

Psychiatric Services – Documentation Requirements

1. ICD-9-CM diagnosis codes supporting the medical necessity must be submitted with each claim. Claims submitted without such evidence will be denied as not medically necessary.
2. Medical records must clearly demonstrate the specific types of services rendered for the treatment of psychiatric problems noted in the plan of treatment. Documentation of medical necessity must exist, must be provided and must include overview of the individual's severity of symptoms and presenting behaviors.
3. **Outpatient psychiatric services** must be designed to reduce or control the patient's psychiatric symptoms to prevent relapse or hospitalization and improve or maintain the patient's level of functioning. Services must meet the following criteria:
 - a. **Physician orders**

Required upon admission and required for all diagnostic and therapeutic services. Order may be written by other than the treating MD/DO and must be signed and dated. Signed and dated treatment plan may serve as MD/DO orders.
 - b. **Physician Supervision and Evaluation**

Physician supervision of outpatient psychiatric services is required by Medicare. Services must be supervised and periodically evaluated by the physician. Physician entries in the medical record must support his/her involvement. Physicians must provide supervision and direction to any therapist involved in the patient's treatment. The physician must see the patient periodically to evaluate the course of treatment and to determine the extent to which the treatment goals are being realized and whether changes in patient care direction is needed. The supervising physician does not need to be the ordering physician. There must be evidence in the patient's medical record reflecting physician encounters, which are not limited to face-to-face encounters. Physician supervision is evident in the medical record as documented by:

 1. Physician written order for services and medication.
 2. Physician signature on the plan of treatment and all updated plans.
 3. Documentation of a patient/physician visit.
 4. Physician written progress notes
 - c. **Evaluations**

Initial evaluation should be completed within seven (7) days of the program admission. The evaluation should provide, but is not limited to, the following information:

 1. Referral source
 2. Medical history/physical history
 3. Patient's chief complaint
 4. History of present illness (initial onset of illness, inpatient admissions, substance abuse)

5. Personal history (family history of psychiatric illness, work, education)
6. Current medication (name(s), dosage and frequency, route of administration)
7. Objective tests and measures
8. Mental status exam (appearance, attitude, behavior, perceptual disorders, mood/effect, suicidal/homicidal ideations, behaviors, cognitive function such as orientation, memory, insight and judgment)
9. Current risks or social factor support systems
10. Patient's desire/motivation for change
11. Strengths and weaknesses
12. Diagnostic impression (axis determination {DSM-IV}, diagnosis)
13. Documentation of medical necessity and recommendations for treatment.

d. Re-evaluations

Re-evaluations and updates to the treatment plan should be reflective of the patient's changing condition so a comparison of the patient can be accomplished.

Documentation must show **re-evaluation of the course of treatment (at least every three (3) months or when a change in the patient's condition occurs)** identifying the patient's response to treatment and specifically noted changes in clinical status and/or treatment plan. When the need for control of symptoms and maintenance of a functional level to avoid further deterioration is indicated, the documentation must be specific.

e. Treatment plan

An individualized written treatment plan, signed and dated by a physician, is required within seven (7) days of program admission. However, if only a few brief visits are planned, a treatment plan need not be completed. The services/modalities indicated on the plan must be prescribed by a physician and must include the following:

1. ICD-9-CM diagnosis code and/or DSM IV
2. Identification of individual patient problems or impairments
3. Anticipated short and long term treatment goals for evaluating a patient's response to treatment. They should be designed to measure the impact of the treatment and serve as a resource for determining the appropriate level of intervention for the patient's condition. In addition, the objective/treatment goals for each problem or impairment should be stated in behavioral terms and be:
 - a. Measurable
 - b. Observable
 - c. Relevant and realistic
 - d. Time limited
4. The intervention (modality/service) for each short/long term goal should be described as follows:
 - a. Type and modality (i.e. group/individual)
 - b. Amount, frequency and duration of each modality, i.e. interpersonal skills group 3 times a week for 6 weeks.

5. Treatment plan updates as the patient condition warrants
6. Discharge and aftercare plans/goals
7. Clinicians involved in the formulation of the treatment plan may also be indicated
8. Services rendered by a physician **must be** indicated on the plan.

f. Progress Notes

Progress notes should be legible, signed and dated, including the credentials of the rendering provider and must reflect the following:

1. The treatment being given
2. The patient's status (behaviors, verbalizations, mental status)
3. The patient's participation and response to treatment, and the relationship to long and short term goals
4. Notes may be written in one of the following formats:

Session by Session:

Date
Modality
Session narrative
Therapist signature and credentials

Weekly/Monthly summary:

Date Span
Modality name: "Interpersonal Skills Group"
Summary narrative
Therapist signature and credentials

g. Medication Treatment Record

Documentation must indicate the date the medication was ordered and given. The name of the drug administration and the route of administration (IM, IV or orally)

h. Lab, Radiology Diagnostic Reports

All laboratory, radiology and other diagnostic reports pertinent to the services billed must be provided.

4. **Consultation/Liaison Services** are psychiatric services provided to medical inpatients and outpatients (ex. Emergency Department). For the initial psychiatric consultation, please refer to the pink and yellow cards provided by the University Compliance Office for the correct use of CPT codes 99251-99255 for inpatients and 99241-99245 for outpatients. For subsequent visits following the initial consultation, use subsequent inpatient code 99231-99233 or follow-up outpatient codes 99211-99215 as appropriate to the place of service and status of the patient.
5. **Inpatient Hospital** services provided to psychiatric patients in an inpatient psychiatric facility can be medical evaluation and management services or psychiatric evaluation and therapy services or a combination of both. Professional medical evaluation and management services are billed using CPT codes 99221-99223 for initial evaluations and

99231-99233 for subsequent hospital visits. Professional psychiatric diagnostic evaluation services can be billed using CPT code 90801. Follow-up inpatient psychotherapy can be billed using inpatient psychiatric therapy codes 90816-90822 (or interactive inpatient psychotherapy codes 90823-90829). In each case, documentation must support the level of services provided and billed.

6. **Partial Hospitalization (PHP)** is distinct and organized intensive psychiatric outpatient treatment of less than 24 hours of daily care, designed to provide patients with profound and disabling mental health conditions a multidisciplinary program not provided in a regular outpatient setting in order to avoid inpatient care. Professional services provided to patients in an outpatient PHP can be medical evaluation and management services or psychiatric evaluation and therapy services or a combination of both. Professional medical evaluation and management services are billed using CPT codes 99221-99223 for initial evaluations and 99231-99233 for subsequent PHP visits. Professional psychiatric diagnostic evaluation services can be billed using CPT code 90801. Follow-up PHP psychotherapy can be billed using inpatient psychiatric therapy codes 90816-90822 (or interactive inpatient psychotherapy codes 90823-90829). In each case, documentation must support the level of services provided and billed.

7. **Evaluation and Management** codes for new and established inpatients and outpatients: Please contact your compliance analyst/educator Linda Tamburello at 273-2131 or Linda.Tamburello@urmc.rochester.edu for the correct use of CPT codes 99221-99223 and 99231-99233 for inpatients and 99201-99205 and 99211-99215 for outpatients.