QRTIPS

Health Care Agency • Behavorial Health Services • CYS Quality, Review & Training

October 2008

Dear Happy to Help,

I keep getting notes returned to me because I forget to put in the Different Day Documentation verbiage. Can you tell me why we have to hassle with it and remind me again what I need to write? It just might help.

Signed,
Harried

Dear Harried,

In answer to your questions:

1) The Service Date and the Different Day Documentation are considered two different Medi-Cal claims when billed. Having the notation for both dates on the progress note helps the outside auditors (and the in-house ones) to identify the claims more quickly and easily in the course of a rather tedious process.
2) Here is a sample notation:

9/5/08 Therapist met with 16 year old, Hispanic, female with bipolar disorder for a family session. Documentation to follow.

Signature

Late entry, 9/10/08 documentation of service rendered on 9/5/08.
S)……I)……R)……O)…….P)

Signature

Sincerely,
Happy to Help

Dear Happy to Help,

I have been questioned recently about the amount of time that I am billing for services, documentation and travel time. Doesn't anybody realize how long it can take to complete an assessment or an O.D. evaluation?

Signed,
Seriously Frustrated☹

Dear Seriously Frustrated,

There is no doubt that certain services like an unusual assessment or crisis situation can give the impression to an auditor/MRT reviewer that a clinician is billing for an excessive amount of time. There are a couple of important components to this issue that can come back to haunt us if it not addressed from the beginning:

1. The documentation must provide first and foremost evidence of medical necessity for such a service. The documentation must also provide enough detail regarding the situation, what the clinician did, and the information obtained in the process in order to justify a very long, out of the ordinary session length. A one page note will not be enough to justify 3-4 hours of service time unless you make reference within the chart to other documents that were completed during this time. Perhaps a good metric is a double spaced typed or single spaced handwritten page for every hour of service time? In addition, consider that it may take 15-20 minutes per page for documentation (it may vary depending on the size of the font.) There are standards out in the community when it comes to billing for mental health services and if one bills outside of this standard then it becomes a red flag and we must justify that the documentation justifies the amount billed.

2. The other issue is the scheduled work day. It is important for a clinician to be very cognizant that the amount of time he/she is billing for the day of the extended assessment or crisis does not go beyond his/her scheduled work time. If this is done red flags start shooting up everywhere!

I hope this framework helps.
Sincerely,
Happy to Help