
Overview

The health plan and Harmony Behavioral Health require that behavioral health providers maintain medical, fiscal, professional, and business records on all services provided to health plan members. Records may be kept on paper, magnetic material, film, or other media including electronic storage, except as otherwise required by law or program requirements. In order to qualify as a basis for reimbursement, the medical records must be signed and dated at the time of service, or otherwise attested to as appropriate to the media. All records must be accessible, legible and able to be understood.

The health plan and Harmony Behavioral Health, Inc. require that the following types of records, as appropriate for the behavioral health service provided, must be retained (the list is not all inclusive):

- claim forms and any documents that are attached
- professional records, such as appointment books, patient treatment plans, and referrals
- medical and other patient records
- copies of member consent forms, advance directives, release of information authorizations and other similar consents
- prior and post authorization, and service authorization information
- prescription records
- orders for laboratory and other diagnostic tests and test results
- business records, such as accounting ledgers, financial statements, invoices, inventory records, check registers, cancelled checks, sales records, etc.
- tax records, including purchase documentation
- drug utilization reports by drug NDC

- partnership records
- patient counseling documentation
- provider enrollment documentation
- purchase documentation
- utilization review and continued stay approvals for psychiatric or substance abuse inpatient stays

All behavioral health provider records must be retained for a period of at least five (5) years from the date of service or longer if required by law.

Right to Review Records

The health plan, Harmony Behavioral Health, and state and federal agencies have the right to audit or examine a behavioral health provider's records. This requirement applies to the behavioral health provider's records and records for which he/she is the custodian. The behavioral health provider must give access to all medical, administrative and financial records upon request. Whenever possible, the health plan, Harmony Behavioral Health, and state and federal agencies will coordinate visits with behavioral health providers in advance of an audit or examination of records.

Behavioral health providers must send, at their expense, legible copies of all requested member-related information to the health plan, Harmony Behavioral Health, and state and federal agencies upon request.

Authorized representatives of an accreditation organization, such as AAAHC or URAC, may request access to behavioral health provider records as part of an accreditation review. Behavioral health providers will be notified by the health plan or Harmony Behavioral Health in advance of an accreditation review and informed of the nature of the review and access requirements.

Medical Records

Each behavioral health provider is required to maintain a complete medical record for each member according to professional practice standards, as well as state and

federal requirements. To comply with regulatory and accreditation requirements, Harmony Behavioral Health's Quality Improvement staff will conduct annual medical record audits in behavioral health provider offices. A member's medical record will be reviewed for content and screenings as applicable. Behavioral health providers will be given preliminary results at the time of the audit and a written report will follow. A Corrective Action Plan will be required if the audit score is below an 80 percent level of compliance.

Behavioral health providers are required to observe medical record requirements and guidelines as follows:

- safeguard member confidentiality in accordance with HIPAA, state and federal guidelines, Quality Improvement and Health Plan Risk Management Programs, and professional practice standards
- make the medical records available for quality care review studies by Harmony Behavioral Health reviewers, authorized representatives of Department of Financial Services, the Centers for Medicare and Medicaid Services (CMS), plan member, and organizations conducting accreditation audits
- comply with Corrective Action Plan requirements imposed as the result of any such review or audit
- when a member changes his behavioral health provider, to provide without charge, and in a timely manner, a copy of a transferring member's medical record to the new behavioral health provider

Medical Record Content

Medical records must state the necessity for and the extent of behavioral health services provided. The following requirements may vary according to the service rendered:

- all entries in the medical record must include the name, professional license and signature or initials of the behavioral health practitioner rendering services

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- records should not be altered, however, if necessary, corrections should be made by a single line through the inaccurate entry, dated and initialed
- use only standard abbreviations and symbols
- all entries in the medical record must be recorded in a timely manner and dated
- medical records must be legible to readers and reviewers and maintained in an orderly fashion
- the following personal and biographical data must be included in the record: name, member ID#, date of birth, sex, emergency contact, and legal guardianship. This may include: marital status, name of spouse, next of kin or closest relative, address, employer, phone numbers, insurance information, family history
- late entries should include date and time of occurrence and date and time of documentation
- record details of informed consent discussions and document incidents of member refusal of treatment, including possible consequences or adverse outcomes of not receiving recommended tests or procedures
- documentation of clinical observations and/or patient symptoms should be descriptive and in sufficient detail to adequately evaluate and diagnose the condition
- clearly document follow-up instructions, including medications, referrals, diagnostic tests, and subsequent appointments
- document all telephonic contacts with the member, indicating the time and date the call was received, by whom, any advice given or diagnosis made, and the time and date of any follow up call
- medical records from the previous behavioral health provider have been obtained and are easily

accessible. Old records include past medical history, physical examinations, necessary tests and possible risk factors for the member relevant to treatment and, are used to assess the periodicity schedule and maintain continuity of care.

- for behavioral health providers authorized to prescribe medications, a listing of all prescribed medications, including dosages and dates of initial and refill prescriptions the member is taking is included in the medical record
- prominently annotate known medication allergies or “no known allergies” in the record
- a problem list, with past and current diagnoses and procedures used to provide continuity of care is in the chart. This includes a summary of significant surgical procedures, past and current diagnoses, medication, reactions etc.
- screening for substance abuse of tobacco, alcohol and drugs with appropriate counseling/referrals if needed, is documented
- there is evidence the member was asked about advance directives and documentation of acceptance or refusal. Note: The record must contain evidence that the member was provided written information concerning the member’s rights regarding advance directives and whether or not the member has executed an advance directive. The member does not have to have advance directives completed; a signed statement that they have been asked if they have them and if not, do they want them, will suffice. A stamp may be utilized. The provider shall not, as a condition of treatment, require the member to execute or waive an advance directive in accordance with Section 765.110, F.S. (20 years and older).
- all records must reflect the primary language spoken by the member, as well as any translation or other communication needs of the member

**Continuity
of Care**

The medical record must show the behavioral health provider's knowledge of the member's course of care as evidenced by the following:

- there is documentation and reports of consultations and referrals to medical or other behavioral health providers, if indicated
- if applicable, there are reports of diagnostic testing in the medical record. The medical record will show documentation of laboratory and other diagnostic testing that was ordered and the results.
- there is documentation of hospitalizations to include discharge summary and discharge planning.
- there is documentation of a plan for hospital discharge and a copy of the hospital discharge summary on the medical record for members who were hospitalized

The following information must be documented in the medical record for each visit:

- history and physical examination as related to the visit, chief complaint or purpose of the visit, objective findings of the practitioner, diagnosis or medical opinion are documented for each visit
- plan of treatment, referrals, disposition, diagnostic testing, therapies and prescribed regimens are documented for each visit as indicated
- there is documentation of follow up plans for abnormal testing/consultation reports or missed/cancelled appointments
- there is documentation that the abnormal results or consultations were reviewed by the provider and documentation of the follow up to be done
- there is documentation of patient education and instruction whether verbal, written or via telephone
- the member is provided with verbal and/or written

education/instruction as indicated and appropriate. Significant medical advice given via telephone is entered in the member's record and appropriately signed and initialed. (This includes medical advice provided by after-hours telephone patient information or triage telephone services.)

Incomplete Records

Behavioral health providers who are not in compliance with the documentation and record retention requirements may be subject to corrective action, administrative sanctions or other adverse actions.

Fiscal Records

All participating behavioral health providers should maintain complete and accurate administrative and fiscal records. Records should be made available for quality care review studies by Harmony Behavioral Health, health plan auditors, national accreditation agencies, and authorized representatives of state and federal government agencies. Behavioral health providers should comply with requirements issued as a result any such review or audit.