# Behavioral Health Tip Sheet

## Clinical Documentation and Code reporting of diagnoses

- **Document and report on claims the *complete clinical picture* of the patient each encounter.**
  Report on claims for each encounter diagnosis and other codes to paint the complete clinical picture.
- **Diagnosis codes:**
  Are assigned weight that measures acuity
  Describe intensity and severity of diseases or conditions
  Explain the use of resources and intensity of services provided to the patient
  Are tied to quality, cost, and outcome data — Data through diagnosis codes
- Inpatient – Conditions that are "suspected," "likely" or "probable" **ARE** to be documented and reported on claims.
- Outpatient – Conditions that are "suspected," "likely" or "probable" **ARE NOT** to be reported on claims. Here document what is "likely" or "suspected" and report on claims what you are certain of.
  *Ex. If you suspect Bipolar d/o in the **inpatient setting**, document and report bipolar d/o. In the **outpatient setting** document what you suspect then report on claims what you are certain of, maybe depression or mania, until bipolar d/o is ruled out or confirmed.*
- Confirmed conditions – ***Not*** appropriate to document as "suspected."
- Once a behavioral health disorder is confirmed, document and link medications and any type of treatment recommended or in use.
- Document the conditions presence even if its manifestations are well-controlled with medication or active treatment, including when in remission to support continued treatment or surveillance.
- Document and code all other chronic conditions that may affect or contribute to the behavioral health condition and all that affect treatment. This is to paint the complete clinical picture.
- The medical record for each date of service must stand alone. Diagnoses from any other encounter are not considered.
- Diagnosis codes reported on claims should be documented for the encounter, diagnosis codes are to come directly from your documentation for the encounter.
- History of (H/O)- Means the condition no longer exists. Please avoid documenting "this patient has a history of" when the condition still exists.
- Past Medical History (PMH) lists - conditions listed here means the condition no longer exists.
- Move all conditions that do exist to the assessment and plan with complete current status.
  ex., Bipolar disorder, in full remission, most recent episode depressed.

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*For many behavioral health conditions, accurate diagnosis coding describes not just the condition but the severity and related complications. **WHEN YOU KNOW WHICH IT IS, PLEASE SPECIFY AND REPORT ON CLAIMS.***

**Mood Disorders** - what is needed: **type, episode, severity, and status**.

- Type: Depressive, Bipolar, Cyclothymic
- Episode: Single or Recurrent
- Severity: Mild, Moderate, or Severe and with or without psychotic elements
- Status: Partial or full remission- identify most recent episode as manic, depressed, or mixed
- Avoid unspecified codes.
- Bipolar I or II? – If bipolar I specify as above (type, episode, severity, status)
- Depression or MDD?- MDD specify as above (type, episode, severity, status)
  *Please do not document and report unspecified depression*
- For patients with bipolar depression, report one concise code
  e.g., *bipolar disorder, current episode depressed, moderate*.
  It is **not** appropriate to report a code for bipolar and depression separately. ICD-10 guideline AHA CC 2020Q1

**Anxiety**

- Is it generalized, panic disorder, other mixed or other specified anxiety?

**Schizophrenia**

- Avoid unspecified!
- Is it Paranoid, disorganized, Catatonic, Undifferentiated, Residual, Other, Simple?
- Note each visit if patient is taking medication, compliant with treatment and if treatment is effective.

F29, Unspecified psychosis not due to a substance or known physiological condition.

- Should only be used when criteria are not met for specific schizophrenia spectrum, other psychotic disorder, or there isn't sufficient information to make a more specific diagnosis.

**Substance Use Disorders**

- Documentation Hierarchy
  - Use, abuse, and dependence—hierarchy to **use** is **abuse** and hierarchy to **abuse** is **dependence**.
  - When documentation states more than one, report the hierarchy term.
  - Avoid documenting and reporting these terms interchangeably.
- Document and report if mild, moderate, or severe
- Document and report if uncomplicated, with intoxication, intoxication delirium, withdrawal, psychotic disorder, or other induced disorder
- Document and report if early or sustained remission

**Alzheimer's**

- Specify: Early, Late, or "other" onset. If "other," specify what "other" is.
  - Coders cannot select late or early onset from patient current age.
- Note each visit if there are changes in acuity, life changes, or changes in treatment.

**Dementia**

- Specify cause: Vascular or in other diseases like Alzheimer's, Parkinson's, etc.
- Specify Mild, Moderate, or severe and with or without agitation, behavioral, psychotic, mood, or anxiety disturbances.
- Note each visit if there are changes in acuity, life changes, or changes in treatment.