Clinical Policy: Behavioral Health Treatment Documentation Requirements

Reference Number: IN.CP.BH.500
Date of Last Revision: 11/25

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

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.[1]

Policy/Criteria

I. It is the policy of Managed Health Services that behavioral health treatment records must contain at a minimum all the following documentation requirements:
- 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. A mental health diagnosis meets criteria outlined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), and documentation includes the following:
  1. Member/enrollee's presenting problems;
  2. Symptom history;
  3. Mental status examination;
  4. Other assessment data;
- E. Certification of the mental health diagnosis by one of the following practitioners:
  1. A physician;
  2. A psychologist endorsed as a health service provider in psychology (HSPP);
  3. Licensed Clinical Social Worker (LCSW);
  4. Licensed Marriage and Family Therapist (LMFT);
  5. Licensed Mental Health Counselor (LMHC);
  6. Licensed Certified Addictions Counselor (LCAC);
  7. Advanced Practice Registered Nurse (APRN);
- F. Results of required screenings, assessments, or reassessments;
- G. Type of service provided;
- H. Rendering service provider;
- I. Length of time spent during each service;
- J. Reason for service (problem statement);
- K. Each service encounter is individualized to the member/enrollee and specific date of service;
- L. Support for medical necessity that clearly outlines justification for frequency/intensity of requested services;
- M. Review of relevant physical health medical records, as applicable;
- N. Medications prescribed, as applicable;

O. Support for medical necessity that clearly outlines justification for frequency/intensity of requested services;
P. Treatment plans/ Plan of care (POC) meet all the following:
   1. Plan for ongoing treatment (i.e., plan for next sessions) is consistent with member/enrollee diagnoses;
   2. Objective, measurable goals and estimated timeframes for goal attainment or problem resolution;
   3. Includes a preliminary transition/discharge plan which is individualized to the specific member/enrollee;
Q. Documentation indicates that one of the practitioners identified in I.E. provided supervision of the treatment plan and has met with member/enrollee during the following timeframes:
   ***Note**: All reviews must be documented in writing. A co-signature is not sufficient.*
   1. Within seven days of the intake process;
   2. During treatment, at intervals not to exceed 90 days;
R. Clear clinical/therapeutic interventions and member/enrollee response to the interventions;
S. Interventions are clearly linked to the member/enrollee's goals, behavioral health needs, and diagnosis;
T. Interventions are related to evidence-based treatment;
U. Summary of progress or lack of progress toward identified goals, with care plan changed accordingly to meet the current need;
V. Discharge summary, includes all of the following, as applicable:
   1. Summary of care, treatment, and services provided;
   2. Member/enrollee's condition at the time of discharge;
   3. Rationale/reason for discharge;
   4. Written discharge instructions including referrals, follow-up care, and medication regimen as applicable.

Background

The Centers for Medicare and Medicaid Services (CMS)[2]

Documentation often serves as the primary method of communication between practitioners to ensure ongoing patient needs are met. Federal and State laws also require practitioners to maintain the records necessary to "fully disclose the extent of the services," care, and supplies furnished to beneficiaries, as well as support claims billed. Each patient encounter needs to be documented completely, accurately, and in a timely manner. Records that are not properly documented with all relevant and key 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.

The Joint Commission[3]

The mission of The Joint Commission is to continuously improve health care for the public, in collaboration with other stakeholders, by inspiring healthcare organizations to excel in providing safe and effective care of the highest quality and value. "Documentation of Care, Treatment, or Services in Behavioral Health Care" is a book published by The Joint Commission to help organizations maintain compliance and effectively use documentation to drive positive outcomes for individuals served. Per The Joint Commission, documentation affects every aspect of care, treatment, or services and outlines the importance of accurate, timely, and appropriate documentation in behavioral health care.

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 2024, 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. 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	

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed.	11/23	11/23
Annual review. Updated description and background with no clinical significance. References reviewed and updated.	12/24	12/24
Annual review. Minor reformatting with no impact to documentation content. Added I.F. "Results of required screenings...". Added I.K. Each service encounter...". Added I.M. "Review of relevant physical health medical records, as applicable;". Added I N. "Medication prescribed..." ". Added I.V. "Discharge summary...". Background updated. References reviewed and updated	11/25	11/25

References

1. Wertheimer M. American Professional Agency (APA): Documentation in Behavioral Health. https://www.americanprofessional.com/wp-content/uploads/DocInBehavHealth_Psychologist_June2019.pdf?x23325. Published June 2019. Accessed November 19, 2025.
2. Centers for Medicare and Medicaid Services (CMS). Medical Documentation for Behavioral Health Practitioners. https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid- Integrity-Education/Downloads/docmatters-behavioralhealth-factsheet.pdf . Published December 2015. Accessed November 04, 2025.
3. The Joint Commission. Documentation of Care, Treatment, or Services in Behavioral Health Care and Human Service. https://store.jcrinc.com/documentation-of-care-treatment-or-services-in-behavioral-health-care-2nd-edition/. Published September 15, 2023
4. Indiana Family & Social Services Administration. Indiana Health Coverage Programs (IHCP). Provider Reference Module. Behavioral Health Services. Mental Health and Addiction Treatment. https://www.in.gov/medicaid/providers/files/modules/behavioral-health-services.pdf. Published June 19,2025. Accessed November 04,2025.
5. Indiana Administrative Code. Title 405. Article 1. Medicaid Services. Rule 20.405 IAC 5-20-8 Outpatient mental health services. http://iac.iga.in.gov/iac//iac_title?iact=405. Adopted January 22, 2025. Accessed November 04, 2025.
6. The Joint Commission. Standards and Elements of Performance. Website. https://publicstandards.tools.jointcommission.org. Effective Date July 1, 2025. Accessed November 4, 2025.
7. Managed Health Services Indiana. 2025 Provider manual. Accessed December 12, 2025. https://www.mhsindiana.com/providers/resources/guides-and-manuals.html

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 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 documentation, 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.

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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