

Clinical Policy: Behavioral Health Treatment Documentation Requirements

Reference Number: CP.BH.500

Date of Last Revision: 05/24

[Coding Implications](#)

[Revision Log](#)

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Description

Documentation in a medical record facilitates patient safety, decreases error, improves quality of care, and ensures regulatory and reimbursement compliance. Behavioral health services must meet specific requirements and be documented in a manner that adheres to applicable regulations, accreditation standards, and professional practice standards.

Policy/Criteria

- I. It is the policy of Centene Advanced Behavioral Health and health plans affiliated with Centene Corporation[®] that behavioral health treatment records must contain at a minimum all the following elements, in addition to any state required components:
 - A. All entries in the treatment record are legible to another person other than the writer, dated and signed/authenticated (including licensure and/or certification) by the rendering provider prior to submission of the claim;
 - B. Member/Enrollee's name is documented on each page;
 - C. Date of service (DOS) is documented at the top of each note and no less frequently than on each page;
 - D. Diagnosis listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders is consistent with the following:
 1. Member/enrollee's presenting problems;
 2. Symptom history;
 3. Mental status examination;
 4. Other assessment data;
 - E. Type of service that will be provided;
 - F. Exact start and stop times of the service;
 - G. Reason for service (problem statement);
 - H. Support for medical necessity that clearly outlines justification for frequency/intensity of requested services;
 - I. Clear clinical/therapeutic interventions and member/enrollee response to the interventions;
 - J. Interventions are clearly linked to the member/enrollee's goals, behavioral health needs, and diagnosis;
 - K. Interventions are related to evidence-based treatment;
 - L. Summary of progress or lack of progress toward identified goals, with care plan changed accordingly to meet the current need;
 - M. Plan for ongoing treatment (i.e., the plan for the next session);
 - N. Treatment plans meet all the following:
 1. Consistent with member/enrollee diagnoses;
 2. Includes objective, measurable goals and estimated timeframes for goal attainment or problem resolution;

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3. Includes a preliminary discharge plan which is individualized to the specific member/enrollee.

Background

*The Centers for Medicare and Medicaid Services (CMS)*¹

Documentation often serves as the primary method of communication between practitioners to achieve continuity of care. Records that are not properly documented with all relevant and important facts can prevent the next practitioner from furnishing sufficient services. Unclear and inconsistent documentation can lead to unintended complications and gaps in care as well as denial of claims.

*National Alliance on Mental Illness (NAMI)*²

According to the National Alliance on Mental Illness (NAMI), millions of people across the country are affected by mental illness each year. In 2021, the number of adults in the United States who experienced a mental illness was estimated to be 22.8% (57.8 million). In addition, 5.5% (14.1 million) experienced serious mental illness and 7.6% (19.4 million) experienced a co-occurring substance use disorder and mental illness. Mental health treatment, therapy, medication, and self-care have made recovery a reality for most people experiencing mental illness. In 2021, 47.2% of US adults with a mental illness and 65.4% with a serious mental illness received treatment.

The Joint Commission

Documentation affects nearly every aspect of care, treatment, or services in behavioral health care. The list of documentation types and uses in this area is long and includes the following: Screenings and assessments to support the development of a plan of care, treatment, or services and to guide ongoing interactions with the individuals served. Plans to guide care, treatment, or services and progress notes to provide a means of communication among clinicians, staff, and individuals served (and their families/ guardians and significant others, as appropriate). Assessments, plans, and progress notes to justify interventions to third-party payers. Performance measurement data to help organizations identify potential or actual problems in their processes and to improve the quality of care, treatment, or services. Specific content required to meet regulatory and accreditation requirements.

The Joint Commission interfaces with the federal government and other stakeholders on key legislative, regulatory, and public policy issues to promote safe and high-quality health care. The organization published a book “Documentation of Care, Treatment, or Services in Behavioral Health Care and Human Services” to help both Joint Commission-accredited and non-accredited BHC organizations maintain documentation compliance and effectively use documentation to drive positive outcomes for all individuals served.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT[®]). CPT[®] is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2023, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage.

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Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
N/A	

HCPCS Codes	Description
N/A	

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed	04/22	06/22
Edited policy statement I to apply to Centene Advanced Behavioral Health as well as plans affiliated with Centene.	12/22	12/22
Annual Review. No changes made to criteria. References reviewed and updated.	06/23	07/23
Annual Review. No changes to criteria. Background updated. References reviewed and updated	05/24	05/24

References

- Centers for Medicare and Medicaid Services (CMS). Medical Documentation for Behavioral Health Practitioners. Published December 2015. Accessed online at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-behavioralhealth-factsheet.pdf> . April 15, 2024
- National Alliance on Mental Illness (NAMI). Mental Health by the Numbers. Updated April 2023. Accessed online at <https://www.nami.org/mhstats> . April 15,2024.
- The Joint Commission. Documentation of Care, Treatment, or Services in Behavior Health Care and Human Services, 2nd Edition. Published September 15, 2023. Accessed online at <https://store.jcrinc.com/assets/1/14/EBBH18SamplePages.pdf>.
- American Society of Addiction Medicine (ASAM). The Standards of Care for the Addiction Specialist Physician. https://downloads.asam.org/sitefinity-production-blobs/practice-support/asam-standards-of-care_81caf74b-f259-4f2a-82ea-8b27f3335a14.pdf?sfvrsn=338068c2_0. Published January 29, 2014. Accessed online at Accessed April 15, 2024.
- Dustman, R. American Academy of Professional Coders. Meet Documentation requirements for Psychotherapy Services. <https://www.aapc.com/blog/88200-meet-documentation-requirements-for-psychotherapy-services/>. Published May 26,2023. Accessed April 15, 2024.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical

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policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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