PROVIDER*Update*

Health Net®

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Behavioral Health Documentation Standards

Health Net of California, Inc., Health Net Community Solutions, Inc. and Health Net Life Insurance Company (Health Net) would like to remind participating behavioral health providers about the documentation standards required by Health Net. This communication includes information on documentation guidelines for behavioral health services, submitting late entries, clarification notes and addenda, and information about the electronic health record (EHR) for providers with EHR.

The intent of this communication is to provide education that may improve the quality and efficiency of providers' billing. Providers are encouraged to share this information with the associates of the practice and the billing staff.

DOCUMENTATION GUIDELINES

Providers must follow the guidelines outlined in this communication when creating clinical and administrative treatment records.

Clinical Records

Clinical records must include the following:

- Member name must appear on each document in the clinical record.
- All clinical record entries must be dated, and the responsible clinician's name, professional degree, and relevant identification number, if applicable, must be included.
- The clinical record must be legible to someone other than the writer.
- The clinical record must include the exact start and stop times of the face-to-face service during which the member was present. As the CPT codes for therapy are time based codes and correlate directly to the time spent in the service, the start and stop times should not include time spent on collaboration and documentation. See example below for documenting time properly:
  - A member is scheduled from 4:00 – 5:00. However, they have only been provided the service from 4:04 – 4:55, which is 51 minutes. The provider should use CPT 90834 (45 minute session) and not CPT 90837 (60 minute session).
- The clinical record must ensure that the duration of the exact face-to-face time spent with the member matches the procedure code service definition.
- The clinical record must confirm that the treatment plan updates include the member's progress towards the goals and objectives, barriers to meeting the goals and objectives, and any changes and/or additions to the goals, objectives and interventions. Goals and objectives need to be specific, measurable, achievable, relevant, and time-limited (SMART).

THIS UPDATE APPLIES TO **CALIFORNIA** PROVIDERS:

- ○ Physicians
- ○ Participating Physician Groups
- ○ Hospitals
- ● Behavioral Health Providers

LINES OF BUSINESS:

- ● HMO/POS/HSP
- ● PPO
- ● EPO
- ● Medicare Advantage (HMO)
- ○ Medi-Cal
  - ○ Kern
  - ○ Los Angeles
    - ○ Molina
  - ○ Riverside
  - ○ Sacramento
  - ○ San Bernardino
  - ○ San Diego
  - ○ San Joaquin
  - ○ Stanislaus
  - ○ Tulare

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Medicare (employer group)
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- Each service must be signed and dated by the rendering provider. The signature must include the rendering provider's credentials, and the date must be the date the note was written and signed.
- All clinical documentation must be completed and entered into the chart in a timely manner. Refer to state guidelines to determine what time frame is allowed.

Clinical Records

Progress notes must include the following:

- Progress notes must describe patient strengths and limitations in achieving treatment plan goals and objectives, and reflect that the treatment interventions are consistent with those goals and objectives. Progress notes must also include clinical interventions (not treatment modality), member response to the interventions provided and a plan for ongoing care.

LATE ENTRY, CLARIFICATION NOTE AND ADDENDUM

Providers must follow the American Health Information Management Association (AHIMA) guidelines outlined below for making late entries, clarification notes and addenda in the medical record.

Late Entry

When a pertinent entry was missed or not written in a timely manner, a late entry should be used to record the information in the medical record.

- Identify the new entry as a "late entry".
- Enter the current date and time – do not try to give the appearance that the entry was made on a previous date or an earlier time.
- Identify or refer to the date and incident for which late entry is written.
- If the late entry is used to document an omission, validate the source of additional information as much as possible (where did you get information to write late entry). For example, use of supporting documentation on other facility worksheets or forms.
- Record late entry documentation as soon as possible. There is not a time limit to writing a late entry; however, the more time that passes the less reliable the entry becomes.

Clarification Note

A clarification note is considered a late entry. A clarification is written to avoid incorrect interpretation of information that has been previously documented. For example, after reading an entry there is a concern that the entry could be misinterpreted. To make a clarification entry:

- Document the current date and time.
- Write "clarification", state the reason and refer back to the entry being clarified.
- Identify any sources of information used to support the clarification.
- When writing a clarification note, complete it as soon after the original entry as possible.

Addendum

An addendum is considered a late entry used to provide additional information in conjunction with a previous entry. With this type of correction, a previous note has been made and the addendum provides additional information to address a specific situation or incident. With an addendum, additional information is provided, but would not be used to document information that was forgotten or written in error. When making an addendum:

- Document the current date and time.
- Write "addendum" and state the reason for the addendum referring back to the original entry.
- Identify any sources of information used to support the addendum.
- When writing an addendum, complete it as soon after the original note as possible.

ELECTRONIC HEALTH RECORD – FOR PROVIDERS WITH EHR

The EHR system must have the capability to identify changes to an original entry, such as addenda, corrections, deletions, and patient amendments.[1] When making changes, the date, the time, the name of the author making the change, and the reason for the change should be included. Some systems automatically assign the date an entry was made. Others allow authorized users to change the entry date to the date of the visit or service. Some systems allow providers to make undated amendments without noting that an original entry was changed. If there is no date and time on the original entry or subsequent amendments, providers cannot determine the order of events, which can impact the quality of patient care provided.

ALTERING DOCUMENTATION

Knowingly altering claim forms, medical records or receipts to receive a higher payment is considered fraud.

LATE SIGNATURES

According to the Centers for Medicare & Medicaid Services (CMS), providers should never add late signatures to the medical record (beyond the short delay that occurs during the transcription process).[2] Doing so can be considered fraud, or the claim may be denied for payment due to late signature. If a signature needs to be added outside the time frame allowed by state laws, providers must sign an attestation that clarifies the reason for the late signature.

ADDITIONAL INFORMATION

Providers are encouraged to access Health Net's provider portal online, as listed in the table below.

If you have questions regarding the information contained in this update, contact the applicable Health Net Provider Services Center within 60 days at:

Line of Business	Telephone Number	Provider Portal	Email Address
ENHANCEDCARE PPO (SBG)	1-844-463-8188	provider.healthnet.com	provider_services@healthnet.com
HEALTH NET EMPLOYER GROUP HMO, POS, HSP, PPO, & EPO	1-800-641-7761	provider.healthnet.com	
MEDICARE (EMPLOYER GROUP)	1-800-929-9224	provider.healthnet.com	

[1] www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-ehr-providerfactsheet.pdf

[2] www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6698.pdf