ADMINISTRATIVE POLICY STATEMENT
Arkansas PASSE

Policy Name & Number	Date Effective
Behavioral Health Service Record Documentation Standards AR PASSE-AD-1097	10/01/2024
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 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. 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. 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, adult developmental day treatment services, and early intervention day treatment are covered in separate policies. Arkansas Department of Human Service (DHS) provides additional guidance on services and record requirements, including program certification requirements, service definitions, and information on specialized programs on the State website. Provider manuals also document appropriate places of service for service provision and allowable performing providers. This policy is provided as a courtesy only. Any information located in the Arkansas Provider Manuals supersede information in this policy, including updates that may occur prior to policy reviews.

C. Definitions

- **Diagnostic & Statistical Manual of Mental Disorders** – 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.
- **Individual Plan of Care (POC)** – A written plan developed for each member in accordance with 42 C.F.R. §§ 456.180-181 to improve conditions to the extent that inpatient care is no longer necessary.
- **Individually Identifiable Health Information** – Information that is a subset of health information, including demographic information collected from an individual, and
  - is created or received by a health care provider, health plan, employer, or health care clearinghouse.

  - relates to the past, present, or future physical or behavioral health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual
    - that identifies the individual
    - with respect to which there is a reasonable basis to believe the information can be used to identify the individual
- **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.
- **Protected Health Information** – Individually identifiable health information that is
  - transmitted by electronic media
  - maintained in electronic media
  - transmitted or maintained in any other form or medium
- **Substance Abuse and Mental Health Services Administration (SAMHSA)** – A 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, legible, or with ability to be validated by comparison to a signature log or attestation statement. CMS permits stamped signatures for providers diagnosed with physical disabilities, but the provider must prove to a CMS contractor an inability to sign due to that disability, if requested.

D. Policy

I. General Guidelines Related to BH Documentation and Supporting Documents

A. General Guidelines

1. Any covered service performed by a provider may be billed only after the service has been provided. All services must be medically necessary.
2. Each provider must complete and maintain accurate, original records fully disclosing the nature and extent of services provided. Records must exhibit the following characteristics:
   a. be legible and concise
   b. reflect names and titles of practitioners of the appropriate professional level for the service documented
   c. completely and accurately explain all evaluation and diagnosis(-es)
   d. support the level(s) of service billed
   e. document prescriptions, admission orders, physician orders, care plans, or other orders for service initiation as required by law or Medicaid rule, or obtain copies within 5 business days (BD) of the date written
   f. document a written prescription for any verbal orders within 14 BDs of the date the prescription is written or received
   g. maintain copies of each subsequent, relevant prescription(s)
   h. document compliance with all prescriptions and care plans

3. 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.
4. Records will be retained for 10 years from the date of service or until all audit questions, review issues, appeal hearings, investigations or administrative or judicial litigation to which the records may relate are finally concluded, whichever period is later.
5. All services must be culturally competent and congruent with the age and abilities of the member, client-centered, and strength-based with emphasis on needs as identified by the member.
6. 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.
7. Falsified Documentation
   Deliberate falsification of medical records is a felony offense can include the creation of new records when records are requested, backdating or post-dating entries, writing over records or information, or adding to existing documentation, except as described in amendments, late entries, or corrections. 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 based on medical review, only the original record will be reviewed in determining payment. 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 record but were not submitted on the initial review.

B. Other Supporting Documents
   1. Release(s) of Information (ROI)
      ROIs 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. Core elements of ROIs include the following:
      a. a description of the information to be used or disclosed that identified in a specific and meaningful fashion
      b. name or other specific identification of the person(s) or group authorized to make the requested use or disclosure
      c. name or other specific identification of the person(s) or group to whom the covered entity may make the requested use or disclosure

d. a description of each purpose of the requested use or disclosure (“At the request of the individual” is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.)
e. an expiration date or event that relates to member or the purpose of use or disclosure (“End of the research study,” “none,” or similar language is sufficient if the authorization is for use or disclosure of protected health information for research, including creation and maintenance of a research database or repository.)
f. signature of member and date (If the authorization is signed by a member’s representative, a description of authority to act for the member must be provided)
g. required statements placing a member on notice of the following:
    01. member right to revoke the authorization in writing, exceptions to revocation, and a description of how to revoke authorization
    02. ability or inability to condition treatment, payment, enrollment, or eligibility for benefit on the authorization
    03. potential for information disclosed to be subject to redisclosure by the recipient and no longer protected by the ROI

2. Referrals
    a. PCP Referrals may be only for medically necessary services, supplies or equipment. *All Providers Provider Manual* has additional guidelines. Some services do not require a PCP referral. If a referral is necessary, refer to the following:
        01. Referrals expire on the date specified by the PCP, upon receipt of the number/amount of services specified by the PCP, or in 6 months, whichever occurs first. (This requirement varies in programs. Applicable regulations are in the appropriate Arkansas Medicaid Provider Manuals.)
        02. There is no limit on the number of times a referral may be renewed, but renewals must be medically necessary and renewed at least every 6 months, unless specified differently in a program-specific manual.
        03. A member’s PCP determines whether it is necessary to see the member prior to writing or renewing a referral.
    b. Other referrals or recommendations for services
    Any referral or recommendation for services must be adequately and timely documented in the member’s medical record and include any member barriers, assistance provided, and compliance or refusal of the request or referral. This includes, but is not limited to, the following:
        01. recommendations for counseling services (eg, family, group, day treatment, individual)
        02. referral to a health professional for physical or medical issues or other preventive services or screenings
        03. referral to inpatient, residential, or emergency settings (eg, emergency department, acute stay), including substance abuse treatment

3. Laboratory testing documentation must support the rationale for test(s) requested. A member's record must include an order for the test, rationale regarding how the results will aid or guide treatment, evidence of physician review of the results, and evidence of appropriate and timely follow-up regarding the results with the member.
4. Treatment Planning
   Outpatient treatment plans (TP) will be signed by the mental health professional directing treatment and completed within 14 BDs of the Mental Health Evaluation/Diagnosis. TPs should be periodically reviewed with the member and treatment team when there is a significant change in member functioning or no less than 6 months from the last review. Inpatient plans of care must be written by a team of professionals to improve conditions to the extent that inpatient care is no longer necessary and must be reviewed every 30 days. Parents, legal guardians, significant others, or family members should participate in the process to the extent possible given member consent and constraints regarding confidentiality, if required. Documentation, at a minimum, must include the following:
   a. type, amount, frequency, and duration of any and all needed/known treatment services
   b. provider of any and all needed/known treatment services if different from the provider or team creating the plan
   c. objective/goals for all treatment services that are
      01. mutually agreed upon and developmentally and/or age-appropriate
      02. quantifiable and measurable with target dates and criteria for continued stay, if appropriate
      03. directly related to the admission reason and diagnosis
      04. relevant to the diagnostic assessment, testing, and any completing screening(s)
   d. interventions to be used or integrated programming for care
   e. frequency of reviews, which must be appropriate for identified needs of the member and progress toward associated goals
   f. documentation that the plan has been reviewed with the member and, as appropriate, family members, parents, legal guardians, custodians, or significant others, including documentation of refusal of participation in the medical record with reason given
   g. estimated length of stay and/or course of treatment
   h. criteria for discharge from treatment and post-discharge plans
5. Interactive complexity (IC) is an add-on code specific for BH services that refers to communication difficulties during service delivery and is reported in conjunction with other codes only. Communication difficulties may include services with members who have other individuals legally responsible for care, those who request others to be involved during the visit, or those who require the involvement of other 3rd parties (eg, parole officers, school officials, child welfare agency personnel).
   IC may be reported when 1 of the following is present:

a. the need to manage maladaptive communication among participants complicates delivery of care
b. caregiver emotions or behaviors that interfere with implementation of the treatment plan
c. evidence or disclosure of a sentinel event and mandated report to a third party (eg, abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with the member and other visit participants
d. use of play equipment, physical devices, interpreter, or translator to overcome significant language barriers

6. Discharge Planning
Discharge plan documentation must include the following:
a. A discharge planning evaluation including, but not limited to, assessment of the following:
01. treatment regimen services that addressed member needs
02. connections completed with appropriate outpatient resources, if needed, including scheduled follow-up appointments within 7-calendar days of inpatient discharges and/or coordinating transportation to follow-up appointments
03. medication reconciliation, including prescriptions available at discharge or 2 weeks medication provided to the member, if physician deems safe to do so, with transportation scheduled for pharmacy
04. assessment of appropriate services needed, including medical, nutritional, household services, or any specialized medical equipment
05. capacity for self-care or availability of care from others
06. readmission risk
07. a review of social determinants of health, including cognitive and functional status, availability of support, potential barriers to care, and availability of community services
b. Member receipt of information that includes the following:
01. provider(s) responsible for follow up care, if needed, including any scheduled appointments with dates, times, names and contact information
02. all necessary medical and BH information pertinent to illness and treatment, including any post-discharge goals
03. coordination and/or referrals with the CareSource care coordinator, community agencies, or providers responsible for follow up care
04. medication reconciliation or management documents or information as deemed appropriate by physician
05. services and supplies in place prior to discharge
06. any crisis plan and notation that copy was provided to caregiver(s), guardian(s), or family as needed

II. Diagnostic and Assessment Services
A. Mental Health Diagnosis- Outpatient

A clinical service for determining the existence, type, nature, and appropriate treatment of a BH disorder, including time spent obtaining necessary information for diagnostic purposes. The psychodiagnostics process may include, but is not limited to, a psychosocial and medical history, diagnostic findings, and recommendations and must include a face-to-face or telemedicine component serving as the basis for documentation of modality and issues to be addressed (plan of care). Minimum documentations requirements include

1. date of service with start and stop times of the face-to-face encounter with the member and the interpretation time for diagnostic formulation
2. place of service
3. identifying information and referral reason
4. presenting problem(s), history of presenting problem(s) including duration, intensity, and response(s) to prior treatment
5. culturally and age-appropriate psychosocial history and assessment
6. mental status (clinical observations and impressions)
7. current functioning plus strengths and needs
8. *DSM* diagnostic impressions and treatment recommendations
9. staff signature, credentials, date of signature

B. Substance Abuse Assessment

A service that identifies and evaluates the nature and extent of substance use using the Addiction Severity Index (ASI) or an assessment instrument approved by DHS that screens for and identifies existing co-morbid conditions and assigns a diagnostic impression resulting in treatment recommendations and/or appropriate referral to treat the diagnosis(-es) identified. Minimum documentation standards include 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(s), history of presenting problem(s) including duration, intensity, and response(s) to prior treatment
5. cultural and age-appropriate psychosocial history and assessment
6. mental status (clinical observations and impressions)
7. current functioning and strengths in specified life domains
8. *DSM* diagnostic impressions, treatment recommendations and prognosis
9. staff signature, credentials, date of signature

C. Psychiatric Assessment

A face-to-face psychodiagnostic assessment by a licensed physician or advanced practice nurse (APN), preferably with specialized training and experience in psychiatry (child and adolescent psychiatry for clients under 18 years of age) to determine the existence, type, nature, and most appropriate treatment of a BH disorder if medically necessary.

1. date of service with start and stop times of the face-to-face encounter with the member and the interpretation time for diagnostic formulation
2. place of service
3. identifying information and referral reason

4. interview that obtains or verifies the following:
   a. member's understanding of the factors leading to the referral
   b. the presenting problem (including symptoms and functional impairments)
   c. relevant life circumstances and psychological factors
   d. history of problems with treatment history and response to prior treatment
   e. medical history and examination as indicated
5. members under the age 18, an interview of a parent, guardian (including any responsible DCFS caseworker(s)), and the primary caretaker, including foster parents, as applicable, in order to
   a. clarify the reason for the referral & nature of current symptoms
   b. obtain a detailed medical, family, and developmental history
6. culturally and age-appropriate psychosocial history and assessment
7. mental status and clinical observations and impressions
8. current functioning and strengths in specified life domains
9. *DSM* diagnostic impressions and treatment recommendations
10. staff signature, credentials, date of signature

D. Admission Evaluation – Inpatient

Inpatient processes are different than those for outpatient services. The *Inpatient Psychiatric Services Provider Manual* offers additional details on prior authorization and concurrent review, Certification of Need (CON), emergency admission, and continued stay review. No later than 60 hours after admission, the facility-based team attending physician or staff physician must complete a medical evaluation of the need for care, and the appropriate facility-based team professional personnel must complete a psychiatric and social evaluation. Documentation to support both evaluations must be maintained in the member's record. Each medical evaluation must include:

1. diagnoses
2. summary of present medical findings and medical history
3. mental and physical functional capacity
4. prognoses
5. recommendation by a physician concerning either of the following:
   a. admission to the facility
   b. continued care in the facility for individuals who apply for Medicaid while in the inpatient psychiatric facility and
6. symptoms, complaints and complications indicating the need for admission

An original written report of each admission evaluation (medical, psychiatric, social) must be prepared by the facility-based team and placed in the member's records, along with the plan of care, no later than 14 days after admission.

E. Pharmacologic Management

This service is tailored to reduce, stabilize, or eliminate psychiatric symptoms, with the goal of improving functioning, including evaluation of the medication prescription, administration, monitoring, and supervision, as well as informing members regarding potential effects and side effects of medication(s) in order to make informed decisions regarding the prescribed medications. General documentation requirements include the following:

1. date of service with start and stop times of actual encounter withmember

2. place of service
3. diagnosis and pertinent interval history
4. brief mental status and observations
5. rationale for and treatment used that coincides with the psychiatric assessment
6. member's response to treatment, including current progress or regression and prognosis
7. revisions indicated for the diagnosis, or medication(s)
8. plan for follow-up services, including any crisis plans
9. if provided by physician who is not a psychiatrist, any off-label uses of medications should include documented consult with the overseeing psychiatrist within 24 hours of the prescription being written
10. staff signature, credentials, date of signature

F. Psychological Evaluation

Licensed psychologists, psychological examiners, and psychological examiners-independent may complete evaluations, including psychodiagnostic assessments of emotionality, intellectual abilities, personality, and psychopathology, face to face with members to establish differential diagnoses of behavioral or psychiatric conditions, particularly if member history and symptomatology are not readily attributable to a particular psychiatric condition or questions to be answered could not be resolved by a psychiatric or diagnostic interview, observation in therapy, or an assessment for level of care at a mental health facility. If testing results in a diagnosis of Autism Spectrum Disorder, the treating professional must document referral to an appropriate autism treatment provider. Minimum documentation requirements include the following:

1. date of service with start and stop times of actual encounter with the client
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 in all axes, if applicable
9. treatment recommendations and findings related to rationale for service and guided by test results
10. staff signature, credentials, date of signature(s)

G. Medication-Assisted Treatment (MAT) for Opioid Use Disorder (OUD)

Providers are required to follow SAMHSA guidelines for MAT services and encouraged to use telemedicine services when in-person treatment is not readily accessible. In accordance with SAMHSA guidelines, MAT requires at a minimum:

1. Initial evaluation and diagnosis of OUD, including
   a. drug screening to accompany proper medication prescribing (Buprenorphine monotherapy is typically reserved for pregnant women and those with a documented anaphylactic reaction to other MAT medications like Buprenorphine/Naloxone combinations.)
   b. lab screening tests for communicable diseases, as appropriate

c. use necessary consent forms for treatment and HIPAA compliant communication
d. execution of a Treatment Agreement or Contract, such as SAMHSA's sample treatment agreement
e. development of a person-centered treatment plan
f. referral for independent clinical counseling or a documented plan for an integrated follow-up visit, including counseling
g. identification of a MAT team member to function as a case manager to offer support services

2. Continuing treatment (first year) includes
   a. regular member outreach to determine assistance needs in accessing resources, providing information on available programs and supports in the community, and referrals as needed to other practitioners
   b. at least 1 follow-up MAT office visit per month for medication and treatment management
   c. drug testing in conjunction with each monthly visit
   d. at least 1 independent clinical counseling visit or a documented plan for an integrated follow-up visit, including counseling per month
3. Maintenance treatment (subsequent years) includes
   a. regular outreach to determine assistance needs in accessing resources, providing information on available programs and supports in the community, and referrals as needed to other practitioners
   b. at least 1 follow-up MAT office visit quarterly for medication and treatment management
   c. drug testing in conjunction with each quarterly visit
   d. at least 1 independent clinical counseling visit or a documented plan for an integrated follow-up visit, including counseling at an amount and duration medically necessary for continued recovery

III. Outpatient Counseling Service Progress Notes

Best practice standards from Centers for Medicare and Medicaid Services require progress notes to be written within 24 hours of the clinical or therapeutic activity and signed and dated within 14 days.

A. General Provisions

Providers must develop and maintain sufficient written documentation (eg, documenting 'homicidal ideation,' 'suicidal ideation,' 'self-harm' without additional clarifying clinical information is not considered sufficient) to support each medical or remedial therapy, service, activity, or session for which reimbursement is sought. This documentation, at a minimum, must:

1. be individualized and specific to services provided (ie, duplicated notes are not allowed)
2. include date and actual time of service provision
3. contain original signature, name, and credentials of the person providing the service(s)
4. document the setting in which the services were provided, including the name and physical address of any locations that are not enrolled sites

5. document the relationship of services to the treatment regimen in the TP
6. contain updates describing the member's progress
7. document involvement for services requiring contact with anyone other than the member and evidence of conformance with HIPAA regulations, including specific authorization or releases of information in the record, if required

B. BH Services in a Physician Clinic or Office

The counseling procedures covered under the Physician Program are a covered service when provided by a physician or a qualified practitioner, who by state licensure, is authorized to provide those services. A physician, physician's assistant, or advanced nurse practitioner may administer a brief, standardized emotional/behavioral assessment screening to a member along with an office visit. Physicians are required to keep the following records for each member:

1. history and physical examinations
2. chief complaint on each visit
3. tests, any results, and all diagnosis(-es)
4. service or treatment, including prescriptions and referrals for other services
5. signature or initials of the physician after each visit
6. copies of records pertinent to services delivered by or under the supervision of the physician and billed to Medicaid
7. service dates of any services billed to Medicaid, including service dates for all components of global services billed

The attending physician's signed authorization of individualized service plans, treatment plans, or plans of care is required for any plans developed by non-physician providers. Copies of authorized plans must be maintained by physicians, as well as subsequent revisions of the plans.

C. Individual BH Counseling

Individual psychotherapy is not permitted with members unable to benefit from the service due to cognitive ability. Additionally, this service is not for clients under 4 years of age except in documented, exceptional cases and acquiring a PA prior to service provision. Minimum documentation requirements for this service include

1. date of service with start and stop times of face-to-face encounter
2. place of service
3. diagnosis and pertinent interval history
4. brief mental status and observations
5. rationale and description of the treatment used that coincides with the most recent intake assessment
6. member response to treatment, including current progress or regression and prognosis
7. any revisions indicated for the diagnosis or medication concerns
8. plan for the next individual therapy session, including any homework assignments and/or advanced psychiatric directive or crisis plans
9. staff signature, credentials, date of signature

D. Group BH Counseling

Psychosocial groups are not a billable medicaid service. Members must demonstrate an ability to benefit from experiences shared by others, participate

in a group dynamic process while respecting the others' rights to confidentiality, and integrate feedback received from other group members. For groups with members 18 years of age and older, the minimum number served must be at least 2 with a maximum of 12. For groups with members under age 18, the minimum number served must be at least 2 with a maximum of 10. Members must be at least 4 years old to receive group therapy.

Group treatment must be age and developmentally appropriate, (eg, 16-year-olds and 4-year-olds would not be treated in the same group). Providers may bill for services only at times during which members participate in group activities, and documentation must reflect any interruptions or incapacitation of members (eg, member leaves group early, member falls asleep during group, member refuses to participate). Other minimum documentation requirements include the following:

1. date of service with start and stop times of actual group encounter that includes identified member
2. place of service with number of participants
3. focus of the group or group topic/subject
4. diagnosis and pertinent interval history
5. brief mental status and observations
6. rationale for group must coincide with the most recent intake assessment
7. member response to group counseling, including current progress or regression and prognosis
8. any revisions indicated for diagnosis or medication concerns
9. plan for next session, including homework assignments, crisis plans, or both
10. staff signature, credentials, date of signature

E. Marital/Family (MF) BH Counseling with or without Member Present

This service is a face-to-face treatment provided to 1 or more family members designed to enhance insight into family interactions, facilitate inter-family emotional or practical support, and develop alternative strategies to address familial issues, problems, and needs. Dyadic treatment is available for parent/caregiver and child for children who are 0 to 47 months of age but must be prior authorized. See *Counseling Services Provider Manual* for additional information. Minimum documentation standard for MF BH services include

1. date of service with start and stop times of actual encounter with member (if present) and spouse or family
2. place of service with participants present and relationship to member; if member is not present, provide rationale for excluding identified member
3. diagnosis and pertinent interval history
4. brief mental status of member (if present) and observations of member interaction with spouse or family (if member is not present, document brief observations of spouse or family)
5. rationale and description of treatment that coincides with the most recent intake assessment and improve the impact the member’s diagnosis has on the spouse or family, improve marital or family interactions, or both
6. member (if present) and spouse or family's response to treatment, including current progress or regression and prognosis

7. any revisions indicated for the diagnosis or medication concerns
8. plan for next session, including homework assignments, crisis plans, or both
9. staff signature, credentials, date of signature
10. HIPAA compliant Release of Information (ROI) completed, signed, and dated

F. Psychoeducation

Psychoeducation provides members and families with pertinent information regarding mental illness, substance abuse, and tobacco cessation and teaches problem-solving, communication, and coping skills to support recovery. The service can be implemented in multifamily groups or single-family groups. The group format allows members and families to benefit from the support of peers and mutual aid. Minimum documentation requirements include the following:

1. date of service with start and stop times of actual encounter with member and spouse or family
2. place of service with names of participants present and nature of relationship with member
3. rationale for excluding the identified client, if applicable
4. diagnosis and pertinent interval history
5. rationale and objective used must coincide with the most recent intake assessment and improve the impact the member's diagnosis has on the spouse or family, improve marital or family interactions, or both
6. member and spouse or family response to treatment, including current progress or regression and prognosis
7. any revisions indicated for the diagnosis or medication concerns
8. plan for next session, including homework assignments, crisis plans, or both
9. HIPAA compliant ROI forms, completed, signed, and dated
10. staff signature, credentials, date of signature

G. Multi-Family BH Counseling

This service provides therapeutic intervention using face-to-face verbal interaction between 2 to a maximum of 9 members and respective family members or significant others to enhance member insight into family interactions, facilitate inter-family emotional or practical support, and develop alternative strategies to address familial issues, problems and needs.

1. date of service with start and stop times of actual encounter with member or spouse/family
2. place of service with participants present and nature of relationship to member
3. diagnosis and pertinent interval history
4. rationale for/objective used to improve the impact the member's diagnosis has on the spouse/family and/or improve marital or family interactions
5. member and spouse/family response to treatment that includes current progress or regression and prognosis
6. any revisions indicated for the diagnosis or medication(s)
7. plan for next session, including homework assignments, crisis plans or both
8. HIPAA compliant ROI forms completed, signed, and dated
9. staff signature, credentials, date of signature

H. Intensive Outpatient Program (IOP) Substance Abuse Treatment

Group based, non-residential, structured interventions consist primarily of counseling and education to improve symptoms that significantly interfere with functioning in at least 1 life domain (eg, familial, social, occupational, educational). The service provides a coordinated set of individualized treatment services to persons able to function in a school, work, and home environment but in need of treatment beyond traditional outpatient programs. Treatment may be used to transition members from higher levels of care or for those at risk of being admitted to higher levels of care. IOPs provide 9 or more hours a week of skilled treatment, 3-5 times a week in groups of no fewer than 3 and no more than 12 members. Minimum documentation requirements include the following:

1. date of service with start and stop times of the face-to-face encounter with the member and the interpretation time for diagnostic formulation
2. place of service and any identifying information
3. referral reason and diagnostic impressions
4. presenting problem(s) and history of presenting problem(s), including duration, intensity, and response(s) to previous treatment
5. rationale for service, including consistency with plan of care
6. brief mental status and observations
7. current functioning and strengths in life domains
8. member's response to the intervention, including current progress or regression and prognosis
9. staff signature, credentials, date of signature

I. Crisis Intervention

This service is unscheduled, immediate, short-term treatment provided to a member experiencing a psychiatric or behavioral crisis to stabilize the member in crisis, prevent further deterioration, and provide immediate treatment in the least restrictive setting. Minimum documentation requirements include

1. date of service
2. start and stop time of actual encounter with member and possible collateral contacts with caregivers of informed persons
3. place of service
4. specific persons providing pertinent information and relationship to client
5. diagnosis and synopsis of events leading up to crisis situation
6. brief mental status and observations
7. utilization of previously established psychiatric advance directive or crisis plan as pertinent to current situation or rationale for crisis intervention activities
8. member response to the intervention that includes current progress or regression and prognosis
9. clear resolution of the current crisis and/or plans for further services
10. development of a clearly defined crisis plan or revision to existing plan
11. staff signature, credentials, date of signature(s)

IV. Community Support System Providers (CSSP) Documentation

Provider information regarding documentation standards is outlined in the *CSSP Certification Manual* and on the Arkansas DHS website. General documentation

requirements may be located in the Intellectual or Developmental Disabilities (IDD) Documentation policy on the CareSource website.

E. Conditions of Coverage

It is the responsibility of each provider to be alert to the possibility of third-party sources of payment and to report receipt of funds from these sources to DMS.Each provider must accept payment from Medicaid as payment in full for covered services, make no additional charges, and accept no additional payment from the beneficiary for these services.

F. Related Policies/Rules

Intellectual or Developmental Disabilities Documentation
Medical Record Documentation Standards for Practitioners
Nonmedical Community Supports and Services
Person-Centered Service Plans

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.
Date Effective	10/01/2024	
Date Archived		

H. References

1. *All Providers Provider Manual, Section I.* Arkansas Dept of Human Services. Accessed May 17, 2024. www.humanserivces.arkansas.gov
2. Alper E, O'Malley T, Greenwald J. Hospital discharge and readmission. UpToDate. Updated February 3, 2023. Accessed May 17, 2024. www.uptodate.com
3. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders, fifth edition, text revised (DSM-5-TR).* American Psychiatric Association; 2022.
4. Bajorek S, McElroy V; Patient Safety Network. Discharge planning and transitions of care. Accessed May 17, 2024. www.psnet.ahrq.gov
5. Clinical documentation. American Psychiatric Association. Accessed May 17, 2024. www.psychiatry.org
6. Condition of Participation: Discharge Planning, 42 C.F.R. § 482.43 (2019).
7. Confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2 (2024).

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

8. *Counseling Services Provider Manual, Part II*. Arkansas Dept of Human Services. Accessed May 17, 2024. www.humanservices.arkansas.gov
9. Definitions, 45 C.F.R. § 160.103 (2013).
10. *Diagnostic and Evaluation Services Provider Manual, Part II*. Arkansas Dept of Human Services. Accessed May 17, 2024. www.humanservices.arkansas.gov
11. Electronic Records and Signatures, ARK. CODE ANN. § 25-31-103 (1999).
12. *Home and Community-Based Services for Client with Intellectual Disabilities and Behavioral Health Needs Provider Manual, Part II*. Arkansas Dept of Human Services. Accessed May 17, 2024. www.humanservices.arkansas.gov
13. Individual Written Plan of Care, 42 C.F.R. § 456.180 (2024).
14. Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs, 42 C.F.R. § § 441.150 - 441.184 (2023).
15. *Inpatient Psychiatric Services for Under Age 21 Provider Manual, Part II*. Arkansas Dept of Human Services. Accessed May 17, 2024. www.humanservices.arkansas.gov
16. *Licensure Manual for Community Support System Providers*. Arkansas Dept of Human Services. Updated January 1, 2023. Accessed May 17, 2024. www.humanservices.arkansas.gov
17. Medicaid documentation for behavioral health practitioners. Centers for Medicare & Medicaid Services. Accessed May 17, 2024. www.cms.gov
18. Medical, Psychiatric, and Social Evaluations, 42 C.F.R. § 456.170 (2024).
19. Privacy of Individually Identifiable Health Information, 45 C.F.R. § § 164.500 to 164.534 (2013).
20. *Provider-Led Arkansas Shared Savings Entity (PASSE) Program Provider Manual, Part II.* Arkansas Dept of Human Services. Accessed May 17, 2024. www.humanservices.arkansas.gov
21. Reports of Evaluations and Plans of Care, 42 C.F.R. § 456.181 (2024).