



The FREE CE Course 1B, continued

Lesson 2



**More On Understanding How Managed Care
'Thinks' . . . An Introduction to the Clinical
Issues Which Drive the 'Care Management'
Process**

Flexibility In Programming – Can Be Painful to Some.

Under Managed Care, program design often takes new twists that are unfamiliar to some professionals and Boards of Directors. Like what? Programs such as **Intensive In-Home Services**, out-of-office service delivery . . . true 24 hour availability and the need to extend telephonic response to ‘around the clock’ . Some Boards of Directors are fearful of the inherent legal liability of out-of-office services.



And we also see new requirements that can be irksome . . . such as the need to pass through some sort of external Utilization Review (UR – or ‘Care Management’) to obtain permission to treat . . . having to play ‘Mother May I?’ with the MCO. And the MCO sometimes says “NO”. These are major issues for providers.

Like It or Not, It's 'Disease Management' – Not Social Service

- **Managed Care is 'Medical Model' – and we must adapt what we write in treatment records (charts), accordingly. The managed care approach is becoming increasingly 'medical' in orientation.**
- **'Medical' means TREATMENT – not simply social service or support. Health plans pay for TREATMENT which targets DYSFUNCTION**
- **When delivering Health Plan services to individuals with behavioral health diagnoses, we must think 'clinical' and 'treatment' and 'remediation of dysfunction' when we DOCUMENT the treatment we provide – which may be a major shift for many professionals.**



We must crank up the 'treatment' perspective. We must make clinical-sounding statements (not just social service talk) in everything we write.

We must think 'Level of Care'. It's what drives everything!

We must think 'LEVEL OF CARE' in everything that we do . . . when we ask for approval to provide treatment, and when we are actually delivering and documenting the service. This applies to all clients (except perhaps those who are 'private pay') regardless of age, sex, or diagnosis.

p.s. – and even with private pay clients, our licensing regulations prohibit most of us from delivering services that are not benefiting the individual. We simply have a bit more discretion with such clients.



So What's the Bottom Line Impact of 'Level of Care' on How We Work?

Many of the 'old ways' of providing treatment have been discarded or radically modified. Funds for health care in general are in very short supply in this country. In order to get a grip on this situation, it makes sense that there must be more rigorous management of the treatment we provide – i.e., what KIND, how INTENSIVE, how OFTEN, and for HOW LONG? This is what "Level of Care" decisions are all about.

The Issue: WHO IS SICK ENOUGH to get the more expensive treatments? This issue has had a major impact on who we treat – and at what LOC! This is particularly true for Chemical Dependency services and for treatment of persons with less-than-severe Mental Health disorders – like depressive episodes and anxiety disorders.

Care Management and Level of Care – How's It Work?



"Just how sick is he?"

Specifically . . . the Care Manager must decide what Level of Care (LOC) is truly essential (read: **MEDICALLY NECESSARY**) in order for your client or patient to improve. And if we ask for more treatment down the line, how has he or she *responded* to treatment thus far? It requires a whole new way of thinking!

* And please note that 'truly essential' is NOT necessarily the same as 'desired' or 'wanted' and certainly is not the same as "the way we have always done it."

These are the bottom line 'LOC' questions that the insurance company's Care Manager (and we) must carefully consider, in order to determine the 'Medical Necessity' of the treatment we propose.

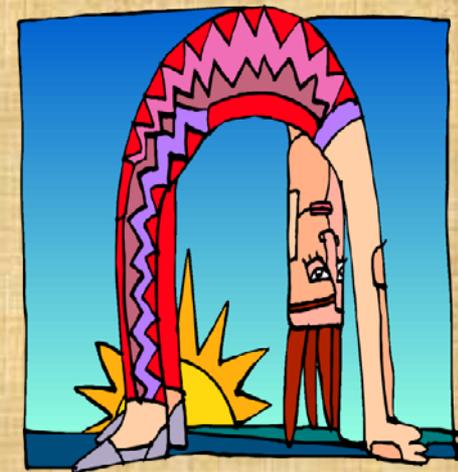
1. What TYPE of treatment is truly *essential* for this patient *at this time*? And HAVE WE TRIED LESS INTENSIVE TREATMENTS FIRST? AND HAS HE BENEFITTED FROM PAST TREATMENT? There are many options for treatment: Inpatient. 23-Hour Observation. Residential (rarely). Day Treatment. Intensive Out Patient. Intensive Home Based. Intensive Case Management. Individual Therapy. Group Therapy. Family Therapy. Meds Only.
2. And in what AMOUNTS? (24/7? Daily? Weekly? Monthly? Quarterly? Other?)
3. And for HOW LONG? (6 months? 6 weeks? 6 sessions over 4 weeks? 12 sessions - whenever? 10 days? Other?)

But . . . how do they make these determinations?

In Courses 2B and 2C, we get into the nitty gritty of how the Care Manager makes these decisions. Important for us to know, if we want to have a shot at getting what our client really needs.

Clearly, the managed care company's decisions may contradict a provider's own CLINICAL BELIEFS about 'how much' of 'what' is needed at any given point in time. For example, the managed care company will probably limit how long an individual remains at the more expensive levels of care. How? The MCO may 'step him down' to a lower level of care (less intensive and less expensive) long before the provider (in the past) would have done so. Is this really 'bad'? Not necessarily. It may just be 'different', PROVIDED THAT EFFECTIVE ALTERNATIVE PROGRAMS are available through the insurance company's plan.

Providers are encouraged to be flexible in providing and using alternative step-down programs for their clients.





Summary Statements About Care Management, As It Applies to Mental Health and AOD Services

 For mental health consumers, Insurance Companies DO NOT look simply at whether or not it would be 'helpful' or 'nice' for the individual to have a certain type of treatment, or whether the patient simply 'wants it'. And they DO NOT base decisions upon a plea that 'we have always done it this way.' They base their 'Level of Care' decisions upon whether or not the treatment is 'Medically Necessary'. The definition of Medically Necessary includes such things as, "Is there a good reason to believe that the client will benefit from the treatment?" And . . .

Summary Statements About Care Management, cont ...

And “Have we tried less intensive (and less expensive) approaches first? Or are less intensive services clearly not appropriate at this point in time?” And, “What is the response of the client thus far to treatment?” etc., etc. Bottom line: Many of the ‘old ways’ have been discarded or radically modified, in this day of ‘short funds’ and more rigorous management of treatment. This impacts WHO gets treatment and WHAT, and FOR HOW LONG and HOW OFTEN.



For the CD client, Insurance Companies DO NOT look simply at whether or not he or she is having an alcohol or drug related crisis, or whether or not he has experienced a recent relapse, in order to say 'OK' to a treatment request. And they DO NOT base decisions upon a plea that 'we have always done it this way.' In fact, if the client has had multiple relapses to use of alcohol or drugs despite treatment, they may begin to question whether additional treatment beyond detox and basic services is really justified. Again, WHO gets treatment and WHAT they get, are impacted.

Summary Statements About Care Management, cont. ...

How we DOCUMENT THE NEED FOR TREATMENT makes all the difference in obtaining an appropriate Level of Care. And, once a Level of Care is determined, your client's treatment record MUST support the Level of Care for which the insurance company is paying you.

It's now official. HCBS (Home and Community Based Services) are part of the New Federal Health Care Reform law. And Cognitive Behavioral Therapy (CBT) is also part of the mix.

The 2010 Health Care Reform law (ObamaCare) authorizes states to use intensive home and community based services (HCBS) without obtaining a Federal Waiver – a huge step. Also, Medicaid programs have followed the lead of commercial insurance companies in emphasizing COGNITIVE-BEHAVIORAL TREATMENT (CBT) as the preferred treatment for individuals with “internalizing” disorders such as anxiety, major depression, and phobias and even for personality disorders, some forms of severe mental illness, and AOD issues.



Alternative treatments have a place in Managed Care – even if they were not previously allowed under the rules for ‘regular’ Medicaid!

In order to reduce the use of inpatient treatment and its huge cost, most Medicaid Managed Care plans DO allow (and even emphasize) innovative, ALTERNATIVE SERVICES – stuff that is truly ‘outside the box’ (e.g., ‘non-traditional’ treatments such as out-of-office, intensive in-home-and-school based programs, mobile crisis and ACT teams, and other community-based treatments for adults as well as youth). When such programs are fully implemented, we know that they often work BETTER and perhaps FASTER than the traditional approaches.

**Thus, new
opportunities
are abounding!**



Case Rates - A Good Alternative For Some Clients

In this contract option, the provider is given a flat-rate fee per month, more control over the individual plan of care, and the determination of which services will be provided to the individual client, and how often. You do not have to ask the MCO for 'permission' at each step of the client's treatment process, with a case rate, once the arrangement has been approved for a period of time – from one to six months or even longer. This option is primarily for clients with major MH and CD disorders, with repeated recidivism.



But how do these specialized services get worked into the provider's contract with the Insurance Company – or the contract with the 'Medical Home' if applicable?



Many Insurance Companies like to delay the addition of specialized services to a Provider's Agreement for a few weeks or even 2 or 3 months into the contract, so that they can see what is actually needed – and so that they can assess the functioning of the provider. **Note: BUT don't hesitate to ask about adding some special contract options – even before they ask you to do so!**

Put On Your 'Internal Auditing Hat' *Before* The Auditors Come – and Before You Request Treatment For Your Client!



In previous slides we suggested that HOW you document the client's needs and his treatment can affect whether or not you get an AUTHORIZATION for treatment . . . and also whether or not you get to 'keep your money' if you are audited. In Courses 2B and 2C we go into details about this. In this min-course, we will give you a quick overview.



Big Question to Ask: Are there holes in your records – and in your thinking? Care Managers and external auditing entities are trained to see the 'HOLES' in your thinking and in the client's treatment record, when they look for indicators that the treatment you provided (or want to provide) is **MEDICALLY NECESSARY.**



“Holes in my thinking? And in my records? Surely not! They’re 3 inches thick! How can there be HOLES?”

Well, yes, there can be holes! And we’ll tell you what they are.

Let’s take a quick look at this list of ‘thinking and documentation’ issues which can sabotage you in this era of revitalized health care reform. And then we’ll give you a couple of examples of exactly what we mean. (For details for ALL of the documentation issues listed here, check out Courses 2B and 2C.)

This is a list of the major 'holes' we find in charts and thinking.



- **The PASSIVE REPORTER Syndrome – Assessments and Progress Notes may simply 'REPORT' what the consumer or family member SAYS about the issues and problems – failing to express our own clinical observations and professional conclusions!**
- **The generic, 'ANY-PATIENT ITP' Syndrome – Individual Treatment Plans may look like they could belong to ANYONE.**
- **The PASSIVE OBSERVER Syndrome – 'Process recording' – A pattern of simply noting in Progress Notes that 'he said this and then said that'. Failure to document the therapeutic ACTIVITY for which the HMO is paying!**

Holes in charts and thinking . . .

- **The 'FAILURE TO HIT THE TARGET' Syndrome – Progress Notes and Treatment Plans that do not pick up on important assessment findings and issues.**
- **The 'FAILURE TO HIT THE TARGET' Syndrome, AGAIN – Progress Notes that do not reflect the diagnosis or the Level of Care (LOC).**
- **The 'COOKIE CUTTER' Syndrome – could be anyone's progress notes. Or the same notes for a single consumer, week after week, after week. And we also see 'cookie cutter' ITPs – not OK!**
- **The 'POOR CONTINUITY' Syndrome – Progress Notes that leave us guessing: Like, where is the client? [The chart just dead-ends with no discharge notation or statement that client is AWOL and not found despite search.] Or, he's here, but where has he been for the past 7 weeks? [Chart has a major gap in notations with no explanation of the pause.] Or what led up to his being admitted to the hospital – no clue provided!**

- **The 'INCOHERENT CHART' Syndrome – Progress Notes that don't tie together – which are inherently contradictory and confusing and/or do not reflect a consistent theme of treatment. May not follow a logical progression, perhaps appearing that some Progress Notes have been lost, or like chart filing has gone awry.**
- **The 'POORLY DOCUMENTED LEVEL OF CARE' Syndrome – deadly if your charts are audited, and the services and Level of Care (LOC) delivered do not match the services and LOC which are authorized !**
- **The 'ZOMBIE CLIENT' Syndrome – Progress Notes, ITP reviews, and new ITPs which give no clue as to the response of the consumer.**
 - **The 'PERPETUAL CARE' Syndrome – ITPs that never change.**
 - **The 'FAILURE TO MODIFY' Syndrome, a.k.a., 'Professional Neglect' – ITPs that do not change despite REGRESSION or NO PROGRESS.**



The PASSIVE REPORTER Syndrome: Assessments and Progress Notes that simply REPORT what the consumer or family member SAYS about the issues and problems – failing to express our own clinical observations and conclusions.

- We all know why some of us still do this type of documentation – the ‘Say Nothing Significant’ approach. We were trained to document as little of our own clinical thoughts as possible because (1) you don’t want to be judgmental, and (2) you might be called to court to explain your comments.

- This type of PASSIVE assessment and progress notation is NOT helpful under a managed care scenario. The managed care company is paying you to give every ounce of professional skill that you can bring to the table, to ASSESS, TREAT, and STABILIZE this person’s DYSFUNCTION. They want to know ‘What do YOU, as my CONTRACTED PROVIDER, THINK about this case.’ Don’t be vague or cryptic!

Bottom line, they DON'T want to see a treatment plan that could apply to 'anyone' – and they don't want to see the same goals and interventions for the patient every time that you review the patient's ITP. They also don't want to see the same ITPs in multiple client charts!

**The 'ANY-PATIENT ITP' Syndrome:
Individual Treatment Plans which
look like they could belong to
ANYONE. Generic and non-specific
will not fly!**

The Managed Care contractor is PAYING you for INDIVIDUALIZED treatment of an individual patient, EVEN IF your state has a standardized treatment approach such as 'Resiliency and Disease Management' in Texas. And in the ITP, they expect to see recognition of this enrollee's various idiosyncratic issues and problems – the nuances of how his diagnosis(es) play out in the real world.

AND also, which of his SPECIFIC functional issues and problems are the most problematic for HIM? And how do you plan to approach these particular behaviors, fears, and deficits?

- **Since Managed Care works on the premise that the HMO is paying the provider to work actively toward PROGRESS and GOOD OUTCOMES . . . and since the assumption is that the Level of Care will CHANGE OVER TIME . . . ITPs which do not change from review to review are a major issue. The managed care contractor EXPECTS for a there to be a change in the treatment activities and goals from review to review.**

The 'PERPETUAL CARE' Syndrome: ITPs That Never Change.

If no changes occur from ITP to ITP, the assumption is that either:

- 1. Nothing has changed with regard to the enrollee's condition. He is neither better or worse. He is simply STATIC and perhaps STAGNANT . . . OR**
- 2. The counselor is not tending to business.**

Neither is a good thing!

In closing . . .



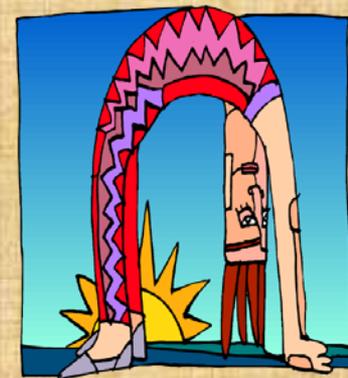
- **If it is not written in your client's treatment record, as far as the auditor (or a court of law or your licensing board) is concerned, it never happened.**
- **Client records are very WYSIWYG – what you see is what you get, in terms of a 'grade' from the auditor. It's best to take a regular hard look at your clients' records (i.e., conduct INTERNAL UTILIZATION REVIEW), and see what's missing, what is not written down, and what needs to be clarified.**
 - **The condition of the clients' treatment records can have enormous impact upon the financial wellbeing of a program or practice – more so NOW than EVER BEFORE!**

The Bottom Line . .

When a Care Manager or on-site auditor looks at a client's chart, here are a few of the 'bottom line' issues:

1. Does this chart *justify* what we have paid you to treat this client?
2. And was/is this Level of Care (LOC) *really* needed at this point in time?
3. And if you are asking for 'more' treatment, is the client responding to treatment, and is he likely to improve with more?





IMPORTANT NOTE: Is the insurance carrier or the Care Management Department (which approves/disapproves services) telling you that you **CANNOT** provide the services which you believe the client needs? **NO.** A provider is *always* free to deliver any service to a patient according to the provider's own professional judgment or organizational philosophy. **HOWEVER** – if the managed care company does not feel that the services are **MEDICALLY NECESSARY** and **ESSENTIAL** for the stabilization of the patient (or if the health plan simply does not cover a certain service or limits how much can be provided), then you **WILL NOT BE PAID** by the managed care company to provide the service. You will have to do it for free ('pro bono'), or will have to use other funds to cover the cost.

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You have completed the second and last lesson for Course 1B. You must pass BOTH short quizzes for this Course, and must complete our short required *Feedback* form for Course 1B, to receive your certificate for 1.5 Clock Hours of CE credit and 1.0 EACC PDH. You can instantly download your certificate for this module, directly from your account. It's always there, online. Print it, save it – even email it!

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