Optum

Medical Records Documentation Used for Reviews

This protocol lists medical records documentation used and which may be required, when applicable for reviews. This medical record documentation content was developed in an effort to decrease the need for repeated requests for additional information and to provide guidance on administrative documentation requirements. We reserve the right to request more information, if necessary. Medical record documentation content used for review(s) may vary among various UnitedHealthcare and External benefit plans. This content is provided for reference purposes only and may not include all services or codes. Listing of a service or code in this protocol does not imply that it is a covered or non-covered health service or code. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws. This protocol is the property of Optum Behavioral Health Solutions and unauthorized copying, use or distribution of this information is strictly prohibited. It is regularly reviewed, updated and subject to change.

Service	Medical Records Guidelines Used for Reviews
General Behavioral Health Services (required for all behavioral health services in addition to the specific elements outlined by services below)	1. The medical record should be complete and legible 2. 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 3. Any error is to be lined through so that it can still be read, then dated and initialed by the person making the change 4. Progress notes should include **Signature of the Practitioner** rendering services 5. First and last name of the member 6. Date of Service 7. Legible identity of the provider with credentials 8. Start and stop times or total time of session for time-based codes **only**
Individual Psychotherapy	1. 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

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	2. Changes in treatment and revision of diagnosis, if applicable. (clinical consideration only) 3. A treatment plan is required, with measurable goals and objectives, that is updated as clinically indicated.
Group Psychotherapy	1. 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 • Subject covered in group • Therapy Intervention Techniques as indicated • Patients progress, response to treatment as indicated 2. Changes in treatment and revision of diagnosis, if applicable. (clinical consideration only) 3. A treatment plan is required, with measurable goals and objectives, that is updated as clinically indicated
Family Psychotherapy	1. 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 2. Changes in treatment and revision of diagnosis, if applicable. (clinical consideration only) 3. A treatment plan is required, with measurable goals and objectives, that is updated as clinically indicated.
Psychiatric Diagnostic Evaluations	1. 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 • Medical and/or Psychiatric history • Mental Status Examination as indicated • Diagnosis/symptoms as indicated • Treatment recommendations

	2. Changes in treatment and revision of diagnosis, if applicable. (clinical consideration only) 3. A treatment plan is required, with measurable goals and objectives, that is updated as clinically indicated. <u>Please note to support the reporting of 90792 must also include one or more of the following</u>: • The psychiatrist/prescriber must document one or more medical services, which can include elements of a physical examination, writing a prescription, or modifying psychiatric treatment.

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

History	
October, 2024	Implementation of Protocol Document; Sunset of Behavioral Health Services Documentation Reimbursement Policy