Insurance Chart Audit Criteria

If we keep all files up to these standards, we will have less to worry about in the event of an audit. The info below has been provided by one of the insurance companies that we work with.

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<tr>
<td><u>Diagnostic Assessment Report</u>: 90791 needs a DA report, not just a regular PN

To be completed prior to the third session

DA must include the following elements:

• Presenting problems/ justification of DSM diagnosis
• Family history
• Chemical health history
• Medical and psychiatric history
• Appropriate psychiatric referral (adherence to DHS guidelines for psychiatric referral)
• Acknowledgment of other practitioners
• Note if client declined or consented for PCP collaboration
• Relevant social conditions
• Mental status
• Risk assessment (i.e. suicidality, homicidality, self-injurious behavior, substance abuse/dependence, physical/sexual abuse, child/elder neglect or eating disorder)
• Patient's strengths and limitations
• DSM 5 codes
• Clinical plan
• Explained informed consent

Medical necessity

Document the medical necessity for psychotherapy in the diagnostic assessment.</td>
<td><u>Treatment Plan:</u>

• To be completed prior to the fourth session
• Must address the following:
• Diagnosis
• Measurable goals (Includes baseline data and desired outcome. Goals are stated with frequencies, percentages, or a Likert scale that can objectively indicate progress.)
• Estimated time frames for treatment goals
• Discharge planning
• Special status situations (if any risks are identified in the diagnostic assessment, they need to be addressed in the treatment plan.)

Must include:

Signatures (Includes patient's signature once a year, provider's signature on each treatment plan and review, and supervisor's signature when applicable.)

Document in the individualized treatment plan (ITP) the specific interventions with measurable goals and objectives (including start and stop time) describing how the mental health professional will use psychotherapy to treat the member's mental illness.

Reviewed and updated every 180 days or if major diagnosis change.</td>
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<tr>
<td><u>Progress Notes:</u></td>
<td><u>Discharge Documentation</u></td>
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Present & signed for each date of service billed Each progress note must include: • Type of service • Date of service • Session start and stop times • Scope of service (nature of interventions or contacts including treatment modalities, phone contacts, etc.) • Client's progress (or lack of) to overall treatment plan goals and objectives • Treatment or intervention activity & Client's response or reaction to treatment intervention(s) • Client provided information (verbal and non-verbal information the client provided) • Formal or informal assessment of the member's mental health status (current functioning and issues) • Name and title of person who gave the service • Date documentation was made in the member's record • Action plan • Type of service rendered (CPT code or name and duration of service) • Date and responsible clinician's name (present on all entries) • Required clinical supervision (when applicable, supervision is documented) Other elements that may be included:	Describes the termination and/or transition of services. It provides closure for a service episode and referrals, as appropriate. There are two (2) types of clinical discharge documentation: • Discharge Note: A brief Progress Note to indicate that the case is closed, per the Minimum Requirements below. (This is considered an administrative activity and is not billable unless it is part of a final billable service with the client present.) • Discharge Summary: A comprehensive document that is clinically necessary in order to provide continuity of care for the next service provider, per the Minimum Requirements below. Timeliness of Discharge Summary & Discharge Note Cases/episodes must be closed within 90 days (3 months) after the client's last service, unless the rationale for maintaining an open case is written in the clinical record. A quarterly written rationale must be provided if the case will be kept open during continued noncontact. Discharge documentation must be entered into the clinical record within one (1) working day of the discharge decision, but prior to closing the episode, and must be clearly labeled as either "Discharge Summary" or "Discharge Note". Minimum Requirements Discharge Note: A Progress Note that includes brief documentation of the following:

• Current risk factors the member may be experiencing • Emergency interventions • Consultations with or referrals to other professionals • Summary of effectiveness of treatment, prognosis, discharge planning, etc. • Test results and medications • Symptoms	a. Reason for discharge/transfer. b. Date of discharge/transfer. c. Referrals made, if applicable. d. Follow-up care plan. Discharge Summary: A document that must meet the requirements of a Discharge Note plus a summary of the following: a. Treatment provided. b. Overall efficacy of interventions c. Progress made toward the mental health goals/objectives. d. Clinical decisions/interventions: • Treatment planning recommendations for future services relevant to the final Client Plan; and • Referral(s) for aftercare services/community support services.