Coding and Documentation: Recommendations for outlining the patient's condition for Behavioral Health
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

• We will discuss the importance of education and training for providers documenting to the highest level of specificity and including the pertinent diagnoses
Payors

- Payors (including MCO’s) are moving toward the model of risk sharing in value-based contracts
  - Improve quality
  - Reduce unnecessary costs and reduce waste
  - Improve patient satisfaction
  - Improve productivity
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

• Risk Adjustment is:
  • The process for compensating insurance carriers with higher risk (“sicker”) populations when compared to other carriers
  • Based on accurate and severity-specific diagnosis codes (ICD-10) included on claims for services and included in the medical record
  • Quantifies the complexity of a patient/client’s condition that can be utilized to determine the collective population risk
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 (i.e. add the illnesses that would have been reflected on Axis III when using DSM criteria.)
Value-based Care

• Why is this important?

  • Value is the new standard for how payors will reimburse/bonus – based upon quality and patient health improvements
  • Doing the right things with the rights costs at the right place by the right people
  • Patient centered and patient engagement
  • Proactive care instead of reactive care
Documentation

• Improvement Opportunities

• Education and Preparation

• Engage Providers
Documentation

The chart must document that the condition was:

- Managed
- Evaluated
- Assessed
- Treated
Documentation

• If providers don’t document their care and work, it can’t be captured, coded and billed
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 diagnosis is identified for billing it must be part of the documentation for the care process and plan
Documentation

• Patient care

• Cash flow
Documentation, Coding and Reimbursement

• The visit note should consistently demonstrate the nature of the presenting problem(s) (i.e. chief complaint/reason for visit).

• The assessment, plan and diagnoses need to be complete and consistent with the reason for the visit.
Documentation and Risk

• Diagnosis and the EMR tool
  
  • Listing a diagnosis on a medical record problem list does not meet documentation requirements.

  • The diagnosis must be present in the note.
Documentation

• Reason for the visit
• Pertinent history for the care provided
• Identified care provided – E&M, therapy, or other intervention
• Identified time if pertinent to service *(therapy)*
• Identified plan of care: goals, objectives, plan and progress and when to return to clinic
• Signed, dated and reference supervision as pertinent to care
Steps to Improving Documentation

• Assess your current documentation
• Implement provider education early and ongoing
• Practice documenting a more complete diagnosis
• Establish a documentation program
• Streamline clinical documentation workflow
• Evaluate EMR templates
Other differences

**DSM-V**
- Produced by a single national professional association for psychiatrists (the American Psychiatric Association)
- Generates revenue for the American Psychiatric Association
- DSM is developed primarily by U.S. psychiatrists
- DSM is approved by the assembly of the American Psychiatric Association

**ICD-10**
- Produced by a global health agency with a public health mission to help countries reduce the disease burden of mental disorders
- ICD is available free on the Internet (WHO not for profit)
- ICD's development is global, multidisciplinary, and multilingual
- ICD is approved by the World Health Assembly
Coding and Documentation Examples
Anxiety

Documentation requires details including:

- Agoraphobia
- Social phobia
- Animal
- Natural environment
- Blood, injection, injury
- Situational
- Other
- Unspecified
Anxiety

• Agoraphobia
  • unspecified
  • with panic disorder
  • without panic disorder

• Social phobia
  • unspecified
  • generalized

• Arachnophobia
  • other animal type phobia
Anxiety

• Panic disorder [episodic paroxysmal anxiety] without agoraphobia

• Generalized anxiety disorder

• Other mixed anxiety disorders

• Other specified anxiety disorders

• Anxiety disorder, unspecified
Anxiety Example

• Mr. Smith is following up on his anxiety and has complaints of feeling tired with no interest in his usual activities. He is sleeping more than usual and has lost his appetite for the last few weeks, since his wife died. He is extremely anxious and states that he is depressed. He has no other complaints currently. No physical problems were noted, and he is in good health. He denies suicidal or homicidal ideation and has no psychotic features. He is not taking any medications. He does not drink but does smoke 1 ppd of cigarettes.
Anxiety Example

• What should be documented to code to the highest level of specificity:
  
  • Acuity – acute - single episode or recurrent
  • Severity – mild, moderate, severe
  • Etiology – recent loss of spouse
  • Details – tobacco dependence

Example:
• Acute, moderate anxiety due to recent loss of spouse
• Acute, major depressive disorder, single episode, moderate due to loss of spouse
• Nicotine dependence, cigarettes
Mood Disorder Example

• Mrs. Jones is a 48 year old female, being seen for individual psychotherapy as part of her long-term treatment for depression. She has been diagnosed with “major depressive disorder.” The patient has been taking her monoamine oxidase inhibitor (MAOI) medication and reports she feels like the medication has helped manage her impulsive, overly emotional, and erratic behavior. She would like a refill on this medication.
Mood Disorder Example

• What should be documented to code to the highest level of specificity:
  
  • Acuity – single episode or recurrent
  • Severity – mild, moderate, severe
  • Etiology – unknown
  • Details – any other signs/symptoms, etc.

• Example: Major depressive disorder, recurrent, mild
Attention Deficit Disorder

• Documentation should include:
  • With or without hyperactivity
  • Combined type
  • Inattentive type
  • Other specified type
Use, Abuse and Dependence Hierarchy

• If both use and abuse are documented, code only abuse
• If both abuse and dependence are documented, code only dependence
• If both use and dependence are documented, code only dependence
• If use, abuse and dependence are all documented, code only dependence
Psychoactive Substance Use, Abuse And Dependence

• **Psychoactive Substance Use, Unspecified**

• As with all other *unspecified* diagnoses, the codes for *unspecified* psychoactive substance use (F10.9-, F11.9-, F12.9-, F13.9-, F14.9-, F15.9-, F16.9-, **F18.9-**, **F19.9-**) should only be assigned based on provider documentation and when they meet the definition of a reportable diagnosis (see Section III, Reporting Additional Diagnoses). These codes are to be used only when the psychoactive substance use is associated with a physical, mental or behavioral disorder, and such a relationship is documented by the provider.
Example

• Sally presents to the office and the provider documents alcohol use and abuse in the assessment.

  • Alcohol abuse, uncomplicated
Example

- Johnny presents with uncomplicated alcohol dependence and cocaine abuse with cocaine-induced anxiety disorder.
  - F10.20 Alcohol dependence, uncomplicated
  - F14.180 Cocaine abuse with cocaine-induced anxiety disorder
Opioid Dependence

• Must document whether the use is:
  • Abuse
    • Uncomplicated
    • With intoxication
    • With delirium
    • With perceptual disturbance
    • With mood disorder
    • Hallucinations
    • Sexual dysfunction
Opioid Dependence

- Dependence
  - Uncomplicated
  - In remission
  - Intoxication
  - With perceptual disturbance
  - Withdrawal
  - Opioid induced mood disorder
  - Delusions
  - Hallucinations
  - Sexual dysfunction
  - Sleep disorder

- Opioid use Unspecified
  - Uncomplicated
  - With intoxication
  - With delirium
  - With perceptual disturbance
  - Withdrawal
  - Psychotic disorder
Cannabis - Abuse

• Must document whether the Abuse is:
  • Uncomplicated
  • With intoxication uncomplicated
  • With intoxication delirium
  • With perceptual disturbance
  • With intoxication, unspecified

• If they have abuse with psychotic disorder
  • With delusions
  • With hallucination
  • Unspecified
Cannabis - Abuse

• Abuse
  • With other cannabis-induced anxiety disorder
  • With other cannabis-induced disorder
  • With unspecified cannabis-induced disorder
Cannabis - Dependence

• Must document whether the Dependence is:
  • Uncomplicated
  • In remission
  • Dependence with intoxication
    • Uncomplicated
    • Delirium
    • With perceptual disturbance
    • Unspecified
Cannabis - Dependence

• Must document:
  • Dependence with psychotic disorder
    • With delusions
    • With hallucination
    • Unspecified

• Dependence
  • With other cannabis-induced anxiety disorder
  • With other cannabis-induced disorder
  • With unspecified cannabis-induced disorder
Cannabis - Use

• Must document whether the Use is:
  • Uncomplicated
  • With intoxication uncomplicated
  • With intoxication delirium
  • With perceptual disturbance
  • With intoxication, unspecified

• If they have use with psychotic disorder
  • With delusions
  • With hallucination
  • Unspecified
Cannabis - Use

• Use
  • With other cannabis-induced anxiety disorder
  • With other cannabis-induced disorder
  • With unspecified cannabis-induced disorder
Alcohol

• Alcohol
  • abuse
  • dependence
  • unspecified
• Uncomplicated
• With intoxication
• With withdrawal
• With alcohol-induced psychotic disorder
• With alcohol-induced persisting amnestic disorder
• With alcohol-induced persisting dementia
• With other alcohol-induced disorder
• With unspecified alcohol-induced disorder
In Remission

• Selection of codes for “in remission” for categories F10-F19, Mental and behavioral disorders due to psychoactive substance use (categories F10-F19 with -.11, -.21) requires the provider’s clinical judgment. The appropriate codes for “in remission” are assigned only on the basis of provider documentation (as defined in the Official Guidelines for Coding and Reporting), unless otherwise instructed by the classification.

• Mild substance use disorders in early or sustained remission are classified to the appropriate codes for substance abuse in remission, and moderate or severe substance use disorders in early or sustained remission are classified to the appropriate codes for substance dependence in remission.
Depressive Disorder

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

• Adjustment disorder with depressed mood
• Prolonged depressive reaction
• Predominant disturbance of other emotions as adjustment reaction
  • Separation anxiety disorder
  • Emancipation disorder of adolescence and early adult life
  • Specific academic or work inhibition
  • Adjustment disorder with anxiety
  • Adjustment disorder with mixed anxiety and depressed mood
  • Other
Adjustment Disorder

• Adjustment disorder with disturbance of conduct
• Adjustment disorder with mixed disturbance of emotions and conduct
• Other specified adjustment reactions
  • Post traumatic stress disorder
  • Adjustment reaction with physical symptoms
  • Adjustment reaction with withdrawal
  • Other
  • Unspecified
Mood Affective Disorder

- Manic episode
- Bipolar disorder
- Major depressive disorder
- Persistent mood (affective) disorder
- Other
Severity

• Mild
• Moderate
• Severe

• With psychotic symptoms
• Without psychotic symptoms
Remission Status

• Currently in remission
• In partial remission
• Full remission
Dementia

• Documentation should include:
  • Vascular dementia
    • With or without behavioral disturbance
  • Dementia in diseases classified elsewhere
    • With or without behavioral disturbance
    • Must specify the underlying physiological condition and it must be coded first
  • Unspecified dementia
    • With or without behavioral disturbances
Conduct Disorders

• Conduct disorder confined to family context
• Conduct disorder, childhood-onset type
• Conduct disorder, adolescent-onset type
• Oppositional defiant disorder
• Other conduct disorders
• Unspecified
Attention Deficit Disorder

• Documentation should include:
  • With or without hyperactivity
  • Combined type
  • Inattentive type
  • Other specified type
Eating disorders

• Anorexia nervosa
• Bulimia nervosa
• Other eating disorder
PTSD

• Documentation must include
  • Acute – F43.11
  • Chronic – F43.12
  • Unspecified – F43.10
Bipolar – F31.-

• Current episode
  • Hypomanic
  • Manic without psychotic features
  • Depressed
  • Mixed

• In remission
  • Hypomanic
  • Manic
  • Depressed
  • Mixed
Schizophrenia

• Documentation must include the type:
  • Paranoid
  • Disorganized
  • Catatonic
  • Undifferentiated
  • Residual
  • Other
  • Unspecified

• Schizotypal disorder
• Delusional disorders
• Brief psychotic disorder
• Shared psychotic disorder
Schizoaffective Disorder

- Schizoaffective disorder, unspecified
- Other schizoaffective disorders
- Schizoaffective disorder, bipolar type
- Schizoaffective disorder, depressive type
Nicotine

• Documentation should include:
  • Use or Dependence

• Dependence:
  • Cigarettes
  • Chewing tobacco
  • Other tobacco product
Inhalant related disorders

• Documentation should include:
  • Abuse
  • Dependence
  • Use
Underdosing

• Document that the patient is noncompliant with his medication.

• Document if there is a medical condition linked to the underdosing that is relevant to the encounter, and ensure the connection is clearly made.

• Intentional or unintentional

• Financial hardship or Age-related dementia
Underdosing

Underdosing of other antidepressants, initial encounter – T43.296A
Underdosing of other antidepressants, subsequent encounter – T43.296D

Patient's intentional underdosing of medication regimen due to financial hardship – Z91.120
Patient's intentional underdosing of medication regimen for other reason - Z91.128

Patient's unintentional underdosing of medication regimen due to age-related debility – Z91.130
Patient's unintentional underdosing of medication regimen for other reason - Z91.138
Things to Think About

• What other conditions does the patient have that impact your decision-making?
  • Thyroid issues
  • Diabetes
  • CKD
  • Weight
Coding Summary

Suggest starting with the top 5 codes you use and begin to document details of those encounters
  • Continue with more codes until you have up to 25 codes used

Create the templates in the EMR that will facilitate necessary documentation

Review the decision tree methodology in the EMR to insure it compliments templates
Contact

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