

March 13, 2002

The Ohio Department of Mental Health

Program Advisory: Community Support Program (CSP) Services ODMH Certification Standard 5122-29-17

❖ *The CSP Certification Standard*

I. The general intent of the Rule

Community Support Program (CSP) services are intended for persons whose mental health needs require active assistance and support to function independently in community settings.

This assumption is articulated in the CSP service rule, which permits the performance of any of ten (10) service activities only to the extent such services are performed to address the individual mental health needs of the client. For the most part, the covered service activities in the rule focus on such treatment and support issues as “managing basic needs,” “development of daily living skills,” “assistance in accessing natural support systems,” “overcoming barriers to seeking or maintaining education and employment,” etc. All of these issue areas relate to one extent or another to functioning independently in community settings. Such services are essential to assist clients whose mental health problems would otherwise prevent them from living effectively in community settings.

Because the service rule permits the ten (10) service activities to be performed only to the extent that they relate to the client’s mental health service needs, and in order for a CSP service intervention to be compliant, this relationship between the intervention and the mental health treatment needs must indeed exist. For example, an intervention related to “managing basic needs,” such as training in maintaining an apartment, is only permitted if it is clear that the client’s mental health problems temporarily impede their ability to carry out that function without assistance.

Further, service documentation in the ISP and progress notes must make clear the relationship between the client's mental health needs and the CSP interventions performed.

Most of the CSP compliance issues over time have arisen from circumstances where either no mental health need existed to warrant the service intervention, or such a need may have existed but the relationship was not documented. CSP compliance issues will be discussed in greater detail in a following section of this Advisory.

It is essential that these programmatic boundaries for CSP be made clear and enforced. The types of supportive interventions available through CSP indeed may be helpful to wide range of persons with varying types of disabilities and social service needs. CSP, as defined in the mental health service rule, is available only to those persons whose mental health problems necessitate these types of interventions. If we are not able to maintain these boundaries, the ability to continue to make this important service available will be compromised because of potential compliance sanctions and, consequently, dissipation of resources to persons whose mental health needs require these types of services.

II. Allowable CSP Activities

The Certification Standards for the Community Support Program Service is found in Section 5122-29-17 of the Ohio Administrative Code. Section (B) of this Rule includes the 10 activities that can be provided and billed as CSP. The following is a listing of the 10 activities accompanied by a general discussion:

- (1) **“Ongoing assessment of needs.”** This refers to activities in which the overall needs of the consumer are assessed by the CSP worker. This might include the need for housing, vocational assistance, income support, social support systems, transportation, etc. The activities must be consistent with professional licensure requirements. CSP assessments must be separate and distinct from a Diagnostic Assessment.
- (2) **“Assistance in achieving personal independence in managing basic needs as identified by the individual and/or parent or guardian.”** This should be accomplished in the context of the consumer's mental health treatment needs as identified in the client's ISP.
- (3) **“Facilitation of further development of daily living skills, if identified by the individual and/or parent or guardian.”** As in item (2) above, the development of daily living skills should also be accomplished in the context of the consumer's mental health treatment needs.
- (4) **“Coordination of the ISP, including:**
 - a. **Services identified in the ISP;**

- b. **Assistance with accessing natural support systems and the community; and**
- c. **Linkages to formal community services/systems.**

It is very important that the development and the ongoing implementation of the ISP be carefully coordinated to assure continuity of care and consistency in the development of the client's treatment goals. It is generally the role of the primary CSP worker to assure this important coordination.

- (5) **“Symptom monitoring;”** This allows the CSP worker to actively engage and document the mental health related symptoms of the client. It should be noted that large amounts of time “observing” the client would be problematic from a Medicaid point of view. This will be discussed in greater detail later in this advisory when clinical intensity issues are discussed.
- (6) **“Coordination and/or assistance in crisis management and stabilization as needed.”** This should be differentiated from the provision of mental health crisis intervention service. These activities include “Wrap-Around” support for client in crisis, immediately following a crisis, and/or to prevent an imminent crisis.
- (7) **“Advocacy and Outreach.”** This allows the CSP worker to advocate for the client in all situations within the community when the client is unable to advocate for themselves due to the symptoms of their mental illness. This also allows the CSP worker to provide outreach services to assure that the client's civil rights are protected.
- (8) **“As appropriate to the care provided to individuals and, when appropriate, to the family, education and training specific to the individual's assessed needs, abilities and readiness to learn.”** These activities must be on behalf of the client and must be reflected in the ISP. This is not intended to be treatment for the family or significant other. Examples of this activity would be the education to the client, family members or essential others concerning the client's illness, medication, side effects, etc.
- (9) **“Mental health interventions that address symptoms, behaviors, thought processes, etc., that assist an individual in eliminating barriers to seeking or maintaining education and employment.”**

Examples of these activities include:

- a. Helping the client develop coping skills,
- b. Helping the client develop interpersonal skills,
- c. Discussions with the client regarding relationships with family/others,
- d. Discussions regarding problems encountered in dealing with disability,
- e. Educating and assisting the client through their recovery process,

- f. Assisting the client in the development of a personal support system, and
- g. Assisting the client with acquiring employment, income, and/or money management skills that are interfered with by the client's mental illness.

(10) “Activities that increase the individual’s capacity to positively impact his/her environment.” These may include activities that empower the client and educational/self-esteem activities that result in the client’s ability to positively impact the environment in which he/she lives.

III. Delegation of CSP Activities

Each person receiving CSP services must have one mental health staff member that is clearly responsible for his or her case coordination. This individual has frequently been referred to as the “primary” CSP worker. This individual may delegate CSP activities to individuals internal or external to the Agency as long as the activities are consistent with the CSP Rule, (i.e. Section 5122-29-17 of the Ohio Administrative Code). In addition, if the service is billed to Medicaid, it must also meet the requirements contained in the Ohio Department of Job and Family Services Medicaid Rules (discussed later in this Advisory) and billing entity must be certified to provide CSP services by the Department of Mental Health. The delegation and coordination of all CSP activities should be clearly documented in the client’s ISP.

IV. The Provision of CSP Activities in Groups

As long as the following conditions are met, CSP services can be provided in a group setting:

1. The services are consistent with the 10 allowable activities documented above,
2. The services and the need for such services are documented in an individualized manner in each client’s ISP.
3. The service activities are provided and sufficiently documented in an individualized manner.
4. There is a sufficient degree of clinical intensity. Clinical intensity will be discussed in greater detail later in this Advisory.

❖ *Community Medicaid Compliance Issues*

The Ohio Department of Job and Family Services, (ODJFS) is the designated single state agency for the administration of Ohio’s Medicaid Plan. The Ohio Department of Mental Health has entered into an Agreement with ODJFS to administer the Community Mental Health Medicaid Program. ODJFS has promulgated a series of Rules that govern the Community Mental Health Medicaid Program that are a section of Ohio’s Medical Assistance Plan, (i.e. Medicaid Plan). The one Rule that has the most relevance to this Advisory is Section 5101:3-27-02 of the Ohio Administrative Code. This Rule entitled “Coverage and limitation policies for community mental health agency services” contains the services that may be billed through the Community Medicaid Program, some limitations on those services, and the documentation requirements for billed services.

I. OAC 5101:3-27-02

A. CSP Service Definition

Concerning the CSP Service, Section 5101:3-27-02 (C) (6) defines this service as “those services as defined in Rule 5122-29-17 of the Administrative Code....” This Rule is the CSP Certification Standard Rule that was discussed earlier in this Advisory. However, the final segment of 5101:3-27-02 (C) (6) places some limitations on the CSP service. The following is a listing of the limitations and a general discussion on each.

B. CSP Service Limitations

In order to be billed to the Community Medicaid Program, CSP services are subject to the following limitations.

1. **“(a) All community support program services provided in a social, recreational or educational setting are allowable only if they are documented mental health interventions that address the specific individualized mental health treatment needs as identified in the ISP of the person served.”** (emphasis added). Therefore, social or recreational outings are not eligible in and of themselves. If however, they are the **setting** where eligible CSP mental health interventions, as

identified above, are provided, then those interventions, and only those interventions may be billed. For example, if a client is taken to the Zoo to address some behavior issues, only the time that the CSP worker and the client address the behavior issues is billable. The remainder of the visit to the Zoo is considered a Social/Recreational Service, that may be therapeutic, but is not billable to the Community Medicaid Program.

2. **“(b) Transportation is an unallowable activity..”**. The act of transporting a client for any reason is not by itself billable. However, transportation may be viewed as a **setting** where eligible CSP interventions can take place. To be billable, the interventions must be consistent with the 10 allowable activities noted above and must be properly documented. As in the example above, only the time spent addressing mental health issues may be billed. For example, if a CSP worker drives a client to the doctor for 1 hour and discusses housing issues for 15 minutes, only the 15 minutes should be billed.
3. **“(c) Vocational job training activities are unallowable.”** This refers to activities that are intended to teach a client how to do a specific job. Examples of this would be teaching computer skills to a client, or teaching a client how to operate a cash register, etc. These activities, while important are considered vocational services and are not eligible for Medicaid reimbursement. However, activities that address mental health issues around a vocational setting may be billable as long they are properly documented and are consistent with the 10 eligible activities in the CSP Certification Standard Rule. Examples of this would include discussions relating to stressful situations at work, identifying supports within the work environment, and assisting a client to cope with the stress involved during an interview.

II Other Unallowable Activities

In addition to the specific unallowable activities identified above, activities that are not consistent with the ten allowable activities identified in the CSP Certification Standard Rule are also not allowable. Examples of this include academic educational services, routine residential services, and routine social services not directly related to the mental health treatment goals of the client.

III Documentation Requirements

O.A.C. Section 5101:3-27-02 (D) contains the documentation requirements for all Community Mental Health Medicaid services. The following is a listing of the requirements and a discussion on those that have caused the most compliance findings in the recent years:

- A. The date of the service contact;**
- B. The time of day of the service contact;**
- C. The duration of the service contact;**
- D. The signature and discipline of the provider of the service and the date of the signature;** The discipline should match the appropriate credentials in the provider eligibility section contained in each Service Rule, (e.g. LISW, SWA, LPN, PC, etc.). The date of the signature should be in addition to the date of the service contact.
- E. The general activities of the service;** This relates to what was occurring during the therapeutic intervention. Did the intervention occur in the client's home, while on route to the Doctor's office, or over the phone with an employment specialist, etc.?
- F. The therapeutic interventions of the provider;** (It should be noted that this has been the requirement that has caused the majority of compliance findings.) This refers to how the provider utilized his/her mental health education and/or training in addressing the specific mental health treatment needs of the client. It is this intervention that is being purchased by the Federal Government. Therefore, it is important to be as specific as possible in identifying and documenting the mental health interventions that occurred. Documentation of the therapeutic interventions will require the provider to specifically address **what** therapeutic interventions occurred and, as importantly, **why** the interventions occurred. This will hopefully assist the provider in developing insight into the purpose of the intervention and will require the provider to give a rationale for each intervention. In addition, this will be of use as a means to assess the client's treatment process. The documented interventions must also address the specific mental health treatment goals as identified in the client's ISP.
- G. The behavior and the response to the intervention of the person served.** The response of the client to the intervention should be viewed as a very important component of the clinical documentation. It can be very useful in treatment process and future treatment planning. It should be as specific and detailed as possible and should include any verbal and non-verbal responses of the client, (or essential other), that is beneficial to the mental health treatment process. Properly documented, the behavior and the response to the intervention will hopefully provide the clinician with insights into

what interventions may or may not be beneficial to the client's mental health treatment.

IV Clinical Intensity Issues

In the Community Mental Health Medicaid Program, it is important to document a significant level of clinical intensity. In the past several years, several compliance findings, (resulting in a significant recovery of funds), have occurred because of this issue. For the purposes of this Advisory, clinical intensity is defined as follows:

The *relative* degree of *documented* mental health interventions between clinicians and clients (or essential others) *addressing the specific mental health needs* of the clients as identified in the ISPs of the clients.

The following is a discussion concerning this issue and how it can be used to enhance documentation and thereby reducing the risk of adverse audit findings.

- A. **The relative nature of clinical intensity.** The concept of clinical intensity is a relative matter. There is no clear dividing line between clinically intense and non-clinically intense interventions. The clinical intensity is a function of the quality of the documentation of the intervention (as compared to the length of the billed intervention), and the content of the documentation. It should be emphasized that the higher the degree of clinical intensity, the lower the financial risk to the agency (i.e. the lower the risk of Federal, or State audit findings). Therefore, it is strongly recommended that Medicaid Provider Agencies implement a review of clinical intensity as a component of its quality improvement system.
- B. **The role of documentation concerning clinical intensity.** The documentation of the interventions is very important in demonstrating an adequate level of clinical intensity. The content of the documentation should support the time spent in the intervention and the amount and/or complexity of the specific mental health interventions that were provided. These interventions should be directly relevant to the mental health treatment goals of the client as identified in the client's ISP. The following is a discussion of these issues in greater detail.
 1. **The completeness of documentation.** As stated above, the content of the documentation should support the time billed to the Community Medicaid Program. In general, it is expected that the larger the amount of time billed, the greater amount and/or complexity of mental health interventions have been provided. For

example, if 2 hours are billed, and the note states “client and CSP worker talked about treatment issues”, this would not be sufficient. The notes should reflect which issues were discussed, the importance and relevance of the topics that were discussed and any decisions that may have been reached in the two hour conversation. However, as noted below, more is not always better.

2. The accuracy and content of the documentation. The accuracy and content of the documentation is very important and has been the cause of the majority of the previous compliance findings. All progress notes should be an accurate reflection of the interventions that were provided. In order to bill Medicaid, the documented mental health interventions that were provided need to be consistent with the appropriate certification standard and all ODJSF Rule requirements. Clinicians should avoid documenting irrelevant conversations or activities that are not directly related to the client’s mental health treatment goals.

V. Previous Compliance Findings.

Over the past several years, the Ohio Department of Mental Health has been active in identifying and correcting non-compliance issues within Agencies. This has been done to demonstrate to the Federal Government that the Department is very serious about the proper stewardship of the funds generated through the Community Medicaid Program. These activities should also help to lower an Agency’s financial risk of future adverse Federal Audit findings. One of the primary reasons for this Advisory is to inform the Community Mental Health System of these previous findings. This will allow Agencies to take preventive measures to assure that future compliance actions do not occur. The following is a listing and discussion of some of the more serious non-compliance findings over the past years.

1. Lack of adequate documentation. As stated in IV B. above, documentation is very important in establishing compliance with Medicaid requirements. Generally, problems with documentation fall into one or both of the following categories:

a. Brief and/or vague documentation of the therapeutic intervention. In order for a reviewer to establish that a service is consistent with the Certification Standard or does not include unallowable activities, it is very important that a precise description of the individualized intervention be documented. For example a progress note that states “Client attended group and actively participated. Needed redirection at times.”, does not adequately describe the therapeutic intervention. This note only documents that the client was present and participated in whatever activity was occurring. An independent reviewer

would have no idea from this note what type of activity was occurring. The group could have been a highly structured, clinically intense individualized discussion of mental health issues related to the client's mental health treatment needs or may have been a social/recreational activity, which may be therapeutic, but is not eligible to be billed to Medicaid. It is recommended that Agencies consistently review the contents of progress notes by individuals who have little or no knowledge of the program or service to assure that notes clearly define the therapeutic intervention that occurred and the client's response to the intervention. This manner of documentation, in addition to lowering financial risk to the agency, should also assist the clinician in future treatment planning and service delivery.

- b. Brief documentation that does not support the time billed.** As stated above, it is assumed that the longer the duration of the service contact, the greater the amount and or complexity of provided services. Therefore, the content of the documentation should support the amount of time billed. A three hour intervention in which the progress note that states "Worked on ADL (Activities of Daily Living) skills" would not be adequate. The notes should specify all activities that occurred in the three hours to assure the reviewer that all activities are allowable. The note should also be more specific. It should have identified which ADL skills were being addressed and the manner in which they were addressed. As stated above, the increased accuracy and specificity in documentation should also help in treatment planning and service delivery.

2. Including non-billable activities with billable interventions. In the past, the Department has found documentation relating to interventions that include other interventions such as dental visits, SAMI appointments, Court proceedings, etc. The time that a CSP worker spends waiting for a specific procedure (e.g. a Doctor's or Dentist appointment) to be completed is not a mental health intervention and is not eligible for Medicaid reimbursement. Therefore it is very important that all unallowable time be excluded from the claim.

3. Billing for General Social services not directly related to the mental health treatment goals of the client.

- a. Children** - Over the past few years, some childrens agencies have had serious compliance findings because of documentation that the services provided were general social services such as

adoption services, general foster care services, social protective services, etc. Such interventions are not directly related to the mental health needs of the child and therefore are not considered mental health interventions. Consequently, such interventions are not eligible for Medicaid reimbursement. The following represents a general overview of the differences between mental health CSP interventions and social interventions:

It is the opinion of the Department that interventions that focus on the specific mental health treatment needs of the client could be billed as mental health CSP interventions. Examples of this type of intervention would be discussions with the client or family members concerning mental health treatment goals, behavior, etc. of the child. However, activities that are primarily related to improving the social condition of the family or child without a direct relationship to the mental health needs of the client are viewed as social interventions, and although they are much needed interventions, should not be billed as mental health CSP interventions. Examples of these types of interventions include assisting a family in accessing food stamps, assisting a parent in finding employment, educating the parents the value of proper hygiene, or finding an academic tutor for the child.

There is general agreement that the social services that are provided to the children or the family are of great value and benefits the mental health treatment process. However, unless the activities **directly** address specific mental health needs of the child, the services cannot be funded as mental health CSP interventions.

- b. **Adults** – In some cases, services provided to adults appear to be a social service rather than a mental health intervention. For example, taking a client to the store to obtain groceries in and of itself, is a social service. However, if the CSP worker is addressing the mental health treatment needs of the client while grocery shopping, then it is more reflective of a mental health intervention. In this example, the CSP worker should identify the mental health symptoms, behaviors, thought processes, etc., that prevent the client from doing the grocery shopping independently. The documentation should reflect interventions that address these issues.

4. Billing for academic educational activities. In some cases, CSP services are provided in a school setting. As stated earlier in this Advisory,

academic educational activities are unallowable. Therefore the time during which a child is receiving academic education must be excluded from a Medicaid claim. However, any intervention in an educational setting with the child that directly addresses the specific mental health treatment goals of the child may be billed as a mental health CSP service.

5. Billing for social/recreational services. Another situation that has resulted in compliance findings is billing social/recreational services as CSP interventions. An example of this is a 2 hour trip to a park with clients to practice socialization skills. It should be noted that even though the purpose of the trip is to work on mental health issues, the trip itself is still considered a social/recreational service and should not be billed to the Community Medicaid Program. However, time spent between a CSP worker and the client discussing mental health treatment issues at the site of the social/recreational service may be billed as a CSP intervention. Therefore, in this example, the 2 hours at the park should not be billed, but if the CSP worker interacted with the client for 15 minutes addressing mental health treatment goals, then the 15 minutes may be billed. The documentation should then reflect what occurred during those 15 minutes.

VI. Tips for improving the quality of the clinical documentation.

As this Advisory has demonstrated, quality clinical documentation of CSP services is extremely important for the following reasons:

- Good clinical documentation lowers the risk to an agency for adverse Federal or State audit findings.
- Good clinical documentation lowers the risk of clinical malpractice to the agency and the clinician.
- Most importantly, quality documentation assists the provider and client in effective treatment planning and service delivery.

Because of the importance of documentation, it is recommended that all CSP staff receive training in these documentation concepts. It is further recommended that agencies include an objective review of the documentation in its ongoing quality improvement process.

Staff training should be done in the context of the third bullet identified above. It is much easier to get staff to “buy in” to quality documentation if they understand its clinical importance, rather than stressing it’s a State or Federal requirement.

1. **Document specific client needs and desires.** Include the client needs and desires in the ISP and be as specific as possible. The needs and desires do not need to be limited to mental health issues.

2. **Identify barriers that prevent the client from attaining the needs independently.** The barriers should also be included in the ISP and should also be specific to the client and related to the client's mental health symptoms. Barriers that are not a result of the client's mental illness may be included but interventions addressing such barriers should not be billed as mental health interventions unless the interventions include "Linkages (*not transportation*) to Formal Services/Systems or "Advocacy and Outreach".
3. **Interventions should be focused on addressing the barriers rather than simply meeting the needs thereby promoting recovery.** If a client needs assistance in grocery shopping, the reasons for the assistance should be clearly documented in the ISP. For example, the ISP may state that the client has difficulty being in community settings because he/she is anxious around strangers. Other examples could be that the client is delusional around others, or the client becomes confused at times, or that the client is impulsive when shopping. Then, when a CSP worker assists the client at a grocery store, the intervention should address the client's anxiety, delusions, confusion, or impulsive nature and the documentation should reflect this. This serves two purposes. First, it documents that a mental health intervention occurred. Secondly, and more importantly, it supports recovery and encourages the transition to more independence for the client.
4. **Honestly document what actually occurred. Be as specific as possible. Then determine whether or not it is billable.** CSP workers should document the exact intervention that occurred. Then, the CSP worker should determine whether or not the intervention was related to the mental health treatment of the client and if the intervention is consistent with the CSP standard and the ODJFS Rule. If the service is eligible, then it may be billed to Medicaid. If not, another funding source may be billed. In the past, some agencies have had compliance findings because CSP workers documented interventions in a manner that made them "look eligible". Evasive or misleading documentation of billed ineligible interventions could potentially be found to be fraudulent and could result in criminal prosecution. Therefore, it is very important that the documentation should be done in an honest and specific manner and should not be done with the service eligibility in mind. The client may legitimately need and the provider may legitimately provide services which are not Medicaid billable.

5. **Documentation should reflect only those interventions and behavioral observations that are important to the mental health treatment of the client. Avoid irrelevant comments.** In the past, the Department has observed instances where CSP workers “over-documented” CSP interventions by including conversations or observations that had nothing to do with the client’s mental health treatment. In addition to being a possibly ineligible intervention, the additions of these irrelevant comments are not an efficient use of the CSP workers time.

It is hoped that this Advisory will be of use to Agency and Board staff and will result in lower financial risk to agencies and enhanced clinical documentation that will be of benefit to the clients of Ohio’s Community Mental Health System.

Please direct any questions concerning this Advisory to:

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