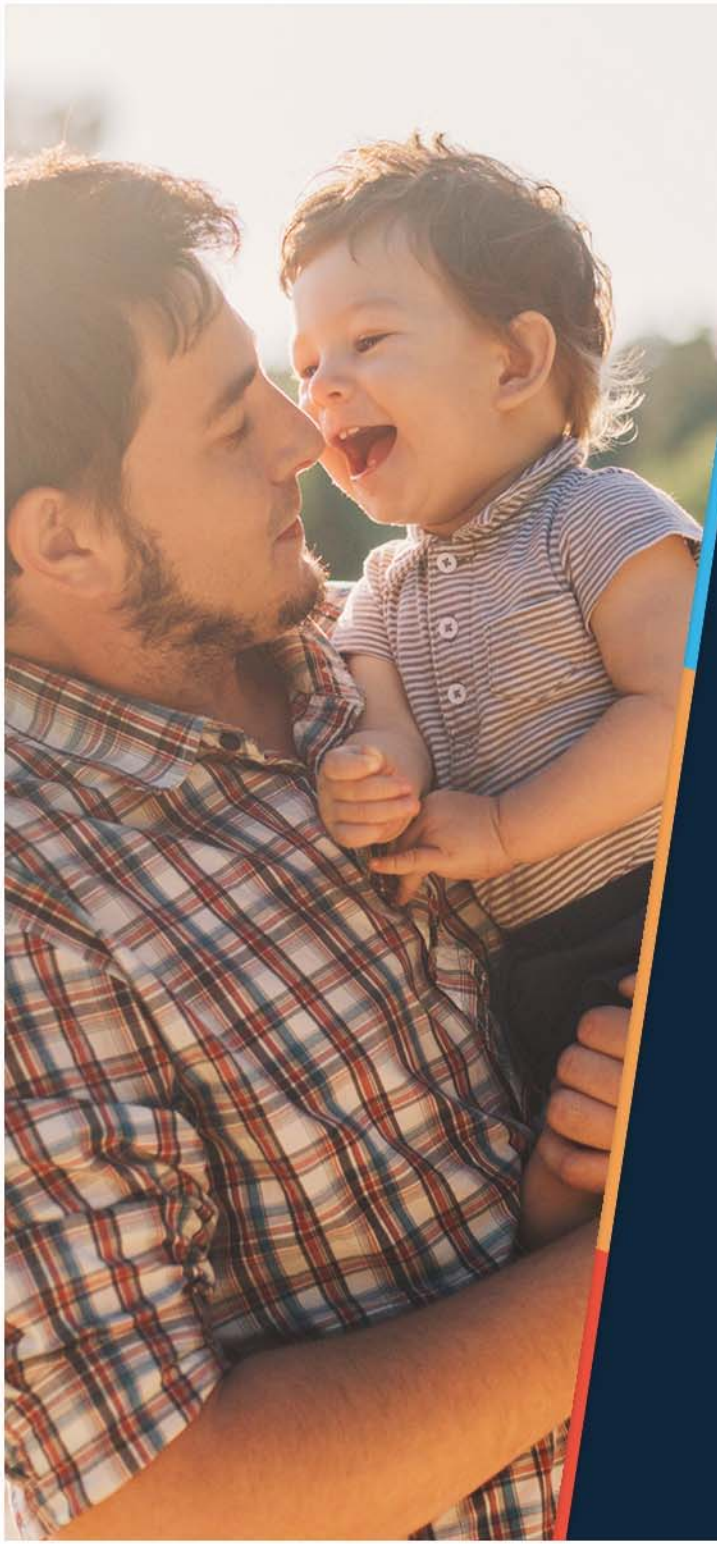

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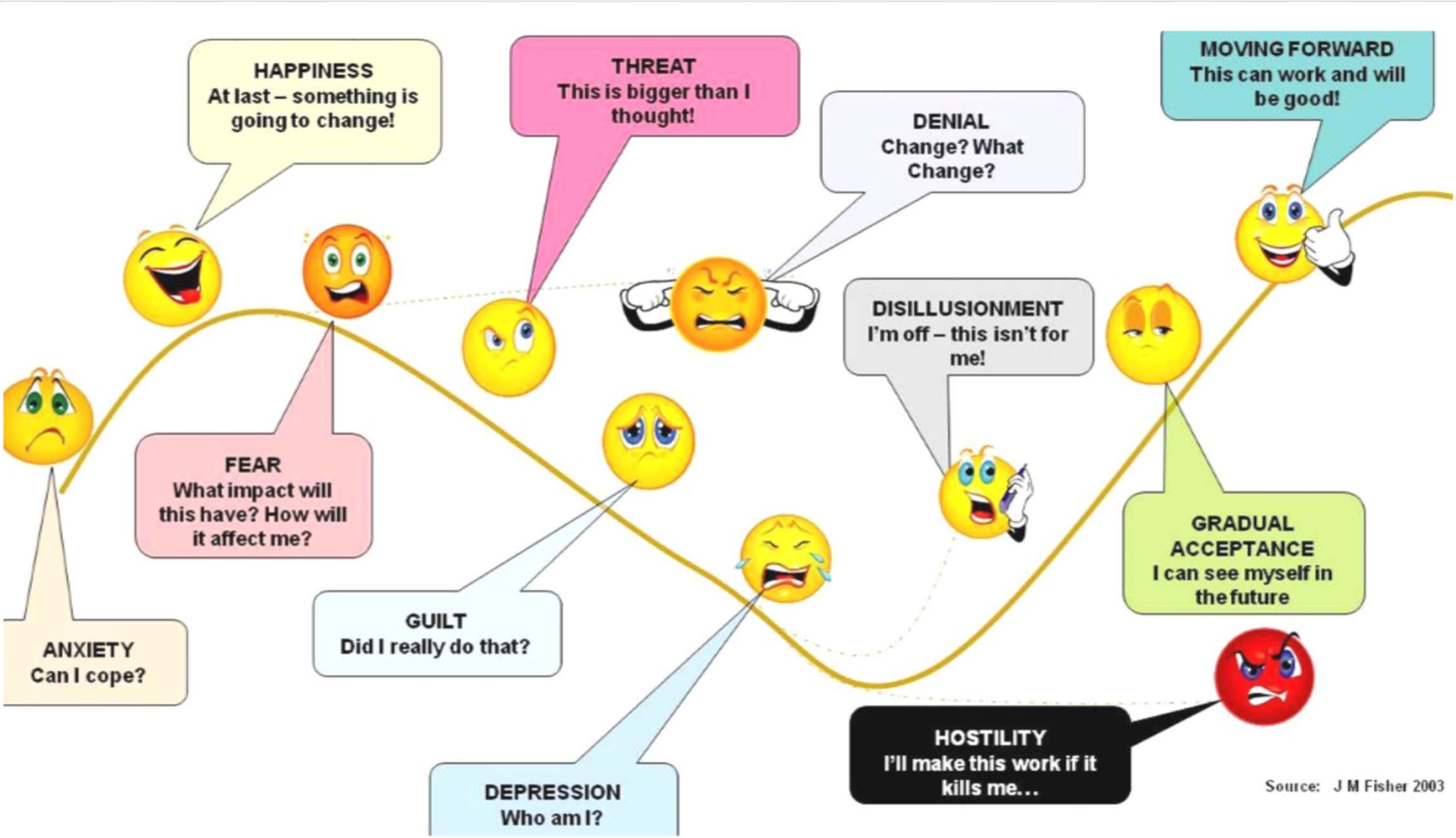
# DOCUMENTATION TRAINING

## Learning Medicaid Documentation Standards and Methods (Revised 2016)

# Purpose of the Training



# Healthcare World is Changing!

- The federal government actively reviews state Medicaid departments AND individual providers with frequent, detailed audits of medical records, contracts, and state policies.
- Compliance expectations have escalated.
- Beacon Health Options is required to meet federal and state regulations.

# AUDITS & PAYBACKS

- Government auditors recoup millions of dollars from providers because of “improper payments” caused by:
  - Missing documentation
  - Incomplete documentation
  - Incorrect service codes
  - Services not covered by Medicaid and Medicare
  - Other errors
  - Intentional fraud

# Today's Purpose

- Learn the details of documentation requirements in the Health First Colorado program.
- Help you maintain your livelihood as a valued Health First Colorado provider.
- Understand the risks of noncompliance:
  - Recoupment (payment has to be returned)
  - Corrective Action Plans
  - Disenrollment from the Network

# Medicaid Mental Health Services in Colorado

- Health First Colorado pays for specific, defined services that are medically necessary and require skilled assessments & interventions.
- Both the federal program and the state government oversee & monitor the program
- 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

# Payment and Documentation

- A service is complete only when it has been documented and billed
- Each claim is built on provider documentation and must be accurate
- Written documentation is the only evidence of the work providers do

# Health First Colorado Defines Services

As an insurance program, Health First Colorado defines covered services and provides specific rules for each service including:

1. Who is an eligible providers for the type of service
2. Where the services may be provided and sometimes how much service must or may be provided
3. What is allowable content for the service
4. Accessibility requirements, e.g., crisis services are to be available 24 hours a day, hours of operation
5. Sequence of service delivery, i.e., (emergency services) case management may be provided before the mental health assessment is completed

Refer to HCPF Uniform Coding Standards Manual

https://www.colorado.gov/pacific/hcpf/mental-health-rate-reform-0.

# Medical Necessity

- Behavioral health services must be medically necessary to be paid by Medicaid.
- The individual has a mental health/substance use condition/illness that ….
  - has produced a current problem in functional status
  - as shown by signs and symptoms that interfere with functionality
  - that can be helped by providing services
  - services named on the treatment plan

# Six Components of Medical Necessity

1. The service must treat a behavioral health condition/illness or functional deficits that are the result of the illness.
2. The service has been authorized or prescribed by a licensed practitioner of the healing arts.
3. The service is 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.
6. It must be an active treatment focus.

# Medically Necessary Services Include

- Reducing or better managing signs and symptoms
- Improving, maintaining or preventing decline of functional status
- Developing age-appropriate functioning in a child when the illness has prevented age- appropriate functioning
- Preventing new co-morbidities

# Health First Colorado Continuum of Care

The major outpatient components of the continuum of care include:

- Treatment—Reducing symptoms of distress in the individual
- Rehabilitation—Learning/recovering skills for functioning in the community
  - not usually done in private practice
- Case Management—Assisting individuals to get & coordinate care/services appropriate to their needs

# GOLDEN THREAD of DOCUMENTATION

- Each piece of documentation should flow logically from one to the next.
- The assessment is coherent, comprehensive, establishes medical necessity & identifies symptoms & behaviors to be addressed.
- The treatment plan structures treatment to accomplish identified goals/objectives using specific interventions.
- Progress notes flow from the tx plan & document both the service provided and the client's response to 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.

# Audits by Beacon Health Options

- Single case agreement and network providers may be audited by Beacon Health Options Colorado for proper medical record documentation and accurate claims.
- Audit standards became effective on 1-1-2012.
- Audits are for technical assistance, education, and compliance purposes.
- Potential consequences when education does not result in compliance could include a corrective action plan, recoupment of money paid to you, removal from the network.

# Required Administrative Elements

- 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 client or guardian
- Acknowledgement of your Notice of Privacy Practices--signed
- 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 —signed or state that client refused
- CCAR—initial done by the 4th session, update annually or whenever major changes occur, discharge within 60 days of last session.

# EPSDT

- Beacon Health Options has updated their policy regarding EPSDT screening and referral requirements. http://www.coloradohealthpartnerships.com/services/pdf/EPSDT.pdf

- Detailed information about EPSDT is listed at the end of this presentation

# What is EPSDT

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) EPSDT is a special health care program for children and youth. It makes sure they get the right preventative, dental, behavioral health, developmental and specialty services.
- With EPSDT, any medically necessary health care service is covered. Services may be covered even if it is not a Health First Colorado benefit.
- Children and youth 20 years old or younger can get EPSDT services. They are automatically enrolled and all Health First Colorado providers can offer the EPSDT services.
- Children 18 years old and younger can get EPSDT with no co-pay for any covered service. Adults 19 and 20 years old can get EPSDT, but may have a small co-pay for some services.

# Provider Responsibilities for EPSDT

- Be aware of the benefit related to children and youth and refer when necessary.
- ASK whether or not children have had their well-child/EPSDT exam in the last year.
- ASK whether the exam made any behavioral health diagnosis or suggested further evaluation.
- Provide services that correspond to needs identified in the EPSDT.
- Coordinate care with EPSDT providers

# 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

- Statement from the client about the nature of the problem and what they want to change
- Reason for seeking services now (as opposed to 3 months ago)
- Provider's detailed description of the present illness
  - This should include information about major symptoms, 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 ability to function in valued roles

# Data Gathering

- Current and past information in multiple areas to verify the issues/diagnosis and prioritize interventions
  - *Should be useful, pertinent information that emphasizes the most recent data*
  - *Don't record trivial details*
- Each required area of inquiry is addressed. If not applicable to current problem, indicate NA (e.g., person who has no medical conditions)

# Data Gathering Elements

- Psychosocial History (family of origin, current family constellation, quality of relationships, other supportive persons)
- Prior behavioral health treatment (include client's perception of outcome; how long stable after treatment, if any; client's perception of their compliance with treatment)
- Family history (relevant medical and psychiatric)
- Cultural factors and how they impact treatment (treatment options, treatment acceptance, relationship with therapist, etc.)
- Education/Employment/Vocational/Military Service history (indication of 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
- MDD/Organic brain conditions
- Legal history (any current issues relevant to tx)

# Data Gathering Elements 3

- Substance use assessment if client is 12 or older (past and current use or patterns;  risk of relapse if currently in recovery; coordination of care if in SA treatment now)
- Strengths (personal qualities, resources, supports or achievements that bode well for treatment outcome)

# Coordination of Care

- Coordination of care between medical and behavioral health providers is a practice promoted by Health First Colorado. Providers should:
- **ASK** whether or not the member has had a physical exam or EPSDT exam in the last year.
- **REFER** to physical health care if needed.
- **REQUEST** for release of information to the physical health care provider. Document member refusal if they do not give permission.
- **NOTIFY** the PCP of enrollment, diagnosis, and medications (if any) with the behavioral health provider.
- **REPEAT** yearly if member is still in treatment.
- Include release of information and notification letter in the member record.

# Assessment: Mental Status Exam

- The HCPF Coding Manual defines a complete mental status exam as:
  - presentation/ appearance
  - attitude toward examiner
  - affect and mood
  - speech
  - intellectual/cognitive functioning
  - thought process/content
  - insight
  - judgment

# Risk & Safety Plan

- Evaluate for risk factors (suicide, homicide, self-harm, harm to others, grave disability, elopement, 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.
  - Needs and deficits need detail to be supported---"as evidenced by…"
  - *Symptoms matched to treatment services*
    - *sadness, as evidenced by flat affect, tearfulness*
    - *sleep problems, as evidenced by am and pm insomnia*
  - *Problems with functioning matched to rehab and recovery services*
    - *Limited social skills, as evidenced by impaired ability to relate to others, especially her children. Needs to learn appropriate conversation skills.*
  - *Problems with accessing services and supports matched with case management services*
    - *Client has no friends or family in the community and no idea what opportunities for her to socialize may exist. Needs linkage to socialization resources.*

# Clinical Formulation 2

- Decide what will be addressed at the current level of care or during the initial stages of treatment
- Explain how symptoms correspond to DSM criteria
  - Explain rule outs and plan to resolve questions.
- Individual strengths, cultural factors, and supports that will be used or will support treatment.
- Justify medical necessity.
  - Client is willing and able to participate
- Diagnosis
- Recommendations:
  - Give initial treatment recommendations and goals for the period from intake until the tx plan is developed.

# Treatment Plan

- Treatment plan is a “contract” with the client that outlines the course of therapy and expected achievements.
  - Must be completed within first 4 appointments (30 days).
  - 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 change or be updated as issues are resolved or new issues emerge.
- Plan must be reviewed/updated every 12 months.

# Content of the Treatment Plan

- Plan must address problems/needs identified in assessment by including a goal/objective, making a referral, or deferring the issue until later
- Include Diagnoses
- P-G-O-I (or some variation on these themes)
    - 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?
- Predict Length of Stay
- Signature of client/guardian
- Signature of Licensed Individual
- Signature of Licensed Supervisor when required

# 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 experiencing depressed mood 5 out of 7 days, sleeps only 3 hours per night and is missing work 1 or more days out of 5.*

# Tx Plan- Goal Statements

- 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 move into my own apartment."*
  - *Treatment Goal: The Individual will be able to manage their depressive symptoms and develop the social skills necessary for independent living within the next year.*
- Choose 1 or 2 to work on for now; others can come later.

# Tx Plan - Objectives

- Objectives are smaller, measureable 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

# 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
  - When the service actually begins, not when it was scheduled---Cannot bill for time spent waiting
  - Helps to look for duplicate services, determine if correct numbers of units were billed, judge whether or not an excessive service was provided etc.
- Persons present, if not the client alone
- Location of service - Used to ensure service corresponds to USCS criteria (refer back to slides 11 & 12)
- 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 diagnosis or deficit being addressed in this session: establishes medical necessity
- 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.
- Statement of Individual's progress and plan
  - State progress toward objectives or 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 year (or earlier if indicated) review diagnosis, goals, progress, new issues, etc.,
  - Analyze the effectiveness of treatment
  - Reevaluate client's commitment to treatment & relevance 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
  - Update CCAR
  - 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
  - Outreach or attempts to re-engage client should be documented

# Contact Us

- Rhonda Borders, LCSW, Quality Specialist
  - 719-589-9872 or 719-580-2010
  - Rhonda.Borders@beaconhealthoptions.com
- Tom Dahlberg, LPC, Quality Specialist
  - 719-538-4698
  - Tom.Dahlberg@beaconhealthoptions.com
- Courtney Hernandez, MS-HSV, Quality Specialist II
  - 719-226-7798
  - Courtney.Hernandez@beaconhealthoptions.com
- Provider Relations
  - 800-804-5040
  - COProviderRelations@beaconhealthoptions.com

# References

- Member and provider handbook
- http://www.coloradohealthpartnerships.org
- HCPF's Uniform Services Coding Manual https://www.colorado.gov/pacific/sites/default/files/Uniform%20Service%20Coding%20Standards%202016.PDF
- http://www.cbhc.org
- http://www.coloradohealthpartnerships.org
- http://www.fbhpartners.org
- http://oig.hhs.gov/
- http://www.colorado.gov/hcpf
- http://www.colorado.gov/cs/Satellite/CDHS-BehavioralHealth
- www.BeaconHealthOptions.com
- Colorado Crisis Services 844-493-Talk (8255)

# EPSDT DETAILS

- EPSDT stands for:

**Early**: Find and assess problems early

**Periodic**: Check children's health at several ages

**Screening:** Check physical, mental, developmental, dental, hearing, vision and other health areas

**Diagnostic:** Do follow-up tests when a health risk or problem is found

**Treatment:** Correct, reduce or control health problems

# EPSDT

- Well-child check-ups make sure your child or teen is growing up healthy. The provider can identify physical and behavioral health risks early and correct, reduce or control health problems.
- Your child also gets needed shots, vaccines and screenings at the right ages.
- Well-child check ups are more comprehensive than sports physicals

# EPSDT

- Under EPSDT, children and youth can get all medically necessary care, such as:
- • Well-child visit and teen check-up
- • Developmental evaluation
- • Behavioral evaluation
- • Immunizations (shots) and vaccines
- • Lab tests, including lead poisoning testing
- • Health and preventive education
- • Vision services
- • Dental services
- • Hearing services

# EPSDT

- Your child should get well-child check-ups at these ages:

• 2-4 days after birth

• 1 month

• 2 months

• 4 months

• 6 months

• 9 months

• 12 months

• 15 months

• 18 months

• 24 months

• 30 months

• Once a year from ages 3-20

# EPSDT

- Well-child check-ups include:

• A comprehensive history and head-to-toe physical exam

• Age-appropriate shots and vaccines (Colorado follows the American Academy of Pediatrics Bright Futures Periodicity schedule))

• Lab tests, including lead poisoning testing

• Health education

• Vision and hearing screening

• Oral health screening

• Behavioral health assessment

# EPSDT

- **Lead poisoning testing:** All children who qualify for Health First Colorado must get lead poisoning screening at 12 and 24 months or between the ages of 36 and 72 months if they were not tested earlier.
- **Dental check-up**: By age 1, or when your child gets a first tooth, your child needs regular dental health check-ups every 6 months and 2 cleanings a year. Your child can get dental services such as office visits, teeth cleanings, fluoride treatment, dental sealants, space maintainers, oral examination, Xrays, dental fillings, crowns, oral surgery procedures, extractions, root canal treatment, gum treatment and dentures (false teeth).
- **Diagnosis and treatment:** Your child will get medically necessary health care services to treat any mental or physical diagnosis. This is true even if the service isn't covered or has service limits. If there is a service limit or the service is not covered, your provider must ask Health First Colorado for the medically necessary service.

# EPSDT

- EPSDT cannot override things like provider licensing or prior authorization requirements. Health First Colorado will read the medical necessity request and approve or deny it.
- **EPSDT medical necessity does not include**:

• Treatments that are untested or still being tested

• Services or items not generally accepted as effective, services outside the normal course and length of treatment, or services that don't have clinical guidelines

• Services for caregiver or provider convenience

EPSDT does not cover services such as in-home support services, home modifications and respite care. If you need extra services for your child who has special needs, update the disability information in your application at Colorado.gov/PEAK to apply for these services. Or for help, contact a Community Centered Board at https://www.colorado.gov/pacific/hcpf/community-centered-boards.

# EPSDT

- Healthy Communities Family Health Coordinators
- Healthy Communities Family Health Coordinators help pregnant women and children ages 20 and younger get services they need. Your Family Health Coordinator can help:
- Explain the services
- Find providers
- Coordinate services for you
- Tell you about and connect you to other community services such as food banks, housing agencies, child care, Head Start, Health Care Program for Children with Special Healthcare Needs (HCP), and Women, Infants and Children (WIC)

# EPSDT

Family Health Coordinators cannot:

- Decide or approve Health First Colorado or Child Health Plan Plus coverage
- Help you with Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP) or Cash Assistance programs

To apply for these programs, go to Colorado.gov/PEAK.

To find your local Family Health Coordinator, go to Colorado.gov/hcpf/healthy-communities. Or call the Health First Colorado Member Contact Center at 1-800-221-3943 (TDD 1-800-659- 2656).

*For a copy of the Beacon Health Options EPSDT Policy (248L) please contact provider relations at 800-804-5040 or by email at COProviderRelations@beaconhealthoptions.com

# Child Mental Health Treatment Act (CMHTA)

The Child Mental Health Treatment Act (CMHTA or HB-1116 and SB-260) is a treatment resource for Colorado children that allows families to access community, residential, and transitional treatment services for their child without requiring a dependency and neglect action, when there is no child abuse or neglect. To be eligible, a child under age 18 must have a mental illness and be at risk of out-of-home placement or at risk of further involvement with a county department of human/social services. The Act applies to both Medicaid eligible and non-Medicaid eligible children, although the application and payment processes differ. Local and State level appeal processes are available if services are denied, and for local interagency disputes.

Non-Medicaid eligible children apply through the local Community Mental Health Center (CMHC). If the CMHC determines that residential treatment is needed, the family must apply for disability benefits through their local Social Security office. The residential treatment costs for non-Medicaid eligible children are covered through private insurance, if available; a parental fee based on the Colorado Child Support Guidelines; Supplemental Security Income (SSI ) benefits; Medicaid; and CMHTA funds when needed. If the CMHC determines that community based treatment is needed, costs are covered by the Act and a parental fee not to exceed 50% of the residential fee.

Families of Medicaid eligible children apply for residential treatment through their Behavioral Health Organization (BHO). The BHO is responsible for residential treatment costs for Medicaid eligible children determined to require this level of care. Families of Medicaid eligible children should contact their local BHO for more information or to apply for this program. The BHO phone number is located on the back of the child's Medicaid card.

Transition services provided to children served through the Act includes case management and post-discharge services provided by a CMHC to children admitted to a residential facility, in collaboration with families, community supports and agencies, and the residential facility. Community-Based services includes, but are not limited to, therapeutic foster care, intensive in-home treatment, intensive case management, and day treatment. Families interested in accessing these services should discuss this with the CMHTA liaison at their local CMHC.

For additional questions or assistance regarding the Child Mental Health Treatment Act, please contact the CMHTA Program Manager, Andrew Gabor at (303) 866-7422 or andrew.gabor@state.co.us.