Documentation and Reimbursement for Behavioral Healthcare Services
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Clinical documentation and health records play a vital role in every aspect of healthcare delivery and decision making, no matter what the setting. Documentation also is a central focus in current efforts to improve healthcare quality and patient safety as well as the efficiency of the U.S. healthcare system. The development and implementation of electronic health record (EHR) systems promise to revolutionize the collection, use, and management of healthcare data over the next decade.

Ensuring the accessibility, accuracy, and integrity of health records has been the primary mission of health information managers since the profession emerged more than seventy-five years ago. Just as important, health information management (HIM) professionals continue to champion the protection of patient privacy and the confidentiality of health information. As experts in the documentation requirements of external government agencies and accreditation organizations, HIM professionals also play an invaluable role in managing their organizations’ regulatory compliance and accreditation performance.

_Documentation and Reimbursement for Behavioral Healthcare Services_ explains the importance of accurate and timely health record documentation in behavioral healthcare settings. However, many of the basic principles discussed also apply to other healthcare settings. Information on legal, regulatory, and accreditation requirements specific to this setting also is provided.

The paper-based forms in this book were designed specifically as examples of data capture and management tools and samples of appropriate health record documentation. In some cases, the sample forms have been simplified to fulfill educational purposes. They also have been sized and formatted to fit the printed book. Therefore, direct use for documentation of actual clinical services would not be appropriate. However, educators and students are free to copy and use the forms as part of their classroom activities. Any other usage would require the expressed permission of the American Health Information Management Association (AHIMA).

The goal of this publication is to help HIM practitioners and students understand the role of health records and clinical documentation in the delivery of direct client services and in the operations of behavioral healthcare organizations. Specifically, chapter 1, Documentation of Care, explains why healthcare information is documented and identifies its key users. It also describes various efforts to provide the healthcare industry with documentation guidelines and standards and discusses different documentation methodologies. Chapter 2, Content, Format, and Organization of the Health Record, explains what information is part of the health record and what is not. It also discusses the components of the acute care psychiatric health record. The electronic health record and its advantages and limitations are discussed in chapter 3, Understanding and Implementing the Electronic Health Record. The chapter also outlines steps for implementing the EHR and steps for selecting and contracting with vendors. Chapter 4, Record
Review and Analysis, examines the documentation challenges that are unique to behavioral healthcare. It explains how to conduct a clinical pertinence review and focuses on the importance of organizational health record policies and procedures and staff training. Chapter 5, Coding and Reimbursement, describes different clinical vocabularies and discusses different types of reimbursement systems, methodologies, and support processes. Chapter 6, Data and Information Management, defines the terms data, information, and knowledge. It also draws attention to the importance of ensuring data quality and describes various data and information management initiatives as well as information management systems. Healthcare regulation is the focus of chapter 7, Regulatory and Accreditation Requirements. The chapter discusses quality improvement organizations and the role of health information management professionals in the accreditation, certification, and licensure process. Chapter 8, Compliance, overviews the primary components of compliance using examples and citations drawn from the Federal Register. Chapter 9, Confidentiality, Privacy, and Security of Protected Health Information, discusses these issues as they are addressed in the behavioral healthcare setting. This chapter draws heavily from the Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules. Finally, chapter 10, Outcomes Management and Performance Improvement, introduces different performance improvement models and the various measures that organizations can use to assess quality improvement program effectiveness.

This publication also includes ten appendixes. Appendix A offers several examples of inpatient forms used in the behavioral healthcare organization, and appendix B contains numerous outpatient forms. Appendix C overviews standards and requirements governing the form and content of the behavioral healthcare record. Appendix D contains principles of form and screen design to assist professionals in developing documents for their organizations. Two Federal Register documents are contained in Appendix E: OIG Compliance Program Guidance for Hospitals, created in 1998, and the draft supplemental guidance, developed in 2004. These documents are referenced numerous times throughout the text. Two AHIMA Practice Briefs are located in appendix F: “Seven Steps to Corporate Compliance: The HIM Role” and “Developing a Coding Compliance Policy Document.” Appendix G contains sample audit tools, forms, and worksheets, and appendixes H and I contain sample compliance plans and sample policies and procedures. Finally, appendix J contains a glossary of key terms mentioned throughout the book.

The American Health Information Management Association hopes that the publication of this book on documentation for behavioral healthcare services will help new professionals, as well as those already in practice, to meet the current demands and future challenges of health information management in this setting.
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Introduction

Rhonda Edgecomb, RHIT

*Documentation and Reimbursement for Behavioral Healthcare* emphasizes the importance of high-quality health information in the behavioral healthcare setting. In short, high-quality documentation yields positive outcomes with client care, organization reimbursement, and compliance with the various regulatory and accrediting bodies discussed throughout this textbook. This book explores best practice and current trends in documentation, data management, quality improvement activities, reimbursement, and privacy practices in the behavioral healthcare setting. It is written as a resource for use by the health information management (HIM) professional working in behavioral health, behavioral healthcare administrators, educators, and students.

**Early History and Background of Mental Health**

The earliest accounts of mental illness date as far back as the days of the ancient Greeks. Often misunderstood, individuals suffering from mental illness were perceived to be possessed or demonic and were often subjected to cruel and inhumane treatment in an effort to rid them of evil spirits. Care for the mentally ill typically was the responsibility of the immediate family and was provided mostly in the home. It was not uncommon for the mentally ill to be caged, chained, and/or isolated for significant lengths of time, hidden from the view of the community (Shorter 1997, 1–4).

During the sixteenth and seventeenth centuries, long before psychiatry was established as a formal discipline, treatment for the mentally ill was provided by physicians in general care hospitals. In this setting, the mad or the insane were separated from the medically ill in distinct wards. Individuals with mental illness were generally grouped together in these wards regardless of their condition. Early accounts of such hospitalization detail torturous flogging, painful restraints, and dysenteric environments (Shorter 1997, 6).

In the late seventeenth century, formal asylums for the insane were established to relieve families of the significant burden of caring for individuals with serious mental illness. For many residents, the asylum simply offered a grim alternative to passing the remainder of their days in cages or man-made pits. However, their time was still spent in almost absolute solitude.

Physical restraints and heavy sedation by means of potent medications, which caused undesirable side effects, were common treatments in the asylum era. Very little was done to determine the actual cause of an affliction, so diagnosis-specific treatment was still an unknown. Because there were no established admission criteria for institutionalizing an individual, the system eventually became abused. By the nineteenth century, it was common practice for a husband to commit his wife involuntarily to an asylum for demonstrating excessive emotional behavior or for exhibiting signs of depression following the birth of a child (Shorter 1997, 4–8).
Biomedical, Technological, and Theoretical Advances in Care

For centuries, experts have debated the origin of mental illness. In the beginning, experts focused on the “spiritual” aspect of the human existence and attempted to modify behavior or, rather, ill behavior through the use of religion, witchcraft, and other forces affecting spirituality. Little or no effort was made to identify the cause of exhibited symptoms; thus, the origin went undiagnosed and untreated.

In more recent times, the debate has been a little more scientific. Starting in the very early 1900s, experts began to study the impact of genetics and simple brain chemistry to determine the severity and course of mental illness in individuals. Formalized universities studied the poorly maintained clinical records of insane asylums to establish trends and patterns of inherited mental illness. During this era, experts hypothesized that mental illness was not only hereditary, but also might actually worsen with each generation. This research marked the onset of a more scientific approach to treating mental illness (Shorter 1997, 93–99).

In the late nineteenth century and into the early twentieth century, research took a bit of a turn when experts, including the psychoanalysis pioneer Sigmund Freud, began to focus on past traumatic events in an individual’s life as a cause for mental illness and ill emotional behavior. This was referred to as the psychoanalytic era in the history of mental health. This era bore images of individuals lying on a couch in a psychiatrist’s office detailing accounts of personality-altering childhood experiences and events. Memories that had left psychological scarring and a permanent residual impact on the psyche were uncovered and explored during such sessions. Clinicians of the day discovered that medication management, hypnosis, and extensive one-on-one therapy sessions were effective tools in the treatment of such residual effects (Shorter 1997, 145–160).

To this day, experts continue to debate the origin of mental illness. Regardless of the cause, however, the treatment for mental illness has advanced significantly. Gone are the inhumane asylums of the early days. Today’s approach to treatment focuses on the specific symptoms, diagnosis, and circumstances of the individual. This individualized approach to treatment provides the mentally ill with the best possible care.

Today’s Behavioral Healthcare Environment

Today, it is estimated that one in five Americans, roughly 22 percent, will suffer from a diagnosable mental illness in any given year (NIMH 2001). These conditions, which encompass a wide variety of cognitive, emotional, and behavioral illnesses, along with mental retardation, developmental disabilities, and substance abuse, are classified in the *Diagnostic and Statistical Manual of Mental Disorders, fourth edition* (DSM-IV). DSM-IV is the classification system utilized in the United States to diagnose and classify mental illness.

The Recipient of Behavioral Healthcare Services

According to the surgeon general, it is estimated that more than 54 million Americans are currently diagnosed with a mental health disorder. Mental illness is prevalent in all races, ages, and social settings and affects almost every family in the United States (USPHS 1999).

Today’s healthcare system offers a number of mental health or “behavioral” healthcare services to individuals living with these conditions. The terms *mental health* and *behavioral health* may be used interchangeably throughout this textbook as both are frequently used in treatment settings around the country.

The individuals who seek these services are commonly referred to as clients, although it is not uncommon for them also to be referred to as patients, consumers, or recipients. These terms are used interchangeably throughout this textbook as well.
Types of Conditions Classified as Mental Disorders

Individuals seek professional healthcare assistance for any number of mental health or behavioral conditions. In many circumstances, such people are diagnosed with more than one condition in the following categories:

- Depressive disorders affect more than 18 million adults in America and are fairly well managed with medication. Conditions in this category include general depression, major depression, and the depressed phase of bipolar disorder. Of interesting note is that nearly twice as many women as men suffer from depressive disorders (NIMH 2001).

- Schizophrenia affects more than 2 million adults in America. One of the more serious forms of mental illness, it is possibly the most disabling of all diseases of the brain, often causing the individual to exhibit psychotic symptoms such as delusions or hallucinations. Long misunderstood by the general public, schizophrenia often subjects its victims to an undeserving stigma. Although acute bouts typically require hospitalization, schizophrenia is commonly treated on an outpatient basis with antipsychotic medications, therapy, and counseling (NIMH 2001).

- Anxiety disorders affect approximately 19 million individuals in America and include such conditions as obsessive–compulsive disorder, panic disorder, social phobias, generalized anxiety disorders, and post-traumatic stress disorder. Individuals commonly suffer from more than one form of anxiety disorder at a time and generally are subject to other forms of mental illness, such as eating disorders or depressive disorders (NIMH 2001).

- Eating disorders afflict more women than men. Consisting primarily of anorexia nervosa and bulimia nervosa, they are among the leading causes of deaths of females between the ages of fifteen and twenty-four in the United States (NIMH 2001).

- Attention deficit hyperactivity disorder (ADHD) is one of the most common mental disorders among children and adolescents under age eighteen. Children are commonly hyperactive, unable to focus, or generally disruptive in social environments. Although ADHD can persist until adulthood, medication management has been very successful in treating individuals affected by this disorder (NIMH 2001).

- Alzheimer’s disease and dementia affect more than 4 million individuals in America over the age of sixty-five. Organic in nature, there is no cure at this time and healthcare providers are limited to treating only the symptoms of the conditions (NIMH 2001).

- Substance abuse and/or chemical dependency affect more than 22 million Americans aged twelve and older. This number reflects the total population of individuals in America abusing illicit drugs and alcohol (SAMHSA 2003). Substance abuse is linked to more deaths and disabilities annually than from all other causes, and it costs the United States approximately $276 billion dollars each year in medical resources used for care, treatment, and rehabilitation (direct expenses) and reduced or lost productivity (indirect expenses) (NCADD 2002).

- Mental retardation affects more than 7 million individuals, according to the most recent survey conducted in the 1990s (Batshaw 1997). Individuals diagnosed with mental retardation generally have an intellectual functioning level (IQ) below 70 and significant limitations in two or more adaptive skill areas (daily living skills necessary to live, work, and play in the community). The onset must occur during childhood (before age 18) for the condition to be classified as mental retardation (AAMR 1992).
• Developmental disabilities affect approximately 17 percent of children under the age of eighteen in the United States. These physical, cognitive, psychological, sensory, and speech impairments include conditions such as autism, cerebral palsy, and specific learning disorders (CDC 2003).

Types of Care

Today’s behavioral healthcare environment allows for a more individualized approach to treatment. Treatment is specifically prescribed after a diagnosis has been established, and careful consideration is given to the individual’s social, medical, and financial circumstances and service needs. It may be provided by a psychiatrist, a psychologist, or a variety of rehabilitative or social work specialists. In many settings, a combination of these individuals is used.

Care typically is prescribed through a well-devised treatment or service plan developed by the provider or provider team in response to the individual’s needs. In today’s environment, the client and his or her family, if available, are often encouraged to actively participate in development of the treatment or service plan.

Types of Facilities

There are three basics types of behavioral healthcare settings: inpatient, residential, and outpatient.

• Inpatient facilities are able to provide the individual with around-the-clock care. They may be a dedicated portion of a hospital or may stand alone. In some circumstances, clients are in need of partial-stay services or partial hospitalization. Such services are provided to individuals who fall between the need for inpatient and outpatient services and would benefit from a short stay at an inpatient mental health facility or hospital. Partial stay provides individuals with mental health treatment that is more intense than the services provided on an outpatient basis. Most payers (including Medicare) cover this service when determined medically appropriate by the physician (CMS 2003).

• Often referred to as group homes or foster homes, residential facilities provide an alternative to the inpatient setting. Clients of such facilities are often encouraged to achieve independence in daily functions with little assistance from the provider. The residence provides a somewhat stable environment that helps many individuals with mental illness to assimilate into the “real world.”

• Outpatient care provides clients with access to a stable treatment provider on an outpatient basis. Such care may occur in a formal office setting or in the comfort of the individual’s home or residence. In some circumstances, outpatient services are provided in homeless shelters in an effort to reach the estimated hundreds of thousands of homeless individuals in America who suffer from mental illness (CMHS 1992).

Employers also are acknowledging the need for mental health services for their employees by providing access to Employee Assistance Programs (EAPs). These outpatient programs are designed to provide employees immediate access to psychological counseling on a limited basis and may be provided on-site or through a local provider.

Schools and universities also commonly provide outpatient mental health assistance to their students through formal clinics, guidance therapy, or direct collaboration with area community-based providers. Moreover, schools often provide crisis therapy or counseling to students exposed to significant trauma due to violence in the school or community or following major devastating events such as the terrorist events that occurred on September 11, 2001. Such therapy or counseling services are commonly provided by local mental health providers and/or local law enforcement.
Organization and Operation

Behavioral healthcare facilities may be private, stand-alone entities or affiliated with an area hospital or larger healthcare organization. In addition, some behavioral organizations are part of a chain, with a main corporate office and facilities in a specific region or throughout the nation. Many organizations today are owned, operated, and funded by the individual states or counties. In most states, healthcare plans such as Medicaid or those run by individual counties are responsible for providing funding for individuals with behavioral healthcare problems. If an individual is fortunate enough to have private insurance that covers behavioral healthcare services, the state or local government may likely be responsible for paying the difference. Additional funding sources such as grants and other charitable organizations and their impact on the quality of care are discussed in chapter 10 of this textbook.

Forces Affecting Behavioral Healthcare

Numerous forces in the healthcare environment have an impact on behavioral healthcare. The following subsections describe some of these forces and their influence.

Quality Improvement Organizations

Quality improvement organizations (QIOs), formerly known as peer review organizations (PROs), are entities operating under the funding of the Centers for Medicare and Medicaid Services (CMS). Their primary function is to assess and improve the quality of healthcare provided to consumers. Oftentimes functioning as advocates for healthcare consumers, QIOs perform retrospective record reviews, conduct national and local quality improvement studies, and investigate consumer complaints regarding the quality of care provided in a number of settings.

Although QIOs do not specifically review mental health facilities, care provided to individuals with mental illness is monitored in other settings in which behavioral healthcare is sought. QIOs also protect the integrity of the Medicare funds by ensuring that services are provided only when medically appropriate or necessary. QIOs are dedicated to protecting the rights of individuals receiving behavioral healthcare services (CMS 2003).

Managed Care

As with other industries in the healthcare delivery system, behavioral healthcare must take measures to control the cost of services. Managed care entities have added behavioral health benefits to their plans and routinely monitor compliance with contractual agreements. Each year, more and more employers opt to contract with large managed care organizations (MCOs) to provide healthcare services to their employees. In many circumstances, however, benefits provided for behavioral health services are less than those provided for traditional medical treatment. For this reason, many employers have opted to establish EAPs to provide employees with access to brief and limited counseling or therapy services during times of need. This service is often fully paid for by the employer.

Integrated Delivery Systems

In today’s healthcare environment, it is not uncommon for a provider or organization to offer a variety of healthcare services. For example, one organization may provide acute care services, home healthcare services, and behavioral healthcare services under the same organizational name. As with any other healthcare provider, access to health information is critical to the successful delivery of care in such an integrated delivery system (IDS). Reliable and timely access to information is essential for the delivery of high-quality client care and yet is one of the most significant challenges in this type of healthcare system.
It is not uncommon for the individual component disciplines to establish and maintain separate and distinct records of care (commonly referred to as clinical records) in the IDS. Thus, it is essential that the provider has a well-maintained information management system or other reliable client indexing system that allows for the identification of shared clients. This permits optimal communication among healthcare providers in each component discipline within the network or IDS arrangement and ensures continuity of care for the client.

**Healthcare Reengineering**

As with other industries in the healthcare delivery system, behavioral healthcare has been subject to attempts at reengineering throughout the years. Healthcare reengineering is an approach to improve client care quality through the restructuring of services and/or redesignation of staff responsibilities to provide optimal services while maintaining control of costs. For some industries, this system has worked successfully with little effort. For recipients of behavioral health services, however, reengineering may cause a threat to the stable provider–client relationship, causing undue stress on the client. For this reason, many behavioral health providers have opted to ignore the financial benefit of reengineering and have chosen, instead, to maintain the personalized treatment sought by so many individuals within the mental health population.

**Performance Improvement**

Performance improvement (PI) activities are an important aspect of any industry in the healthcare delivery system. Behavioral healthcare facilities accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by the Commission on Accreditation of Rehabilitation Facilities (CARF) demonstrate excellence in high-quality service provision by maintaining compliance with hundreds of quality standards developed by the accreditation bodies. Accrediting bodies such as JCAHO and CARF closely monitor organizational policies and procedures related to PI activities. Various PI strategies are discussed later in this book.

**Outcomes Assessment and Management**

Outcomes assessment is an effective tool used to monitor the success of a plan from beginning to end. In behavioral health, it is a way to determine if care and services were prescribed appropriately and provided to assist the client in achieving the expected or desired outcome (Rudman 1997, 81–85).

Although behavioral healthcare experts report that individuals suffering from behavioral health conditions may never be “cured” in the traditional sense of the word, it is highly accepted that many of them can achieve a fairly independent lifestyle when diagnosed and treated properly. Various methodologies for outcomes assessment and management for behavioral health are discussed later in this book.

**Growth of Outpatient and Partial Treatment Settings**

With the rising cost of inpatient services, many individuals are seeking behavioral health services through outpatient or partial-treatment settings. These options provide the client with a stable healthcare provider at a significantly lower expense. Unfortunately, the decision to move to the outpatient setting is not always made by the individual or provider but, rather, by the payer.

**Health Insurance Portability and Accountability Act**

In April 2003, administrators, providers, and HIM professionals throughout the healthcare industry faced one of the most significant laws ever to impact healthcare delivery. This law, known as the Health Insurance Portability and Accountability Act (HIPAA), forever changed the manner in which organizations use and disclose the confidential information that is collected and maintained for healthcare purposes.
For many HIM professionals working in the field of behavioral health, HIPAA was a welcome relief to the constant battle fought with other industries (both inside the healthcare continuum and out) over protection of the highly sensitive information generated in behavioral health encounters. For the first time in the history of healthcare, all providers were required to protect health information with the same respect and care that behavioral healthcare providers had been accustomed to doing for decades.

**Professional Associations, Government Agencies, and Organizations Related to Behavioral Healthcare**

Over the years, professional associations, government agencies, and organizations related specifically to behavioral healthcare have flourished. The discussions below focus on those with the greatest impact.

**Centers for Medicare and Medicaid Services**

The Centers for Medicare and Medicaid Services (CMS) is a division of the U.S. Department of Health and Human Services (HHS). Referenced throughout this book, CMS plays an integral role in the quality of care provided to those individuals utilizing the behavioral healthcare system. It monitors expenses related to behavioral healthcare and provides mental health benefits through its Medicare program to eligible recipients (CMS 2003). Additionally, CMS oversees the QIOs, which monitor medical necessity, quality of care, and the appropriateness of reimbursed services in behavioral healthcare settings.

**National Alliance for the Mentally Ill**

The National Alliance for the Mentally Ill (NAMI) is a nonprofit organization dedicated to providing advocacy and support to individuals affected by severe mental illness (schizophrenia, bipolar disorder, major depressive disorders, and so on). NAMI not only assists individuals with the mental illness but also works with their families and friends. NAMI’s primary mission is to eradicate mental illness and improve the quality of life for those affected by it (NAMI 2003).

**National Mental Health Association**

The National Mental Health Association (NMHA) is a nonprofit organization created to assist the more than 54 million Americans with mental disorders. Through its public advocacy, education, and research programs, NMHA hopes to elevate public knowledge of mental health issues, encourage reform, and promote the effective use of qualified prevention and recovery programs (NMHA 2004).

**Joint Commission on Accreditation of Healthcare Organizations**

The Joint Commission on Accreditation of Healthcare Organizations is a not-for-profit organization dedicated to continuously improving the quality of care provided to individuals throughout the healthcare industry. It offers voluntary accreditation to healthcare providers and organizations through its rigorous evaluation and accreditation process.

The JCAHO bases its accreditation outcome on the ability of the healthcare organization to demonstrate compliance with specific performance standards. The accreditation process includes an on-site survey by an interdisciplinary survey team that evaluates ongoing compliance with the performance standards specific to the healthcare setting (JCAHO 2003).
interaction between the JCAHO and the behavioral healthcare system are discussed throughout this textbook.

**Commission on Accreditation of Rehabilitation Facilities**

The Commission on Accreditation of Rehabilitation Facilities is similar to the JCAHO in that it is a not-for-profit organization devoted to ensuring continuous quality improvement in healthcare, but CARF specifically accredits organizations for quality excellence in rehabilitative and human services. Like JCAHO, CARF has developed performance standards that must be met in order for a healthcare organization to pass the survey process (CARF 2004).

**Substance Abuse and Mental Health Services Administration**

The Substance Abuse and Mental Health Services Administration (SAMHSA) is a federal agency of the HHS established to focus on assessing and improving the lives of individuals with or at risk for mental illness and/or substance abuse disorders. SAMHSA also offers public programs and funding to provide treatment, prevention efforts, and rehabilitation services for substance abuse and mental illness (SAMHSA 2003).

**American Health Information Management Association**

The American Health Information Management Association (AHIMA) is the dynamic professional association that represents more than 46,000 specially educated HIM professionals who work throughout the healthcare industry. HIM professionals serve the healthcare industry and the public by managing, analyzing, and utilizing data vital for patient care and by making that care accessible to healthcare providers when it is needed most.

**The Health Information Management Professional’s Role in Behavioral Healthcare**

The HIM professional is a vital part of any behavioral healthcare organization. From the onset of care, he or she is able to provide best-practice guidance and expertise on documentation issues, compliance issues, and general record maintenance issues.

Successful HIM practices throughout the continuum of care provided in the behavioral healthcare setting assist in the safety and quality of care provided to clients, effective outcomes monitoring, and positive customer satisfaction. As the keepers and manipulators of information and data, HIM professionals play an integral, indispensable, and powerful role in meeting these challenges.

To provide accurate and timely assistance, it is critical that the HIM professional understand the complexity of the behavioral healthcare system, its rules and regulations, and its unique position in the healthcare delivery system.

This book provides HIM professionals with the fundamental tools and resources necessary to gain a greater understanding of the fascinating world of behavioral health.

**References and Bibliography**


A **health record** is a private document, either paper based or electronic, created in the normal course of **client** care. Its compilation may begin prior to admission and proceeds through to the conclusion or transfer of treatment and, ultimately, disposition. This collection of documents, often organized to reflect the order of care events as they occur, should be sufficiently comprehensive to support a client’s **diagnosis**, plan of treatment, course of treatment, outcomes, and billing activity. **Behavioral health** has unique documentation challenges. Clients may be at high risk for suicidal or homicidal behavior. Often they are committed to a behavioral healthcare facility involuntarily or are required to receive treatment against their wishes. Clients who voice suicidal thoughts or exhibit suicidal behaviors present organization staff with significant challenges in terms of care and safety. Consequently, staff must have an organized system for documenting and addressing such behavior (Teich 1998).

The health record is the documentation of a client’s physical and behavioral health and the healthcare **services** provided in any area of the healthcare delivery system or continuum. It consists of individually identifiable data. The term **individually identifiable data** refers to information that identifies, or could be used to identify, an individual. This information:

- May be kept, stored, maintained, and transmitted in any medium
- Is collected and used when providing or documenting care and treatment

Data that are not individually identifiable are known as aggregate data. **Aggregate data** are data extracted from individual client records that have been deidentified and combined. Uses for individual and aggregate data are summarized in table 1.1.

This chapter defines the purposes of healthcare documentation and identifies its key users. It also describes various efforts, legislative and otherwise, to provide documentation guidelines and standards for use by the healthcare industry. Finally, the chapter discusses different documentation methodologies and focuses on the importance of developing organization **policies** and **procedures** and documentation review practices and of implementing employee education and training on the documentation **process**.

### Purposes of Healthcare Documentation

**Documentation** in the client behavioral healthcare record has multiple purposes. It:

- Serves as a basis for planning client care and ensuring continuity in the evaluation of the client’s condition and treatment
Table 1.1. Uses for individual and aggregate data

<table>
<thead>
<tr>
<th>Individually identifiable data</th>
<th>Aggregate data</th>
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<tbody>
<tr>
<td>• Client care and treatment</td>
<td>• Research studies</td>
</tr>
<tr>
<td>• Billing</td>
<td>• Statistical data on use of services</td>
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<td></td>
<td>• Statistical data on treatment</td>
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<td></td>
<td>• Provider patterns</td>
</tr>
<tr>
<td></td>
<td>• Help the facility plan for the future</td>
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</tbody>
</table>

• Furnishes documentary evidence about the client’s evaluation, treatment, and change in condition during the treatment encounter as well as during follow-up care and services
• Provides a mechanism for communication among all the healthcare professionals contributing to the client’s care
• Substantiates treatment and services provided for insurance claims
• Documents client involvement and, when appropriate, family members’ involvement in the client’s treatment program
• Assists in protecting the legal interests of the client, the facility, and the responsible practitioners
• Provides data for research
• Provides data for use in internal training, continuing education, quality assessment, and utilization review

Users of Healthcare Documentation

Many individuals and groups use healthcare documentation for myriad reasons. Some of the key users of healthcare documentation are discussed in the following subsections.

Organization Staff

Myriad staff members provide care and treatment to behavioral healthcare clients, including physicians, psychologists, nurses, social workers, chemical dependency counselors, rehabilitation therapists, mental health workers, and case managers. Staff in administrative support areas such as quality improvement, utilization management, and risk management use both individual client and aggregate data for review activities. Finally, administrative staff members use aggregate data for strategic planning.

Other Healthcare Providers

Complete and accurate documentation is essential to ensure the continuity of care for behavioral healthcare clients across the continuum. Behavioral healthcare services are provided at many levels—from acute inpatient treatment to in-home community-based services.

Billing and Third-Party Payers

An appropriately documented behavioral healthcare record can reduce many of the difficulties associated with claims processing and can serve as a legal document to verify the care provided. Third-party payers review care documentation to ensure that the services provided are:
• Appropriate for the client’s condition
• Medically necessary
• Coded correctly
• Provided in the correct setting

Because payers have a contractual obligation to enrollees, they want to know that their healthcare dollars are well spent and may require reasonable documentation to show that services are consistent with the insurance coverage provided (St. Anthony Publishing 2001). The diagnostic and procedure codes on the health insurance claim form should reflect the documentation in the healthcare record. Therefore, the more completely and accurately the client encounter is described, the easier it is to code the diagnoses and the procedures properly.

Documentation of each client encounter or visit should include the:

• Reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results
• Assessment, clinical impression, or diagnosis
• Evaluation and treatment procedures performed
• Plan of care
• Rationale for ordering diagnostic and other ancillary service
• Client’s progress, changes in treatment and response to those changes, and any revision of diagnosis
• Time taken to perform the encounter
• Date and authentication (signature and credentials) by the healthcare professional

**Regulatory Bodies**

Regulatory bodies include accrediting agencies, and state and federal licensure bodies. These agencies and licensing bodies review behavioral healthcare record documentation to help determine whether the organization or agency under review is in compliance with applicable rules, regulations, and standards. (See table 1.2 for a list of regulatory bodies and table 1.3 for a list of Web sites to access statutes, laws, and administrative code.)

**Documentation Standards**

**Health information management (HIM) professionals** have to keep current with a wealth of rules, regulations, and standards for behavioral healthcare record documentation. They should review the Federal Register for proposed rules and the state regulatory bulletins for changes to rules. Accrediting agency publications and standards should be reviewed on a regular basis for updates and additions. Professional associations such as the American Health Information Management Association (AHIMA) can be an excellent source of information on documentation standards. The health record serves as a legal business record for a healthcare organization, and the regulations and standards vary depending on practice setting, state statutes and rules, and applicable case law.
Table 1.2. Regulatory bodies that govern behavioral health documentation

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<th>Authority and Website</th>
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<td>Behavioral health standards manual</td>
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<td>Conditions of Participation for Hospitals (42 CFR 482)</td>
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<td>Standards for the accreditation of managed behavioral healthcare organizations</td>
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Centers for Medicare and Medicaid Services

Behavioral healthcare organizations that participate in the Medicare program must comply with federal standards issued by the Centers for Medicare and Medicaid Services (CMS) called the Conditions of Participation. Part 482.61 of these standards addresses special medical record requirements for inpatient psychiatric hospitals and states that “the medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.” In other words, the documentation must support the amount and level of services provided.

The standards go on to give specific content requirements of the medical record. Part 482.24 provides guidelines for inpatient hospital medical records.

Joint Commission on Accreditation of Healthcare Organizations

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is a not-for-profit organization established more than fifty years ago to evaluate the quality and safety of healthcare. Its behavioral health accreditation program was established in 1972. Services currently accredited include mental health, addiction services, and child welfare and developmentally disabled care in a variety of treatment settings. Depending on the type of state licensure and the funding source, some behavioral healthcare organizations continue to be surveyed under the hospital standards instead of the behavioral health standards.

JCAHO accreditation includes an intensive on-site survey process at least once every three years. The JCAHO uses documentation review during the survey process to evaluate the quality of care and patient safety. It recently revised its record review process but, as of this writing, has not come out with the revised record review recommendations.

Commission on Accreditation of Rehabilitation Facilities

The Commission on Accreditation of Rehabilitation Facilities (CARF) is an independent not-for-profit accrediting agency. Founded in 1966, CARF uses a continuous quality improvement process for its accreditation process. The commission has specific behavioral health standards and surveys a variety of behavioral health settings, including mental healthcare, substance abuse care, and other addiction programs. The mission of CARF is to promote the quality, value, and optimal outcomes of services through accreditation that centers on enhancing the lives of the persons receiving services. Part of the CARF survey process includes a quality medical record review.

National Committee for Quality Assurance

The National Committee for Quality Assurance (NCQA) is an independent, nonprofit organization whose mission is to improve the quality of healthcare. NCQA started surveying managed behavioral healthcare organizations in 1997. Its survey process is voluntary. NCQA developed its Behavioral Health Accreditation Standards with the input of all affected stakeholders—consumers, employers, policy makers, health plans, managed behavioral healthcare organizations, and providers.

NCQA uses documentation review, in part, to foster accountability within managed behavioral healthcare organizations for the quality of care and services its members receive. It also uses documentation review to help determine effectiveness in the provision of behavioral healthcare.

Council on Accreditation

The Council on Accreditation for Children and Family Services (COA) is an international, independent, nonprofit child and family services and behavioral healthcare accreditation organization. An organization that undergoes COA accreditation is evaluated against best-practice standards in the field.
standards. The COA standards include organizational and management standards along with service standards. These standards are designed to facilitate organizational improvement. The COA uses medical record review during on-site visits to verify that standards are being met.

**Health Insurance Portability and Accountability Act of 1996**

**Privacy Rule**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) took effect on April 14, 2003. Its privacy rule created a basic set of standards for the privacy of individually identifiable health information and set out numerous requirements for the use and disclosure of such information. HIPAA applies to healthcare plans, healthcare clearinghouses, and healthcare providers who transmit specific transactions electronically. These entities are referred to as covered entities under HIPAA. Some state laws or rules are more restrictive, but HIPAA provides a baseline with regard to the protection and disclosure of protected health information (PHI).

HIPAA impacts HIM practice by requiring employee education on privacy, the designation of a privacy officer, and the tracking of disclosures of PHI. The act also requires documentation of notification to a client of his or her privacy rights.

**Client Right to Access Healthcare Records**

The HIPAA privacy rule established, at the federal level, a client’s right to inspect and obtain copies of his or her PHI in all but a limited number of situations. Prior to the privacy rule, some state laws gave a client the right to access. One of the exceptions is the right to access psychotherapy records.

HIPAA defines psychotherapy records as notes recorded (in any medium) by a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session that are separate from the rest of the client’s healthcare record. Few healthcare organizations maintain psychotherapy records under the HIPAA definition. The HIPAA definition most likely applies to private therapy notes or raw data from client psychological testing.

Psychotherapy notes exclude medication prescription and monitoring, results of clinical tests, and any summary of the following items:

- Diagnosis
- Functional status
- Treatment plan, symptoms, prognosis, and progress to date

A healthcare organization also may deny a client access to his or her PHI when:

- A licensed healthcare professional has determined that the access is likely to endanger the life or physical safety of the client or another person. For example, if documentation reveals that the client’s sister supports inpatient hospitalization for the client and her position is contrary to the client’s wishes, the client may retaliate against the sister.

- The PHI makes reference to another person who is not a healthcare provider, and a licensed healthcare professional determines that access to the documentation is likely to cause substantial harm to the person referenced. For example, access granted to a parent to the records of a minor that document abuse would likely put the child in jeopardy.

The HIM professional should note and advise providers that even in these rare instances information can be compelled by a judge to be released to the patient or his or her lawfully authorized representative.
**Patient’s Right to Amend**

The HIPAA privacy rule requires all behavioral healthcare organizations to have policies and procedures in place that address how a client or his or her legal representative can enter an amendment into the healthcare record. For HIM practitioners in some states, giving a client the right to amend his or her healthcare information is nothing new and has been a requirement under state law or rule for many years.

With few exceptions, the privacy rule gives clients the right to request that a covered entity—a healthcare provider that conducts electronic transactions, health plans, and clearinghouses—amend its healthcare information. The rule requires specific procedures and time frames for processing an amendment. (See figure 1.1.) Although not required, it would be prudent to ask that the request be made in writing. Developing a form for the client and the covered entity to facilitate a request for amendment is highly recommended. (See figure 1.2.)

A separate entry in the record should be used for client amendment documentation. The amendment should document the information believed to be inaccurate or incomplete and the information the client or legal representative believes to be correct or needs to be added to. The HIM professional should flag the entry in question by writing “See correction/amendment” and by indicating the amendment with his or her signature and the date. The amendment form should be attached to the incorrect or amended entry. The documentation in question should never be removed or deleted from the healthcare record and must be disclosed when the original document is disclosed.

The privacy rule gives specific conditions under which the request to amend can be denied, for example, when the health information that is the subject of the request is not part of the individual’s health record, was not created by the organization, or is accurate and complete. For example, if a client requests to amend information in his or her chart that was received from another healthcare provider, the facility that received the information would not be required to amend it. Individual state laws or regulations may address how amendments should be processed, and healthcare organizations must comply with those requirements if they happen to be more stringent than those outlined under the HIPAA privacy rule.

**Client’s Right to Refuse Treatment**

Behavioral healthcare poses unique challenges to patient rights. Even though clients may be at high risk for suicidal or homicidal behavior as a result of mental illness, they have the right to refuse psychiatric treatment. Clients are often committed involuntarily to a psychiatric institution, and the institution must define the fine line between safeguarding the client’s rights and protecting the interest of society. Clients who complain of suicidal thoughts or display overtly suicidal behaviors yet persist in refusing care present healthcare providers with significant care and safety challenges. Complete and timely documentation of these situations is critical.

**Advance Directives**

An advance directive, or healthcare directive, is a written legal document that communicates a client’s healthcare decisions in the event he or she is unable to make them or appoints a person to make them on the client’s behalf. Advance directives provide written instructions about the kind of care the client does or does not want when the client is no longer able to direct his or her care. Situations in which an advance directive may be used include the following:

- Schizophrenic patients who refuse medication because they hear command voices to harm themselves
- Patients who decide what medications to take and when
Figure 1.1. Sample policy and procedure client request to amend

<table>
<thead>
<tr>
<th>CLIENT'S REQUEST FOR AMENDMENT/CORRECTION OF THEIR MEDICAL RECORD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PURPOSE</strong></td>
</tr>
<tr>
<td>To establish the client’s right to request to amend and/or correct protected health information (PHI) as long as the Center maintains the client record.</td>
</tr>
<tr>
<td><strong>POLICY</strong></td>
</tr>
<tr>
<td>It is the policy of the Center to determine whether to accept or deny any request for amendment and/or correction to the client record when the client believes information is incorrect or incomplete. It is the Center’s responsibility to ensure that action has been taken within sixty (60) days of the request.</td>
</tr>
<tr>
<td><strong>PROCEDURE</strong></td>
</tr>
<tr>
<td>1. The client may contact his or her primary staff worker, author of the document requested, Director of Health Information Services/Privacy Officer or Designee to complete the Amend/Correct Client Record Information Form.</td>
</tr>
<tr>
<td>a. The client will complete the Amend/Correct Client Record Information Form with distribution as follows:</td>
</tr>
<tr>
<td>i. Original to author of the document</td>
</tr>
<tr>
<td>ii. Copy to Health Information Services</td>
</tr>
<tr>
<td>iii. Copy to client</td>
</tr>
<tr>
<td>b. The author will review the Amend/Correct Client Record Information Form to:</td>
</tr>
<tr>
<td>i. Complete the denied/accepted section</td>
</tr>
<tr>
<td>ii. Make comments</td>
</tr>
<tr>
<td>iii. Sign and date the form</td>
</tr>
<tr>
<td>iv. Forward to Health Information Services to be filed and a copy sent to the client</td>
</tr>
<tr>
<td>2. A denial to any request to amend a client record can be made in one of the following circumstances:</td>
</tr>
<tr>
<td>a. The document was not created at Center but was received as a request for information from an outside source.</td>
</tr>
<tr>
<td>b. The documents/documentation is not considered part of the client record (designated record set) and would not otherwise be available for inspection.</td>
</tr>
<tr>
<td>c. The Center determines that the information is accurate or complete.</td>
</tr>
<tr>
<td>3. If the Center denies a request for amendment in whole or part, the Center:</td>
</tr>
<tr>
<td>a. Must provide the client a written denial statement explaining the reason for the denial</td>
</tr>
<tr>
<td>b. Must describe to the client the process for submitting a Statement of Disagreement</td>
</tr>
<tr>
<td>c. Must provide instructions on how the client may make a complaint to the Center regarding the denial</td>
</tr>
<tr>
<td>d. May prepare a rebuttal to the Statement of Disagreement and must provide the client with a copy</td>
</tr>
<tr>
<td>e. Must identify the location of the disputed amendment/correction and cross-reference the information that is being disputed for the purpose of future release of information</td>
</tr>
<tr>
<td>When the denial process has been completed, the Center has the responsibility to notify:</td>
</tr>
<tr>
<td>a. The client</td>
</tr>
<tr>
<td>b. Individuals and organizations the client identifies</td>
</tr>
<tr>
<td>c. Facilities and business associates that have the information subject to the amendment/correction and may have relied—or might rely—on the information to the detriment of the client</td>
</tr>
<tr>
<td>4. If the Center accepts a request for amendment/correction in whole or in part, the Center must:</td>
</tr>
<tr>
<td>a. Make the amendment/correction*</td>
</tr>
<tr>
<td>b. Identify the challenged entry as amended or corrected</td>
</tr>
<tr>
<td>c. Indicate the location of the amended/corrected information and cross-reference the information that is being amended or corrected for the purpose of future release of information</td>
</tr>
<tr>
<td>When the amendment process has been completed, the Center has the responsibility to notify:</td>
</tr>
<tr>
<td>a. The Client</td>
</tr>
<tr>
<td>b. Individuals and organizations the client identifies</td>
</tr>
<tr>
<td>c. Facilities and business associates that have the information subject to the amendment/correction and may have relied or might rely on the information to the detriment of the client</td>
</tr>
</tbody>
</table>

*See Policy and Procedure Staff Process for Corrections and Amendments to the Client Record

---

Date Established: 
Date of Last Review: 
Date of Last Revision: 
Approved by and Date:
Figure 1.2. Sample form request for amendment of the medical record form

<table>
<thead>
<tr>
<th>REQUEST FOR AMENDMENT OF THE MEDICAL RECORD FORM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name: ________________________________ D.O.B: ____________________</td>
</tr>
<tr>
<td>Medical Record Number: ___________________</td>
</tr>
<tr>
<td>Address: ________________________________________________________________________________</td>
</tr>
<tr>
<td>Phone Number: (H)<strong><strong><strong><strong><strong><strong><strong><strong>(W)</strong></strong></strong></strong></strong></strong></strong></strong></td>
</tr>
<tr>
<td>Date of entry to be amended: __________________________</td>
</tr>
<tr>
<td>Type of entry to be amended: __________________________</td>
</tr>
<tr>
<td>Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete?</td>
</tr>
<tr>
<td>________________________________________________________________________________________</td>
</tr>
<tr>
<td>________________________________________________________________________________________</td>
</tr>
<tr>
<td>Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please specify the name and address of the organization or the individual.</td>
</tr>
<tr>
<td>Name __________________________________________________________________________ Address</td>
</tr>
<tr>
<td>Signature of Client or Legal Representative Date</td>
</tr>
<tr>
<td>For healthcare organization use only:</td>
</tr>
<tr>
<td>Date received: ___________________ Amendment has been: □ Accepted □ Denied</td>
</tr>
<tr>
<td>If denied, check reason for denial:</td>
</tr>
<tr>
<td>□ PHI was not created at this organization. □ PHI is accurate and complete.</td>
</tr>
<tr>
<td>□ PHI is not available to the client for inspection □ PHI is not part of client’s designated record set. as required by federal law (for example, psychotherapy notes).</td>
</tr>
<tr>
<td>Physician/Author Comments:</td>
</tr>
<tr>
<td>______ In response to your request, a correction/addendum will be made part of your permanent medical record.</td>
</tr>
<tr>
<td>______ Your request has been made a part of your permanent medical record.</td>
</tr>
<tr>
<td>Comments of Healthcare Practitioner:</td>
</tr>
<tr>
<td>________________________________________________________________________________________</td>
</tr>
<tr>
<td>________________________________________________________________________________________</td>
</tr>
<tr>
<td>Physician/Author Signature Date</td>
</tr>
</tbody>
</table>
The Patient Self-Determination Act (PSDA), passed as part of the Omnibus Budget Reconciliation Act of 1990, requires hospitals and other healthcare organizations that receive Medicaid funding to give clients written information concerning their rights under state law to make decisions about medical care, including the right to accept medical treatment. In addition, clients must be given information about their rights to formulate advance directives such as living wills and durable powers of attorney for healthcare.

At the time of this writing, seventeen states allow mental health advance directives. These directives may include permission for treatment with neuroleptic medication and electroshock therapy. HIM professionals should know the laws related to advance directives in the state in which they are working and should understand the elements necessary for the advance directives to be legal. (See figure 1.3 for a sample advance directive form.)

State Regulations

Many states have their own regulations, rules, laws, or statutes on behavioral healthcare record documentation. (See table 1.3.) State law trumps federal law when state law is more stringent. It is important to be aware of the laws and to keep up with any changes. Often state regulations are enacted in response to a specific public concern and are strong, detailed, and aimed at the state’s unique experiences. State regulations may cover a broad range of organizations or be specific to certain types of organizations, such as government agencies or hospitals.

Characteristics of Good Documentation

Although originally developed for use with paper-based health record systems, many of the guiding principles discussed above now can be applied successfully to documentation practices in an electronic healthcare record (Dougherty 2002b). The characteristics of good documentation are outlined in table 1.4. Poorly kept medical records or documentation can lead to the following consequences:

- Mistakes or delays in treatment because of missing or inaccurate information
- Loss of malpractice litigation
- Loss of licensure or accreditation status
- Loss of eligibility for reimbursement by Medicare or some other third-party payer
- Lack of data for research projects, client care evaluations, or quality improvement activities

AHIMA’s House of Delegates published a table of best practices in 1999 for documentation and completion of the health record. These are shown in table 1.5.

Individualized Documentation

Each page in the behavioral health record must identify the client by name and by unique identification number (if one is assigned) (Dougherty 2002b). The unique identification number is used to facilitate record accessibility and retrieval in either a paper- or computer-based record system. Although records for inpatient and outpatient encounters can be separated, this method is not recommended due to difficulty in ensuring that all healthcare records are available for continuity of care. The unique identification number may be assigned automatically by a computer system, or some organizations use the client’s Social Security number.
### Figure 1.3. Sample advance directive form

**SAMPLE ADVANCE DIRECTIVE FORM**

I, ____________________________, being of sound mind, willfully and voluntarily execute this mental health advance directive to assure that if I should be found incompetent to consent to my own mental health treatment, my choices regarding my treatment will be carried out despite my inability to make informed decisions for myself. If a guardian, guardian advocate, or other decision maker is appointed by a court to make healthcare or mental health decisions for me, I intend this document to take precedence over all other means of determining my intent while competent. This document represents my wishes, and it should be given the greatest possible legal weight and respect. If the surrogate(s) named in this directive are not available, my wishes shall be binding on whoever is appointed to make such decisions. If I become incompetent to make decisions about my own mental health treatment, I have authorized a mental healthcare surrogate to make certain treatment decisions for me. My surrogate is also authorized to apply for public benefits to defray the cost of my healthcare, to release information to appropriate persons, and to authorize my transfer from a healthcare facility.

My mental healthcare surrogate is:

**Name:** ______________________________________________________________________________________________

**Address:** ____________________________________________________________________________________________

**Day Telephone:** _____________________________ **Evening Telephone:** ________________________________________

If the person named above is unable or unavailable to serve as my mental healthcare surrogate, I hereby appoint and request immediate notification of my alternate mental healthcare surrogate as follows:

**Name of Alternate:** ____________________________________________________________________________________

**Address:** ____________________________________________________________________________________________

**Day Telephone:** _____________________________ **Evening Telephone:** ________________________________________

**Complete the following or initial in the blank marked yes or no:**

A. If I become incompetent to give consent to mental health treatment, I give my mental healthcare surrogate full power and authority to make mental healthcare decisions for me. This includes the right to consent, refuse consent, or withdraw consent to any mental healthcare, treatment, service, or procedure consistent with any instructions and/or limitations I have stated in this advance directive. If I have not expressed a choice in this advance directive, I authorize my surrogate to make the decision that he or she determines is the decision I would make if I were competent to do so.

   _____ Yes   _____ No

B. My choices of treatment facilities are as follows:

1. In the event my psychiatric condition is serious enough to require 24-hour care, I would prefer to receive this care in this/these facilities:

   **Facility:** ___________________________________________________________________________________
   **Facility:** ___________________________________________________________________________________

2. **I do not** wish to be placed in the following facilities for psychiatric care (optional):

   **Facility:** ___________________________________________________________________________________
   **Facility:** ___________________________________________________________________________________

C. My choice of a treating physician is:

   **First choice of physician:** _______________________ **Second choice of physician:** _______________________

   **I do not** wish to be treated by the following physicians: (optional)

   **Name of physician:** ____________________________ **Name of physician:** _____________________________

D. If I am incompetent to give consent, I want staff to immediately notify the following persons that I have been admitted to a psychiatric facility.

**Name:** ____________________________________________ **Relationship:** ____________________________

**Address:** _____________________________________________________________________________________________

**Day Phone:** __________________________________ **Evening Phone:** _________________________________

**Name:** ____________________________________________ **Relationship:** ____________________________

**Address:** _____________________________________________________________________________________________

**Day Phone:** __________________________________ **Evening Phone:** _________________________________
Figure 1.3. (Continued)

E. If I am not competent to consent to my own treatment or to refuse medications relating to my mental health treatment, I have initialed one of the following, which represents my wishes:

1. ______ I consent to the medications that Dr. __________________________ recommends.
2. ______ I consent to the medications agreed to by my mental healthcare surrogate after consulting with my treating physician and any other individuals my surrogate deems appropriate, with the exceptions found in #3 below.
3. ______ I specifically do not consent and I do not authorize my mental healthcare surrogate to consent to the administration of the following medications or their respective brand name, trade name, or generic equivalent (list name of drug and reason for refusal):
   ____________________________________________________________
   __________________________________________________________________________________________
4. ______ I am willing to take the medications excluded in #3 above if my only reason for excluding them is their side effects and the dosage can be adjusted to eliminate those side effects.
5. I have the following other preferences about psychiatric medications:
   ____________________________________________________________
   __________________________________________________________________________________________

F. My wishes regarding electroconvulsive therapy (ECT) are as follows:

1. ______ My surrogate may not consent to ECT without express court approval.
2. ______ I authorize my surrogate to consent to ECT, but only (initial one of the following):
   a. ______ with the number of treatments the attending psychiatrist thinks is appropriate; OR
   b. ______ with the number of treatments that Dr. __________________________ thinks is appropriate; OR
   c. ______ for no more than the following number of ECT treatments: __________________________
3. Other instructions and wishes regarding ECT are as follows:
   ____________________________________________________________
   __________________________________________________________________________________________

G. Other instructions I wish to make about my mental healthcare are (use additional pages if needed):

Check here ( ) if other pages are used.

Signature By signing here, I indicate that I fully understand that this advance directive will permit my mental healthcare surrogate to make decisions and to provide, withhold, or withdraw consent for my mental health treatment.

Printed Name (Declarant):

Signature: ________________________________ Date: ________________________________

Witnesses This advance directive was signed by __________________________ in our presence. At his or her request, we have signed our names below as witnesses. We declare that, at the time this advance directive was signed, the Declarant, according to our best knowledge and belief, was of sound mind and under no constraint or undue influence. We further declare that we are both adults, are not designated in this advance directive as the mental healthcare surrogate, and at least one of us is neither the person’s spouse nor blood relative.

Dated at ____________________________________________________________
   (County & State) (Day) (Month) (Year)

Witness 1: ____________________________________________________________
Signature of witness 1: ____________________________
Printed name of witness 1: ____________________________
Home address of witness 1: ____________________________
City, state, zip code of witness 1: ____________________________

Witness 2: ____________________________________________________________
Signature of witness 2: ____________________________
Printed name of witness 2: ____________________________
Home address of witness 2: ____________________________
City, state, zip code of witness 2: ____________________________

Acknowledgment of Healthcare Surrogate/Alternate

I, ____________________________, mental healthcare surrogate designated by ____________________________________________________________, hereby accept the designation.

____________________________
Signature of mental healthcare surrogate
Date

I, ____________________________, alternate mental healthcare surrogate designated by ____________________________________________________________, hereby accept the designation.

____________________________
Signature of alternate mental healthcare surrogate
Date
To link documentation to a client, the client’s name and unique identification number should be on both sides of a single sheet of paper in the record (Dougherty 2002b). In an electronic health record (EHR), the same information must be on each page or screen, as well as on each page of any paper report or record that is generated. The organization’s name also should appear on each page or screen to help identify where records originated if they are ever sent outside the organization.

### Table 1.4. Characteristics of good documentation

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individualized</td>
<td>To link documentation to a client, the client’s name and unique identification number should be on each page.</td>
</tr>
<tr>
<td>Permanent</td>
<td>Cannot be erased, fade over time, or be water soluble.</td>
</tr>
<tr>
<td>Complete</td>
<td>Document all facts—who, what, when, where, how, and why.</td>
</tr>
<tr>
<td>Appropriate</td>
<td>Documentation that pertains to the client’s care and treatment. Do not document complaints or gripes.</td>
</tr>
<tr>
<td>Concise</td>
<td>Documentation should be factual and objective. Use only facility-approved abbreviations.</td>
</tr>
<tr>
<td>Authenticated</td>
<td>Shows authorship and assigns responsibility.</td>
</tr>
<tr>
<td>Legible</td>
<td>Documentation must be readable by other caregivers.</td>
</tr>
<tr>
<td>Timely</td>
<td>Make all entries as soon as possible after an event or encounter.</td>
</tr>
<tr>
<td>Continuous</td>
<td>Paper-based notes and entries should not contain blank lines or spaces.</td>
</tr>
<tr>
<td>Truthful</td>
<td>Ensure that documentation has not been altered or destroyed in an unauthorized manner.</td>
</tr>
</tbody>
</table>

Source: Adapted from Dougherty 2002b.

### Table 1.5. Table of best practices

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consistent and standard documentation requirements</td>
<td>• Streamline regulatory activities.</td>
</tr>
<tr>
<td></td>
<td>• Develop consistent and standardized documentation requirements with accrediting and regulatory agencies.</td>
</tr>
<tr>
<td>Innovative, quality, and cost-efficient clinical documentation practices</td>
<td>• Develop policies and procedures to facilitate timely completion of medical records.</td>
</tr>
<tr>
<td></td>
<td>• Utilize the latest technology for authentication.</td>
</tr>
<tr>
<td></td>
<td>• Make forms used for documentation user-friendly.</td>
</tr>
<tr>
<td>Promote complete, current, and high-quality healthcare information by developing and using appropriate measures and monitors to assess documentation quality</td>
<td>• Educate staff on the importance of clinical documentation practices.</td>
</tr>
<tr>
<td></td>
<td>• Secure physician champion for documentation improvement.</td>
</tr>
<tr>
<td></td>
<td>• Streamline medical record completion guidelines.</td>
</tr>
<tr>
<td>Plan strategically.</td>
<td>• Develop a computer-based health record.</td>
</tr>
<tr>
<td></td>
<td>• Develop processes to effectively transition to an integrated health delivery system.</td>
</tr>
</tbody>
</table>

Source: Fletcher 1999.
Permanent Documentation

Whether in paper or electronic format, all entries must be permanent. Black ink is preferred for handwritten records to ensure legibility when they are photocopied. Black ink also seems to remain the most legible if a health record gets wet. A pencil should never be used for documentation purposes. Because of fading over time, thermal paper should be copied and the copy, marked as such, should be placed in the chart. When using a printed computer entry for documentation, the print must be permanent and should remain intact despite rubbing or normal handling. Ink jet printers should not be used because the ink is water soluble (Dougherty 2002b).

Complete Documentation

Complete documentation is vital for the continuity of optimum-quality client care. Caregivers need to be complete in their approach and record everything significant to the client’s condition, including answers to who, what, when, where, how, and why. If all staff caring for the client were to suddenly disappear, a new team should be able to immediately continue the best possible care just by reading the record. Each change in a client’s condition or significant client issues should be documented. The medical record confirms the care and treatment provided to the client. If it is not documented in the medical record, it did not happen. (See table 1.6 for specific requirements for progress note documentation.)

**Table 1.6. Requirements for documentation of progress notes**

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Be specific and avoid generalization. Record the facts. Don’t draw conclusions. Use objective terms. Rather than stating that “the client is upset,” state exactly what behavior the client is exhibiting.</td>
<td>At 10:00 a.m., client was heard yelling in the east hallway. Client was shouting in a loud voice that she did not want to be here and that she was not mentally ill. She was waving her arms above her head and stamping her feet.</td>
</tr>
<tr>
<td>Be complete. Record everything significant to the client’s condition, including who, what, when, where, how, and why.</td>
<td>Client refused her 8:00 a.m. dose of Buspar. She is also refusing to eat breakfast and has been isolated in her room the entire shift. Client denies any thought of self-abuse.</td>
</tr>
<tr>
<td>Be sure to document atypical treatment together with reasons for it (for example, restraints). Enter any unusual occurrences together with responsive and corrective steps taken and follow-up of the client’s condition.</td>
<td>At 6:00 p.m., client was observed to have five superficial scratches on her left wrist. Client admits to scratching herself with a plastic knife. Client turned knife in to staff. On-call psychiatrist was notified and gave telephone order for 15-minute checks.</td>
</tr>
<tr>
<td>Use quotes when appropriate. One quote may be worth a thousand words in trying to describe a client’s emotional state.</td>
<td>While in the dining room eating lunch at noon, client quickly stood up, knocking over her chair. Client then threw her meal tray on the floor, yelling, “The food is poison.”</td>
</tr>
<tr>
<td>Use specific time frames rather than vague terms such as “usually,” “frequently,” or “often.”</td>
<td>Client has been to the unit office at least six times during this shift, stating that she is not mentally ill and wants to be discharged right now.</td>
</tr>
</tbody>
</table>

Source: Dougherty 2002.
Appropriate Documentation

The behavioral health record should contain only documentation that pertains to the care of the client. It is not the place to voice complaints or gripes about coworkers, employers, physicians, or staffing issues and should not include statements that blame, accuse, or compromise other healthcare providers, the client, or his or her family (Dougherty 2002b). Likewise, hearsay (for example, from a client’s roommate) should not be documented. If the behavioral health record were to end up in court, unprofessional and inappropriate documentation could bring the entire record under suspicion.

Sometimes it is necessary to refer to another client in the health record. When this happens, the client’s full name should not be used; rather, his or her health record number, initials, or first name should be used.

Concise Documentation

Documentation should be specific. General characterizations should be avoided because they can be confusing. Examples of generalized statements seen frequently in the behavioral healthcare record include “the client is uncooperative” or “the client is doing well.” Documentation should reflect only factual information.

Although they may provide a timesaving benefit, abbreviations used in behavioral health records present potential patient safety issues. Only abbreviations approved by the behavioral healthcare organization should be used in the medical record. The JCAHO National Patient Safety Goal #2b requires that a list be developed of dangerous abbreviations that should not be used in the medical record. At the present time, five abbreviations must be on the dangerous abbreviation list, all of which deal with the administration of medication.

The Institute for Safe Medication Practices (www.ismp.org) also maintains a list of error-prone abbreviations, symbols, and dose designations. Organizations should limit the abbreviations used in the record to help avoid misinterpretation. Two examples of dangerous abbreviations are Q.D. (every day) and Q.O.D. (every other day), which can be mistaken for each other. Abbreviations specific to behavioral health should be avoided because healthcare providers outside the behavioral health arena may be unfamiliar with them and unable to interpret their meaning correctly. For example, SIB (self-injurious behavior) or BP (borderline personality) might be common abbreviations within the behavioral healthcare organization, but unknown to someone outside behavioral health.

Authenticated Documentation

Authentication shows authorship and responsibility for an entry and is the responsibility of the person providing the treatment or evaluation. It is used in behavioral healthcare entries to verify that they are complete, accurate, and final. There are multiple acceptable methods for authenticating an entry in the health record, including use of the first initial, last name, and title/credential or discipline and electronic/digital signatures.

Much debate has centered on compliance with authentication requirements, including the intent of the requirement and the labor-intensive process involved in being compliant. Each behavioral healthcare organization must identify the proper and acceptable method of authentication for the type of entry based on applicable regulations, laws, and payer requirements. Although accrediting agencies such as the JCAHO may no longer require authentication of behavioral healthcare entries, other accrediting agencies or state laws and regulations do. In general, the federal regulations and accreditation standards do not stipulate a specific time frame for authentication. The organization should research the requirements carefully before developing policies and procedures on authentication and acceptable methods of authentication (Welch 2002). It should contact the state licensing authority (usually the state health department’s division of healthcare licensure) for specific requirements.
Documentation audits or reviews should include the need to assess the accuracy of entries that are not authenticated.

At a minimum, paper-based records should include the first initial, last name, and credential, or professional title (Dougherty 2002b). The signature should immediately follow the last word of the entry. Cosignatures, which are most likely required for residents and students, are used to demonstrate supervision by qualified, experienced, and responsible professional staff and should be used as required by state law and regulatory agencies. If initials are used to authenticate an entry, a corresponding master signature sheet with full identification of the initials should be included. Initials are used frequently to authenticate entries on flow sheets. Unless specifically prohibited by state regulations or behavioral healthcare organization policy, facsimile (fax) signatures are acceptable as long as the fax is not thermofax, which fades over time. Electronic and digital signatures are acceptable when allowed by state law.

When electronic signatures are used, the technology should follow the standards as outlined in the HIPAA security rule for message integrity and authentication. The security rule requires facilities to address implementation policies and procedures to protect electronic-protected health information from improper alteration or destruction. It also requires organizations to address mechanisms and procedures for both person or entity authentication and PHI authentication. Person or entity authentication is verification that a person or entity seeking access to electronic PHI is the one claimed. Electronic PHI authentication ensures that electronic PHI has not been altered or destroyed in an unauthorized manner. Rubber stamp signatures are acceptable when allowed by state and reimbursement regulations. Use of rubber stamps requires that a letter be kept on file stating that the individual whose name appears on the stamp is the only one who will use it. Autoauthentication, which allows a physician or provider to state, prior to review of an entry, that it is complete and accurate, is inconsistent with CMS requirements.

**CMS**

To participate in the Medicare program, behavioral healthcare organizations must comply with the Medicare Conditions of Participation. These federal regulations currently require authentication of various health record entries. The 42 Code of Federal Regulations (CFR), Paragraph 482.24, Conditions of Participation for Hospitals, Medical Record Services (a)(1) and (c)(1)(i), state in part:

> Entries in the medical record may be made only by individuals as specified in hospital and medical staff policies. All entries in the medical record must be dated and authenticated, and a method established to identify the author. The parts of the medical record that are the responsibility of the physician must be authenticated by this individual. When non-physicians have been approved for such duties as taking medical histories or documenting aspects of physical examination, such information shall be appropriately authenticated by the responsible physician. Any entries in the medical record by house staff or non-physicians that require counter signing by supervisory or attending medical staff members shall be defined in the medical staff rules and regulations.

The entry goes on to list what system would meet the authentication requirements, including signatures, written initials, or computer entry.

**Legible Documentation**

All entries must be neat and legible. Illegible documentation puts the client at risk. An Institute of Medicine (IOM) report entitled “To Err Is Human: Building a Safer Health System,” published in 2000, estimates that as many as 98,000 people die each year from medical errors that occur in hospitals.
Other caregivers must be able to read and understand all prior documentation. Misspelled words and incorrect grammar create a negative impression, as does illegible handwriting. Caregivers should remember to use appropriate and correct capitalization, punctuation, and spelling. Careless documentation could imply carelessness or haste in the delivery of care.

**Timely Documentation**

The behavioral health record is a legal record. For it to be admissible in legal proceedings, documentation must specify when the encounter or event occurred. Charting that is not timely or is done in advance can lead to serious errors in patient care such as patient medication administration errors. Ongoing chronological entries should be made in behavioral healthcare records. All entries should be entered as soon as possible after the observation or encounter and never before the encounter. Memory recall is most accurate immediately after an encounter.

Timeliness is an area of focus for many accrediting and licensing agencies. Charting in advance compromises the credibility of the entire chart and of the staff member who made the entry. For example, the RN documents in advance that the client’s 8:00 p.m. dose of Risperdal was given. However, the client attempts suicide at 7:00 p.m. and is admitted to the intensive care unit at the acute care hospital at 7:30 p.m. Because nurse documented the dose of Risperdal in advance, the credibility of the entire healthcare record is in jeopardy.

The date (month, day, and year) and time must be noted for each entry. Narrative documentation should reflect the actual time the entry was made. It is important to document when information was charted for continuity of care as well as to support the timely care and treatment of patients. It is unethical and against the law to pre- or backdate an entry. A sample policy on timeliness of medical record documentation is provided in figure 1.4.

In a computer-based health record system or a digital dictation system, an electronic time and date stamp is automatically put on documentation when created or saved.

When a client encounter entry is missed or not written in a timely manner, a late entry should be used to document it. A late entry is documented using the following steps:

1. Identify the new entry as a late entry.
2. Note the date and time of the current documentation as well as the actual date and time of occurrence.
3. Document late entries as soon as possible after the omission is discovered.
4. Note the circumstances of omission, if relevant.
5. Verify the signature of the author.

As more time passes, the reliability and validity of a late entry become more questionable; caregivers should avoid late entries as much as possible by using personal processes such as notes or reminders (Dougherty 2002b). Late entries should be avoided after an incident or occurrence to avoid the appearance of defensive documentation.

**Continuous Documentation**

When using paper-based progress notes, entries should be made on the next available line or space with no blank lines between notes, just as there should be no blank spaces before or after authenticating signatures. Drawing a single line through the balance of a blank line limits the possibility of changes being made to the documentation after the fact. All lines should be completed on a page before a new page is started. Blank lines imply that someone forgot to document (Dougherty 2002b). All blank lines on forms should be completed, or a field that is not applicable should contain some entry to that effect (for example, “not applicable or “N/A”) to show that the field was reviewed. Blank fields or lines could suggest tampering. A staff member could insert an entry that puts the sequence of events into question.
Truthful Documentation

An error in documentation should never be erased, obliterated, or covered with ink or correction fluid. Such practices cast doubt on the chart’s accuracy and damage the credibility of the staff member who made the erasure. The author of the original documentation may make corrections by drawing a single line through the original entry. He or she then should date and sign the edit, and state the reason for the change in the margin or above the note. (See figure 1.5 for a sample policy on this issue.)

When correcting an error in a computerized record system, the original entry should remain viewable, the date and time the correction was made should be recorded, the person making the correction should be identified, and the reason for the error should be documented. The functionality of making an addendum depends on the EHR system used. Some systems allow for making an addendum that is linked to the original documentation; others do not.

An addendum or clarification note may be needed to address a specific entry or to avoid misinterpretation of information previously documented. Such an addendum or note should document the current date and time, prominently indicate “addendum” or “clarification,” and state the reason for the additional entry, referring back to the original entry as necessary. Addenda or clarification notes should be completed as soon as they are deemed necessary. Otherwise, the passage of time brings into question the reliability of the additional entry.

Integrity of the Information

The HIPAA security rule defines integrity as the property that data or information has not been altered or destroyed in an unauthorized manner. The organization must secure the record to
prevent destruction, improper alteration, or unauthorized use. (See chapter 9 for more information on security.) Policies and procedures should be in place to address all aspects of data integrity, specifying implementation mechanisms such as unique user identification, automatic log-off, and data backup and storage.

Verbal Orders

For verbal orders, the Medicare Conditions of Participation for Hospitals, Nursing Services, Paragraph 482.23 (c)(2), require that all orders for drugs and biologicals be in writing and signed by the practitioner(s) responsible for the care of the patient as specified under 482.12(c). When telephone or verbal orders must be used, they must be accepted only by personnel authorized to do so by the medical staff policies and procedures, consistent with federal and state law, and signed or initialed by the prescribing practitioner as soon as possible and used infrequently.

Further, each verbal order must be dated and identified by the name of the individual who gave it and the individual who received it, and the record must document who implemented it.

If the state in which the organization is located requires authentication of verbal orders within a specific time frame, accrediting and licensing agencies will survey for compliance with that requirement. The state licensing authority (usually the state health department’s division of healthcare licensure) should be contacted for specific requirements. Fourteen to thirty days is the generally accepted time frame and should be specified in the organization’s policy and procedure.

A Documentation Methodology: SOAP

Traditional progress notes frequently contain a combination of facts and opinions without delineating which is which. As a result, opinions are apt to be interpreted as proven facts. Recording only factual observations solves the problem but leaves the reader without the valuable interpretation of those facts by an on-the-spot person.
The problem-oriented healthcare documentation method, also known as the Subjective–Objective–Analysis–Plan, or SOAP, allows the inclusion of both objective and subjective data and the documenter’s assessment of those data. In addition, the system actually encourages the development of responses to observations and assessments.

The S refers to subjective information. This includes statements made by the client or family such as descriptions of the client’s symptoms or history and opinions concerning how the client is doing. Using direct quotations can be helpful so that other staff members can have a clear idea of what the client is saying. Moreover, this is the place to record hearsay evidence or hunches reported by others. If there are no subjective data in the report, the S should be eliminated or “none” should be written after it.

The O refers to objective material or measurable data. This includes factual observations made by the writer about events or client behavior. It also may include the results of psychological or medical tests and physical examination findings. Again, if there are no objective data, either the O should be eliminated or “none” should be written after the O.

The A refers to the author’s analysis of the subjective and objective data combined. It can consist of opinions or impressions. If the author is unable to offer an assessment, he or she might write “none at this time” or “need more information before assessing.”

Finally, the P is the treatment plan. This may include therapeutic interventions or patient education. The plan should be in sufficient detail to allow another care provider to follow it to completion. No further specific format for documentation is recommended and depends on the provider and the setting.

There are several variations of SOAP, including SOAPER with E for expectations and R for results. The DAP methodology (data, assessment, plan) also is used in behavioral healthcare. For practical examples of all of these documentation methodologies, see figures 1.6, 1.7, and 1.8.

Figure 1.6. Example of SOAP documentation methodology

| S: | The client’s roommate reports concern that the client’s voice is slurred and she seems to be very sleepy. |
| O: | This staff member talked to the client in her room and confirmed that the client’s speech does seem to be slurred. Explained my concern with her slurred speech. Questioned whether she had been using any alcohol or chemicals or meds other than those prescribed. At first, she denies, but after being asked several times admits that during an outing to the mall on December 22, she had a fake prescription filled for Xanax. The client admits to taking three Xanax pills earlier in the day. |
| P: | Order obtained from Dr. Smith to do a urine drug screen with vital signs to be taken every two hours. Order obtained for a room search. |

Figure 1.7. Example of SOAPER documentation methodology

| S: | Client states he is doing well and is ready to be discharged. |
| A: | Bipolar. |
| P: | Continue current meds. Sugarless candy given to improve dry mouth. |
| E: | Client to continue with current meds and treatment plan. |
| R: | No significant side effects. Previous complaints of lip smacking and stuttering are resolved. |

Figure 1.8. Example of DAP documentation methodology

| D: | Client had complained of memory loss and dry mouth. He feels he is on too much medication. Client does believe he is bipolar. Client has demonstrated social interactions without becoming suspicious. Olanzapine and depakote levels drawn. |
| A: | Client has demonstrated progress on all goals. |
| P: | Notify Dr. Smith when lab results received. Encourage group attendance and interaction. |
Internal Policies and Procedures

Policies provide guidance for staff and procedures operationalize policies. Policies and procedures should be the starting point for an ongoing monitoring system to ensure compliance. Policies need to be measurable, concise, and practical and need to define responsibilities. If staff members who need to comply with the policy do not understand what it means or how to handle hypothetical situations based on it, the policy should be clarified. Procedures need to be comprehensive. When writing procedures, a list or flowchart might be useful in detailing the steps to be completed. All supporting documents, such as forms, should be included along with the policy. Additionally, the latest version of policies and procedures should be made readily available to staff.

Policies and procedures that address documentation in the client’s behavioral healthcare record and are based on all federal and state statutes and regulations, accrediting body standards, professional practice standards, and third-party payer requirements are essential. Internal policies and procedures and the training to properly disseminate them should be considered the cornerstone of good documentation practice.

The following activities should be taken when researching regulations and standards for the development of documentation policies and procedures:

- Applicable federal regulations should be researched. If the organization is not governed by federal law, accreditation standards, state regulations, and professional practice standards should be used.

- If the organization is accredited by a third party such as the JCAHO, CARF, or COA, applicable standards pertaining to documentation should be researched. Even if the organization is not accredited, standards can provide a good foundation for establishing policies and procedures.

- All applicable state statutes should be searched to determine if any state regulations govern the practice setting. Some states have regulations by practice setting or organization licensure (Smith 2001).

Policies and procedures should be reviewed at least annually but updated more frequently, as needed, to reflect changes in regulations, standards, or other requirements. In addition, HIM professionals should use their networking opportunities to share policies and procedures.

Documentation Review

A concurrent review process should be established to identify and promote improved documentation. “Staff need to be aware of the importance of documentation and they also need to be involved in the regular review and evaluation of the patient’s medical record” (Wilson 1998, 797). Having professional and other staff members who document in the record creates an awareness of real-life issues and can serve as an opportunity to increase awareness and education on proper documentation.

The behavioral health record also should be reviewed to see whether:

- Information is recorded in an objective factual manner.

- The record contains complaints or other undesirable comments regarding the patient, family, physician, or staff.

- The record is legible.
The health record review should evaluate the presence, timeliness, completeness, and accuracy of documentation on an ongoing basis. The following steps describe the overall approach in a good record review process:

1. Gather a multidisciplinary review team to perform the reviews.
2. Use a sample size of approximately five percent of the organization’s average monthly discharges.
3. Include a sample of both inpatient and outpatient health records from all treatment settings within the organization.
4. Perform reviews on a monthly basis.
5. Report the results of the review to the necessary committees.
6. Display supporting data in a visual or graphic format, making them easy to comprehend.
7. After reviewing the findings, develop a corrective action plan that includes recommendations for corrective action for all documentation deficiencies.
8. Present the corrective action plan to individual departments or individuals, specifying what actions are expected (Pinder 2003).

Education and Training

Staff education is critical to a successful documentation process. Educational opportunities include new employee orientation, annual mandatory training, and continuing education opportunities. The HIM manager should develop education programs that stress the importance of documentation in client care and increase sensitivity to the risk of poor documentation. A comprehensive education program should be targeted toward direct-care staff, including physicians, and should cover issues from proper documentation to the development of policies and procedures. If the organization has identified a problem area, mandatory education may be necessary to train employees in specific areas of documentation.

In an effective education program, the presentations are useful, informative, and entertaining. Education programs uniquely designed for specific target audiences also should be considered. Because of budget constraints, it may not be possible to do in-person training in a classroom setting, in which case computer-based training may be an alternative. A train-the-trainer program provides trainers with the skills, knowledge, and materials to train staff who work in various areas of the organization or on different shifts. Sample topics to include in documentation training include (Burt 2000):

- Examples of less-than-desirable documentation
- The purpose of the medical record
- Basic guidelines for good documentation
- Specific requirements for progress note documentation
- The DOs and DON’Ts of daily charting
- Case studies in documentation

Educational objectives for a documentation training session may include the following (Burt 2000):

- Participants should be able to describe their responsibility for documentation in the medical record.
• Participants should be able to discuss the importance of proper documentation.
• Participants should be able to state the general guidelines to follow when making entries into the medical record.

The results of the documentation review should be used to determine what, if any, areas of documentation education need to be focused on. The documentation review process also is a good way to review the success of the training program.

Conclusion

Documentation is a critical component of the HIM profession. The need for HIM professionals working in the behavioral healthcare setting to have a thorough knowledge and understanding of documentation law, rules, regulations, standards, and best practices is crucial to the operation of the behavioral healthcare organization.

Various groups and different attempts at legislation have promulgated documentation standards for the healthcare industry as a whole. In addition, the industry recognizes myriad characteristics associated with good documentation procedures. Every type of healthcare organization should implement a formal documentation review process and establish policies and procedures to follow as well as offer education and training on the importance of accurate documentation to their employees.

References and Bibliography


