Chapter 1 Section 5.1

Requirements For Documentation Of Treatment In Medical Records

Issue Date: June 1, 1999
Authority: 32 CFR 199.2; 32 CFR 199.6(b); 32 CFR 199.7(b), and (b)(1)

1.0 ISSUE

Minimum requirements for medical record documentation.

2.0 BACKGROUND

The need for thorough medical documentation for verification of services has been dramatically demonstrated through the utilization review of services provided to TRICARE beneficiaries, particularly within various mental health settings. The lack of pertinent information has often made it impossible to determine the patient's clinical condition, actual treatment rendered, the quality and effectiveness of the care provided, or the identity and qualifications of the staff providing treatment services.

Maintenance of accurate individual treatment records is an essential ingredient in the overall care of the patient. Medical records serve many important functions and constitute one of the critical components of any health care delivery system. The most important function of a medical record is its use as a tool in the care and treatment of the patient. It serves as the basis for planning a patient's care and for the ongoing evaluation of the patient's condition and treatment. Appropriate documentation is especially relevant in the field of psychiatry since there are few objective indicators that validate medical opinions about diagnoses, response to treatment, and severity of illness.

3.0 POLICY

3.1 An adequate medical record should give a pertinent chronological report of the patient's course of care and should reflect any change in condition and the results of treatment. All significant information pertaining to a patient should be incorporated into the patient's medical record and be subject to utilization review and quality assurance established and maintained through the provider's administration and medical staff.

3.2 Institutional and medical professional providers must maintain adequate contemporaneous clinical records to substantiate that specific care was actually furnished, was medically necessary and appropriate, and to identify the individual(s) who provided the care. The requirements apply to

all medical records environments, both paper-based and computerized or electronic. The minimum requirements for medical documentation are requirements set forth by either:

- The cognizant state licensing authority;
- The Joint Commission;
- State standard of medical practice; or
- 32 CFR 199. If more than one of the four standards is applicable, then the strictest standard is mandatory.

3.3 The medical records for Residential Treatment Centers (RTCs), acute care psychiatric hospitals, psychiatric units within acute care institutions, alcohol rehabilitation facilities, partial hospitalization programs, and outpatient psychotherapy must, at a minimum, be maintained in accordance with the Joint Commission's **Consolidated Standards Manual for Child, Adolescent, and Adult Psychiatric, Alcoholism, and Drug Abuse Facilities and Facilities Serving the Mentally Retarded**, along with the requirements set forth in paragraph 3.4.

3.4 Due to the importance of documentation in assuring quality of care and verification of services, the following are minimum documentation requirements, along with specific time-frames for their incorporation into the medical records:

ACUTE MEDICAL/SURGICAL	TIME-FRAMES
Admission evaluation report	Within 24 hours of admission
Completed history and physical examination report	Within 72 hours of admission
Registered nursing notes	End of each shift
Physician notes	Daily

MENTAL HEALTH SERVICES	TIME-FRAMES
Psychiatric admission evaluation examination report	Within 24 hours of admission
Completed history and physical examination report	
• Acute and residential programs • Partial hospitalization	Within 72 hours of admission Within three working days
Individual and family therapy notes	
• Acute, detoxification and residential programs • Partial programs	Within 24 hours of procedure Within 48 hours of procedure
Preliminary treatment plan	Within 24 hours of admission
Master treatment plan	
• Acute care • Residential programs • Full-day partial programs • Half-day partial programs	Within five days of admission Within 10 days of admission Within seven days of admission Within five days of admission

MENTAL HEALTH SERVICES	TIME-FRAMES
Family assessment	
• Acute care • Partial and residential programs	Within 72 hours of admission Within seven days of admissions
Nursing assessment report	
Nursing notes	
• Acute and detoxification programs • Partial hospitalization • Residential programs	End of each shift Every 10 visits At least once a week
Physician notes	
• Intensive treatment, detoxification, and rapid stabilization programs • Acute programs • Partial programs • Residential programs	Daily Twice per week Once per week Once per week
Group therapy	Once per week
Ancillary services	Once per week

3.5 All care rendered and billed must be appropriately documented in writing. Failure to document the care billed will result in the claim on specific services or the claim being denied TRICARE cost-sharing.

3.6 Medical record entries should be legible and contemporaneous with the clinical event, and benefits should only be extended for those days for which there is specific documentation of services.

3.7 Cursory notes of a generalized nature that do not identify the specific treatment and the patient's response to the treatment are not acceptable; e.g., in the case of individual psychotherapy, a statement that "the patient is still depressed about the divorce and does not feel ready to face the outside world" does not adequately document the therapy session. The documentation should reveal the content of the therapy session, the therapeutic intervention attempted during the session, and degree of progress towards established treatment goals.

3.8 All entries in the medical records, including paper-based and computerized or electronic, must be dated and authenticated, and a method must be established to identify the authors of the entries. When rubber stamp signatures are authorized, the medical practitioner should place a signed statement in the facility's administrative files that he or she is the one who has the stamp and is the only one who will use it. There shall be no delegation of use of such stamps to another individual. The provider must authenticate those parts of the medical records for which he or she has responsibility.

3.9 A pattern of failure to adequately document medical care will result in episodes of care being denied TRICARE cost-sharing.

- Application: A pattern of failure to adequately document professional care may make it impossible to establish medical necessity in an institutional setting. In this case, the entire

Episode Of Care (EOC) would be denied (both institutional and professional claims).

3.10 A pattern of failure to meet minimum documentation requirements may also result in provider sanctions prescribed under 32 CFR 199.9.

3.11 Certification of Services

3.11.1 Claims submitted by hospitals (or other authorized institutional providers) must include the name of the individual actually rendering the care, along with the individual's professional status (e.g., Medical Doctor (MD), PhD, Registered Nurse (RN), etc.).

3.11.2 A participating professional provider must certify that the specific medical care listed on the claim form was, in fact, rendered to the specific beneficiary for which benefits are being claimed, on the specific date or dates indicated, at the level indicated and by the provider signing the claim unless the claim otherwise indicates another individual provided the care. For example, if the claim is signed by a psychiatrist and the care was rendered by a psychologist or licensed social worker, the claim must indicate both the name and profession of the individual who rendered the care.

4.0 POLICY CONSIDERATIONS

4.1 The psychiatric records should contain four broad categories of information:

- Administrative information related to patient identification;
- Assessments obtained through examination, testing, and observations;
- Treatment planing; and
- Documentation of care.

4.2 The modern psychiatric record contains varied types of information produced by a multidisciplinary group of health care professionals with different types of orientation and training. This provides an integrated approach by which members of each discipline jointly develop a comprehensive plan specifying the responsibility of each discipline.

4.3 The psychiatric record must include regular progress notes by the clinician that relate to the goals and objectives outlined in the patient's treatment plan. This feedback is essential for guiding members of the therapeutic team. The progress notes must also contain information to verify that the services rendered were medically necessary and appropriate. The following indications are examples of information that should be included in the progress note to document individual psychotherapy:

4.3.1 The date of the therapy session.

4.3.2 Length of the therapy session.

4.3.3 A notation of the patient's current clinical status evidenced by the patient's signs and symptoms.

4.3.4 Content of the therapy session.

4.3.5 A statement summarizing the therapeutic intervention attempted during the therapy session.

4.3.6 Description of the response to treatment, the outcome of the treatment, and the response to significant others.

4.3.7 A statement summarizing the patient's degree of progress towards the treatment goals.

4.3.8 Progress notes should intermittently include reference to progress regarding the discharge plan established early on in the patient's treatment.

- END -