Billing Properly for Behavioral Health Services Checklist

The risk of improper payments to behavioral health providers is real and can pose problems for the provider. According to the 2013 Payment Error Rate Measurement (PERM) report, over 89 percent of all Medicaid Fee-For-Service and nearly 88 percent of all Children's Health Insurance Program (CHIP) improper payment dollars resulted from documentation errors, number of units billed errors, and policy violations.[1] Understanding the cause of these errors and addressing them can ensure timely payment of claims and reduction in improper payments.

This checklist assists providers with identifying common billing errors in behavioral health services. Addressing these errors will help ensure timely payment of claims and reduction in improper payments.

Documentation Review

Providers should develop and maintain documentation (paper or electronic) that is sufficient to support each service, therapy, or activity billed.[2] Documentation should be complete, and meet State Medicaid agency (SMA) requirements.

Do Your Clinical Records for Each Patient Include:	Check for Yes ☑
Documentation to show eligibility for services?	☐
Consent for treatment signed by the beneficiary or designated person responsible?	☐
Behavioral health intake assessments with indicated diagnosis, identified problems, and the medical need for each treatment service recommended? • Was the intake assessment completed within the required SMA time frames? • Was it completed by a professional who meets SMA criteria?	☐
Completed copies of relevant assessments, reports, and tests?	☐
A behavioral health plan of care that: • Is person-centered with measurable objectives? • Addresses the diagnoses directly and is consistent with the assessment? • Is signed and dated by the beneficiary or designated person responsible, planning team, and treating practitioner (indicating that services are medically necessary and appropriate)? • Has current physician orders attached? • Includes a specific schedule for review of the plan? • Has been updated according to required SMA time frames?	☐

Do Your Clinical Records for Each Patient Include:	Check for Yes ☑
Case notes that include treatment goals and recipient progress?	☐
Name, signature, and credentials of the person providing the service?	☐
Authorizations for services as required by the SMA? (For example, prior authorization is required before services can be rendered or for services that exceed SMA limits.)	☐

Claims Review

Each State has different billing requirements related to provider types, categories of services, and the specific services for which the provider can bill. Providers should bill correctly; this includes proper calculation of units and use of appropriate codes. If a provider determines that claims were billed incorrectly, the provider should contact their SMA for potential payment adjustments.[3] Check your claims to make sure that they meet State Medicaid requirements.

General Billing Requirements	Check for Yes ☑
Is the beneficiary's name and Medicaid number correct?	☐
Was the beneficiary eligible according to SMA requirements on the date services were provided?	☐
Does the documentation support the services billed including clearly distinguishing and referencing each separate service?	☐
Does the provider meet SMA requirements to provide the service?	☐
Does the date of the claim match the date of service?	☐
Does the claim meet SMA coding requirements including any modifiers?	☐
Do any billing dates for outpatient services overlap with time periods the beneficiary was hospitalized or an inpatient in another type of facility (except for dates of admission or discharge when applicable)?	☐
Was the number of units calculated correctly? • Did you combine total treatment time, regardless of distinct services, and only use enough codes to cover that time? • Did you use the correct time-based codes?	☐

General Billing Requirements	Check for Yes ☑
Does the beneficiary have other insurance that would be the primary payer? • If yes, did you submit the claim to the other insurance for payment? • Did you receive payment or partial payment from the other insurance? • Do you have documentation to support payment or denial of claim from the other insurance?	☐

This checklist should help providers identify opportunities to improve the care they provide to individuals with behavioral health needs, reduce the number of rejected Medicaid claims, and direct their billing staff to additional resources for properly documenting behavioral health claims.

To see the electronic version of this checklist and the other products included in the "Billing Behavioral Health" Toolkit, visit the Medicaid Program Integrity Education page at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

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References

1 Centers for Medicare & Medicaid Services. Medicaid.gov. (2014). Medicaid and CHIP 2013 Improper Payments Report. Retrieved December 16, 2015, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Downloads/2013MedicaidandCHIPImproperPaymentsReport.pdf

2 Social Security Act. § 1902(a)(27). Retrieved December 16, 2015, from https://www.ssa.gov/OP_Home/ssact/title19/1902.htm

3 Centers for Medicare & Medicaid Services. Medicaid.gov. The National Correct Coding Initiative Policy Manual for Medicaid Services. Chapter A: Introduction. Retrieved December 16, 2015, from http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html

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