

Lesson 2 of Course 2B



**'Medical Necessity', 'Level of Care' and
YOUR Documentation – Yes, They ARE
Connected! And There May Be Ethical
Decisions To Make.**

Why Documentation Style Is Crucial to Managed Care Success

- **Managed Care programs are 'not your same old' Block Grant or State Revenue Program – the HMO or other such managed care company is typically dispensing funds 'a dollar at a time' . . . for specific types of TREATMENT interventions, for specific types and severities of PROBLEMS, at specific LEVELS of care.**



Your documentation of the treatment you do must clearly support this level of specificity.

Learning How to Document Is The Key To Obtaining Appropriate 'Levels of Care' . . . and to Keeping Your Money When You Are Audited! And It Often Collides With Our ETHICS About What Is Appropriate To Say and Share About a Client In His Record.

- You must think about your client's treatment in the same way that the HMO's Care Manager is thinking when he or she reviews the case: "WHY should the HMO spend money on this case – and for THIS treatment?"**



You must put away soft-pedal language and euphemistic ways of talking about the client's problems

- You must be willing to address DYSFUNCTION and PROBLEMS as well as strengths, because they do not pay for strengths – they pay for stabilization of DYSFUNCTION, PROBLEMS and SYMPTOMS!**

(Re)Training, Culling, New Hiring Is Often Needed!



- This type of work is not 'for everyone'. It is irksome to some. Impossible for others. Some may not be able to justify, in their own minds, the need to be more forthright in their documentation about the client and his weaknesses and illness.
- (Re)Training, culling, and some new hiring approaches are often necessary, in order to get the right staff who can rise to the occasion. (But we think that *most providers can in fact rise to the occasion – and they can do it ethically!*)

The Core Concepts Behind Level of Care and Approval of Treatment

Managed Care plans approve or deny treatment based upon some CORE CONCEPTS related to LEVEL OF CARE (LOC) – and we are going to look at the four Core Concepts here.

EVERYTHING that we write in a client's treatment record (chart) needs to be guided by these concepts. Why? Because what we write in the record SUPPORTS THE AUTHORIZATION that we obtained, and demonstrates that we did in fact DO THE TREATMENT which was authorized.

One purpose of this course is for providers to understand that they CAN comply with these requirements within ETHICAL BOUNDARIES.



Four Core Concepts – Yes, They Also Shape How We Document Treatment



These four core concepts are dear to the heart of the HMO and they determine whether they approve a treatment request or not. Obviously, these concepts should shape our approach to documentation within the client's treatment record (chart).

If we will adhere to these concepts when we write in a chart, we will ensure that we and the HMO are 'on the same page'. This is crucial, when the HMO's auditors come to pay us (AND our treatment records) a visit!

1. Medical Necessity

THE CORE CONCEPTS

1. It must be CLEAR that the treatment (the Level of Care or LOC) which is approved is MEDICALLY NECESSARY. Medical necessity is defined differently in every state. But these are some of the criteria that are quite common, in determining MEDICAL NECESSITY. To be 'Medically Necessary', the proposed treatments . . .

- are REASONABLE AND NECESSARY in order to diagnosis or treat a specific mental health or chemical dependency disorder;**
- are needed to IMPROVE OR TO MAINTAIN or to prevent deterioration of functioning resulting from the disorder;**
- are in accord with PROFESSIONALLY ACCEPTED clinical guidelines and standards of practice for behavioral health care; and**



- are the most appropriate level or supply of service which can **SAFELY** be provided; and
- are furnished in the most appropriate and **LEAST RESTRICTIVE** setting in which services can be safely provided; and
- could not be omitted without **ADVERSELY AFFECTING** the Member's mental and/or physical health or the quality of care rendered, **AND**
- there is a **REASONABLE EXPECTATION** that the treatment will result in **PROGRESS**.

2. Functionality – It's Primary

- **The diagnosis is important – BUT diagnosis alone will not justify a particular treatment. WHY? It is the patient's FUNCTIONALITY that is the most important, when deciding if a particular treatment is needed, and for how long. For example, an individual may have a diagnosis of Bipolar Disorder (and may have been hospitalized many times in the past) . . . but is now stabilized on medication, is back to work, is relating well to family and friends and co-workers, and is otherwise no longer a danger to himself or others. Does this individual continue to need intensive services? NO.**
- **On the other hand, e.g., if an individual is struggling with maintaining a job, is having acute symptoms of a disorder, is perhaps at risk of inpatient admission, and/or is having major difficulty with everyday functionality, then intensive treatment may well be considered MEDICALLY NECESSARY.**

3. Treatment Goals and Interventions – Must Match the Functional Deficits & the Diagnosis

When treatment is authorized, it is not a 'free pass' to do whatever the provider wants to do. The managed care company is authorizing a SPECIFIC SERVICE. And that is the only service for which we can submit a CLAIM FOR PAYMENT.

As to the DETAILS of how we provide the service, everything we do must address the major FUNCTIONAL ISSUES that we identified in the assessment, and for which we obtained the authorization to provide treatment.

And we CANNOT IGNORE A DIAGNOSIS! For example, if a consumer is depressed AND is also using or abusing DRUGS or alcohol, we MUST ADDRESS the substance abuse or dependency in the treatment plan and in the services we provide.

4. Progress – It's Essential If We Are to Continue Treatment

Managed Care cannot pour limited resources down the drain! Therefore, the HMO looks for PROGRESS being made, when we approach them to authorize more care.

If a consumer is NOT RESPONDING to an approved service – i.e., if he is NOT MAKING PROGRESS, then we must . . .

. . . take a close DOCUMENTED look at what needs to be changed, AND THEN

- **make significant CHANGES IN THE ITP – what we are doing with the consumer, and perhaps even**
- **REQUEST CHANGES IN THE AUTHORIZED SERVICE.**

NOTE: If the individual FAILS TO BENEFIT from the treatment that is available to him, and has not benefited from revised plans of care, then the HMO may ultimately make a decision to move to a 'maintenance' regimen that seeks to keep the individual basically stable and out of danger. Goals to move the individual forward with significant progress may be abandoned, if it is clear that he has reached a 'plateau'. A PLATEAU means that it is unlikely that he is going to make additional progress regardless of what interventions are applied.

**Q: Do these HMO concepts
ALWAYS shape what we write in
a treatment record?**



A: YES, if you want to be paid for what you do. When an HMO or other such managed care company has paid the provider for providing a 'billed service' to an enrollee, they ASSUME that we have adhered to ALL of these Core Concepts seen on previous pages.

The next few slides will give some specific APPROACHES to writing and maintaining AUDITABLE RECORDS.

But the only way that they can know for sure that we have been faithful to these concepts is to read our records. It's called an AUDIT. If the HMO finds our records to be lacking, they can take back all or a portion of what they have paid us. Certainly, this is to be avoided!

Approach 1: This Is No Time for a 'Non-Committal' or Neutral Style, No Lite-Weight Stuff!

- **The HMO's UR department cannot read your mind - so be clear and unmistakable about the reasons for requesting a particular Level of Care, in both the assessment and in the treatment plan and in your progress notes!**
- **Your assessments, ITPs, and your progress note must present a CLEAR picture of exactly what is 'wrong' with this consumer and how you intend to 'fix it', and 'when'. Don't just talk about 'strengths'!**
- **Assessments must spell out clearly why he/she requires SPECIALIZED services vs. less expensive, routine services, if this is in fact the case.**



Approach 2: Paint Them a Picture

- What are the **FUNCTIONAL** problems – how serious are they in terms of how the client **FUNCTIONS** in the real world, day to day? How long has this been going on? What has already been **TRIED BEFORE NOW**? These things will tell a lot about whether the client **REQUIRES** what you propose to do.
- If we claim that she is **SMI (Severely Mentally Ill)**, have we justified this in our **ASSESSMENT**? What are the **SYMPTOMS**? And do they **MATCH** the description for the **DIAGNOSIS** that we have given to her? **AND** do we see these same **SYMPTOMS** in the **PROGRESS NOTES**?

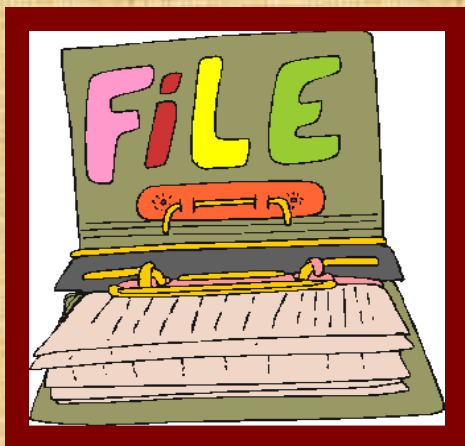


- **What are the TARGETED GOALS, issues and outcomes for the limited time we will have with the consumer? (And DON'T BE VAUGE HERE.)**
- **AND do these goals relate SPECIFICALLY to the AREAS OF DSYFUNCTION and to the DIAGNOSIS?**
- **And do the goals SPECIFIAALLY tie into the SYMPTOMS and their reduction?**
- **How do we plan to STABILIZE the symptoms?**
- **Then . . . For subsequent reviews, what PROGRESS has he made on the specific problems we are addressing?**

Please DON'T list a goal such as "Will reduce the symptoms of her Mental Illness." WHICH symptoms?



Approach 3: It Has To Hang Together!



It is not enough to GET that authorization with a good assessment and individual treatment plan (ITP) – we must also ensure that everything in the client’s treatment record (chart) ‘hangs together.’ We must be sure that **EVERYTHING in the chart supports . . .**

. . . the Assessment and the ITP,

. . . the authorization that we have been given to deliver a particular treatment, and

. . . the claims for payment that we have filed.

What exactly do we mean by 'the entire chart must hang together'? We mean that the whole chart must make SENSE. It has to be CLINICALLY CONSISTENT. In our assessments, and in our ITPs, and in our progress notes, we must demonstrate that our authorization request is an ACCURATE reflection of the client's need for treatment – and that we have actually implemented the ITP that we have developed.



A client's chart is no place for disorganization! It is not a place for INCONSISTENCIES or contradictions without explanation! Auditors really do hate that!

Approach 4: Be Prepared For Unannounced Audits!

We must be prepared for both announced and unannounced audit activity. Even if most on-site audits are announced and pre-arranged, a record audit may come at any time, in the form of a call from the Managed Care company for a copy of key pieces of a client's record for purposes of Utilization Management, or in response to a client's complaint. So ongoing, impeccable maintenance of our ITPs and progress notes is a **MUST!**



'You've GOT to be kidding! They're coming WHEN?'

Approach 5: Remember, Veracity Is KEY.



“Are we talking about the same patient here?”

Providers must have pre-authorization to deliver services. We get those ‘auths’ based upon what we tell the HMO’s Care Manager, up front. And we get RE-authorizations based upon what we tell the Care Manager when it is time to get additional authorization. Our ETHICAL practices demand veracity in how we obtain authorizations to treat.


When the managed care auditors come to visit you, what they see in that client record must look like what you told them up front and when you called for re-auth – from the assessment to the treatment plan to the progress notes. VERACITY IS KEY.



'Poorly Documented Level of Care' – It's Deadly If You Are Audited!

CRITICAL ISSUE: Your client's treatment record **MUST** support the Level of Care for which the HMO or other such managed care contractor is paying you! If they are paying for one of the more intensive Levels of Care, and your documentation looks like the client **DOES NOT MEET THE CRITERIA** for that Level of Care (i.e., he does not really need that level of intensity), you may have to repay some or all of the money that you have been paid for the period of time that the documentation did not appear to 'match the level'.

- **The Bottom Line with HMOs and other such auditors:** "Does this chart justify what we are paying them to do the treatment – and is this Level of Care (LOC) really needed – and is it working?" We **MUST** do 'Internal Utilization Management' to assess this LOC issue, on an ongoing basis. 21

 *The need to do Internal Utilization Management (IUM).* Remember . . . Just as the HMO, BHO, or MCO must carefully MONITOR the progress of the client through 'Care Management' (or 'Utilization Management'), the PROVIDER must *also* closely MONITOR 'how-often-how-much' treatment is needed and provided. Therefore you will need to develop an INTERNAL UTILIZATION MANAGEMENT (IUM) PROGRAM, to monitor the appropriate Level of Care (LOC) and the UTILIZATION of services. Just like the HMO must do!



Providers: Must do 'Internal Utilization Management' (IUM) to monitor the client's NEED for services (*which is an ethical requirement, regardless of how the care is paid*) AND how much service you have provided to him. Have you provided more units than the number of units authorized for this client? You will not be paid for 'overruns'. Time to ask for more units?

Note: Failure to perform this task regularly can result in denied claims or recoupment of payments after you have received them!

Looking to Lesson 3 of Course 2B . . .

In Lesson 3 of Course 2B we will go into more detail about documentation in client records – including some of the specific flaws that auditors find in the records of individuals who are receiving ‘Community Support’ or ‘Rehabilitative’ treatment for major mental disorders as well as those receiving Cognitive Behavioral therapy for depression, anxiety, and the like.





Congratulations!

You have completed Lesson 2 of 3, for Course 2B. You may complete the short quiz for this lesson either now or later. To reach the links for the quizzes and the lessons, simply close this page. You will see your list of Study Guides and Quizzes displayed in the previously opened window.

You can take each quiz as many times as you want, until you pass it. There is no penalty for failing a quiz, and you may retake it immediately.

So either take the quiz now, or you may resume the course – your choice!