Division of Behavioral Health

Medicaid Documentation Requirements: Screening through Discharge

Training Module Goals

- To review the basic components of behavioral health regulation documentation requirements

- Identify *common* areas of problematic documentation with the identification of:

✓ Compliant documentation

versus

- Problematic documentation

Documentation Standards

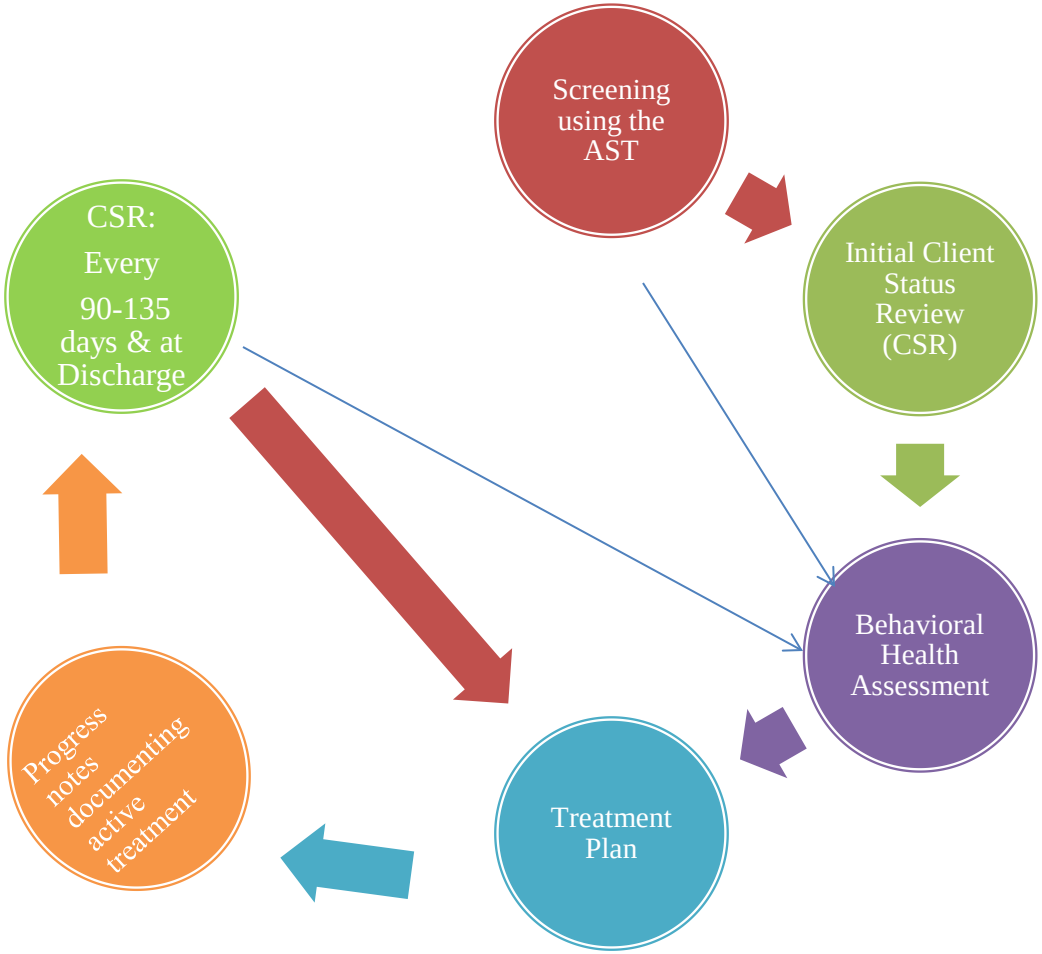
Behavioral Health Services Integrated Regulations
(chapters 70, 105 & 135)

- Represent the minimum standards for payment only

Organizations must also consider and apply:

- Professional standards
- Accreditation standards
- Any grant driven requirements

Flow of Treatment



Alaska Screening Tool (AST) Audit Points:

- Present and complete in the clinical record
- Completed before the assessment was conducted
- Documented evidence that the results of the AST were reviewed and considered during the assessment

Alaska Screening Tool (Symptoms)

Mental Health Screen

- Depression
- Anxiety
- Risk: self/others

Substance Abuse Screen

- Co-occurring Disorders

Additional life areas

- Adverse Experiences
- FASD
- Traumatic Brain Injury
- Major Life Change
- Intimate Partner Violence

Alaska Screening Tool (AST)

<u>Compliant documentation:</u>

- ✓ Assessment documents areas the AST identified as significant and needing assessment
- ✓ If using a statement to indicate the AST was considered, it is individualized and meaningful

Alaska Screening Tool (AST)

<u>Problematic documentation:</u>

- Date of AST is ***after*** the date of assessment
- Statement AST was considered, but information in the assessment is not consistent with AST
- AST identified areas that were not assessed and/or not documented in the assessment
- A “cut & paste” statement that is placed in all assessments regardless of the AST results

Client Status Review (CSR) Audit Points:

- Present in the clinical record
- Completed with the client physically present & administered using the department's current CSR form
- Administered and reviewed every 90-135 days while the client is in treatment
- Used by the directing clinician to assist in *measuring outcomes* of the behavioral treatment provided
- Used by the directing clinician *to revise the client's behavioral health treatment plan*
- Used to assist in *determining the client's functioning* in the life areas identified on the form

CSR Timelines

- Regulations require that a Client Status Review (CSR) be conducted concurrent with a behavioral health assessment
- If a provider conducts and bills for a behavioral health assessment, the date the next (i.e. second) CSR is due is 90-135 days from the date of the assessment and then every 90-135 days thereafter during the course of treatment
- The CSR administered at discharge should be completed with the client present as close to the end of treatment as possible regardless of the date of the previous CSR
- A CSR must be conducted at intake (concurrent with a behavioral health assessment) and again at discharge from treatment regardless of the elapsed time between intake and discharge

CSR: 14 Domains

CSR

Compliant documentation: integrates information from the CSR into the:

- ✓ Assessment- functioning in life areas identified on the form
- ✓ Treatment plan
- ✓ Modification of the treatment plan- through review of the CSR results every 90-135 days
- ✓ Discharge- treatment outcomes

CSR

Problematic documentation:

- Areas are identified on the CSR but they are not documented in the assessment or treatment plan
- CSR is not completed every 90-135 days

- Note: Any Medicaid service delivered past the due date of the client status review is not billable and payment is subject to recovery

Professional Behavioral Health Assessments

If a behavioral health screening (AST), or a referral by a court or other agency, has identified an individual suspected of having a behavioral health disorder that could require behavioral health services, the Dept. will pay a CBHS for one of the following behavioral health intake assessments [7 AAC 135.110]:

1. Mental Health intake assessment
2. Substance Use intake assessment
3. Integrated MH and Substance Use intake assessment
4. Psychiatric Assessment (used as Intake Assessment)

- ✓ ALL assessments must be conducted upon admission

Mental Health Assessment Audit Points:

- Conducted upon admission
- Document the recipient's mental status, social and medical history
- Document functional impairments
- Document the problems identified during the professional behavioral health assessment and client status review processes, including functional deficits that require mental health treatment
- Complete DSM diagnosis consistent with multi-axial classification
- Document the nature and severity of any identified mental health disorder

Mental Health Assessment Audit Points (continued)

- Document treatment recommendations that include services identified as treatment needs that form the basis of a subsequent behavioral health treatment plan
- Document recipient eligibility for the recommended services
- Document referral of the recipient to a provider of behavioral health rehabilitation services in the community (if during the assessment, evaluation, or treatment of a child experiencing an emotional disturbance, a provider determines that the recipient may have a severe behavioral health disorder and that the recipient is in need of behavioral health rehabilitation services)
- Conducted by a mental health professional clinician
- Updated as new information becomes available

Substance Use Intake Assessment Audit Points:

- Conducted upon admission
- Document functional impairments
- Document the problems identified during the professional behavioral health assessment and client status review processes
- Document the recipient has a substance use disorder
- Identifies the correct diagnosis
- Document the nature and severity of any identified substance use disorder
- Document treatment recommendations that includes services identified as treatment needs that form the basis of a subsequent behavioral health treatment plan

Substance Use Intake Assessment Audit Points (continued)

- Document recipient eligibility for the recommended services
- Document referral of the recipient to a provider of behavioral health rehabilitation services in the community (if during the assessment, evaluation, or treatment of a child experiencing an emotional disturbance, a provider determines that the recipient may have a severe behavioral health disorder and that the recipient is in need of behavioral health rehabilitation services)
- Conducted by a substance use disorder counselor, social worker, or other qualified program staff member performing duties regularly within the scope of the individuals authority, training and job description (note: if substance use intake assessment is conducted as part of detoxification services subject to 7AAC 70.110 and 7AAC 135.190, the assessment must be conducted by an individual identified in 7AAC 70.110 for the type of detoxification service provided)
- Updated as new information became available

Integrated Behavioral Health Assessment Audit Points:

- Conducted upon admission
- Document the recipient's mental status, social and medical history
- Document functional impairments
- Document the problems identified during the professional behavioral health assessment and client status review processes, including functional deficits that require mental health treatment
- Complete DSM diagnosis consistent with multi-axial classification (both mental health & substance use diagnoses if applicable)
- Document the nature and severity of any identified mental health disorder and/or substance use disorder

Integrated Behavioral Health Assessment Audit Points (cont'd)

- Document treatment recommendations that include services identified as treatment needs that form the basis of a subsequent behavioral health treatment plan (in relation to both mental health and substance use)
- Document recipient eligibility for the recommended services
- Document referral of the recipient to a provider of behavioral health rehabilitation services in the community (if during the assessment, evaluation, or treatment of a child experiencing an emotional disturbance, a provider determines that the recipient may have a severe behavioral health disorder and that the recipient is in need of behavioral health rehabilitation services)
- Conducted by a mental health professional clinician
- Updated as new information became available

Common compliance issues with assessments:

- Documenting functional impairments
- Documenting a complete DSM diagnosis
- Documenting the nature and severity of the diagnosis
- Documenting treatment recommendations that form the basis of a subsequent treatment plan
- Documenting client eligibility for services
- Updating assessments as new information becomes available

Documenting functional impairments

Compliant documentation:

- ✓ Documentation within the assessment clearly describes how a client is functionally impaired
- ✓ Documentation provides specific and detailed examples of the client's functional impairments that support and justify treatment recommendations

Problematic documentation:

- Documentation within the assessment is vague, general, or the assessment does not contain a description of functional impairments
- Lack of sufficient documentation regarding functional impairments to support the GAF, client eligibility for services, or treatment recommendations

Example of documentation to support functional impairment in the area of school: Client is failing all classes at school, has had three suspensions in the past year due to initiating fights with other children, and exhibits frequent (weekly) behavioral problems in the classroom such as refusing to do school work, talking back to the teacher, and being disruptive in the classroom that requires teacher intervention. *Example of documentation that does not support functional impairment in the area of school*: Client is having problems at school.

Functional Impairments

- Reminder: The CSR addresses life areas such as housing, productive activity, legal involvement, basic needs, supportive relationships, etc. that can provide information that applies to this area. Thus, the CSR assists the provider in identifying functional impairments which should then be reflected in the assessment.

Documenting a complete DSM diagnosis

<u>Compliant documentation:</u>

- ✓ All five axes documented

<u>Problematic documentation:</u>

- Some but not all axes are documented in the assessment
- When it is clear from the content of the assessment that a diagnosis exists, but there is no diagnosis documented in the assessment

Documenting nature and severity of the diagnosis

<u>Compliant documentation:</u>

- ✓ The diagnoses in the assessment are fully supported within the body of the assessment by describing how the client meets the DSM criteria for each diagnosis

- ✓ Diagnoses identified are correct (based on the information in the assessment)

Documenting nature and severity of diagnosis (cont'd)

Problematic documentation:

- Diagnoses are not supported by the information in the assessment
- When it is clear from the content of the assessment that a diagnosis exists, but there is no diagnosis documented in the assessment
- The GAF is not supported by the information in the assessment
- General information about a diagnosis is captured in the clinical summary, rather than fully documented in the body of the assessment

Documenting nature and severity of diagnosis (cont'd)

Symptoms must be specified:

Too General	Specific
Client is struggling with depression.	The client identifies they are struggling with depression and endorse the following symptoms: feels sad most of the time, crying spells at least once a day, do not experience any pleasure in life, has trouble falling asleep and staying asleep (frequently wakes in the night and can not fall back to sleep), is experiencing excessive guilt about not adequately caring for the family, and is having difficulties thinking and concentrating. Client reports the depression started in February 2012 and it has become increasingly worse.

Documenting nature and severity of diagnosis (cont'd)

Time aspects: Avoid general language:

General language	Specific
Has a history of…	Identify the last episodes of the issue: The client reports a history of suicide attempts, the last incident in March 2012 where she cut her wrist with a kitchen knife and had to go to the ER. She also reports additional attempts in August 2011 (overdose of her medication) and June 2011 where she contacted her therapist before taking any action. The suicide attempt in March resulted in a hospitalization at API for 3 days.
Recently	The client was suspended from school last week for smoking on the school grounds.
Frequently	The client's mother estimates that the client has had episodes of anger outburst where she yells, swears, throws things, and slams her bedroom door, at least 3 times a week for the last 2 months.

Documenting treatment recommendations that form the basis of a subsequent treatment plan

Compliant documentation:

- ✓ Identifies recommended services using behavioral health regulation service language
- ✓ Services recommended are fully supported by the assessment (i.e. assessment establishes that services are medically necessary)

Problematic documentation:

- Recommendation is simply a level of care (for SUD providers) without documenting actual services that are recommended
- General or vague recommendations
- Recommendations look the same across all assessments (“cookie cutter”)

Documenting treatment recommendations (continued)

Documentation of services in assessment:

Use Medicaid service language

Clinic Services

- Individual Psychotherapy- insight oriented, interactive
- Group Psychotherapy
- Family Psychotherapy -with recipient, without recipient
- Multi-family Group Psychotherapy
- Short-term Crisis Intervention
- Pharmacologic Management Services

Rehabilitation Services

- Case Management
- Detoxification Services
- Comprehensive Community Support Services for adults
- Therapeutic Behavioral Health Services for children
- Recipient Support Services
- Medication administration Services
- Day Treatment Services for children
- Daily Behavioral Rehabilitation Services
- Residential Substance Abuse treatment services
- Short-term crisis stabilization services

Documenting client eligibility for services

Compliant documentation:

- ✓ Eligibility criteria are stated and clearly supported or justified within the assessment

Problematic documentation:

- Eligibility criteria are not addressed in the assessment
- Assessment contains a standardized statement that eligibility criteria are met, but information in the assessment does not support the statement

Documenting client eligibility for services:

Clinic Services

A Child experiencing:

1) An emotional disturbance (ED)

2) A severe emotional disturbance (SED)

An Adult experiencing:

1) An emotional disturbance (ED)

2) A serious mental illness (SMI)

Rehabilitation Services

A Child experiencing a severe emotional disturbance (SED)

An adult experiencing a serious mental illness (SMI)

An individual experiencing a substance use disorder characterized by:

A) A maladaptive pattern of substance use; or

B) cognitive, behavioral, or physiological symptoms indicating that the individual will continue to use a substance despite significant substance-related problems associated with its use

Updating assessments as new information becomes available

Compliant documentation:

- ✓ Assessment is updated as new and relevant information emerges during the treatment process
- ✓ Significant changes that impact treatment are reflected in assessment updates (i.e., diagnosis, eligibility, new problem areas, new services, etc.)

Problematic documentation:

- Changes to the client's treatment is documented in the treatment plan and implemented without updating the assessment.

Treatment Plan Audit Points:

- Document the recipient's identifying information
- Date that TX plan implementation will begin
- TX goals directly related to the findings of the BHA
- Document services and interventions that will be employed to address the goals
- Identify the goals, objectives, services, and interventions selected to address a recipient's behavioral health needs identified by a professional behavioral health assessment
- Document the frequency and duration of the services and interventions
- Document the treatment team members and their ability to participate in the TX planning session (if the recipient is under 18 years of age)
- Documentation the TX plan remains current based upon the periodic client status review
- Document the name, signature, and credentials of the directing clinician
- Document the name and signature of the recipient or the recipient's representative

7 AAC 135.990. Definitions.

(7) "behavioral health treatment plan" means

(A) a written *individualized* treatment plan that details

(i) the goals, objectives, services, and interventions selected to address a recipient's behavioral health needs identified by a professional behavioral health assessment under 7 AAC 135.110; and

(ii) with respect to selected services and interventions, their frequency and duration;

Treatment Plan

- The treatment plan is a *living document* that is expected to change over time
- Providers should reflect the goals, objectives, treatment services, and interventions as they are known at any point in time to meet client needs
- Additional information is updated to the treatment plan as clients participate in active treatment and problems and needs continue to be identified

Components of the Treatment Plan

- GOAL: what you want to accomplish in treatment related to the identified problem
- OBJECTIVE: the steps the client will take to accomplish the goal
- SERVICE MODALITY: the service the provider will render
  - ✓ Use Medicaid service language
- INTERVENTION: the provider's active intervention while rendering the service to assist the client in meeting the treatment goal
- FREQUENCY: how often you will provide the service & intervention
- DURATION: how long the service and intervention will be provided

Documentation of Treatment Goals & Objectives

Considerations:

- Goals and objectives should be individualized to each client
- Goals and objectives should be specific and easy for the client to understand (can be written in their own language)
- Goals should be related to one problem rather than addressing multiple problems at once

Treatment Plan

Compliant documentation:

- ✓ Treatment plan is individualized to each client
- ✓ Plan contains goals, objectives, services, and interventions that are supported by the behavioral health assessment
- ✓ Identifies recommended services using Medicaid service language

Problematic documentation:

- Treatment plan contains services, but no provider interventions
- Goals are not directly related to or supported by the behavioral health assessment
- Plan lacks frequency or duration for both services *and* interventions

Recipient Support Services (RSS)
Additional documentation requirements

- Need for RSS must be documented in a behavioral health assessment that:

  documents the client's history of high-risk behavior or the rationale for heightened vigilance;

  AND

  recommends the <u>frequency and location</u> where the service should be provided

- The client's treatment plan clearly identifies:

  the client's target symptoms

  AND

  how staff is expected to respond to and resolve a client's high-risk behavior

Progress Notes
Audit Points:

- Document date of service
- Document type of clinic service or type of rehabilitation service
- Document duration of the service expressed correctly in either units or clock time
- Document a description or listing of the active TX provided

  Note: To document active treatment, the provider must set out a description or a listing of the active, pre-planned, specific interventions that the provider provides to, or on behalf of, the recipient to assist them in achieving the goals documented in the treatment plan.
- Document the treatment goals that the service targets
- Document a description of the recipient's progress toward the TX goals
- Document the name, signature, and credentials of the individual who rendered the service

Common compliance issues in progress notes:

- Documenting active treatment
- Documenting the treatment goals the service targets
- Description of the client's progress toward the treatment goals

Active Treatment

Means that the individual who renders the services **actively engages** the client and provides ***pre-planned, specific interventions, supports or other actions*** that assist the client in achieving the goals written in the behavioral health treatment plan

Documenting active treatment

Compliant documentation:

- ✓ The progress note clearly documents active, pre-planned, specific interventions that assist the client in achieving the goal being addressed

Problematic documentation:

- No active interventions or the interventions are not related to the interventions documented in the treatment plan
- Note focuses on client information only
- Progress note infers active treatment, but no active interventions are described. Example: "Client participated in a group for the purpose of learning communication skills."

Documenting the treatment goals the service targets

Compliant documentation:

- ✓ Progress note documents treatment goals *and* treatment goals are related to the service and interventions rendered

Problematic:

- No treatment goals are documented on the progress note
- Goals are documented but they are not related to the information in the note or the service rendered
- Goals are documented but they are not identified on the treatment plan or supported by the assessment

Description of the client's progress toward the treatment goals

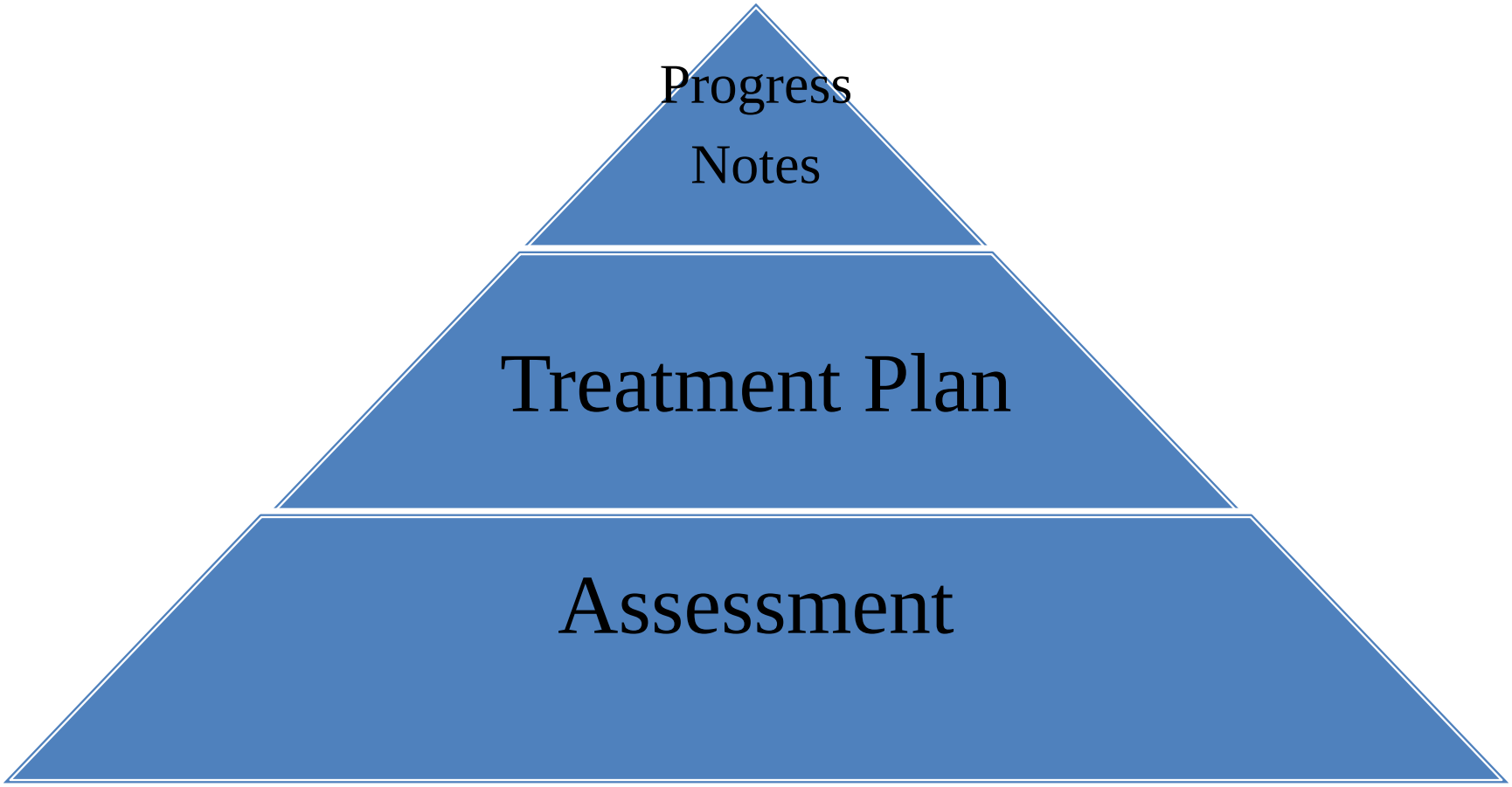
<u>Compliant documentation:</u>

- ✓ Progress note documents client's progress toward the treatment goals *and* the goals are related to the service rendered

<u>Problematic documentation:</u>

- No progress toward treatment goals documented in the progress note
- Progress is noted but it is not related to the treatment goal

All documentation builds on the foundation of the assessment



Important Reminder:

- Behavioral health services may only be provided if they are ***recommended in a behavioral health assessment*** and ***identified in an individualized treatment plan***

- Any service authorizations must be fully supported by the assessment and the treatment plan

How to find Alaska Regulations on the Internet

- Start at the Alaska State home page: http://www.alaska.gov/
- Select "Departments" located under the HOME tab on the top left of the site
- Select "Legislature" under the MY GOVERNMENT section
- Select "Alaska Statutes and Current Legislative Information" under the STATE LEGISLATURE section
- Scroll down and find the section Alaska Information and select "The Alaska Administrative Code
- Select Title 7 Health and Social Services
  - Select part 5. Services for Behavioral Health Recipients, Seniors and Persons with a Disability. (for chapter 70)
  - Select part 8. Medicaid Coverage and Payment (for chapter 105 & 135)

Internet Resources (cont'd)

State of Alaska Division of Behavioral Health website Implementation of the New Integrated Behavioral Health Regulations web-page: http://www.hss.state.ak.us/dbh/bh-Regs.htm

- New Integrated Behavioral Health Regulations
- Provider Technical Assistance
- Resources
- Technical Assistance
- Frequently Asked Questions (FAQ's)
- Regulation Clarification Process