

Checklist for psychotherapy services

Documentation is critical to providing patients with quality care as well as receiving accurate and timely reimbursement for furnished services. Complete medical record documentation also assists physicians and other health care professionals in evaluating and planning a patient's immediate treatment and overall health care. It is the physician's responsibility to ensure documentation reflects the services furnished and the codes selected reflect those services accurately.

This checklist is an aid to assist providers when responding to medical record documentation requests pertaining to psychotherapy services.

It is the responsibility of the practitioner who provided the services to ensure the correct submission of documentation.

Note: To print and include this checklist with your medical documentation, click the print button at the end of this form.

Documentation requirements

- Complete and legible medical record documentation should be submitted.
- Should include specific documentation that may have been requested and any other dates of service that may be needed to support medical necessity of treatment services billed.
- Submit medical records for the date(s) of service(s) on the claim under review.
- Ensure the medical record submitted supports the service(s) that was (were) ordered and/or rendered.

Documentation required by local coverage determination (LCD) for psychotherapy services include:

Initial evaluation/assessment that includes a past, family, and social), psychiatric history, a complete mental status exam, establishment of a tentative diagnosis, and an evaluation of the patient's ability and willingness to participate in the proposed treatment plan. Information may be obtained from the patient, other physicians, other clinicians or community providers, and/or family members or other sources. There may be overlapping of the medical and psychiatric history depending upon the problem(s).

- The reason for the evaluation/patient's chief complaint
- A referral source (if applicable)
- History of present illness, including length of existence of problems/symptoms/conditions
- Past history (psychiatric)
- Significant medical history and current medications
- Social history
- Family history
- Mental status exam
- Strengths/liabilities
- Multi-axis diagnosis or diagnostic impression list-including problem list

Initial treatment plan that includes the following:

- Methods of therapy, anticipated length of treatment to the extent possible, and a description of the planned **measurable and objective goals** related to expected changes in behavior or thought process that can be used throughout treatment to show patient's progress or if progress is not shown show that treatment plan is being adjusted as needed.
- Updated treatment plans (as applicable)** - It is expected that the treatment plan for a patient receiving outpatient psychotherapy or psychoanalysis services, (e.g., measurable and objective treatment goals, descriptive documentation of therapeutic intervention, frequency of sessions, and estimated duration of treatment) will be updated on a periodic basis, generally at least every three months.
- Progress notes as applicable**
- Group notes if applicable**
- Behavior monitoring flow sheets if applicable**

- Documentation of treatment times-** if applicable for code billed. Psychotherapy times are for face-to-face services with the patient. The patient must be present for all or some of the service. In reporting, choose the code closest to the actual time (i.e., 16-37 minutes for 90832 and 90833, 38-52 minutes for 90834 and 90836, and 53 or more minutes for 90837 and 90838). Do not report psychotherapy of less than 16 minutes duration.
- Medical records should justify that the service was medically reasonable and necessary.** Psychotherapy will be considered medically necessary when the patient has a psychiatric illness and/or is demonstrating emotional or behavioral symptoms sufficient to cause inappropriate behavior or maladaptive functioning.
- Ensure documentation contains legible signatures and credentials** of person providing the service. Psychotherapy services must be performed by a person licensed by the state where practicing, and whose training and scope of practice allow that person to perform such services.
- If psychotherapy codes are billed incident-to, all incident-to rules must be met,** and the person providing the psychotherapy service must be licensed in the state to perform psychotherapy.
- The presence of a psychiatric illness and/or the demonstration of emotional or behavioral symptoms sufficient to alter baseline functioning; and
- A detailed summary of the session, including descriptive documentation of therapeutic interventions such as examples of attempted behavior modification, supportive interaction, and discussion of reality; and
- The degree of patient participation and interaction with the therapist, the reaction of the patient to the therapy session, documentation toward goal oriented outcomes and the changes or lack of changes in patient symptoms and/or behavior as a result of the therapy session.
- The rationale for any departure from the plan or extension of therapy should be documented in the medical record. The therapist must document patient/therapist interaction in addition to an assessment of the patient's problem(s).

Disclaimer: This checklist was created as an aid to assist providers. This aid is not intended as a replacement for the documentation requirements published in national or local coverage determinations, or the CMS's documentation guidelines. It is the responsibility of the provider of services to ensure the correct, complete, and thorough submission of documentation.