<table>
<tr><th colspan="2">ADMINISTRATIVE POLICY STATEMENT
Arkansas PASSE</th></tr>
<tr><th>Policy Name & Number</th><th>Date Effective</th></tr>
<tr><td>Behavioral Health Service Record Documentation Standards
AR PASSE-AD-1097</td><td>07/01/2026</td></tr>
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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

B. Background
Medical record documentation is a fundamental element required to support medical necessity and is the foundation for coding and billing. Chronological documentation of member care contributes to high quality care, allows other healthcare professionals to plan treatment and 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 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.

C. Definitions
- **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.
- **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.
- **Plan of Care** – A document used to plan, direct, and deliver care to meet specific measurable goals; may also be called a care plan, service plan, or treatment plan.
- **Substance Abuse and Mental Health Services Administration (SAMHSA)** – The agency within the US Dept of Health and Human Services that leads public health efforts to advance the behavioral health of the nation.
- **Valid Signature** – A signature by a healthcare professional for ordered or provided services that may be handwritten or electronic, and legible or able to be validated by comparison to a signature log or attestation statement. Stamped signatures are permitted for providers diagnosed with physical disabilities who can prove that the disability prevents them from signing, if requested.

D. Policy
I. General Provisions

A. General Service Record Documentation Guidelines

1. Covered services may be billed only after the service has been provided. All services must be medically necessary.
2. Documentation substantiates the claim submitted for each service.

3. Documentation adheres to the standards set by federal, state, and CareSource requirements.
4. Records are legible, complete and accurate, and fully disclose the nature and extent of services provided. Illegible handwritten records are not valid proof of service and may result in recoupment.
5. Prescriptions and provider orders are obtained within 5 business days of the date written. A verbal order is documented by a written prescription within 14 business days of the date the prescription is written or received.
6. If a provider maintains more than 1 office, the provider must designate a "home" office where original records are maintained. Copies of records must be maintained at service delivery sites.
7. Records will be retained for 10 years from the date of service or until all audit questions, reviews, appeal hearings, investigations, or administrative or judicial litigation to which the records may relate are concluded, whichever period is later.
8. Changes to documentation must be completed in the following manner:
   a. Electronic medical record (EMR) changes: All amendments, corrections, and delayed entries must be easily identifiable via a reliable manner to identify original content, modified content, and the date and person modifying the record.
   b. Paper medical record changes: Changes must be clearly visible with a single line drawn through an entry labeled with "error," initialed, and dated by the person making the change. White out or similar products may not be used for corrections.
9. Falsified documentation includes creating new records when records are requested, backdating or postdating entries, writing over records or information, or adding to existing documentation except as described in amendments, late entries, or corrections.
   a. Corrections legally amended prior to claims submission or medical review will be considered in determining the validity of services billed. If the changes appear in the record following payment determination, only the original record will be considered in determining payment.
   b. Appeal of claims denied based on an incomplete record may result in a reversal of the denied claim if the information supplied includes components that were part of the original record but were not submitted on the initial review.

B. Other Supporting Documents
   1. Release(s) of Information (ROI) 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 individual 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.
   2. Primary Care Provider (PCP) referrals may be only for medically necessary services, supplies or equipment and must be documented in the medical

record. Referrals must meet requirements in Section 171.400 of the *Arkansas Medicaid Provider Manual, Section I*.

NOTE: Referral requirements may vary by program as specified in the *Arkansas Medicaid Provider Manual*.

3. Other referrals or recommendations for services must be adequately and timely documented in the medical record and include member barriers, assistance provided, and compliance or refusal of the request or referral. Referrals may include but are not limited to:
   a. counseling services (eg, day treatment or family, group, or individual treatment)
   b. treatment for physical or medical issues or other preventive services or screenings
   c. treatment in inpatient, residential, or emergency settings, including substance abuse treatment
4. Laboratory testing must be supported in the medical record by a rationale for the test(s) requested. The medical record must include **ALL** the following:
   a. order for the test by a qualified provider
   b. rationale regarding how the results will aid or guide treatment
   c. evidence of provider review of the results
   d. evidence of appropriate and timely follow-up regarding the results with the member

II. Diagnostic and Assessment Services
   A. Mental Health Diagnosis, Substance Abuse Assessment, and Psychiatric Assessment documentation require **ALL** the following:
      1. date of service with start and stop times of the face-to-face encounter with the member and interpretation time for diagnostic formulation
      2. place of service
      3. identifying information and referral reason
      4. presenting problem and history of presenting problem including duration, intensity, and response to prior treatment
      5. culturally and age-appropriate psychosocial history and assessment
      6. mental status and clinical observations and recommendations
      7. current functioning and strengths in specified life domains
      8. *DSM* diagnostic impressions and treatment recommendations
      9. staff signature, credentials, date of signature
   B. Mental Health Diagnosis documentation must also include **ALL** the following:
      1. assessment to determine the existence, type, nature, and appropriate treatment of a BH disorder
      2. time spent obtaining necessary information for diagnostic purposes
      3. a face-to-face component serving as the basis for the recommended modality of treatment and plan of care
   C. Substance Abuse Assessment documentation must include **ALL** the following:
      1. identification and evaluation of the nature and extent of substance use using the Addiction Severity Index (ASI) or other approved instrument
      2. screening and identification of any co-morbid conditions

3. referral(s) to treat co-morbid conditions including a psychiatric consultation as indicated
4. recommendation of a treatment regimen and initial plan of care

D. Psychiatric Assessment documentation must include **ALL** the following:
   1. face-to-face diagnostic assessment to determine the existence, type, nature, and most appropriate treatment of a BH disorder if medically necessary
   2. interview that obtains or verifies the following:
      a. member understanding of the factors leading to the referral
      b. presenting problem including symptoms and functional impairments
      c. relevant life circumstances and psychological factors
      d. history of problems including treatment history and response to prior treatment
      e. medical history and examination as indicated
   3. for members under 18 years of age, an interview with a parent, guardian (including the DCFS caseworker if applicable), and/or the primary caretaker (including foster parent if applicable) to:
      a. clarify the reason for the referral and nature of current symptoms
      b. obtain a detailed medical, family, and developmental history
   4. time spent obtaining necessary information for diagnostic purposes

III. Psychological Evaluations

A. Documentation must substantiate that a licensed psychologist (LP), psychological examiner (LPE), or psychological examiner-independent (LPEI) met face-to-face with the member to complete an evaluation that included psychodiagnostic assessments of emotionality, intellectual abilities, personality, and/or psychopathology to establish differential diagnoses of behavioral or psychiatric conditions, particularly if
   1. member history and symptomatology are not readily attributable to a particular psychiatric condition
   2. questions to be answered could not be resolved by a psychiatric or diagnostic interview, observation in therapy, or by assessment for level of care at a mental health facility

B. Psychological evaluation documentation requirements include **ALL** the following:
   1. date of service with start and stop times of actual encounter with the member
   2. start and stop times of scoring, interpretation, and report preparation
   3. place of service and member identifying information
   4. rationale for referral and presenting problem(s)
   5. culturally and age-appropriate psychosocial history and assessment
   6. mental status and clinical observations and impressions
   7. tests used, results, and interpretations, as indicated
   8. *DSM* diagnostic impressions to include all axes
   9. treatment recommendations and findings related to rationale for service and guided by test results
   10. staff signature, credentials, date of signature

IV. Inpatient Services

A. Admission Evaluations are completed no later than 60 hours after admission and include **BOTH** a medical evaluation of the need for care by the facility-based attending or staff physician **AND** a psychiatric and social evaluation by the facility-based professional team personnel. Evaluations are placed in the medical record along with the plan of care no later than 14 days after admission and include **ALL** the following:
   1. diagnosis(-es)
   2. summary of present medical findings and medical history
   3. mental and physical functional capacity
   4. prognoses
   5. recommendation by a physician for **EITHER** of the following:
      a. admission to the facility
      b. continued care in the facility for individuals who apply for Medicaid while in the facility
   6. symptoms, complaints, and complications indicating the need for admission

   NOTE: The *Arkansas Medicaid Provider Manual, Section II: Inpatient Psychiatric* offers additional details on initial stay review, Certificate of Need (CON), emergency admission, and continued stay review
B. Plans of Care are completed no later than 14 days after admission, reviewed every 30 days, and must be a written plan to improve the member condition to the extent that inpatient care is no longer necessary. The Plan of Care is developed for the individual member by the facility-based team involving the member, parent(s), legal guardian(s), significant other(s), or family member(s) to the extent possible given member consent and constraints of confidentiality. Documentation must include **ALL** the following:
   1. type, amount, frequency, and duration of all treatment services
   2. provider(s) of each treatment service
   3. estimated length of stay and/or course of treatment
   4. objectives and goals for treatment services that are
      a. mutually agreed upon and developmentally appropriate
      b. measurable with target dates and criteria for continued stay, if appropriate
      c. directly related to the admission reason and diagnosis
      d. relevant to the diagnostic assessment, testing, and any completed screenings
   5. interventions or integrated program of care
   6. frequency of review that is appropriate for the identified needs of the member and progress toward goals
   7. reviewed every 30 days with the member and, as appropriate, the parent(s), guardian(s), significant other(s), or family member(s), including documentation of refusal of participation with reason given
   8. criteria for discharge and post-discharge plans
C. Progress Notes for daily psychiatric care include **ALL** the following:
   1. daily face-to-face encounter with a physician or psychiatrist, physician assistant, or advanced practice nurse including mental status exam, rationale

for changes in medication, member progress, and reason for continued stay or discharge
2. therapeutic interventions including start and stop times as applicable
3. medication administration including response, any known side effects, and prn utilization

D. Discharge Plan documentation must include **ALL** the following:
1. treatment regimen that addressed member needs
2. scheduled follow-up appointments within 7 calendar days of discharge with transportation scheduled for follow-up appointments
3. medication reconciliation, including prescriptions available at discharge or 2 weeks of medication provided to member, if physician deems safe to do so, with transportation scheduled for pharmacy
4. assessment of services needed, including medical, nutritional, household services, or any specialized medical equipment
5. capacity for self-care or availability of care from others
6. readmission risk
7. review of social drivers of health including cognitive and functional status, availability of support, potential barriers to care, and availability of community services
8. member receipt of information that includes **ALL** the following:
   a. provider(s) responsible for follow-up care including any scheduled appointments with dates, times, names, and contact information
   b. all necessary medical and BH information pertaining to illness and treatment, including post-discharge goals
   c. coordination and/or referrals with the CareSource coordinator, community agencies, or providers responsible for follow-up care
   d. medication reconciliation
   e. services and supplies in place prior to discharge
   f. any crisis plan and notation that copy was provided to caregiver(s), guardian(s), or family as needed

V. Outpatient Physician Services

A. Pharmacologic Management documentation substantiates a service that is tailored to reduce, stabilize, or eliminate psychiatric symptoms with the goal of improving functioning, including evaluation of medication prescription, administration, monitoring, and supervision, and includes **ALL** the following:
1. date and place of service with start and stop times of actual encounter with the member
2. diagnosis and pertinent interval history
3. history and physical examinations
4. chief complaint on each visit
5. tests with results
6. brief mental status and observations
7. rationale for treatment that coincides with the psychiatric assessment
8. the service or treatment provided at each visit including prescriptions and referrals

9. member response to treatment, including current progress and prognosis
10. revisions indicated for the diagnosis or medication(s)
11. plan for follow-up services including any crisis plans
12. off-label uses of medications by a physician other than a psychiatrist include consult with the overseeing psychiatrist within 24 hours of the written prescription
13. staff signature, credentials, date of signature

VI. Outpatient Counseling Services

A. Outpatient services are documented in accordance with the *Arkansas Medicaid Provider Manual* and consistent with best practice standards including:
1. documentation that is legible and concise
2. progress notes written within 24 hours of the clinical visit and signed and dated within 14 days
3. evaluation and triage of all member reports of suicidal or homicidal ideation or self-harm behavior including **ALL** the following:
   a. risk factors and protective factors
   b. assessment of thoughts, plans, behaviors, and intent
   c. intervention(s) to address the ideation and the safety plan
4. documentation individualized to the specific services provided (ie, duplicated notes are not allowed)
5. relationship of the services to the treatment plan
6. updates describing member progress
7. HIPAA-compliant communication

B. Outpatient service documentation includes **ALL** the following:
1. substantiation of the billed service
2. date of service with start and stop times of the encounter
3. participants in the session and relationship to the member
4. for group modalities, the number of participants present and the group topic
5. for crisis intervention and crisis stabilization, events leading up to the crisis admission, a clear resolution of the crisis and/or plans for further services, and a clearly defined crisis plan
6. place of service
7. diagnosis and pertinent interval history
8. brief mental status and observations
9. rationale and description of the treatment that coincides with the most recent intake assessment
10. member response to treatment
11. plan for the next session
12. staff signature, credentials, date of signature

VII. Arkansas Department of Human Services (DHS) provides additional guidance on services and record requirements, including program certification requirements, service definitions, appropriate places of service, allowable performing providers, and information on specialized programs (humanservices.arkansas.gov). This policy is provided as a courtesy only. Any information located in the *Arkansas Medicaid*

Provider Manual supersedes information in this policy, including updates that may occur prior to policy reviews.

E. Conditions of Coverage

NA

F. Related Policies/Rules

I. CareSource Policies and Manuals
   A. 2025-2026 CareSource PASSE Provider Manual
   B. Applied Behavior Analysis for Autism Spectrum Disorders
   C. Documenting Self Harm in Residential Settings
   D. Drug Testing

II. Other Applicable Documents or Rules
   A. *Arkansas Medicaid Provider Manual, Section I*: *General Medicaid Policy*
   B. *Arkansas Medicaid Provider Manual, Section II*
      1. Counseling and Crisis Services
      2. Diagnostic and Evaluation Services
      3. Inpatient Psychiatric Services for Under Age 21
      4. Physician
      5. Psychiatric Residential Treatment Facility Services for Under Age 21
   C. Basic Hospital Functions, Condition of participation: discharge planning, 42 C.F.R. § 482.43 (2025).
   D. Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2 §§ 2.1 to 2.68 (2024).
   E. Electronic Records and Signatures, ARK. CODE ANN. § 25-31-103 (2024).
   F. Inpatient Psychiatric Services for Individuals Under Age 21, 42 C.F.R. §§ 441.150 to 441.184 (2023).
   G. Medical, Psychiatric, and Social Evaluations, 42 C.F.R. § 456.170 (2017).
   H. Privacy of Individually Identifiable Health Information, 45 C.F.R. §§ 164.500 to 164.534 (2024).
   I. Rules for Hospitals and Related Institutions, ARK. CODE R. 20 § 41-114 (2024).

G. Review/Revision History

DATES		ACTION
Date Issued	04/28/2021	New Policy
Date Revised	07/06/2022	Additions in D.I.F PCP referral is not required for BH services; Removed MTP; Added II.A. 16-18 & II.B 9 Sec. c-e; Added NCSS; updated references.
	05/10/2023	Added sec. II.C.4 on signed and dated progress notes. Updated references. Approved at committee
	06/19/2024	Annual review. Added MHPAEA info. Rewrote based on AR DHS provider manuals. Updated references. Approved at Committee.
	09/25/2024	Out of cycle review. Added D.I.B.2.b. Approved at Committee.

	04/08/2026	Periodic review. Formatting revised for clarity and conciseness; D.I.A.2 replaced service code descriptions; added D.IV.C and D.VI.A.3. Updated references. Approved at Committee.
Date Effective	07/01/2026	
Date Archived		

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3. Bajorek S, McElroy V; Patient Safety Network. Discharge planning and transitions of care. Accessed March 13, 2026. www.psnet.ahrq.gov
4. Medicaid documentation for behavioral health practitioners. Centers for Medicare & Medicaid Services. Accessed March 13, 2026. www.cms.gov
5. SAFE-T suicide assessment five step evaluation and triage. PEP24-01-036. Substance Abuse and Mental Health Services Administration. Updated December 2024. Accessed March 13, 2026.