Medical Necessity

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Agenda

- Medicaid Definition: Medical Necessity
- Basics of Medical Necessity
- Documentation of Medical Necessity
- Documentation Examples
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.
Medicaid Definition: Medical Necessity
Definition – Glossary Section IV

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: Why?

• All Medicaid RSPMI benefits are based upon medical necessity.
  • Rehabilitative Services for Persons with Mental Illness
  • School Based Mental Health Services
  • Licensed Mental Health Practitioner
  • Substance Abuse Treatment Services
  • Rehabilitative Services for Youth and Children
Medical Necessity: Definition

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Medical Necessity: Definition

that

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• is generally regarded by the medical profession as experimental, inappropriate or ineffective unless objective clinical evidence demonstrates circumstances making the service necessary.
Basics of Medical Necessity
Basics of Medical Necessity

- Personnel with appropriate level of licensure must render service
- Service documented is in compliance with service definition
- Beneficiary should have a DSM/ICD mental health diagnosis
- Beneficiary should have sufficient cognitive ability to benefit
DSM or ICD Diagnosis

- Diagnosis alone is not sufficient
- Should include:
  - Diagnosis (DSM or ICD Mental Health Diagnosis)
  - Supporting behaviors and/or symptoms
  - Functional impairments
DSM or ICD Diagnosis

- Current behaviors/symptoms and functional impairments are critical to medical necessity.
- Acuity and other clinical information should support services.
- Each service must be directed toward a ICD/DSM mental health diagnosis.
Active Treatment/Participation

- Client must be an active participant
- Documentation must be clear in reference to the beneficiary’s participation in treatment
  - Possible Causes for Concern:
    - Non-compliance, non-participation
    - Catatonia and other diagnoses that may prevent participation
    - Sleeping during treatment program
    - Staying outside smoking
    - Severe Mental Retardation
    - Insufficient cognitive ability to benefit
Sufficient Cognitive Ability

Does the beneficiary have sufficient cognitive ability to benefit from or participate in treatment?

- Possible Causes for Concern:
  - Very young children receiving individual services or group
  - Dementia (may be appropriate in early stages)
  - Mental Retardation (Moderate or severe)
  - Autism (substantiate mental health diagnosis apart from PDD)
  - Other (intoxication, severe disorganized thinking, etc.)
  - Length of services (ability to sustain attention for length of service documented)
Treatment Services Should Be:

- Provided according to an individualized treatment plan
- Provided in the least restrictive setting that is available and safe
- Developmentally appropriate for children and those with intellectual deficiencies

Note: Services may not be for the exclusive purpose of social or recreational activity but must evidence a clear therapeutic objective specifically identified in the beneficiary’s individualized treatment plan and directed toward the resolution or reduction of behavioral or mental health symptomology.
Documentation of Medical Necessity
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:

A. Must be individualized to the beneficiary and specific to the services provided, duplicated notes are not allowed.

B. 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.),

C. Name and credentials of the person, who provided the services,

D. 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,

E. The relationship of the services to the treatment regimen described in the plan of care and

F. Updates describing the patient’s progress and

G. 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.
Documentation:  
• Is the primary means of determining whether claims should be paid  
• Makes the case for current and on-going medical necessity  
  • Mental Health Evaluation/Diagnosis  
  • Psychiatric Diagnostic Assessment  
  • Master Treatment Plan and Periodic Review of Master Treatment Plan  
• Progress notes/treatment notes  
• Testing, labs, and other reports  
• Non-billable/communication notes
Documentation of Medical Necessity

• Is there a diagnosis that meets RSPMI Medicaid criteria?
• Is there evidence to support or substantiate all diagnosis in the MHE, PDA, and in subsequent documentation/assessments?
• Is there assessment of the beneficiary’s functioning and documented functional impairments?
• Are there sufficient deficits or threats to justify the level of care being prescribed?
• Is there a current individualized treatment plan?
• Is the array of services appropriate for the clinical picture presented in the documentation? (too much, too little, family involvement, etc.)
Documentation of Medical Necessity

• Are services provided in accordance with the Master Treatment Plan and within Medicaid RSPMI service definitions?
• Are all service providers appropriately credentialed for level of services provided?
Documentation of Medical Necessity

• Is there evidence of beneficiary participation in Treatment?
  • Signature or documentation of cooperation of the beneficiary in the development of the individualized plan of care
  • Documentation supports cognitive ability to participate in and benefit from treatment
  • Evidence of family participation with younger beneficiaries
  • Beneficiary is willing to participate in treatment
• Is there evidence that beneficiary is benefiting from treatment?
  • Medical necessity is closely linked to documented outcomes
  • Service provided for the prevention of relapse or for maintenance requires continuous monitoring and documentation
    • Document behavior/symptom status (increase, decrease, no change) during
      • Titration of services
      • Natural gaps in services (i.e. school breaks, vacations, etc.)
Documentation of Medical Necessity

- If beneficiary is not benefiting:
  - Are services medically necessary?
  - Is the level of care appropriate?
  - Is there documentation of extenuating circumstances prohibiting/interfering with ability to meet goals and objectives? How are these circumstances being addressed?
Progress Notes/Documentation

• Required for each claim submitted
• Should describe a service, treatment activity, or intervention that meets service definition
• Should indicate necessity for service – should document to the objective addressed, not just the overall goal
• Should document level of licensure or certification of staff providing service, treatment activity, or intervention
Progress notes/documentation should document:

- A service, treatment activity or intervention by the providing provider
- Circumstance (planned or unplanned contact)
- Beneficiary participation
- Beneficiary Response
- Plan for next contact including homework, etc.
- Change/s to the plan of care
Documentation
Examples
Disclaimer

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 the examples.
“Attempted to call Sue to reschedule appointment but no one home. Left message.”

“Reviewed treatment plan and wrote up monthly documentation of what services have been provided without beneficiary.”

“John attended NA/AA meeting with MHPP. He was very enthusiastic about meeting.”

“Jane came in to pick up check. We discussed her plans for the weekend. She will go to the movies with friends and go to her son’s house for a cookout.”
Met with Jim today for regularly scheduled session. He appeared well-groomed and in a good mood. He stated he went to choir practice and sang last Sunday at both services. States he felt exhausted. Jim did state that he enjoyed himself but that he needed encouragement from family to participate.
Susie came for regular appointment today. Her affect is bright and she has a bounce in her step down the hall and into the office. Susie tells me about her visit to her grandmothers house and how much fun she had. Said that she was not sad at all during the visit. She says she just kept thinking about all of the good things in her life if she started to feel bad. She says that the journaling has helped her write down her feelings so she is not keeping them all inside any more. Wants to start coming to appointments every three months instead of once per week. She says she has not had any thoughts of hurting herself in months.
Reviewed steps with client on how to catch bus from her apartment to the store including: arriving at the bus stop ten minutes ahead of time, showing her pass to the driver, sitting where she feels comfortable, having her bus schedule available, familiarizing her with names of streets and keeping an eye out for stops ahead of hers for the apartment and the store.
Intervention: Met with Sue and her husband to discuss Sue’s anxiety in interactions with strangers. Helped her to express her fears to her husband and to voice ways that he can be more supportive when she is having a bad day. Encouraged him to talk about how her mental health disorder effects their lives.

Response: Sue tearfully expressed her fears to her husband, and was able to listen and restate his feelings as to how her disorder has affected him and their lives. They agreed to make time each day to talk and process their feelings.

Progress: Sue was anxious during discussion but was able to express her fears. Only had to stop once to deep breath and calm herself.

Plan: Will set up time to talk to each other daily. Return in two weeks for family session.
**Intervention:** Met with Timmy, and his mother and brother for scheduled session. Mother reports that the boys fight all the time and Timmy gets angry when told no and states “You don’t love me”. Educated mother on a token system for behaviors and asked Timmy for ideas for rewards when he has enough tokens to cash in. Assisted brother in identifying ways that he can ignore and get away from the situation rather than getting into an argument with Timmy. Coached mother on specific ways to give directions and immediate use of consequences.

**Response:** Timmy and his brother argued and punched each other through most of the session and were openly refusing to comply with mother’s directions to reduce their behaviors. Mother responded to coaching on being more clear in her directions.

**Progress:** Timmy continues to instigate arguments with others and have problems with complying with instructions. Mother is using a behavior chart, but does no have consistent reward system set up for positive behaviors.

**Plan:** MHPP visit to review behavior chart and token system implemented by mother before the next clinical session in two weeks. Will schedule family session with just Timmy and his mother to work on issues related to his feeling unloved.
**Intervention:** Facilitated group interaction and process in relation to dealing with anxiety. Used interactions between group members to encourage processing of situational anxiety, solution focused feedback and group support.

**Response:** Sue shared her experiences last week with anxiety when talking with the job placement expert at workforce office. Was able to utilize feedback from other group members to identify strategies to reduce anxiety. Was encouraged to hear that others had the same experience and stated that this helped her know that she should keep working toward her goal.

**Progress:** Sue was anxious during discussion but did not have to leave group due to panic attack during this session as she has in the past.

**Plan:** Sue plans to continue practicing new skills and report back to the group. Continue weekly group sessions.
Professional Group

**Intervention:** Facilitated group interaction and process in relations to dealing with abuse. Used interactions between group members to encourage identifying and processing of feelings including anger, solution focused feedback and group support.

**Response:** Tiffany shared her experiences with being taken from her family because Mom left them alone for two days while she went to Tunica with her boyfriend. Was able to utilize feedback from other group members to identified her feelings, especially anger. Was encouraged by leader and others to allow herself to admit her feelings of anger.

**Progress:** Tiffany became tearful during the group when she talked about her mother. Was obviously surprised to hear that others felt the same way she did at time. Says she will share more often in group.

**Plan:** Sue plans to talk more about her feelings with her therapist in individual session. Continue weekly group sessions.
**Intervention:** Role played some possible scenarios as taught by clinician in contacting agencies for information and prompted use of coping strategies when she became anxious.

**Response:** Sue was able to role-play scenarios and to resolve anxiety using visualization.

**Progress:** Sue reports that she called benefits counseling services and was able to get some information about her benefits through that agency. But did not make an appointment because she was anxious about the process.

**Plan:** Sue agreed that she would call again this week and set up an appointment using skills we reviewed. Will check in with her next week to see if she has followed through.
**Intervention:** Went to the foster home and worked with Tiffany on practicing identifying emotions using cards with pictures of kids in different settings. Discussed progress on homework of writing a letter to her mother.

**Response:** At first Tiffany just said that everyone was sad. After reviewing cards the first time, she was asked to look again and was able to talk about some of the kids being angry. Says that her foster mother is helping her write the letter.

**Progress:** Tiffany was able to identify the emotion of anger in some of the cards, but she told me that if she is angry, then people will not like her.

**Plan:** Tiffany will bring letter to session with her therapist next week. Continue to practice identifying emotions per treatment plan.
Intervention: Cognitive behavioral therapy to address negative thought patterns that lead to obsessive thoughts of being kidnapped. Practiced thought stopping techniques with Sara. Discussed the need to plan out the process so as to reduce anxiety while riding the bus.

Response: Sara states that she was able to stop her obsessive thoughts and evaluate whether her fears were rational or irrational.

Progress: Sara road the bus last week and was able to get on the bus, show her pass and sit where she was comfortable and could see the names of the streets. She says she was very anxious, but was able to ride for 6 blocks. Was very happy about her progress.

Plan: Sara will ride the bus again in the next two weeks to practice skills. Plans to try to ride across town this time, but will call friend to pick her up if she gets anxious. Session to evaluate progress in two weeks.
Professional Group

**Intervention:** Used group process of this cohesive group to address negative thought patterns and self defeating messages. Encouraged group to provide constructive feedback to members when negative self talk was noted. Offer alternative positive affirmations.

**Response:** Sara was able to identify negative self talk by another member and constructively offered reframing of the situation. Received positive feedback from member and she smiled and sat up taller in her chair.

**Progress:** This was the first time that Sara has offered feedback to another group member. She was very engaged in the group. Stated that it felt safe here and she was gaining confidence to take skills outside of clinic setting.

**Plan:** Sara agrees to share her experience from her homework of riding the bus again in the next two weeks to practice skills. Will return to group in two weeks.
Intervention: Assisted Sara in implementing skills needed to go to the store without having to call an ambulance. Prompted her to use skills she had learned in therapy including thought stopping and critical thinking to evaluate if fears were rational or irrational.

Response: Sara states that she was able to stop her obsessive thoughts and evaluate whether her fears were rational or irrational. Decided that they were not rational but was not able to follow through with going into the store this week.

Progress: Sara was able to go to the store parking lot last week, but became very anxious when she got out to the car. Had to drive back home without the milk and bread she needed. She made no further attempts.

Plan: Sara will go back to the store this week and will use techniques that she has practiced to go into the store. MHPP will meet her at the store parking lot to help her implement skills.
Rehab Day

**Intervention:** Facilitated scheduled rehab day activities today including medication identification and compliance, health living habits and hygiene. Utilized structured group and interactive activities to assist beneficiaries in learning identified skills.

**Behavioral Observations:** Autumn began a new medication this week. Appeared sleepy at times but was able to focus and participate in activities. She interacted appropriately with staff and other members most of the time. She did have two episodes when she was talking to her dead mother. But responded to prompts from staff and hallucinations cleared.

**Progress:** Medications as still being adjusted and Autumn continues to live in the group home due to episodes of severe auditory and visual hallucinations. She knows the names of her medications and with some prompts is taking a bath and putting on clean clothes. Sleep at night continues to be poor due to reported voices and seeing her dead mother.

**Plan:** Continue daily group and class activity to improve competence in daily living skills and so she can live more independently.
Rehab Day

**Intervention:** Facilitated scheduled rehab day activities today including social skills, anger management, and problem solving skills. Utilized structured group and interactive activities to assist beneficiaries in learning identified skills.

**Behavioral Observation:** Timmy uses threats and bullying during the program to get his way with other beneficiaries, but responded to staff redirection to more positive behaviors. He walks around most the day with fist clenched.

**Progress:** Timmy is no longer actively hitting other children in the program. He continues to threaten and bully, but can now be redirected by staff without having to be pulled from activities 3-4 days per week.

**Plan:** Continue group and class activity three time per week to improve competence in anger management, problem solving and social skills. Work toward partial day in regular classroom.
**Intervention**: Scheduled follow-up meeting with Jane Smith, School Counselor at Hogwarts Middle School to discuss plan to return Timmy to regular classes. Provided Ms. Smith with daily behavior reports from alternative school showing his progress. She reports plan is to allow him to return for part day classes in two weeks if progress continues, based on these reports.

**Plan**: Will pass information on to clinical team for evaluation of treatment plan and services frequencies.
Questions?
Please watch for a survey following this webinar. We appreciate your feedback.
Thank you