WYO MEDICAID
DIVISION OF HEALTHCARE FINANCING

PROVIDER AND BENEFITS MANAGEMENT UNIT

DOCUMENTATION STANDARDS

September 1, 2018

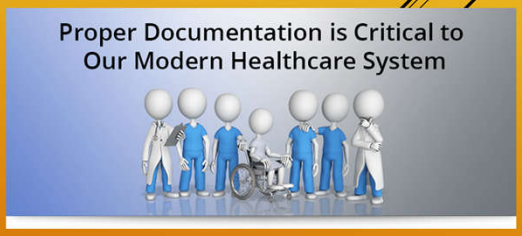
ACKNOWLEDGEMENT

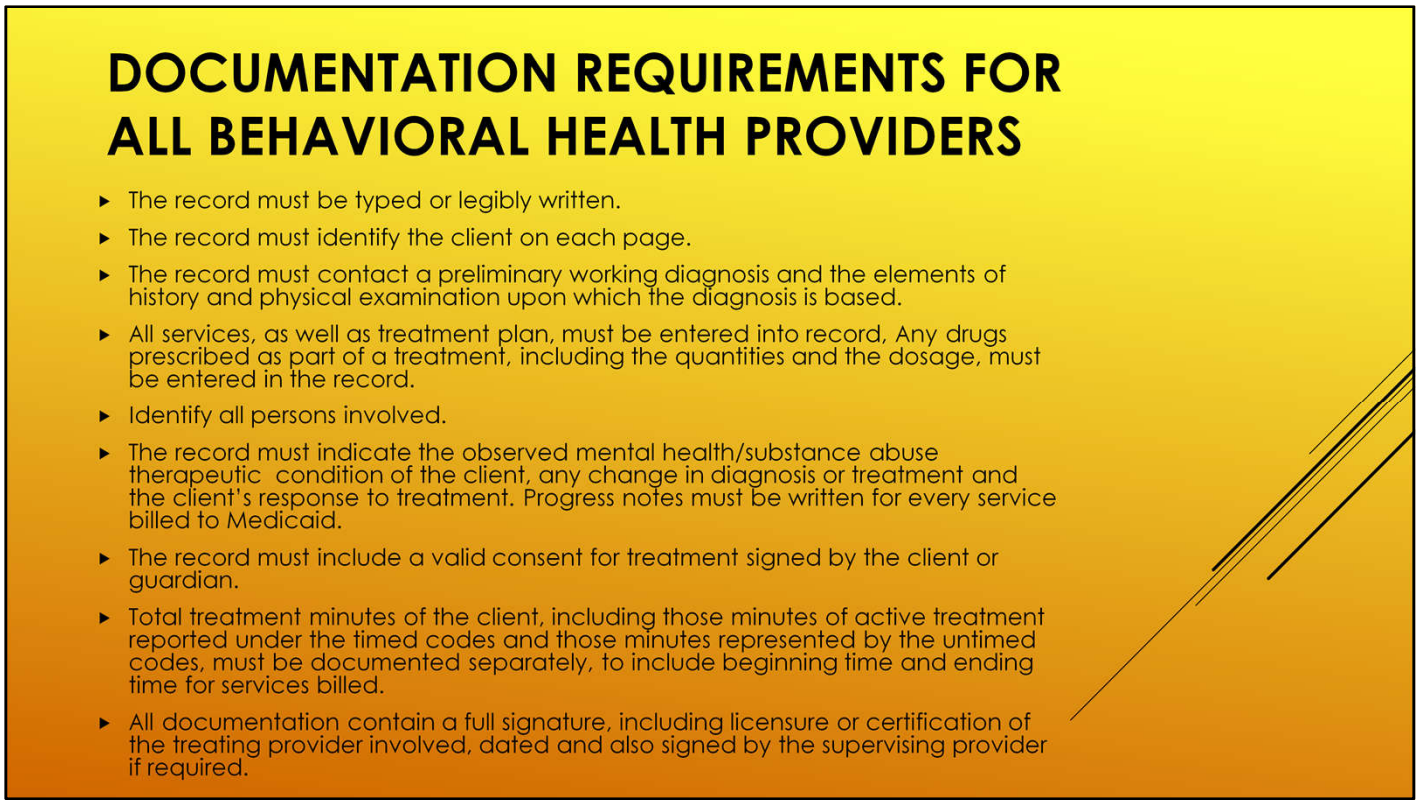
THE PRESENTATION IS A COMPILATION OF INFORMATION FOUND IN A NUMBER OF RECENT REPORTS ON DOCUMENTATION STANDARDIZATION, AS WELL AS CONTENT AND RECOMMENDATIONS FROM WYOMING STATE STAFF. THE PRESENTATION RELIES PRIMARILY ON INFORMATION FROM A TRAINING MANUAL PRODUCED BY MARY THORNTON & ASSOCIATES, INC. AND THE COLORADO BEHAVIORAL HEALTHCARE COUNCIL (2011), COLORADO TRAINING AND REFERENCE MANUAL FOR BEHAVIORAL HEALTH SERVICES. IT WAS RETRIEVED FROM HTTP://WWW.CBHC.ORG/NEWS/WP-CONTENT/UPLOADS/2011/05/COLORADO-TRAINING-AND-REFERENCE-MANUAL-FOR-CLINICIANS.PDF. GENERAL CONTENT HAS BEEN INTEGRATED INTO THE PRESENTATION.

THE PRESENTATION WAS SUPPLEMENTED WITH INFORMATION FROM OTHER SOURCES INCLUDING OHIO STATE MEDICAID PROGRAM, WASHINGTON STATE MEDICAID PROGRAM, THE CENTERS FOR MEDICARE & MEDICAID SERVICES, A CERLERIAN GROUP COMPANY, HOUSE OF NEW HOPE, AND WEBPT.

OBJECTIVES

- Provide a clear understanding of documentation standards.
- To review clinical record content requirements.
- Introduce the Golden Thread
- Present best practices





Documenting every detail of a service is not necessary, reasonable or practical. The degree of documentation required depends on many factors such as level of service or provider specialty. The higher the level of service billed the more detailed the documentation should be. A Claim may be denied, down coded, or undergo further scrutinization if the documentation is borderline. It is just as important to document routine medical services as it is to document unusual medical services.

For each service provided, the documentation must support the patient's chief complaint, diagnosis and medical necessity. For behavioral health services, there are essentially two types of encounters:

1. Initial or re-evaluation visits
2. Subsequent or treatment visits

The purpose of each type of visit is different, and therefore, the requirements for properly documenting each type of visit are also different.

REMEMBER: If it is not written down, then it didn't happen!

The information included on this slide is in Chapter 13 of the CMS 1500 Provider Manual.

CLINICAL RECORDS CONTENT REQUIREMENT

- A clinical assessment completed prior to the provision of treatment services.
- A diagnostic interpretation or treatment plan within five (5) working days of the third face-to-face contact with a licensed mental health professional.
- Properly executed release of information, as applicable, and chart documentation of information received or released as a result of the written client consent.
- Testing, correspondence and like documents or copies.
- For any client receiving ten (10) or more therapeutic contacts, a discharge summary which includes each type of Medicaid service provided, client's progress in achieving treatment goals and plans for follow-up. Documentation of the reason for case closure. This discharge summary shall be complete within 90 days of the last contact.

CLINICAL RECORDS CONTENT REQUIREMENT

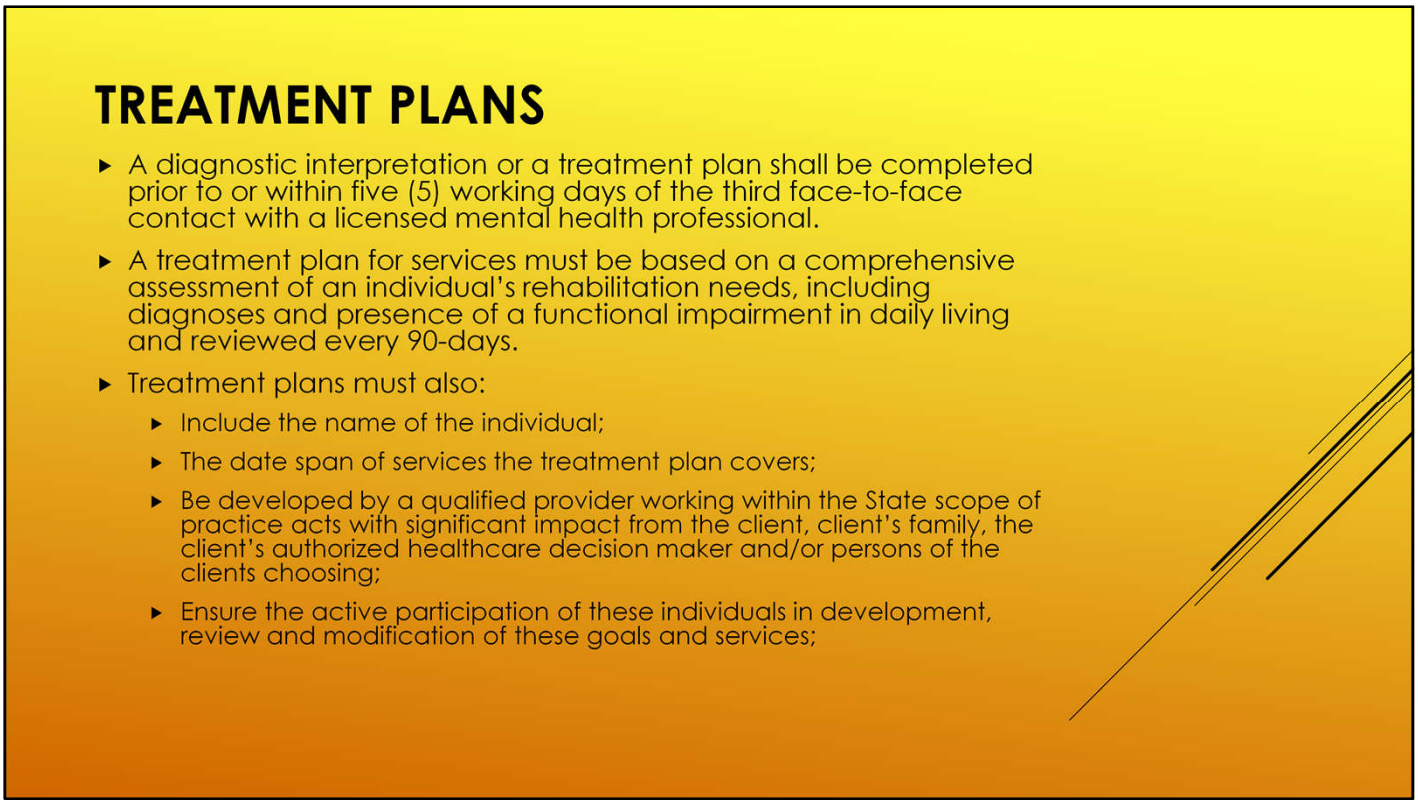
- Documentation of client consent to treatment at the agency.
- A client fee agreement, signed by the client or guardian. For Medicaid, this agreement shall include authorization to bill Medicaid and other insurance if applicable, using the following statement, "I authorize the release of any treatment information necessary to process Medicaid/insurance claims."
- A specific fee agreement for any Medicaid non-covered services and fee they agree to pay.
- Documentation that each client has been informed of his or her client rights.

ASSESSMENT

- A clinical assessment must be updated at a minimum annually and include the following:
  - The specific symptoms/behaviors of a mental/substance use disorder which constitute the presenting problem.
  - History of the mental/substance use disorder and previous treatment.
  - Family and social data relevant to the mental/substance use disorder.
  - Medical data, including a list of all medications being used, major physical illnesses, and substance use (if not the presenting problem).
  - Mental status findings.
  - A diagnostic interpretation.
  - A DSM (current edition) diagnosis.

A thorough assessment of the individual's presenting issues must be documented in the record. The assessment includes numerous mandatory elements. Unless the individual's clinical needs are clearly identified, the treatment may not be determined to be medically necessary and the payer may deny payment.

As treatment plans need to be reviewed every 90 days, a clinical assessments needs to be updated at least once a year. In some cases, it is important for providers to re-assess the patient and ensure a formal review of current clinical presentation. The Assessment Update provides a review of the presenting issues the individual has after having received treatment, therefore ensuring the individual is receiving treatment for those identified issues.



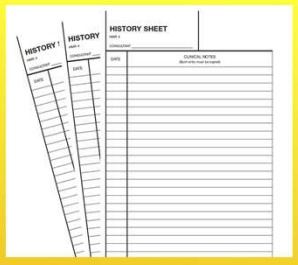
A complete, current, and appropriately signed treatment plan is the crux of the documentation requirements. The treatment plan is a "living" document that drives the individual's services and gives clear direction as to the course of treatment. It is living because it changes with the changing needs of the individual. As the individual resolves issues or new issues are identified, the treatment plan should be updated to reflect these changes. The treatment plan specifies the long term recovery Goals and the short term Objectives for treatment that you and the individual have developed together as well as the Interventions the provider will be using to assist that individual meet their Goals and Objectives. The payer will evaluate treatment plans to determine whether or not the treatment strategy makes sense given generally accepted standards of practice. The treatment plan serves as the "authorization" for services as well as the road map for providing services.

TREATMENT PLANS (CON'T)

- Specify the client's rehabilitation goals to be achieved, including recovery goals For persons with mental health and/or substance related disorders;
- Specify the mental health and/or substance related disorder that is being treated;
- Specify the anticipated outcomes within the goals of the treatment plan;
- Indicate the type frequency, amount and duration of the services;
- Specify a timeline for reevaluation of the plan, based on the individual's assessed needs and anticipated progress, but no longer than 90 days;
- The progress made toward functional improvement and attainment of the individual's goals
- Be signed by the individual responsible for developing the treatment plan;
- Document that the individual or representative participated in the development of the plan, signed the plan, and received a copy of the treatment plan.

Medicaid requires that treatment plans be reviewed every ninety (90) days to ensure that the progress the individual is making is sufficient, that the treatment strategy is still appropriate, and that treatment should continue as currently authorized in the plan. The review should occur with the individual and their family, as appropriate, and should be documented in a progress note, updated treatment plan, or on a special form if your agency requires this. These reviews may also need to be signed by a supervisor or licensed professional to ensure that they agree with the analysis and the continuation of services.

PROGRESS NOTES



In addition to the assessment and treatment plan, the following requirements shall be met:

- There shall be a separate clinical record made for each client's progress notes for every treatment contact that is billed to Medicaid. This includes face to face contact with the client and with others who are collaterals to implement the client's treatment plan. Progress notes shall include:
  - The name of the medical reimbursable service rendered and the procedure code.
  - The date, length of time (time in and time out standard or military time) and location of contact.
  - Persons involved (in lieu or in addition to the client).
  - Summary of client condition, issues addressed and client progress in meeting treatment goals.
  - Signature, date and credentials of treating staff member.

PROGRESS NOTES BY SERVICE TYPE OR PROVIDER

In addition to all clinical note requirements, some services or providers have additional documentation requirements. These include:

- Psychosocial Rehabilitation – separate progress note with all clinical note requirements
  - Separate progress note describing therapeutic activities provided, the procedure code billed to Medicaid, and client's progress in achieving goals to be accomplished through psychosocial rehabilitation.
  - Co-signature of the primary therapist on progress notes for services provided by non-licensed, certified staff or qualified case managers.
- Individual Rehabilitative Services (IRS) – separate progress note with all clinical note requirements
  - Separate progress note describing activities of skill trainer and activities of client.
  - Co-signature of the skills trainer and primary therapist on progress notes for services provided.
- Peer Specialist Services – separate progress note with all clinical note requirements
  - Description of activities of skilled training and activities of client.
  - Co-signature of the skills trainer and primary therapist on progress notes for services provided.
- Ongoing Case Management and Targeted Case Management services – separate progress with all clinical note requirements
  - Type and description of each service and the procedure code billed to Medicaid
  - Date and signature of the case manager

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

MISCELLANEOUS

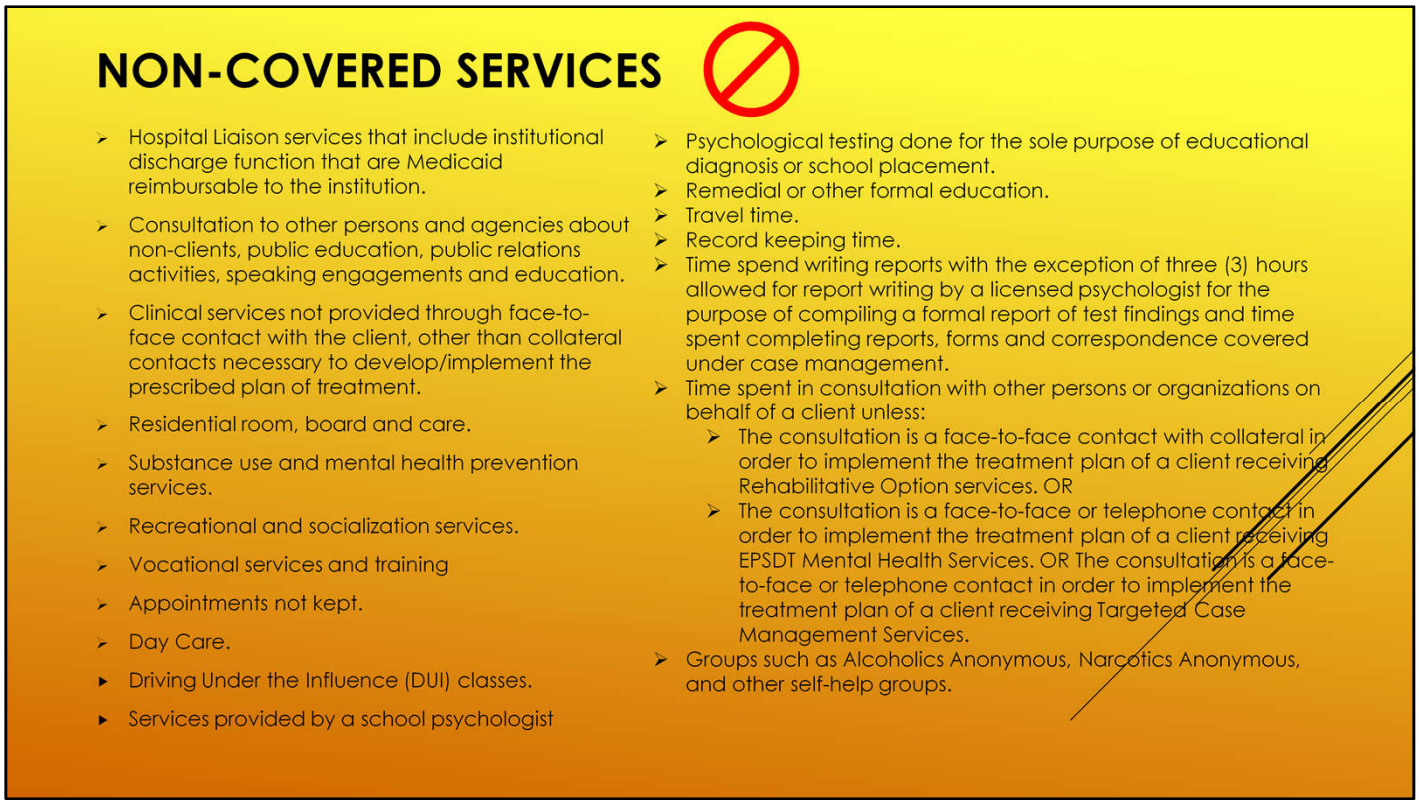
- Behavioral health services cannot overlap date and time for a client.
- All documentation must be accurate with the date and times the services were rendered. (3.11 Record Keeping, Retention and Access, 13.9 Documentation Requirements for all Behavioral Health Providers),
- All signatures must be completed prior to billing Medicaid for services provided.
- The report writing segment, for the purpose of compiling a formal report of psychological test findings, is limited to a maximum of three (3) hours.
- Span billing is not allowed for fee for service behavioral health services. Each date of service must be billed on its own separate line.
- The following conditions do not meet the medical necessity guidelines and therefore cannot be covered:
  - Clients age 21 and over are limited to restorative/rehabilitative services only.
  - Maintenance therapy can be provided to clients age 20 and under.
  - Treatment whose purpose is vocationally or recreationally based.
  - Diagnosis or treatment in a school based setting
  - Services which are not medically necessary.

UNITS OF SERVICE

Most payers will not reimburse for services provided less than 8 minutes. As a result, all invoiced services must be for a unit of service that exceeds 8 or more minutes. Units of Service should be reported as follows:

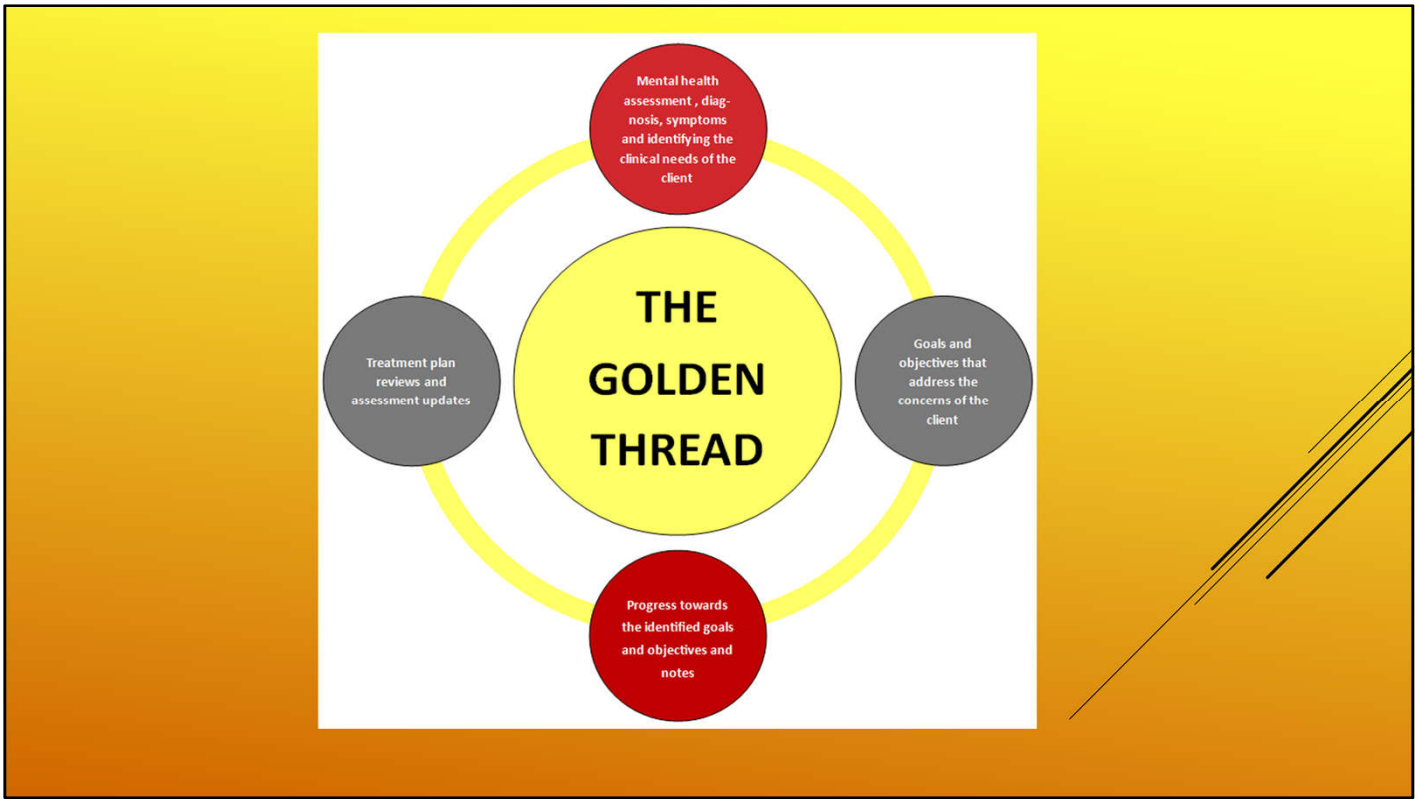
Services provided are more than	Services provided are less than	Provider will bill
8 minutes	23 minutes	1 unit
22 minutes	38 minutes	2 units
37 minutes	53 minutes	3 units
52 minutes	68 minutes	4 units
67 minutes	83 minutes	5 units
82 minutes	98 minutes	6 units

When billing time-based codes, the CPT time rule applies. The exact times must be documented in the medical record. Psychotherapy should not be reported if less than 16 minutes of therapy is provided and the code reported should be selected based on the time closest to that indicated in the code descriptor. For psychotherapy sessions lasting 90 minutes or longer, the appropriate prolonged service code should be used. The duration of a course of psychotherapy must be individualized for each patient. Prolonged treatment may be subject to medical necessity review. The provider must document the medical necessity for prolonged treatment.



Medicaid non-covered services include but are not limited to

Room and board
Recreational and socialization
Vocational training
Day care
Dui classes
Travel time
Record keeping time
Groups for AA, NA or self-help groups



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

The mental health assessment must identify the critical clinical needs of the individual based on their presentation and history. The assessment paints the picture of the individual as they present currently and assesses their ability to engage in and benefit from the treatment process.

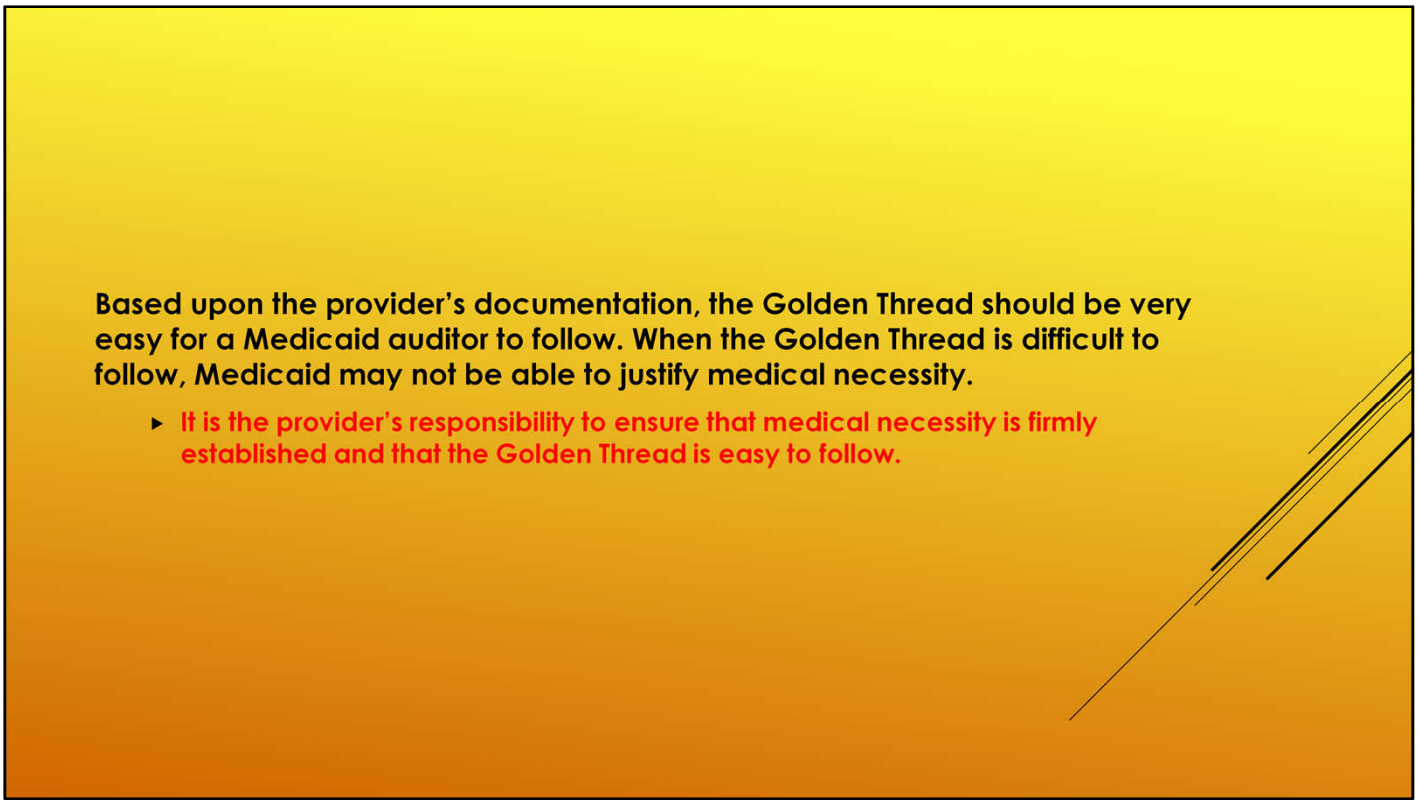
The treatment plan must reflect Goals and Objectives that address the concerns of the individual as identified in the assessment. This is done by the development of measurable, attainable goals and objectives that provide the opportunity for the individual to actively focus on the needs reflected in their assessment in a targeted manner. The treatment plan must be coherent and cohesive in order to establish medical necessity.

The progress notes must flow from the treatment plan by specifically reflecting progress towards the identified goals and objectives and the individual's response to treatment as well as describing services that are "authorized" in the plan.

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

ANY ELEMENT DONE IN ISOLATION BREAKS THE GOLDEN THREAD AND DISRUPTS THE LOGIC THAT SHOULD BE EVIDENT FROM THE DOCUMENTATION OF THE INDIVIDUAL'S TREATMENT. THIS COULD INCLUDE:

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



Medical necessity establishes the basis for Medicaid reimbursement and is easily recognized through the Golden Thread. To begin the Golden Thread, a diagnosis based on a thorough mental health assessment is completed and incorporated into the treatment plan, relating to the needs, behaviors, conditions and deficits of the client highlighting the diagnosis. Progress notes continue to establish a medical necessity for the service, along with the client's participation and progress towards the treatment objectives and goals. Finally, a review of the treatment plan every 90 days is completed to evaluate the progress or lack of progress. The treatment plan may need to be updated with changes or a new treatment plan created.

BEST PRACTICES

- Treatment plans must be based on objective outcomes and assessments that give third parties little in which to deny your claims.
- Facilities and providers should have quality assurance review completed to make sure there records are accurate and complete.

In all situations, the ultimate goal is to reduce the scope, duration and intensity of medical care to the least intrusive level possible which sustains health. The Medicaid goal is to deliver and pay for clinically appropriate, Medicaid-covered services that would contribute to the treatment of the client. Within the rules, Medicaid encourages a focus on recovery. The client's goals and needs will drive the priorities within the treatment plan. Clients must participate in the creation of their treatment plans; regularly review their treatment plan and services as well as their progress towards their goals with the provider. It is vital that the client participate and work towards measurable goals with the right amount of provider support.

For reimbursement of a Medicaid service, medical necessity must be supported in the documentation. The client must be able to be an active participant in their treatment and have sufficient cognitive ability to benefit from the treatment. Progress notes must document the services that were provided.

CONTACT INFORMATION

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