HIGHMARK. HEALTH OPTIONS

2025 PROVIDER MEDICAL RECORD STANDARDS – Behavioral Health Providers

1. INDIVIDUAL RECORD*	Each member's individual medical record is maintained separately.
2. MEMBER ID*	Each page in the record contains member name or member ID number.
3. BIOGRAPHICAL DATA*	Personal data includes address, employer, telephone numbers, emergency contact, marital status, etc.
4. ENTRY ID*	All entries include the responsible clinician's name, professional degree and relevant identification number, as appropriate.
5. ENTRY DATE*	All entries are dated.
6. LEGIBILITY*	The record is legible to someone other than the physician or physician's staff.
7. PSYCHOLOGICAL ASSESSMENT/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 prominently noted, documented and revised in compliance with protocol. A complete developmental history is documented for children and adolescents.
8. MEDICATION LIST*	Prescribed medications and dosages are documented on a medication list.
9. ALLERGIES OR ADVERSE REACTIONS*	In addition, presence/absence of allergies or adverse reactions to medications are prominently noted on each member chart. An absence of allergies should also be clearly documented in the record.
10. TOBACCO USE	Use/nonuse of tobacco products is documented on members age 12 and older.
11. ALCOHOL/DRUG USE	Use/nonuse of alcohol and illicit drugs is documented on members age 12 and older.
12. LAB, DIAGNOSTIC TESTS & OTHER STUDIES	Labs and other studies must be appropriate to the presenting complaint, or diagnosis.
13. WORKING DIAGNOSIS*	There is a clearly documented diagnostic impression by the practitioner that is consistent with findings for each member visit. The appropriate DSM diagnosis code is documented.
14. PLAN OF ACTION /THERAPIES /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.
15. 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.

16. CONSULTATION/REFERRALS/ CONTINUITY/COORDINATION 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.
17. DISCHARGE PLAN	If the member terminates treatment, documentation of a discharge plan is present.
18. CARE MEDICALLY APPROPRIATE	Documentation in the medical record describes the services provided to the member and demonstrates that medically appropriate care is being provided. Records reflect that members who become homicidal, suicidal or unable to conduct activities of daily living, receive immediate and relevant interventions (behavioral and pharmacotherapeutic), and are promptly referred to the appropriate level of care.
19. CONFIDENTIALITY	Each record contains copies of confidentiality statements/HIPAA forms and copies of all signed consents to release information.
20. TELEHEALTH VISIT CONSENT	For telehealth/virtual visits, the member's verbal consent must be documented in the member's medical record.

***Indicates Critical Factors**