

The logo consists of three overlapping rectangular boxes. The leftmost box is dark blue with a white letter 'C'. The middle box is light grey with a dark blue letter 'C'. The rightmost box is dark blue with a light grey letter 'I'. The background features abstract blue and purple wavy lines and a grid pattern.

C

C

I

CODING & COMPLIANCE INITIATIVES, INC.

Behavioral Health Coding and Documentation

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My Background

- My connection to coding and documentation
- My connection to clinical processes
- My connection to ICD-10
- My connection to YOU

Disclaimer

The information provided within this presentation is for educational purposes only and is not intended to be considered legal advice. Opinions and commentary are solely the opinion of the speaker. Many variables affect coding decisions and any response to the limited information provided in a question is intended to provide general information only. All coding must be considered on a case-by-case basis and must be supported by appropriate documentation, medical necessity, hospital bylaws, state regulations, etc. The CPT codes that are utilized in coding are produced and copyrighted by the American Medical Association (AMA).

Agenda

- Review qualified providers for Medicare
- Review behavioral health coding and documentation
- Review ICD-10 coding and documentation

Medicare

FQHC Services

- Physician services;
- Services and supplies furnished incident to a physician's services;
- NP, PA, certified nurse midwife (CNM), **clinical psychologist (CP), and clinical social worker (CSW) services;**
- Services and supplies furnished incident to an NP, PA, CNM, CP, or CSW services; and
- Outpatient diabetes self-management training (DSMT) and medical nutrition therapy (MNT) for beneficiaries with diabetes or renal disease.

G codes

- A medically-necessary, face-to-face mental health encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit
- G0469 - FQHC visit, mental health, new patient
- G0470 - FQHC visit, mental health, established patient
 - Revenue Code 0900 (behavioral health treatments/services) or 0519 (clinic, other clinic – ONLY for the FQHC supplemental payment)

Qualifying Codes

G0469 – FQHC visit, mental health, **new patient**

- 90791 – Psych diag eval
- 90792 – Psych diag eval w/med services
- 90832, 90834, 90837 – psychotherapy
- 90839 – psychotherapy crisis
- 90845 - Psychoanalysis

G0470 – FQHC visit, mental health, **established patient**

- 90791 – Psych diag eval
- 90792 – Psych diag eval w/med services
- 90832, 90834, 90837 – psychotherapy
- 90839 – psychotherapy crisis
- 90845 - Psychoanalysis

Medicare

- Group mental health services **DO NOT** meet criteria for one-on-one, face-to-face encounter in a FQHC.

Code Type	Use for
E/M Evaluation of a new medical problem	<ul style="list-style-type: none"> • Must contain all three of the required documentation elements (history, examination, and medical decision-making). • May be billed only once every three years by the provider (or other provider in the same group practice).
Psychiatric diagnostic evaluation	<p>Integrated biopsychosocial and medical assessment</p> <ul style="list-style-type: none"> • Includes history, mental status, other physical examination elements as indicated, and treatment plan recommendations. • May be billed more than once a year in order to complete the initial evaluation (if needed to perform over more than one visit). • May also be billed for periodic re-evaluations.

E/M Codes

- Can to be reported for the medical issues – by physicians, APRN, CNS and PA's
- Cannot be used by psychologists, social workers or other behavioral health providers
- Office services have 5 levels of care and are either new or established
- Only one E&M service per day can be coded

Medical Necessity

- Support for medical necessity begins with the initial evaluation resulting in a diagnosis or signs/symptoms as the primary focus of treatment
- It also supports the individual's capacity to participate in treatment, development of an individualized treatment plan, etc.

90791 and 90792

- Psychiatry assessment codes with and without medical component – are not defined as “new” or “established” but status driven. E&M services are based on “new” versus “established” criteria

Initial Diagnostic Exam (90791 and 90792)

- Statement of needs, goals, and treatment expectations from the individual requesting services. The family's perceptions are also obtained, when appropriate and available;
- Presenting situations/problem and referral source;
- History of previous psychiatric and/or substance abuse treatment including number and type of admissions; documentation of prior counseling received by previous and current provider including date range, purpose, duration and provider;
- Current medications and identifications of any medication allergies and adverse reactions;
- Recent alcohol and drug use for at least the past 30 days and, when indicated, a substance abuse history that includes duration, patterns, and consequences of use;

Initial Diagnostic Exam (90791 and 90792)

- Current psychiatric symptoms;
- Family, social, legal, and vocational/educational status and functioning.
- The collection and assessment of historical data unless short-term crisis intervention or detoxification is the only services being provided;
- Current use of resources and services from other community agencies;
- Personal and social resources and strengths, including the availability and use of family, social, peer and other natural supports; and
- Multi-axis diagnosis or diagnostic impression in accordance with the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association or the International Classification of Diseases, current edition (ICD).
- The diagnosis code on the Treatment Plan for billing purposes.

90791 and 90792 – template for documentation

- Documentation
 - Date
 - Chief complaint
 - Referral source
 - HPI
 - Past psychiatric history
 - Past medical history
 - Social history
 - Family history
 - Comprehensive mental status exam
 - Treatment plan with prognosis
 - Assessment of the patient's ability to adhere to the treatment plan
 - Multiaxial diagnoses
 - Referrals and follow-up plan
 - Legible signature

Psychiatric diagnostic evaluation

- 90791 Psychiatric diagnostic evaluation
- 90792 Psychiatric diagnostic evaluation **with medical services**
 - Cannot be reported with an E/M code on same day by same provider
 - Cannot be reported with psychotherapy service code on same day
 - Codes may be reported once per day

Treatment Plan

- Establish long and short term goals that are easily understood, concrete, measurable and obtainable so that progress can be demonstrated.
- Avoid repetitive goals from client to client (i.e. “stabilization of mood,” “improved social functioning,” “absence of risk,” “normalization of functioning,” etc.)
- Update goals regularly or when interventions appear ineffective.

Progress Notes

- Should be written in narrative form, fully describe each session, and be kept in the patient's medical record for each date of service for which a claim is filed.
- Progress notes for Behavioral Health services should specify:
 - First and last name of client
 - Specific service rendered
 - Date (month/day/year)
 - Actual clock begin and end times (1:00 p.m. to 2:00 p.m.)
 - Name of person who provided the service
 - Setting
 - Patient's report of recent symptoms and behaviors related to diagnosis and treatment plan goals
 - Therapist's intervention for the visit and participant's response
 - **The pertinence of the service to the treatment plan**
 - Patient's progress towards goals in treatment plan

Psychotherapy

- Individual Psychotherapy separated in to 2 broad categories:
 - Interactive
 - Incorporates physical aids to over come barriers to therapeutic treatment
 - Insight-oriented, behavior-modifying and/or supportive
 - Conversation between therapist and client

Psychotherapy

- Choose code closest to actual time
 - 90832 (30 min) for 16-37 minutes
 - 90834 (45 min) for 38-52 minutes
 - 90837 (60 min) for 53 and more minutes
- Psychotherapy of less than 16 minutes is not reported
- Includes ongoing assessment and adjustment of psychotherapeutic interventions, and may include involvement of family member(s) or other in the treatment process

Psychotherapy

- According to Medicare, the start and stop time of the face-to-face counseling session must be documented. Many Medicaid contractors as well as commercial payors require start and stop time as well.
- The documentation should clearly outline the patient's report of recent symptoms and behaviors related to their diagnosis and treatment plan goals.
- Also, the documentation should include the therapist interventions for that visit and patient's response.

Psychotherapy

- According to Medicare: The definition of psychotherapy notes expressly excludes the following information:
 - Medication prescription and monitoring,
 - Counseling session start and stop times,
 - Modalities and frequencies of treatment furnished,
 - Results of clinical tests, and any summary of: diagnosis, functional status, treatment plan, symptoms, prognosis, progress, and progress to date.
- The preceding class of information does not qualify as psychotherapy note materials, and physically integrating this information into protected psychotherapy notes does not automatically transform it into protected information

Psychotherapy Documentation

- Date of service
- Time spent for the encounter face-to-face (start and stop time)
- Type of therapeutic intervention
- Target symptoms
- Progress toward achievement of treatment goals
- E/M services when appropriate
- Diagnoses
- Legible signature

Additional Documentation Requirements

- Usually written in narrative form, fully describe each session, and be kept in the patient's medical record for each date of service for which a claim is filed.
- First and last name of client
- Specific service rendered
- Date (month/day/year)
- Actual clock begin and end times (1:00 p.m. to 2:00 p.m.)
- Name of person who provided the service
- Setting
- Patient's report of recent symptoms and behaviors related to diagnosis and treatment plan goals
- Therapist's intervention for the visit and participant's response
- **The pertinence of the service to the treatment plan**
- Patient's progress towards goals in treatment plan

Psychotherapy

- Family Therapy - must identify:
 - Each member of the family, first and last name, included in the session
 - Description of immediate issue addressed
 - Identification of underlying roles, conflicts or patterns
 - Description of therapist intervention, patient response, and progress toward specific goal
- Group Therapy - must identify:
 - The number of group members present
 - Description of immediate issue addressed
 - Identification of underlying roles, conflicts or patterns
 - Description of therapist intervention, patient's response, and progress towards goals

Family Psychotherapy

- Face-to-face therapeutic contact with a patient and family member(s), or other person(s) significant to the patient, for improving patient-family functioning.
- Family Psychotherapy is appropriate ***when intervention in the family interactions would be expected to improve the patient's emotional/behavioral disturbance.***
- ***The primary purpose of family psychotherapy is the treatment of the patient.***

Family Psychotherapy

- 90846 – without patient present
 - 90847 – with patient present
-
- In family psychotherapy, the family is brought into the treatment process, and the interactions of the family as they relate to the patient are the main theme of the psychotherapeutic sessions. *The emphasis here is on the patient's care with the therapy aimed at the environment in which the patient lives or will live, and the interactions of that particular family-based environment.*

Family Psychotherapy with Patient

- 90847 example:
- Conjoint psychotherapy in the office, eighth weekly session for a married couple in their early 40s, for marital problems. The woman is having moderate depression with vegetative signs and is gradually improving with antidepressant medication.
- Next slide outlines the pre and intra-service work

Group Psychotherapy

- “therapeutic contact facilitated by a qualified mental health professional (MHP) in a group setting with two (2) or more patients who are typically not family members. The MHP facilitates structured group interactions in an effort to change individual behavior of each person in the group and assist group members in meeting individual recovery goals.”
- *Typically in an FQHC group services are not covered*

Interactive Complexity - 90785

- **Interactive complexity** is billed when the patient encounter is *complicated due to specific communication issues* such as:
 - Discordant or emotional family members.
 - Very young, verbally under-developed or impaired patients.
 - Patients with third-parties involved in their care (examples: parents, guardians, family members, interpreters, translators, child welfare agencies, parole officers, probation officers, schools).
 - Patients with others legally responsible for their care (examples: minors, adults with guardians).
 - Patients who request others to be involved in their care (examples: adults, family members, interpreter, or translator).

Interactive Complexity

- Bill when at least one of the following is present:
 - The need to manage maladaptive communication by the patient, family member, or caregiver (examples: due to high anxiety, high reactivity, repeated questions, disagreements).
 - Emotions or behaviors interfere with the caregiver's understanding and ability to assist in the implementation of the treatment plan.
 - Evidence, disclosure, or discussion of a sentinel event and the mandated reporting to a third party (examples: abuse or neglect with report to a state agency).
 - Use of play equipment, physical devices, interpreter, or translator to communicate with the patient to overcome barriers to therapeutic or diagnostic interaction in a patient who:
 - Is not fluent in the same language.
 - Has not developed or lost the expressive or receptive language communication skills, ability to explain, or understanding of symptoms and response to treatment.

Interactive complexity – 90785 (add-on code)

- Add-on code to be reported with:
 - Diagnostics Evaluations (90791-90792)
 - Psychotherapy (90832-90838)
 - E/M codes (99201-99255; 99304-99377; 99341-99350) – Group Psychotherapy (90853)

Interactive complexity – 90785 (add-on code)

- Documentation Requirements
 - Primary service minimum documentation requirements must be met
 - Means of interactive complexity should be clearly defined

Psychotherapy for Crisis (90839 – first 30 minutes (add-on 90840))

- An *urgent assessment and history of a crisis state, mental status examination and a disposition*. The presenting problem is typically *life threatening or complex* and requires *immediate attention* to a patient in high distress.
- Treatment includes:
 - Psychotherapy
 - Mobilization of resources to defuse the crisis and restore safety
 - Implementation of psychotherapeutic interventions to minimize the potential for psychological trauma.
- Since crisis codes are time-based, the service is reported *only for face-to-face time* and cannot be billed with a psychiatric diagnostic evaluation.
- The medical record must support that a crisis service was provided.

Psychotherapy for Crisis

- 90839 – 90840
- Services rendered include:
 - Urgent assessment and history of crisis state
 - Mental status exam
 - Disposition
- Treatment includes:
 - Psychotherapy
 - Mobilization of resources to diffuse crisis and restore safety
 - Implementation of psychotherapeutic interventions

Psychotherapy for Crisis

- Presenting problem typically life-threatening or highly complex
- Used to report total duration of face-to-face time
 - Time does not have to be continuous
 - Provider must devote full attention to patient
- 90839 Psychotherapy for crisis: first 60 minutes
 - Once per day
- +90840 each additional 30 minutes

Common Findings

- Incomplete documentation of therapy services specific to time, goals, treatment plan and status
- Initial assessments not including treatment plan
- Incomplete E&M services missing pertinent history, mental status exam and/or medical decision making
- Incomplete Medication Management documentation missing the mental status exam, response to medication and education

Common Findings

- Progress notes not tied to care plans in a meaningful way
- No documentation of skilled interventions provided
- No documentation of clinical progress (symptom resolution, etc.)

Documentation

Medical Necessity

- **Medical necessity** speaks to the cost effectiveness of the service and to the reasonable expectation that the service will result in some improvement in or maintenance of the individual's health or mental health.
- Payors determine medical necessity by reviewing the documentation in the medical record.

Clinical Documentation

- *The only way an auditor can evaluate the quality and accuracy of the service rendered is by what is written in the chart!*
- All payors require that any service billed be backed up by sufficient and legible documentation in the individual's medical record.
- Documentation must describe a service the payor will pay for:
 - Demonstrate that the service was medically necessary,
 - Must meet the payor's requirements for all of the information needed to document the service

Components of Clinical Record Documentation

- Assessment
- Assessment Updates
- Treatment Plan
- Treatment Plan Reviews
- Progress Notes
- Patient ID, date of service, author and credentials on each note

Assessment

- The assessment must *identify the critical clinical needs of the individual* based on their presentation and history.
- The assessment paints the picture of the individual as they present currently and assesses their ability to engage in and benefit from the treatment process.

Assessment Update

- A review of the presenting issues, the diagnosis, the individual's continuing commitment to treatment, their current recovery goals, and the need for a specific level of care.

Treatment Plan

- A complete, current, and appropriately signed treatment plan is the root of the documentation requirements.
- The treatment plan is a “living” document that drives the individual’s services and gives clear direction for the course of treatment. It changes with the changing needs of the individual.

Treatment Plan

- The treatment plan must reflect goal(s) and objective(s) that address the concerns of the individual as *identified in the assessment*.
- This is done by the development of measurable, attainable goals and objectives that provide the opportunity for the individual to actively focus on the needs reflected in their assessment in a targeted manner.
- The treatment plan must be coherent and cohesive in order establish medical necessity.

Treatment Plan

- Objectives for treatment that you and the patient have developed together as well as the interventions the clinician/provider will be using to assist that patient to meet their goals and objectives.
- The treatment plan serves as the “authorization” for services as well as the road map for providing services.

Treatment Plan Review

- Payors and other regulatory agencies require treatment plans be reviewed periodically to ensure:
 - the progress the individual is making is sufficient,
 - the treatment strategy is still appropriate
 - the treatment should continue
- The review should occur with the individual and family (if applicable), and should be documented
- Most payors require a licensed person to sign off on treatment plans.

Treatment Plan - Summary

- Measurable goals and outcomes
- How each goal/outcome will be accomplished
- Involvement of family, when indicated
- Identification of and plan for coordinating with other agencies
- Referrals to other organizations for other needed services
- Identification of medications
- Projected time frame for completion of each goal/outcome
- Estimated completion/discharge date

Progress Notes

- Snapshots of both the treatment provided and the progress.
- The documentation should describe the service provided as well as the progress the individual is making towards the identified treatment goal(s) and objective(s).

Documentation

- Each piece of documentation must flow logically from one to another such that someone reviewing the record can see the logic and understand the story you are telling about the individual's treatment and progress.

Alcohol and/or Drug (AOD) Assessment – HCPCS Code H0001

- This code reports provision of alcohol and/or drug assessment services
- Protocols vary, but an **assessment is systematic and thorough and addresses all aspects of a patient's encounters with alcohol and/or drugs.**
- A **detailed family, social, and legal history** is usually solicited and components may be verified independent of the patient interview.
- **Quantity and frequency of alcohol and/or drug use** is documented.
- **Physical manifestations** associated with alcohol or drug use or abuse may be noted if present, such as depression, mania, anxiety, etc.

Behavioral Health Counseling – HCPCS Code H0004

- Behavioral health counseling and therapy, **per 15 minutes**
 - Behavioral health counseling and therapy provides individual counseling by a clinician for a patient in a private setting

ICD-10

ICD-10 Diagnosis - All care must have a diagnosis...

- It may be a symptom – agitation, violent behavior
- It may be an actual disease:
 - Alcohol dependency with mood disorder
 - Severe depression with hallucinations
 - Post traumatic stress disorder
- There is no “rule out”, possible or maybe
- The ICD 10 CM codes change and get updated every October 1st
- Must be documented by the physician or clinician
- If a diagnoses is identified for billing it must be part of the documentation for the care process and plan

Value-based and Risk Coding

- To promote diagnosis coding on claims submitted that reflects more accurate acuity and severity of illness(es) being treated
- To explain the impact of risk coding on patients, providers and insurance carriers

Value-based and Risk Coding

- Include codes for other mental disorders that impact the treatment of the primary illness during each session
- Include other medical disorders that impact the mental disorder being treated in the session (ie. add the illnesses that would have been reflected on Axis III when using DSM criteria.)

ICD-10

- ICD-10-CM has increased specificity in the form of extra digits to further clarify the exact pathophysiological processes for these codes.
 - 4th digit to qualify the specific aspects of the effects (abuse and dependence)
 - 5th digit to identify the aspects of use (withdrawal state)
 - 6th digit to identify some of the manifestations
- **EXAMPLE: F10.150 Alcohol abuse with alcohol induced psychotic disorder with delusions.**

Anxiety ICD-10

- Documentation requires details including:
 - Agoraphobia
 - Social phobia
 - Animal
 - Natural environment
 - Blood, injection, injury
 - Situational
 - Other
 - Unspecified

Depressive Disorder

- Documentation must indicate:
 - Single episode vs. recurrent
 - Major Depressive vs. NEC
 - Mild/Moderate/Severe
 - With or without Psychotic behavior
 - Partial remission vs. full remission

Attention Deficit Disorder

- Documentation should include:
 - With or without hyperactivity
 - Combined type
 - Inattentive type
 - Other specified type

Bipolar

- Current episode
 - Hypomanic
 - Manic without psychotic features
 - Depressed
 - Mixed
- In remission
 - Hypomanic
 - Manic
 - Depressed
 - Mixed

Diagnosis

- Document and report diagnosis codes to their highest level of specificity to reflect medical necessity as documented by the physician
- Sequence and link ICD-10 codes to CPT codes on claims
- When multiple ICD codes are used to accurately represent an encounter or service

Diagnosis

- Why the patient received health care services
- The severity of the patient's conditions they are being seen for on the specific date of service

Diagnosis

- Report the ICD-10 codes that describe signs and symptoms when a diagnosis has not been established.



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About CCI and TSP Healthcare

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Ms. Sulzberger spent approximately six years as a coding/billing consultant with National accounting and consulting firms (BKD, Grant Thornton) before becoming the President of Coding & Compliance Initiatives, Inc. (CCI) in April 2003. Ms. Sulzberger assists her clients with improving their operational performance in a variety of critical outcome areas, including coding/billing, corporate compliance, charge capture processes, etc. Ms. Sulzberger works with a variety of health care providers including hospitals, physician practices, and rural health clinics in their daily compliance and operational activities.

Ms. Sulzberger presents locally and nationally on coding topics as well as developing specialized training programs to meet the needs of her clients. Shellie recently was credentialed through American Institute of Healthcare Compliance as a Certified ICD-10 Trainer.

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