Washington State Department of Social and Health Services

Transforming Lives

Providing and Documenting Medically Necessary Behavioral Health Services

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KR6

Objectives

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

- Identify Medicaid documentation rules
- Explain that services rendered must be well documented and that documentation lays the foundation for all coding and billing
- Understand the term “Medical Necessity”
- Describe the components of Effective Document of Medical Necessity:
  - Assessment
  - Planning Care
  - Documenting Services
- Identify key elements to avoid repayment and other consequences

Slide 2

KR6 Kathy will do

Kathy Robertson, 9/24/2016

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Goals

- Participant will become familiar with Medicaid documentation rules.
- Participant will discover the importance of complete and detailed documentation as the foundation for coding, billing and quality of care for the client.
- Participant will learn how insufficient documentation leads to both poor client care and to improper payments.

The Golden Thread

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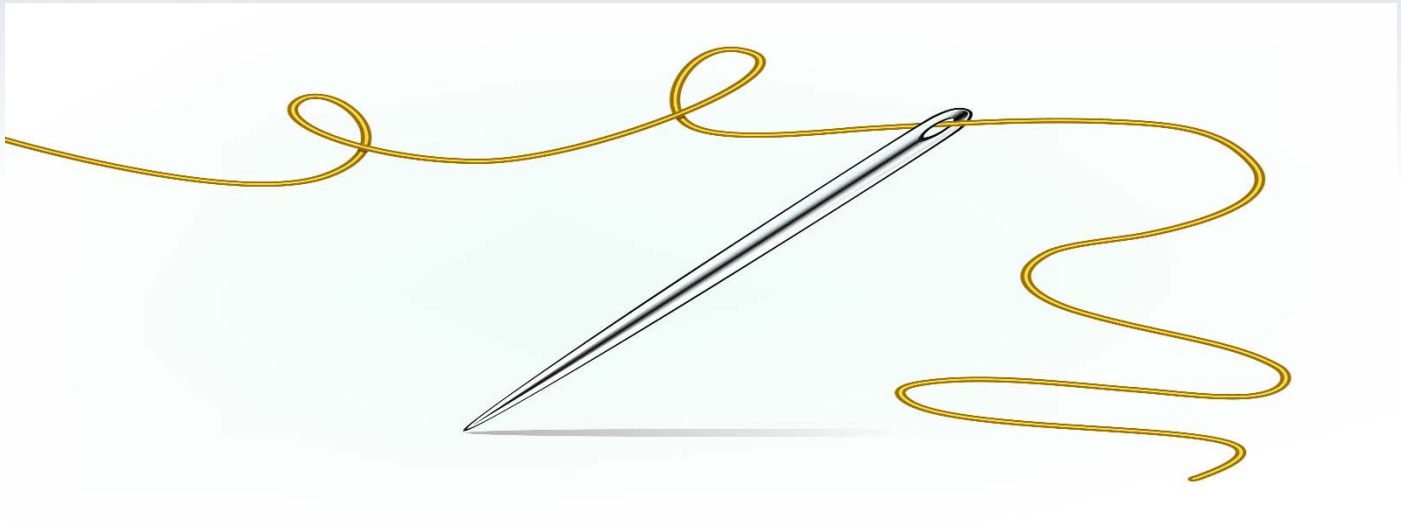
It is the Practitioner's responsibility to ensure that medical necessity is firmly established and that The Golden Thread is easy to follow within your documentation.



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Medical Necessity Contract Definition

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- The service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction.
- There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable.

KR5 David Section

Kathy Robertson, 9/24/2016

Medical Necessity Contract Definition

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- This course of treatment may include mere observation, or where appropriate, no treatment at all.
- Bottom line: the treatment interventions must help the person get better, or at the very least, prevent a worsening of the person's health.

Medical Necessity

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- Requires that all services/interventions be directed at a medical problem/diagnosis and be necessary in order that the service can be billed
- A claims based model that requires that each service/encounter, on a *stand alone basis, reflects the necessity for that treatment intervention

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

Why Document Medical Necessity?

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

- Coordinate services and provides continuity of care among practitioners
- Furnish sufficient services
- Improve client care – provides a clinical service map
- Comply with regulations (Medicaid, Medicare and other Insurance)
- Support claims billed
- Reduce improper payments
- Medical record is a legal document

Tests for Medical Necessity

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- There must be a diagnosis: ICD 10
- The services ordered are considered reasonable and effective for the diagnosis
  - Directed at or relate to the symptoms of that diagnosis
  - Will make the symptoms or persons functioning get better or at least, not get worse
- The ordered services are covered under that person's benefit package (State Plan Services)

State Plan Services

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

What is included in the State Plan?

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

- Methods of administration
- Eligibility
- Services covered
- Quality control
- Fiscal reimbursements

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

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Golden Thread

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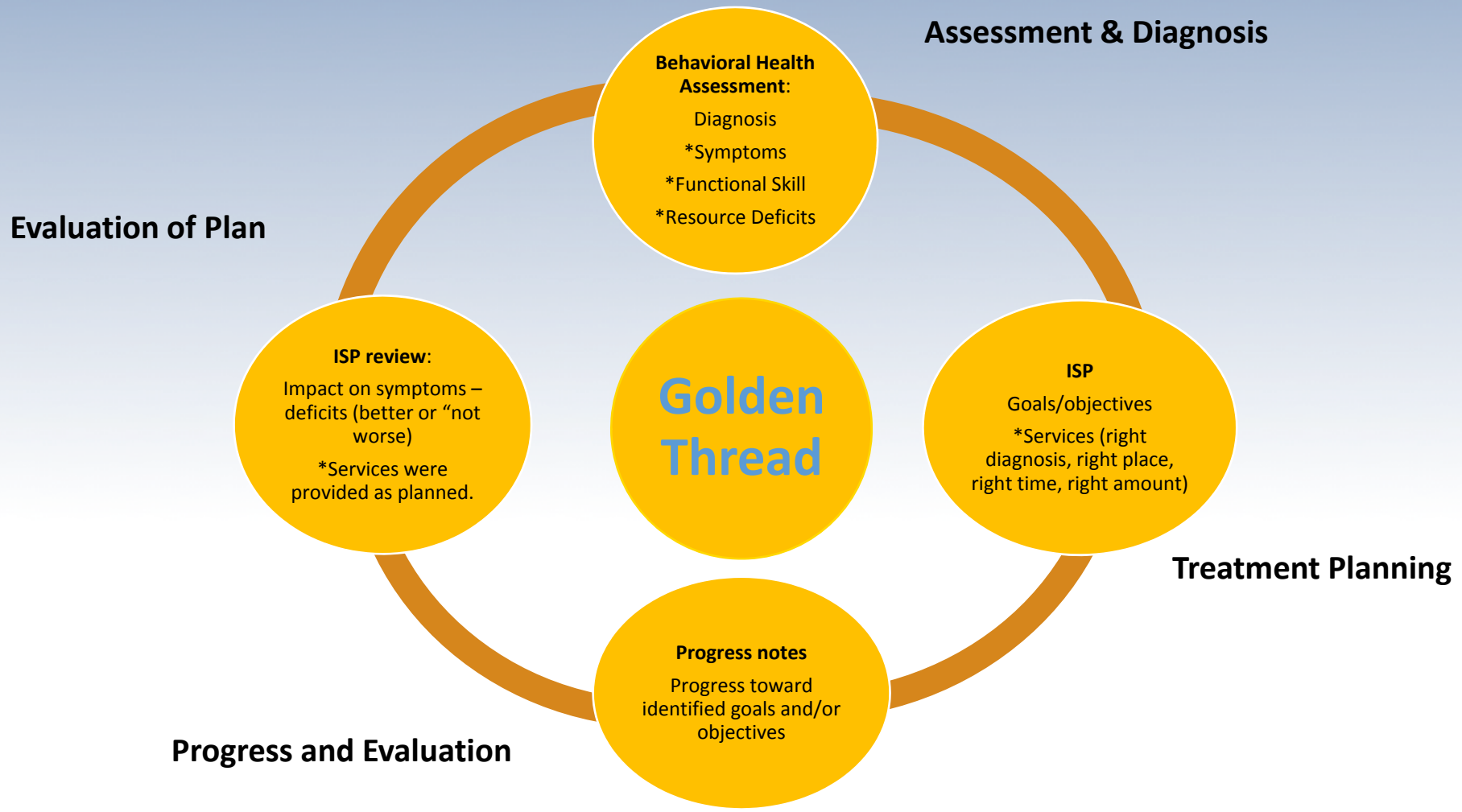

Slide 11

KR9 Crystal

Kathy Robertson, 9/24/2016

The Golden Thread

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- There are documented assessed needs
- Needs lead to specific goals
- There are treatment goals with measurable objectives
- There are specific interventions ordered by the practitioner
- Each intervention, is connected to the assessed need, ordered by the treatment plan, documents what occurred and the outcome

Difficulty Following The Golden Thread

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Assessment Deficits

- Diagnosis poorly supported
- Symptoms, behaviors and deficits underlined
  - No baseline against which to determine progress or lack

Individual Service Plan/Care Plan

- Goals and objectives unrelated to assessed needs/symptoms/behaviors and deficits (example: “comply with treatment”)

Progress Notes

- Documents “conversations” about events or mini-crisis
- Does not assess behavior change, (i.e. progress toward a goal or objective)
- Does not spell out specifics of intervention(s) used in session.

Components of the Golden Thread

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- Assessment
- Individual Service Plans (aka: Treatment plan, Care plan)
- Progress Notes

Slide 14

KR10 Marc

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The Intake Assessment

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- Diagnosis with clinical rationale: how the diagnostic criteria are present in the person's life
  - Based on presenting problem (Reflect an understanding of unmet needs relating to symptoms and behaviors)
  - Data from client—their story and the client's desired outcome
  - Observation
- Safety or risks
- Client functioning
  - Evidence that the diagnosis/client condition, causes minimally, moderate distress or functional impairment in Life Domains
- Recommendation for treatment and level of care.

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Assessment

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WAC Required Elements for Assessments

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- WAC 388-877-0610
- Clinical—Initial assessment.
- Each agency licensed by the department to provide any behavioral health service is responsible for an individual's initial assessment.

1. The initial assessment must be:

   a) Conducted in person; and

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

WAC Required Elements for Assessments continued

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2) The initial assessment must include and document the individual's:
   a) Identifying information;
   b) Presenting issues;
   c) Medical provider's name or medical providers' names;
   d) Medical concerns;
   e) Medications currently taken;
   f) Brief mental health history;
   g) Brief substance use history, including tobacco;

WAC Required Elements for Assessments continued

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2) The initial assessment must include and document the individual's - continued:
   - g) Brief problem and pathological gambling history;
   - h) The identification of any risk of harm to self and others, including suicide and/or homicide;
   - i) A referral for provision of emergency/crisis services must be made if indicated in the risk assessment;
   - j) Information that a person is or is not court-ordered to treatment or under the supervision of the department of corrections; and
   - k) Treatment recommendations or recommendations for additional program-specific assessment

Individual Service (Treatment) Plan

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A Quality Plan should:

- be linked to needs identified in the assessment
- include desired outcomes relevant to the presenting problems and symptoms and utilize client's words (How client knows when they are ready for discharge)
- have a clear goal statement
- include measurable objectives (how will practitioner and client know when an objective is accomplished)
- use client strengths and skills as resources
- clearly describe interventions and service types
- identify staff and staff type. (The staff should be qualified to deliver the care)
- address frequency and duration of interventions

WAC Requirements

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WAC 388-877-0620

(1)The individual service plan must:

- (a) Be completed or approved by a professional appropriately credentialed or qualified to provide mental health, chemical dependency, and/or problem and pathological gambling services.
- (b) Address age, gender, cultural, strengths and/or disability issues identified by the individual or, if applicable, the individual's parent(s) or legal representative.
- (c) Be in a terminology that is understandable to the individual and the individual's family.
- (d) Document that the plan was mutually agreed upon and a copy was provided to the individual.
- (e) Demonstrate the individual's participation in the development of the plan.
- (f) Document participation of family or significant others, if participation is requested by the individual and is clinically appropriate.
- (g) Be strength-based.
- (h) Contain measurable goals or objectives, or both.
- (i) Be updated to address applicable changes in identified needs and achievement of goals and objectives.
- (2) If the individual service plan includes assignment of work to an individual, the assignment must have therapeutic value and meet all the requirements in (1) of this section.
- (3) When required by law, the agency must notify the required authority of a violation of a court order or nonparticipation in treatment, or both.

Goals

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- Behavioral description of what the individual will do or achieve in measurable terms, directly related to the diagnosis and the presenting problem
- Often describe barriers to be resolved in order that the goal may be met
- Tied to discharge and transition planning

Example:

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

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

Objectives

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- Objectives are smaller, must be measurable (if Goal is not) steps for the client to accomplish on the road to his/her recovery (discharge goals)
  - Specific and focused
  - Can be step-by-step
  - 2 or 3 at most for each goal
  - Realistic and specific
  - Measurable – focused on measurable change or events within a specified time period. (Example: as evidence by an observable behavioral change, times per week, every time, etc.)
  - Try not to use words like “improve” or “increase” or “decrease” <u>unless they are tied to a measurement</u>. (Example: 3 times weekly, daily, rating scale (with scale defined)

Key Elements of a Quality Objective

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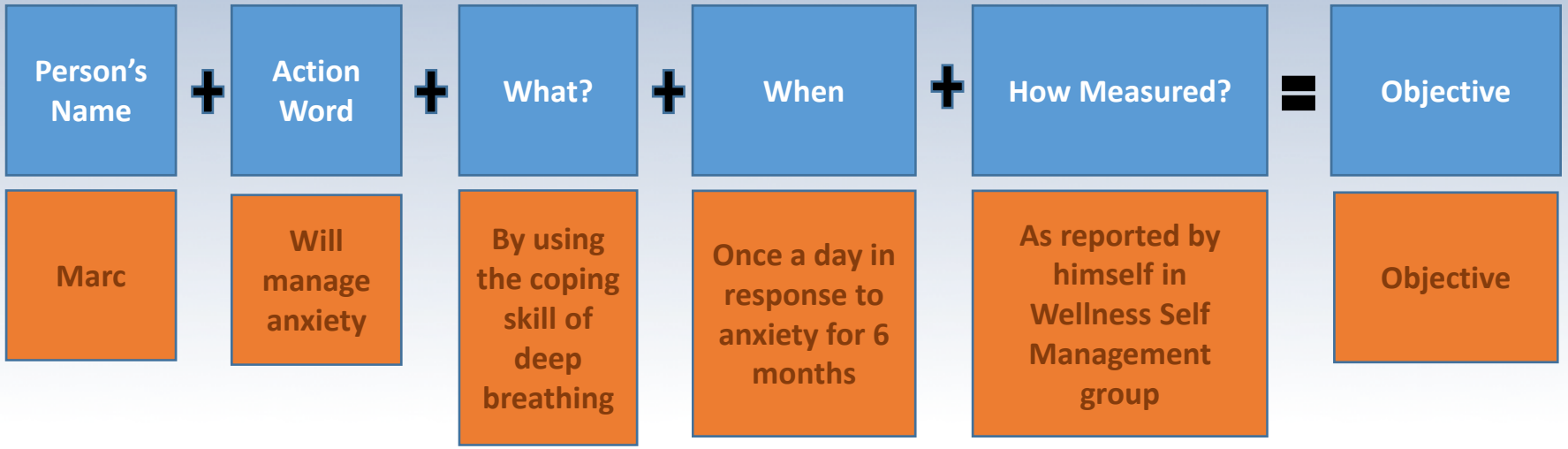

Interventions

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- Interventions are the specific clinical actions providers will do to help the client achieve their objectives
- Must be linked to treatment plan goals and objectives
- Should be an activity and demonstrate what is occurring in the interaction with the client
- Must include the frequency and duration of the intervention

Tips:

- Staff will: use active verbs in describing what staff will do
- Time period: length of time you will do the above action
- Frequency: how often you will do it
- Type of treatment service to be provide (Group therapy, cognitive behavioral therapy, family therapy, individual therapy) and a reason for it

Interventions - Examples

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- Type of treatment service to be provide (Group therapy, cognitive behavioral therapy, family therapy, individual therapy) and a reason for it
  - Use Cognitive Behavioral Therapy (CBT) to assist individual in identifying relapse triggers 1x/week for 6 months
  - 1x/week for the next 6 months teach the client self-calming techniques to use during high stress activities through discussion modeling and role-play

Treatment Plan - Examples

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

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

Objective: Sally will learn five triggers for alcohol and drug use.

Intervention: 1x/week for the next 4 weeks clinician will utilize Cognitive Behavioral Therapy techniques to assist Sally in identify Sally's triggers for alcohol and drug use.

Treatment Planning Tips

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- The treatment plan is a "contract" with the client that outlines the course of therapy and expected achievements.
- Reviewer should see both a plan and a progress note describing the treatment planning process:
  - Summarize who participated, individual's level of participation/family involvement (critical for children/youth) and primary goals/objectives set, etc.
- Client should be given a copy of the plan
- Plan will be changed or updated as issues are resolved or new issues emerge.

Treatment Plan Reviews

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- At least every 6 months (or earlier depending on contract and WAC requirement) review diagnosis, goals, progress, new issues, etc.,
  - Analyze the effectiveness of the treatment strategy
  - Reevaluate client's commitment to treatment & relevancy of goals
  - Discuss progress or lack of progress and how the treatment strategy will be modified (if at all) in response
  - Document either in a progress note or on a separate form

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Treatment Plan Reviews continued

- Revised, update, or continue the treatment plan based on reassessment. Explain the reasons for your decisions.
  - If there is progress, consider next steps. Ready for discharge?
  - If there is no progress, revise goals, treatment strategy, diagnosis, etc., as needed
- Get new signatures to indicate continued agreement.
- Start the Golden Thread cycle over again

Frequent Treatment Plan Problems

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- Goals and objectives are the same as interventions
- Too many goals; plan too complicated
- Goals reflect provider concerns and needs rather than those of the client
- Too difficult to understand
- Goals do not address Medicaid billable services (not a requirement for all goals, but for reimbursable treatment plans there must be some Medicaid reimbursable goals identified.)
- Goals do not address the diagnosis, symptoms or need
- Goals are not identified in a strength based manner
- Goals are not linked to discharge or transition from care

Progress Notes

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

Progress notes provide evidence of:

- The covered service delivered
- The Individual's active participation
- Progress toward the goals and objectives
- On-going analysis of treatment strategy and needed adjustment
- Continued need for services (medical necessity)

Progress Notes continued

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- Must be written for each encounter
- Must address the goals and objectives of the treatment plan
- Must document the intervention via the services ordered by the treatment plan
- Services not tied to the treatment plan need to be clearly identified.
  - Rule of 3 – If a service not on the treatment plan occurs more than 3 times it must be added to the treatment plan
  - "intervention is not part of the treatment plan"
- If different services are needed: plan must be revised

Progress Note Elements

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- Date of Service
- Start time and duration
- Goal and/or objective
- Location of service
- Service code (local or CPT/HCPC)
- Medical necessity (purpose of encounter)
- States the intervention(s) used: techniques targeted to achieve the outcomes provider is looking for
  - More specific than just “individual therapy”
- Assessment and clinical impression

Progress Note Elements continued

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- Client response to the intervention
  - Were they able to demonstrate the skill or participate in role playing?; Could they list how to apply the skills being taught? Or did they not get it, refuses to participate, resist, etc.
- Plan for next interaction
- Optional: homework assignment or other task to complete before the next visit
- Note must be legible
- Legible signature of the provider
- Date the actual progress note was completed

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Examples

Example 1:

Date: 08/01/2015	**Start time:** 1:30pm
Location: 99-other place of service	**Duration**: 240 min
Provider type: 05- Below Master's Degree	**Code**: H0004- behavioral health counseling and therapy

- **Progress note**: Went to the clients home to provide additional support because the client was refusing to go on the family vacation.
- **Assessment**: client was open to the idea and was respectful.

- What are the key elements of the progress note present?

Medical Necessity	
Intervention	
Individual Voice	
Individual Response	
Objective/Link to ISP	
Progress	
Plan/Next Steps	

Answer to Example 1:

Key Elements with the Progress Note:

Medical Necessity	**Not provided**
Intervention	Not clear what “additional support” was provided
Individual Voice	Not provided
Individual Response	Not clear (open to idea – not sure what idea?)
Objective/Link to ISP	Not provided
Progress	Not provided
Plan/Next Steps	No plan identified

Note did not identify the management, reduction or resolution of the identified problems.

Example 2:

Date : 08/25/2015	**Start time:** 1:30pm
Location: 99-other place of service	**Duration**: 55 minutes
Provider type: 4- MA/Ph.D	**Code**: 90847- Family Therapy with Individual

- **Progress note:** Joe's mother, Sally, reports that she offered choices (a parenting technique from last week's session) in order to set limits with Joe on two occasions this week, instead of previous practice of yelling at Joe. She reports that Joe was able to make a "good choice" (i.e., not have an angry outburst) on one of these occasions, which represents an improvement as Joe previously "almost never" made a "good choice" per Sally. Sally agreed to continue trying to remember to offer Joe choices instead of yelling this coming week, say she will attempt to offer choices three times. Reviewed with Joe and Sally reciprocal trust and security for both Joe and Sally as they continue to develop a more mutually responsive relationship. We also reviewed several behavioral observations which indicate behavioral triggers for Joe, e.g. being late for pick up, eating a late dinner and brushing teeth. Practitioner reframed the behavioral observations for Sally towards understanding that Joe is communicating his fear and possible anxiety and his outbursts are a function of his desire for getting his needs met. Next session we will continue to build on sustainable relationships and behavior identification.

- What are the key elements of the progress note present?

Medical Necessity	
Intervention	
Individual Voice	
Individual Response	
Objective/Link to ISP	
Progress	
Plan/Next Steps	

Answers to Example 2:

Key Elements with the Progress Note:

Medical Necessity	Anxiety/anger outburst
Intervention	Reframing. Reviewed behavioral observations which indicate behavioral triggers for Joe
Individual Voice	Report of making good choices: "almost never" "good choice" (mother reports improvement)
Individual Response	Agreement improvement and to continue offering choices technique
Objective/Link to ISP	Offering choices (parenting techniques) – setting limits
Progress	Improvement note (making good choice)
Plan/Next Steps	Next session will continue to build on sustainable relationships and behavioral identification.

Example 3:

Date : 03/20/2015	**Start time: 7:45pm**
Location: 23- Emergency room hospital	**Duration**: 255 min
Provider type: 4- MA/Ph.D	**Code**: 90847- family psychotherapy with patient present

- **Progress note**: Safety and determining stay location after discharge from ED. Staff met family at the Emergency Room after they called and said that client tried to grab a knife and cut himself and go after family members. Family members stated that they were done a month ago but that today was the last straw. They are scared for family safety. They do not want to have him home. Staff will look into short term stay location for him and will check in on him tomorrow.

- What are the key elements of the progress note present?

Medical Necessity	
Intervention	
Individual Voice	
Individual Response	
Objective/Link to ISP	
Progress	
Plan/Next Steps	

Answers to Example 3:

Key Elements with the Progress Note:

Medical Necessity	Identified a high risk factor
Intervention	No intervention provided – except statement of seeking short term stay location
Individual Voice	Not provided – not sure if client was present
Individual Response	Not provided – not provided for family either
Objective/Link to ISP	Not Provided
Progress	Not Provided
Plan/Next Steps	Check in tomorrow is not a plan for the individual nor does it state what will transpire.

Note reflects the family input into the individual presentation, identified concerns and family dynamics as they relate to the patient's mental status and behavior may have been the focus of the session, but is unclear. Attention was given to the impact the patient's condition has on the family, but it did not address the therapy aimed at improving the interaction between the patient and family members and for 255 minutes more treatment elements should have been identified.

Example 4:

Date : 06/02/2015	**Start time: 9:00 a.m.**
Location: 99-other place of service	**Duration**: 30 minutes
Provider type: 4- MA/Ph.D	**Code**: H2015 CCSS

- **Progress note:** Sally Smith, Jane's assigned probation officer (PO), Jane and I reviewed Jane's probation guidelines at clinician's office. Group explored Jane's perception of her guidelines (i.e. her frustration that she receives a probation violation each time she leaves the house without her foster parent's permission) and this appears to frequently trigger Jane's anger and often results in violent behavior. We all discussed how altering Jane's probation guidelines and leaving out the recommendation for a probation violation each time she leaves the home without permission might reduce some of her unsafe behavior at home. Jane was in agreement with this potential change, 'I want to go hang out with my friend and not get in trouble'. Jane will discuss some options with PO over the next week and review the outcomes with therapist at next session. Jane seemed enthusiastic about a possible positive outcome, 'I will go home right away and write down the plan I want to discuss'.

- **What are the key elements of the progress note present?**

Medical Necessity	
Intervention	
Individual Voice	
Individual Response	
Objective/Link to ISP	
Progress	
Plan/Next Steps	

Answers to Example 4:

Key Elements with the Progress Note:

Medical Necessity	Frequent triggers of anger and violent behavior
Intervention	Explored perception of Probation Guidelines, discussed alternatives to reduce unsafe behavior at home
Individual Voice	'I will go home right away and write down the plan…."
Individual Response	Jane was in agreement and plan to participate in development of plan
Objective/Link to ISP	Reviewed Jane's probation guidelines/anger outburst
Progress	Enthusiastic about possible outcome – goal to reduce anger outburst and unsafe behavior
Plan/Next Steps	Jane will discuss options with PO and discuss at next session

Amending and Appending Documentation

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

- When and how to add and modify documentation
- Must be dated
- Indicate who made the modification
- What the modification included
- Reason for the modification

Amending and Appending Documentation

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

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Amending and Appending Documentation - Late Entry

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

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

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Amending and Appending Documentation - Addendum

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

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

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Amending and Appending Documentation - Correction

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

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

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What to do if you have questions

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- Clinicians should discuss questions with their supervisors
- Supervisors should discuss with their BHA Quality Managers
- BHA quality managers should discuss with the BHO Quality Manager
- BHO quality manager can email the SERI workgroup: cpt-seriinquiries@dshs.wa.gov

Again Why follow the Golden Thread?

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To ensure quality of client care and better outcomes

Possible Consequences from audits:

- Loss of employment
- Repayment of funds
- Fines
- Criminal charges
- Loss of contract
- Loss of ability to do business with Medicare and Medicaid

Avoid “Improper payments” caused by:

- Missing documentation
- Incomplete documentation
- Wrong codes for services
- Services not covered by Medicaid

Questions?

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Remember:

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

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References

- Noridian Health Solutions 2016
- https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/documentation-matters.html
- ValueOptions-Innovative Solutions. Better Health
- http://apps.leg.wa.gov/WAC/default.aspx?cite=388
- https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/seri-cpt-information