Documentation Standards

For all Medicaid contracted providers that do not hold a Certificate of Approval (COA) with the State

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General Information	

	• Maintain records that fully support the extent of services for which payment has been requested. Include sufficient detail and clarity to permit internal and external review to validate encounter submissions, and to assure medically appropriate services are provided consistent with the documented needs of the member.
	• Information contained in the members record shall be appropriate in quality and quantity to meet the professional standards applicable to the provider and any additional standards for documentation found in relevant Oregon Administrative Rules and pertinent contracts.
	• "Behavioral Health Services" means medically appropriate services rendered or made available to a member for treatment of a behavioral health or substance use disorders diagnosis.
	• "Medically appropriate" means the services and supports required to diagnose, stabilize, care for, and treat a behavioral health condition. Payment shall be made for medically appropriate behavioral health services when the services or supports are:
	  ◦ Rendered by a provider whose training, credentials, or license is appropriate to treat the identified condition and deliver the service;
	  ◦ Safe, effective and appropriate for the member based on standards of evidence-based practice generally recognized by the relevant scientific or professional community based on the best available evidence;
	  ◦ Appropriate and consistent with the diagnosis identified in the behavioral health assessment;
	  ◦ Provided in accordance with an individualized service plan and appropriate to achieve the specific and measurable goals identified in the service plan;
	  ◦ Not provided solely for the convenience or preference of the member, the member's family, or the provider of the service item or supply;
	  ◦ Not provided solely for recreational purposes; Not provided solely for research and data collection;
	  ◦ Not provided solely for the purpose of fulfilling a legal requirement placed on the member; and
	  ◦ The most cost effective of the covered services that can be safely and effectively provided to a member.

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Assessment	• Initiated prior to the provision of any other mental health services, except crisis and stabilization services. • Must document the member's diagnosis, a clinical justification for the diagnosis, and demonstrate the medical need for the service. • An evaluation that is culturally and age relevant.
Service Plan	• An individualized service plan that describes the member's condition and services that will be needed, the specific and measurable goal(s) of services, and expected outcome(s) and duration of the services • Created in collaboration with the member. • Reflective of the mental health assessment and the intended outcomes of treatment. • Conforms to accepted professional practice. For example, the LCSW Code of Ethics requires that a client record is maintained that includes a treatment or intervention plan.
Service Note	• Documentation shall be completed before the service is billed and meet the following requirements: • How the services are connected to the individualized service plan and appropriate to achieve the specific and measurable goals identified in the service plan. • Specific service provided (Procedure Code) • The number of services comprising the service provided (Units of service) • The extent of the service provided (Type of contact and context of service. For example, "Met face to face in the office for psychotherapy to work on CBT skills", or "Met with member in ER for crisis response related to...") • The dates on which the service was provided • The individual who provided the service • Annotated each time a service is provided and be signed or initialed by the individual providing the service.