Ethics Course 4D, cont.

'Medical Necessity', 'Level of Care' and YOUR Documentation – Yes, They ARE Connected! And There Can Be Ethical Decisions To Make.

The primary purpose of this course is to demonstrate to providers how they can comply with these expectations, and do it within ETHICAL BOUNDARIES – professional AND license-related.

So what's good DOCUMENTATION of your clients' treatment got to do with ETHICS? Particularly in this day and age, documentation of your clients' treatment is a basic part of your PROFESSIONAL RESPONSIBILITY. It's part of most licensure standards. It's good legal protection for you, in the event of a professional liability lawsuit. And furthermore, without it, you may be unable to secure or retain needed services for clients whose services are paid by insurance (whether that be private healthcare insurance, Medicaid, or another public health plan). When you carefully document services, you are acting IN THE BEST INTEREST of your client.

Now let's be more specific!

Why Documentation Style Is Crucial to Delivering Treatment Under an Insurance Plan's Provider Agreement

- **Today's health insurance programs are 'not your same old' insurance or Medicaid. The managers of today's public and private insurance plans are looking for EVIDENCE of specific PROBLEMS – at SPECIFIC levels of acuity or SEVERITY. They AUTHORIZE specific TYPES of TREATMENT interventions, at specific LEVELS OF CARE (i.e., the intensity of service such as inpatient vs. outpatient, what kind of service, how long it's provided and how often).**

Your documentation of the treatment you do must clearly support this level of SPECIFICITY. Will you have ethical issues here?

Learning how to 'document' is the key to obtaining appropriate 'levels of care' . . . and to keeping your money when you are audited! And it often collides with our ETHICS about what is appropriate to write and share about a client in his record. (Share with whom? The insurance company who is paying for the treatment. The client agrees to this when he enrolls in the plan.)

- **You must think about your client's treatment in the same way that the insurance company's 'Care Manager' is thinking when he or she reviews the case: "WHY should the insurance plan spend money on this case – and for THIS treatment?"**

- **You must put away soft-pedal language and euphemistic ways of talking about the client's problems**

- **You must be willing to address DYSFUNCTION and PROBLEMS as well as strengths, because they do not pay for strengths – they pay for stabilization of DYSFUNCTION, PROBLEMS and SYMPTOMS!**

(Re)Training, Culling, New Hiring Is Often Needed!

- **This type of work is not 'for everyone'. It is irksome to some. Impossible for others. Some may not be able to justify, in their own minds, the need to be more forthright in their documentation about the client and his weaknesses and illness.**

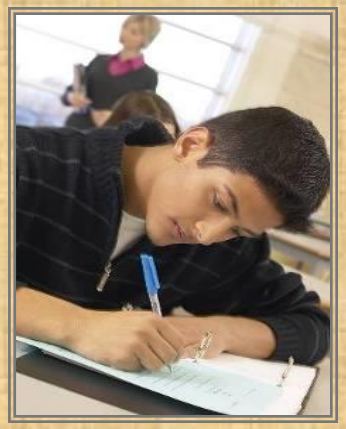
- **(Re)Training, culling, and some new hiring approaches are often necessary, in order to get the right staff who can rise to the occasion. (But we think that *most providers can in fact rise to the occasion – and they can do it* ETHICALLY!)**

The 'Four Core Concepts'

The Behavioral Health Plan decides whether the treatment you want to provide to the client is really 'MEDICALLY NECESSARY'. They will either AUTHORIZE or DENY or CHANGE the treatment, using four primary CORE CONCEPTS. In the end, we may disagree with many of their decisions, based upon our own professional ETHICAL BELIEFS and PERCEPTIONS about what our client needs.

The primary purpose of this course is to show providers how they CAN comply with these expectations, within ETHICAL BOUNDARIES – and in ways which will ALSO protect them LEGALLY, in the event of a professional liability lawsuit.

But despite our disagreement, EVERYTHING that we write in a client's treatment record (chart) should be guided by these 4 core concepts. Why? Because what we write in the record will SUPPORT the justification for the treatment we requested, and will demonstrate that we did in fact DELIVER THE TREATMENT . . . as it was AUTHORIZED, and as we BILLED for it.



And what are these four CORE CONCEPTS which drive the AUTHORIZATION process?

1. **Medical Necessity – Is the Treatment Needed to Improve, Maintain, or Prevent Deterioration?**
2. **Current Functionality – Diagnosis is Not Enough!**
3. **Treatment Goals & Interventions – Do They Match the Diagnosis and Functionality That Is Described in the Assessment and Elsewhere?**
4. **Progress – Is the Client Responding to Treatment, and Likely to Benefit with More?**

The Four Core Concepts – And Yes, They Also Shape How We Document Treatment

- **These four (4) Core Concepts are dear to the heart of the insurance carrier, and they determine whether the Care Manager AUTHORIZES your treatment request, or not. Obviously, these Core Concepts should shape our approach to DOCUMENTATION within the client's treatment record (chart).**

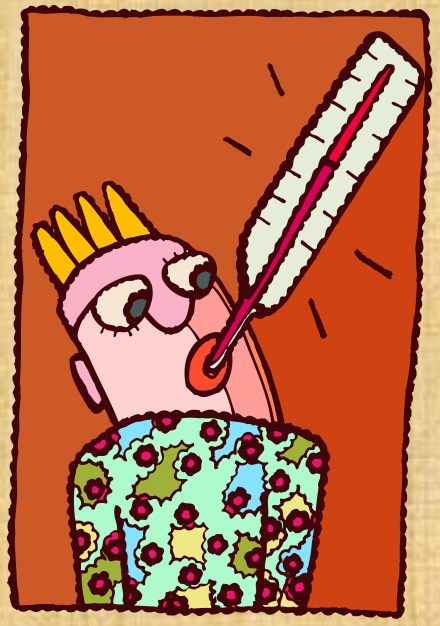
- **If we adhere to these concepts when we write in a client's treatment record, we and the insurance carrier will be 'on the same page'. This is crucial, when the company's auditors come to pay us (AND our treatment records) a visit! And documenting according to these Core Concepts is crucial if our clients are to receive treatment through their health plan. The core ETHIC here is 'Best Interest'.**

#1. Medical Necessity

THE CORE CONCEPTS WHICH GUIDE AUTHORIZATION

In order for the carrier to AUTHORIZE a given treatment, it must be CLEAR that the treatment (at a certain Level of Care or LOC) is MEDICALLY NECESSARY. 'Medical Necessity' is defined somewhat differently in every state, and by every insurance carrier. But these are some of the criteria that are quite common, in determining MEDICAL NECESSITY. Here, the proposed treatments MUST BE . . .

- **REASONABLE AND NECESSARY in order to diagnosis or treat a specific mental health or substance use disorder;**
- **needed to IMPROVE OR TO MAINTAIN functioning, or to prevent deterioration of functioning resulting from the disorder;**
- **in accord with PROFESSIONALLY ACCEPTED clinical guidelines and standards of practice for behavioral health care; and**



- **the most appropriate level (intensity) of service which can SAFELY be provided; and**
- **furnished in the most appropriate and LEAST RESTRICTIVE setting in which services can be safely provided; and**
- **a service that could NOT be omitted without ADVERSELY AFFECTING the client's mental and/or physical health or the quality of care rendered, AND**
- **a treatment which is REASONABLY EXPECTED to result in PROGRESS!**

What ACTIONS are necessary to determine 'Medical Necessity'?

We emphasize <u>continuous</u> ASSESSMENT and DOCUMENTATION of participants' PROGRESS and FUNCTIONAL STATUS - including the effects of medication management when applicable. Also, there must be regular review and modification of the TREATMENT PLAN, to document what does and doesn't work – and if it works, how well? Might there be options in the treatment approach, which would work even better? When things AREN'T working, it's time to re-visit the treatment plan and make changes as needed. *To continue the status quo in the face of inadequate response leads to treatment failure.* The PROFESSIONAL ETHICS involved here are 'Professional Responsibility' and 'Best Interest of Client'.

'But what, exactly, are we ASSESSING, to determine Medical Necessity? And HOW do we go about it?'

OK. First issue: Should treatment continue? **We assess this question through a 'Care Management' approach [i.e., is continued treatment truly necessary and reasonable?]. This includes careful 'documentation of progress toward goals' to guide us. As with any mental health treatment, the need for continued treatment in a program such as this is judged by assessing whether the treatment is . . .**

a. **APPROPRIATE AND NECESSARY to treat the individual's condition, and**

b. **whether there is a reasonable EXPECTATION OF IMPROVEMENT if we continue the treatment.**

. . . assessing what?

Is he or she in fact improving? **Professional staff must formally assess whether the client is BENEFITING from the treatment - i.e.,**

- **Has the treatment been reasonably effective in addressing the cognitive and behavioral problems?**
  - **Is he or she getting something of significance from the treatment that cannot be provided in other ways or settings?**
- **And is improvement likely to continue if the treatment continues?**
- **And . . . will he or she REGRESS if we stop treatment in this setting? In other words, is treatment essential to maintain STABILIZATION?**

. . . assessing what?

- **When measuring IMPROVEMENT, the implications of CONTINUING treatment vs. DISCONTINUING treatment must be considered.**

QUESTION TO ASK:

- **Is there a reasonable expectation that if treatment in this setting is withdrawn, the client's condition would deteriorate? Relapse further, or require hospitalization? If so, the implication is clear: Treatment should continue if possible.**

. . . assessing what?

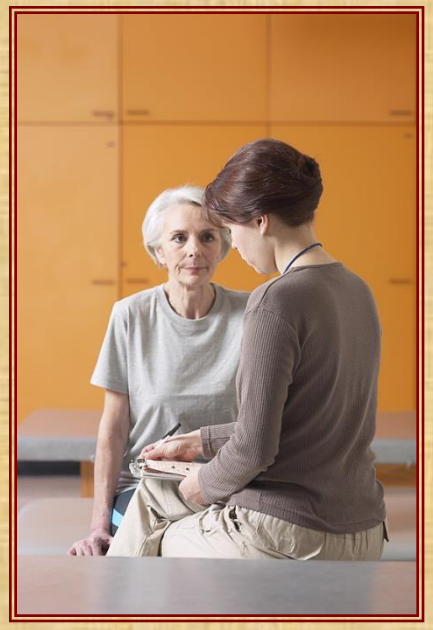
And will the person regress without continued treatment at a particular level of care?

The issue here is, do we 'wean' the client from his or her current intensity of care to 'less intensive'?

- **It's often recommended [indeed, it's REQUIRED by our ETHICAL STANDARDS] that we move toward reducing the Level of Care when a 'plateau' has been reached in key functional areas. [A 'plateau' is the point at which it seems that s/he has reached the MAXIMUM level of improvement within a given Level of Care – i.e., that he or she can no longer BENEFIT from additional treatment at the current level.]**

. . . assessing what?

- **But the ETHIC of "acting in the best interest of the client' ALSO suggests that we 'wean' clients in a stepwise manner – by *decreasing* the number of hours or days per week that s/he attends a day treatment program, for instance . . . or the number of counseling sessions per week or per month. Or could some group sessions be substituted for some of the current individual sessions?**



. . . assessing what?

- **If family members or caretakers are involved, we should also attempt to solicit their support throughout the treatment process – including the STEP-DOWN phase of treatment. This is a crucial ethical issue, given that treatment will likely not be funded for as long as we would like. We must do all that we can, to facilitate a structure for the client which will sustain him or her when treatment is withdrawn.**

All of this assessment and related activity should be DOCUMENTED in the treatment record and the treatment plan, to support our requests to the individual's Care Manager for continued treatment into a 'step-down' mode. Step-down eventually comes for all – it's our ethical responsibility to provide guidance and effective closure.

Part of Assessment: 'IS RESTORATION POSSIBLE for this individual?' . . . assessing what?

- **For some individuals, but not all, the goal of treatment is RESTORATION to the level of functioning which was present prior to the onset of illness. And we assess the HISTORY of the illness and the current level of PROGRESS to determine if restoration is a reasonable goal.**

  - **But bear in mind that insurance carriers are oftentimes satisfied with far less than 'restoration to one's pre-morbid condition' when determining Medical Necessity; all they want is basic FUNCTIONALITY.**

- **HOWEVER, we may have a good case for continuation of treatment [with a reasonable goal of 'RESTORATION'] when the client is a child or adolescent who is not yet entrenched in a pattern of mental illness or substance abuse. Look to your ETHIC of Professional Responsibility to guide you – and be CLEAR in your documentation of the client's progress or lack thereof.**

. . . assessing what?

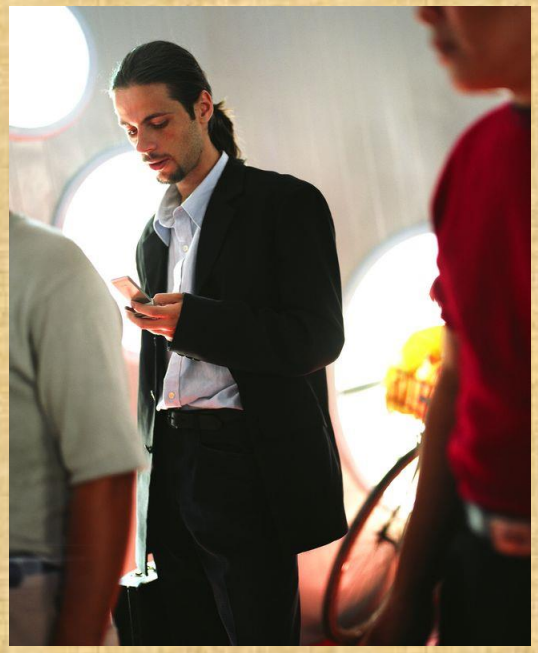
A note about determining the need for treatment – and the ability to BENEFIT from treatment – with the elderly population:

An important DIFFERENTIAL DIAGNOSIS issue when dealing with geriatric populations: Major Depression in the elderly is oftentimes mistaken for (and misdiagnosed as) cognitive impairment or early dementia. It is important for a physician who is familiar with geriatric populations to make this differential diagnosis, which is usually accomplished by a trial of anti-depressant medication.

WHY is this differential diagnosis CRITICAL? Because Care Management does not typically approve or pay for treatment for DEMENTIA. And if it's NOT dementia, the correct treatment needs to be provided.

CORE CONCEPT #2. Functionality – It's Primary

- **Remember that the diagnosis is important – BUT diagnosis alone will not justify a particular treatment. WHY? It is the patient's FUNCTIONALITY that is the most important, when deciding if a particular treatment is needed, and for how long. For example, an individual may have a diagnosis of Bipolar Disorder (and may have been hospitalized many times in the past) . . . but is now stabilized on medication, is back to work, is relating well to family and friends and co-workers, and is otherwise no longer a danger to himself or others. Does this individual continue to need intensive services? NO.**



- **On the other hand, e.g., if an individual is struggling with maintaining a job, is having acute symptoms of a disorder, is perhaps at risk of inpatient admission, and/or is having major difficulty with everyday functionality, then intensive treatment may be MEDICALLY NECESSARY. In that case, the insurance company's Care Management Department will hopefully approve some level of intensive treatment.**

SIDE NOTE: It is RARE for an insurance carrier to approve residential treatment lasting more than a few days, no matter how dysfunctional the individual is – and may not authorize it at all. There are various alternatives to residential treatment, however, that may work even better for the client in the long run – such as an Intensive Outpatient Program (IOP), home-based services for children and adolescents, etc..

Does this second core principle of authorization – providing ONLY the level of care that the client's FUNCTIONING requires – mesh with our professional and ethical responsibility to act 'IN THE BEST INTEREST OF THE CLIENT'?

We think that generally speaking, it does . . . despite the fact that it is often the most painful of all of the Core Authorization Principles to live with.

Considering and respecting whether or not the client actually 'NEEDS continued treatment' is a requirement of most Ethical Standards for behavioral health practitioners.

Thus, compliance with this particular CORE PRINCIPLE OF AUTHORIZATION – the FUNCTIONALITY of the client – is inherently consistent with licensees' own core ethics as set forth by the States and professional organizations.

- **We think most of us would agree – at least those who have been at this business for many years – that providers can occasionally lose sight of what is in the best interest of clients, if we 'do what we have always done' . . . which may be provision of services for longer than truly necessary. This was a 'negative benefit' of having generous funding for behavioral health in the 1960s through the '80s.**

- **The following illustrates the ETHICAL expectation that we 'provide ONLY' the treatment that is NEEDED according to the client's functionality, and the ethics of knowing when to TERMINATE.**

Ethics Area - Client Welfare

Issue: 'Always act in the best interest of the client.'

Behavioral Health Care Professionals (BHCPs) may not take any action that is in – or in support of – the self-interest or gratification of the counselor or someone other than the client (e.g., the agency, parent, or client's intimate partner). As with many ethics issues, we are not necessarily talking about LAWS here – but rather about 'ethical judgment', about what supports the BEST INTEREST of the client.

– For example, the BHCP cannot recommend longer or more intensive treatment which will make more money or to support goals of one's agency or practice, when such treatment is NOT JUSTIFIED . . .

Issue: 'Termination of Services'

- **Unless ordered by a court of law, conventionally accepted BHCP ethical standards require termination of services when:**
  - **it is reasonably clear that the client is no longer benefiting from services,**
  - **services are no longer needed,**
  - **clients have not fulfilled agreed upon arrangements (e.g. payment of fees, arriving at sessions without using alcohol or other drugs),**
  - **services no longer meet the needs and interests of the client, or**
  - **there are agency or institutional or insurance coverage restrictions on continuing current services.**

And when it is the agency's or insurance company's policy to limit the services . . .

- "If the [company's or provider's] policies . . . **LIMIT SERVICES** in some way (e.g., only five individual sessions allowed), the BHCP is ethically bound to refer the client to an agency or individual who can provide the additional needed services at a fee which the client can afford – recognizing in this day of shrinking healthcare funding, that waiting lists for continued services may be inevitable.

  NOTE: This situation occurs frequently in behavioral health programs which are funded by a managed care plan – resulting in significant issues for BH providers as well as their clients." - Gary Fisher, Ph.D. – University of Nevada

REPEAT OF AN IMPORTANT POINT: If the managed care company (or other insurance carrier) tells you 'NO': Are they telling you that you CANNOT provide the services which you believe the client needs? NO. A provider is *always* free to deliver any service to a patient according to the provider's own professional judgment or organizational philosophy. HOWEVER – if the managed care company does not feel that the services are MEDICALLY NECESSARY and ESSENTIAL for the stabilization of the client (or if the health plan simply does not cover a certain service or limits how much can be provided), then you WILL NOT BE PAID by the insurance company to provide the service. If you choose to provide the service, you will have to do it for free ('pro bono'), or will have to use other funds to cover the cost.

And when terminating because of a client's inability to pay (which would be an issue if the insurance company refuses to pay) . . .

- **In cases in which the client NEEDS continued services, if the [professional] decides that he or she cannot continue to provide services on a PRO BONO basis (i.e., without charge), the [professional] is responsible for making a REFERRAL to an agency or individual who can perform services that are as close to what the client needs as possible, at a price the client can afford. Whenever possible, [providers] should attempt to secure the client's signed agreement with a decision to terminate and the reasons for doing so.**

More on service limitations . . .

And how often does this happen – where the provider feels that the client needs treatment but the insurance carrier says NO?

Generally speaking, these occurrences are more frequent with addiction services than with mental health services – *unless* we are talking about mental health clients who don't have a major mental illness.

Put simply, availability of extended services is shrinking, for mental health clients who DON'T have a history of inpatient treatment or major dysfunction. 'Brief' and 'limited' is what is authorized for such individuals.

More on service limitations . . .

This reduction in service availability is the result of PRIORITIZATION of services when the funds for health care are in short supply.

This fact directly affects providers – placing them continually in one ETHICAL DILEMMA or another.

What to do, when the insurance authorization stops? And how to ETHICALLY keep it coming as long as truly needed?

And is there anything that we are unlikely to impact – no matter what?

Remember the earlier slide in Lesson 1 – about problems with Care Management decisions when it comes to ADDICTION TREATMENT? In some states, many providers and chemically dependent clients are having a very tough time of it – especially where mental health and substance abuse dollars are combined into one (1) large healthcare fund, with no special 'set aside' for CD. Many are questioning the ethics of Managed Care's handling of CD clients, in general.

The main issue with insurance's handling of addiction clients is, the inherently recidivistic nature of addiction illness . . . i.e., the fact that repeated intensive services are often needed for individuals who DO NOT APPEAR TO BE 'BENEFITING' from treatment.

And certainly, the TRADITIONS of the addiction field are challenged, in terms of just what services are 'essential' for such recidivistic clients.

Routine 28 Day Residential programs are generally not approved. And, repeated relapses are NOT enough reason for the health plan to authorize 'more treatment'. Why is that? Because they want to see some POSITIVE RESPONSE from the client.

How does this affect you – the provider of services and the documenter of 'needs' and 'progress'? You are called upon to employ professional COMPETENCE in how you DOCUMENT treatment and the RESPONSE to it . . . which is part of your ETHICAL responsibility.

- **It is crucial that you, as the documenter of a recidivistic client's treatment, be especially clear (verbally AND in writing) about the SERIOUSNESS of his or her issues, and about each and every positive sign of PROGRESS he or she makes – even if followed by a 'backslide'. (This applies to clients with major mental illness and Dual Diagnosis – MH and CD – as well as to the client with a primary addiction diagnosis.) If the carrier does not see PROGRESS, services may be stopped or the LOC may be reduced.**

- **And it is crucial – in the BEST INTEREST OF THE CLIENT – that the provider be willing to look at ALTERNATIVES to the TRADITIONAL services provided to addiction clients. Meaning what? With an addiction client, forego your requests for '28 Day Residential', and for MH, make residential SHORT, for stabilization ONLY. Instead, consider requesting authorization for a few weeks of Intensive Outpatient Program (IOP) for your adult or adolescent clients . . . and then heavily document the CONTENT of the program and all signs of POSITIVE RESPONSE on the part of the client.**

Intensive Home Based (IHB) and School Based programs – and after-school and evening IOP – have been shown to be extremely effective for adolescents with drug and alcohol and juvenile justice problems.

- **Or, ask the Health Plan to consider a CASE RATE reimbursement approach for your *most difficult, recidivistic, high risk* mental health and addiction clients - including dual diagnosis adults and children and adolescents with Serious Emotional Disturbance – SED. (We'll get to case rates in the next slide.)**

And bear in mind that with a Case Rate arrangement, DOCUMENTATION of ALL that you do for the client – and clear reasons WHY the services were provided – and the details of his or her positive RESPONSE to treatment, are critical.

What's a Case Rate?

A CASE RATE FEE is NOT like fee-for-service, where you are paid for each separate contact with the client. A CASE RATE is a flat fee (usually 'monthly') which covers (pays for) a specified 'package' of outpatient and case management services which the client may require throughout an authorization period – say, a month. In this contract option, the provider is given more control over the individual plan of care and the determination of 'which' services will be provided 'when' and 'how often' to the individual client. You do not have to ask the Health Plan for 'permission' at each step of the client's treatment process, with a case rate, although you'll have to obtain authorization to continue the CASE RATE arrangement when the approval period expires.

Case Rates allow flexibility!

Example: SED adolescents may require highly flexible services if treatment is to be effective.

- **In other words, a Case Rate provides more FLEXIBILITY to treat the individual without the need for frequent 'authorization', once the Case Rate is approved for a period of time – usually a month.**
- **Severely disturbed or addicted clients may need to be seen with varying frequency from one week to the next – and with a CASE RATE, the provider can do that, without having to ask the MCO for 'more sessions'. Such flexibility gives most providers a sense of better control over delivery of what the client needs and can BENEFIT from – a major feature of ETHICAL TREATMENT.**

Caveat about case rates:

Unfortunately, the MCO or other health insurance company does not have an unlimited amount of money to plow into Case Rates for CD and MH consumers. Thus, in order to keep its own expenditures in line, the managed care company will almost certainly LIMIT Case Rate arrangements to those clients who are the 'highest risk' clients, based upon repeated admission to inpatient treatment – and they will utilize fee-for-service contracts for the rest of the enrolled patient population.

Caveat . . .

NOTE: One possible exception to this may be Severely Emotionally Disturbed (SED) children and adolescents (with or without a co-occurring CD diagnosis), even if they have never been admitted to an inpatient facility. Why? They are oftentimes more cost-effectively served with a Case Rate due to the need for extensive in-home and community services. 'Flat rate' is better than 'what's it going to cost this month?'

- **Case Rates CAN WORK if the provider uses some non-traditional, creative interventions on an outpatient basis – such as day, evening, and weekend IOP – and superior case management. You can learn more about this type of arrangement in Course 3B, which is specific to Addiction Services, or in Course 5B.**

But bottom line is this: There will be times when services are simply denied or reduced in intensity by the MCO – *regardless of how diligent* you are in documenting the need for services and the detail of what you did, and the response of the client. In that situation, the previous slides about how to handle TERMINATION and REFERRAL to other services will apply – it's part of your ETHICAL RESPONSIBILITY.

CORE CONCEPT #3. Treatment Goals and Interventions – They Must Match the Client's Functional Deficits and His Diagnosis

- **When treatment is authorized by an insurance company, it is not a 'free pass' to do whatever the provider wants to do. The company's Care Management department is authorizing a SPECIFIC SERVICE. And that is the ONLY service for which we can ETHICALLY and LEGALLY submit a CLAIM FOR PAYMENT, if we expect to be paid.**

As to HOW we provided that service for which we submitted a claim: It must be clear in the client's record that what we did (intervention, role play, feedback, skills development, 'homework' assignment, cognitive restructuring, etc.) was RELEVANT to his major FUNCTIONAL ISSUES. (And of course, we *identified* those major functional issues in the assessment – that was the basis upon which we obtained the AUTHORIZATION to provide treatment). And we must document the client's RESPONSE.

Is this 'ETHICAL', to be this specific in a treatment record? OF COURSE! It's also good clinical practice, in today's 'legalistic' environment.

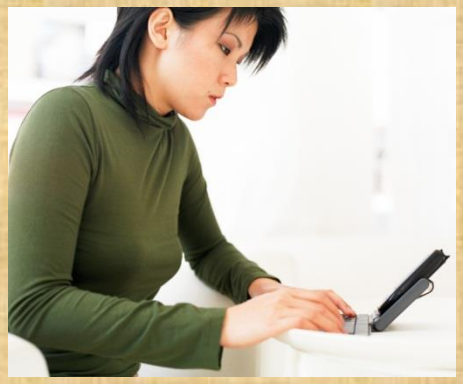
- **Additionally: With Dual Diagnosis clients, when we are documenting in his or her treatment record, we CANNOT IGNORE A DIAGNOSIS! For example, if a consumer is depressed AND is also using or abusing drugs or alcohol, we MUST ADDRESS the substance abuse or dependency – AS WELL AS the depression – in the assessment, in the formal DIAGNOSIS, in the TREATMENT PLAN, and in the PROGRESS NOTES for the services which we actually provide.**

Addressing all current diagnoses: It's part of the ETHICS of COMPETENT practice.

If diagnosing is within the 'SCOPE OF PRACTICE' of our license, we are addressing the diagnosis(es) which we ourselves determined. If diagnosing is NOT within our 'scope of practice', we are addressing the diagnosis(es) which another responsible professional has documented (such as a physician).

Bottom line, we need to provide competent treatment within our 'scope of practice'.

- **Our professional and ethical responsibilities require that we provide competent behavioral health services to those whom we serve – and that we do it within our SCOPE OF PRACTICE. This means that if our Scope of Practice includes DIAGNOSIS of a client, then we need to do a competent job of it. Thus, ALL diagnoses of the client must be considered and documented. We cannot choose to ignore a diagnosis when we develop a treatment plan, without making a clear statement about WHY that particular diagnosis is not being addressed.**



CORE CONCEPT #4. Progress. Document It! It's Essential If Treatment Is to Continue!

- **Health plans cannot pour limited resources down the drain! Therefore, the Care Manager looks for PROGRESS being made, when we approach for additional authorized care. If a consumer is NOT RESPONDING to an approved service – i.e., if he is NOT MAKING PROGRESS, then we must . . .**

. . . take a close 'DOCUMENTED' look at what is not working in the Individual Treatment Plan (ITP), and then . . .

- **make significant CHANGES in the ITP – what we are doing 'with' and 'for' the consumer . . . and perhaps even**

- **REQUEST CHANGES IN THE AUTHORIZED Level of Care (LOC).**

- **NOTE: If the individual FAILS TO BENEFIT from the treatment that is available to him – and has not benefited from revised ITPs – then the Health Plan may make a decision to move to the client a 'maintenance' plan which simply seeks to keep him or her stable and out of danger. In that case, goals to move the individual forward with significant progress may be abandoned, if it is clear that he has reached a 'plateau'. A PLATEAU means that it is unlikely that he is going to make additional progress regardless of what interventions are applied.**

And what does this have to do with ETHICS? Is it ethical for the Health Plan to do this? Is it ethical for the provider to cooperate with this? YES. It relates to the ethical standard of 'INABILITY TO ASSIST'.

Client Welfare Ethics . . .

'Inability to Assist'

- **Behavioral Health Care Practitioners (BHCPs) do not initiate services or continue to provide services when the services are NOT BENEFICIAL to the client. (Possible exception is when services are court ordered.)**

- **When the BHCP is unable to effectively assist the client, he or she should refer the individual to an agency or practitioner who may be BETTER ABLE TO PROVIDE beneficial services.**

- **Even if the client refuses a referral, BHCPs should not provide services which they believe are NOT BENEFITING the client.**

Q: Do these 4 concepts ALWAYS shape what we write in a treatment record?

- **A: YES, if you want to be paid for what you do, and if we want our clients to continue to receive care. When an MCO or other such health insurance company has paid the provider for providing a 'billed service' to an enrollee, they ASSUME that we have adhered to ALL of these Core Concepts seen on previous pages.**

- **But the only way that they can know for sure that we have been faithful to these concepts is to read our records. It's called an AUDIT. If the MCO finds our records to be lacking, they can take back all or a portion of what they have paid us. Certainly, this is to be avoided!**

The next few slides will give some specific APPROACHES to writing and maintaining AUDITABLE RECORDS.

Approach 1: This Is No Time for a 'Non-Committal' or Neutral Style, No Lite-Weight Stuff!

- **The MCO's UR department cannot read your mind - so be clear and unmistakable about the reasons for requesting a particular Level of Care, in both the assessment and in the treatment plan and in your progress notes!**

- **Your assessments, ITPs, and your progress note must present a CLEAR picture of exactly what is 'wrong' with this consumer and how you intend to 'fix it', and 'when'. Don't just talk about 'strengths!**

- **Assessments must spell out clearly why he/she requires SPECIALIZED services vs. less expensive, routine services, if this is in fact the case.**

Approach 2: Paint Them a Picture

- **What are the FUNCTIONAL problems – how serious are they in terms of how the client FUNCTIONS in the real world, day to day? How long has this been going on? What has already been TRIED BEFORE NOW? These things will tell a lot about whether the client REQUIRES what you propose to do.**

- **If we claim that she is SMI (Severely Mentally Ill), have we justified this in our ASSESSMENT? What are the SYMPTOMS? And do they MATCH the description for the DIAGNOSIS that we have given to her? AND do we see these same SYMPTOMS in the PROGRESS NOTES?**

- **What are the TARGETED GOALS, issues and outcomes for the limited time we will have with the consumer? (And DON'T BE VAGUE HERE.)**
- **AND do these goals relate SPECIFICALLY to the AREAS OF DSYFUNCTION and to the DIAGNOSIS?**
- **And do the goals SPECIFIALLY tie into the SYMPTOMS and their reduction?**
- **How do we plan to STABILIZE the symptoms?**
- **Then . . . For subsequent reviews, what PROGRESS has he made on the specific problems we are addressing?**

Please DON"T list a goal such as "Will reduce the symptoms of her Mental Illness." WHICH symptoms?

Approach 3: It Has To Hang Together!

It is not enough to GET that authorization with a good assessment and individual treatment plan (ITP). We must also ensure that everything in the client's treatment record (chart) 'hangs together.' We must be sure that EVERYTHING in the chart supports . . .

. . . the DIAGNOSIS and the ITP,

. . . the authorization that we have been given to deliver a particular treatment, and

. . . the claims for payment that we have filed.

- **What exactly do we mean by 'the entire chart must hang together'? We mean that the whole chart must make SENSE. It has to be CLINICALLY CONSISTENT. In our assessments, and in our ITPs, and in our progress notes, we must demonstrate that our authorization request is an ACCURATE reflection of the client's need for treatment – and that we have actually implemented the ITP that we have developed.**

A client's chart is no place for disorganization! It is not a place for INCONSISTENCIES or contradictions without explanation! Auditors really do hate that! And it's not consistent with our ethical responsibility to be PROFESSIONALLY COMPETENT.

Approach 4: Be Prepared For Unannounced Audits!

- **We must be prepared for both announced and unannounced audit activity. Even if most on-site audits are announced and pre-arranged, a record audit may come at any time, in the form of a call from the health insurance company for a copy of key pieces of a client's record for purposes of Utilization Management, or in response to a client's complaint. So ongoing, impeccable maintenance of our ITPs and progress notes is a MUST!**

'You've GOT to be kidding! They're coming WHEN?'

Approach 5: Remember, Veracity Is KEY.

"Are we talking about the same patient here?"

- **Providers must have pre-authorization to deliver services. We get those 'auths' based upon what we tell the MCO's Care Manager, up front. And we get RE-authorizations based upon what we tell the Care Manager when it is time to get additional authorization. Our ETHICAL practices demand VERACITY in how we obtain authorizations to treat.**

- **When the health insurance auditors come to visit you, what they see in that client record must look like what you told them up front and when you called for re-auth – from the assessment to the treatment plan to the progress notes. VERACITY IS KEY.**

'Poorly Documented Level of Care' – It's Deadly If You Are Audited!

- **CRITICAL ISSUE: The treatment you are providing MUST support the Level of Care for which the MCO or other such health insurance contractor is paying you! That's part of professional ETHICS – you deliver what you are paid to do. AND it's DOCUMENTED, in the client's record!**

  - **Furthermore . . . if they are paying for one of the more intensive Levels of Care, and your documentation looks like the client DOES NOT MEET THE CRITERIA for that Level of Care (i.e., he does not really need that level of intensity), you may have to repay some or all of the money that you have been paid for the period of time that the documentation did not appear to 'match the level'. Remember – VERACITY IS KEY.**

The final word from MCOs and other such Health Plan auditors: "Does this client's treatment record justify what we are paying you to do the treatment – and is this Level of Care (LOC) really needed – and is it working?"

In a sense, when your documentation is audited by a Health Plan in this manner, it serves a good secondary purpose: The audit VERIFIES your compliance with one element of professional ETHICS – i.e., "Behavioral health providers do not initiate services or continue to provide services when the services are NOT BENEFICIAL to the client."

Congratulations!

You have completed the 2nd of 3 'lessons' in Ethics Course 4D. You may complete the short quiz for this lesson either now or later. To reach the links for the quizzes and the lessons, simply *close this page (i.e., exit this presentation)*. You will be returned to your My Home Page. Or you may return to the site at any time you wish – sign in with your user name and password, and you will be taken to your My Home Page.

On 'My Home Page', just click through, starting with the LINK to this course, and you will see your list of Study Guides and Quizzes displayed. Or you may return at any time to the site – sign in – and click through to your course or quiz.

You can take each quiz as many times as you want, until you pass it. There is no penalty for failing a quiz, and you may retake it immediately. We require 75% correct to pass. So either take the quiz now, or you may resume the course – your choice! Cheers! CEU By Net