ADMINISTRATIVE POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Behavioral Health Service Record Documentation Standards-OH MCD-AD-1066	02/01/2025-02/28/2026
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 Record Documentation Standards-OH MCD-AD-1066

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. The Ohio Department of Medicaid (ODM) provides additional guidance on services and record requirements, including behavioral health hotline services, forensic evaluation, and prevention, located within the Ohio Administrative Code (OAC). This policy is a courtesy only. Any information published by the State of Ohio or ODM supersedes information in this policy.

C. Definitions

- **Audit** – A post payment examination, made in consideration of generally accepted auditing standards, of a provider's records and documentation to determine program compliance, the extent and validity of services paid for under the Medicaid program, and to identify any inappropriate payments.
- **Behavioral Health (BH)** – A service or procedure that is 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.
- **General Supervision** – A supervising practitioner (Ohio Administrative Code [OAC] 5160-8-05) available by telephone to a trainee to provide assistance as needed.
- ***Diagnostic & Statistical Manual of Mental Disorders*** **(DSM)** – The American Psychiatric Association's classification and diagnostic tool for behavioral health conditions. When the term DSM is referenced, it is specifically in reference to the

current version of the manual.

- **Direct Supervision** – A supervising practitioner (OAC 5160-8-05) being "immediately available" and "interruptible" to aid a trainee as needed.
- **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.
- **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.

D. Policy

I. General BH Service Standards

A. Every BH service reported on a claim 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.

B. Each provider will maintain a complete and adequate record for at least 7 years after discharge or service discontinuation for each client that includes an account compiled by health and BH professionals of client health, addiction, and mental health, including the following:

1. any assessment of findings, diagnosis, treatment details, and progress notes
2. documentation of consent for treatment, refusal, or withdrawal of consent
3. documentation regarding service fees and the client or parent/guardian responsibility for payment, including portions not covered by insurance or other funding sources
4. documentation that the client was given a copy of the following:
   a. service or program expectations of clients, if applicable (ie, required attendance, maintaining sober environment, consequences for not meeting expectations)
   b. summary of federal laws and regulations that indicate confidentiality of client records as protected as required by 42 C.F.R. § 2.22, if applicable
5. each authorization (or withdrawal) for release of information (ROI) form(s) signed by the client (see below for additional information)
6. documentation verifying client attendance at alcohol and drug addiction education, if provided

C. Deliberate falsification of medical records is a felony offense and can include the creation of new records when records are requested, back- or post-dating entries, writing over, and/or adding to existing documentation except as described in amendments, late entries and/or legitimate corrections. Corrections to the medical record legally amended prior to claim(s) 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. Changes to documentation must include the following:

1. Electronic medical records must clearly identify any amendments, corrections or delayed entries with the original content, modified content, and date/signature of person modifying the record clearly and reliably identifiable.
2. Paper medical record changes must also clearly identify any changes to original content. Use of 'white out' products is prohibited. A single line must be drawn through the original content with 'error' written above the content corrected. The person correcting the content must initial and date the marked through error.

II. Documentation Standards

A physician or psychiatrist, physician assistant, or advanced practice nurse (APN) must see the member face-to-face daily during any inpatient stay and record a progress note for the session. All inpatient and outpatient documents must have numbered pages, be legible, and contain the member's name on each page.

A. All Service Activity Notes, including Progress Notes

State required components must be included along with the following information:

1. dated signature of the provider, including licensure or certification where applicable, prior to claim submission
2. date and type of service at the top of each note
3. diagnosis(-es) listed in most current version of DSM consistent with member information (presenting problems, symptoms, history, mental status exam, assessment data)
4. exact start and stop times for service provision
5. reason for the service (eg, problem statement)
6. support for medical necessity that clearly outlines justification for the frequency or intensity of the service
7. evidenced-based treatment intervention summation that is clearly linked to member goals, behavioral health needs and diagnosis
8. member response to intervention and any provider observation(s)
9. summary or progress (or lack of) toward identified goals and any changes to the care plan accord to current needs
10. plan for ongoing treatment, which may include plans for the next session or service(s) needed
11. group notes must include relationships, names, and credentials (if applicable) of other professionals present at each session and the number of participants in the group therapy or treatment session

B. Release of Information (ROI) Forms

For records relating to mental health services, information from other providers

contained in the client record may be released with written authorization in accordance with OAC 5122-27-06. For addiction services records, information from other providers contained in the client record may be released only if written authorization explicitly authorizes both the disclosure of provider's records and the re-disclosure of the other provider's records.

C. Diagnostic Assessments

Significant or abnormal findings must be described. Assessments will include

1. presenting problem and/or history of present illness (eg, symptoms, including changes in and onset of, circumstances leading to evaluation)
2. medical information, including history, health concerns, current medications, and any allergies
3. behavioral health information, including psychiatric or BH history, previous treatment, medication history, and substance use history
4. strengths-based assessment of member, including identification of natural, community, and professional supports
5. family and social history
6. any standardized assessment tools, diagnostic testing, results, and interpretation, if applicable
7. mental status exam

D. Treatment Planning

Each client must have an individualized treatment plan (TP). Development is a collaborative process between the client and provider(s). TPs must

1. document that the member has the ability and capacity to benefit from treatment
2. be consistent with member diagnosis
3. include objectives and measurable goals directly related to diagnosis(-es) and identified problems
4. estimated timeframes for goal attainment, including frequency and duration of services
5. a preliminary discharge plan
6. documentation of review of plan with member, and, as appropriate, family members, parents, legal guardians or custodians or significant others or inability or refusal of member to participate in treatment planning

E. Referrals for Laboratory Testing or Other Services

Referrals for laboratory testing or other services must be documented in the medical record despite compliance by the member. Member records should document

1. order for test or written referral by appropriate medical professional
2. evidence of how test results or referral will guide treatment plan(s)
3. physician review of results, if applicable
4. documentation of timely follow-up with member regarding results, if applicable

E. Conditions of Coverage
NA

F. Related Policies/Rules
NA

G. Review/Revision History

DATES		ACTION
Date Issued	04/28/2021	New Policy
Date Revised	04/27/2022 05/10/2023 06/19/2024 10/23/2024	Removed date of birth on every page Added sec. II.C.4 on signed and dated progress notes; updated references. Approved at Committee. Annual review. Added MHPAEA info. Revised definitions (OAC). Updated D.I-II. & H. Approved at Committee. Out of cycle review. Deleted 6/19/24 additions from OAC per ODM. Approved at Committee.
Date Effective	02/01/2025	
Date Archived	02/28/2026	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.

H. References

1. Alper E, O'Malley T, Greenwald J. Hospital discharge and readmission. UpToDate. Updated February 3, 2023. Accessed June 3, 2024. 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 June 3, 2024. www.psnet.ahrq.gov
4. Clinical documentation. American Psychiatric Association. Accessed June 3, 2024. www.psychiatry.org
5. Community Behavioral Health Agency Services, OHIO ADMIN. CODE chapter 5160-27-01 to 13 (2024).
6. Definitions, 45 C.F.R. § 160.103 (2013).
7. Definitions, OHIO ADMIN. CODE 3701-59-01 (2020).
8. *Documentation Guidelines for Evaluation and Management Services.* Centers for Medicare & Medicaid Services; 1997. Accessed June 3, 2024. www.cms.gov
9. Individual Written Plan of Care, 42 C.F.R. § 456.180 (2024).
10. Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs, 42 C.F.R. §§ 441.150 - 441.184 (2023).
11. *Medicaid Behavioral Health State Plan Services Provider Requirements and Reimbursement Manual*. Ohio Dept of Medicaid. Updated December 22, 2023. Accessed June 3, 2024. www.medicaid.ohio.gov
12. Medicaid documentation for behavioral health practitioners. Centers for Medicare &

Medicaid Services. Accessed June 3, 2024. www.cms.gov

13. Medical, Psychiatric, and Social Evaluations, 42 C.F.R. § 456.170 (2024).
14. Minimum Requirements for Integrated Clinical Records, OHIO ADMIN. CODE Chapter 5160-22-01 to 07 (2019).
15. Privacy of Individually Identifiable Health Information, 45 C.F.R. § § 164.500 to 164.534 (2013).
16. Reports of Evaluations and Plans of Care, 42 C.F.R. § 456.181 (2024).
17. Requirements and Procedures for Behavioral Health Services, OHIO ADMIN. CODE Chapter 5122-29-01 to 31 (2023).
18. Review of Provider Records, OHIO ADMIN. CODE 5160-1-27 (2015).

Approved by Ohio Dept of Medicaid 11/07/2024