CareSource

ADMINISTRATIVE POLICY STATEMENT
Nevada Marketplace

Policy Name & Number	Date Effective
Behavioral Health Service Record Documentation Standards-NV MP-AD-1535	11/01/2026
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statements contain supplemental information regarding standard benefit administration and coverage details. Administrative Policy Statements do not guarantee an authorization or payment of services. The Member's plan contract (e.g., Evidence of Coverage, Member Handbook) contains specific terms and conditions, including limitations, exclusions, benefit maximums, eligibility, and other relevant conditions of coverage. Except as otherwise required by law, if there is a conflict between the Administrative Policy Statement and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document. Reasonable discretion may be used in interpreting and applying this Policy Statement to services provided in a particular case, and the policy may be modified at any time. Policy Statements may be superseded by federal and state laws and regulations, as applicable. In the case of a discrepancy between the Policy Statement's effective date and any applicable legal or regulatory requirement, the law or regulation will govern.

Coverage for mental health and substance use disorder (MH/SUD) benefits are provided at the same level as coverage for medical and surgical (M/S) benefits, as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). MH/SUD benefits are not subject to limits or requirements that are more restrictive than those that apply to M/S benefits.

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A. Subject

Behavioral Health Service Record Documentation Standards

B. Background

Medical record documentation is a fundamental element required to support medical necessity and is the foundation for coding and billing. Documentation relays important information, such as, but not limited to, assessments completed, services provided, coordination of services, timeliness of care, plan of care/treatment, rationale for orders, health risk factors, progress towards goals on treatment plans, and responses to treatment. Chronological documentation of member care contributes to high-quality care and allows other healthcare professionals to plan treatment, monitor wellness and interventions over time, and ensures continuity of care.

Medical record documentation serves as a legal document that verifies care provided to members. Information in the record may be used to validate place(s) of service, medical necessity and appropriateness of diagnostics and/or therapeutic services provided, or that services provided have been accurately reported. According to the rules of the Mental Health Parity and Addictions Equity Act (MHPAEA), coverage for the diagnosis and treatment of behavioral health (BH) conditions will not be subject to any limitations that are less favorable than limitations that apply to medical or surgical conditions as covered under this policy.

Specific documentation requirements for applied behavior analysis for the treatment of autism is covered in a separate policy, including standards for evaluations, reviews of medical necessity, treatment plans, and discharge criteria. Centers for Medicare and Medicaid Services (CMS) provides additional guidance on services and record requirements, including behavioral health hotline services, evaluation, and prevention. This policy is a courtesy only. Federal and state legislation, including changes or revisions to law or individual state manuals, supersede this policy and might change prior to annual review of this policy.

C. Definitions

- **Behavioral Health (BH)** – A service or procedure performed for the diagnosis and treatment of mental, behavioral, substance use, or emotional disorders by a licensed professional or under the supervision of a licensed professional.
- **Valid Signature** – Signature of a provider for a service/order that is handwritten or electronic, legible, and can be validated by comparison to a signature log or attestation. Stamped signatures are permitted for individuals with a physical disability if that disability prevents written or electronic signatures.
- **Mental Health Parity and Addictions Equity Act (MHPAEA)** – A 2008 federal law that generally prevents group health plans and health insurance issuers who provide mental health and substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations than on medical/surgical (M/S) coverage.

D. Policy

I. Service Documentation Standards

A. General Requirements
Documentation adheres to standards set by federal, state, and CareSource requirements.
1. Every service reported must be within the scope of practice of the licensed professional with appropriate certification and/or training for the service who renders or supervises it and must be performed in accordance with any supervision requirements established in law, regulation, statute, or rule.
2. Each page of the record must be numbered, include the member's name, date of service, and be legible.
3. Records must include member diagnosis(-es) and legible signature, date, and credentials of practitioner.
4. Documentation must indicate that the service(s) billed was or were the service(s) provided.
    a. Timed services must document the total number of minutes (ie, start and stop time) with service code(s) and/or type of treatment. In addition to times, group services must also include
        01. Documentation to support that the member was present and participating at each session. If member is not present for the duration of the session, document start and stop times for the member.
        02. Relationships/name/credentials of other professionals present at each session.
        03. Number of participants in group therapy/treatment.
    b. Service codes and any applicable modifiers appropriate for the service and provider.
    c. Location of the service using the appropriate place of service code, or if rendered via tele-health, the location of the member and the location of the provider, as well as the modality of telehealth rendering the service.
5. Content of documentation must indicate the specific needs, intervention, and progress (or lack of) toward goals on the treatment plan. Duplication of notes is not acceptable documentation practice.
6. Documentation must reflect medical necessity for payment of services provided and the specific needs/desires of the member in the treatment plan.
7. Changes to documentation must include amendments, corrections or delayed entries that are easily identified and clearly visible.
    a. Electronic medical record changes must have a reliable way to identify original and modified content and the date and person modifying content.
    b. Paper medical record changes must be marked with a single line through the entry, labeled with 'error,' initialed and dated. No white out products may be utilized for any reason.

B. Consents
Consents must be maintained in the record and include consent to treatment, refusal to consent, or withdrawal of consent. All consents must be signed and dated.

C. Release(s) of Information (ROI)
ROIs must be valid (not expired), filled out completely with respect to requested elements, and consistent with requested information. Plain language must be

used, and the covered entity must provide the member with a copy of the signed authorization if seeking disclosure of protected health information. ROIs adhere to the standards set forth in 45 C.F.R. § 164.508 and, as applicable, 42 C.F.R. Part 2.

D. Referral Documentation
Referrals will support rationale for the referral and include to whom and for what specialty the member is referred. The record will demonstrate evidence of coordination of referrals and qualified provider review of documentation or collaboration with other medical professionals or qualified providers.

E. Laboratory testing documentation must support the rationale for test(s) requested. The record must include an order for the test, rationale for how results will guide treatment, evidence of qualified provider review of the results, and evidence of appropriate and timely follow-up regarding review of the results with the member.

F. Falsified Documentation
Deliberate falsification of medical records is a felony offense and viewed seriously when encountered. This includes creating new records, backdating or post-dating entries, writing over or adding to existing documentation, except as described in amendments, late entries, or corrections. Corrections to the medical record legally amended prior to claims submission and/or medical review will be considered in determining the validity of services billed. If changes appear in the record following payment determination based on medical review, only the original record will be reviewed in determining payment of services billed. Appeal of claims denied on the basis of an incomplete record may result in a reversal of the original denial if the information supplied includes pages or components part of the original medical record but not submitted on the initial review.

II. Service Specific Documentation Expectations

A. Diagnostic Assessments
Diagnostic assessments must include the following (not an all-inclusive list):

1. presenting problem and history of present illness including
   a. current symptoms, including onset
   b. changes in functional impairment or symptoms
   c. circumstances leading to evaluation
2. evaluation of comorbid physical health concerns/needs, medical history, and previous/current medications
3. member strengths
4. natural, community, and professional supports, where applicable
5. social determinant of health concerns/needs, where applicable
6. substance use history
7. past BH treatment, including past psychiatric medications
8. family and social history
9. review of organ systems/body areas depending upon the level of the examination performed and coded
10. allergies

11. standardized assessment tools, diagnostic testing results, and any interpretation, including any rating scales or member questionnaires
12. psychiatric assessment and mental status exam that includes, but not limited to, the following:
    a. description of member's judgment and insight
    b. orientation to time, place, and person, recent and remote memory, and mood and affect
    c. constitutional indications (eg, vital signs, general appearance)
    d. attitudes and behavior witnessed
    e. estimated intellectual, memory functioning, and orientation
13. summary, diagnosis, and plan

B. Treatment plan documentation must include all of the following:
1. type, amount, frequency, and duration of any and all needed and/or known treatment services
2. provider(s) of the services
3. goals for services that are
    a. mutually agreed upon (or refusal of member participation)
    b. age and developmentally appropriate
    c. quantifiable with target dates
    d. measurable with criteria for continued stay
    e. directly related to the admission reason
    f. relevant to the diagnostic assessment, testing, and/or screening
4. interventions to be used
5. frequency for review of the treatment plan (ie, must be appropriate for identified member needs and progress toward associated goals)
6. documentation that the treatment plan has been reviewed with the member and, as appropriate, family members, parents, legal guardians, or significant others
7. estimated length of stay or treatment
8. criteria for discharge or completion of the treatment plan

C. Progress Notes

Best practice standards require progress notes to be written within 24 hours of the clinical or therapeutic activity and signed and dated within 14 days. A physician or psychiatrist, physician assistant, or advanced practice nurse (APN) must see the member face-to-face daily during any residential stay and record a legible progress note for the session.

1. Outpatient progress notes must include the following:
    a. level of billed service requirements per service code guidelines, including start and stop times
    b. symptoms since last visit and current symptoms
    c. changes in family, social, or medical history
    d. mental status exam, including, but is not limited to
        01. description of member judgment and insight
        02. orientation to time, place, and person, memory functioning, and mood and affect
        03. constitutional presence and general appearance

04. description of attitudes and behavior
05. estimate of intellectual functioning

e. rationale for changes in medications or other interventions
f. member progress and response to interventions toward goals identified on treatment plan
g. signature, credentials, and date of practitioner, including identification of any others present during the session

2. Inpatient notes for daily psychiatric care must include the following:
   a. level of billed service requirements per code guidelines, including any start/stop times, as applicable
   b. summary of occurrences since previous day and current symptoms
   c. review of response to medications, any known side effects, and prn utilization
   d. mental status exam including, but is not limited to
      01. description of member judgment and insight
      02. orientation to time, place, and person, memory functioning, and mood and affect
      03. constitutional presence and general appearance
      04. description of attitudes and behavior
      05. estimate of intellectual functioning
   e. rationale for changes in medications or other interventions
   f. member progress and response to interventions toward goals identified on treatment plan
   g. reason for continued stay
   h. signatures, credentials, date of practitioner, including identification of any others present during session, if applicable

D. Discharge Planning Standards and Documentation
   1. Discharge planning must include an assessment of the following (not an all-inclusive list):
      a. treatment included services addressing rehabilitation needs
      b. appropriate outpatient BH resource connections or referrals, including community BH resources
      c. scheduled follow-up appointments within 7-calendar days of discharge, and/or coordination of transportation to follow-up appointments
      d. medication reconciliation and/or prescriptions related to treatment available at discharge, if the qualified provider deems safe to do so
      e. transportation to the pharmacy scheduled, if necessary
      f. availability of appropriate services, including medical, meals, and household services
      g. need for and feasibility of specialized medical equipment or permanent physical modifications to the home
      h. capacity for self-care or availability of others to deliver care
      i. readmission risk or severity score
      j. member’s access to appropriate or referred services
      k. social determinants of health, including, but not limited to
         01. cognitive and functional status, including activity level

02. current home environment and suitability for member's condition
03. availability of appropriate family or community support
04. ability to obtain medications, meet nutritional needs, and participate in community services
05. potential barriers to care (eg, homelessness, telephone availability, transportation)

2. Discharge documents should detail the following information:
   a. provider(s) responsible for follow up care, including contact information (ie, names, phone numbers, websites, addresses) and appointment dates and times (BH follow-up recommended within 7 days of discharge)
   b. medical and BH information pertinent to illness and treatment and confirmation that post-discharge goals were provided to appropriate post-service providers
   c. coordination and/or referrals with the CareSource case manager, community agencies, and provider(s) responsible for follow up care
   d. instructions regarding medication reconciliation or management
   e. DME and/or supplies put in place prior to discharge
   f. crisis planning and copies provided to caregiver(s)/others(s), if needed

III. Supervision Documentation
Supervision documentation might vary according to state law. At a minimum, supervision documentation must include (not an all-inclusive list)
   A. date of supervision, type (ie, general, direct), and start/end times
   B. member identifying information, if applicable
   C. purpose and outcome of supervision, including any modification(s) to treatment interventions or the treatment plan
   D. if documenting for billing purposes, the National Provider Identifier number of the supervisor
   E. validation that supervision was rendered within the scope of the license or certification of the supervisor/supervisee
   F. name, credentials, date and signature of supervisor and supervisee

E. Conditions of Coverage
NA

F. Related Policies/Rules
Applied Behavior Analysis for Autism Spectrum Disorders – Medical Policy
Applied Behavior Analysis for Autism Spectrum Disorders – Reimbursement Policy
Medical Necessity Determinations
Medical Record Documentation Standards for Practitioners

G. Review/Revision History

	DATES	ACTION
Date Issued	05/21/2025	New policy. Approved at Committee.
Date Revised	07/29/2026	Periodic review. Removed service code descriptions and updated references. Approved at Committee.

Date Effective	11/01/2026	
Date Archived		

H. References

1. Alper E, O'Malley T, Greenwald J. Hospital discharge and readmission. UpToDate. Updated May 21, 2025. Accessed July 17, 2026. www.uptodate.com
2. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revised (DSM-5-TR).* American Psychiatric Association; 2022.
3. Bajorek S, McElroy V; Patient Safety Network. Discharge planning and transitions of care. Accessed July 17, 2026. www.psnet.ahrq.gov
4. Clinical documentation. American Psychiatric Association. Accessed July 17, 2026. www.psychiatry.org
5. Condition of Participation: Discharge Planning, 42 C.F.R. § 482.43 (2019).
6. Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2 (2024).
7. Individual Written Plan of Care, 42 C.F.R. § 456.180 (2024).
8. Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs, 42 C.F.R. §§ 441.150 -184 (2023).
9. Medical, Psychiatric, and Social Evaluations, 42 C.F.R. § 456.170 (2024).
10. *Nevada Marketplace Evidence of Coverage*. CareSource; 2026. Accessed July 17, 2026. www.caresource.com
11. Privacy of Individually Identifiable Health Information, 45 C.F.R. §§ 164.500-534 (2023).
12. Reports of Evaluations and Plans of Care, 42 C.F.R. § 456.181 (2024).