04/12/02	11/14/2023	3/15/05;7/26/05; 9/5/06;4/23/10; 2/24/14;10/08/15; 3/17/17;11/27/17; 11/5/18; 12/16/19; 12/16/20; 12/20/21; 12/21/22; 11/14/23; 12/13/24

1.11. Text Messages

1.11.1. Text messages should become a part of the clinical record when related to diagnosis and/or significant treatment issues.

1.11.2. Text messages should be documented in a progress note. Individual responses without any context should not be included in the clinical record.

1.11.3. The primary clinician will inform persons served and the supports of persons served that texting is not to be used to communicate emergencies.

1.11.4. The primary clinician should obtain consent for text communication whenever possible using the agency Text/Email consent form.

1.11.5. Communication preferences should be clearly noted in the electronic health record.

1.11.6. Persons served may withdraw their consent verbally or in writing at any time by informing an agency employee. Medical Records must be notified and withdraw must be documented in the electronic medical record.

2. Records Review

Peer Review of clinical records are completed at least quarterly on a pre-determined sample of all agency consumer clinical records. The reviews shall ensure that proper documentation and services are being provided based on the individual's identified goals, needs, medical necessity, and selection guidelines. Clinical record reviews are to be completed on the agency approved clinical record review form.

3. Timeliness of Documentation

Chapter Title	Chapter #		Subject #
Fiscal	F		281.1
Subject Title	Adopted	Last Revised	Reviewed
Documentation	04/12/02	11/14/2023	3/15/05;7/26/05; 9/5/06;4/23/10; 2/24/14;10/08/15; 3/17/17;11/27/17; 11/5/18; 12/16/19; 12/16/20; 12/20/21; 12/21/22; 11/14/23; 12/13/24

3.1. Providers shall document services and submit said documentation to Medical Records within 72 business hours of providing the service, excluding agency closures and weekends.

3.2. Providers shall document all crisis contacts and pre-screen services and submit required documentation within 24 hours of the services.

3.3. Medical Records staff shall ensure that all documents and reports are entered into the electronic filing system within 24-hours of receiving said documents and reports.

References:

Michigan Medicaid Manual Section 14: Record Keeping

CARF Standards Manual

Kerry L Possehn, Chief Executive Officer	Date		