Recovery Oriented Documentation

THE INTERSECTION BETWEEN CLINICAL PROCESS AND BILLABLE ACTIVITY
# Introductions

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<thead>
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Presentation Overview

Clinical vs Billable
- Are these concepts really in opposition?

Signs and Symptoms of Misunderstanding
- Common traps to avoid

Effective Course Correction
- Documentation training framework

Q & A
Content Disclaimer

General Overview
- Non-exhaustive list of rules and regulations
- Reference slide describes sources of more exhaustive lists

Primary Authority
- The presenters of this training are NOT claiming to be the primary authority on all documentation questions
- Please consult with your DHCS liaison

Teaching Examples
- All examples discussed in this presentation are hypothetical
Clinical Process vs Billable Activity

CAN’T WE ALL JUST GET ALONG?
The Conflict

Why is clinical quality of care and billable activity seen as in opposition to each other?

◦ What are some of the assumptions underlying this question?
  √ Documentation has become “The ENEMY”
  √ Documentation competes with time spent with clients
  √ A provider’s “Paper Life” is separate from their “Clinical Life”
  √ A client’s “Paper Life” is separate from their “Clinical Life”
  √ Focusing on clinical care means ignoring billable rules and regulations
  √ Billable service requirements are a bunch of “tricks” to memorize
  √ Documentation is just about billing

◦ Doesn’t Medi-Cal pay for good clinical care?
Conflict Reframed

Reactive vs Planned Delivery of Services

◦ Be aware of the Client Plan BEFORE the session and know what Goals/Objectives you plan to work on with the client
  ◦ Your plan may need to change, but you should have a plan

◦ When you ask “How are you doing?” people will generally answer the question “What crisis happened this week?”
  ◦ By preparing for interventions, you can keep the focus on “How are you doing?”
  ◦ E.g., “What tools can we use in this situation?”

◦ Working with a plan helps the client track progress and get better

◦ Being intentional and thoughtful about interventions keeps the treatment focused on behavioral health needs and goals
Definition of Recovery

Substance Abuse and Mental Health Services Administration (SAMHSA) working definition of recovery:

◦ “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.”
Four Dimensions that Support a Life in Recovery

<table>
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<tr>
<th>Health</th>
<th>Home</th>
<th>Purpose</th>
<th>Community</th>
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<tbody>
<tr>
<td>Overcoming or managing one’s disease(s) or symptoms</td>
<td>A stable and safe place to live</td>
<td>Meaningful daily activities</td>
<td>Relationships and social networks the provide support, friendship, love, and hope</td>
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<tr>
<td>Making informed, healthy choices that support physical and emotional well-being</td>
<td></td>
<td>The independence, income, and resources to participate in society</td>
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10 Guiding Principles of Recovery

- Hope
- Person-Driven
- Many Pathways
- Holistic
- Peer Support
- Relational
- Culture
- Addresses Trauma
- Strengths / Responsibility
- Respect

Recovery
Golden Thread: MHP and DMC-ODS

Assessment and Diagnosis
- Symptoms, Needs, Strengths, Impairments

Client Plan
- Goals address impairments

Progress Notes
- Interventions address goals
Medical Necessity Documentation Refresher

Initial Assessment
- Establishes Medical Necessity

Initial Client Plan
- Based on the Initial Assessment
- A licensed signature on the Plan is attestation that Medical Necessity is met

Client Plan Updates
- Serve as progress reports and support ongoing Medical Necessity

Progress Notes
- Must contain evidence that the services claimed for reimbursement meet Medical Necessity
- Claim submission is attestation that this requirement is met
Medical Necessity Criteria

Criterion #1 (MHP): The client has an “included” DSM 5 diagnosis that is substantiated by chart documentation
  ◦ A client’s excluded diagnoses may be noted, but there must be an “included” diagnosis that is the primary focus of treatment

DMC-ODS: The client has an “included” DSM 5 SUD diagnosis substantiated by an ASAM six-dimensional Assessment
Medical Necessity Criteria

Criterion #2 (MHP): Client must have at least one of the following impairments as a result of the diagnosis(es) listed in Criterion #1:
- A significant impairment in an important area of life functioning
- A reasonable probability of significant deterioration in an important area of life functioning
- For children (a person under 21 years old):
  - A reasonable probability that the child will not progress developmentally as individually appropriate

DMC-ODS: Client must met the ASAM Adult/Adeolescent Dimensional Admission Criteria

SUD: Services that are reasonable and necessary to:
- Protect life
- Prevent significant illness or significant disability
- Alleviate severe pain through the diagnosis or treatment of a disease, illness or injury
Medical Necessity Criteria

Criterion #3 (MHP): Identify how the proposed service intervention(s) meet the following requirements:

- The focus of the proposed intervention addresses the condition identified in Criterion #2
- There is an expectation that the proposed intervention(s) will do at least one of the following:
  - Significantly diminish the impairment
  - Prevent significant deterioration in an important area of life functioning
  - For children (a person under 21 years old): allow the child to progress developmentally as appropriate
  - The condition would not be responsive to physical healthcare-based treatment

SUD: the services furnished can reasonably achieve their purpose

- Must ensure that services are sufficient in amount, duration or scope
Medical Necessity: Determined by the Assessment
Authorizes services through the Client Plan
Evidenced through the Progress Notes
Noticing the Signs

DANGER, THERE’S TROUBLE UP AHEAD
Signs of Drift

Reactive  Prescriptive
Traps to Avoid

Progress vs Observation Notes
  ◦ What does “client response” mean?

Charting to Role vs Activity
  ◦ Cramming the service encounter into a coding box

Assessing to the Algorithm
  ◦ Qualifying for a level of care vs assessing current need
Integrating Physical Health with MH/SUD

SUD: Physical Exam requirements

MHP: Medical Social Work, particularly in older adult populations

Questions to consider:
- Do MH/SUD conditions affect physical health?
- Do physical health conditions affect MH/SUD recovery?
- Do MH/SUD providers assist clients with advocacy and linkage to healthcare services?
  - What part of that assistance requires the MH/SUD provider to have a license/certification?
Shifting the Paradigm

EMPOWERING RECOVERY-ORIENTED CHARTING
“A Person and a Mentally Ill Patient” by Wally Kisthardt

We use words in many ways, to understand our being.
And we know our point of view affects what we are seeing...
A diagnosis is a powerful word, it’s true.
For once a ‘disorder’ is defined, it’s the lens that we look through.

A person gets excited; with a patient it is manic.
A person has concerns; with a patient it is panic.
A person is expressive; a patient’s histrionic.
A person can get better; while a patient’s often chronic.
“A Person and a Mentally Ill Patient” by Wally Kisthardt

A person may get angry; a patient becomes agitated.
A person is a creative thinker; a patient’s thoughts are not related.
A person may be sad; a patient is depressed.
A person may be childlike; a patient is regressed.

A person may be cautious; with a patient it is guarded.
A person may change her mind; a patient must finish what is started.
A person tries to influence; a patient manipulates.
A person gets a second opinion; a patient triangulates.
“A Person and a Mentally Ill Patient” by Wally Kisthardt

A person is an activist; a patient’s antisocial.
A person is a visionary; a patient is delusional.
A person lives in a home; a patient in a facility.
A person has many strengths; a patient has a disability.

A reminder to us all that mental illness does not nullify personhood.
And each and everyone we try to help may not behave as we think they should.
Don’t let their illness shift our sights from the gifts that people possess,
And we will see the wonder in each life and the joys of each success.
Recovery Framework in Documentation

We all want to treat clients with appropriate clinical interventions that help the client progress toward their goals.

If clinicians do that, and then write down what they did and why, they almost always have a billable note (or at least a really good start!)
Reuniting Clinical Work & Documentation

Bring clinical reasoning into documentation training

◦ What is the clinical benefit to any given documentation requirement?
  ◦ Does it help the clinician assess if the treatment is working?
  ◦ Does it help the clinician think through why they want to do a particular intervention?
  ◦ Does it help keep the client and clinician moving toward the client’s goals?

◦ How does it help the client?
  ◦ Would having a copy of a clear, client-centered treatment plan help the client?
  ◦ Can a clinician’s clarity about the purpose and effect of an intervention help the client progress?

Focus on treatment, not reimbursement

◦ Avoid making reimbursement the center of your message
◦ Avoid “tips & tricks” framework
◦ Instead, try: “Know what you’re doing and why you’re doing it, then write that down.”
What Did I Do? Why Did I Do It?

What did I do?

◦ Service activity definitions are foundational
◦ Frequent misunderstandings:
  ◦ Targeted Case Management is not a catch-all
  ◦ Rehabilitation is not therapy-lite
  ◦ Doing everything for the client is not recovery-oriented treatment
◦ Clarity on service definitions required for appropriate treatment, client plans, and progress notes

Why did I do it?

◦ Medically necessary services (not medically necessary clients!)
◦ Client treatment plan goals
Client Plans

If you have a solid plan, balancing billable and clinical is easier
◦ Do approved service activities *(billable!)* that will help the client move toward their goals *(clinical!)*

Treatment planning is a clinical intervention
◦ Clients learn skills to develop meaningful, measurable goals
◦ Clients learn how to track their own progress
◦ Good treatment planning incorporates SAMHSA’s dimensions of recovery: health, home, purpose, community
◦ By agreeing to meaningful goals at the start, treatment moves away from “reactive” services
Client Plans Continued

Dignity of Risk

- Individuals have a right to make informed choices in relation to a variety of life experiences and take advantage of opportunities for learning, developing competencies and independence and, in doing so, taking calculated risks.
- Don’t be a dream killer in an effort to “protect” your client.
- A “protective” client plan does not give the clinician or client any path forward for successful treatment.
Progress Notes

What did you actually do?
◦ Is it a Specialty Mental Health Service? Is it a Substance Use Disorder Service?
◦ Is it a medically necessary service for this client?
◦ Is it helping the client move toward recovery?

Why did you do it?
◦ The purpose might not be the surface-level activity itself
  ◦ “Played Apples To Apples with client” vs. “Using structure of game, helped Violet learn that labels can be arbitrary to introduce concept of cognitive distortions”

How does that intervention move the client toward a recovery goal?

How did the client respond?

What changes are we seeing over time?
◦ Is treatment working as planned?
◦ Do we need to change course to meet the client’s goal?
Level of Care Changes

The ASAM or CANS/ANSA score alone is not sufficient to document level of care changes
- What changes in the client’s recovery resulted in the changed scores?

Achieved the goals/objectives necessary to transition to the next step

No longer meeting criteria for this level of care
Questions?

“QUESTIONS ARE CREATIVE ACTS OF INTELLIGENCE.”
—FRANCIS KINGDON WARD
References

References
- Medi-Cal:
  - California Code of Regulations, Title 9
  - California Code of Regulations, Title 22
  - Mental Health Plan (MHP)/Drug Medi-Cal: Organized Delivery System (DMC-ODS) contract with California Department of Health Care Services (DHCS)
  - DHCS Information Notices
  - 42 CFR, Part 2
- MediCare
  - Centers for Medicare & Medicaid Services (CMS)
  - Noridian
  - California State regulations & licensing boards
- Substance Abuse and Mental Health Services Administration (SAMHSA)
  - Collaborative Documentation
  - Working Definition of Recovery