CareSource

ADMINISTRATIVE POLICY STATEMENT
Indiana Medicaid

Policy Name & Number	Date Effective
Behavioral Health Service Record Documentation Standards IN MCD-AD-1073	11/01/2023-10/31/2024
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates 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 documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) 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, member's progress towards goals of the treatment plan, and response to treatment.

C. Definitions

- **Behavioral Health -** An umbrella term that includes mental health and substance use disorder conditions and developmental disabilities/delays, such as Autism.
- **General Supervision -** The supervisor must be available by telephone to provide assistance and direction if needed.
- **Direct Supervision -** The supervisor must be "immediately available" and "interruptible" to provide assistance and direction throughout the performance of the procedure but does not need to be present in the room when the procedure is performed.
- **A Valid Signature for Services Provided or Ordered -**
  - May be handwritten or electronic;
    - CMS permits stamped signatures if an individual has a physical disability and can prove to a CMS contractor an inability to sign due to that disability; and
  - Is legible or can be validated by comparing to a signature log or attestation statement.

D. Policy

I. General Service Documentation Standards

A. General Requirements

1. Each member must have their own medical record.
2. Documentation must be legible.
3. Each page of the record must include the member's name and date of service.
4. Multiple pages must be numbered.
5. Documentation must include:
   a. Diagnosis;
   b. Signature, date, and credentials of practitioner.
6. Documentation must indicate that the services(s) billed were the services provided.
   a. If service is based on a timed service, the total number of timed minutes and/or start and stop time with service codes/type of treatment is documented.
   b. If service is based on a group of members, the following is included:

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01. Documentation to support that the member was present at each session. If member is not present for the duration of the session, document start and stop time for the member.
02. Relationships/name/credentials of other professionals present at each session.
03. Number of participants in group therapy/treatment.

c. Service code/modifiers codes appropriate for service and provider.
d. The location of service using the appropriate Place of Service (POS) code and/or, if rendered via telehealth, the location of the member and the location of the provider, as well as the modality of telehealth used to render the service.

7. Content of documentation must indicate the specific needs, intervention, and progress toward the goals of the treatment plan for each service rendered. Duplication of notes is not acceptable documentation practice.
8. Documentation must reflect medical necessity for payment of services provided and the specific needs/desires of the member that are reflected in the treatment plan.
9. Changes to documentation
   a. Electronic Medical Record (EMR) changes
      01. Amendment, correction, or delayed entry is identified; and
      02. A reliable way to identify the original content, the modified content, and the date and person modifying the record is provided.
   b. Paper medical record changes:
      01. Change is clearly visible;
      02. White out is not utilized; and
      03. A single line is through an entry labeled with error, initialed, and dated.

B. Consents must be maintained in the medical record and include the following:
   1. Consent to treatment, refusal to consent, or withdrawal of consent; and/or
   2. Authorization for release of information; and
   3. Signature and date.
C. Referral Documentation
   1. Supports rationale for referral that includes who and what specialty member is referred to; and
   2. Demonstrates evidence of:
      a. Coordination of referrals to specialty practitioners; and
      b. Physician review of or documentation of collaboration notes.
D. Laboratory Testing Documentation
   1. Documentation supports rationale for test;
   2. An order for the test is present;
   3. How test results will guide treatment plan is evident;
   4. Evidence of physician review of results; and
   5. Evidence of appropriate timely follow up on test results with member.
E. Preventive Care Documentation include the following when appropriate:

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1. Evidence that preventive screenings/services were discussed, or referral placed;
2. Risk assessments are completed (i.e., substance use, suicide, depression); and
3. Crisis/safety plan.

II. Service Specific Documentation Expectations
   A. Diagnostic assessment documentation must include the following:
      1. Presenting problem and/or history of present illness
         a. Current symptoms,
         b. Changes in functional impairment or symptoms,
         c. Onset of symptoms,
         d. Circumstances leading to evaluation;
      2. Evaluation of comorbid physical health concerns/needs;
      3. Strengths-based assessment of member, where applicable;
      4. Identification of natural, community, and professional supports, where applicable;
      5. Evaluation of social determinant of health concerns/needs, where applicable;
      6. Substance use history;
      7. Past psychiatric/behavioral health treatment, including past psychiatric medications;
      8. Medical history;
      9. Past family and social history (PFSH);
      10. Review of organ systems/body areas depending upon the level of the examination performed and coded, where applicable;
      11. Current physical and behavioral health medications, including changes and prn medication utilization;
      12. Allergies;
      13. Standardized assessment tools/diagnostic testing, results, and interpretation (i.e., Clinical Institute Withdrawal Assessment or Alcohol (CIWA), Clinical Opioid Withdrawal Scale (COWS), Autism Diagnostic Observation Schedule (ADOS), Patient Health Questionnaire (PHQ), Columbia Suicide Severity Rating Scale (CSSRS) or Vanderbilt Diagnostic Rating Scales), if pertinent
      14. Psychiatric assessment and mental status exam that includes, but not limited to, the following:
         a. Description of patient's judgment and insight;
         b. Assessment of mental status, including orientation to time, place, and person, recent and remote memory, and mood and affect (i.e., depression, anxiety, agitation);
         c. Constitutional, including vital signs and general appearance;
         d. Attitudes and behavior described;
         e. Estimated intellectual and memory functioning and orientation; and
      15. Summary, diagnosis, and plan.

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NOTE: Significant or abnormal findings need to be described in a narrative format.

B. Treatment plan documentation must include all of the following:
   1. Type, amount, frequency, and duration of any and all needed/known treatment services;
   2. Provider of any and all needed/known treatment services;
   3. Goals for any and all needed/known treatment services. Goals must be
      a. Mutually agreed upon;
      b. Age-appropriate;
      c. Quantifiable with target dates;
      d. Measurable with criteria for continued stay;
      e. Directly related to the admission reason if applicable; and
      f. Relevant to the diagnostic assessment, testing, and/or screening;
   4. Interventions to be used;
   5. Frequency of review of the treatment plan. Frequency of review must be appropriate for the identified needs of the member and progress towards the associated goals;
   6. Documentation that the treatment plan has been reviewed with the patient and, as appropriate, with family members, parents, legal guardians, custodians, or significant others.

      NOTE: If the member is unable or refuses to participate in the treatment planning or services, document reason given.
   7. Estimated length of stay and/or course of treatment for any and/all treatments;
   8. Criteria for discharge from treatment and completion of the treatment plan;
   9. Applied Behavior Analysis (ABA) treatment plans must:
      a. Show a clear connection between the results of the behavioral assessment to the member specific goals. The goals must focus on identified areas of specific behaviors or targeted deficits. The goals must include baseline data, measurement, and mastery criteria to address the core deficits of Autism Spectrum Disorder (ASD); and
      b. Be based on member's other daily activities.

C. Inpatient/Outpatient psychiatric progress note includes the following as applicable:
   1. Per service code guidelines, documentation supports the specific requirements based on the level of service billed.
   2. Daily psychiatric inpatient progress note includes the following as applicable:
      a. Summary of what has occurred since previous day and current symptoms;
      b. Review of response to medications/side effects and prn utilization;
      c. Mental Status Exam, include, but is not limited to:
         01. Description of patient's judgment and insight;

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02. Assessment of mental status including orientation to time, place, and person, recent and remote memory, and mood and affect (i.e. depression, anxiety, agitation);
03. Constitutional including vital signs and general appearance;
04. Attitudes and behavior described;
05. Estimated intellectual and memory functioning and orientation.

d. Rationale for changes in medications or other interventions is clearly documented;
e. Reason for continued stay.

3. Outpatient psychiatric progress note includes:
   a. Symptoms since last visit and current symptoms;
   b. Changes in family, social or medical history;
   c. Mental Status Exam, include, but is not limited to:
      01. Description of patient's judgment and insight;
      02. Assessment of mental status including orientation to time, place, and person; recent and remote memory; and mood and affect (i.e. depression, anxiety, agitation);
      03. Constitutional including vital signs and general appearance;
      04. Attitudes and behavior described;
      05. Estimated intellectual and memory functioning and orientation;
   d. Rationale for changes in medications or other interventions is clearly documented.
4. All notes must be written on the date the service is rendered and signed and dated within 14 days per 410 IAC 17-15-1.
5. Interactive Complexity documentation must include:
   a. Evidence of communication factors that complicate the delivery of a behavioral health service during the delivery of the service. This may include:
      01. The need to manage maladaptive communication (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care;
      02. Caregiver emotions or behaviors that interfere with implementation of the treatment plan;
      03. Evidence or disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants;
      04. Use of play equipment, physical devices, interpreter, or translator to overcome barriers to diagnostic or therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language. This does not include billing solely for the purpose of translation or interpretation services.

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b. Evidence of interactions with others or interventions to overcome communication factors that complicate the delivery of a behavioral service during the delivery of the services. This may include:
   01. Interactions with individuals legally responsible for the care of a member, such as minors or adults with guardians;
   02. Interactions with others involved with the care of a member during the service, such as adults accompanied by one or more participating family members or interpreter or language translator. This does not include billing solely for the purpose of translation or interpretation services;
   03. Interactions other third parties, such as child welfare agencies, parole or probation officers, or schools.

D. Discharge plan documentation must include the following:
   1. A discharge planning evaluation including, but not limited to assessment of the following:
      a. Treatment regimen was established; services including addressing rehabilitation needs;
      b. Connections were made with appropriate outpatient behavioral health resources, including community behavioral health resources;
      c. Scheduled follow-up appointments within 7 calendar days of discharge, and/or coordinating transportation to follow-up appointments;
      d. Medication reconciliation occurred and prescriptions related to treatment regimen were available at discharge, and /or
      e. Two weeks' worth of medication was provided to the member at the time of discharge, and/or
      f. Transportation to the pharmacy was scheduled;
      g. Availability of appropriate services which would include services such as medical, meals, and household services;
      h. Need for and feasibility of specialized medical equipment, or permanent physical modifications to the home;
      i. Capacity for self-care, or alternatively to be cared for by others;
      j. Criticality of the appropriate services;
      k. Readmission risk score or severity score; and
      l. Member's access to appropriate services.
   2. A provider should review of social determinants of health (SDoH) when determining if member is ready for discharge including, but not limited to:
      a. Cognitive status;
      b. Activity level and functional status;
      c. Current home and suitability for member's condition (i.e. drug free environment);
      d. Availability of appropriate family or community support;
      e. Ability to obtain medications and services;
      f. Ability to meet nutritional needs;
      g. Potential barriers to care, such as homelessness and telephone availability;

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h. Availability of transportation for follow up care; and
i. Availability of community services.

3. Documentation should support the following discharge standards:
   a. A discharge plan that includes the provider(s) responsible for follow up care (the discharge planning evaluation should be used as a guide in the development of the discharge plan);
   b. All necessary medical and behavioral health information pertinent to illness and treatment, post-discharge goals of care was provided to the appropriate post-acute care service providers at the time of discharge;
   c. Coordination and/or referrals with the CareSource case manager, community agencies, and providers responsible for follow up care;
   d. Completion of medication reconciliation/management;
   e. Needed DME and supplies are in place prior to discharge;
   f. Scheduled appointments are listed with dates, times, names, telephone numbers and addresses (mental health practitioner follow-up is recommended within 7 days of discharge for members with a mental illness);
   g. Crisis plan and notation that copy was provided to caregiver; and
   h. Member/guardian and family engagement as needed.

III. Supervision Documentation Expectations
   A. General supervision documentation must include:
      1. Dates of supervision;
      2. Start and end times;
      3. Member identifying information;
      4. Purpose of supervision;
      5. Outcome of supervision, including any modification to treatment interventions and/or treatment plan;
      6. Name/credentials of the supervisor and, if documenting for billing purposes, the National Provider Identifier number of the supervisor;
      7. Type of supervision: general or direct;
      8. Validation that supervision was rendered within the scope of the license/certification of the supervisor/supervisee;
      9. Date and signature of supervisor/supervisee, including credentials.
   B. ABA Supervision documentation must include:
      1. Dates of supervision visit;
      2. Start and end times of visit;
      3. Names of individuals present at each session. If individual is not present for the duration of the visit, document start and stop time for that individual;
      4. Relationships/credentials of individuals present at each session;
      5. Review of services provided (number and type);
      6. Review of data that will form the basis of a continued treatment plan;
      7. Review of progress;
      8. Results of monitoring tools to note progress;
      9. Changes to treatment plan;

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10. Collaboration of care among providers; and
11. Date, signature, and credentials of treating provider.

IV. Falsified Documentation

A. Providers are reminded that deliberate falsification of medical records is a felony offense and is viewed seriously when encountered. Examples of falsifying records include:
   1. Creation of new records when records are requested;
   2. Back-dating entries;
   3. Post-dated entries;
   4. Writing over;
   5. Adding to existing documentation (except where described in amendments, late entries, or corrections).

B. 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.

C. 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.

E. Conditions of Coverage

NA

F. Related Policies/Rules

Medical Record Documentation Standards for Practitioners

G. Review/Revision History

	DATES	ACTION
Date Issued	04/28/2021	New Policy
Date Revised	05/11/2022 05/10/2023	Removed Covid red box and DOB; updated references Added section II.C.4. requiring signed and dated notes. Updated references. Approved at Committee.
Date Effective	10/01/2023	
Date Archived	10/31/2024	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

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

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