	MEDICAL ASSISTANCE BULLETIN **COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE**	
	SUBJECT Documentation and Medical Record Keeping Requirements	**BY** Peg J. Dierkers **Peg J. Dierkers, Ph.D.** Deputy Secretary for Medical Assistance Programs
NUMBER:	29-02-03, 33-02-03, 41-02-02	
ISSUE DATE:	March 21, 2002	
EFFECTIVE DATE:	March 21, 2002	

PURPOSE:

The purpose of this bulletin is to reinforce the Office of Medical Assistance (MA) Programs documentation and medical record keeping requirements for providers that render behavioral health services to eligible MA recipients.

SCOPE:

This bulletin is applicable to all psychologists, outpatient psychiatric clinics and psychiatric partial hospitalization programs enrolled in either the MA Program's Fee-For-Service or Managed Care Organizations delivery systems.

BACKGROUND:

MA Regulations § 1101.51 (d) establish standards of practice and § 1101.51 (e) establish record keeping requirements for all provider types. Providers must also adhere to record keeping requirements specified in the provider's specific regulation, as well as, any additional instructions issued by the Department.

DISCUSSION:

Departmental review of medical records has revealed that providers are failing to meet documentation and record keeping requirements. This documentation is used by the Department in utilization activities to determine the validity of claims submitted, the medical necessity and quality of services provided to MA recipients. Providers should review their record keeping practices to ensure compliance with applicable Federal and State statutes and regulations, as well as, compliance with their licensing and approval standards. Failure to comply with documentation and medical record keeping requirements may result in the Department's termination of a provider's enrollment in the MA Program, provider restitution or Departmental recoupment of overpayments as specified in § 1101.83.

PROCEDURE:

Providers must adhere to requirements in § 1101.51(d) and (e), and treatment plan documentation as required by § 1153.42 (b) (1) (2) and § 1153.52 (a) (7) (i) (ii) (iii). Providers must develop a treatment plan which contains a written description of the treatment objectives related to the individual's diagnosis and includes the specific medical and remedial services, therapies, and activities that will be used to meet the treatment objectives. The treatment plan must be included in the patient's record and the treatment objectives must state:

1. A projected schedule for service delivery which includes the expected frequency and duration of each planned therapeutic session;

2. The name(s) of the individual(s) who will be delivering the services;

3. The schedule for completing a reassessment of the individual's status in relation to the individual's diagnosis and treatment goals and objectives; and

4. The schedule for updating the treatment plan.

The documentation of treatment or progress notes, at a minimum, must include:

1. The specific services rendered;

2. The date that the service was provided;

3. The name(s) of the individuals(s) who rendered the services;

4. The place where the services were rendered;

5. The relationship of the services to the treatment plan, specifically any goals, objectives and interventions;

6. Progress at each visit, any change in diagnosis, changes in treatment and response to treatment; and

7. The actual time in clock hours that services were rendered. For example: the recipient received one hour of psychotherapy. The medical record should reflect that psychotherapy was provided from 10:00 A.M. to 11:00 A.M.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll-free number for your provider type.

Visit the Office of Medical Assistance Programs website at www.dpw.state.pa.us/omap.