HIGHMARK HEALTH OPTIONS

2023 Medical Record Standards For Behavioral Health Providers

1. **MEMBER ID**	Each page in the record contains member name or member ID number.
2. **SIGNED ENTRY**	All entries are signed or initialed (electronically) by the provider.
3. **DATED ENTRY**	All entries are dated.
4. **LEGIBILITY**	The record is legible to someone other than the provider or provider's staff.
5. **PSYCHOLOGICAL ASSESSMENT AND PRESENTING PROBLEM LIST**	A mental status examination is documented in the medical record. Presenting problems and relevant psychological and social conditions affecting the member's medical and psychiatric status are documented. Imminent risk of harm or suicidal ideation are documented.
6. **MEDICATION LIST**	Prescribed medications and dosages are documented on a medication list.
7. **ALLERGIES**	Presence/absence of allergies or adverse reactions to medications are prominently noted (1 year of age and older). An absence of allergies should be clearly documented in the record.
8. **TOBACCO USE**	Use/nonuse of tobacco products is documented on members age 12 and older.
9. **ALCOHOL USE**	Use/nonuse of alcohol is documented on members 12 years of age and older.
10. **DRUG USE**	Use/nonuse of illicit drugs is documented on members 12 years of age and older.
11. **LAB, DIAGNOSTIC TESTS AND OTHER STUDIES**	Labs and other studies must be appropriate to the presenting complaint, or diagnosis.
12. **WORKING DIAGNOSIS**	There is a clearly documented diagnostic impression by the provider that is consistent with findings for each member visit.
13. **PLAN OF ACTION, THERAPIES, AND TREATMENT**	The provider initiating a treatment plan must describe the active target interventions with specific, measurable goals, and stated in behavioral terms, at the level of care proposed. Includes follow-up care.
14. **PREVENTIVE SERVICES**	There is documentation of preventive services, as appropriate, such as relapse prevention, stress management, wellness programs, lifestyle changes and referrals to community resources.
15. **CONTINUITY OF CARE**	The medical record reflects continuity and coordination of care between the PCP, specialists, consultants, ancillary providers and healthcare institutions, as applicable. Discharge summaries are included, if applicable.
16. **DISCHARGE SUMMARY**	If the member was in the hospital, there is a discharge summary signed and dated within 30 days.
17. **CARE MEDICALLY APPROPRIATE**	Medical record describes medically appropriate and necessary care, and there is no evidence of the member being placed at inappropriate risk.
18. **CONFIDENTIALITY**	Medical records contain confidentiality statements or a copy of signed consents to release information.
19. **TELEHEALTH VISIT CONSENT**	For telehealth and virtual visits, the member's verbal consent must be documented in the member's medical record.