Consistency and Accuracy in Documenting Behavioral Health Diagnoses

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Special Review
Project-Report
An Analysis of Diagnosis and Claims for Outpatient Rehabilitative Services for Persons Mental Illness (RSPMI)

In April 2015, Beacon Health Options clinical staff performed an analysis of 385 beneficiaries’ RSPMI records and claims for the Calendar Year (CY)2014.
ADHD Episode of Care (EOC) launched

Arkansas Center for Health Improvement (ACHI) produced an analysis of claims from 2009-2013

EOC reconsideration process and review of records indicated a need for further review

Beacon conducted additional record reviews and claims data comparison of the sample records chosen for this review
Beneficiaries Chosen:

- had one or more RSPMI claim(s) in the CY2013 with an ADHD-only
- between the ages of 6 and 17

These beneficiaries were then compared to claims from CY2014 and selected based on beneficiaries having one or more claim that included:

1) a different diagnosis (no ADHD),
2) a comorbid diagnosis (including ADHD), or
3) claims that met both of these criteria (claims with no ADHD diagnosis and a comorbid diagnosis including ADHD)

*Charts were submitted from 27 different RSPMI providers
Beacon compared documentation and claims for CY2014 specifically to determine the answers to these questions:

• Did the ADHD diagnosis remain primary?
• Did the ADHD diagnosis move to a different level of focus of treatment?
• Did the ADHD diagnosis no longer appear?
• Were all diagnoses submitted on claims substantiated on the medical record?
• Did the medical record documentation support any changes in diagnoses?
During CY2014, it was found that:

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>22.9 percent of the charts no longer included documentation of any ADHD diagnosis.</td>
</tr>
<tr>
<td>2</td>
<td>12.21 percent of the charts reviewed had documentation reflecting the only focus of treatment was on ADHD symptoms, even when a diagnosis other than ADHD had been added to the PDA, MTP, claims, etc. or the ADHD diagnosis had been removed.</td>
</tr>
<tr>
<td>3</td>
<td>3.9 percent of the charts reviewed documented the primary focus of treatment was the beneficiary’s developmental disability, which is currently excluded from Medicaid-reimbursed RSPMI treatment.</td>
</tr>
</tbody>
</table>
# Results of Clinical Review

## Table 2.0 Primary Diagnosis For Clinical Chart Documentation (CY2014)

<table>
<thead>
<tr>
<th>Primary Diagnosis</th>
<th>Number of Beneficiaries</th>
<th>Percentage of Charts Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD</td>
<td>69</td>
<td>17.9%</td>
</tr>
<tr>
<td>Oppositional Defiant Disorder (ODD)</td>
<td>60</td>
<td>15.5%</td>
</tr>
<tr>
<td>Mood Disorder</td>
<td>51</td>
<td>13.25%</td>
</tr>
<tr>
<td>Disruptive Behavior Disorder</td>
<td>47</td>
<td>12.21%</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>40</td>
<td>10.39%</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>36</td>
<td>9.35%</td>
</tr>
<tr>
<td>Other*</td>
<td>21</td>
<td>5%</td>
</tr>
<tr>
<td>Adjustment Disorder</td>
<td>20</td>
<td>5%</td>
</tr>
<tr>
<td>Impulse Control</td>
<td>10</td>
<td>2.6%</td>
</tr>
<tr>
<td>PTSD</td>
<td>9</td>
<td>2.34%</td>
</tr>
<tr>
<td>Bipolar</td>
<td>6</td>
<td>1.56%</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>4</td>
<td>1.04%</td>
</tr>
<tr>
<td>Obsessive-Compulsive</td>
<td>4</td>
<td>1.04%</td>
</tr>
<tr>
<td>Reactive Attachment</td>
<td>4</td>
<td>1.04%</td>
</tr>
<tr>
<td>Child Sex Abuse</td>
<td>2</td>
<td>0.52%</td>
</tr>
<tr>
<td>Intermittent Explosive</td>
<td>1</td>
<td>0.26%</td>
</tr>
<tr>
<td>Psychosis</td>
<td>1</td>
<td>0.26%</td>
</tr>
</tbody>
</table>

*When diagnosis changed

## Table 2.1 Location Of ADHD In Beneficiary Diagnosis From Clinical Chart Documentation (CY2014)

<table>
<thead>
<tr>
<th>ADHD Primary</th>
<th>ADHD Secondary</th>
<th>ADHD Tertiary*</th>
<th>No ADHD in diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>69 (17.9%)</td>
<td>105 (27.3%)</td>
<td>123 (32%)</td>
<td>88 (22.9%)</td>
</tr>
</tbody>
</table>
Documenting Diagnoses
According to the DSM 5:

The *primary diagnosis* is the *main focus* of attention in treatment. Therefore, the *primary diagnosis* should be listed first when documenting the diagnoses, with any remaining diagnoses listed in order of focus of attention or as having an impact on treatment.

According to Section 252.420 of the Arkansas Medicaid Manual:

For an RSPMI provider delivering an RSPMI service, the *primary diagnosis* is the DSM mental health disorder that is the *primary focus* of the mental health treatment service being delivered.
# Documenting Diagnoses-Trends

<table>
<thead>
<tr>
<th>Charts Reviewed</th>
<th>Identified Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>62%</td>
<td>Diagnosis submitted on claim was different from documentation provided*</td>
</tr>
<tr>
<td>42%</td>
<td>Provider billing error or Medical Necessity denial*</td>
</tr>
<tr>
<td>22%</td>
<td>Different diagnosis submitted for Prior Authorization than was found in the documentation provided</td>
</tr>
</tbody>
</table>

* Charts reviewed had one or more claim(s) with the identified trend
# Documenting Diagnoses-Trends

## Table 2.3 Diagnosis Changed in CY2014

<table>
<thead>
<tr>
<th>Diagnosis changed</th>
<th>Diagnosis change was supported by documentation</th>
<th>Diagnosis change was not supported by documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>74 (74%)</td>
<td>26 (26%)</td>
</tr>
</tbody>
</table>

*No change in diagnosis in 285 charts*

## Table 2.4 Diagnosis Substantiation in Psychiatric Diagnostic Assessment (CY2014)

<table>
<thead>
<tr>
<th>Diagnosis in Psychiatric Diagnostic Assessment substantiated</th>
<th>303 (78.7%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis in Psychiatric Diagnostic Assessment not substantiated</td>
<td>82 (21.3%)</td>
</tr>
</tbody>
</table>
Inconsistencies When Documenting Diagnosis

- Physician changed the diagnosis during a medication management visit or Psychiatric Diagnostic Assessment (PDA) but this change was not carried forward by the therapist on the treatment plan or periodic review of the treatment plan.
- Therapist changed the diagnosis but this was not reflected in the physician documentation.
Client A:
Entered treatment in February 2013

- MD notes consistently documented diagnosis as:
  - Major Depressive Disorder (MDD), Disruptive Behavior Disorder (DBD), Attention Deficit/Hyperactivity Disorder (ADHD), and Pervasive Development Disorder (PDD)

- MTP/Periodic Reviews of MTPs:
  - 2/2013-MDD, DBD, ADHD, R/O PDD (all listed as active with goals to address)
  - 11/2013-MDD, DBD, ADHD, PDD (PDD no longer a r/o-no documentation supporting change)
  *DBD and ADHD marked as complete-no active goals or objectives and no notes following to address any symptomology
Example-Inconsistent Diagnosis Documentation

Client A:

2014 Periodic Review and Progress Notes:

• 2014 Periodic Review: Diagnosis documented as DBD, ADHD only
  • States these are active problem/goals and being addressed in treatment (previously marked as complete)
  • Only goal/objectives relate to depression
  • Claim for this periodic review listed 314.01 as primary
  • MD notes during this time frame continue to list MDD, DBD, ADHD, PDD

Progress Notes:

• Vary between listing diagnosis-some notes list DBD, ADHD, MDD other notes list PDD as primary
• Actual interventions addressing depression/depressive symptoms only
• Claims submitted with MDD as primary
Summary of findings in this example:

• Inconsistency in primary diagnosis
• Inconsistency in focus of treatment
• Inconsistency in primary diagnosis on claims submitted versus primary diagnosis documented in medical record
• Inconsistency in documentation on MTPRs
Client B:
March 2013 Psychiatric Diagnostic Assessment and SED form document diagnosis as:
  • Axis I: Oppositional Defiant Disorder, Adjustment Disorder with mixed disturbance of mood and conduct

March 2013 Prior Authorization request:
  • Listed Adjustment Disorder NOS *only*
  • PA request in September then corrected diagnosis to ODD and Adjustment D/O with mixed disturbance
  • PA request in March 2014 listed diagnosis as Adjustment D/O primary and ODD secondary
Issues Identified - Example: Client B

Summary of findings in this example:

• Diagnosis submitted on prior authorization request does not match chart documentation (Section 190.008-Arkansas Medicaid RSPMI Manual)

  • The previous authorization was based upon misrepresentation by act or omission

• Progress notes in this particular case did not identify the diagnosis as required per Outpatient Procedure Codes (Section 252.110-Arkansas Medicaid RSPMI Manual)
Documentation
Purpose of Documentation

- Providing evidence that services were provided
- Recording pertinent facts, findings, and observations about:
  - Medical history
  - Treatment
  - Outcomes
- Facilitating communication and continuity of care among:
  - Counselors
  - Other health care professionals involved in care
- Facilitating accurate and timely claims review and payment
- Supporting utilization review and quality of care evaluations
- Enabling data collection useful for research and education
Basic Documentation Requirements

- All billable activities must have a start and stop time.
- Service codes used in claims for payment must match codes used in charts.
- Progress notes for beneficiaries must be individualized.
- Number of units billed must match number of units in documentation.
- Full signature with credentials and dates must be documented as required by the RSPMI manual.
- Services provided/documented must meet service code definition.
- Progress notes must be legible.
Arkansas Medicaid RSPMI Manual Section 142.300

Each provider:

• Must prepare and keep complete and accurate original records that fully disclose the nature and extent of goods, services or both provided to eligible beneficiaries

• Must contemporaneously establish and maintain beneficiary records that completely and accurately explain all evaluation, care diagnoses, and any other activities

• Must document in the beneficiary medical record the delivery of all goods and services billed to Medicaid

• Support the level of services billed to Medicaid within the beneficiary medical record
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.
Ensuring Consistency Throughout Documentation

The sequence of documentation in which Medical Necessity requirements converge is:

- The Mental Health Evaluation/Diagnosis
- The Master Treatment Plan
- The Psychiatric Diagnostic Assessment
  - Initial
  - Continuing Care
- The Periodic Review of Master Treatment Plan
- The Progress Note
Ensuring Consistency Throughout Documentation

**Step One** - Completion of a Mental Health Evaluation/Diagnosis (MHE/D)

- Evaluation of symptoms/behaviors leading to an included diagnosis
- Functional impairments in daily living, needs, and strengths
- Psychosocial history including past medical and mental health treatment, supports, legal issues, education/work, etc.

**Step Two** - Carry this information forward into the Master Treatment Plan and document:

- Goals/Objectives linked to the identified symptoms/behaviors
- Interventions to address the identified impairments
Ensuring Consistency Throughout Documentation

**Step Three** – Completion of the Psychiatric Diagnostic Assessment

- Psychiatric assessment including current symptoms and functional impairments
- Medications and responses
- Response to current treatment interventions
- Medical history (and examination as indicated)
- Confirm/substantiate diagnosis on MHE/D

**Step Four** - Carry these goals/objectives forward into the Progress Note which documents:

- Goal-based interventions provided to client
- Individualized response to intervention
- Progress/regression towards goals and objectives
The Mental Health Evaluation/Diagnosis determines eligibility for RSPMI services and establishes the basis for treatment.

Diagnosis should have clinical utility determining:

- Treatment plans
- Potential outcomes

When more than one diagnosis is given for a beneficiary:

- The principal diagnosis is the main focus of treatment
- The principal diagnosis is listed first
- The remaining diagnoses are listed in order of focus of attention and treatment
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.

Treatment Plans are individualized based on:

- Presenting problem
- Symptom severity and chronicity
- Identified behaviors
- Identified functional impairments
- Strengths

Good progress notes begin with effective treatment planning.
Purpose:

Determine the existence, type, nature and most appropriate treatment for a mental illness or emotional disorder as defined by DSM/ICD

224.201 Must contain sufficient detailed information to substantiate:

- All diagnoses specified in the assessment and treatment plan
- All functional impairments listed on the SED or SMI certification
- All problems or needs to be addressed in the treatment plan
Progress notes are used to document a reimbursable service.

Interventions must be linked to a goal/objective on the Treatment Plan

- Should be about the purpose of the activity, not the activity itself
  - Decreasing symptoms or behaviors
  - Increasing adaptive behaviors/skill development
  - Prevent deterioration
- Contain beneficiary’s response to the intervention
- Progress
- Regression
- Plan
Treatment Team Collaboration
A Multi-disciplinary team is a group of professionals from different disciplines that provide comprehensive care through expertise and in consultation with one another to accomplish clinical goals

- **Physician**- supervises and coordinates all psychiatric and medical functions as indicated in treatment plans. (see Section 224.000)
- **Clinicians**- support and collaborate with Psychiatrist, provide clinical behavioral health care, manage beneficiary's primary care
- **Paraprofessionals**- support and collaborate with Clinician to provide interventions prescribed on the Master Treatment Plan
- **Utilization Review and Billing personnel**- enter the actual requests for Prior Authorization and submit the claims data
Treatment teams should actively communicate to ensure an appropriate exchange of information

- Communication exists when each member of the treatment team shares needed treatment information with other members of the treatment team caring for a beneficiary either:
  - Verbally
  - Manually in writing
  - Electronic Medical Records (EMR)

- Effective communication is:
  - Frequent
  - Timely
  - Understandable
  - Accurate
Physician Changed Diagnosis during Psychiatric Diagnostic Assessment - Initial

- MHE/D completed by MHP – initial diagnosis given
- MTP completed by MHP – signed by MD
- PDA completed by MD – diagnosis changed

New diagnosis communicated to MHP

- MTP updated
- MHPP and other treating staff alerted
- Progress notes for services provided written with correct diagnosis
- UR and Billing personnel are able to submit PA requests and billing accurately

New diagnosis NOT communicated to MHP

- MHP and MHPP continue to submit progress notes on original diagnosis and MTP
- MD visits have different diagnosis listed than on the MTP
- Treatment Plan reviews continue to list original diagnosis
- UR and Billing personnel submit PAs and Claims under different diagnosis
MHP Changed Diagnosis during a Periodic Review of the MTP

- **PDA completed – MD agrees with MHP on diagnosis**
- **MTP review 180 days into treatment – MHP updates diagnosis**
- **MD signs review but does not realize diagnosis has been updated**
  - **New diagnosis communicated to MD**
    - MD agrees or disagrees with MHP
    - MHPP and other treating staff alerted
    - Progress notes for services provided written with correct diagnosis
    - UR and Billing personnel are able to submit PA requests and billing accurately
  - **New diagnosis NOT communicated to MD**
    - MD sees beneficiary for medication management – progress notes document previous diagnosis
    - MD notes have different diagnosis listed than on the MTP
    - Treatment Plan reviews continue to list updated diagnosis
    - UR and Billing personnel submit PAs and Claims under different diagnosis
Claims Submission
Listing Diagnosis in ProviderConnect/Prior Authorization

Behavioral Diagnoses

Primary Behavioral Diagnosis
* Diagnostic Category 1
DEPRESSIVE DISORDERS

* Diagnosis Code 1
F33.0
* Description
Major Depressive Disorder, Recurrent Episode

Additional Behavioral Diagnoses

Diagnostic Category 2
SELECT...

Diagnostic Category 3
SELECT...

Diagnostic Category 4
SELECT...

Diagnostic Category 5
SELECT...

Primary Medical Diagnoses

Primary medical diagnosis is required. Select primary medical diagnostic category from dropdown or select medical diagnosis code and description.

* Diagnostic Category 1
BLOOD, BLOOD-FORMING ORGANS, & IMMUNOLOGICAL

* Diagnosis Code 1
D51
* Description
Vitamin B12 deficiency anemia

Diagnostic Category 2
SELECT...
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

Enter the applicable ICD indicator to identify which version of ICD codes is being reported.
Use “9” for ICD-9-CM.
Use “0” for ICD-10-CM.
Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.
Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
Diagnosis on Claims-Electronic
Arkansas Medicaid
Provider Representatives

Provider Relations
(800) 457-4454 In-State Toll-Free
(501) 375-2211 Local and Out-of-State
Select Option 0 for "Other Inquiries" then
Option 1: EDI Support Center
Option 2: Provider Assistance Center
Option 3: Provider Enrollment
Option 4: Arkansas Incentive Payment Team (AIPT)
Fax (501) 374-0549

Provider Enrollment
Evronee Carage, Supervisor
PO Box 8105
Little Rock AR 72203
(501) 244-5991
Fax (501) 374-0746

Pharmacy
Magellan Medicaid Administration
(800) 424-7395 Help Desk

Arkansas Payment Improvement Initiative Help Desk
501-301-8311 Local and Out-of-State
1-888-222-4898 In-State Toll-Free
ark61@hpe.com

Important Phone Numbers
PCP Assignment Voice Response . . . . (800) 805-1512
ARKids First Enrollment ................. (888) 474-8275
ConnerCare ................................ (800) 275-1131
Local .................................... (501) 614-4689
BreastCare Billing ......................... (866) 961-7930

Hewlett Packard Enterprise Provider Reps (Claims Processing)
David Jarnagin, Provider Relations Manager ... (501) 244-5877
Karyotee Simoons, Provider Relations and
Electronic Data Interchange (EDI) Supervisor . . (501) 244-5917
EDI e-mail ................................ arked1@hpe.com
Jessie Smith, BreastCare Manager ........... (501) 244-5869

Area | Representative | Phone Number | E-mail
-----|---------------|--------------|---------------------
All Provider Reps | (800) 457-4454 | ARKNWRegion@hpe.com |
 Arkansas | Drew Howell | (501) 244-5875 | ARKNCRegion@hpe.com |
 Little Rock | Shequila Lowman | (501) 244-5937 | ARKNERegion@hpe.com |
 Fort Smith | Sarah Coleman | (501) 244-5974 | ARKSRegion@hpe.com |
 West AR | Tanasia Johnson-Kamal | (501) 244-5980 | ARKPArkansas@hpe.com |
 East AR | Tonya Clark | (501) 244-5810 | ARKEKRegion@hpe.com |
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Amelia Rich-Ellam, CFHT
Program Manager, Provider Relations
1020 West 4th Street
Little Rock AR 72201
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Fax (501) 375-1201

Hewlett Packard Enterprise

Arkansas Department of Human Services

Hewlett Packard Enterprise

BreastCare

beacon
Next Steps
Based on the results of this review, it was determined that the Retrospective Review process will include a review of documented diagnoses for congruency across paid claims, prior authorization requests, and the medical record:

- Effective **October 2016**, the Retrospective Review process includes a review comparing the primary diagnosis submitted on paid claims and PA requests to the chart documentation.

- Effective **January 1, 2017** any diagnosis inaccuracies will be identified as deficiencies, will require a Corrective Action Plan and may be subject to recoupment.

This process will allow for the identification of patterns or trends. Ongoing training and consultation with Beacon will be available.
The mission of the Office of Medicaid Inspector General (OMIG) is to prevent, detect, and investigate fraud, waste, and abuse within the medical assistance program. This mission is achieved through auditing Medicaid providers and medical assistance program functions; recovering improperly expended funds; and referring appropriate cases for criminal prosecution. OMIG works closely with providers and the medical assistance program to prevent fraud, waste, and abuse.

Pursuant to Ark. Code Ann. §20-77-2106, OMIG may pursue civil and administrative actions against an individual or entity that engages in fraud, abuse, or illegal or improper acts within the medical assistance program.
Contact

http://omig.arkansas.gov/

Medicaid Fraud Hotline

1-855-527-6644
31 U.S.C. §§ 3729 - 3733

The Federal False Claims Act applies to any federally funded contract or program and establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the United States government for payment.
Summary of Provisions

The provisions of the False Claims Act impose civil liability on any person or entity who:

- knowingly files a false or fraudulent claim for payment
- knowingly uses a false record or statement to obtain payment on a false or fraudulent claim, or
- conspires to do either of the above

“Knowingly” means:

- actual knowledge that the information on the claim is false
- acting in deliberate ignorance of whether the claim is true or false; or
- acting in reckless disregard of whether the claim is true or false
False Claims Act

Penalties

• The False Claims Act imposes civil penalties. *No proof of specific intent to defraud is required.* A person or entity, such as a hospital, found liable under the False Claims Act is subject to a civil money penalty of between $5,500 and $11,000 plus three times the amount of damages that the government sustained because of the illegal act.

“Whistleblower” Provision

• To encourage individuals to come forward and report misconduct involving false claims, the FCA includes a *qui tam* or whistleblower provision. Anyone may bring a *qui tam* action under the federal False Claims Act in the name of the United States in federal court. Part of the penalty paid by the wrongdoer is paid to the informer with the remainder going to the government.
Reverse False Claims

- Apart from traditional claims, liability under the FCA also attaches to anyone who acts improperly to avoid having to pay money to the government (known as “reverse” false claims).

One Final Note

- Arkansas Medicaid providers who receive or make payments totaling at least $5,000,000 annually are required to educate their employees about the False Claims Act. (section 142.800 of the Arkansas Medicaid Provider Manual; also, see the Arkansas OMIG’s False Claims Act Policy Memo at https://static.ark.org/eeuploads/omig/FalseClaimsActPolicyMemo.pdf)
Conclusion

• Beacon reviewed 385 charts across 27 RSPMI providers
  • Trends/Patterns identified (but not limited to):
    • Incongruent documentation of diagnosis on paid claims, prior authorization requests, and the medical record
    • Poor communication among treatment team members

Going forward, there will be increased monitoring of documented diagnoses to ensure those diagnoses are congruent across paid claims, prior authorization requests and the medical record.
Thank you