Mental Health Integration Program (MHIP)

Advanced Documentation Training

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OBJECTIVES

- Identify core elements of Medical Necessity and the Clinical Loop
- Demonstrate the ability to assess and document client symptoms, strengths, impairments and activity level in an Assessment for the MHIP population.
- Demonstrate the ability to develop goals/objectives utilizing MHIP tools to measure progress (e.g., PHQ-9) and document these in the Client Care Plan
- Document the purpose of the intervention and how it links back to the identified mental health needs of the client.

Audience – Who is out there today?

- DMH Directly-Operated Agencies
- DMH Contract Agencies
- Community Partner Agencies

DMH/DHS Integrated Primary & Behavioral Health Care

- DMH joins DHS in moving closer to integrated primary care-behavioral health services

- DMH has chosen the MHIP treatment strategy as the collaborative care model to be used with clients enrolled in HWLA Tier II who meet mental health **medical necessity** criteria

What is Medical Necessity?

Medical Necessity

- Definition:
  - A term used by third party payers that encompasses criteria they feel are essential for reimbursement of services.
  - Treatment services which may be justified as reasonable, necessary and/or appropriate based on clinical standards and practice.

Medical Necessity

- Criteria involves 3 main components:
  - Included diagnosis
  - Impairments that are a result of that diagnosis
  - Interventions that are aimed at diminishing the diagnostic symptoms and/or impairments.

Included Diagnosis

- Client must have an “Included” Diagnosis from the current DSM as the primary disorder requiring treatment
- Refer to list of “Included” Diagnosis (i.e., qualifying mental disorders)
- **Note**: MHIP targets the Tier II population (refer to HWLA Toolkit)

Included Diagnosis

- Having a diagnosis that is not "included" does not exclude a client from having his/her services reimbursed **AS LONG AS**
  - he/she also has an "included" diagnosis as the primary diagnosis, and services/interventions are directed toward the impairment resulting from an "included" diagnosis.
- The primary diagnosis will be the diagnosis associated with a claim

Impairments

- A significant impairment in an important area of life functioning (e.g., home, work, school, social, family) as a result of the client's **mental health symptoms**.

Identifying Impairments

- You said you've been feeling very sad, anxious and irritable. How does this play out at home, at work, with friends?

- What do you think is making it difficult for you to…
  - Do your work?
  - Take care of things at home?
  - Get along with others?
  - Do the things/activities that you once enjoyed?

Identifying Impairments

- How do your (depressive/anxious) symptoms impact your
  - **Social/family relationships?**
    - Decreased contact with friends
    - Loss of intimate relationships
    - Affected family relationships
  - **Performance at work? school?**
    - Cause avoidance of certain jobs
    - Being late to work due to depression
    - Decreased contact with co-workers
    - Failing grades due to depressive mood / poor concentration
  - **Participation in hobbies, leisure activities?**
    - Avoidance of certain leisure activities

Interventions

- What must an intervention do to meet medical necessity?
  - Address an identified functional impairment
  - Significantly diminish the impairment or prevent deterioration in an important area of life functioning

Interventions

- Interventions must always link back to an identified mental health need(s) of the client
- Interventions must clearly show how what STAFF did will:
  - improve the client's functioning, and/or
  - diminish the client's mental health symptoms

The Clinical Loop

Definition

- The “Clinical Loop” is the sequence of documentation that supports the demonstration of ongoing medical necessity and ensures all provided services are reimbursable.
- The sequence of documentation on which medical necessity requirements converge is:
  1. The Assessment
  2. The Client Care Plan
  3. The Progress Note

The Clinical Loop

Medical Necessity

- Completion of a Mental Health Assessment which documents:
  - Symptoms/behaviors/impairments to determine a diagnosis
  - Strengths / needs / barriers
- Carry Assessment info forward into the Client Care Plan which documents:
  - Objectives linked to symptoms/behaviors/impairments
  - Interventions to achieve the identified objectives
- Carry forward into the Progress Note which documents:
  - Goal-based interventions provided to the client

How do we document the MHIP Model throughout the Clinical Loop?

Characteristics of MHIP Model

- **Collaborative / Stepped Care Model**
- **Primary Care Provider (PCP)**
  - Oversees medical / medication aspects of patient's care
  - Consults with Care Manager and Consulting Psychiatrist and makes treatment adjustments as needed
- **Care Manager**
  - Supports and collaborates with PCPs managing patients in primary care
- **Consulting Psychiatrist**
  - Provides consultation on patients followed in primary care, focusing on patients who are not improving clinically
  - Supports care managers and PCPs

Care Manager
Therapeutic Components

- **Facilitates** patient engagement and education
- **Assesses** symptoms and impairments using standard assessment and symptom scales (e.g., PHQ-9)
- **Develops** targeted treatment plan
- **Provides** brief, evidence-based treatment (PST, Behavioral Activation) or refers to other providers for mental health treatment services
- **Supports** medication mgmt by PCP
- **Monitors** status / treatment response at each visit
- **Reviews** challenging patients with the consulting psychiatrist weekly
- **Facilitates** referrals to other services (e.g., substance abuse treatment, community resources) as needed

Mental Health Assessment

with a MHIP Approach

Step 1 of the Clinical Loop

Step 1: Mental Health Assessment

- What is the purpose?
  - Learn the client's story
  - Gather a lot of information about the client in a brief period of time in order to formulate a diagnosis, develop a conceptualization, and collaboratively create a treatment plan
  - Determine if the client meets medical necessity
    - (does he/she have an "included" diagnosis and an impairment in life functioning due to his/her mental health symptoms?)

Step 1: Mental Health Assessment

- Presenting Problems (symptoms/behaviors)
  - Document the intensity, frequency, duration and onset of current symptoms/behaviors
- Impairments in Life Functioning
  - Document the connection between impairments and their relationship to symptoms/behaviors
    - e.g., difficulty keeping a job due to his depressed mood, lack of energy, and difficulties concentrating, which are significantly interfering with his work performance.
  - Document the client's activity level both **prior to** and **at the onset** of symptoms

Step 1: Mental Health Assessment

- Substance Use/Abuse:
  - Step 1:
    - Administer the Co-Occurring Joint Action Council Screening Instrument (COJAC) (MH 659)
  - Step 2:
    - Using the client's responses on the COJAC, complete the first part of "Section VI Substance Use/Abuse" on the Assessment
    - If indicated, complete the remainder of "Section VI Substance Use/Abuse" on the Assessment.
- **Note**: if services related to substance use are to be provided, a link between substance use and mental health MUST be identified
- Resources:
  - MH 633 (Supplemental Co-Occurring Disorder Assessment)
  - Clinical Records Bulletin 2009-01

Step 1: Mental Health Assessment

- *Only **Authorized Mental Health Disciplines** (AMHD) can fully complete an Assessment
  - Licensed MD/DO
  - Certified NP (Nurse Practitioner)
  - Registered CNS (Clinic Nurse Specialist), Registered Nurse
  - Licensed or waivered PhD or PsyD
  - LCSW or Registered MSW (Associate Clinical Social Worker – ASW) or out-of-state Licensed-Ready Waivered MSW
  - Licensed MFT or Registered MFT (MFT Intern) or Out-of-State Licensed-Ready Waivered MFT
  - And students of these disciplines with co-signature

- *<u>COMMUNITY PARTNERS (CP)</u>: refer to your Contract to determine who can complete an Assessment

Step 1: Mental Health Assessment

- Must be completed:
  - Within 2 months (1 month if opened elsewhere)
    - Best practice suggests that an Assessment be completed prior to providing treatment services
    - MHIP recommends that the Assessment be completed by the end of the 2nd visit with the client.
      - Information can always be added by using an Addendum
  - On a DMH-approved Assessment form
  - By each agency seeing the client
    - May use a prior assessment of another agency as baseline

Step 1: Mental Health Assessment

- If all information for the initial assessment is gathered in <u>one assessment contact</u>
  - Reference initial assessment completed in the Progress Note
    - “Completed Initial Assessment (see Initial Assessment dated xx/xx/xx in clinical record)”
  - Sign/date the assessment as of the date of the assessment contact

Step 1: Mental Health Assessment

- If information for the initial assessment is gathered in multiple assessment contacts,
  - Reference sections of the initial assessment completed in each Progress Note
  - Sign/date the sections subsequently added to the initial assessment
  - Sign/date the assessment as of the date of the last assessment contact

Step 1: Mental Health Assessment

- If information is gathered AFTER the initial assessment period, an Assessment Addendum MUST be used instead of adding to the original Assessment
  - The Assessment Addendum should be used to update/confirm information on the original Assessment

Step 1: Mental Health Assessment

- In Progress Note, separate out the non-reimbursable activities (e.g., completed consent forms, addressed confidentiality, gathered ct's financial info) which were completed during a reimbursable activity (Assessment) and make a notation that it is "NOT CLAIMABLE."

- Do not include the time for this non-reimbursable activity in the claim time on the Progress Note. (Bulletin No. 11-03)

Step 1: Mental Health Assessment

- 5 Axis Diagnosis
  - Primary diagnosis in the clinical record must match the primary diagnosis in the IS
  - Must identify a primary from either Axis I or Axis II
    - May then select a secondary from Axis I or Axis II
  - If revised in any way, must complete a Diagnosis Information form (MH 501)
  - Should only be documented on the Assessment or Diagnosis Information form

Step 1: Mental Health Assessment

- Discussion: MH 678 Adult Short Assessment
  - Any questions regarding doing Mental Health Assessments?
  - Any tips for completing the Mental Health Assessment

Client Care Plan

with a
MHIP Approach

Step 2 of the Clinical Loop

Step 2: Client Care Plan

- What is the purpose?
  - Ensures a client's care is goal directed and purposeful
  - Allows anyone involved in a client's care to see, at a glance, what a client's services are aimed at and directed toward
  - Creates a "road map" for the client, family, and mental health / medical staff
  - Lists markers of progress; "is the client getting better?"
  - Ensures all payor requirements are met

Step 2: Client Care Plan

- Must be completed:
  - Within 2 months (1 month if opened elsewhere)
    - Best practice suggests that a Client Care Plan be completed prior to providing treatment services
    - For MHIP – recommended that the Client Care Plan be developed by the end of the 2nd visit with the client.
  - Annually prior to the cycle date
    - Annual cycle month = month of admission
  - By each program providing services to the client.
  - For all non-emergent, direct services
    - Must have an objective associated with each type of service provided (e.g., MHS, TCM)
    - One time unplanned services do not need an objective

Step 2: Client Care Plan

- **Long-Term Goal**
  - Exactly what the client says
  - All goals are valid (does not have to be “Mental Health” statements)

Step 2: Client Care Plan

- **Short-Term Objectives**
  - A way to see if the CLIENT is improving
  - Measurable change in helping the client achieve his/her long-term goals
    - Can address symptoms, behaviors or impairments identified in the Assessment
  - Should match where the client is at and be meaningful to the client
    - What is he/she identifying as the problem? Why did he/she reach out for help?
  - Must be SMART (Specific, Measurable, Attainable, Realistic and Time-Bound)
  - In developing objectives, it is important to look at how they might impact and build upon strengths and supports

Step 2: Client Care Plan

- **Interventions**
  - How will STAFF contribute to achieving the behavioral changes
  - Describe the intervention(s) you are planning to use with your client (e.g., PST, Seeking Safety, CORS, Motivational Interviewing).
  - Under the MHIP Model,
    - If you are not trained in PST, then you must get approval from Kathleen Kerrigan to use another intervention.
    - If you are trained in PST and have determined that PST is not a good treatment fit, then describe what intervention you are going to use.
- **Client Participation**
  - How will the client contribute to achieving the behavioral change

Step 2: Client Care Plan
Example: Info from the Assessment

- **Symptoms / behaviors / impairments related to the primary diagnosis**
  - For the past month, client has been experiencing depressed mood with a loss of energy, loss of interest or pleasure in almost all activities, and social withdrawal
  - Depressive symptoms are significantly interfering with client's academic/work performance, and impacting his social and family relationships

Step 2: Client Care Plan
Example - OBJECTIVE targeting symptoms

- **Long-Term Goal:**
  - "I just want to feel better"
- **Objective:**
  - Diminish depressive symptoms as evidenced by client's PHQ-9 score decreasing from 20 to 4
- **Interventions**:
  - Teaching and reinforcing active problem-solving skills in order to increase client's self-efficacy and improve his/her mood.
  - Engaging the client in 'behavioral activation' in order to reduce depressed mood by gradually increasing engagement in pleasant and enjoyable activities.
  - Facilitating linkage to community resources to strengthen social support system and provide opportunities for increased social involvement.

Step 2: Client Care Plan

Example - OBJECTIVE targeting impairments

- **Long-Term Goal:**
  - "I want to be able to go out do things with my family/friends, again"
- **Objective:**
  - To increase # of social interactions from 0x to 3x per week
- **Interventions:**
  - Assisting the client in re-engaging in pleasant activities and learning new ways of dealing with distress
  - Teaching and reinforcing active problem-solving skills in order to increase client's self-efficacy and improve his/her mood.
  - Helping the client to identify early warning signs of relapse, reviewing skills learned during therapy, and developing a plan for managing challenges in order to help prevent the relapse of depressive symptoms.

Step 2: Client Care Plan

Additional Examples of Objectives

- Identified impairments can become targets of improvement, which can be measured to determine the effectiveness of interventions
  - To increase # of minutes engaging in pleasurable activities from 0min to 30min per day
  - To decrease # of days arriving late to work from 4x to 0x per week

Step 2: Client Care Plan

Verb	Measure	Target Person	Client's Behaviors	Baseline measure	Goal Measure
To increase	# of minutes	client	Engages in pleasurable activities (social, physical, pleasant)	From 0 minutes a day	To 30 minutes a day
To increase	# of times	client	Uses active problem-solving skills	From 0 times per week	To 5 times per week
To increase	# of times	client	Uses relaxation skills	from 0 times per week	To 5 times per week

Step 2: Client Care Plan

- A Client Care Plan (CCCP) is not needed if the client is being referred out to other Providers
- When adding new INTERVENTIONS to an existing Client Care Plan, new signatures from the client are not required
- When adding a new OBJECTIVE to an existing Client Care Plan, have the client sign and date.
- For each objective, the AMHD signature is needed

Step 2: Client Care Plan
FAQ

- **Who must sign the objective? Would I have to see the client to sign off on the objective?**
  - All objectives must **minimally** be signed off by an AMHD to identify that the services are provided under his/her direction.
  - **MINIMALLY** means that the staff consulted on the objective with other staff (e.g., AMHD, MD/DO or NP)
  - For all objectives, the client should always be encouraged to participate by signing. If client does not sign it, regular efforts must be attempted /documented to obtain approval with the plan.

Step 2: Client Care Plan
FAQ

- **Does there have to be an objective for every type of service?**
  - There must be an objective for every service PROVIDED to the client
  - However, an objective is not required for an unplanned service
  - For an unplanned type of service (e.g., TCM), if the type of service is NOT already associated with an objective on the Client Care Plan, staff must determine if the service will be provided again and, if so, create an objective on the Client Care Plan for that type of service AND attain new signatures.
  - It is possible to combine different types of service interventions under the same objective. However, staff must ensure that each type of service (e.g., MHS) is clearly indicated for the objective and the specific interventions for each type of service are clearly identified.

Step 2: Client Care Plan

- Discussion: CCCP
  - Any questions regarding the CCCP?
  - Any tips for completing the CCCP?

Progress Notes (Services)

with a MHIP Approach

Step 3 of the Clinical Loop

Progress Notes

- What is the purpose?
  - Documents what is going on with the client (brief narrative)
  - Identifies what you did (i.e., what intervention was provided toward the client's objectives)
  - Identifies client's response toward the interventions and progress toward his/her objectives
  - Provides continued care information (for the next person working with the client)

Progress Notes

- Ask yourself:
  - What did I do?
  - What was the purpose of what I did?
  - Why was the service provided?
  - What benefit was provided to the client?
  - Does the service/intervention match to an objective on the Client Care Plan?

Progress Notes

- Progress Notes must:
  - Be linked/connected to an objective on the Client Care Plan
  - Be completed prior to the end of the next scheduled workweek day (for Directly-Operated only)
  - Be done prior to submission of a claim
  - Not combine different types of services
    - e.g., combining therapy and targeted case mgmt in a single note

Progress Notes

- Progress Notes are used to document a reimbursable service.
- If “YES” to the following, then you have a strong reimbursable Progress Note:
  1. Is it clear that I took some action that will help my client?
  2. Will the action work toward improving or maintaining my client’s mental health?
  3. Did the service I provided relate directly back to the identified mental health needs / diagnosis of my client?

Progress Note Interventions

- All interventions must always link back to an identified mental health need(s) of the client
  - Decreasing symptoms or behaviors must always link back to the identified mental health need
  - Increasing adaptive behaviors / skill development must always link back to the identified mental health need

Progress Note Interventions

- The intervention documented should be about the purpose of the activity, not the activity itself.
  - When doing Problem Solving Treatment, the purpose is about skill building – which will strengthen the client's ability to exert control of his/her problems and improve his/her mood.
  - Document the stages of skill building that you're working on with your client rather than the client's specific problem that he/she is addressing to build the skill.

Progress Note Interventions
Examples

- Engagement with Client at beginning of treatment
  - "Engaged client to establish rapport, explain treatment rationale, clarify treatment process, and understand and address barriers to treatment to improve participation."

Progress Note Interventions
Examples

- Psychoeducation with Client: Introduced Problem Solving Treatment to the client –
  - explained the structure of PST,
  - established link between client's symptoms and depression,
  - established the link between problems and depression,
  - facilitated a problem-solving orientation
  - described the 7 stages of PST

Progress Note Interventions
Examples

- Psychoeducation with Client – Introduced Behavioral Activation to the client
  - Established the link between activities and feelings
  - Illustrated how positive activities can be mood-enhancing for the client
  - Assisted the client in generating simple pleasurable activities (social, physical, pleasant)

Progress Notes
Quality of Writing

- Concise
- Clear
- Cohesive
- Reader-centered
- Written in language anyone can understand

Always keep in mind that the Clinical Record belongs to, and is about, the client!

Progress Notes

Key things to ask yourself

- What did you do? Why did you see the client? Is it reflected in the Progress Note?
- Does the Progress Note clearly relate back to an objective on the Client Care Plan?
- Did you sign, write your discipline, and date the Progress Note?
- Can the Progress Note be read by someone else (legible)?
- Did you separate out clerical, transportation, and interpretation services since they are NON-CLAIMABLE services?
- Did you turn in your Progress Note to be filed (or file it yourself) prior to turning in the claim?

Screening Tools (PHQ-9, GAD-7, etc)

- Used according to MHIP model to monitor treatment progress and respond accordingly:
  - if score decreasing then continue doing what you're doing
  - if score increasing or not changing, then troubleshoot (e.g., consult psychiatrist, assess client's treatment adherence, increase supports, assess your treatment fidelity - "Am I doing PST / Exposure Therapy / etc., as it was intended?")
- Referenced in the Progress Note
  - "Administered the PHQ-9 to the client to monitor treatment progress. Client's current PHQ-9 score is 14, which indicates that his/her depressive symptoms are continuing to diminish."
- Filed in the Assessment Section of the chart (for directly operated)

Consultations with the Consulting Psychiatrist

- MHIP: Reviews challenging clients with the consulting psychiatrist
  - Make sure you document:
    - the reason for the consult,
    - what information was shared/gathered,
    - and how it will benefit the client (what is the outcome of the consult?)

Procedure Codes

Procedure Codes: Community Partners ONLY

- All Community Partner service claims must only use the **H2016** procedure code. The unit claimed in the IS = one (1).

- Community Partners cannot bill for phone-based services

Key things to ask yourself when choosing a Procedure Code

- Does the Procedure Code reflect what is written in the Progress Note?
- Who was the service directed to/at?
  - Directed at client means there will be face-to-face time (presence of client does not assume face-to-face time)
  - Directed at inter/intra-agency staff means case consult/team conference or targeted case mgmt
- If there are no interventions documented towards the client, there should be no face-to-face time.
  - If there is no face-to-face time, then Assessment / Individual Therapy / Family Therapy codes cannot be used

Mental Health Assessment

- Procedure Codes during the Assessment process:
  - 90801/90802 – gathering info from the client
    - Mental Health Assessment **requires** face-to-face time that must be both documented in the clinical record and entered into the IS
  - 90887 – gathering info from a collateral
  - H0032 – gathering info from other agency staff that will add to the Assessment or treatment plan for the client
  - 90885 – gathering info by reviewing records

TCM-Targeted Case Management
(Procedure Codes page 10; Org manual page 2-14)

- Definition:
  - Services needed to access medical, educational, social, prevocational, vocational, rehabilitative, or other community services. These services, whether face-to-face, by phone, or through correspondence, provide for the continuity of care within the mental health system and related social service systems. Services include linkage and consultation, placement, and plan development

- Procedure Code – T1017

Targeted Case Management (T1017)

- TCM is a multi-step process that includes assessing needs, providing linkage, and monitoring.
- TCM is not just handing out referrals
- Should be associated with an Objective
- Should be very specific

Targeted Case Management (T1017)

- TCM Objectives on the Client Care Plan should be within the scope of specialty mental health services.
- The reason the client's identified mental health symptoms prevents the client from doing it themselves should be evident while outlining TCM Objectives.

Targeted Case Management (T1017)

- The same objective can be used for TCM and MHS:
  - **Objective**: Reducing symptoms of depression as evidenced by a decrease in PHQ-9 scores from 20 to 4
  - **Interventions**:
    - **TCM**: to link the client to socialization resources such as a Senior Center and monitor the progress on this linkage
    - **MHS**: to assist the client in re-engaging in pleasant activities and learning new ways of dealing with distress
  - For both of these interventions, the objective could still be the same – reducing symptoms of depression as evidenced by a decrease in PHQ-9 scores from 20 to 4.

MHS – Individual or Group Rehab
(Procedure Codes pages 5 and 8; Org manual page 2-4)

- Assistance in improving, maintaining, or restoring client's functional, daily living, social/leisure, grooming/personal hygiene, meal prep skills, support resources
- Procedure Code-H2015

MHS – Therapy

(Procedure Codes pages 3 and 4; Org manual page 2-4)

- A service activity which is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments.
- Therapy may be delivered to an individual or group and may include family therapy at which the client is present

MHS – Individual Psychotherapy

- Duration of Face-to-Face time is a determinant in selecting the psychotherapy codes:
  - H0046 (0 to 19 minutes – face-to-face)
  - H0046 (Any length over the phone)
  - 90804 (minimum of 20 minutes)
  - 90806 (45 to 74 minutes)
  - 90808 (75+ minutes)

MHS - Individual Therapy

- PHONE THERAPY: regardless of how much time spent in ‘phone therapy,’ always use procedure code H0046 (**0** to 19min) b/c ‘on the phone’ is not face-to-face time.

MHS - Collateral

(Procedure Codes pages 9; Org manual page 2-5)

- Definition: Gathering information from and/or interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist clients
- Procedure Code-90887

MHS – Plan Development
(Procedure Codes pages 11; Org manual page 2-9)

- Definition: A stand-alone service that includes developing Client Care Plans, approval of Client Care Plans and/or monitoring of a client's progress. Plan development may be done as part of a interdisciplinary inter/intra-agency conference and/or consultation in order to develop and/or monitor the client's mental health treatment. Plan development may also be done as part of a contact with the client in order to develop and/or monitor the client's mental health treatment.
- Procedure Codes – H0032

Thank You for Your Participation

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