Documentation Requirements

General documentation requirements are provided as follows and should be applied to all CWS client records regardless of funding source. The following information is required to be included in the client's medical record. Documentation must be timely, legible, and support the claims information submitted to Optum for provider reimbursement.

- Informed Consent/Agreement for Services
- The client's name or identification number on each page of the record
- The client's address; employment status; home and work telephone numbers, including emergency contacts; marital or legal status; and guardianship status
- Treatment records should be made contemporaneously with treatment description and dated with the date of entry; if records are not contemporaneously made with treatment, then the date of service should be noted along with the date of entry
- Clear and uniform modifications; any error is to be lined through so that it can still be read, then dated and initialed by the person making the change
- Relevant physical health conditions reported by the client must be prominently identified and updated as appropriate
- Client self-report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities must be clearly documented
- Documentation must include medications that have been prescribed, dosages of each medication, dates of initial prescriptions and refills, and documentation of informed consent for medications
- For children and adolescents, prenatal and perinatal events and complete developmental history must be included
- A clear summary of presenting problems and relevant conditions affecting the client's physical health and mental health status must be documented; for example, living situation, daily activities, and social support
- A mental health history must be documented, including previous treatment dates and providers, therapeutic interventions and responses, sources of clinical data, relevant family information, and relevant results of lab tests and consultation reports
- A mental status examination must be documented
- Documentation must include and describe client strengths and any limitations in achieving client plan goals and objectives, and reflect treatment interventions that are consistent with those goals and objectives
- A five-axis diagnosis from the most current DSM, or a diagnosis from the most current ICD, must be documented, consistent with the presenting problems, history, mental status evaluation, and/or other assessment data
- Special status situations that present a risk to client or others must be prominently documented and updated as appropriate

- Documentation of continuity and coordination of care activities between the primary clinician and other behavioral health or medical clinicians, referring agency, or other professionals involved in the client's case; if the client refuses to allow such communication, this must be documented; the client's reason for refusal should also be noted
- Separate treatment records for each identified and diagnosed member of a family when care involves more than one family member; billing records should reflect the primary client who was treated and the modality of care
- Time spent face to face with the client must match CPT code on the contracted rate schedule. The CPT code submitted on a claim form and the amount of time a provider spends face to face with a client must match the amount of time associated with that CPT code in the provider's contract fee schedule and the American Medical Association Current Procedural Terminology

Progress Notes

The following items related to the client's progress must be entered in the client record at every service contact:

- Timely and legible documentation of relevant aspects of client care
- Amount of time spent face-to-face with client
- Specify symptoms and problems that were the focus of clinical attention
- Relevant clinical decisions; interventions that are consistent with the treatment plan; identification of progress on established goals
- Signature of the provider providing the services (or electronic equivalent); the provider's professional degree and licensure
- Date services were provided
- Documented dates for follow-up visits
- Referrals made to community resources and other agencies
- Follow-up care, or as appropriate, a complete discharge summary