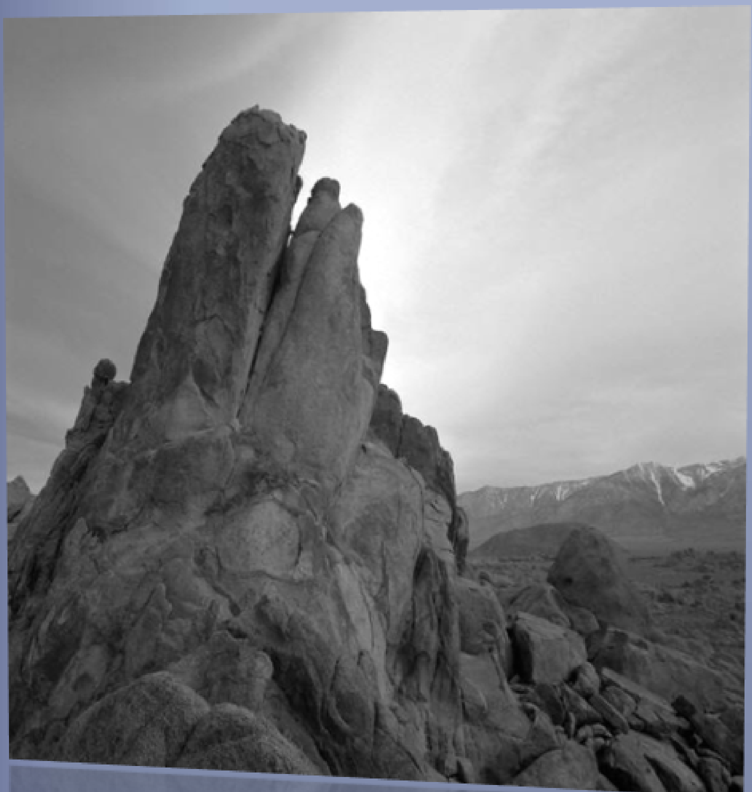


Colorado Basic Documentation Training Slides and Trainer's Notes

This document is intended as a guideline for use by Behavioral Health Organizations and their contracted providers in Colorado in conjunction with the Colorado Uniform Service Coding Manual, the regulations of the Colorado Division of Behavioral Health, and other pertinent laws and regulations.

Produced September 2011 by the Colorado Behavioral Healthcare Council by the the Colorado Committee on Quality and Compliance sic Training and Documentation Committee whose members are Mary Thornton, Paul Baranek, Chayne Boutillette, Allen Brown, Ann Fleming, Spencer Green, Alex Hale, Maureen Huff, Heather Piernik, Vicki Rodgers (Chair), Tracy Thayer, and Charlotte Yianakopulos-Veatch.

The slides and note pages included in this document were developed by the Training Committee of the CCQC, a project sponsored by Colorado's Behavioral Health Organizations to improve compliance and quality of care.

The slides are not intended to be read to the audience. Instead the slides act as reminders for the trainer of the content to be covered, amplified, explained and individualized to the audience and its expertise and training.

The trainer may want to add content to the slides for specific types of services such as therapy, case management, etc.

Good luck!

Why Us and Why Now ?

- Medicaid has become a primary funding source for behavioral health care agencies over the past 10 years
- The State of Colorado and the federal government share a combined responsibility for the oversight and monitoring of the use and documentation of Medicaid dollars

1. The federal government is actively reviewing providers and states through audits of medical records audits. They are recouping hundreds of millions of dollars from providers because of "improper payments" caused by:
   - Missing documentation
   - Incomplete documentation
   - Wrong codes for services
   - Services not covered by Medicaid and Medicare
   - Others
2. These audits are intended to protect federal and state dollars from fraud, abuse and waste AND to insure high quality service delivery.
3. The federal government has invested heavily in auditors and it is likely that most providers will be audited at some time in the future. Understanding how Medicaid and Medicare work and how to document so that your services pass an audit has never been more important.

Copyright Mary Thornton & Associates and NWBCC

Healthcare World is Changing!

- Compliance expectations have escalated
- Audits more common and expensive
- New healthcare laws emphasize paybacks
- Extrapolated paybacks are a threat to most organization's financial future

Trainer note: Explain example of how extrapolated paybacks could effect your center.

Number of Clinical Staff 139
If only 10% had past due Tx plans, Staff = 14
If the 14 staff had 6 clients with past due Tx plans, Clients = 83
If each of those clients had 6 encounters, Encounters = 500
The Average Billed Amount Per Encounter $ 119
The Average Billed Amount x 516 Encounters $ 59,548
The Penalty Fee per Encounter $ 11,000
The Cost of Penalty Fees for 516 Encounters $ 5,504,400
Total Cost to MHC for HCPF/CMS Audit $ 5,563,948
Total Budgeted Expenses for MHC in FY 11 $ 14,133,046

One audit could cost our center 40% of its annual budget, which could mean a termination of 2 of every 5 staff members and dramatically reduce the number and type of services we offer to those in our community

Explain the term – "extrapolated"

So, exactly what is Medicaid?

- Medicaid is a ***modified medical model, federal insurance*** for individuals who meet income and other requirements
- It is a ***very highly regulated business***
- The federal government and the state government split the cost of Medicaid – for some services it is 50/50 for others the federal government can pay up to 90% of the costs
- Both have oversight responsibilities and may have different opinions about how the rules get implemented

See Chapter 2 of Training Manual

So, exactly what is Medicaid?

- Medicaid pays for services that are defined and require skilled interventions and assessments
- Medicaid only wants to pay for services that they believe are medically necessary and supported by the federal laws and regulations that define Medicaid
- Medicaid is currently one of the largest budget items in the federal budget and in many states as well. There is a great deal of emphasis on controlling costs, reducing waste and eliminating fraud and abuse

Copyright Mary Thornton & Associates and NWBCC

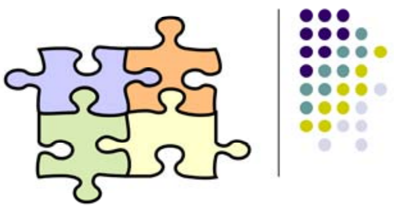
Medicaid State Plans

- Each state has developed a plan for management of Medicaid services
- There are differences among states in how they decide to design their Medicaid programs
- Many individuals we see may have more than one source of funds. We must understand who is the appropriate payer and each of their requirements

1. Each state develops a Medicaid plan, however these plans are based on the federal government's outline of the Medicaid program.
2. Each state has to have their state's plan approved by the federal government.
3. See capitation and description of how Colorado manages its community behavioral health services in Training Manual – Chapter 2.

Copyright Mary Thornton & Associates and NWBCC

Funding Sources



- There are multiple sources of funding for many Individuals. For example:
  - Medicaid
  - Medicare
  - 3rd Party Insurance
  - Block Grant
- In Colorado the Health Care Policy and Financing (HCPF) department is primarily responsible for Medicaid

Medicaid Mental Health Services

- Colorado is divided into 5 Service Areas
- Served by 5 Behavioral Health Organizations
  - Colorado Access Behavioral Health Care (Denver) 800 984 9133
  - Behavioral Health Care, Inc. (Adams, Arapahoe, Douglas) 877-349-7379
  - Colorado Health Partnerships (many south and western counties) 800-804-5008
  - Foothills Behavioral Health (Boulder, Jefferson, Gilpin, Clear Creek, Broomfield) 866-245-1959
  - Northeast Behavioral Health Partnership (12 counties in NE Colorado 888-296-5837
  - Note - The last 3 have a management relationship with Value Options

Colorado is divided into five areas for delivery of Medicaid mental health services. Contracts are put out to bid by the state (usually) once every five years. Any qualified, interested organization may bid for these contracts. (History- in 1995 the state of Colorado applied for and received a 1915 (b) Managed Care/Freedom of Choice Waiver, from the Center for Medicaid/Medicare Services, the agency of the federal government that manages Medicaid programs. Contracts were awarded for the areas and have been rebid every five years since. There were originally more than five areas which were served by MHASA's, Mental Health Assessment and Service Agencies. These areas were later merged into five areas served by our current Behavioral Health Organizations.)

The five areas of the state are served by:

Colorado Access Behavioral Health Care 800 984 9133 (Denver)

Behavioral Healthcare, Inc. 877 349 7379 (Adams, Arapahoe, Douglas)

Colorado Health Partnerships 800 804 5008
Alamosa, Archuleta, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, Delta, Dolores, Eagle, El Paso, Fremont, Garfield, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Kiowa, Lake, La Plata, Las Animas, Mesa, Mineral, Moffat, Montezuma, Montrose, Ouray, Otero, Park, Pitkin, Prowers, Pueblo, Rio Blanco, Rio Grande, Routt, Saguache, San Juan, San Miguel, Summit, Teller

Foothills Behavioral Health Partners 866 245 1959
Boulder, Broomfield, Clear Creek, Gilpin, Jefferson

Northeast Behavioral Health Partnership 888 296 5827
Cheyenne, Elbert, Kit Carson, Larimer, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, Weld, Yuma

Please note that the area where the member currently resides may not be the responsible BHO for the member's Medicaid. The most common situation in which this happens is when a child from one area is placed in foster care in another area. It is still possible for the member to obtain sevices even when theya re living outside the area (BHO) responsible for them. Most often, services would be delivered by the local mental health center.

All 17 community mental health centers in Colorado are qualified to provide mental health services to Medicaid enrollees.

Each area also has private practitioners that are qualified to see Medicaid members. In order to see Medicaid members private practitioners must be licensed by the state of Colorado as mental health professionals with at least 3 years of post licensure experience. The entity holding the Medicaid mental health contract for each area is responsible for credentialling and maintaining a network of providers. Medicaid members have a right to choose their credentialled Medicaid mental health provider.

Payment For Services

- The state of Colorado operates a capitated model for funding **for most of its Medicaid BH services**
  - Encounters are submitted for each covered service which justifies our funding. Each encounter must be supported by sufficient documentation.
- Medicare and "straight" Medicaid are paid FFS
- **We get paid for what we do, document, and bill - not for what we cost**

•For capitated Medicaid all MHCs report encounters to the state
  •Each MHC receives an allocated dollar amount from HCPF for Medicaid eligibles
•There are also FFS Medicaid services as well – for these services, claims – not encounters are submitted
•We also serve individuals with both Medicaid and Medicare –these services are FFS as well

•Every encounter is submitted with all the required information including:
  •Start/end time
  •Length of intervention
  •Client identification
  •Type of service
•Claims require the same information
•For all encounters/claims there must be back-up documentation in the medical record

When is a service complete?

- A service is complete only when it has been documented and billed
- Audits are conducted on the documentation we provide
- **The documentation we provide is the only evidence of the work we do**

Audits conducted may review all the above mentioned information submitted to the state, as well as the narrative part of the progress note and all documentation in the chart including the treatment plan and the most recent assessment.

Copyright Mary Thornton & Associates and NWBCC

Slide 10

---

m1 mthornton, 8/18/2011

m2

Claims must be accurate

- Each service billed (the claim) is built on your documentation and must be accurate
- Examples of some required elements include:
  - **Time**
  - **Location**
  - **Type of service: is it covered by Medicaid and coded correctly?**
  - **Medical necessity**
- Billing staff rely on your accurate and complete record – they bill what you tell them to bill

1. Explain that encounters are the background documents that produce a Medicaid claim and must be accurate.

2. Centers may have a Business Office check for these technical data points like dates and completion of all fields in a progress note form but they cannot review medical necessity, make sure you have coded correctly or make sure you have accurately described a covered service. Even so it is still your responsibility to make sure the data is accurate.

Slide 11

---

m2 mthornton, 8/18/2011

Isn't Compliance with Colorado Standards Good Enough?

- Not necessarily – remember the federal government has an opinion as well
- Recent state audits by the federal government OIG (Office of the Inspector General) have NOT always supported the state's guidance to providers
- Auditors follow stricter guidelines, regardless if they are state or federal guidelines

See Chapter 4 of the Training Manual

Personal Accountability

- Your name is on every encounter/bill
- Evaluators will evaluate individual actions which may include penalties
- Stricter adherence to documentation guidelines is critical right now

The federal government can hold a provider personally accountable for the errors in the encounter or documentation

GENERAL PAYER RULES

How do Medicaid and Medicare define services?

Medical Necessity

- All services provided to individuals must be supported by **establishing medical necessity**
- Medical necessity is the criteria payers use to determine if they will or will not pay for a service
- **All behavioral health services for treatment must be medically necessary to receive payment from Medicaid**

See Chapter 1 of the Training Manual for state and Medicare definitions of Medical Necessity and see Chapter 5 for how to incorporate medical necessity into your operations.

Medical Necessity

- State of Colorado's Definition:
  - "Medically necessary means a **covered service** that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury or disability; and for which there is no other equally effective or substantially less costly course of treatment suitable for the client's needs."

Colorado Department of Health Care Policy and Financing - Medical Necessity

- A covered service shall be deemed medically or clinically necessary if, in a manner in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care, the service:
  - Is reasonably necessary for the diagnosis or treatment of a covered mental health disorder or to improve, stabilize or prevent deterioration of functioning resulting from such a disorder; and
  - Is clinically appropriate in terms of type, frequency, extent, site and duration;

Discuss:

Continuum of care and how services should relate to the expected outcome and services that cannot produce the expected outcome would not be considered equally effective even if less costly:

Treatment services: focused on reduction of distress associated with symptoms; reduction of functional deficits that are caused by the mental illness
Rehabilitation services: focused on improving functionality through the attainment of valued roles
CM: accessing necessary services and supports
Crisis: resolution of the crisis

Ask: What would be an example of choices a provider might need to make that would fit this situation, e.g.

- Parents want child in residential but Intensive In-home is available –what do you do?
- Client wants outpatient services, he appears to need Intensive Outpatient Services –what should provider do?
- Hospital refers client to ACT program but there is a wait list - ?

Colorado HCPF Continued

- Is furnished in the most appropriate and least restrictive setting where services can be safely provided; and
- Cannot be omitted without adversely affecting the Member's mental and/or physical health or the quality of care rendered.

- B. The Contractor, in consultation with the service provider, Member, family members, and/or person with legal custody, shall determine the medical and/or clinical necessity of the covered service."

Note: services that are considered to be medically necessary if they address stated needs include:
- Prevention services
- Diagnostic services
- Services designed to cure, correct or ameliorate mental illness, injury or disability
- Services designed to reduce pain and suffering – usually measured by level of distress in mental health
- Services designed to improve functionality where it has been impacted by the mental illness

What types of prevention services are available that you have referred to or are needed by clients ? In CMHCs? In community?
- Peer services
- Mental Health First Aid
- Parenting classes
- Alanon

What other diagnostic services might be needed and are available for mental health or substance abuse?
- Psychological testing
- Neuro-psych testing
- Medical imaging: dementia
- Referral for psych assessment

Note: cure, correct, reduce or ameliorate the mental effects of an illness, injury or disability – range of impact from cure to ameliorate fits into definition of medical necessity, Cure is not always expected but some benefit is expected. E.g. CM is a service designed to help compensate for the cognitive impact a mental illness can have on an individual. Skill building to help increase the ability of the individual to develop and use skills that were negatively affected by their mental illness.

Medical Necessity and Payers

Although the definitions for medical necessity from various payers do not sound exactly the same, the concepts are quite similar.

In all of these areas, the provider needs to understand what services are medically necessary so that the Individual's insurance (Medicaid, for example) will cover the service and where referrals will result in positive and significant benefit to the individual.

C. Focus is on the distress sometimes caused by the mental illness –e.g. Client really needs to focus on the changes in their life or life expectations caused by their mental illness - grief, grieving; med management to assist the individual in managing anxiety so that talking and other therapies can be instituted.
D. Focus on functionality: coping skills; social skills development; as well as concrete ADL skills –remember social skills are activities of daily living as well as basic hygiene.

In all of these areas provider needs to understand what services are medically necessary so that the Individual's insurance (Medicaid) will cover the service and where referrals will result in positive and significant benefit to the individual.

Operational Definition

- The individual has a mental health/substance use condition/illness that has produced a current problem in functional status, including current signs and symptoms that interfere with functionality, that can be helped by providing the services listed on the treatment plan

This is our interpretation of what those actual definitions mean in practice. It is not the actual regulatory definition.

Operatinal Definition of Medical Necessity

Help can be focused on:

- Reduction or better management of signs and symptoms
- Betterment of a functional status
- Prevention of a worsening or maintenance of functional status
- Development of age appropriate functioning in a child where mental illness has prevented age appropriate functioning
- The prevention of new morbidities when threatened by the individual's mental illness

Go over each type of help carefully and have trainees give examples of what types of services are available for each.

Six Components of Medical Necessity

1. The service treat a **mental health condition/illness** **or** **functional deficits** that are the result of the mental illness
2. The service has been **authorized, recommended, or prescribed**
3. The service should be **generally accepted as effective** for the mental illness being treated
4. The individual must **participate** in treatment
5. The individual must be **able to benefit** from the service being provided
6. It must be an **active treatment focus**

1. See Chapters 1 and 5 of the Training Manual

Medicaid Defines Services

- Medicaid defines covered services and provides specific rules for each service including:
  1. What is allowable content for the service
  2. Who are the eligible providers
  3. Where the services may be provided and sometimes how much service must **or may** be provided

•Good time to introduce Coding Manual and how it works –walk through a page or two

•Outline specific services & parameters, ie

- •CM—who can provide
- •Where can it be provided
- •What does it entail
- •How long

See Training Manual Chapter 5 – WHAT SECTION?

Medicaid Defines Services (cont.)

4. The approved mode of delivery of each service (face to face, phone, collateral, videoconference)
5. Hours of services are to be provided or other accessibility requirements, e.g., crisis services are to be available 24 hours a day
6. Sequence of service delivery, i.e., (emergency services) case management may be provided before the mental health assessment is completed

Copyright Mary Thornton & Associates and NWBCC

Services Documentation

- Medicaid expects each progress note will list and clearly describe the service being provided
- The description should result in a service code being assigned to a particular service code and this should be the code that best describes the service provided

1. The assignment of a service code may vary depending on your center. Providers must understand the Coding Manual and how it is put together, how to read it, and how their organization expects them to use the manual to code services.

Copyright Mary Thornton & Associates and NWBCC

Credentials are Critical

- Medicaid specifies the credentials necessary to provide specific services
- These credentials may be licenses, educational requirements, or training requirements
- You can only provide services that meet the payer's criteria for your level of license, training or education

Show a coding manual page and where credentials are listed

Licensed Professional Signature

- Evidence that a licensed professional has reviewed the document, agrees with the content and conclusions, and with treatment plans, provides the clinical direction and authorizes services
- **A licensed professional must sign the Individual Treatment Plan**
- **More guidance about signatures on treatment plans will be coming**

1. See Chapter 5 of the Training Manual
2. NEED UPDATED INFORMATION: HCPF has told providers to follow Rehab Option services for all treatment plans except those for Medicare and Medicare/Medicaid clients. Treatment plans must be signed by a “licensed practitioner of the healing arts”. They can only sign off on treatment plans that include services they can either provide or supervise according to state licensing regulations.

Some Things will Never be Billable

- Services that do not meet ALL the requirements spelled out in Uniform Service Coding Manual
- Services that do not meet the definition of the service content are not billable
- Some things, although therapeutic and helpful, will never be billable:
  - ***Helping put up a Christmas Tree***
  - ***Helping a Individual pack and move***
  - ***Transportation***
  - ***Calling a client to schedule an appointment***

1. This will vary depending on your specific agency. Discuss your agencies policies regarding this or add additional relevant examples.
2. The point you are trying to make here is that insurance programs only pay for certain services. The ones they do not pay for may still be valuable and therapeutic but they are simply not Medicaid eligible. In some cases, because most mental health centers are charitable organizations, you will be expected to provide certain services even if they are not billable to Medicaid.
3. If you have a question about whether or not something you did with an Individual is billable – always ask your supervisor. Do not guess!

COLORADO MEDICAID

How is Medicaid is set up in Colorado and what does this means for billing?

Colorado State Medicaid Continuum of Care

- Colorado provides a continuum of services the major outpatient components which are:
  - Treatment, Rehabilitation, and Case Management
- Services provided should be based on clinical need and generally accepted practice, i.e. medical necessity

See Chapter 2 of Training Manual.

Treatment Services

- Always a recovery and resiliency focus
- The focus of treatment is on symptom reduction and the reduction of feelings of distress in the Individual
- Examples: Med management, individual therapy, family therapy, group therapy

See Chapter 3 of Training Manual on Recovery and Resilience

Note: in some cases therapy may also be provided in the home – e.g. intensive in-home services, PACT servicesic – but usually therapy is provided in a clinic of other therapeutic facility. If provided in the home there should be a reason why and it cannot be simply for the convenience of the Individual.

What are Rehab Services?

- Always a recovery and resiliency focus
- Services can be provided in the community in lots of locations
- Focus on skill building and role achievement
- More flexible services and staff qualifications
  - Staff are trained in skill building and in resource development

Rehabilitation services are intended to help the Individual gain, regain, or better perform in valued social roles. The focus is on functionality – the ability of the individual to function in their day to day environment and within the roles they value and want to achieve. These roles are usually defined as being within 4 environments –the living, learning, working, and socializing environments – e.g. living alone, living near family, going back to school or work, making friends, getting married, etc.

Where skills are not enough, Individuals are helped to identify resources that can help them maintain functionality. For example, someone who cannot manage medications by themselves may be helped to identify a friend, relative, or social services that may help them.

The focus of rehab services is role retention and independence – as much as possible – from the mental health system, i.e. recovery and resiliency.

Rehab Services Focuses On:

- **Natural locations**: Don't have to do everything in the clinic; you can teach skills in the locations where consumers will use those skills; you can meet with other providers or family involved in the individual's care in their offices or homes
- **Skill building:** Helping individuals regain the skills they need to manage their community and day to day living

Copyright Mary Thornton & Associates and NWBCC

Additional Types of Rehab Services

Peer:

- Drop in and clubhouse
- Peer Specialists
- Warm lines

Vocational

Supported housing

Wellness and psychoeducation

These services are sometimes called "B3" services. They are special services allowed in the Colorado Medicaid mental health state plan.

Case Management

Case management is an activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual (From Medicaid manual Chapter 4, 4302)

Case Management Services

- These services are designed to link an Individual to necessary services, supports, and resources
  - These can be community organizations, churches, recreational, schools, and other community supports
  - Natural supports such as family and friends and other local community members such as neighbors
  - Services such as tutoring, medical services, mental health services, etc.

Consult coding manual

What are NOT Covered Services

- Services to family members to benefit them and not exclusively the individual
- Helping to achieve normal developmental milestones
- Transportation
- Social and recreational activities
- Skill building that is not specific to or effective for treating the mental illness – e.g. diapering, how to put on make-up, etc.

1. Trainer note: Ask the audience why the first example would not be covered. Answer: This falls under the "exclusive benefit" provision. Services not directed exclusively to the benefit of the Medicaid member are not covered.
2. Helping someone to attain normal developmental milestones implies that they do not currently have a mental illness that needs treatment. The mental health system generally intervenes when a child or young adult is not achieving developmental milestones because of their mental illness.
3. Transportation: this is covered by Medicaid through a separate contract. Trainer should discuss –particularly with Case Managers – what the organization's rules are on driving Individuals to services, providing billable services while driving, etc.
4. Social and recreational activities: these are not considered to be specific and effective interventions for a mental illness
5. Skill building: normal not necessary activities.

These activities may all be valuable to an individual in certain circumstances but they are not billable to Medicaid.

Copyright Mary Thornton & Associates and NWBCC

Take a look at some examples of documentation denied in audits

- From audits of mental health rehabilitation services the following were NOT acceptable and the agency was NOT paid;
  - ***"Transported the consumer and his sibling to lunch and to the mall"***
  - ***"Played Candyland two times with the consumer in the office"***

1. The first is an example of transportation that we talked about in the previous slide.
2. How would the second example relate to the categories on the previous slide? (Social and recreational activities)
3. Ask would either of these activities be ok for Case Management? For therapy?
4. Relate this back to the slide earlier in the presentation which demonstrated extrapolation. Payback is not just for this one instance but is extrapolated for the entire category of case management; i.e. if the auditor audits ten charts and finds this one example then ten per cent of case management monies must be returned.

More Refused Billings

- **Skill building:** “The worker vacuumed the living and dining room and changed the consumer’s sibling’s diaper. She filled two trash bags and disposed of them. The worker assisted in jumpstarting the mother’s boyfriends van and followed him to a repair shop. She took him to her office to make phone calls for rental properties and then took him to view two properties.”

This is an example of doing for the client rather than teaching the client skills. Ask trainees to identify how many things are wrong with what provider did?

Vacuuming
Changing diaper
Cleaning house and throwing out garbage
Jump-starting boyfriends car
Following boyfriend to repair shop
Taking boyfriend to office and helping HIM find housing
Taking boyfriend to look at housing options

Please note that the problem here is not how the services were documented, but that the services were not covered services. You could not change the language to make them billable?

More Refused Billings

- ***From an audit of a day programs:***

  Group therapy: "Group documentation on (date) stated that the patient laughed frequently to himself and made several off-topic remarks. He had a poor ability to focus and concentrate on task. The Weekly Progress Note stated the Individual had been non-compliant with attendance and had been wandering off during the day."

What requirement(s) of medical necessity are not met by this description of a service?

- How did this consumer benefit from this group?
- Could the individual participate?

Copyright Mary Thornton & Associates and NWBCC

More Refused Billings

- ***From another audit of services:***

Case management: "The social worker made a home visit accompanied by another social worker who stated that they were working on budgeting, parenting, and the child's setting."

What services provided were not case management?
•Budgeting? No
•Parenting? No
•Child's setting? Yes if evaluating the child's setting for safety, adequacy, etc.?

The explanation given by the social worker as to why there were two of them was that one was evaluating the services of the other. Medicaid does pay for Case managers to coordinate care and to intervene where services are not adequate or sufficiently beneficial to the Individual. Does it seem as if evaluating by one social worker of the other's work is what is being done here?

More Refused Billings

- ***From a state audit of psychotherapy services:***

  Individual Therapy: "Individual reported that all is going well. We discussed career options again today and Individual stated he is basically quite happy the way things are now as he gets to spend a lot of time with his daughter. A condition of probation is to get his GED and he is not interested in pursuing anything else currently."

So if the client is not interested in pursuing anything else and all is going well, why are we still doing therapy? What therapeutic interventions were used here?

What were the problems with these services?

- Some concepts that were illustrated in these examples though are:
  - Exclusive benefit
  - Skilled interventions
  - Ability to benefit from services
  - Providing covered services
  - The problem in these examples is not the way they were documented but that they were not covered services

Exclusive benefit means the services must be exclusively for the benefit of the Medicaid recipient; not their spouse, family, etc.

A skilled intervention must teach the client some skills or develop their ability to use skills. Chatting with the client is not psychotherapy. Doing tasks for the client is not teaching them skills.

If the client is not able to benefit from the service, i.e. insight oriented psychotherapy with someone who is actively psychotic, the service should be changed to match what the client will benefit from. This may involve having to modify the treatment plan in light of the current situation.

Only certain services are covered by Medicaid/Medicare. It may benefit the client to be driven to the auto repair shop to pick up their car, but it is not a covered service. And it is especially not covered if it is for the client’s mother’s boyfriend and not the client at all.

We will discuss how to properly document in just a few minutes. Proper documentation is very important but if the service is not a covered service it will not be paid for no matter how it is documented. The problem in these examples is not that the notes need to be “tweaked” or rewritten. Making sure the service is a covered service needs to occur before documentation issues are addressed.

Other Issues Related to Medicaid Audits

- Audits can help us to identify common problems in how we understand and document covered services under Medicaid
- Medicaid is the payer of last resort. If the service is available from another community resource, we link the client to those resources
- Risks of noncompliance:
  - Recoupment (payment has to be returned)
  - Corporate Integrity Agreements (CIA)

Most organizations do internal audits to try to discover problems with services delivered and documented before outside auditors come in. Internal audits may seem like a bother and a stressful experience but they do have their place in the scheme of things. If we can identify patterns or areas of service that are problematic we can correct those to optimize our revenue and avoid paybacks.

More revenue means more staff, more services provided to people who need them, maybe even more salary for present staff!

Payer of last resort is a federal guideline in which we have no choice. This means that Medicaid will only pay for a service if it is a covered service and there is no other way to pay for it. If there is other insurance, that insurance must be used first before Medicaid will even consider paying for the service. If there is another community agency providing the same service that Medicaid pays for, then that community service should be used first.

Risks of non-compliance:

See Chapter 4: examples of audits and extrapolation. Review a couple of the audits to see what types of documentation errors Medicaid and Medicare look for.

Explain Corporate Integrity Agreement (Chapter 4 part 3) –this is also a very very expensive outcome for providers. This is a compliance plan written for you by the government. It usually involves outside auditors and other expenses to ensure that you are documenting and providing services correctly.

Copyright Mary Thornton & Associates and NWBCC

GENERAL DOCUMENTATION RULES

Why is it so important?
Why is it so hard?

Cold Hard Facts

- No Documentation
- No Bill/Encounter
- No Cash
- No Services
- No Jobs
- No help for people who need help

Training Tip: Put this slide up and let the audience absorb it for a moment before you start talking.

Explain that an encounter is what is used in place of a bill for a CMHC (Chapter 1) for Medicaid Capitation payments

These are the cold hard facts. If you think documentation is not important but the services you provide are important then be aware that without proper documentation and understanding of these rules and regualtions those services are in danger of being curtailed.

Copyright Mary Thornton & Associates and NWBCC

Why is Documentation so Important in Behavioral Health?

- It is the **only** evidence that we have provided services
- It is the only evidence that the services meet the definition of medically necessary and that they are a covered service

You have probably all heard the old saying, "If it wasn't documented, it didn't happen." An auditor will never sit in with you on a service to see what you are doing. They will only read your notes, your treatment plans and your assessments.

If your note does not reflect the good work you did the auditor will never know about it and will assume you didn't do it.

Medically necessary : see training manual Chapter 1 . If the service does not meet the criteria of medical necessity then it is not eligible for reimbursement
Covered services: Medicaid only pays for those services listed and described in the coding manual

Copyright Mary Thornton & Associates and NWBCC

Cannot Bill Without Documentation

- In order to bill, documentation must be complete and current
  - Audit risks: payers expect to see documentation immediately
  - Individual risks: in emergencies providers should have the most up to date information
  - Financial risks: Medicaid is a primary source of revenue for the organization. Risk of recoupment without appropriate documentation

Remember, CMHC's have to submit encounters which is essentially the same as a bill and must meet the same criteria. (see Chapter 1 of training manual)

Audits: You cannot go back and change or add documentation once you know you are being audited. The sooner the documentation is entered into the medical record the more accurate it is likely to be. Trainers note: check the policy of your agency in terms of when documentation needs to be entered.

Individual: If your client shows up at crisis services or in the hospital it may be critical for these responders to know what is currently going on with the client.

Financial: See Chapter 2 of the training manual, "Medicare and Medicaid Fraud, Abuse and Waste" for some statistics on the overall impact of these programs on health care spending. For CMHC's the percentage of revenue that comes from Medicaid will vary by individual CMHC but in all cases is a VERY significant source of revenue. What would happen to your CMHC if they lost 20 or 30 % of their revenue?

Why is it so Hard and Confusing?

- Documentation must comply with multiple expectations and meet all requirements consistently and accurately
- It is important to balance various expectations for documentation among the individual, the treatment team, payer and regulatory agencies

See Chapter 4 of the training manual.

•The payers: the Office of the Inspector General (OIG), the Medicaid Integrity Program (MIP), privately contracted Recovery Audit Contractors (RAC), as well as Colorado's Health Care Policy and Financing Department (HCPF) and the Department of Behavioral Health (DBH). All of the requirements of these various agencies must be met and they are not always the same. They will all audit provider services. HCPF is the agency in Colorado that is supposed to help providers clarify contradictions between payers.
•The individual: the medical record belongs to them. They should be able to understand it? Some of the key fields should be written in their own words: the recovery goal, the reason for coming to treatment, comments on how they believe they are progressing, etc. They should never have to read judgmental comments about themselves. If they cannot understand words or concepts these should be explained to them.
•The treatment team: needs the most accurate, up-to-date information

•Trying to satisfy them all is difficult.

Expectations for Documentation

- **The medical record of the individual and their family:**
  - Comply with HIPAA
    - Record belongs to the individual
  - Record should be person-centered and recovery/resilience oriented

A person-centered record is still going to contain some jargon. However, this should be explained.

See Chapter 3 of the training manual for a discussion of what it means to be person centered and recovery oriented.

Expectations for Documentation

- **The Treatment Team:**
  - Treatment efforts are directed toward agreed upon measurable goals and objectives
  - Focus on coordination of care
  - Non-duplication of services

Auditors will not only look to see if the service is medically necessary and is a covered service but if it is in the treatment plan. How does your note relate to the treatment goals and objectives stated in the treatment or service plan? Which of the goals or objectives did your intervention direct itself towards?

Auditors will examine records to determine if care is coordinated both internally and externally. Are there other providers involved? If so, were they contacted? Remember this could include medical doctors, teachers, social service agencies and others.

Payer sources do not want to pay twice for different providers who are providing the same service.

Expectations for Documentation

- **The Payer/Regulatory Agencies:**
  - Evidence of medical necessity
  - Evidence that a covered service was provided
  - There is adequate content for time billed *(can't have one sentence for a 3 hour service)*
  - The individual's response to the treatment: are they participating and are they benefiting?

1. Trainer can refer to documentation grid for required elements. See Chapter 1 for a description of medical necessity. There is more than one definition which must be followed. They are similar but not exactly the same.

2. The service must be one that is covered by Medicaid/Medicare as discussed previously in this presentation. No matter how good your note is we won't get paid if it is something that is not covered. Not covered is not the same as not needed or not valuable. Many valuable services are not covered by Medicaid/Medicare.

3. Be sure to include the individual's response to the intervention especially emphasizing how they are benefitting interms of advancement toward their goals and objectives from the treatment/service plan.

4. You do not have to write a lot to satisfy Medicaid but the documentation must be focused on the information that is important to the payer.

Copyright Mary Thornton & Associates and NWBCC

Documentation

"Without complete clinical record documentation, including a description of what took place in a therapy session, the medication prescribed, the individual's interaction with group members, his or her progress compared to the treatment plan goals, and future plans of treatment, the appropriateness of the individual's level of care is unclear.

Trainer's note: You can read this or allow the audience to read it themselves. Continue on to the next slide which is a continuation of this quote.

Documentation

Furthermore, inadequate documentation of individual therapies and treatment provides little guidance to physicians and therapists to direct future treatment. In this regard, the lack of required documentation precludes reviewers from determining whether those services are needed."

This summarizes the view that auditors take of documentation. If they cannot determine that the services were needed from the note they will assume the services were not needed. The burden of proof is on the person writing the chart note. The auditors do not have to prove the service was not needed. You have to prove the service was medically necessary and a covered service.

MARY – Please note where this quote is from.

Basic Documentation Guidelines

- All Services billed must be ordered in a current, appropriately signed treatment plan that is based on information located in the most current assessment of the individual's status and needs
- **Documentation must be individualized**
- All entries must be signed and dated by the provider of the service

1. The treatment plan is the prescription for services, it is the order that the services be performed. If it is not ordered it does not count.
2. Trainer: Read the red part of this out loud with emphasis. This means that the note must be different for each service and for each individual. You cannot copy and paste notes. This is known as cloning and will not support medical necessity. If your session note is the same as last week but with a different date, you are cloning.

The Golden Thread-Connecting the Dots

- Each piece of documentation must flow logically from one to another such that someone reviewing the record can see the logic
- The assessment must lead to the treatment plan and be coherent and cohesive and establish medical necessity
- The progress notes must flow from the treatment plan and document the services provided and the individual's response to treatment
- The progress notes lead to the treatment plan review/update that lead to the progress notes, etc.

Chapter 1 and Chapter 5 of the training manual discuss the Golden Thread. This is an important concept emphasizing how all the documentation must be tied together. The idea is that you can't look at your documentation in isloation from the rest of the medical record. When writing your note think about how it ties in to the treatment/service plan and how it makes sense in light of the assessment and problem/needs list. Remember, the auditors will not be reading your note in isolation. They will be asking themselves these questions;

- "What treatment plan goal/objective does this note address?"
- "How does this follow from the assessment I just read?"
- "What is the continuity from the last session note I just read?"
- "Is this medical record telling me a story with a beginning, a middle and an end that all tie together or does it seem like a disconnected series of events?"
- Can the auditor say, "I can see where the treatment is going and it does follow the plan I read earlier."

Copyright Mary Thornton & Associates and NWBCC

What is the Golden Thread?

- The Golden Thread begins with the assessment (identified needs) then pulls through the treatment plan (interventions and goals) to ongoing progress notes (client efforts, services provided, progress made)
- It is golden because, if accurately followed through, the documentation that supports each decision, intervention, or client progress note contributes to a complete record of client care that is error free and ready for reimbursement

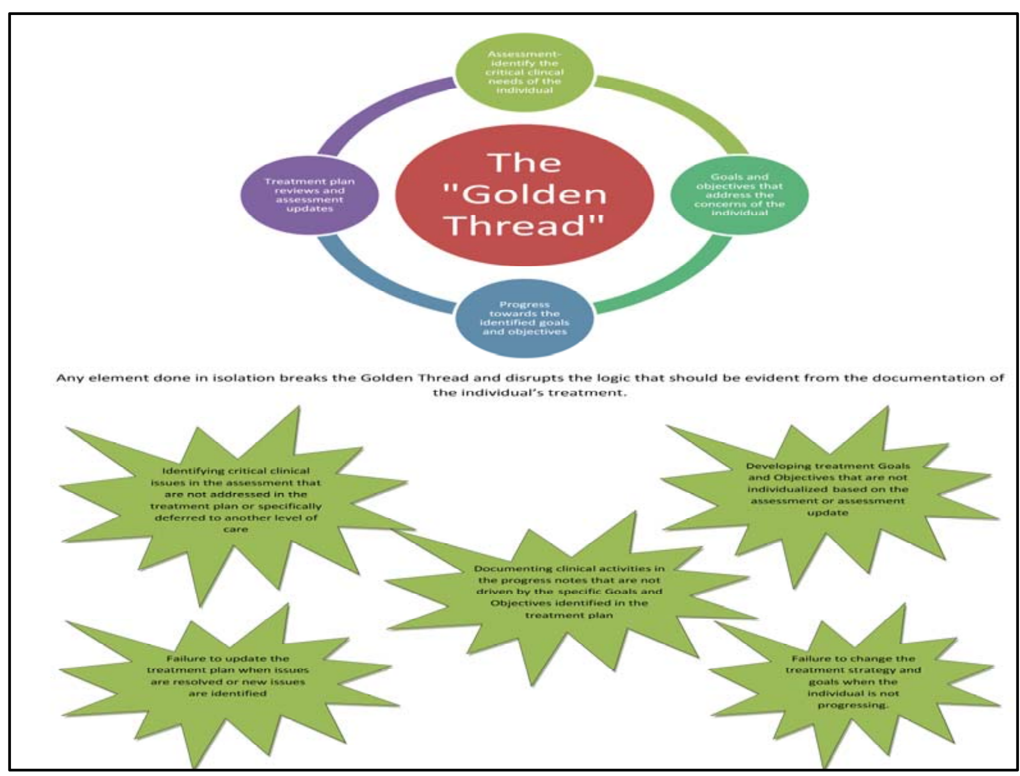
Please make sure to emphasize the need to have a continuous coherent picture of what is
going on with the Individual's treatment and services.
The clinician should always review other providers notes. Their notes will have an impact on whether or not auditors will agree that services need to continue. If the coherency of the story breaks down anywhere, it will have an impact payment decisions.

Documentation Linkage- A Reflection of the Golden Thread

- Assessing with the Client-----Completing the Assessment Form
- Planning with the Client--------Completing the Treatment Plan
- Working with the Client--------Completing the Progress Note

Note the need to develop all of the key documents in the medical record directly with the
Individual. (See Chapter Three of the manual on Recovery Based Approaches to Treatment)

The only exception would be consultations with others with the Individual not present This is allowed, but even with these consultations, there should be an effort made to let the Individual know what occurred. This discussion should include information on what effect the consultation had on the clinician's treatment strategy. Does the clinician now need to discuss changes to the treatment plan with the individual as a result on the consultation?



The top of this diagram shows how the documentation should all relate to each other . The bottom of the diagram shows documentation is isolation. Each element does not connect or flow from one to the other. Our documentation should resemble the upper diagram and not the lower one. The documentation should be more like a book with chapters than a collection of separate articles.

Have everyone refer to the manual for this full page diagram in the Appendix since this is too small to read.

Assessments

- There are different types of assessments that ***may*** be completed to determine an Individual's needs during the treatment episode
  - Mental Health Assessment, by non physician H0031 – this could be a detailed assessment or a screening tool
  - Psychiatric Diagnostic Interview examination, 90801 and 90802 completed by prescriber or a licensed clinician

1. Trainer Note: Check the policy of your agency as to what types of assessments are required or commonly done. In addition to the intake assessment there may be case management assessments, risk assessments, vocational assessments, psychological testing or any of a number of other types of assessments.

2. 90801 and 90802 and H0031 are billing codes for assessments. The trainer should review these codes in the coding manual in order to familiarize themselves. These codes are generally used to bill for the bio-psycho-social assessments and for the psychiatric assessments. These codes should not be used to bill for psychotherapy of any kind.

3. Functional assessments and case management assessments are usually billed as the service itself – e.g. billed as case management or skill building or psychiatric rehabilitation. Vocational assessment are usually billed as supported employment. That is because these codes include the assessment within their definition of the services.

Assessments

- Other assessments that ***may*** be completed to determine an Individual's needs within each episode of care
  - Functional Assessment: usually completed as part of rehab service- no separate code
  - Case Management Assessment: usually completed as part of case management service- no separate code
  - Vocational assessment: usually completed as a part of supported employment services – no separate code

1. Assessment is an integral part of treatment and the issues and strategies for treatment should flow out of the results of the assessments. A person reading the chart should be able to see that because issue A and strength B were identified in the assessments goal C and strategy/intervention D appear on the treatment plan. Treatment begins with assessment.

Copyright Mary Thornton & Associates and NWBCC

The Mental Health Assessment

- Usually the first piece of documentation in the record (with the exception of crisis services)
- Should be completed before the individual begins treatment and on-going services are provided
- Includes targeted treatment needs
- Includes diagnoses (complete five axes)

The mental health assessment answers the crucial question of why the person is coming in for services. What does the individual want to get out of treatment?

All payer sources will require a diagnosis. The H0031 definition has been changed in a new version of the Coding Manual. The diagnosis and an MSE are optional. If these two pieces of the assessment are not completed, a licensed professional should complete them and add their signature to the assessment document.

Provisional and rule out diagnoses should be changed as treament progresses. Diagnoses must be in the format of the current Diagnostic and Statistical Manual of Mental Disorders (DSM). This manual is revised every few years.

Please note that because a diagnosis appears in the DSM does not guarantee that it is a covered diagnosis. That will depend on the payer source. For example, developmental disability diagnoses are not covered under mental health Medicaid in Colorado as a primary diagnosis.

Mental Health Assessment

- To be completed prior to the development of the treatment plan
- The treatment plan based on this assessment must be completed according to agency policy and payer rules
- The assessment and treatment plan must be reviewed semi-annually
- Dated signature of provider is required – no backdating is allowed

At the time the assessment is completed it should contain a “temporary” treatment plan to cover the services to be provided between the time of the assessment and the time the initial treatment plan is completed. DBH rule is 10 days from the assessment and HCPF rule is 30 days for treatment plan to be completed. Check your agency’s policy on this. Sometimes agencies are having the initial treatment plan completed at the time of the assessment.

The treatment plan and the assessment must be reviewed every six months or more often if circumstances warrant. If new issues are identified or priorities change, the treatment plan should change. In an audit, payment for services may be questioned if the issues addressed in the sessions are not reflected the treatment plan (The Golden Thread is broken!). This is true even if the type of intervention, e.g. individual therapy is ordered in the plan. If an issue not on the plan is addressed, the progress note should contain information on why it was being addressed and whether or not it needs to be added to the treatment plan.

Check your agencies policies on who must sign the treatment plan. Some agencies require a licensed clinician’s signature and others may require an MD’s signature. A treatment plan that is not signed by the appropriate professional is like a prescription that is not signed by the doctor. It is not valid.

Copyright Mary Thornton & Associates and NWBCC

Major Elements of the Assessment

- Presenting Problem
  - *Reason for coming to treatment (Why Now?)*
  - *Comprehensive, chronological story of what has happened that led to seeking treatment.*
- Data Gathering
  - *Should be only pertinent information and should emphasize most recent information*
  - *Should be gathered and documented in such a way that it provides useful information*
- Mental Status/Risk Assessment
- Clinical Formulation
- See coding manual description

Each agency may have their own form for assessments. However, they all should contain the common elements listed above. The persons completing assessments need to be qualified to do so. Assessments involve not just gathering information but analyzing it as well.

The essential question is, "Why is the individual here for treatment NOW?" Do they have a mental illness that can be helped by the community based system? What is their level of commitment to treatment? What does the individual want to get out of treatment? It is helpful to use the individual's own words for a part of the presenting problems though these may need to be modified when it comes to writing goals and objectives. The way in which the individual states what they want may not be in objective or measurable form. It is the service providers task to reflect the individual's goals in an objective way.

Data gathering should be thorough but relevant. Often individual's have gone through the historical information on multiple occasions with many different people. The focus should be on the current situation and concerns. The information should be relevant to formulating current goals and objectives for the treatment.

The assessment should contain a mental status exam/risk assessment. See example in the training manual appendix of a mini mental status exam and full mental status exam. Your agency may have a specific format for the mental status exm. Risk assessment should always include asking questions about suicidal and homicidal ideation.

State Coding manual definition of assessment (page 41):
"A behavioral health (BH) assessment is an evaluation of a consumer's medical, psychological, psychiatric, and/or
social condition to determine the presence of and/or diagnose a mental illness (MI) and/or substance-related
disorder, and to establish a treatment/service plan for all medically necessary behavioral health (BH) treatment
services."

Presenting Problem and Chief Complaint

- Statement from the individual as to the nature of the problem – chief complaint
- The reason for seeking services now- history of the present illness
  - This should include information about when the problem started, how it progressed, situations in which it is worse, self-help that has been tried, what has worked in past if this is a recurrence, major symptoms, significant impact on the person's life, impact on ability to function

Record in the individual's own words why they are seeking treatment now.

Description from state coding manual:
"The MHP (mental health professioanl) interviews the consumer in a culturally and age-relevant
initial diagnostic examination, which includes taking the consumer's
history and assessing his/her mental status, as well as disposition. The
MHP may spend time communicating with family, friends, co-workers,
or other sources as part of this examination, and may even perform
the diagnostic interview on the consumer through other informative
sources. Laboratory or other medical diagnostic studies and their
interpretation are also included, within the scope of practice of the
MHP"

Minimum documentaiton requirements from the state coding manual include:

"● Date of service (DOS)
● Consumer demographic information
● Chief complaint(s), presenting problem(s) and duration, reason(s)
for diagnostic interview
● Referral source"

More on Presenting Problem and Chief Complaint

- Under what circumstances does the presenting problem occur?
- When did it start?
- When was the last time the individual was free of this problem?
- With whom does the problem occur?
- What makes it go away or diminish?

The individual may need some prompting to help them realize the problem/symptoms are not always present or are less in certain situations, times of day, locations, etc.

The individual may relate the problem to a specific incident or the problem may have worsened gradually. There may not be a specific date when the problem started but some type of time frame is helpful. Has the problem been there for a year, ten years, a few months?

The problem may occur with everyone or just with certain people. The problem may occur more often or more seriosuly with certain people.

It is important not to discourage openess about what helps. The individual may list some less than desirable strategies such as drinking alcohol or fighting. At this point we are just gathering information that may give us insight into the problem and the individual.

Data Gathering

- <u>Relevant</u> Treatment History
- Cultural assessment and impact on treatment options, treatment acceptance, etc.

There is no need to dig up past trauma or issues if they are not related to the present problem or have been thoroughly worked through in previous treatment.

Cultural awareness and issues have been heavily emphasized in recent audits. Sometimes interviewers are reluctant to discuss these issues. It is OK to explain to the individual that we are obliged to conduct treatment in a way that takes into account their culture and background. Ask if they identify wth a certain culture even though it may not be obvious from their appearance. There is a cultural assessment example in the manual's appendix.

Data Gathering

- Family history: relevant medical and psychiatric
- Educational history: relevant client history
- Relevant medical background: more emphasis on current issues that may be relevant to diagnosis/TX
- Employment/Vocational history: relevant client history; indication of periods of stability or reduced symptoms; indication of functional baseline

The coding manual lists area of inquiry. However, make sure you are writing down only what is relevant.

Check your agency's requirements. Your electronic health record system will dictate fields that must be completed which should include the elements on this slide.

More Data Gathering…

- Psychological/psychiatric treatment history (should also include substance abuse treatment history as well): length of time client has been ill; should include client assessment of outcomes and length, if any, of period of stability; should also include client assessment of their compliance with treatment

- Military service history: indication of periods of stability or baseline functioning; may be relevant diagnostically

Data Gathering

- Legal history: emphasis on current history
- Alcohol/Drug use history: emphasis on current use or patterns; assessment of level of risk if currently in recovery
- Mental status examination: should be complete and completed by trained professional
- A description/summary of the significant problems that the client experiences: list of current problems and their impact on client or how the current problems are evidenced

Continuation of elements that should be included in the assessment

Medical Issues

- Date of last physical exam
  - Refer if not recent
- Ask the individual if their Primary Care Physician (PCP) can be contacted
- Coordination with medical care providers

With the advent of the Patient Protection and Affordable Care Act (PPACA) in 2010 the need to integrate all health care services, including behavioral health, into one coordinated, coherent package came to the forefront. We are health care providers just as other medical specialties are. Many referrals come from PCP's and we need to coordinate the care we give with the other health care issues that are going on in the individual's life. This is especially true in the case of medications that may be prescribed.

The PCP and behavioral health prescriber need to be aware of all medications as some medications may interact with others. For anyone with complicated medical problems consider referral to a case manager.

Auditors will increasingly be concerned with the level of coordination with physical health providers.

Risk Assessment

- Usually considered to be an addendum to the Mental Status Exam
- Considers: suicide, homicide, self- harm, harm to others, grave disability, etc.
- Should only be completed by those with proper credentials, training, and experience

The examiner should ask direct and pointed questions such as; "Are you having any thoughts of suicide or harming yourself?" "Have you ever made a suicide or self harm attempt?" "Are you having any thoughts of harming other people?" If so, "Who?" "Have you thought about how you might harm yourself/others?"

If you are completing a risk assessment and there are positive answers to any of the questions, consider consulting with a licensed professional about planning for this individual.

Explain proper credentials according to your particular agencies policies; i.e. does your agency require crisis/risk assessments be completed by a licensed clincian?

Mental Status Exam

- This is a required portion of the assessment
- Must be accurate and complete
- Only completed by those with proper credentials, training and experience
- See handout on Mental Status Exam in the Appendix

Explain proper credentials: May vary by agency but basicaly a licensed mental health provider or someone with master's level training.

Trainer note: Appendix of the training manual has a sample mini mental status exam and full mental status exam. Check if your agency has a specific format for the mental status exam.

State coding manual description of a mental status exam:

"Complete mental status exam – presentation/ appearance, attitude toward examiner, affect and mood, speech, intellectual/cognitive functioning, thought process/content, insight, judgment, high risk factors (danger to self/others)"

Copyright Mary Thornton & Associates and NWBCC

Identifying Needs

- One of the primary outcomes of all assessments is identification of needs, concerns, deficits, behaviors or other issues that may need to be addressed in the treatment episode
- Some issues may need to be addressed in subsequent levels of care
- The individual and provider may disagree about what is a priority issue and can defer the issue for future discussion (always leave the door open)

Treatment should be viewed through the lens of episodes. What needs to be addressed for this episode of care? Not every issue will be addressed currently (or ever) so a collaborative approach should be taken to determine what will be the focus of care. If issues are deferred, they should be documented as deferred along with the rationale for deferring the issue at this time.

Copyright Mary Thornton & Associates and NWBCC

Identifying Symptoms/ Behaviors/ Problems with Functioning

- ***The needs should be targeted, focused, prioritized and relevant to the individual's goals***
- ***They will be matched to services in the continuum of care***
  - ***Symptoms matched to treatment services***
  - ***Problems with functioning matched to rehab and recovery services***
  - ***Problems with accessing services and supports matched with case management services***

Be sure to match the issues correctly with the approach in addressing the issues.

Symptoms and Problems with Functioning

- Both symptoms and functional deficits should be supported by behavior and reports from the individual

- *"As evidenced by…"*

i.e. 'client is depressed' does not adequately describe what is needed. 'client is depressed *as evidenced by* flat affect, sad mood most of the day, reports of loss of interest in all activities, hypersomnia, and reports of feelings of worthlessness' provides specific context to this client's presentation.

Symptoms

- *Name specific symptoms as they apply to the individual:*
  - *sadness, as evidenced by flat affect, tearful*
  - *sleep problems, as evidenced by pm and am insomnia*
  - *loss of appetite, as evidenced by, lost 10 pounds*
  - *no energy, as evidenced by, lays on the couch all day*

Symptom Focus

- Client is not able to sleep more than 2 hours at a time without waking. She is sometimes able to fall back into a troubled sleep, but often lays awake and anxious.
- Client has not been attending more than one day per week of school. Her mom says she claims her stomach aches and get considerably distressed if the mom tries to insist she get dressed.
- Client admits to hearing voices. Started last week when she stopped taking her meds. Voices described as “mean and yelling.”

See Chapter 5 of the Training Manual “Symptom and Problem List”

Problems with Functioning

- ***Name specific problems as they apply to the individual and the needs behind them:***
  - ***Limited social skills, as evidenced by impaired ability to relate to others, especially her children. Needs to learn appropriate conversation skills.***
  - ***ADL improvement needed as evidenced by wearing clean clothing everyday, bathing each day, brushing teeth twice a day.***
  - ***Parenting issues, as evidenced by inability to set appropriate limits for children. She needs to be persistent in enforcing household rules.***

Be sure to differentiate between symptoms and functional needs.

Functional Focus

- Client is not able to manage her medications and needs to understand their purpose and state their major side effects.
- Client understands hallucinations and paranoia are a result of her MI. She needs to clearly understand her diagnosis and articulate the impact of illness on ability to maintain community independence.
- Client would like to work and will obtain competitive employment as a waiter over the next 90 days and maintain that employment for 60 days.

Remind staff that this is the tx focus but that we MUST include a measurable component to these statements when they are adding them as objectives to the tx plan.

Case Management Needs

- **Case Management can be in a clinic, in the community, or in the form of intensive case management but have the same overall definition of:**

  It is NOT the direct delivery of services but is the activities we do to LINK a client to needed services through assessing, treatment planning, referral, and monitoring of the treatment plan effectiveness.

From the Medicaid manual Chapter 4, 4302 A: Case management is an activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual.

Three types: Clinic Based (usually by the therapist), Community Based (usually more intense and involving multiple systems), Intensive Case Management (more than one hour per week)

Case Management is NOT the direct delivery of services but is the activities we do to LINK a client to needed services through 1. assessing, 2. tx planning, 3. referral and 4. monitoring of the tx plan effectiveness.

Three types: Clinic Based (usually by the therapist), Community Based (usually more intense and involving multiple systems), Intensive Case Management (more than one hour per week)

Case Management: Services and Support Focus

- Client is in need of multiple services to assist with location and maintenance of a living environment. She is currently homeless. Will link client to at least 2 needed services.
- Mom states she has been unable to get her daughter (the client) in to see a neurologist as recommended by the child's pediatrician and needs linkage to this service.
- Client has no friends or family in the community and no idea what opportunities for her to socialize may exist. Needs linkage to socialization resources.

Remind staff that this is the tx focus but that we MUST include a measurable component to these statements when they are adding them as objectives to the tx plan.

Conceptualization/Formulation: Analyze the Data

- Don't just summarize, **analyze the data**
- What are the individual's goals, in their own words, and commitment to treatment (able and willing)

1. Case conceptualization is a summary of the data with an emphasis on key areas of focus as reflected by the data gathered as well as clinical presentation. It is not the interpretation of data based on a clinical model. i.e. you would not provide psychoanalytic interpretations to the information provided in a formulation.

Diagnosis and Rationale

- Diagnosis and symptoms or behaviors that support the diagnosis
  - List of rule outs and strategy for gathering additional assessment or diagnostic information

There needs to be symptoms and behaviors noted that meet all the required elements of a diagnosis in the DSM. i.e. the client presenting with flat affect does not automatically mean they have a major depressive episode. All required criteria for that diagnosis must be present and noted.

See examples or vignettes.

Conceptualization/Formulation: Analyze the Data (cont)

- **Prioritized problem/needs:** what will be addressed or deferred at the current level of care or during the initial stages of treatment
  - *Symptoms and/or behaviors*
  - *Functional or skill deficits*
  - *Services and supports that require referral*

High risk areas should be addressed first. Note: should address major areas of the continuum of care: case management needs, treatment needs, and rehab needs.

Copyright Mary Thornton & Associates and NWBCC

Conceptualization/Formulation: Analyze the Data (cont)

- Description of clinician's decision making process for level of care, treatment priorities and anticipated duration of treatment
- Individual strengths, cultural factors, and supports that will be used in treatment or will support treatment

1. Documentation is not just a report-out of what the client stated although those elements should be included. It should demonstrate that the clinician thought about what was stated as evidenced by the tying of data to decisions priorities. This is called medical decision-making.
2. Strength based treatment should incorporate the client's intrinsic and extrinsic strengths into the approach to treatment.
3. The cultural issues that impact treatment options and treatment strategies should be discussed here as well.

Treatment Recommendations

- The initial assessment should also include recommendations for the services, including additional assessment services, that will need to be provided between the initial encounter and the development of the first comprehensive treatment plan
- Providers use different formats and have different requirements for how these are done, what they include and how formal they must be

Trainer: describe your agency's policy

Specialty Assessments

- May be used for designing specialty service plans, if needed, to gather additional data for diagnosing, etc
- Examples include:
  - Case Management
  - Functional
  - Vocational

Specialty Assessments

- Case management assessment that looks at:
  - How is lack of access to certain services and supports impacting client? (Medical necessity)
  - What is the severity of the impact? (Medical necessity)
  - Who else is or could help the client? (Medicaid must be payer of last resort)
  - What is the priority for accessing these services and supports? (Should be based on some method)
  - What type of help will the client need to help them access services and supports?
    - Referral and advocacy related activities

Specialty assessments are center based. Check your center's policies on specialty assessments.

Specialty Assessments

- Functional
  - Additional and specific assessment that looks at:
    - Specific functional areas that have been impacted by the client's mental illness
    - Determines the level of the functional deficit
    - Prioritizes the need for rehabilitation (skill building) services

Treatment Planning

- Must be completed with the Individual within a period of time determined by your agency's policy
- Documentation of the treatment planning process includes the treatment plan AND a progress note describing as your agency requires:
  - Description of the development of the plan
  - Who was there
  - Individual's level of participation/family involvement – critical for children
  - Outcomes: plan completed, goals set, etc.

Trainer: 10 days is Department of Behavioral Health guideline and some agencies use 30 days (HCPF) or other criteria. Know your agency's policy.

Note: the progress note is needed to describe the service (treatment planning) for billing purposes

Content of the Treatment Plan

- Must flow from the mental health assessment
- Must address current prioritized problems/needs
- Must describe treatment goal(s) and objectives that address prioritized problem areas preventing the individual from reaching their recovery goal
  - If applicable includes strengths/cultural factors
  - If applicable includes client language
  - Measurable, objective, and achievable
  - Focused on the desired outcome, not the treatment intervention
- **Remember the golden thread**

Treatment Plan Discharge Criteria

- Need to be thinking about discharge the day the individual enters treatment
  - 'How will we know when we're done with treatment?' or 'I know I'm ready for discharge when…'
  - Presents an environment of hope
  - Person centered approaches important here
- Not everyone will be discharged
  - Example: Individuals on long term medications
  - Treatment plan will change to reflect current status

Copyright Mary Thornton & Associates and NWBCC

Treatment Goals

- Must relate directly to the diagnosis and the presenting problem
- Describe the realization of a clinical outcome
  - Individual's Goal: "I want to move into my own apartment."
  - Treatment Goal: The Individual will be able to manage their symptoms and develop the social skills necessary for managing independent living.

The language will vary depending on your organization. Your agency may label a goal as a discharge goal or may label a goal as a life goal. Goals should be recovery oriented and emphasize using strengths and resources of the individual.

Remember that it is important for an auditor to understand how the treatment goal relates to the mental health system and its capacity to help the individual.

Medical necessity requires that the treatment be specific and effective for a diagnosis (es). So the goal of I want to move into my own apartment has to be explained as a issue the mental health system can help with. For this individual it may be symptoms, problems with skills, inability to manage medication or other reasons why they are not able to manage this. The reasons should relate to their mental illness.

Think of your own health insurance would they pay for you to go to the doctor in order to get your own apartment? If not why not? If so, under what circumstances?

Treatment Goals

- Usual content of a treatment goal:
  - Behavioral description of what the individual will be, achieve in measurable terms
    - Do, finish, keep, stay in, live in, be successful at, develop
  - Within what environment
  - Within what time frame

You should be able to observe or confirm achievement in some way. This can be through others reporting, the individual reporting or actual observation – or in the case of a change in attitude or beliefs that impact positive actions –the thinking should be able to be described.

"Individual will be able to recognize when their anger is escalating and they need to remove themselves from a situation." You can't see it but the Individual can explain it to you.

Copyright Mary Thornton & Associates and NWBCC

Developing a Treatment Strategy

- Steps, services, and modalities for reaching goals
  - Does the strategy flow logically from the goals and objectives?
  - Can you articulate it?

This should also be developed/agreed upon collaboratively with the client.

1. To go from goals to objectives, there needs to be a strategy. The next step of the treatment planning process is to work with the Individual to develop strategy. Once decided, this strategy should help in the definition of objectives which are the steps needed to achieve the treatment goal(s).
2. For common treatment strategies –see below:
   - •Maslow’s Hierarchy: use this as an example of how to prioritize or develop objectives. E.g. first steps are to stabilize basic needs, then look at safety issues, etc.
   - • Stages of Change: use this example to discuss how you move from cognitive objectives (Objectives = steps towards the recovery and treatment goals) to behavioral objectives.

5. Suggest trainer: discuss re: other common strategies.

Developing Objectives

The objectives are the measureable steps by which the client is working to achieve their discharge goal

- 2 or 3 at most for each goal
- Steps or benchmarks that will indicate progress towards the goal

1. Auditors are looking for incremental measures for success of an objective. Make sure the objective is measurable towards desired outcomes.
2. The goals lay out the outcomes of treatment. The objectives begin to articulate the treatment strategy because those are the short term outcomes that will tell you and Individual that moving towards their goal.
3. Objectives add to the Individuality of the plan. Should be able to look at the treatment plan and know who it is built for because it is so individualized.
4. See objectives as successes for the Individual and you! Cross them out and move on to the next ones.
5. Always be forward thinking. Individual should be able to recognize forward movement to fuel motivation.

Objectives

- Objectives are developed collaboratively with the client
  - Objectives must incorporate strengths and cultural factors
  - Measurable and observable statement of potential progress towards goals

1. What will be different if treatment works and I am gaining on my goals?
2. How much would something that is happening now have to be reduced for me to know that treatment is working?
3. Think in terms of a road map. It should be clear to Individual and to the treatment team.
4. Should not be trivial. Make them significant achievements even if not “big” steps.

Objectives

- The usual content of the objective
  - Identify the measure that will be used to determine if/when the Individual is moving towards their goal – short term steps
  - Measurable—Individual will be able to: as evidenced by an observable behavioral change, times per week, every time, etc.
  - Within a time frame

1. Objectives should be realistic
2. Always identify the strengths that they can use to reach objectives.
3. Stay away from percentages if you can because very hard to measure
4. The objectives can describe changes in behavior as well as attitude/understanding (cognitive changes).

Building Intervention Statements Including Modality

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

- **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
- **Modality**: enter the type of treatment and a reason for it

1. These describe the interventions and are often overlooked in treatment/care planning.
2. The more detailed the interventions, the less likely the provider will lose focus in the treatment process. Interventions help set agenda’s for meetings.

Interventions Based on Service Type: Individual Therapy

- The Staff Member will:
  - Use CBT to assist individual in identifying relapse triggers 1x/week for 6 months
  - 1x/week for the next 6 weeks teach the individual self-calming techniques to use during high stress activities through discussion, modeling and role-play

Examples: for Skill Building:

The staff member will meet with the Individual:

On a weekly basis for 1 hour in individual sessions teach the Individual the basic steps for managing a checking account to increase financial independence

On a bi-weekly basis for ½ hour face to face with the Individual in individual sessions to develop with the Individual a reminder card for taking her medications

Examples: for case management:

Meet with Individual weekly to evaluate progress with plan implementation

Meet bi-weekly with Individual to develop schedule for appointments

Meet monthly with Individual and family to evaluate progress in getting school to agree to ISP and determine what other services may be needed in interim.

1. Detail assists with focus.
2. Intervention statements should be related to the outcomes listed in the objectives. What skilled interventions will be used to assist the Individual in reaching objectives.

Treatment Plans in Colorado

- Must include: (remember to include the details)
  - Diagnoses
  - P-G-O-I (or some variation on these themes)
    - Problem
    - Goal
    - Objective
    - Intervention
  - Individual signature of client
  - Provider(s) signature(s)
  - Signature of Licensed Practitioner of Healing Arts

1. See Chapter 5 in training manual for more information
2. Remember: having lots of goals and objectives make it difficult to track progress; difficult to implement the whole plan (how much can you really accomplish in a three month period); hard to stay focused.
3. Remember: if you provide a service not ordered on the plan then you cannot bill for it. This does not mean that the treatment plan should be increased to cover any possible subject or situation, but rather that the provider needs to be able to help the Individual focus and to stay on the track.
4. Remember: Treatment plans must be individualized.
5. Remember: there is no treatment plan until the last required signature, with date of signature, is on the plan.

Copyright Mary Thornton & Associates and NWBCC

Treatment Plan Review

- Further guidance will be coming about treatment plans and reviews regarding signatures and timing
- Review every 6 months or based on payer
- Do not need to rewrite the treatment plan unless the treatment plan is changing
  - **If there is progress: Should treatment strategy change? Why or why not?**
  - **If there is no progress: Should the treatment strategy change? Why or why not?**

1. How you update the treatment plan will vary from center to center based on your protocol.
2. Suggest: Ask participants under what circumstance would a review need to be completed sooner than required?
3. Suggest discuss: What if Individual has achieved an objective early? Medicaid will not pay you for something you have already achieved.
4. Remind attendees that this document is an analysis of the effectiveness of the treatment strategy, a reevaluation of the Individual's commitment to treatment and relevancy of goals, and a discussion of their progress or lack of progress and how the treatment strategy will be modified (if at all) to respond to this.

Documentation of Individual Services MUST Include:

- What mental health condition or deficit is being treated (component 1)
- Connection to goals/objectives from treatment plan (component 2 and 6)
- Description of the intervention/service you provided and how or why it is appropriate (generally accepted as effective) to this individual (component 3)
- The individual's response to the intervention, their level of participation and the strategy for assessing effectiveness of services and planning for future care. (components 4 and 5)

PROGRESS NOTES ARE IMPORTANT BECAUSE THEY BACK UP SPECIFIC CLAIMS/ENCOUNTERS

1. Refers back to slide 24, the six components of medical necessity. Trainer can also refer to Chapter Five of the manual.
2. Note that the

Progress Notes

- Provide evidence a covered service was provided
- Provide evidence of the Individual's continuing commitment to treatment through active participation
- Revisit the estimated discharge date and discharge criteria for level of care in order to gauge progress
- Measures progress against the recovery/treatment goals
- Address objectives and progress towards meeting objectives as a means of measuring progress

Copyright Mary Thornton & Associates and NWBCC

Progress Note Content

- List the goal and/or objective from treatment plan that was the primary focus of intervention
- State the specific service provided
- Document the location of the service – be specific
- The start and end time of the visit

1. The progress note should be able to be easily linked to a service and a service focus ordered on the treament plan. The easiest way to guide the auditor or reader to the goal or objective that is the focus of the service is to actually list it on the note.
2. Usually because the objectives are shorter term and more specific it is easier to understand how a particular service links to an objective rather than a longer term goal. Suggest attendees use objectives not goals on treatment plans.
3. Be specific. Services are supposed to be focused. An auditor would have a difficult time believing that a provider could target more than 1-2 objectives in a treatment session.
4. The start and end time are used by Medicaid for a number of purposes, e.g. looking for duplicate services, determining if correct numbers of units are billed, judging whether or not an excessive service was provided (e.g. individual therapy of 90 minutes), etc. Suggest: explain agency rules for how time recorded, e.g. do you allowing rounding? How specific must the provider be? How does the agency look for duplicate services.
5. Remind providers that the start time is when the service actually begins, not when it was scheduled. They cannot bill for time they spend waiting if the Individual is late.

Progress Note Content

- State the reason for the visit: establish medical necessity
- List the interventions and describe specifically the techniques you used in the session to get the clinical outcomes you were looking for
  - Should be specific to the type of service being provided

1. Reason for visit: should not be just listed as “follow-up” but e.g. to continue working on _______; to continue exploring _________: to evaluate the use of a coping skill (list skill). If the provider had listed on the progress note for the previous session, the plan for the next time, this can be used to describe the reason for the visit. This should tie to the treatment plan.
2. See manual for examples of interventions. Remind attendees that without interventions, the payer cannot determine if an actual service was provided and what that service was.

Progress Note Content (cont.)

- Document the Individual's response to the interventions. This may include:
  - Level and type of participation
  - 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, refuse to participate, resist, etc.

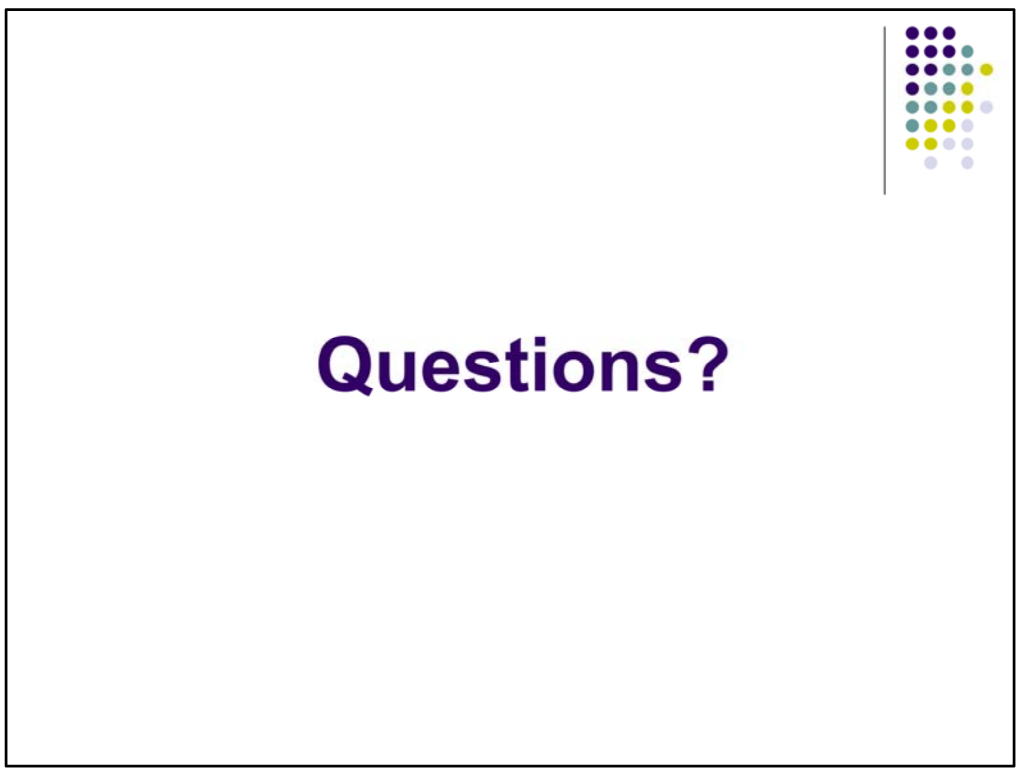
1. Observing and documenting the Individual's response to the skilled interventions should help the provider determine if the strategy they used was helpful, successful, not successful, neutral, should be used again, should be used differently, etc. They should keep these observations in mind when documenting the plan for the next visit.
2. The auditor will review the response to determine if:
   - there was active participation
   - If the Individual could participate (were they responding to hallucinations, fall asleep, not able to stay on task, etc.)
   - If the clinical strategy is being used and is appropriate

Progress Note Content

- Statement of Individual's progress and plan
  - State progress in relationship to objectives or goals
  - Homework or other tasks to complete before the next visit
  - Plan for next visit or visits – consider your observations about the Individual's response to your interventions
  - Agency specific requirements
    - GAF/CGAS
    - Other requirements

1. There does not need to be progress each time. But over time the payer either expects progress or expects the clinical strategy to change.
2. Best practice is to consult with the Individual. How do they feel about their progress? Do the provider and Individual agree on progress? Could be an interesting discussion and person-centered!

Copyright Mary Thornton & Associates and NWBCC


Questions?

OH, Golden Thread!

OH, Golden Thread, OH, Golden Thread

- You keep us out of payback!
- You keep the cash flowing in
- You keep the Centers open

OH, Golden Thread, OH, Golden Thread

You keep us out of payback!