



## Substance Use Treatment Providers Per Diem Documentation Requirements

CBH requires substance use treatment providers, both per diem hospital-based and per diem non-hospital based, to document the daily provision of services to members. This document provides guidance on the daily documentation requirements for substance use disorder treatment providers contracted for per diem levels of care. Levels of care impacted include:

- Detoxification (both hospital-based and non-hospital based)
- Rehabilitation (both long- and short-term and hospital and non-hospital based)

CBH compliance audits include member chart reviews to ensure services are documented in accordance with the requirements outlined herein. CBH will recoup payments associated with documentation that is insufficient to substantiate the services billed. Programs are expected to provide substantive behavioral health interventions for each day of service billed, including weekends and holidays. Staffing patterns must allow for meaningful treatment to be provided for each day of service billed.

## DOCUMENTATION REQUIREMENTS

### Per Diem Substance Use Services

Each service billed to CBH must be documented in the individual's clinical record. The primary function of documentation is to record interventions, progress made, and challenges encountered during treatment. This allows the provider staff, the individual in treatment, and subsequent providers/staff to review effective treatment strategies and interventions as well as those that proved to be less effective and/or ineffective.

Additionally, clear and concise clinical documentation is crucial for substantiating payments made to the provider.

This document will provide general guidelines for what can be considered sufficient documentation for substance use disorder treatment billed per diem. This document will evolve and be refined as additional requirements and/or new levels of care/services are introduced/reviewed.

### General Considerations

In general, for any billed service, clinical documentation must fully substantiate both the service and duration/amount billed. All progress notes must have a clear behavioral health intervention documented. All notes must provide a clear and concise description of both the member's contribution to the billed service and the provider staff's contribution/intervention.

An individual unfamiliar with the member's course of treatment should be able to discern, through record review alone, what has been effective versus ineffective and what is in-process in the member's care.

Additionally, the full number of units billed for each service must be fully substantiated. For example, a short-term rehabilitation stay lasting 28 days must have a clear indication of the need for the authorized level of care and documentation to support billing for each of the 28 days.

When documenting interventions, the writer must provide an accurate and complete description of the service. Clinical documentation should avoid the use of vague, general language, and/or buzzwords for theoretical models. Examples of statements that would not be considered a sufficient summary of the intervention delivered include (but are not limited to):

- (1) "Listened and provided positive feedback"
- (2) "Used Cognitive-Behavioral Therapy"
- (3) "Role-played with the individual"
- (4) "Provided a warm and safe environment for exploration of the individual's concerns"
- (5) "Watched a video on the effects of substance use"

Specific concerns with each include:

- (1) This is a basic tenet of all behavioral health care.
- (2) This is a statement of a broad evidence-based theoretical framework that contains a number of specific clinical interventions that can be utilized.
- (3) Alone, there is no specific information about what scenario(s) was (were) role-played, how it tied to the treatment plan, and the outcome of the role-playing.
- (4) This is a basic tenet of all recovery-based behavioral health care.
- (5) Watching videos does not constitute an intervention alone. Discussions of relevant audio-visual presentations can, at times, include behavioral health interventions.

All providers should develop and maintain a policy and procedure for progress notes, including the required elements to substantiate a service rendered. The policy should include a discussion/review of the following:

- The provider's quality assurance process for review of progress notes to ensure sufficiency
- Components of the progress note, which at a minimum should include:
  - Documentation of interventions utilized/implemented and the member's response to those interventions
  - Documentation of an assessment of the individual's behavior, mood, and interpersonal functioning
  - Documentation of review(s) of relevant medical conditions and lab work
  - An individualized response to group sessions
- Listing of who is authorized to document interventions/interactions in the clinical record
- Any formal progress note format adopted by the agency
- Expectations of content to be included in the adopted progress note format
- Expectations, and review process, to ensure that progress notes reflect treatment plan goals
- Expectations that the note will be entered and considered final prior to the submission of a claim for that date of service or within 7 days of the date of service, whichever occurs first
- Expectations that corrections to note entries will be completed consistent with overall agency policy and applicable regulations

The remainder of this document provides sufficiency guidelines for specific levels of care.

### **Detoxification**

A progress note must be entered for each day of service billed. Each date of service must have documentation of the following, at minimum:

- At least one behavioral health intervention delivered to the individual within the following parameters:
  - The intervention may be delivered by any inpatient staff.
  - Interventions do not necessarily need to be delivered via traditional treatment modalities such as group therapy or individual therapy. An example of a non-traditional

treatment intervention would include supports provided by staff, in the milieu setting, to a member who is clearly upset during the evening/overnight.

- Psycho-educational groups alone do not constitute the behavioral health intervention.
- There is no minimum duration required for a behavioral health intervention.
- Documenting medication management only for detoxification is considered sufficient when the individual is too ill to participate in other treatment modalities.

**Any individual admitted to a detoxification unit prior to 4PM should receive their first dose of a detoxification related taper on the day of admission. If the individual is admitted prior to 4PM and does not begin a detoxification related taper, the date of admission is NOT billable.** Admissions at any time should have medications available and ordered immediately to mitigate withdrawal related symptoms. When detoxification protocol and tapers cannot be initiated secondary to a clinical reason, this reason must be clearly documented in the chart for the dates of service impacted by the delay.

### Rehabilitation

A progress note must be entered for each day of service billed. Each date of service must have documentation of the following, at minimum:

- At least one behavioral health intervention delivered to the individual within the following parameters:
  - Interventions do not necessarily need to be delivered in traditional treatment modalities (i.e. group therapy, individual therapy).
  - The intervention may be delivered by any residential treatment staff.
  - There is no minimum duration required for a behavioral health intervention.
  - Psycho-educational groups alone do not constitute the behavioral health intervention.
  - Documenting medication dosing only for rehabilitation is NOT considered sufficient substantiation of payment for a day of service.

For providers with both short-term and long-term rehabilitation available within the same program, there must be clear evidence of distinction in programming for the levels of care. This is demonstrated through scheduling and types of treatment (different group topics, different frequencies, frequency of individual sessions, etc.). Documentation MUST clearly support and document these differences.

When there is no clear distinction between short and long-term programming and services, the services will be coded as “insufficient” by CBH Compliance Analysts and subject to overpayment recovery. As a reminder, long-term rehabilitation should be designed to focus on habilitation, while short term rehabilitation is designed to focus on rehabilitation.

<sup>1</sup> Elizabeth A. Evans & Maria A. Sullivan, “Abuse and Misuse of Antidepressants,” *Substance Abuse and Rehabilitation* 5 (August 2014) 14. doi: [10.2147/SAR.S37917](https://doi.org/10.2147/SAR.S37917).