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Behavioral Health Documentation and Denial Risks in 2026



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As we move through 2026, the landscape of behavioral health and drug dependence continues to evolve — marked by both encouraging policy wins and persistent systemic barriers. Overdose rates have finally started to decline after years of relentless increase, and telemedicine access for treatment medications has become permanent. Yet clinics and patients still face familiar struggles: limited access to care, administrative hurdles, stigma, and misinformation.

This year offers an opportunity to take stock of what is working, what is not, and how the behavioral health field can better align policy with practice.

A year of incremental but important change

The biggest shift shaping 2026 is the permanent authorization of telemedicine for buprenorphine prescribing, finalized by the DEA and HHS.

This change removes one of the last pandemic-era uncertainties and allows patients to begin treatment for opioid use disorder (OUD) without an in-person visit. It is a win for access — especially in rural and underserved areas where specialist care is scarce.

Meanwhile, national overdose trends have shown their first sustained improvement since 2018. CDC data indicate that total overdose deaths began to decline modestly in 2023 and 2024. While the overall picture is cautiously optimistic, progress remains uneven. Fentanyl continues to dominate the illicit market, xylazine has emerged as a new adulterant complicating overdoses, and stimulant-related deaths are on the rise in some regions. And the cost of burnout is not abstract. Replacing a single physician can cost two to three times their salary. In many cases, that reaches $500,000 to $2 million per departure.

The paradox is clear: we are seeing national progress, but local crises remain.



Common myths that still undermine care

Despite advances in science and policy, many persistent myths about addiction continue to block access to effective care.

Myth 1: Addiction is a moral failing.

Reality: Substance use disorders cause measurable changes in brain function, creating compulsion and craving that require medical and behavioral treatment — not moral judgment.The pattern often looks like this:

Myth 2: People must "hit rock bottom" before they can recover.

Reality: Early intervention leads to far better outcomes. Waiting for crisis often means waiting too long.

Myth 3: Medication for opioid use disorder just swaps one drug for another.

Reality: Medications such as buprenorphine and methadone are proven to cut overdose risk in half and help people rebuild their lives.

Myth 4: Abstinence-only approaches are the gold standard.

Reality: Recovery is not one-size-fits-all. Harm reduction, including medication, counseling, and naloxone distribution, saves lives even when abstinence is not immediately possible.

Myth 5: Stigma motivates people to quit.

Reality: Stigma isolates and discourages treatment-seeking, worsening health outcomes. Dispelling these myths is more than an educational exercise — it is central to closing the treatment gap that still leaves millions without help.





What practices are struggling with in 2026

Even with better policy support, behavioral health and addiction practices continue to face serious operational pain points:

- **Administrative overload:** Prior authorization and medical-necessity denials remain among the top frustrations for behavioral health providers. While some payers have pledged to simplify or eliminate prior authorizations, automation and AI-driven claim decisions are creating new layers of complexity.
- **Workforce shortages:** Turnover and burnout remain chronic problems. Rural and community clinics in particular report difficulty hiring and retaining licensed therapists and prescribers qualified to deliver medication-assisted treatment.
- **Low uptake of medications for OUD:** Despite clear evidence that medications save lives, fewer than one in five people with opioid use disorder receive them. Barriers include stigma, lack of training, rigid clinic protocols, and transportation challenges.
- **Fragmented care systems:** Coordination between primary care, behavioral health, and community services remains weak, leading to gaps in follow-up and continuity.
- **Emerging drug threats:** The increasing mix of fentanyl, xylazine, and stimulants complicates overdose response and treatment planning, requiring ongoing clinical education and updated protocols.

The solution isn't simply asking providers to document better. It's redesigning where responsibilities belong. Providers and coders bring different types of expertise, and both are essential.



Denial trends and insurance friction

Insurance-related denials remain a key bottleneck.

Beyond payer denials, another form of resistance often goes unnoticed: patient denial. Many individuals with substance use disorders struggle to acknowledge the severity of their problem or fear the stigma of being labeled “addicted.” Providers report that even when treatment is available, internalized shame or distrust of medical systems keeps many from engaging.

Addressing denial requires empathy, motivational interviewing, and consistent, nonjudgmental communication. The message must shift from “you need to quit” to “we can help you live better.”



Improving psychotherapy documentation

Psychotherapy documentation remains a major area of vulnerability in behavioral health records.

Too often, notes list the modality — such as cognitive behavioral therapy (CBT), dialectical behavior therapy (DBT), or supportive therapy — without capturing the actual therapeutic exchange that occurred. While progress notes do not need to be lengthy, they must show substance and clinical intent.

A strong psychotherapy note briefly describes what intervention was used and how the patient/client responded. For example, “Used CBT techniques to challenge client’s negative self-talk related to relapse; reinforced progress in identifying triggers.” Even a short sentence like this demonstrates medical necessity and distinguishes the session from a generic entry.

E-BRIEF

Documenting time accurately

Psychotherapy time should always reflect the exact duration of the therapeutic interaction—either by total minutes or a start and stop time. Payers expect precision, not estimates. Phrases such as “approximately 45 minutes,” “roughly 60 minutes,” or “greater than 50 minutes” create ambiguity and can raise red flags during audits.

Avoid documenting the same exact time for every session. Identical time entries across multiple notes can appear cloned or automated, which may trigger payer scrutiny. Small natural variations between sessions are expected and more reflective of clinical practice.

In addition, EHR or scheduling timestamps should never be used as psychotherapy time. The documented time must represent actual face-to-face therapy — not administrative tasks, waiting time, or charting.

When E/M and psychotherapy occur together

When an evaluation and management (E/M) service and psychotherapy are performed during the same visit, the E/M portion must be leveled based on medical decision-making (MDM), not time. The psychotherapy time should be documented separately and should include the same level of detail regarding interventions and response.

For example:

> *“E/M: Reviewed medication adherence, adjusted dosage. MDM—moderate complexity. Psychotherapy: 40 minutes (start 2:10 p.m., end 2:50 p.m.). Used supportive therapy to process recent work-related stressor.”*



Audit-readiness and compliance

Documentation should be specific, timely, and patient-centered. Avoid copy-and-paste entries or repeating identical phrases across notes. Each entry should clearly show medical necessity and align with the CPT time thresholds for psychotherapy codes (90832–90838).

	Physician / QHP who may report E/M	
	New Pt	**Established Pt**
Synchronous Audio-Video	98000 (15–29 min) 98001 (30–44 min) 98002 (45–59 min) 98003* (60–74 min)	98004 (10–19 min) 98005 (20–29 min) 98006 (30–39 min) 98007* (40–54 min)
Synchronous Audio-Only (requires 10 min. medical discussion)	98008 (15–29 min) 98009 (30–44 min) 98010 (45–59 min) 98012* (60–74 min)	98013 (10–19 min) 98014 (20–29 min) 98015 (30–39 min) 98016* (40–54 min)

Reportable with psychotherapy codes

90832, 90833, 90834, 90836, 90837, 90838



Proper use of CPT and HCPCS modifiers ensures accurate billing and reduces the risk of denials or audits. Common modifiers in behavioral health include:

- 52 (Reduced Services): Indicates a service was partially reduced or discontinued.
- 59 (Distinct Procedural Service): Shows that services that might otherwise be bundled were separate and distinct.
- 95 / –GT (Telehealth): Used when services are delivered via synchronous telehealth platforms.
- GQ (Asynchronous Telehealth): Used for store-and-forward telehealth interactions.

Modifier 93 (AudioOnly Telehealth): Effective January 1, 2022, Modifier 93 designates "synchronous telemedicine service delivered via audio-only telecommunications system." It should be appended when an otherwise reportable service, such as an E/M visit or psychotherapy session, is provided via telephone or real-time audio-only, and the interaction meets the same key components as an in-person visit.

Best practice tip: Document clearly that video was available, but the patient chose or required audio-only, that the service met the same clinical components as face-to-face, and apply Modifier 93 where allowed. Always confirm payer-specific guidance, as recognition and reimbursement policies vary.

Modifiers should be applied judiciously and accurately, reflecting the actual service delivered. Misuse can trigger audits or claim denials.

Keep in mind:

Documentation rules can vary by state and by level of care.

Requirements may differ depending on whether the patient is in an inpatient, residential, intensive outpatient (IOP), or standard outpatient setting. Some states impose stricter timelines for note completion or additional signatures for group or family therapy notes. Always confirm your facility's policy and your state's behavioral health documentation standards to remain fully compliant.

Precise documentation not only supports compliance but also reflects the therapeutic value of each session. Ultimately, well-documented psychotherapy demonstrates the clinical reasoning, skill, and accountability behind behavioral health care.



Practical steps for 2026 and beyond

To translate policy gains into real-world results, practices can focus on a few concrete actions:

1. **Simplify access.** Adopt same-day starts for medication treatment and leverage telemedicine wherever possible.
2. **Reduce stigma**. Use people-first language and train all staff — from reception to leadership — on compassionate engagement.
3. **Track denial patterns**. Keep organized records of claim denials and appeals; aggregate data helps strengthen parity enforcement.
4. **Integrate harm reduction.** Offer naloxone (Narcan®), safe-use education, and linkages to recovery services, even if a patient is not ready for abstinence.
5. **Collaborate locally.** Connect with public health agencies and community organizations to stay ahead of local drug trends.

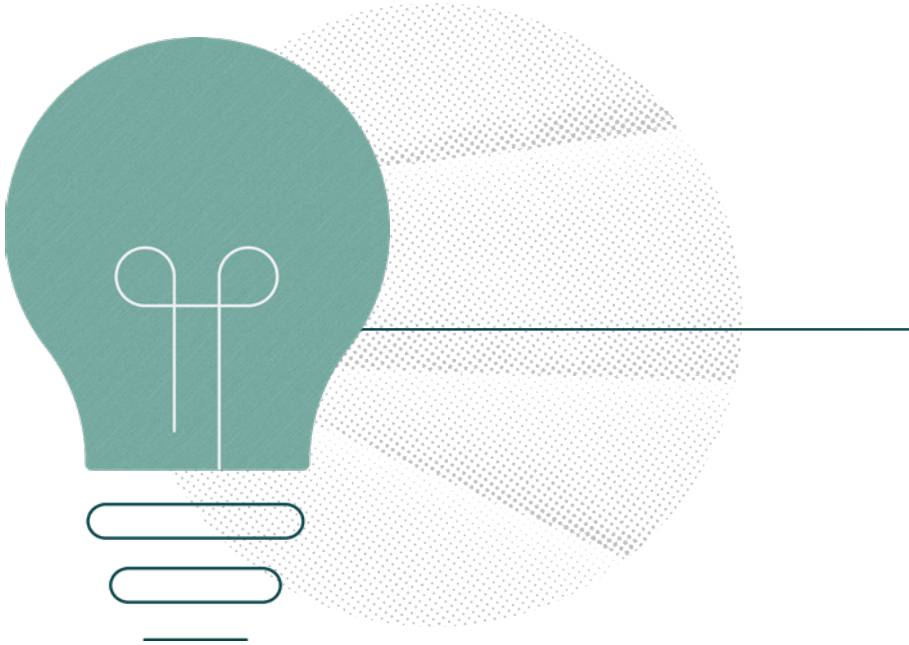
How AAPC can help

AAPC Services provides the specialized expertise to navigate the high-scrutiny environment of behavioral health RCM. We offer targeted solutions to solve the documentation problem and reduce your denial rates, including:

- **Documentation vulnerability assessments**: Identify specific gaps in psychotherapy and SUD notes before they trigger an audit.
- **Customized CDI training**: Capture therapeutic intent and medical necessity through education tailored for behavioral health providers.
- **Compliance reviews**: Ensure accurate usage of Modifiers 93, 95, and GT across all behavioral health encounters.
- **Denial management and support:** Navigate AI-driven claim reviews and mental health parity limitations with expert intervention.



The bottom line



2026 marks a moment of cautious progress in behavioral health and addiction care. Permanent telehealth prescribing, early declines in overdose deaths, and heightened parity enforcement are encouraging signs. But the work is not done. Stigma, systemic barriers, and inequitable access remain deeply rooted.

The future of addiction care depends on blending science, compassion, and policy. By challenging myths, reducing friction in access, and meeting people where they are, the behavioral health community can turn slow progress into sustained transformation.

Sources

DEA & HHS final telemedicine rule for buprenorphine — SAMHSA summary (Jan 17, 2025). **SAMHSA**

CDC — Xylazine: clinical management & harm reduction (guidance + wounds PDF). **CDC+1**

SAMHSA — Naloxone use and access (distribution guidance & educational materials). **SAMHSA+1**

NIDA — Medications for opioid use disorder & treatment resources. **nida.nih.gov+1**

FDA — Information about MOUD (buprenorphine, methadone, naltrexone). **U.S. Food and Drug Administration**

AMA — Prior authorization reform resources & state law chart. (Practical tools for practices to reduce PA burden.) **American Medical Association+1**

CMS — MHPAEA resources and statements on parity / prior authorization (includes final rules and enforcement updates). **Centers for Medicare & Medicaid Services+1**

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AUTHOR BIO

Tracy brings over 20 years of experience in the healthcare industry, with deep expertise in auditing, training, and compliance across all sectors. She has partnered with large healthcare systems and multi-specialty practices, where she has played a pivotal role in supporting accurate documentation and adherence to regulatory guidelines.

Tracy is passionate about collaborating directly with auditors and providers to deliver education and clear direction on proper documentation and compliance standards. She has extensive hands-on experience with various EHR systems and audit tools, making her adaptable and tech-savvy in a fast-evolving landscape.

Her diverse background spans the entire revenue cycle, including billing, coding, auditing, and compliance. Tracy has also served as a Compliance Officer, where she prioritized the development and ongoing improvement of compliance plans.

You can learn more or get started by visiting:

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