PrimeWest HEALTH™
Your greater Minnesota health plan

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2026 Mental Health Record Documentation Standards

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

Element	Standard	Regulatory Requirement
A. Record Format		
1. Elements in the mental health record are organized in a consistent manner. All entries are legible to someone other than the author.	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 • MN Rules part 4685.1110, subp.13 (A) • MN Rules part 9505.2175, subp. 2 (A)
2. Member name is present on every page.	A separate mental health record is maintained for each unique member with the member's name present on every page. The author is also identified.	• MN Rules part 9505.2175, subp. 2 (B) (C) (4) • NCQA guidelines
3. 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 9505.2175, subp. 2 (C) (3) • MN Stat. sec. 245I.08, subd. 4
4. Medical and mental health providers can access each other's notes through a fully integrated electronic health record (EHR) and/or accommodate requests for appropriate record access.	Providers can 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 and 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 and legal status, appropriate consent forms, and guardianship information, if applicable. Member demographic data is documented in a prominent location in each mental health record and includes member's preferred language,	• NCQA guidelines • Title 45 Code of Federal Regulations (CFR) Part 170.207 (f) (g) • 45 CFR 170.315 (a) (5) (A)

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Member demographic data includes preferred language, sex, race, ethnicity, and date of birth.	sex, race, ethnicity, and date of birth. Documentation also includes whether a member declines to specify race, ethnicity, and/or a preferred language.	
2. Health Care Directives and/or Advance Psychiatric Directives/ Declarations are documented in the mental health record for members age 18 and over.	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. If not executed, there is documentation that Health Care Directive and/or Advance Psychiatric Directive/ Declaration information was offered. 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.	• 2026 Minnesota Department of Human Services (DHS) Families and Children contract, article 14 • 2026 DHS Minnesota Senior Health Options (MSHO)/Minnesota Senior Care Plus (MSC+) contract, article 14 • 2026 DHS Special Needs BasicCare (SNBC) contract, article 14 • MN Stat. sec. 145C.01 – 03 • MN Stat. sec. 253B.03 subp. 6d • MN Stat. sec. 253B.092 • 42 CFR 422.128 (b) (1) (ii) (E)
3. Member authorization to release private information and member information obtained from outside sources is documented.	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. No treatment information can be exchanged without member/legal representative authorization or court order.	• 2026 DHS Families and Children contract, article 13 • 2026 MSHO/MSC+ contract, article 13 • 2026 DHS SNBC contract, article 13 • MN Stat. secs. 144.292 – 144.294 • 45 CFR 164.510 • 45 CFR 164.522
C. Assessment		
1. Diagnostic assessment includes a face-to-face interview and the reason for the assessment. All assessments utilized to complete the diagnostic assessment are noted.	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. **This standard applies to all diagnostic assessments.** For adults, all assessment methods and use of standardized assessment tools (including a WHODAS 12 or 36 questions, questionnaire) by the provider…are documented. For children ages 5 – 18, completion of other assessment standards for children is documented.	• 2026 DHS Families and Children contract, article 6.1.31 • 2026 DHS MSHO/MSC+ contract, article 6.1.35 • 2026 DHS SNBC contract, article 6.1.37 • MN Stat. sec. 245I.10, subd. 6 (a) (b) • MN Stat. sec. 245I.10, subd. 6 (e) (3) • Minnesota Health Care Programs (MHCP) Provider Manual, Mental Health Services chapter

Element	Standard	Regulatory Requirement
2. Diagnostic assessment includes appropriate items including, but not limited to, relevant history, prior treatment, development, trauma, substance use, family history, and presenting symptoms.	There is documentation in the diagnostic assessment of these items to address any present or past experiences contributing to presenting concern and diagnosis.	• 2026 DHS Families and Children contract, article 6.1 • 2026 DHS MSHO/MSC+ contract, article 6.1 2026 DHS SNBC contract, article 6.1 • MN Stat. sec. 245I.10, subd. 6 (c) (4) • MHCP Provider Manual, Mental Health Services chapter
3. 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.	• 2026 DHS Families and Children contract, article 6.1.30 • 2026 DHS MSHO/MSC+ contract, article 6.1.35 • 2026 DHS SNBC contract, article 6.1.36 • MN Rules part 9505.2175, subp. 2 (E) • MN Stat. sec. 245I.10, subd. 6 (b) (5) • MHCP Provider Manual, Mental Health Services chapter • NCQA guidelines • PrimeWest Health standard
4. 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).	• 2026 DHS Families and Children contract, article 6.1.31 • 2026 DHS MSHO/MSC+ contract, article 6.1.35 • 2026 DHS SNBC contract, article 6.1.37 • MHCP Provider Manual, Mental Health Services chapter

Element	Standard	Regulatory Requirement
5. 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.	• 2026 DHS Families and Children contract, article 6.1.31 • 2026 DHS SNBC contract, article 6.1.37 • MHCP Provider Manual, Mental Health Services chapter
6. 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 is identified and an action plan put in place and documented. Continued assessment is documented in subsequent progress notes or follow-up visits.	• 2026 DHS Families and Children contract, article 6.1.31 • 2026 DHS MSHO/MSC+ contract, article 6.1.35 • 2026 DHS SNBC contract, article 6.1.37 • MN Stat. sec. 245I.10, subd. 6 (b) (6) • MHCP Provider Manual, Mental Health Services chapter • NCQA guidelines • PrimeWest Health standard
7. A clinical summary and provisional clinical hypothesis are documented and include an assessment of needs, recommendations, and prioritization of needed services. (Provisional clinical hypothesis should only be used for a brief diagnostic assessment.)	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. There is assessment of the member's needs based on the member's baseline measurements, symptoms, behavior, skills, abilities, resources, vulnerabilities, and safety	• 2026 DHS Families and Children contract, article 6.1.31 • 2026 DHS MSHO/MSC+ contract, article 6.1.35 • 2026 DHS SNBC contract, article 6.1.37 • MN Stat. sec. 245I.10, subd. 5 (c)(d), 6 (e) • MN Rules part 9505.0355 • 42 CFR 438.236 • MHCP Provider Manual, Mental Health Services chapter

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	needs. Documentation of clinical significance, functional impairment and the baseline of need at the start of treatment. There is documentation of a clinical summary, recommendations, and prioritization of needed mental health, ancillary, or other services. Recommendations or referrals for preventive or other external services, as appropriate.	
D. Treatment Plan		
1. 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 9505.2175, subp. 2 (G) (H) • MN Stat. sec. 245I.10, subd. 7, 8 • NCQA guidelines
2. Treatment plans identify a target date.	Treatment plans contain measurable, time limited objectives for the member.	• MN Rules part 9505.2175, subp. 2 (G) (H) • MN Stat. sec. 245I.10, subd. 7, 8 • NCQA guidelines
3. Treatment plans are completed in a timely manner.	After completing a member's diagnostic assessment and before providing services to the member, the license holder completes the member's individual treatment plan.	• MN Stat. sec. 245I.10, subd. 8 • NCQA guidelines
4. There is documentation of provider consideration of member's input into the treatment plan and any needed consultations. Informed consent for the individual treatment plan is documented.	The assessor consults the member and the member's family about which services the member and the family prefer. The participants involved in the member's treatment planning are identified. The member is a participant in treatment planning. If applicable, the license holder documents the reasons that the license holder did not involve the member's family or other natural supports in treatment planning	• MN Rules part 9505.2175, subp. 2 (G) (H) • MN Stat. sec. 245I.10, subd. 6 (f), 8 • NCQA guidelines
5. Treatment plan is reviewed and signed at least once every 180 days.	The member's individual treatment plan is reviewed every 180 days, and the individual treatment plan is updated with treatment progress, new treatment objectives and goals, or, if the member has not made treatment progress, changes in the license holder's approach to treatment are noted.	• MN Stat. sec. 245I.10, subd. 8 (6) • NCQA guidelines
6. For prescribing providers, there is ongoing documentation and medication reconciliation of prescribed medications. There is also evidence of informed consent on prescribed medications.	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 are also clearly noted.	• 2026 DHS Families and Children contract, article 6.1.31 • 2026 DHS MSHO/MSC+ contract, article 6.1.35 • 2026 DHS SNBC contract, article 6.1.37 • MHCP Provider Manual, Mental Health Services chapter

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	The member participates in the development of the medication treatment plan. Informed consent and the member's understanding of treatment are documented for 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 has signed.	• MN Stat. sec. 245I.10, subd. 8 • NCQA guidelines • PrimeWest Health standard
7. Evidence of coordination of care with other relevant mental health providers and/or medical professionals is documented.	As required for continuity and coordination of care, all mental health providers, 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 Stat. sec. 144.293 • MHCP Provider Manual, Mental Health Services chapter • 45 CFR 164.501 • 45 CFR 164.506 • 45 CFR 164.508
E. Progress Notes and Follow-Up		
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 are noted and reflect treatment interventions that are consistent with those goals and objectives. Any educational interventions, including medication and preventive education, are also noted.	• MN Rules part 9505.2175, subp. 2 (G) (H) • MN Stat sec. 245I.08, subd. 4 (5) • NCQA guidelines • PrimeWest Health standard

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2. Progress notes reflect current treatment interventions and mental status, including special status situations.	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 is identified and an action plan is put in place and documented.	• MN Rules part 9505.2175, subp. 2 (G) (H) • MN Stat. sec. 245I.08, subd. 4 (8) • NCQA guidelines • PrimeWest Health standard
3. Unresolved problems from previous visits are addressed in subsequent visits.	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.	• MN Rules part 9505.2175, subp. 2 (H) • NCQA guidelines
4. Consultation, laboratory, and imaging reports filed in the mental health record are initialed by the practitioner who ordered them to signify review.	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.	• MN Rules part 9505.0175, subp. 35 (B)
5. At the closing of the case, a statement of the reason for termination, current member condition, and the treatment outcome are documented.	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.	• MN Stat. sec. 245I.09, subd. 3 (10)