

5122-27-01

Applicability.

(A) The provisions of the rules contained in this chapter are applicable to each provider:

(1) Providing mental health and addiction services that are funded by, or funding is being sought from:

(a) The Ohio medicaid program for community mental health or community addiction services.

(b) A board of alcohol, drug addiction, and mental health services.

(c) Federal or department block grant funding for certified services.

Any service contact provided by a provider that is paid for by the Ohio medicaid program for community mental health or community addiction services, or in whole or in part by any community mental health board of alcohol, drug addiction, and mental health service or federal or department block grant funding shall be subject to the provisions of this chapter.

(2) Subject to department certification as a driver intervention program according to section 5119.38 of the Revised Code.

(3) That voluntarily request certification.

(B) These rules do not diminish or enhance the authority of boards of alcohol, drug addiction, and mental health services to administer the community mental health or addiction treatment system pursuant to the Ohio Revised Code, and applicable federal law.

(C) The provisions of the rules contained in this chapter are applicable to all services certified by the department, except where specifically exempted and the following:

(1) 5122-29-07 Forensic evaluation service;

(2) 5122-29-08 Behavioral health hotline service;

(3) 5122-29-15 Self-help/peer support service;

(4) 5122-29-16 Consumer-operated service;

(5) 5122-29-18 Inpatient psychiatric service;

(6) 5122-29-19 Consultation service;

(7) 5122-29-20 Prevention service;

(8) 5122-29-21 Mental health education service;

(9) 5122-29-22 Referral and information service;

(10) 5122-29-27 Other mental health services;

(11) 5122-29-37 Detoxification program certification; and,

(12) 5122-37 Driver intervention programs.

(D) Additional requirements for individual client records (ICR) may be specified in Chapter 5122-26, Chapter 5122-29, or Chapter 3793 of the Administrative Code.

(E) Modified requirements for record keeping apply to the following services:

(1) Behavioral health hotline service shall maintain a log of all telephone calls including but not limited to the following information:

(a) Reason for call;

(b) Presenting problem;

(c) Disposition and/or referral(s) made;

(d) Date, time and person receiving call; and

(e) Name of caller, if given.

(2) Forensic evaluation service shall maintain records according to rule 5122-29-07 of the Administrative Code, including the requirement to:

(a) Provide a written summary of the forensic evaluation to the court or adult parole authority; and

(b) Store reports of forensic evaluations and any related records separately from records of persons served in other services.

(3) Prevention services. Each provider shall maintain documentation for prevention services provided, which shall include, at a minimum, the following:

(a) Date the prevention service was provided.

(b) Location where the prevention service was provided.

(c) Approximate number of consumers who received the prevention service.

(d) Types of prevention strategies/services provided.

(e) Description of activities conducted.

(f) Signature of an individual who is qualified to provide prevention services in accordance with this rule.

(4) Medical services provided pursuant to rule 5122-29-05 of the Administrative Code shall be shall be documented by progress notation or other results placed in the client's file.

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5122-27-02

Individual client record requirements.

(A) Each provider shall maintain a complete and adequate individual client record for each client.

(B) An individual client record shall mean the account compiled by health and behavioral health care professionals of information pertaining to client health, addiction, and mental health; including, but not limited to, assessment of findings and diagnosis, treatment details, and progress notes.

(C) Documentation of consent for treatment, refusal to consent, or withdrawal of consent, shall be kept in the individual client record.

Consent by minors shall be in accordance with sections 5122.04 and 3719.012 of the Revised Code.

(D) A provider shall include documentation regarding:

(1) Service fees;

(2) The individual's, or individual's parent or guardian, responsibility for payment.

Responsibility for payment includes any portion not covered by insurance or other funding source.

(E) Documentation to reflect that the client was given a copy of the following:

(1) Service or program expectations of clients, if applicable. Examples include required attendance, or maintaining a sober environment, and consequences if client does not meet expectations.

(2) Summary of the federal laws and regulations that indicate the confidentiality of client records are protected as required by 42 C.F.R. part B, paragraph 2.22, if applicable.

(F) Each authorization for release of information form signed by the client.

(G) If provided, documentation verifying the client's attendance at alcoholism and drug addiction client-education.

(H) Providers shall maintain treatment records for at least seven years after a client has been discharged from a program or services are no longer provided, and prevention records for at least three years.

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5122-27-03

Treatment planning.

(A) Each provider required by chapter 5122-27 of the Administrative Code to maintain an individual client record (ICR) for a certified service, shall also develop an individualized treatment plan (ITP) for each client.

(B) The development of the ITP is a collaborative process between the client and service provider based on a diagnostic assessment, a continuing assessment of needs, and the identification of interventions and services appropriate to the individual's diagnosis and other related needs. An AoD case management plan of care may be based upon the diagnostic assessment or a separate case management assessment.

(C) The ITP shall document, at minimum, the following:

(1) A description of the specific mental health or addiction services and supports needs of the client, including the AoD level of care if applicable;

(2) Anticipated treatment goals and objectives based upon the needs identified in this rule. Such goals shall be mutually agreed upon by the provider and the client. If these goals are not mutually agreed upon, the reason needs to be fully documented in the ICR;

(3) Name or description of all services being provided;

(4) Frequency and duration of treatment services;

(5) Documentation that the plan has been reviewed with the active participation of the client, and, as appropriate, with involvement of family members, parents, legal guardians or custodians or significant others;

(6) As relevant, the inability or refusal of the client to participate in service and treatment planning and the reason given;

(7) The signature of the agency staff member responsible for developing the ITP, the date on which it was developed, and documented evidence of clinical supervision of staff developing the plan, as applicable. Evidence of clinical supervision may be by supervisor signature on the ITP, or other documentation by the supervisor in the ICR; and,

(8) For clients receiving addiction services treatment, the level of care to which client is admitted.

(D) An initial ITP may be developed within seven days of completion of the assessment or at the time of the first face-to-face contact following assessment, whichever is later. An initial ITP is one which documents the immediate clinical needs of the client, and includes the items required of an ITP in paragraphs (C)(1) and (C)(3) of this rule to meet those immediate needs.

A provider may develop separate ITP and AoD case management plans or integrate the ITP and case management plan of care into one plan.

(E) The complete ITP must be completed within five sessions or one month of admission, whichever is longer, excluding crisis intervention mental health service provided in accordance with rule 5122-29-10 of the Administrative Code or pharmacologic management service provided as the least restrictive alternative in an emergency situation in accordance with rule 5122-29-05 of the Administrative Code.

(F) An AoD case management plan of care for a client receiving addiction services treatment shall be developed within seven days of completion of the assessment or at the time of the first face-to-face contact following assessment, whichever is later.

(G) The ITP shall be periodically reviewed at the client's request; when clinically indicated; when there is a change in the level of care; or when a recommended service is added, terminated, denied, or no longer available to the client.

(1) Documentation of review of an AoD case management plan of care or integrated plan shall be at least every ninety days, or as clinically indicated, if sooner.

Reviews of a case management plan of care shall be based upon a case management reassessment at least every ninety days.

(2) Documentation of the results of non-case management periodic review shall occur at least annually, and shall include:

(a) Evidence that the plan has been reviewed with the active participation of the client, and, as appropriate, with involvement of family members, parents, legal guardians or custodians or significant others;

(b) As relevant, the inability or refusal of the client to participate and the reason given; and

(c) The signature of the provider staff member responsible for completing the review, the date on which it was completed; and documented evidence of clinical supervision of staff completing the review, as applicable.

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5122-27-04

Progress notes.

(A) The provider shall document the progress or lack of progress toward the achievement of specified treatment goals identified on the ITP and the continuing need for services.

(B) Documentation of progress may be done through brief narrative or checklists. Such documentation shall provide sufficient detail to address all required components.

(C) Progress notes shall be documented either on a per provision of the service basis, or on a daily or weekly basis.

(D) Urinalysis testing is exempt from this rule.

(E) Service level progress notes shall include, at a minimum, the following:

(1) Client identification (name or identification number);

(2) The date, time of day, and duration of the service contact;

(3) The location of the service contact;

(4) A description of the service rendered;

(5) The assessment of the client's progress or lack of progress, and a brief description of progress made, if any;

(6) Significant changes or events in the life of the client, if applicable;

(7) Recommendation for modifications to the ITP, if applicable; and,

(8) The signature and credentials of the provider of the service and the date of the signature.

(F) Daily or weekly progress notes shall include, at a minimum, the following:

(1) Client identification (name or identification number);

(2) For daily progress notes, the calendar day the progress note is applicable to;

(3) For weekly progress notes, the weekly period, i.e. the continuous seven day period to which the progress note is applicable;

(4) The assessment of the client's progress or lack of progress, and a brief description of progress made, if any;

(5) Significant changes or events in the life of the client, if applicable;

(6) Recommendation for modifications to the ITP, if applicable; and,

(7) Date, original signature and credential of the staff member writing the daily or weekly progress note. The staff member must be qualified to provide all of the services documented in the daily or weekly service log.

(G) Client records utilizing daily or weekly progress notes must contain a service log that includes, at a minimum, the following:

(1) The date, time of day and duration of each service contact;

(2) The location of each service contact;

(3) A description of the service rendered; and,

(4) The signature and credential of each clinician who provided services during the day or week.

(H) Documentation in the progress note, or elsewhere in the individual client record, may include a notation addressing the client's risk of harm to self or others, including a review of the client's ideation, intent, plan, access, and previous attempts, if relevant.

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5122-27-05

Discharge summary.

(A) Each provider shall have policies and procedures addressing the completion of discharge summaries.

(B) The discharge summary shall include, but not be limited to, the following information:

(1) Date of admission of the client;

(2) Date of the last service provided to the client;

(3) Outcome of the service provided, i.e. amount of progress or the level of care;

(4) AoD level of care, if applicable;

(5) Recommendations made to the client, as appropriate to the ITP, including referrals made to other community resources;

(6) Medications prescribed by the agency upon the client's termination from service;

(7) Upon involuntary termination from service, documentation that the client was informed of their right to file an appeal; and

(8) Dated signature and credentials of the staff member completing the summary.

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5122-27-06

Release of information.

(A) Each request for information regarding a current or previous client shall be accompanied by an authorization for release of information, except as specified in sections 5119.27, 5119.28, and 5122.31 of the Revised Code.

(B) The authorization for release of information shall include, but not be limited to, the following:

(1) The full name of the client.

(2) Date of birth of the client.

(3) The specific information to be disclosed.

(4) The name of the person or entity disclosing the information.

(5) The name of the person or entity receiving the information.

(6) The date, event, or condition upon which the authorization shall expire.

(7) Statement that the consent is subject to revocation at any time except to the extent the provider or person who is to make the disclosure has already acted in reliance on it.

(8) The dated signature of the client or, as appropriate, a legally authorized agent and the agent's relationship to the client.

(9) For clients receiving addiction services treatment, the following statement:

"This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client."

(C) If the client is a minor, the release of information shall either:

(1) Be signed by the client's parent or legal guardian;

(2) In the case of providers who are certified to provide AoD treatment services, be signed by the client and the client's parent or legal guardian; or,

(3) In the case of providers who are certified to provide AoD treatment services and minor client's providing consent to treatment pursuant to section 3719.012 of

the Revised Code, the client shall sign the release of information.

(D) In the case of providers who are certified to provide AoD treatment services, when providing services to clients who are minors but who are not providing consent pursuant to section 3719.012 of the Revised code; the provider must either obtain the client's authorization to contact the client's parent or legal guardian or find the minor lacks in capacity to make a rational choice in accordance with 42 C.F.R. part 2.14(c)(2).

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5122-27-07

AoD level of care protocols.

(A) The purpose of this rule is to establish criteria for assessing the appropriate level of care for clients receiving addiction services treatment.

(B) The admission, continued stay, discharge, or referral to each level of care shall be based on the American society of addiction medicine criteria, also known as the ASAM patient placement criteria.

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TO BE RESCINDED

5122-27-08 **Release of information.**

- (A) Each request for information regarding a current or previous client shall be accompanied by an authorization for release of information, except as specified in section 5122.31 of the Revised Code.
- (B) The authorization for release of information shall include, but not be limited to, the following:
- (1) The full name of the client;
 - (2) Date of birth of the client;
 - (3) The specific information to be disclosed;
 - (4) The name of the person or entity disclosing the information;
 - (5) The name of the person or entity receiving the information;
 - (6) The date, event, or condition upon which the authorization shall expire, not to exceed six months from the date of its completion, unless documentation reflects that the client agrees to a longer authorization period;
 - (7) A statement notifying the client of his/her right to shorten or lengthen the authorization period, as well as his/her right to revoke the authorization at any time; and
 - (8) The dated signature of the client or, as appropriate, a legally authorized agent and the agent's relationship to the client.

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TO BE RESCINDED

5122-27-09

Security of clinical records systems.

- (A) Each agency shall have policies and procedures addressing the security of its clinical records system.
- (B) Policies and/or procedures for agencies maintaining a computer-based clinical records system shall include consideration of the following components:
- (1) Authentication - providing assurance regarding the identity of a user and corroboration that the source of data is as claimed;
 - (2) Authorization - the granting of rights to allow each user to access only the functions, information, and privileges required by his/her duties;
 - (3) Integrity - ensuring that information is changed only in a specific and authorized manner. Data, program, system and network integrity are all relevant to consideration of computer and system security;
 - (4) Audit trails - creating immediately and concurrently with user actions a chronological record of activities occurring in the system;
 - (5) Disaster recovery - the process for restoring any loss of data in the event of fire, vandalism, disaster, or system failure;
 - (6) Data storage and transmission - physically locating, maintaining and exchanging data; and
 - (7) Electronic signatures - a code consisting of a combination of letters, numbers, characters, or symbols that is adopted or executed by an individual as that individual's electronic signature; a computer-generated signature code created for an individual; or an electronic image of an individual's handwritten signature created by using a pen computer. Client record systems utilizing electronic signatures shall comply with section 3701.75 of the Revised Code.

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