ILLINOIS
MENTAL HEALTH COLLABORATIVE
FOR ACCESS AND CHOICE

Technical Assistance for Clinical Documentation

August 11, 2016

Presenters

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Goals for Today

- Understand roles and responsibilities
- Understand Rule 132 documentation requirements
- Learn what resources are available to you for further questions and support

The Role and Responsibility of DHS/DMH Specific to Provider Monitoring

- Ensure that community mental health services comply with federal and state statutes and regulations
- Ensure that services meet standards of quality
- Ensure prudent stewardship of taxpayer dollars
- Establish all policies and procedures related to monitoring

The Role and Responsibility of the Collaborative Quality Management Department

- A department within Beacon Health Options / Illinois Mental Health Collaborative for Access and Choice

- The Quality Management department provides administration of DHS/DMH provider monitoring priorities:
  - Completes provider monitoring functions by clinically licensed staff
  - Communicates with providers, both pre- and post-monitoring visits
  - Provides trainings, as requested by DHS/DMH

The Role and Responsibility of Providers Pertaining to Clinical Documentation

- Read, understand and comply with Rule 132
- Become familiar with the monitoring tools
- Ask questions, as needed, to DHS/DMH Regional staff
- Read notices and letters completely
- Grant access and make requested records available
- Void unsubstantiated claims in the required time frame

Determining Medical Necessity

An LPHA must document consideration of the following factors:

- The definition of medical necessity in Rule 132 (132.25)
  - Diagnosis (or at least 2 criteria if under 21)
  - Impairment of role functioning due to symptoms of mental illness.
  - In need of at least one service to stabilize /restore/ rehabilitate to maximum level of functioning
- The type, severity and chronicity of the person's symptoms
- The severity of impairment in the person's role functioning

Determining Medical Necessity

- The risks that a person's symptoms or level of role functioning pose to the safety of the person or to others with whom the person interacts

- The expected short-term and long-term outcome of each service needed by the person

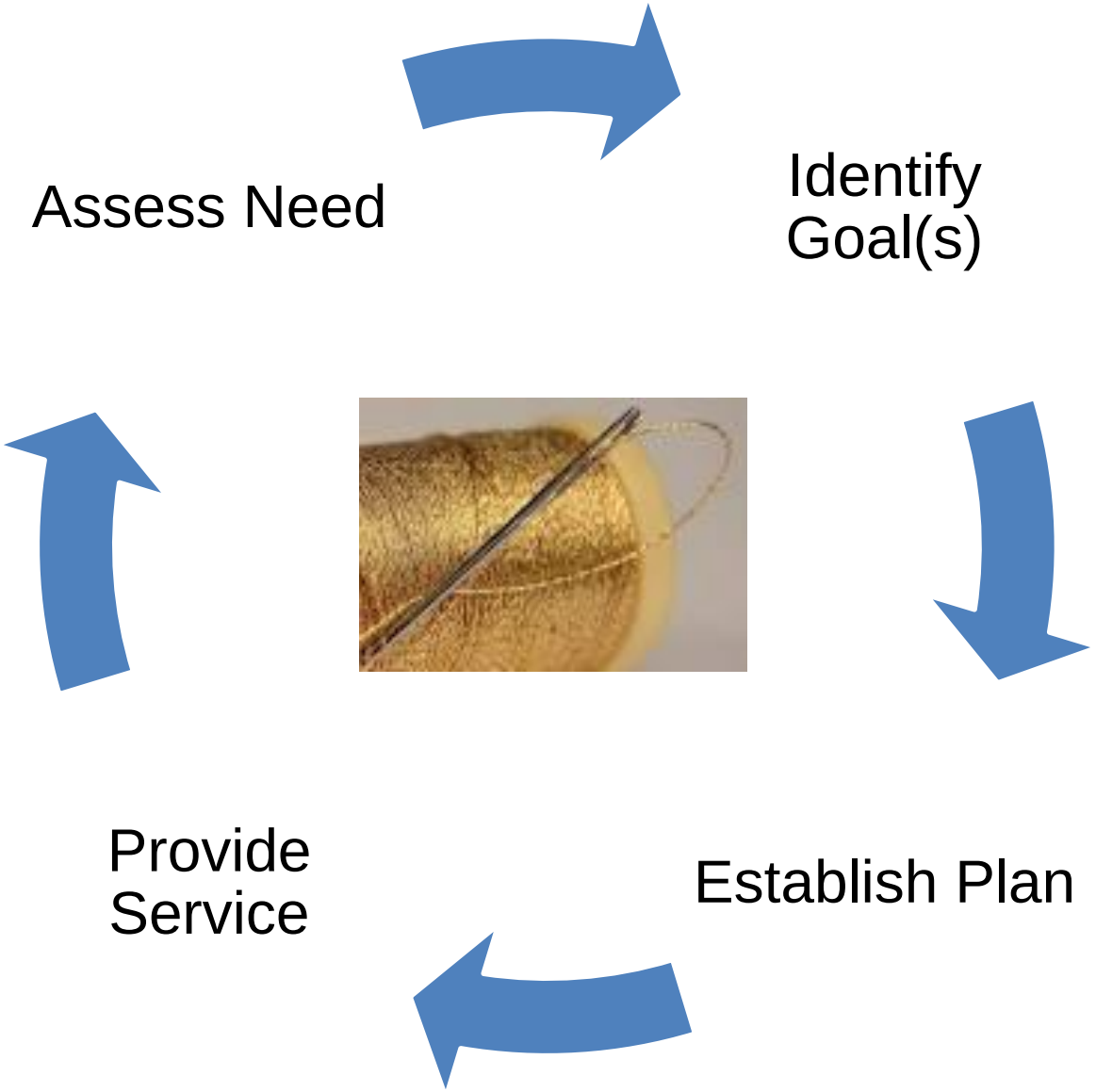
- Progress made in response to treatment, if the person is currently receiving treatment

- Criteria or guidance published by the public payer for the purposes of defining and evaluating the medical necessity of each service. 132.145 (b) (1-7)

Determining Medical Necessity

When an LPHA signs a mental health assessment and a treatment plan, the LPHA is affirming that s/he has considered these seven factors and believes that all treatment recommendations contained therein are medically necessary for the individual. 132.145 (b) (1-7)

The Golden Thread



Beginning the Golden Thread: Assessment

Mental Health Assessment (MHA) is a Rule 132 service that results in a Mental Health Assessment Report.

This is where the clinician documents the assessed needs of the individual and begins to make the case for medical necessity for specific Rule 132 services.

Complete details on all areas which must be considered are detailed at 132.148 (a).

The Golden Thread Continued: Identify Goals and Develop Plan

- Active involvement of the individual served along with the clinician
- Determine the goals to be achieved and to develop the plan for treatment.
- Clinician's opportunity to document the short and long term expectations of treatment, as well as the interventions that are medically necessary.

Full requirements for treatment plan development, review and modification are listed at 132.148 (c).

Goals vs. Objectives

- Goal:

  The individual's expected outcome from services.

- Objectives:

  Steps identified through discussion between the individual and the clinician that will assist the individual in attaining the goal.

Community Support Individual vs. Case Management Mental Health

Community Support Individual

Doing **with** individual and/or family; demonstrating, teaching, practicing, role play (see Rule 132.150 (e))

- Example: Assisting the individual with identifying his/her interests/hobbies

Case Management – Mental Health

Doing **for** the individual; linking, referring, identifying resources, making appointments (see Rule 132.165 (a))

- Example: Helping consumer gain access to public entitlements and additional resources **outside** of the agency.

Following the Golden Thread: Service Provision

In documenting services, the clinician must clearly link each service provided back to the interventions on the treatment plan, which are connected to the assessed needs.

MHA Updates

- Updates are required annually, from the date of the LPHA original signature on the most recent MHA.
- The purpose is to identify any changes that may have occurred in the individual's life, along with documenting the current needs of the individual.

Sufficiently Making the Case for Medical Necessity – The ITP Review

- Thorough review of the ITP is required
- Consideration must be given to progress towards each goal
- Well written objectives
- Measure progress
- Assess the efficacy of current services
- Identify necessary changes in interventions
- The “no change” red flag

Questions so far?

Case Study: Betty Doe
Information Gathered for the MHA

- Betty Doe is a 56-year-old Caucasian female, Birthdate: 4/3/1960
- Speaks English as her primary language, communicating verbally
- Betty was referred by her primary care physician, Dr. Moe for depression and anxiety that has worsened since the death of her husband. Dr. Moe's phone number is 1-217-555-1234. She reports the only physical condition she has is that she was recently diagnosed with Type 2 Diabetes.
- She is her own guardian.
- She has no prior or current legal issues.
- She has no risk of harm to self, others.

Case Study: Betty Doe, Cont'd

- High school graduate, Associate's Degree in Liberal Arts and Sciences
- Has a driver's license and dependable vehicle
- Works part-time at the local bank in the customer service department
- She reports loss of interest
- Recently widowed, two adult children – one living out-of state, one estranged
- Has minimal family support
- No history of substance abuse
- She reports no known mental illness in her family
- No current psychotropic medications

Case Study: Betty Doe, Cont'd

- She has never received mental health services
- She has been written up at work for calling in too many times and for not being able to have a balanced drawer at the end of her shift. She has also become "short" with her co-workers and bank customers
- She is receptive to receiving services, states that "I want to get a handle on my depression and anxiety so that I can keep my job".

Case Study of Betty Doe, continued

During the Mental Health Assessment the following were noted:

- Irritable
- Feels sad and depressed most of the day, every day
- Poor family relationships, poor communication skills, limited problem solving skills
- Diminished ability to think and concentrate
- Insomnia – reports 4 times a week since the passing of her husband
- Denies suicide and homicide ideation
- Denies substance use

➢ Diagnosed with Major Depressive Disorder

MHA – Recommended Services for Betty Doe

- Community Support – Individual
- Therapy/Counseling – Individual
- Case Management - Mental Health

Betty's ITP, Date: 1/30/16

Goal #1: I want to get a handle on my depression and anxiety so that I can keep my job".

Objective	Service	Amount, Frequency, Duration	Responsible staff person	Expected Outcome Date
1. I want to understand why I feel so depressed and anxious all the time.	Therapy/Counseling – Individual	1 x a week for 1 hour for 6 months	Bob Smith, QMHP	7/30/16
2. I will learn three coping skills to help me deal with my feelings of depression and anxiety so that I can get through my work day.	Community Support Individual	1 x a week for 1 hour for 6 months	Bob Smith, QMHP	7/30/16
3. I will learn three ways of relaxing to help me get more sleep.	Community Support Individual	1 x a week for 1 hour for 6 months	Bob Smith, QMHP	7/30/16
4. I will work with my counselor to identify and access 2 resources to help me with my depression and anxiety.	Case Management-Mental Health	1 x week for 1 hour for 6 months	Bob Smith, QMHP	7/30/16

Betty's ITP Review, Date: 7/30/16

- Goal #1: I want to get a handle on my depression and anxiety so that I can keep my job".
- Betty has made moderate progress with her feelings of depression and anxiety as evidenced by her ability to identify some underlying reasons for her depression and anxiety. Betty is responding well to Therapy/Counseling Individual, but as she has only made moderate progress, this service will continue.

Betty's ITP Review, Date: 7/30/16, continued

- She has learned 3 coping skills to deal with her anxiety and depression; however she needs more practice with applying them. As a result, Community Support Group, 1 time per week, will be added to the ITP.
- Relaxation – Betty continues to report difficulty with relaxing enough to be able to fall asleep most nights. As a result, she will continue to work on this in Community Support Group and Community Support Individual, 1 time per week.
- Resources - Case Management Mental Health is being discontinued as Betty has been connected with outside resources, a grief group in the community, and she has joined a Relay for Life team.

Modification of ITP, July 30, 2016

Goal #1: I want to get a handle on my depression and anxiety so that I can keep my job".				
Objective	**Services**	**Amount, Frequency Duration**	**Responsible Staff Person**	**Expected Outcome Date**
1. I want to understand why I feel so depressed and anxious all the time.	Therapy/Counseling – Individual	1 hour, 1 x week for 6 months	Bob Smith, QMHP	1/30/17
2. I will learn three coping skills to help me deal with my feelings of depression and anxiety so that I can get through my work day.	Community Support – Group – ADDED	1 hour, 1 x week for 6 months	Bob Smith, QMHP	1/30/17
	Community Support - Individual	2 hours, 1 x week for 6 months		
3. I will learn three ways of relaxing to help me get more sleep.	Community Support – Group ADDED	45 min., 1 x week for 6 months	Bob Smith, QMHP	1/30/17
	Community Support - Individual	2 hours, 1 x week for 6 months		
4. I will work with my counselor to identify and access 2 resources to help me with my depression and anxiety.	Objective completed. REMOVED from ITP.	N/A	N/A	N/A

ACCEPTABLE VS. UNACCEPTABLE DOCUMENTATION

Please note that the following slides contain example notes of both acceptable and unacceptable progress notes. It will be indicated on the first slide of each example note in red.

Sample Progress Note – Betty Doe, Therapy/Counseling – Individual

THIS NOTE IS ACCEPTABLE

Client Name: Betty Doe **Date:** Feb 7, 2016
RIN: 000-000-000 **Location:** On-site
Start Time: 10:00 AM **Duration:** 1 hour
Service: Therapy/Counseling –Individual

Betty attended therapy/counseling today to work on treatment plan goal 1, objective 1. **Description of intervention:** Betty and this therapist began to process her feelings of depression and anxiety. Betty reports her depression has increased since her husband passed. "He was my biggest support and helped me when I felt sad. I just feel so alone". This therapist assisted her with identifying other factors that contribute to her depressed feelings.

Betty Doe T/C –I note, continued

Betty's **response to the intervention:** Betty was actively involved in today's session and appeared open in relating her feelings and history of depressed feelings.

Betty is beginning to make slow **progress** towards this objective. Today she was able to identify a few factors that contribute to her depression.

Signature/Credentials: *Cindy White, QMHP* Date: 2/7/16

Sample Progress Note – Betty Doe, Community Support – Individual

THIS NOTE IS ACCEPTABLE

Client Name: Betty Doe **Date:** Feb 9, 2016

RIN: 000-000-000 **Location:** On-site

Start Time: 9:00 AM **Duration:** 45 min.

Service: Community Support - Individual

Betty arrived on time for her community support individual session today to work on treatment plan goal 1, objective 2. **Description of intervention:** Today's session focused on identifying coping skills that she can utilize when she feels she can't get out of bed in the morning. Therapist provided examples of coping skills and worked with Betty on which ones would work for her.

Betty Doe C/S – I note, continued

She **responded to this intervention** by: Betty initially was unable to think of ways to make herself get out of bed in the morning, stating that "life is just too hard". After some prompting from this therapist, Betty was able to identify one coping skill that she would be open to try this week.

Betty made minimal **progress** today towards this objective as she is having a hard time accepting life without her partner.

Signature/Credentials: *Cindy White, QMHP* **Date**: 2/9/16

Sample Progress Note – Betty Doe, Therapy/Counseling- Individual

THIS NOTE IS UNACCEPTABLE

Client Name: Betty Doe **Date:** Feb 14, 2016

RIN: 000-000-000 **Location:** On-site

Start Time: 9:30-10:00 AM **Duration:** 30 min.

Service: Therapy/Counseling -Individual

Description of Intervention: This writer provided Betty with Therapy/Counseling-Individual today to work on treatment goal #1, objective #1: Betty reported she was late to work 3 times this past week. She reported that her supervisor gave her another written warning. She reported that her sugar level was 300. She stated she is a stress eater and when she received the written warning she went to her freezer and grabbed the biggest container of ice cream she could find. She also stated that today is Valentine's Day and she has no one to share this day with.

Betty Doe T/C – I note, continued

Betty **responded to this intervention** by being talkative.

Betty made some **progress** today towards this objective.

Signature/Credentials: *Cindy White, QMHP* **Date**: 2/14/16

Sample Progress Note – Betty Doe, Case Management-Mental Health

THIS NOTE IS ACCEPTABLE

Client Name: Betty Doe **Date:** Feb 20, 2016
RIN: 000-000-000 **Location:** On-site
Start Time: 10:00 AM **Duration:** 30 min.
Service: Case Management-Mental Health

Description of Activity: This case manager contacted American Cancer Society office to inquire about volunteer opportunities for the upcoming Relay for Life or any other volunteer opportunities that would be appropriate for a surviving spouse. The office staff stated she would fax me some information regarding upcoming committee meetings/events.

Sample Progress Note – Case Management-Mental Health– Johnny

THIS NOTE IS UNACCEPTABLE

Client Name: Johnny Appleseed **Date:** Feb 22, 2016

RIN: 000-000-000 **Location:** On-site

Start Time: 10:00 AM **Duration:** 15 min.

Service: Case Management-Mental Health

- **Description of Activity:** This case manager reviewed Johnny's medication chart and then called a refill in to the pharmacy. I then called his mom and left a voicemail.

- **Signature/Credentials**: *Nancy Nurse, LPN* **Date**: 2/22/16

Sample Progress Note – Community Support Residential Group – PETE

THIS NOTE IS UNACCEPTABLE

Client Name: Pete Wilson **Date:** May 13, 2016

RIN: 000-000-000 **Location:** On-site

Start Time: 8:00 AM **Duration:** 1 hour

Service: Community Support Residential - Group

Description of Intervention: Facilitated illness self-management, skill building, identification and use of adaptive and compensatory strategies, identification and use of natural supports, and use of community resources. Discussed with the group the household rules and chores. Pete **response to this intervention:** Pete slept through the meeting.

No **progress** made.

Sample Progress Note –Community Support Residential – Individual, PETE

THIS NOTE IS UNACCEPTABLE

Client Name: Pete Wilson **Date:** May 13, 2016

RIN: 000-000-000 **Location:** On-site

Start Time: 8:00 AM **Duration:** 60 min.

Service: Community Support Residential - Individual

Description of the intervention: This writer provided Pete with Community Support Residential – Individual to work on treatment goal #1, objective #2: "I want to prepare healthy meals." This writer observed Pete preparing breakfast and then packing his lunch for the day. Pete did a great job.

Sample Progress Note – Community Support Residential Individual, PETE, continued

Pete's response to the intervention: Pete said, "I make great blueberry muffins."

Progress toward goals/objectives in the ITP: Pete was able to complete task with minimal prompts.

Signature/Credentials: *Debra Thomas, MHP* **Date**: 5/13/16

Sample Progress Note – Community Support Residential – Individual – PETE

- **THIS NOTE IS ACCEPTABLE**

Client Name: Pete Wilson **Date:** April 28, 2016
RIN: 000-000-000 **Location:** On-site
Start Time: 11:00 AM **Duration:** 15 minutes
Service: Community Support Residential – Individual

Description of the intervention: This writer provided Pete with Community Support Residential – Individual to work on treatment goal #1, objective #2: "I want to prepare healthy meals." This writer educated Pete on healthy choices for breakfast. Staff assisted him in comparing the nutritional value of the different choices that would impact his diabetes. He could choose between bacon and eggs, fruit and oatmeal, and biscuits and gravy.

Sample Progress Note –Community Support Residential – Individual – PETE Cont'd

Pete's response to the intervention: Pete said, "I had no idea how these foods would make my sugar go up or down."

Progress toward goals/objectives in the ITP: Pete was able to understand the differences in his choices and their effects on his diabetes.

Signature/Credentials: *Debra Thomas, MHP* **Date**: 4/28/16

Problems Reviewers Continue to See with Mental Health Assessments

- LPHA is required to sign initial MHA within 30 days of first face-to-face
- Initial MHA is required to be signed by the LPHA **before** LPHA signs the ITP
- MHA's are required to be updated **annually** and signed by the LPHA within a year of the prior MHA
- Credentials must accompany signatures

Problems Reviewers Continue to See with Individual Treatment Plans and/or Reviews

- Initial ITP must be signed by the LPHA within **45 days** of the LPHA signature on the Initial MHA
- The ITP GOALS must be reviewed **at least** every 6 months by the QMHP and signed by the LPHA whether or not the client is present
- Credentials must accompany signatures

Specific Services on Individual Treatment Plans

Acceptable	**Unacceptable**
Psychotropic Medication Training	Psychiatric Services
Community Support- Individual	Community Support Services
Therapy/Counseling-Family	Therapy/counseling
Case Management-Mental Health	Case Management

Problems Reviewers Continue to See with Progress Notes

- Progress notes must be signed by the person providing the service with credentials

- Progress note must document a billable Rule 132 intervention
    - Not only “person reporting……”
    - Not just the definition of service

Tips from Reviewers

- Consistent organization of records
- Staff know and understand Rule 132 required documentation requirements and the recordkeeping system of the provider
- Handwritten records are legible
- Conduct regular internal reviews
- Canned documentation does not occur
- Avoid excessive use of jargon

Resources

Today's presentation will be available online at:

www.illinoismentalhealthcollaborative.com

- You can follow these steps:
- Step 1: Go to

www.illinoismentalhealthcollaborative.com

- Step 2: Click on "Providers"
- Step 3: Click on "Provider Information"
  - Under "Training" – Training Slides
  - Under "Provider Resources" – mp3 recordings
  - FY17 Provider Monitoring Tools

Resources

- Your DHS/DMH Regional Staff

- Websites
  - ➢ IL Mental Health Collaborative
    www.illinoismentalhealthcollaborative.com

  - ➢ DHS/DMH
    http://www.dhs.state.il.us

    - ❑ Rule 132 Q & A's

- DHS/DMH mailbox: **dhs.mh@Illinois.gov**

Questions?