DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES	**Behavioral Health and Developmental Disabilities (BHDD) Division** Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health
	Date effective: October 1, 2025
Policy Number: *115*	**Subject:** Biopsychosocial Assessments

Each Medicaid member receiving behavioral health treatment must have a current biopsychosocial assessment that meets the following requirements:

(1) Must be provided by an appropriately licensed clinical mental health professional or licensed addictions counselor trained in performing biopsychosocial assessments and operating within the scope of practice for their respective license.

(2) A provider may use a biopsychosocial assessment completed by another provider within the past 12 months, if clinically indicated. The provider must obtain the biopsychosocial assessment for preparation of the individualized treatment plan, and it must be kept in the member's file.

(3) Collateral information may be used to support and clarify the information provided by the member. Collateral information may be obtained from family members, adult friends, school, work, court officials, social service workers, and other treatment providers (previous & current) including primary care.

(4) For a member receiving SUD treatment services, the assessment process must include risk ratings, address immediate needs, and be organized according to the six dimensions as described in the ASAM Criteria.

(5) The interpretation of any completed relevant diagnostic or screening instrument is required and must be kept in the member's file.

(6) The biopsychosocial assessment must include the following information to substantiate the members' diagnosis and must provide sufficient detail to individualize treatment plan goals and objectives:

(a) Presenting problem(s) and history of problem(s);

(b) Family history (including substance use, social, religious/spiritual, medical, and psychiatric);

(c) Developmental history (including pregnancy, developmental milestones, temperament);

(d) Current and past substance use and addictive behavior history;

(e) Personal/social history (including school, work, peer relationship, leisure, sexual activity, abuse, disruption of relationships, military service, financial resources, living arrangements, and religious and/or spiritual);

(f) Legal history relevant to history of mental illness, substance use, and addictive behaviors (including guardianships, civil commitments, criminal mental health commitments, current criminal justice involvement, and prior criminal background);

(g) Psychiatric history (including psychological symptoms, cognitive issues, behavioral complications, and psychiatric hospitalizations);

(h) Medical history (including current and past problems and diagnoses, treatment, and medications);

(i) Mental status examination (including memory and risk factors to include suicidal and/or homicidal ideation);

(j) Physical examination (specifically focused on physical manifestations of withdrawal symptoms or chronic illnesses);

(k) Diagnostic impressions;

(l) Survey of needs, strengths, skills, and resources in each dimension; and

(m) Treatment recommendations.

(7) If a member is receiving services through a psychiatric collaborative care or primary care behavioral health model, as defined in in 33-22-702, MCA, the provider may utilize the member's medical record to satisfy the requirements in (6).