C·B·H

a division of DBHIDS

PROGRAM INTEGRITY

Clinical Documentation Requirements: Specific Levels of Care

Updated August 2026

Community Behavioral Health

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CBH has developed documentation requirements, both for general reference and for specific levels of care. Please see the Program Integrity, Clinical Documentation Requirements section of the **CBH Provider Manual** for general reference.

1. MENTAL HEALTH OUTPATIENT PROVIDERS

Expectations presented in this document apply to services provided in facilities licensed as mental health outpatient (MHOP) clinics. Individual practitioners and those in group practices providing MHOP care are also strongly encouraged to follow these guidelines as well when possible. Individual practitioners are required to follow the documentation requirements presented separately in the **Independent Practitioner requirements** below.

MHOP Providers are responsible for the completion and retention of clinical records for each service provided and billed to CBH. CBH may request records at any time to aid in coordination of care and investigations of quality or compliance concerns. In addition to the General Record Maintenance and Storage, Retention, and Destruction sections above, mental health outpatient providers must comply with the following:

1.1. Content of Records

1.1.1. Progress Notes

Progress notes are the evidence of services provided and relate to the individual's progress in treatment. Progress notes are to be completed within seven days of the date of service or prior to the submission of claims, whichever occurs first. Missed appointments should also be documented within the clinical chart but may not be billed. Progress notes should be written in a standardized format (e.g. - DAP, SOAP, BIRP) and should include the following:

- The date with start and end clock times of the service, including AM/PM designation or using military time
- Type of service rendered
- Assessment of the individual's current clinical presentation
- Interventions utilized by a practitioner and the individual's response to said intervention
- Treatment goals and the individual's progress towards each stated goal
- Collateral information (with consent from the person receiving a service or services)
- Unresolved issues from previous contacts
- Plans, next steps, and/or clinical decisions
- Signature of rendering practitioner

1.1.2. Treatment Planning

Providers can find specific requirements for treatment plans, including required participants/signatures, timeframes for initial and plan updates, and regulatory basis in the Program Integrity Treatment Planning Guide. We encourage all individuals providing care to the Member to participate in the planning session and note their participation by signing treatment plans and/or updates.

While changes in MHOP settings may be incremental in nature, care should be given to ensure that treatment plans and updates are not duplicated across periods. Significant reuse of content in treatment plans may result in Program Integrity action.

1.1.3. Continuing Support Plans

The continuing support process (previously referred to as the discharge planning process) should be initiated at the time an individual begins treatment. A timeline for transitioning out of care should be discussed regularly. Individuals should be discharged from care consistent with agency policy. Discharge documentation should include, at minimum, the following:

- Type of discharge (e.g., successful completion of treatment, transfer, AMA)
- Name of next level of care Provider with date and time of appointment (if applicable)
- Supports needed (e.g., housing, case management, educational)
- Medications with dosages and date/time of next medication appointment (if applicable)
- Individualized crisis/safety plan (triggers, warning signs, coping strategies)
- Signature of the person receiving service AND clinician (in general if over age 14)
- Signature of the parent/guardian AND clinician (in general if under age 14)

Please Note: *A signature of the individual receiving service and/or parent/guardian is not required for unplanned discharges.*

1.2. Special MHOP Considerations

Providers are reminded that there is no CBH requirement that 'therapy' services are needed to receive medication management services. In fact, for many individuals for whom medications management has helped afford stability, medication management sessions alone may be clinically indicated.

MHOP Providers treating Members with medication management-only services are reminded that Medicaid regulations (**55 Pa. Code § 1153.42.** Ongoing responsibilities of providers.) require treatment plans for Members receiving these services.

Some Providers have advised Members that they must receive both individual and group therapies to participate in outpatient mental health services. ***This is not a CBH or Medicaid requirement.***

Some Providers are conducting annual Comprehensive Biopsychosocial Evaluations or Re- Evaluations or psychiatric evaluations, listing a reason for the evaluation as "Annual Evaluation." ***This is also not a CBH requirement, nor is this a sound clinical rationale for conducting an evaluation.***

Members do not need to receive an annual evaluation to continue receiving outpatient mental health services. These practices contradict the importance of Member choice and may also represent waste if not clinically necessary. CBH expects Providers to consult best practices, medical necessity, and Member choice when determining course of treatment, including whether a member should receive individual and/ or group psychotherapy along with medication, or whether medication only is sufficient. In every instance, the level of services provided must be guided solely by clinical need.

CBH will continue to monitor network providers for overuse and medically unnecessary services and will recoup payments for services not clearly demonstrated as medically necessary.

MHOP providers utilizing group psychotherapy as a component of care adhere to requirements for group psychotherapy services. These requirements include, but are not limited to:

- Therapeutic in nature only, psycho-educational groups are not a billable service in MHOP
- The maximum group size is 12
- The number of participants must be documented in the record
- Individual response to the group must be documented

Additional information specific to group services may be found in the Documentation Standards for Group Services section below.

2. GROUP SERVICES

Expectations presented in this document apply to services provided in a group setting. The definition of group services varies slightly depending on the setting. For example, consider the distinction between Mental Health Outpatient and Outpatient Drug and Alcohol Clinic Services:

2.1. Mental Health

- Governed by MA Regulations **55 Pa. Code § 1153.2.** Outpatient Psychiatric Services; Definitions.

  Group Psychotherapy: Psychotherapy provided to no less than two and no more than 12 persons with diagnosed mental disorders for a period of at least one hour. These sessions shall be conducted by a clinical staff person.

2.2. Substance Use Disorder Treatment (SUD)

- Governed by MA Regulations **55 Pa. Code § 1223.2.** Outpatient Drug and Alcohol Clinic Services, Definitions.

Group Psychotherapy: Psychotherapy provided to no less than two and no more than 10 persons with diagnosed drug/alcohol abuse or dependence problems for a minimum of one hour. These sessions shall be conducted by drug/alcohol clinic psychotherapy personnel under the supervision of a physician.

In addition, while mental health settings are not permitted to bill for groups that are psychoeducational in nature, they have historically been accepted in a limited manner in SUD care.

In all cases, all Providers utilizing any form of group therapy services must follow relevant Commonwealth regulations.

2.3. Content of Records

2.3.1. Progress Notes

Progress notes are the evidence of services provided and relate to the individual's progress in treatment. Progress notes are to be completed within seven days of the date of service or prior to the submission of claims, whichever occurs first. Missed appointments should also be documented within the clinical chart but may not be billed. Progress notes should be written in a standardized format (e.g., DAP, SOAP, BIRP) and should include the following:

- The date with start and end clock times of the service including AM/PM designation or using military time
  - Absences from the group should be noted. Examples may include late arrivals, early departures, leaving group for other appointments, etc.
- Notation that group was provided
- Group topic
- Summary of the group response/dynamic
- Individualized response that should include:
  - Assessment of individual's current clinical presentation
  - Interventions utilized by practitioner and individual's response to said intervention
  - Treatment goals and individual's progress towards each stated goal
  - Plans, next steps, and/or clinical decisions
- Signatures, if not legible, should be accompanied by a printed name or name stamp
- The number of participants should be clear to the reader

Note: *PHI for each Member must appear only in their individual record. As a result, special care*

should be given to not use full names, birthdates, etc., of other group participants to indicate group size.

2.3.2. Treatment Planning

Specific requirements for treatment plans, including required participants/signatures, timeframes for initial and plan updates, and regulatory basis can be found in the **Program Integrity Treatment Planning Guide**.

2.4. Other Reminders

Group psychotherapy services may not exceed 10-12 participants in most cases, depending on the license type of the program. When individualized psychoeducational groups are permitted, the maximum group size is 15.

Individualized psychoeducational groups may be permissible as a limited adjunct to more traditional therapy modalities (Individual, Group, and Family) in some treatment settings. If you are unsure about your program's ability to utilize and bill for these services, please contact the **CBH Program Integrity Team** for assistance. Examples of setting where they are permitted on a limited basis include, but may not be limited to:

- Partial Hospital Programs
- Residential Treatment Facilities
- Inpatient and Non-Hospital Detoxification and Rehabilitation Units
- Halfway Houses

When permitted, common psychoeducational group topics include, but are not limited to:

- Vocational and Occupational
- Life Skills
- Parenting/Family Reunification
- Structured Social Activities
- Dynamics and Medical Aspects of Addiction
- Abstinence and Its Role in Recovery
- Use of Self Help and Support Group
- Nutrition
- Sex and Sexuality

- Family Dynamics of Addiction
- Confrontation Skills
- Refusal Skills
- Avoiding and Defusing Triggers for Relapse
- HIV and STDs

When Medicaid restricts the number of participants, as previously noted, billing for services provided in excess of these parameters is subject to repayment for all CBH participants, not just those exceeding the limits.

Group size maximums represent the maximum number of TOTAL participants, not just CBH Members. This number also excludes any treatment staff and may not be increased by using co-facilitators.

To be eligible for CBH reimbursement, individualized psychoeducational groups must be conducted by staff appropriately credentialed to provide this service in the relevant level of care. Appropriately credentialed interns may conduct psychoeducational groups as long as the fully credentialed supervisor co-signs all notes for services completed by the intern.

In some instances, Certified Peer Specialists may also lead psychoeducational groups, so long as the provisions set forth in the Medical Assistance Handbook are followed:

> *"Provider agrees that it will typically provide peer support services on an individual (1:1) basis but may offer group services for several individuals together when such services are beneficial, provided that group services may not include social, recreational, or leisure activities. To receive peer support services in a group, individuals must share a common goal, and each individual must agree to participate in the group. Services such as psychoeducation or WRAP (Wellness Recovery Action Planning) are the types of services that may be provided in groups.*

3. COMPREHENSIVE BIOPSYCHOSOCIAL EVALUATION AND RE-EVALUATION (CBE/R)

3.1. Staffing Requirements

CBE/Rs must have a licensed psychiatrist or licensed psychologist actively involved in the completion of the evaluation. Specifically, the licensed staff person must spend at least one hour of face-to-face time with the member over the course of the completion of the CBE. For CBRs, the licensed psychiatrist or licensed psychologist must have completed at least one half-hour of face-to-face time with the member as part of the evaluation. The psychiatrist (MD evaluations) or psychologist (Non-MD evaluations) must meet the requirements for each position as documented in CBH's MRPPF.

For MD level CBE/Rs, those domains listed previously as not requiring licensed staff may be completed by staff who meet the requirements for any of the following positions as defined in the MRPPF:

- Psychologist
- Certified Registered Nurse Practitioner (CRNP)
- Mental Health Professional
- Master's Level Psychology Intern (w/ appropriate supervision and co-signature)
- Drug and Alcohol Counselor (for substance use CBE/Rs only)
- Drug and Alcohol Counselor's Assistant (for substance abuse CBE/Rs only)
- Drug and Alcohol Assessors (for substance use CBE/Rs only)

Everyone completing work on the CBE/R must clearly note the time spent completing the evaluation. This must include date and clock times and not simply duration. The information should be readily available and evident in the clinical chart. When the data collection and licensed psychiatrist's work are separated, it is expected that the non-licensed staff's work will precede that of the psychiatrist. To be eligible for payment, CBE/R-MDs must be completed by a psychiatrist holding a valid a license. Physicians in other disciplines/specialties are not able to complete and bill for CBE/Rs.

Per the Commonwealth's billing codes, CBE/Rs completed by psychologists must be completed in their entirety by the licensed psychologist or staff with graduate training (doctoral level) as permitted and defined by **49 Pa. Code § 41**.

3.2. Clinical Process and Documentation

All CBE/Rs must address several required elements. Ideally, information will be obtained from the member through conversation rather than a series of questions and answers. All areas with potentially clinically relevant information should be explored, either in the CBE/R or during treatment. The CBE/R report should include comprehensive descriptions of the following required domains:

- Referral source
- Reason for evaluation
- Identifying data demographics
- History of presenting challenges/needs – multiple sources and integrate discrepant information
- Review prior/current treatment- multiple sources
- Medications – current and past
- Medical history (and active medical conditions)

- Family history (physical and behavioral health challenges), including social determinants of health
- Developmental
- Educational
- Psychosocial history and current functioning
- Trauma assessment
- Aggression/self-harm/risk/safety assessment
- Suicide assessment
- Bullying assessment (when appropriate)
- Substance use assessment
- Current mental status exam
- Diagnosis/provisional – must be completed by a licensed psychiatrist or psychologist, depending on type of CBE/R
- Strengths and protective factors
- Family Engagement
- Community supports/preferences
- Potential barriers/challenges to recovery
- Formulation - must be completed by a licensed psychiatrist or psychologist, depending on type of CBE/R
- Comprehensive recommendations/discharge option - must be completed by a licensed psychiatrist or psychologist, depending on type of CBE/R

There should also be clear evidence of collaboration with other existing healthcare providers for the member. For children and adolescents, CBE/Rs must also review:

- Family engagement
- Education (current and past)
- Developmental history
- Any intellectual disability

CBRs should explore, in detail, those areas that have had changes. Areas with no significant change should be noted as such.

CBH Program Integrity staff frequently encounter CBE/Rs with concerns related to completion and documentation of the CBE/R based on the following requirements:

- A licensed psychiatrist or licensed psychologist must complete the diagnosis, formulation, and recommendations.
- There must be a clinical rationale for the completion of any CBE/R. Reasons such as "annual" or "initial" are insufficient to establish the need for a CBE/R.
- Rule-out diagnoses are appropriate for members who are initially entering treatment with the provider or when there is a significant clinical change. Rule-out diagnoses should not be carried over for multiple CBE/Rs. The clinical formulation is what sets a CBE/R apart from other assessments and evaluations.

The clinical formulation must be completed by a licensed psychiatrist or licensed psychologist actively involved in the CBE/R process. There is no established length for the clinical formulation; it should be a thorough but concise conceptualization of the member's current case. The formulation must include clarification of any observed discrepancies during the evaluation process and the licensed psychiatrist or licensed psychologist's synthesis of the information presented. The formulation must not be a simple rehashing or repeating of information already obtained during the evaluation.

The formulation will lead directly to recommendations for treatment. This cannot simply be a level of care, (e.g., IBHS, outpatient mental health psychiatric) or even specific service types within the LOC (e.g., mobile therapy, cognitive behavioral therapy). Rather, the recommendations must include the evaluator's recommendations for specific interventions to be used and specific needs and challenges to be addressed.

3.3. Billing

Because of the detail required in the evaluation, it is understood that the CBE/R process may be conducted across more than one visit. Claims for CBE/R activities must correspond to the date the activities were completed. However, no portion of the CBE/R may be billed until the entire evaluation is completed. While there is no time frame specified to complete the CBE/R process, each provider must submit "clean claims" no more than 90 days following the date of service. This, by default, means that, for members who have CBH as their primary/only coverage, the CBE/R must be completed within 90 days of the initiation of the evaluation.

If the provider is pursuing coordination of benefits, the provider must obtain a final determination from the primary payer(s) dated no more than 180 days following the date of service and submit a clean claim to CBH within 90 days after receipt of the final determination.

CBE/Rs are billed in 30-minute units. Each CBE may be billed for a maximum of 8 units (4 hours) per evaluation. Each CBR may be billed for a maximum of 4 units (2 hours). It is expected that a significant number of CBE/Rs will not require the full time permitted. Further, it is expected that CBE/R durations will vary depending on many factors.

Documentation must accurately reflect the time spent completing each portion of the evaluation with start and end times noted. Simply noting duration is insufficient. Clock times must reflect a.m./p.m. designations or use military time. Best practice is to document clock times on the note for the session in which each portion of the CBE/R occurred. However, clock times may be recorded in a separate section of the member's record. Notes for each portion of the CBE/R should include pertinent details of who was involved in the contact and purpose; details of names, contact information, or follow-up on the process completed thus far. Signing consents and releases is not considered billable time.

CBH currently contracts for eight different types of CBEs:

- 300-50 CBE MD: Mental Health CBE completed by a licensed psychiatrist
- 300-51 CBE NON-MD: Mental Health CBE completed by a licensed psychologist
- 300-54 CBR MD: Mental Health CBR completed by a licensed psychiatrist
- 300-57 CBR NON-MD: Mental Health CBR completed by a licensed psychologist
- 350-40 CBE MD: Drug and Alcohol CBE completed by a licensed psychiatrist
- 350-41 CBE NON-MD: Drug and Alcohol CBE completed by a licensed psychologist
- 350-42 CBR MD: Drug and Alcohol CBR completed by a licensed psychiatrist
- 350-43 CBR NON-MD: Drug and Alcohol CBR completed by a licensed psychologist

4. PER DIEM SUBSTANCE USE DISORDER SERVICES

Each service billed to CBH must be documented in the individual's clinical record. The primary function of documentation is to record interventions, progress made, and challenges encountered during treatment. This allows the provider staff, the individual in treatment, and subsequent providers/staff to review effective treatment strategies and interventions as well as those that proved to be less effective and/or ineffective. Additionally, clear, and concise clinical documentation is crucial for substantiating payments made to the provider.

This section will provide general requirements for what can be considered sufficient documentation for substance use disorder services billed per diem. This section will evolve and be refined as additional requirements and/or new levels of care/services are introduced/reviewed.

4.1. General Considerations

In general, for any billed service, clinical documentation must fully substantiate both the service and duration/amount billed. All progress notes must have a clear behavioral health intervention documented. All notes must provide a clear and concise description of both the member's contribution to the billed service

and the provider staff's contribution/intervention. An individual unfamiliar with the member's course of treatment should be able to discern, through record review alone, what has been effective versus ineffective and what is in-process in the member's care. Additionally, the full number of units billed for each service must be fully substantiated. For example, a Clinically Managed Low-Intensity Residential treatment stay lasting 30 days must have a clear indication of the need for the authorized level of care and documentation to support billing for each of the 30 days.

When documenting interventions, the provider staff must provide an accurate and complete description of the service. Clinical documentation should avoid the use of vague, general language, and/or buzzwords for theoretical models. Examples of statements that would not be considered a sufficient summary of the intervention delivered include (but are not limited to):

1. "Listened and provided positive feedback"
2. "Used Cognitive-Behavioral Therapy"
3. "Role-played with the individual"
4. "Provided a warm and safe environment for exploration of the individual's concerns"
5. "Watched a video on the effects of substance use"

Specific concerns with each include:

1. This is a basic tenet of all behavioral health care.
2. This is a statement of a broad evidence-based theoretical framework that contains several specific clinical interventions that can be utilized.
3. Alone, there is no specific information about what scenario(s) was (were) role-played, how it tied to the treatment plan, and the outcome of the role-playing.
4. This is a basic tenet of all recovery-based behavioral health care.
5. Watching videos does not constitute an intervention alone. Discussions of relevant audio- visual presentations can, at times, include behavioral health interventions.

All providers should develop and maintain a policy and procedure for progress notes, including the required elements to substantiate a service rendered. The policy should include a discussion/review of the following:

- The provider's quality assurance process for review of progress notes to ensure sufficiency.
- Components of the progress note, which at a minimum should include:
  - Documentation of interventions utilized/implemented and the member's response to those interventions. Evidence Based Practices and Interventions (EBPs/EBIs) are recommended.

  - Documentation of an assessment of the individual's behavior, mood, and interpersonal functioning.
  - Documentation of review(s) of relevant medical conditions and lab work.
  - An individualized response to group sessions.

- Listing of who is authorized to document interventions/interactions in the clinical record.
- Any formal progress note format adopted by the agency.
- Expectations of content to be included in the adopted progress note format.
- Expectations, and review process, to ensure that progress notes reflect treatment plan goals.
- Expectations that the note will be entered and considered final prior to the submission of a claim for that date of service or within 7 days of the date of service, whichever occurs first.
- Expectations that corrections to note entries will be completed consistent with overall agency policy and applicable regulations.

The remainder of this section provides sufficiency requirements for specific levels of care.

4.2. ASAM 3.1: Clinically Managed Low-Intensity Residential Services

CBH requires services be provided daily, in addition to the minimum 5 hours/week of clinical services required by ASAM. Each date of service must have documentation of the following, at minimum:

- Progress note(s) with at least one behavioral health intervention delivered to the individual.
  - Interventions beyond the 5 hours of clinical services/week minimum do not necessarily need to be delivered in traditional treatment modalities (i.e., group psychotherapy, individual therapy) and may be delivered by any residential treatment staff.
  - Psycho-educational groups alone do not constitute the behavioral health intervention.
  - House meetings and 12-Step/ "Self-Help" meetings including NA/AA held on-site in the residential/inpatient program do not constitute a clinical service
  - Documenting medication dosing only for residential/inpatient treatment is NOT considered sufficient substantiation of payment for a day of service.
- Start and end clock time for every service (with am/pm designation or military time)
  - There must be evidence from the documentation collectively that the 5 hours/week clinical services minimum is met.

- For group psychotherapy, per CBH, the maximum group size is 10 participants.
    - Progress notes should clearly indicate the number of participants in the group, without listing names or identifiers of other group members.

4.3. ASAM 3.5: Clinically Managed High-Intensity Residential Services

CBH requires services be provided daily, with the recommendation of a minimum of six hours of clinical services each day. Each date of service, including weekends and holidays, must have documentation of the following, at minimum:

- Progress note(s) with at least one behavioral health intervention delivered to the individual.
    - Interventions beyond the daily intervention of clinical services do not necessarily need to be delivered in traditional treatment modalities (i.e., group psychotherapy, individual therapy) and may be delivered by any residential treatment staff.
    - Psycho-educational groups alone do not constitute the behavioral health intervention.
    - House meetings and 12-Step/ "Self-Help" (like NA/AA, etc.) seminars and meetings held on-site in the residential/inpatient program do not constitute a clinical service
    - Documenting medication dosing only for residential/inpatient treatment is NOT considered sufficient substantiation of payment for a day of service.
- Start and end clock time for every service (with am/pm designation or military time)
- For group psychotherapy, per CBH, the maximum group size is 10 participants.
    - Progress notes should clearly indicate the number of participants in the group, without listing names or identifiers of other group members.

ASAM addresses both habilitation and rehabilitation within 3.5 services in the move from program- driven care to individualized services based on needs identified by comprehensive assessment (ASAM criteria, 2013 text, pp 244-246).

4.4. ASAM 3.7: Medically Monitored Intensive Inpatient Services

CBH requires services be provided daily, with the recommendation of a minimum of six hours of clinical services each day. Due to the level of medical monitoring, CBH expects to see daily documentation from medical and/or nursing staff. For 3.7 WM, the Withdrawal Management requirements listed below also apply. Each date of service, including weekends and holidays, must have documentation of the following, at minimum:

- Daily documentation by physicians and/or nursing professionals.
- Progress note(s) with at least one behavioral health intervention delivered to the individual.
  - Interventions beyond the daily intervention of clinical services do not necessarily need to be delivered in traditional treatment modalities (i.e., group psychotherapy, individual therapy) and may be delivered by any residential treatment staff.
  - Psycho-educational groups alone do not constitute the behavioral health intervention.
  - House meetings and 12-Step/ "Self-Help" (like NA/AA, etc.) seminars and meetings held on-site in the residential/inpatient program do not constitute a clinical service
  - Documenting medication dosing only for residential/inpatient treatment is NOT considered sufficient substantiation of payment for a day of service.
- Start and end clock time for every service (with am/pm designation or military time)
- For group psychotherapy, per CBH, the maximum group size is 10 participants.
  - Progress notes should clearly indicate the number of participants in the group, without listing names or identifiers of other group members.

4.5. ASAM 4.0: Medically Managed Intensive Inpatient Services

CBH requires services be provided daily. Due to the level of medical management, CBH requires daily documentation from both medical and nursing staff. For 4.0 WM, the Withdrawal Management requirements listed below also apply. Each date of service, including weekends and holidays, must have documentation of the following, at minimum:

- Daily documentation by both physicians and nursing professionals
- Progress note(s) with at least one behavioral health intervention delivered to the individual.
  - Interventions do not necessarily need to be delivered in traditional treatment modalities (i.e., group psychotherapy, individual therapy and may be delivered by any residential treatment staff.
  - Psycho-educational groups alone do not constitute the behavioral health intervention.
  - House meetings and 12-Step/ "Self-Help" (like NA/AA, etc.) seminars and meetings held on-site in the residential/inpatient program do not constitute a clinical service
  - Documenting medication dosing only for residential/inpatient treatment is NOT considered sufficient substantiation of payment for a day of service.

- Start and end clock time for every service (with am/pm designation or military time)
- For group psychotherapy, per CBH, the maximum group size is 10 participants.
  - » Progress notes should clearly indicate the number of participants in the group, without listing names or identifiers of other group members.

4.6. Withdrawal Management

Withdrawal Management can be provided in ASAM levels 3.7 and 4.0 and the sufficiency requirements stated above apply. Admissions at any time should have medications available and ordered immediately to mitigate withdrawal related symptoms. When withdrawal management protocol and tapers cannot be initiated secondary to a clinical reason, this reason must be clearly documented in the chart for the dates of service impacted by the delay.

4.7. References

1. Elizabeth A. Evans & Maria A. Sullivan, "Abuse and Misuse of Antidepressants," *Substance Abuse and Rehabilitation* 5 (August 2014) 14. doi: 10.2147/SAR.S37917.
2. PA Department of Drug & Alcohol Programs WebEx Presentation *3.0 Residential/Inpatient Services, Aligning Service Delivery to the ASAM Criteria, 2013.*
3. Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller, eds. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. 3rd ed. Carson City, NV: The Change Companies;2013. Copyright 2013 by the American Society of Addiction Medicine.

5. FAMILY-BASED MENTAL HEALTH SERVICES

5.1. Progress Notes

- Indicate the goal(s) for the session
- Clearly record the delivery of services and what occurred in the session
- Demonstrate modality of treatment, including specific Ecosystemic Structural Family Therapy (ESFT) methods and interventions used in the session
- Reflect the stage of treatment
- Document the progression of treatment from one session to the next, including evidence of movement towards attaining/sustaining treatment goals
- Include the clinician's interpretation of the session, how this relates to their overall case formulation, and promotes treatment progress

- Include treatment team's clinical rationale for use of interventions and observations of response to those interventions
- Include anticipated interventions to be used in the next session based on what occurred in this session
- Also include following up on any homework given to the family
- Illustrate specialized level of care services provided (i.e., Autism)
- Indicate how the use of Family Support Services (FSS) funds relates back to treatment plan
- Document place of service
- Clearly document start, end, and duration of travel

5.2. Treatment Plans

The treatment plan should be inclusive of therapy goals, crisis planning goals, case management goals, and family support/advocacy goals as appropriate. As teams discuss with families the overall goals, both individual and family, they will narrow the discussion to prioritize specific goals and objectives. Teams assist families to focus on a few meaningful, attainable goals for the 32-week length of care. The identified goals should require the intensity of FBMHS. Goals are subject to change, should be replaced with new or more relevant goals if prior goals are met, and should be flexible enough to incorporate key individuals as needed while maintaining treatment fidelity by adherence to the 32-week authorization period. Goals are monitored continually, revisited at monthly treatment reviews and modified as treatment unfolds. This process helps the family to see progress and readiness for discharge. Goals that can be achieved with a less restrictive level of care can be identified through the discharge planning process.

Specific considerations for treatment plans:

- An initial treatment plan addressing the issues that led to Member referral for FBMHS is to be initiated within five days of the first day of service (**55 Pa. Code Proposed § 5260.43**).
- A comprehensive treatment plan should be developed with the family and completed within the first 30 days of the initiation of services. This treatment plan must be updated at least every 30 days throughout the treatment period and treatment plan reviews must be documented. The planning process and resulting treatment plan should address the strengths and needs of each family member and clearly define goals, objectives, interventions, and discharge dates. All goals and objectives reflect the ESFT model, are specific and measurable, and have realistic, practical meaning for families
- Required Treatment Plan signatures:
  - Parent/Legal Guardian (if the member under 14 years old)
  - Member and/or Parent/Legal Guardian (if the member 14-17 years old)

- Member (if the member is 18 years old or older)
- Program Director
- Clinical Consultant (if applicable)
- Best practice is for team members to also sign (e.g., MHPs, MHWs)

6. INDEPENDENT PRACTITIONER

An independent practitioner is defined by Community Behavioral Health (CBH) as a sole practitioner or practitioner in a group practice providing services to CBH members, who possesses and is paid on their own tax identification number.

Credentialing requirements for independent practitioners can be found in the CBH Credentialing Manual. Documentation should be in alignment with the requirements laid out in the CBH Credentialing Handbook for Network Providers.

Independent practitioners are responsible for the completion and retention of clinical records for each service provided and billed to CBH. CBH may request records at any time to aid in coordination of care and investigations of quality or compliance concerns. Independent practitioners must comply with the General Record Maintenance and Storage, Retention, and Destruction sections above, in addition to the following:

6.1. Content of Records

6.1.1. Progress Notes

Progress notes are the evidence of services provided and relate to the individual's progress in treatment. Progress notes are to be completed within seven days of the date of service or prior to the submission of claims, whichever occurs first. Missed appointments should also be documented within the clinical chart but should not be billed. Progress notes should be written in a standardized format (e.g., DAP, SOAP, BIRP) and should include the following:

- Date with start and end times of the service including a.m./p.m. designation or using military time
- Type of service rendered
- Assessment of individual's current clinical presentation
- Interventions utilized by practitioner and individual's response to said intervention
- Treatment goals and individual's progress towards each stated goal
- Collateral information (with consent from person receiving service)
- Unresolved issues from previous contacts

- Plans, next steps, and/or clinical decisions
- Practitioner's signature

Independent practitioners are not responsible for completing separate recovery/resilience plans with each person receiving service. However, elements of recovery/resilience plans should be contained within the progress notes. Goals, interventions, and the plan for the next session should be evident in each progress note. In addition, there needs to be a rationale for treatments, including medications, documented within the progress note. Simply documented plans such as "John will return in one week" will not be considered sufficient for documentation of on-going care planning.

6.1.2. Continuing Support Plans

The continuing support process (previously referred to as the discharge planning process) should be initiated at the time an individual begins treatment. A timeline for transitioning out of care should be discussed during sessions. Individuals should be discharged from care consistent with practitioner policy. Discharge documentation should include, at minimum, the following:

- Type of discharge (e.g., successful completion of treatment, transfer, AMA)
- Name of next Level of Care (LOC) provider with date and time of appointment (if applicable)
- Supports needed (e.g., housing, case management, educational)
- Medications with dosages and date/time of next medication appointment (if applicable)
- Individualized crisis/safety plan (e.g., triggers, warning signs, coping strategies)
- Signature of person receiving service **and** independent practitioner (if over age 14)
- Signature of parent/guardian **and** independent practitioner (if under age 14)

Please note: *Signature of the individual receiving service and/or parent/guardian is not required for unplanned discharges.*

7. INTEGRATED BEHAVIORAL HEALTH IN LONG-TERM CARE (IBHLTC)

IBHLTC is a supplemental service in the Medicaid system. Although it does not follow specific regulations, CBH uses the Long-Term Structured Residence (LTSR) regulations as a guide to govern this LOC's treatment planning requirements, and the **Mental Health Outpatient Providers** and **Group Services** documentation standards for progress note completion. Providers must also develop their own policies and procedures regarding documentation.

In addition to the General Record Maintenance and Storage, Retention, and Destruction sections (**CBH Provider Manual** Section 5.18), providers must comply with the following:

7.1. Treatment Plan Summary

The initial plan is due within 72 hours of admission; the comprehensive treatment plan is due within 14 days of admission.

Treatment Plan Updates Due: At least every 90 days or more frequently as the member's condition changes

Signature Requirements: Member, interdisciplinary treatment team

7.2. Progress Notes

The IBHLTC program is structured as a per diem, billed as a unit-based program. It includes weekly individual therapy, daily group services, ongoing family support, and psychiatric services, including medication management. It must follow the requirements for documentation for each of these types of services. Although a daily summary note may be written by the behavioral health registered nurse, there should also be separate progress notes for each service provided. Below are the requirements for general documentation and each of the types of services.

Services must be provided by, and corresponding documentation completed by, individuals qualified to provide the service as referenced in the program's supplemental service description.

7.3. Clock Times

Therapy services, including individual, family, and group therapies, and psychiatric services, including medication management, must be documented using clock times. The start and end clock times for the service must be documented (e.g., 7:15 a.m. to 8:15 a.m.). It is not sufficient to document only the duration, the start, or the end time. Providers must also designate a.m./p.m. or utilize military style time (1:00 p.m. = 1300) in the documentation of start and end times for the service.

The program must follow the clinical documentation requirements for **MHOP providers**. Although IBHLTC is not licensed as a MHOP service, it is expected that providers will follow the standards regarding documentation for its weekly therapy services.

7.4. Group Services

The section below is adapted from the **Group Services** section. The IBHLTC program is expected to follow standards regarding documentation for its group therapy services, as well as the components above in the Progress Notes section. In addition, the program will follow **55 Pa. Code § 1153.** Outpatient Psychiatric Services regulations regarding group size:

> "*Group psychotherapy*—Psychotherapy provided to no less than 2 and no more than 12 persons with diagnosed mental illness or emotional disturbance. These sessions shall be conducted by a clinical staff person."

For non-clinical group services not included in the supplemental services programming, such as exercise groups, a sequential note listing all groups attended may be utilized, with start and end times, utilizing a DAP

or similar format. Content must be individualized to the member, and member records must not have other members' identifying information.

Group services included in the supplemental services programming must comply with the following:

- Notation that group therapy was provided
- Group topic
- Summary of the Group response/dynamic
- Individualized response that should include
  - Assessment of individual's current clinical presentation
  - Interventions utilized by practitioner and individual's response to said intervention
  - Treatment goals and individual's progress towards each stated goal
  - Plans, next steps, and/or clinical decisions
- Signature of rendering practitioner
  - If the signature is illegible, an accompanying printed name must be present.
- The number of participants should be clear to the reader
  - Protected Health Information (PHI) for each member must appear only in their individual record. As a result, special care should be given to not use full names, birthdates, etc., of other group participants to indicate group size.

7.5. Treatment Planning

The use of group therapy as a treatment modality must be reflected in treatment plans for individuals in group therapy. Specific requirements for treatment plans, including required participants/signatures, timeframes for initial and plan updates, and regulatory basis can be found in the **Program Integrity Treatment Planning Guide**.

Individualized psychoeducational groups are to be provided in this program. It is expected that topics are relevant to each individual attending the group.

7.6. Per Diem Daily Note

A daily summary progress note must be written for each member in the program. This note can be written by a behavioral health registered nurse. This section was adapted from the **Per Diem Substance Use Disorder Services** section.

These notes may contain the following, depending on relevancy:

- Documentation of interventions utilized/implemented and the member's response to those interventions
- Documentation of an assessment of the individual's behavior, mood, and interpersonal functioning
- Documentation of review(s) of relevant medical conditions and lab work
- Documentation of in and out times when member leaves and returns to the program for appointments, etc.

For dates when the member is not present or unable to participate in services, a progress note should be written to reflect the reason the member was not present.

7.7. Medication Management and Other Psychiatric Services

7.7.1. Medication Management

The following information, at a minimum, must be captured in a medication monitoring session:

- The name of individual prescribed the medication
- The name and dosage of medication including all over-the-counter medications, home remedies, and herbal supplements—as dosages change, the note shall indicate the rationale for the change
- Documentation regarding medication reconciliation shall include medications prescribed to an individual by all internal and external entities to the agency, to include medications prescribed by the individual's PCP and other specialties
- The date of each medication order
- The means of administration
- The medication schedules
- The reason for the medication, to include the individual's diagnosis
- The individual's response to medication
- The adverse effects of medication
- Written consent of the individual and/or legal guardian
- Adherence to the agency's off-label medication prescribing policy
- Adherence to the agency's policy regarding the screening for and treatment of the components of metabolic syndrome

- Adherence to the agency's policy regarding the **Clinical Practice Guidelines** for the Prescribing and Monitoring of Antipsychotic Medication for Youth (if appropriate)
- Detail regarding who administers the medication. (e.g., a healthcare provider administers the medication, or a written prescription is provided)
- Collaboration with PCPs regarding prescribed psychotropic agents, with consent (if appropriate)
- Involvement of any other professionals (e.g., home psychiatric nurse, etc.)
- Involvement of parents and individuals who administer or supervise the use of medication (if appropriate)
- Providers should note all corresponding/required lab work for monitoring continuity of care.
- Overall documentation includes areas of progress, continuing or new challenges for the person, collaboration with the therapist/team, detailed rationale of medication changes, and possible referrals, etc.

7.7.2. Other Psychiatric Services

The psychiatrist should document any interactions with the member by following the general documentation guidelines above, including clock times.

7.7.3. 1:1 Services

In some cases, it may be clinically appropriate for a member to receive a 1:1 behavioral health technician staff person monitoring their care. It is expected that this individual document the service in progress notes following the general standards as above, corresponding to the time spent in the delivery of the 1:1 service.