# 2022 Mental Health Record Documentation Standards

Gray text indicates quoted regulatory, statutory, or other language not subject to change

<table>
<thead>
<tr>
<th>Element</th>
<th>Standard</th>
<th>Regulatory Requirement</th>
</tr>
</thead>
</table>
| **A. Record Format**                                                    | **1. Elements in the mental health record are organized in a consistent manner.**  
The contents of the mental health record are affixed and organized in a logical and consistent manner. The record is organized in chronological order. | • National Committee for Quality Assurance (NCQA) guidelines                                                                   |
| **2. Member name is present on every page.**                           | A separate mental health record must be maintained for each unique member with the member's name present on every page.                                                                                       | • MN Rules part 9505.2175, subp. 2 (B)  
• MN Rules part 9520.0790, subp. 5  
• NCQA guidelines                                                                                                              |
| **3. Author identification is present for every entry.**               | All entries in the mental health record contain the author's identification, which may be a handwritten signature, unique electronic identifier, or initials, title/professional degree, and relevant identification number, if applicable. Services provided/ordered are authenticated by the author of the entry to signify knowledge, approval, acceptance, or obligation. Stamped signatures are not acceptable. Use of a rubber stamp for signature is permitted in the case of an author with a proven physical disability unable to sign his/her signature. Signatures from someone other than the author are also not acceptable. If there is no legible identifier in the form of a handwritten or electronic signature, a signature log is required. The log must be included in the mental health record and clearly identify the author associated with the initials, mark, sign, or illegible signature. The identifier may be on the actual page where the initials, mark, sign, or illegible signature appear or may be in a separate log. The log must be part of the member's mental health record. **If electronic signatures are used as a form of authentication, the system must authenticate the signature at the end of each note.** Electronic signatures are preceded by “Electronically signed by,” “Authenticated by,” “Approved by,” “Completed by,” “Finalized by,” or “Validated by,” and include the practitioner's name, credentials, and date signed. | • MN Rules part 9505.0371, subp. 8 (A)  
• MN Rules part 9505.2175, subp. 2 (C) (4)  
• MN Stat. sec. 221.173  
• Centers for Medicare & Medicaid Services (CMS) Manual System, Pub 100-08, CR 6698  
• NCQA guidelines                                                                                                                   |
<table>
<thead>
<tr>
<th>Element</th>
<th>Standard</th>
<th>Regulatory Requirement</th>
</tr>
</thead>
</table>
| 4.      | Each occurrence of service includes date, type of service, stop/start time, scope of the service, who gave service, and date of documentation. | There is documentation of each occurrence of service to the member including the date, type of service, start and stop times, scope of the mental health service, name and title of the person who gave the service, and date of documentation. If level of service is based on face time with the member, time spent with the member must be documented in the mental health record entry. | • MN Rules part 9505.0371, subp. 8 (A)  
• MN Rules part 9505.2175, subp. 2 (C) (3) |
| 5.      | All entries are legible to someone other than the author. | There is a system in place to ensure that all entries in the mental health record are legible to someone other than the author. Content of the record is presented in a standard format that allows a reader to review without the use of separate legend/key. Late entries must be clearly labeled “late entry.” Corrections to an entry must be made in a way in which the original entry can still be read. | • MN Rules part 4685.1110, subp.13 (A)  
• MN Rules part 9505.2175, subp. 2 (A)  
• NCQA guidelines |
| 6.      | Medical and mental health providers can access each other’s notes through a fully integrated electronic health record (EHR). | Providers are able to accommodate for the timely, effective, and confidential exchange of patient information between primary care providers, mental health care professionals, specialists, and organizational providers through an EHR (individual health care providers in private practice with no other providers are excluded from the requirements). | • MN Stat. sec. 62J.495 |

**B. Record Content**

| 1.      | Personal biographical data includes member address, employer or school, home and work phone numbers including emergency contacts, marital or legal status, appropriate consent forms, and guardianship information, if applicable. | Personal biographical data is documented in a prominent location in each mental health record and includes member’s address, employer or school, home and work phone numbers including emergency contacts, marital or legal status, appropriate consent forms, and guardianship information, if applicable. | • NCQA guidelines |
| 2.      | Member demographic data includes preferred language, sex, race, ethnicity, and date of birth. | Member demographic data is documented in a prominent location in each health record and includes the member’s preferred language, sex, race, ethnicity, and date of birth. Documentation also includes whether a member declines to specify race, ethnicity, and/or a preferred language. **This standard applies to clinics using EHRs.** | • Title 45 Code of Federal Regulations (CFR) Part 170.207 (f) (g)  
• 45 CFR 170.314 (a) (3) |
<table>
<thead>
<tr>
<th>Element</th>
<th>Standard</th>
<th>Regulatory Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Health Care Directives and/or Advance Psychiatric Directives/Declarations are documented in the mental health record for members age 18 and over.</td>
<td>Documentation is in a prominent part of the member’s current mental health record, for those age 18 and over, whether or not the member has executed a Health Care Directive and/or Advance Psychiatric Directive/Declaration. <strong>If not executed, there is documentation that Health Care Directive and/or Advance Psychiatric Directive/Declaration information was offered.</strong> The Advance Psychiatric Directive/Declaration applies only to treatment with neuroleptic medications and electro-convulsive therapy (ECT). It does not apply to other mental health medications or other types of therapy.</td>
<td>• 2022 Minnesota Department of Human Services (DHS) Families and Children contract, article 14  • 2022 DHS Minnesota Senior Health Options (MSHO)/Minnesota Senior Care Plus (MSC+) contract, article 14  • 2022 DHS Special Needs BasicCare (SNBC) contract, article 14  • MN Stat. sec. 145C.01  • MN Stat. sec. 145C.02  • MN Stat. sec. 145C.03  • MN Stat. sec. 253B.03  • MN Stat. sec. 253B.092  • 42 CFR 422.128 (b) (1) (ii) (E)</td>
</tr>
<tr>
<td>4. Member authorization to release private information and member information obtained from outside sources must be documented.</td>
<td>There must be a signed and dated authorization for all external people with whom treatment information is exchanged. The period of authorization must not exceed one year. For a minor or adult unable to give consent, the parent or legal representative must have signed. <strong>No treatment information can be exchanged without member/legal representative authorization or court order.</strong></td>
<td>• 2022 DHS Families and Children contract, article 13  • 2022 MSHO/MSC+ contract, article 13  • 2022 DHS SNBC contract, article 13  • MN Rules part 9505.0371, subp. 6  • MN Rules part 9520.0790, subp. 5 (G)  • MN Stat. secs. 144.292 – 144.294  • Minnesota Health Care Programs (MHCP) Provider Manual, Mental Health Services chapter  • 45 CFR 164.510  • 45 CFR 164.522</td>
</tr>
</tbody>
</table>

C. Assessment

<table>
<thead>
<tr>
<th>Element</th>
<th>Standard</th>
<th>Regulatory Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Diagnostic assessment includes a face-to-face interview.</td>
<td>The mental health professional conducting the diagnostic assessment must conduct a face-to-face interview with the member. Diagnostic assessments may be conducted using telemedicine technology when appropriate. <strong>This standard applies to all diagnostic assessments.</strong> For an extended diagnostic assessment, the face-to-face interview is conducted over three or more assessment appointments.</td>
<td>• 2022 DHS Families and Children contract, section 6.1.30  • 2022 DHS MSHO/MSC+ contract, section 6.1.35  • 2022 DHS SNBC contract, section 6.1.35  • MN Rules part 9505.0372, subp. 1 (B), (C), (D), (E)  • MHCP Provider Manual, Mental Health Services chapter</td>
</tr>
<tr>
<td>Element</td>
<td>Standard</td>
<td>Regulatory Requirement</td>
</tr>
<tr>
<td>---------</td>
<td>----------</td>
<td>------------------------</td>
</tr>
</tbody>
</table>
| 2. Reason for diagnostic assessment is documented. | The reason for the assessment is documented, including the member’s perceptions of their condition and description of symptoms, including reason for referral. **This standard applies to standard and extended diagnostic assessments.** For a brief diagnostic assessment, documentation includes only description of symptoms, including reason for referral. For an adult diagnostic assessment update, update the most recent assessment document with a review of the member’s presenting problems, including current presenting problems, a written update of those parts where there is significant new or changed information, and note parts where there has not been significant change. | • 2022 DHS Families and Children contract, section 6.1.30  
• 2022 DHS MSHO/MSC+ contract, section 6.1.35  
• 2022 DHS SNBC contract, section 6.1.35  
• MN Rules part 9505.0372, subp. 1 (B) (2), (C), (D), (E) (2)  
• MHCP Provider Manual, Mental Health Services chapter |
| 3. Type of diagnostic assessment is documented. | A description of which type of diagnostic assessment being conducted is documented to include either brief diagnostic assessment, standard diagnostic assessment, extended diagnostic assessment, or adult diagnostic assessment update. **This standard applies to all diagnostic assessments.** | • MHCP Provider Manual, Mental Health Services chapter |
| 4. Current life situation is documented. | The member’s current life situation is documented, including member’s age; current living situation, including household membership and housing status; basic needs status, including economic status; education level and employment status; significant personal relationships, including the member’s evaluation of relationship quality; and general physical health and relationship to member’s culture. **This standard applies to standard, and extended diagnostic assessments.** For an adult diagnostic assessment update, update the most recent assessment document with a review of the member’s life situation, including an interview with the member about the member’s current life situation, a written update of those parts where significant new or changed information exists, and documentation where there has not been significant change. | • 2022 DHS Families and Children contract, section 6.1.30  
• 2022 DHS MSHO/MSC+ contract, section 6.1.35  
• 2022 DHS SNBC contract, section 6.1.35  
• MN Rules part 9505.0372, subp. 1 (B) (1), (C), (D), (E) (1)  
• MHCP Provider Manual, Mental Health Services chapter |
<table>
<thead>
<tr>
<th>Element</th>
<th>Standard</th>
<th>Regulatory Requirement</th>
</tr>
</thead>
</table>
| 5. Maltreatment, trauma, or abuse issues are addressed. | There is documentation of maltreatment, trauma, and/or abuse issues the member has experienced. If there are no issues identified, this is also documented. This standard applies to standard and extended diagnostic assessments. | • 2022 DHS Families and Children contract, section 6.1.30  
• 2022 DHS MSHO/MSC+ contract, section 6.1.35  
• 2022 DHS SNBC contract, section 6.1.35  
• MN Rules part 9505.0372, subp. 1 (B) (2), (C)  
• MHCP Provider Manual, Mental Health Services chapter |
| 6. A health history and family health history is documented. | A health history that includes current and/or past major or chronic medical conditions, serious accidents, operations, and illnesses is documented. A family health history including physical, chemical, and mental health history must also be documented. All history of note should be documented that impacts member's genetic predisposition to potential physical and mental health issues. This standard applies to standard and extended diagnostic assessments. | • 2022 DHS Families and Children contract, section 6.1.30  
• 2022 DHS MSHO/MSC+ contract, section 6.1.35  
• 2022 DHS SNBC contract, section 6.1.35  
• MN Rules part 9505.0372, subp. 1 (B) (2), (C)  
• MN Rules part 9505.2175, subp. 2 (D) (1)  
• MN Rules part 9520.0790, subp. 3, 5 (B)  
• MHCP Provider Manual, Mental Health Services chapter  
• NCQA guidelines  
• PrimeWest Health standard |
| 7. Absence or presence of medication allergies and adverse reactions are prominently noted in the mental health record. | Documentation of the presence of medication allergies, including adverse reactions, must be consistently and clearly documented in a prominent location of all mental health records. If the member has no known allergies or history of adverse reactions, this is also prominently noted in the mental health record. Allergies to environmental allergens, food, pets, etc., should also be noted. This standard applies to standard and extended diagnostic assessments. | • 2022 DHS Families and Children contract, section 6.1.30  
• 2022 DHS MSHO/MSC+ contract, section 6.1.35  
• 2022 DHS SNBC contract, section 6.1.35  
• NCQA guidelines  
• PrimeWest Health standard |
<table>
<thead>
<tr>
<th>Element</th>
<th>Standard</th>
<th>Regulatory Requirement</th>
</tr>
</thead>
</table>
| 8. A developmental history for members includes prenatal and perinatal events, along with a complete developmental history. | A comprehensive developmental history must be documented that includes relevant prenatal and perinatal events. A complete developmental history and important developmental incidents, including developmental milestones, accidents, issues that were an impediment to meeting milestones, etc., as well as a psychological, social, intellectual, and academic history are also included. **This standard applies to standard and extended diagnostic assessments.** | • 2022 DHS Families and Children contract, section 6.1.30  
• 2022 DHS SNBC contract, section 6.1.35  
• MN Rules part 9505.0372, subp. 1 (B) (2), (D)  
• MN Rules part 9505.2175, subp. 2 (D) (1)  
• MN Rules part 9520.0790, subp. 3, 5 (B)  
• MHCP Provider Manual, Mental Health Services chapter  
• NCQA guidelines  
• PrimeWest Health standard |
| 9. Cultural influences and their impact on the member are documented. | Cultural influences and their impact on the member are documented. Issues of race, class, social-economic and geographical aspects of the member’s life and how they impact current functioning should be addressed. Cultural influences means historical, geographical, and familial factors that affect assessment and intervention processes. Cultural influences that are relevant to the member may include the member’s racial or ethnic self-identification, experience of cultural bias as a stressor, immigration history and status, level of acculturation, time orientation, social orientation, verbal communication style, locus of control, spiritual beliefs, and health beliefs and the endorsement of or engagement in culturally specific health practices. **This standard applies to brief, standard and extended diagnostic assessments.** | • 2022 DHS Families and Children contract, section 6.1.30  
• 2022 DHS MSHO/MSC+ contract, section 6.1.35  
• 2022 DHS SNBC contract, section 6.1.35  
• MN Rules part 9505.0372, subp. 1 (B) (2), (C)  
• MHCP Provider Manual, Mental Health Services chapter  
• PrimeWest Health standard |
<table>
<thead>
<tr>
<th>Element</th>
<th>Standard</th>
<th>Regulatory Requirement</th>
</tr>
</thead>
</table>
| 10. Current medications prescribed by all prescribing practitioners, as well as over-the-counter and herbal preparations are documented. | Current medications prescribed by all prescribing practitioners, as well as over-the-counter and herbal preparations are documented. This standard applies to standard and extended diagnostic assessments. | - 2022 DHS Families and Children contract, section 6.1.30  
- 2022 DHS MSHO/MSC+ contract, section 6.1.35  
- 2022 DHS SNBC contract, section 6.1.35  
- MN Rules part 9505.0372, subp. 1 (B) (1), (C), (D), (E)  
- MN Rules part 9505.2175, subp. 2 (E)  
- MN Rules part 9520.0790, subp. 5 (E)  
- MHCP Provider Manual, Mental Health Services chapter  
- NCQA guidelines  
- PrimeWest Health standard |
| 11. A mental health treatment history is documented, including review of member’s records. | A mental health treatment history must be documented and should include, if applicable, previous treatment dates, identification of former treating practitioner(s), therapeutic interventions and responses, sources of clinical data, laboratory test results, consultation reports, and relevant family information. A review of the member’s records should also be included. This standard applies to all diagnostic assessments. | - 2022 DHS Families and Children contract, section 6.1.30  
- 2022 DHS MSHO/MSC+ contract, section 6.1.35  
- 2022 DHS SNBC contract, section 6.1.35  
- MN Rules part 9505.0372, subp. 1 (B) (2), (C)  
- MN Rules part 9520.0790, subp. 3, 5 (B)  
- MHCP Provider Manual, Mental Health Services chapter  
- NCQA guidelines |
<table>
<thead>
<tr>
<th>Element</th>
<th>Standard</th>
<th>Regulatory Requirement</th>
</tr>
</thead>
</table>
| 12. For members age 10 and over, there is appropriate notation concerning the past and present use of tobacco and alcohol, as well as illicit, prescribed, and over-the-counter drugs, and present caffeine use. | A substance use history of alcohol and drug usage and treatment must be documented for members age 10 and over. The history must include past and present use of tobacco (cigarettes, chewing tobacco, cigars, etc.), alcohol (beer, wine, spirits, etc.), illicit drugs (cannabis, cocaine, amphetamine-type stimulants, inhalants, sedatives or sleeping pills, hallucinogens, opioids, other psychoactive substances, etc.), and any misuse of prescription or over-the-counter drugs. Present caffeine use should also be noted. Additionally, negative consequences of use and history of assessment and/or treatment should be documented. For school-aged children and adolescents, documentation could also include any provided interventions, including education or brief counseling, to prevent initiation of tobacco use. **This standard applies to standard and extended diagnostic assessments.** | • 2022 DHS Families and Children contract, section 6.1.30  
• 2022 DHS MSHO/MSC+ contract, section 6.1.35  
• 2022 DHS SNBC contract, section 6.1.35  
• MN Rules part 9505.0372, subp. 1 (B) (2), (C)  
• MN Rules part 9520.0790, subp. 3, 5 (B)  
• MHCP Provider Manual, Mental Health Services chapter  
• NCQA guidelines  
• PrimeWest Health standard |
| 13. Standardized substance use screening questionnaire results are incorporated in the initial assessment of members age 12 and over. | A nationally recognized tool of the provider’s choice is utilized upon initial access of mental health services to screen members for the presence of substance use disorder. For members age 18 and over, the State recommends Section 3 (Substance Use Disorder Screener) of the Global Assessment of Individual Needs-Short Screener (GAIN-SS) or the CAGE-AID (CAGE [mnemonic acronym for Cut, Annoyed, Guilty, Eye-opener] Adapted to Include Drugs). For members ages 12 – 17, the State-recommended tools are Section 3 (Substance Use Disorder Screener) of the Global Assessment of Individual Needs-Short Screener (GAIN-SS) or the CRAFFT (mnemonic acronym for Car, Relax, Alone, Forget, Family or Friends, Trouble). Another suggested tool is the KIDDIE CAGE (mnemonic acronym for Chemical, Avoid, Group, Emotions). Other screenings as determined by the commissioner are included. **This standard applies to all diagnostic assessments.** | • 2022 DHS Families and Children contract, section 6.1.30  
• 2022 DHS MSHO/MSC+ contract, section 6.1.35  
• 2022 DHS SNBC contract, section 6.1.35  
• MN Rules part 9505.0372, subp. 1 (B) (5), (C), (D), (E) (3)  
• MHCP Provider Manual, Mental Health Services chapter |
<table>
<thead>
<tr>
<th>Element</th>
<th>Standard</th>
<th>Regulatory Requirement</th>
</tr>
</thead>
</table>
| 14. The Child & Adolescent Service Intensity Instrument (CASII) or the Early Childhood Service Intensity Instrument (ECSII), and the Strength & Difficulties Questionnaire (SDQ) are utilized in the assessment of children receiving mental health services at intake, periodic review, and discharge planning. | The CASII or the ECSII, and the SDQ are to be utilized for intake, periodic review, and discharge planning. The CASII and SDQ are to be completed on every child (age 6 and over) receiving mental health services at intake, at least every six months, and at discharge. The ECSII and SDQ should be completed on young children (under age 6) at intake, at least every three months, and at discharge. This standard applies to brief, standard, and extended diagnostic assessments. | • 2022 DHS Families and Children contract, section 6.1.30  
• 2022 DHS SNBC contract, section 6.1.35  
• MN Rules part 9505.0372, subp. 1 (B) (5), (C) (1) (2)  
• MHCP Provider Manual, Mental Health Services chapter |
| 15. Results of a mental status exam are documented.                    | A mental status examination must be documented that describes general observations including the member’s appearance, build, demeanor/response to interviewer, eye contact, activity level and speech; thought content and perception including delusions and hallucinations; self-danger including self-abuse, violence to others, and destruction of property; cognition including orientation, memory issues, attention/concentration, and judgment/insight; thought and perceptual process; mood; affect; behavior; anxiety; and intelligence estimate. Continued assessment should be documented in subsequent progress notes or follow-up visits, to include, at a minimum, thought content, specifically, imminent risk of harm to self or others. All notes should reference suicidal and homicidal ideation. This standard applies to all diagnostic assessments. | • 2022 DHS Families and Children contract, section 6.1.30  
• 2022 DHS MSHO/MSC+ contract, section 6.1.35  
• 2022 DHS SNBC contract, section 6.1.35  
• MN Rules part 9505.0372, subp. 1 (B) (3), (C), (D), (E) (4)  
• MN Rules part 9520.0790, subp. 3, 5 (B)  
• MHCP Provider Manual, Mental Health Services chapter  
• NCQA guidelines  
• PrimeWest Health standard |
| 16. Special status situations are prominently noted.                   | Special status situations and safety needs, such as imminent risk of harm to self or others, which includes suicidal and homicidal ideation, are prominently noted. If a risk level is documented other than reference to no risk of harm to self or others, the specific risk should be identified and an action plan put in place and documented. Continued assessment should be documented in subsequent progress notes or follow-up visits. This standard applies to all diagnostic assessments. | • 2022 DHS Families and Children contract, section 6.1.30  
• 2022 DHS MSHO/MSC+ contract, section 6.1.35  
• 2022 DHS SNBC contract, section 6.1.35  
• MN Rules part 9505.0372, subp. 1 (B) (3) (4), (C), (D), (E) (4) (5)  
• MN Rules part 9520.0790, subp. 3, 5 (B)  
• MHCP Provider Manual, Mental Health Services chapter  
• NCQA guidelines  
• PrimeWest Health standard |
<table>
<thead>
<tr>
<th>Element</th>
<th>Standard</th>
<th>Regulatory Requirement</th>
</tr>
</thead>
</table>
| 17. Member strengths and resources are documented. | Member strengths and resources, including the extent and quality of social networks, belief systems, and contextual non-personal factors contributing to the member's presenting concerns must be documented in the diagnostic assessment. **This standard applies to standard and extended diagnostic assessments.** There should be consideration of member strengths and resources in the development of the treatment plan. The treatment plan notes detail member strengths and resources in achieving treatment plan goals. | • 2022 DHS Families and Children contract, section 6.1.30  
• 2022 DHS MSHO/MSC+ contract, section 6.1.35  
• 2022 DHS SNBC contract, section 6.1.35  
• MN Rules part 9505.0372, subp. 1 (B) (1) (C), (D)  
• MN Rules part 9520.0790, subp. 3, 5 (B)  
• MHCP Provider Manual, Mental Health Services chapter  
• PrimeWest Health standard |
| 18. A clinical summary and provisional clinical hypothesis is documented. | There is documentation of a clinical summary that explains the provisional diagnostic hypothesis. The clinical hypothesis may be used to address the member’s immediate needs or presenting problems. A provisional diagnostic hypothesis should include aspects of the following that are known at this time: The clinician’s formulation of the cause of the client’s mental health symptoms, the client’s prognosis, and the likely consequences of the symptoms; how the client meets criteria for the diagnosis by describing the client’s symptoms, the duration of symptoms, and functional impairment; an analysis of the client’s other symptoms, strengths, relationships, life situations, cultural influences, and health concerns and their potential interaction with the diagnosis and formulation of the client’s mental health condition; and alternative diagnoses that were considered and ruled out. **This standard applies to brief diagnostic assessments only.** | • 2022 DHS Families and Children contract, section 6.1.30  
• 2022 DHS MSHO/MSC+ contract, section 6.1.35  
• 2022 DHS SNBC contract, section 6.1.35  
• MN Rules part 9505.0372, subp. (1) (D)  
• MHCP Provider Manual, Mental Health Services chapter |
| 19. Assessment of member’s needs is documented. | There is assessment of the member’s needs based on the member’s baseline measurements, symptoms, behavior, skills, abilities, resources, vulnerabilities, and safety needs. Documentation of clinical significance, functional impairment and the baseline of need at the start of treatment. **This standard applies to standard and extended diagnostic assessments, and adult diagnostic assessment updates.** | • 2022 DHS Families and Children contract, section 6.1.30  
• 2022 DHS MSHO/MSC+ contract, section 6.1.35  
• 2022 DHS SNBC contract, section 6.1.35  
• MN Rules part 9505.0372, subp. (1) (B) (4), (C), (E) (5)  
• MHCP Provider Manual, Mental Health Services chapter |
<table>
<thead>
<tr>
<th>Element</th>
<th>Standard</th>
<th>Regulatory Requirement</th>
</tr>
</thead>
</table>
| 20. Assessment methods are documented.                                  | For adults, all assessment methods and use of standardized assessment tools (including a WHODAS 12 or 36 questions, questionnaire) by the provider as determined and periodically updated by the commissioner are documented. For children ages 5 – 18, completion of other assessment standards for children as determined and periodically revised by the commissioner is documented. **This standard applies to standard and extended diagnostic assessments.** | • 2022 DHS Families and Children contract, section 6.1.30  
• 2022 DHS MSHO/MSC+ contract, section 6.1.35  
• 2022 DHS SNBC contract, section 6.1.35  
• MN Rules part 9505.0372, subp. (1) (B) (6), (C)  
• MHCP Provider Manual, Mental Health Services chapter |
| 21. A clinical summary, recommendations, and prioritization of needed services are documented. | There is documentation of a clinical summary, recommendations, and prioritization of needed mental health, ancillary, or other services. A clinical summary is the formulation of the cause of the member’s mental health symptoms, the member’s prognosis, and the likely consequences of the symptoms; how the member meets the criteria for the diagnosis by describing the member’s symptoms, the duration of symptoms, and functional impairment; an analysis of the member’s other symptoms, strengths, relationships, life situations, cultural influences, and health concerns and their potential interaction with the diagnosis and formulation of the member’s mental health condition; and alternative diagnoses that were considered and ruled out. Recommendations or referrals for preventive or other external services, as appropriate, such as stress management, relapse prevention, wellness programs, lifestyle changes, or community services, as appropriate, are also documented. **This standard applies to standard and extended diagnostic assessments, and adult diagnostic assessment updates.** | • 2022 DHS Families and Children contract, section 6.1.30  
• 2022 DHS MSHO/MSC+ contract, section 6.1.35  
• 2022 DHS SNBC contract, section 6.1.35  
• MN Rules part 9505.0370, subp. 5  
• MN Rules part 9505.0372, subp. (1) (B) (7), (C), (E) (6)  
• MN Rules part 9505.0355  
• MN Rules part 9520.0790, subp. 5 (F) (I)  
• MHCP Provider Manual, Mental Health Services chapter  
• 42 CFR 438.236  
• NCQA guidelines |
| 22. Involvement of the member and the member’s family in assessment, service preferences, and referrals to services are documented. | There is documentation of involvement of the member and the member’s family in assessment, service preferences, and referrals to services required by statute or rule. “Family” means a person who is identified by the member or the member’s parent or guardian as being important to the member’s mental health treatment. Family may include, but is not limited to, parents, children, spouse, committed partners, former spouses, persons related by blood or adoption, or persons who are presently residing together as a family unit. **This standard applies to standard and extended diagnostic assessments, and adult diagnostic assessment updates.** | • 2022 DHS Families and Children contract, section 6.1.30  
• 2022 DHS MSHO/MSC+ contract, section 6.1.35  
• 2022 DHS SNBC contract, section 6.1.35  
• MN Rules part 9505.0370, subp. 14  
• MN Rules part 9505.0372, subp. (1) (B) (7), (C), (E) (6)  
• MHCP Provider Manual, Mental Health Services chapter |
<table>
<thead>
<tr>
<th>Element</th>
<th>Standard</th>
<th>Regulatory Requirement</th>
</tr>
</thead>
</table>
| 23. A *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition, text revision (DSM-5), diagnosis is documented. | A DSM-V diagnosis is documented, consistent with the presenting problems, history, mental status examination, and/or other assessment data. This standard applies to standard and extended diagnostic assessments, and adult diagnostic assessment updates. | • 2022 DHS Families and Children contract, section 6.1.30  
• 2022 DHS MSHO/MSC+ contract, section 6.1.35  
• 2022 DHS SNBC contract, section 6.1.35  
• MN Rules part 9505.0372, subp. 1 (B) (8), (C), (E) (7)  
• MN Rules part 9505.2175, subp. 2 (D) (3) (H)  
• MN Rules part 9520.0790, subp. 3, 5 (B)  
• MHCP Provider Manual, Mental Health Services chapter  
• NCQA guidelines |
| 24. Laboratory and other studies are ordered, as appropriate. | The results of all diagnostic tests and examinations, consistent with the exam and assessment, must be documented in the mental health record. Documentation of the order for laboratory or X-ray services must also be in the record. | • MN Rules part 9505.2175, subp. 2 (D) (2) (I)  
• MN Rules part 9520.0790, subp. 5 (F)  
• NCQA guidelines |

### D. Treatment Plan

| 1. Treatment plans are consistent with diagnoses. | Treatment plans are consistent with diagnoses, based on the member’s current diagnostic assessment, and measurable objectives for the member. | • MN Rules part 9505.0370, subp. 15  
• MN Rules part 9505.0371, subp. 7  
• MN Rules part 9505.2175, subp. 2 (G) (H)  
• MN Rules part 9520.0790, subp. 4, 5 (D)  
• NCQA guidelines |
| 2. Treatment plans identify the needs and cultural influences of the member in developing goals. | Treatment plans are developed by identifying the member’s service needs and considering relevant cultural influences to identify planned interventions that contain specific treatment goals. | • MN Rules part 9505.0370, subp. 15  
• MN Rules part 9505.0371, subp. 7  
• MN Rules part 9505.2175, subp. 2 (G) (H)  
• MN Rules part 9520.0790, subp. 4, 5 (D)  
• NCQA guidelines |
<table>
<thead>
<tr>
<th>Element</th>
<th>Standard</th>
<th>Regulatory Requirement</th>
</tr>
</thead>
</table>
| 3. Treatment plans identify a target date. | Treatment plans contain measurable, time limited objectives for the member. | • MN Rules part 9505.0370, subp. 15  
• MN Rules part 9505.0371, subp. 7  
• MN Rules part 9505.2175, subp. 2 (G) (H)  
• MN Rules part 9520.0790, subp. 4, 5 (D)  
• NCQA guidelines |
| 4. Treatment plans include the main participants and information about recovery and resiliency. | Treatment plans should include the main participants in the treatment process, recommended services that are based on the diagnostic assessment, and other meaningful data that are needed to aid the member’s recovery and enhance resiliency are included, and a preliminary discharge plan, if applicable. | • MN Rules part 9505.0370, subp. 15  
• MN Rules part 9505.0371, subp. 7  
• MN Rules part 9505.2175, subp. 2 (G) (H)  
• MN Rules part 9520.0790, subp. 4, 5 (D)  
• NCQA guidelines |
| 5. Treatment plans are completed in a timely manner. | Treatment plans must be developed no later than the end of the first psychotherapy session after the completion of the member’s diagnostic assessment. | • MN Rules part 9505.0370, subp. 15  
• MN Rules part 9505.0371, subp. 7  
• MN Rules part 9505.2175, subp. 2 (G) (H)  
• MN Rules part 9520.0790, subp. 4, 5 (D)  
• NCQA guidelines |
| 6. There is documentation of provider consideration of member’s input into the treatment plan and any needed consultations. | There is evidence of provider consideration of member input into the proposed treatment plan, and in consultation with any specialists caring for the member. | • MN Rules part 9505.0370, subp. 15  
• MN Rules part 9505.0371, subp. 7  
• MN Rules part 9505.2175, subp. 2 (G) (H)  
• MN Rules part 9520.0790, subp. 4, 5 (D)  
• NCQA guidelines |
| 7. Informed consent for the individual treatment plan is documented. | The member must participate in the development of the treatment plan and should sign the initial plan and sign all subsequent revisions before treatment begins. For a minor or adult unable to give consent, the parent or legal representative has signed. If the member or authorized person refuses to sign the plan or a revision of the plan, the mental health provider shall note on the plan the refusal to sign the plan and the reason(s) for the refusal. | • MN Rules part 9505.0371, subp. 7  
• MN Rules part 9520.0790, subp. 4  
• NCQA guidelines |
<table>
<thead>
<tr>
<th>Element</th>
<th>Standard</th>
<th>Regulatory Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Treatment plan is reviewed and signed at least once every 90 days.</td>
<td>The treatment plan must be reviewed and signed at least once every 90 days and, if necessary, revised. For a minor or adult unable to give consent, the parent or legal representative has signed. If the member or authorized person refuses to sign the plan or a revision of the plan, the mental health provider shall note on the plan the refusal to sign the plan and the reason(s) for the refusal.</td>
<td>• MN Rules part 9505.0371, subp. 7&lt;br&gt;• MN Rules part 9520.0790, subp. 4&lt;br&gt;• NCQA guidelines</td>
</tr>
<tr>
<td>9. There is ongoing documentation and medication reconciliation of prescribed medications.</td>
<td>Ongoing documentation and medication reconciliation of prescribed medications, including quantity, dosage (actual rather than prescribed), name of prescribed medication, and dates of initial or refill prescriptions, is clearly visible in the mental health record and listed in a composite form. Over-the-counter and herbal preparations should also be clearly noted. This standard applies to all treatment plans for medication management for prescribing providers.</td>
<td>• 2022 DHS Families and Children contract, section 6.1.30&lt;br&gt;• 2022 DHS MSHO/MSC+ contract, section 6.1.35&lt;br&gt;• 2022 DHS SNBC contract, section 6.1.35&lt;br&gt;• MN Rules part 9505.0372, subp. 1 (B) (1), (C), (D), (E)&lt;br&gt;• MN Rules part 9505.0371, subp. 9&lt;br&gt;• MN Rules part 9505.2175, subp. 2 (E)&lt;br&gt;• MN Rules part 9520.0790, subp. 5 (E)&lt;br&gt;• MHCP Provider Manual, Mental Health Services chapter&lt;br&gt;• NCQA guidelines&lt;br&gt;• PrimeWest Health standard</td>
</tr>
<tr>
<td>10. Evidence of informed consent for medication is documented.</td>
<td>The member must participate in the development of the medication treatment plan. Informed consent and the member’s understanding of treatment should be documented to include use, treatment alternatives, risks, and possible outcomes and side effects of treatment for each new medication ordered or for any dosage change in maintenance medication. For a minor or adult unable to give consent, the parent or legal representative must have signed. This standard applies to all treatment plans for medication management.</td>
<td>• MN Rules part 9505.0372, subp. 7&lt;br&gt;• MN Rules part 9520.0790, subp. 4&lt;br&gt;• NCQA guidelines&lt;br&gt;• PrimeWest Health standard</td>
</tr>
<tr>
<td>Element</td>
<td>Standard</td>
<td>Regulatory Requirement</td>
</tr>
<tr>
<td>---------</td>
<td>----------</td>
<td>-----------------------</td>
</tr>
</tbody>
</table>
| 11. Evidence of coordination of care with other relevant mental health providers and/or medical professionals must be documented. | As required for continuity and coordination of care, all mental health providers shall, when appropriate, convey pertinent information to members’ primary care provider, consulting practitioner, ancillary provider, or health care institution. This shall include medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. It is expected that timely updates will be provided regarding the member’s progress under continuing care. This standard excludes “psychotherapy notes,” which are defined as notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session. Psychotherapy notes must be separated from the rest of the individual’s health record to qualify as psychotherapy notes. Member authorization must be obtained prior to the release of any psychotherapy notes. If the member does not wish to have treatment information exchanged, the member’s refusal must also be documented. | • MN Rules part 9505.0371, subp. 6, 9  
• MN Rules part 9520.0790, subp. 1, 5 (G) (I)  
• MN Stat. sec. 144.293  
• MHCP Provider Manual, Mental Health Services chapter  
• 45 CFR 164.501  
• 45 CFR 164.506  
• 45 CFR 164.508  
• NCQA QI 4  
• NCQA guidelines |
| 1. Progress notes describe member strengths and limitations in achieving treatment plan goals and objectives. | Relevant updates to the member’s strengths, weaknesses, and barriers that enable or inhibit the member’s ability to achieve treatment goals and objectives should be noted and reflect treatment interventions that are consistent with those goals and objectives. Any education interventions, including medication and preventive education, should also be noted. | • MN Rules part 9505.2175, subp. 2 (G) (H)  
• MN Rules part 9520.0790, subp. 5 (D) (F)  
• NCQA guidelines  
• PrimeWest Health standard |
<table>
<thead>
<tr>
<th>Element</th>
<th>Standard</th>
<th>Regulatory Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Progress notes reflect current treatment interventions and mental status, including special status situations.</td>
<td>There is documentation in the progress notes to reflect treatment interventions that are consistent with current treatment plans, goals, and objectives. Documented interventions include continuity and coordination of care activities, as appropriate. Assessment of current mental status and special status situations includes, at a minimum, thought content. More specifically, imminent risk of harm to self or others, which includes suicidal and homicidal ideation, is documented in each visit progress note. If a risk level is documented other than reference to no risk of harm to self or others, the specific risk should be identified and an action plan put in place and documented.</td>
<td>• MN Rules part 9505.2175, subp. 2 (G) (H) • MN Rules part 9520.0790, subp. 5 (D) (F) • NCQA guidelines • PrimeWest Health standard</td>
</tr>
<tr>
<td>3. Encounter forms or notes include information about follow-up care, visits, calls, or as applicable, discharge plans. Specific time of return is noted in weeks, months, or as needed.</td>
<td>There must be notation in each entry about the need for follow-up care, plans for a return visit, or termination of treatment. Telephone encounters (phone contact) with people relevant to treatment (e.g., referral sources, physicians, or parents) must be documented in the mental health record and reflect practitioner review. The specific date or time frame of a return visit must be noted.</td>
<td>• MN Rules part 9505.2175, subp. 2 (G) • MN Rules part 9520.0790, subp. 5 (D) (F) (I) • NCQA guidelines • PrimeWest Health standard</td>
</tr>
<tr>
<td>4. Unresolved problems from previous visits are addressed in subsequent visits.</td>
<td>Continuity of care from one visit to the next is demonstrated when follow-up of unresolved problems from previous visits are documented in subsequent visit notes. The record must report the member’s progress or response to treatment and changes in the treatment or diagnosis.</td>
<td>• MN Rules part 9505.2175, subp. 2 (H) • MN Rules part 9520.0790, subp. 5 (D) (F) • NCQA guidelines</td>
</tr>
<tr>
<td>5. Note from consultant is present for each consultation requested.</td>
<td>Treatment records include consultation reports/summaries that correspond to specialist referrals, or documentation that the practitioner attempted to obtain reports that were not received.</td>
<td>• MN Rules part 4685.1110, subp. 13 (A) • MN Rules part 9505.2175, subp. 2 (F) • MN Rules part 9520.0790, subp. 5 (F) (I)</td>
</tr>
<tr>
<td>6. Consultation, laboratory, and imaging reports filed in the mental health record are initialed by the practitioner who ordered them to signify review.</td>
<td>All reports of consultation, laboratory, and imaging studies ordered are filed in the mental health record and are initialed by the practitioner who ordered them to signify review. Documentation of the order for service must also be in the mental health record. If reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Review and signature by professionals other than the ordering practitioner do not meet this requirement.</td>
<td>• MN Rules part 9505.0175, subp. 35 (B) • MN Rules part 9520.0790, subp. 5 (F) (I)</td>
</tr>
<tr>
<td>Element</td>
<td>Standard</td>
<td>Regulatory Requirement</td>
</tr>
<tr>
<td>---------</td>
<td>----------</td>
<td>------------------------</td>
</tr>
<tr>
<td>7. Clinically significant consultation and abnormal laboratory and imaging reports have an explicit notation of follow-up plans.</td>
<td>Clinically significant consultation and abnormal laboratory and imaging reports have an explicit notation of follow-up plans. Follow-up care, communication of test results, and calls/visits should be documented to indicate continuity of care. Subsequent visit notes and treatment plans reflect results of the reports as may be pertinent to ongoing care.</td>
<td>• MN Rules part 9505.0175, subp. 35 (A) (B) • MN Rules part 9520.0790, subp. 5 (F) (I) • PrimeWest Health standard</td>
</tr>
<tr>
<td>8. Discharge summaries are filed in the member’s record.</td>
<td>Discharge summaries for diagnostic and therapeutic services for which the member was referred, such as hospital discharge reports, specialty physician reports, home health nursing reports, and physical therapy reports, are found in the member’s record when applicable.</td>
<td>• MN Rules part 4685.1110, subp. 13 (A) • NCQA guidelines • PrimeWest Health standard</td>
</tr>
<tr>
<td>9. At the closing of the case, a statement of the reason for termination, current member condition, and the treatment outcome are documented.</td>
<td>A statement of the reason for the discontinuation of mental health services, dates that treatment begins and ends, current member condition, and the treatment outcome must be documented at the closing of the case.</td>
<td>• MN Rules part 9505.0371, subp. 8 (C) • MN Rules part 9520.0790, subp. 5 (H)</td>
</tr>
</tbody>
</table>
# Mental Health Record Review Tool

Facility name:  Provider ID:  Date:

Member name:  Member ID:  Member date of birth:

## A. Record Format

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
1. Elements in the mental health record are organized in a consistent manner.

| ☐   | ☐  | ☐  |
2. Member name is present on every page.

| ☐   | ☐  | ☐  |
3. Author identification is present for every entry.

| ☐   | ☐  | ☐  |
4. Each occurrence of service includes date, type of service, stop/start time, scope of the service, who gave service, and date of documentation.

| ☐   | ☐  | ☐  |
5. All entries are legible to someone other than the author.

| ☐   | ☐  | ☐  |
6. Medical and mental health providers can access each other’s notes through a fully integrated electronic health record (EHR).

## B. Record Content

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
1. Personal biographical data includes member address, employer or school, home and work phone numbers including emergency contacts, marital or legal status, appropriate consent forms, and guardianship information, if applicable.

| ☐   | ☐  | ☐  |
2. Member demographic data includes preferred language, sex, race, ethnicity, and date of birth.

| ☐   | ☐  | ☐  |
3. Health Care Directives and/or Advance Psychiatric Directives/declarations are documented in the mental health record for members age 18 and over.

| ☐   | ☐  | ☐  |
4. Member authorization to release private information and member information obtained from outside sources must be documented.

## C. Assessment

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
1. Diagnostic assessment includes a face-to-face interview.

| ☐   | ☐  | ☐  |
2. Reason for diagnostic assessment is documented.

| ☐   | ☐  | ☐  |
3. Type of diagnostic assessment is documented.

| ☐   | ☐  | ☐  |
4. Current life situation is documented.

| ☐   | ☐  | ☐  |
5. Maltreatment, trauma, or abuse issues are addressed.  *(Standard and extended diagnostic assessments)*

| ☐   | ☐  | ☐  |
6. A health history and family health history is documented.  *(Standard and extended diagnostic assessments)*

| ☐   | ☐  | ☐  |
7. Absence or presence of medication allergies and adverse reactions are prominently noted in the mental health record.  *(Standard and extended diagnostic assessments)*
8. A developmental history for members includes prenatal and perinatal events, along with a complete developmental history. 

(Standard and extended diagnostic assessments)

9. Cultural influences and their impact on the member are documented. 

(Brief, standard, and extended diagnostic assessments)

10. Current medications prescribed by all prescribing practitioners, as well as over-the-counter and herbal preparations are documented. 

11. A mental health treatment history is documented, including review of member’s records. 

(Brief, standard, and extended diagnostic assessments)

12. For members age 10 and over, there is appropriate notation concerning the past and present use of tobacco and alcohol, as well as illicit, prescribed, and over-the-counter drugs, and present caffeine use. 

(Standard and extended diagnostic assessments)

13. Standardized substance use screening questionnaire results are incorporated in the initial assessment of members age 12 and over. 

14. The CASII or ECSII, and the SDQ are utilized in the assessment of children receiving mental health services at intake, periodic review, and discharge planning. 

(Brief, standard, and extended diagnostic assessments)

15. Results of a mental status exam are documented. 

16. Special status situations are prominently noted. 

17. Member strengths and resources are documented 

(Standard and extended diagnostic assessments)

18. A clinical summary and provisional clinical hypothesis is documented. 

(Brief diagnostic assessments)

19. Assessment of member’s needs is documented. 

(Standard and extended diagnostic assessments, and adult diagnostic assessment updates)

20. Assessment methods are documented. 

(Standard and extended diagnostic assessments)

21. A clinical summary, recommendations, and prioritization of needed services are documented. 

(Standard and extended diagnostic assessments, and adult diagnostic assessment updates)

22. Involvement of the member and the member’s family in assessment, service preferences, and referrals to services are documented. 

(Standard and extended diagnostic assessments, and adult diagnostic assessment updates)

23. A DSM-5 diagnosis is documented. 

(Standard and extended diagnostic assessments, and adult diagnostic assessment updates)

24. Laboratory and other studies are ordered, as appropriate. 

D. Treatment Plan

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. Treatment plans include main participants and information about recovery and resiliency.

5. Treatment plans are completed in a timely manner.

6. There is documentation of provider consideration of member’s input into the treatment plan and any needed consultations.

7. Informed consent for the individual treatment plan is documented.

8. Treatment plan is reviewed and signed at least once every 90 days.

9. There is ongoing documentation and medication reconciliation of prescribed medications.

10. Evidence of informed consent for medication is documented.

11. Evidence of coordination of care with other relevant mental health providers and/or medical professionals must be documented.

**E. Progress Notes and Follow-Up**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Progress notes describe member strengths and limitations in achieving treatment plan goals and objectives.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Progress notes reflect current treatment interventions and mental status, including special status situations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Encounter forms or notes include information about follow-up care, visits, calls, or as applicable, discharge plans. Specific time of return is noted in weeks, months, or as needed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Unresolved problems from previous visits are addressed in subsequent visits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Note from consultant is present for each consultation requested.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Consultation, laboratory, and imaging reports filed in the mental health record are initialed by the practitioner who ordered them to signify review.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Clinically significant consultation and abnormal laboratory and imaging reports have an explicit notation of follow-up plans.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Discharge summaries are filed in the member’s record.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. At the closing of the case, a statement of the reason for termination, current member condition, and the treatment outcome are documented.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Elements met: percent (90 percent Performance Goal)

Review meets PrimeWest Health standards:

Forward to Quality and Care Coordination Committee (QCCC) for review:

Reviewer: Date:

Clinic representative: