

Welcome!

Training with Highmark Wholecare

The program will begin at noon.

You will hear silence until we begin.

Please take this opportunity to check your connections.



The Q&A box is available to type any questions or issues.



Lunch and Learn with Highmark Professional Education
CME/CEU Webinar Series

Breaking Down Behavioral Health: Coding Concepts

November 5, 2024

Anne Lacienski, CPMA
Jayme Patterson, CPC
Cynthia Scott, CPC
Sherry Roedersheimer, COC, CPC, CPMA

Presented by:



Learning Objectives

- Identify what constitutes Behavioral Health
- Illustrate the importance of medical record documentation, medical necessity and HIPAA requirements
- Demonstrate proper *Incident to* billing
- Identify common areas of Fraud, Waste and Abuse (FWA) within Behavioral Health

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This information is issued on behalf of Highmark Wholecare, coverage by Gateway Health Plan, which is an independent licensee of the Blue Cross Blue Shield Association. Highmark Wholecare serves a Medicaid plan to Blue Shield members in 13 counties in central Pennsylvania, as well as, to Blue Cross Blue Shield members in 14 counties in western Pennsylvania. Highmark Wholecare serves Medicare Dual Special Needs plans (D-SNP) to Blue Shield members in 14 counties in northeastern Pennsylvania, 12 counties in central Pennsylvania, 5 counties in southeastern Pennsylvania, and to Blue Cross Blue Shield members in 27 counties in western Pennsylvania.

Disclosure

Allegheny General Hospital is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

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Allegheny General Hospital designates this live activity for a maximum of 1.00 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Disclosure Statement

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The following presenters disclose no conflicts

Kylie Wilson; Anne Lacienski, CPMA; Cynthia Scott, CPC; Jayme Patterson, CPC; and Sherry Roedersheimer, COC, CPC, CPMA

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Questions?

Email ahncme@ahn.org

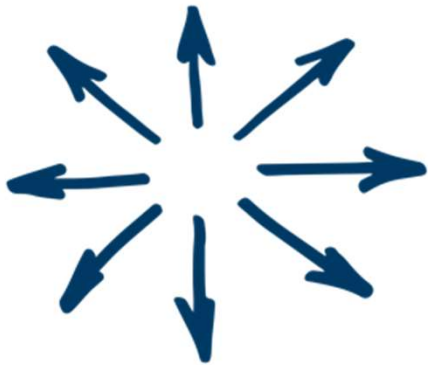


Today's Speakers



**Highmark Wholecare, Highmark Health Options
and Highmark Inc.**

Financial Investigations Provider Review (“FIPR”)



Anne Lacienski, CPMA, *Manager*

Jayne Patterson, CPC, *Senior Investigator*

Cynthia Scott, CPC, *Senior Investigator*

Sherry Roedersheimer, COC, CPC, CPMA,

Lead Investigator



Agenda



- ❖ Defining Behavioral Health
- ❖ Medical Record Documentation and Medical Necessity
- ❖ HIPAA Requirements
- ❖ *Incident to billing*
- ❖ Common areas of Potential Fraud, Waste and Abuse (FWA)
- ❖ Reporting Potential FWA



Defining Behavioral Health



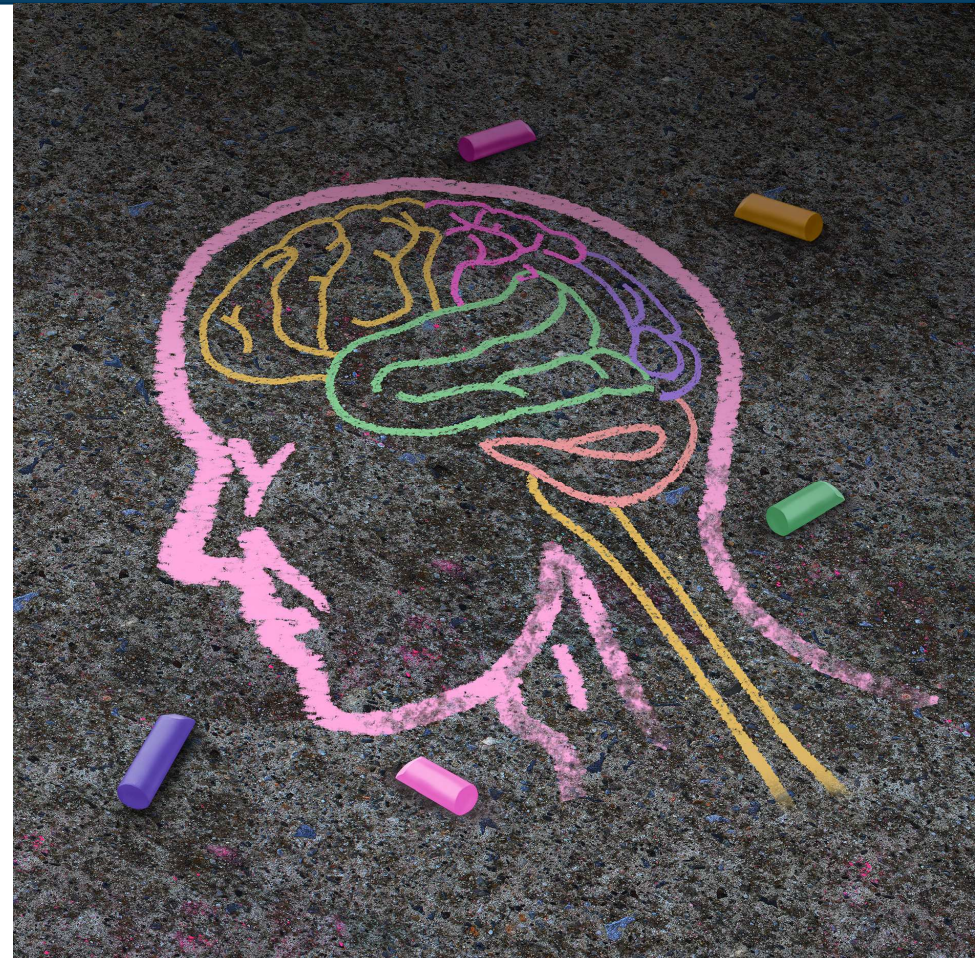
Behavioral Health is a broad term that refers to how a person's behaviors, emotions and thoughts affect their overall well-being.

It includes mental health, substance use and other factors that impact a person's physical health, such as:

- Eating habits
- Exercise
- Sleep patterns

Behavioral healthcare involves the prevention, diagnosis and treatment of conditions that impact a person's behavioral health.

Behavioral healthcare providers can help people learn ways to manage their thoughts and emotions and develop healthy behaviors.



Medical Record Documentation and Medical Necessity



Medical Record Documentation

A medical record must clearly document the medical care provided to a member.

- Medical record documentation is necessary to record applicable observations and findings regarding the member's history, examinations, diagnostic tests and procedures, diagnoses, treatments and treatment plan, necessary follow-up care and outcomes or responses to care per date of service or encounter.

Requirements:

1. Entries must be accurate and unique to the individual member. Functions such as cloning, copy and paste, cookie cutter, copy forward and carrying forward have the potential to create inaccuracies in documentation by using the same language from member to member.
2. Every page of the record must be legible and include appropriate patient identification information. The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
3. All CPT, HCPCS and ICD-10 codes reported on the claim must be substantiated.
4. Start and stop times and total time must be documented when time is a required factor for reporting services.
5. The medical record documentation must support the medical necessity of the services.



Providers are required to retain all records, including medical records, in accordance with the provider's participation agreements and Highmark's administrative requirements, as well as all applicable state and federal laws, regulations and governmental program requirements.

Documentation Standards for Behavioral Health Services



When providing outpatient behavioral health services to Highmark members, progress notes must be documented for each office visit or encounter. Clinical documentation should be created at the time of services and/or before a claim is submitted to Highmark.



Initial evaluations must have a comprehensive history, full mental status exam and a treatment plan documented. If the services are performed by a licensed or certified therapist under the supervision of an eligible professional provider, the initial evaluation must include the signature of the supervising provider.



The provider's progress notes for outpatient office visits should, at a minimum, include the following information:

Member's name, Date of Service, Length of session (if billing code submitted is time-dependent), Therapy/modality utilized, Appropriate subjective and objective data, Assessment and Treatment plan.

Psychotherapy Services and Procedures



The Current Procedural Terminology (CPT) code range for Psychiatry Services and Procedures 90785-90899 is a medical code set maintained by the American Medical Association. This code range is found in the Psychiatry subsection of the Medicine section of the CPT Manual.

Psychotherapy Services for the following CPT codes:

- Interactive Complexity: 90785 (add-on code; Code first, when performed (90791-90792, 90832-90834, 90836-90838, 90853))
- Psychiatric Evaluations 90791 – 90792 (w/o and with medical services)
- Individual Patient: 90832-90834, 90836-90838 (time-based, face-to-face services)
- Psychotherapy for Crisis: 90839, 90840 (time based, face-to-face services)
- Family Psychotherapy: 90846, 90847 (time based, face to face services; w/o and with patient present)
- Multi-Family Group Therapy: 90849
- Group Psychotherapy: 90853 (other than multi-family)
- Consultation with family: 90887
- Preparation of report 90889 (other than for legal or consultative purposes)
- Pharmacologic management 90863 (add-on code; Code first, when performed 90832, 90834, 90837)

Psychotherapy Service with Evaluation and Management (E/M) Service on Same Day

Key Considerations and Notes:

- 
- ❖ You may report services with an appropriate E/M code and an add-on code specifically for psychotherapy when performed with an E/M service (90833 – 30 mins, 90836 – 45 mins, 90838 - 60 mins).
 - ❖ To report both E/M and psychotherapy, the two services must be significant and separately identifiable. Both the E/M and psychotherapy services must be medically necessary and documented as such.
 - ❖ The type and level of E/M service is selected based on medical decision making.
 - ❖ Time spent on the activities of the E/M service is not included in the time used for reporting the psychotherapy service. Time may not be used as the basis of the E/M code selection and prolonged services may not be reported.
 - ❖ A separate diagnosis is not required for the reporting of E/M and psychotherapy on the same date of service.
- 



E/M and Psychotherapy Coding Example

Scenario:

Patient: A 35-year-old female presenting for a follow-up appointment for anxiety and depression.

Reason for Visit:

- The patient is experiencing increased anxiety and difficulty sleeping. She wants to discuss strategies for managing her symptoms.

Services Provided:

- E/M: The physician conducts a comprehensive history and physical exam to assess the patient's overall health and address any potential medical factors contributing to her anxiety. Medication discussed and prescribed.
- Psychotherapy: The therapist provides 30 minutes of individual psychotherapy, focusing on cognitive-behavioral techniques to manage anxiety and improve sleep.

Medical Necessity

- Psychotherapy will be considered medically reasonable and necessary when the patient has a psychiatric illness or is demonstrating emotional or behavioral symptoms sufficient to cause inappropriate behavior or maladaptive functioning.
- Psychotherapy services must be comprised of clinically recognized therapies that are pertinent to the patient's illness or condition. The type, frequency and duration of services must be medically necessary for the patient's condition under accepted practice standards.
- There must be a reasonable expectation of improvement in the patient's disorder or condition, demonstrated by an improved level of functioning or maintenance of level of functioning where decline would otherwise be expected in the case of a disabling mental illness or condition or chronic mental disorders.
- The patient must have the capacity to actively participate in all therapies prescribed.
- To benefit from psychotherapy, an individual must be cognitively intact to the degree that he/she can engage in a meaningful verbal interaction with the therapist.
- For patients suffering from dementia, the type and degree of dementia must be taken into account in planning and evaluating effective psychotherapeutic interventions. If psychotherapy is provided to a patient with dementia, the patient's record should support that the patient's cognitive level of functioning was sufficient to permit the patient to participate meaningfully in the treatment.
- The duration of psychotherapy must be individualized for every patient. The provider of service must document in the patient's record the medical necessity for continued (prolonged) treatments.


HIPAA Requirements




The Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule provides consumers with important privacy rights and protections with respect to their health information, including important controls over how their health information is used and disclosed by health plans and healthcare providers.

Ensuring strong privacy protections is critical to maintaining individuals' trust in their healthcare providers and willingness to obtain needed healthcare services, and these protections are especially important where very sensitive information is concerned, such as mental health information.



At the same time, the Privacy Rule recognizes circumstances arise where health information may need to be shared to ensure the patient receives the best treatment and for other important purposes, such as for the health and safety of the patient or others. The Privacy Rule is carefully balanced to allow uses and disclosures of information—including mental health information—for treatment and these other purposes with appropriate protections.



Key Points in Sharing Information Related to a Patient's Mental Health under HIPAA



- HIPAA allows for communication with family members, friends or others involved in the patients' care. This is especially important for patients who are unable to make their own decisions or who need support from others.
- Mental health information is protected under HIPAA but there are some exceptions. For example, psychotherapy notes are subject to stricter protection than other types of mental health information.
- Emergency situations allow for the disclosure of information to prevent harm to the patient or others.
- HIPAA defers to state laws regarding the rights of parent's access to their child's mental health information. This means that the provider should be familiar with the laws in their state.
- HIPAA allows for the disclosure of information to other healthcare providers for treatment, case management and coordination of care. This is important for ensuring that patients receive the best possible care.
- HIPAA allows for the disclosure of information to social service agencies in certain circumstances. This is important for helping patients access the resources they need.

See [HIPAA Privacy Rule](#) for further information

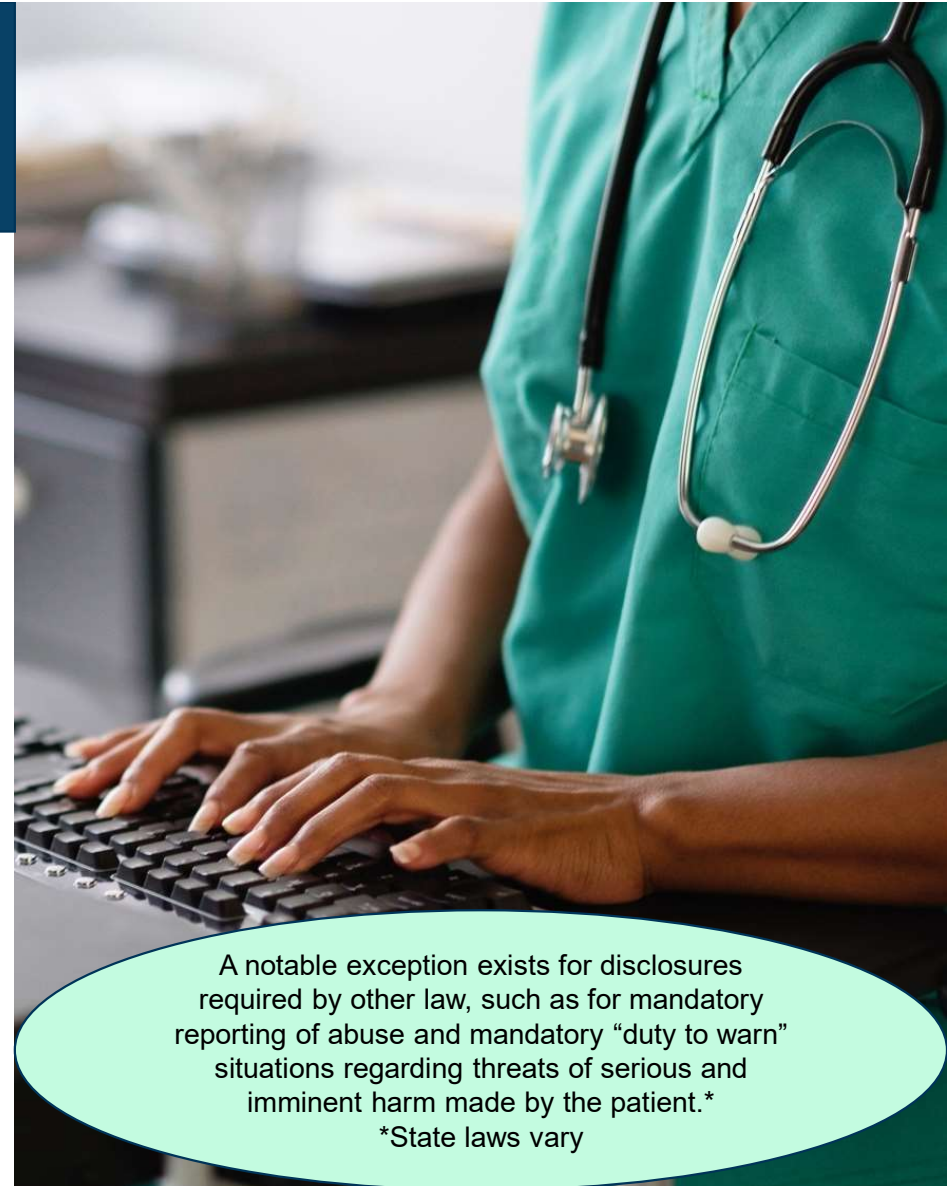
HIPAA provide extra protections for mental health information compared with other health information

Psychotherapy notes are treated differently from other mental health information because they:

- contain particularly sensitive information; and
- are the personal notes of the therapist that typically are not required or useful for treatment, payment or healthcare operations purposes, other than by the mental health professional who created the notes.

Therefore, with few exceptions, the Privacy Rule requires a covered entity to obtain a patient's authorization prior to a disclosure of psychotherapy notes for any reason, including a disclosure for treatment purposes to a healthcare provider other than the originator of the notes.

See 45 CFR 164.508(a)(2) for further information



A notable exception exists for disclosures required by other law, such as for mandatory reporting of abuse and mandatory “duty to warn” situations regarding threats of serious and imminent harm made by the patient.*

*State laws vary

Incident to Billing: Psychiatry and Psychology Services



Furnishing Psychiatry and Psychology Services



CMS National Coverage Policy

42 CFR 410.73 – 410.76 describes coverage of services provided by clinical social workers, physician assistants, nurse practitioners or clinical nurse specialists.

CMS Publication 100-02: Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services:

- ❖ §160 Clinical Psychologist Services
- §170 Clinical Social Worker (CSW) Services
- §180 Nurse-Midwife (CNM) Services
- §190 Physician Assistant (PA) Services
- §200 Nurse Practitioner (NP) Services
- §210 Clinical Nurse Specialist (CNS) Services

**CMS Publication 100-03: Medicare National Coverage Determinations (NCD) Manual, Chapter 1 – Coverage Determinations, Part 1:
§30.1 Biofeedback Therapy.**

CMS Publication 100-04: Medicare Claims Processing Manual, Chapter 12 – Physician/Nonphysician Practitioners:

- ❖ §110 Physician Assistant (PA) Services Payment Methodology
- §120 Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS) Services Payment Methodology
- §120.1 Limitations for Assistant-at-Surgery Services Furnished by Nurse Practitioners and Clinical Nurse Specialists
- §150 Clinical Social Worker (CSW) Services
- §160 Independent Psychologist Services
- §170 Clinical Psychologist Services
- §170.1 Payment
- §210 Outpatient Mental Health Treatment Limitation

➤ <https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdId=34616&ver=40>

Incident To for Mental Health



Outpatient psychiatric services furnished as 'incident to' professional services are limited to the following:

- ❖ Physicians, Clinical Psychologists, Nurse Practitioners, Clinical Nurse Specialists, Physician Assistants and Certified Nurse-Midwives

To be covered and paid under 'incident to' the services and supplies must be furnished in compliance with State law and certain criteria must be met:

- ❖ An integral, although incidental, part of the physician's professional service
- ❖ Commonly rendered without charge or included in the physician's bill
- ❖ Of a type that are commonly furnished in physician's offices or clinics
- ❖ Furnished by the physician or by auxiliary personnel under the physician's direct supervision
- ❖ 'Auxiliary personnel' means any individual acting under the supervision of a physician. Where a physician supervises auxiliary personnel to assist in rendering services to patients and includes the charges for their services in his/her own bills, the services of such personnel are considered 'incident to' if there is a physician's service rendered to which the services of such personnel are an incidental part and there is direct supervision by the physician.

Services and supplies may also be covered when furnished as 'incident to' the professional services of a physician or other specified NPP as listed below:

- ❖ Clinical Psychologists, Clinical Social Workers, Clinical Nurse Specialists, Nurse Practitioners, Physician Assistants and Certified Nurse Midwives
 - <https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00150921>
 - <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>

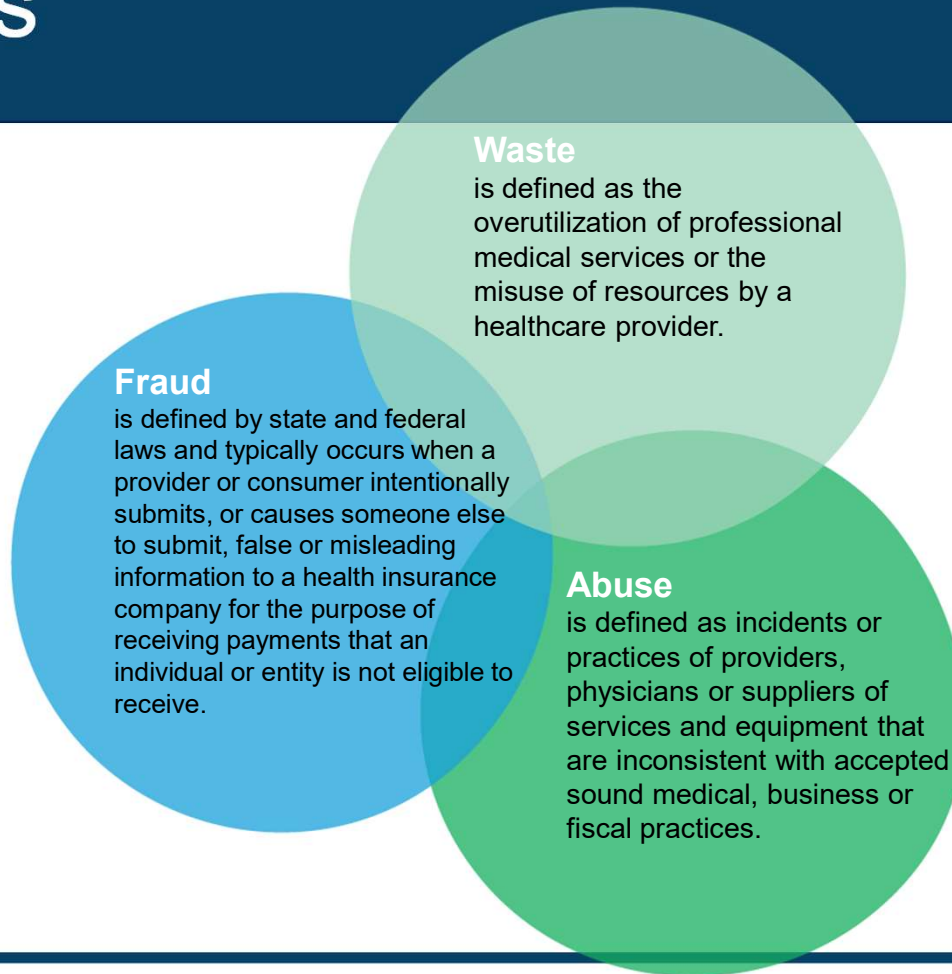
Common Denial reasoning for Incident to requirements - Documentation submitted for review did not support sufficient evidence of physician supervision required to bill under the physician.

- <https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00270108>

Caution – Learn Common Areas of Potential Fraud, Waste and Abuse



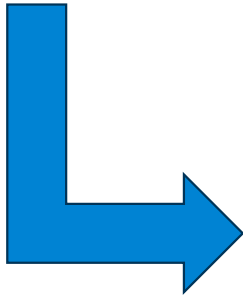
Definitions



Definitions

Material Misrepresentation

When a provider submits claims to Highmark for reimbursement, the provider is contractually obligated to ensure that the information in the claim accurately reflects the services performed as documented in the provider's records. Claims that do not accurately reflect the services performed are misrepresentations; when a misrepresentation results in an overpayment to the provider, it is a material misrepresentation.

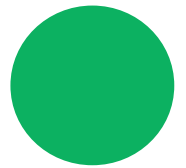


Because the provider is contractually obligated to submit claims that accurately reflect the services performed, Highmark may retroactively adjust payments to reflect the services actually performed following a review of the provider's records or receipt of other information that indicates a claim materially misrepresents the services performed. Highmark may retroactively adjust payments in these circumstances and seek recoupment even where there is no evidence that the provider or entity intentionally submitted claims containing misrepresentations.

Financial Investigations and Provider Review (FIPR)

Highmark's Financial Investigations and Provider Review (FIPR) department's mission is to support Highmark's vision of providing affordable, quality healthcare by ensuring that provider reimbursements are appropriate and to protect Highmark's assets by investigating and resolving suspected incidents of healthcare insurance fraud, waste, abuse or material misrepresentation ("FWAM").

In addition to conducting post-payment practice pattern reviews, FIPR also investigates potential member and provider FWAM. Highmark's FIPR unit takes a proactive approach to detecting and investigating potential healthcare FWAM. When necessary, FIPR takes internal and/or external corrective action regarding fraudulent activity that impacts Highmark, its customers or members.



Why is this Important for Behavioral Health Providers?

Financial Penalties

Fraud, waste and abuse can lead to significant financial penalties, including fines, audits and even criminal charges

Reputational Damage

These practices can damage your reputation and erode public trust in your practice

Patient Harm

Fraudulent billing can lead to patients receiving inappropriate care or being denied necessary services



Common Areas of Potential FWA



Watch out for red flags that could indicate potential fraud. If you suspect potential healthcare fraud, please let us know.

Some of the factors that could indicate potential fraud include:

- Resubmitting denied claims (e.g., billing for the same services using a different procedure code after the first procedure was denied)
- Billing for services that aren't covered by coding the service as a procedure that is a covered service
- Altering claims or patient record (e.g., date inserted, items handwritten when the rest of claim isn't)
- Misusing or misspelling medical terms
- Listing services as rendered in another state or on a holiday or weekend
- Submitting multiple billings for the same service
- Billing for services that haven't been rendered
- Billing for an amount that doesn't correspond to the services rendered
- Altering receipts or claims
- Using the same last name for both the provider and the patient (most benefits list an exclusion of providers billing for the treatment of family members)
- Circumventing benefit exclusions (patient exhausts all behavioral health benefits and the provider continues to render therapy services and bills them as an office visit or submits the therapy services under the spouse's name)
- Submitting high dollar claims (e.g., charges for the service being billed are out of the ordinary)

Common Areas of Potential Behavioral Health

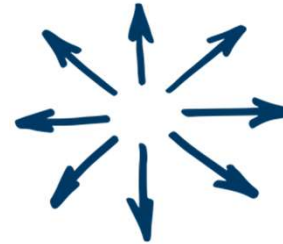
FWA



Upcoding: Billing for a higher level of service than was actually provided

Unbundling: Billing for multiple codes for a single service

Double billing: Billing for the same service twice



Billing for services not provided: Billing for services that were not actually performed

Misusing CPT codes: Using the wrong CPT code for a service

Lack of documentation: Failing to document all of the services provided

Examples of Fraud and Abuse

Upcoding

A therapist provides a 30-minute individual therapy session to a patient.

The therapist bills for a 60-minute session (CPT code 90839) instead of the correct 30-minute code (CPT code 90834).

This is considered upcoding and is a form of fraud.

Unbundling

A therapist provides a 45-minute individual therapy session to a patient, during which they also discuss medication management.

The therapist bills for both a psychotherapy session (CPT code 90837) and a medication management service (CPT code 99213).

This is considered unbundling and is a form of abuse.

Billing for Services not Provided

The therapist bills for a medication management service (CPT code 99213) for a patient who did not receive any medication.

This is considered billing for services not rendered and is a form of fraud.

Examples of Waste

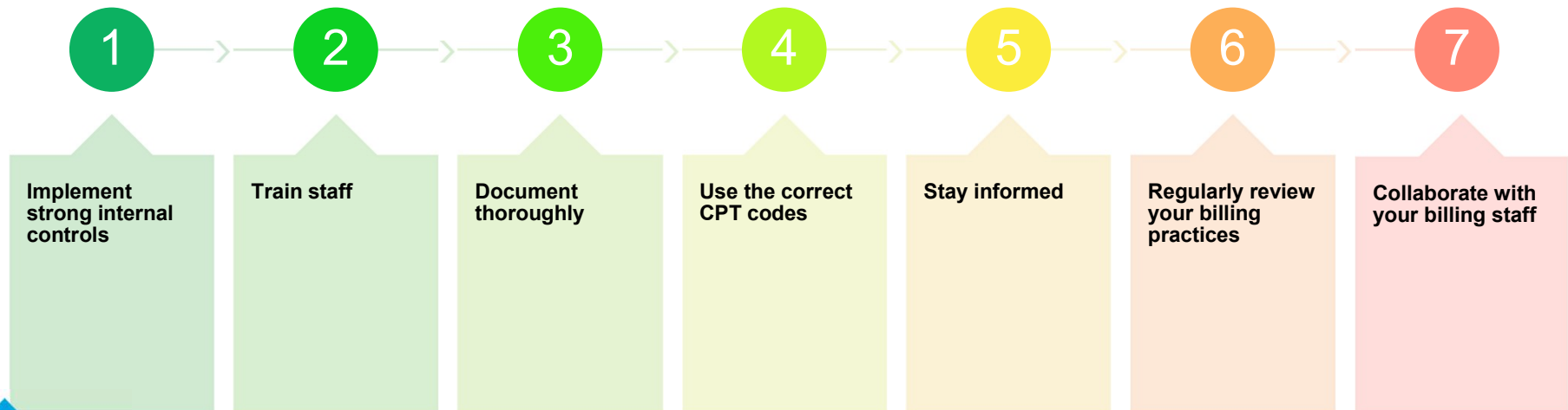
Ordering unnecessary tests and/or procedures, which leads to higher costs for patients and the healthcare system

Duplicate testing: repeating tests that have already been performed

Overutilization of medications-prescribing more medication than necessary



How to Prevent Fraud, Waste and Abuse



Reporting Potential Fraud, Waste and/or Abuse



Reporting Fraud, Waste and Abuse Government Segment

You have the option to remain anonymous at all times. We have a team of people who look into all calls or mail regarding possible FWA of healthcare services.



Highmark Wholecare
Delivery Code: FIPR
Attn: FWA/SIU Unit
120 Fifth Ave.
Pittsburgh, PA 15222

844-718-6400

SIU@highmark.com

[Online Form](#)



Highmark Health Options
Delivery Code: HHOFRAUD
Attn: FWA/SIU Unit
120 Fifth Ave.
Pittsburgh, PA 15222

844-325-6256

SIU_HHO@highmark.com

[Online Form](#)



Highmark Health Options
Delivery Code: FIPR
Attn: FWA/SIU Unit
120 Fifth Ave.
Pittsburgh, PA 15222

844-718-6400

SIU_HHO@highmark.com

[Online Form](#)

**If you suspect Fraud,
Waste or Abuse, please
report it so we may look
into your concerns.**

Reporting Fraud, Waste and Abuse Highmark Enterprise

Highmark – PA & DE

P.O. Box 890138
Camp Hill, PA 17089-0138

1-800-438-2478

Online Form

Fax: 717-635-4590

Highmark WV

614 Market Street
P.O. Box 1948
Parkersburg, WV 26102

800-788-5661

Online Form

Fax: 717-635-4590

Highmark NY

257 W. Genesee Street
Buffalo, NY 14202

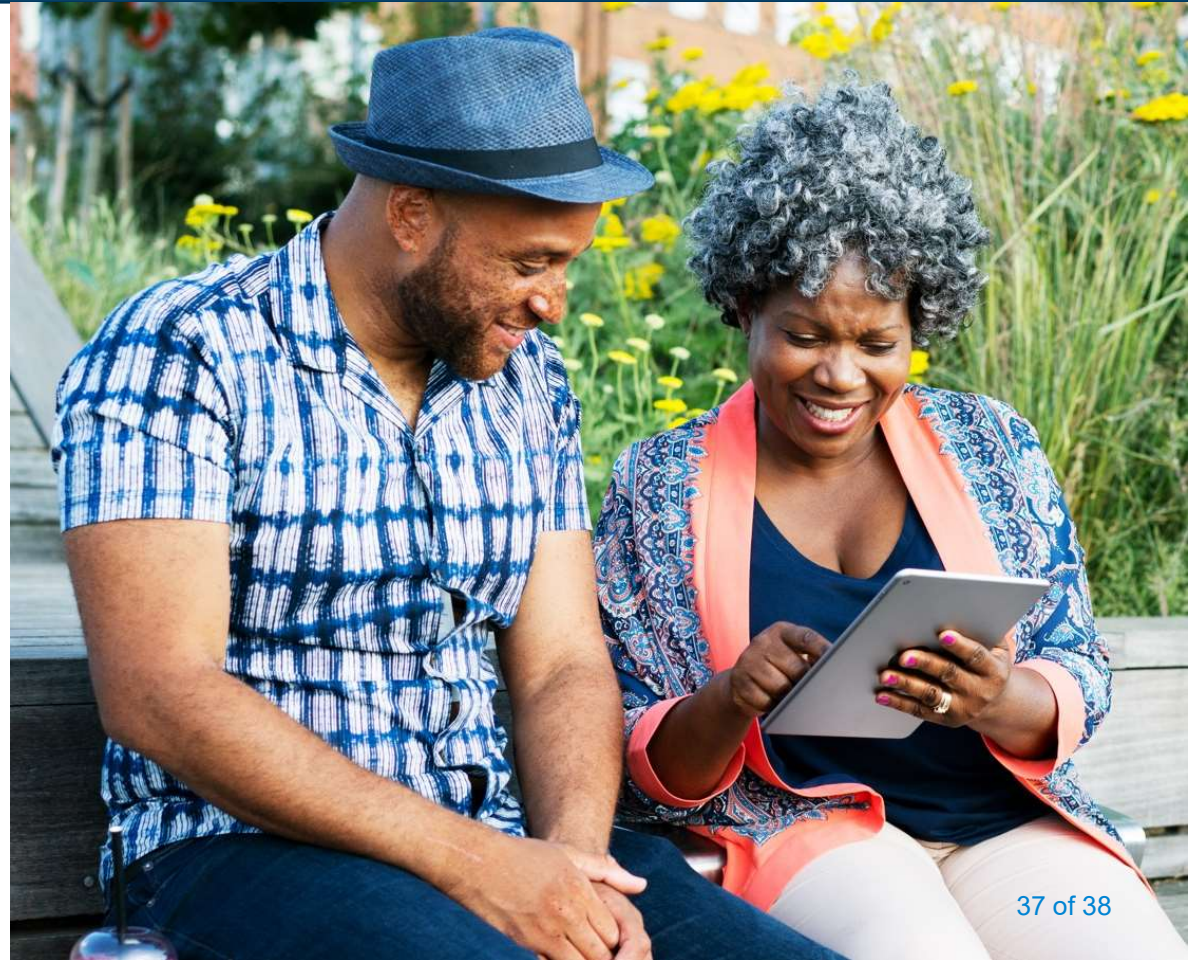
800-333-8451 or 800-314-0025

Online Form

Fax: 717-635-4590

Resources

- [Centers for Medicare & Medicaid Services \(CMS\)](#)
- [Office of the Inspector General \(OIG\)](#)
- [National Committee for Quality Assurance \(NCQA\)](#)
- [Novitas Solutions](#)
- 42 and 45 CFR





Thank you!

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- **Login to cme.ahn.org,**
 - Click on the my activities tab
 - Click on the pending activities tab
 - **complete the evaluation to receive credit**