Transforming
Lives

Providing and Documenting Medically Necessary Behavioral Health Services

Presented by:

David Reed, Office Chief, Division of Behavioral Health and Recovery

Marc Bollinger, LISCW, CEO, Great Rivers BHO

Crystal Didier, MEd, Qualis Health

Kathy Robertson, MSW, CCO, Great Rivers BHO

Objectives

Transforming
Lives

At the end of this session you should be able to:

◆ Identify Medicaid documentation rules

◆ Explain that services rendered must be well documented and that documentation lays the foundation for all coding and billing

◆ Understand the term "Medical Necessity"

◆ Describe the components of Effective Document of Medical Necessity:

  ▪ Assessment

  ▪ Planning Care

  ▪ Documenting Services

◆ Identify key elements to avoid repayment and other consequences

Transforming
Lives

Goals

◆Participant will become familiar with Medicaid documentation rules.

◆Participant will discover the importance of complete and detailed documentation as the foundation for coding, billing and quality of care for the client.

◆Participant will learn how insufficient documentation leads to both poor client care and to improper payments.

The Golden Thread

It is the Practitioner's responsibility to ensure that medical necessity is firmly established and that The Golden Thread is easy to follow within your documentation.

Medical Necessity Contract Definition

Transforming Lives

◆The service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction.

◆There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable.

Medical Necessity Contract Definition

Transforming
Lives

◆This course of treatment may include mere observation, or where appropriate, no treatment at all.

◆Bottom line: the treatment interventions must help the person get better, or at the very least, prevent a worsening of the person's health.

Medical Necessity

Transforming
Lives

◆Requires that all services/interventions be directed at a medical problem/diagnosis and be necessary in order that the service can be billed

◆A claims based model that requires that each service/encounter, on a *stand alone basis, reflects the necessity for that treatment intervention

* Stand alone means information in the service note should include pertinent past clinical information, dealing with the issue at hand, and making plans for future care such as referrals or follow up, based upon the care plan. Each service note needs to stand-alone completely.

Why Document Medical Necessity?

Transforming
Lives

Documentation is an important aspect of client care and is used to:

◆ Coordinate services and provides continuity of care among practitioners

◆ Furnish sufficient services

◆ Improve client care – provides a clinical service map

◆ Comply with regulations (Medicaid, Medicare and other Insurance)

◆ Support claims billed

◆ Reduce improper payments

◆ Medical record is a legal document

Tests for Medical Necessity

Transforming
Lives

◆There must be a diagnosis: ICD 10

◆The services ordered are considered reasonable and effective for the diagnosis

- Directed at or relate to the symptoms of that diagnosis

- Will make the symptoms or persons functioning get better or at least, not get worse

◆The ordered services are covered under that person's benefit package (State Plan Services)

State Plan Services

Transforming
Lives

A State Plan is required to qualify for federal funding for Medicaid services. Essentially, the Plan is our state's agreement that it will conform to the requirements of the federal regulations governing Medicaid and the official issuances of DHHS.
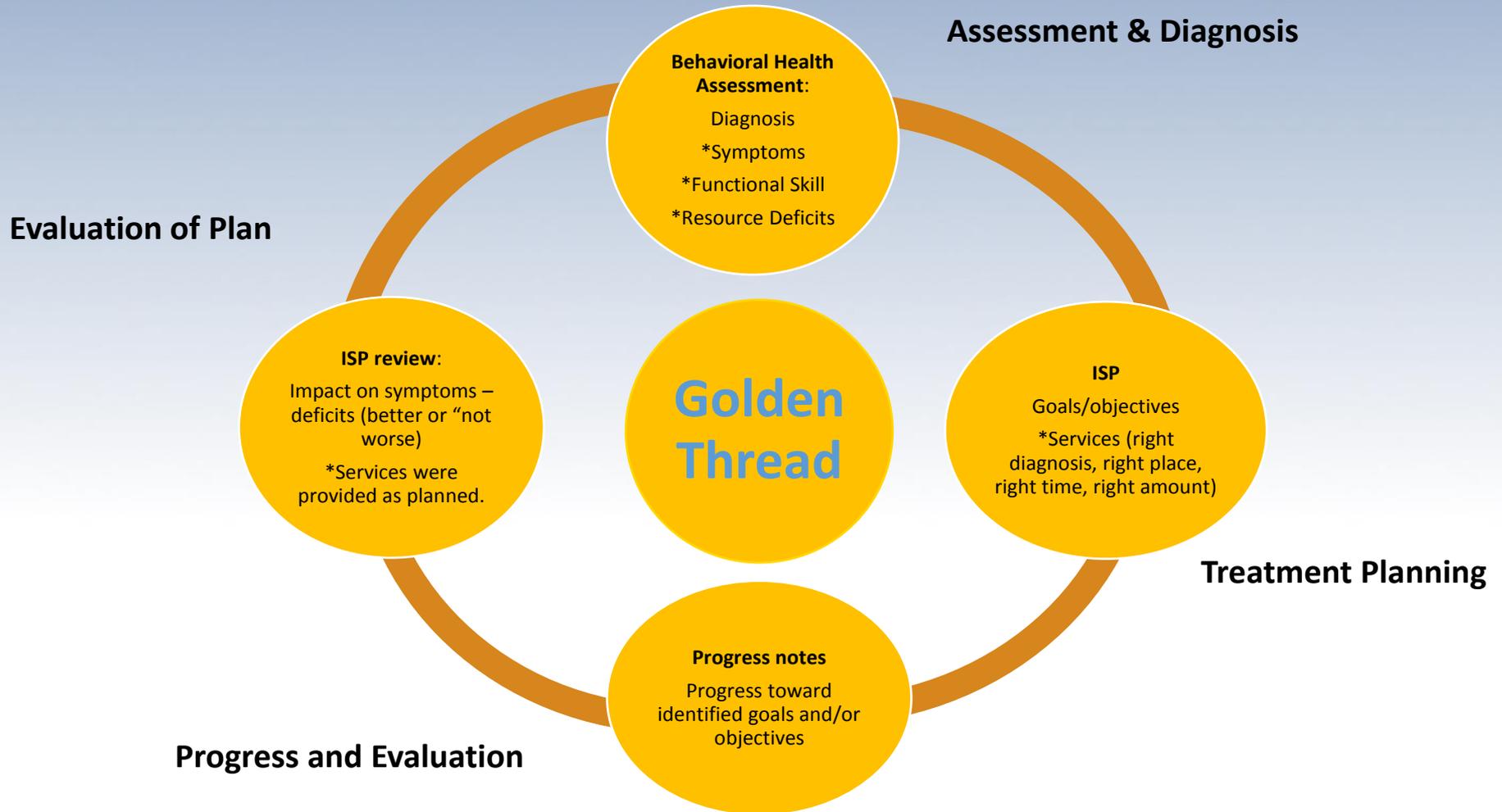
What is included in the State Plan?

The State Plan includes many provisions required by the Act, such as:

- ◆ Methods of administration

- ◆ Eligibility

- ◆ Services covered

- ◆ Quality control

- ◆ Fiscal reimbursements

Service Encounter Reporting Instructions: https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/seri-cpt-information

Golden Thread

Transforming
Lives

Assessment & Diagnosis

Evaluation of Plan

Behavioral Health Assessment:
Diagnosis
*Symptoms
*Functional Skill
*Resource Deficits

ISP review:
Impact on symptoms – deficits (better or "not worse)
*Services were provided as planned.

Golden Thread

ISP
Goals/objectives
*Services (right diagnosis, right place, right time, right amount)

Treatment Planning

Progress notes
Progress toward identified goals and/or objectives

Progress and Evaluation

The Golden Thread

Transforming
Lives

◆There are documented assessed needs

◆Needs lead to specific goals

◆There are treatment goals with measurable objectives

◆There are specific interventions ordered by the practitioner

◆Each intervention, is connected to the assessed need, ordered by the treatment plan, documents what occurred and the outcome

Difficulty Following The Golden Thread

Transforming Lives

Assessment Deficits

◆ Diagnosis poorly supported

◆ Symptoms, behaviors and deficits underlined

  ■ No baseline against which to determine progress or lack

Individual Service Plan/Care Plan

◆ Goals and objectives unrelated to assessed needs/symptoms/behaviors and deficits (example: "comply with treatment")

Progress Notes

◆ Documents "conversations" about events or mini-crisis

◆ Does not assess behavior change, (i.e. progress toward a goal or objective)

◆ Does not spell out specifics of intervention(s) used in session.

Components of the Golden Thread

Transforming
Lives

◆ Assessment

◆ Individual Service Plans (aka: Treatment plan, Care plan)

◆ Progress Notes

The Intake Assessment

Transforming
Lives

◆ Diagnosis with clinical rationale: how the diagnostic criteria are present in the person's life

- Based on presenting problem (Reflect an understanding of unmet needs relating to symptoms and behaviors)

- Data from client—their story and the client's desired outcome

- Observation

◆ Safety or risks

◆ Client functioning

- Evidence that the diagnosis/client condition, causes minimally, moderate distress or functional impairment in Life Domains

◆ Recommendation for treatment and level of care.

WAC Required Elements for Assessments

Transforming Lives

◆ WAC 388-877-0610

◆ Clinical—Initial assessment.

◆ Each agency licensed by the department to provide any behavioral health service is responsible for an individual's initial assessment.

1. The initial assessment must be:

   a) Conducted in person; and

   b) Completed by a professional appropriately credentialed or qualified to provide substance use disorder, mental health, and/or problem and pathological gambling services as determined by state law.

WAC Required Elements for Assessments continued

Transforming
Lives

2) The initial assessment must include and document the individual's:

   a) Identifying information;

   b) Presenting issues;

   c) Medical provider's name or medical providers' names;

   d) Medical concerns;

   e) Medications currently taken;

   f) Brief mental health history;

   g) Brief substance use history, including tobacco;

WAC Required Elements for Assessments continued

Transforming
Lives

2) The initial assessment must include and document the individual's - continued:

g) Brief problem and pathological gambling history;

h) The identification of any risk of harm to self and others, including suicide and/or homicide;

i) A referral for provision of emergency/crisis services must be made if indicated in the risk assessment;

j) Information that a person is or is not court-ordered to treatment or under the supervision of the department of corrections; and

k) Treatment recommendations or recommendations for additional program-specific assessment

Individual Service (Treatment) Plan

Transforming
Lives

A Quality Plan should:

◆ be linked to needs identified in the assessment

◆ include desired outcomes relevant to the presenting problems and symptoms and utilize client's words (How client knows when they are ready for discharge)

◆ have a clear goal statement

◆ include measurable objectives (how will practitioner and client know when an objective is accomplished)

◆ use client strengths and skills as resources

◆ clearly describe interventions and service types

◆ identify staff and staff type. (The staff should be qualified to deliver the care)

◆ address frequency and duration of interventions

Goals

Transforming
Lives

◆Behavioral description of what the individual will do or achieve in measurable terms, directly related to the diagnosis and the presenting problem

◆Often describe barriers to be resolved in order that the goal may be met

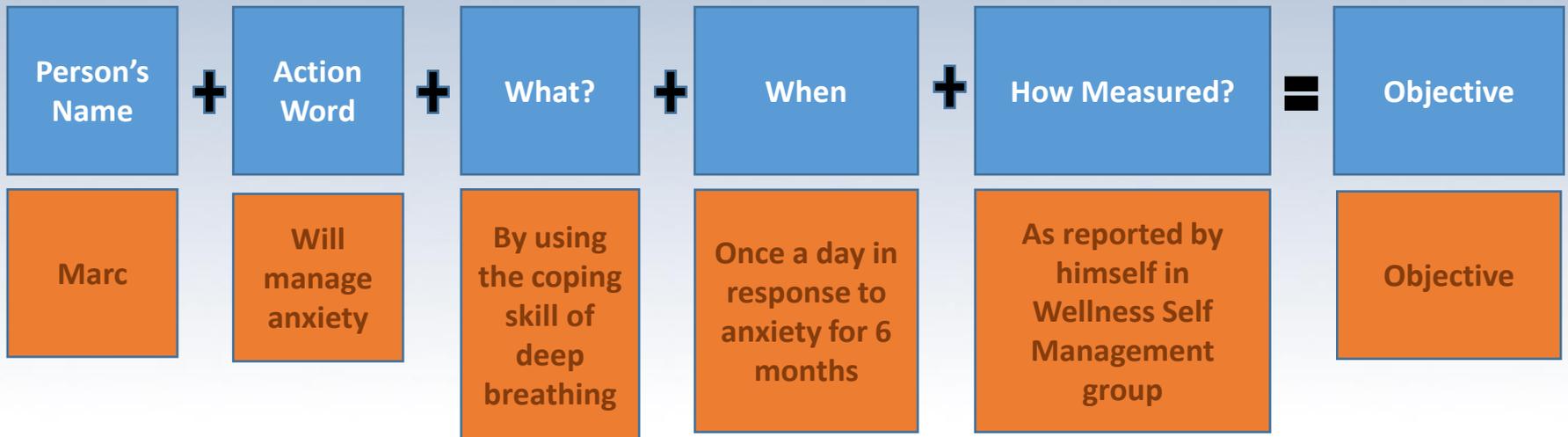◆Tied to discharge and transition planning

Example:

Individual's Goal: "I want to attain and maintain sobriety."

Treatment Goal: The individual will be able to reliably avoid use in his daily life and feel comfortable with his ability to refuse within the next month.

Objectives

Transforming
Lives

◆Objectives are smaller, may be measurable (if Goal is not) steps for the client to accomplish on the road to his/her recovery (discharge goals)

- Specific and focused

- Can be step-by-step

- 2 or 3 at most for each goal

- Realistic and specific

- Measurable – focused on measurable change or events within a specified time period. (Example: as evidence by an observable behavioral change, times per week, every time, etc.)

- Try not to use words like "improve" or "increase" or "decrease" unless they are tied to a measurement. (Example: 3 times weekly, daily, rating scale (with scale defined)

Key Elements of a Quality Objective

Transforming Lives

Person's Name	+	Action Word	+	What?	+	When	+	How Measured?	=	Objective
Marc		Will manage anxiety		By using the coping skill of deep breathing		Once a day in response to anxiety for 6 months		As reported by himself in Wellness Self Management group		Objective

Interventions

Transforming
Lives

◆ Interventions are the specific clinical actions providers will do to help the client achieve their objectives

◆ Must be linked to treatment plan goals and objectives

◆ Should be an activity and demonstrate what is occurring in the interaction with the client

Tips:

◆Staff will: use active verbs in describing what staff will do

◆Time period: length of time you will do the above action

◆Frequency: how often you will do it

◆Type of treatment service to be provide (Group therapy, cognitive behavioral therapy, family therapy, individual therapy) and a reason for it

Interventions - Examples

Transforming
Lives

◆Type of treatment service to be provide (Group therapy, cognitive behavioral therapy, family therapy, individual therapy) and a reason for it

■ Use Cognitive Behavioral Therapy (CBT) to assist individual in identifying relapse triggers 1x/week for 6 months

■ 1x/week for the next 6 months teach the client self-calming techniques to use during high stress activities through discussion modeling and role-play

Treatment Planning Tips

Transforming
Lives

◆The treatment plan is a "contract" with the client that outlines the course of therapy and expected achievements.

◆Auditor should see both a plan and a progress note describing the treatment planning process:

■ Summarize who participated, individual's level of participation/family involvement (critical for children/youth) and primary goals/objectives set, etc.

◆Client should be given a copy of the plan

◆Plan will be changed or updated as issues are resolved or new issues emerge.

Treatment Plan Reviews

Transforming
Lives

◆ At least every 6 months (or earlier depending on contract and WAC requirement) review diagnosis, goals, progress, new issues, etc.,

- Analyze the effectiveness of the treatment strategy

- Reevaluate client's commitment to treatment & relevancy of goals

- Discuss progress or lack of progress and how the treatment strategy will be modified (if at all) in response

- Document either in a progress note or on a separate form

Transforming
Lives

Treatment Plan Reviews continued

◆ Revised, update, or continue the treatment plan based on reassessment. Explain the reasons for your decisions.

- If there is progress, consider next steps. Ready for discharge?
- If there is no progress, revise goals, treatment strategy, diagnosis, etc., as needed

◆ Get new signatures to indicate continued agreement.

◆ Start the Golden Thread cycle over again

Frequent Treatment Plan Problems

Transforming
Lives

◆Goals and objectives are the same as interventions

◆Too many goals; plan too complicated

◆Goals reflect provider concerns and needs rather than those of the client

◆Too difficult to understand

◆Goals do not address Medicaid billable services (not a requirement for all goals, but for reimbursable treatment plans there must be some Medicaid reimbursable goals identified.)

◆Goals do not address the diagnosis, symptoms or need

◆Goals are not identified in a strength based manner

◆Goals are not linked to discharge or transition from care

Progress Notes

Transforming
Lives

Progress notes must reflect the providers delivery of services, according to the nature, frequency, and intensity 'prescribed' in the treatment plan.   Progress notes back up specific claims & justify payment.

Progress notes provide evidence of:

◆   The covered service delivered

◆   The Individual's active participation

◆   Progress toward the goals and objectives

◆   On-going analysis of treatment strategy and needed adjustment

◆   Continued need for services (medical necessity)

Progress Notes continued

Transforming
Lives

◆ Must be written for each encounter

◆ Must address the goals and objectives of the treatment plan

◆ Must document the intervention via the services ordered by the treatment plan

◆ Services not tied to the treatment plan need to be clearly identified.

- ■ Rule of 3 – If a service not on the treatment plan occurs more than 3 times it must be added to the treatment plan

- ■ "intervention is not part of the treatment plan"

◆ If different services are needed: plan must be revised

Progress Note Elements

Transforming
Lives

- ◆ Date of Service

- ◆ Start time and duration

- ◆ Goal and/or objective

- ◆ Location of service

- ◆ Service code (local or CPT/HCPC)

- ◆ Medical necessity (purpose of encounter)

- ◆ States the intervention(s) used: techniques targeted to achieve the outcomes provider is looking for
    - More specific than just "individual therapy"

- ◆ Assessment and clinical impression

Progress Note Elements continued

Transforming
Lives

◆ Client response to the intervention

- ▪ Were they able to demonstrate the skill or participate in role playing?; Could they list how to apply the skills being taught? Or did they not get it, refuses to participate, resist, etc.

◆ Plan for next interaction

◆ Optional: homework assignment or other task to complete before the next visit

◆ Note must be legible

◆ Legible signature of the provider

◆ Date the actual progress note was completed

Transforming
Lives

Example

Why follow the Golden Thread?

Transforming
Lives

To ensure quality of client care and better outcomes

Possible Consequences from audits:

- Loss of employment

- Repayment of funds

- Fines

- Criminal charges

- Loss of contract

- Loss of ability to do business with Medicare and Medicaid

Avoid "Improper payments" caused by:

- Missing documentation

- Incomplete documentation

- Wrong codes for services

- Services not covered by Medicaid

Amending and Appending Documentation

Transforming
Lives

Behavioral Health Organizations and Behavioral Health Agencies should have a policy that outlines how amending and appending documentation can be completed that include:

◆ When and how to add and modify documentation

◆ Must be dated

◆ Indicate who made the modification

◆ What the modification included

◆ Reason for the modification

Amending and Appending Documentation

Transforming
Lives

Late entries, addendums, or corrections to a medical record are legitimate occurrences in documentation of clinical services. A late entry, an addendum or a correction to the medical record, bears the <u>current date</u> of that entry and is <u>signed</u> by the person making the addition or change.

Noridian Health Solutions 2016

Amending and Appending Documentation - Late Entry

Transforming
Lives

Late Entry: A late entry supplies additional information that was omitted from the original entry. The late entry <u>bears the current date</u>, is added as soon as possible, is written only if the person documenting has total recall of the omitted information and <u>signs</u> the late entry.

Example: A <u>late entry</u> following supervision review of a note might add additional information about the service provide *"The services was provided in the families home with the mother (Jane Doe) and father (Jon Doe) present. Marc Dollinger, LISCW, MD 06/15/09"*

Noridian Health Solutions 2016

Amending and Appending Documentation - Addendum

Transforming Lives

Addendum: An addendum is used to provide information that was not available at the time of the original entry. The addendum should also be timely and bear the current date and reason for the addition or clarification of information being added to the medical record and be signed by the person making the addendum.

◆ Would typically be used with an E&M code to input additional clinical or medical information, such as lab results.

Noridian Health Solutions 2016

Amending and Appending Documentation - Correction

Transforming Lives

Correction: When making a correction to the medical record, never write over, or otherwise obliterate the passage when an entry to a medical record is made in error. Draw a single line through the erroneous information, keeping the original entry legible. Sign or initial and date the deletion, stating the reason for correction above or in the margin. Document the correct information on the next line or space with the current date and time, making reference back to the original entry.

◆ Correction of electronic records should follow the same principles of tracking both the original entry and the correction with <u>the current date, time, reason for the change and initials of person making the correction.</u> When a hard copy is generated from an electronic record, both records must show the correction. Any corrected record submitted must make clear the specific change made, the date of the change, and the identity of the person making that entry.

Noridian Health Solutions 2016

What to do if you have questions

Transforming
Lives

◆Clinicians should discuss questions with their supervisors

◆Supervisors should discuss with their BHA Quality Managers

◆BHA quality managers should discuss with the BHO Quality Manager

◆BHO quality manager can email the SERI workgroup: cpt-seriinquiries@dshs.wa.gov

Questions?

Transforming
Lives

Transforming
Lives

Remember:

It is the Practitioner's responsibility to ensure that medical necessity is firmly established and that The Golden Thread is easy to follow within your documentation.

References

Transforming
Lives

◆Noridian Health Solutions 2016

■ https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/documentation-matters.html

◆ValueOptions-Innovative Solutions. Better Health. (slide name)

■ http://apps.leg.wa.gov/WAC/default.aspx?cite=388

■ https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/seri-cpt-information