Documentation Improvement

HCCA: Behavioral Health Immersion Session

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Objectives

- Context – Know your environment
- Goal – Accurately record the clinical work being provided
- Strategies – Achieve success

Context

- Know your environment
  - Payer Rules
  - Federal and State Rules
  - Other oversight bodies
  - Internal Policies (Reviews of Internal Policy Manual)

Office of Inspector General

In a 12/04/00 Final Audit Report, the OIG concluded that

>50% of Medicare claims for partial hospitalization programs and other outpatient psychiatric services contained errors including beneficiary eligibility, intensity of services, physician review, treatment plans, and medical necessity.

Medical Necessity

Medical Necessity is defined by CMS as the appropriateness of a diagnosis or treatment by a physician, based on the medical community's perception and understanding of the diagnosis and/or treatment plan..

(Source: Coding and Payment Guide for Behavioral Health Services 2002, (Medicode), page 17)

Medical Necessity

To be considered medically necessary, items and services must be:

- consistent with symptoms or diagnosis of the illness or injury under treatment
- necessary and consistent with generally accepted professional standards
- not furnished primarily for the convenience of the client, the physician, or the supplier
- furnished at the most appropriate level that can be provided safely and effectively to the client

Services Which Are Not Medically Necessary

- Services that are not typically accepted as safe and effective in the setting where they are provided
- Services that are not generally accepted as safe and effective for the condition being treated
- Services that are not proven to be safe and effective based on peer review or scientific literature
- Experimental or investigational services

Services Which Are Not Medically Necessary

- Services that are furnished at a duration, intensity or frequency that is not medically appropriate
- Services that are not furnished in accordance with accepted standards of clinical practice
- Services that are not furnished in a setting appropriate to the client's medical needs and condition

Medicaid Regulations Pertaining to Outpatient Psychiatric Services

- From the State Medicaid Manual—CMS Publication 45
- Section 4221A. General
  - "Medicaid provides coverage of various types of organized outpatient programs of psychiatric treatment. These programs are covered primarily as either outpatient hospital services (42 CFR 440.20(a)) or as clinic services (42 CFR 440.90)."
- Services rendered are considered "clinic services"

Medicaid Regulations Pertaining to Outpatient Psychiatric Services

- From the State Medicaid Manual—CMS Publication 45
- Section 4221B. "Outpatient Program Entry.--An intake evaluation should be performed for each recipient being considered for entry into an outpatient psychiatric treatment program. This applies to any organized program or course of treatment that a recipient enters or attends to receive scheduled or planned outpatient psychiatric services. The evaluation is a written assessment that evaluates the recipient's mental condition and, based on the patient's diagnosis, determines whether treatment in the outpatient program would be appropriate."

Medicaid Regulations Pertaining to Outpatient Psychiatric Services

- From the State Medicaid Manual—CMS Publication 45
- Section 4221B Outpatient Program Entry (continued) "The evaluation team should include, at a minimum, a physician and an individual experienced in diagnosis and treatment of mental illness (both criteria can be satisfied by the same individual, if appropriately qualified). For each recipient who enters the program, the assessment should include a certification by the evaluation team that the program is appropriate to meet the recipient's treatment needs. The assessment should be made a part of the patient records."

Medicaid Regulations Pertaining to Outpatient Psychiatric Services

- From the State Medicaid Manual—CMS Publication 45
- Section 4221C. "Treatment Planning.--For each recipient who enters the outpatient program, the evaluation team should develop an individual plan of care (POC). This consists of a written, individualized plan to improve the patient's condition to the point where the patient's continued participation in the program (beyond occasional maintenance visits) is no longer necessary. The POC is included in the patient records, and contains a written description of the treatment objectives for that patient."

Medicaid Regulations Pertaining to Outpatient Psychiatric Services

- From the State Medicaid Manual—CMS Publication 45
- Section 4221C.Treatment Planning (continued) "The treatment plan also describes:
  - the treatment regimen--the specific medical and remedial services, therapies, and activities that will be used to meet the treatment objectives;
  - a projected schedule for service delivery--this includes the expected frequency and duration of each type of planned therapeutic session or encounter;
  - the type of personnel that will be furnishing the services; and
  - a projected schedule for completing re-evaluations of the patient's condition and updating the POC."

Medicaid Regulations Pertaining to Outpatient Psychiatric Services

- From the State Medicaid Manual—CMS Publication 45
- Section 4221D. "Documentation.--The outpatient program should develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. This documentation, at a minimum, should consist of material which includes:
  - the specific services rendered;
  - the date and actual time the services were rendered;
  - who rendered the services;
  - the setting in which the services were rendered;
  - the amount of time it took to deliver the services;
  - the relationship of the services to the treatment regimen described in the POC and
  - updates describing the patient's progress."

Medicaid Regulations Pertaining to Outpatient Psychiatric Services

- From the State Medicaid Manual—CMS Publication 45
- Section 4221D. Documentation (continued) "For services that are not specifically included in the recipient's treatment regimen, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's POC should be submitted with bills. Similarly, a detailed explanation should accompany bills for a medical or remedial therapy, session, or encounter that departs from the POC in terms of need, scheduling, frequency, or duration of services furnished (e.g., unscheduled emergency services furnished during an acute psychotic episode), explaining why this departure from the established treatment regimen is necessary in order to achieve the treatment objectives.

Medicaid Regulations Pertaining to Outpatient Psychiatric Services

- From the State Medicaid Manual—CMS Publication 45
- Section 4221E. "Periodic Review.--The evaluation team should periodically review the recipient's POC in order to determine the recipient's progress toward the treatment objectives, the appropriateness of the services being furnished and the need for the recipient's continued participation in the program. The evaluation team should perform such reviews on a regular basis (i.e., at least every 90 days) and the reviews should be documented in detail in the patient records, kept on file and made available as requested for State or Federal assessment purposes."
- It is important to note that Pennsylvania treatment plan review requirements are "at least every 120 days or 15 clinic visits, whichever is first" (*PA Code, Chapter 1153.51(7)(ii)*)

Claims Processing

- Understanding Payer processes
- Issues that cause a claim to be problematic
- Issues that lead to a denied claim
- Fiscal Intermediaries
- Claims Monitoring
- Error Logs

Goal

Accurately record the clinical work being provided

Your Role in the Reimbursement Cycle

Proper Documentation

Accurate Claim

Improper Documentation

Inaccurate Claim

Proper Documentation = Accurate Claim Submission

- Assuming medical necessity is established, proper documentation is critical to accurate claim submission
- Presently, over 700 providers are under a CIA – nearly all involve substantial documentation and claim submission issues
- From the government's perspective, "if it wasn't documented, it didn't occur"
- Medical necessity is a significant problem with psychiatric services

Clinical Documentation Policies and Procedures

- Progress Note Format
- Adult/Children's Mental Health Outpatient Documentation Requirements
- Partial Hospitalization Documentation Requirements
- Drug and Alcohol Documentation Requirements –

Documentation Standards for Progress Notes

What is a Progress Note?

- The sequential narrative that depicts the client's progress, or lack thereof, in relation to the treatment plan
- Communicates information about the client and services provided
- Records all clinical events and contacts throughout treatment
- Documents what happens and monitors progress

Quality Improvement Documentation Standards For Progress Notes

Why do we need Progress Notes?

- Document services provided
- Support level of care decisions
- Justify payment and supports post-payment validation
- Record client status
- Assess appropriateness and effectiveness
- Support clinical review and Quality Improvement initiatives
- Evaluate compliance

Quality Improvement Documentation Standards For Progress Notes

Progress Notes must:

- Be clear, legible and written in permanent ink
- Document date and time in/out for each session
- Document the service actually provided
- Be consecutive, in sequential time order and signed, with credentials, and dated by author
- Record client name and identification number on each page
- Document all contacts and interactions
- Not be erased or contain white-out. Errors are to be crossed out, initialed and dated
- Document next scheduled visit

Quality Improvement Documentation Standards For Progress Notes

Clinical components must document::

- Medical/clinical necessity and support appropriate LOC
- Client status at each encounter
- Treatment plan goals and objectives
- Presenting problems and client's needs
- Services and interventions
- Impact of services and interventions and client's response
- Referrals to other services, LOC, or provider
- Coordination and continuity
- Clinically significant events
- Medication

Quality Improvement Documentation Standards For Progress Notes

Keep In Mind Notes Should…

- Reflect evaluation of client progress towards treatment objectives
- Serve as an informal review of the treatment plan
- Must be factual and concise
- Document changes in the client's condition

Goal

Accurately record the clinical work being provided

- Barriers
- Strengths

Barriers

- *Documenting is only one of many things competing for a clinician's time*
- *Tension between recording what actually occurred and the perception of what payers and regulators want*

Strengths

- Clinical Skills
- Clinical Experience

Issues in Documentation

- Payer cannot be billed for services with no supporting documentation of service rendered
- All services rendered must have corresponding medical record documentation
- Several cases without corresponding treatment plans covering the date of service under review
  - Comprehensive treatment plans must be in place for all clients
  - Treatment plans must include objective data describing clients issues or needs, measurable, client-centered goals, interventions designed to meet these goals, as well as the staff assigned to carry out the stated interventions

Documentation – Correcting Medical Record Entries

- White-out must not be utilized to correct errors
- Scribbling over or writing over entries is unacceptable
- Amendments to the medical chart must be made consistently, pursuant to regulations, and in accordance with Quality Improvement Documentation Standards

Strategies

- Start at point of Hire – incorporate a writing skills test as part of employment process
- Documentation expectations of your particular facility should be outlined as part of the orientation process
- Don't assume staff know how to document – find out where they are and assist them to improve
- Educate staff about their context-globally and specifically
- Documentation should be an integral part of supervision
- Provide line supervisors with resources to help clinicians improve
- Make sure staff document what they do

Documentation is a part of Compliance and Quality

- Standards of conduct
- Written compliance plan
- Monitoring
- External auditing
- Internal Documentation Standards
- Policies and Procedures
- External Hotline