Tips for documenting medical necessity

You work hard and do a great job to provide high quality care. You use best practices to facilitate a wonderful session with your client. How can you save time on paperwork and receive payment faster?

For fast, hassle-free records review, follow the tips below to document medical necessity after a session.

TOP 10 STEPS TO BETTER DOCUMENTATION

1. **Paint a congruent picture.**
   Offer accurate documentation without apparent contradictions (i.e. narrative, severity scales, risk reports; and scored measures like ORS, BDI-2, PROMIS, GAF, DLA-20, CAFAS, etc.

2. **Follow the treatment plan.**
   Document execution of all interventions listed on the treatment plan. When there are issues with completion of the interventions, record the efforts and the response. If the intervention is no longer part of the plan, note the change or removal.

3. **When it is not working, try something different.**
   Record reassessment and the resultant change to the treatment plan when the patient shows no progress or deterioration.

4. **Accurately bill E/M codes.**
   Select the E/M code associated with the intensity of history and examination, and the complexity of medical decision-making that was provided and documented in the chart.

5. **Include treatment plan updates in progress notes**
   Indicate changes to goals, next scheduled appointment, etc.

6. **Include amount of face-to-face time**
   Time-based codes require documentation of either the total time or the start-and-stop times. Only face-to-face time with the service provider is included.

7. **Bill the correct time-based CPT* therapy code.**
   - 16 - 37 minutes with the client = 90832 Psychotherapy 30 mins
   - 38 - 52 minutes with the client = 90834 Psychotherapy 45 mins

- 53 minutes or more with the client = 90837 Psychotherapy 60 mins

*Please see a current CPT manual for additional information.

8. **Put the spotlight briefly on you, to document therapy.**
   A progress note for therapy services is to include a therapy intervention(s). Client quotes and status updates are insufficient
   to demonstrate what service was rendered.

9. **Differentiate dates of service.**
   Keep the information current and accurate for each record. Information may repeat or duplicate, as long as it is correct and does not reflect rote documentation.

10. **Send records that exist as of the date a request is received.**
    Please send the records on file at the time you receive a records request, rather than creating and/or amending records before sending them.

Please review New Directions' Medical Necessity Criteria **here**.