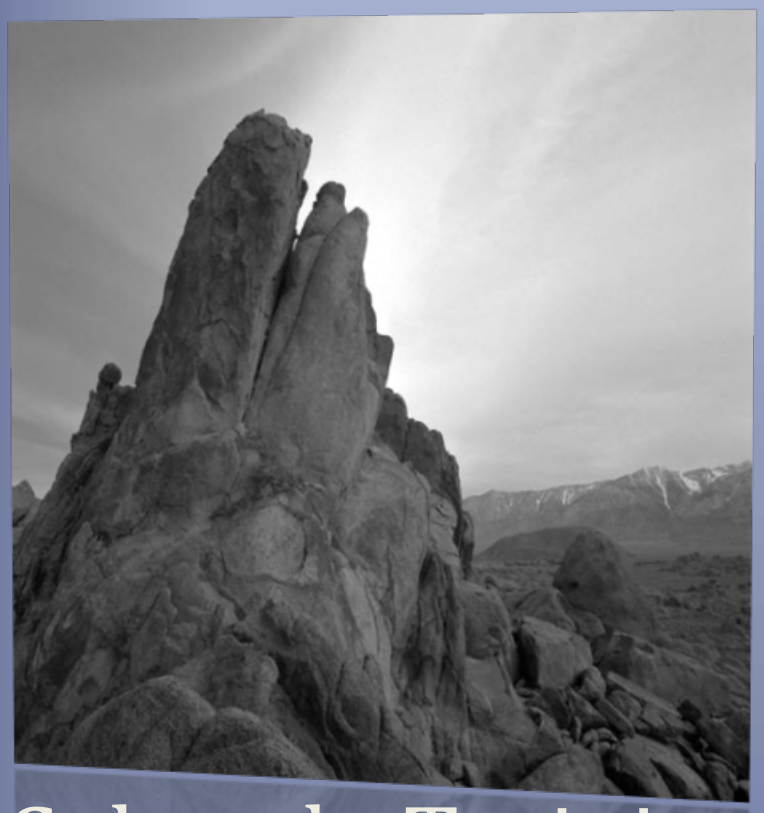

Colorado Training and Reference Manual for Clinicians in Behavioral Health Services

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.

Disclaimer: This manual is not a legal description of all aspects of Medicaid clinical record documentation regulations. It is a practical guide for providers who participate in the Medicaid Program. Guidelines and procedures in this Manual are based on requirements of State and Federal law. Thus the guidelines and procedures are subject to change if the requirements of the law or accrediting organizations change. Where there is conflict between this edition of the Manual and a subsequent notification of a modification to a policy or procedure, the information in the subsequent notification shall prevail.

While this manual contains basic information about the Colorado Community Mental Health Services Program, providers are required to fully understand and apply BHO requirements when administering covered services. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Whilst every effort has been made to ensure that the guidelines in this Manual are correct and in keeping with accepted standards of practice at the time of publication, the authors cannot be held liable or responsible for any errors or omissions, or for any harm or damage resulting from the use of the information contained in this publication.

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Chapter I: Introduction and Key Concepts

The CCQC was created to help balance the quality and compliance objectives of state Medicaid and Medicare providers.

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 members of the Colorado Behavioral Healthcare Council (CBHC) which includes the BHOs and community mental health centers in contract with Mary Thornton & Associates, Inc.

Project Origin and Purpose

Over the last few years Federal and State oversight agencies have increased their focus and funding for activities designed to identify fraud, abuse, and waste in the federal health care programs – Medicare and Medicaid. These activities include a focus on reviewing claims, both before payment and after payment, to see if the claim should have been paid. Improper payments can be caused by problems with the content of the service described in the documentation as well as by the poor quality of the documentation of the service provided. In order for mental health centers, and other providers, as well as, the BHOs to understand the challenges and opportunities facing behavioral health in this climate, the CCQC was created to help balance both quality and compliance objectives.

Please Note – This Document Will Be Frequently Revised & Is Not Meant to Supersede Organizational Policies and Procedures

This is a work on progress - At the time of the preparation of this guide and initial trainings by the CCQC, CMHC, and BHOs in the fall of 2011, this guide was still being updated concerning recommendations for service plan signatures and timelines, some services codes are being tweaked in the Colorado Uniform Coding Manual, and we are waiting for interpretation of other Medicaid regulations. As final decisions are made concerning these items and recommendations are made by the BHOs concerning Medicaid, these will be communicated to providers. The most recent version of this guide will be on **www.cbhc.org** and we encourage providers to stay up-to-date by visiting this site.

Nomenclature – Different providers and provider organizations may refer to documents and forms by different names but they have the same meaning. This guide is not meant to replace or require naming of forms and processes with new names.

Finally, this document does not supersede the policies and procedures of the BHOs or each provider organization, but is meant as a guide for organizations to use to add, delete, or update current policies and to use as a training tool for clinical staff. For example, some Community Mental Health Centers have created an internal billing manual for service documentation purposes and list internal codes to choose from but not the service codes that are referred to as "CPT" or "HCPCS" codes. Because this document refers to the Colorado Uniform Coding Manual, it is not meant to suggest that that is the only guide to use.

Although this document was created to create clarity about Medicaid documentation, it also contains references to the Colorado Division of Behavioral Health (indigent) and Medicare because a client's payer source can change quickly. This guide will help clinicians recognize any needed changes in documentation requirements when this happens.

Key Concepts

Medicare and Medicaid (and health care in general) are big business. National expenditures grew in 2009 to 17.6% of gross domestic product for a total of $2.5 trillion. Medicare in that same year accounted for 20% of health expenditures or $502.3 billion. Medicaid grew 9% to $373.9 billion or 15% of the total. Medicaid costs also represent a significant part of Colorado's annual budget and have expanded rapidly during this period of poor economic growth.

Given the size, scope and costs associated with Medicare and Medicaid it is not surprising that the government closely regulates the services and costs of the program. It is also not surprising that the government has established systems to identify faulty or fraudulent billing practices and have investigators who look for fraud, abuse and waste. Auditors will look for evidence of organizational implementation and integration of necessary standards which are based in the important ideas communicated through these concepts.

Medicare Program

Medicare is a social insurance program administered by the United States government, providing health insurance coverage to people who are aged 65 and over, or who meet other special criteria or are disabled. Medicare operates similar to a single-payer health care system. The Centers for Medicare and Medicaid Services (CMS), a component of the Federal Department of Health and Human Services (HHS), administers Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP).

Many beneficiaries are "dual eligible" meaning they qualify for both Medicare and Medicaid. In those instances, providers should note Medicaid is always the payer of last resort; therefore, services for dual-eligible clients must be billed first to Medicare. Providers must be able to show

evidence that claims for dual eligible clients, where appropriate, have been denied by Medicare prior to submission to Medicaid.

Medicaid Program

Medicaid is the United States health program for people and families with low incomes and minimal or insufficient resources. It is a "means-tested" program that is jointly funded by the state and federal governments and is managed by the states. A means test is a determination of whether an individual or family is eligible for help from the government. Among the groups of people served by Medicaid are certain U.S. citizens and resident aliens, including low-income adults and their children, and people with certain disabilities. Poverty alone does not necessarily qualify someone for Medicaid. Medicaid is the largest source of funding for medical and health-related services for people with limited income in the United States.

Capitation

Capitation is the term used for the payment model the State of Colorado uses to administer most of its community based Medicaid behavioral health services. Basically, in a capitated system, providers are paid a set amount each month for every Medicaid enrolled person assigned to that provider or group of providers, whether or not that person receives care. In return providers are obligated to provide all of the necessary contracted services a member needs and if they are "at risk" the provider would be obligated to continue to provide services even if they cost more than the money the provider is receiving.

Colorado Medicaid Mental Health Services

The Colorado Mental Health Services Program is a statewide managed care program that provides comprehensive mental health services to all Coloradans with Medicaid. In the Mental Health Program Medicaid members are assigned to a capitated Behavioral Health Organization (BHO) based on where they live. BHOs are responsible for arranging or providing for medically necessary mental health services to clients in their service areas. Regardless of which specific geographic BHO a Medicaid beneficiary is assigned to, all BHOs in Colorado share the following requirements for services to clients:

Eligibility: To receive many BHO services, individuals must have a mental health diagnosis that is covered by the program to receive covered services. A list of the covered diagnosis for Colorado is in available at your organization. There are also a variety of service codes available for prevention, early intervention, and assessment that do not require a covered diagnosis. Refer to the area BHO if clarification is needed concerning which service codes require a covered diagnosis.

Access: BHOs must have appropriate numbers of providers in locations that allow individuals to access services geographically. Certain services must be available at night, on weekends or even 24 hours per day. And there must be sufficient providers available so that there are not excessive wait times that discourage individuals from requesting treatment.

Medical necessity: Mental health services to clients must be reasonable, necessary, and appropriate for the diagnosis or treatment of the client.

State Providers, such as CMHCs, need to implement standards which are based on compliance expectations.

Covered Services: Covered services are medically necessary services included in the Colorado Medical Assistance Program's State Plan approved by CMS to assist, support and encourage each Medicaid eligible person to achieve and maintain the highest possible level of health and self-sufficiency. The list of actual codes and service descriptions can be found in the Colorado Uniform Coding Standards Manual.

Required Services: HCPF mandates certain covered services to be required in the BHO benefit plan. The examples below of required mental health services in Colorado should be recovery-based/strengths-based in orientation.

- Assessment
- Case Management Services
- Crisis and Emergency Services
- Inpatient Services
- Psychiatric Services and Medication Management
- Individual, Family, and Group Therapy
- Psychosocial Rehabilitation
- School-based Services
- Residential Treatment
- Outpatient Day Treatment

Optional Services: In addition to required services, BHOs contracts may also provide additional optional covered services to Medicaid clients. Examples of optional mental health services in Colorado are:

- Vocational and Employment Services
- Intensive Case Management
- Recovery Services
- Assertive Community Treatment
- Respite Services
- Drop-In Centers and Clubhouse
- Peer Services and Support
- Prevention and Early Intervention Services
- Residential Treatment

Cost: There are no co-pays for Medicaid capitated mental health services. However, Medicaid clients with other insurance must use that insurance first before using Medicaid benefits.

Compliance

The term 'compliance' is associated with both an expectation and a program. As an expectation, compliance refers to the adherence by providers and contractors, as well as those working for

providers and contractors, to established standards or requirements mandated by the outside entities which have oversight responsibilities at both the state and federal level for mental health services. These standards may be embedded in law, regulation, written advice and guidance, specific contract requirements, and accrediting agency standards. Depending on the oversight agency, these expectations may involve a broad array of standards (***often called "conditions of participation"***) that cover all aspects of provider or contractor operations including leadership, clinical/medical service delivery, billing, information technology, human resources, medical records, quality of care, and facilities. In addition, the regulations and payer-produced provider manuals will delineate the services that Medicare and Medicaid will pay for – including what the service consists of, who can provide it, where it can be provided, how often, and the duration of the service. The BHOs and the CMHCs are responsible for making sure its employees, contractors, or agents understand these requirements and expectations and then implement the necessary processes and protocols to ensure these expectations are being met.

Encounters verses Claims

When a service is rendered by a CMHC provider to a Medicaid recipient, information regarding that encounter must be submitted to the BHO indicating the type and length of service that was offered. These encounters serve the same purpose as bills (claims) for services and they are reviewed, analyzed and counted in order to determine the monthly capitation rates that will be paid to the CMHCs. Each encounter must be documented in the medical record and be sufficient to support the medical necessity (see definition below) of the service. The service must be signed off by the provider who rendered the service, certifying that what was encountered and documented was actually the service that was provided and that all information on the encounter is correct.

The following is the provider certification statement required for each billing claim/encounter. Although this is not a statement that is seen on each encounter signed by a clinician, this is the language on a background document or bundle of payments that are submitted when a claim is sent to a payer.

"I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals or an individual under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request. I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost sharing charge.

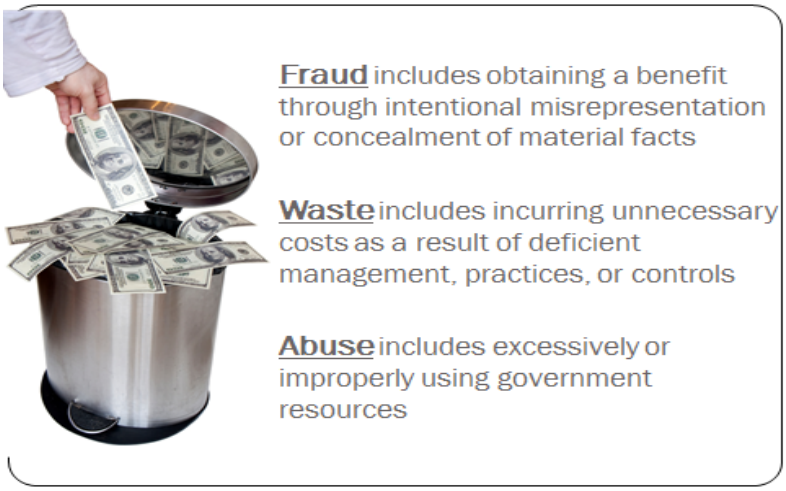
*All payers, Medicaid included, require that **any billed service** be backed up by documentation in the individual's medical record.*

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.
NOTICE: This is to certify that the foregoing information is true, accurate and

complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws."

A summary of encounters indicating the services rendered are appropriate is submitted by the BHO to Health Care Policy and Financing (HCPF), which is the State of Colorado's Department responsible for managing the Capitated Medicaid program.

Defining Health Care Fraud, Waste and Abuse



Fraud is knowingly and willfully attempting to falsely obtain money from any health care benefit program. Fraud is distinguished from abuse in that there is clear evidence that the acts were committed knowingly, willfully and intentionally or with reckless disregard. Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law (42 CFR 455.2). Some typical examples of healthcare fraud are:

- **Phantom Billing**: The medical provider bills Medicare/Medicaid for unnecessary procedures, or procedures that are never performed; for unnecessary medical tests or tests never performed. For example, a case manager goes out to meet with the patient who "no shows" but bills for the service anyway as if it had taken place.
- **Patient Billing**: A patient who is in on the scam with a fraudulent provider allows the provider or another individual to use his or her Medicare/Medicaid number in exchange for kickbacks, but never receives medical services. The provider bills Medicare and the patient is told to admit that he or she indeed received treatment. For example, a psychiatrist adds names of patients no longer receiving services to their current list of open patients and bills for services.
- **Upcoding**: In this type of activity, the provider inflates diagnoses and billing by using a billing code that indicates the patient received more expensive procedures than what the patient received. For example, a provider bills for 40-50 minutes of therapy when they only provided 15 minutes. Another example is providing more services than are necessary. In this activity the patient receives services they do not need or more of a particular type of service than they need. For example, a patient is stable and has no additional need for therapy services, but the patient wants to continue and therapist continues to see them or is a provider who has not been trained or does not have the

required education provides a service they are not qualified to provide. For example, psychotherapy services are provided by someone who is not trained in psychotherapy.

Waste is health care spending that can be eliminated without reducing the quality of care, such as overuse (prescribing too many antibiotics,) underuse and ineffective use of treatments or medications. It is also the inefficiency in redundant testing, delays in treatment and making processes unnecessarily complex. Waste means overutilization of services, or other practices that result in unnecessary costs. Generally not considered caused by criminally negligent actions but rather the misuse of resources.

Abuse is defined as improper actions or billing practices that creates unnecessary costs. This means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program, such as, provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Auditors are generally not concerned with the reason for the improper payment; they will want a payback!

The Difference between Fraud, Abuse, Waste, and Errors

Fraud, abuse, and waste happens when a provider ***intentionally decides to not comply with rules, regulation and law in their service delivery, documentation, or billing practices.*** Some examples of fraud and abuse may include but are not limited to; recording more time spent in a session then 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. Note also that a significant pattern of errors may indicate a deliberate or intentional disregard for the rules, laws and regulation by the provider and could result in a charge of fraud or abuse as well.

Errors happen when a ***provider inadvertently makes a mistake in the service delivery, documentation, or billing this would constitute an error***. 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. Errors are usually random and do not have a pattern to them. Often new employees commit more errors than older employees who are more experienced and have incorporated the requirements into their day to day practice.

A Closer Look at Medicare and Medicaid Fraud, Abuse and Waste

In addition to looking for fraud, abuse and waste in the Medicaid and Medicare systems, investigators and auditors are also looking for **"improper payments". *These result usually from errors made by the provider or the billing department and include both technical and***

content errors. For example, ***Medicaid and Medicare both have requirements for the elements that must be included in the documentation of a service***. Elements such as the name of the service, the amount of time it took, the name of the rendering provider, the date of the service, and others are technical requirements. If these are missing from the bill or encounter they would result in a denial of the service and the service would be denied before being paid. However, if the claim has all the required information but the back-up progress note does not, an auditor can come in even years later and request that the money paid for the service be returned for incomplete documentation.

Improper Payments result when an inaccurate, incomplete, or non-compliant claim or encounter is submitted to the payer. Improper payments can be the result of fraudulent or abusive activities but many are simply the results of errors or mistakes. Unfortunately an auditor is generally not concerned with the reason for the improper payment. They will want a payback and depending on the numbers of errors may assess penalties or further investigate. In cases where they find a pattern of inaccuracies on the part of the organization or a clinician they may assess individual penalties.

Services can also be denied as improper payments if the progress note does not adequately describe the service that was billed or how the service is related to the treatment plan or for other reasons having to do with the content of the service. These improper payments will also require the provider to payback any monies received.

Scope of Practice

All service providers ("Practitioners of the healing arts") must work within the scope of their license or experience and education. An individual's scope of practice is defined by the state's licensing laws. For unlicensed individuals it is usually up to the CMHC to determine the types and kinds of services that can be provided based on an individual assessment of competencies and experience as well as regulatory or payer guidance. For example, licensed Medical Doctors, Physician's Assistants, and Nurse Practitioners scope of practice would include medical and medication services. However, a licensed therapist would not be able to provide these services because they fall outside of the scope of practice for their particular license. Case managers would also not be able to provide these services, even though they don't have a license that limits what they can do, because they do not have the education or experience to provide medical or medication management services.

Individuals, who are not licensed but are providing therapy or certain other skilled services, may be able to provide these services under the supervision of a licensed professional. Therapy services, for example, could be delivered by an unlicensed provider with a Masters or Doctoral degree in psychology or a related social science field under the supervision of a licensed provider with an LPC, LCSW, LMFT, PhD, or PsyD. However, therapeutic services could not be delivered by a vocational specialist without these educational credentials as they would fall outside of their training and, therefore, scope of practice.

Scope of practice is an important concept for payers, who will usually specify who can provide each type of service.

Scope of practice is an important concept for payers. They will usually specify who can provide each type of service in order to ensure the service is provided by someone they have determined has the right education and experience but it is still up to the CMHC to determine if they are competent to provide the service. More about signature requirements for documentation is provided in Chapter 5. Also, each provider organization will have a procedures that further explain who needs to sign which documents and when.

How Federal and State Auditors Are Enforcing the Rules

Given the size and scope of Medicare and Medicaid programs in the United States, it should come as no surprise that the government is making massive investments in fighting waste, fraud and abuse. The new audit environment is complex, multi-layered, and continuously changing as government payers at the state and federal levels look for new and better ways to protect health care services from providers unwilling or unable to follow the rules. While the various compliance entities are too numerous to mention in this training manual, a few key enforcement and oversight programs are defined below:

Office of Inspector General (OIG: Federal agency of the OIG works each year from an Annual Work Plan that details their areas of interest, potential fraud, and presumed high risk. Behavioral health has had a prominent place in the last several work plans of the OIG and will likely continue to be a target from some time.

Medicaid Integrity Program: Within the Department of Health and Human Services the Center for Medicare and Medicaid Services is the new Medicaid Integrity Program. This program is similar to one on the Medicare side where private contractors are hired to audit both provider organizations and states. The primary purpose of these auditors is not primarily to identify fraud and abuse but rather it is looking for payments that, once the medical record has been examined, should not have been made. These "improper payments" are also resulting in very large paybacks by providers as the same technique of "extrapolation" described above. MIP auditors use data mining technology to analyze and identify patterns and indicators of overpayment.

Recovery Audit Contractors: "RAC" auditors are privately contracted "bounty hunters" who are paid a fee based on the amount of federal overpayments and improper payments they discover. The term bounty hunter was actually applied to them by the federal government who inserted provisions for Medicaid RAC auditors in the health care reform law.

In addition to enforcement and oversight efforts at the federal level, states are now becoming more aggressive in their own oversight efforts. One of these efforts by many states is to develop a False Claims Act statute that is similar to the federal law.

This law is quite powerful because of the following:

- Establishes civil penalties for having "deliberate ignorance" or "reckless disregard" with respect to fraud, abuse, and waste. This is a lower level of intent then that required in criminal laws where they must prove an individual knew that they were committing fraud.
- Whistleblower provisions that allow for individuals to share in any government recoveries from an investigation.
- Can be used for quality of care as well as for false claims
- Severe monetary penalties for persons and organizations found guilty of violations.

Exclusions from the Medicare and Medicaid Programs

In addition to all the other penalties mentioned above, the health care provider is subject to expulsion from the Medicare and Medicaid programs. 42 U.S.C. 1320a-7(a)(3) provides for mandatory exclusion upon a felony conviction of fraud in connection with the delivery of health care items or services, or with respect to any act or omission in a government health care program. No payment will be made by any Federal health care program for any items or services furnished, ordered or prescribed by an excluded individual or entity.

Loss of Licensure

The Colorado Department of Regulatory Agencies (DORA) has authority to discipline licensed practitioners including permanent suspension of one's license if the practitioner commits abuse of health insurance pursuant to CRS 18-13-119.

Overview of Clinical Documentation/Medical Record Documentation

All payers require that any service that is billed or encountered be backed up by sufficient and legible documentation in the individual's medical record. Documentation must describe a service the payer will pay for, must demonstrate that the service was medically necessary, and must meet the payer's requirements for all of the information needed to document the service, for example the credentials of the provider and the location of the service. *The only way an auditor can evaluate the quality and accuracy of the service rendered is by what was written and billed/encountered 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.

The only way an auditor can evaluate the quality and accuracy of the service rendered is by what is written

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, the treatment may not be determined to be medically necessary and the payer may deny payment. (See definition following for medical necessity.)

Components of a Clinical Record:

- *Assessment*
- *Treatment Plan*
- *Progress Notes*
- *Treatment Plan Reviews*
- *Assessment Updates*

Treatment Plan (Plan of Care, Recovery Plan, Individual Service Plan, Care Plan)

A complete, current, and appropriately signed 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 as 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 long term recovery Goals and the short term Objectives for treatment that you and the individual have developed together as well as the Interventions the clinician/provider will be using to assist that individual meet to meet their Goals and Objectives. The payer will evaluate treatment plans to determine whether or not the treatment strategy makes sense given generally accepted standards of practice. The treatment plan serves as the "authorization" for services as well as the road map for providing services.

Progress Notes/Progress-to-date Forms

Progress notes provide snapshots of both the treatment provided and the treatment progress. Payers usually will require a progress note each time a billed/encountered service is delivered. The note must describe the service provided as well as 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 form they have adopted. These forms are usually based on the payer's required elements as well as best practices in documentation of care.

Treatment Plan Reviews

Payers and some oversight agencies require that treatment plans be reviewed periodically to ensure that the progress the individual is making is sufficient, that the treatment strategy is still appropriate, and that treatment should continue as currently authorized in the plan. The review should occur with the individual and their family, as appropriate, and should be documented in a progress note, updated treatment plan, or on a special form if your agency requires this. These reviews may also need to be signed by a supervisor or licensed professional to ensure that they agree with the analysis and the continuation of services. Most payers require a licensed person to sign off on treatment plans.

Assessment Update

Like treatment plans, payers and certain oversight agencies require that assessments be updated periodically to ensure a formal review of the individual's current clinical presentation. The

Assessment Update provides a review of the presenting issues, the diagnosis, the individual's continuing commitment to treatment, their current recovery goals, and the need for a specific level of care. The updated assessments and the treatment plan reviews together assist the payer in determining the medical necessity for services.

Medical Necessity

Medical necessity is a concept that payers use to determine if each service rendered by the CMHC will be paid. Payers determine medical necessity only by reviewing the documentation in the medical record, so it is essential in justifying the need for the service, which in turn supports payment for that service.

Medical necessity is defined differently by different payer entities. The challenge for the CMHC is to understand how each payer views medical necessity and to help providers document so that it is clearly demonstrated. What can make medical necessity definitions difficult is that they encompass all services paid for by the payer including medical services and are, therefore, sometimes hard to relate to the types of services provided in CMHCs. However, most definitions of medical necessity have some common elements and fortunately in Colorado, the current definitions support each other. CMHCs generally use two definitions, one from the state Medicaid agency and one from the Division of Behavioral Health Services, to evaluate documentation and to train providers. Note how the two definitions correlate despite the use of different verbiage.

> ***Medical necessity*** *speaks to the cost effectiveness of the service and to the reasonable expectation that the service will result in some improvement in or maintenance of the individual's health or mental health.*

The Division of Behavioral Health 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."

The Colorado Department of Health Care Policy and Financing defines medical necessity as; 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

1. Is clinically appropriate in terms of type, frequency, extent, site and duration;
2. Is furnished in the most appropriate and least restrictive setting where services can be safely provided; and
3. Cannot be omitted without adversely affecting the Member's mental and/or physical health or the quality of care rendered.

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."

Agency	Service Definition
HCPF	Reasonably necessary for the diagnosis and treatment of a covered mental health disorder to improve, stability or maintenance, clinical appropriate in type, frequency, extent, and duration, furnished in most appropriate and least restrictive setting, and cannot be omitted without adverse affect.
DBH	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.
Medicare	Reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Note to readers – we all agree this does not sound very "strength-based!"

The Golden Thread

The Golden Thread is a term that references the tying together of all the concepts described above in medical record documentation. Each piece of documentation must flow logically from one to another such that someone reviewing the record can see the logic and understand the story you are telling about the individual's treatment and progress.

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 they present currently and assesses their ability to engage in and benefit from the treatment process.

The treatment plan must reflect Goals and Objectives that address the concerns of the individual as *identified in the 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 in order establish medical necessity. Additionally, new audits have revealed that auditors are reviewing plans from a recovery and strengths-based perspective for content and the required elements. Chapter 3 discusses the concepts of recovery and resiliency further.

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 as well as describing services that are "authorized" in the plan.

The progress notes tie to the treatment plan reviews and assessment updates which review the progress described in the notes at particular points in time, reiterate needs and goals, and establish the continuing need for services. *Treatment plans may need to be updated* as a result of the treatment plan review or the assessment update if new issues and new strategies are identified and developed with the individual.

Please note that in recognition of the importance of person centered treatment and recovery and resilience in documentation, meaning that recovery-based treatment views the individual not as a mental illness or a set of symptoms but as a unique individual with needs and goals that can be addressed through evidenced based therapeutic techniques using the natural resources and strengths identified in the assessment. The entirety of the person's life situation is taken into consideration when composing and following through with the treatment plan.
For providers this is an exciting time. The provider is able to think outside the box and not be restricted to a very small toolbox of traditional interventions or goals. At the same time, however, it is important to remember that the payer is a medical insurance program with many regulatory requirements.

In summary, 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 could include: Identifying critical clinical issues in the assessment that are not addressed in the treatment plan or specifically deferred to another level of care

- Developing treatment Goals and Objectives that are not individualized based on the assessment or assessment update
- Documenting clinical activities in the progress notes that are not driven by the specific Goals and Objectives identified in the treatment plan
- Failing to update the treatment plan when issues are resolved or new issues are identified or
- Failing to change the treatment strategy and goals when the individual is not progressing.

Chapter 2: Recovery-Based Approaches to Treatment

In February of 2001 President George W. Bush announced his New Freedom Commission on Mental Health. This commission set out to accomplish six goals. The first two of them were:

> ***Americans understand that mental health is essential to overall health and that mental health care is individual and family driven.***
>
> ***Their vision statement was, "We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports - essentials for living, working, learning, and participating fully in the community."***

It is important to note that the regulatory agencies in Colorado that monitor mental health care are committed to the recovery model as expressed by the National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation (December 2004.) It is the expectation that contractors and providers will demonstrate commitment to the recovery models for adults and the corresponding resiliency model for children/youth throughout all aspects of service development and delivery. These agencies recognize that recovery must be highly individualized and support individual empowerment along with community reintegration and normalization of the life environment. It is the goal that individuals are fully in charge of their lives and recovery includes the individual and family, as appropriate, in decisions from treatment planning to resources planning.

Although regulatory agencies in Colorado support the concept of recovery and resilience, there are still required elements to insure appropriate documentation of each encounter or claim. Many of these claim structures are built on a medical model of billing (for example, strict adherence to definitions for service codes and what practitioner of the healing arts is allowed to provide which service.) In order to understand the impact of health care reform on clinical documentation, it is important to consider changes in the regulatory environment for the behavioral health field and the evolution of behavioral health from a traditional medical model to a medical model embedded in a recovery-based approach to care. This change has impacted the manner and focus of documentation. Let's examine some of these concepts and how they affect documentation.

Traditional Medical Model Shifts to Medical Model Embedded in a Recovery-Based Approach

In a traditional medical model some years back, mental health issues were treated only as a disease that needs to be cured or managed. The primary focus of intervention, as is typical in a disease-based model, was on the physical pathology presented. Elimination or reduction of symptoms (where elimination is not possible) was the goal of treatment; a causation and then

mitigation approach. Recovery under this model was often not possible as many individuals with mental illness remained symptomatic at least episodically. They were then considered to be chronically ill with expectations lowered and treatment focused on maintenance. In the traditional medical model treatment plans were developed by "experts"- usually licensed mental health professionals who then oversaw the implementation of "their" plans and then evaluated their effectiveness, often without input or sufficient input from the individual or families.

The recovery-based approach had dramatic impact on the traditional medical model. In recovery-based models the individual with a mental illness goes into treatment with the assumption that recovery is the norm and is to be expected. Skill development and access to resources becomes a much greater focus with eliminating the impact of a particular symptom or improving the person's ability to function as goals of treatment and rehabilitation services. This new model for treatment has evolved beyond the former philosophy of viewing the patient as a diagnosis that needs to be treated.

The recovery-based approach is person centered treatment. The "patient" is viewed as a person who has every right and ability to participate fully in developing their own treatment plan and goals. The person seeking treatment is viewed as a competent individual fully capable of collaborating in their care throughout all phases of treatment such as planning, implementation, and termination of treatment. The therapist increases the individual's knowledge of mental illness and helps them to become the experts in their own wellness and recovery management. Recovery plans are formulated by the individual with identification of treatment interventions and also the supports and strengths the individual agrees to use in their continuing process of recovery.

There are still remnants of the medical model in recovery-based treatment, such as, the requirements by payers that licensed mental health professionals still be involved in the development of treatment/recovery plans. They must still sign them, oversee their implementation and evaluate their effectiveness. But this is now done in conjunction with the individual as partner. The mental health professional is the expert on the mental health system and how it might best help the individual. The individual is the expert on themselves and this is now, in recovery models, regarded as a very highly valued expertise in developing and implementing recovery planning.

Symptom-Based Shifts to Strengths-Based

In the traditional medical model of treatment, services were based on symptoms presented by the patient that led to a diagnosis based upon those symptoms. The diagnoses were developed by those who, according to the state, had the required education and experience to do so. Treatment was focused on the symptoms the patient presented in much the same way that a medical doctor

would focus on alleviating the physical symptoms of their patients. The focus of treatment in mental health was the individual and their intra-psychic processes. The patient's symptoms were seen as the result of some type of aberrant process in their psyche. The symptoms were the result of a mental "illness" much as a high fever might be the result of an infection. The traditional treatment model was based on symptoms or problems with little, if any, focus or use of the strengths of the individual.

The recovery model emphasizes the individual's strengths rather than just their symptoms, deficiencies or problems. Being strengths-based begins during the assessment phase of treatment where the individual along with friends, family and the treatment team should begin to develop the list of the individual's strengths, talents and resources and discuss how they might be used to help build recovery. The development of strengths lists helps focus the individual on the fact that everything is not bad and pushes the provider to incorporate the whole person, not just the problems or symptoms in their assessment and planning activities.

A "strength" is not the absence of a problem. Strengths include resources, support systems, abilities, accomplishments, motivation, likes, physical and mental health, coping skills and personality traits. There is a list of strengths at the end of this chapter. A strengths-based approach should be reflected in the language of the treatment plan and not just the assessment. In a traditional medical model a provider might write for a goal: "The patient will remain medication compliant for three months." In the recovery models of care, the focus would be on what will happen next. For example, if the individual and their doctor are able to agree on an effective medication regimen that is acceptable in terms of its effects on symptoms as well as side effects what would happen next? Would the individual be able to go back to school, develop a social support network, successfully manage a transition that is upcoming, etc? The person's life goal for themselves becomes incorporated into the planning process and is used as an outcome measure to focus treatment.

Strengths-based treatment goes well beyond just identifying strengths of the individual. Those strengths must be used in the treatment plan. They are vital elements in how the individual will cope with the barriers to success that he or she faces. Every goal and objective should have at least one corresponding strength that the client can use in accomplishing it.

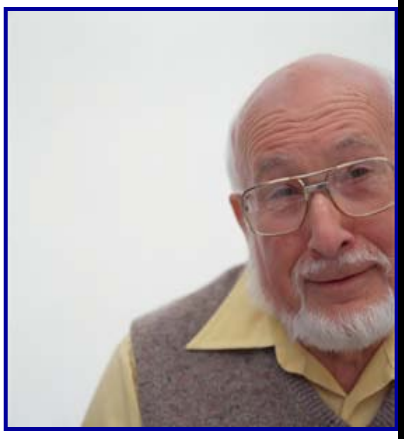
Because of payer demands that parts of the medical model still be used in recovery-based treatment, it will be important to make sure that any goals or objectives adhere at least partially to medical model outcomes. In the example above, the life goal on the treatment plan might read: "I will go back to school and graduate from college." However, because the individual might need all sorts of help to go back to college and graduate, most payers expect the mental health system to focus on a goal that delineates our role in the ability of the person to achieve their life goal. In that case, we might write a treatment goal as well. For example, "the individual will be able to manage their symptoms so that they can successfully manage college level educational demands." In this way we remain focused on the life goal of the individual, but have limited our involvement for payment purposes to helping the individual identify and then eliminate, reduce, cope and manage those symptoms that are creating barriers to their recovery.

Provider as Director Shifts to Provider as Partner

In the Traditional Medical Model, the provider was viewed as the expert in deciding how the symptoms would best be treated. The patient was more of a passive recipient of the treatment methods of the provider. To be sure, the patient presented the material through which the provider worked, but the provider did the interpretation of what was significant and how it should be handled. The provider suggested healthy ways to handle the symptoms the patient brought up and used the therapeutic techniques he or she had been taught to increase the patient's insight into the root cause of their distress or provided an accepting atmosphere in which the patient could gravitate toward better mental health through the warmth and understanding the provider projected.

In the recovery based approach, the process shifts from a provider driven to an individual driven process. The provider becomes more of a partner and the individual assumes a major responsibility for treatment. Each individual charts their own course to recovery rather than a standard treatment approach based on diagnosis or symptoms. The individual defines the goals rather than the provider. The provider teaches the individual the necessary skills and knowledge to manage their recovery process and helps them identify coping techniques that they are willing and able to use in their recovery. The barriers to success are identified and strategies are developed to deal with these barriers.

Curing Illness Shifts to Managing Illness



In the traditional medical model the focus was on curing the underlying condition. The theory was the symptoms would go away if the underlying condition was "cured". The provider made the decision as to what the underlying condition was that needed to be treated: the real problem. The alleviation of the symptoms of this underlying problem was merely a step along the way to cure of the causative mental illness.

The recovery-based approach shifts the focus of care from professionally directed management of acute episodes of symptoms to client directed management of long term recovery.

- Treatment is seen not as eliminating all symptoms of the mental illness but giving the individual the skills and confidence to manage their condition on a long term basis.
- This involves having a treatment plan developed by and for the individual with strategies to promote and maintain health.
- Recovery emphasizes the resiliency of the individual and their strengths and abilities to manage their life rather than the professional's ability to alleviate symptoms.
- The provider's job shifts to helping the individual identify their own resources and how to use them in challenging situations that may arise.
- The reliance is more on the individual and less on the professional community.

The effect of this focus on assisting the individual in managing their life is to normalize or de-stigmatize living with a mental illness. Every individual has to manage their life and work on

their life goals taking into consideration the strengths and resources they have. All people face challenges along the way whether they may be physical limitations, financial difficulties or emotional challenges.

Professional Focus Shifts to Social System Focus

In the traditional medical model the professional is emphasized as the expert to cure and manage illness. As treatment has moved into a strengths-based and recovery-oriented system, the individual's place in the broader social system and the individual's attributes are emphasized as the keys to treatment. The culture and unique strengths and situation of the individual must be considered and incorporated into their treatment plan. Culture could be defined as the shared values, beliefs and behaviors of certain people who identify themselves as a group perhaps through similar ethnicity, gender, class or other shared characteristics. Culture affects the way people view, respond to and accept treatment. Culture is a two-way street. The culture of the individual effects treatment and the culture of the service provider also effects treatment.

Culturally competent treatment involves an understanding of the way in which various factors such as gender, race, ethnicity, age, disability, language, sexual orientation, religious beliefs, and social class effect treatment. The way in which individuals are approached may vary depending upon these factors. The type of interventions utilized may vary depending upon these factors. Cultural competence, like being strengths-based, begins in the assessment phase of treatment, cultural issues need to be identified in the assessment, and then addressed in the treatment plan.

Language Has Meaning

Language is important. In a medical model the provider works with a "schizophrenic" while the strength based provider works with a person who has schizophrenia ("person first" language.) The diagnosis does not define the person. In recovery based treatment models, the provider uses the individual's language as much as possible. Goals are stated in the individual's own words and operationalized to be observable and measureable. The language of the plan is understandable to all participants. Deficit based language is replaced by strength based language. Promoting recovery advances a different mindset than preventing relapse. "Professional language" can subtly convey unintended messages to the individual leading them to limit their options.

Language Counts

Deficit-based language	Strengths-based, Recovery-oriented alternative language
A schizophrenic, a bipolar, a crack addict, a substance abuser	A person diagnosed with Schizophrenia who experiences delusions or hallucinations. A person diagnosed with bipolar disorder who experiences rapid changes in mood and behavior. A person diagnosed with an addiction to crack cocaine. A person whose substance use interferes with their life.
Suffering from	Working to recover from; experiences; living with
High functioning vs. low functioning	A person is able to function well in most activities of daily living, despite the presence of mental health symptoms VS limited or impaired ability to function that interferes with activities of daily living due to mental health symptoms
Acting out	Individual prefers to use alternative strategies to deal with emotions (swearing at peers or throwing things at staff)
Denial	A person who disagrees with diagnosis or that they have a mental illness. A reluctance to acknowledge stigmatizing designations is not unusual.
Resistant	Individual is not open to…. Chooses not to…..Has their own ideas about what may be helpful.
Unmotivated	Individual is not interested in what a program has to offer; interests and motivating incentives unclear.
Weaknesses	Areas to address in treatment; possible barriers to change.
Manipulative	A person is resourceful; seeking support; or trying to get help.
Entitled	Individual is a strong self-advocate and aware of one's rights.
Lack of insight	A person struggles with having a clear and realistic picture of themselves and their behavior.
Failure	Individual has an opportunity to develop and/or apply new strategies and coping skills OR individual has chance to draw meaning from managing an adverse situation.
Dysfunctional	A person experiencing challenges in managing the functions of daily life or a particular domain of functioning like family life.
Baseline	What a person looks like when they are functioning as well as possible for them.
Non-compliance	Individual who prefers alternative strategies. Pre-contemplative to proposed changes and strategies recommended.
Danger to self, others or gravely disabled	Describe current behaviors that renders a person a danger to self/others.
"Owns" a client	Client is able to makes choices about where to receive services for which they are eligible.

Adapted from : Tondora et al., (2007) Yale University School of Medicine Program for Recovery and Community Health. New Haven, CT

Summary

Recovery-based treatment views the individual not as a mental illness or a set of symptoms but as a unique individual with needs and goals that can be addressed through evidenced based therapeutic techniques using the natural resources and strengths identified in the assessment. Whereas social isolation might be a symptom of the person's mental illness, their relationship with their sister might be used to help them accomplish their goal of feeling more connected to people. Feelings of worthlessness might be addressed through using the person's affiliation with a church to get them involved in volunteer work. The entirety of the person's life situation is taken into consideration when composing and following through with the treatment plan. For providers this is an exciting time.

Recovery-based models, where embraced, are working. The provider is able to think outside the box and not be restricted to a very small toolbox of traditional interventions or goals. At the same time, however, it is important to remember that the payer is a medical insurance program with many regulatory requirements. As such they need to understand the medical necessity of provided services and how the provider's expertise is needed and is being applied to help the individual reach their recovery goals. This expertise and medical necessity should be evident in the assessment, the development of a reasonable and articulate plan of recovery, and in the progress notes. Recovery-based models are not diminished by their reliance on mental health experts to help guide the process.

Chapter 3: Documentation Rules

Colorado Service Definitions

In 2009, Colorado prepared the Uniform Service Coding Standards Manual (Coding Manual) and updated this in 2011 to help guide Health Care Policy and Financing and providers to achieve uniform documenting and reporting of **covered** Colorado Medicaid State Plan and Waiver services. Standardizing the documentation and reporting of behavioral health encounters contributes to the accurate estimation of services costs, development of actuarially sound capitation rates, and compliance with federal regulations for managed care utilization oversight. The Coding Manual also provides guidance in documenting and reporting covered services in coding formats that are in compliance with the Health Insurance Portability and Accountability Act of 1996 so billing and sharing of service information can be done electronically. Most clinicians do not use the Coding Manual but use parts of it through a smaller coding manual for their center or team. Here is the link to the most recent version of the manual: http://www.colorado.gov/cs/Satellite?c=Page&childpagename=HCPF%2FHCPFLayout&cid=1251569171131&pagename=HCPFWrapper

It is almost 300 pages long so view it electronically rather than printing. **This document was updated in 2011 and will continue to be reviewed and edited. As new versions of the manual are made available, provider organizations will be updated.**

Demonstrating Medical Necessity

The ability to communicate medical necessity clearly and succinctly is critical for the provider.

As discussed in Chapter 1, medical necessity is a foundational concept that payers use to ensure the services offered to a client are needed to treat the conditions with which they are presenting so that payment can be rendered for those services. The challenge for the provider is to document such that the need for these services is clearly communicated to a payer or any auditor reviewing the documentation.

There are key components that should be included within the documentation to support the medical necessity of the services offered. ***References to these elements should be communicated to support why the client must receive the identified service in order to avoid a deterioration of their condition if they did not receive the services or if they received a less intensive service than is necessary for their condition. The ability to communicate this information clearly and succinctly is a critical skill for the provider. Great clinical care will be unknown unless there is great clinical documentation to communicate the care the client is receiving.***

Again, treatment plan authorized 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. The problem lists for adults and children at the end of this chapter help define medical necessity.

Basic Medicaid Documentation Requirements

Documentation of every service you provide and bill for is required by Medicaid. The documentation should be completed before the service is billed and should be located in an organized medical record where services are filed by date so they can be easily located..

There are some very general rules about all documentation that should be followed:

- If you have a paper record.
  - Legibility: you must write clearly enough so that someone else can actually read what you have written. An outside auditor will not take the time to decipher your handwriting. They will simply deny payment for the service you have provided.
  - In paper records make sure all the original writing can be seen: don't "white out" cross out and write in the new information as you complete the documentation.

- All medical records:
  - If you find an error after the documentation has been completed and signed, then follow your agency's rules for correcting the information. In general, the new entry must be dated and signed and clearly marked as a "late entry or correction".
  - Make sure you are accurate to the best of your ability with everything you write in a medical record: be very careful about dates, the time it took to provide the service, the type of service you provided, etc.
  - Remember the medical record is the Individual's information, not yours: be careful about judging the Individual's actions, statements, and ways of dressing or behaving in your comments in their medical record.

There are four primary documents that make up the medical record – the assessment, the treatment plan, the treatment plan review, and progress notes/progress-to-date forms. Your agency may have additional documents that it wants you to complete.

Assessments: You may have multiple assessments for each Individual, especially in situations where they are receiving multi-disciplinary services. There is usually a bio-psychosocial assessment completed by a clinician who is trained to do some or all of this type of assessment. There may also be case management or functional assessments: these are not required but are used by many organizations to provide additional information about the individual, their current level of functioning, and their current service needs. You will need to consult with your supervisor about whether or not you are expected to complete these assessments and how they must be used to plan treatment. And, for Individuals seeing the psychiatrist for medication management there is usually a psychiatric assessment completed as well.

Treatment Plans: The treatment plan is a dated document (there is both a beginning and an ending date for each plan), signed by individuals with the required professional credentials that authorized medically necessary services.

Consult the BHO in your region before billing Medicaid encounters for an out-of-date treatment plan.

If the treatment plan is out of date, consult the BHO in your region, Division of Behavioral Health, or Trailblazer (Medicare) to determine if services can be billed, even if they are medically necessary.

In Colorado you are required to attempt to get the Individual's signature on the treatment plan. In the case of a younger child, the caretaker or guardian's signature should be solicited. The signature is generally seen as evidence of the individual's active participation in the development of their treatment plan. If the individual is unwilling or unable to sign then you should make a note of that in the medical record, i.e. complete a progress note that describes your meeting with the individual and the reason why they will not sign the plan. Even agencies with electronic medical records must often print a hard copy of the medical record to allow it to be signed. Under no circumstances ever have an individual sign a blank treatment plan form and then just fill it in at a later date. This is true even if you and the individual have discussed what will be included in the plan and even though their signature is not required by regulations. If you do not get the individual's signature, you should discuss with your supervisor how to proceed with treatment planning and treatment.

Each agency has its own policies on who must participate in completing the treatment plan and who is ultimately responsible for making sure it is kept current and is signed by the right people. Make sure you understand your responsibilities under your agency's policies and procedures.

Treatment Plan Reviews/Updates: Every 180 days in Colorado, there should be a review and/or update of the individual's treatment plan. This review must be documented and placed into the medical record. The documentation of the treatment plan review can be in the form of a progress note, a special form that is completed specifically for this review, or notes made on the current treatment plan. However the review is documented, it should be signed by the "Practitioner of the Healing Arts" and the client (family member if appropriate) and then reviewed in another 180 days. Your agency will have its own requirements, be sure you understand them.

Whatever form the documentation takes, the review should record:

- The participants in the treatment plan review.
- The progress the Individual has either made or not made towards meeting their goals and objectives. This is best done by separately addressing each goal rather than a summary statement that is more of a general discussion of individual activities and progress towards goals.
- Any suggested and agreed upon modifications to the treatment plan as a result of the joint discussions of the Individual and the treatment team.

- An auditor will expect that if the Individual has not progressed that there will be some discussion of why and that there will likely be changes to the plan to attempt to meet the Individual's goals in another way.
- An auditor will expect that if there has been progress that there will be some discussion of whether or not the treatment plan should change to reflect this progress, for example, should objectives change so that the individual is working on the next steps they need to take to meet their goals.

Progress Notes/Progress-to-date Forms: You are required to document each and every service you provide to the individual that is focused on one or more goals or objectives in their treatment plan and that you plan to bill to a third party. You do not need to record conversations that are general check-in conversations or do not have a specific treatment purpose. If you have a question as to whether or not to include a meeting or phone call with the Individual in their medical record, always ask your supervisor for guidance.

The purpose of the progress note is to:

- Allow communication between members of the treatment team.
- Record for the Individual, the purpose and content of each interaction they have with their treatment team.
- Record for the payer each service they are being asked to pay for. It is this purpose that we are most concerned with in this training manual.

The payer, when auditing medical records, looks at the progress notes to determine whether or not:

- The service delivered is a covered service
- The service has been ordered by the appropriate professionals on a current treatment plan.
- The service was provided in the appropriate location, by the appropriately credentialed worker
- The bill for the service and the documentation of the service match each other as to date, time, and type of service provided.

The Golden Thread

Payers will look for the "golden thread" in the documentation they review. As discussed in Chapter 1, this "thread" starts with the assessment, moves through the treatment plan, and then, hopefully, can be found in and through each of the services that are billed on progress note/progress-to-date form.

Assessment: Let's take a look at each of the 4 primary elements in the assessment and their value to the Medicaid auditor:

Part 1 – Presenting Problem: The presenting problem tells the auditor why the Individual is coming for services now. What behaviors, symptoms, signs, trouble, problems, etc. have been noticed by the Individual, their family, other providers or referral sources that have resulted in the Individual seeking mental health services? This is an important statement and forms the basis for the determination of medical necessity. The presenting problem should be a situation, behavior, emotion, symptom, etc. that is having a significant impact on the Individual's life – either interrupting their ability to function, to continue in their usual life roles (whether adult or child), or to participate in their usual important family, work, and social relationships. This statement is often at least partly described by using the Individual's own words and therefor provides some very good information about how the Individual views his or her current problems. The more comprehensive this statement is, including information about how long, how symptoms have changed, what was tried already to relieve symptoms, etc. the easier it is for the auditor to determine if the admission and resulting episode of care is medically necessary.

Part 2 - Data Gathering: The assessment will usually have information on past family history, past social history of the Individual, past treatment history for both mental health and substance abuse problems, developmental history, sexual abuse, parenting and custody structures, work/educational history, military history, correctional or legal history, and more IF it is relevant to your decision making on diagnosis or treatment recommendations. The list of issues or domains that should be addressed and then documented, if relevant, is located under the assessment codes in the Coding Manual and in the DBH On-site Audit Tool. This part of the assessment also gathers data on the current signs and symptoms or problems in functioning the individual is experiencing and describes the evidence that those problems exist. This part also looks at the strengths and resources the individual brings with them and how those resources and strengths have helped in the past.

Part 3 - Mental Status Exam or MSE: Information on what is contained in a complete MSE is located in the Appendix of this manual. This is the exam portion of the assessment, similar to the physical exam given by medical doctors or nurse practitioners. In order to do an MSE, you must have this expertise within your scope of practice. The Coding Manual allows assessments to be partially completed without the MSE or a complete Diagnosis if the person completing the assessment is not credentialed to do so. In those cases, the Individual should be assessed by a licensed provider trained to do this and/or a prescriber in order to complete the MSE.

Part 4 – Analysis and Summary: This is the analysis of the data that has been gathered to produce a diagnosis, the individual/family's commitment to treatment and their goals, a prioritized problem list, level of care recommendations, and a recommendation for the types and intensity of services. This analysis is generally found at the end of the assessment and is called by various names such as the clinical formulation. It is important that this be an analysis of the information already gathered and not simply a summary of the information that has already been documented.

Following the Golden Thread in Treatment Plans and Treatment Plan Reviews:

The treatment plan authorizes medically necessary treatment for the Individual. According to the Coding Manual, this document should include the following information on strengths and culture, goals, objectives, and discussion of service modalities to be used in treatment.

Strengths and Culture: Colorado wants the treatment plan to include the Individual's strengths and cultural attributes that will be used to achieve the goals and objectives. See Chapter 3 for a larger discussion on strengths. You should be aware of your agency's policies regarding strengths and how they are listed. In some cases you may simply list key strengths one time in the document. In other cases you may need to list specific strengths that will be used to reach a goal or an objective. The Coding Manual also requires that you consider the impact of the individual's culture on treatment and its design. See the Appendix for an example of a cultural assessment. Culture may impact the types of services **a**n individual of family is willing to entertain, where they are willing to get services (e.g. will they allow you in their home), how other family members and which family members can be asked to provide some supports, and so forth. Clearly these cultural issues will have a significant impact on your planning with the Individual.

Goals: Life or recovery goals for the individual are directed as the "treatment of mental illness." In many organizations, the individual's own words for their goal are used in the treatment plan. This goal is sometimes called a recovery goal, life goal, rehabilitation goal, etc. This helps link in the Individual's mind the relevancy of the treatment and other services to an aspiration they have, something they want to achieve. In some cases you may need to translate the Individual's words into a "Treatment Goal: that more specifically addresses how mental health treatment will assist the individual in reaching their goal. The auditor must understand the relationship of the goal to the need for mental health services.

Treatment goals take the individual's goal and restate it so that it is clear what the mental health system's role is in helping the Individual reach their life/recovery goal. Goal statements generally follow a certain format and should describe:

- An endpoint of achievement. In order to recognize this, the goal should be tangible or able to be described, observed and/or measured. The goal describes what the Individual wants to be able to do – for example, where the Individual wants to be able to live, what level of independence they want to reach in different areas of their life, where and how they want to be able to contribute to their community, relationships they would like to build or rebuild, and so forth.
- Within what time frame or how often they will be able to do it within the time frame you have specified.

Examples of Life Goals and possible treatment goals:

Life: I want to move back in with my family.

Treatment Goal: Name will be able to learn and use key social skills that will allow him to develop and manage positive parental and sibling relationships so he can move home in 6 months to 1 year.

Life: I want to complete high school

Treatment Goal: Name will be able to manage symptoms of anxiety in order to control outbursts in school, avoid expulsion, and graduate from high school in 6 months.

Life: I want to be able to make and keep some good friends.

Treatment Goal: Name will be able to develop and use the social skills necessary for identifying, making and managing at least one friendship within one year.

Life: I want to live in my own apartment.

Treatment Goal: Name will be able to use necessary daily living and coping skills in order to move into an independent living situation in one year.

There is no right or wrong number of goals, but they should be prioritized and the more important ones dealt with first. As much as possible you should limit goals to 1 or maybe 2 so that the Individual and the treatment team are focused. The Individual must agree to the order in which the goals are addressed but as you develop the list with the Individual keep in mind which goals will most affect their ability to function and to move towards greater independence. You cannot demand that the Individual deal with these issues first, but you can point out to the Individual the potential consequences of not giving these issues a high priority.

Objectives: These must be listed for each of the goals that describe the smaller steps the Individual must take to reach their goal within the timeframe you and the Individual have agreed to. These should be able to be seen and measured so that both you and the Individual can see and celebrate progress. Because you are going to be measuring progress at least every 180 days in your Treatment Plan Reviews, it makes sense to look at steps or objectives that can be reached within that time period where possible. If objectives are reached prior to 180 days, the Treatment Plan may need to be changed to add additional objectives.

Treatment Goal: The Individual will locate and move into independent living within one year.

Objective 1: Individual will be apply for HUD housing within 3 months.

Objective 2: Individual will be able to travel on the bus from the group home to the mental health center by himself within two months.

Objective 3: Individual will be able to demonstrate his ability to cook three simple meals within 5 months.

These objectives can all be measured or observed. You can determine if the Individual has been able or not able to meet the objective by watching them or asking for self-report of cooking meals, or by meeting them at the doctor's office after they have traveled there on their own, or by confirming that the Individual is on the wait list for HUD housing.

Objectives should follow a specific format and include the following information:

- What the Individual will do (this is similar to the goal statements only with objectives you are looking for shorter term accomplishments, changes in behavior, increases in functioning, reduction in signs and symptoms or the ability to manage them better, etc.) Objectives should be outcome statements, not statements about process. For example, Individual will attend all psychiatric appointments, is not an objective –it describes the process. The objective should document what step towards their goals the Individual will be able to reach if they do make all their appointments. For example, Individual will be able to independently manage his psychiatry appointments within 6 months.
- Where and/or with whom the Individual will do it.
- How often – the percent of the time they will do it, or the numbers of times they will do it, in the time frame you both agree to – days, weeks, months and so forth.

The objectives should be negotiated with the Individual and you should both agree on the steps, the time frame and the Individual's willingness to work at the level of intensity required to meet the objectives.

There is no right or wrong number of objectives but consideration must be given to the level of intensity and complexity of treatment that the Individual can tolerate and benefit from. Also lots of objectives mean lots of tracking and difficulty focusing on a few achievements. Think in terms of 1- 3 objectives for each goal and then cross off the ones achieved and add new ones as the Individual progresses.

Modalities: These are the services that will be provided by you or you will link the Individual to (such as, case management) in order to assist them to reach their objectives. Modality statements in the treatment plan should be as specific as possible so that the treatment team members listed in the plan understand what is expected of them.

The modality statement should list:

- Type of service
- Content or focus of the service
- Length of time for each intervention, and
- Reason for the service being ordered (this last item is optional.)

Some examples of modality statements:

- Individual skill building sessions weekly for 1 hour to teach the Individual the basic steps for managing a checking account (optional: to increase financial independence)
- Face to face, individual, bi-weekly skill building sessions for ½ hour to develop with the Individual a reminder card for taking her medications
- Group sessions weekly for 2 hours to work with the Individual to successfully complete the Anger Management Curriculum
- Individual therapy sessions, bi-monthly for 1 hour assist the mom in developing calming strategies for Individual prior to visits with brother
- On a monthly basis in individual skill building sessions for ½ hour to evaluate the Individual's ability to self-manage medications

The above statements are written out in longhand so that they are easier to understand for training purposes. You can use agency approved abbreviations and do not need to have complete sentences.

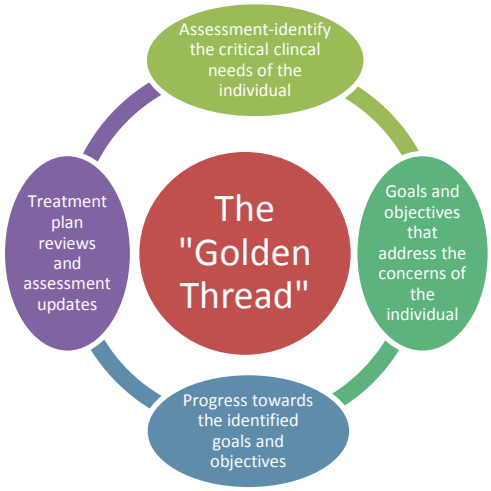
- Who will be responsible for the interventions - list the type of credentialed provider that will provide each service. In some cases your agency will require that you list the actual name of the case manager or others involved in the Individual's treatment, make sure you understand your own policies.
- The anticipated length of time to meet the goals and objectives: In our examples, the time frame is actually listed in each of the goal and objectives statements and does not need to be separately listed again.

The Treatment Plan is the Road Map: The treatment plan should provide you with a road map for your interactions with the Individual. The more specific it is, the easier it will be for the treatment team and the Individual to follow. Treatment plans that are vague and that provide little detail can result in treatment interventions that are not effective and focused. The treatment plan provides you with your agenda for each and every meeting with the Individual.

The regulations do not require that you use a certain form for the treatment plan so each agency usually develops its own. It is important to remember that the form does not make the documentation right – it is what you put into the form – the content – that is important to the Medicaid auditors.

Following the Golden Thread to the Progress Notes/Progress-to-date Forms:

A progress note should be done for each and every encounter you have with the Individual that will be billed to Medicaid. In some cases, summary notes can be used that describe multiple services provided in a day, but for all services billed there should be a back-up trail to show when and where an Individual received billable/encountered services.



Progress notes are very easy to write correctly if you use the Individual's treatment plan as the basis for scheduling and providing services. Consult them frequently to make sure you are focusing your services on the Individual's goals and objectives and that your services will be able to be billed. (If you take copies of your plans out into the community when you see Individuals for services, make sure you follow your own agency's requirements for how to protect this information, e.g. should you cross out the Individual's name and only list their initials, etc.)

The progress note should always follow a format so that the payers, your Individuals, you, and other treatment team members can find information quickly and easily. There are lots and lots of progress note formats and providers should consult their own policies and also the Coding Manual for specific instructions about content. In general there are two parts to the note. The part that requires certain documentation to meet the technical requirements of the payer and the part that describes the content of the service actually provided, the Individual's response and your plan for next time.

NOTE: The following gives general guidance on the content of the note. Your agency may have additional requirements or a specific format they want you to follow and check with the Coding Manual for the specific content requirements for each service.

Progress Notes/Progress-to-date Forms – Technical Requirements:

- The date of the service being provided. If, for a particular service you are required to do a daily note, you should not describe services that took place on more than one day.
- The time of the service being provided. At a minimum this should include the actual time the service began and the total time of the service. In some agencies you may be required to list both the start and stop time of the service. If you provide more than one service on the same day you can include them all on one progress note but you must be able to list individual times and describe the individual services so that they can be billed correctly. Medicaid wants to see every service it is expected to pay for listed and described separately.
- The name of the service that was provided. The title of each service must be listed separately above the description of the encounter. Medicaid needs to be able to easily determine if the service is a case management, medication management services, or skill building service. You must also list whether or not it was a group, individual, family, or collateral service (consulting with others who are not family but are involved in the Individual's care.
- The location of the service. Certain services are only allowed to be provided in clinic locations or in residential settings. Other services can be provided in all sorts of community locations. Consult the Coding Manual on allowed locations.
- Your signature and your credentials.
- The date of your signature. This may differ from the date of the service if you do not write your progress notes right away. Medicaid prefers that progress notes be written immediately but your agency may allow you some additional time to complete your documentation. Please make sure you understand your agency's rules.

Progress Notes – Content of the Service Provided:

- **Linking to the treatment plan.** Each service must be authorized on the treatment plan and must focus on the issues listed on the plan. The best practice for this is to actually list the goal and/or objective right in the note. This makes it easy for the Individual, the

treatment team, and any auditors to understand how the treatment plan and services are linked. It is easiest for the auditor if you list the objective rather than the goal because it is often more specific and it is easier to see the linkage.

- If you are focusing on more than one objective, you can list both or the one that is the primary focus of your visit.
- You do not need to write each objective out if you number the goals and objectives on your treatment plan. You can just list the numbers on the progress note so that the auditor can easily get from the treatment plan to your progress note. Many electronic medical records allow the provider to "pull" the relevant objectives over into the note.

The presenting problem, chief complaint, or the reason for the visit: In the assessment the Individual's reason for asking for mental health or substance abuse services is listed in Part 1– the presenting problem. This tells the payer what the problems or issues are so that they can determine if the problems are mental health or substance abuse problems and if there is coverage for treatment of those problems. The payers are looking for something similar for each visit and on each progress note. The reason for visit statements can be very brief:

- Connecting name to community health center.
- Lesson 5 of anger management curriculum.
- Focus on controlling outbursts in school
- Teaching on filling med box
- Advocacy in meeting with Social Security.

In each case you are describing why you are meeting with the Individual and what the intended focus of the session will be.

Do not write the following in your Reason for Visit statements:

- The Individual's diagnosis – a diagnosis is not a reason for you to meet with the Individual.
- "Individual is stable" or anything similar: First: the determination that the Individual is stable is a conclusion you make after meeting with the Individual not a reason for a visit. Second: if the Individual is stable, Medicaid wants to know why they still need mental health services.
- List the service: for example do not say "case management" or "skill building" -that is the service you are providing not the reason for the visit.

List the mental health interventions you provided: After the reason for the visit, Medicaid wants to know what it was you did at the visit. Remember Medicaid is paying for mental health services and wants to see that you provided skilled interventions that required specialized mental health knowledge and experience.

- Do not state that you observed or oversaw the Individual's activities –Medicaid does not pay for these because they are passive or custodial services not active interventions.
- Do not state that you accompanied the Individual on some activity. This is not an intervention either – why did you accompany the Individual? Why did they need you along?

- Do list the types of actions you took with the Individual: discussions, demonstrations, making lists, reviewing lists, teaching skills, showing, having the Individual show you, role playing, and other activities that describe what you and the Individual did together. See examples in the Grids for types of interventions.

Describe the Individual's response to your interventions and progress: Medicaid wants to understand how the Individual responded. Did the Individual participate and how do you know? For example:

- "Individual listened and was able to list three examples of when to use their anger management skills"
- "Individual stated she understood why it was important to complete the paperwork on time"
- "Role-played with Individual introducing herself to other members of the team"
- "Assisted Individual to develop the list of questions she had for her doctor's visit"

Did the Individual's participation indicate that they had benefited from your services? Ask them – what did they get out of the visit? How do they think it helped them? Write down what you were able to observe and check with the Individual to see if they agree. How does the Individual think they progressed with mastering a skill or with completing agreed upon tasks? How comfortable are they now with performing a skill or the steps they learned on their own? How has their understanding changed about how to best use a service or resource? Do they think your discussion about their current treatment needs was helpful? How?

- "Individual's states confidence increasing. Filled med box with only 5 prompts." Progress towards objective.
- "Individual agrees that she can move forward with plans to move out of her mother's house." Progress towards goal.
- "Individual states that she understands how to call and use help line at Social Security" Progress towards independence.

Plans for next visit or visits – this serves as a useful reminder to you and the Individual about what you will work on next time you see each other:

- "Will review treatment plan at next visit"
- "Will continue with role plays from Making Friends Curriculum"
- "Continue work on coping skills - focus on public locations"

Each progress note should end with a plan for next time, even if the next time you meet you will be discussing the Individual's ending his or her work with you and moving on to other activities. Planning for the next meeting requires that you and the Individual both reflect at each visit on how best to keep moving forward and what steps to take.

Signature Requirements for Authorizing/Recommending Treatment on Individual Treatment/Service Plans

Most payers have specific requirements for who must sign the treatment plan. These signatures are required for different reasons. The person who wrote the treatment plan is required to sign. They are responsible for making sure the plan is individualized and for working with the Individual (hopefully through person-centered practices) so that the treatment plan is owned by the Individual as well as the treatment team.

Because the treatment plan represents the clinical strategy and the resources the provider intends to commit to achieve clinical outcomes, many payers now want the Individual's signature on the plan. This shows their agreement with the strategy and their commitment to using their own resources to further the treatment process.

In Colorado the Individual must be asked to sign the plan to show that they have participated in the development of the plan, that they agree with its contents, and that they have been given a copy. If they are unwilling to sign then (see above) a progress note should be written to describe their participation and reason(s) for not signing.

There will be guidance coming about who needs to sign which treatment plans for a Medicaid client under the Medicaid Rehabilitation Option in the coming months. The final signature needed on a treatment plan is that of clinical professional. The BHOs recently requested official guidance from HCPF whether providers should use the Medicaid Rehabilitation Option Rules for determining who should sign the plan UNLESS the individual has Medicare or is dually eligible for both Medicare and Medicaid in which case a physician's signature is required.

All services must be authorized or recommended by the signature of a Licensed Practitioner of the Healing Arts acting within their scope of practice.

The Rehabilitation Option states that services must be authorized or recommended by a Licensed Practitioner of the Healing Arts acting within the scope of their license under state law. This means that all treatment plans must be signed by someone licensed in Colorado. They would be called an LPHA. However, in addition to having a license, the LPHA can only recommend/authorize services that are within the scope of their own license under state law. This means, for example, that licensed social workers cannot order medication management services or nursing or other medical services. They cannot provide nor supervise these services under state licensing law.

The LPHA's signature on the treatment plan is intended to show their agreement that the services are medically necessary. What does this mean? It means that they agree that services as authorized constitute generally accepted practice for treating the diagnosis listed, that they reflect in intensity and duration the current mental health status of the Individual, and that they are, in the opinion of the signatory, the most cost-effective, least intrusive and safest services for the Individual. It makes sense given the weight that payers give to the treatment plan in making

payment decisions that they are concerned with just who has the credentials and experience to authorize or recommend a service plan.

Until further guidance is made available, the following options are recommended in #1 and #2 for Medicaid clients:

1. If an individual's services (MEDICAID only) include medication or nursing services there are 3 options:

    a. Have the physician or NP sign to cover the med services

    b. Don't include med services and have a separate med management plan signed by MD or NP

    c. Include on the treatment plan a referral for medication evaluation and on-going treatment if necessary and then have the physician/nurse practitioner prescribe their own services and any other medical services directly on each progress note. By doing it this way, the physician does not have to sign the treatment plan.

2. If the individual's services (Medicaid only) do NOT include medication or nursing services, the Licensed Practitioner of the Healing Arts can sign the treatment plan as long as what is written into the plan is within their scope of practice.

3. With Medicare/Medicaid clients –a physician (not an NP must sign). Note: this is for clinic providers only. Private practitioners who bill Medicare under their own number can create a plan for the services they will provide with no additional signatures needed.

4. With Medicare only clients – a physician (not an NP must sign) Note: this is for clinic providers only. Private practitioners who bill Medicare under their own number can create a plan for the services they will provide with no additional signatures needed.

All signatures must be dated. **THE TREATMENT PLAN IS NOT ACTIVE UNTIL THE LAST REQUIRED SIGNATURE IS IN PLACE ON THE PLAN**. Remember that a late or not properly signed plan will mean that services cannot be billed to Medicare or Medicaid without approval from the BHOs who will develop policy concerning this. For all other payers the provider agencies are responsible for determining payer requirements and for developing internal operational policy to meet those requirements. Check your agency policies for treatment planning and signatures for commercial insurances or other government health programs.

Colorado Compliance Gird and Example Problem Lists for Assessment

The problem lists on the following pages provide examples to help define medical necessity for treatment. **Please keep in mind that problem lists are not required and only provide guidance.**

Symptom and Function Based Problem List for Adults

ADDICTIONS

Substance Use/Addiction

- Identify and describe current issues with drugs/alcohol.
- Examples: Client currently in recovery from cocaine addiction and enrolled in intensive outpatient program. Client suspended from work for drinking on the job. Reports no plan for assessment or treatment of possible addiction problem.

Other Addictive Behaviors

- Identify and describe the specific addictive behaviors.
- Examples: Client reports weekly gambling resulting in significant losses and eviction form apartment for not paying rent. Client reports daily use of internet pornography.

ADJUSTMENT/ BEREAVEMENT

Bereavement Issues

- Identify any bereavement issues identified by client and the length of time since the cause(s) of the bereavement occurred.
- Examples: Client's biological mother died 6 months ago and client has been living with grandmother since the death. Grandmother reports significant problems with school since mother's death including fighting and unruliness frequent detention, and poor grades.

Adjustment issues

- Identify and list the key stressors.
- Examples: Client reports distress related to recent change of his residence. Client very anxious since mother's move to live with sister in western part of state. Client's childhood friend died unexpectedly from heart problems this past month. Client is being threatened by co-worker after he reported co-worker to boss.

ANXIETY

Anxiety

- Identify and describe symptoms of anxiety.

- Examples: Client reports constant feelings of worry and uneasiness. Parent reports client is afraid of playing outdoors and will not go outside without parent. Client will not or cannot explain why there is change in behavior. Parents report client participates in obsessive rituals in morning resulting in client being frequently late for school.

Traumatic Stress

- Identify if client is reporting stress related to current or past traumatic events. Summarize, where possible, the traumatic events that are the reported cause of the stress.

- Examples: Client has nightmares 4x per week since auto accident 3 months ago. Client startles and becomes physically aroused when uncle who sexually abused him is present. Client has flashbacks, at least weekly, about friend's death in house fire 2 years ago.

ATTENTION

Inattention

- Identify and describe the specific signs of inattention.
- Examples: Client reports problems with concentration and attention resulting in great difficulty in finishing what he starts. Client becomes easily distracted resulting in two warnings at work. Supervisor complains that client is frequently off-task and constantly seems lost with regard to assignments.

COMMUNITY RESOURCES

Access and Knowledge

- Identify and describe needs in the area of community services.
- Examples: Does client know about and how to access community services, self-help groups, food programs, and public transportation?

DEMENTIA

Dementia

- Identify and describe memory loss or impaired cognitive function.
- Examples: Client reports problems with remembering to eat or take medications or pay bills. Client reports a significant decline from previous level of cognitive functioning. Gradual and continuing onset of cognitive decline.

DISSOCIATIVE

Dissociative

- Identify and describe involuntary escape from reality through amnesia or alternate identities, usually a reaction to trauma.
- Examples: Client reports unexplained memory loss or chronic sense that their identify or the world around them is blurry or unreal. Client or others report a dramatic change in behavior when under stress.

EATING

Nutritional/Eating Pattern Changes/Disorders

- Identify any nutritional or eating disorders or problems.
- Examples: Client reports weekly binging and purging cycle. Client has had weight gain of 30 lb. past 2 months but states she is not pregnant. She has not been tested. Client noncompliant with prescribed diet for diabetes and gets into power struggles with parents about diet.

EDUCATION

- Identify and describe educational needs.
- Examples: Is educational level sufficient? Are there areas where family education would assist family in providing better support for the client?

HOUSING

Stable and Sufficient

- Identify and describe housing needs.
- Example: Is the client at risk of losing housing? Are they able to maintain a clean environment, abide by rules and contribute to maintenance if living with others?

HYGIENE/GROOMING

- Identify and describe care of personal hygiene
- Examples: Does the client care for personal cleanliness, hair, brushes teeth daily, dresses in clean clothes appropriate for the weather?

IMPULSE CONTROL

Anger/Aggression

- Identify and describe problems related to client's display of anger.

- Examples: Client reports angry mood almost all of the time. Client states she blows up easily when teased at work and her first response is to strike out. Client has been suspended from work for acting out behavior.

Impulsivity

- Identify and describe the specific signs of impulsivity.
- Examples: Client engages in risk-taking behavior without considering consequences resulting in frequent warnings from local police. Client appears to act without thinking especially with regards to family members who they claim are afraid to be alone with him.

Oppositional Behaviors

- Identify and describe the specific oppositional behaviors.
- Examples: Client refusing to participate in chores at residential facility. Client not attending morning groups as required by parole.

LEGAL

- Identify and describe legal problems
- Examples: Client needs assistance and/or linkage to address legal issues

MOOD

Depressed Mood/Sad

- Identify and describe symptoms of depression.
- Examples: Client reports constant feelings of sadness and irritability. Parent reports client seems unhappy, "not himself" for past six months, but do not know if there was a precipitant.

Mood Swings/Hyperactivity

- Identify and describe the specific signs/symptoms of mood swings/hyperactivity.

- Examples: Client reports sudden shift of mood from quiet and clam to agitated and hyperactive behavior with no apparent stressor or precipitating event. Client cannot sit still; always on the go; restless.

PERSONALITY

Personality

- Identify and describe an enduring pattern of inner experience and behavior in thinking, feelings, interpersonal functioning, or impulse control that markedly deviates from the person's culture.

- Examples: Client reports significant distress or impairment in important areas of functioning. The pattern of behavior is stable and of long duration, tracing back to at least adolescence or early adulthood.

PHYSICAL

Pain Management

- Identify pain that interferes with activities, if present. Indicate the degree of interference and indicate the source of pain, if known. Note any current treatment including prescribed or OTC medications and prescriber, if applicable.
- Examples: Client reports severe headaches 3x per week that interfere with work. Client has pain daily since leg surgery, cries every evening, but is refusing pain medication which she believes gives her nightmares.

Sleep Problems

- Identify and describe the specific sleep problems.
- Examples: Client reports insomnia "most nights." Client indicates it takes 2-3 hours to fall asleep most nights.

Health Issues/Medical History (Include any Allergies and Food/Drug Reactions)

- IDENTIFY CLEARLY ANY ALLERGIES AND DRUG/FOOD SENSITIVITIES TO MEDICATION OR OTHER SUBSTANCES. List the key health issues that are having a current impact on client. Include all current medical problems and include description of current level of acuity. If client is receiving treatment, list from whom and include other pertinent information. It may be important to explore recent or past medical issues that are no longer current as well.
- Examples: Client has multiple problems with pain in legs as a result of early physical abuse by step-father. Client on medication for seizure disorder for 10 years. Client was recently diagnosed with diabetes and is on oral medication and prescribed diet. Client has not received physical or dental exams for past 3 years.

PRODUCTIVITY

- Identify and describe functioning in primary role

- Examples: Discuss whether client is working in paid employment, has a volunteer position, is a home manager or other primary role. Do they have a sense of meaning in how they spend their time?

PSYCHOTIC

Disturbed Reality Contact

- Identify and describe the specific signs related to disturbed reality.
- Examples: Client reports auditory hallucinations. Client disoriented during interview; appeared to respond to internal stimuli; described visual hallucination. Residential staff reported client frequently expresses delusional beliefs.

SAFETY

- Identify and describe maintenance of personal safety
- Examples: Does the client move safely around the community? Do they make safe decisions? Is client safe in the kitchen using appliances and knives?

SEXUAL/ GENDER ISSUES

Sexual Dysfunctions (including sexual desire or arousal disorders)

Gender Identity Disorders

- Identify and describe any sexual difficulties that is causing marked distress or interpersonal problems

- Identify and describe a strong and persistent cross-gender identification and persistent discomfort with his/her sex

SOCIAL NETWORK

- Identify and describe quality of interactions with close social network
- Examples: Describe client's network of friends, neighbors, co-workers and peers. What is the quality of the relationships?

Symptom and Function Based Problem List for Children and Adolescents

ADDICTIONS

Substance Use/Addiction

- Summarize information about current drug/alcohol abuse.
- Examples: Client currently in recovery from cannabis addiction and enrolled in intensive outpatient program. Client suspended from school for drinking on the grounds. He does not have a plan for assessment or treatment of possible addiction problem.

Other Addictive Behaviors

- Identify and describe specific behaviors.
- Examples: Client reports weekly gambling that requires him to steal from family members. Client reports daily use of internet pornography.

ADJUSTMENT/ BEREAVEMENT

Bereavement Issues

- Identify any bereavement issues identified by client and the length of time since the cause(s) of the bereavement occurred.
- Examples: Client's biological mom died 6 months ago and client has been living with grandmother since the death. Grandmother reports significant problems with school since mom's death including fighting and unruliness, frequent detention, and poor grades.

Adjustment Issues

- Identify and describe adjustment issues, the length of time, and identifiable stressor.
- Examples: Client and family moved to a new neighborhood and had to leave good friends behind. Parents are getting a divorce. Child is now acting up at school, not completing homework, cries a lot, and fears separation from mother.

ANXIETY

Anxiety

- Identify and describe symptoms of anxiety.
- Examples: Client reports constant feelings of worry and uneasiness. Parent reports client is afraid of playing outdoors and will not go outside without parent. Client will not or cannot explain why change in behavior. Parents report client participates in obsessive rituals in morning resulting in client being frequently late for school.

Traumatic Stress

- Identify if client is reporting stress related to current or past traumatic events. Summarize, where possible, the traumatic events that are the reported cause of the stress.
- Examples: Client has nightmares 4x per week since auto accident 3 months ago. Client startles, becomes physically aroused when uncle who sexually abused him is

present. Client has flashbacks, at least weekly, about friend's death in house fire 2 years ago.

ATTENTION

Inattention

- Identify and describe specific behaviors.
- Examples: Client reports problems with concentration and attention. Parent reports client never finishes what he starts and becomes easily distracted. Teacher indicates client is frequently off-task, constantly seems lost with regard to assignments, and frequently does not finish in time allotted for tests, quizzes, and in-school assignments.

EATING

Nutritional/Eating Pattern Changes/Disorders

- Identify any nutritional or eating disorders or problems.
- Examples: Client reports weekly bingeing and purging cycle. Client has had weight gain of 30 lb. past 2 months but states she is not pregnant. She has not been tested. Client noncompliant with prescribed diet for diabetes and gets into power struggles with parents about diet.

ENVIRONMENTAL SUPPORTS/ SKILLS TRAINING

Client's Family Needs Education to be Able to

- Identify areas where family education would assist them in providing better support for the client.

Client Needs Other Environmental Supports

- Identify areas where environmental supports are needed to support the client in community living (i.e., housing, food, social supports, etc.) Identify also possible sources of that support.

Other Problems or Skills Training Needs

- Identify any other problems or skills training needs identified by client and/or others involved in the assessment process.

Skills Deficit/Skills Training/Community Support Needs

- Identify areas where community support services or linkages to appropriate services are needed. In the narrative section describe the specific skill deficits or areas where improvement/skills training are needed. These should be prioritized.

GENDER IDENTITY

Gender Identity

- Identify and describe a strong and persistent cross-gender identification and persistent discomfort with his or her sex.
- Examples : Preference for cross dressing, cross sex roles in make believe play, intense desire to join in games or pastimes of other sex, insistence that he or she is the other sex, assertion that genitalia are disgusting and will disappear.

IMPULSE CONTROL/ DISRUPTIVE BEHAVIOR

Anger/Aggression

- Identify and describe problems related to client's display of anger or anger management.
- Examples: Client reports angry mood almost all of the time. Client states she blows up easily when teased at school, and her first response is to strike out. Parents report client has physically attacked two children in past week, although none experienced significant injuries.

Oppositional Behaviors

- Identify and describe specific behaviors.
- Examples: Client describes negative and hostile view of teachers and parents. Client argues daily with parents about routine rules and expectations often refusing to complete chores, assist with care of siblings, and complete homework.

Impulsivity

- Identify and describe specific behaviors.
- Examples: Client engages in risk-taking behavior without considering consequences resulting in frequent warnings from local police. Parents complain that client appears to act without thinking especially with regards to interactions with siblings who they claim are afraid to be alone with him.

MOOD

Depressed Mood/Sad

- Identify and describe symptoms of depression.
- Examples: Client reports constant feelings of sadness and irritability. Parent reports client seems unhappy, "not himself" for past 6 months but do not know if there was a precipitant. Client endorsed all depression items as "frequent" on depression scales.

Mood Swings/Hyperactivity

- Identify and describe specific behaviors.
- Examples: Client reports sudden shifts of mood that he cannot control and that at times scare him. Parents report quick mood swings form quiet and calm to agitated and hyperactive, resulting in frequent scolding by teachers which embarrass and anger client. Client can't sit still, always on the go, restless resulting in poor school performance.

PHYSICAL (PAIN, SLEEP, HEALTH)

Pain Management

- Identify pain that interferes with activities, if present. Indicate the degree of interference and indicate the source of pain, if known. Note any current treatment including prescribed or OTC medications and prescriber, if applicable.
- Examples: Client reports severe headaches 3x per week that interfere with schoolwork. Parent reports client has pain daily since leg surgery, cries every evening, but is refusing pain medication which she believes gives her nightmares.

Sleep Problems

- Identify and describe specific behaviors.
- Examples: Client reports having insomnia "most nights." Parents describe client as taking 2-3 hours to fall asleep most nights resulting in frequent complaints by teachers of client sleeping in class.

Enuresis/Encores

- Describe specific behaviors.
- Examples: Client reports nocturnal enuresis. Parents report that this continues to cause embarrassment and distress for client with siblings.

Health Issues/Medical History (include any allergies and food/drug reactions)

- IDENTIFY CLEARLY ANY ALLERGIES AND DRUG/FOOD SENSITIVITIES TO MEDICATION OR OTHER SUBSTANCES. List the key health issues that are having a current impact on client. Include all current medical problems. Include description of current level of acuity, if client is receiving treatment, from whom, and other pertinent information. It may be important to explore recent or past medical issues that are no longer current as well.
- Examples: Client had multiple spina bifida surgeries, related issues of pain management and prolonged school absences. Client dislikes medications for seizure disorder and is noncompliant with medication regime. Client has not received physical or dental exams for past 3 years.

<u>PSYCHOTIC</u>

Disturbed Reality Contact

- Identify and describe specific behaviors.
- Examples: Client reports auditory hallucinations; client disoriented during interview, appeared to respond to internal stimuli; described visual hallucination. Parents reported client frequently expresses delusional beliefs.

<u>SOCIAL OR FAMILY CONCERNS</u>

Psychosocial Stressors

- List the key stressors as identified by client and/or family.
- Examples: Client reports distress related to recent change of his residence from foster care to residential program. Client very anxious since mom's move to live with her sister who he believes is a drug addict. Client's childhood friend died unexpectedly this past month from long standing medical problems. Client is being threatened by group at school after he reported them to school authorities.