Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Behavioral health medical record documentation requirements and privacy regulations – for services other than ABA

For Blue Cross commercial, Medicare Plus Blue℠, Blue Care Network commercial and BCN Advantage℠

Revised: September 2025

Service / practitioner	Behavioral health medical record documentation requirements for services other than applied behavioral analysis (all levels of care)
All services for practitioners with a medical degree	Providers with a medical degree must follow the medical record documentation guidelines published by the Centers for Medicaid & Medicare Services in the Medical Learning Network guide MLN006764. The providers who must follow these guidelines are: • Physicians • Nurse practitioners • Physician assistants
General guidelines: Initial outpatient evaluation for all practitioners without a medical degree	For the initial outpatient visit for a specific problem or group of problems, the medical record must include legible documentation of the items listed here. Note: If the initial visit is provided by a psychiatrist, a medical history — including all prescriptions, over-the-counter medications, and holistic and "natural" supplements — must be documented. The following information must be kept in the medical record: ○ Date of birth / calculated age ○ Gender ○ Home address ○ Home / work telephone numbers ○ Contact name and relationship ○ Employer or school ○ Marital or legal status ○ Emergency contact information ○ Appropriate consent forms / guardianship information ○ Active problem list ○ List of current medications (periodically reconciled with or by prescribing provider) ○ Michigan Automated Prescription System queries as indicated or required by state law The initial outpatient evaluation must include: • Visit information: ○ Date of the initial visit ○ Session start and stop times ○ Names of those present during the session. If separate individuals are interviewed, include the duration for which each is present. • Presenting circumstances / clinical presentation: ○ Presenting problems and precipitating factors ○ Complete mental status examination • Comprehensive history: ○ Results of the relevant diagnostic testing available, including results completed with interpretation and screening tools when available ○ Medical history and current medications along with prescribing medical provider, including evidence of coordination of care ○ Psychosocial history including, as appropriate, the case developmental and family history

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	○ Past psychiatric and substance use disorder history, including inpatient or outpatient treatment • Clinical decision making / plan of care: ○ Objectively stated treatment plan and rationale with as much detail as possible outlining interventions and monitoring protocols ○ Transition and termination benchmark / goals ○ Care coordination goals with other professionals, parents, and others providing care • Summary and recommendations / documentation of process: ○ Referrals to other services / disciplines ○ Assignment of appropriate DSM codes ○ Treatment or education provided in the session ○ Instructions, recommendations and precautions given to the patient or other significant parties • Signature and credentials of the treating provider
General guidelines: Subsequent therapy, for all practitioners without a medical degree	For subsequent therapy sessions for continuing care problems, the medical record must include legible documentation of the following: • Date of the visit • Session start and stop times • Names of those present during the session. If separate individuals are interviewed, include the duration each is present. • Identification of the service / intervention provided • Updated medical history and current medications (changes) along with the name of the prescribing medical provider and evidence that coordination of care has occurred at least quarterly • Clinical findings on re-examination • Brief indication of the patient's response to therapeutic intervention • Objectively stated treatment plan and rationale, if changed from the last visit • Results of objective screening or monitoring tools to gauge symptom improvement • Instructions, recommendations and precautions given to the patient or other significant parties • Signature and credentials of the treating provider and supervisor, where applicable
Specific guidelines: Group of family psychotherapy for all	A progress note for each group or family therapy session is required. Each progress note must include: • For both family and group therapy: ○ Date of the session ○ Session start and stop times

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	○ Statement summarizing the clinical intervention used in the therapy session ○ Primary focus of the therapy session ○ Whether the member participated in the group or family session, or how the member participated in the group or family session ○ A statement summarizing the current clinical status and progress of the patient or the group as a whole ○ Signature and credentials of the treating provider and the supervisor, as applicable • For family therapy only (in addition to the above): ○ Names of those present during the session. If separate individuals are interviewed, include the duration each is present. ○ Relationship of additional participants to the patient in family therapy (for example, spouse or child) ○ The nature and degree of the patient's participation and response in the session if the patient was present at family therapy • For group therapy only (in addition to the above): ○ Number of participants in group therapy (minimum of four, maximum of 12) Note: Other than the group member in whose chart the note is written, there should be no mention of other patients in the group by name. Note: Group psychotherapy sessions should last 90 minutes. For patients unable to tolerate group sessions of 90 minutes due to significant limitations in attention span or frustration tolerance, the minimum time limit may be reduced to one hour. Documentation must explain the reason for limiting the length of the group session or the patient's participation.
Specific guidelines: Individual therapy, for all practitioners without a medical degree	Each psychotherapy session must be documented with a progress note and include: • Date of the session • Session start and stop times • Names of those present during the session and if separate individuals are interviewed, include the duration each is present • Patient's current clinical status as evidenced by the patient's signs and symptoms at the time of each session. For example, progress notes might refer to continuation or resolution of suicidal ideation, abnormalities identified on mental status examination, psychomotor retardation interfering with activities of daily living, decreased or increased anxiety. • Statement summarizing the relationship between signs and symptoms and the primary focus of the therapy session. For example, anxiety and depression are linked to problems with self-esteem, or poor assertive skills or paranoid thinking. • Statement summarizing the clinical intervention used in the therapy session • Statement summarizing the patient's degree of progress toward the treatment goals, including the use of objective tools to monitor progress

Service / practitioner	Behavioral health medical record documentation requirements for services other than applied behavioral analysis (all levels of care)
	• Reference to progress in the treatment plan / discharge plan • Signature and credentials of the treating provider and supervisor, where applicable

HIPAA privacy regulations and documentation — for all non-ABA services by all practitioners

The Health Insurance Portability and Accountability Act affects the documentation of mental health and substance use disorder treatment. To protect the patient's privacy, HIPAA restricts the way psychotherapy notes may be used and disclosed.

Psychotherapy notes

Note: Psychotherapy notes may be referred to as "process notes" by some clinicians.

HIPAA describes psychotherapy notes as all of the following:

- Notes recorded by a mental health professional (in any medium) to document or analyze the contents of conversation during a private individual, group, joint or family therapy session
- Notes that may capture the therapist's impressions about the patient, or details of the patient's feelings, wishes or fantasies
- Notes that are considered inappropriate for inclusion in the medical record and for this reason are separated from the rest of the medical record

Under HIPAA privacy regulations, the originator of psychotherapy notes must obtain the patient's authorization to use or disclose information contained in the notes, except in the following specific situations:

- Treatment of the patient
- Supervision and training of the writer
- Defending a legal action brought by the patient
- Regulatory oversight

In all other circumstances, the originator of the psychotherapy notes must obtain the patient's authorization to use and disclose them.

Note: The special protection given to the therapist's psychotherapy notes applies only if the notes are kept separate from the individual's medical record.

Other information in the medical record

HIPAA guidelines do not require the provider to obtain patient authorization to use and disclose other information in the medical record when it will be used for:

- Treatment coordination
- Payment
- Health care operations, including audit

When the information is used for the reasons noted above, the provider is not required to obtain patient authorization to disclose the following:

- Medication prescription and monitoring
- Session start and stop times
- Treatment modalities and frequency
- Clinical test results
- Summary of the diagnosis, patient's functional status, treatment plan, symptoms, prognosis and progress to date

In keeping with HIPAA privacy regulations, we have modified our documentation guidelines for psychotherapy sessions. We require progress notes documenting each psychotherapy session. Progress notes are contained in the portion of the medical record that is separate from psychotherapy notes.