Missouri Department of SOCIAL SERVICES
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MoHealthNet

MHD Behavioral Health Services: Program Updates & Documentation Requirements

MO HealthNet Division

June 23, 2022

Telemedicine Update

- MO HealthNet covers telemedicine/telehealth services.
- 2018 Provider Bulletin is here.
- MO telemedicine statutes: 191.1145, 191.1146, 208.670, and 208.677.
- New MHD regulation (13 CSR 70-3.330) is here (effective 7/30/22).
- Reimbursement is equal to in person services

Telemedicine Update (cont.)

- Originating site can be participant's home
- Telemedicine services must be delivered with same standard of care as in person services
- Broad definition of telemedicine/telehealth – includes telephonic
- MO licensed professionals
- Includes psychologists licensed in PSYPACT states

Show Me Healthy Kids Update

- Effective 7/1/22, managed by Home State Health
- See DSS press release
- Current “carve out’ of behavioral health services will end 6/30/22
- Six month continuity of care period beginning 7/1/22 – SMHK/HSH will pay out of network during this period
- SMHK training resources are here.

Show Me Healthy Kids Update (cont.)

- Providers not currently contracted with Home State Health should visit https://www.homestatehealth.com/providers/join-our-network.html to request a contract

OR

- Send an email to ManagedCareContracting@Centene.com. Please include “SMHK” in the email subject line and include taxpayer identification number (TIN) and group National Provider Identifier (NPI) in the body of the email. Please do not include personally identifiable information or protected health information about participants in the email to the contracting team.

- Providers who wish to see members enrolled in SMHK only, may indicate this when speaking with the Home State Health contract negotiator.

Provider Responsibilities in 13 CSR 70-98.015

- Services must be medically necessary
- Services must be within provider's scope of practice
- Provider must verify eligibility on date of service and whether fee-for-service or managed care
- On request, furnish information/documentation to MO HealthNet, Missouri Medicaid Audit and Compliance Unit or Medicaid Fraud Control Unit

Medically Necessary – Section 22.2 of Manual

- Medically Necessary - Service(s) furnished or proposed to be furnished that is (are) reasonable and medically necessary for the prevention, diagnosis, or treatment of a physical or mental illness or injury; to achieve age appropriate growth and development; to minimize the progression of a disability; or to attain, maintain, or regain functional capacity; in accordance with accepted standards of practice in the medical community of the area in which the physical or mental health services are rendered; and service(s) could not have been omitted without adversely affecting the participant's condition or the quality of medical care rendered; and service(s) is (are) furnished in the most appropriate setting. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.

Federal Law – Social Security Act

- 1902(a)27)
- A State plan for medical assistance must–
- Provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request;
- Social Security Act is here.

Adequate Documentation (13 CSR 70-3.030)

- Services rendered & reimbursement received can be readily discerned & verified with reasonable certainty
- Adequate medical records – symptoms, conditions, diagnosis, treatments, prognosis, & identity of patient can be readily discerned and verified with reasonable certainty
- All documentation must be made available at the same site at which the service was rendered
- Adequate and complete record – legible, contemporaneous with delivery of service (within 5 working days), addresses patient/client specifics, include individualized statements that support the assessment or treatment encounter

Adequate Documentation (cont.)

- Shall include:
  - First name, last name, middle initial or DOB of participant
  - Accurate, complete, and legible description of each service provided
  - Name, title, signature of MHD enrolled provider delivering service
  - Name of referring entity when applicable
  - Date of service

  - (continued next page)

Adequate Documentation (cont.)

- Actual begin and end time for service delivery
- Setting in which service was rendered
- Plan of treatment, evaluation(s), test(s), findings, results, and prescription(s) as necessary
- Need for service in relation to treatment plan
- Progress toward treatment plan goals (progress notes)

Diagnostic Evaluation / Assessment Guidelines

- Diagnostic assessment is a required component in the health record. A diagnostic assessment must include the following elements:
- First name and last name and either middle initial or date of birth of the participant
- Referral source, when applicable
- Date(s) of service and begin and end times
- Setting in which the service was rendered (e.g., home, office)
- Presenting problem
- Statement of needs, goals, and treatment expectations from individual/family requesting services

Diagnostic Evaluation / Assessment Guidelines (cont. 1 of 3)

- Summary of relevant behavioral health (i.e., mental health and/or substance use disorder) treatment history
- Current behavioral health symptoms
- Developmental (if under age 6), family, social, legal, and vocational/educational status and functioning. Historical information related to these domains should also be included if pertinent
- Current medications

Diagnostic Evaluation / Assessment Guidelines (cont. 2 of 3)

- Personal and social resources and strengths, such as family, peers, and other natural supports
- Diagnostic impression in accordance with the current edition of the Diagnostic and Statistical Manual of Mental Disorders (must be supported by symptoms, significant distress or impairment in functioning).
- Provider signature and date

Diagnostic Evaluation / Assessment General Information (cont. 3 of 3)

- For diagnostic assessments, it is a best practice recommendation to screen for anxiety, depression, substance use disorder, suicide risk, and trauma at a minimum.
- Updated documentation templates for diagnostic assessments, treatment plans, and progress notes are available here.

Diagnostic Evaluations that Span Multiple Days

- If the assessment spans multiple days, progress notes may be used to indicate dates of service and start and stop times and to ensure services are documented within 5 business days.

Updating Assessments

- Considered up to date if within one year for adolescents or adults (13 years and older) or within 6 months for children.
- Don’t need to bill assessment to update your assessment document. You can make updates as new information is identified during the course of treatment. Ongoing assessment is part of therapy.

Treatment Plans

- A treatment plan is a required document in the overall record of the participant.
- The treatment plan must reflect the participant's unique needs and goals and must include:
  - Measurable goals or outcomes;
  - Services, supports, and actions to accomplish each goal/outcome. For example, provider interventions, action steps for participant, other family or social supports or resources.
  - Projected time frame for the completion of each goal/outcome not to exceed 12 months;
  - Estimated completion/discharge date; and
  - Provider signature and date.

Progress Notes

- Providers must document each treatment encounter with an individualized progress note that includes the following elements:
  - First and last name of participant;
  - The specific service rendered (e.g., group therapy) or the procedure code;
  - The date (month/date/year) and the actual begin and end time (e.g., 4:00-4:30 p.m.) of the face-to-face service;
  - The setting in which the service was rendered;
  - Description of the immediate issue(s) addressed in therapy;

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Progress Notes (cont.)

(…includes the following elements – continued)

- Participant's report of recent symptoms and/or behaviors related to diagnosis and treatment plan goals;
- Therapist intervention(s) and participant response;
- Progress toward treatment goal(s)
- For family therapy, identify each family member present;
- For group therapy, the number of group members present;
- Provider's name, signature and date.

For Children's Division

- A copy of the treatment plan must be provided to the Children's Division or contracted case worker if the child or youth is in CD custody

- Communicate with Children's Division or contracted case worker regarding specific requirements

Recommendations

- Never bill “chance, momentary social encounters between a therapist and a patient” as therapy sessions
- Never bill undocumented services
- Never “upcode”
- Implement self-auditing to prevent problems – see this CMS document

Precertification

- For new patients, you can provide 14 hours prior to requesting precertification (ages 3 and up) – if a clinic or group practice, need to know if therapist seeing this participant has worked with this participant in past year

- If you had precertified in past 12 months for this participant, need to request precertification

- 12 month default precertification period

Precertification

- To continue services beyond 12 month period or if all hours used, need to submit documentation along with precertification request
- Precertification form, letter with rationale, assessment, treatment plan, most recent 3 progress notes
- Precertification Request Form is here

Questions?

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