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Documentation Redesign

Mental Health
Community Based Organizations (CBOs)

Scott Alexander, LMFT
Gerold Loenicker, LMFT

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Housekeeping

- This session is being recorded. Your video feed will not be part of the recording, however your audio may be when asking questions or making comments.
- This meeting is in focus mode, meaning you will only be able to see the presenter and your video feed. You will only see other participant's names.
- Please stay on mute, unless asking a question.
- Please put questions in the Chat. There will be time for questions at the end.
- There will be an evaluation at the end that all attendees must complete.

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Agenda

I. Role of documentation redesign in CalAIM
II. Quality vs. fraud, waste, & abuse
III. What Constitutes Fraud, Waste and Abuse
IV. Assessment, Problem List, Progress Note
V. Exceptions: TCM, ICC, IHBS, and others
VI. Authorization and corrective action
VII. Complete Evaluation

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Primary Goals of CalAIM

Manage Risk

- Through whole person care approaches and addressing Social Determinants of Health (SDOH)

Reduce Complexity

- Move Medi-Cal to a more consistent and seamless system and increasing flexibility

Improve Outcomes

- Reduce health disparities, and drive delivery system transformation and innovation

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Leaner Documentation

- More time treating and less time documenting
- Emphasis on beneficiary care and outcomes
- Treating the whole person rather than a limited treatment plan: the problem list
- Simplified internal utilization review
- Decrease recoupment: disallowances limited to fraud, waste, & abuse
- Quality paperwork is required

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Fraud, Waste and Abuse

- **Fraud** is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program (18 U.S.C. §1347).
- **Waste** is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.
- **Abuse** includes actions that may, directly or indirectly, result in:
  - Unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary.
  - Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

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What Constitutes Fraud, Waste and Abuse?

- Medicaid fraud and abuse negatively impacts health care use by wasting limited resources and potentially endangering patients through unnecessary care or preventing access to medically necessary services.
- Most providers try to work ethically, provide high-quality patient medical care, and submit proper claims.
- Most mistakes made in clinical documentation are **not** fraud, waste or abuse.
- More details to come in the DHCS 2022-2023 Annual Review Protocol (coming later in 2022).

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What is NOT Fraud, Waste and Abuse?

- Selecting the incorrect service code/CPT
- Entering incorrect service/documentation/travel time
- The service does not meet the definition of a SMHS
- The content of the progress note does not justify the amount of time billed
- The note that was billed is not present in the chart
- The date of service of the progress note does not match the date of the service claimed
- Documenting non reimbursable services or including mention of “non-billable” interventions during an otherwise billable note
- Service provided was not within scope of the person delivering the service
- Documentation was completed but not signed
- Group services not properly apportioned to all clients present

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What Conduct Can Infer of Fraud, Waste or Abuse?

- Repeated pattern of unnecessary services
  - Example: "assembly line" non-individualized treatment patters, or "cookie-cutter" progress notes.
- Pattern of knowingly false statements on billings, or corresponding progress notes
  - Example: deliberately listing wrong location of service or provider to conceal license/eligibility issues.
  - Intentional concealment of known errors or overpayments
  - Example: use of inaccurate statements, or deliberate failure to disclose adverse facts, in response to audit questions.

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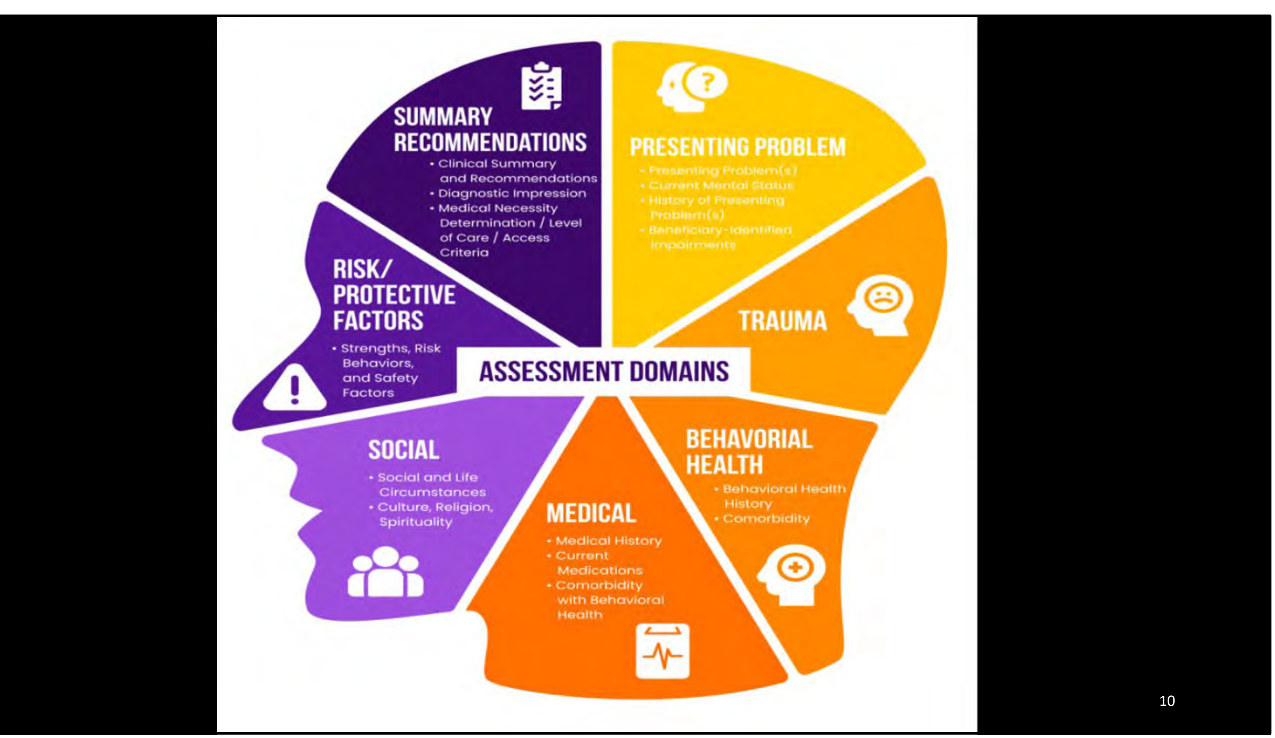

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21 and Over Assessment: Summary of Changes

- Combined clinician and psychiatrist assessment
- Differentiation of assessment type within the single form: initial vs annual
- Assessment is leaner
- More narrative along with prompts from which to choose; only pertinent prompts require a response
- More robust mental status exam
- Added question for medical necessity determination
- Annual assessments need only address more recent developments, not the entire history

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Functional Impairments

- Moved immediately beneath Presenting Problem
- No need to include impairment content within presenting problem section
- No mild, moderate, or severe
- Free text to describe the impairment
- Only respond to relevant areas of impairment

Presenting Problem
What is the primary reason for current referral? Describe current precipitating event, primary stressors, primary symptoms, and functional impairment.

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Functional Impairment: Comment on all that apply

Food/Shelter

Family Relations

Social Relations

Mental Health Impact on Physical Health

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Client Name: Client MRN/ID:

Occupation/Education

Substance Use

Activities of Daily Living

Recreational/Leisure Activities

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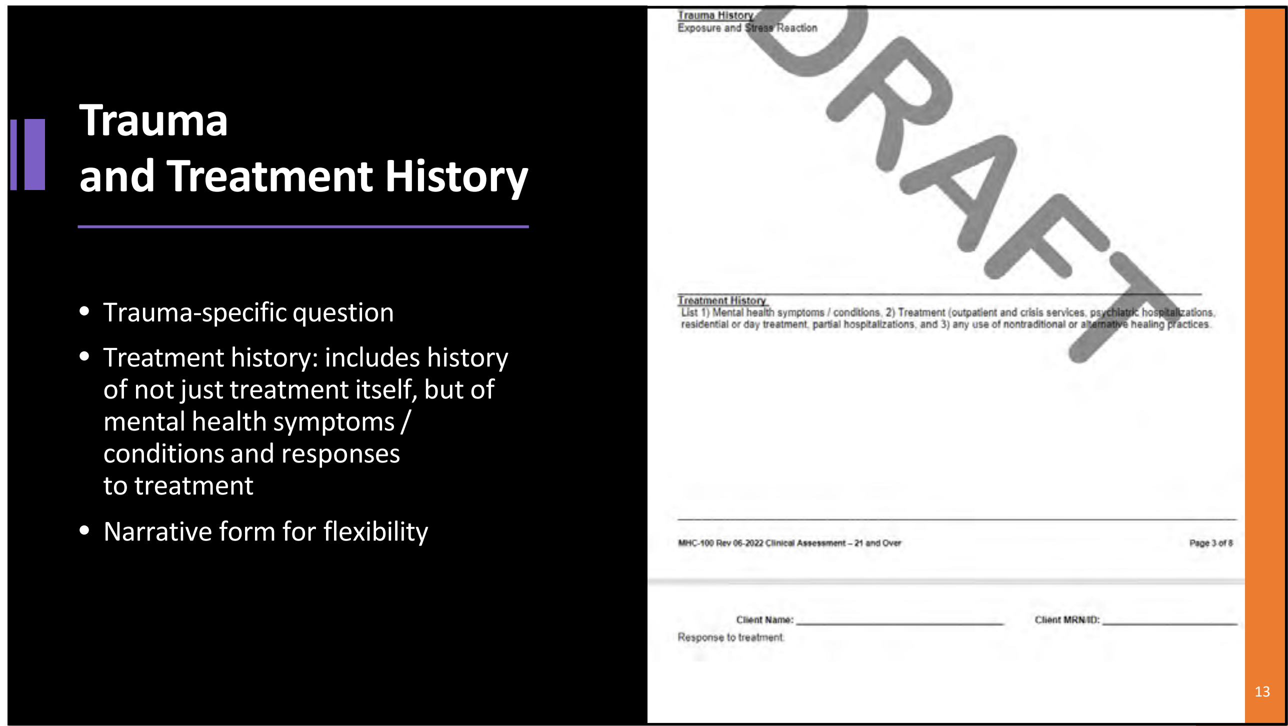

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Medical

- Fewer questions
- More narrative

Medical History

Are there any physical health concerns (medical illness, medical symptoms), including access to physical health services?
☐ No ☐ Yes (if so, please describe):

MHC-033 Rev 06-2022 Clinical Assessment – Under 21 Page 4 of 7

Client Name: ______________ Client MRN/ID: ______________

Medication or non-medication allergies/serious reactions? ☐ No ☐ Yes (if so, please describe):

Current medication(s), including over-the-counter, herbal, psychiatric, and homeopathic. Include start date/dose/frequency and any compliance issues):

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Risk Assessment

- Slightly Briefer

Risk Assessment
Danger to self (Intent, Plan, Means):

Danger to self (Past history):

Danger to others (Intent, Plan, Means):

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Client Name: ____________ Client MRN/ID: ____________

Danger to others (Past history):

Additional Risk Factors: Check all that apply. Document details.

- ☐ Access to Firearms (family, friends)
- ☐ Animal Cruelty
- ☐ Emotional/Physical Neglect
- ☐ Fire Setting
- ☐ Impulsivity/Threatening Behavior
- ☐ Physical Abuse/Emotional Abuse
- ☐ Severe Hopelessness
- ☐ Substance Use
- ☐ Other (specify in comments)
- ☐ Adverse Childhood
- ☐ Behavior Influenced by Delusions or Hallucinations
- ☐ Family History of Suicide
- ☐ History of Domestic Violence
- ☐ Inappropriate Sexualized Behavior
- ☐ Self-Injurious Behavior
- ☐ Sexual Abuse
- ☐ Trauma or Loss in Family

Comments:

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Robust Mental Status Exam

Mental Status Exam
Appearance/Grooming

Behavioral Relatedness

Motor Activity

Speech

Mood

Affect

Thought Process

Thought Content

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Client Name: ____________ Client MRN/ID: ____________

Perceptual Content

Cognition/Orientation

Attention/Concentration

Memory

Abstract Reasoning

Insight

Judgment

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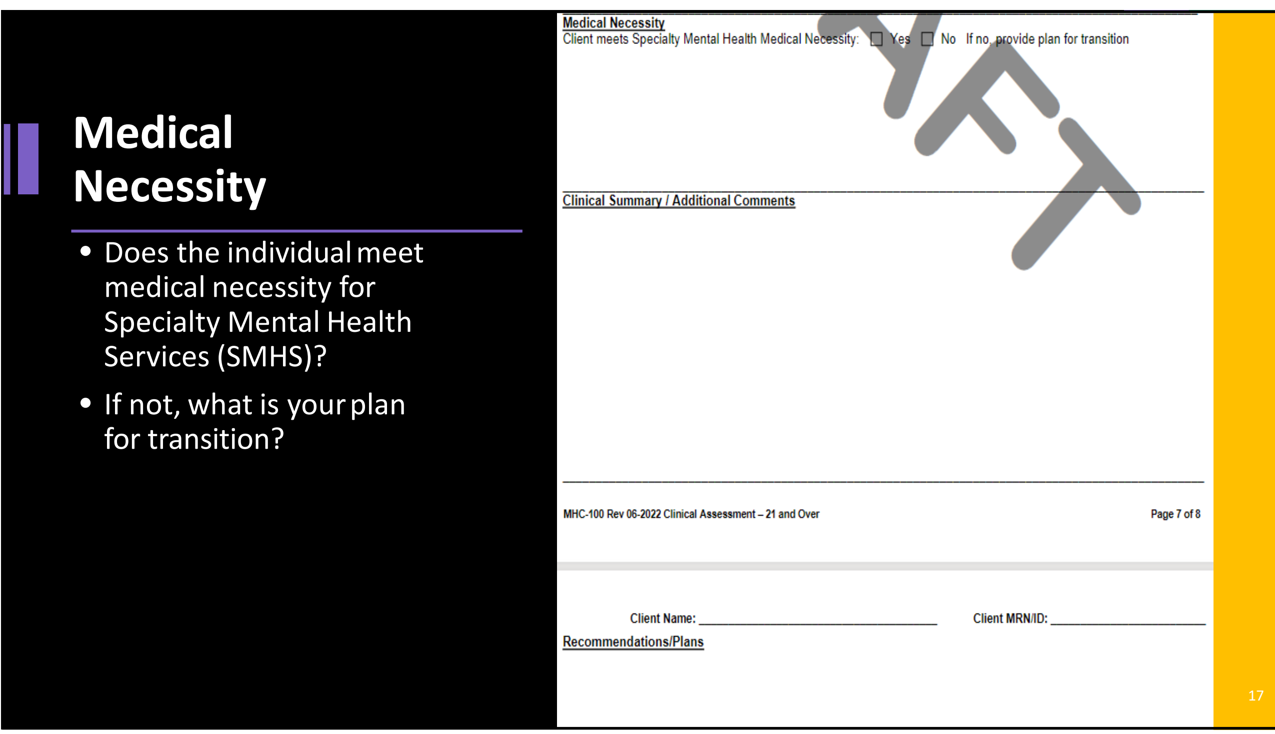

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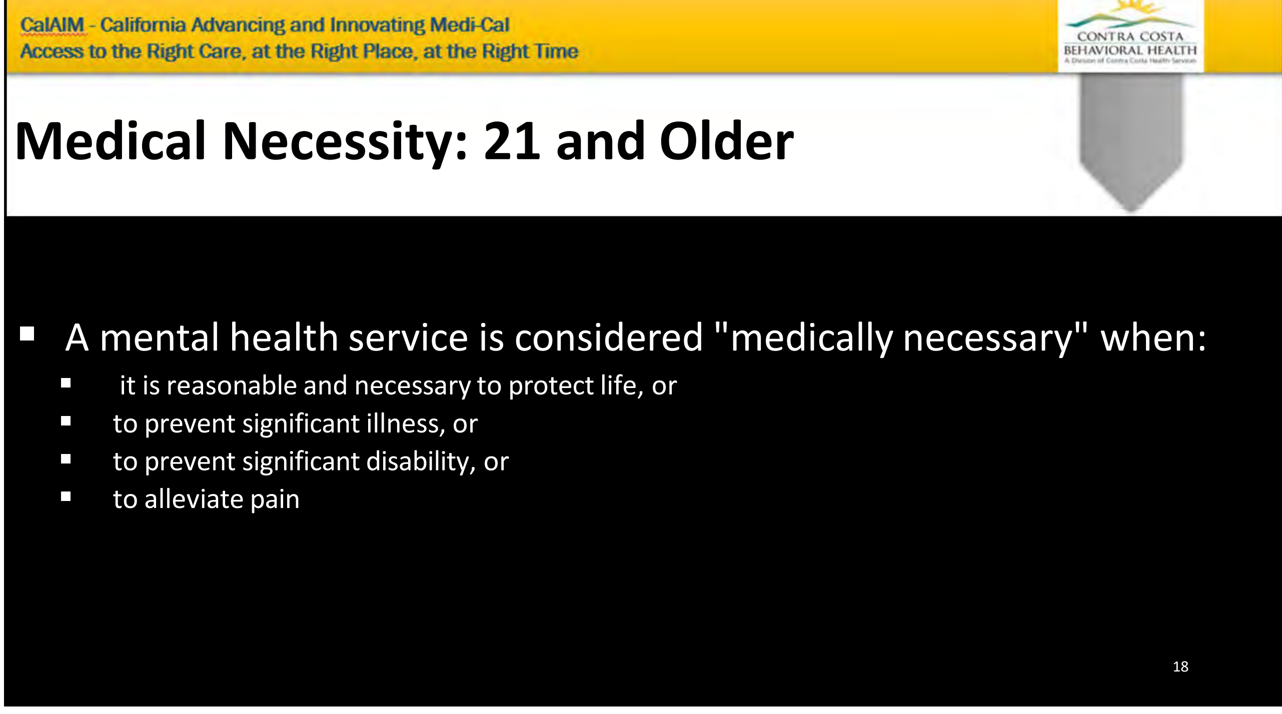

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Access Criteria: 21 and Older

- Must meet one or both of the following criteria, (1) and (2) below:
- (1) Client has one or both of the following:
- a. Significant impairment (distress, disability, or dysfunction in social, occupational, or other important activities)
- b. A reasonable probability of significant deterioration in an important area of life functioning

AND

- (2) Client's condition above is due to either:
- A diagnosed mental health disorder, according to the criteria of the current editions of the DSM and ICD and related health problems
- A suspected yet undiagnosed mental health disorder.

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Under 21 Assessment: Changes

- Organized by Domains 1-7
- CANS-supplemented
- Only one assessment form: no initial and update
- No separate assessment for under 6
- Substance use section is more compact
- Developmental History is more compact
- New Medical Necessity Section
- Referrals prompted in the plan section

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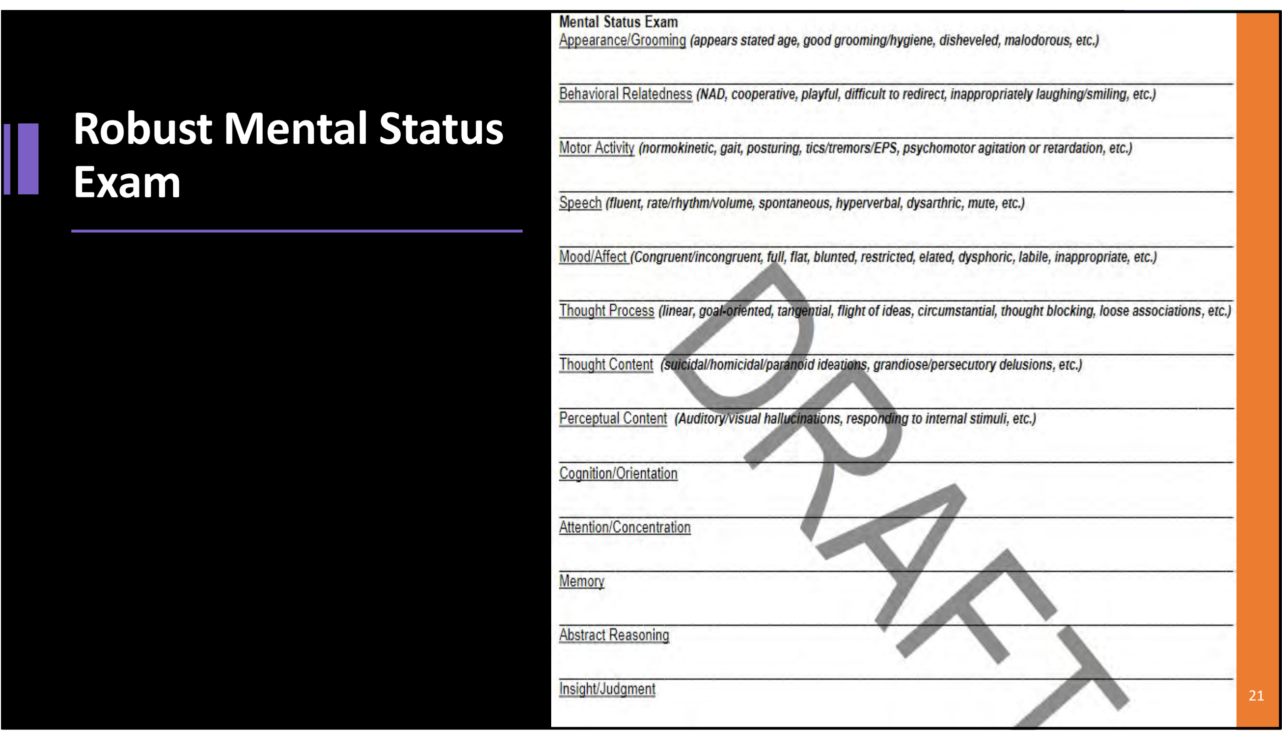

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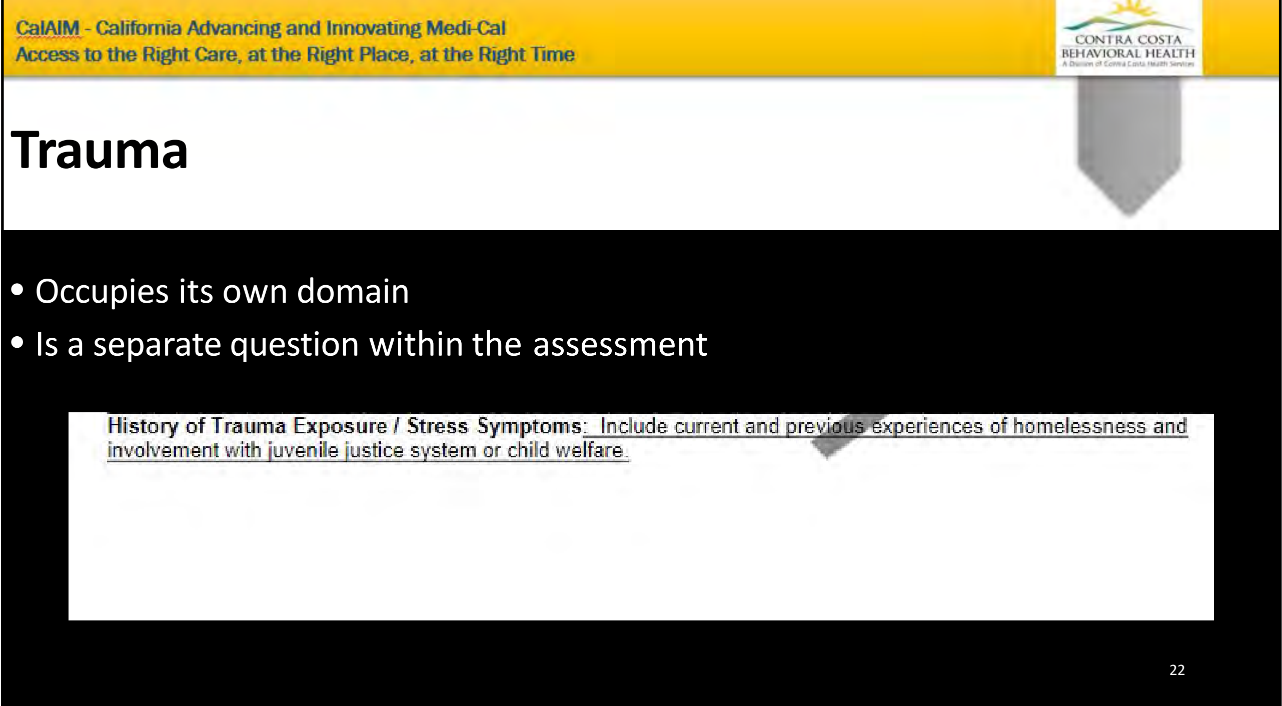

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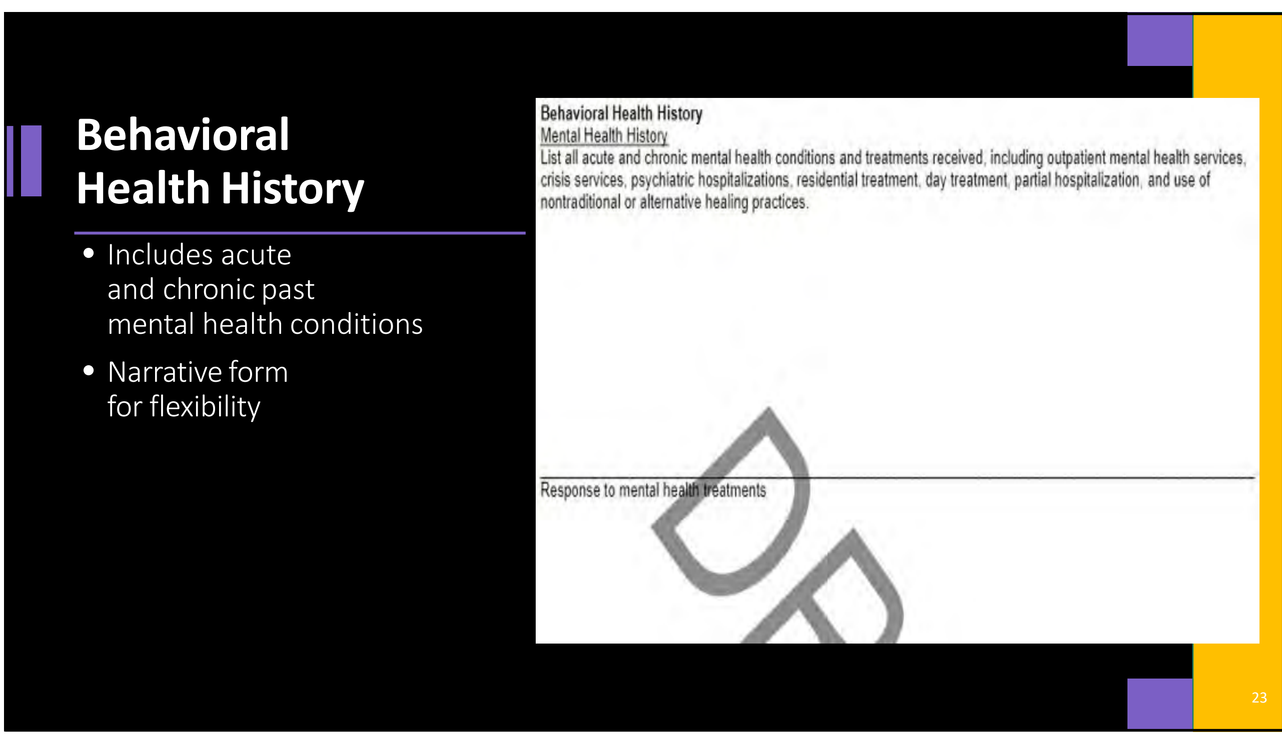

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Medical History

- Fewer questions with more narrative

Include problems with accessing care or medical compliance

Medical History

Are there any physical health concerns (medical illness, medical symptoms), including access to physical health services?

☐ No ☐ Yes (if so, please describe):

MHC-033 Rev 06-2022 Clinical Assessment – Under 21 Page 4 of 7

Client Name: ______________ Client MRN/ID: ______________

Medication or non-medication allergies/serious reactions? ☐ No ☐ Yes (if so, please describe):

Current medication(s), including over-the-counter, herbal, psychiatric, and homeopathic. Include start date/dose/frequency and any compliance issues):

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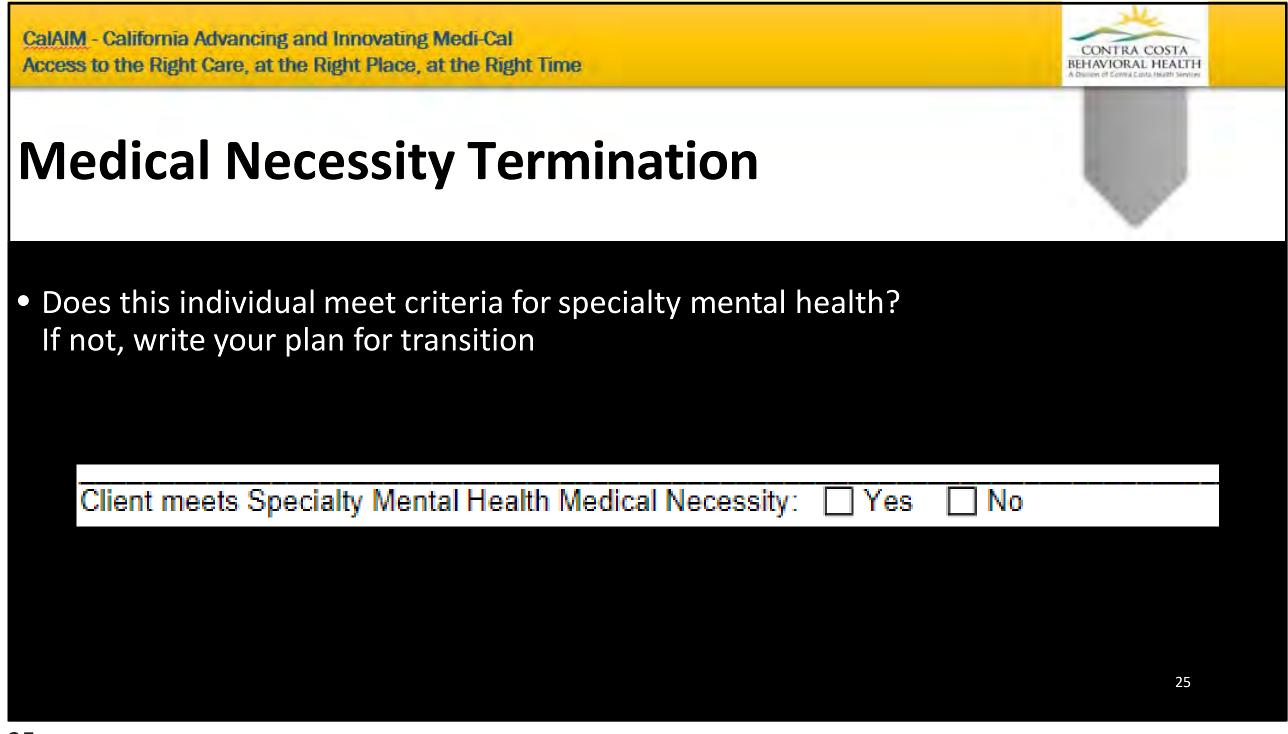

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Medical Necessity: Under 21

- Defined under EPSDT:
  - To correct or ameliorate a mental illness or condition discovered by a screening service whether or not the service is covered under the State Plan
  - These services need not be curative or restorative
  - Services can be delivered to sustain, support, improve, or make more tolerable a mental health condition

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Access Criteria: 20 and Under

- Must meet either of the following criteria, (1) or (2), below:
  - Client is at high risk for a mental health disorder due to:
    - -history of trauma exposure
    - -homelessness
    - -involvement in juvenile justice system
    - -involvement in child welfare system

OR

- (2) Client's meets both requirements in a) and b), below:
  - a) Client has at least one of the following
    - Significant impairment
    - Probability of significant deterioration
    - Probability of not progressing developmentally

AND

  - b) Clients condition above is due to one of the following:
    - A diagnosed mental health disorder
    - A suspected yet undiagnosed mental health disorder
    - Significant trauma causing risk of future mental health condition

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Assessment Procedures

- Initially and annually
- 60 days is the assessment period for add-on services, service providers, and programs
- An included DSM-5/ICD 10 diagnosis should be assigned by the end of 60- day authorization period
- Partial authorization may be given for up to 90 days from the date of review to update the diagnosis
  - indicate on a progress note why you cannot diagnose a DSM/ICD-10 code
- Quality and timely assessments are still expected
- No recoupment for tardy assessments

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Z-Codes

- Z codes ranging from Z55-Z65
  - Identify significant problems that impact treatment or condition
  - Are ICD-10 codes
  - Are not diagnoses of a mental health disorder
  - Z55-Z65 may be selected by any mental health worker
  - Example: Parent-Child Relational Problem (Z62.820)

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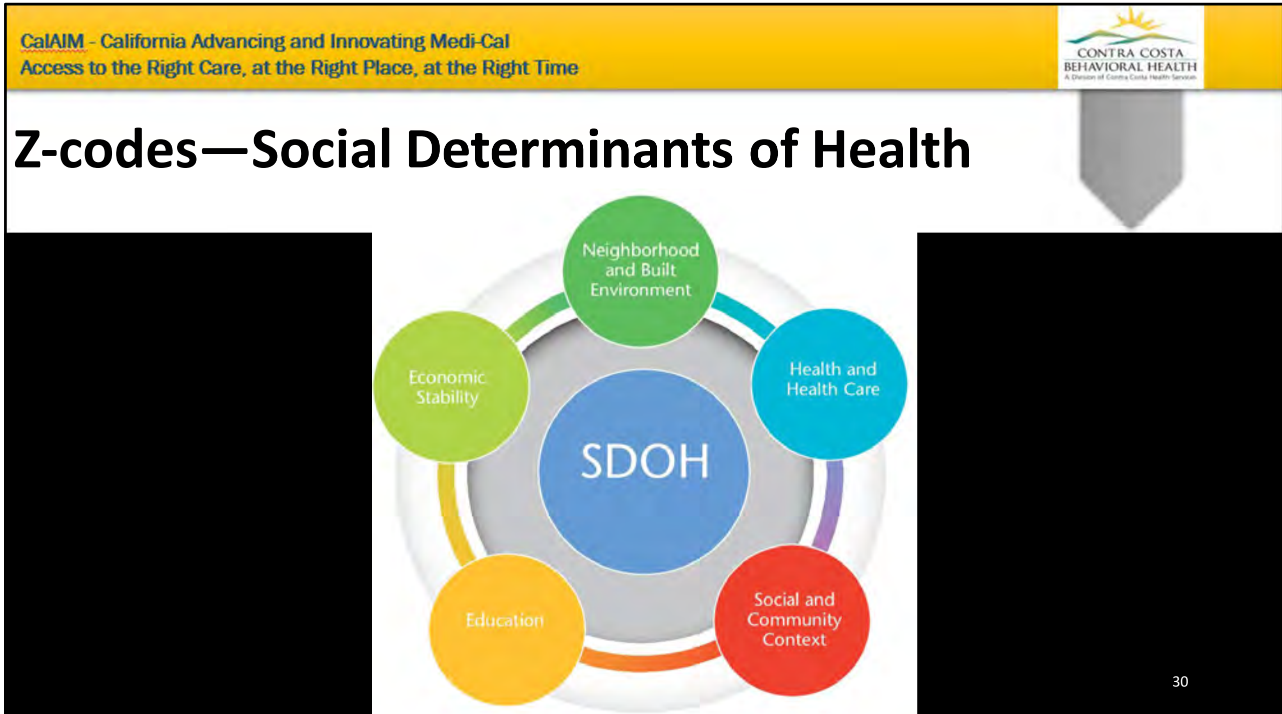
Z-codes—Social Determinants of Health



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Z Codes and Authorization

- Z55: Illiteracy / Academic-related
- Z56-57: Employment
- Z59: Housing
- Z60: Phase of life / cultural
- Z62: Parenting
- Z63: Marital
- Z64: Pregnancy
- Z65: Legal

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Z-Codes and Authorization

- Z codes may remain on the problem list if they are pertinent
- By the end of the 60-day assessment period, an "included" DSM 5 diagnosis is required
- If a diagnosis is not obtained within the 60-day assessment period, the individual may be partially authorized to allow providers more time to establish a firm diagnosis

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Problem List

- List of current symptoms, diagnoses, conditions, and/or risk factors
- Identified through assessments, evaluations, and other service encounters
- Denotes when problems start, change, and resolve
- Includes physical health and mental health problems
- Living document that regularly gets updated over time
- Any mental health provider may contribute within scope of practice

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Mental Health Client Problem List

NAME/MRN

Facility Name: ______ ID: ______ Program Name: ______ ID: ______

Problem (Provide diagnostic narrative; or list symptoms, conditions, and/or risk factors)	**DMS-5 and ICD-10 code** (if applicable)	**Problem Identified By** (Name & Credentials)	**Date Problem Identified**	**Date Problem Resolved / Deleted**	**Removed by** (Name and Credentials)

Signature/License/Designation ______ Printed Name ______ Date ______

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Why a Problem List?

- Partnership Plans tend to be rigid and stringent
- All services were restricted to treating only goals found in the plan
- Needs of the beneficiary are no longer understood "in terms of achieving the goals of the beneficiary's client plan"
- We treat the person rather than the plan
- Mental health aligns with physical health in tracking problems

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Problem List

- All mental health workers may directly add to the problem list within their scope of practice. Notes to each problem may also be entered.
- Diagnoses selected must be within provider's scope of practice
- The problem does not have to already live on the problem list before it is treated and charted.
- The problem list should be updated within a reasonable time.
- Problems need to be reviewed, deleted, and resolved over time

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Clinical Progress Note

- Section 1a (Treatment goal) and 1b (Current Situation/Reason for Contact) combined
- Addition of Targeted Case Management care plan

Progress Note:
Problem/Behavioral Health Need Addressed
(problem/need, reason for contact, status update, clinical impressions):
Here is where I will write the problem and need addressed.

Focus of Activity
(type of service rendered; how the service addressed behavioral health need; how the beneficiary responded—symptoms, condition, diagnosis, and/or risk factors): The type of service rendered and how the service addresses the bh need.

Plan
(next steps--action steps by provider or consumer, collaboration with the beneficiary or other providers, updates to the problem list as appropriate):
Action steps by the provider and beneficiary.

Targeted Case Management:
Goals (including client participation in development of goals):
Write goals and participation in this box

Actions / Interventions:
The actions and interventions we will take are as follows

Transition plan when client has achieved goals:
When the client has achieved goals we will transition

DSM-5 Diagnosis and Narrative, ICD-10 Code

Primary Diagnosis: Social anxiety disorder (social phobia) 300.23 (F40.10)
Secondary Diagnosis(if applicable): Other specified anxiety disorder 300.09 (F41.8)
Tertiary Diagnosis(if applicable):

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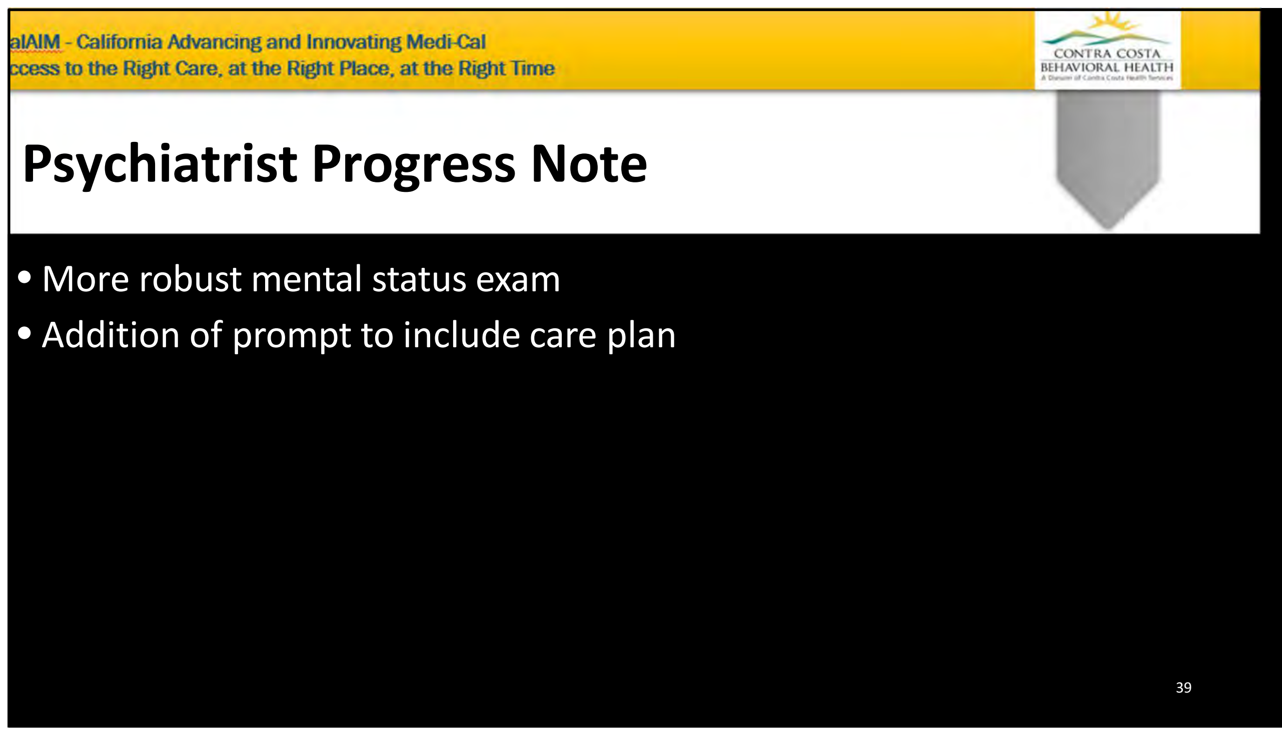

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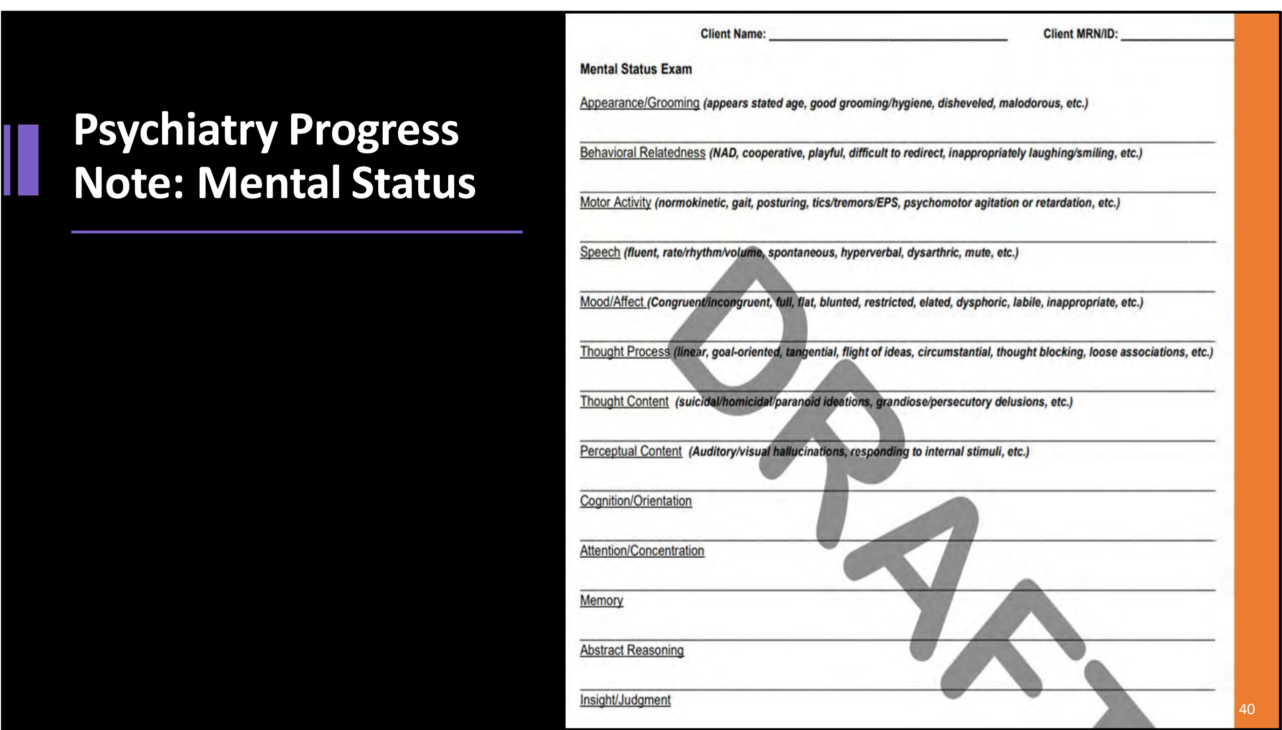

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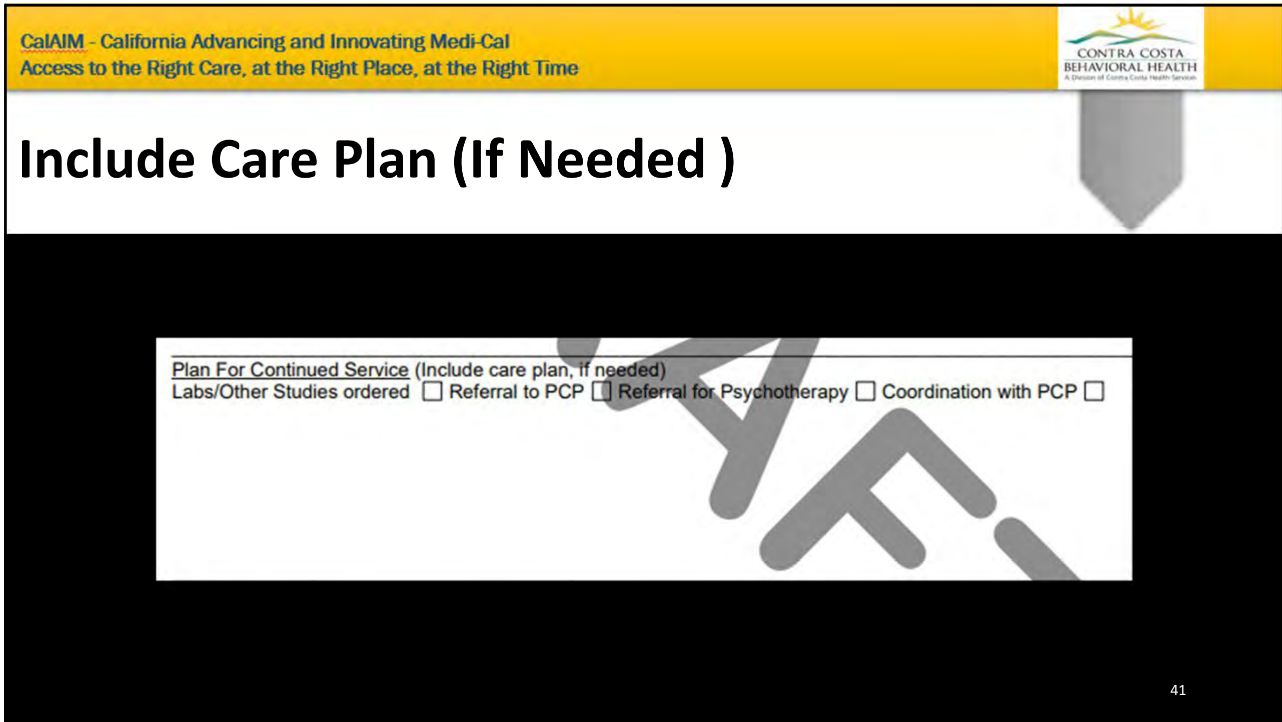

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What is Targeted Case Management?

- Defined: services furnished to assist individuals in <u>gaining access to needed medical, alcohol and drug treatment, social, educational and other services</u>.
- The service activities may include:
  - communication, coordination, and referral;
  - monitoring service delivery to ensure beneficiary access to service and the service delivery system;
  - monitoring of the beneficiary's progress;
  - placement services;
  - plan development.

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Care Plan for Targeted Case Management

- Goals, treatment, service activities, and assistance to address the negotiated objectives of the plan and medical, social, educations, and other needed services
- Includes activities such as ensuring the active participation of the individual, and working with the individual and others to develop those goals
- Identifies a course of action to respond to the assessed needs of the individual
- Develops a transition plan when one has achieved care plan goals

(Monitoring and update of the care plan is annual or shorter as appropriate)

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Goals

- Goals, treatment, service activities, and assistance to address the negotiated objectives of the plan and medical, social, educations, and other needed services
- Based on mutually discussed and agreed upon goals / treatment / type of needed services
- Examples: Live independently, increase energy in the morning, find work, find a partner, go to psychotherapy, use public transportation, see family more often, rehabilitate knee, decrease auditory hallucinations, join a club, get sober

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Active Participation

- Includes activities such as ensuring the active participation of the beneficiary, and working with the beneficiary (or authorized health care decision maker) and others to develop those goals
- Explain that you discussed and agreed upon case management goals
- Describe when other significant people were central in establishing the goals
- Describe efforts made with beneficiaries reluctant or unable to participate in the goal-making process
- E.g., 1. Discussed and agreed with beneficiary upon case management goals.
  2. Beneficiary unwilling to discuss a plan due to paranoia. Will attempt to discuss further in subsequent encounters.

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Course of Action

- Identifies a course of action to respond to the assessed needs of the individual
- Case management: linkage, placement, case management planned-development
- Monitoring / evaluating to ensure engagement in services received
- E.g., monitor medication compliance via speaking regularly with house manager; inform psychiatrist of problems with compliance and changes in symptoms; encourage beneficiary to directly communicate concerns with psychiatrist about side effect. Refer to Putnam Clubhouse. Facilitate purchasing of groceries by making a list beforehand and taking slow, deep breaths when dysregulated in the store.

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Develops a Transition Plan

- Develops a transition plan when one has achieved care plan goals

- Step-down to network provider therapist
- Refer for group therapy
- Step-down to primary care provider
- Change placement from large board and care to a small one
- Facilitate movement to independent housing

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Who is not a case-managed client?

- Medication-management individuals
- Individuals receiving therapy only
  - Coordination of care with other providers may qualify as evaluation, assessment, or plan development services, and not case management
  - Services are primarily psychotherapy, rehab, group, and collateral
- Very brief case management support
  - Mental health workers who provide one or two case management services, such as officer-of-the-day clinicians, are not required to write care plans

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ICC, IHBS, TBS, STRTP

- Intensive Care Coordination (ICC) need no longer submit partnership plans: the updated CFT plans will suffice.
- Intensive Home-Based Services (IHBS), Therapeutic Behavioral Services (TBS), Therapeutic Foster Care (TFC), Short Term Residential Therapeutic Program (STRTP): UR paperwork requirements and forms remain unchanged.

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Utilization Review, Authorization and Quality

- Problematic or absent UR paperwork (assessments, care plans, or medication consents) will not result in denial of authorization
- Partial authorization for problematic or absent paperwork is generally 90 days
- UR will address problems of quality by ongoing communication via the chart alerts and/or in writing (in-baskets and/or worksheets)
- Repeated quality problems from mental health workers will be brought to the attention of supervisors

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UR Paperwork Requiring Initial / Annual Submission

- Assessment: initial / annual for clinicians; initial / biennial for psychiatrists
- CANS (under 21): initial / annual
- Progress note with targeted case management plan: initial / annual
- Problem list: initial / annual
- ICC eligibility (under 21): initial / annual
- (CFT plan if ICC; current Partnership Plan from IHBS)
- PSC 35 (under 19): initial / annual

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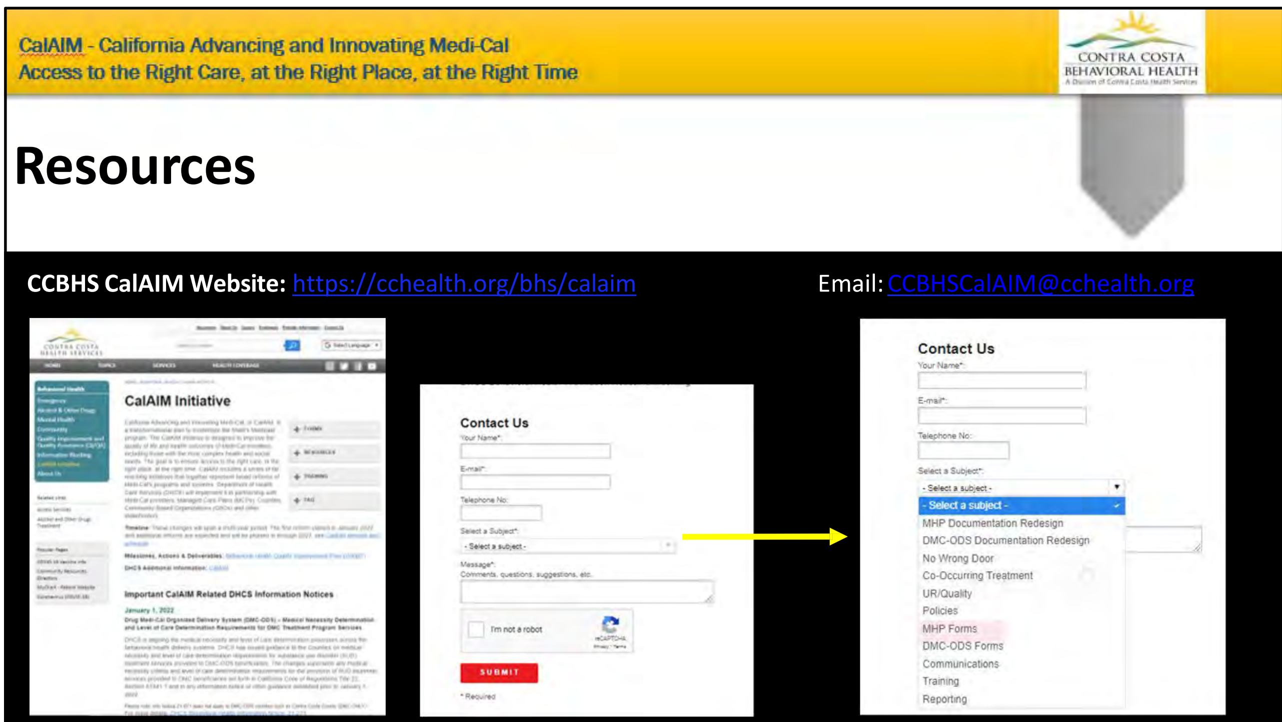

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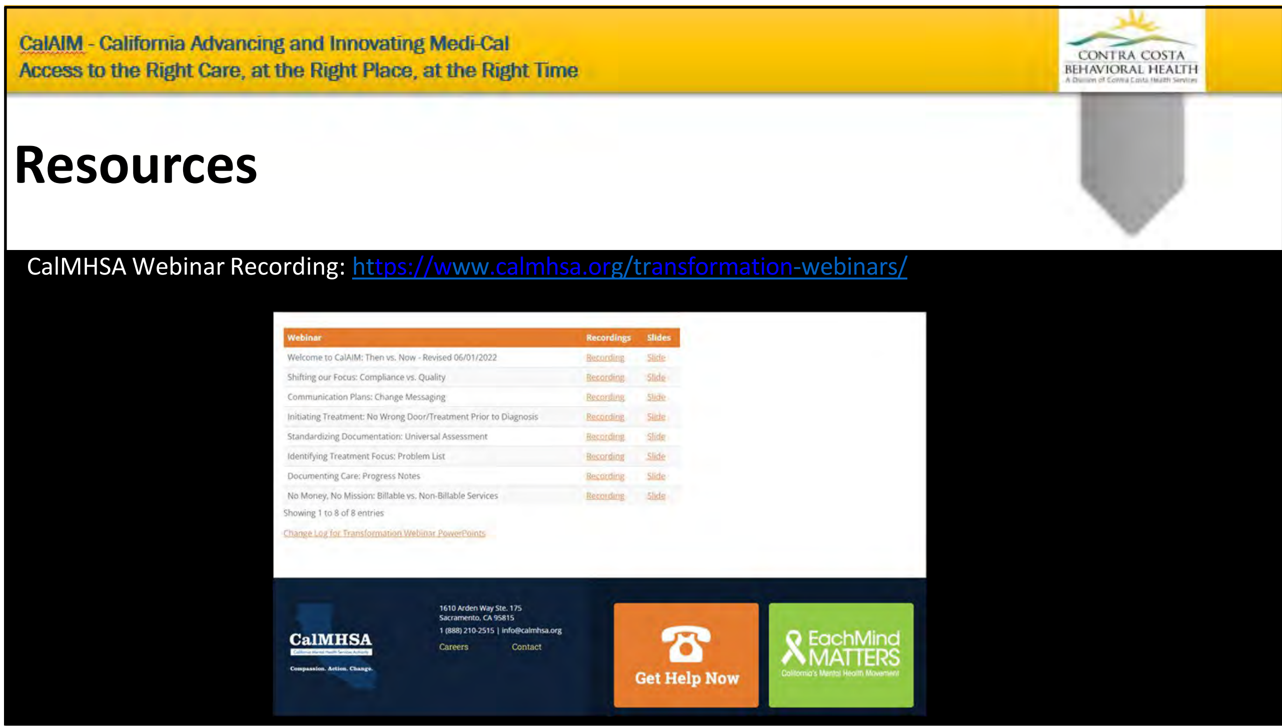

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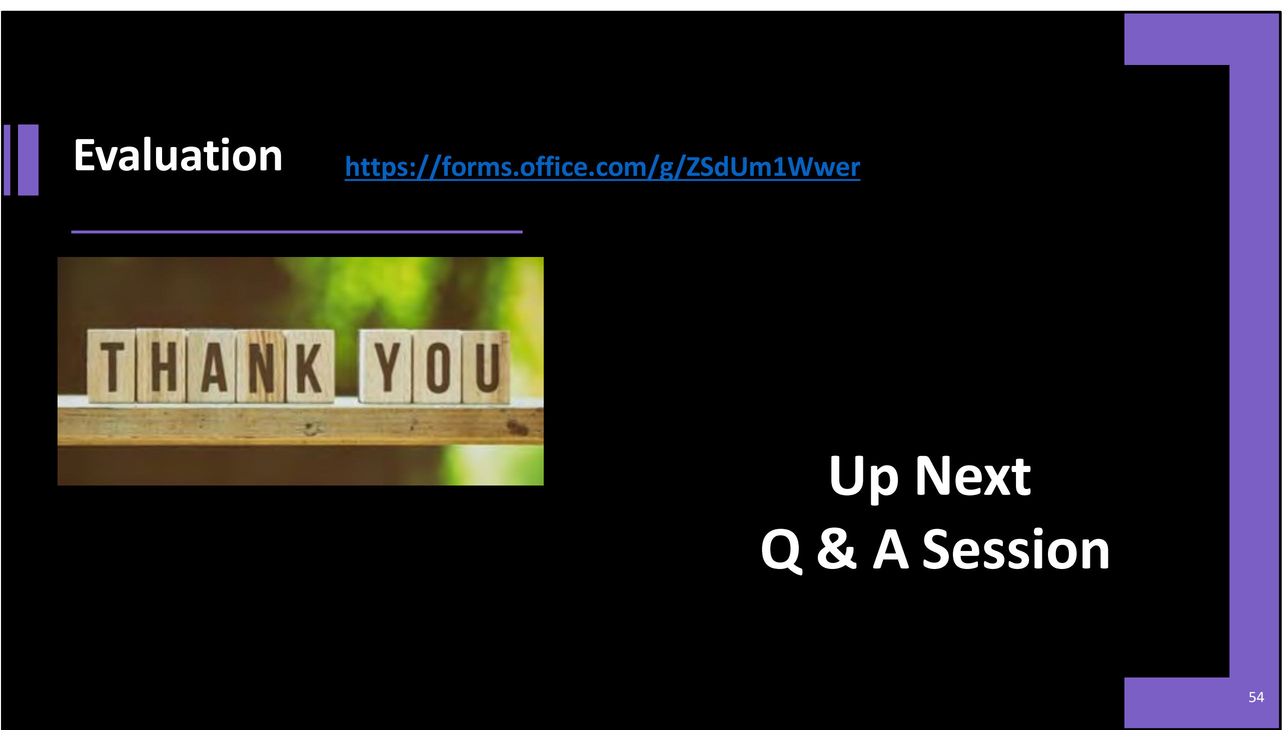

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