Treatment Planning

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Agenda

- Reminders Regarding New Prior Authorization Process
- Treatment Planning
  - Measurable Goals and Objectives, Periodic Review of the Master Treatment Plan and Service Code Definitions
- Examples
- Questions
New Prior Authorization Process

- Effective July 18, 2016, Beacon Health Options will review for prior authorization of services in conjunction with the Master Treatment Plan (MTP)/Periodic Review of Master Treatment Plan (TPR).
- When submitting a prior authorization, providers will be required to submit the current MTP/TPR.
- Authorizations will be provided in 90 day increments in order to review in conjunction with the TPR.

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Reminders for Treatment Plans and Periodic Reviews

Treatment Plans/Periodic Reviews submitted:

• Must cover the dates of services requested
• Must contain the beneficiary’s diagnosis, relevant goals/objectives and document specific progress/regression towards goals/measureable objectives
• Must contain the frequency of services being provided (zero is not a frequency). Family Therapy Without Beneficiary will need to be ordered separately.
Reminders for Treatment Plans and Periodic Reviews

Treatment Plans/Periodic Reviews submitted:

• Only request units for the timeframe covered by the current treatment plan/periodic review and based on the frequency of services ordered.

• If parent/guardian signatures are not obtained at the time the PA is requested, documentation of collaboration with beneficiary/family/guardian must be reflected on the TPR submitted for prior authorization or in additional chart documentation. Providers should still have all treatment plans signed by the beneficiary/guardian in accordance with RSPMI regulations. The physician’s signature is mandatory for PA review.
Disclaimer

This training does not contain a legal description of all aspects of Medicaid clinical record documentation regulations. It is a practical guide for providers who participate in the Medicaid Program. The information provided is not intended to be all-inclusive or otherwise limit the inquiry and consideration applicable to decisions regarding a beneficiary’s rehabilitation needs. Guidelines and procedures in this training are based on requirements of States and Federal law. Thus the guidelines and procedures are subject to change if the requirements of the law or accrediting organization change. Where there is conflict between this edition of the training and a subsequent notification of a modification to a policy or procedure, the information in the subsequent notification shall prevail.
Treatment Planning
A range of mental health rehabilitative or palliative services is provided by a duly certified RSPMI provider to Medicaid-eligible beneficiaries suffering from mental illness, as described in the American Psychiatric Association Diagnostic and Statistical Manual (DSM-IV and subsequent revisions).

Rehabilitative Services for Persons with Mental Illness may be covered only when:

- provided by qualified providers,
- approved by a physician within 14 calendar days of entering care,
- provided according to a written treatment plan/plan of care, and
- provided to outpatients only except as described in Section 252.130.
In order to be valid, the treatment plan/plan of care must:

- be prepared according to guidelines developed and stipulated by the organization’s accrediting body and
- be signed and dated by the physician who certifies medical necessity.

If the beneficiary receives care under the treatment plan, the initial treatment plan/plan of care must be approved by the physician within 14 calendar days of the initial receipt of care.

The physician’s signature is not valid without the date signed.
For each beneficiary entering the RSPMI Program, the treatment team must develop a written, individualized master treatment plan to:

• treat, ameliorate, diminish or stabilize, or maintain remission of symptoms of mental illness that:
  • threaten life, or cause pain or suffering resulting in impaired functioning

The Master Treatment Plan goals and objectives must be based on problems identified in the intake assessment or in subsequent assessments during the treatment process.

• included in the beneficiary’s records

• contain written description of treatment objectives for that beneficiary
The Master Treatment Plan must describe:

- the treatment regimen—the specific medical and remedial services, therapies and activities that will be used to meet the treatment objectives
- a projected schedule for service delivery—this includes the expected frequency and duration of each type of planned therapeutic session or encounter
- the type of personnel that will be furnishing the services and
- a projected schedule for completing reevaluations of the patient’s condition and updating the master treatment plan

“For each beneficiary entering the RSPMI Program, the treatment team must develop a written, individualized master treatment plan, signed by a Physician within 14 calendar days.”
Section 218.000 Master Treatment Plan

Timeframes:

• The RSPMI master treatment plan must be completed by a mental health professional and approved by a psychiatrist or physician, within 14 calendar days of the individual’s entering care (first billable service). Subsequent revisions in the master treatment plan will be approved in writing (signed and dated) by the psychiatrist or physician verifying continued medical necessity.

Additionally, per Section 217.000:

• For each beneficiary served through the RSPMI Program, the treatment team must certify that the program is appropriate to meet the beneficiary’s needs. This certification must be documented in the beneficiary record within 14 calendar days of the person’s entering continued care (first billable service), through treatment team signatures on the treatment plan/plan of care.
The treatment plan should be based on the beneficiary’s or guardians’ articulation of the problem or needs to be addressed.

Each problem or need should have one or more clearly defined behavioral goals or objectives (from which the beneficiary, guardian and others can assess progress or achievement of the goal or objective)

- Each goal or objective must specify the treatment interventions determined to be medically necessary to address the problem or need and to achieve the goal or objective.

“The treatment plan must specify the beneficiary’s and family’s strengths and natural supports that will be the foundation for the treatment plan.”
Documenting beneficiary/guardian participation:

Beneficiary, parent or guardian must be provided an opportunity to express comments about the treatment plan with a space on the treatment plan to record these comments.

• Treatment Plan must be signed by:
  • MHP who drafted the plan
  • physician authorizing and supervising treatment
  • agency staff who will provide specific interventions
  • beneficiary (unless clinically or developmentally contra-indicated) and
  • parent or legal guardian for beneficiaries under the age of 18
Documenting Beneficiary/Guardian Participation

If the parent or legal guardian of the beneficiary under the age of 18 is not available to provide a signature on the treatment plan, the client record must have documentation indicating barriers to obtaining that signature within 14 calendar days of the treatment plan.

- Documentation, either on the treatment plan or in a progress note must include:
  - method of communication with the parent/guardian
  - description of the parent/guardian’s input on treatment goals and services to be provided
  - Role and/or involvement of the parent/guardian in ongoing treatment services for the beneficiary
Measureable Goals and Objectives
Importance of Treatment Planning

• Treatment plans are essential (and required) tools that provide a map to assist beneficiaries.

• The treatment plan addresses problems identified in the beneficiary’s Mental Health Evaluation/Diagnosis, defines and measures interventions and provides a measure for the beneficiary’s progress in treatment.

• The treatment planning process is key in demonstrating the effectiveness of treatment interventions for beneficiaries.

• Good progress notes begin with effective treatment planning.

• Comprehensive treatment planning leads to easy documentation in progress notes; poorly developed treatment planning leads to incomplete or unclear documentation of services.
Treatment Goals

Treatment Goals are:

• An observable and defined result having one or more objectives to be achieved within a fixed timeframe.

• A behavioral outcome statement.

Developing Treatment Goals:

• Review the beneficiary’s Mental Health Evaluation/Diagnosis and other assessments.

• Develop long term goal/s and begin to formulate, with the beneficiary and/or guardian, what objectives need to be met in order to achieve the goal/s.
Treatment Goals

Helpful questions to ask the beneficiary:

• What do you want to accomplish?

• What do you want to do differently?

• How do you think treatment can improve your life?

• What new skills do you want to learn to improve your quality of life?
Treatment Objectives are:

- The roadmap on the path toward achievement of the goals.
- A statement in **specific** and **measurable** terms that describes what the beneficiary will accomplish as a result of treatment and interventions.
Why are Treatment Objectives Important?
Achieving a goal is easier with a plan….

Objectives:

• Set treatment priorities
• Monitor progress toward goal/s
• Set targets for accountability
• Provide framework for treatment and outcomes
Treatment Objectives should be individualized:

• Symptom severity and chronicity vary by beneficiary with the same diagnosis.

• Developmental and intellectual factors result in symptoms being expressed differently by beneficiaries with the same diagnosis.

• Expression of symptoms varies between genders.

• Cultural issues which impact treatment must be considered.

• Community, support systems, and environmental factors must be considered in the formulation of objectives (i.e. toxic environments, transportation, family support, access to basic necessities, etc.).
Treatment Objectives are Individualized:

• What will the beneficiary do that indicates that a goal is attained?

• The objective must be measurable and specific.

• Objectives should be written from the perspective, “The beneficiary will…..”

• The objective should be realistic, something the beneficiary can achieve or accomplish.
Treatment Objectives

Should be: SMART

• **Specific**: concrete, detailed, and well defined.

• **Measurable**: numeric or descriptive, quantity, quality or comparative

• **Achievable**: feasible, attainable, actionable

• **Realistic**: considers resources, barriers, strengths, can be achieved

• **Time Specific**: identifies target dates, includes interim steps to monitor progress and defines a time line in which objectives are to be achieved
Development of Treatment Activities

What will the treatment team do to bring about the change?

Treatment Activities

- All services to be provided by the treatment team must be specific to the objective.

- There may be several treatment activities/services pertaining to each objective or to more than one objective.

- The goal, objectives, treatment activities and progress are described in the progress notes.
Prescriptions shall be based on consideration of:

- the RSPMI Assessment
- proposed master treatment plan
- an evaluation of the enrolled beneficiary (directly or through review of the medical records and consultation with the treatment staff)

The prescription of the services will be documented by the psychiatrist’s or physician’s written approval of the RSPMI master treatment plan.

“Medicaid will not cover any RSPMI service without a current prescription signed by a psychiatrist or physician.”
Subsequent revisions of the patient’s RSPMI master treatment plan will also be documented by the psychiatrist’s or physician’s written approval in the enrolled beneficiary’s medical record.

Approval of all updates or revisions to the Master treatment plan must be documented within 14 calendar days by the physician’s dated signature on the revised document.
Reviewing Treatment Plans
RSPMI treatment plan must be periodically reviewed by the treatment team in order to determine:

- beneficiary’s progress toward the rehabilitative treatment and care objectives
- appropriateness of the rehabilitative services provided and
- need for the enrolled beneficiary’s continued participation in the RSPMI program

Periodic Reviews must be:

- performed on a regular basis (at least every 90 calendar days)
- documented in detail in the enrolled beneficiary’s record
- kept on file and made available as requested
Frequency of Periodic Reviews:

Reviews must be performed on a regular basis (at least every 90 calendar days)

• If provided more frequently, there must be documentation of significant acuity or change in clinical status requiring an update in the beneficiary’s treatment plan.

“The clock for the 90-day review begins to run on the earliest date set forth on the form that contains the treatment plan.”
The review of the treatment plan must reflect the beneficiary’s, or in the case of a beneficiary under the age of 18, the parent’s or guardian’s, assessment of progress toward meeting treatment goals or objectives and their level of satisfaction with the treatment services provided.

Based on progress made, barriers encountered or changes in clinical status and any new information, the following should be revised:

- problems
- needs
- goals
- objectives
- strengths
- supports
Documenting beneficiary/guardian participation:

• The beneficiary, the parent or the guardian must be provided an opportunity to express comments about the treatment plan and a space on the treatment plan form to record these comments and their level of satisfaction with the services provided.

• The review of the plan of care must be signed by the MHP who drafted the plan, the physician authorizing and supervising the treatment, agency staff members who will provide specific treatment interventions, the beneficiary (unless clinically or developmentally contra-indicated) and a parent or legal guardian for beneficiaries under the age of 18.
Documenting beneficiary/guardian participation:

If the parent or legal guardian for beneficiaries under the age of 18 is not available to provide a signature on the review of the treatment plan, the client record must have documentation indicating barriers to obtaining that signature within 14 calendar days of the treatment plan review.

Documentation, either on the review of treatment plan form or in a progress note must include:

- method of communication with the parent or guardian
- parent or legal guardian’s perception on treatment progress and services provided
- revisions needed to the treatment plan
- involvement of the parent or guardian in ongoing treatment
Changing a Treatment Plan

When should a goal or objective be discontinued or modified?

- The beneficiary chooses not to work on the objective.
- The objective was not achieved and is not likely to be achieved.
- There are too many objectives (not specific enough or diffuse attention)
- New information has been provided that was not known earlier and the objective is no longer a focus of treatment.
- **Goals and/or objectives have been accomplished.**

Be sure if you discontinue or change a goal or objective, you state why it has been changed or discontinued during the periodic review.
Documentation and Medical Necessity
Medical Necessity

227.000 Medical Necessity 10-4-09

All RSPMI services must be medically necessary.

Definition in Section IV of Arkansas Medicaid Manual:

“All Medicaid benefits are based upon medical necessity. A service is “medically necessary” if it is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or injury, threaten to cause or aggravate a handicap or cause physical deformity or malfunction and if there is no other equally effective (although more conservative or less costly) course of treatment available or suitable for the beneficiary requesting the service. For this purpose, a “course of treatment” may include mere observation or (where appropriate) no treatment at all. The determination of medical necessity may be made by the Medical Director for the Medicaid Program or by the Medicaid Program Quality Improvement Organization (QIO). Coverage may be denied if a service is not medically necessary in accordance with the preceding criteria or is generally regarded by the medical profession as experimental, inappropriate, or ineffective unless objective clinical evidence demonstrates circumstances making the service necessary.”
Medical Necessity

Remember, per Section 218.000:

For each beneficiary entering the RSPMI Program, the treatment team must develop a written, individualized master treatment plan to:

• treat, ameliorate, diminish or stabilize, or maintain remission of symptoms of mental illness that:
  • threaten life, or cause pain or suffering resulting in impaired functioning
The RSPMI provider must develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity or session for which Medicaid reimbursement is sought. This documentation, at a minimum, must consist of:

- individualized to the beneficiary and specific to the services provided, duplicated notes are not allowed
- the date and actual time the services were provided (Time frames may not overlap between services. All services must be outside the time frame of other services.)
- name and credentials of the person who provided the services,
- the setting in which the services were provided (for all settings other than the provider’s enrolled sites, the name and physical address of the place of service must be included)
(continued)

• the relationship of the services to the treatment regimen described in the plan of care

• updates describing the patient’s progress

• for services that require contact with anyone other than the beneficiary, evidence of conformance with HIPAA regulations, including presence in documentation of Specific Authorizations, is required

Documentation must be legible and concise. The name and title of the person providing the service must reflect the appropriate professional level in accordance with the staffing requirements found in Section 213.000.
These examples are meant to be informational only and do not meet all service definition requirements for services indicated. Times, dates, goals and objectives, etc. are excluded for the purpose of brevity in examples.
Example: Symptomomology from MHE

- Loss of interest in daily activities:
- Sadness or feeling down:
- Hopelessness:
- Tiredness and lack of energy:
- Low self-esteem, self-criticism or feeling incapable:
- Trouble concentrating and trouble making decisions:
- Irritability or excessive anger:
- Decreased activity, effectiveness and productivity:
- Avoidance of social activities:
- Poor appetite or overeating:
- Sleep problems:
Diagnosis: Depression

G: Sally will report no panic attacks at the store.
O: Sally will attend rehab day and participate in milieu.
O: MHPP will monitor Sally’s behavior at school.

1. Is the goal consistent with symptomology identified?
2. Is the goal and are the objectives measurable and outcome focused?
3. Is this written from the perspective of what beneficiary will do?
Diagnosis: Depressive Disorder NOS

G: Sally will report symptoms of depression reduced and no longer interfere with her daily functioning.

O: Sally will report sleeping 7-8 hours per night, 5 out of 7 nights per week.

O: Sally will decrease documentation of office referrals for classroom disturbance due to anger outbursts to no more than two per week as reported by teacher.

O: Sally will become involved in at least one extracurricular activity or sport.

O: Sally will learn 2 coping skills, including problem solving and emotional regulation.
Goal 1: Sally will report symptoms of depression reduced and no longer interfere with her daily functioning.

Progress: Since last review period, Sally reports that her symptoms have improved as she has noticed days of increased energy and activity. She joined a local art club and her interests and confidence have improved. However she does report days in which she still has low energy, crying spells/irritability and has had periods of social isolation lasting entire weekends; as well as missed days from school and work due to continued symptoms. Her sleep has improved overall, however there she reports episodes of poor sleep occurring. Overall, Sally and her parents feel that current focus of treatment goals is helping improve her overall mood and decrease her feelings of hopelessness.
Obj 1: Sally will report sleeping 7-8 hours per night, 5 out of 7 nights per week.

Progress: Sally reported that she has had improved sleep on nights in which she utilizes relaxation techniques, however this has been limited to 2-3 nights a week with some weeks of ongoing poor sleep. Sally will continue to use relaxation techniques consistently to improve sleep 5 out of 7 nights per week.

Obj 2: Sally will decrease documentation of office referrals for classroom disturbance due to anger outbursts to no more than two per week as reported by teacher.

Progress: Sally has worked this review period on coping skills such as problem solving to reduce outbursts and has practiced implementing these skills in the classroom. This has resulted in a decrease of office referrals, however Sally has not been able to consistently decrease to less than 2 per week.
Obj 3: Sally will become involved in at least one extracurricular activity or sport.

Progress: Sally did join an art club after school, however reports that she has missed some due to lack of energy or as a consequence for behaviors. She reports involvement and feedback in the club has helped in feeling more confident and improved mood and wants to continue to work towards increased involvement.

Obj 4: Sally will learn 2 coping skills, including problem solving and emotional regulation.

Progress: Sally is working on the steps to problem solving and emotional regulation and relaxation techniques; however has not been able to implement these consistently. Sally has worked with the MHPP in various settings to practice these skills in order to implement during outbursts or inability to calm or get to sleep at an appropriate time.
Questions?