Behavioral Health Services Documentation Requirements Reimbursement Policy					
Policy Number	2019RP502A	**Annual Approval Date**	3/27/2019	**Approved By**	Optum Behavioral Reimbursement Committee

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the procedure code or codes that correctly describe the health care services provided to individuals whose behavioral health benefits are administered by Optum, including but not limited to UnitedHealthcare members. This reimbursement policy is also applicable to behavioral health benefit plans administered by OptumHealth Behavioral Solutions of California.

Our behavioral health reimbursement policies may use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other procedure coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement. This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to services billed on the UB-04 claim form and to electronic claim submissions (i.e., 837p and 837i) and for claims submitted online through provider portals. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.*

This information is intended to serve only as a general reference resource regarding our reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, Optum may use reasonable discretion in interpreting and applying this policy to behavioral health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for behavioral health care services provided to members. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: member's benefit coverage, provider contracts and/or legislative mandates. Finally, this policy may not be implemented exactly the same way on the different electronic claim processing systems used by Optum due to programming or other constraints; however, Optum strives to minimize these variations.

Optum may modify this reimbursement policy at any time by publishing a new version of the policy on this website. However, the information presented in this policy is accurate and current as of the date of publication.

**CPT® is a registered trademark of the American Medical Association*

Applicability

This reimbursement policy applies to all health care services billed on CMS 1500 forms and for services billed on the UB-04 claim form and to electronic claim submissions (i.e., 837p and 837i) and for claims submitted online through provider portals. This policy applies to all products, all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Policy

Overview

In order to ensure accurate and appropriate claims processing, Optum may request access to treatment record documentation. You are required to maintain high quality medical, financial and administrative records (including appointment or scheduling books) related to the behavioral health services you provide. These records must be maintained in a manner consistent with the standards of the community, and conform to all applicable laws and regulations including, but not limited to, state licensing, Centers for Medicare and Medicaid Services (CMS) and/or national certification board standards.

In accordance with HIPAA and the definition of Treatment, Payment or Healthcare Operations, you must provide such records upon request. Federal, state and local government or accrediting agencies may also request such information as necessary to comply with accreditation standards, laws or regulations applicable to Optum and its Payors, Customers, Clinicians, and Facilities.

Reimbursement Guidelines

General Documentation Guidelines required for all behavioral health services:

- Treatment record entries should be made on the date services are rendered and include the date of service; if an entry is made more than 24 hours after the service was rendered, the entry should include the date of service, date of the entry, and a notation that this is a late entry
- Any error is to be lined through so that it can still be read, then dated and initialed by the person making the change
- Progress notes should include **Signature of the Practitioner** rendering services
- First and last name of the member
- Date of Service
- Legible identity of the provider with credentials

Documentation Guidelines for Group Therapy;

1. The medical record should be complete and legible
2. The documentation of each patient encounter should include:
   - First and last name of the member
   - Date of Service
   - Legible identity of the provider with credentials
   - Start and stop times or total time of session for time-based codes
   - Subject covered in group
   - Therapy Intervention Techniques as indicated
   - Patients progress, response to treatment as indicated
3. Changes in treatment and revision of diagnosis, if applicable. (clinical consideration only)

4. A treatment plan is required, with measurable goals, that is updated as clinically indicated.(clinical consideration only)

Documentation Guidelines for Family Therapy;

1. The medical record should be complete and legible
2. The documentation of each patient encounter should include:
   - First and last name of the member
   - Date of Service
   - Legible identity of the provider with credentials
   - Start and stop times or total time of session for time-based codes
   - Relationship Identification as to who in the family attended
   - Therapy Intervention Techniques as indicated
   - Patients progress, response to treatment as indicated
3. Changes in treatment and revision of diagnosis, if applicable. (clinical consideration only)
4. A treatment plan is required, with measurable goals, that is updated as clinically indicated.

Documentation Guidelines for Individual Psychotherapy;

1. The medical record should be complete and legible
2. The documentation of each patient encounter should include:
   - First and last name of the member
   - Date of Service
   - Legible identity of the provider with credentials
   - Start and stop times or total time of session for time-based codes
   - Therapy Intervention Techniques indicated
   - Patients progress, response to treatment indicated
3. Changes in treatment and revision of diagnosis, if applicable.(clinical consideration only)
4. A treatment plan is required, with measurable goals, that is updated as clinically indicated.

Resources

- Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
- Provider Express Network Manual

History / Updates	
August, 2022	Updated Reimbursement Guidelines Sections
January, 2022	Updated Reimbursement Guidelines Section: General Documentation Guidelines required for all behavioral health services
May, 2021	Updated title from Therapy Services Documentation to Behavioral Health Services Documentation Requirements; Added Provider Signature Requirements
March, 2021	Annual Review; Updated title from Therapy Services Documentation to Behavioral Health Services Documentation Requirements; Updated Reimbursement Guidelines Section added #5
March, 2020	Annual review
March, 2019	New policy