

# Behavioral Health Documentation and Code Reporting

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Kim Hahn, CPC, CDEO, CRC



# Disclaimer

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*This presentation is intended for healthcare providers and their staff for education purposes. This should not be considered a legal/consulting opinion. The information presented is based on current guidelines. The Centers for Medicare & Medicaid Services (CMS) expects that medical coders comply with the following coding resources, in sequential order: Conventions in the ICD-10-CM and ICD-10-PCS classification, Official Guidelines for Coding and Reporting, AHA Coding Clinic, and professional judgment. CPT is the official resource for selection of evaluation & management levels and documentation required for the evaluation & management service. Over time, coding and documentation guidelines may change. When that occurs, the most current advice should be followed. No part of this presentation may be copied, reproduced, or transmitted in any form or by any means (graphically, electronically, or mechanically, including photocopying, recording, or taping) without the expressed consent of Arkansas Blue Cross and Blue Shield.*

# Risk Adjustment & Psychiatric Medicine

## How Risk Adjustment is Related to your practice

- ◆ Diagnosis codes reported on claims
  - Representing the full clinical picture of your patient
  - Supporting care and treatment provided and recommended
  - Each patient encounter/claim stands alone
  - Documentation for each encounter must support diagnoses sent in on claims
  - Fulfill HEDIS and Quality measures
- ◆ Determine expected cost to care for your patients
  - Data to CMS through diagnosis codes sent in on claims

# Clinical documentation accuracy

## Accurate Documentation leads to accurate diagnosis coding

- ◆ Provides **complete** and **accurate** data
- ◆ Supports **treatment** and **services** provided
- ◆ Improves **continuity of care** for patients



# A true picture of the patient

## Diagnosis codes:

- ◆ Are assigned **weight** that measures **acuity**
- ◆ Describe **intensity** and **severity** of diseases or conditions
- ◆ Explain **use of resources** and **intensity** of services provided to the patient
- ◆ Are tied to **quality**, **cost** and **outcome** data



# Clinical documentation

- ◆ **Inpatients** – When a condition is **suspected** yet **not confirmed**, document “**suspected,**” “**likely**” or “**probable**”
- ◆ **Outpatients** – When a condition is **suspected** yet not confirmed, document “**suspected**” and include **all signs and symptoms** of the probable condition
- ◆ **Confirmed conditions** – **Not** appropriate to document as “**suspected**”



# Clinical documentation

- ◆ The medical record for **each date of service** must **stand alone**
- ◆ Once a behavioral health disorder is confirmed, document and link **medications** and any type of **treatment** recommended or in use
- ◆ Document its **presence** even if its **manifestations** are **well-controlled** with medication or active treatment



# Healthcare spending

## Hierarchical Condition Category (HCC) models, per CMS

- ◆ Use demographics and diagnosis codes to calculate **risk factor scores** that help determine **expected costs**



# Calculating risk scores

- ◆ **An equation with two parts:**
  - Demographics (age & gender)
  - Hierarchical Condition Category diagnosis (HCC Dx)
- ◆ **Demographics + HCC codes = Risk-Adjustment Factor (RAF) score**

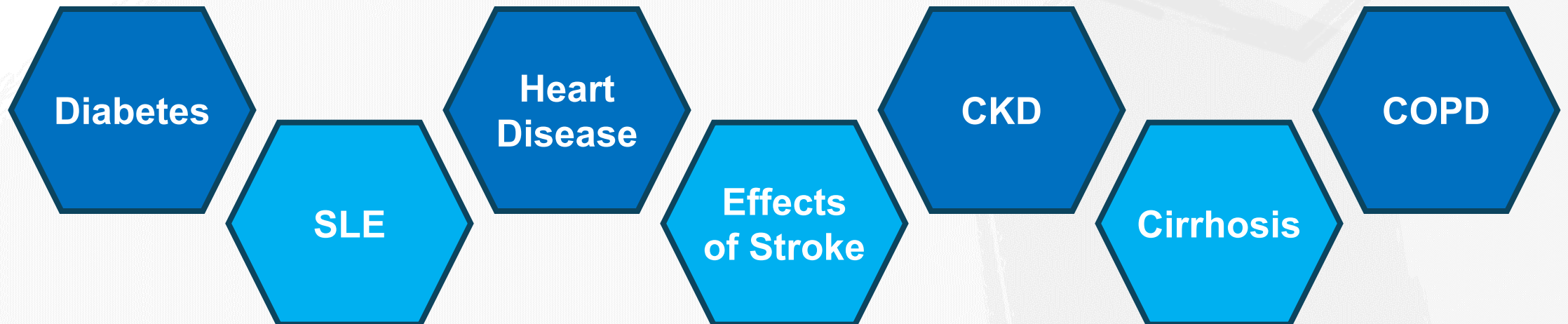
*Provider **documentation and coding** are **essential!***



# Chronic conditions

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Document and code **all other** chronic conditions that may **affect** or **contribute to** the behavioral health condition and all that **affect treatment**



# Clinical documentation

- ◆ **History of (H/O)** – Means the condition **no longer exists**
- ◆ Consider **moving** behavioral health conditions **from the PMH** (same as H/O) **to A/P**, with update in **current status**
- ◆ **No “history of” diagnosis** for some chronic conditions:
  - Schizophrenia
  - Substance use disorder
  - Bipolar
  - Mood disorders



# Consider

History of		Examples of complete current diagnosis
H/O bipolar	→	Bipolar disorder, in partial remission, most recent episode depressed
H/O MDD	→	Major depressive disorder, severe, single episode, in full remission
H/O anxiety	→	Generalized Anxiety controlled with Celexa as well as exercising situational coping skills
H/O alcohol dependence	→	Alcohol use disorder, moderate, in sustained remission Alcohol dependence in partial remission
H/O ADHD	→	Attention-deficit hyperactivity disorder, predominantly inattentive, doing well on Vyvanse

# Clinical documentation

## ◆ Documentation of Assessments/visits

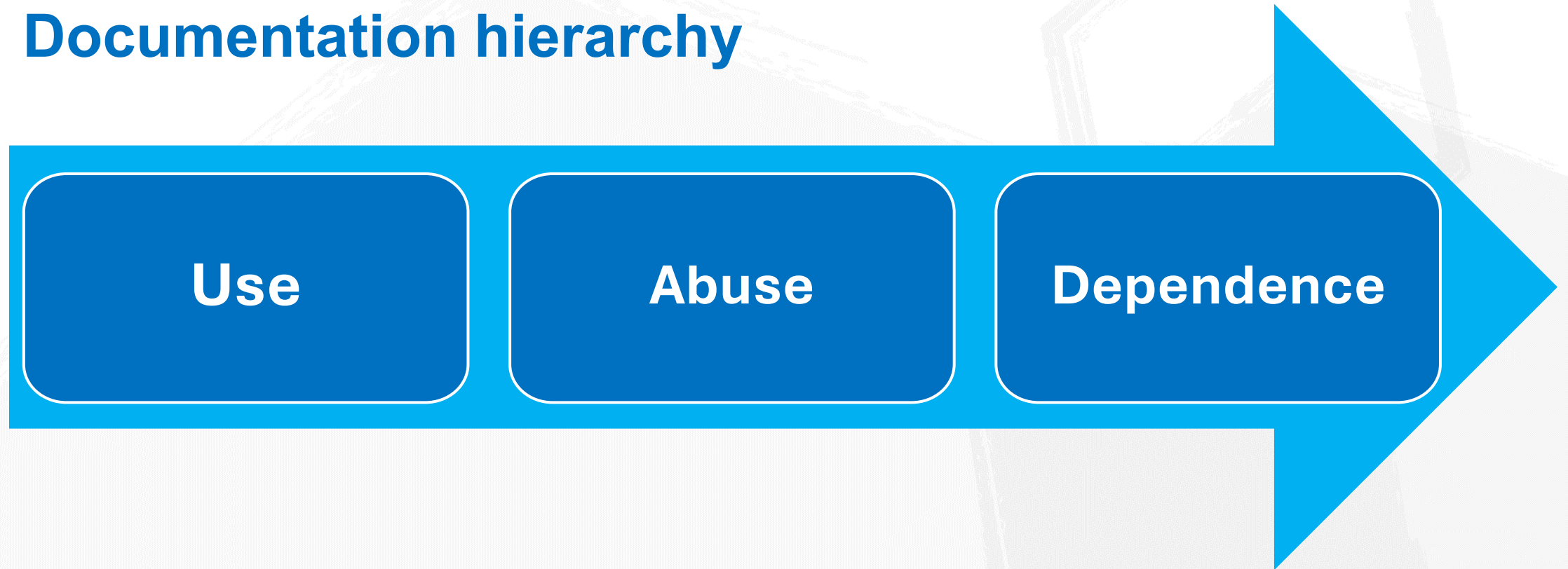
- Chief Complaint
- History of Present Illness
- Past, Medical, Family and Social History
- Mental Status Exam
- Diagnosis/Diagnostic impression
- Summary/Plan



# Substance use disorder

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## Documentation hierarchy



# Substance use-related

## Mental/behavioral disorders due to psychoactive substance use

### ◆ Use, abuse and dependence

- Uncomplicated, with intoxication
- Delirium
- Withdrawal
- Psychotic disorder
- Other substance-induced disorder
- In early or sustained remission

**F10** – Alcohol-related disorders

**F11** – Opioid-related disorders

**F12** – Cannabis-related disorders

**F13** – Sedative, hypnotic or  
anxiolytic related disorders

**F14** – Cocaine-related disorders

**F15** – Other stimulant-related  
disorders

**F16** – Hallucinogen-related disorders

**F17** – Nicotine dependence

- Cigarettes
- Chewing tobacco
- Other tobacco product
  - Mild, moderate and severe
  - Uncomplicated
  - In early or sustained remission
  - Withdrawal
  - Other or unspecified nicotine-induced disorder

**F18** – Inhalant-related disorders

**F19** – Other psychoactive substance-related disorders

# Substance use – inclusion terms

## DSM-5 to ICD-10-CM

- Use in situations in which physically hazardous
- Social/interpersonal problems related to use
- Neglected major roles to use
- Craving-strong desire or urge to use
- Withdrawal syndrome or substance taken to relieve SXS
- Tolerance or increased amounts to achieve desired effect
- Used large amounts or longer period than intended
- Repeated attempts to quit/ control use
- Much time spent obtaining, using or recovering
- Physical/psychological problems related to use
- Activities given up to use

**2-3 = Mild SUD**

**4-5 = Moderate SUD**

**6 ≥ Severe SUD**

**Mild = Abuse**

**Moderate or Severe = Dependence**

AHA CC 2020 4<sup>th</sup> Q

# Substance use – added 2023

## ◆ Substance use in remission

- **F10.90** – Alcohol use, unspecified, uncomplicated
- **F10.91** – Alcohol use, unspecified, in remission
- **F11.91** – Opioid use, unspecified, in remission
- **F12.91** – Cannabis use, unspecified, in remission
- **F13.91** – Sedative use, unspecified, in remission
- **F14.91** – Cocaine use, unspecified, in remission
- **F15.91** – Other stimulant use, unspecified, in remission
- **F16.91** – Hallucinogen use, unspecified, in remission
- **F18.91** – Inhalant use, unspecified, in remission
- **F19.91** – other psychoactive substance use, unspecified, in remission



# Schizophrenia

## ICD-10 – Schizophrenia is *not* classified or coded as “In Remission” or “Personal history of”

- **F20.0** – Paranoid schizophrenia
  - Paraphrenic
- **F20.1** – Disorganized schizophrenia
  - Hebephrenic
- **F20.2** – Catatonic schizophrenia
  - Catalepsy, catatonia
- **F20.3** – Undifferentiated schizophrenia
  - Atypical
- **F20.5** – Residual schizophrenia
  - Residual state
- **F20.8** – Other schizophrenia
- **F20.81** – schizophreniform disorder
- **F20.89** – Other schizophrenia, simple schizophrenia
- **F20.9** – Schizophrenia, unspecified

**Important to note** if patient is *taking medications or compliant with treatment and if treatment is effective*

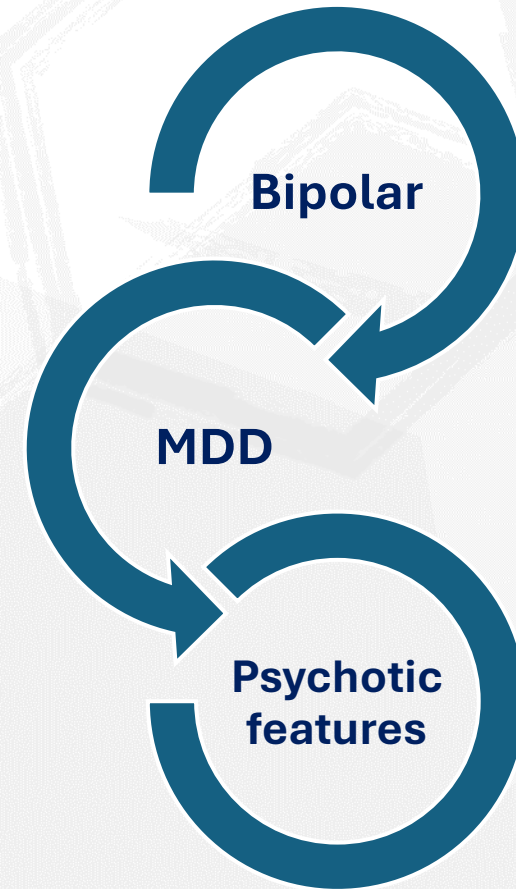
# Behavioral health disorders

- ◆ **F28: Other** psychotic disorder not due to a substance or known physiological condition
  - Chronic hallucinatory psychosis
  - Other specified schizophrenia spectrum and other psychotic disorder
    - If you report “other,” please **specify** what the “other” is
- ◆ **F29: Unspecified** psychosis not due to a substance or known physiological condition
  - Psychosis NOS
  - Unspecified schizophrenia spectrum and other psychotic disorder
    - Should **only** be used when criteria are not met for specific schizophrenia spectrum disorder or there isn’t sufficient information to make a more specific diagnosis



# Mood disorders

- ◆ **Type:** Depressive, bipolar, cyclothymic
- ◆ **Episode:** Single or recurrent
- ◆ **Severity:** Mild, moderate or severe
  - With or without psychotic elements
- ◆ **Status:** Partial remission or full remission
  - Identify most recent episode as **manic**, **depressed** or **mixed**



# Mood disorders

## ◆ Single or recurrent:

- For an episode to be considered **recurrent**, there must be an interval of at least **two consecutive months** between **separate episodes**, where the criteria was not met for major depressive episode

## ◆ Partial remission:

- **Symptoms of MDD** are present, but full criteria are not met, or there is a period lasting **less than two months** without any significant symptoms of MDD

## ◆ Full remission:

- **No** symptoms of MDD for a period of at least **two months**



# Other bipolar disorders

## ◆ F31.8 – Bipolar II or bipolar type 2

- Defined by a **pattern** of depressive episodes shifting back and forth, with **hypomanic** episodes, but no full-blown manic or mixed episodes
- **Less severe** than bipolar type 1

## ◆ F31.89 – Other bipolar disorder

- Recurrent **manic** episodes NOS

## ◆ F31.9 – Bipolar disorder, unspecified

- Manic depression



# Major depressive disorder

## ◆ F32.9 – MDD, single episode, unspecified

- Major depression NOS

## ◆ F32.A – Depression, unspecified

- Depression NOS
- Depressive disorder NOS
- **Recurrent severe episodes** of reactive depressive psychosis



# Clinical documentation

## The true picture of the patient with concise diagnoses

### ◆ Bipolar with depression

- Instead of **two diagnoses** listed:
  - Bipolar disorder
  - Major depressive disorder recurrent, moderate

### ◆ Best represented in documentation:

- Bipolar disorder, current episode depressed, moderate



# Precise code reporting

## Recap

### Psychosis

Please do not report F29 separately if psychosis is due to known substance or physiological condition

F15.15- Other Stimulant abuse with stimulant-induced **psychotic disorder**

F3.2- Manic episode, **severe with psychotic symptoms**

### **Bipolar disorder manic, depressed, or mixed w, w/o psychotic features**

F31.11- Bipolar Disorder, **current episode manic without psychotic features, mild**

F31.2- Bipolar Disorder, current episode **manic severe with psychotic features**

**Please report specific code to indicate current episode**

# Mood disorders

## F34 – Persistent mood (affective) disorders

- AHA: Q4 2017

### F34.0 – Cyclothymic disorder

- Affective personality disorder
- Cycloid personality
- Cyclothymia
- Cyclothymic personality

### F34.1 – Dysthymic disorder

- Depressive neurosis
- Depressive personality disorder
- Dysthymia
- Neurotic depression
- Persistent anxiety depression
- Persistent depressive disorder
- **EXCLUDES2:** anxiety depression (mild or not persistent) (F41.8)

## F34.8 – Other persistent mood (affective) disorders

- **F34.81** – Disruptive mood dysregulation disorder
- AHA: Q4 2017, Q4 2016
- **F34.89** – Other specified persistent mood disorders
- AHA: Q4 2017, Q4 2016

## F34.9 – Persistent mood (affective) disorder, unspecified

- AHA: Q4 2017

## F39 – Unspecified mood (affective) disorder

- AHA: Q4 2017
- Affective psychosis NOS

# Anxiety

## ◆ F41 – Other anxiety disorders

- F41.0 – Panic disorder (episodic paroxysmal anxiety)
- F41.1 – Generalized anxiety disorder
  - Anxiety neurosis
  - Anxiety reaction
  - Anxiety state
  - Overanxious disorder
- F41.3 – Other Mixed Anxiety Disorders
- F41.8 – Other Specified Anxiety Disorders
  - Anxiety Depression (mild or not persistent)
  - Anxiety hysteria
  - Mixed Anxiety and Depressive Disorder



# Alzheimer's disease

- **G30.0** – Early onset
  - **G30.1** – Late onset
  - **G30.8** – Other
  - **G30.9** – Unspecified
- ◆ **Specify: Early, late or other onset**
  - ◆ It is **not appropriate** to report late or early onset **without the descriptor** of late or early onset in documentation
    - The **age** of the patient *is not* a sufficient indicator
  - ◆ When reporting “**other**” onset, specify what “other” is

**Note:** Each DOS if there are changes in acuity, changes in treatment or life changes



# Dementia

## ◆ F01 – Vascular dementia

- An infarction of the brain due to vascular disease including hypertensive cerebrovascular disease and arteriosclerotic disease or arteriosclerotic dementia (post-stroke dementia)

## ◆ F02 – Dementia in other diseases classified elsewhere

- Like Alzheimer's disease, Parkinson's, Huntington's and list of others

## ◆ F03 – Unspecified dementia

- Presenile, Senile or degenerative NOS

## ◆ Added in 2023

- **Specify:** Mild, moderate or severe *with* or *without* agitation, behavioral, psychotic, mood or anxiety disturbance

*Note: Each DOS if there are changes in acuity, changes in treatment or life changes*



# Clinical documentation

- ◆ Please also document if the encounter is **face-to-face** or via **synchronous audio and video** or **audio only** telemedicine service.
- ◆ **New Modifier added 2023:**

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▶ Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive **Audio-Only** Telecommunications System: Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located away at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction. ◀



# True disease state & claim coding

For many behavioral health conditions, **accurate diagnosis coding** describes not just the condition but the **severity** and **related complications**

## Specificity:

- ◆ Catatonic
- ◆ Residual
- ◆ Undifferentiated
- ◆ Reactive
- ◆ Early or late onset
- ◆ Use/abuse/dependence
- ◆ Vascular/frontotemporal/Lewy body
- ◆ Single/recurrent episodes
- ◆ Early or sustained remission
- ◆ Manic, depressed or mixed

## Acuity:

- ◆ With or without psychotic features
- ◆ Mild, moderate or severe
- ◆ With other acute symptoms
- ◆ Acute or chronic syndromes associated

# Evaluation & management codes – 2023

- ◆ **Select the appropriate level of evaluation & management (E/M) services, based on one of the following:**

1. The **level of the MDM** as defined for each service
2. The **total time for E/M services** performed on the date of the encounter

- ◆ **Document the following to support the complexity of the visit:**

- Importance of what you are **looking at**
- Importance of what you are **looking for**
  - Document **all elements of MDM** and/or **time required** to perform services

[www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf](http://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf)



# Benefits for you

- ◆ Supports **medical decision making** in CPT codes
- ◆ Increased **authorization approvals**
- ◆ Fewer **medical record** requests
- ◆ Better **CMS audit** performance
- ◆ Fewer **denials**



# Coding and Documentation Guidelines

- ◆ Principle diagnosis is defined as:
  - Condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care
- ◆ Level of detail in coding:
  - Code to the highest level of specificity supported in documentation
- ◆ Reporting additional diagnoses:
  - All conditions that exist at the time of admission, that develop subsequently, or that affect the treatment and/or length of stay.
- ◆ Unspecified codes:
  - Are used when the information in the medical record is insufficient to assign a more specific code.
- ◆ Use of signs/symptoms:
  - Use when a definitive diagnosis has not been established by the end of the encounter
- ◆ Borderline diagnosis documented at the time of discharge:
  - Code as confirmed unless classification provides a specific code for the condition. (e.g., borderline personality disorder.)

# Medical record requests

- ◆ The health plan is expected to submit **correct diagnosis codes to CMS**
  - It is important for the health plan to **review the medical records** to confirm the condition is **present** and **documented appropriately** in the chart prior to CMS submission
- ◆ The medical record requested **should contain the member's:**
  - Name
  - Sex
  - Date of birth
  - Current mental/behavioral health status
  - Medications and/or treatment plan
  - Dates of service
  - Signature of the licensed provider that performed services



# Providers and Coders create a query policy

- ◆ There are different appropriate types of queries. Keep in mind that no query should be leading.

look up Query types and examples to decide how you wish to query

**Open-ended – Yes/No – Multiple choice – and query forms**

- ◆ References:

1. ACDIS. “Guidelines for achieving a compliant query practice” *CDI Journal* March 1, 2019 accessed via web <https://acdis.org/articles/2019-update-guidelines-achieving-compliant-query-practice>
2. AHIMA. “Managing an Effective Query Process” *Journal of AHIMA* 79, No. 10 (October 2008): 83-88.
3. Centers for Medicare and Medicaid Services (CMS). Web 2016.
4. Health and Human Services (HHS). Web 2016.
5. International Classifications of Diseases (ICD-9-CM and ICD-10-CM). *Official Guidelines for Coding and Reporting*, 2015 and 2016.
6. National Center for Health Statistics. Web 2016.
7. The Essential CDI Guide to Provider Queries. Kruse & Cavagnac, HCPro, Inc., 2016.

# Do you have a Policy and Procedures or Compliance Plan

## Policy, Process and Procedure plan for:

Telehealth visits	Initial visits	Follow-up visits	Patient calls	Therapy notes
documentation	coding	billing	PHI/HIPAA	EHR/portal
Updates	ICD-10	CPT	CMS	HHS

## Policy

- Rules and regulations for how your practice operates. The what, who, and why
- Everything above and more

## Process

- Laying out the big picture, with options.
- Who is responsible for each task, overview to complete task, what order it is done in and alternate plan for issues that arise

## Procedure

- Step by step instructions for each individual task

## Compliance Plan

- Internal monitoring, and auditing. Conduct appropriate training. Develop open lines of communication. Enforce disciplinary standards through well-publicized guidelines.
- see OIG's [Compliance Program Guidance for Individual and Small Group Physician Practices](#)

# Resources

- ◆ *ICD-10-CM Guidelines for Coding and Reporting – 2025*
- ◆ CPT 2025 –current procedural terminology
- ◆ CMS – [cms.gov](https://www.cms.gov)
- ◆ AHA Coding Clinic, 1<sup>st</sup> Quarter 2017
- ◆ AHA Coding Clinic, 1<sup>st</sup> Quarter 2020
- ◆ *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5)*
- ◆ National Institute of Mental Health (NIMH)
- ◆ *Risk Adjustment Documentation & Coding (2<sup>nd</sup> edition)*



# Questions?

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[kmhahn@arkbluecross.com](mailto:kmhahn@arkbluecross.com)



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