MSDP STANDARDIZED DOCUMENTATION INITIATIVE

2013 Training Manual

MSDP Training Manual

MASSACHUSETTS

Standardized Documentation Initiative

2009:
Developed by the MSDP Standardized Documentation Team
Compliance Review by the MSDP Compliance Review Team
Natick, MA

2013:
Compliance updates completed by the MSDP Leadership Committee

For more information and updates on this initiative visit the MSDP UPDATE Website:

http://www.abhmass.org/msdp.html

Table of Contents

INTRODUCTION:

The statewide MSDP Standardized Documentation Initiative was developed as a proactive response to Goal Six of the *2003 New Freedom Commission Report* and to the Executive Order to develop e-health initiatives to support a migration to Electronic Health Records (EHR) for all persons served. The critical first step to developing statewide capacity to electronically document mental health and substance use disorder services is to develop a standardized clinical documentation flow process that includes standardized data elements per type of form/process.

Historically, statewide provider agencies/programs have independently developed and used a wide variety of different versions of clinical and medical documentation processes. As a result, in current practice statewide, there are a significant number of different genres/styles of assessments, service plans and progress notes being used. The costs associated with developing a standardized electronic record based on using the multiple approaches being used would be significant for each provider/program individually. The ultimate goal of the MSDP initiative through the development of a standardized set of clinical documentation processes and data elements within each process is to be able to create open source code for electronic forms that can be developed at a much lower cost for use by all provider agencies/programs.

Further, the standardized documentation model is an appropriate response to the need to support a more person-centered assessment, planning and service delivery approach. In addition, the standardized documentation approach provides a positive response to the enhanced compliance requirements to adequately document qualitative support for Medical Necessity for services billed to Medicaid, Medicare and private insurance/third party payers. The standardized documentation process will provide a new ***systems learning*** capacity for continuously improving the quality of documentation statewide. Also, experience in other states using a standardized documentation model has demonstrated support for more objective audit/review outcomes.

Over 80 different programs representing over 25 different provider agencies statewide participated in the MSDP Pilot Study in 2008. The evaluation and feedback received from those individual direct care staff and participating programs was critically important to develop the final set of documentation processes that are contained within these manuals

Section 1

What is the *MSDP* Initiative?

What is the MSDP Initiative?

It is an initiative to develop statewide standardized integrated clinical and medical services forms and processes that provide enhanced compliance and quality for mental health and substance use disorder service delivery throughout Massachusetts. All documentation processes were designed to accommodate and comply with the following documentation requirements:

1. **State Payers**: Medicaid/DMA; DMH; DPH-BSAS; and DPH-HCQ
2. **Managed Care**: MBHP and State MCOs
3. **National Accreditation**: JOINT COMMISSION; COA; CARF; and NCQA
4. **Federal Payers**: Medicaid and Medicare
5. **Medicaid/Medicare Documentation Support Focus**: Medical Necessity; Person Served Participation; and Person Served Benefit

What is the MSDP Statement of Purpose?

The purpose is to design, develop and implement a standardized documentation process that includes identification of the required clinical processes and the specific data elements within each process. Further, the new process needs to adequately support the delivery of quality recovery focused services that are compliant with the requirements of all applicable funders and national accreditation bodies included in the scope of work. The secondary outcome of the MSDP will be to use the identified standard data elements to enhance the timely and cost efficient development of a standardized EHR.

What is the Scope of Work for the MSDP Initiative?

The identified scope of work for the MSDP initiative includes documentation requirements for services identified below:

a. All Department of Mental Health community services
b. Medicaid Mental Health acute services, regardless of health plan, carve out or Fee For Service status
c. Services purchased by the Bureau of Substance Abuse Services
d. Substance Use Disorder Services purchased by Medicaid
e. EATS, CBATS and Supported Education and Employment Services
f. Programs that do not have an individual record will not be included in the scope of work (i.e., Disaster Response, Training, Trauma Response, Consultation Programs, etc.)

Within the context of the above services, the MSDP will support the development and implementation of the following scope of work:

1. Develop the data elements necessary in each clinical form type to support an integrated standardized documentation approach.

2. Develop a data element dictionary and cross walk for all data elements in each form type

3. Provide compliance review to ensure the created form processes meet applicable state, federal and national accreditation requirements/standards

What does it mean for you?

Several things… especially about documentation:

- A consolidation of rules/requirements and a lessening of duplicative language and paperwork
- Standardized statewide forms for mental health and substance use disorder providers
- Forms that will assure financial and clinical compliance and reduce opportunity for rejection from auditors and payers
- Forms that are compliant with JOINT COMMISSION, CARF, COA and NCQA accreditation standards
- Structured forms (check boxes) to record less narrative and reduce completion time.
- MSDP forms cover all of the most common clinical documentation requirements, including a Personal Information Form, Comprehensive Assessment, Comprehensive Assessment Updates, Individualized Action Plans, Initial Psychiatric Evaluation, Progress Notes, and the Discharge/Transfer Summary.

Why the statewide forms development initiative?

- Lack of similarity in forms between agencies and within agencies. (Lack of standardization, which has resulted in provider agencies using hundreds and hundreds of different form formats and data fields.)
- Difficult for auditors to find information required for reimbursement and clinical audits.
- Huge federal fines and legal problems for providers in other states struggling with adequate documentation.
- Need to reduce paperwork so providers can dedicate more time to providing service rather than documentation
- Requirement to move to statewide electronic health records in Massachusetts which can best be accomplished using one standardized documentation process.

Stakeholders Guiding the MSDP Initiative

The following stakeholders have participated in the MSDP initiative to help design the standardized documentation processes with a clear focus on the goals of improved quality of care, increased administrative efficiencies, and full legal, regulatory, and accreditation compliance:

- Association of Behavioral Health Care (ABH)
- Executive Office of Health and Human Services (EOHHS)
- Department of Mental Health (DMH)
- MassHealth
- Department of Public Health Bureau of Substance Abuse Services DPH/BSAS
- Massachusetts Behavioral Health Partnership (MBHP) Medicaid Carve Out
- Medicaid Managed Care Organizations (MMCOs):
  - BMC HealthNet
  - Neighborhood Health Plan
  - Fallon Community Health Plan
  - Network Health

Consumer/Families and Advocate Organizations:

- Parent Professional Advocacy League (PPAL)
- National Alliance for the Mentally Ill of Massachusetts (NAMI)
- The Consumer Quality Initiative (CQI)
- Massachusetts Organization for Addiction Recovery (MOAR)
- Massachusetts People/Patients Organized for Wellness, Empowerment and Rights (M-Power)

Information regarding the Operational components and project history can be found in the archived introductory handbook.

The MSDP statewide documentation model includes two final products:

1. **E-form Electronic Format**: This format will provide a Microsoft WORD e-form version of each form that can be used by local staff on their local computers. The e-form model will offer tab to next data element and expandable text field features, however this version does not provide any link to billing services.

2. **Data Mapping of MSDP Data Elements:** The data mapping of all data elements will be available to all providers and software vendors to assist in the design and development of electronic medical records (EMR) that include all of the required MSDP data elements and Medical Necessity Documentation Linkage requirements. Further, a software vendor certification program will be available to software vendors that want their EMR version certified as compliant with the MSDP processes. Additional information about the vendor certification process is available at: http://www.abhmass.org/msdp/become-msdp-certified.html

2013 Updates to the Forms and Manuals

Starting in 2010, the MSDP Leadership Committee undertook the task of reviewing and updating the forms and manuals based on feedback from providers as well as changes in compliance standards. These revised manuals and a new form set are the results of countless hours of volunteers' time.

The following is a list of forms that have been modified:

Assessments

Adult Comprehensive Assessment - Revised
Adult Comprehensive Assessment Update – Revised
Child/Adolescent Comprehensive Assessment – Revised
Child/Adolescent Comprehensive Assessment Update – Revised
Mental Status Exam – Revised
Risk Assessment – Revised
Psychiatric Evaluation – *(previously Initial Psychiatric Evaluation)*
Tobacco Assessment – Revised
Infectious Disease Risk Assessment *(previously HIV Risk Assessment)* - Revised
Physical Health Assessment – Revised

Individual Action Plan/Treatment Plan Forms

IAP V1
IAP V1 Goals and Objective extra sheet
IAP V2
IAP V2 Goals and Objective extra sheets
Individual Action Plan Review/Revision - Revised
Individual Action Plan: Detoxification – Revised
Individual Action Plan: Psychopharmacology – Revised
Multi-Disciplinary Team Review/Response - Revised

Transition Forms

Discharge Summary/Transition Plan *(previously Transition/Discharge Summary Plan)* - Revised

Addenda

Employment Addendum - Revised
Military Service Addendum – Revised
Addictive Behaviors and Substance Use History Addendum *(previously Substance Use Addendum)* - Revised
Trauma History Addendum – Revised
Medication Addendum - New
CANS Transition to Adulthood Addendum - New

Progress/Service Notes

Psychiatry/Medication Progress Note (*previously Psychopharmacology Progress)* - Revised

Psychiatry/Medication – Psychotherapy Progress Note *(previously Psychopharmacology/ Psychotherapy Progress Note)* - Revised
CBFS Service Note

Since the start of the MSDP, several levels of care have been added and several removed. At the present time, the following is a list of the Levels of Care that the MSDP applies to in Massachusetts:

- Child Day Services
- Children's Behavioral Health Initiative (CBHI)
- Community Based Acute Treatment (CBAT)
- Community Support Program (CSP)
- Crisis Stabilization (CSU)
- Detox – ATS
- Detox – EATS ATS/DDART
- Detox – Adolescent
- Detox – Level III (Inpatient Pregnant Women)
- Detox – Level II.5 (Inpatient Residential/Dual Diagnosis)
- Detox - Level III.5 (Short Term Intensive Inpatient Treatment)
- Detox - Level III.7 (Inpatient)
- Detox - Level IV (Inpatient: All Inclusive Detox Adult/Adolescent)
- Detox - Outpatient
- Family Stabilization Team (FST)
- Flex Support Program
- Intensive Community Based Acute Treatment (ICBAT)
- Intensive Outpatient Program - Substance Abuse (IOP)
- Intensive Residential Treatment Program
- Mobile Crisis Intervention (MCI)
- Opiate Treatment Program
- Outpatient Mental Health
- Outpatient Substance Use Disorder
- Partial Hospitalization Program (PHP)
- Program of Assertive Community Treatment (PACT)
- Psychiatric Day Treatment
- Residential Services - Adult DPH
- Residential Services - Child/Adolescent DPH
- Respite
- Structured Outpatient Addiction Program (SOAP)
- Transitional Support Services (TSS)

Training Materials, Manuals, and Compliance Grids:

There are a number of resources available on the MSDP website intended to assist providers in adopting and/or updating their use of the MSDP forms and data sets. These include:

Training Materials:

- Slides from the April 30, 2013 MSDP Update Training.

- Form samples

Updated Manuals: Significant changes have been made to the manuals. In addition to updating the manuals to match the form changes, all new examples have been written throughout. As much as possible, four clinical cases (Adult Outpatient, Adult CBFS, Adult BSAS, and Child CBHI) were used throughout the manuals to provide consistency and continuity in the examples. These same cases were used to develop the above mentioned Form Samples.

Compliance Girds: All changes made to the forms for compliance reasons have been documented in the Updated Compliance Grids.

Data Map: All form changes are reflected in the 2013 Data Map.

All of the above mentioned materials are available on the MSDP website:
http://www.abhmass.org/msdp/forms-and-manuals.html

About the MSDP Training Manual

This manual is intended to enable providers to:

- Use the MSDP forms to effectively and efficiently document the individual treatment process for each person served
- Meet compliance with rules, regulations and accreditation standards
- Apply good clinical practices to deliver quality, recovery/resiliency-based mental health and substance use disorder services

The terms *person/person served* are used throughout this manual, based on feedback from the Consumers, Families and Advocates Advisory Committee (CFAAC). It is recognized that different preferences exist surrounding the use of certain terms. While some prefer to use *consumer*, others prefer to use *client* or *patient*.

Additionally, reference to P*erson-Centered* is used where appropriate, when more specificity helps to provide more clarity. In cases where the person served is a child or adolescent, the convention of person/family is used, recognizing that children and adolescents will participate in a treatment process in the context of their family.

How the MSDP Training Manual is Organized

Each section of this MSDP Training Manual will provide uniquely different areas of information that will hopefully equip your team with key qualitative and compliance concepts used in the development of the forms. Also, the manual will focus on specific information regarding how to utilize the data fields and clinical flow of each form. A summary of each section of the manual follows:

Section 1: Simplifying and Standardizing the Mental Health/Substance Use Disorder Treatment Process.
This section contains background information about the MSDP effort and the benefit that MSDP documentation provides. Also, this section provides specific information regarding Medical Necessity, payer, signature and compliance requirements and a discussion of a person-centered Recovery/Resiliency approach to services.

Section 2: Using the MSDP Assessment Group Documentation Processes/Forms.
This section provides a sample of each Assessment form type, guidelines for the use of each form, and instructions for completion of the forms, including definitions for each data field.

Section 3: Using the MSDP Individualized Action Plan (IAP) Group Documentation Processes/Forms.
This section provides a sample of each Action Plan Group form type, guidelines for the use of each form, and instructions for completion of the forms, including definitions for each data field.

Section 4: Using the MSDP Progress Note Group Documentation Processes/Forms.
This section provides a sample of each Progress Note form type, guidelines for the use of each form, and instructions for completion of the forms, including definitions for each data field.

Section 5: Appendix
This section contains supporting reference information.

Standardized Documentation Benefits

1. Improved Service Quality and Compliance

All forms in the MSDP Standardized Forms set, were cross referenced with applicable standards and regulations to insure compliance. In addition the structure and content of forms were designed to efficiently support core clinical and recovery processes.

The **Comprehensive Assessment** promotes participation by the person being served and encourages an interactive dialogue. Through a carefully planned sequence of assessment focus areas and prompts, the Assessment supports the efficient collection and analysis of information to:

- Accurately determine and support diagnoses
- Identify individual strengths, preferences, and personal goals
- Identify social, environmental and other barriers to recovery
- Identify available supports and resources
- Establish baselines for symptoms, domains of functioning, skills and abilities
- Articulate and prioritize needs and recommended services
- Justify the medical necessity for the types and intensity of services to be provided
- Lay the groundwork for development of a meaningful Individualized Action Plan

The **Comprehensive Assessment Update** is designed to ensure that:

- Relevant new or updated information is incorporated into the Assessment
- Current assessment data and conclusions directly support the current Individualized Action Plan

The **Individualized Action Plan** is designed to efficiently:

- Ensure active linkage to the findings and recommendations of the current Assessment
- Encourage collaboration between the provider and the person served
- Encourage the meaningful consideration of strengths and preferences in the development of goals and objectives
- Support the development of meaningful Goals
- Support the development of realistic, relevant, and measurable Objectives that are changes to the baselines established in the Comprehensive Assessment

- Support the clear articulation of interventions (methods), and service strategies that are expected to help achieve stated objectives and can meaningfully direct staff activities

Progress Notes are designed to efficiently:

- Ensure that Interventions/Methods remain focused on the Goals and Objectives developed in the Individualized Action Plan.
- Encourage description of interventions provided, the response/reaction to the interventions by the person served, and progress toward Goals/ Objectives.
- Articulate plans for activities recommended prior to the next session as well as the focus for the next session.
- Document pertinent new information that may trigger a Comprehensive Assessment update and potentially require a change in the Individualized Action Plan

All other forms in the MSDP Standardized Forms set were similarly designed to support the underlying processes they reflect.

2. Support for Person Centered, Recovery Oriented Services

The MSDP Standardized Forms and Processes were designed to help move efforts to provide Person Centered, Recovery/Resiliency Oriented services from theory to practice.

Person Centered Approach:

A Person Centered approach involves a genuine partnership between a provider and the person being served throughout all aspects of the service process including assessment, action planning and service interactions. Person Centeredness is not just about 'respect' or good 'customer relations'. These should be core elements of any responsible service orientation. Rather, Person Centeredness is about improving outcomes!

Engaging in the recovery process takes significant and prolonged effort on the part of the recovering person. Unless individuals believe that providers fully understand their personal goals, strengths, obstacles, and what they hope to gain from services, motivation and engagement will suffer.

Motivation and engagement are enhanced when individuals have real input into the development of goals and objectives that reflect personally desired change and can be easily related to the achievement of personal goals. Finally, ongoing service engagement will only occur if individuals understand how the services they receive are helping them reach the objectives both the persons served and their service providers committed to working on.

Person Centered services ensure that Assessment and Action Planning are considered more than just paperwork, and that services provided are focused and of value to the person served. The MSDP Standardized Forms set provides significant support for Person Centered Services.

Recovery Orientation:

Recovery is another concept that has been difficult for many service providers to implement in a practical sense. One nationally accepted definition of Recovery is, "A personal process of overcoming the negative impact of a psychiatric disability despite its continued presence."

For obvious reasons the Person Centered approach discussed above is central to supporting recovery. In addition, a Recovery orientation requires a shift from a primary focus on symptom reduction to a focus on improvement in functioning, resilience and adaptation.

The MSDP Standardized Forms and Processes are designed to support a Person Centered, Recovery Oriented approach. It is up to service providers to take advantage of that support.

The Comprehensive Assessment is designed to efficiently prompt exploration of a wide range of issues. The focus is not limited to symptoms and diagnoses, but includes functioning domains, skills, strengths, preferences, available and needed supports, and personal goals. It is important to encourage the persons being served to offer their perspectives in areas of importance to them and to ensure that they understand the purpose and value of the assessment. This is particularly important when developing identified needs that will form the basis for the Individualized Action Plan.

The Individualized Action Plan is also designed to encourage the active participation of the person being served and to allow a focus on functioning. This is particularly important in the development of goals and objectives, which should be achievable, realistic and of value to the person. The opportunity to identify individual strengths and how they can be brought to bear to help achieve goals and objectives is also provided.

Individual Action Plans should not be overly complex. It is difficult for most people (including provider staff) to maintain a focus on more than one or two goals and a few objectives at a time. By focusing on a few, relevant objectives, success is easier to achieve and measure thus further building motivation and engagement.

The Progress Note is also designed to support this approach. It is important to maintain "Action Plan Awareness" when providing services. This means that it should be clear to the provider as well as the person served what the current intervention session has to do with the achievement of a particular objective(s) in their Action Plan. It is all too common to find progress notes that document conversations about current 'mini crises' or other 'topics of the day' with no obvious connection to the Action Plan. As providers, we have a responsibility to help maintain Action Plan Awareness and provide interventions that help the person achieve the agreed upon objectives or, based on changing conditions, modify the Action Plan in collaboration with the person served.

For many of the people we serve, past experience with services has left them with low expectations. In their experience, Assessment and Action Planning may have been primarily paperwork exercises with little connection to the service interactions they have with provider staff. For these individuals, involvement in Person Centered, Recovery/Resiliency Oriented services will involve some relearning. This involves extra effort on the part of provider staff to help instill a sense of hope and engagement.

3 . Clinical Focus of the MSDP Documentation Process

The Massachusetts Standardized Documentation Project aims to create a standardized set of forms and processes, to be used as tools for documentation across the state, which are fully compliant with a wide variety of regulatory and payer requirements. The recent shift in the field towards electronic health records, prompted by the Federal mandate requiring all states employ electronic record formats in the near future, points to a pressing need for clinicians and practitioners to shift thinking about documentation itself. Along with the importance of demonstrating medical necessity and moving towards person and family centered planning and treatment, today's behavioral health care provider must also use documentation to accurately capture the person's assessed needs, goals for treatment, and work toward meeting the stated goals. As the persons we serve are not unchanging, neither can the documentation be a one-time-only, "snap shot", of a person's history, presentation, and goals. The form set and processes developed by the MSDP reflect this need and create a framework for a dynamic system of gathering and documenting the person's treatment, response to treatment and movement toward chosen goals over time.

The MSDP documentation process is one that is horizontal and integrated. It allows the provider to work collaboratively with the person served to continuously discover more about the person's needs and to maintain a clear, but dynamic plan for working towards the person's desired outcomes. The forms/processes allow for a logical and natural flow of information gathering and service documentation. When used as developed, as a "required record set", they serve as synergistic tools to:

- Assess the person in a comprehensive way,
- Ensure the determination of the medical necessity for treatment,
- Guide the development of treatment goals and objectives which meet the needs and desires of the person served and
- Document the progress or lack thereof of the person's course of treatment.

Each required form in the set supports the documentation of key service delivery processes from intake to discharge. Each form within the "required" record set for any service type addresses some of the essential elements needed to comply with funder and payer requirements. Therefore forms should not be "pulled apart" from each other and used individually. If some of the MSDP forms types are used, but not all of the required forms, the clinical information may be incomplete and compliance with funder/payer requirements will not be attained.

The chart below emphasizes the integrative design of the forms developed.

INTAKE	
Personal Information	✓ Must be completed at the time of initial contact with the person who is seeking services. ✓ Reflects the minimum amount of demographic information to record for each person served. ✓ Captures essential demographic, contact and insurance/billing information. ✓ This form can be completed by support staff or clinical staff.

CRISIS	
Risk Assessment	✓ Used to assess risk of harm to self or others as part of a comprehensive assessment or when assessing a person in crisis. ✓ Gathers data on relevant risk issues and severity. ✓ Completed by a masters level clinician or a paraprofessional, under the supervision of a licensed clinician; or a licensed clinician.
ASSESSMENT	
Adult Comprehensive Assessment	✓ Complete after the Personal Information form, as the person enters services, in compliance with agency policies and funding requirements. ✓ The Adult Comprehensive Assessment provides a standard format to assess mental health, substance use and functional needs of persons served. This Assessment provides a summary of assessed needs that serve as the basis of Goals and Objectives in the Individualized Action Plan. ✓ A qualified clinician must complete or oversee the completion of this form after interviewing the person served, face to face.
Child/Adolescent Comprehensive Assessment	✓ Complete after the Personal Information form, as the person enters services, in compliance with agency policies and funding requirements. ✓ The Child/Adolescent Comprehensive Assessment provides a standard format to assess mental health, substance use and functional needs of persons served. This Assessment provides a summary of assessed needs that serve as the basis of Goals and Objectives in the Individualized Action Plan. ✓ A qualified clinician must complete or oversee the completion of this form after interviewing the person served, face to face.
Mental Status Exam	✓ Use anytime to assess symptoms and behaviors. ✓ This is a data gathering tool, with multiple uses, to assess current symptoms and behaviors. This is a component of the comprehensive assessment, or is completed as part of a risk assessment. Also it is provided as a stand-alone document. ✓ A licensed practitioner as determined by agency policy must complete this form after interviewing the person served, face to face.
Psychiatric Evaluation	✓ Complete after the Personal Information form, as the person enters services, in compliance with agency policies and funding requirements. ✓ Used to assess the bio-psychosocial health and service needs of the person served. Components of this evaluation are included in the comprehensive assessments. Also it is provided as a stand-alone document. ✓ This form is to be completed by a psychiatrist, CNS or other APN with credential in psychiatry and prescribing privileges.
Tobacco Assessment	✓ Required for DPH licensed programs; completed in concert with the comprehensive assessments. ✓ Optional for other programs following agency policies. ✓ Assesses current and past tobacco use and readiness to change. ✓ Completed by staff following agency policy.
Infectious Disease Risk Assessment	✓ Required for DPH licensed programs; completed in concert with the comprehensive assessments. ✓ Optional for other programs following agency policies. ✓ Assesses current and past risk behaviors as well as willingness for testing and treatment. ✓ Completed by staff following agency policy.
Physical Health Assessment	✓ Required for JOINT COMMISSION certified programs and some DPH services; completed in concert with the comprehensive assessments. ✓ Optional for other programs following agency policies. ✓ Assess current and past medical issues of the person served that may impact current functioning. ✓ To be completed by qualified Medical Professional.

INDIVIDUALIZED ACTION PLANNING	
Individualized Action Plan	✓ To promote principles of recovery, this form serves as what most of us have known as a treatment plan. The name, “Individualized Action Plan” reflects the recovery concept of shared decision making. ✓ Used to document goals, objectives, and therapeutic interventions. ✓ Links to needs identified during the assessment phase or ongoing treatment. ✓ Serves as a tool to collaboratively build a treatment plan, which reflects both medical necessity and the desired outcomes of the person served in his or her own words. ✓ The design encourages collaboration among programs and across agencies. ✓ Again supporting a recovery focus, transition/discharge planning is advised from the earliest point in treatment possible. The section provided on the form assists in this process.
IAP Psychopharmacology Plan	✓ Used for persons receiving outpatient psychopharmacology services only. ✓ Designed for ease of use and to capture all required information succinctly and accurately.

IAP Detox Plan	✓ Used for persons receiving inpatient detoxification treatment. ✓ Modeled after the standard Individualized Action Plan and reflective of the ASAM dimensions of treatment. ✓ Reflects and supports the short-term nature of this treatment modality.
MONITORING AND TRACKING	
Consultation/Collateral Contact Progress Note	✓ Used for billable or non-billable face-to-face or telephonic consultation or collateral contacts ✓ Identifies next action step and responsible party
Group Psychotherapy Progress Note	✓ Used to document therapeutic interventions and person's response to the intervention(s) during a specific contact ✓ Use for outpatient group psychotherapy ✓ Documentation links to specific goals in IAP
Health Care Provider Orders Progress Note	✓ Required for Rehabilitative Treatment in the Community (RTC) ✓ This note is used when a person is either living in a DMH-funded residential program, such as a group home, or is living in their own apartment and receiving DMH-funded Supported Housing Services. ✓ This serves as an ongoing communication tool between the residential support staff and the health care providers, which may include outpatient behavioral health prescribers, primary care physicians/nurse practitioners, and dentists. ✓ This can be used in outpatient behavioral health settings as the progress note for a medication visit for the outpatient chart. ✓ This ensures thorough and current medication lists, as well as instructions for both the staff and the individual taking the medications.
Intensive Services Progress Note	✓ Used to document therapeutic interventions and person's response to the intervention(s) during a specific contact ✓ Use for all individual and group services as part of Community Based Adolescent Treatment (CBAT), Intensive Community Based Adolescent Treatment (ICBAT), Partial Hospitalization Program (PHP), Detox, Intensive Outpatient Program (IOP), Structured Outpatient Addiction Program (SOAP) and Dual-Diagnosed Addiction Residential Treatment (DDART). ✓ Documentation links to specific goals in IAP. This form incorporates all therapeutic services specifically provided by the program during the course of the day.
Monthly Progress Note	✓ Used for services requiring monthly documentation. ✓ Required for Residential Services (DMH) ✓ Summarizes progress made by the individual toward the IAP goals and significant changes in the person's environment over the course of the month. ✓ Documentation links to specific goals in IAP.
Outreach Services Progress Note	✓ Used in home visit community support interactions with the person and family receiving services ✓ Required for Community Rehabilitation Services (CRS), Community Support Program (CSP), Family Stabilization Team (FST), Flex Support Program, Program of Assertive Community Treatment (PACT) ✓ Documentation links to specific goals in IAP
CBFS Service Note	✓ Used by CBFS Providers. ✓ Used to document the implementation of IAP interventions. ✓ Used to document the significant events in the person's life. ✓ Documentation links to specific Goals, Objectives, and Interventions in the IAP.
MONITORING AND TRACKING	
Psychiatry/Medication Progress Note	✓ Used by psychiatrists or Advanced Nurse Practitioner when member is seen only for outpatient medication management *or* as part of more intensive (bundled) service, such as when the psychiatrist meets individually with someone receiving services in a Partial Hospital Program. ✓ Documentation links to specific goals in the Psychopharmacology Plan or IAP.

MONITORING AND TRACKING - Continued	
Psychiatry/medication Psychotherapy Progress Note	✓ Used by psychiatrist or Advanced Nurse Practitioner when the prescriber provides service of outpatient med management *and* psychotherapy. ✓ Documentation links to specific goals in IAP.
Psychotherapy Progress Note	✓ Used to document therapeutic interventions and person's response to the intervention(s) during a specific contact ✓ Use for outpatient individual, couple or family psychotherapy ✓ Documentation links to specific goals in IAP
Nursing Progress Note (Long and Short Version)	✓ Used to document therapeutic interventions and person's response to the intervention(s) during a specific contact ✓ To be completed by a LPN, RN, BSN or MSN. ✓ Use either the short or long version, whichever provides sufficient space to record the

	information. The long version contains additional data fields to document additional information including a mini-mental status exam. ✓ Required for Intensive Residential Treatment Program (IRTP) ✓ This form can be used as a shift note by a nurse in any Detox, SOAP or DDART program.
Shift/Daily Progress Note	✓ Required for Child Day Services, Crisis Stabilization Unit (CSU), Detox Level III, Intensive Residential Treatment Program (IRTP), Respite ✓ Documentation links to specific goals in IAP.
Weekly Services Progress Note	✓ Used to document therapeutic interventions over the course of a week and person's response to the interventions ✓ Documentation links to specific goals in IAP ✓ Summarizes services/interventions and the person's responses/progress. ✓ Required for Psychiatric Day Treatment and Transitional Support Services (TSS)
ACTIVE REVIEW AND RESPONSE	
Adult Comprehensive Assessment Update	✓ This form saves time and effort. ✓ Used to update information in Comprehensive Assessment. ✓ Use whenever substantial change in person's status occurs. ✓ A qualified clinician must complete or oversee the completion of this form after interviewing the person served, face to face.
Child/Adolescent Comprehensive Assessment Update	✓ This form saves time and effort. ✓ Used to update information in Comprehensive Assessment. ✓ Use whenever substantial change in person's status occurs. ✓ A qualified clinician must complete or oversee the completion of this form after interviewing the person served, face to face.
Individualized Action Plan Review/Revision	✓ The Individualized Action Plan Review/Revision form has been created to document information from ongoing review(s), revision(s) of treatment goals and objectives and/or periodic rewrites. This form has been designed to minimize duplication of effort in creating subsequent action plans and maximize the documentation of information, which demonstrates evidence and/or rationale for revision. ✓ Use the IAP Review/Revision form to update or modify the IAP in any of the following ways: • **Revisions** – to add a new goal; change goals, objectives or interventions; or change the frequency or duration of services; • **Reviews** - to record the progress of the person served and ✓ Use both pages of the Individualized Action Plan Review/Revision form for either a Review or Revision; additional goal and/or objective sheets should be added as necessary. If you are adding a new goal or objective, attach the goal and/or objective page(s) from the IAP form to the IAP Review/Revision form. ✓ When a Rewrite is being completed, page 1 of the IAP Review/Revision should be used and the new IAP should be attached. ✓ If a goal/objective is new and not currently supported by the most recent Comprehensive Assessment, it is important to also complete a Comprehensive Assessment Update form. ✓ It is important to remember that as with the IAP, any IAP revisions should be completed in collaboration with the person served. This form requires evidence of collaboration in a number of ways. In all cases, if a person refuses to collaborate, does not agree to goals, or will not review goals, a separate progress note should be written to describe the person's participation and the plan for moving forward.
Multi-Disciplinary Team Review and Response	✓ As required, use this form to document the review of Individualized Action Plans and other necessary clinical documentation by a multi-disciplinary team. ✓ This form is designed to be used as a tool to provide feedback regarding required actions by the primary provider.
TRANSITION AND DISCHARGE	
Discharge Summary/ Transition Plan	✓ Use at the time of transition or discharge, including any movement throughout the continuum of care both internal and external. ✓ Summarize treatment, reasons for transition/discharge, and plans for referral to assist the person in following through on aftercare recommendations.
Note: The forms stay true to their purposes of assessment, action planning, and documentation of progress. By monitoring and ensuring ongoing dynamic review of and response to CA Updates, IAP Review and Revision, and MDT Review and Response, the person's needs are integrated formally into the treatment process.	

4. Enhances Necessary Person-Driven Documentation

This standardized record-keeping system and training manual guides clinicians and rehabilitation providers (in a variety of programs and throughout the state) toward meeting documentation requirements for medical necessity in a timely fashion. A standardized system is one remedy for the fragmentation of communication, resources and personal dreams that is often created by the current health and mental health care system. The forms themselves prompt for documentation of evidence-based services that are person-driven, goal oriented and a good fit for the individual's cultural context.

What is Being Documented?

Effective and high quality services have been described in a multitude of research studies and through personal accounts.[1] In 2006, the Institute of Medicine made several recommendations for clinicians and organizations to improve the quality of mental health and substance use treatment services that included:

- *incorporating informed, patient-centered decision making throughout their practices;*
- *adopting recovery-oriented and illness self-management practices that support patient preferences for treatment;*
- *maintaining effective, formal linkage with community resources to support patient illness self-management and recovery; and*
- *having policies that implement informed, patient-centered participation and decision making in treatment, illness self-management and recovery plans.* [2]

In this section of the manual, there are references to "person-centered", "recovery-oriented", "culturally competent", "collaborative" and "sustainable" models of care. These approaches, as well as many others, rest on a common framework that we call "person-driven". Language, structures and decisions that are driven and fueled by the person using services, the whole of the person, are essential to effective care.

The surge of interest and funding for evidence-based practices in behavioral healthcare has affirmed the focus on person-driven treatment:

---

[1] Slater, *Welcome to My Country*. Jamison, *An Unquiet Mind* and *Touched with Fire: Manic Depressive Illness and the Artistic Temperament.* Kaysen, *Girl Interrupted.* Millet, *The Looney Bin Trip.* Rogers, PhD., *A Shining Affliction* (extraordinary account by a therapist of her parallel recovery journey as client and clinician at the same time). Geller et al, (Ed). *Women of the Asylum.* Estroff, *Making it Crazy: An Ethnography of Psychiatric Clients in an American Community.* Stanford, L. *Strong at the Broken Places: Overcoming the Trauma of Childhood Abuse.* Styron, *Darkness Visible: A Memoir of Madness.* Manning, *Undercurrents* (journal of a therapist who uses ECT treatment to good effect). Beard et al., *Nothing to Hide: Mental Illness in the Family*

[2] IOM (2006). *Quality Chasm Reports: Improving the Quality of Health Care for Mental and Substance-Use Conditions.*

"Evidence based medicine is grounded in the concept of person-centeredness … [meaning] acknowledging individual differences and characteristics, including different biology, culture, beliefs, values, preferences, history, abilities, and interests." [3]

5. Satisfies Reimbursement and Compliance Requirements

Clinical documentation serves many purposes, among the most important purposes are:

- Clinical: management of the treatment process, especially where a treatment team is involved.
- Provider Agency: management of best practices, utilization management and resource allocation, and utilization review, audit trail for claims to third parties.
- Payer: determination of medical necessity, covered services, and the post or pre-payment review of claims for payment.

The integrated MSDP forms were designed to enable providers to fulfill key compliance and reimbursement elements, which include:

- Medical necessity for each service provided
- Documentation linkage requirements, especially the linkage of services to the plan of treatment or action plan.
- Signature and credentialing requirements to make sure all services are properly ordered as well as provided by appropriately credentialed individuals.

The MSDP forms were developed to allow providers/programs' to successfully meet the documentation requirements of state and federal regulations, accreditation standards, and major payers, including;

1. **State Payers**: Medicaid/DMA; DMH; DPH-BSAS; and DPH-HCQ
2. **Managed Care**: MBHP and State MCOs
3. **National Accreditation**: JOINT COMMISSION; COA; CARF; and NCQA
4. **Federal Payers**: Medicaid and Medicare
5. **Medicaid/Medicare Documentation Support Focus**: Medical Necessity; Person Served Participation; and Person Served Benefit

Good clinical practice and use of the MSDP documentation process will assist both providers and programs to meet payer requirements and high quality medical record-keeping practices. The forms, when properly completed' will substantiate diagnostic and service eligibility requirements, functional deficits where they are critical to supporting rehabilitative services, and treatment goals and treatment strategies all within an umbrella of recovery-based programming and person-centered planning.

The consistent use of the MSDP documentation across Massachusetts' mental health and substance use disorder delivery system, positions providers/programs to mitigate reimbursement and compliance-related risk.

[3] Hyde, PS, Falls, K, et al, *Turning Knowledge into Practice: A Manual for Behavioral Health Administrators and Practitioners about Understanding and Implementing Evidence-based Practices*.

Medical Necessity

The concept of *medical necessity* is a critical one for providers/programs to grasp. *Medical necessity* is:

- A payment concept that requires that services must be both directed towards a medical problem and a necessary service in order to be reimbursable
- Medicaid, Medicare and most third party payers' standard for determining payment of claims
- A claims based model that requires that each service on a stand-alone basis demonstrate its medical necessity

The concept is sometimes viewed as applicable only to a *medical model*. However, Medicaid and Medicare both insist that rehabilitative as well as recovery-based services that they pay for meet these standards as well.

Medicaid Definition of Medical Necessity

Medical necessity starts with a practitioner who based on a comprehensive evaluation of an Individual determines that the Individual has a mental health or substance disorder AND either current signs and symptoms or current problems with daily functioning caused by the impact of their disorder/illness that are necessary in order to help the individual recover from or better manage their disorder/illness. Key here for purposes of medical necessity is an understanding of payer rules (and they often are different) as to who can diagnose mental illness and substance use disorder and who can order services. Most payers will rely minimally on state licensure laws that determine scope of practice for each license but in some cases payers will require more experience and higher credentials than even state law. If the service is not ordered by the appropriately credentialed person the first test of medical necessity is not met.

For example:

A social worker cannot order medication management services to be provided by a physician. They cannot by state law either provide or supervise medication management services and so, therefore, cannot determine if these services are medically necessary.

The second test of medically necessary services is that they must be considered to be reasonable and generally effective for the specific diagnosis and clinical picture of the individual. They must help the person served either get better, prevent them from getting worse, or prevent the development of symptoms/ problems. . Services, therefore, must be directed at signs and symptoms or functionality that is directly related to the diagnosis. So, for example, Medicaid will not pay for general parenting training because this service would not be considered to be specific to a particular diagnosis or generally considered to be effective for treatment of a mental illness or substance use disorder. Medicaid will, however, pay for specific parenting training that is directed at how parenting must change in order to manage or support a child with a particular diagnosis.

The third test of medical necessity is that the service provided be a covered service under the insurance benefits package held by the Individual. All payers define their service packages and outline services that are therapeutic but are not covered because they are not considered to be medically necessary.

In order to meet the conditions above, Medicaid requires that the payer document that the services are:

- Delivered at an intensity that is appropriate and that will likely be effective
- Provided in the lowest level of care that is reasonable and safe

Please also remember that diagnostic services must also be medically necessary and the services ordered to assist in a diagnostic assessment period must be capable of providing unique, essential and appropriate information that cannot be obtained in an interview process. This would include services like, psychological testing, neurological consults, lab work, etc.

Medicaid Criteria for Payment of Medically Necessary Services

Even though a service may be medically necessary, it may still not be reimbursable. Criteria that Medicaid uses to determine whether medically necessary services can be paid includes:

- Outpatient services are voluntary and initiated by the Individual , or the Individual's family/guardian *(Note: Payers believe with some justification that people who come freely to services and are actively involved in developing their individualized action/service plans are more likely to participate actively in their treatment and to comply with their treatment regimen.) In some cases, inpatient admissions can be involuntary and these criteria would not need to be met.*
- The Individual's right to select both the provider agency and the specific providers of their choice. Again, this promotes the active participation of the person served in his/her own care and is a fundamental right addressed in the State Medicaid Manual. In some cases, as in Massachusetts, federal Medicaid waives the requirement for absolute choice by allowing managed care entities to limit their provider pools.
- The services are provided by an eligible provider. In addition to ordering the service, an eligible provider must also render the service. (*Note: Most payers list the credentials they require for the provider of each service covered under their benefit plans. For most payers credentials include a combination of licensure (if required), education, and experience. Providers are expected to comply with these credentialing requirements as a condition of payment.)*
- The service must be provided in compliance with the Medicaid definition for the service as defined by the eligible service codes in the CPT or HCPCS code books. Although some states have been quite liberal in their use of a code and expanded on some definitions, providers should be careful to maintain internal coding integrity.
- The service must be the lowest cost service that effectively addresses the problem of the person served.

Medical Necessity in Mental Health and Substance Use Disorder Services

In Massachusetts the state Medicaid agency is the Department of Medical Assistance. They define medical necessity as follows:

Medical Necessity

The MassHealth agency will not pay a provider for services that are not medically necessary and may impose sanctions on a provider for providing or prescribing a service

or for admitting a member to an inpatient facility where such service or admission is not medically necessary.

(A) A service is "medically necessary" if:

(1) it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and

(2) there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to the MassHealth agency. Services that are less costly to the MassHealth agency include, but are not limited to, health care reasonably known by the provider, or identified by the MassHealth agency pursuant to a prior-authorization request, to be available to the member.

(B) Medically necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality. A provider must make those records, including medical records, available to the MassHealth agency upon request.

(C) A provider's opinion or clinical determination that a service is not medically necessary does not constitute an action by the MassHealth agency.

What this means in operational terms is that:

1. The individual must have one or more diagnoses – the latest version of either ICD or DSM and that diagnosis must currently "endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity". In other words, a diagnosis is not enough. There must be manifestations of the diagnosis in the clinical picture of the individual for services to be medically necessary.
2. The services provided must be the lowest cost and most conservative that are both appropriate AND available.
3. The services or help provided by the mental health or substance use disorder systems of care can be directed towards:
   a. Diagnosing mental illness or substance use disorder.
   b. Preventing the worsening of the diagnosed illness.
   c. Alleviate the symptoms or other manifestations of the diagnosed illness.
   d. Correct or cure the diagnosed illness.
4. The service must be documented in a medical record that is available to Medicaid for review.

Medical Necessity and Recovery

Recovery-based service models with their rehabilitative focus also must meet *medical necessity* criteria if they are going to be billed to a third-party payer who covers rehabilitative services. Federal Medicaid law defines a rehabilitative service as "*any medical or remedial services (provided in the facility, a home, or other setting), recommended by a physician or other licensed practitioner of the healing arts, within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level*."[1] *Medical*

necessity, therefore, is not just based on diagnosis (with its attendant signs and symptoms) but also on functional criteria.

This federal definition is very compatible with the description of the Rehabilitation Model found in the IAPSRS[2] publication, *Best Practices in Psychosocial Rehabilitation*. This rehab model "*focuses on the functioning of the individual in the normal, day-to-day environment, and looks at the strengths and skills people bring to the rehabilitation process and supports in the community. Although an individual may still be symptomatic, the rehabilitation process helps a person learn ways to compensate for the effects of the mental illness through environmental supports and coping skills. The person with the mental illness becomes the expert in managing the disability*."[3]

Both the federal and IAPSRS definitions focus on improving the functioning of the individual. Both also make it clear that the services are directed toward keeping the person served in the community setting and, therefore, contemplate the necessity for services to be provided in multiple settings in order to maximize benefit to the person. In addition, the IAPSRS definition stresses the active participation of the person served. The person served must actively participate in the development of their individualized action/service plan and they must become the experts in their own recovery. IAPSRS is also specific about their expectations of benefit to the person served, using a strengths-based model to promote:

- Greater functionality
- Independence
- Integration into their community and support network

The rehabilitation option model, therefore, uses a functional test as the base for a *medical necessity* determination for covered services, and then adds the generally accepted criteria of benefit, participation and individual planning.

What is clearly very important about the rehabilitation option and its coverage by Medicaid is the difference in the approach to services and the impact this has on the overall model of care.

For example:

Recovery is a holistic treatment process that deals with all aspects of a person's life. Under this model, the person served becomes knowledgeable about his/her mental illness/substance use disorder, works with other community and environmental supports toward self-defined realistic goals, and eventually manages his/her mental health/substance use disorder. Community providers support the person's efforts using their training, research and knowledge.

Some of the services included in a recovery model are not reimbursable under the Medicaid program's rehabilitation option, or under most third-party payers' benefit plans. Providers must be clear about which services:

- Do meet Medicaid criteria and, can be appropriately billed
- Do not meet Medicaid criteria and, therefore, must be funded by alternative sources. In particular, Providers should pay attention to state and federal regulations and service definitions about educational, vocational, recreational, social, and peer services.

The Massachusetts Department of Mental Health has been a vocal advocate of recovery models of care and has used its array of resources to support the development of these models. Medicaid is one of these resources that, with judicious use, can assist persons served and providers in making recovery/resiliency programs possible.

Medical Necessity and Provider Documentation

One of the primary means for determining *medical necessity* is the review of the provider's documentation. The "big three" areas of documentation that support medical necessity are the

1. diagnostic assessment and any updates or additional diagnostic testing done at the outset or during the treatment episode,
2. the Individualized Action Plan and any reviews, updates or modifications,
3. each and *every progress note which must describe an ordered, covered service that is necessary to realize the clinical outcomes of treatment.

Together, all of these documents make the initial and continuing case for the medical necessity of the services being delivered and billed. Documentation is a requirement of all payers, and in particular, all Medicaid/Medicare providers are required to keep such records as are necessary to establish medical necessity and to fully disclose the basis for the type, extent, and level of the services provide.

In reviewing documentation for medical necessity, the reviewer looks for key elements in the documentation, such as the following:

1. Is there a diagnosis that meets payer criteria? Is there sufficient documentation in the initial assessment or additional diagnostic work that provides evidence that this is the correct diagnosis?
2. Is there an assessment of functioning for the person served? Are there sufficient symptoms, behaviors and functional deficits or the threat of developing deficits to support the level of care ordered?
3. Is there an Individualized Action Plan, signed by the appropriate provider, for an array of services that are generally accepted as being appropriate for the diagnosis and functional level of the person served?
4. Are the services rendered in accordance with the Individualized Action Plan and with payer definitions? This is called "active treatment" and includes the requirement that services are rendered by the appropriately credentialed provider.
5. Is there evidence of participation by the person served? There are two issues here. First, the person must have the cognitive ability to be able to participate in treatment and to benefit from it. And, second, the person served must be willing to participate in treatment and, therefore, benefit from it. For example, persons with early Alzheimer's may be able to benefit from talking therapies for depression and other mental illnesses until their disease has progressed to the point where there is no potential for therapeutic progress. Individuals with severe or profound mental retardation are generally not covered for talking therapies either but can be covered for medication management if warranted and medically necessary to control behaviors. In any case where services that are not "generally accepted" as beneficial to a person served with certain diagnoses are being provided the practitioner should expect that auditors and payers will expect an explanation and will look for it in the clinical documentation.
6. Is the person "committed" to outpatient treatment? This is very different than a situation where a judge tells an Individual that they can choose between jail or treatment and are effectively being coerced into treatment. In these cases, medically necessity must be determined independent of any court decision or recommendation for a third party payer to be billed. A commitment to outpatient

treatment is different than the choice between jail or treatment. In these cases the Individual chooses one form of treatment over the other and there is usually sufficient evidence of the need for mental health services. And, so even though the court stands behind the individual with powerful punitive tools should the Individual be non-compliant, services can still be considered voluntary and therefore eligible for third party reimbursement.

7. Is there evidence that the person being served is actually benefiting from treatment? This is a critical issue in medical necessity. Most services are directed towards improving the health status of an Individual. Medicaid and other third party payers want to see that improvement recorded in the medical record or want to know why they should be continuing to pay for services that do not appear to be effective. There is also a concept in medical necessity that considers situations where, especially with significant chronic conditions, where services may be primarily directed towards the prevention or the slowing down of further deterioration and the need for higher levels of care. However, again there must be evidence in the medical record that these "maintenance" services are necessary and that they constitute the lowest cost service for this individual and their particular clinical picture.

The forms developed by MSDP have been designed to encourage the complete and accurate documentation of the diagnosis/condition, functional level and/or deficits, treatment goals, and level of care decision-making for the person served. There are cues to remind providers to document the individual's participation and benefit from treatment. And, there are places for providers to sign, date, code, and time the interventions so they may be appropriately and accurately billed. As with all forms, they cannot make up for sloppy or inadequate content, but they do help the writer organize their information in ways that make it easier for reviewers to locate and to determine medical necessity.

---

[1] Social Security Act, Section 1905(a)(13)

[2] International Association of Psychosocial Rehabilitative Services

[3] Hughes, R. and Weinstein, D. editors, *Best Practices in Psychosocial Rehabilitation*, IAPSRS, 2000, p. 42.

Medical Necessity Documentation Linkage Requirements

(Note: Reprinted with permission from Chapter Seven of ***How to Deliver Accountable Care*** written by David Lloyd and published by the National Council of Community Behavioral Healthcare)

The common thread of concern and findings within qualitative audits is that the documentation model utilized does not continuously support the need for the intensity, frequency and duration of the service(s) being provided to the Medicaid and/or Medicare eligible person.

A key issue in the audit findings is the lack of a link (Golden Thread of Necessity) between the assessed therapeutic needs that result in specific goals supported by measurable objectives with specific therapeutic interventions ordered to be provided by specific clinicians within specific service modalities/locations (outpatient individual, group, IOP, Residential, Psychopharmacology, etc.) within the provider organization.

The Five major linkage processes that are designed into the MSDP form documentation system to support compliance with qualitative reviews are identified below.

1. **Comprehensive Assessment (CA)** – Identifies Treatment Recommendations/ Assessed Needs
2. **CA Updates** – Identifies New Treatment Recommendations/ Assessed Needs
3. **Individualized Action Plan (IAP)** – Links goals to specifically numbered Treatment Recommendations/Assessed Needs
4. **IAP Review/Revision** - Links goals to specifically numbered Treatment Recommendations/Assessed Needs and/or changes in Objectives, Therapeutic Interventions, Frequency, Duration and/or Responsible Type of Provider.
5. **Progress Notes** – Links interventions being delivered to specific Goal(s)/Objective(s) and identified client response and outcomes/progress towards Goal(s)/Objective(s).

Purpose of Comprehensive Assessment in Medical Necessity Linkage Requirements

1. Establishes a baseline measurement for the **Symptoms, Behaviors, and Skills/Needs Deficits of the person served** and documents how each of these areas impact the person's ability to **function, which is the basis for developing the individualized action plan**.

2. The more specific/objective the information gathering process during the assessment, the easier it is to demonstrate the necessity for treatment.

3. Use of standardized assessment tools (BASIS 32, CAFAS, ASI, GAF, etc.) in conjunction with initial assessment will help support the assessed functioning baseline and help justify continued necessity.

4. The assessment contains an integrative summary of prioritized therapeutic treatment needs of the person served that can be the only supportive medical necessity basis of goals in the action/service plan.

Purpose of Comprehensive Assessment Updates in Medical Necessity Linkage Requirements

The key "dis-link" observed in the typical chart is the lack of current, continuous updates of newly assessed therapeutic needs identified by the person served and/or direct care staff after

the initial comprehensive assessment is completed. In many cases the Progress Note has been used to record any additional assessed needs after the initial assessment is completed which makes it the "primacy" documentation in the chart.

The challenge with the Progress Note being the primacy documentation tool in the chart is that it is very difficult to demonstrate to reviewers the qualitative assessed basis for the services ordered in the IAP if the additional assessed needs are buried in hundreds of Progress Notes. The Progress Note is not designed to support the qualitative weight and data elements needed to provide an updated assessment of treatment needs/'recommendations, diagnostic changes and a prioritized summary of assessed therapeutic needs and justification for treatment that can be linked to Goals in the Individualized Action Plan. The standardized CA Update (adult and child versions) is an appropriate assessment form to record additional assessed information after the treatment process has begun that will provide a direct link between the assessed therapeutic need and the goal(s) in the Individualized Action Plan.

Purpose of Individualized Action Plan and IAP Review/Revisions in Medical Necessity Linkage Requirements

1. **Goals:** Utilizes assessed prioritized therapeutic needs from the comprehensive assessment (or subsequently dated CA Updates) to link to a corresponding goal in the IAP. Each numbered Goal in the IAP can be specifically linked to a numbered assessed Treatment Recommendation/Assessed Need from the Comprehensive Assessment, or CA Update, or Risk Assessment or Initial Psychiatric Evaluation. The *linkage occurs* by entering the Treatment Recommendation number, form date and checking the specific MSDP form type adjacent to the specifically numbered Goal.

   Each goal needs to reflect the person served desired outcome for the assessed therapeutic needs. (i.e., if the assessed therapeutic need is anger management, the person's desire may be, "I would like to stop losing my cool all the time!" and this desire, in the person's own words, becomes the basis of a goal in the action plan.

   By establishing this link to the Treatment Recommendations/Assessed Needs from the Comprehensive Assessment/CA Update(s), the IAP fully supports an integrated clinical formulation that effectively addresses the assessed symptoms, behaviors and functional needs of the person served.

2. **Objectives:** Develops measurable Objectives that support step by step attainment of each goal. Objectives that end in "ing" (i.e., "increasing", "decreasing", or "improving", etc.) usually do not have the ability to specifically measure attainment. Perhaps the best and most humorous example of the need to develop very specific and measurable objectives was a handwritten notation from an auditor beside an objective that read "Improving client's relationships". The auditor's note read "With NATO? With Mexico?" As written, it is difficult to know if and when the objective will be achieved. In training staff, the concept of writing very specific objectives can produce a level of anxiety which can result in objectives that are too general/non-measurable and are difficult to achieve. When the Goal is formulated to be a broad long term achievement effort, then the objectives must be

connected to the goal, measurable and observable in order to demonstrated attainment and benefit to the person served. Writing Goals and objectives in this way will better ensure medical necessity compliance. **Therapeutic Interventions Methods:** In many cases, Therapeutic Intervention Methods and Services have been used interchangeably. The service, such as individual therapy, is not the intervention method, but rather the service location/modality where the therapeutic interventions will be provided. The specific interventions in the Individualized Action Plan provide guidance for service providers in the provision and documentation of the therapeutic interventions within the Progress Notes. This linkage from the IAP to the progress note is critical to documenting Medical Necessity.

3. **Services:** The IAP will serve as the order for therapeutic interventions and services if the following elements are incorporated:

    a. Goals and Objectives with start date and target date of completion
    b. Service Code or Descriptor link to specific therapeutic interventions for each Objective
    c. Disposition to specific staff with appropriate credential to deliver the ordered interventions in the service location/type ordered
    d. Indication of Frequency and Duration of Services ordered

Purpose of IAP Review/Revision in Medical Necessity Linkage Requirements

The use of an IAP Review/Revision is essential for the following reasons:

1. Attainment of Goal and/or Objective that requires the development of an additional Goal(s) or Objective(s)
2. Need to increase the Frequency and/or Duration of an ordered intervention
3. Need to modify or add therapeutic interventions in number or intensity
4. Need to modify or add an ordered service/modality

The standardized IAP Review/Revision form is a critical part of maintaining a Medical Necessity Linkage between the assessed therapeutic need and the documentation of the interventions provided that are appropriately linked to a specific goal(s)/objective(s).

Purpose of Structured Progress Notes in Medical Necessity Linkage Requirements

The Progress Note documents linkages between the therapeutic interventions identified in the IAP (IAP Review/Revisions) by requiring that the Goal(s) and Objective(s) being addressed in the service session be clearly documented within the note. If the person served shares new information with the clinician that was not included in the original assessment then one of two actions is required:

1. If the person served shares an issue that can be resolved within the session of service, briefly identify the issue, indicated the interventions provided and the response in the appropriate sections of the Progress Note.

2. If the person served shares new information/issues during the session that *were not included in the original Comprehensive Assessment, (or an earlier CA Update)*, and the clinician determines that the information shared **does** constitute a continuing treatment need, the Progress Note should document that an CA Update is required. The new information provided by the person served should be recorded on the CA Update by checking the appropriate element of the Assessment that is being updated, then writing the element and the information in the open narrative section of the form.

If there is not an existing Goal and Objective that meets the newly assessed needs or if other information needs to be changed, the clinician should complete an IAP Review/Revision.

Signature Requirements for MSDP Documentation Process

Each Provider Agency must independently determine its own policy and procedures regarding signature requirements for each of the MSDP forms. Most of the forms provide for multiple provider and/or supervisory signatures to accommodate Provider Agencies' internal policies/procedures.

Signature Instructions

Signature instructions for all forms universally require a legible signature. This is critically important. Federal and state auditors will throw out perfectly good claims on an audit if they cannot determine who provided the service. Additionally, day-to-day practice requires an understanding of who had an interaction with a person served, and subsequently entered information into the medical record. JOINT COMMISSION standards require that Provider Agencies develop a register of provider names and their signatures in order to be able to identify particularly obscure or sloppy signatures. (This is good practice regardless of your accrediting body.) Additionally, signature instructions universally require that a provider's or supervisor's signature be accompanied by their credentials and the date of the signature. This is both a payer/payment issue, as well as a risk management issue.

- Most states have laws regarding the licensure of professionals and the services or service array they are eligible to provide as a result of their licensure.
- Some states may issue certification requirements or licensing requirements for facilities that also are concerned with the credentials of providers and the services they are allowed to provide.
- Most payers have very specific standards for the type of provider credentials they will allow to reimburse for specific services.

- In many cases, both the state and the payers have similar requirements. In some cases, payer standards are more stringent than state law or may cover providers who are not the subject of state laws, such as paraprofessionals. In those cases, payer rules must be followed in order to bill for a service.
- Provider Agencies may issue their own requirements that exceed and state and payer requirements, but cannot allow for lesser credentials.

Signature instructions also require that each provider date their signature. This may or may not be the date of service. Providers should not, under any circumstances, back-date their signature to match the date of service.

Credentials Instructions

In listing the credentials of the Provider, it is recommended that the following generally accepted conventions apply:

1. If the Provider is licensed, he/she should list next to his/her name the highest level of licensure achieved that is related to the service being recording. For example; if an individual who is an RN, and is also an independently licensed social worker, is providing psychotherapy, then social work credentials would be recorded. If a medical-somatic service is being provided, the RN credentials would accompany the signature.
2. If the Provider is not licensed and the service requires a certain educational degree, record the degree, e.g. B.A.S.W., B.S.R.N., B.S.
3. If the provider is not licensed and the service requires specialized training and certification, record the certification, e.g. CADAC.
4. If the Provider is not licensed and the service requires that the provider have a certain amount of educational or specialized training or experience that is not easily recorded as credentials, then agency policy/procedure should be followed regarding the credentials that should accompany the signature. For example: *"The provider must have 2 years of experience in providing services to the seriously mentally ill population."* In many cases, the provider should also list or abbreviate his/her job title; such as, CSW or Community Support Worker, CM or case manager, DSWI or DSWII or Direct Service Worker Level I or II. Providers are encouraged to consult state laws, regulations and certification standards to define internal policy for signatures and credentials required to authorize services. In **all** cases where licensure, training, education, and/or experience are required, the documentation that provides proof of this should be kept in the Provider Agency's personnel files and available to auditors.

The MSDP forms contain multiple signature lines to accommodate multiple signature possibilities. The signatures required on the forms are determined by rule, licensure and scope of practice. In general, the provider authorizing and delivering a service is required to sign the clinical documentation for that service. Providers may "order" services only for those services for which they are licensed. Certain services, if provided by paraprofessional staff, must be reviewed and signed for by the supervisor.

Person served and/or family signatures are required by DMH and many of the accrediting bodies on Individualized Action Plans and are suggested as a good practice for all persons served. New rules issued by federal Medicaid indicate that they are also very interested in the Individual's signature and their participation in developing the action plan and this may soon be a federal requirement. Obtaining signatures from the person served

on Comprehensive Assessments, CA Updates, Individual Progress Notes and Group Progress Notes are suggested as a good practice.

MSDP Process Billing Strip Instructions

Below are the instructions for completing the Billing Strip.

Standard Billing Strip Sample:

Date of Service	Provider Number	Loc. Code	Prcdr. Code	Mod 1	Mod 2	Mod 3	Mod 4	Start Time	Stop Time	Total Time	Diagnostic Code

Instructions to complete the Billing Strip:

Data Field	Billing Strip Completion Instructions
Date of Service	Date of session/service provided
Provider Number	Specify the individual staff member's "provider number" as defined by the individual agency.
Location Code	Identify Location Code of the service. Providers should refer to their agency's billing policies and procedures for determining which codes to use.
Procedure Code	Identify the procedure code that identifies the service provided and documented. Providers should refer to their agency's billing policies and procedures for determining which codes to use.
Modifier 1, 2, 3 and 4	Identify the appropriate modifier code to be used in each of the positions. Providers should refer to their agency's billing policies and procedures for determining which codes to use for Modifiers 1, 2 3 and/or 4.
Start Time	Indicate actual time the session started. **Example: 3:00 PM**
Stop Time	Indicate actual time the session stopped. **Example: 3:34 PM**
Total Time	Indicate the total time of the session. **Example: 34 minutes**
Diagnostic Code	Use the numeric code for the primary diagnosis that is the focus of this session. Providers should use either ICD-9 or DSM code as determined by their agency's billing policies and procedures.

General Medicare "Incident to" Services Only Information

Medicare allows for payment of certain services that are provided "incident to" the services of a physician or "certain non-physician practitioners such as clinical psychologists, nurse practitioners, clinical nurse specialists, and physician assistants".

Incident to services are those that are integral to the services of the professional but are not provided directly by them. This allows in certain cases for providers not eligible to bill Medicare directly to bill for their services provided under the direct supervision of an eligible supervising professional.

There are a number of rules that must be followed in order to bill services "incident to" and the Medicare Carrier for Massachusetts, NHIC should be contacted in order to make sure all requirements can be met.

One of the most important of the incident to rules is that each and every service must be provided under the "direct" supervision of a Medicare eligible professional. These professionals can only supervise services they can either provide or supervise under their scope of practice under state law. They must also be available and in the office suite at the time the service is provided.

The MSDP forms allow for the provider to document compliance with the direct supervision rule with a checkbox to alert billing that the service was provided "incident to" and the name and credentials of the supervising professional. Medicare will be easily able to audit compliance with this requirement and providers will have sufficient back up for the claim. Below are the MSDP forms that contain the Medicare "Incident to" checkbox:

1. Group Psychotherapy Progress Note
2. Psychotherapy Progress Note
3 Intensive Services Progress Note
4. Nursing Progress Notes

Standard *Medicare "Incident to" Services Only* box:

❑ Medicare "Incident To"	**Name and credentials of Medicare Provider on Site:**

Instructions for Completing the *Medicare "Incident to" Services Only* Box

Data Field	Billing Strip Completion Instructions
Medicare "Incident To" Services Only	Check the box when service is to be billed using the "incident to" billing rules.
Name and credentials of Medicare Provider on Site:	Enter the name of the supervising professional who provided the on-site supervision of the "incident to" service. **Note:** The presence of an appropriate licensed supervising professional is one of the key requirements for an "*incident to"* service. In some cases, the service is billed under the number of the supervising professional. In others, the attending professional's number should be used. Providers should consult with their Medicare Carrier's Local Medical Review Policies.

MSDP Compliance Grids

Compliance Review Team Develops Data Element Grids to Support Form Development Process

The Reasons for the Compliance Grids

The Compliance Grids can be found on the ABH MSDP webpage. The Compliance Grids were developed as a way to ensure that the forms once completed would allow a provider to successfully meet the documentation requirements of the major accreditors: JOINT COMMISSION, CARF, COA and NCQA, as well as the documentation requirements of the major payers for community mental health and substance use disorder services in the Commonwealth of Massachusetts.

The compliance grids list the areas of information that need to be documented within each MSDP form type and provide information on which payers and/or accreditors require the information for clinical documentation purposes. These grids look only at the actual standards or regulations, they do not consider quality of the documentation or other indicators that might also create audit risk for agencies and providers. Accreditors are generally looking at clinical documentation for evidence that provider agency policies and procedures related to documentation and also clinical care of the persons served are being followed and are resulting in quality care and positive clinical outcomes.

The grids cite the most recent standards available at the time of the publication of the grids in this version of the manual. Future changes to rules, regulation and standards may make the information contained in the grids dated and less useful for training and/or other purposes.