Transforming Lives

Providing and Documenting Medically Necessary Behavioral Health Services Part Two: Individual Service Plans

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Webinar Controls

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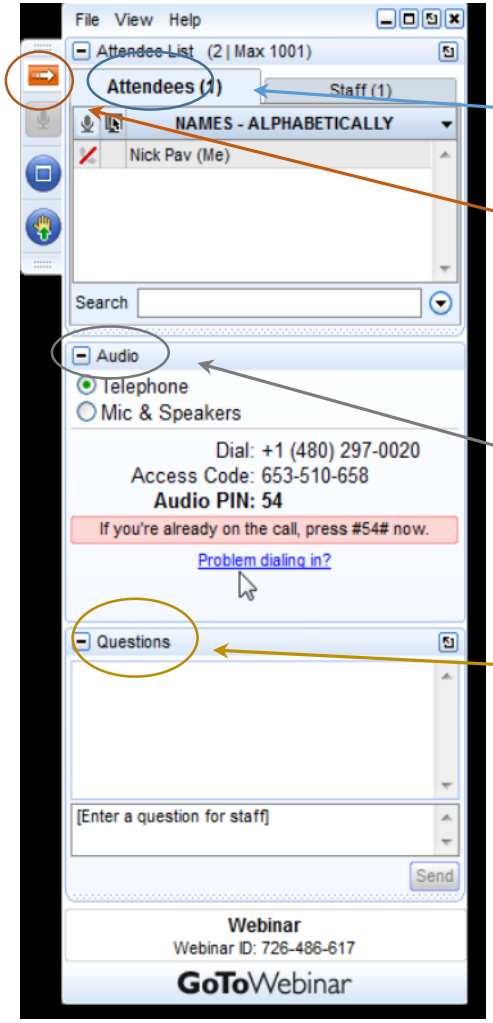
Webinar Controls



- Attendee List - Displays all the participants in-session
- Grab Tab –Allows you to open/close the Control Panel, mute/unmute your audio (if the organizer has enabled this feature) and raise your hand
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- Questions panel – Allows attendees to submit questions and review answers (if enabled by the organizer). Broadcast messages from the organizer will also appear here.

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

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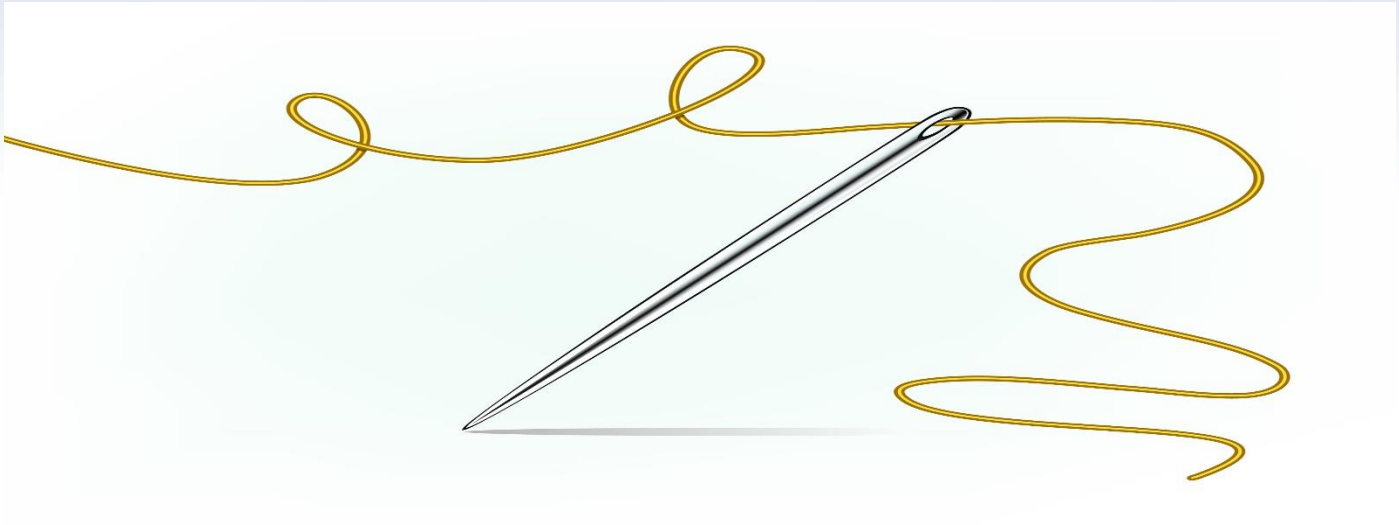
It is the Practitioner's responsibility to ensure that medical necessity is firmly established and that The Golden Thread is easy to follow within your documentation.



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)

Golden Thread

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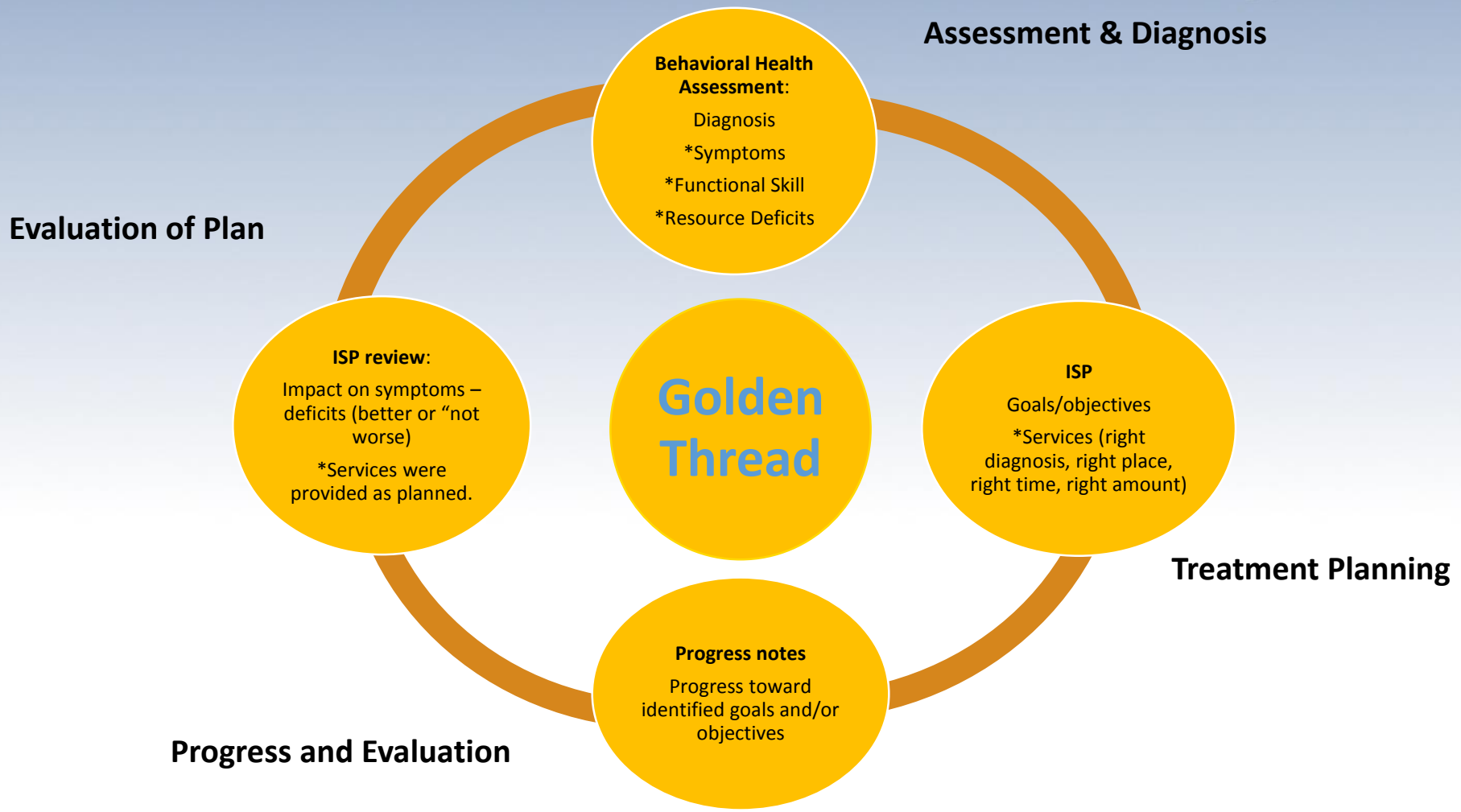

The Golden Thread

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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

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.

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

Interventions

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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

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Individual Service Plan Examples

Example of Treatment Plans – #1 for Substance Use Disorder services

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Individual's Goal: NA

Problem: Robert is continuing to use drugs while in treatment and has been referred to Intensive Outpatient Treatment

Treatment Goal: Robert will work on relapse prevention skills

- **Objective**: Robert will introduce himself to the group and share why his treatment has been intensified.
- **Objective**: Robert will identify his 5 most troublesome relapse warning signs and develop at least 2 alternatives to each. Share in group and ask for feedback.
- **Objective**: Robert will verbalize reasons why it is essential to work a daily program of recovery to maintain abstinence. Share in group and ask for feedback.
- **Objective**: Robert will complete and share in group Benefits of Not Drinking/Using Worksheet.

Intervention: Robert will attend group services for support.

Revised Example of Treatment Plans – #1: Substance Use Disorder services

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Individual's Goal: Robert "I want to stop using drugs, so I can see my family and feel better about myself".

Problem: Robert is continuing to use drugs while in treatment and has been referred to Intensive Outpatient Treatment

Treatment Goal: Robert will work on relapse prevention skills to assist him in his goal of abstinence in his recovery.

Objective: Robert will introduce himself to the group and share why his treatment has been intensified.

Objective: Robert will identify his 5 most troublesome relapse warning signs and develop at least 2 alternatives to each. Share in group and ask for feedback.

Intervention: CDP will provide services in a group setting as prescribed by the requirements under Intensive Outpatient Treatment program. Individual will receive 3 hour of group services three days per week for the next 30 days.

Objective: Robert will verbalize reasons why it is essential to work a daily program of recovery to maintain abstinence. Share in group and ask for feedback.

Objective: Robert will complete and share in group Benefits of Not Drinking/Using Worksheet.

Intervention: CDP will provide work book for Robert to utilize and will facilitate discussion on barriers and successes during group services. Individual will receive 3 hours of group services three days per week for the next 30 days.

Examples of Treatment Plans #2: Substance Use Disorders

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Individual's Goal: NA

Problem: Todd continues to withdraw and isolate from people and activities outside of his comfort zone.

Treatment Goal: Todd would like to reach out and engage in volunteer work, participate in healthy activities with family and friends, extend the number of people he includes in his community.

Objective: Todd will continue to add to his phone list names an phone numbers of individuals either recovery, or individuals who may provide support to him. Todd keep a log of individuals whom he has made contact with and report to group the outcome of.

Objective: Todd will attend his first meeting with Minnie Duck from Salvation Army to discuss volunteer work. Todd will consider continuing to volunteer and make a plan with Minnie to continue to do so..

Objective: Todd will continue to identify healthy activities during 3:00 p.m. and 6:00 p.m. Todd will add new activities to participate in during the that time. He will identify new activities to share them with the group members.

Revised Example of Treatment Plans – #2: Substance Use Disorder services

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Individual's Goal: Todd "I want to be around people I like who aren't getting drunk"

Problem: Todd continues to withdraw and isolate from people and activities outside of his comfort zone, this has been a factor for Todd in maintaining his recovery from alcohol abuse.

Treatment Goal: Todd will develop supports for his recovery by reaching out and engage in volunteer work, participate in healthy activities with family and friends, extend the number of people he includes in his community.

Objective: Todd will continue to add to his phone list names an phone numbers of individuals either recovery, or individuals who may provide support to him. Todd keep a log of individuals whom he has made contact with and report to group the outcome of.

Intervention: Todd currently has two supportive individuals identified in his phone tree, CDP will provide Todd with opportunities during groups and encourage Todd to identify other resources in the community. Todd's goal is to have 5 new numbers within 30 days of treatment. Clinician will provide 1 group session for 60 minutes weekly for the next 30 days.

Objective: Todd will attend his first meeting with Minnie Duck from Salvation Army to discuss volunteer work. Todd will consider continuing to volunteer and make a plan with Minnie to continue to do so.

Objective: Todd will continue to identify healthy activities during 3:00 p.m. and 6:00 p.m. to avoid trigger of alcohol consumption. Todd currently has 4 activities to assist him in his recovery and will add 4 new activities to participate in during the that time. He will identify new activities to share them with the group members.

Intervention: CDP will provide support to Todd in the development of healthy activities, during group services 1x per week for 90 minutes for the next 30 days.

Example of Treatment Plans – #3: Mental Health

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Individual's Goal: NA

Individual's Statement of Problem: Fighting for parental rights for daughter causes anxiety—heart races; hand sweat; paces; thoughts race; feels angry, anxious, irritated, sad, powerless.

Problem: Generalized anxiety disorder.

Treatment Goal: Decrease daily anxiety.

- **Objective**: Katri will learn and practice breathing techniques daily for five minutes.
- **Objective**: Katri will learn and practice relaxation techniques twice a week for five minutes.
- **Objective**: Katri will process stressors in weekly individual therapy sessions
- **Intervention**: Therapist will use active and reflective listening, motivational interviewing, cognitive-behavioral therapy, expressive therapy, relaxation techniques, focusing, and/or other techniques as appropriate.
- **Intervention**: Case Manager/peer support counselor will provide case management as needed.
- **Intervention**: Therapist will coordinate care with psychiatric medication provider at Family Health center.

Discharge Criteria: Katri's anxiety level will be at a 4 or 5 out of 10 (with 10 is the highest level) and majority of days for one month.

Revised Example of Treatment Plans—#3: Mental Health

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Individual's Goal: Regain custody of my daughter.

Individual's Statement of Problem: Fighting for parental rights for daughter causes anxiety—heart races; hand sweat; paces; thoughts race; feels angry, anxious, irritated, sad, powerless.

Problem: Katri is experiences symptoms of generalized anxiety disorder that are interfering in her ability address her legal issues addressing her parental rights for her daughter.

Treatment Goal: Katri will be able to decrease her experienced level of anxiety to assist in functioning level during stressful situations.

Objective: Katri will learn and practice relaxation techniques twice a week for five minutes. Katri will learn three new techniques (such as Deep Breathing as a relaxation technique) and will record on a daily log each time she practices the new relaxation technique with a goal of practicing the skill each time she feels anxious. Individual currently rates her anxiety at a 8 out of 10, with 10 being anxious most of the day and interfering with all aspects of her daily living.

Objective: Katri will process stressors in weekly individual therapy sessions

Intervention: Therapist will use active and reflective listening, motivational interviewing, cognitive-behavioral therapy, expressive therapy, relaxation techniques, focusing, and/or other techniques as appropriate. Therapist will meet with the client for 60 minutes, 1x every week for the next 6 months.

Intervention: Case Manager/peer support counselor will provide case management services 1x per month for 45 minutes for the next 6 months.

Intervention: Therapist will coordinate care with psychiatric medication provider at Family Health center 1x every 90 days for 30 minutes for the next 6 months.

Discharge Criteria: Katri's anxiety level will be at a 4 or 5 out of 10 (with 10 being anxious most of the day and interfering with all aspects of her daily living) and 20 or more days for one month.

Example of Treatment Plans – #4: Mental Health

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Individual's Goal: NA

Individual's Statement of Problem: NA

Problem: Depression.

Treatment Goal: Alleviate depressed mood and return to previous level of effective functioning.

Treatment Goal: Recognize, accept, and copy with feelings of depression.

Objective: Describe current and past experiences with depression complete with its impact on function and attempts to resolve.

Objective: Identify and replace cognitive self-talk that is engaged in to support depression.

Intervention: Assist the client in developing an awareness of his/her automatic thoughts that reflect a Depressogenic schemata.

Intervention: Assign the client to keep a daily journal of automatic thoughts associated with depressive feelings. Process the journal material to challenge depressive thinking patterns and replace them with reality-based thoughts.

Intervention: Assist the client in developing coping strategies (e.g., more physical exercise, less internal focus, increased social involvement, more assertiveness, greater need sharing, more anger expression) for feelings of depression; reinforce success.

Treatment Goal: Develop healthy interpersonal relationships that lead to alleviation and help prevent the relapse of depression symptoms.

Discharge Criteria: Client's anxiety level will be at a 4 or 5 out of 10 (with 10 is the highest level) and majority of days for one month.

Revised Example of Treatment Plans – #4: Mental Health

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Individual's Goal: Beverly "I want to work and be around people and feel good doing it"

Individual's Statement of Problem: Beverly "I feel that my mood prevents me from doing anything, I never want to get out of bed, I feel blah and I just don't care about anything"

Problem: Depression.

Treatment Goal: Client will be able to obtain and maintain a job in the community by managing his depressed mood/symptoms.

Treatment Goal: Client will be able to identify and using learn strategies for addressing his symptoms of depression (social isolation, tearfulness, emptiness, easily frustrated, loss of interest in sports). Currently individual is able to utilize "talk with someone he trust" strategy when feel depressed and will obtain three more strategies to assist him in managing his depression. This will be measured via a self report by the individual upon identification and practice of the three strategies he plans to utilize.

> **Objective**: Client will be able to describe his current and past experiences with depression complete with its impact on function and attempts to resolve to better understand what has worked in the past and what efforts have not been successful in addressing symptoms of his depression.
>
> **Objective**: Client will be able to identify and replace cognitive self-talk that is engaged in to support recovery of depression symptoms.
>
> **Intervention**: Clinician will assist the client in developing an awareness of his/her automatic thoughts that reflect a dysfunctional beliefs that are rigid, extreme, and counterproductive that lead to depression when under stress. This will be achieved through clinical sessions that will utilize cognitive behavioral therapy. Sessions will occur 1 X per week for 60 minutes for the next 180 days.
>
> **Intervention**: Clinician will assign the client to keep a daily journal of automatic thoughts associated with depressive feelings. Clinician and client will process the journal material to challenge depressive thinking patterns and replace them with reality-based thoughts. This will be achieved through clinical sessions that will utilize cognitive behavioral therapy. Sessions will occur 1 X per week for 60 minutes for the next 180 days.
>
> **Intervention**: Clinician will assist the client in developing coping strategies (e.g., more physical exercise, less internal focus, increased social involvement, more assertiveness, greater need sharing, more anger expression) for feelings of depression; reinforce success.

Discharge Criteria: Client's anxiety level will be at a 4 or 5 out of 10 (with 10 is the highest level) and majority of days for one month.

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

Amending and Appending Documentation

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Behavioral Health Organizations and Behavioral Health Agencies must 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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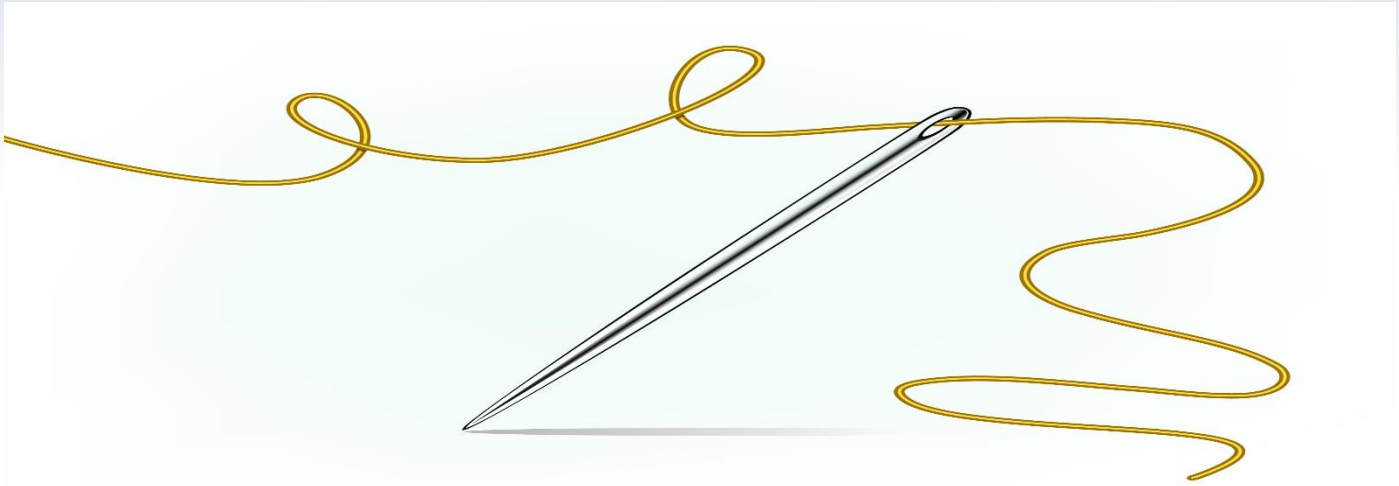
Remember:

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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