QUALITY IMPROVEMENT DOCUMENTATION TRAINING

Distributed May 1, 2019
Goal
To provide an overview of behavioral health documentation standards in the outpatient setting, expectations, and helpful examples.

Objective
To equip providers with information on documentation standards for:

- Assessment & Treatment Planning
- Case Management
- Progress Notes
- General tips & Information
Written documentation is the only evidence of the work providers do. If it's not documented, it didn't happen.
REFERENCE MATERIALS

USCS – Uniform Services Coding Standards
Please refer to the Colorado Department of Health Care Policy & Financing Behavioral Health Rate Reform site for the most up-to-date USCS Manual
https://www.colorado.gov/pacific/hCPF/mental-health-rate-reform-0

OBH – Office of Behavioral Health, Colorado Code of Regulations
Please refer to the Code of Colorado Regulations site for current versions:
https://www.sos.state.co.us/CCR/DisplayRule.do?action=ruleinfo&ruleId=2157&deptId=9&agencyID=70&deptName=500&agencyName=502%20Behavioral%20Health&seriesNum=2%20CCR%20502-1
Centers for Medicare & Medicaid Services (CMS)
https://www.cms.gov/

Code of Federal Regulations
https://gov.ecfr.io/cgi-bin/ECFR
https://www.law.cornell.edu/cfr/text/42

Colorado Access provider website, manual & bulletins
https://www.coaccess.com/providers/

Current contract materials
QUALITY VS COMPLIANCE REVIEWS

**Quality Monitoring**
- Best practices related to the quality of care provided
- Service content

**Compliance Monitoring**
- Fraud, waste, and abuse
- Accurate and complete documentation that supports the claims submitted
- Conditions of payment

**Shared Goals:**
High-quality, medically-necessary care that is delivered to our members at the appropriate level.

See medical records request to determine what type of audit you are participating in.
Golden Thread of Documentation

• Intake assessment that clearly identifies an appropriate clinical presenting issue and corresponding diagnosis

• Treatment plan reflects clear, measurable, person-centered goals for helping the client through the identified problem

• Progress notes that demonstrate each service delivered matches what was prescribed in the treatment plan
## WHAT’S CHANGED

From previous Colorado Access Standards

<table>
<thead>
<tr>
<th>Area of Documentation</th>
<th>Old Standard</th>
<th>New Standard</th>
<th>Citation</th>
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</thead>
<tbody>
<tr>
<td>Technical Documentation Requirements</td>
<td>Provider’s dated signature and credentials or title/position</td>
<td>Provider’s dated signature, credentials, and title/position</td>
<td>USCS section X.iii.5</td>
</tr>
</tbody>
</table>
TECHNICAL DOCUMENTATION REQUIREMENTS (USCS)

For codes noted, the following are minimum documentation requirements:

1. Date of Service (DOS)
2. Start and End Time OR duration
3. Session Setting/Place of Service
   • Example: Where? Office, field, home, etc.
4. Mode of Treatment
   • Example: How? Face-to-face, telephone, video*, etc.
5. Provider’s Dated Signature, Credentials, and Title/Position
6. Separate Progress Note for Each Service

*Only certain HIPAA compliant modes of tele-conferencing are approved.
GENERAL DOCUMENTATION REQUIREMENTS

• **Legible** records – must be clear enough to read

• Member **name** should be listed in the medical record

• **Identification** and **demographic** information
BEHAVIORAL HEALTH
ASSESSMENT

90791 & 90792
Psychiatric diagnostic evaluation is an integrated biopsychosocial assessment, including history, mental status, social/environmental factors, and recommendations.
90791 & 90792

90791: Psychiatric diagnostic evaluation
90792: Psychiatric diagnostic evaluation with medical services

There is one major difference between 90791 and 90792: the use of medical services.

Whereas both codes are used for psychiatric diagnostic evaluations, 90791 can’t include medical services and 90792 can. Medical services may consist of any medical activity, such as writing prescriptions, performing physical exams, and modifying psychiatric treatment.
Timeliness

“Assessment shall be completed as soon as is reasonable upon admission and no later than seven business days of admission into services.” 21.190.3

Exceptions:

• Acute treatment within 24 hours
• Detox and inpatient within 72 hours
We will request documentation of the member’s first contact to assess:

- Timeliness of appointment
- Timeliness of assessment/treatment plan completion
- Timeliness of updates: six months or sooner as needed

See treatment plan timeliness slides and FAQ for more details
REQUIRED ASSESSMENT COMPONENTS

90791 & 90792

- Timeliness
- All Technical Documentation
- Demographic & Cultural Information
- Chief Problem/Complaint
- Strengths & Barriers
- Mental Status Exam
- Risk Assessment: Suicide & Homicide
- History: Medical, Psychosocial, Behavioral Health, Substance Use Disorder, Trauma
- Diagnosis with Clinical Formulation
- Summary including Medical Necessity
- Next Steps
Chief Problem/Complaint

- A statement about why the member is coming in for services
- Could be in the client’s own words
- Include symptoms, duration, concerns, and main “agenda” of the member

Examples:
“I’ve really been struggling to sleep because I cannot shut my brain off. All I do is worry.”

Client presented to the outpatient intake describing his three recent panic attacks over the last four months, inability to sleep through the night, and reduced ability to participate at work and in his home life.
Cultural Information

- Include relevant cultural issues that may impact treatment

Example:
Swahili-speaking refugee from the Democratic Republic of the Congo. Requires Swahili-speaking interpreter.
Demographic Information

- May have been collected on a face sheet elsewhere
- Integrate key information as needed

**Examples:**
Race, ethnicity, gender, age, education, profession, occupation, income, marital status, sexual orientation, etc.
ASSESSMENT COMPONENTS

90791 & 90792

**Strengths**
Specific and individualized factors that will help this member in treatment

**Example:** Client is intelligent, highly insightful and introspective, and highly motivated to make gains through individual psychotherapy.

**Barriers**
Specific and individualized factors that may interfere with treatment

**Example:** Client is currently homeless with very few social supports.
ASSESSMENT COMPONENTS

90791 & 90792

Mental Status Examination
A structured assessment of the member’s behavioral and cognitive functioning

CMS guidelines:
• Orientation to time, place and person
• Recent and remote memory
• Attention span and concentration
• Language (i.e. naming objects, repeating phrases)
• Fund of knowledge (i.e. awareness of current events, past history, vocabulary)
• Mood and affect (i.e. depression, anxiety, agitation, hypomania, lability)

Example of what does NOT meet minimum standards: Client oriented x4.
**ASSESSMENT COMPONENTS**

90791 & 90792

**Example:**

- Appearance: Normal
- Dress: Appropriate
- Motor Activity: Normal
- Insight: Good
- Judgment: Good
- Affect: Appropriate
- Mood: Euthymic
- Orientation: X3: Oriented to person, place and time
- Memory: Intact
- Attention: Good
- Thought content: Normal
- Thought process: Normal
- Perception: Normal
- Interview behavior: Appropriate
- Speech: Normal
ASSESSMENT COMPONENTS

90791 & 90792

Risk Assessment: Suicidal and homicidal ideations

- **If** there is a risk of suicide and/or homicide
  - Current or significant history
- **Then** further risk assessment/screening is needed *and* a safety plan needs to be developed

Example Crisis Plans:

Example of what does **NOT** meet minimum standards: Clinician and client will develop a safety plan in the first three sessions.
ASSESSMENT COMPONENTS

90791 & 90792

History Report

• **Medical** - current or past, medications, allergies, and any special health care needs

• **Behavioral** - screening for mental illness, screening for trauma, previous diagnoses, previous treatment/response to treatment, voluntary/involuntary treatment, and family history of mental illness

• **Substance Use** - current or previous substance use/abuse/dependence, previous treatment/response to treatment
ASSESSMENT COMPONENTS

History continued
Psychosocial assessment may include:

- Capacity for daily functioning
- Cultural factors that may impact treatment
- Education, vocational training
- Family and social relationships
- Trauma
- Physical/sexual abuse or perpetration and current risk
- Legal issues
- Special health needs
- Children/adolescents
Behavioral Health Diagnosis

- Based on the information collected during the assessment
- A currently approved ICD/DSM diagnosis is documented consistent with the presenting problems, history, mental status examination, and/or assessment data
- Include applicable supporting evidence for the individual member, a clinical formulation
  - Include duration, symptoms that make up diagnosis and severity of symptoms
- Update diagnosis if symptoms change

Example: Client has been experiencing depressed mood more than half the days of the week for more than three months with little symptom relief. Sleep has declined and frequently waking. Diminished interest in previously engaging activities (baseball) and inability to motivate.
ASSESSMENT COMPONENTS

90791 & 90792

Readiness for Treatment/Admissions Summary

• A brief review of assessments and other relevant intake data, including screenings, which summarizes the current status and provides a basis for individualized service planning.

• Considering the assessment components, what is the individual’s readiness for treatment and determination of medical necessity?
Next Steps for Treatment and/or Referrals

- Plan for next contacts, referral, third party coordination, and disposition

Example: Member will attend weekly psychotherapy for six weeks or until symptom improvement.
BEHAVIORAL HEALTH
TREATMENT PLAN
The formulation and implementation of an \textit{individualized}, integrated, comprehensive written treatment/service plan designed with the purpose of promoting the client’s highest possible level of independent functioning and to reduce the likelihood of hospitalization/re-hospitalization or restrictive confinement.
TREATMENT PLAN COMPONENTS

Timeliness

• An initial service plan shall be formulated to address the immediate needs of the individual within 24 hours of assessment
• By an interdisciplinary team (when applicable)
• As soon as is reasonable after admission and no later than 14 business days after the assessment (for outpatient)
• Revisions/reviews for outpatient are every six months, or more often as needed
  o i.e. a change in client’s level of functioning, level of care, updated diagnosis, etc.
  o Review goals, interventions, frequency as necessary
  o Re-sign (new effective/start/end dates)

OBH, 21.190.4
TREATMENT PLAN COMPONENTS

Must be completed before other services may be billed. Check the USCS coding manual for clarification on outreach codes and details.

Exception example: Crisis, outreach, assessment, and treatment planning.
TREATMENT PLAN COMPONENTS

Client Participation and Signature

- The record shall contain documentation whenever the individual or participating parties do not sign a revised plan
- There shall be documentation that the individual was offered a copy of the plan
- All parties (the individual, legal guardian, interdisciplinary team members) who participate in the development of the plan shall sign the plan. The record shall contain documentation whenever a plan is not signed by the individual or participating parties
  - Substance Use Disorder programs - the minor child needs to sign, not the parent/guardian
TREATMENT PLAN COMPONENTS

Individualized

• Strength based
• Gender, age, and culturally appropriate
• Based on assessment information
• Written in a manner that the client understands
TREATMENT PLAN COMPONENTS

Treatment Goal
• Based on the assessment
• Specific

Treatment Objective
• Measurable
• Time-bound
• Attainable
• Related to goal

Treatment Services
• Services that are expected to improve functional impairment or maintain level of functioning as related to the diagnosis, goals, and objectives
• Many codes require documentation with linkage back to treatment plan
  Can’t bill for a service that requires linkage but was not on the treatment plan

Discharge Planning
• Articulate how when an individual will be ready to leave treatment
Example Goal: The purpose of this treatment is to increase Jane Doe’s ability to regulate emotions and develop healthy attachments while decreasing outbursts of anger that are disproportionate to the situation in order to manage emotions and behaviors, maintain healthy relationships, and maintain her ability to attend school without supervision.

Example Objective: Jane will increase her ability to respond appropriately to stressors four out of five times, as evidenced by creating and participating in three routines a week that promote safety, coping mechanisms, and positive communication.
Example Interventions:
Psycho-education will be provided one time per week with family regarding attachment and communication. Jane will practice dyadic attunement exercises during and between sessions, at least one time per week.

Jane will attend therapy three times per month to practice reflexive listening, reflective responses, and modeling behaviors.

Example Discharge Plan: Outbursts will decrease from daily to once a week in the next eight months.
CASE MANAGEMENT
T1017, T1016, H0006
Services “designed to assist and support a client to gain access to needed medical, social, educational, and other services.”
**CASE MANAGEMENT**

**T1017, T1016, H0006**

**Includes:**
- Assessing services needs
- Service plan development for case management services
- Referral for services
- Monitoring and follow-up

**Does NOT Include:**
- Coordinating with other providers in your agency
- Calling to “check in” on client
- Driving client to services
- Waiting while client attends appointment
- Coordination with family members
- Internal staff meetings
- Providing school staff with updates on client
- Scheduling/rescheduling appointments
- Activities integral to the administration of foster care programs.
PROGRESS SUMMARIES
FOR THERAPY

90832 - 90838
The progress note is a written, chronological record of an individual’s progress in relation to planned outcomes of services.
Include:

• Summary of the activity for the session and how it relates to the goals/objectives of the current treatment plan
• The clinical intervention (modality that supports service provided)
  o Progress notes should include what psychotherapy techniques were used, and how they benefited the member in reaching his/her treatment goals
• The individual's response to treatment approaches
• Any changes in the service plan with reasons for such changes
• Additional needs such as medical, dental or Substance Use Disorder, with referral to additional services as needed
The note length should reasonably correspond to the length of time being billed and contain the minimum requirements for the service being billed.
A score of 80% or greater is considered passing for a quality audit. This threshold for passing is lower than a program integrity (or fraud/waste/abuse), which is 95%.

If results from the audit show a score less than 80%, provider may be subject to provider training, coaching, corrective action, and/or the recovery of overpayment.

The Quality department at Colorado Access uses audit tools that are tailored to the Quality audit criteria to standardize measures and scoring practices across providers and individual auditors. These audit tools are tested and validated through inter-rater reliability and calibration activities to ensure consistency in scoring.
CORRECTIVE ACTION PLAN GUIDELINES

- If placed on a corrective action plan (CAP), Colorado Access will specify the deficit areas for improvement and will provide a template to propose your corrective actions to address those areas.
- Once approved, providers will have 90 days to implement the proposed actions.
- Colorado Access reserves the right to conduct audits after the CAP timeline to ensure compliance with the terms of the provider contract.

When identifying your interventions, please make sure they are achievable, objective, and measurable.
ADDITIONAL FAQ & TIPS
• There are no procedure codes for missed appointments (i.e., cancellations and/or “no-shows”)
• A missed appointment is a “non-service” and is not reimbursable
• Per state and federal guidelines, Medicaid patients cannot be charged for missed appointments
• From a risk management perspective, missed appointments should be documented in the clinical record
• No “late” fees
Authorization forms signed as applicable

• This form is important for care coordination and continuity of care

Example of an applicable authorization may be a signed authorization with the school or day care provider.
# TIMELINESS/ACCESS TO CARE

## Behavioral Health Standards

<table>
<thead>
<tr>
<th>Service</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone</td>
<td>24/7</td>
</tr>
<tr>
<td>Emergency Phone</td>
<td>15 Minutes</td>
</tr>
<tr>
<td>Emergency In-Person (Urban/Suburban)</td>
<td>1 Hour</td>
</tr>
<tr>
<td>Emergency In-Person (Rural)</td>
<td>2 Hours</td>
</tr>
<tr>
<td>Outpatient Follow-Up</td>
<td>7 Days</td>
</tr>
<tr>
<td>Non-Urgent Symptomatic</td>
<td>7 Days</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>30 Days</td>
</tr>
</tbody>
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See the Provider Manual for more details. Days refers to calendar days.
ADDITIONAL DOCUMENTATION TIPS

• Review agency materials for any old references to BHI, BHO, RCCO, etc. and ensure updates for current RAE/CHP+ contracts are implemented
• Attend the Colorado Access Behavioral Health Documentation training webinars, hosted by provider relations
• Sign up to receive Navigator newsletters to be notified of any updates
• Look through our provider resources on our website: coaccess.com/providers/resources/
Customer Service can assist you with basic eligibility and claims questions toll free at 800-511-5010

You have a provider relations representative (PRR) that is available as a resource to offer assistance: https://www.coaccess.com/providers/resources/

General PRR questions: ProviderRelations@coaccess.com

Contracting questions: Provider.Contracting@coaccess.com

Credentialing questions: Credentialing@coaccess.com

Compliance: Compliance@coaccess.com

Quality of Care Concerns: QOC@coaccess.com

Other questions or to sign up for the Navigator newsletters: ProviderCommunication@coaccess.com
QUESTIONS & THANK YOU