ruralMED
REVENUE CYCLE RESOURCES

Behavioral Health Documentation

The Ins and Outs

CAH Conference 2025

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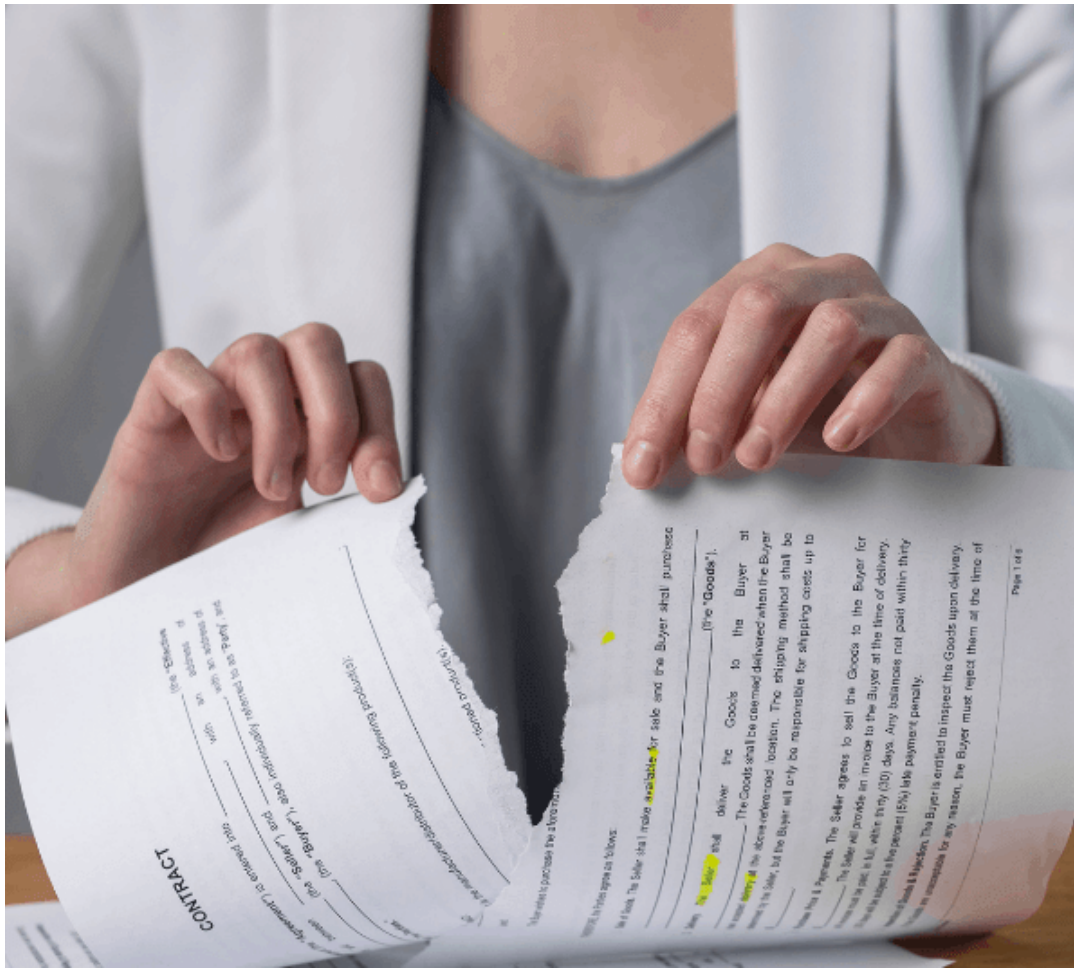
Office of Inspector General

OIG: *Over half of Medicare's $1B spending on psychotherapy was 'improper'*

Expected issue date 2025

OIG: Problematic Areas

- Documentation does not exist for date of service
- Lack of medical necessity
- Cloned documentation
- Missing elements
- Time notations
- ICD-10 is not indicated in documentation



OIG: Problematic Areas

- Lack of medical necessity
  - Documentation should clearly demonstrate medical necessity of the visit
  - Chief complaint must be clear
    - Follow-up is not sufficient
  - Crisis
  - Interactive complexity
  - Frequency of visits
  - Tests, labs, and other services
- No appeal in most cases

OIG: Problematic Areas

- Cloned documents
  - Be weary of copy and paste
- Each document should indicate the patient's presentation on that particular day and should be distinct from all other dates of service
  - Reason for visit
  - Presentation
  - Treatment modality
  - Services provided
  - Barriers
  - Outcomes
  - Homework

OIG: Problematic Areas

- **Missing documentation elements**
  - Therapist treatment plans
    - Behavioral definition of problem identified
    - Objective for treatment with specific targeted goals
    - Timeframes for achieving goals
    - Interventions to be utilized
    - Frequency of treatment and who is involved

OIG: Problematic Areas

- **Time**
  - Amount of time spent face to face with patients is present on documentation for CPT codes that are time based
    - Sign in sheets with time in/out does not substantiate service

- **ICD-10 not indicated in documentation**
  - Where did the DX come from?
  - Code all DX that effects treatment
  - If the problem no longer exists do not code
  - History of vs Acute

Psychiatric Diagnostic Evaluation

- **90791**
  - Psychiatric diagnostic evaluation
    - Complete medical and psychiatric history
    - Mental status exam
    - Evaluation of the patient's ability and capacity to respond to treatment
    - Initial plan of treatment
    - Recommendations (including communication with family or other sources)
- **90792**
  - Psychiatric diagnostic evaluation with medical services
    - Includes all services in psychiatric diagnosis evaluation PLUS
    - CMS psychiatric specialty examination
    - Prescription of medications when appropriate
    - Ordering of laboratory tests as needed

Coding Tips 90791, 90792

- Use for reassessments if required
- Do not report on the same date as psychotherapy or crisis psychotherapy
- Do not report on the same date as an E/M service performed by the same individual for the same patient

Diagnostic Assessment Documentation

- Date, Chief Complaint, Referral Source
- Complete medical and mental health history
  - Development, strengths, vulnerabilities
  - Information obtained from family/caregivers
  - Information obtained through review of medical record
- Examination
  - Mental status exam
- Diagnosis and plan of care
  - Ordering and/or interpretation of lab or other medical diagnostic tests
  - Formulation of opinion, tentative diagnosis and recommendations
  - Evaluation of patient's ability and willingness to adhere to treatment plan

Complete Mental Status Exam

Affect	Speech	Mood	Thought Content
Judgement	Insight	Attention/ Concentration	Memory
Impulse Control			

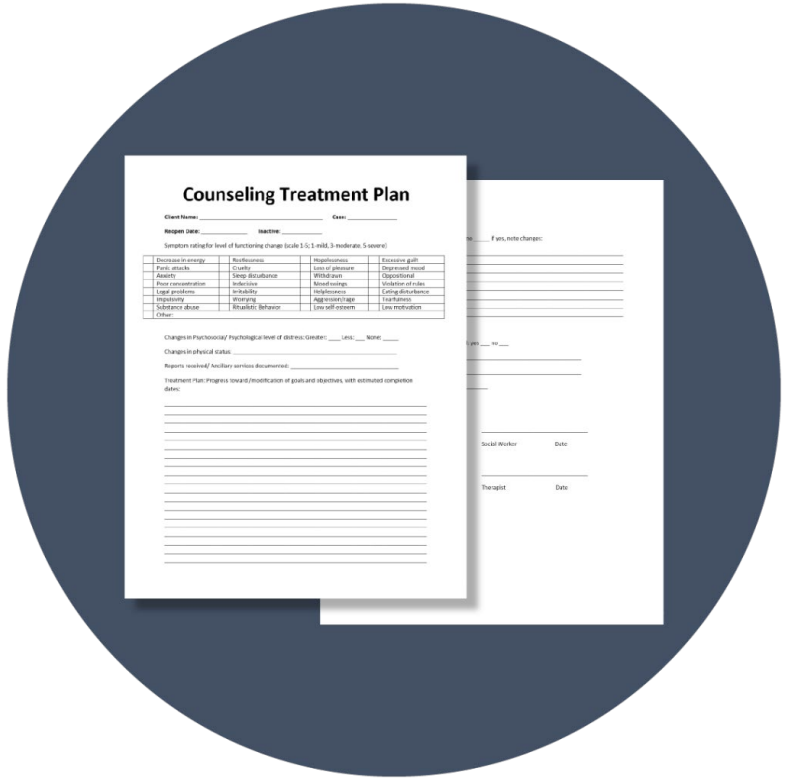
Plan of Care

Patient's diagnosis

Short and/or long term treatment goals that are objective and measurable

The *type,* amount, duration, and frequency of services (interventions should be consistent with treatment plan goals)

Evaluation of the patient's ability and capacity to respond to treatment (client's understanding of the treatment plan is documented)



Psychotherapy

- Psychotherapy with patient or family
  - Time specifications consistent with CPT convention
  - “Individual” is not in the code titles and psychotherapy may include face to face time with family members as long as the patient is present for part of the session
  - Codes for psychotherapy with medication evaluation were replaced with add on codes with are reported in conjunction with E/M services. +90833, +90836, +90838.
    - Services must be significant and separately identifiable

Psychotherapy Time

- CPT Time Rule
  - A unit of time is attained when the midpoint is passed
  - When codes are ranked in sequential typical times and the actual time is between two typical times, the code closed to the actual time code is used
    - 30 minutes (16-37 minutes)
    - 45 minutes (38-52 minutes)
    - 60 minutes (53+minutes)
  - Psychotherapy of less than 16 minutes is not reported
  - Time must be documented

Psychotherapy Minimum Documentation

- Date
- Time spent with the patient (length of session)
- The *specific therapeutic maneuvers used*, such as cognitive restricting, behavior modification, to produce therapeutic change
- A periodic summary of goals, progress towards goals, and an updated treatment plan must be included in the health record
- Progress or lack of progress toward the goals stipulated in the individual treatment plan
- Diagnosis
  - Must be clearly documented for each visit and related to the treatment/therapy

Who should have access to mental health notes?

- Under HIPAA, elements NOT considered part of the psychotherapy note:
  - Medication prescription and monitoring
  - Session start and stop times
  - Modalities and frequency of treatment
  - Results of clinical tests, summary of diagnosis, functional status, treatment plan, symptoms, prognosis, progress, and progress to date.

Individual vs Family Psychotherapy

- When are psychotherapy family codes used?
  - Selection is based on the primary clinical focus of the treatment
    - Is the patient being treated with the spouse present for clinical support? (90834)
    - Client in marriage distress and active couples therapy is being completed? (90847)

How this is documented in the medical record will form the basis of coding decisions

Family Psychotherapy (90846-90849)

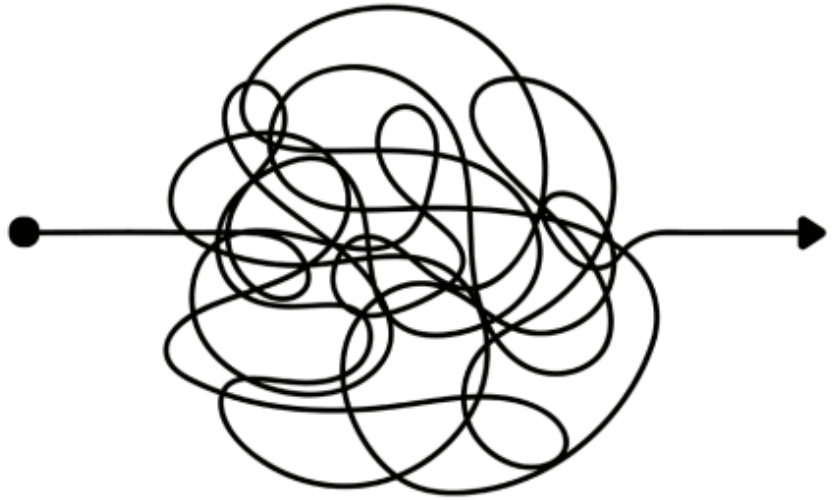
- One or more family members participation during some of the patient's sessions of psychotherapy
  - Documentation must include:
    - Persons present for services
    - Length of time for each session
    - Type of therapeutic intervention
    - Target symptoms (diagnoses)
    - List of general topics addressed during the session
    - Content notes
      - Patients interpersonal and/or interverbal exchanges
      - Progress or lack of progress towards goals in the treatment plan
      - Impairment, severity/complexity of illness, and intensity of needed services

Family Psychotherapy

- **90846**
  - Used when there is a need to assess the capability of and assist family members in the management of the patient **without** the patient present
- **90847**
  - Used when there is a need to observe the patient's interaction with family members **with** the patient present some or all of the session
- **90849**
  - Used with multi-family group psychotherapy
    - Talking with family members after a session about the client's progress does not meet criteria to report this code

Interactive Complexity +90785

- +90785 Interactive complexity (list separately in addition to the code for primary procedure)
  - 1 of the following must exist
    - Maladaptive communication
      - High anxiety, high reactivity, repeated questions or disagreement)
    - Emotional or behavioral conditions inhibiting implementation of the treatment plan
    - Mandated reporting/event exists
    - Play equipment, devices



Group Psychotherapy

Psychotherapy administered in a group setting with a trained group leader in charge of several clients

- Other than a multiple family group

Documentation must include:

- Length of time for each session
- Number of persons in the group
- Documentation of key issues presented
- Individual client's unique issues related to the group discussion
- Attempt to relate the specific group session to a therapeutic theme or goal for the individual client

Group Psychotherapy

- One group note, that is common to all clients, is only one aspect of appropriate documentation
- In addition to the group note, the patient's unique issues (including diagnosis) should be documented in each individual client's record
- 90853 does not include
  - Socialization, music therapy, recreational activities, art classes, excursions, eating together or sensory stimulation

Psychotherapy for Crisis

- 90839 1st 30-74 minutes
- 90840 each additional
  - Crisis visits are urgent assessment and history of a crisis state including mental status exam and disposition
  - Visit should include mobilization to defuse crisis and restore safety and efforts to reduce psychological trauma
  - Present problem is typically life threatening or complex
  - Requires immediate attention to a patient in high distress
  - Crisis visits not scheduled weeks in advance
    - AUDIT AWARENESS!

Evaluation & Management Services

- When psychotherapy is performed with medical management or medication management
  - E/M service selected and documented separately from the psychotherapy (add-on) code
    - E/M service may not be time based when billed with psychotherapy
  - Time notation for psychotherapy is still required
- E/M service may only be based on time when psychotherapy is **not** performed on the same date of service
- Must be a reportable service for the provider type

Tips for Success

- Verify medical necessity
  - Ensure documentation supports the need for services
  - Look for clear links between diagnosis, symptoms, and interventions
- Timely and complete notes
  - Notes should be completed and signed promptly
  - All entries should include date, time, provider credentials, and signature
- Confirm and update diagnosis
  - Diagnosis should be accurate, current and supported by clinical evidence in the record
  - Watch for generic our outdated diagnosis codes that won't align with current treatment

Tips for Success

- Ensure treatment plan is goal oriented
  - Treatment plans should include measurable goals, specific interventions, regular progress updates
  - Goals should be individualized– not templated
- Review CPT accuracy
  - Ensure the code matches the service
  - Time based codes should be clearly documented
- Watch for copy-paste and cloning
  - Cloning without meaningful updates can lead to red flags!

Tips for Success

- Look for proper use of add-on codes
  - Ensure supporting documentation exists for all codes
- Audit for crisis services and risk documentation
  - Documentation should include, risk assessment, interventions, follow-up/safety plan
- Check licensure and scope of practice
  - Confirm the provider rendering and billing matches the scope of practice for services provided
  - Supervisory signatures may be required for some personnel

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Questions?

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