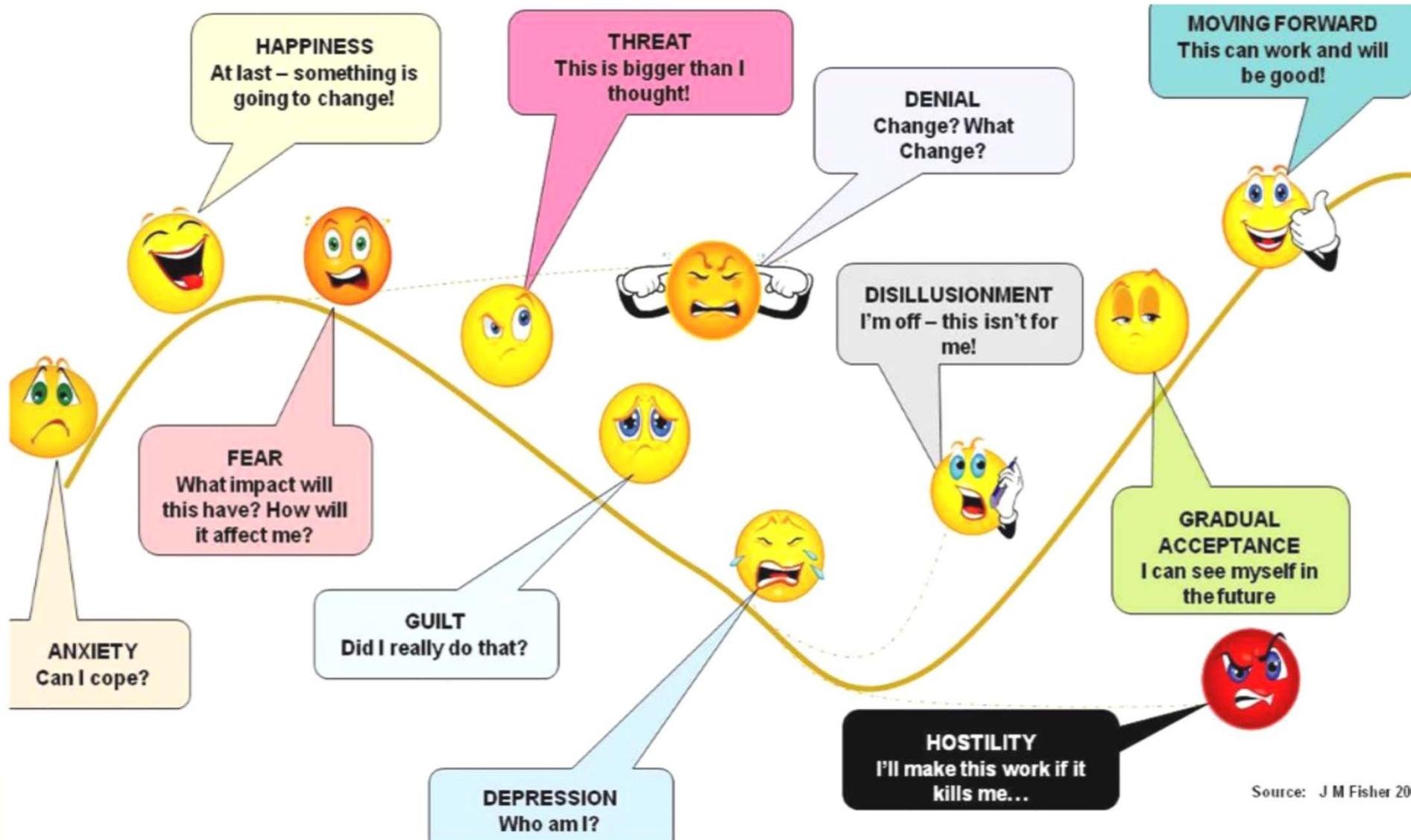




Documentation Training for SUD Providers

Colorado Health Partnerships
September, 2014





Source: J M Fisher 200



Healthcare World is Changing!

- Government healthcare programs seek to combat waste, fraud & abuse
- Medicaid (and Medicare) is currently one of the largest budget items in the federal budget and many states. Controlling costs by reducing waste and eliminating fraud and abuse is paramount.
- Compliance expectations have escalated, and documentation is being monitored and audited at all levels to determine whether the provider should be paid.



AUDITS & PAYBACKS

- Government is **recouping hundreds of millions of dollars** from providers because of “improper payments” caused by:
 - Missing documentation
 - Incomplete documentation
 - Wrong codes for services
 - Services not covered by Medicaid
 - Lots of other details



Today's Purpose

- Inform providers about changes in documentation standards that are necessary to bill Medicaid.
- Describe increasingly stringent requirements for documentation and claims
- Help providers maintain good status and help members continue to receive necessary services.
- Risks of noncompliance:
 - Recoupment (payment has to be returned)
 - Corrective Action Plans
 - Disenrollment from the Network



Medicaid is a Type of Insurance

- Medicaid is a *federal insurance* program and a *highly regulated business*.
- Medicaid pays for specific services that are medically necessary and require skilled assessments & interventions.
- Both the federal government and state government oversee & monitor the program, and when they have different opinions about the rules, we may get mixed messages.
- Without understanding the rules and regulations and properly documenting care, important services to persons who are suffering may be in danger of being curtailed.



Medicaid Mental Health Services

- Colorado is served by 5 Behavioral Health Organizations
 - Colorado Access Behavioral Health Care (Denver)
 - Behavioral Health Care, Inc. (Adams, Arapahoe, Douglas)
 - Colorado Health Partnerships (many south and western counties)
 - Foothills Behavioral Health (Boulder, Jefferson, Gilpin, Clear Creek, Broomfield)
 - Northeast Behavioral Health Partnership (12 counties in NE Colorado)
- CHP and FBHP have a management relationship with Value Options



Payment For Services

- Providers receive payment from the BHO based on claims submitted for covered services to an eligible individual, **regardless of what cost you incur.**
- Some services you provide are not reimbursed.
- A service is complete only when it has been documented and billed.
- Each claim is built on provider documentation and must be accurate.
- **The documentation providers write is the only evidence of the work they do.**



Why is Documentation so Hard?

- Documentation must consistently and accurately comply with multiple expectations.
- It is important to balance various expectations for documentation among:
 - the member (readable & understandable)
 - the treatment provider (convenient & practical)
 - the payer (justifies the claim)
 - the regulatory agencies (meets standards)



Medicaid Defines Services

Medicaid defines which services are covered and the specific rules for each service, including:

1. Who are the eligible providers for the type of service
2. Where the services may be provided
3. Minimum and maximum duration for the service
4. What is allowable content for the service
5. The approved mode of delivery of each service (face to face, phone, collateral, videoconference)
6. Accessibility requirements to avoid delays, e.g., crisis services are to be available 24 hours a day

Refer to HCPF Uniform Coding Standards Manual



Auditor's View of Documentation

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



Medical Necessity

Behavioral health services must be medically necessary to receive payment.

- Medical necessity is the criteria payers use to determine whether they will pay for a service.
- The provider must prove in the documentation that the service was necessary and covered.



Summarized Definition of Medical Necessity

- The individual has a behavioral health condition that
 - has produced a current problem in functional status,
 - as shown by signs and symptoms that interfere with normal daily functionality.
 - The problem can be helped by providing services listed on the treatment plan.



Six Components of Medical Necessity

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



Delivering a Medically Necessary Service

TREATMENT:

- ❖ Reducing or better managing signs and symptoms
- ❖ Improving functional status
- ❖ Preventing the condition from getting worse or maintaining functional status

REHABILITATION:

- ❖ Recovering functionality in daily life lost due to the condition.
- ❖ Preventing new morbidities when threatened by the individual's illness

CASE MANAGEMENT:

- ❖ Accessing and using community resources
- ❖ Coordinating care with other providers



Case Management Services

- CM services link an individual to necessary services, supports, & resources, and to coordinate those services to avoid duplication.
 - Community supports such as organizations, churches, recreation, schools, and other providers
 - Natural supports such as family, friends, neighbors, volunteers and other local community members
 - Services such as tutoring, medical services, income or housing assistance, additional mental health services, etc.
- Colorado requires Medicaid providers to coordinate care with primary medical services, and where possible, to integrate physical/MH/SUD treatment.



NOT All Services are Covered

- Some services that might be “good for” the client are not covered by Medicaid
 - Services to family members to benefit them exclusively and not the covered individual
 - Transportation
 - Social and recreational activities
 - Learning skills not specific to or effective for treating the diagnosis (learning to drive, getting one’s GED)



GOLDEN THREAD of DOCUMENTATION

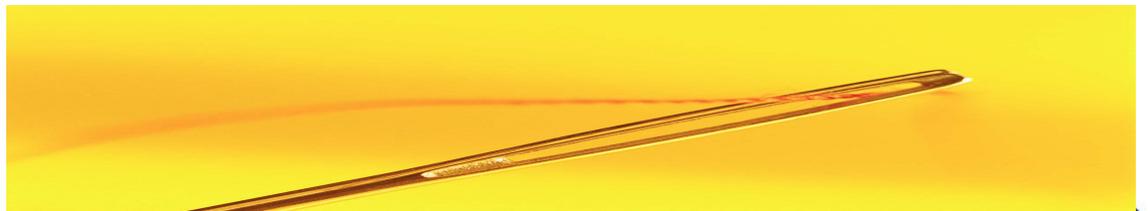
Each piece of documentation must flow logically from one to another so that a reviewer can see the logic.

- The assessment must be coherent, cohesive, & establish medical necessity, identifying symptoms & behaviors to be addressed in the treatment plan.
- The treatment plan structures treatment to accomplish identified goals/objectives using specific interventions.
- Progress notes must flow from the tx plan & document both the service provided and the client's response to the interventions.
- The notes then lead to the treatment plan review/update.
- Cycle continues until discharge.
- It is **golden** because, if accurately followed, documentation will support each decision, intervention, & note—It contributes to a complete record of client care that is error free and ready for reimbursement.



Documentation Reflects the Golden Thread

- Assessing with the Client → Completing the Assessment Form
- Planning with the Client → Completing the Treatment Plan
- Working with the Client → Completing the Progress Note
- Evaluating progress with the Client → Completing an assessment review and updating the Treatment Plan as needed



AUDIT STANDARDS

- ValueOptions audits clinical services and claims periodically to ensure that Medicaid money is being spent in accord with contract provisions.
- Chart documentation is only one of the multiple reviews an agency might be subject to.

Key Administrative Elements

- Documentation must be legible or claim may be rejected
- Standard Abbreviations only—not personal shorthand
- Client name & identifier (DOB, Record#, Medicaid #) on each page
- Medicaid Client Rights & Responsibilities in addition to your usual disclosure—signed by the client
- Acknowledgement of your Notice of Privacy Practices—signed by the client
- EPSDT or Well-Child questions/referrals
- Advance Directive questions/referrals
- Coordination of care with medical provider or others
- Releases of information to medical & other providers that meet HIPAA/ 42CFR standards—signed or state that client refused



Initial Assessment—Major Elements

1. Presenting Problem
2. Data Gathering
3. Mental Status
4. Risk Assessment
5. Clinical Formulation
6. Diagnosis
7. Recommendations



Initial Assmt-Presenting Problem

- Chief complaint: Client's statement about the nature of the problem and what they want to change
- Why seeking services now (as opposed to 3 months ago)
- Provider's detailed description of the present illness
 - Includes details about major symptoms and their intensity and frequency, when the problem started, how it progressed, situations in which it is worse or better, the last time the individual was free of this problem, what has been tried to improve it, what worked in past if this is a recurrence, the impact on the person's life, AND the impact on one's ability to function in valued roles



Initial Assmt-Data Gathering

- Current and past information in multiple areas (education, legal, medical, cultural, etc.) to help flesh out the issues/diagnosis and prioritize interventions
 - *Should be useful, pertinent information that emphasizes the most recent data*
 - *Don't record trivial details*
- Please mark each required area of inquiry as "none/not applicable" rather than leaving it blank when it is not relevant to current problem (e.g., person who has no medical conditions)



Initial Assmt-Data Gathering

- ASAM Dimensions

- Acute Intoxication and Withdrawal
- Bio-Medical Conditions and complications
- Cognitive, Behavioral, and Emotional Conditions
- Readiness/Motivation
- Relapse, Continued Use, Continued Problem
- Recovery Environment

May be helpful in formulating medical necessity and current functional impairments.

Data Gathering Elements

- Psychosocial History (family of origin, current family constellation, quality of relationships, other supportive persons)
- Prior treatment history (include client's perception of outcome; how long stable after treatment, if any; client's perception of their compliance with treatment)
- Family history (SUD, medical and psychiatric)
- Cultural factors *and* how they impact treatment (treatment options, treatment acceptance, relationship with therapist, etc.)
- Education/Employment/Vocational/Military Service history (indicate functional baseline; relevant incidents or events and their impact)



Data Gathering Elements 2

- Medical issues, allergies, and current medications:
 - Emphasize current issues that may be relevant to diagnosis/TX
 - Date of last physical exam---Refer if not recent
 - Get release for Primary Care Provider
 - Coordinate with PCP—It is your responsibility to notify of enrollment, diagnosis, and medications
- Developmental history if client is under 18
- Disabilities or challenges
- Legal history



Data Gathering Elements 3

- Substance use assessment (past and current use or patterns; risk of relapse, etc.)
- Mental Status and mental health history
- Strengths (personal qualities, resources, supports or achievements that bode well for treatment outcome)



Initial Assmt-Mental Status Exam

- A mental status exam includes:
 - presentation/ appearance
 - attitude toward examiner
 - affect and mood
 - speech
 - intellectual/cognitive functioning
 - thought process/content
 - insight
 - judgment



Initial Assmt- Risk & Safety Plan

- Evaluate for risk factors (suicide, homicide, self-harm, harm to others, grave disability, etc.)
 - If risk assessment is positive, record agreements, instructions, involvement of others, etc. that will keep client safe at least until next session.
 - Evaluate for higher level of care.



Clinical Formulation

- A logical, professional summary & analysis of the information you have gathered
- Identify and prioritize needs, concerns, deficits, behaviors or other issues, and impact on the client.
 - Match identified needs, deficits, symptoms to treatment services
 - Match identified functioning issues with rehab/recovery services
 - Match identified needs for services & supports with case management services
 - ALL these must be supported---”as evidenced by...”
 - Give details



Clinical Formulation 2

- State what will be addressed now by this provider. Refer out or Defer until later for other needs.
- Explain how symptoms correspond to DSM criteria
 - Explain rule outs and plan to resolve questions.
- Individual strengths, cultural factors, and supports that will be relevant for treatment.
- Justify medical necessity.
 - Client is willing and able to participate
- Recommendations:
 - Give initial treatment recommendations and goals for the period from intake until the tx plan is developed.



Treatment Planning

- The treatment plan is a “contract” with the client that outlines the course of therapy and expected achievements.
 - Must be completed within 14 days of intake.
 - Sessions must be devoted to treatment planning until it is complete.
- Auditor 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) and primary goals/objectives set, etc.
- Client should be offered a copy of the plan.
- Plan will be changed or updated as issues are resolved or new issues emerge.
- Plan must be reviewed/updated every 6 months.



Content of the Treatment Plan

- **Remember the golden thread**

- Plan must address the problems/needs identified. Through a goal/objective or a referral to outside services, or defer the issue until later

- Include Diagnoses

- P-G-O-I (or some variation)

- Problem statement (identified need)
- Goal or desired outcome
- Objectives
- Interventions

- Discharge Criteria

- How much change is necessary so we know that we're done with treatment? or I know I'm ready for discharge when...

- Predict an anticipated Length of Stay

- Signature of client/guardian

- Signature of the person who wrote the plan and a credentialed provider

Tx Plan-Problem Statement

- Clear description of issues, symptoms, or behaviors that are causing dysfunction.
- The more detailed the problem statement, the easier it is to write goals and objectives.
 - *EXAMPLE: Client abuses alcohol as evidenced by daily consumption to excess and deleterious effects on health, relationship, work success*



Tx Plan- Goal Statements

- Usual content of a treatment goal:
 - Behavioral description of what the individual will do or achieve in measurable terms, directly related to the diagnosis and the presenting problem
 - Do, finish, keep, stay in, live in, be successful at, develop
 - Within what environment
 - Within what time frame
- *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.*



Tx Plan - Developing Objectives

- Objectives are smaller, measurable steps for the client to accomplish on the road to his/her discharge goal.
 - 2 or 3 at most for each goal
 - Measurable—Individual will be able to: as evidenced by an observable behavioral change, times per week, every time, etc.
 - Realistic and specific
- Incorporate strengths/resources and cultural factors, as applicable
- Attendance at group or completing UA's are recommended services, NOT objectives for personal change!



Tx Plan-Interventions & Modality

- Interventions are the specific clinical actions providers will do to help the client achieve their objectives
 - Staff will: use **active verbs** in describing what staff will do
 - Time period: **length of time** you will do the above action
 - Frequency: **how often** you will do it
 - Modality: enter the type of treatment and a reason for it
- *Examples:*
 - *Use CBT to assist individual in identifying relapse triggers
1x/week for 6 months*
 - *1x/week for the next 6 weeks teach the individual self-calming techniques to use during high stress activities through discussion, modeling and role-play*



Progress Notes

- Auditor wants to see that provider delivers 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 continuing commitment to treatment through active participation
 - progress toward the goals & objectives
 - on-going analysis of treatment strategy & needed adjustments
 - continued need for services (medical necessity)



Progress Notes- Elements

- Date of service
- Start time and end time (or start time and duration)
 - When the service actually begins, not when it was scheduled
 - Cannot bill for time spent waiting or if client leaves early
- Persons present, if not the client alone
- Location of service
- CPT Code or Modality (individual, group, CM, etc.) provided
- Signature of the provider, with credentials—must be legible
- Date the note was signed—must be within 48 hours of date of service



Progress Notes- Content

- State the reason for the visit or the diagnosis or deficit being addressed in this session:
 - establishes medical necessity
 - May vary from session to session
- List the objective from treatment plan that was the primary focus of session
- State the intervention(s) used: techniques targeted to achieve the outcomes provider is looking for
 - *More specific than just “individual therapy”*



Progress Notes- Content 2

- Document the Individual's response to the interventions:
 - Level and type of participation
 - Were they able to demonstrate the skill or participate in role playing?; Could they list how to apply the skills being taught? Or did they not get it, refuse to participate, resist, etc.
- State progress and plan
 - State the individual's progress toward his objectives/goals
 - Homework or other tasks to complete before the next visit
 - Plan for next visit or visits – consider your observations about the Individual's response to your interventions



Treatment Review

- At least every 6 months (or earlier if indicated) 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
- Revise, 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 if changes have been made to the plan to indicate continued agreement
- Start the **Golden Thread** cycle over again



Additional Tips

- Change of Diagnosis
 - Explain & justify diagnosis in a progress note
 - Change diagnosis on claims
- If an important issue arises not on the tx plan
 - Use 1 or 2 sessions to explore or resolve & explain in note
 - Change tx plan if this becomes a focus
- No shows
 - Frequent No Shows indicate lack of commitment to treatment
 - Takes you away from the treatment plan
- PCP Coordination of Care
 - letter notifying PCP of enrollment, diagnosis and meds



Contact Us

- Terry Krow, LCSW, CACIII, Substance Abuse Coordinator
 - 719-538-1470
 - Terry.krow@valueoptions.com
- Rhonda Borders, LCSW, Quality Specialist
 - 719-589-9872 or 580-2010
 - Rhonda.borders@valueoptions.com



References

- <http://www.cbhc.org>
- <http://www.valueoptions.com>
- <http://www.coloradohealthpartnerships.org>
- <http://oig.hhs.gov/>
- <http://www.colorado.gov/hcpf>
- <http://www.colorado.gov/Office of BehavioralHealth>

