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STEPS TO A GREAT CAREER IN SOCIAL WORK

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documenting for medicare: tips for clinical social workers

Medicare requires providers to document all activities and interventions performed for a Medicare beneficiary. These services include office visits, telephone calls, consultations, and referrals. Documenting services for a Medicare beneficiary is an important tool validating that services were performed. It also reveals the ongoing professional activities of a clinical social worker.

» PURPOSE OF DOCUMENTATION

Medicare uses documentation to:

- Evaluate a clinical social worker's ability to plan and assess a patient's treatment
- Monitor patient's care
- Demonstrate communication and continuity of care among providers
- Assist with accurate and timely claim review and payment
- Provide appropriate utilization review and quality care evaluation; and
- Collect data for research and educational purposes

» GENERAL GUIDELINES

Although a Medicare Administrative Contractor (MAC) determines documentation requirements for its providers, there are general paper and electronic guidelines required by all MACs. The general guidelines may include the following:

- Recording the start and stop time of each session
- Documenting patient's name at the top of each page
- Dating all entries
- Signing all entries in the record with your name, degree, and other significant credentials
- Recording the type of procedure provided such as individual, family, or group therapy and the appropriate Current Procedural Terminology (CPT) code to identify the procedure
- Recording the diagnosis with the appropriate International

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Classification of Diseases (ICD) Code
- Documenting an emergency back-up plan for records when using electronic tools

» AREAS TO DOCUMENT

To help avoid overpayment requests and pass a record audit, it is helpful to document the following areas in a Medicare record when performing psychotherapy services:

- A diagnostic assessment
- A treatment plan
- Progress notes
- A closing or discharge summary

» DIAGNOSTIC ASSESSMENT

A diagnostic assessment, also known as a psychosocial evaluation, should be documented in each Medicare record. The diagnostic assessment assists in establishing medical necessity and should reveal evidence that the treatment services are warranted. Services are considered medically necessary if they:

- Are proper and needed for diagnosis and treatment of patient's mental health condition
- Are provided for the diagnosis, direct care, and treatment of patient's mental health condition
- Meet the standards of good mental health practice
- Are not for the convenience of the patient or the clinical social worker

The diagnostic assessment includes, but is not limited to, the presenting problem, an interval history, a mental status examination, and a treatment plan.

» TREATMENT PLAN

A treatment plan describes how the patient's problems identified in the diagnostic assessment may be improved or resolved. The treatment plan is developed to be consistent with the diagnosis and should contain objective, measurable goals and a time frame for obtaining those goals. The patient should participate in the treatment plan which is signed by both the clinical social worker and the patient.

» PROGRESS NOTES

Progress notes are an important and ongoing part of Medicare documentation and record psychotherapy interventions that occur in each session. Progress notes should reveal the therapeutic interventions used such as behavior modification, insight-oriented or cognitive behavior techniques. They also demonstrate the patient's response to treatment including strength, limitations, and progress. Dates of subsequent, missed, and cancelled appointments are always recorded. Coordination of care with the primary care physician, and other significant health care providers, guardians, and caretakers is also recorded.

» QUARTERLY SUMMARY

For long-term Medicare patients receiving psychotherapy services, it is helpful to document a quarterly summary which includes:

- A review of the goals of therapy
- Progress as a result of therapy
- An updated treatment plan

PSYCHOTHERAPY NOTES

Progress notes that are psychotherapy notes deserve special attention. For electronic transactions, HIPAA defines psychotherapy notes as "notes recorded by a mental health professional which document or analyze the contents of a conversation during a private counseling session, group, joint, or family counseling session and are separate from the rest of the individual's medical record." Clinical social workers and other providers are exempt from submitting psychotherapy notes without a patient's authorization when the notes in question fit this definition. Psychotherapy notes exclude the following:

- Medication and prescription monitoring
- Counseling session start and stop times
- Types and frequencies of treatment
- Results of clinical tests

Proper documentation of a Medicare record can help clinical social workers to achieve successful Medicare audits and help avoid Medicare overpayment requests.

- Any summary of patient's diagnosis, functional status, treatment plan, symptoms, and progress to date.

» ERRORS

Existing documentation cannot be embellished at a later time and should be corrected as soon as possible. If an error is made in an electronic record, a dated addendum should be added to the record to explain the error and signed. For paper records, do not erase nor white out. Instead, draw a single line through the error, mark it "error," date and initial it. If space does not permit, an addendum may be written to explain the error. A clinical social worker should be prepared to explain the error if the record is audited by Medicare and be aware of the requirements and special safeguards required to protect an electronic health record.

» CLOSING SUMMARY

A closing or discharge summary is necessary when services are completed or patient is terminated. It includes a summary of the problems and treatment provided including achievement of goals, referrals, and reason for closing or discharging patient.

Proper documentation of a Medicare record can help clinical social workers to achieve successful Medicare audits and help avoid Medicare overpayment requests. Important components of a Medicare record include a diagnostic assessment, a treatment plan, progress notes, and a closing or discharge summary.

RESOURCES

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