VI. DSM-5 TRAINING

For: Yolo County

Coding and Documentation Compliance

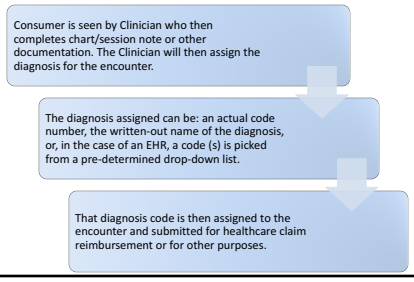
Behavioral Health Solutions
March 7-8, 2017

INTRODUCTION OF THE TABULAR INDEX AND CODING

The Relationship Between Coding, Comprehensive Diagnosing, and How the DSM-5 Is Not All-Inclusive

What is Diagnosis) Coding?

- The actual assignment of a diagnosis code to a client's healthcare encounter, such as Depression, PTSD, Adjustment Disorder, Asthma, etc.



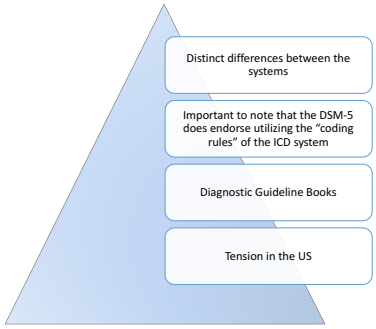
Statement: Parties Responsible for Coding

Scenario	Pros	Cons	Myth	Risk?
Rendering clinician assigns DSM code and Billing Office converts it into an ICD-code	• Saves clinician time • Clinician does not need to be trained on ICD-series	• Billing Office personnel not CPCs • DSM to ICD conversions are not all 1:1 • Clinician is liable for Billing Office misdiagnoses • Clinical judgment necessary, especially regarding Substances	• "This has worked in the past, so why won't it work now?" • "If we are using a crosswalk, what difference does it make?" • "The internet has reliable sites for ICD conversions and obtaining the codes!"	Yes
Billing office personnel, not CPCs, assign the ICD-code	• Saves clinician time	• Billing Office personnel not CPC or trained to interpret medical charts • Not licensed to assess and assign diagnoses • Clinician is liable for misdiagnoses	• "We have always done it this way" • "I've been working in billing for 30 years and I know the codes" • "As long as the insurance company sends us money, how can this be problematic?"	Yes
California: Submit DSM code to County; County uses CMS-approved crosswalk for Medi-Cal	• Longstanding workflow	• County personnel are not likely CPCs • Entire medical record not going to the county, just a DSM-code • DSM to ICD conversions are not all 1:1 • Clinical judgment in converting DSM-ICD is necessary, especially regarding Substances • DSM-5 diagnoses in Substance Use category are not aligned with ICD-10 language	• "This is the statewide system in CA so it must not be problematic" • "Every county in CA uses the same crosswalk" • "Trained personnel at the County are converting the diagnoses so I feel comfortable doing this"	• Yes
Handwritten diagnosis codes sent to billing office for typed claim entry	• Longstanding workflow	• Poor handwriting, some guessing at the decimals • Human error with data entry	• The diagnosis is close enough to the right one • Our clinicians won't do it any other way	• Yes

Coding Rules: Book Excerpts

- The majority of ***behavioral health and substance use*** provider entities in America have never learned the Official Guidelines for Coding and Reporting provided by the Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS);
- The document, "*ICD-10-CM Official Guidelines for Coding and Reporting FY 2017*" is little known in our industry. Yet it contains much of the information necessary for an accurate and standardized approach to behavioral healthcare documentation objectives. In fact, utilization of these guidelines is mandated by HIPAA and are designed to "*accompany and compliment the official conventions and instructions provided within the ICD-10-CM itself…. Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA)*.

DSM versus ICD



ICD-10 Coding Format

- Chapter F = Chapter 5 in ICD-10
- Category = drug of choice/condition
- Last 4 digits represent the clinical state: etiology, severity, manifestation, and placeholders
- Note: Some X, T, Y, N, R, Y and other codes are applicable to us

ICD-9-CM	ICD-10-CM	For Fun: DSM-5
Mental, Behavioral, & Neurodevelopmental DO (290-319)	**Mental, Behavioral, & Neurodevelopmental DO (F01-F99)**	
Neurotic DO, Personality DO, & Other Nonpsychotic Mental DO (300-316)	Behavioral & Emotional DO w/ Onset Usually Occurring in Childhood & Adolescence (F90-F98)	
314 Hyperkinetic Syndrome of Childhood	F90 Attention-Deficit Hyperactivity DO	
314.0 Attention Deficit DO		
314.00: ADD, adult, child, w/o mention of hyperactivity	F90.0 : ADHD, predominantly inattentive type	same
314.01: ADD, adult, child, with hyperactivity	F90.1: ADHD: predominantly hyperactive type	F90.1 ADHD, predominantly hyperactive-impulsive type
	F90.2: ADHD, combined type	same
	F90.8: ADHD, other type	same
	F90.9: ADHD, unspecified	same

Expanded Diagnoses Examples in ICD-10

- Substance Use codes contain the most expansion
  - DSM-IV-TR has 9 diagnoses involving Cannabis
  - DSM-5 has 22 diagnoses involving Cannabis
  - ICD-10 has 34 diagnoses involving Cannabis
- Bipolar
- Substance Use
- Anxiety
- Schizophrenia's

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The Tabular Index

- The Authoritative Source from the CDC
- 1900+ pages long/Comprehensive
- Why You Need It

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Tabular Index First Page

ICD-10-CM TABULAR LIST of DISEASES and INJURIES

Table of Contents

Instructional Notations

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Chapter 5

Mental, Behavioral and Neurodevelopmental disorders (F01-F99)

Includes: disorders of psychological development

Excludes2: symptoms, signs and abnormal clinical laboratory findings, not elsewhere classified (R00-R99)

This chapter contains the following blocks:

F01-F09	Mental disorders due to known physiological conditions
F10-F19	Mental and behavioral disorders due to psychoactive substance use
F20-F29	Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders
F30-F39	Mood [affective] disorders
F40-F48	Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders
F50-F59	Behavioral syndromes associated with physiological disturbances and physical factors
F60-F69	Disorders of adult personality and behavior
F70-F79	Intellectual disabilities
F80-F89	Pervasive and specific developmental disorders
F90-F98	Behavioral and emotional disorders with onset usually occurring in childhood and adolescence
F99	Unspecified mental disorder

Mental disorders due to known physiological conditions (F01-F09)

Note: This block comprises a range of mental disorders grouped together on the basis of their having in common a demonstrable etiology in cerebral disease, brain injury, or other insult leading to cerebral dysfunction. The dysfunction may be primary, as in diseases, injuries, and insults that affect the brain directly and selectively; or secondary, as in systemic diseases and disorders that attack the brain only as one of the multiple organs or systems of the body that are involved.

F01 Vascular dementia
Vascular dementia as a result of infarction of the brain due to vascular disease, including hypertensive cerebrovascular disease.

Includes: arteriosclerotic dementia

Chapter 20: Self-Harm

- Note: "*…It is intended that (if a code from this section is applicable), it shall be used secondary to a code from another chapter…*"

Chapter 20

External causes of morbidity (V00-Y99)

Note: This chapter permits the classification of environmental events and circumstances as the cause of injury, and other adverse effects. Where a code from this section is applicable, it is intended that it shall be used secondary to a code from another chapter of the Classification indicating the nature of the condition. Most often, the condition will be classifiable to Chapter 19, Injury, poisoning and certain other consequences of external causes (S00-T88). Other conditions that may be stated to be due to external causes are classified in Chapters I to XVIII. For these conditions, codes from Chapter 20 should be used to provide additional information as to the cause of the condition.

This chapter contains the following blocks:

Self-Harm Section Of Tabular Index

- Discretion on the level of specificity used by organization

Intentional self-harm (X71-X83)
Purposely self-inflicted injury
Suicide (attempted)

X71 Intentional self-harm by drowning and submersion

The appropriate 7th character is to be added to each code from category X71
A - initial encounter
D - subsequent encounter
S - sequela

Note: Since the Tabular Index indicates to specify "encounter codes" with this diagnosis ("A, D, S"), then it would look like this for an initial encounter:

X71.8XXA

Intentional self-harm (X71-X83)
Purposely self-inflicted injury
Suicide (attempted)

X71 Intentional self-harm by drowning and submersion

The appropriate 7th character is to be added to each code from category X71
A - initial encounter
D - subsequent encounter
S - sequela

X71.0 Intentional self-harm by drowning and submersion while in bathtub
X71.1 Intentional self-harm by drowning and submersion while in swimming pool
X71.2 Intentional self-harm by drowning and submersion after jump into swimming pool
X71.3 Intentional self-harm by drowning and submersion in natural water
X71.8 Other intentional self-harm by drowning and submersion

X71.9 Intentional self-harm by drowning and submersion, unspecified

X72 Intentional self-harm by handgun discharge
Intentional self-harm by gun for single hand use
Intentional self-harm by pistol
Intentional self-harm by revolver
Excludes1: Very pistol (X74.8)

The appropriate 7th character is to be added to code X72
A - initial encounter
D - subsequent encounter
S - sequela

X73 Intentional self-harm by rifle, shotgun and larger firearm discharge
Excludes1: airgun (X74.01)

The appropriate 7th character is to be added to each code from category X73
A - initial encounter
D - subsequent encounter
S - sequela

X73.0 Intentional self-harm by shotgun discharge
X73.1 Intentional self-harm by hunting rifle discharge
X73.2 Intentional self-harm by machine gun discharge
X73.8 Intentional self-harm by other larger firearm discharge
X73.9 Intentional self-harm by unspecified larger firearm discharge

X78 Intentional self-harm by sharp object

The appropriate 7th character is to be added to each code from category X78
- A - initial encounter
- D - subsequent encounter
- S - sequela

X78.0 Intentional self-harm by sharp glass

X78.1 Intentional self-harm by knife

X78.2 Intentional self-harm by sword or dagger

X78.8 Intentional self-harm by other sharp object

X78.9 Intentional self-harm by unspecified sharp object

X79 Intentional self-harm by blunt object

The appropriate 7th character is to be added to code X79
- A - initial encounter
- D - subsequent encounter
- S - sequela

X80 Intentional self-harm by jumping from a high place
Intentional fall from one level to another

X93 Assault by handgun discharge
Assault by discharge of gun for single hand use
Assault by discharge of pistol
Assault by discharge of revolver

Excludes1: Very pistol (X95.8)

The appropriate 7th character is to be added to code X93
- A - initial encounter
- D - subsequent encounter
- S - sequela

X94 Assault by rifle, shotgun and larger firearm discharge

Excludes1: airgun (X95.01)

The appropriate 7th character is to be added to each code from category X94
- A - initial encounter
- D - subsequent encounter
- S - sequela

X94.0 Assault by shotgun

X94.1 Assault by hunting rifle

X94.2 Assault by machine gun

X94.8 Assault by other larger firearm discharge

Stressors Related To Military Deployment

Z63.6 Dependent relative needing care at home

Z63.7 Other stressful life events affecting family and household

Z63.71 Stress on family due to return of family member from military deployment
Individual or family affected by family member having returned from military deployment (current or past conflict)

Z63.72 Alcoholism and drug addiction in family

Z63.79 Other stressful life events affecting family and household
Anxiety (normal) about sick person in family
Health problems within family
Ill or disturbed family member
Isolated family

Cannabis Abuse Sample From Tabular Index

F12 Cannabis related disorders

Includes: marijuana

F12.1 Cannabis abuse

Excludes1: cannabis dependence (F12.2-)
cannabis use, unspecified (F12.9-)

F12.10 Cannabis abuse, uncomplicated

F12.12 Cannabis abuse with intoxication

F12.120 Cannabis abuse with intoxication, uncomplicated

F12.121 Cannabis abuse with intoxication delirium

F12.122 Cannabis abuse with intoxication with perceptual disturbance

F12.129 Cannabis abuse with intoxication, unspecified

F12.15 Cannabis abuse with psychotic disorder

F12.150 Cannabis abuse with psychotic disorder with delusions

F12.151 Cannabis abuse with psychotic disorder with hallucinations

F12.159 Cannabis abuse with psychotic disorder, unspecified

F12.18 Cannabis abuse with other cannabis-induced disorder

F12.180 Cannabis abuse with cannabis-induced anxiety disorder

Z3A.28 28 weeks gestation of pregnancy

Z3A.29 29 weeks gestation of pregnancy

Z3A.3 Weeks of gestation of pregnancy, weeks 30-39

Z3A.30 30 weeks gestation of pregnancy

Z3A.31 31 weeks gestation of pregnancy

Z3A.32 32 weeks gestation of pregnancy

Z3A.33 33 weeks gestation of pregnancy

Z3A.34 34 weeks gestation of pregnancy

Z3A.35 35 weeks gestation of pregnancy

Z3A.36 36 weeks gestation of pregnancy

Z3A.37 37 weeks gestation of pregnancy

Z3A.38 38 weeks gestation of pregnancy

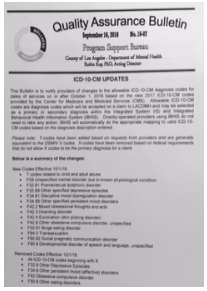
Z3A.39 39 weeks gestation of pregnancy

Z3A.4 Weeks of gestation of pregnancy, weeks 40 or greater

Z3A.40 40 weeks gestation of pregnancy

Z3A.41 41 weeks gestation of pregnancy

Lisette's Soapbox Moment



Quality Assurance Bulletin

September 15, 2016 No. 16-07

Program Support Bureau

County of Los Angeles - Department of Mental Health

Robin Kay, PhD, Acting Director

ICD-10-CM UPDATES

This Bulletin is to notify providers of changes to the allowable ICD-10-CM diagnosis codes for dates of services on or after October 1, 2016 based on the new 2017 ICD-10-CM codes provided by the Centers for Medicare and Medicaid Services (CMS). The ICD-10-CM codes provided in these code tables which will be accepted on a claim to LACDMH and may be selected as a primary or secondary diagnosis within the Integrated System (IS) and Integrated Behavioral Health Information System (IBHIS). Directly-operated providers using IBHIS do not need to take any action. IBHIS will automatically do the appropriate mapping to valid ICD-10-CM codes based on the diagnosis description entered.

Please note: T-codes have been added based on requests from providers and are generally not allowable as the primary diagnosis. If codes have been removed based on federal requirements that do not allow it codes to be the primary diagnosis for a client.

Below is a summary of the changes:

New Codes Effective 10/1/16

- T codes related to child and adult abuse
- F09 Unspecified mental disorder due to known physiological condition
- F32.89 Other specified depressive episodes
- F33.89 Other specified depressive episodes
- F34.81 Disruptive mood dysregulation disorder
- F34.89 Other specified persistent mood disorders
- F42.2 Mixed obsessional thoughts and acts
- F42.3 Hoarding disorder
- F42.4 Excoriation (skin picking) disorder
- F42.8 Other obsessive-compulsive disorder, unspecified
- F50.81 Binge eating disorder
- F50.89 Other eating disorder
- F80.82 Social pragmatic communication disorder
- F80.9 Developmental disorder of speech and language, unspecified

Removed Codes Effective 10/1/16

- All ICD-10-CM codes beginning with X
- F32.8 Other Depressive Episodes
- F34.0 Other persistent mood (affective) disorders
- F42 Obsessive-compulsive disorder
- F50.8 Other eating disorders

The DSM-5 On Coding

- "For most clinicians, the codes are used to identify the diagnosis or reason for visit for CMS and private insurance service claims. The official coding system in use in the US is…the ICD-10-CM "
- Introductory statement to Section II: Diagnostic Criteria and Codes
  - *"This section contains the diagnostic criteria approved for routine clinical use along with ICD-9 codes….Where needed, specific recording procedures are presented with the diagnostic criteria. In some cases, separate recording procedures for ICD-9/10 are provided."*

(P.23 and 30)

2017 ICD-10 CM Official Coding Guidelines

- Published by: CMS and National Center for Health Statistics (NCHS)
- Approved by: American Hospital Association, AHIMA, CMS, and NCHS
- "*These guidelines are a set of rules that have been developed to accompany and compliment…ICD-10-CM itself….These guidelines are based on the coding and sequencing….Adherence to these guidelines when assigning ICD-10CM diagnosis codes is required under HIPAA."*
- www.cdc.gov/nchs/icd

Generally Speaking, We Will Need To:

- Add details in the record to support the more specific diagnosis
- Link symptoms, complications, and manifestations to the diagnosis
- Understand that the diagnostic details needed will depend on the diagnosis given
- "What Would a Certified Coder or Auditor Do?"
  - Accuracy
  - Thorough
  - Detailed
  - Specific

Itemization Of Pertinent Rules To BH/SU

1. Highest level of specify (i.e.: as many digits as applicable)
2. Etiology and Manifestation, "Code First"
3. Multiple coding for a single condition
4. Excludes 1 and Excludes 2
5. Other and Unspecified
6. NEC and NOS
7. External Cause Code

"The term provider is used throughout the Guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis. Only this set of guidelines, approved by the cooperating Parties, is official."

Cooperating parties include: CMS, NCHS, DHHS, AHA, AHIMA

Rules About "Other" And "Unspecified"

"Unspecified" Codes:

- Use these when the information in the medical record is insufficient to assign a more specific code. For those categories for which an unspecified code is not provided, the "other specified" code may represent both other and unspecified.

"Other" Codes:

- Codes titled "other" or "other specified" for use when the information in the medical record provides detail for which a specific code does not exist.

Use Of Sign/Symptom/Unspecified Codes

- …"Unspecified codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, there are instances when unspecified codes are the best choices for accurately reflecting the healthcare encounter. Each healthcare encounter should be coded to the level of certainty known for that encounter. If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to code an unspecified in lieu of a definitive diagnosis. When sufficient clinical information isn't known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate "unspecified" code…next page…

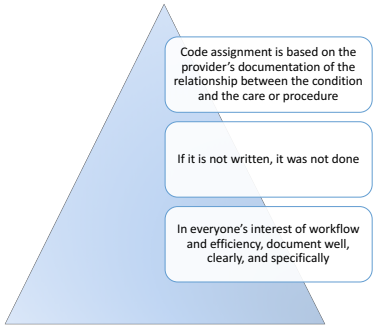
Unspecified Codes Should Be Reported When…

- …..Unspecified codes should be reported when they are the codes that most accurately reflects what is known about the patient's condition at the time of that particular encounter. It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code."
- *THEREFORE:* What if: you want to "down-code"? "Protect the consumer from discrimination?" Just don't want to write all the necessary info in the chart because you have better things to do on a sunny day?

Coding General Medical Conditions

- Unchartered territory
- Integrated Care
- Good Policy/Procedure topic
- Must follow scope of practice rules in the State
- Coding Rules and the ICD-10 itself indicate coding of medical conditions is necessary, and at times, mandatory
- Annex in the Blue Book lists all the pertinent Medical Conditions
- Remember, the DSM-5 even endorses this practice
- BHS Rule of Thumb: Code the medical condition broadly

Keep In Mind…..



DOCUMENTATION

Documentation Focus Areas For ICD-10-CM

1. Disease type
2. Disease acuity (mild, moderate, severe)
3. Disease stage (Acute, Chronic, Intermittent, Recurrent, Persistent, Transient, Major, most recent episode)
4. Site specificity
5. Laterality (self-harm)
6. Encounter type (initial, subsequent, sequela)
7. Current condition vs. past history
8. Relationship of condition to procedure
9. Etiology
10. Symptoms/manifestations associated with disease process
11. External cause

Other Helpful Items To Document

- Acute versus Chronic; With/Without complications, behavioral disturbance, psychotic symptoms
- Itemize the clinical indicators for the diagnosis
- Provide documentation in your analysis of how the condition impairs the consumer
- LOCUS: Levels of Care Utilization System Elements:
  - Risk: harm to self/others
  - Functional Status
  - Medical, Addictive, psychiatric Co-morbidity
  - Recovery Environment (is consumer supported outside of treatment?) Level of Stress, of Support
  - Treatment and Recovery history
  - Engagement and Recovery Status

Long List of Tips

- Itemize each of the signs, symptoms, frequency, intensity, and duration of the symptoms to justify the severity of the diagnosis given.
- Detail the degree of the client's challenges and how they are coping with the condition.
- Label, define, and discuss severity throughout the record at every opportunity.
- Document the level of impairment due to the condition or how the client will not progress developmentally due to the condition.
- List behaviors and motor symptoms, their duration, frequency and intensity.
- Identify the client's level of functioning.
- Give a clinical rationale as to why this level of intervention is indicated at this time.
- Itemize clinical indicators, by history, and within the last 5 days: symptoms and severity
- Document any previous admissions.
- Document Intent: accidental, intentional, undetermined, intentional self-harm.
- Document using phrases or terms such as: acute versus chronic, with or without complications, with or without behavioral disturbance, with or without psychotic features, continuous versus episodic, and make this a regular habit.

ICD-10 Coding & Documentation Guideline Adaptions for Behavioral Health

Item/Condition	Coding and Documentation Guidelines	Interpretation/Comments
Abuse and Neglect	Sequence first the appropriate code from categories T74. - (Adult and child abuse, neglect and other maltreatment, confirmed) or T76. - (Adult and child abuse, neglect and other maltreatment, suspected) for abuse, neglect and other maltreatment, followed by any accompanying mental health or injury code(s). If the documentation in the medical record states abuse or neglect it is coded as confirmed (T74.-). It is coded as suspected if it is documented as suspected (T76.-). For cases of confirmed abuse or neglect an external cause code from the assault section (X92-Y08) should be added to identify the cause of any physical injuries. A perpetrator code (Y07) should be added when the perpetrator of the abuse is known. For suspected cases of abuse or neglect, do not report external cause or perpetrator code.	For use with any instance of abuse or neglect, in children or adults, perpetrator, or survivor. Also note the delineation between suspected and confirmed. These terms are best defined in a clinical policy for standardized utilization. Note: This guideline references the T-codes for abuse and neglect. There are other abuse and neglect codes, but they are located in Y07 section of the Tabular Index.
V00-Y99 Codes	The external causes of morbidity codes should never be sequenced as the first- listed or principal diagnosis. They must accompany S and T codes and injury and Poisoning codes must accompany External cause codes and Place of Occurrence codes as well. External cause codes are intended to provide data for injury research and evaluation of injury prevention strategies. These codes capture how the injury or health condition happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), the place where the event occurred, the activity of the patient at the time of the event, and the person's status (e.g., civilian, military). There is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless a provider is subject to a state-based external cause code reporting mandate or these codes are required by a particular payer, reporting of ICD-10-CM codes in Chapter 20, External Causes of Morbidity, is not required. In the absence of a mandatory reporting requirement, providers are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.	X71-X83: While "optional," this is a critical category for use in behavioral health regarding any suicide attempts. Tracking these X-codes, and seeing the possible progression of increasing lethality, may save a life. This is also important for national data and research on suicide and suicide prevention.
Child and Adult Abuse Guideline	Adult and child abuse, neglect and maltreatment are classified as assault. Any of the assault codes may be used to indicate the external cause of any injury resulting from the confirmed abuse. For confirmed cases of abuse, neglect and maltreatment, when the perpetrator is known, a code from Y07. Perpetrator of maltreatment and neglect, should accompany any other assault codes.	This is the Y07 section of the Tabular Index. Having a clinical policy, or training on these codes (compared to the T-codes in the graph above) will be essential for standardized utilization and data tracking purposes.
Use of Z Codes	Z codes are for use in any healthcare setting. Z codes may be used as either a first-listed (principal) diagnosis code in the inpatient setting) or secondary code, depending on the circumstances of the encounter. Certain Z codes may only be used as first-listed or principal diagnosis.	Z68 (BMI) category may be particularly useful for those who treat Eating Disorders; general screenings, counseling, psychosocial and socioeconomic factors impacting the clinical case are found here.

Clinical Areas and Documentation Elements

Diagnostic Area	Documentation Suggestions by Authors
Medical	Have a Clinical Policy and Procedure in place to determine specificity, number of character/digits coded. The list below is suggested by AHIMA, and may or may not apply to your practice: Disease type Disease acuity (mild, moderate, severe) Disease stage (Acute, Chronic, Intermittent, Recurrent, Persistent, Transient, Major, most recent episode) Site specificity (arms, legs, etc.) Laterality (self-harm) Encounter type (initial, subsequent, sequela) Current condition vs. past history Relationship of condition to procedure (or intervention) Etiology Symptoms/manifestations associated with disease process External cause
Self-Harm	Site Specificity, Laterality, Means, align chart note with diagnosis (i.e.: sharp versus blunt object)
Psychological	Intensity, Duration, Frequency, Severity, Scope of Signs, Symptoms, Behaviors and Manifestations

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Book Excerpt on Documentation Compliance

- To achieve a high degree of compliance with coding and documentation standards, the documentation must: support the services that were provided and billed, be medically necessary, meet payers and regulatory requirements, support the diagnosis and treatment plan, and demonstrate the golden thread discussed earlier. Documentation of utilizing Evidence-Based Practices (EBP) is critical for certain certifications or other requirements, both at an agency level, as well as at the clinical level. If these protocols are not followed, standardization will not be achieved and behavioral health clinicians will continue to document in ways that put the client, provider and healthcare industry at risk.

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For Discussion:

- How often do you perform a full diagnostic assessment and/or update the diagnosis?
- How do you support the ongoing treatment of a diagnosis and reflect that the diagnosis is still active in the ongoing session/chart notes?
- How would you document, on a continual basis, for client who has 4 diagnoses, including medical diagnoses?
- Everyone at your organization has a different opinion for updating and substantiating diagnoses. How might a clinical policy and procedure help?
- How would you write the chart/session notes for the two samples above?

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Santa Barbara Documentation Training (2016)

- Describe limitations in functioning related to the mental health condition which are apparent in the five domains: daily living activities, socialization, work/academics, attention/focus/ concentration, and the consequences the client experiences when he/she relapses (mental health symptoms, not substance use)
- Include the degree, scope, and chronicity of the impairments and individualize them contextually (giving examples). Avoid stating generalizations such as 'impaired daily living activities'
- Include the client's perspective regarding the impact of the impairments in his life, relationships, work, cognition, and how these are limiting for him/her

AUDITS: WHAT YOU NEED TO KNOW

Specific to Coding and Documentation

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Coding and Documentation Manuals: 1-Slide Plug for Manuals

- A resource to minimize billing and coding errors
- Demonstrates business processes and standardization
- Inclusive of CPT, HCPS, provider types & requirements, modifiers, definitions, samples and explanations
- Commitment to Compliance, laws, regulations and clients
- Can help mitigate corrective action plans or negative findings
- Reference to Policies and Procedures

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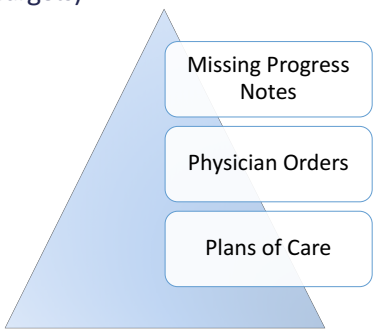
What are Improper Payments? CMS Defined..

- Paid to the Wrong Entity
- Wrong Amount
- Services not Received
- Services not supported by the documentation

CMS on Medicaid Behavioral Health Services

- 2013 PERM Report (Payment Error Rate Measurement)
  - Medicaid claims paid out $894 million IN ERROR for psychiatric, mental health, and behavioral health services
  - $23 million under CHIP
  - 89% of improper Medicaid payments resulted from documentation errors, insufficient documentation, number of units billed errors, and policy violations (not documenting start/stop times)
- 2014 PERM Report: essentially the same results
- Fewer errors/improper payments via MCO's than FFS
- Receipt of overpayments, whether self-identified or other, must be returned within 60 days of discovery

Most Common Documentation Errors (and Audit Targets)



Allegations of Fraud, Waste and Abuse

- Sources of these claims:
  - Whistleblowers: receive a percentage of the recovered amount
  - Fraud hotlines
  - Claims Data mining
  - Audits
- How is a "credible allegation" of fraud defined? CMS Bulletin CPI-B 11-04:
  - CMS defined
  - Different States also have different definitions, and state laws

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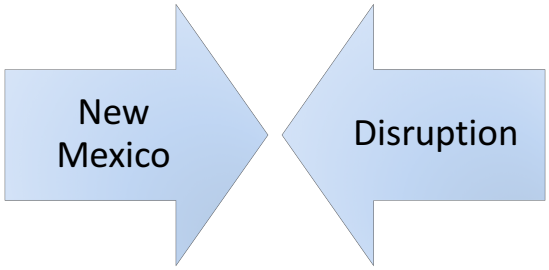
Sometimes Even a Good Offense….



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Best Defense? Good Offense

- Compliance Programs must be living/breathing/growing and thriving
  - "Effective" needs to be measured, defined, and demonstrable
  - Programs in name-only will not protect you
- Education and Training: a critical component for effective CP
- Auditing and Monitoring: internal, external, requested, and non-voluntary
  - Clinical Documentation Improvement is a part of this process
  - Concurrent/Prospective Audits: Ideal
  - Retroactive/Retrospective Audits: (if you find something you must pay it back!)

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Coding and Documentation Audit Elements

Abbreviations: Approved/Standardized versus unapproved abbreviations	Misspellings of medications, Wrong dosages documented	Misspelling or transposition of client names
Demographic errors, wrong client, wrong narrative	Persistent use of outdated mode of clinical diagnoses, such as using the 5 Axes of the old DSM-IV-TR	Inconsistent use of abbreviations or other frequently used items

Auditing for Coding and Compliance: Questions

- ✓Does the documentation support the diagnosis assigned or addressed for that healthcare encounter?
- ✓Are the required documentation elements present in the record to back up the treating diagnosis?
- ✓If an Unspecified or Other diagnosis is used, does it meet the CMS criteria for assigning those diagnoses?
- ✓Are the ICD-10-CM Official Guidelines for Coding and Documentation being followed?
- ✓Is there a consistent and standardized clinical diagnostic approach to itemizing the signs and symptoms, such as using the ICD-10 CDDG or the DSM?

Other Audit/Review Issues to Consider

- To what degree are self-harm, suicidal/homicidal ideation, medical, and all other pertinent diagnoses being ***coded*** in the record to fully describe the diagnostic picture for the case?
- Are these other diagnoses being consistently applied and are they consistent with agency policy?
- Is laterality and other documentation elements suggested by AHIMA being applied to the medical record to substantiate medical necessity?
- To what degree is the "copy and paste" function being used and is this consistent with policy?
- Is the clinician using the ICD series specifiers and corresponding digits for the diagnosis or just notating them in the text/narrative portion of the record?

City and County of San Francisco
Department of Public Health
COMMUNITY BEHAVIORAL HEALTH SERVICES
A DIVISION OF COMMUNITY PROGRAMS

BEHAVIORAL HEALTH SERVICES (MH)
CHART REVIEW PROTOCOL
FY _____

PROGRAM Name/RU#	CLINICIAN:	Reviewer:	Review DATE:
CLIENT Name:	**BI\$#:**		**Review Period:**

DRAFT NOTES ARE NOT CONSIDERED FINALIZED/VALID

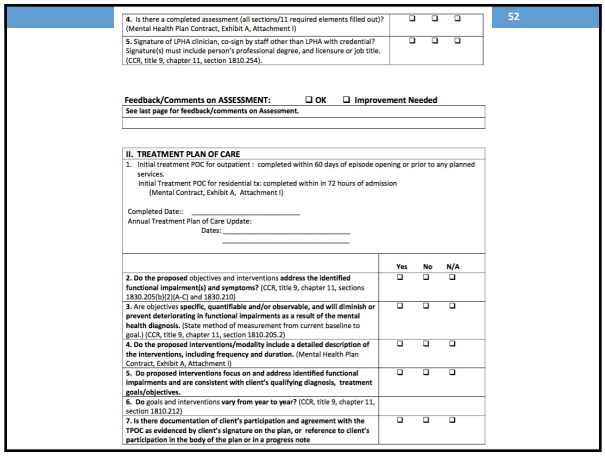
1

I. ASSESSMENT: Assessment and Annual Assessment Updates

OPENING DATE:

Assessment Date: (no later than 60 days of opening for outpatient services)
Completed: _____
(no later than 3 days of admission to residential treatment)
Completed: _____
Annual Assessment Update: **Completed:** _____
Completed: _____

	Yes	No	N/A
1. Case has an included primary DSM/ICD Diagnosis that meets medical necessity, and diagnosis was determined within clinician's scope of practice. (Mental Health Plan Contract, Exhibit A, Attachment I)	❑	❑	❑
2. Assessment justifies diagnosis by stating current symptoms and behaviors (including frequency, severity and duration) listed in DSM/ICD criteria. (CCR, title 9, chapter 11, section 1830.205(b)(1)(A-R)	❑	❑	❑
3. As a result of the mental disorder **(a)** client has a significant impairment in life functioning, or **(b)** client has the probability of significant deterioration in an area of life functioning, or **(c)** (For EPSDT only) child/youth will not progress developmentally as individually appropriate. (CCR, title 9, chapter 11, section 1830.205(b)(1)(A-R).	❑	❑	❑



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4. Is there a completed assessment (all sections/11 required elements filled out)? (Mental Health Plan Contract, Exhibit A, Attachment I)	❑	❑	❑
5. Signature of LPHA clinician, co-sign by staff other than LPHA with credential? Signature(s) must include person's professional degree, and licensure or job title. (CCR, title 9, chapter 11, section 1810.254).	❑	❑	❑

Feedback/Comments on ASSESSMENT: ❑ **OK** ❑ **Improvement Needed**

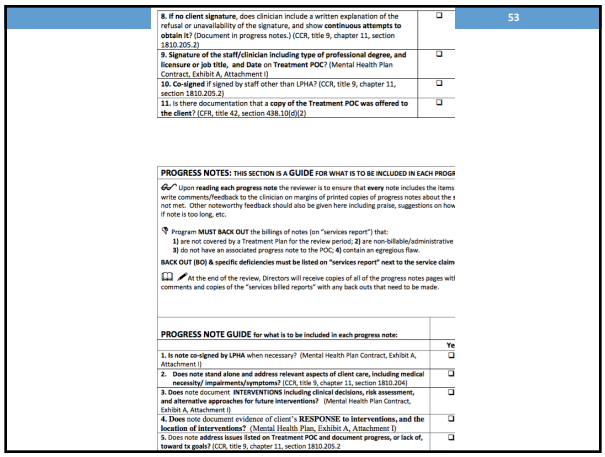
See last page for feedback/comments on Assessment.

II. TREATMENT PLAN OF CARE

1. Initial treatment POC for outpatient : completed within 60 days of episode opening or prior to any planned services.
   Initial Treatment POC for residential tx: completed within in 72 hours of admission
   (Mental Contract, Exhibit A, Attachment I)

Completed Date:: _____
Annual Treatment Plan of Care Update:
Dates: _____
_____

	Yes	No	N/A
2. Do the proposed objectives and interventions **address the identified functional impairment(s) and symptoms?** (CCR, title 9, chapter 11, sections 1830.205(b)(2)(A-C) and 1830.210)	❑	❑	❑
3. Are objectives **specific, quantifiable and/or observable, and will diminish or prevent deteriorating in functional impairments as a result of the mental health diagnosis.** (State method of measurement from current baseline to goal.) (CCR, title 9, chapter 11, section 1810.205.2)	❑	❑	❑
4. Do the proposed interventions/modality include a detailed description of the interventions, including frequency and duration. (Mental Health Plan Contract, Exhibit A, Attachment I)	❑	❑	❑
5. Do proposed interventions focus on and address identified functional impairments and are consistent with client's qualifying diagnosis, treatment goals/objectives.	❑	❑	❑
6. Do goals and interventions **vary from year to year?** (CCR, title 9, chapter 11, section 1810.212)			
7. Is there documentation of client's participation and agreement with the TPOC as evidenced by client's signature on the plan, or reference to client's participation in the body of the plan or in a progress note	❑	❑	❑



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8. If no client signature, does clinician include a written explanation of the refusal or unavailability of the signature, and show **continuous attempts to obtain it?** (Document in progress notes.) (CCR, title 9, chapter 11, section 1810.205.2)	❑
9. Signature of the staff/clinician including type of professional degree, and licensure or job title, and Date on **Treatment POC?** (Mental Health Plan Contract, Exhibit A, Attachment I)	❑
10. Co-signed if signed by staff other than LPHA? (CCR, title 9, chapter 11, section 1810.205.2)	❑
11. Is there documentation that a **copy of the Treatment POC was offered to the client?** (CFR, title 42, section 438.10(d)(2)	❑

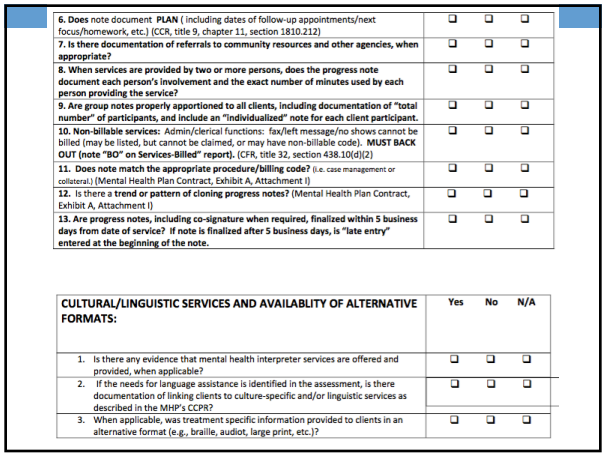
PROGRESS NOTES: THIS SECTION IS A GUIDE FOR WHAT IS TO BE INCLUDED IN EACH PROGR

Upon **reading each progress note** the reviewer is to ensure that **every** note includes the items write comments/feedback to the clinician on margins of printed copies of progress notes about the not met. Other noteworthy feedback should also be given here including praise, suggestions on how if note is too long, etc.

Program **MUST BACK OUT** the billings of notes (on "services report") that:
1) are not covered by a Treatment Plan for the review period; **2)** are non-billable/administrative **3)** do not have an associated progress note to the POC; **4)** contain an egregious flaw.
BACK OUT (BO) & specific deficiencies must be listed on "services report" next to the service claim

At the end of the review, Directors will receive copies of all of the progress notes pages with comments and copies of the "services billed reports" with any back outs that need to be made.

PROGRESS NOTE GUIDE for what is to be included in each progress note:	Ye
1. Is note co-signed by LPHA when necessary? (Mental Health Plan Contract, Exhibit A, Attachment I)	❑
2. Does note stand alone and address relevant aspects of client care, including medical necessity/ impairments/symptoms? (CCR, title 9, chapter 11, section 1810.204)	❑
3. Does note document **INTERVENTIONS including clinical decisions, risk assessment, and alternative approaches for future interventions?** (Mental Health Plan Contract, Exhibit A, Attachment I)	❑
4. Does note document evidence of client's **RESPONSE to interventions, and the location of interventions?** (Mental Health Plan, Exhibit A, Attachment I)	❑
5. Does note **address issues listed on Treatment POC and document progress, or lack of, toward tx goals?** (CCR, title 9, chapter 11, section 1810.205.2	❑



6. Does note document **PLAN** (including dates of follow-up appointments/next focus/homework, etc.) (CCR, title 9, chapter 11, section 1810.212)	❑	❑	❑
7. Is there documentation of referrals to community resources and other agencies, when appropriate?	❑	❑	❑
8. When services are provided by two or more persons, does the progress note document each person's involvement and the exact number of minutes used by each person providing the service?	❑	❑	❑
9. Are group notes properly apportioned to all clients, including documentation of "total number" of participants, and include an "individualized" note for each client participant.	❑	❑	❑
10. Non-billable services: Admin/clerical functions: fax/left message/no shows cannot be billed (may be listed, but cannot be claimed, or may have non-billable code). **MUST BACK OUT (note "BO" on Services-Billed" report).** (CFR, title 32, section 438.10(d)(2)	❑	❑	❑
11. Does note match the appropriate procedure/billing code? (i.e. case management or collateral.) (Mental Health Plan Contract, Exhibit A, Attachment I)	❑	❑	❑
12. Is there a **trend or pattern of cloning progress notes?** (Mental Health Plan Contract, Exhibit A, Attachment I)	❑	❑	❑
13. Are progress notes, including co-signature when required, finalized within 5 business days from date of service? If note is finalized after 5 business days, is "late entry" entered at the beginning of the note.	❑	❑	❑

CULTURAL/LINGUISTIC SERVICES AND AVAILABLITY OF ALTERNATIVE FORMATS:	Yes	No	N/A
1. Is there any evidence that mental health interpreter services are offered and provided, when applicable?	❑	❑	❑
2. If the needs for language assistance is identified in the assessment, is there documentation of linking clients to culture-specific and/or linguistic services as described in the MHP's CCPR?	❑	❑	❑
3. When applicable, was treatment specific information provided to clients in an alternative format (e.g., braille, audiot, large print, etc.)?	❑	❑	❑

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Closing Thoughts on Audits

- Internal audits demonstrate an effective CP
- Payers, OIG, and OCR audits: looking for different things, purposes and methods
- However, these audit findings are discoverable
- NOT conducting or having a clear process for Auditing and Monitoring is even more risky!

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2015: Medicaid Documentation for BH

- Meet each state's Medicaid program participation rules;
- Reflect medical necessity and levels of care as defined by the state to justify the treatment and clinical rationale for medically necessary treatment;
- Reflect active treatment provided;
- Be complete, concise, accurate, and include face-time;
- Be legible, signed, dated, and available for review;
- Be coded correctly for billing purposes.

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Shameless Book Excerpts

- How does a clinician justify the diagnosis assigned to their client? Generally speaking, clinicians will need to:
  - Add details in the record to support the more specific ICD-10 diagnosis,
  - Link symptoms, complications and the manifestations to the diagnosis,
  - Understand that the diagnostic details needed will depend on the diagnosis and criteria.
- By supporting the diagnosis and condition, we are simply itemizing the intensity, frequency and duration of the signs and symptoms our client is exhibiting. In other words, we need ***solid clinical*** documentation, not necessarily ***more*** documentation or verbiage in the medical record.

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How Not to Diagnose: Betty Boo

- Betty Boo is a long-time client of the agency, 15 years to be exact. Almost every clinician has interacted with her over time. She always comes into her appointments looking and talking like Eeyore, from the Winnie-the-Pooh series. She also wears a red hat, purple shoes, and bright red lipstick smeared all over her face. You are a recently-graduated clinician, new to the agency. You see her for one session and after she leaves, you run into your colleague's office to discuss Betty Boo. You find out Betty Boo has been around for a very long time and everyone at your agency knows her. As a result of this information, you then assign her a diagnosis of Dysthymia and Histrionic Personality Disorder and justify this by indicating "*Client is known to this agency.*" No itemization of symptoms, duration, frequency is given.
  - ✓What documentation issue(s) might be problematic in this chart note?
- ✓How might you change the chart note to substantiate the diagnosis?

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Homework

Read through each Introduction of applicable chapters

Get clarification about using a holistic, comprehensive way of diagnosing from leadership (i.e.: X-codes, medical, etc..)

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Contact Information

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