The Ohio Council

Of Behavioral Health & Family Services Providers

Compliance Training – Part 2

October 29, 2020

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Copies of the power point slides and information on our sponsors are available in the handouts section of the GoToWebinar screen

We are offering CEUs for this training if you complete the evaluation at the end of the training, it will also be emailed to you tomorrow.

If you have any questions following the presentations today, please feel free to contact The Ohio Council at whiteside@theohiocouncil.org

Clinical Documentation Compliance

10/29/20

Jennifer Riha, MAC, LSSGB

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Agenda

1. Introduction to Quality Record Documentation
   a) Purpose
   b) Risks
   c) Required Chart Elements
2. Four Main Documents in a Behavioral Health Chart
3. Service Specific Documentation
4. Record Review Systems
5. Organizational Documentation

Documenting the Provision of Behavioral Healthcare

Training today:

- Assumes OMHAS certification
- Assumes desire to comply with Ohio Department of Medicaid billing rules
- Does not incorporate national accreditation standards

Purposes of a Client Chart

For the client

Historical record of what has worked/ not worked, progress over time

Safety: Medications, allergies, contraindications, trauma, risks

For the providers

To ensure coordination of care between providers

A historical record of what has worked/ not worked, progress over time

To demonstrate compliance with regulation

For the payer

To ensure correct reimbursement is provided for the care provided

Elements of a quality record

- Accurate
- Legible, easy to understand or interpret
- Complete
- Timely completion of documentation and signatures
- Medical Necessity well supported
- Identifiable flow and progression of treatment through documents over time
- Evidence of collaboration and coordination among providers

When an organization enrolls as a Medicaid provider, it agrees to…

- Render medical services as medically necessary and only in the amount required by the patient without regard to race, creed, color, age, sex, national origin, source(s) of payment, or disability
- Submit claims only for services actually performed
- Bill ODM no more than the usual and customary fee charged other patients for the same service
- To bill to other payers first
- To accept Medicaid payments (after third party liability, as applicable) as full reimbursement
- To maintain all necessary records to fully disclose the basis for the type, frequency, extent, duration, and delivery setting of services provided to Medicaid recipients
- To maintain all necessary records regarding significant business transactions
- To keep these records at least 6 years or until any audits are finished (if longer)
- To provide ODM access to or copies of these records
- To notify ODM of major changes related to licensure, certification, control of the organization, or bankruptcy
- To disclose ownership and control information of the organization and to disclose and attest that no person working with, in, for, or controlling the organization is prohibited from providing services to Medicare, Medicaid, or Title XX beneficiaries
- To comply with advance directives requirements
- To comply with confidentiality safeguards

Falsifying Documentation

See OAC 5122-25-07

OMHAS may deny or revoke certification from an organization and prohibit the organization from becoming certified for 3-5 years if:

- Provider provides false or misleading information or documentation to OMHAS, ODM, or a board
- Provider permits an employee to falsify information on client records
- Provider becomes aware of an employee falsifying information on client records which have been billed to ODM and fails to pay back the funds or notify ODM within 30 days

*Not a complete list

Required Elements: ODM Rules

- Medical Necessity of Services Provided
- All records/documents/ notes signed by the provider (with credential indicated)
- All relevant diagnoses, including physical and medical plus behavioral health
- Compliant Treatment Plan(s)
- Results of any applicable testing, with interpretation
- Evidence that the client has sufficient cognitive capacity to benefit from treatment
- Compliant Progress Notes
- Compliant Discharge Summary, if applicable
- Claims/ Billing Records, including correct modifiers, POS, and NPI numbers

Required Elements: OMHAS Rules

- Consent, Refusal to or Withdrawal of Consent for Treatment
- Evidence that the client/ guardian was informed of:
  - Service Fees & Responsibilities for Payment
  - Service/ Program Expectations or Rules
  - Summary of confidentiality information
- Authorization for Release of Information Forms Signed
- If provided, any attendance records verifying the client's attendance at SUD education services
- Treatment Records must be kept for 7 years after discharge and Prevention Records for 3 years
- Diagnostic Assessment (Initial and/or Comprehensive)
- Compliant Treatment Plan(s)

The Big 4

Assessment

Treatment Plan

Service Notes

Discharge Summary

Required Elements of an Assessment

- Individualized
- Age, gender, and culturally appropriate
- Used to determined diagnosis, treatment needs, and used to create the treatment plan
- Can accept diagnostic assessments (initial or comprehensive) from other providers, as long as they were completed in the past 12 months and the agency must document that they reviewed the prior assessment and updated it if needed

Initial Assessment

- Presenting Problem
- Risk of harm to self or others
- Use of alcohol or drugs
- Treatment history for mental illness or substance use/ abuse
- Medical history and examination (mental status or physical)

Treatment and an Initial Treatment Plan (to be discussed) can be initiated following an Initial Assessment, however a Comprehensive Assessment that expands on the Initial Assessment must be completed within 30 days of the Initial Assessment.

Comprehensive Assessment

- Must have all the elements of the initial assessment + all additional information required by the agency's accrediting body
- Must be comprehensive enough to support the diagnoses and recommendations for treatment (medical necessity)

Treatment Plan Required Elements

- Need/ Diagnosis/ Problem
- Goal
- Objectives to measure progress toward the goal
- Specific Service(s) or Support(s) that will be provided*
- Frequency
- Anticipated Duration (Provider does not have to update the plan solely because an anticipated duration passes)
- Documentation of review & participation, or inability or refusal to participate and why
- Dated signature of individual who developed the plan and evidence of clinical supervision, if needed (evidence of clinical supervision could be on the plan itself or elsewhere in the client's record)
- SUD Only: Level of Care

*Except Crisis Services

Treatment Plan Requirements

- Should indicate mutually agreed upon goals for treatment.
  - If the client is unable or unwilling to participate in creating, agreeing to, or reviewing goals and progress, then that should be documented with a reason given
  - Should indicate review with client and other appropriate persons

- Should track progress in treatment over time
- Must be completed within 5 sessions or one month of admission, whichever is longer*
- Must be developed by an eligible professional (TBS Provider/ CDCA/SUD Care Management Specialist or higher credential, i.e. not a peer support specialist or PSR Only provider)

**Will discuss Initial treatment plans separately*

Treatment Plan Requirements

Must be reviewed, and updated, as applicable when:

- A services is added or terminated
- Clinically indicated
- There is a change in the SUD LOC, excluding sub-level changes
- Requested by the client
- At least every 12 months*

*Certain services require treatment plan reviews more frequently than every 12 months

What does “clinically indicated” mean, with regard to updating a treatment plan?

Not defined in rule, but examples could include:

- A new problem, diagnosis, or symptom that will be a focus of treatment
- A significant worsening of a problem or symptom that indicates the need for a change in treatment of frequency or intensity
- A significant change or life event that is impacting or could impact functioning
- A significant reduction in a problem or symptom (improvement) that indicates support for reducing or changing the focus, frequency, or intensity of treatment
- A stated goal or objective being met or no longer being relevant
- A new goal or focus of treatment (ex. previously deferred)

More Frequent Treatment Plan Review Interval Requirements

- SUD Case Management: 3 months
- IHBT: 3 months
- ACT: 6 months

Initial Treatment Plan

- A shorter initial Treatment Plan is allowed.
- Initial Treatment Plans only include what the Need/ Diagnosis/ Problem is, what services are going to be provided, and dated signature(s).
- If a provider chooses to do this, it must be developed within 7 days of assessment or at first face-to-face service after assessment (whichever is longer), a comprehensive Treatment Plan (5 sessions/ 30 days) must still be developed.
- Why would you want to do this? If you're using the Initial Assessment Process and plan to have a Comprehensive Assessment and full Treatment Plan within the next 30 days

SUD Case Management Plan of Care: Additional Requirements

- SUD CM Plan of Care is a separate or integrated plan that focuses on the targeted case management needs related to SUD care
- Provider can choose whether or not to integrate the full treatment plan with the SUD CM POC
- SUD CM Plans of Care must be developed within 7 days of assessment or at first face-to-face visit following the assessment (whichever is longer)
- SUD CM Plans of Care must be reviewed and updated, as applicable, every 90 days based on reassessing the client's case management needs
- If the organization chooses to integrate the two plans, then the integrated plan must be reviewed as clinically indicated, but at least every 90 days

Progress Note Required elements: ODM

- Type of Service
- Description of the Service Provided
- Date (or dates + frequency if a weekly note)
- Time of Day
- Duration
- Location
- Description of symptoms & any changes in functional impairment
- Changes in medication taken by or prescribed for the client, if applicable
- The amount of time spent face to face (versus telephone, asynchronous tele-services,
- The amount of time spent interpreting/ reporting (testing)
- Assessment of progress and description, if applicable
- Significant changes in symptoms, functioning, or life events
- Any recommendations for modification of the treatment plan
- Evidence of clinical supervision, if required

Progress Note Required Elements: OMHAS

- Should indicate progress or lack of progress toward specified goals
  - Can be documented via narrative or checklists, as long as it provides sufficient detail and includes all the required elements
- Can be per service, daily, or weekly
  - Per Service Progress Note Requirements:
    - Client ID
    - Date, time, duration
    - Location
    - Description of Service
    - Assessment of progress, with description of progress made, if any
    - Significant life changes or events
    - Treatment Plan Updates needed
    - Signature with credentials of the provider of the service and date of signature

Progress Note Required Elements: Daily Notes

- Daily Progress Note Requirements:
  - Client ID
  - Date the note pertains to
  - Log of the date, time, duration, and location of each service contact that the note covers
  - Description of each Service
  - Assessment of progress, with description of progress made, if any
  - Significant life changes or events
  - Treatment Plan Updates needed
  - Signature with credentials of the person writing the note and date of signature
  - Signatures and credentials of each person who provided any of the services that the note covers

Progress Note Required Elements: Weekly Notes

- Weekly Progress Note Requirements:
  - Client ID
  - The week/ 7 day period the note pertains to
  - Log of the date, time, duration, and location of each service contact that the note covers
  - Description of each Service
  - Assessment of progress, with description of progress made, if any
  - Significant life changes or events
  - Treatment Plan Updates needed
  - Signature with credentials of the person writing the note and date of signature
  - Signatures and credentials of each person who provided any of the services that the note covers

Medical Activities Documentation (under General Services)

Applies to services provided by and within the scope of nurses, physicians, and pharmacists that are intended to address the behavioral health or other physical needs of clients receiving treatment for psychiatric or substance use disorders.

Documentation must include, as applicable:

- Progress Notation (screenings, gathering vitals, assessments, exams, observations)
- Prescription Information (prescribing, administering, and monitoring)
- Review of Test Results

Note: The billing code the medical provider selects may have additional required documentation to support the billing code selected (ex. E/M codes)

Discharge Summary: Required Documentation

- Date of Admission
- Last Date of Service
- Outcome of Services Provided/ Rating of Progress or changes in the level of care
- ASAM Level of Care at discharge (SUD Only)
- Recommendations made to the client, including referrals to other community resources (Planned Discharges Only)
- Medications prescribed by the agency at time of discharge
- Documentation of informing the client of the right to appeal an involuntary discharge (if applicable)
- Dated signature and credentials of staff person completing the summary

SUD Level of Care: Required Documentation

- Must use ASAM Levels of Care criteria
- Must have a documented recommended level of care determination:
  - At admission
  - For continued stay (ex. residential care)
  - At the time of any changes in level of care
  - At discharge
- If the recommended level of care based on the ASAM criteria assessment is different from the level of care the client will/ did receive, then the rationale must be documented.

Service Specific Additional Documentation


QUALITY
CONTORL
a.bacall

Crisis Intervention Documentation

(This is not referring to Psychotherapy for Crisis)

Documentation—2 parts, Evaluation & Plan

Evaluation focuses on:

- Understanding of what initiated the crisis and the client's response(s)
- Risk assessment of lethality, propensity for violence, and medical/ physical condition including alcohol or drug use
- Mental Status
- Information about the individual's resources
- Identification of immediate treatment needs and the appropriate setting for care

Plan focuses on:

- Plan to de-escalate, stabilize, restore safety
- Referrals, linkages, and coordination with other systems/ settings needed

Assertive Community Treatment (ACT): Additional Documentation Requirements

- Documentation of eligibility for ACT
- Circumstances surrounding disenrollment
  - Reason
  - For Planned Dis-enrollments
    - Progress toward goals
    - Documentation re: linkage and transfer to new provider/ team
    - Signature of client or guardian, ACT Team Leader, and prescriber
- DACTS Model fidelity (Org level documentation)
- Treatment Plan more robust
- Treatment Plan reviewed as clinically indicated or at least every 6 months
- Summary of progress in treatment at least every 6 months
- Treatment plan signed by client
- If client discontinues services without communication, documentation of at least 2 face-to face attempts at contact per month for 3 months (or until the client communicates their desire to disenroll)

Intensive Home Based Treatment: Additional Documentation Requirements

- Documentation of eligibility for IHBT
- Circumstances surrounding disenrollment
- Documentation of fidelity to model, including supervision plan (organizational level)
- More robust treatment plan
- Review and update of treatment plan as clinically indicated or at least every 3 months
- Treatment plan update includes a summary of progress at least every 3 months
- Treatment Plan signed by the recipient and specified adult
- Identification of collaterals (ex. family members, guardians) to be involved in treatment
- Continued stay review for continuation of services beyond 6 months

SUD Services: Additional Documentation Requirements

- Documentation supporting Level of Care
- Referrals to other Levels of Care (SUD Residential & W/M Only)
- Residential levels of care Only: Treatment Plan must include treatment services to be provided by practitioners/ agencies outside the residential treatment organization, if applicable
- Residential & W/M Discharge Summaries must include specific referral information regarding SUD treatment referrals
- Residential & W/M Programs Only: Follow Up Communication with Client & Service Provider the client was referred to post discharge.
- Residential & W/M Programs Only: Health history, including food allergies and drug reactions
- For SUD Targeted Case Management: More robust inclusion of social determinants of health needs in treatment plan

Other Services: Additional Documentation Requirements

Behavioral Health Hotline Services

- Log of all calls
- Documentation within the client record of the call, if the caller is also a treatment client of the agency's

Forensic Evaluation Services

- Written summary of evaluation and related records stored separately from other service records, see OAC 5122-29-07 for additional requirements

Prevention Services

- Records pertaining to the prevention service noting date, location, # of participants, types of strategies/ services provided, description, signature with credentials

Other Services: Additional Documentation Requirements

Supported Employment

- Agency evidence of fidelity to model and providing the supports listed in 5122-20-11

Driver Intervention Programs

- Intake report
- Screening(s)
- Assessment(s), if applicable
- Program Completion Report
- See also 5122-29-12 for additional requirements

Consultation Service

- Record of consultation service provided including the person or system it was provided to, nature, and outcome of the consultation

Other Services: Additional Documentation Requirements

Referral & Information Service

- Log of all calls and contacts including date, time, and person answering the call/ contact

Client Specific Seclusion & Restraint Record Keeping

If an agency uses seclusion and restraint:

- And an individual is believed to be a risk to self or others
- And may experience the use of seclusion or restraint
- Or the agency knows that seclusion or restraint has been used in the past, then the client needs to have an Individual Crisis Plan.

The Individual Crisis Plan must:

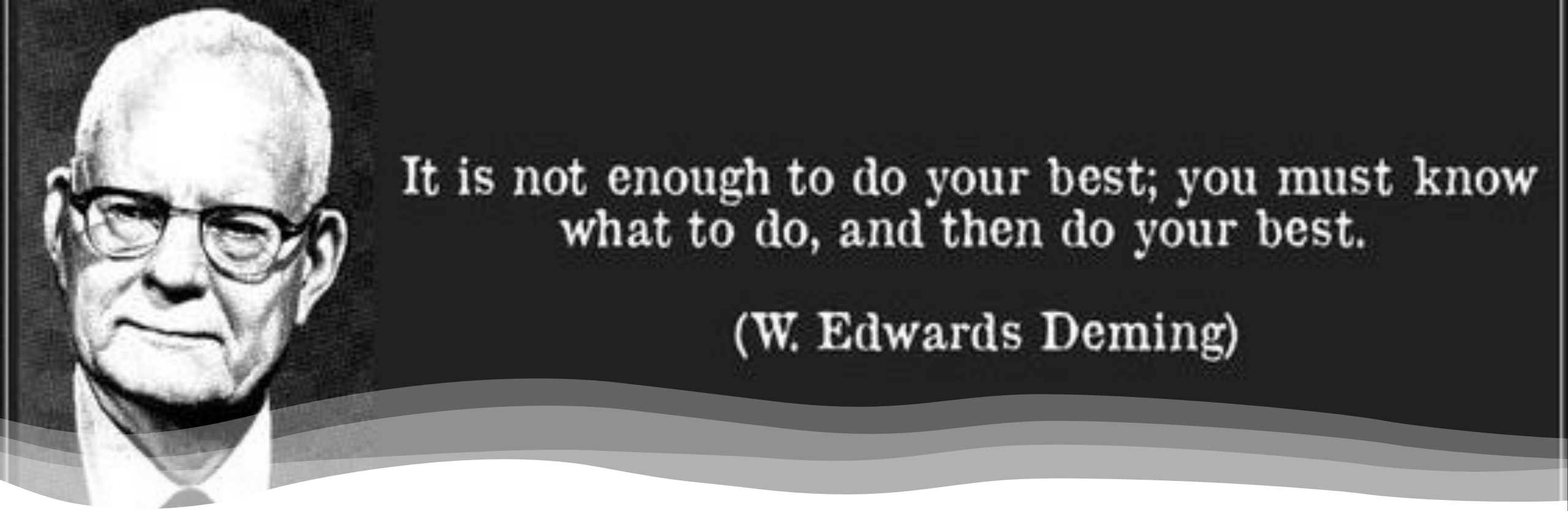
- Include Methods & Tools the individual will use to de-escalate themselves
- Include Techniques & Strategies for staff to use to support individual to manage their own behavior
- Include Methods or Tools the staff will use to control the individual's behavior
- Be based on a comprehensive assessment that includes consideration of gender, age, developmental issues, culture, race, ethnicity, primary language, history of abuse or trauma, medical or other conditions that may compromise well being, physical disabilities.

A Debriefing must be documented following each incident of seclusion or restraint.

See OAC 5122-26-16 for additional documentation requirements outside the client record

Record Review

Completeness & Quality



Record Review System

Ensure there is an up to date documentation policy in place that outlines expectations clearly.

Determine who is responsible for record reviews (completeness & quality). (Supervisors, Peers, QA)

Determine the frequency or interval of reviews (see accreditation standards).

Establish a record review audit tool based on expectations.

Determine how charts will be selected or assigned for review, by staff person, client ID #, random sampling.

Identify where the record review results will go and what will be done with them? Who is responsible?

Identify who is responsible for:

- Ensuring any areas for improvement have been fixed within individual charts
- Ensuring any areas for improvement trends within a team, program, organization have a performance improvement plan developed and implemented

Create a system for monitoring the completion of record reviews and the appropriate follow up activities.

Best Practice Rules:

- No one reviews their own chart.
- No one selects their own chart to have their peer review.
- Review both open and closed charts.
- Review a representative sampling from all programs, teams, divisions, types of services, etc.

Completeness of Record Review:

- Are the required intake forms (consents, ROI's, financial documents, etc.) present and do they appear to be complete and signed?
- Are all necessary service document categories present and active (if applicable) (ex. assessment, treatment plan, progress notes, discharge summary)?
- Do all services requiring prior auths have the necessary documentation?
- Do all services have a signed note?
- Through a random sampling of service notes, do they have all required elements?
- Have all completed services have been billed?
- Can we attest that we do not see any evidence of inappropriate overlapping or duplicative services or of claims submitted without appropriate correlating documentation to support it?
- Providers of services appear to be appropriately credentialed per their signature line

General Billing Requirements for billing to Medicaid

- Name & Medicaid Number Correct
- Individual was eligible for Medicaid services on date of service
- Documentation supporting the claim is present
- Provider was eligible to provide that service
- Dates on service and claim match
- Correct Modifiers
- Client was not inpatient or in another type of facility*
- Correct units (whether time based, encounter, roll up, or distinct)
- TPL reviewed and handled correctly
- ICD 10 diagnosis

Record Reviews

Quality of Record Reviews:

- Focused on the quality of documentation, clinical appropriateness/ best practice standard of the services provided.
- Looking for a logical “storyline” from assessment to plan to progress notes to treatment plan updates, additional progress notes, all the way to discharge and outcome of care.
  - If things don’t make clinical sense or can’t be followed through from beginning to end, then there is either something wrong with either the documentation or with the care being provided.

Diagnostic Assessment Record Review

- Does it cover all required areas?
- Is it signed or co-signed by an eligible provider?
- Do the reported symptoms, history, and problems support the diagnoses?
- Do the recommendations for treatment make sense in light of the diagnoses and history of treatment?
- Is it clear that all of the services recommended or referred for are medically necessary based on what is reported in the assessment?
- If the diagnostic assessment references using other assessments, reports, tests, or records (other than the assessment) to base the recommendations for treatment and diagnoses are, are those document available?

Treatment Plan/ Service Plan Record Review

- Do the goals make sense based on the diagnosis and problems described in the record (ex. in the DA, DA Update, on a referral document or in a progress note)?
- Are the goals Person Centered (individualized, focused on the client—not the professional)?
- Are the objectives measurable? (numbers, yes/no, tests or rating scales, etc.)
- Does it list the services to be provided and do those services makes sense based on the goals and objectives listed?
- Frequency, target dates
- Does the plan indicate the person served participated in developing the plan, or if not, indicate why?
- Is it signed by the person who developed the plan and is there evidence of supervision, if needed*?
- Has the plan been reviewed and updated, as clinically indicated, or at least annually or more frequently if the specific services have a more frequent review interval required?
- Are all services that have been provided in the applicable time period also listed on the plan?

*Evidence of supervision could be on the plan itself or elsewhere in the client's record

Progress Notes Record Review

- Are all the required elements present?
- If a disclosure is referenced or noted in a note, is a valid ROI on record, as needed?
- If the service requires a prior authorization, is the authorization in the record?
- Do the notes reference the goal being addressed, and this is an active goal on the treatment plan?
- Are the interventions, care, assessment described appropriate for the procedure code selected?
- Is progress or lack of progress noted?
- If a significant change, life event, or progress/ lack of progress is noted that would “clinically indicate” a change is necessary on the treatment plan, was the treatment plan updated?

Discharge Summary Record Review

- Does it have all of the required elements?
- Does the reason for discharge make sense in context of the rest of the record?
- Does the rating of progress or outcome of treatment align with the rest of the record?
- After reviewing this record, is it clear to me that we provided high quality treatment to this person and either ensured that a warm handoff happened to other providers/ services or that this client likely knows how to get additional services or help, if needed?

Additional documents to review

Sometimes there are additional documents that help show the full story of treatment. These may include:

- Non-billable notes, short phone call records, etc.
- Records, reports, or summaries from outside sources
- Internal and external referral forms
- Internal/ external transfers or transition plans between programs, primary clinicians, levels of care, etc.
- Lab or test orders/ results
- Disclosure of information logs
- Outside provider prescription information

From a quality perspective, what are we looking for in this additional information?

“Does all of this information make sense in context of the treatment we are providing and/or are we missing anything meaningful?”

“Do all of the treatment team members appear to be coordinating and on the same page with the same information and recommended course of treatment?”

Using Record Review Data

- Reviews that no one acts on are meaningless (and could create additional risk and liability, because now there is a record that the organization knew about a potential problem and should have done something)
- Record Reviews Should Be Used:
  - To monitor for accuracy, completeness, and timeliness of record keeping
  - To prevent fraud, waste, and abuse
  - For ensuring quality in specific client records/ treatment
  - To identify areas where additional training or staff development is needed
  - To identify areas within the organization where a new or updated policy, process, or procedure is needed
  - To identify where there is inconsistency in practice within the organization
  - To identify where there is lack of collaboration and coordination within an organization (ex. where referrals are getting dropped or focus of treatment is not consistent)
  - To identify staff or teams who are excelling in their provision of high quality care and documentation, celebrate that and build on their expertise

Organizational Required Documentation

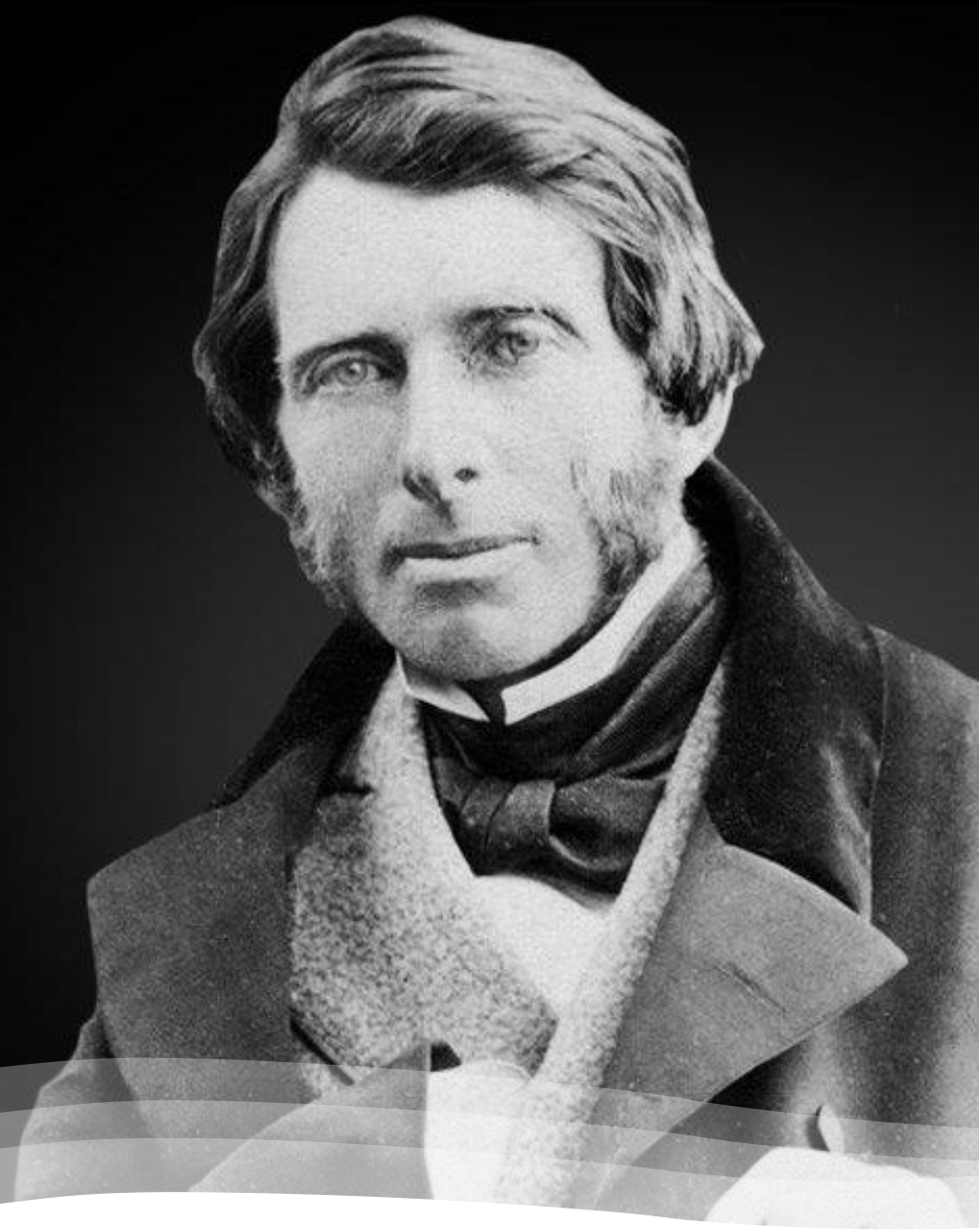
- Waitlist of individuals seeking opioid and co-occurring drug addiction services and recovery supports
- Governance/ Leadership Structure and Records
- Table of Organization
- Financial Records/ Budget
- Quality Assurance Plan/ Records
- Risk Management Records and Adequate Malpractice & Liability Insurance
- Client Rights, Complaints, and Grievance Records
- Records regarding Soliciting Input & Feedback
- Duties & Responsibilities of leadership
- Policies & Procedures, and evidence of review
- Provider Service Plan detailing services provided
- Safety Drill and Health and Safety Inspection and Permit Records
- Physician/ Dietician approval for meals of clients with specialized diet needs
- Personnel & Training Records
- Incident Reports, and evidence of review
- TDDD, if applicable
- Medication Handling Records
- Seclusion & Restraint Logs, if applicable, and evidence of review
- Curriculum used to train staff on seclusion or restraint, if applicable
- Organizational Plan to Reduce Seclusion or Restraint, if applicable
- Performance Improvement Plans
- Consumer Outcomes Data
- Affiliation Agreements for less intensive levels of care, if a SUD W/M provider

Additional Organizational Documentation that may be required:

- Non-deemed Status (meaning without national accreditation) Providers, see OAC 5122-25-03
- Organizations seeking Deemed Status (meaning with national accreditation) or Deemed Status Providers seeking certification for services they are not yet deemed status for (meaning with national accreditation for some, but not all services provided), see OAC 5122-25-04

Quality is never an accident.
It is always the **result**
of intelligent effort.

– *John Ruskin*



Questions

Building Compliance into your Electronic Health Record (EHR)

Thursday, October 29th, 2020

Presented by:

Chelsea Kohler
Lead EHR Implementation and Billing Project Manager
Behavioral Health Billing Solutions, LLC

Who is *Behavioral Health Billing Solutions?*

Teresa Heim started Behavioral Health Billing Solutions in 2017 after 10+ years working in Ohio Behavioral Health. She realized there was a significant need for billing training and support by a billing expert.

Our Service Offering:

Comprehensive Billing Services

Our thorough Process Includes:

- Evaluation of all billing processes
- Complete 270 eligibility processing
- Expert Advice for best practices
- Recommendations for outstanding AR collection
- Full and partial billing service options
- Developed detailed, monthly financial reporting, denial and appeal remediation

Qualifacts Official Affiliate Provider

Benefits of Becoming a BHBS CareLogic Associate Include:

- Built & hosted by Ohio BH redesign experts
- Fully functional EHR system
- EHR implementation takes a fraction of the time and fraction of the cost
- Access to top Ohio redesign experts
- Dedicated team of billing and EHR professionals trained specifically for CareLogic EHR

Today's Topics

- Ways to STOP Incorrect Billing From Going Out
- Managing the Coding Complexities of BH Redesign
- The Importance of Data and Reporting

**Most examples in this presentation are specific to Ohio Medicaid payers since this is where we have the most consistent guidance (unlike Commercial Insurance or Medicare Advantage)

Ways to STOP Incorrect Billing From Going Out

- High Units
- Low Units
- Incorrect Service Location
- Diagnosis Categories
- Prior Authorizations
- Correct Use of Add-Ons
- Allowed Services for Allowed Practitioners

High Units – Preventing the AM/PM Error

- AM/PM Errors:
  - Clinician saw a client for Individual Counseling from 8AM-9AM. Clinician accidentally puts 9PM instead of 9AM, turning a 1-hour service into a 13-hour service. The system tries to bill a 90837, 99354 and 22 units of 99355.
  - This is OBVIOUSLY incorrect and most likely the payer will deny BUT sometimes they wont.
- How to prevent?
  - Adding mapping to error or fail services if they are over a certain time threshold.
    - Example: Fail any service greater than 719 minutes or 12 hours.

Low Units – Preventing Billing Below the Billable Minimum

- Every time-based code has a billable minimum
- Medicaid and other payers work with the "rule of halvsies"
  - See "Time Based CPT Codes" Below
- Establish blocks within your EHR to prevent billing below the billable minimum

Activity Code	Minute Range
Ambulatory Detox - Nurse	0 - 30
Ambulatory Detox - Physician	0 - 239
Assessment or Assessment Update	0 - 15
Crisis	0 - 15
Developmental Testing	0 - 30
Family with or without Patient	0 - 25
Individual Counseling	0 - 15
MH Group	0 - 15
MH Screening	0 - 14
Psychiatric Evaluation with Medical	0 - 4
Psychological Testing Evaluation	0 - 30
Smoking Cessation	0 – 2
Any 15 Minute Unit Service	0-7

Time Based CPT Codes

When billing time-based codes the CPT/HCPCS time rule applies, unless otherwise specified:

For the minimum billable service of the code, divide the time by two and add one minute in order to determine if that code can be billed. For example; 90832 = 30 minutes, therefore the minimum length of service must be 16 minutes (30/2 = 15 then 15 + 1 = 16) in order for the service to be billable.

Preventing Incorrect Service Location Denials

- Common Errors
  - 53 instead of 57 (Or vice versa)

53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services. If the facility is not certified by Medicare as a CMHC, POS should be 11, indicating office.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.

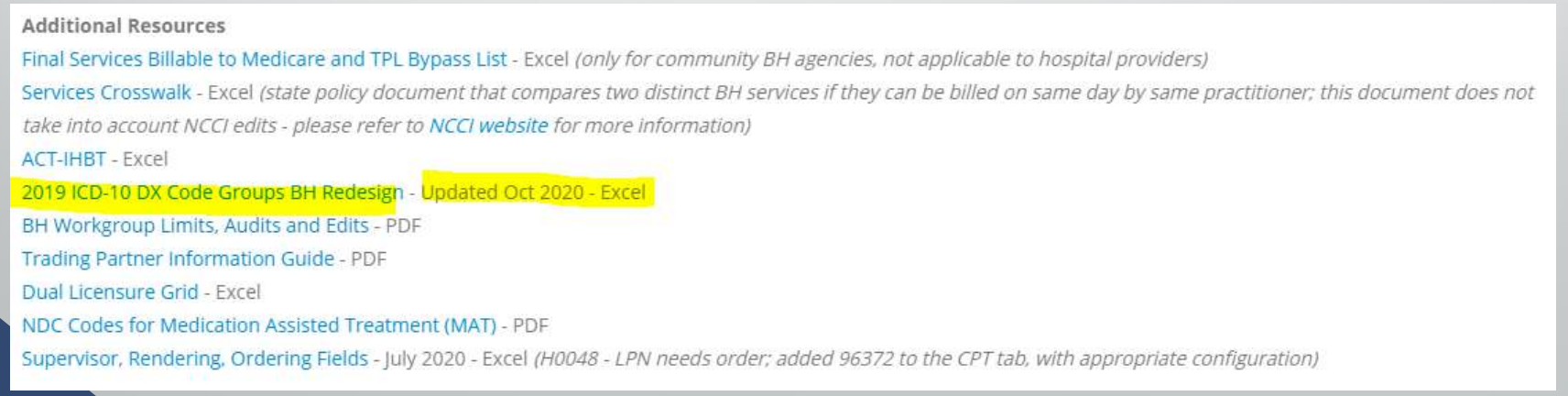
  - 55 instead of 57 or 11

55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

- Services in Jail (09)
  - Not Billable to Medicaid, Commercial Insurance or Medicare – MIGHT be billable to a Board Payer per Specific Contracts. Set Up Bypass

Using Diagnosis Categories

- MH Diagnosis Ranges vs SUD Diagnosis Ranges
  - Allows use of a program or indicator in the service to "point" at the correct diagnosis for the service if the client is dually diagnosed
  - Example:
    - Client is dually diagnosed – F10.10, F32.9, F41.9
    - Clinician sees the client for a MH Individual Counseling session.
    - System should know to only POINT to the F32.9 and F41.9 MH Diagnoses since those would be in the MH range
  - Up to date information on allowable diagnoses can be found on the ODM – BH Manuals, Rates and Resources page (FYI – Last Updated October 2020):



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Using Diagnosis Categories, cont.

- Services with Specific Applicable Diagnoses
  - ACT vs IHBT

Group E: Assertive Community Treatment	
ACT (H0040)	
F20.0	Paranoid schizophrenia
F20.1	Disorganized schizophrenia
F20.89	Other schizophrenia
F20.2	Catatonic schizophrenia
F20.3	Undifferentiated schizophrenia
F20.5	Residual schizophrenia
F20.81	Schizophreniform disorder
F20.9	Schizophrenia, unspecified
F21	Schizotypal disorder
F25.0	Schizoaffective disorder, bipolar type
F25.1	Schizoaffective disorder, depressive type
F31.0	Bipolar disorder, current episode hypomanic
F31.10	Bipolar disord, crnt episode manic w/o psych features, unsp
F31.11	Bipolar disord, crnt episode manic w/o psych features, mild
F31.12	Bipolar disord, crnt episode manic w/o psych features, mod
F31.13	Bipolar disord, crnt epsd manic w/o psych features, severe
F31.2	Bipolar disord, crnt episode manic severe w psych features
F31.30	Bipolar disord, crnt epsd depress, mild or mod severt, unsp
F31.31	Bipolar disorder, current episode depressed, mild
F31.32	Bipolar disorder, current episode depressed, moderate
F31.4	Bipolar disord, crnt epsd depress, sev, w/o psych features
F31.5	Bipolar disord, crnt epsd depress, severe, w psych features
F31.60	Bipolar disorder, current episode mixed, unspecified
F31.61	Bipolar disorder, current episode mixed, mild
F31.62	Bipolar disorder, current episode mixed, moderate
F31.63	Bipolar disord, crnt epsd mixed, severe, w/o psych features
F31.64	Bipolar disord, crnt episode mixed, severe, w psych feature
F31.71	Bipolar disord, in partial remis, most recent epsd hypomani

Group F: Intensive Home Based Therapy (IHBT)	
IHBT (H2015)	
F20.81	Schizophreniform disorder
F20.9	Schizophrenia, unspecified
F22	Delusional disorders
F23	Brief psychotic disorder
F25.0	Schizoaffective disorder, bipolar type
F25.1	Schizoaffective disorder, depressive type
F29	Unsp psychosis not due to a substance or known physiol cond
F31.0	Bipolar disorder, current episode hypomanic
F31.10	Bipolar disord, crnt episode manic w/o psych features, unsp
F31.12	Bipolar disord, crnt episode manic w/o psych features, mod
F31.13	Bipolar disord, crnt epsd manic w/o psych features, severe
F31.2	Bipolar disord, crnt episode manic severe w psych features
F31.30	Bipolar disord, crnt epsd depress, mild or mod severt, unsp
F31.32	Bipolar disorder, current episode depressed, moderate
F31.4	Bipolar disord, crnt epsd depress, sev, w/o psych features
F31.73	Bipolar disord, in partial remis, most recent episode manic
F31.74	Bipolar disorder, in full remis, most recent episode manic
F31.75	Bipolar disord, in partial remis, most recent epsd depress
F31.76	Bipolar disorder, in full remis, most recent episode depres
F31.81	Bipolar II disorder
F31.89	Other bipolar disorder
F31.9	Bipolar disorder, unspecified
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressv disorder, recurrent severe w/o psych feature
F33.3	Major depressv disorder, recurrent, severe w psych symptoms
F34.81	Disruptive mood dysregulation disorder (New code effective 10/1/2016)
F34.89	Other specified persistent mood disorders (New code effective 10/1/2016)
F40.00	Agoraphobia, unspecified

Preventing Billing for Services without a Prior Authorization (that require one)

- Most Common:
  - Partial Hospitalization requires prior authorization from day 1
  - SUD Residential requires prior authorization after 30th day for the first two stays
  - SUD Peer Services require prior authorization for more than 4 hours in one day

- How to prevent?
  - For applicable payer types, set up a failure or error if a service is provided outside of the allowable threshold
    - Example: Cause partial hospitalization claims to error if there is no prior authorization in the system since one is needed from day one
  - Establish reporting to monitor when a client may be nearing their 31st day of residential and partner with the clinical team to determine whether they intend to keep in the same level of care, discharge or refer to a lower level of care.

Prior Authorizations, cont.

Description and Code	Benefit Period	Authorization Requirement
Assertive Community Treatment (ACT) H0040	Based on prior authorization approval	ACT must be prior authorized and all SUD services must be prior authorized for ACT enrollees.
Intensive Home Based Treatment (IHBT) H2015	Based on prior authorization approval	IHBT must be prior authorized.
SUD Partial Hospitalization (20 or more hours per week)	Calendar year	Prior authorization is required for this level of care for adults and adolescents.
Psychiatric Diagnostic Evaluations 90791, 90792	Calendar year	1 encounter per person per calendar year per code per billing agency for 90791 and 90792. Prior authorization once limit is reached.
Psychological Testing 96112, 96113, 96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137	Calendar year	Up to 20 hours/encounters per patient per calendar year for all psychological testing codes. Prior authorization once limit is reached.
Screening Brief Intervention and Referral to Treatment (SBIRT) G0396, G0397	Calendar year	One of each code (G0396 and G0397), per billing agency, per patient, per year. Cannot be billed by provider type 95. Prior authorization once limit is reached.
Alcohol or Drug Assessment H0001	Calendar year	2 assessments per patient per calendar year per billing agency. Does not count toward ASAM level of care benefit limit. Prior authorization once limit is reached.
SUD Residential H2034, H2036	Calendar year	Up to 30 consecutive days without prior authorization. Prior authorization then must support the medical necessity of continued stay, if not, only the initial 30 consecutive days are reimbursed. Applies to first two stays; any stays after that would be subject to full prior authorization.
SUD Peer Recovery H0038	Calendar year	Up to 4 hours per day without prior authorization. Prior authorization would be needed to cover more than 4 hours in a day once limit is reached.
Any service or ASAM level of care not listed in this table is not subject to prior authorization.		

Correctly Using Add-On Codes

- E&M with Psychotherapy
  - Did psychotherapy apply?
  - If yes, how much time was used for psychotherapy?
    - 16-37 Minutes - 90833
    - 38-52 Minutes - 90836
    - 53-719 Minutes - 90838
- Prolonged Service Codes for E&M Codes

Code	Typical Time for Code	Threshold Time to Bill Code 99354	Threshold Time to Bill Codes 99354 and 99355
99201	10	41	86
99202	20	51	96
99203	30	61	106
99204	45	76	121
99205	60	91	136
99212	10	41	86
99213	15	46	91
99214	25	56	101
99215	40	71	116

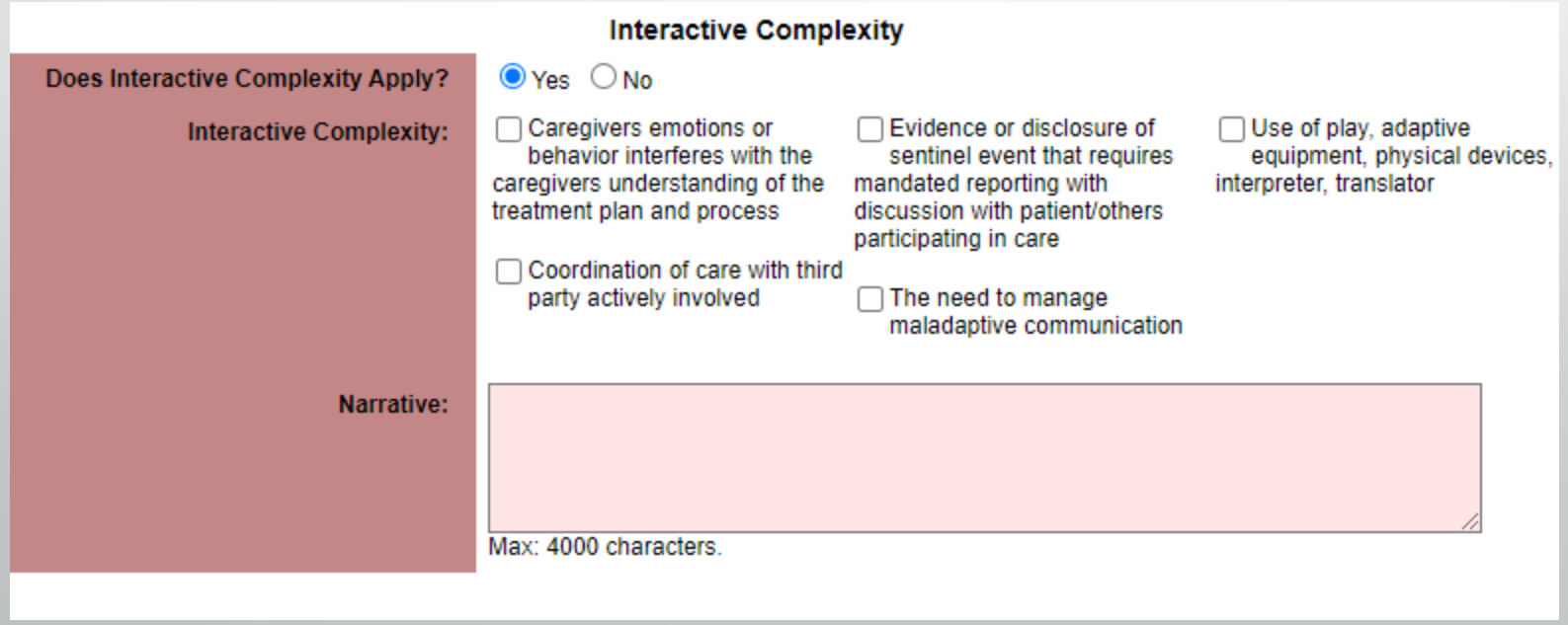
Correctly Using Add-On Codes

It's important to document why Prolonged services occur. Best practice, build it into your note and do frequent audits.

- Prolonged Service Codes
  - When to trigger based on time? Example of 90837:
    - +53 Minutes - 90837
    - +91 Minutes – 99354 (First 60 Minutes)
    - +135 Minutes – 99355 (Each Additional 30 Minutes)
- Interactive Complexity
  - See next slide

Correctly Using Add-On Codes

- Interactive Complexity
  - Specific reasons in which Interactive Complexity applies.
  - Should have the ability to add the add-on based upon clinical documentation supporting the applicability



Allowed Services for Allowed Practitioners

- Each service in the BH Manual has a list of applicable practitioners
- Recommendation is to set up your EHR to only allow billing for allowable practitioners
- Examples:
  - If a QMHS chooses an Individual Counseling service, this should give an error or failure to allow the clinician to review and either be coached not to provide the service or allow for unintended error (choosing the wrong service)
  - Similarly, if a CDCA chooses a Peer service, the Peer service should error or fail since the CDCA cannot provide Peer Services

Managing the Coding Complexities of BH Redesign

- Understanding the rules, time requirements and programmatical differences between:
  - IOP
  - PHP
  - MH Day Treatment (Hourly and Per Diem)
- Building TPL Bypass into your EHR
  - Explaining Bypass
  - Proper Payer Order Utilizing Bypass
- Billing for Dual Credentials

IOP vs PHP

- IOP
  - Total Service Time Per Week Expectation = 9 to 19 hours (Recommend EHR reporting on all services provided to a client to determine if they are meeting the hours required of this level of care)
    - This includes ALL combined services
  - To bill for the per diem group, must hit 2 hours 1 minute (Recommend procedure mapping to allow 90853 > H0005 > H0015)
  - Able to bill for other provided services (individual counseling, CPST, etc.) in addition to the per diem
  - Able to bill for an additional 1-hour group (different subject) in addition to the per diem group
- PHP
  - Total Service Time Per Week Expectation = Over 19 hours (Recommend EHR reporting on all services provided to a client to determine if they are meeting the hours required of this level of care)
    - This includes ALL combined services
  - To bill for the per diem group, must hit 3 hours 1 minute (Recommend procedure mapping to allow 90853 > H0005 > H0015:TG)
  - Able to bill for other provided services (individual counseling, CPST, etc.) in addition to the per diem
  - Able to bill for an additional 1-hour group (different subject) in addition to the per diem group

MH Day Treatment

- Based on time spent, its 150 minutes (2.5 hours) to bill for the per diem H2020 and prior to that, 30 minutes - 149 minutes will bill as H2012, 1 or 2 units (maxing at 2 units).

See notes from OhioMHAS and Medicaid below on the hours and then unit conversions. Although the administrative code mentions a minimum of two hours. With the rule of halvsies and each unit being 1 hour, this would require 2.5 hours to bill the per diem service. How do you build this into your EHR?

- **Per Ohio Administrative Code:**
  - https://mha.ohio.gov/Portals/0/assets/AboutUs/Regulation/Rules/5122-29-06.pdf

(E) For purposes of this rule, a ~~partial hospitalization~~mental health day treatment program day shall consist of a minimum of two hours and up to a maximum of seven hours of scheduled intensive activities that may include, but are not limited to, the following:

- **Per Medicaid:**

Unit Value	H2012: Hourly, maximum of 2 per day H2020: Per diem

	Minute Range	Service Count Range	Billable Unit	Procedure	
Select	0 - 30		1 Unit(s) with Truncate to nearest 1 Unit	LOWUNITS:HN	Delete
Select	31 - 149		60 Minute(s) with Round Nearest to nearest 1 Unit	H2012:HN:HQ	Delete
Select	150 - 719		1 Unit(s) with Truncate to nearest 1 Unit	H2020:HN	Delete

TPL Bypass and Payer Order

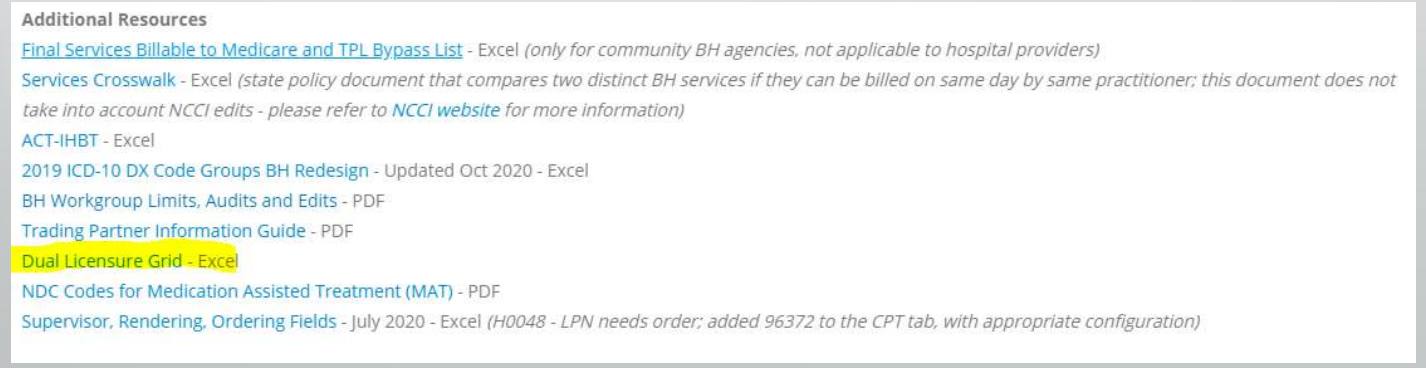
- Commercial Insurance and Medicare Advantage
  - Must bill all provider types
  - Cannot bill HCPCS/Medicaid Only Service Codes
  - NOT Automatic Crossover (In Most Circumstances)
- Original Medicare
  - Cannot bill all provider types (only specific independent providers)
  - Cannot bill HCPCS/Medicaid Only Codes
  - Automatic Crossover

Dual Credentials

- If a clinician is dually credentialed for both MH and SUD, their SECONDARY credential may require an additional modifier to tell the payer which credential to look at when adjudicating

- Example: Clinician is an LICDC and an LSW. If LICDC is primary and LSW is secondary, any MH claim should go out with the U4 modifier EVEN for payer who do not generally require the U modifiers.

- **Side note:** If you provide SUD Residential services, the INDEPENDENT license needs to be the primary. This includes situations such as a LICDC/LSW. The LSW technically has the wider scope BUT the independent is required for residential billing. LSW/LICDC will deny.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The Importance of Data and Reporting

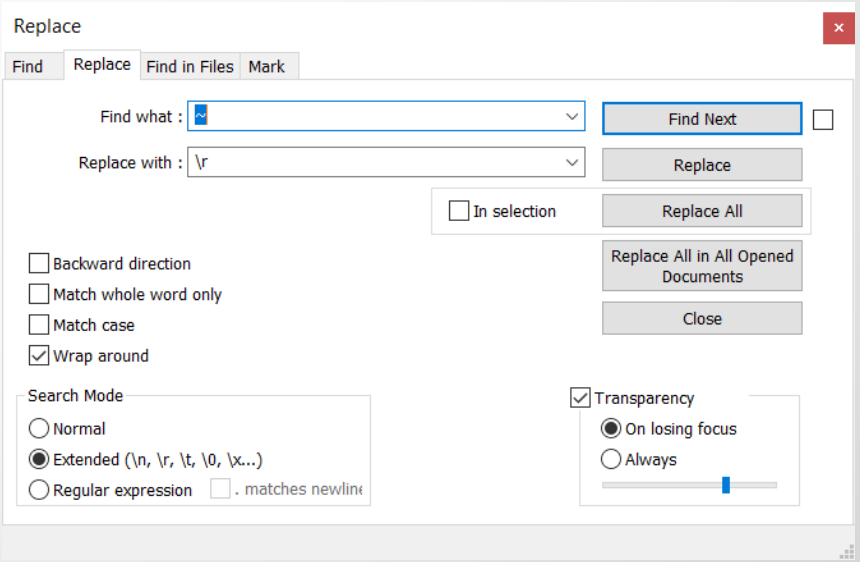
- 270/271 Eligibility Reporting
- 824 Rejections and Clearinghouse Rejections
- Standard Reports
  - Client Reports
  - Employee/Staff Reports
  - Billing Reports
  - Gap Reporting
- Proper Document Retention

270/271 Eligibility Reporting

- Medicaid and Board Payers are the Payer of Last Resort
  - Except for some board specific services
- Run your ENTIRE client bases eligibility, this includes any active or recently active client (even if they are no longer active)
- Compare Medicaid's 271 Response to your EHR to highlight differences where changes, additions or terminations need made and the subsequent rebilling

824 Rejections and Clearinghouse Rejections

- 824 is FFS Medicaid's invalid Medicaid ID rejection. These IDs will reject if they are in the wrong format, not necessarily if they are just incorrect.
  - Medicaid Trading Partner – Search for file type .824
  - To read the ANSI file, download NOTEPAD++ and replace ~ with \r



- Clearinghouse Rejections – Two levels
  - Clearinghouse Rejections
  - Payer Rejections

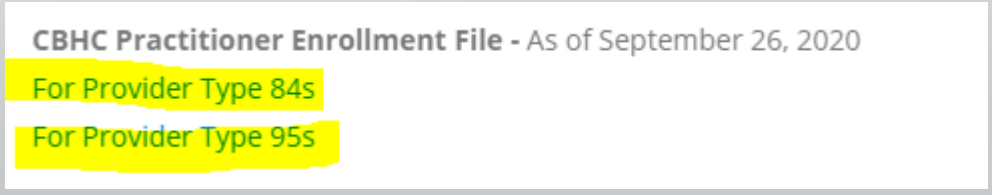
Standard or Custom Reports – Client Reports

Your EHR should have the ability to track your services and clients in any way you wish:

- Clients by Program
- Demographics Missing
- Admissions and Discharges Report - Critical with OBHIS
- Utilization Report
- Residential Per Diem
- Payer Plan and Sequence
- Procedure by County
- Activity since Assessment
- Compliance for their LOC
- Prior Authorizations
- Treatment Plan Tracking and Expiration

Standard or Custom Reports – Employee Reports

- Productivity
- Incomplete Clinical Documentation
- Credentials in comparison to the reporting available from ODM.
  - Current state ODM provides us with a current list of all type 84/95 providers and their affiliations. Having the ability to do a side by side comparison between your EHR (which drives coding - example, using a HM modifier for HS associate vs a HN for Bach, HO for Masters) is critical.

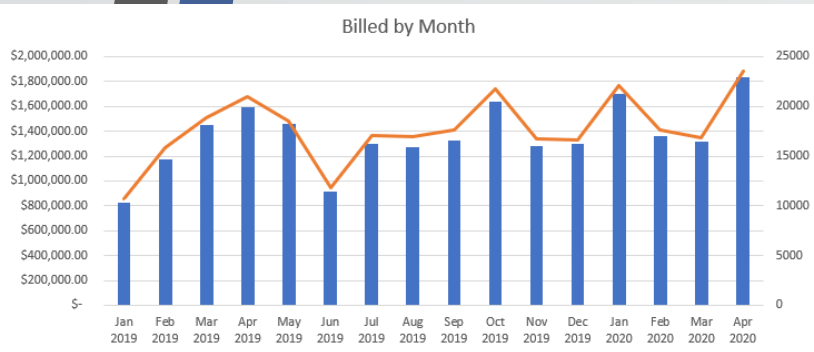


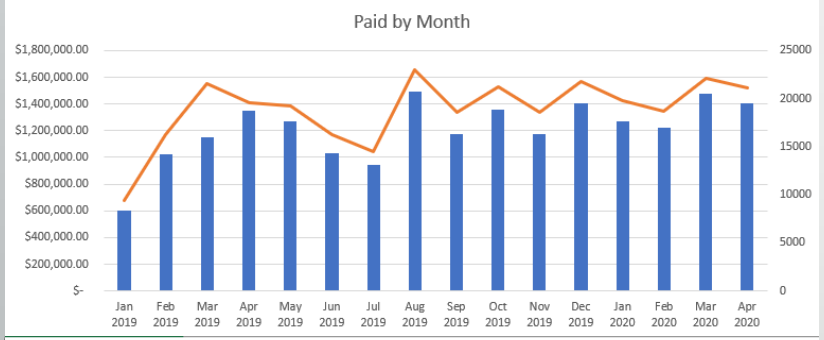
Standard or Custom Reports – Billing Reports

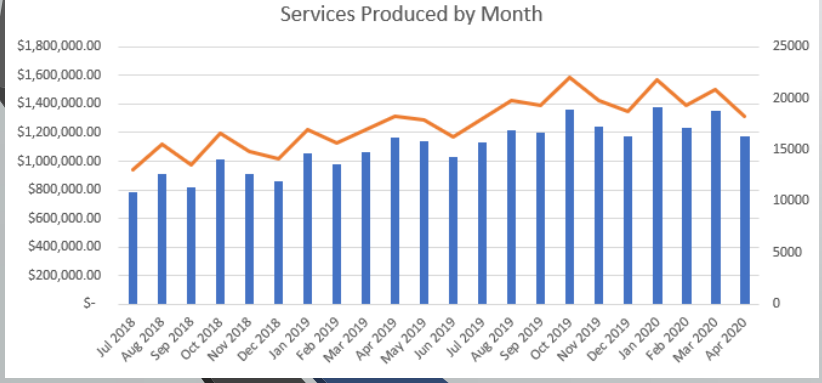
- Ability to track the lifecycle of a claim and additional important claim data
  - How much did you bill the payer?
  - How much do you expect to receive?
  - How much have you received after all payments and recoups?
  - Did the payments satisfy the balance?
  - What batches/deposits is the claim in? What dates are associated to those batches and deposits?
  - Other data points that can help predict or diagnose whether a claim will be paid:
    - Diagnosis
    - Place of Service
    - Rendering Provider
    - Procedure/Modifier Combination
    - Payment Notes
  - Data points to assist with the AR process in your EHR
    - Most recent ICN
    - All Deposits/Checks and Billing Batches
    - Write Offs/Ups
    - Balance Transfers (Billing Next from One Payer to Another)

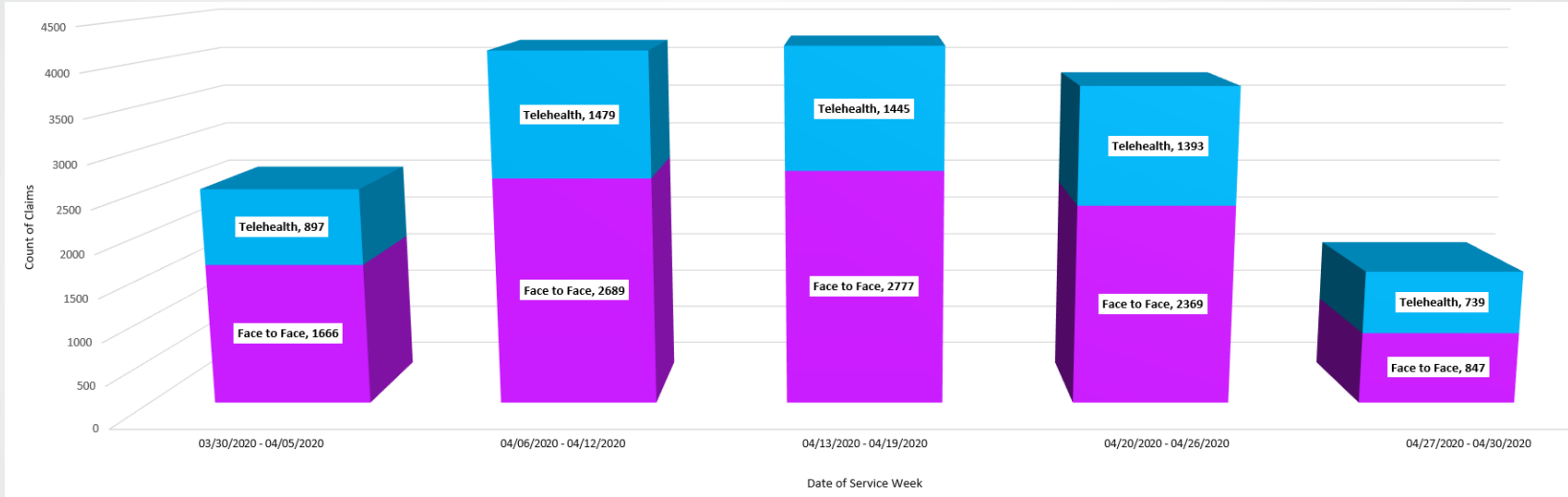
Standard or Custom Reports – Billing Reports

- Comfort with Excel to manipulate the data to make it meaningful to your organization:









Payer	< or = 30	>30	>60	>90	>180	Outside Timely Filing (>365)	Grand Total
Medicaid	$ 697,925.81	$ 166,553.98	$ 65,163.06	$ 104,616.22	$ 103,759.44	$ 13,032.43	$ 1,151,050.94
Commercial	$ 16,808.40	$ 13,049.60	$ 6,035.77	$ 16,178.93	$ 28,952.87	$ 51,272.65	$ 132,298.22
Managed Medicaid	$ 21,989.54	$ 7,858.72	$ 7,576.41	$ 18,646.07	$ 27,816.76	$ 39,895.70	$ 123,783.20
Medicare	$ 8,975.74	$ 8,119.57	$ 2,731.29	$ 9,904.41	$ 14,650.32	$ 56,319.91	$ 100,701.24
Self Pay	$ 3,281.00	$ 1,841.00	$ 974.69	$ 1,376.00	$ 225.85	$ (251.73)	$ 7,446.81
Board	$ 3,865.11	$ 1,858.55	$ 397.00	$ 70.00	$ -		$ 6,190.66
Grand Total	$ 752,845.60	$ 199,281.42	$ 82,878.22	$ 150,791.63	$ 175,405.24	$ 160,268.96	$ 1,521,471.07

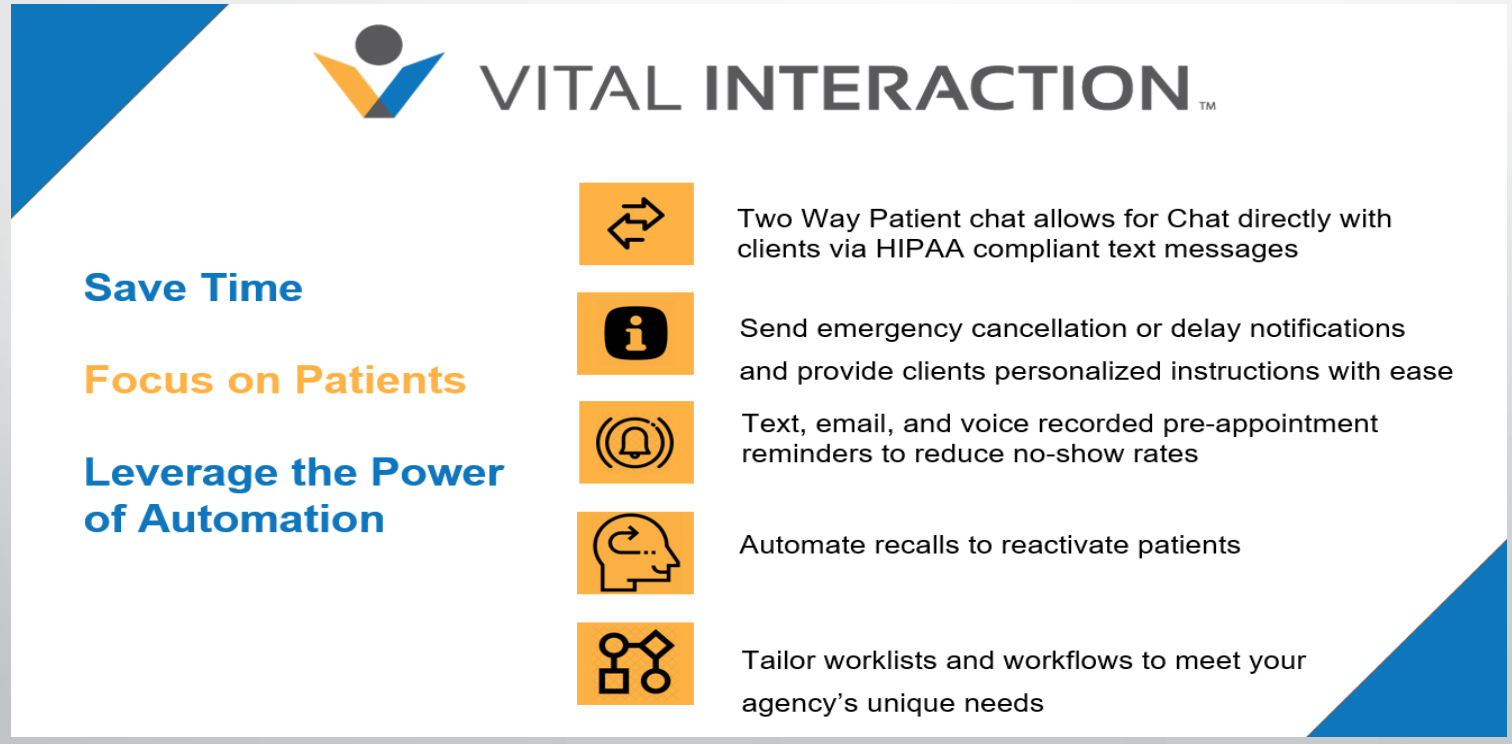
Payer	Count of Claims	Recalculated Expected Amount	Total Payments	Total Balance	Reimbursement %
Medicaid	15932	$ 1,315,128.58	$ 1,265,410.36	$ 42,043.00	96.2%
Managed Medicaid	498	$ 38,157.66	$ 30,183.01	$ 7,374.69	78.8%
Commercial	97	$ 5,216.20	$ 62.08	$ 5,057.42	0.5%
Medicare	149	$ 9,120.58	$ 4,516.78	$ 2,226.47	33.3%
Self Pay	215	$ 8,396.69	$ 7,518.00	$ 832.69	89.5%
Grand Total	16891	$ 1,376,019.71	$ 1,307,690.23	$ 57,534.27	94.2%

Standard or Custom Reports – Gap Reporting

- Tracking outstanding balances and non-responded to claims
  - Everyone knows FFS Medicaid pays within 15 days, if you are missing a payment on claims billed greater than 15 days, you might be missing a payment or perhaps the claim rejected, and it wasn't caught
  - Monitoring whether your commercial claims are being responded to by the payers or if due to licensure, they are being rejected and fall into new TPL guidelines
- Self pay claims
  - Has someone administratively made an error by either incorrectly dating a payer or not obtaining payer information
- Missing or Unsigned Documentation
  - Anything clinically unresolved over 7 days is a higher risk to your agency. If a provider leaves and hasn't started the documentation or is not detailed enough to be finished by a supervisor, that service is at risk for loss.
- Unbilled Claims
  - Is there a missing set-up to pick up claims for a new payer that is preventing these claims from being batched and billed?

Build a successful program with lower no-show rates and track clients that don't maintain services

- Many EHR software programs offer Call Reminder Systems. Pick a proven one that offers all of the pieces and parts that are important to your agency. We work closely with Vital Interactions because they offer a full circle platform for call reminders.



Proper Document Retention

- Maintaining proper records (Medicaid requires 7 years and any mandated financial audit or voluntary audit will usually require these records)
  - Scanning and Saving Received Paper EOBs
  - Keeping All Billing 837 Files and All Received RA 835 Files – Both raw and exported to excel and maintained in a database
    - Any billing agency you work with should recognize that these files belong to you, regardless of who is sending/receiving

Questions?

Thank you!!

Thank you for attending!

A survey will appear on your screen after the training ends and you will receive it via email tomorrow. You must complete this survey to receive CEUs.

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