

The Do's and Don'ts of Behavioral Health Documentation and Coding: Why Policies and Procedures Matter

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Agenda



- Introduction
- Policies and Procedures
- Preventing Fraud, Waste and Abuse
- Documentation Standards
- Coding Standards
- Review
- Questions

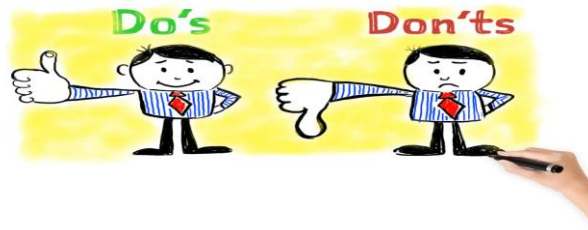
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Introduction



Documentation and coding for any practice can be tricky, especially for a Behavioral Health Practice. Policies and procedures must be in place to ensure proper guidelines are followed. In this webinar, we will discuss the Do's and Don'ts of Behavioral Health documentation and coding and why having policies and procedures are core of a successful practice.



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Policies and Procedures



Policies and Procedures

- Standards of Care
- Use of Medical Records
- Confidentiality
- Training

Questions to ask yourself

- ❖ Does my practice have policies and procedures?
- ❖ Are they actionable or just "words"?

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Standards of Care

- Guidelines of patient care - Emergent Situations
 - Timeline for life-threatening emergency
 - Suicidal with intent/plan
 - Assessed within one hour?
 - Timeline for non life-threatening emergency
 - Suicidal without intent/plan
 - Intervention within 6 hours?
 - Timeline for urgent call
 - Intervention within 24 hours?

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Standards of Care

- Timeline for general appointments
- Initiation of Alcohol or Drug Treatment
 - NCQA and HEDIS considerations
 - 14 days
- Hospital Follow up appointments
 - NCQA and HEDIS considerations
 - 7 days of discharge

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Use of Medical Records

- Professional responsibility
 - Importance
- Communicate information clearly, understandable
 - Others may view the record
 - Format, legible
- Documentation should justify services rendered
- Outcome and process improvement
- Patient involvement in care
 - Non-compliance, ongoing needs

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Use of Medical Records

- EMR Considerations
 - Cloning of statements, sentences
 - Scheduled appointment time vs actual time spent with patient
 - Attachments, scanned documents
 - Summaries
 - Access
 - Storage

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Policies and Procedures



Confidentiality

- Ethical principle
- Promise not to reveal anything about a patient except under circumstances agreed to by both provider and patient
- Discuss and document disclosure exceptions
- Disclosure without consent
 - Suspected child abuse/neglect
 - Duty to warn of potential harm to third party

Legal counsel sought prior to breaching confidentiality should be documented

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Policies and Procedures



Training

- Staff education and training should be done on an ongoing basis
- Documentation of that training should be kept, with the date completed
- FWA, HIPAA
- Correction Action Training

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Preventing Fraud, Waste and Abuse (FWA)



Remember that during an audit or review by CMS, your policies and procedures can be requested by reviewer

- Waste
 - Inefficiencies
- Abuse
 - Bending the rules
- Fraud
 - Intentional deception

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Preventing Fraud, Waste and Abuse (FWA)



Waste

- Refers to overuse of medical services, behaviors or practices that result in inflated costs, misuse or resources and that may be inconsistent with acceptable medical practices
 - Services with higher or inflated costs
 - Excessive or obscure administrative or operating costs
 - Inefficiently delivered services
 - Unnecessary services
 - Unlimited visits do not equal medical necessity

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Preventing Fraud, Waste and Abuse (FWA)



Abuse

- Incidents or practices that result in unnecessary costs that are wasteful, not intentional
- Conduct that is not consistent with acceptable business or medical practice that results in payments

Examples:

- Pattern of non collection of patients cost share of services – copays, deductibles, coinsurance
- Failure to maintain proper medical records
- Failure to maintain proper financial records

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Preventing Fraud, Waste and Abuse (FWA)



Fraud

- An intentional misrepresentation or deception, to obtain money or some other personal benefits by deliberate deception to the detriment of another party. Fraud involves acting with knowing intent or conscious disregard

Examples

- Billing for services not rendered
- Misrepresentation of services rendered or dates of service
- Up-coding
- Altered claims
- Altered medical records to “fit” billing

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Documentation Standards



Policies and procedures should incorporate accepted documentation standards for Behavioral Health

- Initial Assessment
- Risk Assessment
- Treatment Plan
- Progress Notes
- E/M
- Other documents

E/M applicable to MD/CRNP

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Documentation Standards



Initial Assessment

- Chief Complaint
- History of Present Illness
- Past, Family and Social History
- Review of Symptoms
- Mental Status Exam
- Diagnosis/Diagnostic Impression
- Summary/Plan

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Documentation Standards



Risk Assessment

Well documented risk assessments are a core measure of quality care and the first step in developing a treatment plan

- Should be completed at the time of initial evaluation in any care setting
- When suicidal behaviors emerge or change in clinical status
- When there is a change in treatment level
- Evaluation for discharge

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Documentation Standards



Treatment Plans

- All treatment plans should include information on the frequency of treatment and who will be involved in the treatment
- Therapist treatment plans should include:
 - Definition of problem identified as objective for treatment
 - Specific targeted goals
 - Timeframes for goals
 - Interventions
- Physician treatment plans should include:
 - Pharmacotherapy
 - Labwork/testing
 - Psychological testing
 - Referrals for therapy with a broad statement of therapy goals

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Documentation Standards



Progress Notes/Therapy Notes

- Time spent in psychotherapy must be specified as time in and time out for each session
 - This time MUST correspond with the CPT code that is submitted on claim
 - MUST reflect face to face time
 - Notes should include who is present for the session and relationship to the patients
 - Patient's presentation and new issues identified, progress toward objectives, barriers to treatment, noncompliance and interventions given
 - Any homework given
 - Any physicians who are E/M and therapy during same session should notate approximate time spent in psychotherapy
 - Any interactive complexity
 - Telehealth is considered face to face
 - Remember: Place of service = 02

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Documentation Standards



Progress Notes/Therapy Notes

- Psychotherapy for crisis
 - Urgent assessment and history of a crisis state
 - Treatment includes psychotherapy, mobilization of resources to defuse crisis and restore safety
 - Therapeutic interventions to minimize the potential for trauma
 - Presenting problem is usually life threatening or complex and requires immediate attention

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Documentation Standards



E/M (Evaluation and Management)

Key Components

- History
- Exam
- Medical Decision-Making
- Nature of Presenting Problem

Be mindful of Chief complaint – why is the patient in your office today?

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Documentation Standards



Other documents

- Psychological Testing
- Feedback
- Patient Assessment Questionnaires

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Coding Standards



Proper and accurate coding is no longer only a function of a “billing” person or office manager. Clinicians are expected to not only document properly, but to have knowledge of what is being coded on their claims.

- CPT code selection should be based on services rendered
 - Criteria and Description
 - Time spent – Face to face time
 - Documentation elements
 - Therapist codes vs MD/CRNP codes
 - Appointment time vs actual time

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Coding Standards



Continuing education is key!

- CPT codes can be changed, added or deleted each year
- Not coding properly can result in over charging for services, under charging for services, wasted utilization of patient benefits
- Strive to be transparent
- Remember: Your patient will receive an Explanation of Benefits from their insurance plan detailing services

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Review



Policies and procedures must be in place to ensure your Behavioral Health practice is successful

- Stay ahead of the curve
- Continue to evolve policies as new situations and hurdles come up
- Document, document, document!

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Resources



- www.cms.gov
- www.hhs.gov
- 2020 AMA CPT
- www.optum.com

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Thank you attending the webinar!