Section 2

Satisfying Reimbursement and Compliance Requirements

Clinical documentation serves many purposes. Clinicians need comprehensive documentation to manage the treatment process. Payers require complete and accurate documentation to establish *medical necessity* and authorize reimbursement. Providers use documentation to disclose the type, extent and level of mental health treatment to demonstrate *medical necessity* and to substantiate reimbursement requests.

The integrated SOQIC forms were designed to enable Providers to fulfill key compliance and reimbursement elements, which include:

- Medical necessity
- Linkage requirements
- Signature and credentialing requirements

The SOQIC forms were developed to allow Provider Agencies' to successfully meet the documentation requirements of regulations, accreditation standards, and major payers, including;

- ODMH
- ODADAS
- JCAHO/CARF/COA
- HIPPA
- Medicaid/Medicare

Good clinical practice and use of the SOQIC documentation process will help Provider Agencies to demonstrate *medical necessity* and support the complete documenting of clients' conditions, functional levels/deficits, treatment goals, participation and benefits from treatments in the medical, rehabilitation and recovery-based service models.

The consistent use of the SOQIC documentation across Ohio's mental health delivery system, positions Providers to mitigate and overcome reimbursement and compliance-related issues.

Medical Necessity

The concept of *medical necessity* is a critical one for Provider Agencies to grasp. *Medical necessity* is:

- A concept that demonstrates the individualized need for specific mental health interventions
- The standard by which Medicaid determines whether it, or another revenue source should be used to pay for services provided
- The underpinning of most third-party payers' reimbursement systems, including the Medicare and Medicaid programs, and the reimbursement systems for state and local payment for behavioral health services.

The concept is sometimes viewed as applicable only to the *medical model*. However, rehabilitation services, because they are paid at least in part by Medicaid, must also use the concept of *medical necessity* to determine if the services provided are reimbursable.

Medicaid Definition of Medical Necessity

Medical necessity starts with a practitioner evaluating a client and authorizing or rendering services that fall within the scope of their license. This is important, for a practitioner cannot authorize or order services that they cannot by licensure, or law, perform themselves. If the service is not ordered by the appropriately credentialed person the first test of medical necessity is not met. For example: *A social worker cannot order medication management services by a physician.*

Services ordered also need to meet additional tests.

They must be "*necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part or significant pain and discomfort.*"[1]

As you can see from this definition in the Ohio Administrative Code for Medicaid, medically necessary services are those that prevent the client from getting worse (either deteriorating or prolonging the illness) or developing new problems. The definition also asserts the role of medically necessary services in dealing not just with the symptoms or signs of an illness, but the impact of the illness on the ability of the individual to function. This speaks directly to rehabilitation services, which are primarily focused on maintaining or raising the functional level of the client.

In addition, medically necessary services are those that are:

1. Not experimental and are generally accepted as reasonable and effective for the particular problem being addressed;
2. Delivered at an appropriate intensity;
3. Provided in the appropriate level of care setting; and
4. When used for diagnosing, "*capable of providing unique, essential and appropriate information about the client*."[2]

Medicaid Criteria for Payment of Medically Necessary Services

Even though a service may be medically necessary, it may still not be reimbursable. Criteria that Medicaid uses to determine whether medically necessary services can be paid include:

- The services are voluntary and initiated by the client, or client's family/guardian *(Note: Payers believe with some justification that clients who come freely to services and are actively involved in developing their individualized service plans are more likely to participate actively in their treatment and to comply with their treatment regimen.)*
- The client or client's family/guardian selects the provider of his/her choice. Again, this promotes the active participation of the client in his/her own care and is a fundamental right addressed in the state's Medicaid plan.
- An eligible provider, in addition to ordering the service, must also render the service. (*Note: Most payers list the credentials they require for a Provider of each service covered under their benefit plans. For most payers credentials include a combination of licensure (if required), education, and experience. Providers are expected to comply with these credentialing requirements as a condition of payment.)*
- The service must be provided in compliance with the Medicaid definition for the service as defined by the eligible service codes in the CPT or HCPCS code books.
- The service must be the lowest cost service that effectively addresses the client's problem.[3]

Medical Necessity in Mental Health and Substance Abuse Services

In addition to the general Medicaid rules, the Ohio Administrative Code gives additional guidance on *medical necessity* to Providers of mental health and substance abuse services:

1. The client must have a DSM-IV (or successor) or ICD-9 CM (or successor) diagnosis of a mental illness.

   (Please note that a diagnosis alone is not sufficient justification for behavioral health services. The diagnosis must exist in conjunction with current acute or chronic signs and symptoms or current functional deficits that interfere with the consumer's ability to function in the community. ICD diagnosis codes require, for many mental health diagnoses, the addition of a 5th digit, which has clinical meaning re: acuity, chronicity, etc.)

2. The client must be an active participant in their care.
3. The client must have sufficient cognitive ability to benefit from the treatment prescribed.
4. Services must be:
   a. "*Preventive, diagnostic, therapeutic, rehabilitative and palliative interventions, provided for the symptoms, diagnosis and treatment of a particular disease or condition*."[4]
   b. Necessary to prevent the client from developing additional, prolonged or increased psychiatric symptomatology or impairment of function;
   c. Provided according to an individualized service plan;
   d. Be in the least restrictive setting that is available and safe;
   e. Developmentally appropriate for children services.

Medical Necessity and the Rehabilitation Model

As stated above, recovery-based service models with their rehabilitative focus also must meet *medical necessity* criteria if they are going to be billed to a third-party payer who covers rehabilitative services.

Federal Medicaid law defines a rehabilitative service as "*any medical or remedial services (provided in the facility, a home, or other setting), recommended by a physician or other licensed practitioner of the healing arts, within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level*." [6] *Medical necessity*, therefore, is not just based on diagnosis (with its attendant signs and symptoms) but also on functional criteria.

This federal definition is very compatible with the description of the Rehabilitation Model found in the IAPSRS[6] publication, *Best Practices in Psychosocial Rehabilitation*. This rehab model "*focuses on the functioning of the individual in the normal, day to day environment, and looks at the strengths and skills people bring to the rehabilitation process and supports in the community. Although an individual may still be symptomatic, the rehabilitation process helps a person learn ways to compensate for the effects of the mental illness through environmental supports and coping skills. The person with the mental illness becomes the expert in managing the disability*." [7]

Both the federal and IAPSRS definitions focus on improving the functioning of the individual. Both also make it clear that the services are directed toward keeping the client in the community setting and, therefore, contemplate the necessity for services to be provided in multiple settings in order to maximize benefit to the client.

In addition, the IAPSRS definition stresses the active participation of the client. The client must actively participate in the development of their individualized service plan and they must become the experts in their own recovery. IAPSRS is also specific about their expectations of client benefit, using a strengths-based model to promote:

- Greater functionality
- Independence
- Integration into their community and support network

The rehabilitation option model, therefore, uses a functional test as the base for a *medical necessity* determination for covered services, and then adds the generally accepted criteria of client benefit, client participation and individual planning that are the same hallmarks of the state's Medicaid definition.

What is clearly very important about the rehabilitation option and its coverage by Medicaid is the difference in the approach to services and the impact this has on the overall model of care. In particular, the rehabilitation option has moved the rehabilitation services out of the hospital or the acute residential setting and into the community. The broker-

age services, performed by case management in the former models of care, have morphed into community support services[8] with a focus on skill building, self-advocacy, and recovery in addition to some continuing brokerage services. For example:

Pre-rehabilitation Option

A case manager might accompany their client to many of their medical visits and act as both the client's advocate and their primary historian - the main action or a significant amount of the action taking place between the physician and the case manager.

Rehabilitation Option

The community support worker and the client would work together to make medical visits an independent function of the client. The client would become his/her own advocate and historian, and would work with the physician to manage his/her physical and mental health. There would be a multi-modal approach to developing this skill in a client, and skill building might range from travel training, to medication education, to the development of self-advocacy skills.

This change in focus also changes the filters under which the determination of *medical necessity* is made. Under the rehabilitation model of care Medicaid is looking for services that promote the independence of the client, not services that promote dependency. In the pre-rehabilitation model, a Provider might have been able to bill for a case manager to take a client grocery shopping on a weekly basis, month after month. That is no longer true, unless the Provider can describe to the payer's satisfaction why a particular client is unable to learn and perform that skill on his or her own, or why no other environmental and natural supports are available to substitute for the mental health system.

Medical Necessity and Recovery

Recovery-based models of care go even further than the rehabilitation option in the range of services and supports for clients.

Recovery is a holistic treatment process that deals with all aspects of a client's life. Under this model, the client becomes knowledgeable about his/her mental illness, works with other community and environmental supports toward self-defined realistic goals, and eventually manages his/her mental health. Mental health Providers support the client's efforts using their training, research and knowledge.

Some of the services included in a recovery model are **not** reimbursable under the Medicaid program's rehabilitation option, or under most third-party payers' benefit plans. Providers must be clear about which services:

- Do meet Medicaid criteria and, can be appropriately billed
- **Do not** meet Medicaid criteria and, therefore, must be funded by alternative sources. In particular, Providers should pay attention to state and federal regulations and service definitions about educational, vocational, recreational, social, and peer services.

In Ohio, Medicaid does cover a number of services that are the cornerstones of a recovery model of care. These services include community support and medical- somatic services.

The Ohio Department of Mental Health has been a vocal advocate of recovery models of care and has used its array of resources to support the development of these models. Medicaid is one of these resources that, with judicious use, can assist clients and Providers in making recovery programs possible.

Medical Necessity and Provider Documentation

One of the primary means for determining *medical necessity* is the review of the Provider's documentation, including; their assessment of the client, the subsequent Individualized Service Plan, and Progress Notes that sufficiently describe the interventions and the client's response to those interventions. Together, all of these documents make the initial

and continuing case for the *medical necessity* of the services being delivered and billed.

Documentation is a requirement of all payers, e.g. *". . . all Medicaid providers are required to keep such records as are necessary to establish medical necessity and to fully disclose the basis for the type, extent, and level of the services provided . . ."* [9]

In reviewing documentation for *medical necessity*, the reviewer looks for key elements in the documentation, such as the following:

1. Is there a diagnosis that meets payer criteria? Is there sufficient documentation in the initial assessment or additional diagnostic work that provides evidence that this is the correct diagnosis? Such as:

   - Symptoms and impact of the illness on the client's life

   - Diagnosis and prognosis

2. Is there an assessment of client functioning? Are there sufficient functional deficits or the threat of developing deficits to support the level of care ordered? Such as:

   - A description of the functional deficits the client is experiencing as a result of their mental illness that are preventing their realization of self-defined goals and objectives

3. Is there an Individualized Service Plan, signed by the appropriate Provider, for an array of services that are generally accepted as being appropriate for the diagnosis and functional level of the client? Such as:

   - A detailed description of the client's goals, including all life domains (e.g. mental health treatment, vocations, housing, etc.) that are related to identified needs

   - Agreed upon steps that need to be taken by the client with assistance of the mental health worker and others to address the barriers of the client

4. Are the services rendered in accordance with the Individualized Service Plan and with payer definitions? This includes services being:

   - Delivered by the appropriately credentialed Provider

   - Properly documented and consistent with the specified mental health treatment goals

5. Is there evidence of client participation? There are two issues here.

   First, the client must have the cognitive ability to be able to participate in treatment and to benefit from it.

   Second, the client must be willing to participate in treatment and, therefore, benefit from it. One significant exception to this is clients who cannot participate because they are moderately or severely mentally retarded, have a form of dementia, and/or are in treatment because they have been *committed to the board*. In these cases, *medical necessity* can still be met if the treatment prescribed can benefit the client and is not contraindicated because of the client's clinical picture.

   For example, most moderately retarded individuals cannot participate in the so-called "talking" treatments, but can benefit from psychotropic medications and medication management. Early Alzheimer's consumers may be able to benefit from talking therapies for depression and other mental illnesses until their disease has progressed to the point where there is no potential for therapeutic progress. In any case, where services are being provided that are not generally accepted as beneficial to a client with certain diagnoses, the practitioner should expect that auditors and payers will expect an explanation and will look for it in the clinical documentation.

6. Is there evidence that the client is actually benefiting from treatment? This is a critical issue in *medical necessity*. Services are medically necessary if they:

   - Are primarily for the purpose of preventing a client from deteriorating into greater dysfunc-

tion or more acute symptomatology. However, there must be evidence that the current level of care the client is receiving is responsible for preventing the client from deteriorating.

- Result in greater functionality and reduction of symptomatology, but again, the evidence has to be clear that the services are necessary for this to continue.

SOQIC Forms Support Medical Necessity

The SOQIC forms are an integrated toolset that is designed to:

- Facilitate the complete and accurate documentation of the client's condition, functional level and/or deficits, treatment goals, and level of care decision making.
- Provide linkage between the Diagnostic Assessment, the Individualized Service Plan and the Progress Notes, as well as the Diagnostic Assessment Update and Individualized Service Plan Revision/Review to demonstrate on-going progress and medical necessity.
- Contain cues to remind Providers to document client participation and benefit from treatment.

There are fields for Providers to date, code, and time stamp the interventions so they may be appropriately and accurately billed. The SOQIC forms also contain fields for all required signatures and credentials of individuals authorizing/recommending treatment and service plans.

Complying with Medical Necessity Linkages Requirements

(Note: Adapted with permission from Chapter Seven of *How to Deliver Accountable Care* written by David Lloyd, President of M.T.M. Services and published by the National Council of Community Behavioral Healthcare.)

Supporting the determination of *medical necessity* in clinical documentation requires a critically important documentation linkage process. The SOQIC forms have been specifically designed to facilitate the requirement to link:

- An identified assessed need at the conclusion of the Diagnostic Assessment, **to;**
- A Goal/Objective and Therapeutic Intervention in the Individualized Service Plan, **to;**
- The specific Goal(s)/Objective(s) addressed, the therapeutic intervention(s) provided, the client response and progress achieved as recorded in the Progress Note(s).

This *golden thread* between the Diagnostic Assessment, Individualized Service Plan (ISP) and Progress Notes **must** be present in clinical documentation to ensure qualitative compliance when billing Medicaid and Medicare.

A common focus of concerns/findings in a large number of qualitative audits for Medicaid and Medicare funded services has been the documentation model used by Provider Agencies. The model did not sufficiently support documentation for *ongoing* determination of necessity for the level of care, intensity, frequency and duration of the service(s) provided. This lack of *ongoing* documented support for medical necessity has been typically due to a *failure to link* the *services* being provided to an assessed need/treatment recommendation in the Diagnostic Assessment and a Goal(s)/Objective(s) in the ISP.

SOQIC Form Processes Link Services

Five major linkage processes have been designed into the SOQIC form documentation system to support compliance with qualitative reviews. These linkages are:

1. Diagnostic Assessment

Identifies Treatment Recommendations/

Assessed Needs

2. Diagnostic Assessment Updates
Identifies New Treatment Recommendations/ Assessed Needs

3. Individualized Service Plan
Links goals to specifically numbered Treatment Recommendations/Assessed Needs

4. Individualized Service Plan Revisions
Links goals to specifically numbered Treatment Recommendations/Assessed Needs and/or changes in Objectives, Therapeutic Interventions, Frequency, Duration and/or Responsible Type of Provider.

5. Progress Notes
Links interventions being delivered to specific Goal(s)/Objective(s) and identified client response and outcomes/progress towards Goal(s)/ Objective(s).

Each of these primary documentation processes have been designed to function in support of each other to ensure appropriate linkage between treatment recommendations/assessed needs and interventions being delivered by Providers. An outline of the primary linkage and support functions for each process follows.

Diagnostic Assessment and Medical Necessity Linkage Requirements

The Diagnostic Assessment must assimilate and establish a baseline measurement for client's **Symptoms, Behavior, and Skills/Abilities**, and document how they impact the client's ability to **function** in the community. **This then becomes the basis/justification for developing the Individualized Service Plan**. Also, it is important that all three areas (symptoms, behaviors and skills/ abilities) be assessed by the same clinician within the same assessment process to ensure that the Axis Five – Global Assessment of Functioning (GAF) score accurately represents the client's identified level of functioning.

Additionally, the Diagnostic Assessment provides an opportunity for the clinician to address with the client/family their preferences for specific clinic-based behavioral health services (therapy or medical-somatic) as well as rehabilitative community-based skills training services that the clinician, in collaboration with the client/family, agree are needed.

Finally, the Diagnostic Assessment provides an opportunity for the clinician to list the identified treatment recommendations/assessed needs of the client (based on assessment of all three areas - symptoms, behaviors and skills/abilities needs) as evidenced by information gathered in the Diagnostic Assessment that supports each assessed need (i.e., Anger management as evidenced by angry outbursts at spouse, parents, boss and co-workers).

The Treatment Recommendations/Assessed Needs section of the SOQIC Diagnostic Assessment and the Diagnostic Assessment (DA) Update forms is illustrated below in Figure 1.

Figure 1.

Treatment Recommendations / Assessed Needs	☐ No Additional Recommendations Clinically Indicated
1.	
2.	
3.	
4.	

Individual Service Plan and Medical Necessity Linkage Requirements

The Treatment Recommendations/Assessed Needs identified numerically (i.e., 1, 2, 3, etc.) and in priority order in the initial Diagnostic Assessment (as well as the DA Update, Crisis Intervention and Initial Psychiatric Evaluation) are linked to and become the core basis for each Goal in the Individualized Service Plan.

The Goal linkage section from the SOQIC Individualized Service Plan is shown below in Figure 2. As indicated, each numbered Goal in the ISP can be specifically linked to a numbered assessed Treatment Recommendation from the Initial Diagnostic Assessment, or DA Update, or Crisis Intervention Plan or Initial Psychiatric Evaluation. The *linkage occurs* by entering the Treatment Recommendation number and form date, and then checking the specific SOQIC form type adjacent to the specifically numbered Goal.

By establishing this link to the Treatment Recommendations/Assessed Needs from the Diagnostic Assessment, the ISP addresses client symptoms, and fully integrates all three assessed areas of symptoms, behaviors, and skills/abilities/needs into individual goals in the plan.

Figure 2.

Goal No.	Linked to Treatment Recommendation No._________ from form dated __________. ☐ DA ☐ DA Update ☐ Crisis Intervention Plan ☐ Psych Eval				
Start Date	Target Completion Date		Adjusted Target Date	Reason for Adjustment	
State Goal Below in Collaboration with Client					
Desired Results in Client's Words			Client has reviewed? ☐ Yes ☐ No	Client Agrees? ☐ Yes ☐ No	Client Initials

Structured Progress Notes and Medical Necessity Linkage Requirements

As the client continues in treatment, based on the strategies outlined in the ISP, he/she reveals/identifies additional personal information/experiences that enhance the original information recorded in the initial Diagnostic Assessment.

Progress notes are the primary tool to document the treatment strategies and progress. A critical linkage portion of the SOQIC Progress Note is the section entitled "New Issues Presented Today". This section accommodates the documenting of this new information and is illustrated below in Figure 3.

This section provides two check box indicators - "*None Reported*" and "*DA Update Required*," that are to be used as follows:

- If the client *does not* share any *new information/ issues* at the session being documented, check "None Reported" for this section of the Progress Note.
- If the client *shares new information/issues* during the session that are assessed by the clinician to **not** constitute a continuing treatment need, the clinician can record the information in this section of the Progress Note and not complete a DA Update.

Figure 3.

New Issue(s) Presented Today ☐ None Reported ☐ DA Update Required

Diagnostic Assessment Update and Medical Necessity Linkage Requirements

If the client shares new information/issues during the session *that were not included in the original Diagnostic Assessment, (or an earlier DA Update)*, and the clinician determines that the information shared *does* constitute a continuing treatment need, SOQIC documentation provides a process that preserves the linkage requirements using the following steps and forms:

Step One

Indicate on the **Progress Note** in the "New Issues Presented Today" section:

1. Client has self-reported new information
2. Check the "DA Update Required" box
3. Note that the new information has been recorded on a Diagnostic Assessment Update and indicate the date

Step Two

Record information/issues provided by the client on the **DA Update** by checking the appropriate data element(s) from the initial Diagnostic Assessment (or an earlier DA Update) in the "Diagnostic Assessment Sections" and write the data element title and the information shared by the client in the "Update Narrative" section of the form. Figure 4 shows the update indicators sections of the DA Update Form (For more information, please see Section Four of this manual to review a sample of the DA Update form).

By completing the narrative summary (*See bottom of Figure 4*) of the new information/issues provided by the client, the DA Update now provides support for identifying new Treatment Recommendations/Assessed Needs (*See Figure 5, next page*) based on this information.

Figure 4.

Diagnostic Assessment Update

Client Name (first, MI, last)		Client No.
☐ Annual Update ☐ Readmission ☐ Interim Update of New Information		Date of Most Recent Assessment

Diagnostic Assessment Sections

Check the box(es) next to the section(s) of the Assessment which you are updating. Be sure to label all additional/updated information in your narrative with the heading of the section of the Assessment being updated.

☐ Referral Source and Reason for Referral	☐ Friendship/Social Peer Support	☐ Current Medication Information
☐ Description of Problem	☐ Meaningful Activities	☐ Past Psychotropic Medications
☐ Family/Guardian Perceptions of Problems	☐ Community Supports/Self-Help Groups	☐ Legal History
☐ Living Situation	☐ Religion/Spirituality	☐ Alcohol Use/Drug History
☐ Primary Household	☐ Cultural/Ethnic/Information/Concerns	☐ AoD Treatment History
☐ Secondary Household	☐ Pertinent Developmental Issues	☐ Abuse History
☐ Custody and Parenting Plan	☐ School Functioning	☐ Problem Checklist
☐ Pertinent Family Plan	☐ Family Environment/Relationships	☐ Ohio Scales
☐ Strengths/Capabilities	☐ Employment	☐ Mental Status Summary
☐ Limitations of Activities Other	☐ Mental Health Treatment	☐ Other Information

Update Narrative: List each section being updated with narrative explanation below it.

Step Three

If these Treatment Recommendations/Assessed Needs are adequately addressed by the Treatment Recommendations/Assessed Needs as identified in the original Diagnostic Assessment or earlier DA Updates, check the box for "No Additional Recommendations Clinically Indicated" in the Treatment Recommendations section of the DA Update (*See Figure 5, below*).

The clinician will then need to determine if existing Goal(s) and Objective(s) address the newly identified recommendations/needs.

- If yes, then the clinician should go back to the Progress Note and check the appropriate Goal and Objective and provide the interventions ordered.

Step Four

If there is no existing Goal, Objective, Intervention, Service, frequency and provider type that will meet the client's newly identified Treatment Recommendations/Assessed Needs, then the clinician will need to link the newly assessed needs from the DA Update (*See Figure 5, below*) to an ISP Revision by checking the indicator in the "Change In ISP Required" field in the "For Annual or Interim Updates" section of the DA Update (*See Figure 6 below*).

Figure 5.

Treatment Recommendations/Assessed Needs	☐ No Additional Recommendations Clinically Indicated
1.	
2.	

Figure 6.

For Annual or Interim Uptdates
Change In ISP Required? ☐ No ☐ Yes (If yes, complete the ISP Revision/Review form to record needed changes in goal(s), objectives(s), interventions, services, frequency, and/or provider type.

ISP Revision/Review and Medical Necessity Linkage Requirements

Step Five

If the newly identified information that has been documented in the DA Update requires a change in the ISP, use the ISP Revision/Review form to update or modify the existing ISP which will preserve the linkage between newly assessed needs and any new therapeutic interventions (*See Figure 7, next page*).

If the intervention being provided in the service visit/session **is not linkable** to a specific Goal/Objective in an Individualized Service Plan (or ISP Revision), then it is not adequately ordered and therefore, **not reimbursable**. As a result, the use of an ISP Revision is essential to demonstrate:

1. Attainment of Goal and/or Objective that requires the development of additional Goal(s) or Objective(s).
2. Need to increase the Frequency and/or Duration of an ordered Service.
3. Need to modify or add therapeutic interventions in number or intensity.
4. Need to modify or add an ordered service.
5. Need to modify the type of responsible staff.

The SOQIC ISP Revision/Review form is a critical part of maintaining:

- A *medical necessity* linkage between the treatment recommendations/ assessed needs.
- Documentation that the interventions provided in the service visit/session are appropriately linked to a specific Goal(s)/Objective(s).

Figure 7, the revision/review section of the ISP Revision/Review form.

Purpose		Revision Date
☐ ISP Revision ☐ ISP Review ☐ Both		
Goal No.	☐ New Goal No. ☐ Same Goal No. ______ Revisions Below	☐ Revised Goal No. ______ Other:
Objectives		
☐ Objective revision under identified Goal No.________	☐ New objective revision under identified Goal No.________	
☐ Objective No. _______ discontinued under Goal No. _______	☐ Objective No. _______ under Goal No. _______ completed	
Interventions		
☐ Intervention revision under Objective No.________	☐ New intervention under Objective No.________	
☐ Intervention discontinued under Objective No. _______	☐ Intervention under Objective No. ________ completed	
Services		
☐ Service(s) revision under Objective No.________	☐ New service(s) under Objective No.________	
☐ Service(s) discontinued under Objective No. _______	☐ Completed service(s) under Objective No. ________ completed	
Provider Type		
☐ Provider revision under Objective No.________	☐ New provider under Objective No.________	
Other Agencies		
☐ Other agency revision	☐ New other agency(s) on second sheet	
Transfer/Discharge		
☐ Revision to transfer/discharge criteria	☐ Revision to level of care	

In addition to the link to newly assessed treatment recommendations/needs identified above, Progress Notes provide an opportunity for specific linkages between the therapeutic interventions provided in the service visit/session to the ISP and/or ISP Revision by *requiring that the specific Goal(s) and Objective(s)* being addressed in the service *be clearly identified within the note*.

In some cases, clinicians and trained others have indicated an inability to record the specific Goal(s) and Objective(s) addressed in the service visit/session in the Progress Note, because the Individualized Service Plan (ISP Revision) is not completed or unavailable. The practice of providing services without a plan beyond the "*thirty days after intake*" state standard and/or the inability to link the interventions provided to specific Goal(s) and Objective(s) **does not** meet qualitative review criteria for *medical necessity* linkage requirements.

The SOQIC forms provide specific, structured progress notes for individual counseling/ psychotherapy, group therapy, community support services, psychiatric services, nursing services, and partial hospital activities that have been designed to record specific elements of information on each note to support documentation linkage requirements.

Further Information on Diagnostic Assessment Updates In Medical Necessity Linkage Requirements

Typically in many local documentation models, new information provided by the client/family after the completion of the initial Diagnostic Assessment, has been historically recorded in a Progress Note. In this model, the Diagnostic Assessment became a historical document in the chart and not a current collective summary of assessed needs of symptoms, behaviors or skills/abilities identified by the client/ family. In many cases, the Progress Note has become the primary document in the chart, requiring staff to thoroughly read every Progress Note in the chart to learn what has been identified as assessed client needs.

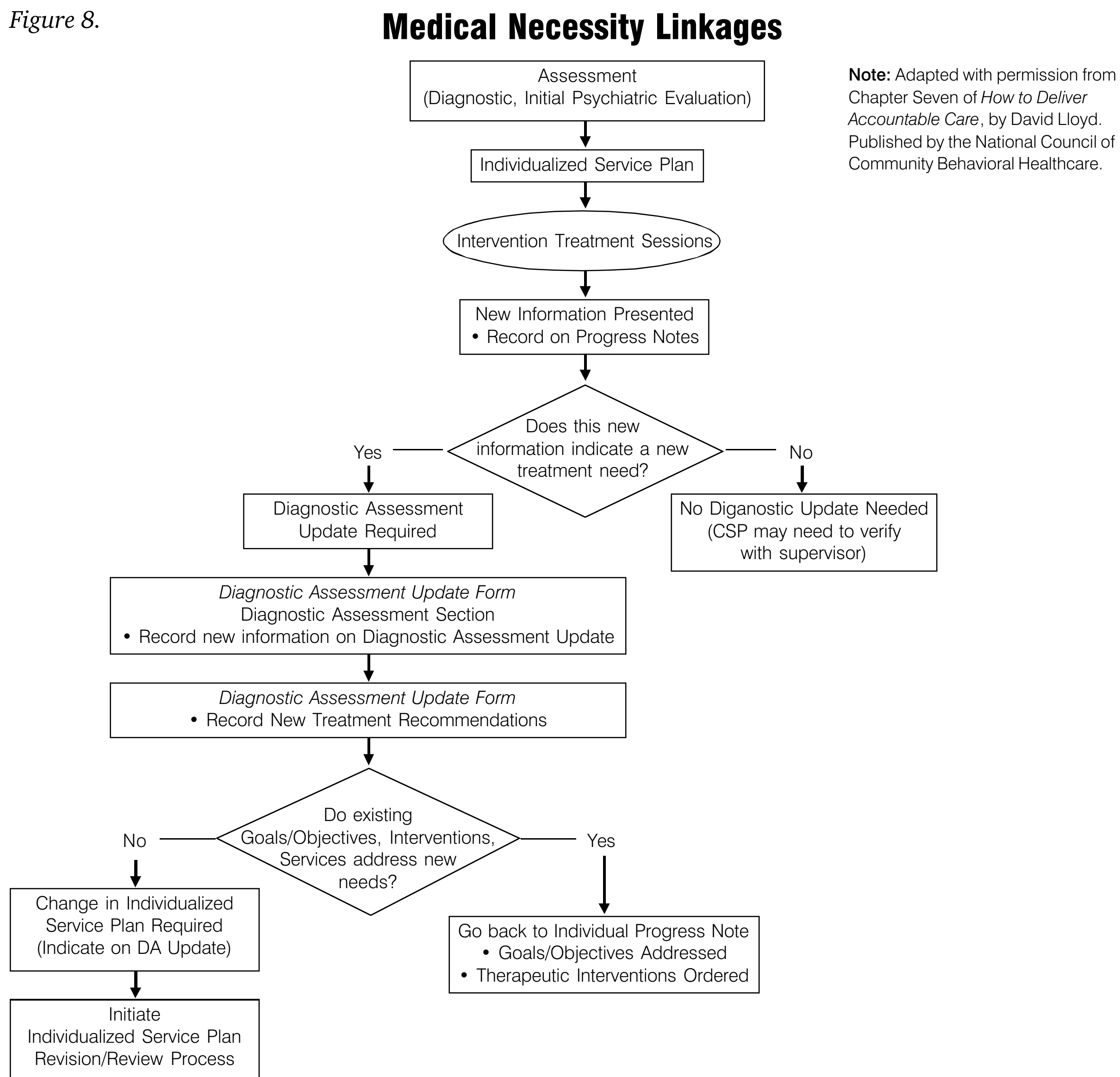
The SOQIC documentation process uses the DA Update form to provide a time-effective method to continuously update new Treatment Recommendations/Assessed Needs identified by the clinician after the initial Diagnostic Assessment is completed. By filing DA Updates in the charts in ascending date order, on top of the original Diagnostic Assessment, it will be easy for staff to quickly identify the assessed needs of the client.

The ongoing process for supporting *medical necessity* for services can best be provided through DA Updates that support the qualitative weight for the need to document the following on a continuing basis during treatment:

- Interim updates of newly assessed information provided by the client/family;
- A prioritized summary of assessed Treatment Recommendations/Needs; and
- If required, revisions to the ISP to link the Treatment Recommendations to an appropriate new Goal/Objective(s).

Figure 8 illustrates the linkages available in the SOQIC Form Process to document Medical Necessity on an ongoing basis.

Figure 8.



Signature Requirements: Authorizing/Recommending Treatment on Individualized Service Plans

Note: The information provided below is a summary of the signature requirements for authorizing/ recommending treatment on Individualized Service Plans. Please review local Provider Agency policy, procedures and practices to ensure that all areas identified in this section are being addressed on the local Provider Agency level. The differences in payer requirements make it very difficult for Providers to come up with a uniform policy and procedure that satisfies all payer requirements. This means that Providers may need to develop payer-specific policies, or use a universal conservative approach for obtaining appropriate signatures on treatment plans.

General Discussion Regarding Authorizing Services

It is critical for Providers to obtain appropriate signatures on all treatment plans. Appropriate signatures are required to:

- Meet certification standards by some payers.
- Certify *medical necessity* for other payers.
- Legitimately bill for services for most payers.

In general, payers for behavioral health services require that services be authorized/ recommended by appropriate Providers *who signify* their *agreement* with the authorization/recommendation *by signing* a treatment plan or some other document held in the medical record. By signing, the Provider certifies that the services as listed on the plan, or in the authorization, are medically necessary for the client and/or important to the client's recovery. This means that the Provider agrees that the services, as ordered:

- Constitute generally accepted practice for treating the diagnosis of the client.
- Reflect in intensity, and duration, the current status of the client.
- Are, in the opinion of the signatory, the most cost-effective, least intrusive and safest services for the client.

Given the weight that payers give to the treatment plan in making payment decisions, it apparent that payers are concerned with who has the credentials and experience to authorize or recommend a service plan.

Professional Credentials

Determining who needs to sign a treatment plan generally has to do with the issue of professional credentials. In general, payers agree that an individual who *cannot* either *provide or supervise* services according to state professional licensing laws *cannot authorize/ recommend* services. For example:

- The medical-somatic services of a physician/APRN listed on an ISP need the agreement of the physician/APRN that the services are appropriate and medically necessary. This agreement is documented by an order for the services, or on a service plan developed for the specific client.
- A physician can authorize/recommend nursing services, psychotherapy services, and rehabilitative services as their license allows them to either provide or supervise all of these services.
- An independently licensed psychologist cannot authorize/recommend or agree to medical-somatic services, but they can authorize/recommend psychotherapy, community support, partial hospital and other services that fall within the scope of their license.

The same logic holds true for other licensed practitioners of the healing arts (LPHA). *(NOTE: In Ohio, this term currently refers to Physicians, Psychologists, Nurses, LISW, LSW, PC, and PCC.)*

Ohio Medicaid Regulations

The Medicaid regulations in Ohio follow the model above and require the appropriately credentialed individuals to recommend and order **only** those services that they can provide or supervise. (*See OAC Section 5101:3-27-02[A]*.)

A treatment recommendation, or order, does not have to be on a treatment plan form. It can be located in a Progress Note or on another form within the medical record. However, even if it is located in a Progress Note, the content of the authorization/recommendation must meet regulatory requirements by including goal, objectives, recommended provider, therapeutic interventions and duration of services.

Using the Progress Note to document authorization/recommendation of medical- somatic services is *not* recommended. For those providers who choose to use the Progress Note to record medical somatic services, it's important to consider the following:

1. The authorization/recommendation must be able to be easily located within the medical record by an auditor to verify its existence. This includes both current and expired orders/treatment plans. Both internal and external auditors should be considered.
2. The authorizations/recommendations must be kept current in order for medical–somatic services to be billed.

Other Payer Requirements

Individual Provider Agencies are responsible for determining other payer requirements and for developing internal operational policy to meet those requirements.

Accrediting Body Standards

The accrediting body standards do not prescribe which types of credentialed providers are required to sign the treatment plan. See the *Documenting the Treatment Plan* section that follows.

Documenting the Treatment Plan

The SOQIC forms accommodate for alternative Provider practices for documenting treatment plans.

- The Individualized Service Plan form contains multiple signature lines for team members.
- The Psychiatric Evaluation and Progress Notes both have *Follow Up Plan* sections that can be used to document and confirm physician/APRN medical-somatic service plans, if the Provider chooses not to have a physician's signature on the ISP.
- The Psychiatric/Pharmacological Management Plan form can be used for clients who are receiving *only* physician/APRN and nursing services. This form was designed by SOQIC to eliminate the need to use the longer ISP form for these services.

Recommended Use of SOQIC Forms to Document the Treatment Plan

1. For clients receiving *only* psychiatric/pharmacological services, use *either* the:
   - SOQIC Psychiatric/Pharmacological Management Plan and have the form signed by the physician or Advanced Practice Nurse. This form provides a relatively quick and simple way to develop goals and objectives for a relatively stable client who is participating in just the one service category. The form also provides room to individualize the plan beyond the standard goals and objectives for this service.
   - Standard SOQIC Individualized Service Plan (ISP), and have the physician/APRN sign the form.
2. For clients whose services are being paid for by Ohio Medicaid, refer to the following chart to identify signature requirement possibilities. *(Note: For other payers, Provider Agencies should consult provider/billing manuals)*:

Clinical Scenarios		Signature Requirements
If psychiatric services are ordered/ authorized on the ISP along with psychotherapy/counseling and other rehabilitative services	The required signatures are	A physician's signauture only on the ISP **or** A physician's signature on a progress note specifically ordering services **and** A signature of a licensed practitioner of the healing arts (LPHA*) in which services fall within the scope of their license.
If psychotherapy/counseling or other rehabilitative services are ordered/ authorized on the ISP with **no** psychiatric services needed	The required signatures are	A signature of a licensed practitioner of the healing arts (LPHA) in which services fall within the scope of their license **or** A physician's signature.

*In Ohio, LPHA currently refers to a physician, psychologist, nurse, LISW, LSW, PCC, PC.

Compliance Grids

The Reasons for the Compliance Grids

One of the planned outcomes for the SOQIC Initiative was to ensure that completed clinical forms would allow a Provider to successfully meet the clinical documentation requirements of the major accreditors; JCAHO, CARF, and COA, as well as the documentation requirements of the major payers for community mental health services in the State of Ohio: Medicaid, ODMH, ODADAS, and Medicare.

Generally, clinical documentation is looked at by:

- **Accreditors** for evidence that agency policies and procedures related to documentation and clinical care of the client are being followed and are resulting in quality care and positive clinical outcomes.
- **Payers** to determine if the documentation justifies payment for the services provided, and if the clinical care described in the documentation meets their standards for service quality, which are embedded in their regulatory requirements.

Compliance Grids were developed by the Compliance Review Team (CRT) as a way to monitor development of the SOQIC clinical forms. The grids list every element on each form and identify which payers and/or accreditors require the information contained in that field for clinical documentation purposes. The Compliance Grids can be found in the Appendix of the SOQIC Training Manual.

(Note: The grids cite the standards available to the CRT from both payers and accreditors at the time of the publication of the grids in this manual - July 2004. The grids will be revised as standards are updated. Revised grids will be published on the SOQIC

website. Additionally, the CRT believes that the Medicare standards fairly represent the documentation requirements of many commercial payers who use Medicare's guidelines for their audit standards.)

Since Medicare has less specific standards or rules on documentation, the CRT team developed an alternative method to evaluate the forms for compliance purposes. This method was based on how the various fields on forms might be used, or valued, by a Medicare auditor in both individual payment decisions, and in fraud and abuse audits of providers.

This method assessed the following basic tenets of both payment and compliance with Medicare, using the following Medicare Evaluation Questions:

Question	**Rationale**
Does the documentation support the medical necessity for the treatment episode or for the particular service being provided?	The services must be medically necessary. This determination is made using both the original assessment documentation to determine if the episode of care was itself medically necessary, and all follow up progress notes, treatment plans, and diagnostic updates to show continuing evidence of the medical necessity.
Does the documentation support the requirement that the client and/or family be an active participant in their treatment?	The client /family must be able to, and must want to, actively participate in treatment. Medicare requires that clients/families voluntarily participate in their behavioral healthcare services and that they have both the cognitive ability and communication skills necessary to be able to actively participate in treatment. The *ability to communicate* standard does incorporate alternate methods, including interactive methods such as; play, interpreter services, communication boards.
Does the documentation support the requirement that the client be capable of benefiting from treatment?	The client must be able to benefit from treatment within a reasonable period of time. In behavioral health services, Medicare makes it clear that for some clients, benefit may consist of maintaining the client at their current functional level and preventing more restrictive environments and treatment. However, this is usually restricted to adults with severe and chronic forms of mental illness and to children with long-term, severe emotional disturbances.

How to Interpret Compliance Grids

The grids are intended as a tool to give Provider Agencies an understanding of the purpose of many of the fields on the SOQIC forms.

There is a grid for each SOQIC form with billable services (*See Appendix*). Each grid lists every field on the form and cites, if applicable, the particular regulation, rule or standard of Medicaid, ODMH, ODADAS, and/or the accreditors that applies to that field. (*Note: MCD/CARE = Medicaid/Medicare.*)

To use a compliance grid:

1. Locate the grid for the form you are interested in. The Form Name appears in upper left corner.
2. Read down the left side of the form to find the *Element* field.
3. Read across to find the citation in the *State payer's requirements* and the number of the *Accreditation issues*, if any.
4. Read the *MCD/CARE Requirements* section to determine if the field/element is a primary source (**P**) or supporting source (**s**).

   Primary source (**P**) is likely to be used by an auditor as a primary source of information to support medical necessity, active participation and/or client benefit.

   Secondary source (**s**) provides supporting information regarding medical necessity, active participation and/or client beneift.
5. Read the *Comments* relating to the field/element.

Compliance Grid for Ohio SOQIC Forms											
Group Progress Note											
								MCD/CARE Requirements			*Please note the issues of medical necessity/ participation and benefit are similar for both Federal and Ohio Medicaid as well as for Medicare.*
		State payer requirements			Accreditation Issues			This helps make the case for:			
		5101.3-27-	5122-27-06	3973:2-1-							
# on form		MEDICAID	DMH	ODADAS	JCAHO	COA	CARF	Medical Necessity	Client Participation	Client Benefit	Comments
1	Client Name (First, MI, Last):	Yes		06-F1	IM.6.20						All payers require that the client be identified. Also, National Accreditors all require sufficient identifying information. Best practice requires that the name or client number or both of the individual appear at the top of every page in case the record becomes dissassembled.
2	Client #:			06-F1	IM.6.20						Use of an ID number would allow the PHI to be de-identified as defined by HIPAA.
3	CSP/Counseling/Other/Client No Show or Cancel Checkboxes										Need for billing to identify service codes
4	Group Name				IM.6.20		3C4				For convenience of the clinician.
12	Response to Intervention/ Progress Towards Goals	02(D)7	(B)(3)	06-N5	IM.6.20		3C4	**P**	**s**	**P**	The payers expect that the therapeutic interventions described above will produce a response from the client. This response may be anywhere on the continuum from negative to neutral to positive. Auditors will look for a description of the response and its relationship to the progress of the individual towards their goals and objectives in all progress notes. The auditors do not expect that each intervention will result in tangible progress, but do expect that the clinet's reaction or response will be used to develop continuing strategy. OAC 5101:3-27-(D)(7) requires that the individual's response to the intervention be documented in the progress note.

References:

[1] Ohio Administrative Code, 5101:3-1-01.
Medicaid: medical necessity/general principles.

[2] Ibid.

[3] Ibid.

[4] Ohio Administrative Code, 5101:3-27-06.
Alcohol, drug addiction and mental health services board or community mental health board/mental health agency annual compliance and medical necessity documentation review.

[5] Social Security Act, Section 1905(a)(13).

[6] International Association of Psychosocial Rehabilitative Services

[7] Hughes, R. and Weinstein, D. eidtors, Best Practices in Psychosocial Rehabilitation, IAPSRS, 2000, p.42.

[8] Note: There is still, in some states, a smaller, very focused Targeted Case Management service included within the rehabilitation option. Targeted Case Management is not a service under the Ohio Medicaid Plan.

[9] Ohio Administrative Code, 5101:3-1-27.
Review of provider records.