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Behavioral Health Billing Compliance

Close the gap between documentation and revenue integrity

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Behavioral health billing has unique challenges. Services are complex, documentation standards vary by payer, and organizations often struggle to connect clinical work to the codes they submit. These issues create significant risks for noncompliance, overpayment, and revenue loss.

This article outlines frequent problem areas found in behavioral health audits and offers practical steps to strengthen oversight, improve documentation, and reduce risk.

Why behavioral health billing is risky

Behavioral healthcare is, at least since COVID-19, one of the most audited and error-prone areas of healthcare billing. The reasons are clear:

Multiple payer rules – Medicare, Medicaid, managed care organizations, and commercial insurers each have different documentation and billing standards.

Supervision requirements – Services are often delivered by dependently licensed (see sidebar) or unlicensed certified providers with Medicaid-based services under a supervising provider. If supervision rules are misunderstood or poorly documented, billing is noncompliant.

Disconnect between treatment plans and billing – Often, organizations fail audits because the progress notes do not support the billed code or align with the initial assessment or treatment plan. This is inherently different from other types of services such as evaluation and management (E/M) codes that only consider services delivered during the encounter or on the encounter date. Behavioral health reviews require consideration of more than just the progress notes.

Complex service types – Psychotherapy, crisis care, and now more community-based support such as detoxification (detox), residential case management, and peer support require documentation that reflects interventions, progress, and clinical necessity.

A dependently licensed* behavioral health professional is an individual who is authorized to practice but must do so under the supervision of a more senior, independently licensed clinician. The specific requirements are determined by each state's licensing board, so titles and requirements vary by state, but common examples include:

- Licensed Professional Counselor (LPC): In some states, an LPC is a dependent license that requires supervision.
- Licensed Master Social Worker (LMSW): In some states, an LMSW must work under the supervision of a higher-level license, such as a Licensed Clinical Social Worker (LCSW).
- Post-Doctoral Fellow or Resident: In many fields, individuals must complete supervised practice after finishing their degree before they are eligible for full licensure.

**This link is specific to Ohio, but the explanation it offers is reasonably universal.*

Substance use disorder (SUD) programs introduce additional layers of complexity. Payers often require documentation consistent with the American Society of Addiction Medicine (ASAM) criteria for level-of-care decisions, yet organizations fail to consistently capture this information. Detox, intensive outpatient (IOP), and residential treatment each require different documentation standards, and inadequate evidence supporting medical necessity for the chosen level of care

Substance use disorder programs introduce additional layers of complexity.

is frequently brought forth as an adverse audit finding. For you, this means understanding the ASAM framework and reviewing whether records clearly justify the intensity and setting of services provided. Your review of one encounter might require reviewing the episodic care of different disciplines' contributions to the documentation overall.

Different types of substance use disorder providers add layers to the complexity of documentation, coding, and billing. Some facilities are providing medication-assisted treatment only, acting as an Opioid Treatment Program. They also have many different ways to bill their services based on Medicare vs Medicaid vs commercial payers. In this article, we only scratch the surface of the unique requirements facing these providers.

Auditor takeaway

A service may be clinically appropriate but fail an audit if payer rules for documentation, supervision, or medical necessity are not met. Learn all elements that may be considered in the payer's determination of medical necessity. Make sure your organization's different disciplines are working together, not independently.

Common documentation gaps

Behavioral health audits frequently uncover the following documentation issues:

- *Vague or repetitive progress notes* – Notes are sometimes nearly identical across sessions, with little detail about patient progress or the interventions provided.
- *Outdated or generic treatment plans* – Plans lack individualized goals or are not updated when the patient's condition changes.
- *Incorrect use of add-on codes* – Add-on codes such as 90833 (psychotherapy with E/M) or 90785 (interactive complexity) are often billed without meeting documentation requirements.
- *Improper use of crisis codes* – Codes 90839 and 90840 are billed when the notes do not clearly support the time spent or the severity that justifies the crisis designation.

In SUD programs, additional documentation gaps include the lack of ASAM criteria to justify the level of care, incomplete discharge or transition planning, and progress notes that fail to support continued stay at higher levels of care, such as residential treatment, when outpatient criteria are met. These gaps are significant because payers increasingly require robust justification for both admission and continued stay in SUD programs.

Auditor takeaway

You should compare progress notes to treatment plans (and the most recent assessment) and verify that the documented interventions align with problems identified in the assessment and active goals developed in the treatment plan. Understanding ASAM criteria and ensuring the clinical team integrates that information into documentation will be important to the entire organization.

Behavioral health operational red flags

Operational and system-level practices often contribute to compliance risks, so audits should extend beyond reviewing individual progress notes to look for:

- *Template overuse* – Electronic health records (EHRs) sometimes include auto-populated content that appears identical across multiple patients. This may indicate "note cloning," which can undermine the accuracy of the record.
- *Weak audit trails* – Missing or incomplete audit trails make it difficult to verify when entries were made, edited, or co-signed.
- *Lack of coding oversight* – A high volume of the same Current Procedural Terminology (CPT) code (for example, consistent billing of 90837 for 60-minute psychotherapy) may suggest upcoding or a failure to document varying session lengths.

For SUD services, per diem bundled billing creates additional risks. Facilities may inappropriately bill separately for psychiatric or primary care services that are already included in the bundled per-diem rate. You should review payer contracts, policies, and claims to ensure that only services legitimately excluded from the per diem are billed separately.

Auditor takeaway

Audit for variability. If every note looks the same, every psychotherapy session is billed at the highest duration, or supervision is never explicitly documented, those are signs that controls are weak or nonexistent. Actual payer contracts play a role in understanding when unbundling occurs in the SUD sector. This is when collaboration with clinical and operational team members is essential for billing compliance.

Key behavioral health risks

Behavioral health billing risks typically fall into three categories:

- *Documentation risk* – Notes do not reflect medical necessity, services rendered, or the time spent.
- *Compliance risk* – Supervision requirements are not followed or documented, particularly when dependently licensed or unlicensed providers render services.
- *Revenue cycle risk* – Claims are denied or underpaid due to mismatched coding, poor treatment plan integration, or missing prior authorizations.

Each of these risks can result in repayment obligations, penalties, or lost revenue.

Auditor takeaway

Internal or external audit teams can reduce risk and strengthen behavioral health compliance by:

- *Developing behavioral health-specific audit tools* – Include checklist items for treatment plan linkage, time documentation, supervision verification, and CPT code accuracy.
- *Performing targeted reviews* – Select high-risk services such as crisis intervention, psychotherapy add-ons, and community-based services for deeper review.
- *Engaging clinical leadership* – Partner with clinical teams early to interpret ambiguous notes and ensure findings lead to meaningful corrective action. A collaborative approach is key!
- *Monitoring denial trends* – Review denial trends for patterns that may indicate upstream process issues, while recognizing that these denials typically occur before documentation or medical necessity is ever evaluated. These trends often reveal systemic issues.
- *Providing education* – Use audit findings to drive targeted training for clinicians, supervisors, and billing staff. Remember to show the good with the bad. Support the right way to document, do not just include education based on the wrong way to document. Providers are used to hearing what they should not do and are usually more interested in what they should do.

For substance use disorder programs, you should specifically evaluate whether documentation includes ASAM criteria for level-of-care determinations, validate that services billed outside of bundled per-diem rates are appropriate, and confirm that provider types delivering SUD services are eligible under state Medicaid and payer-specific requirements.

Sample Audit Questions for Behavioral Health Encounters

Audit Focus	Sample Questions
Treatment plan	• Is there a current, individualized plan with measurable goals?
Progress notes	• Do notes clearly support the billed service type and duration?
Supervision/provider type eligibility	• If unlicensed staff provided the service, is supervision documented appropriately? Are providers delivering SUD services eligible and credentialed under payer and state Medicaid Rules?
Time-based services	• Is time documented, and does it match the code billed?
Code accuracy	• Do codes align with documented interventions and payer rules? • Is there accuracy with coding per diem and professional services?

(See Exhibit 1 for a full checklist)

Exhibit 1 – Comprehensive Behavioral Health Audit Checklist

You can use this checklist to evaluate the compliance of behavioral health services. It covers treatment planning, documentation, coding, supervision, and operational controls to ensure claims are supported and compliant with payer and regulatory requirements. This is a general list and is not intended to replace specific payer requirements. Please make sure to understand payer requirements for behavioral health services.

Audit Focus	Questions for Evaluation of Data and Documentation
System and process	• Are EHR templates used appropriately without overuse or note cloning? • Is there a clear audit trail for documentation edits, co-signatures, and supervisory notes? • Are denial trends reviewed to identify front-end process issues? • Is there a process for regularly auditing behavioral health documentation and providing feedback to clinical staff? • Are prior authorizations and eligibility checks documented and aligned with billing practices?
Assessment/treatment plan	• When was the last assessment to evaluate the client? Within 12 months? • Is there a current, individualized treatment plan with measurable goals?
Progress notes	• Do progress notes clearly support the billed service type and duration? • Are interventions documented with enough detail to reflect active treatment? • Is time documented for all time-based codes, and does it match the CPT code billed?
Provider credentials and supervision	• Is the rendering provider credentialed and authorized to deliver the billed service? • If unlicensed staff provided the service, is the appropriate level of supervision documented? • Are incident-to or general supervision requirements met and documented?
Coding and billing	• Do billed CPT and ICD-10 codes match the conditions and services documented in the record? • Is there evidence pointing to potential upcoding or overuse of high-level codes (e.g., 90837 for every psychotherapy session)? • Are modifiers used appropriately and supported by documentation? • Do billing patterns align with payer-specific rules (e.g., Medicaid vs. Medicare)? • As applicable: Are crisis intervention codes (90839, 90840) supported by documentation of severity and time? • As applicable: Are add-on codes (e.g., 90833, 90785) supported by documentation that meets all criteria?

	Additional Substance Use Disorder Considerations
ASAM criteria	• Does documentation include ASAM criteria supporting the level of care for admission and continued stay?
Level-of-care justification	• Do progress notes justify the current level of care (e.g., residential, IOP) based on clinical need?
Bundled billing	• Are services billed outside per-diem bundles appropriate and justified?
Discharge/transition planning	• Is there documentation of discharge planning and transitions to lower levels of care when appropriate?
Provider type eligibility	• Are providers delivering SUD services eligible and credentialed under payer and state Medicaid rules?

Practical steps for strengthening compliance

Improving compliance in behavioral health requires cross-functional action:

- *Establish clear supervision protocols* – Ensure that supervisory requirements are well-documented and integrated into workflows.
- *Leverage EHR capabilities wisely* – Use templates carefully to maintain efficiency without compromising note quality.
- *Implement routine internal audits* – Perform regular reviews to catch issues before they become external audit findings.
- *Integrate billing and clinical teams* – Encourage collaboration so documentation reflects both clinical care and payer requirements.

Conclusion

Behavioral health compliance is complex, but you can make a meaningful impact by focusing on the right risks, developing tailored audit tools, and working closely with clinical and revenue cycle teams. By identifying and correcting weaknesses in documentation, supervision, and coding, organizations can reduce compliance exposure and protect revenue. **NP**

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