

# Providing and Documenting Medically Necessary Behavioral Health Services

## Part One: Medical Necessity and Assessments

April 10, 2017

Developed by:

David Reed, Office Chief, Division of Behavioral Health and Recovery

Marc Bollinger, LISCW, CEO, Great Rivers BHO

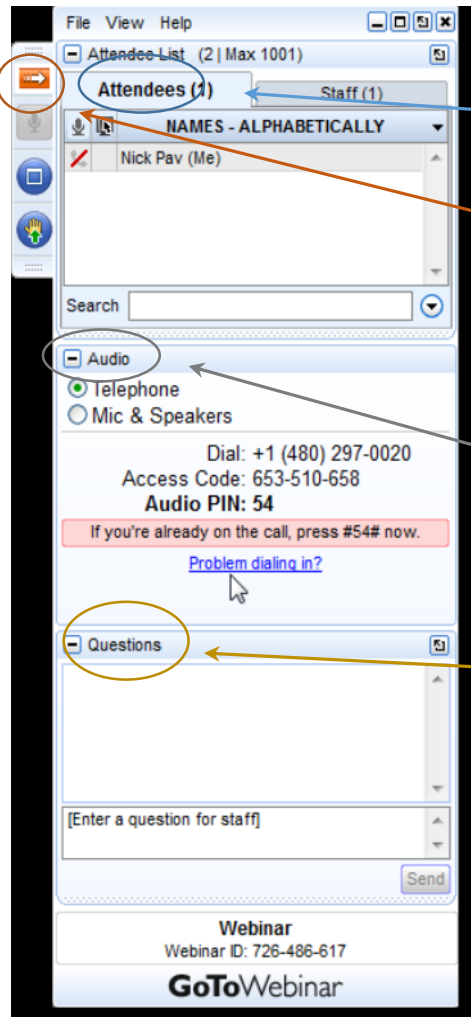
Crystal Didier, MEd, Qualis Health

Kathy Robertson, MSW, CCO, Great Rivers BHO

# Webinar Controls

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# Webinar Controls



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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

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

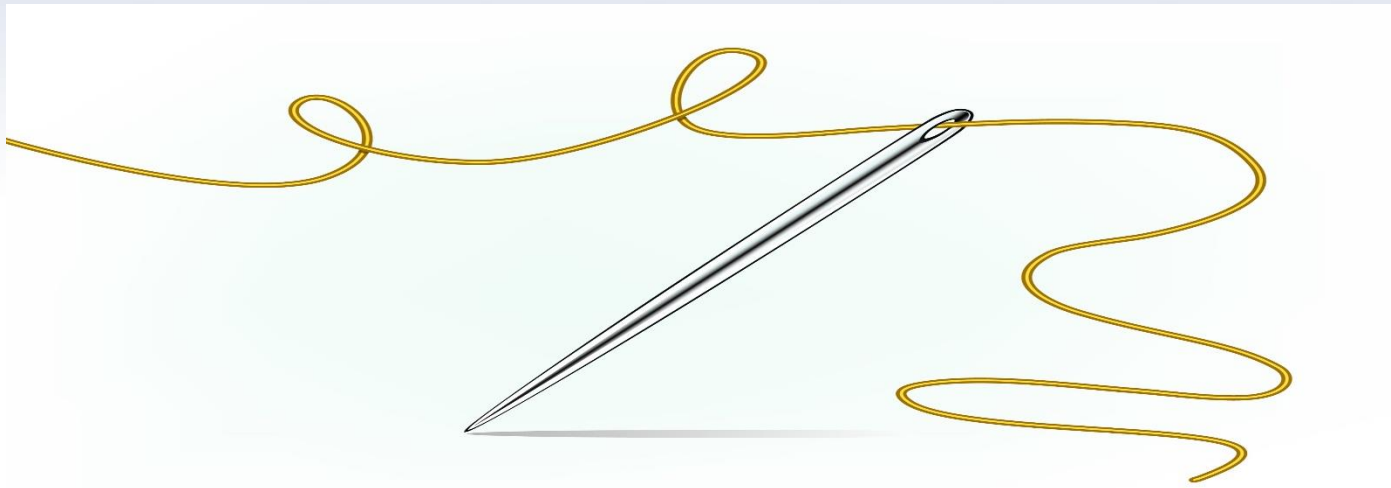
# Goals

- ◆ 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 Contract Definition

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

# Medical Necessity Contract Definition

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



# Medical Necessity

- ◆ 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?

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

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

# State Plan Services

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

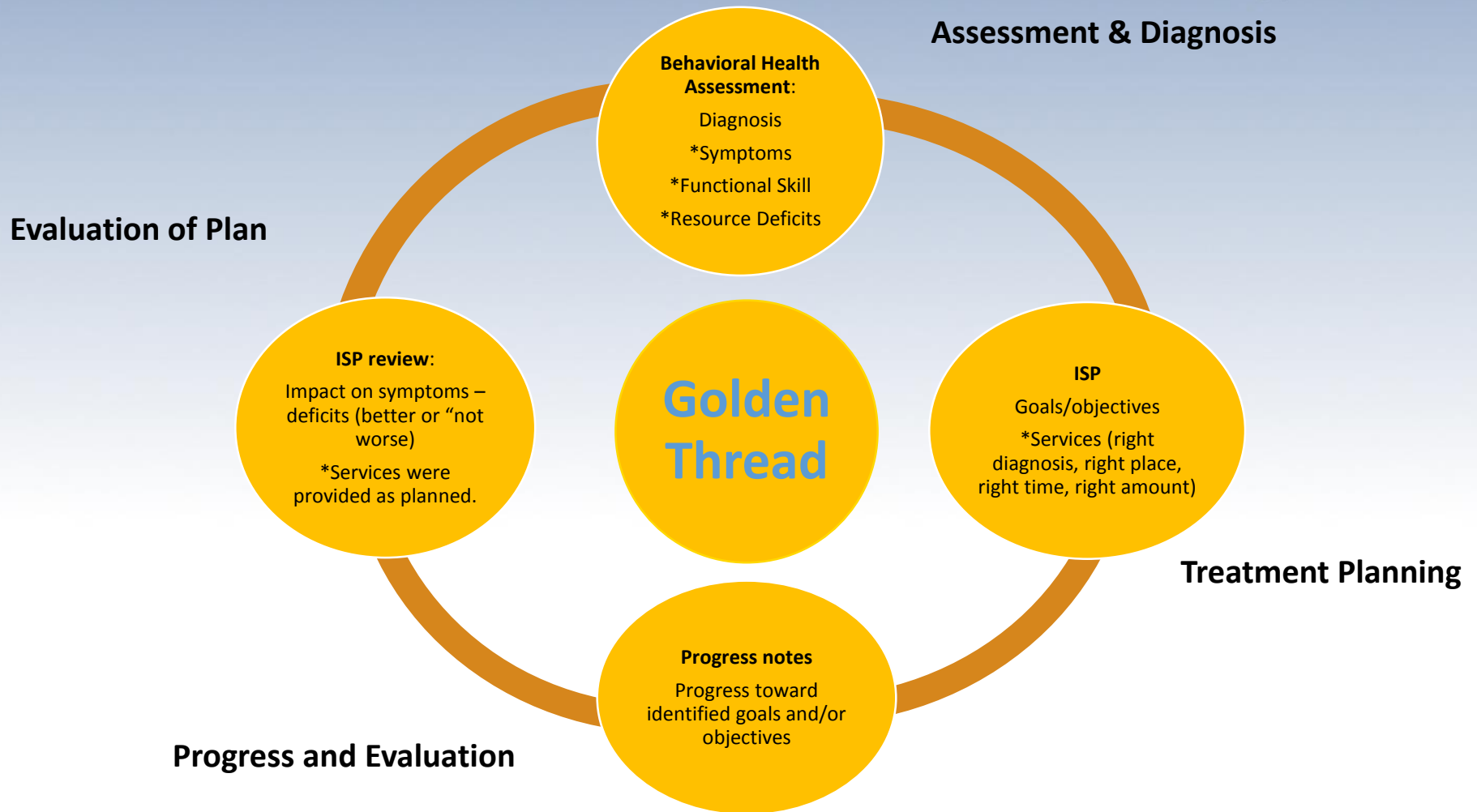
## What is included in the State Plan?

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

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

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

# Golden Thread



# The Golden Thread

- ◆ 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

## 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

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





# The Intake Assessment

- ◆ 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.

# WAC Required Elements for Assessments

- ◆ WAC 388-877-0610
- ◆ Clinical—Initial assessment.
- ◆ Each agency licensed by the department to provide any behavioral health service is responsible for an individual's initial assessment.
  1. The initial assessment must be:
    - a) Conducted in person; and
    - b) Completed by a professional appropriately credentialed or qualified to provide substance use disorder, mental health, and/or problem and pathological gambling services as determined by state law.

# WAC Required Elements for Assessments continued

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

## WAC Required Elements for Assessments continued

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

# Amending and Appending Documentation

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



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.

Noridian Health Solutions 2016

# Amending and Appending Documentation - Late Entry



**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"*

Noridian Health Solutions 2016

# Amending and Appending Documentation - Addendum

**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.

Noridian Health Solutions 2016



## Amending and Appending Documentation - Correction

**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.

# What to do if you have questions

- ◆ 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](mailto:cpt-seriinquiries@dshs.wa.gov)

# Again Why follow the Golden Thread?

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

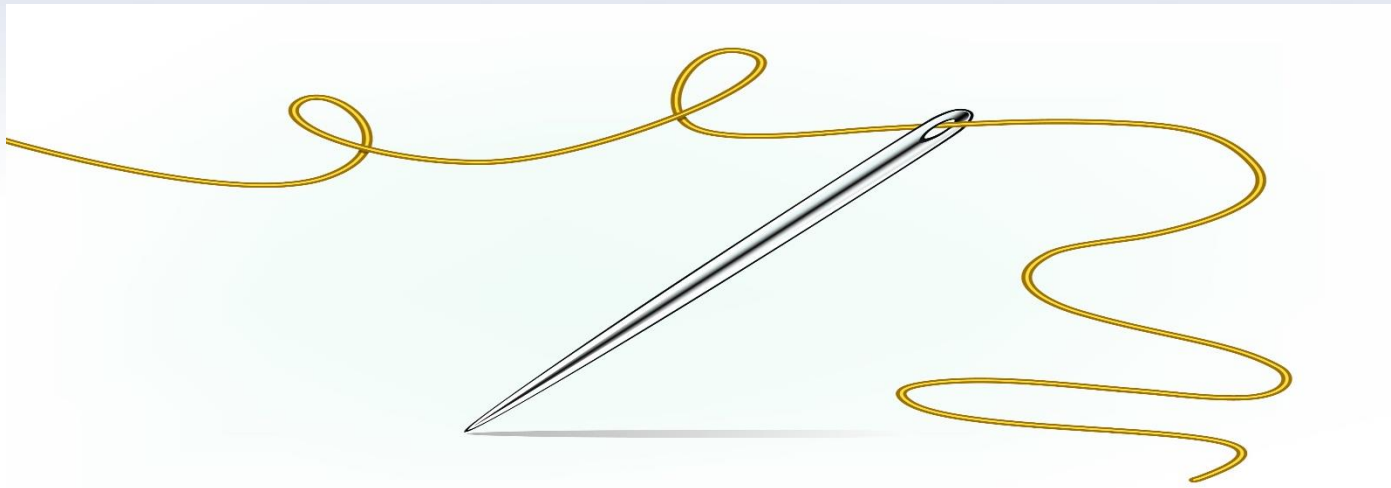
# Questions?

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## Remember:

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# References

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