DIVISION OF HEALTH CARE FINANCING AND POLICY
CLINICAL POLICY TEAM, BEHAVIORAL HEALTH PROGRAM

BEHAVIORAL HEALTH TECHNICAL ASSISTANCE
Minutes – Wednesday, April 11, 2018
10:00 - 11:00 a.m.

Facilitator: Dorothy Pomin, DHCFP Supervisor, Social Services Program Specialist

Webinar Address: WEBEX Registration Link

1. **Purpose of BH Monthly Calls**
   a. Questions and comments may be submitted to BehavioralHealth@dhcfp.nv.gov
   b. Prior to the webinar or after for additional questions. The webinar meeting format offers providers an opportunity to ask questions via the Q & A or the "chat room" and receive answers in real time.
   c. Introductions – DHCFP, DXC Technology
2. **Documentation Training**
   Social Services Program Supervisor, Dorothy Pomin
   a. Treatment Plan documentation
      Link Medicaid Services Manual Chapter 400:
      http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSM/C400/MSM_400_17_11_17.pdf

Covered Policy: 400 Introductions: 403.4 Assessments, 403.2A Supervisor, Clinical Supervision (C., D. E.) 403.2B Documentation\Progress Notes (3 & 4), QMHA Pg. 13/Identify the QHMP

DOCUMENTATION TRAINING 4/11/18

1. Documentation includes all recipient case file documentation
   a. Documents from other providers
   b. Guardian consents
   c. Release of Information
   d. Treatment Plan; Progress Notes, Progress Summary; Discharge Summary, etc.
   e. Other
2. This training focused primarily on PROGRESS NOTE documentation
   a. Tie together w/Golden Thread
      i. Assessment
      ii. Treatment Plan
      iii. Progress Notes
   b. Following the Golden Thread concept supports a logical flow of documentation so that someone reviewing the record can see the logic
3. CH 400: 403.2B (3)
   a. *3. **Progress Note** – The written documentation of the treatment, services or services coordination provided which reflects the progress, or lack of progress towards the goals and objectives of the Treatment and/or Rehabilitation Plan(s). All progress notes reflecting a billable Medicaid mental health service must be sufficient to support the services provided and must document the amount, scope, duration and provider of the service.*
4. Narrative components of Progress Notes:
   a. Type of service provided
   b. Identifies the Treatment Plan Goal, Objective addressed
   c. Specific activities or interventions used during the service (scope)
   d. Response by recipient to service, progress/regress, and as evidenced by (describe)
   e. Recipient engagement and discussions toward meeting TP objective/goal and overall wellbeing
   f. Identify next steps in services, activities, interventions to support stability

g. Identify possible need to modify, amend, or update the Treatment Plan and if so, how?

5. Content components of Progress Notes:
    a. Notes MUST be LEGIBLE, succinct, and easily understood by all readers
    b. Provider of service
    c. BH Service and Code
    d. Date of Service
    e. Duration - The length of time to provide a service and the anticipated or actual time of treatment (Time started; time ended)
    f. Amount - number and frequency of treatment session provided (number of units provided)
    g. Scope - extent or range of the intervention or services provided to a recipient (description of actual services [activities/interventions] provided)
    h. Signature of provider of services and date progress notes were written.
6. **CAUTION:** Do NOT copy and paste progress notes from a different day/time or to a different recipient. Duplicative notes could be cause for recoupment as those notes do not demonstrate individualized Progress Notes to the specific recipient, specific date/time, specific activities, specific needs.

7. Progress notes are a good place to provide specific rationale for continued services or transfer criteria for higher or lower level of service.
    a. Progress notes are not just a mandatory component of being a NV Medicaid provider. They make up part of the treatment foundation (aka the Golden Thread), progress notes become important to a recipient's overall treatment, helpful to the provider to identify specific progress/regress, behaviors, medical necessity, along with establishing the legal documentation to support the provider's claims and payment. Types of note content identifying specific, individualized details:
        i. They demonstrate that the recipient has achieved the goals articulated in his or her individualized treatment plan thus resolving the problem(s) that justified admission to the present level of care, thus a lower level of care is appropriate.
        ii. Articulate that recipient has been unable to resolve the problem(s) despite amendments to the treatment plan, therefor treatment to another level of care or type of service therefore is indicated.
        iii. Identifies a recipient has demonstrated a lack of capacity to resolve his or her problem(s) or had developed new problem(s) and can be treated effectively at a more intensive level of service. Or,
        iv. Recipient has experienced an intensification of his or her problem(s) or has developed new problems(s) and can be treated only at a more intensive level of care
8. Good Progress Notes provide the necessary information for completion of other types of required treatment documentation
9. Other Treatment Documentation
    a. <u>Discharge Plan / Summary</u>
        i. Discharge Summary – Written documentation of the last service contact with the recipient, the diagnosis at admission and termination, and a summary statement that describes the effectiveness of the treatment modalities and progress, or lack of progress, toward treatment goals and objectives, as documented in the mental health Treatment and/or Rehabilitation Plan(s). The Discharge Summary also includes the reason for discharge, current level of functioning, and recommendations for further treatment. Discharge summaries are completed no later than 30 calendar days following a planned discharge and 45 calendar days following an unplanned discharge. In the case of a recipient's transfer to another program, a verbal summary must be given at the time of transition and followed with a written summary within seven calendar days of the transfer.

ii. The Discharge Summary is a summation of the results of the Treatment Plan, Rehabilitation Plan and the Discharge Plan.

b. Medical Necessity within Prior Authorization Requests
   i. Good Progress notes can assist a provider in completing their FA-# to be able to include all the necessary and specific detailed information to demonstrate the medical necessity of the recipient.

c. Revise/Update Treatment Plan /Rehabilitation Plan
   i. Progress Notes identify when goals and objective are completed.
   ii. Show new or emerging maladaptive behaviors/issues requiring attention
      1. Identify specific behaviors to be targeted to support positive progress for the recipient.
   iii. Identify when recipient has reached maximum capacity toward goal achievement
   iv. Can identify when recipient has met discharge criteria for reduction of LOC or need for higher LOC
   v. Etc.

10. BENEFIT
   a. Progress Notes serve as a legal document to show the service provider furnished the billed service.
   b. No progress notes = no service rendered, recoupment may likely occur.
   c. Auditor can evaluate quality & accuracy of service provision by what is written and billed to support the service.

3. **DHCFP Updates**

a. Public Workshops Update:
http://dhcfp.nv.gov/Public/AdminSupport/PublicNotices/
Public Work Shop: Health Care Guidance Program Phase-Out 04/20/2018

b. Announcements/Updates:
https://www.medicaid.nv.gov/providers/newsannounce/default.aspx
New training material available on Nevada Medicaid Website: Provider Training
https://www.medicaid.nv.gov/providers/training/training.aspx

c. Behavioral Health Community Networks (BHCN) Updates: Social Services Program Specialist, Sheila Heflin-Conour.

4. **DHCFP Surveillance Utilization Review Section (SURS)**

Updates or reminders for Providers: Kurt Karst, Surveillance and Utilization Review (SUR) Unit. Surveillance Utilization Review Section (SURS)

Documentation Requirements

Kurt discussed the importance of provider's adherence to MSM Policy 400 Section 403.6B Rehabilitative Mental Health (RMH) services which states "progress notes must reflect the date and time of day that RMS services were provided; the recipient's progress toward functional improvement and the attainment of established rehabilitation goals and objectives; the nature, content and number of RMH service units provided; the name, credential(s) and signature of the person who provided the RMH service(s). Progress notes must be completed after each session and/or daily; progress notes are not required on days when RMH services are not provided; a single progress note may include any/all the RMH services provided during that day." Policy section for provider viewed during the webinar.

5. **DXC Technology Updates**

Updates or reminder for Providers:

Joann Katt, LPN, Medical Management Center/Behavioral Health Team Lead.

Request timelines

- **Initial request** for Outpatient Mental Health (OMH) and Rehabilitative Mental Health (RMH) services (Basic Skills Training, Day Treatment, Peer-To-Peer Support and Psychosocial Rehabilitation): Submit no more than 15 business days before and no more than 15 calendar days after the start date of service.
- **Continued service requests:** If the recipient requires additional services or dates of service (DOS) beyond the last authorized date, you may request review for continued service(s) prior to the last authorized date. The request must be received by Nevada Medicaid by the last authorized date and it is recommended these be submitted 5 to 15 days prior to the last authorized date.
- **Unscheduled revisions:** Submit whenever a significant change in the recipient's condition warrants a change to previously authorized services. Must be submitted during an existing authorization period and prior to revised units/services being rendered. The number of requested units should be appropriate for the remaining time in the existing authorization period.
- **Retrospective request:** Submit no later than 90 days from the recipient's Date of Decision (i.e., the date the recipient was determined eligible for Medicaid benefits). All authorization requirements apply to requests that are submitted retrospectively.

Claim form instructions

- Use the CMS-1500 Claim Form or the 837P electronic transaction to submit claims to Nevada Medicaid. Claim requirements are discussed in the CMS-1500 Claim Form Instructions at https://www.medicaid.nv.gov (select "Billing Instructions" from the "Providers" tab).

Stephanie Ferrell, Provider Services Field Representative Updates:

- New Training Information Web-Link for self-paced training, https://lms-nv.myhcplatform.com/
- Field Representative information link provided: https://www.medicaid.nv.gov/Downloads/provider/Team_Territories.pdf

Please email questions, comments or topics that providers would like addressed any time prior to the monthly webinar.
Email Address: BehavioralHealth@dhcfp.nv.gov

Upcoming topics and dates: June 13th, Therapy treatment milieus and July 11th, Rehabilitative Mental Health Services.