


O.A.C. 5101:3-27-06
Training on Medicaid Compliance
and Medical Necessity
Documentation Reviews



Purpose of the Training

- Required by O.A.C. 5101:3-27-06 (K)
- To reinforce and clarify procedures for the completion of annual Community Medicaid Compliance Reviews.
- To reinforce and clarify procedures for the completion of annual Medical Necessity Documentation Reviews.

Applicable ODJFS Rules

- 5101:3-27-01 Eligible Provider
- 5101:3-27-02 Coverage and Limitations of Medicaid Community Mental Health Services
- 5101:3-27-05 Rate Setting
- 5101:3-27-06 Annual Compliance Reviews
- 5101:3-27-07 Cost Reconciliation

5101:3-27-02 “Coverage and Limitations of Medicaid Community Mental Health Services”

- Referenced rule combines rules 5101:3-27-02 and 5101:3-27-03. The rule defines the six Medicaid reimbursed services and references the appropriate ODMH certification standards. They are as follow: mental health assessment, behavioral health counseling, pharmacologic management, partial hospitalization, crisis intervention and CPST services.
- There are additional requirements for partial hospitalization and community psychiatric supportive treatment (CPST formerly CSP) services.

5101:3-27-02 Partial Hospitalization Requirements

- Partial hospitalization services provided in social, recreational and/or educational **settings (internal or external to the partial hospitalization site)** are allowable only if there are documented mental health interventions that address the specific individualized mental health treatment needs as identified in the Individual Service Plan (ISP) of the person being served.

5101:3-27-02 Partial Hospitalization Requirements

- Is not intended to encourage services in social settings.
- Social/recreational activities are not eligible to be included in the partial hospitalization day.
- When the budget goes through, the Revised Code will no longer indicate the three hour provision for Medicaid billing. It will defer to the certification statute which indicates 2-7 hours of partial hospitalization.

5101:3-27-02 Partial Hospitalization Requirements

- Partial hospitalization services include activity therapies, group activities, or other services and programs which are designed to enhance skills needed for living in the least restrictive environment are allowable.
- Paragraph (H) (7) provides examples of unallowable services;
 - Crafts;
 - General non-therapeutic art projects;
 - Recreational Outings purely for recreational purposes; and
 - Exercise groups.

5101:3-27-02 CPST Requirements

- Defines some unallowable services;
- Allows services in social, recreational, or educational **settings only** if the intervention addresses the **specific individualized mental health** treatment needs that are identified in the client's ISP.
 - Transportation in and of itself is unallowable;
 - Vocational job training activities are unallowable.

5101:3-27-02 CPST Requirements

- A billable unit of service for CPST service may include either face-to-face, telephone contact, or video conferencing between the mental health professional and the client or an individual essential to the mental health treatment of the client.

5101:3-27-02 CPST Requirements (Cont.)

- Consultation between staff in a multi-service agency is not a billable CPST unit of service when the client is not present. The following exceptions to this rule apply:
- The consultation occurs between the CPST worker and the staff of a distinct residential treatment program; and/or
- The consultation occurs between the CPST worker and the staff of a distinct partial hospitalization program; and
- The CPST services are not time limited or site specific.

5101:3-27-02 Documentation Requirements

All Medicaid community mental health services must be documented in the individual client record and clearly relate to the mental health assessment, crisis assessment, individual service plan or psychiatric diagnostic interview.

Such documentation shall include:

- The date of the service contact; and
- The time of day of the service contact; and
- The duration of the service contact; and
- The signature and discipline of the provider of the service and the date of the signature; and

5101:3-27-02 Documentation Requirements (Cont.)

- The description of the activities of the service (*What was occurring during the intervention*); and
- The therapeutic interventions, as defined in rule 5122-24-01 of the Ohio Administrative Code, rendered by the provider (*How did the clinician use his/her training in addressing the mental health needs of the client*); and

5101:3-27-02 Documentation Requirements (Cont.)

- The behavior and the response to the intervention of the person served. (*How did the client respond to the intervention? Did the client express or display any insights into the treatment process or did the client response to the intervention provide the clinician any insights into the treatment process and next steps?*)

5101:3-27-02 Billable Services

For the purposes of Medicaid Community Mental Health services, a billable unit of service is defined as the following:

✓ **A face-to-face contact between a client and a professional authorized to provide Medicaid reimbursable services; or**

5101:3-27-02 Billable Services (Cont.)

- ✓ A face-to-face contact with family members, parent, guardian and/or significant other as defined in rule 5122-24-01 of the Administrative Code for children or adolescents receiving behavioral health counseling and therapy, pharmacologic management, mental health assessment, or crisis intervention

5101:3-27-02 Billable Services (Cont.)

- ✓ A face-to-face contact with family members or significant others of adults receiving crisis intervention mental health services, when the purpose of the contact is directed to the exclusive benefit of the Medicaid eligible beneficiary; or

5101:3-27-02 Billable Services (Cont.)

- ✓ Community Psychiatric support treatment interventions provided to individuals other than the client as allowed in paragraphs (A) (6) (b) and (A) (6) (c) of this rule; or
- ✓ Services rendered via interactive video conferencing as described in rules 5122-29-03 and 5122-29-05 of the Administrative Code.

5101:3-27-02 Definition of billable units

- All Medicaid community mental health services are to be billed on a unit rate basis in accordance with definitions, standards and eligible providers of service requirements as set forth in Chapter 5101:3-27 of the Administrative Code.

5101:3-27-02 Non Billable Services

- Community meetings or group sessions that are not designed to provide specific mental health treatment services to clients. Some examples include: orientation sessions for new clients, mental health presentations to community groups, etc.


5101:3-27-02 Non Billable Services

- Monitoring clients while they are sleeping.
- Observing clients when not performing a therapeutic intervention (e.g., client is watching television, resting, eating, etc.)
- Transportation in and of itself.
- Vocational job training activities, e.g., job shadowing, job coaching, teaching computer skills, math skills, or other trade skills.

5101:3-27-02 Non Billable Services

- Unallowable partial hospitalization activities include, crafts, general non-therapeutic art projects, recreational outings purely for recreational activities, exercise groups, etc.
- Other than consultation authorized in paragraph (A) (6) (c) of this rule, consultation between staff of the same agency without the client present is not reimbursable.

O.A.C 5101:3-27-06
ADAMH/CMH Board/Mental Health
Agency Annual Compliance and
Medical Necessity Documentation
Reviews



O.A.C. 5101:3-27-06

The two primary components of this Rule include:

1. The Community Medicaid Compliance Review, and
2. The Medical Necessity Documentation Review, (MNDR)

Definitions

- “Medically necessary mental health services” refer to those mental health services, including but not limited to preventive, diagnostic, therapeutic, rehabilitative and palliative interventions, provided for the symptoms, diagnosis and treatment of a particular disease or condition.

Definitions continued

- “Medical necessity documentation review” means the retrospective review of community mental health Medicaid services to assure that clinical documentation exists in such cases and are related to the definition of medical necessity.

5101:3-27-06 Purpose of the Rule

- Set forth the duties and responsibilities of mental health boards to conduct annual Medicaid Compliance Reviews on each provider agency that has a Medicaid agreement with the Board;
- To establish minimum service compliance criteria which must be met in order for the provider agency to retain a Medicaid agreement.

5101:3-27-06 Purpose of the Rule (Cont.)

- To establish requirements ODMH and Boards must follow prior to a Medicaid agreement being terminated by ODMH for a provider agency that fails to meet minimum compliance requirements; and
- To establish requirements for Medical Necessity Documentation Review procedures.

5101:3-27-06 Applicability

The provisions of this Rule are applicable to each Board and Mental Health Agency participating in the ODMH Community Mental Health Medicaid Program described in Chapter 5101:3-27 of the Administrative Code and are applicable only to those services funded through that program.

General requirements

- The Board shall review annually a number of client records for those individuals who have received services reimbursed through the community mental health Medicaid program during the state fiscal year to assure that minimum service compliance and medical necessity documentation review criteria are met.

General requirements (Cont.)

- The Board shall review the number of cases required by this Rule of residents of its service district in each agency holding a Medicaid agreement with the Board, except for agencies identified by ODMH as serving a large number of residents outside the Board service districts in which the agencies are located.

General requirements (Cont.)

- For each of those specially designated agencies, the Board which has the Medicaid agreement shall conduct the review. In circumstances where the agency has Medicaid agreements with more than one Board, the Board which has the largest number of Board residents receiving services from the agency shall conduct the review.

Sample Size

- “Annual Review Period” is defined as the 365 day period concluding one month prior to the Review date.
- Boards need to determine how many of the Agency’s Medicaid clients received Medicaid services during the Annual Review Period.
- For the purposes of determining the sample size, exclude out of county Medicaid recipients.

Sample Size (Cont.)

- No agency which provides Medicaid services to fewer than 10 clients during the annual review period shall be reviewed.
- Once the number of Medicaid recipients is known, refer to the matrix for the sample size.

Sample Size Selection Matrix

Number of agency clients receiving Medicaid services	Total number of cases selected	High cost cases	Randomly selected cases
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10 to 99

10

5

5

100 to 499

20

10

10

500 to 999

30

15

15

1,000 to 1,999

50

25

25

2,000 and above

70

35

35

Case Selection Process

- Rank clients from highest to lowest Medicaid service cost.
- Select the appropriate number of high cost clients for the first review sample.
- Randomly select the appropriate number of cases from the remaining client records for review.
 - This assures that all records have the possibility of being reviewed.

Out of County Agencies

- ODMH will identify agencies serving a large number of residents outside the Board service districts.
- For these agencies, the Board with the largest number of residents receiving services from the agency will conduct the review.
- Boards may wish to conduct joint reviews with other Boards depending on Medicaid contract and the total number of clients receiving services.

Medicaid Review Sample

- The Compliance Review should be done on at least two weeks of service billings from at least one service category for each case selected.
- The Board shall assure that all service categories contained in the Agency's Medicaid agreement are represented in the review across all cases.

Medicaid Review Sample

The Medicaid Compliance Review shall determine that:

1. The clinical records contain individualized service plans for cases with five sessions or within one month of admission, whichever is longer.
2. The services were provided by individuals meeting the eligibility criteria as defined in Chapter 5122-29 of the Administrative Code.
3. The services were clinically supervised by individuals meeting the supervision criteria as defined in Chapter 5122-29.

Medicaid Compliance Review

4. The billing did not contain any time discrepancies (e.g., overlapping service times billed to Medicaid by the provider, etc)
5. The documented activity of the service is consistent with the service definition contained in rule 5101:3-27-02.
6. There is evidence of progress note documentation of the billed service.

Next Steps

- Following the Medicaid compliance review, the Board shall accomplish the following:
- For all clinical records where there is no ISP present, the Board shall seek recovery of funds for all reimbursed Medicaid services provided to the individual during the period in which this criterion was not met.

Next Steps (Cont.)

- For all non-compliant claims in paragraphs (E) (2) (c) through (E) (2) (f) of this rule, the Board shall seek recovery of funds for all ineligible reviewed claims.
- For cases when a Board finds that a Medicaid service was provided by a person not meeting the eligibility criteria, the Board shall seek recovery of all funds for those ineligible services provided by that person during the period of the review.

Next Steps (Cont.)

- For all non-compliant claims in paragraph (E) (2) (d) of this rule, the Board shall seek recovery of funds for any over-billing. For example, if an agency bills for one hour, and there is documentation for half an hour, the Board shall seek repayment for half of the claim.

Next Steps (Cont.)

- The Board shall notify ODMH if there are duplicate billings in any of the claims reviewed. A duplicate billing is defined as two or more Medicaid claims which have been reimbursed by Medicaid for the services delivered to the same individual at the same time on the same day.
- The Board shall notify ODMH if there is evidence that an entire service (or majority of service) is not compliant with the criteria contained in rule 5101:3-27:02.

Compliance Thresholds

A Board must notify ODMH if the agency fails to meet any of the following compliance thresholds:

- Evidence of ISPs in at least 90% of the clinical records reviewed.
- Evidence of eligible providers in at least 95% of the claim lines, (i.e. service contacts that were reviewed).

Compliance Thresholds (Cont.)

- Evidence of eligible clinical supervision in at least 90% of the claim lines, (i.e. service contacts that were reviewed).
- Evidence that the duration of the service noted in the progress note is the same as the amount billed in at least 85% of the claim lines (i.e. service contacts) that were reviewed.

Compliance Thresholds (Cont.)

- Evidence of progress note documentation in at least 95% of the claim (i.e. service contacts) lines reviewed.
- The documented activity of the billed service must be compliant with the criteria contained in Chapter 5101:3-27 (Certification Standards) in at least 90% of the claim lines (i.e. service contacts) reviewed.

Consequences of not Meeting Compliance Thresholds

- ODMH shall conduct a follow-up focused review of an agency if it has verified that any of the compliance thresholds are not met. Prior to the follow-up review ODMH shall provide written notification to an agency that it has been placed on focused review. A copy of this notice will be provided to the Board.

Consequences of not Meeting Compliance Thresholds

- Agencies placed on focused review must submit a plan of correction to ODMH and the Board for review and approval by ODMH within thirty days of notification of being placed on focused review. ODMH shall provide the agency with written approval or disapproval of the plan of correction within thirty days of receiving the agency's proposed plan of correction. ODMH shall provide the Board with a copy of its approval or disapproval. The Medicaid agreement will be retained during this time period.

Consequences of not Meeting Compliance Thresholds

- ODMH will schedule a follow-up compliance review not later than six months following Departmental approval of the plan of correction to determine whether or not the agency now meets the thresholds.
- If the results of this review demonstrates that the agency again fails to meet the compliance thresholds, ODMH will terminate the Medicaid agreement for a minimum of one year.

Consequences of not Meeting Compliance Thresholds

- If the follow-up focused review identifies additional ineligible billings as defined in paragraph (E) (2) of this rule, an additional recovery of funds as defined in the aforementioned paragraph must be implemented by the Board.

Medicaid Compliance Review Instruments

Medicaid Compliance Review

- Worksheet 1 (Service Contacts by Individual)
 - For Boards working papers only
 - Do not submit to ODMH
- Worksheet 2 (Agency Summary)
 - Submit to ODMH by October 1
- Worksheet 3 (Board Summary)
 - Submit to ODMH by October 1

O.A.C 5101:3-27-06

**Medical Necessity
Documentation Review (MNDR)
Process**

MNDR

Topics to be Covered

- MNDR
 - Medical Necessity Documentation Review
- Purpose
- Licensing Requirements
- Scope
- Recovery of funds
- Review of data collection tools
- Reports

Purpose

A “Medical Necessity Documentation Review” means the retrospective review of Community Mental Health Medicaid services to assure that clinical **documentation** exists in such cases and are related to the definition of Medical Necessity as described in Paragraph C (3) of this Rule.

This review does **not** evaluate clinical judgment or treatment decisions.

Who can perform these reviews?

- Medical Doctors
- Doctors of Osteopathy
- Psychologists
- Licensed Independent Social Workers
- Licensed Social Workers
- Licensed Professional Clinical Counselors
- Licensed Professional Counselors
- Registered Nurses
- Certified Utilization Review/Management Specialists

Additional Requirement

In addition to those aforementioned staff who can perform the MNDR reviews, staff must have also received training as referenced in paragraph (E) (2) (i) of this rule and must possess a certificate of such training issued by ODMH

MNDR Required Elements

A review of medical necessity will be operationalized through a review of the clinical record, which must contain the following elements:

1. Documentation that the consumer has participated in the development of the ISP;
2. Documentation of a DSM IV or ICD 9, or their successor diagnosis codes;
3. A description of symptoms;
4. A description of the client's condition/ functioning;

MNDR Required Elements (Cont.)

5. Interventions for each service goal;
6. An Individualized Service Plan that addresses the client's symptoms;
7. Stated outcomes for service goals;
8. Documentation of consideration of a least restrictive setting appropriate to the needs of the client;

MNDR Required Elements (Cont.)

9. Service interventions addressing identified developmental needs for children and adolescents are documented; and
10. Documentation that family has been involved for children and adolescents when the service plan describes need for family involvement or a description as to why the family is not participating as expected.

Recovery of Funds

With respect to MNDR, the Board shall seek recovery of funds for all reimbursed Medicaid services provided in the period of the review in all of the following circumstances:

- ❑ There is no documentation that the consumer has participated in the development of the ISP as indicated by a signature or a progress note or an explanation of why the consumer did not participate.

Recovery of Funds (Cont.)

- ❑ There is no documentation of a diagnosis code;
- ❑ There is no description of symptoms;
- ❑ There is no description of the client's condition/functioning;
- ❑ There is no documentation of interventions for each service goal;

Recovery of Funds (Cont.)

- ❑ There is no documentation that the ISP addresses the client symptoms;
- ❑ There are no stated outcomes for service goals;
- ❑ There is no documentation of consideration of a least restrictive setting appropriate to the needs of the client.

Recovery of Funds (Cont.)

- ❑ That service interventions addressing identified developmental needs for children and adolescents have not been documented when such needs have been identified in the ISP; and
- ❑ There is no documentation that family has been involved for children and adolescents when the ISP describes the need for family involvement (or there is no description as to why the family is not participating as expected).

Follow-up

- The Board must issue a draft report of findings to the agency within 15 working days of the review.
- The agency has the opportunity to respond in writing within 14 days of receiving the report.
- The response should include information that supports the agency's position. The Board shall amend its draft report if it concurs with the agency's response.

Follow-up (Cont.)

- If the Board does not concur with the agency's objections, the Board shall include in its final report each of the agency's objections and the basis upon which the Board made its decision not to accept the agency's objections.
- When the Board provides the agency with its final report, the Board shall also submit a copy to ODMH and shall also provide to the appropriate Board a copy of any report containing findings for recovery of funds from a specially designated agency which serves residents of other Board service districts.

Appeal Process

- Agencies can appeal to ODMH after the final report by providing written notice to the Deputy Director for Administrative Services.
- Agencies can appeal:
 - any finding in the final report.
 - any proposed or actual adverse determination as a result of Board's compliance or medical necessity documentation review activities.

Appeal Process

- Appeal of findings related to Medical Necessity Documentation Review will be reviewed by a licensed psychiatrist arranged by ODMH.
- Recovery of funds will not occur until all appeals have been concluded.

Review and Data Collection Instruments

All Boards must utilize the checklist that is attached or a version that reflects the same information and general format

Review and Data Collection Instruments

For performance improvement purposes,
Boards may add additional comments related
to the reviewed components;

however,

the contents of the attached summary form is
the only information that is required to be
submitted to ODMH

Medicaid MNDR Review Instruments

MNDR

- Section A “Determination for the Recovery of Funds”
 - Boards retain as working papers
 - Check only one box per element
 - A checked second box results in a recovery of funds

MNDR Checklist

Description of the Client's Symptoms

_____ Description of the client's symptoms
is in the record

_____ **NO** description of the client's symptoms
is contained in the record

MNDR Checklist

Description of the Client's Condition/Functioning

_____ Description of the client's
Condition/Functioning is in the record

_____ **NO** description of the client's
Condition/Functioning is contained in the record

MNDR Checklist

Least Restrictive Setting

_____ Documentation contains consideration of a least restrictive setting appropriate to the needs of the client

_____ Documentation contains no reference of a least restrictive setting

Note: This category applies only to clients residing in facilities where mental health care is provided, and recovery of funds only applies to Medicaid Services provided by the agency.

MNDR Checklist

Diagnosis Codes

_____ Documentation contains DSM IV or ICD-9, or their successor, diagnosis code(s)

_____ Documentation does not contain DSM IV or ICD-9, or their successor, diagnosis code(s)

MNDR Checklist

ISP Addresses the Client's Symptoms

____ ISP addresses the client's symptoms

____ ISP does **not** address the client's symptoms

MNDR Checklist

Documentation of Intervention(s) for each service goal

_____ The record contains documentation of interventions for each service goal

_____ The record does **not** contain documentation of interventions for each service goal

MNDR Checklist

Documented Outcomes for Service Goals

_____ The record contains stated outcome(s)
for service goals

_____ The record does not contain stated
outcome(s) for service goals

MNDR Checklist

Client Participation in the Development of the ISP

The record contains at least one of the following:

- 1) Client, or other authorized person's signature on the ISP indicating participation in the development of the ISP, or
- 2) Progress note indicating client or other authorized person's signature on the ISP indicating participation in the development of the ISP, or
- 3) An explanation of why the client or other authorized person did not participate in the development of the ISP.

MNDR Checklist

Client Participation in the Development of the ISP

The record does **not** contain at least one of the following:

- 1) Client, or other authorized person's signature on the ISP indicating participation in the development of the ISP, or
- 2) Progress note indicating client or other authorized person's signature on the ISP indicating participation in the development of the ISP, or
- 3) An explanation of why the client or other authorized person did not participate in the development of the ISP.

MNDR Checklist

Service Interventions for Children/Adolescents

___ Interventions addressing the **identified** developmental needs for children and adolescents, as specified in the ISP are documented

___ Interventions addressing the **identified** developmental needs for children and adolescents, as specified in the ISP are **not** documented

MNDR Checklist

Involvement of Family for Children/Adolescents

- ___ Record contains documentation that the family has been involved for children and adolescents when the ISP describes the need for family involvement, or there is a description of why the family is not participating as expected
- ___ Record does **not** contain documentation that the family has been involved for children and adolescents when the ISP describes the need for family involvement, or there is a description of why the family is not participating as expected

Medicaid MNDR Review Instruments

MNDR

- Section B “Quality Improvement”
 - Only to be used for quality improvement purposes
 - Not a component of the formal report
 - Do not submit to ODMH

MNDR Checklist

Section B: Quality Improvement

- Pertains to quality improvement opportunities only
- Does not relate to a recovery of funds
- The data from this section will only be used to determine system wide QI initiatives

MNDR Checklist

Section B: Quality Improvement

Example

Description of the client's symptoms

___ Description of symptoms is contained in the record, but quality improvement is indicated.

Comments:

Medicaid MNDR Review Instruments

MNDR

- Medical Necessity Documentation Summary Report
- Boards should complete and submit to ODMH when report is finalized

Recovery of Funds

With respect to Medical Necessity Documentation Review, the Board shall seek recovery of funds for all reimbursed Medicaid services provided in the period of the review if any of the ten elements of the MNDR are not met.

Recovery of Funds

- Boards must reverse claims determined to be ineligible using the Medicaid Claim Correction Process Within MACSIS. When the reversal is reported on the 835 (Health Claim Payment Advice) to the agency, the amount is deducted from the check to the agency for that claim.
- Use Reversal Reason code MCDUN, Claim Adjusted Following MH Compliance Review.
- The reversal will be reported on the Agency's 835 (HCPA).

Recovery of Funds

- ODMH will distribute quarterly reports of the reversals to the Boards. Boards are required to submit a check for the total amount of reversals for their Board to ODMH.
- ODMH will deduct the amounts of the checks on the request for payment from ODJFS.

Timelines to Begin the Reversal Process

- If an appeal is filed, the reversal/recovery of funds process is suspended pending the outcome of the appeal.
- ODMH will notify the Board if an appeal is filed.
- Boards should begin the reversal process after all appeals have been finalized.
- If no appeal is filed, Boards should begin the reversal process 30 days after the final report has been issued.

QUESTIONS

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and

ANSWERS