CareSource

ADMINISTRATIVE POLICY STATEMENT
Nevada Marketplace

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

Administrative Policy Statements are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

Administrative Policy Statements do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced in the Administrative Policy Statement. Except as otherwise required by law, if there is a conflict between the Administrative Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Behavioral Health Service 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 individuals. 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
      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 and include the member's name and date of service.
      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 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. Core elements of ROIs include the following:

1. a description of information to be used or disclosed that identified in a specific and meaningful fashion
2. name or other specific identification of the person(s) or group authorized to make the requested use or disclosure
3. name or other specific identification of the person(s) or group to whom the covered entity may make the requested use or disclosure
4. a description of each purpose of the requested use or disclosure (“At the request of the individual” is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.)
5. an expiration date or event that relates to the member or the purpose of the use or disclosure (“End of the research study,” “none,” or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research repository.)
6. signature of the member and date (If the authorization is signed by a personal representative of the individual, a description of such representative's authority to act for the individual must also be provided.)
7. required statements noted on ROIs that place a member on notice of the following:
    a. the member’s right to revoke authorization in writing, exceptions to revocation and how the member may revoke authorization
    b. the ability or inability to condition treatment, payment, enrollment or eligibility for benefit on the authorization
    c. the potential for information disclosed to be subject to redisclosure by the recipient and no longer protected by the ROI

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 physician review of documentation or collaboration with other physicians.

E. Laboratory testing documentation must support the rationale for test(s) requested. A member’s record must include an order for the test, rationale regarding how the results will aid or guide treatment, evidence of physician review of the results, and evidence of appropriate and timely follow-up regarding 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 these 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 that were part of the original medical record but were not submitted on the initial review.

II. Service Specific Documentation Expectations
   A. Diagnostic Assessments
      Diagnostic assessments must include the following:
      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 patient’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 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 least 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

3. Interactive Complexity
Interactive complexity (IC) is an add-on code specific for BH services that refers to communication difficulties during service delivery reported in conjunction with other codes only. Communication difficulties may include services with members who have other individuals legally responsible for care, those who request others to be involved during the visit, or those who require the involvement of other 3rd parties (eg, parole officers, school officials, child welfare agency personnel). IC may be reported when 1 of the following is present:
a. the need to manage maladaptive communication among participants complicates delivery of care
b. caregiver emotions or behaviors that interfere with implementation of the treatment plan
c. evidence or disclosure of a sentinel event and mandated report to a 3rd party (eg, abuse/neglect with report to state agency) with discussion of the event and/or report with member and other visit participants
d. use of play equipment, physical devices, interpreter, or translator to overcome significant language barriers

D. Discharge Planning Standards and Documentation
1. Discharge planning must include an assessment of the following:
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 physician 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 (SDoH), 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
   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
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		
Date Effective	01/01/2026	

The ADMINISTRATIVE Policy Statement detailed above has received due consideration as defined in the ADMINISTRATIVE Policy Statement Policy and is approved.

Date Archived		

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