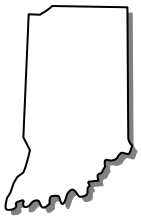

PROVIDER BULLETIN

BT200925 AUGUST 7, 2009

To: Community Mental Health Center Providers

Subject: Correction: Medical Record Documentation Guidelines and Appropriate Provider Qualifications and Supervision

Preamble

This bulletin is being issued in response to Office of Inspector General's (OIG) findings related to documentation and provider qualifications within the Medicaid Rehabilitation Option (MRO) program. The Indiana Division of Mental Health and Addiction is currently working to revise many services within the MRO program, but has not yet released official guidance regarding these changes. This bulletin is not related to the proposed changes to the MRO program and is solely in response to previous OIG findings.

Overview

This bulletin notifies all community mental health center (CMHC) providers, specifically those providing Medicaid Rehabilitation Option (MRO) services, of the importance of preparing and retaining complete medical record documentation for services provided to Indiana Health Coverage Programs (IHCP) members to fully support federal and state claiming provisions. Additionally, this bulletin reminds CMHC providers of appropriate provider qualifications and supervision required for rendering services to IHCP members.

General

The IHCP provides coverage for various types of organized outpatient programs of psychiatric treatment. These programs are covered primarily as outpatient hospital services (*42 CFR 440.20(a)*) or as clinic services (*42 CFR 440.90*). MRO services are clinical mental health services provided to members, families, or groups living in the community who need rehabilitation for emotional disturbances or mental illness. IHCP reimbursement is available for the following MRO outpatient mental health services:

- Case management services
- Crisis intervention
- Diagnostic assessment
- Prehospitalization screening

- Family counseling or psychotherapy
- Group counseling and psychotherapy
- Individual counseling or psychotherapy
- Medication or somatic treatment
- Partial hospitalization
- Training in activities of daily living
- Group training in activities of daily living
- Assertive Community Treatment

As stated in *405 IAC 5-21*, IHCP reimbursement is available for community mental health services for members with mental illness when those services are provided through a mental health center that is an enrolled IHCP provider and meets applicable federal, state, and local laws concerning the operation of CMHCs. Outpatient mental health services may include clinical attention in the member's home, workplace, mental health facility, emergency room, or wherever needed. Reimbursement for MRO services is restricted to providers enrolled as CMHCs (provider type 11, specialty 111) meeting the requirements for Division of Mental Health and Addiction approval under *IC 12-29,* in accordance with *440 IAC 4*.

Assessment

An intake assessment must be performed for each member considered for entry into an outpatient psychiatric treatment program. This applies to any organized program or course of treatment that a member enters or attends to receive scheduled or planned outpatient psychiatric services. The evaluation is a written assessment that evaluates the member's mental condition and, based on the patient's diagnosis, determines whether treatment in the outpatient program is appropriate.

For each member who enters the program, the assessment must include a certification by the provider that the program is appropriate to meet the member's treatment needs.

The assessment must be made a part of the patient records, whether electronic or paper.

The clinical assessment includes the following:

- Review of the psychiatric symptoms and how they affect the member's functioning
- Review of the member's skills and the support needed for the member to function in living, working, and learning environments
- Review of the strengths and needs of the member documented in the member's permanent records

Treatment Plan Requirements

A treatment plan is an individualized plan of care developed by the provider for medical or rehabilitation services aimed at recovery and at improving the member's level of functioning. The treatment plan is developed after completion of a clinical assessment.

A treatment plan is developed with the member and must be person centered, reflecting the goals and choices of the member, and must document the following:

- Outline of goals directed at the treatment of mental illness
- Individuals or treatment teams responsible for treatment
- Specific treatment modalities and services that will be provided to the member
- Time limitations for service
- Review at intervals not to exceed 90 days
- Document certification by the supervising physician, psychiatrist, or health service provider in psychology (HSPP), consistent with the CMHC's Clinical Plan for Professional Services or a similar document defining services under policies and procedures for the facility

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. The records must be of sufficient quality to fully disclose and document the extent of services provided to individuals receiving assistance under the provisions of the Indiana Medicaid program. The following general principles of documentation apply to all types of CMHC clinical settings. This list is not intended to provide an all-inclusive list of items that should be included in medical record documentation, but provides a list of items that, at minimum, should be included.

- The medical record should be complete (refer to *405 IAC 1-5-1*).
- The medical record should be legible.
- The record should include:
  - Specific services rendered
  - The date, actual time of day (begin and end times), and amount of time it took to render the services
  - Individual or team rendering the services
  - The setting in which the services were rendered
  - The relationship of the services to the treatment plan
  - Updates describing the patient's progress and response to/changes in treatment, and revision of diagnosis
  - Reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results
- The rationale for ordering diagnostic and other ancillary services should be easily inferred.
- Past and present diagnoses should be accessible to the treating and/or consulting physician.
- Appropriate health risk factors should be identified.
- The patient's progress should be documented.

- The Common Procedural Terminology (CPT®[1]) and International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM) codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

When a new problem is identified, the treatment plan must be adjusted to reflect the problem and needed services for billing to occur. In cases of crisis intervention in which problems are short term, for the purposes of acute stabilization of the crisis, and not identified on the treatment plan, crisis services must be reviewed and approved by an HSPP or physician and evidenced within the crisis contact documentation.

The Office of Medicaid Policy and Planning, surveillance utilization review (SUR) department, will monitor and recoup payments made to CMHC providers in which medical record documentation is insufficient to support services.

Periodic Review

The evaluation team should periodically review the member's treatment plan to determine the member's progress toward the treatment objectives, the appropriateness of the services being furnished, and the need for the member's continued participation in the program. The provider should perform such reviews on a regular basis (for example, 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.

Qualifications

Community mental health services must be rendered by a qualified mental health professional, as outlined in *405 IAC 5-21-1-C,* or by personnel who meet appropriate federal, state, and local regulations for their respective disciplines and are under the supervision or direction of a qualified mental health professional.

As defined in the Indiana Administrative Code, *405 IAC 5-21-1-C*, a "qualified mental health professional" means any of the following:

(1) A psychiatrist

(2) A physician

(3) A licensed psychologist or a psychologist endorsed as an HSPP

(4) An individual who has had at least two years of clinical experience treating persons with mental illness under the supervision of any of the persons listed in (1), (2), or (3), such experience

[1] *CPT® is a registered trademark of the American Medical Association.*

occurring after the completion of a master's degree or doctoral degree, or both, in any of the following disciplines:

(A) In psychiatric or mental health nursing from an accredited university plus a license as a registered nurse in Indiana

(B) In social work from a university accredited by the Council on Social Work Education

(C) In psychology from an accredited university

(D) In mental health counseling from an accredited university

(E) In pastoral counseling from an accredited university

(F) In rehabilitation counseling from an accredited university

(G) In marital and family therapy from an accredited university

(5) A licensed independent practice school psychologist under the supervision of any of the persons listed in (1), (2), or (3)

(6) An individual who has documented education, training, or experience, comparable or equivalent to those listed in this subsection, as approved by the supervising physician or HSPP, under the supervision of any of the persons listed in (1), (2), or (3)

(7) An advanced practice nurse under *IC 25-23-1-1(b)(3)* who is credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center under the supervision of any of the persons listed in (1), (2), or (3)

Supervision

The supervising provider is enrolled in the IHCP as a rendering provider linked to the CMHC. The supervising physician, psychiatrist, or HSPP has the following responsibilities:

- To review information submitted by the QMHP
- To approve the initial treatment plan and certify the diagnosis within seven days
- To see the member or review the treatment plan submitted by the QMHP at intervals not to exceed 90 days
- To be available to see the member in emergency situations and when additional consultations are requested
- To keep all documentation in the individual treatment record
- To provide clinical attention in the member's home, workplace, provider facility, emergency room, or wherever attention is required
- To put in place procedures for emergency provision of medication, first aid, or other medical care

Waiver Services

A member can receive waiver services and other IHCP-covered services, such as MRO services, at the same time. However, a federally approved waiver requires that waiver services not duplicate services already available.

Waiver case managers are responsible for insuring that the services are billed to the appropriate program. The CMHC must coordinate the provision of services with the waiver case manager.

Additional Information

For more information about topics covered in this bulletin, refer to the IHCP *Medicaid Rehabilitation Option Provider Manual*, available on the IHCP Web site at http://provider.indianamedicaid.com/media/23438/mro_provider_manual.pdf.

The latest information regarding the IHCP can be found in IHCP newsletters at http://www.indianamedicaid.com/ihcp/Publications/newsletters.asp. IHCP bulletins and banner pages can be accessed at http://www.indianamedicaid.com/ihcp/index.asp.

Contact Information

Questions regarding this bulletin may be directed to Customer Assistance at (317) 655-3240 or toll-free at 1-800-577-1278.

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