Documentation Standards and Requirements

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Carelon Behavioral Health (Carelon) has multiple compliance and integrity functions to promote accuracy with claims payment and to detect and correct fraud, waste, and abuse. Providers are expected to submit claims and maintain provider records in accordance with national and industry standards.

Carelon conducts retrospective and prospective reviews of claims and provider records to ensure claims and payment accuracy as well as to identify potential fraud, waste, and abuse. Carelon relies on claims edits and investigative analysis to ensure providers are in compliance with applicable coding and billing rules and requirements through the application of coding standards outlined by the American Medical Association (AMA), Centers for Medicare and Medicaid Services (CMS), state Medicaid agencies, National Committee for Quality Assurance (NCQA), as well as other applicable regulatory and advisory agencies. The following are references to the national standards:

- Centers for Medicare and Medicaid Services Website
- American Medical Association: CPT coding
- National Correct Coding Initiative (NCCI), including information on Medically Unlikely Edits (MUEs)
- National Committee for Quality Assurance

Carelon will review provider claims and records through progressive samples.

- Carelon will start with an initial sample of claims.
- If significant documentation or billing errors are identified in the initial sample, Carelon will progress to an expanded sample of claims based on the size of population.
- If there are significant billing errors, Carelon will progress to an on-site audit or self-audit of focused population.

Carelon may report non-compliance to the National Credentialing Committee and will report suspected fraud, waste or abuse to its Special Investigations Unit. The Special Investigations Unit may conduct additional or separate reviews based on applicable laws.

Carelon will recover claims payments that are contrary to national and industry standards or do not have the required minimum documentation in the provider records. Carelon's recovery policy outlines the following procedures for recovering overpayments:

- Carelon will comply with all federal and state guidelines to recover overpayments.
- Carelon will notify clients, providers, and members (when applicable) of overpayments.
- Carelon will make attempts to recover overpayments within 60 business days of notification or identification.
- Carelon will extend dispute and reconsideration rights for claim denials and adjustments.
- Carelon will immediately report all suspected fraud and abuse.

Beacon may pursue overpayments for the following reasons (but is not limited to):

1. NCCI Procedure to Procedure (PTP) edits
2. NCCI Medically Unlikely Events (MUE) edits
3. NCCI Add-On Code edits

4. Retrospective coordination of benefits
5. Retrospective termed member eligibility
6. Retrospective rate adjustments
7. Incorrect fee schedule applied to claim
8. Member cost sharing
9. Negative balance collections
10. Provider excluded
11. Provider license terminated or expired
12. Provider does not meet the requirements
13. Different rendering provider
14. No authorization or invalid authorization
15. Inaccurate claim information
16. Duplicate claims
17. Non-covered services
18. Excessive services
19. Outpatient services while member was inpatient
20. Overlapping services
21. Patient different than member
22. Per diem services billed as separate or duplicate charges
23. Services provided outside of practice standards
24. Group size exceeds limitations
25. No services provided
26. No-shows or cancellations
27. No records
28. Invalid code or modifier
29. Invalid code combinations
30. Diagnosis codes that do not support the diagnosis or procedure
31. Add-on codes reported without a primary procedure code
32. Clinical documentation issues
33. Claims documentation issues
34. Insufficient documentation
35. Potential fraudulent activities

Carelon requires providers to have minimum documentation standards that comply with AMA, CMS, state Medicaid agencies, NCQA, as well as other applicable regulatory and advisory agencies. Additionally, providers should meet practice standards outlined by professional licensing boards and maintain clinical principles through the provider records. For payment integrity reviews, providers must meet the following minimum documentation standards for payment:

A. Providers are responsible to follow all requirements under federal and state regulations, publications, and bulletins that are pertinent to the treatment and services provided. The minimum documentation standards outlined for payment integrity are a reference guide for payment and should be used in coordination with contracts, provider manuals, and all regulations.
B. All providers must have member charts that include all requirements, are individual and kept secure.
C. All members must sign the appropriate releases of information authorizing Carelon to use and to disclose member records for purposes of payment and health care operations.
D. All mental health services including assessing, diagnosing, and treating require consents to treatment prior to any mental health service being rendered or paid.
E. Providers are responsible to obtain the appropriate order, referral, or recommendation for service.
F. All documentation must meet the requirements of the service codes that are submitted on the claims form.

G. All progress notes and billing forms must be completed and signed after the session, except when certain documentation interventions may be integrated as treatment services. The exception has specific requirements. Please confirm that the requirements are met before billing for the session.
H. All documentation and medical record requirements must be legible.
I. All encounters must have a progress note to support the service billed.
J. All amendments or changes to the documentation must be signed and dated by the clinician amending or changing the documentation.
K. All requirements for documentation must be completed prior to the claim form submission date.
L. Training related to documentation standards is offered through our *Giving Value Back to the Provider* webinar. To register or access the archive, visit our Provider Webinar page.
M. All providers should ensure that the consent to treatment and release of information meet all regulatory requirements.
N. Each provider record should be individualized and unique and should include a patient identifier on every page. (Providers are not permitted to clone or copy and paste member or treatment information in provider records.)
O. All providers must ensure that consents to treatment, releases of information, treatment plans, progress notes, and discharge summary contain the following minimum documentation requirements in order to receive payment for all claims billed:

I. Consent to Treatment
   a. Name and signature of the member, or if appropriate, legal representative
   b. Name of the provider (should correspond with license)
   c. Type of services and/or treatment
   d. Benefits and any potential risks
   e. Alternative services and/or treatment
   f. Date and time consent is obtained
   g. Statement that treatment and services were explained to member or guardian
   h. Signature of person witnessing the consent (clinician)
   i. Name and signature of person who explained the procedure to the member or guardian

II. Assessment
   a. Presenting concerns
   b. Medical history
   c. Psychiatric history
   d. Substance use history
   e. Developmental history (children and adolescents)
   f. Allergies/adverse reactions
   g. Medications
   h. Risk assessment
   i. Mental status exam
   j. Member strengths
   k. Clinical formulation
   l. Clinical formulation validated by clinical data
   m. Diagnosis validated by clinical data
   n. CANS administered and integrated (under 21), as applicable
   o. Outcome tool administered and integrated, as applicable
   p. Documentation of time spent and duration of assessments
   q. Clinician's signature, credentials, and signature date

III. Other Clinical Documentation
   a. Evaluations that meet clinical practice standards
   b. Releases of information are valid and signed by clinician and member

IV. Individual treatment plan or plan of service

a. Service requirements indicating completion
b. Treatment plan or plan of service date
c. Diagnoses and/or symptoms being addressed
d. Clinician's signature, credentials, and signature date
e. Member or guardian's signature and signature date (or acknowledgement that the member or guardian participated in the development of the plan)
f. Evidence that member or guardian participated
g. in treatment plan development
h. Goals and objectives based on evaluation and mental health strengths and needs
i. Treatment objectives prescribed as an integrated program of therapies, activities, experiences, and appropriate education designed to meet these objectives
j. Treatment plan or plan of service has measurable goals
k. Treatment plan or plan of service has established timeframes
l. Treatment plan or plan of service referencing less restrictive alternatives that were considered
m. Treatment plan or plan of service is easy to read and understand
n. Treatment plan or plan of service documents the necessity for services
o. Treatment plan or plan of service documents the utilization of services
p. Treatment plan or plan or service reviewed in accordance with clinical standards

V. Progress notes

a. Each billable encounter that is represented
b. Name or member identification number
c. Date of service matches the claim billed
d. Duration or start and stop times of service, depending on applicable law
e. Units that match the claims billing and supported by duration or start and stop times of service
f. Place of service on claims is supported in documentation (specific location for community services)
g. Reason(s) for the session or encounter
h. Documentation to support the definition of the procedure code billed
i. Treatment plan or plan of service goals addressed
j. Current symptoms and behaviors
k. Interventions and response to treatment plan or plan of service
l. Next steps and progress in treatment plan or plan of service
m. Narrative with the clinical justification to support utilization and time billed
n. Supporting documentation attached to progress note for intervention development and indirect services
o. Clinician's signature, credentials, and signature date

VI. Discharge summary

a. Summary of services provided
b. Status toward meeting goals
c. Diagnosis at time of discharge
d. Reason for discharge
e. Medications prescribed
f. Referrals documented
g. Aftercare options identified
h. Clinician's signature, credentials, and signature date
i. All services should be provided prior to discharge summary date

Documentation and Reporting Guidelines for Evaluation and Management Services

According to the American Medical Association, all entries to the medical record should be dated and authenticated. Carelon Health Options requires medical records documentation include signature of the individual who provided/ordered the services. The signature for each entry must be legible and should include the practitioner's first and last names and credentials. The reported service must be complete and legible.

Carelon Health Options follows the CMS 1995 and 1997 documentation guidelines, that both require some or all of the following elements of the types of history:

- Chief Complaint (CC);
- History of Present Illness (HPI)
- Review of Systems (ROS); and
- Past, Family and/or Social History (PFSH)

The extent of HPI, ROS and PFSH that is obtained and documented is dependent upon clinical judgment and the nature of the presenting problem. The chief complaint must be indicated at all levels.

The chief complaint is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter. The medical record should clearly reflect the chief complaint.

Split (or Shared) Visits

Carelon follows CMS guidelines on split (or shared) visits. A split (or shared) visit is an evaluation and management visit in the facility setting that is performed in part by both a physician and a non-physician practitioner of the same group. Payment will be made to the practitioner who performs the substantive portion of the visit.

Incident to

The "incident to" provision may apply to coverage for psychological services furnished "incident to" the professional services of certain non-physician practitioners including clinical psychologists, clinical social workers, nurse practitioners, and clinical nurse specialists.

The training requirements and state licensure or authorization of individuals who perform psychological services are intended to ensure an adequate level of expertise in the cognitive skills required for the performance of diagnostic and therapeutic psychological services. Therefore, only the types of individuals listed in this policy are considered qualified to perform medically necessary psychological services. Delegation of diagnostic and therapeutic psychological services to personnel not performing within the scope of practice as authorized by state law, under the "incident to" provision, would bypass the safeguards afforded by professional credentialing and state licensure requirements. Such delegated services under the "incident to" provision would be inappropriate, unreasonable, and medically unnecessary, and therefore not covered by Carelon.

For psychology services rendered under the "incident to" provision, the billing provider must first evaluate the patient personally and then initiate the course of treatment. The appropriately trained therapists may then render psychological services to the patient under the billing provider's direct supervision.

Direct supervision means that the billing provider must be present in the immediate office suite to render assistance if needed. Direct supervision can be provided using real-time interactive audio and video technology to leverage additional staff and technology necessary to provide care that would ordinarily be provided incident to a physicians' service.

It is not permissible for the billing provider to hire and supervise a professional whose scope of practice is outside the provider's own scope of practice as authorized under State law, or whose professional qualifications exceed those of the "supervising" provider.

Individuals who are not licensed or otherwise authorized by state law to provide psychological services may not provide psychological services under the "incident to" provision. This level of professional credentialing is necessary to furnish appropriate medically necessary services under the "incident to" provision.

Psychological services furnished to Carelon members under the "incident to" provision by individuals other than those listed above are not covered. For Carelon's Medicaid business, state guidelines will be followed.