DISCLAIMER
North Carolina Psychological Association and its Division of Independent Professional Practice, as well as the individuals who have worked on this information have acted in good faith in providing this information to members. We will not be held liable for actions any person takes as a result of the information contained herein or for failure to collect reimbursement from any third party payer. We disclaim legal responsibility for the consequences of any specific legal financial or accounting advice. It is the responsibility of each individual to verify all information in this document prior to any action, and to consult with legal and accounting advisers.

We would appreciate your input about inaccuracies in this product so that we may attempt to correct them and to maintain a document which is as accurate and up-to-date as possible.

INTRODUCTION

The NCPA insurance committee has become increasingly aware of efforts by CMS (Centers for Medicare and Medicaid Services) to audit record keeping by mental health professionals. We have been advised that this may extend to private (i.e. commercial) insurers. In the interest of helping our members respond to audit requests, we provide some general suggestions here.

First and foremost, please regard this as an opportunity to refine your documentation practices. To this date most audits have come in response to irregularities in billing, which would not occur in most practices. We hope the following information is helpful in the unlikely event that you are audited.

I. GENERAL SUGGESTIONS:

[ADAPTED FROM: "Brief Comments" FILE FROM Georgoulakis 2009]

a. Records (Individual sessions) must stand on their own merit;
b. Clinical note must meet billing documentation requirements;
c. Auditors often understand behavioral language better than theoretically oriented language;
d. Identify the treatment method used in the session;
e. Stress the importance of medical necessity especially;
   i. Use an ICD-9 CM diagnosis;
   ii. Be watchful of "self improvement" issues and "counseling" terminology (CMS pays for the treatment of mental disorders not self improvement);
   iii. Record must indicate that the patient can benefit from psychotherapy treatment in that session (Note: Psychotherapy is also justified if it is necessary to maintain, or avoid regression in, the patient's current level of functioning.);
f. Our records should reflect periodic reviews of treatment plans and patient status;

II. SPECIFIC PROGRESS NOTE SUGGESTIONS:

Did the record include, at a “minimum” the following:

1. Date of Service;
2. A start and stop time for the service;
3. An indication that the patient was capable of benefiting from treatment;
4. An ICD-9-CM diagnosis (Can use a DSM-IV diagnosis as well);
5. Description indicating that the patient has active signs of the disorder;
6. A description of the type of service provided, e.g., if the service provided was individual
psychotherapy (90806) were all the requirements for the service met, i.e., 45 to 50 minutes face-to-face with the patient;

7. Goals for the session;
8. Techniques utilized to bring about the desired goals;
9. Assessment of how the patient responded to the session;
10. Signature of the individual providing the service including degree.
III. SAMPLE PROGRESS NOTES

Sample Progress Note I (A simple "SOAP" note format)

Patient seen ___________________________      Start/Stop time ________________  Date of Service
_________________

Additional Participants in Patient’s treatment_______________________________

Psychotherapy Treatment Service provided

☐ 90804 Individual Psychotherapy (25-30 min.)
☐ 90806 Individual Psychotherapy (45-50 min.)
☐ 90847 Family/Conjoint Therapy
☐ 90846 Family/Conjoint Therapy, without patient present
☐ _____ Other

SUBJECTIVE: What did the patient say about their condition and sx's

OBJECTIVE: What do you observe about the patient? What did you do in the way of intervention(s) to treat the patient's disorder or sx? Goal?

ASSESSMENT: Statement whether the patient is able to benefit from psychotherapy. Description of progress (or regression) in terms of sx's
List DX (5 axes)

PLAN: Describe what is the plan to treat the patient. Also can include documentation of adjunct medication management by Dr. X and the medication and dosage

________________________________________

John Doe, PhD HSP-P
Licensed Psychologist, Lic #: xxxx
Sample Progress Note II (A "checklist" note format)

PT. NAME: *____________ BIRTHDAY *__________ AGE *__________
INTAKE DATE: *_________ INS: ____________________*

Therapist: Jane Doe, PhD
Licensed psychologist, NC# xxxxx

DATE: ___/___/____ Sess # (year): _____ Sess # (MC Auth): ___/____ Length: ______ Time:

Initial Diagnosis: *_____________ Dx change: ___ yes ___ no     Additional dx:

Tx Plan: Ind Psy (90806) ___ Psych Testing (96101) ___ Educ Testing (90899) ___ Fam Ther (90847) ___
Other __________________________

Tx Intervention: ___ C-B Ther ___ Reality Ther ___ Play Ther ___ Beh Mod ___ Other ____________
Medications: *______________ Changes in meds: ____________ Phys __________________
Phone # ____________________

Attending: ___ Client ___ Mo ___ Fa ___ Other

Client Able to Benefit from Session: ___ Yes ___ No

Mental Status/Current Symptoms:

___ Attn Prob ___ Anxiety ___ Depression ___ Anger ___ School prob
___ Hyperactivity ___ Phobias ___ Guilt ___ Anger contr ___ Narcissism
___ Impulsivity ___ Panic attacks ___ Hopelessness ___ Family stress ___ Sibling Rivalry
___ Opp beh ___ OCD ___ Anhedonia ___ Social Prob ___ Parenting Beh
___ Other
___________________________________________________ ______________________

Purpose/Medical Necessity (as shown by):

___________________________________________________ _____________________________________

Session Goal:

Other Notes:

___________________________________________________ _____________________________________

Response to Tx: ___ Positive ___ Neutral ___ Negative ___ Other ____________

Continue tx on:

___________________________________________________ _____________________________________

Plan: Continue with: ___ Current tx ___ End tx ___ Referral to ___________________________
Other/Next session on
___________________________________________________ _____________________________________
TX Plan reviewed with client: _____ yes   _____ no

Detail

___________________________________________________

Signature/Degree

________________________________________________________________________
Sample Progress Note III (A "SOAP" note with checklist format)

NAME:________________________________ DOB:__________ DATE:__________

Treatment Modality: Individual, Group, Family, Other_____________________(specify)
Location: Office, School, Home, Hospital, Other_____________________(specify)
Other People Present:____________________________________________________

SUBJECTIVE (Pt. Report of Problem):

OBJECTIVE – (What You Observe and What You Do in Session):

a. Psychomotor activity level:

b. Attention/concentration:

c. Affect:       __Broad __Restricted __Flat __Inappropriate __Labile __Anxious
                     __Appears fatigued __Irritable __Appropriate

d. Mood:        __Depressed (__Mild __Moderate __Severe)
                     __Denies suicidal ideation __Denies suicidal plan or intent
                     __Euthymic __Irritable __Elevated __Euphoric __Expansive __Angry
                     __Intent to harm others

e. Speech: __Spontaneous __Pressured __Forced __Mute __Slow
                     __Loose associations __Flight of ideas __Rapid

f. Thoughts:     __Logical __Tangential __Circumstantial __Disorganized __Illogical
                     __Blocked __Delusions __No psychotic thoughts

g. Perceptions: __No psychotic perceptions
                     __Hallucinations (__Visual __Auditory __Tactile
                     __Command __Observed __Reported)

h. Oriented:     __x4 __Time __Person __Place __Situation

ASSESSMENT (Symptoms of DX?)

Medical Necessity: (improved patient’s condition, prevented the onset or worsening of condition, assist patient to achieve or maintain maximum functional capacity)

PLAN (Treatment Plan Update or Next Treatment Steps)
Problems Addressed (evidenced in DX):

Intervention Techniques:

Goals:

Response to RX:
   Progress towards goals?
   Benefiting from RX?
Capacity to participate and benefit from RX?

If homicidal or suicidal a plan to address:

DX:

Start Time:___________ Stop Time:__________ Signature and Title:_____________________________
IV. DOCUMENTATION RESOURCES:
A primary source for guidance is the Cigna Government Services Medicare Bulletin: "Documentation of Psychotherapy Techniques" - July/August 2001


Recent post-payment medical record reviews indicate psychiatry/psychology providers are not adequately documenting therapeutic techniques used in psychotherapy sessions. An assessment of the patient's mental status is not enough, in itself, to support psychotherapy services. The CPT Code Book defines the psychotherapy codes as including insight oriented, behavior modifying, and/or supportive techniques. Therapy notes should include at least one of these techniques and how they were used to help a patient's particular problem. Notes that do not include the specific psychotherapy techniques applied will be denied as not meeting policy guidelines.

Especially problematic are psychiatrists who bill individual psychotherapy with medical evaluation and management services. In many instances, the documentation includes an assessment of the patient's mental status and medications prescribed, but does not include the psychotherapy portion of the service. Upon review, these services have been reduced to medication management services only.

Each psychotherapy note should include what psychotherapy techniques were used and how they benefited the patient in reaching his/her goals. Psychotherapy notes do not have to include intimate details of the patient's problems, but do have to meet medical necessity guidelines. Examples of documentation of psychotherapy techniques used may include, but are not limited, to the following:

1. "Supportive psychotherapy was utilized to help alleviate the patient's depression."
2. "Behavior modifying techniques were used to change the patient's maladaptive behavior. Positive reinforcement was used when the patient did not exhibit violent outbursts”
3. "Insight oriented psychotherapy was utilized to help the patient identify what negative thoughts are contributing to her depressed feelings."

In addition, each patient record should include a plan of care. This plan of care should include visit frequency, expected duration of therapy services, and measurable and realistic goals. The plan of care may be documented in the actual visit note or may be documented separately and kept in the patient record.

All money overpaid will be collected. See the appropriate Psychiatry and Psychology Services Local Medical Review Policy for more information.

Additional resources can be found at the websites below:
1. The Recovery Audit Contractor for North Carolina (and many other states):
   http://www.connollyhealthcare.com/RAC/Pages/cms_RAC_Program.aspx

2. CMS manuals provide documentation guidelines
   http://www.cms.gov/manuals/

3. New FAQ on CMS website reviews options for providers who receive overpayment decisions

4. RAC audits: CMS approved audit issues published
   http://www.lexology.com/library/detail.aspx?q=e94eb566-e6ab-4878-9a2b-95b73f72ca75

5. CMS info on RAC
   http://www.cms.gov/RAC/

6. Recent updates from CMS
http://www.cms.gov/RAC/03_RecentUpdates.asp#TopOfPage

7. AHA RACTrac Initiative
http://www.aha.org/aha/issues/RAC/ractrac.html