Health Care Agency **Behavioral Health Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Information Management Clinic Records Documentation 05.01.02 ☐New ☒Revised

	SIGNATURE	DATE APPROVED
Chief of Operations Behavioral Health Services	_____	_____

SUBJECT: Use and Flow of the Encounter Document: Outpatient Clinic

PURPOSE:

To ensure a consistent system of checks and balances is in place to accurately capture and document all charges generated during a consumer encounter.

POLICY:

All mental health services provided and billed from a county operated mental health clinic (currently utilizing paper charts) to an outside payor shall be reviewed and certified as meeting the documentation criteria for the payor. This policy does not apply to county operated clinics utilizing an Electronic Health Record.

SCOPE:

This policy and procedure applies to all mental health services provided in Behavioral Health Services (BHS) county operated outpatient mental health clinics utilizing the Encounter Document (ED). This scope does not apply to county operated clinics utilizing an Electronic Health Record.

REFERENCES:

Title IX Chapter II Subchapter I Article 3 §1810.345 Scope of Covered Mental Health Services

Agreement between the Department of Mental Health and Orange County Behavioral Health Services, Exhibit A, Attachment 1, Appendix C

Medical Billing Unit Operating Policies and Procedures: #M-12 Audit and Review Process of Coding and Billing for Medicare

FORMS:

Children and Youth Prevention Services :

Encounter Document and Progress Note:
http://www1.ochca.com/ochealthinfo.com/training/bhs/apt/cys/attachments/

Financial Form: \\CYS\CYSCounty\IRISInformation\FinancialInformation

Adult and Older Adult Behavioral Health Services:

For Encounter Documents and Progress Notes please contact your Service Chief, Program Manager or AQIS.

Financial Form for Behavioral Health Programs:
\\ochca.com\hcashares\amhsiris\contractprovidersFinancialForms

Financial Form for Alcohol and Drug Abuse Programs:
\\ochca.com\hcashares\ADASIRIS\ShareFolder\FinancialDocumentsManualsand Forms

Coder Clarification Form

PROCEDURE:

I. The Encounter Document ED shall contain the necessary prompts to assist in the accurate documentation for services provided and claimed to outside payors.

The Authority and Quality Improvement Services Division shall coordinate billing and clinical staff for an annual review of the ED which shall be updated to reflect changes in standard billing or diagnosis codes.

II. The provider is responsible to:

A. Accurately document each service provided.

B. Select the Current Procedural Terminology/Health Care Common Procedural Coding System (CPT/HCPC) code that best describes the service provided.

C. Document any and each service provided to a consumer.

D. Identify and link the diagnosis(es) to the mental health service provided.

E. Submit the ED with attached documentation to office support staff within 24 hours of the provided service.

F. Correct errors or complete information if/when the ED is returned by office support staff, Medical Billing Unit (MBU) Coder and/or BHS Review Team, or Service Chief (SC).

III. Office Support (OS) staff is responsible to:

A. Prepare labels with demographic and insurance information.

B. Verify with the consumer that the label information is correct.

C. Complete any changes to the label for demographic or insurance information reasons and submit a Change of Information form; generate a new set of labels for the consumer's clinical record; discard all labels with inaccurate information.

D. Review and ensure all fields of the ED are completed.

E. Enter the billing information into the IRIS billing system within 48 hours of receiving the ED from the provider.

F. Ensure consumer's financial status is accurate by:

1. Pre-registering new consumers in IRIS.

2. Referring the consumer to the Financial Evaluator (FE) for an Initial Financial Evaluation once a Financial Identification Number (FIN) is assigned by IRIS.

3. Conducting a "Check-in" for returning consumers using the IRIS Scheduling Tool.

4. Referring consumers to the Financial Evaluator if their financial has expired or will expire within thirty (30) days.

5. Referring the consumer, if the consumer, plan coordinator or psychiatrist reports a change in the consumer's financial status, to the Financial Evaluator for a new financial evaluation.

IV. Service Chief (SC) is responsible to:

A. Review the clinical record for each consumer open to their treatment team to ensure compliance of the clinical record with documentation requirements. Once the clinical record is compliant, sign the Documentation Review form to indicate review due date and the chart's compliance with database requirements from and to period noted with the SC's signature.

B. Follow up with the provider to ensure corrections required on the ED/progress notes, Intake Assessment or Periodic Re-Evaluation are completed before the Documentation Review form is signed to indicate compliance with documentation requirements.

C. Review corrected EDs and forward the corrected EDs to Office Support staff.