

Chapter I: Introduction and Key Concepts

1. **Introduction to the Colorado Project** – The Colorado Committee for Quality and Compliance (CCQC) is a comprehensive project designed to make Medicaid and Medicare coding, documentation, and compliance easier and more transparent for both provider agencies and Behavioral Health Organizations (BHOs). The Committee is led by mental health center members of the Colorado Behavioral Healthcare Council (CBHC) and the BHOs in contract with Mary Thornton & Associates.
2. **Project Origin and Purpose** – Over the last few years Federal and State oversight agencies have been increasing their focus on reducing fraud, abuse, waste, and improper Medicare and Medicaid claims. With healthcare reform we can only expect this trend to continue. In order for mental health centers and BHO's to understand the challenges and opportunities facing behavioral health in this climate as they strive to balance quality and compliance the CCQC was created.
3. **Goals and Objectives** – The goals of the CCQC are to increase education and understanding of the current enforcement environment, differentiate the types of risks providers are facing, educate providers on the range of risks associated with different types of programs, and to provide solutions. Concrete trainings on compliance, documentation, and high risk areas will be developed and delivered. Trainers from each mental health center will work with the Committee to become experts in these areas so that they can educate all staff in their respective agencies on an ongoing basis. A documentation manual will be developed that includes references for specific regulations affecting the provision of behavioral health services. The Uniform Service Coding Manual will be reviewed and revised to more closely align with Healthcare Policy & Financing's expectations.
4. **Key Concepts** – It is important to understand the key concepts that provide the foundation for the goals of the Colorado Project. Integrating these concepts into the culture of your Community Mental Health Centers (CMHC) is critical to the success of the project as they align with the expectations oversight agencies have on the work provided by the organization. Auditors are looking for evidence of organizational implementation and integration of necessary standards which are based in the important ideas communicated through these concepts.
 - A. **Compliance** – The term 'Compliance' is associated with both an expectation and a program.
 1. Expectation - As an expectation, Compliance refers to the adherence to established standards or requirements established by outside entities. These standards may be driven by state and federal law, specific contract requirements, and accrediting agencies with which a CMHC is involved. Depending on the oversight agency, these expectations may involve a broad array of topics that cover all aspects of an organization including but not limited to leadership, clinical/medical, billing, information technology, human

resources, medical records, quality, and facilities. The CMHC must be aware of the various expectations and implement the necessary processes and protocols to ensure these expectations are being met.

2. **Program** – The federal Office of the Inspector General (OIG) requires that agencies providing health care services using federal dollars such as Medicaid or Medicare have a formal Compliance Program that over sees the agency’s activities as it relates to the use of those dollars for services. The OIG requires that the program be based on seven elements identified in the Federal Sentencing Guidelines. These elements include standards and procedures, oversight, education and training, monitoring and auditing, reporting, enforcement and discipline, and response and prevention. It is imperative that the CMHC has a program established that demonstrates these elements are in place and are an active part of evaluation of the use of federal healthcare dollars.

B. Improper Payments – Improper Payments can be a result of fraud and abuse or errors. *An auditor is not concerned with the reason for an inaccuracy (purposeful or by mistake) but that services are rendered, recorded, and billed accurately. Penalties for inaccuracies will be present regardless of the reason.*

1. **Fraud and Abuse** – When a provider is purposefully/willfully making a decision that is not in alignment with proper service delivery, documentation, or billing practices, this would constitute fraud and abuse. Some examples of fraud and abuse may include but are not limited to; recording more time spent in a session than actually occurred; offering services that are not medically necessary to generate revenue; billing for a more expensive service than was actually rendered; or billing for services that never occurred.
2. **Errors** – When a provider inadvertently makes a mistake in the service delivery, documentation, or billing. Some examples of errors may include but are not limited to; selecting the incorrect service type for the service rendered; not referencing the treatment plan goals or objectives the individual is working on in the session; or selecting the incorrect time for the service.

C. Clinical Documentation – It is imperative that there is thorough documentation available that describes and demonstrates the services an individual receives. *The only way an auditor can evaluate the quality and accuracy of the service rendered is by what was written and billed to support the service.* Excellent clinical work will not be known to an auditor unless he or she can read the information that demonstrates that excellence.

Clinical documentation must include the following elements:

1. Assessment – a thorough assessment of the individual’s presenting issues must be documented in the record. The assessment includes numerous mandatory elements that are referenced later in this manual. Unless the individual’s clinical needs are clearly identified, treatment the individual will receive may be compromised.
2. Treatment Plan – the treatment plan is the crux of the documentation requirements. The treatment plan is a “living” document that drives the individual’s services and gives clear direction to the course of treatment. It is living because it changes with the changing needs of the individual. As the individual resolves issues or new issues are identified, the treatment plan should be updated to reflect these changes. The treatment plan specifies the Goals and Objectives an individual has in treatment as well as the Interventions the clinician will be using to assist that individual meet those Goals and Objectives.
3. Progress Notes – Progress notes provide snapshots of treatment progress at points in time. The progress notes reflect the progress the individual is making towards the identified treatment Goals and Objectives. Each CMHC will have required elements that are needed in the Progress notes based on the format adopted by that agency.
4. Treatment Plan Reviews – various oversight agencies require that treatment plans are reviewed periodically to ensure they accurately reflect current treatment focus as evidenced by accurate Goals and Objectives. Because of the critical role Treatment Plans play in the treatment of individuals, maintaining a current Treatment Plan is imperative to maintaining current treatment direction and focus.
5. Assessment Update – like treatment plans, various oversight agencies require that assessments are updated periodically to ensure a formal review of current clinical presentation. The Assessment Update provides a review of the presenting issues the individual has after having received treatment, therefore ensuring the individual is receiving treatment for those identified issues.

D. Medical Necessity – the State of Colorado defines Medical Necessity as; “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 individual’s needs.”

There are 7 key elements that demonstrate Medical Necessity for services.

1. It treats a **mental health condition/illness or functional deficits** that are the result of the mental illness. These would not include issues such as normal developmental milestones or other issues unrelated to a mental illness.
2. It has been **ordered or prescribed**. This speaks to the importance of the treatment plan; the treatment plan would support the specified interventions necessary to treat the identified mental health issues.
3. The service should be **generally accepted as effective** for the mental illness being treated. Ensuring the use of current practices, particularly Evidences Based Practices which have research support behind them, is essential. Unproven or controversial approaches introduce risk into the treatment process and should be avoided.
4. The individual must **participate** in treatment. If an individual is not active in treatment or not following through on treatment recommendations, it is difficult to justify continued medical necessity since the impact of treatment interventions cannot be assessed.
5. The individual must be **able to benefit** from the service being provided. Services must be offered to match the developmental and cognitive level of functioning of those being served. The efficacy of the type of service offered also plays a role in the benefit an individual may have from that service.
6. It must be a **covered service**. Services are only considered covered based on the contractual and regulatory delineations that identify the service as covered.
7. It must be an **active treatment focus**. The focus of treatment must be maintained in relation to the treatment needs. Again, treatment plan driven services would ensure that what is being offered to the individual has been identified as the areas of growth necessary for that individual to be successful. Focusing on issues not identified as critical to treatment success may be detrimental to the success of that individual and would make the support of medical necessity difficult to justify.

E. **The “Golden Thread”** – The Golden Thread is a term that references the **tying together** of all the concepts described above. Each piece of documentation must flow logically from one to another such that someone reviewing the record can see the logic.

1. The assessment must identify the critical clinical needs of the individual based on their presentation and history. The assessment paints the picture of the individual as well as their ability to engage in the treatment process.
2. The treatment plan must reflect Goals and Objectives that address the concerns *identified in that assessment*. This is done by the development of measurable, attainable goals and objectives that provide the opportunity for the individual to actively focus on the needs reflected in their assessment in a

targeted manner. The treatment plan must be coherent and cohesive and establish medical necessity.

3. The progress notes must flow from the treatment plan by specifically reflecting progress *towards the identified goals and objectives* and the individual's response to treatment.
4. The progress notes lead to the treatment plan review and update. As treatment unfolds, issues are resolved or new ones are identified. Those changes should be reflected in the *update of the treatment plan which is evidenced in Goals and Objectives that would address current treatment needs*.

Any element done in isolation breaks the Golden Thread and disrupts the logic that should be evident from the documentation of the individual's treatment. This would include but is not limited to; identifying critical clinical issues in the assessment that are not addressed in the treatment plan; developing treatment Goals and Objectives that are not individualized to the individual based on their assessment; documenting clinical activities in the progress notes that are not driven by the specific Goals and Objectives identified in the treatment plan or; failing to update the treatment plan when issues are resolved or new issues are identified.