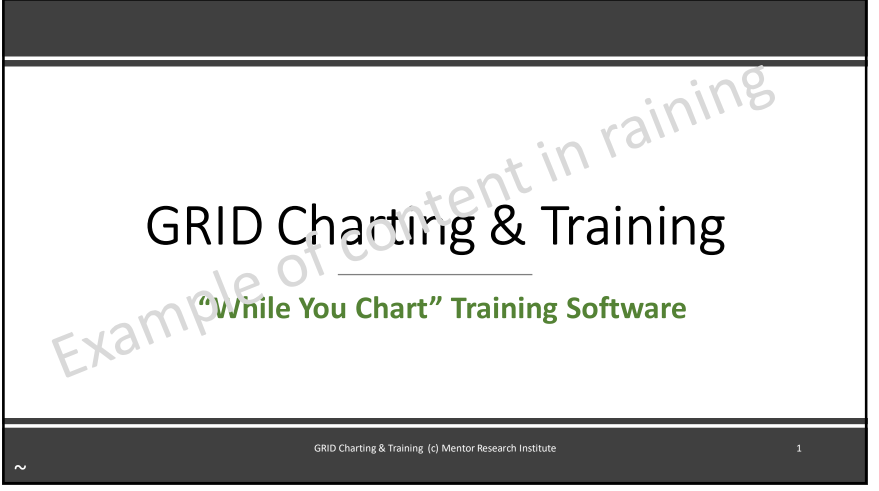

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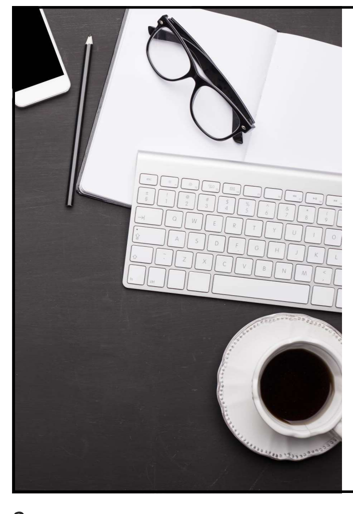

Highlights of Grid Charting

- Create 30 high quality notes in 30 minutes.
- Use or customize templates to document for
  - medical necessity,
  - contract compliance,
  - clinical thoroughness
  - risk mitigation
  - different diagnoses & treatment methods.
- Learn about best charting methods
  - CBE - Charting by Exception (to the normal)
  - ADPIE - Assessment, Diagnosis, Planning, Intervention, Evaluation

GRID Charting & Training (c) Mentor Research Institute 2

2

True Story 1…

A psychotherapist posted a message on a listserv stating she was audited by a Healthplan. She sent the requested records.

Many months later she received a letter stating that,

…my progress notes were not thorough enough, and they want ALL the money back from my work with that client.

Her response was,

Is that even a real thing? A really good scam? Do I have any recourse? They insist I have to pay it all, even if I want to contest it. That is a lot of money.

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3

True Story 4 …

The patient

"…. has been ordered to sign an "Order for Parent Coordination" that includes a provision for the parent coordinator to have access not only to the children's mental health notes past and present, but the parents' as well."

"...I can see why one of these parents is freaked out, especially because she is being asked to release all of her mental health records (past, not just during divorce to this "coordinator."

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4

Why are audits going to increase?

- There are no longer annual limits on the number of psychotherapy sessions.
- According to the U.S. Office of General Accounting the demand for mental health services is going to increase by 30%.
- The pandemic experience has increased public eagerness for psychotherapy services.
- Payers have financial pressures due to increase in overall healthcare expenditures: aging population, pandemic service demands, more medical service options of many types.
- The only way to manage costs is to audit to assure the record is complete, and services are medically necessary.

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5

What are the rationales for a payer's demand for repayment? i.e. clawback

Example of content in training

- Record deficiency
- Improper coding
- Insufficient proof that service was provided
- No treatment plan
- Substandard progress notes
- Failure to demonstrate care is medically necessary and appropriate
- Charging for services that are not necessary
- Failure to provide empirically supported or evidence-based services
- Need to supplement the records.

You must go through the entire administrative process if they send a demand letter.

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6

"What percentage of my patient records would not pass an audit?"

Example of content in training

Ask yourself!

7

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7

"What percentage of my patient records do not have a formal written treatment plan?"

Ask yourself!

8

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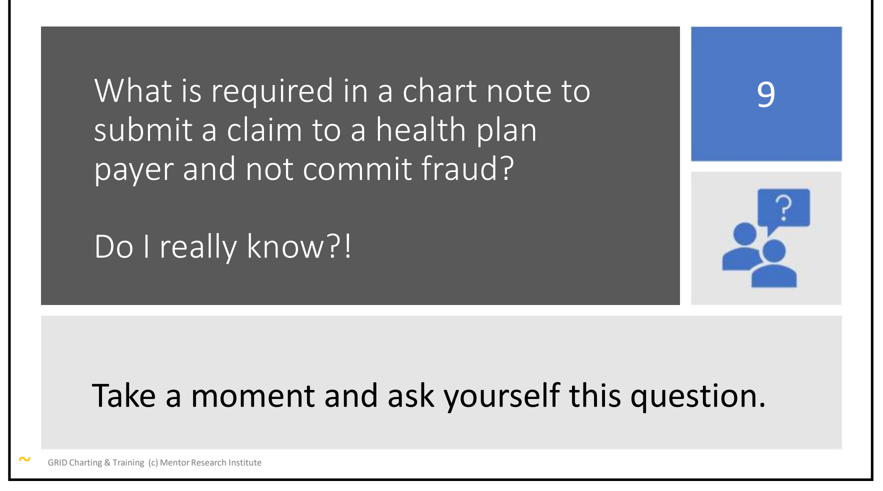

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How many hours could it take to create a treatment plan and 30 chart notes that will pass an audit by any payer?

Ask yourself!

10

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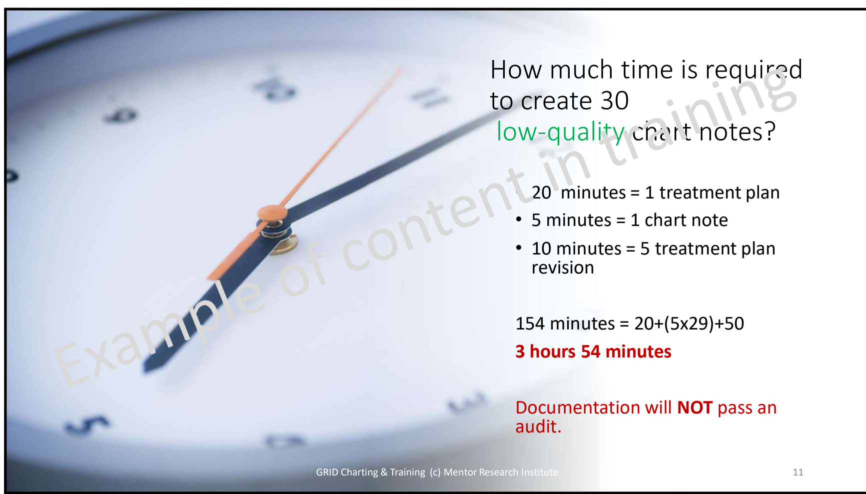

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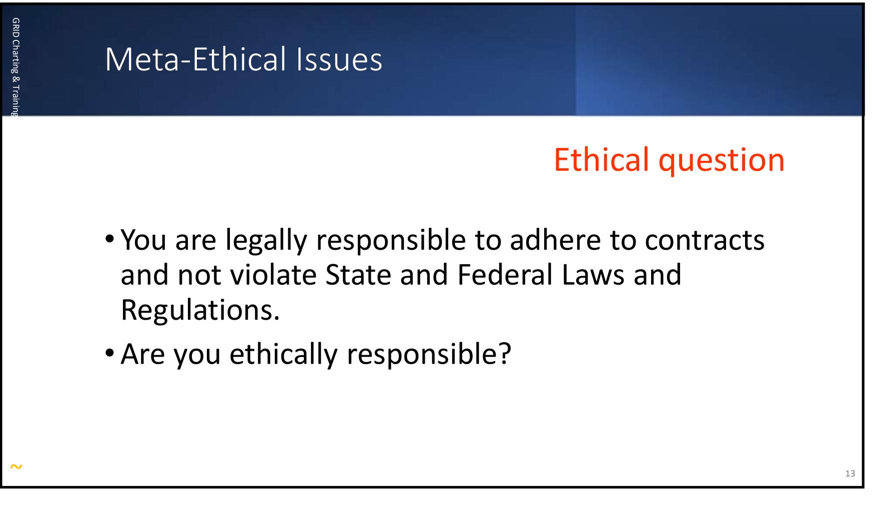

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How is chart quality defined?

Complete & reasonable

Categories (approximate)

- 5 = Billing and claims requirements
- 11 = Contractual requirements
- 8 = Ethical requirements
- 8 = Legal requirements
- 40 = Clinical thoroughness
- 25 = Medical necessity - appropriateness
- 47 = Healthshare/CareOregon/Providence
- 74 = Medicare/Medicaid

Example of content in training

14

“While you chart” training software

GRID Charting and Training

15

Bottom Line

- State and federal laws require psychotherapists to document “minimum necessary” information for legitimate medical purposes in the patient’s medical record .
- Psychotherapists can keep notes that include private, personal and sensitive information for assessment and process purposes in psychotherapy notes.
- Healthcare providers may view a lawful medical record. Patients and auditors are entitled to view the designated medical record.
- Patients and auditors can’t tell the difference between a chart created by the psychotherapist or one created using charting simulation software.
- Charting has no clinical value and does not improve outcomes.

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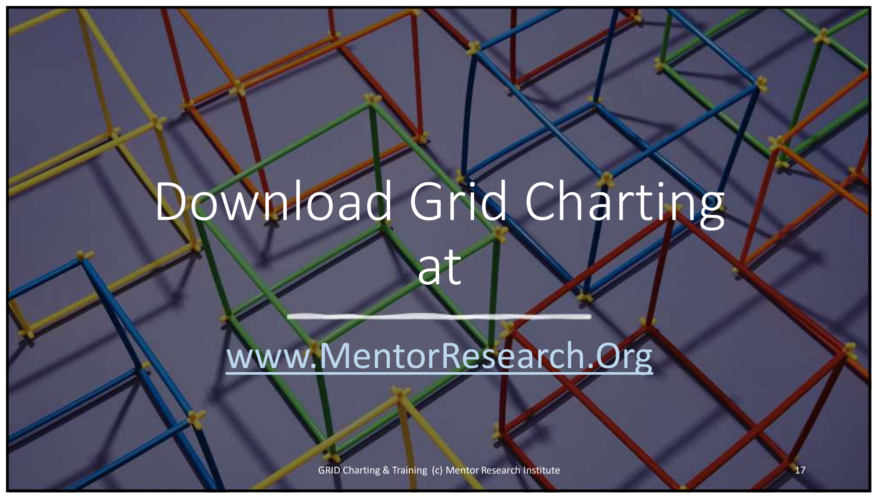

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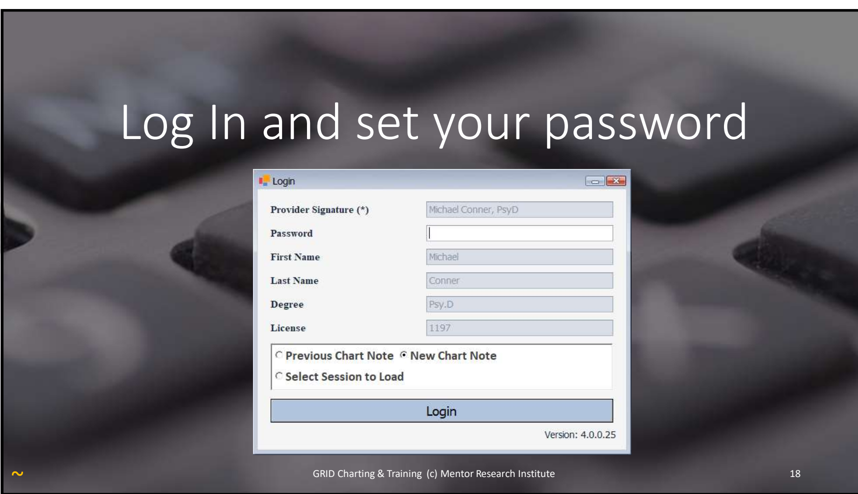

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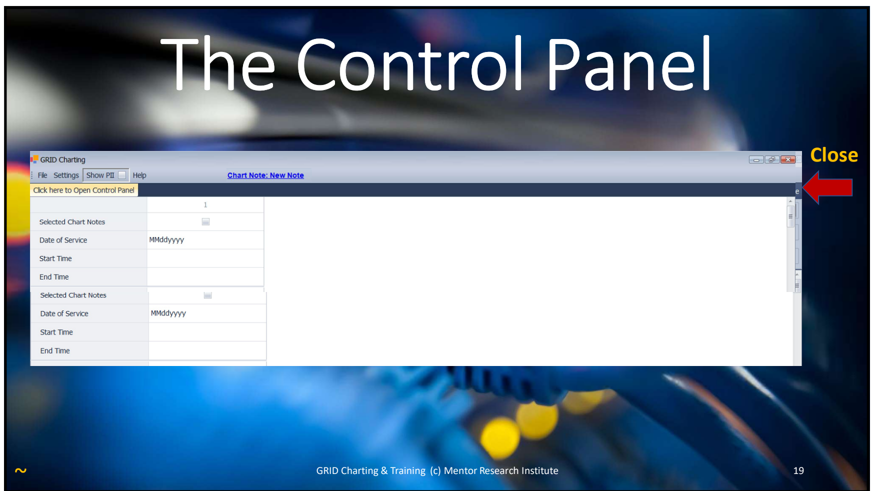

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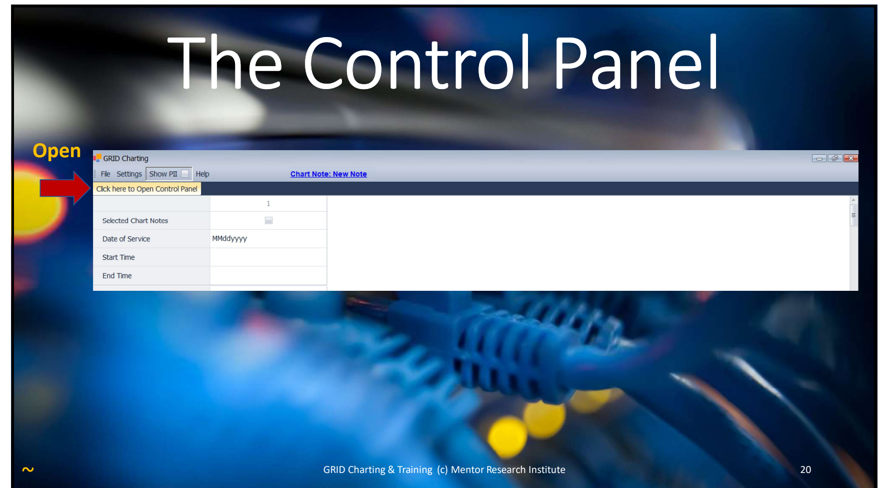

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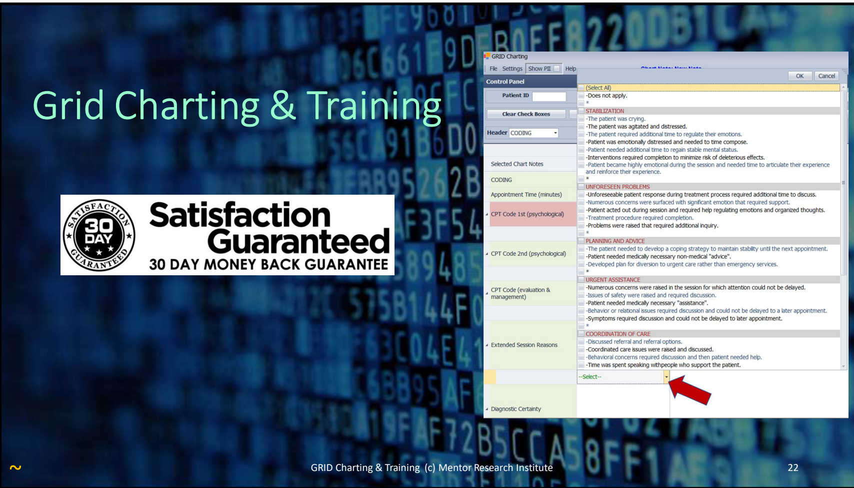

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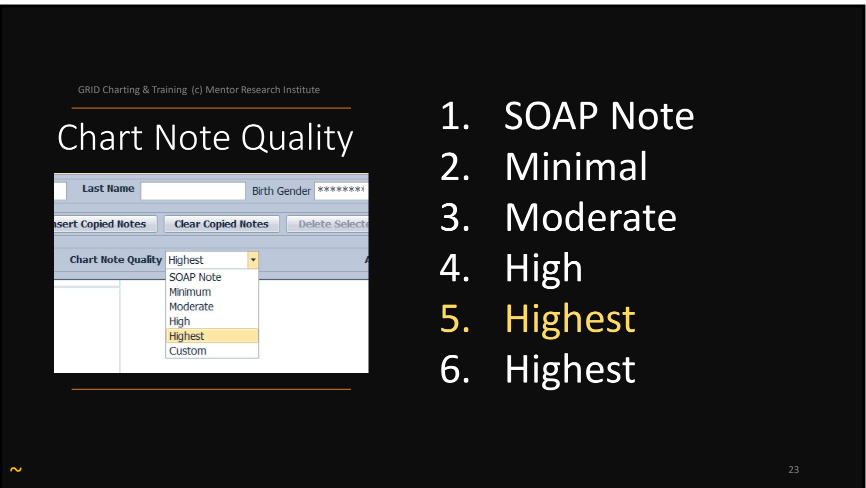

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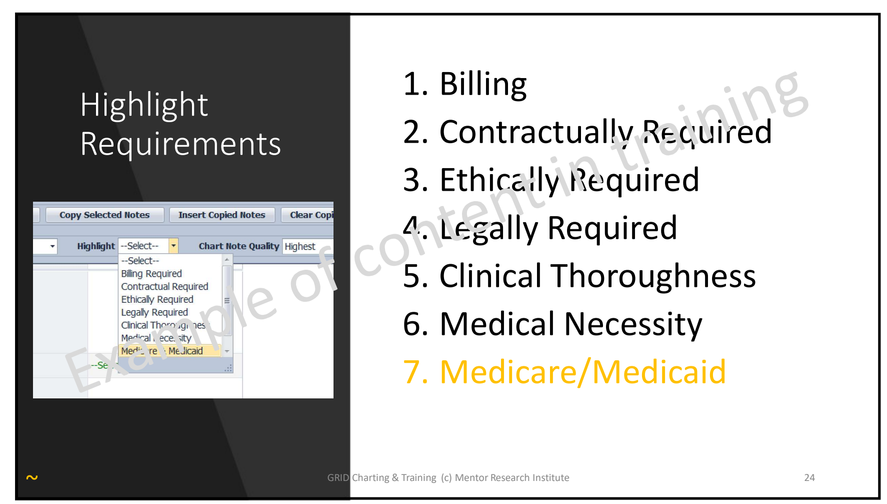

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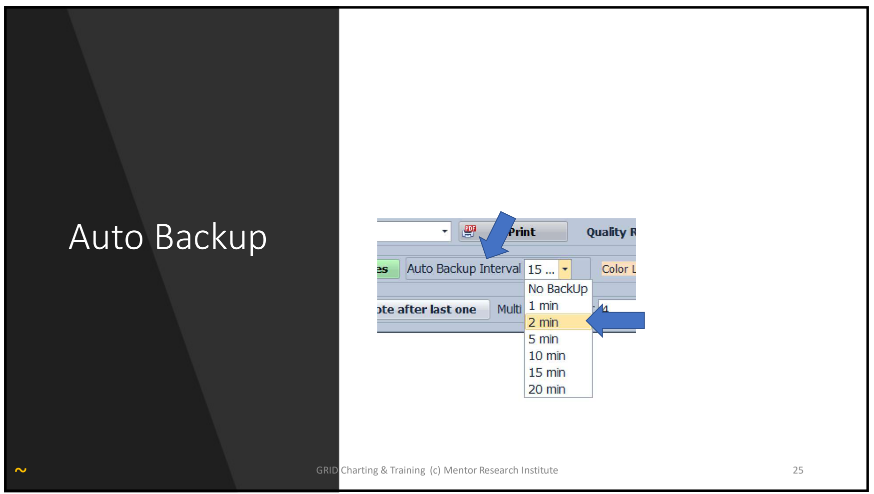

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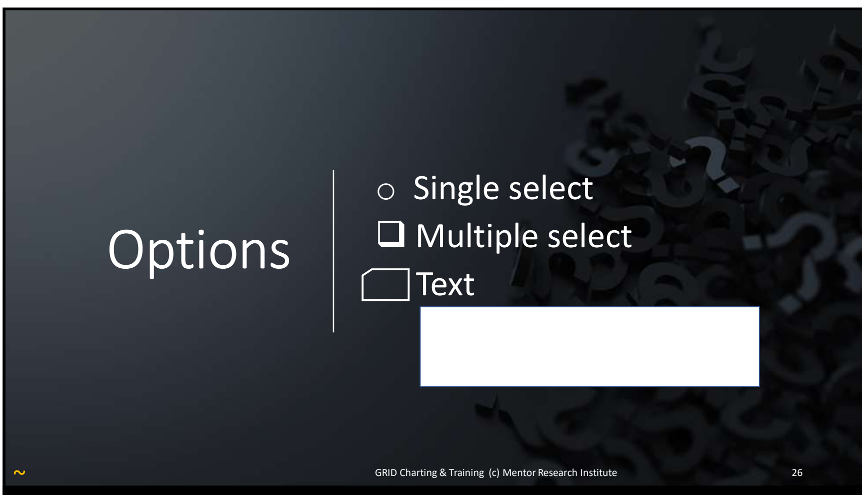

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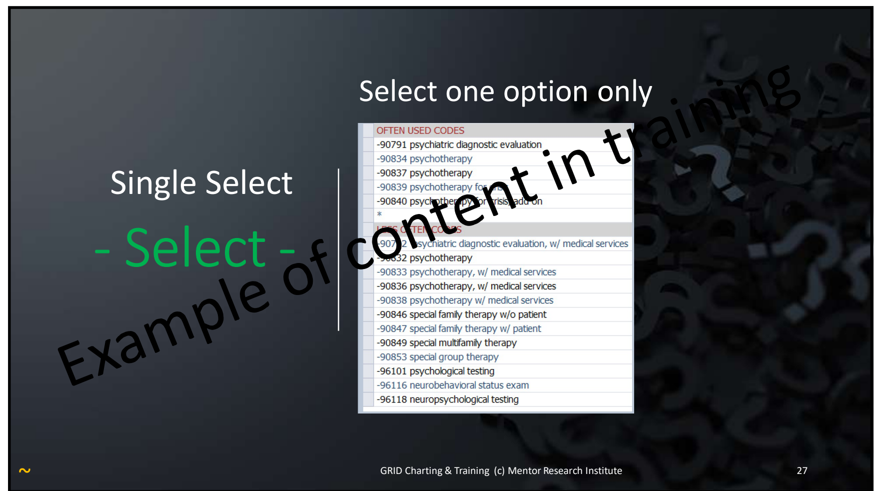

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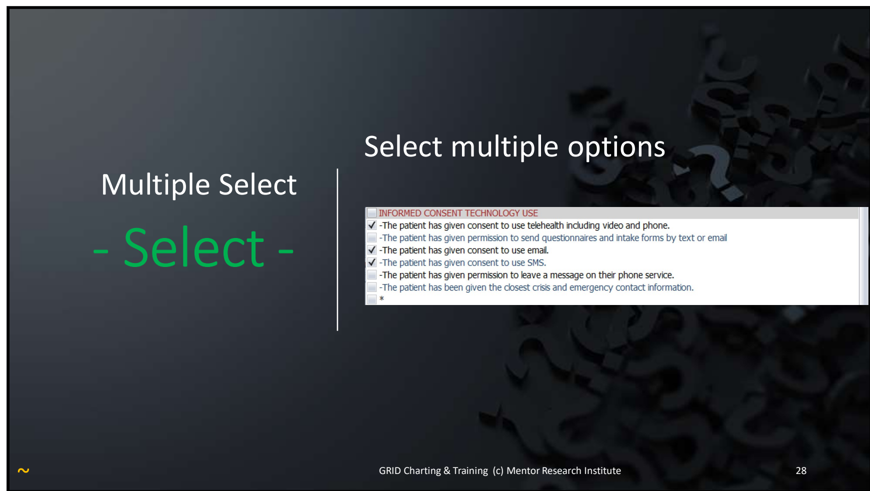

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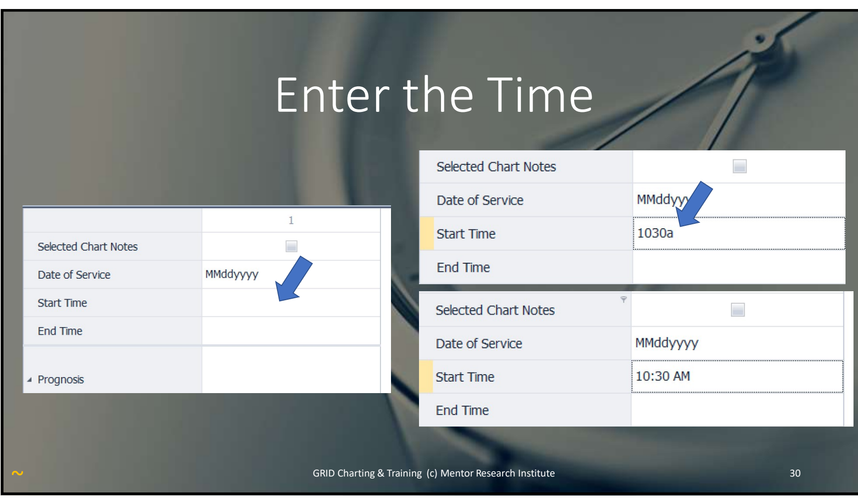

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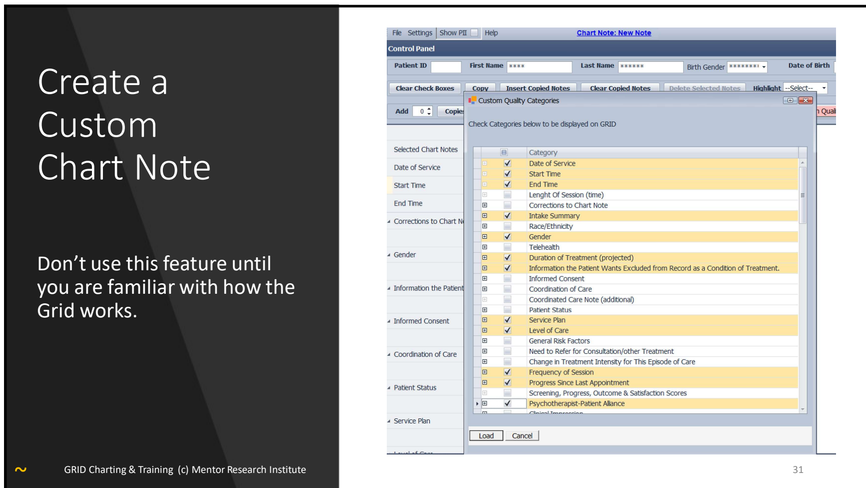

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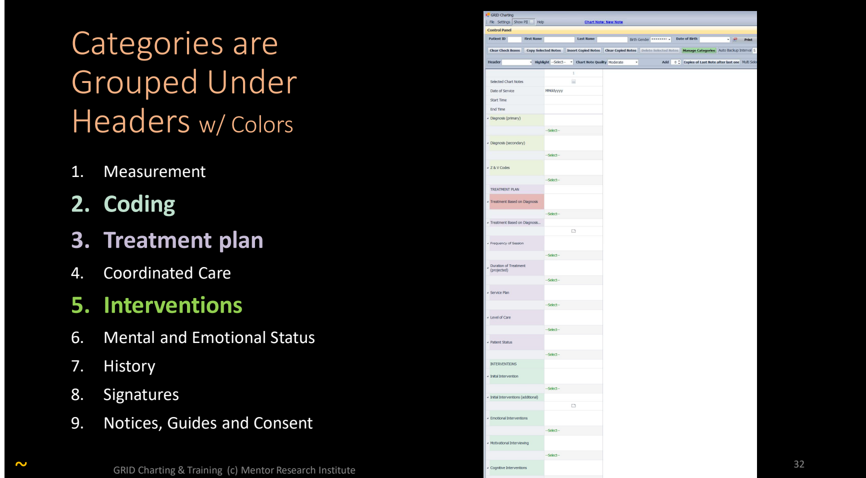

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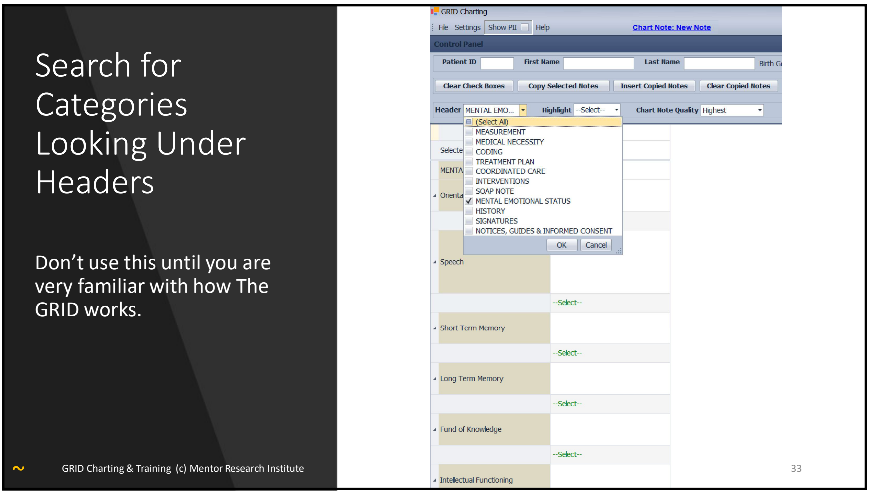

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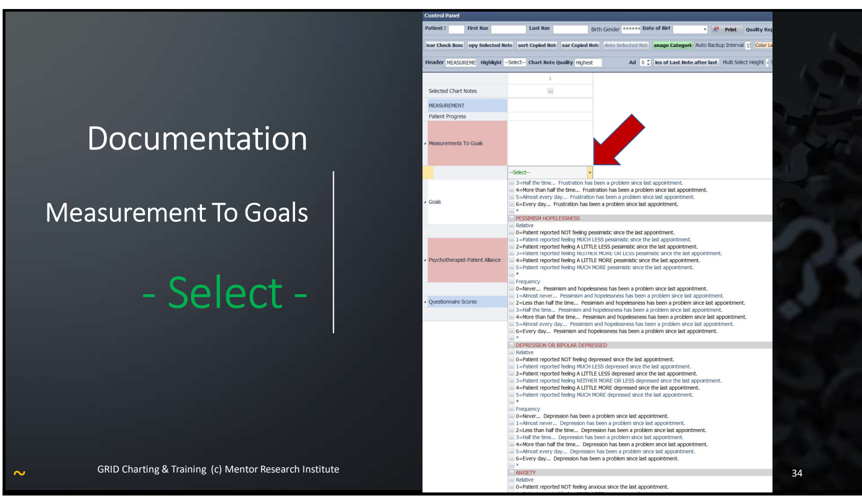

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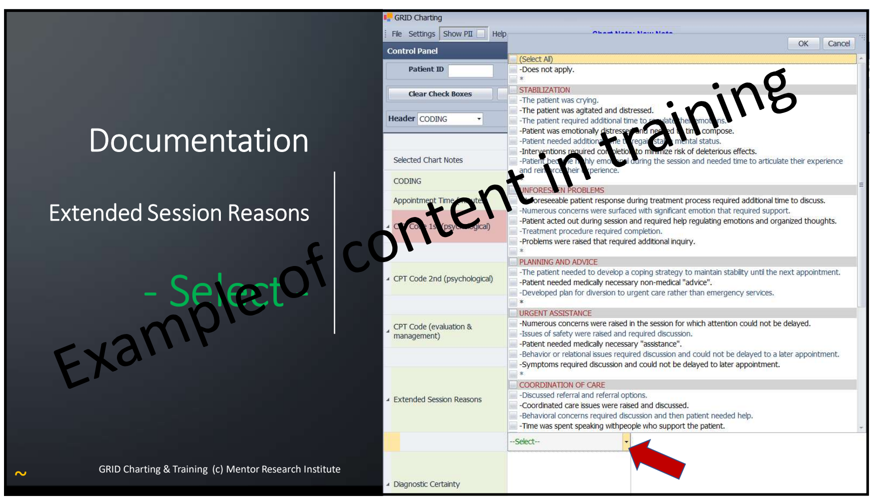

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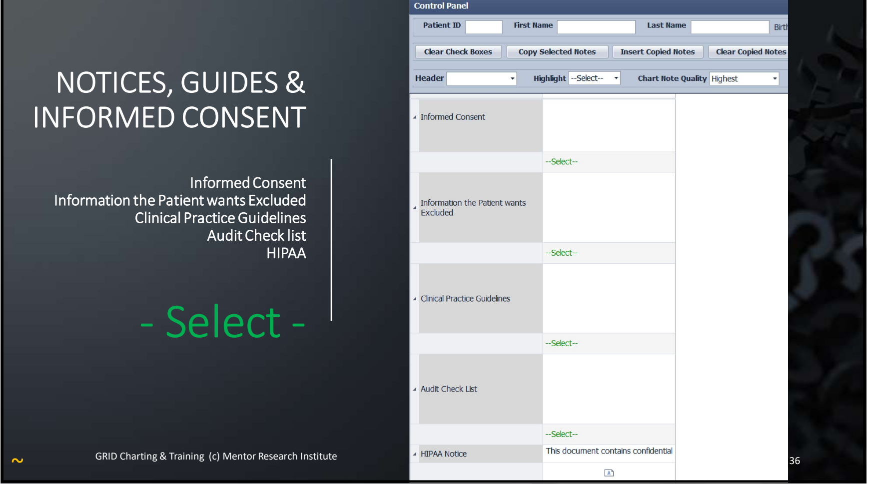

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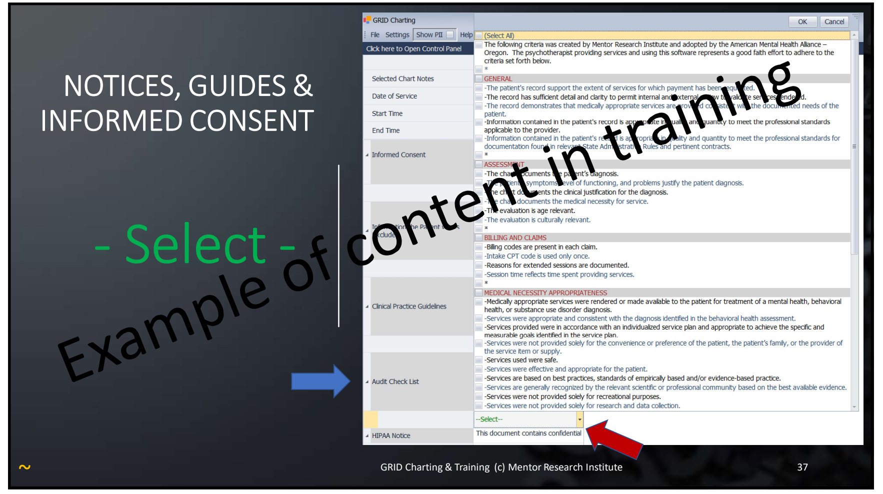

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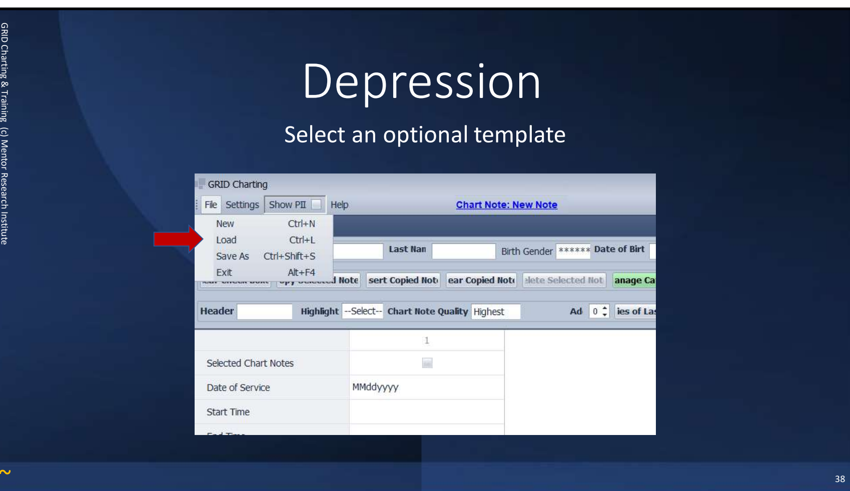

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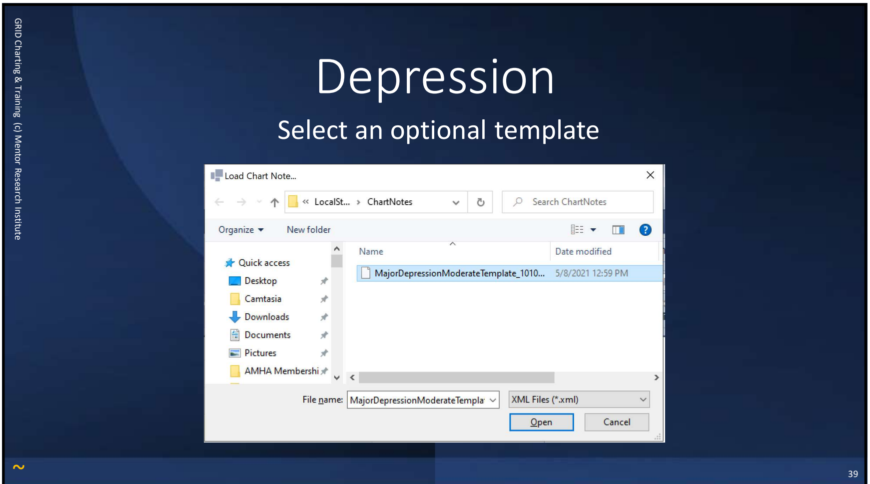

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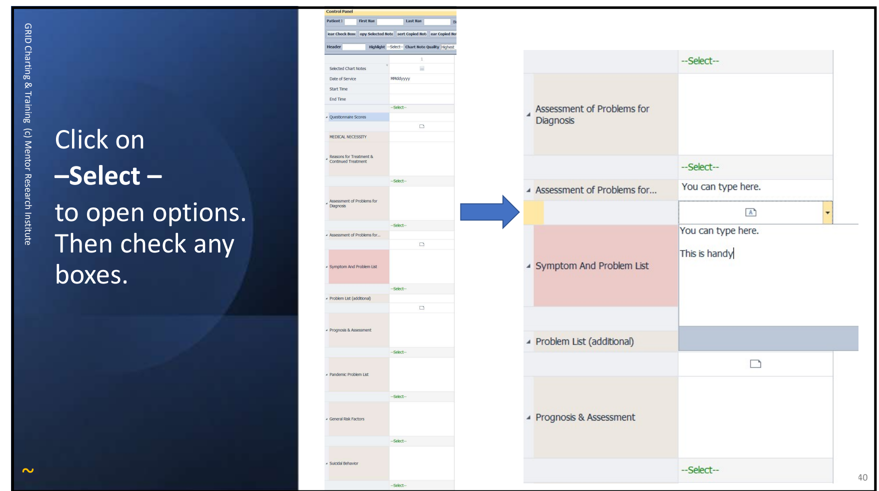

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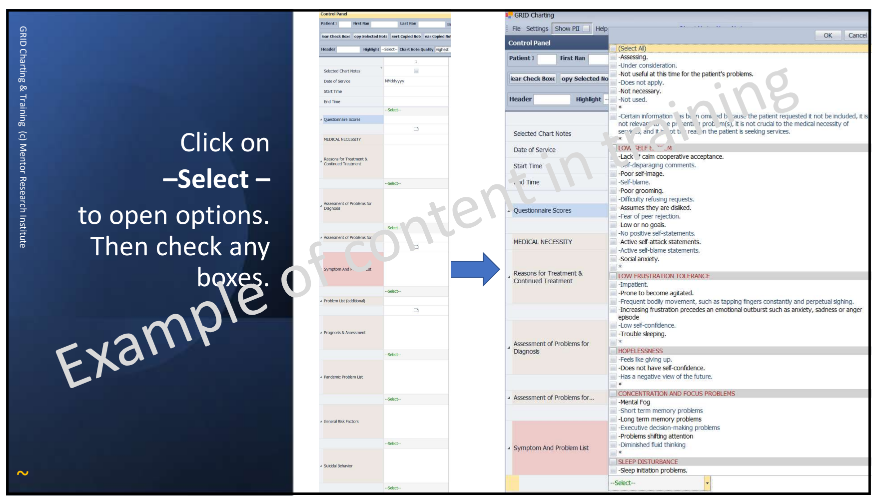

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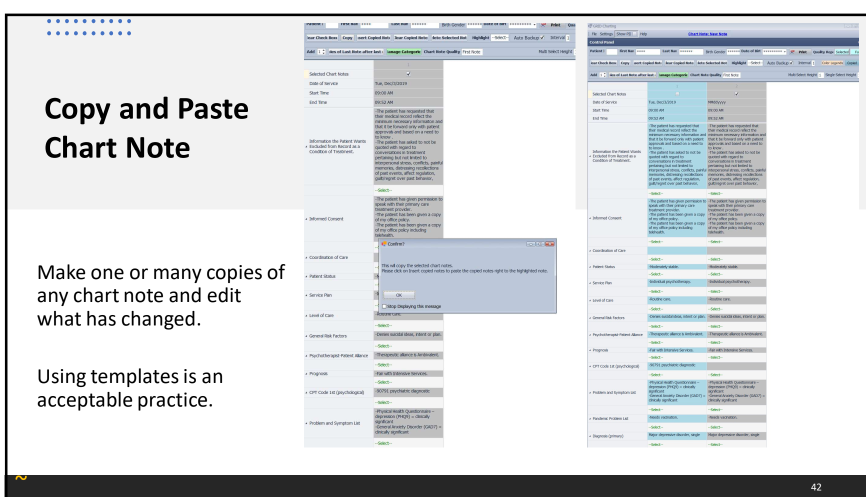

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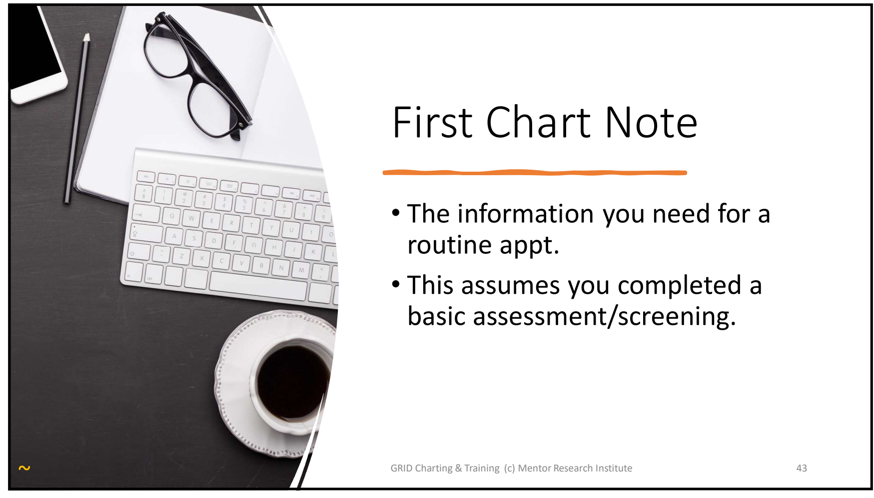

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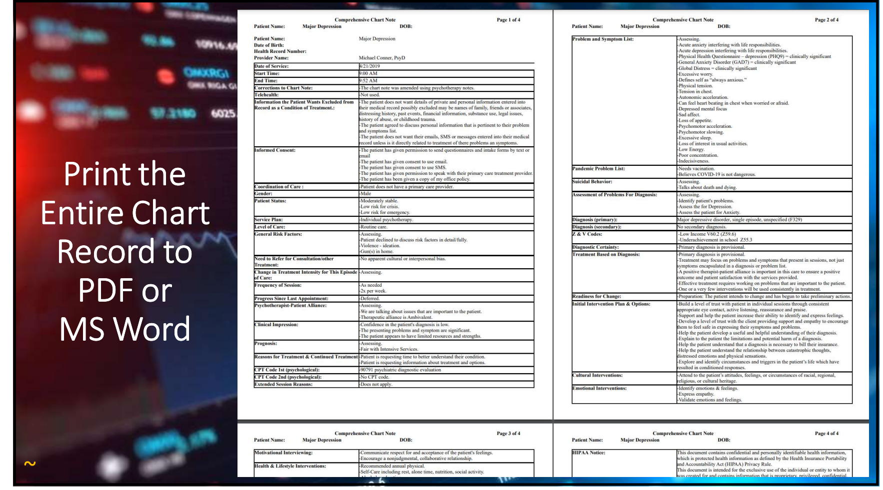

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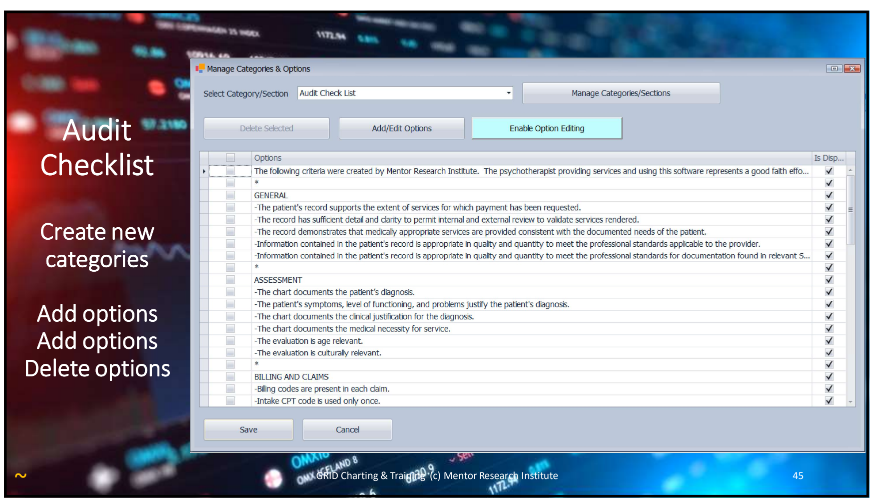

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Examine the quality of 1 or more chart notes

Chart Note Quality Report — **Page 1 of 1**

Date of service: **12/3/2019 12:00:00 AM**

Quality Report	FirstNote
Billing Required	8 out of 9
Contractual Required	11 out of 12
Ethically Required	8 out of 9
Legally Required	8 out of 9
Clinical Thoroughness	13 out of 13
Medical Necessity	12 out of 12

Total QUALITY SCORE	Excellent Quality (93%)
Failed Validations	General Violations - Failure to Provide Final Signature

46

Are Fraud, Waste, or Contract Abuse Unethical?

GRID Charting & Training

Ethical issues!

1. Failure to document medical necessity.
2. Providing service that is not medically appropriate.
3. Failure to justify a diagnosis.
4. Providing services that are not evidence or empirically based.
5. Providing services for symptoms and problems that are not covered by the payer.
6. Failure to create a treatment plan.
7. Billing for services that are not necessary.
8. Payment was for services the provider cannot prove were provided.

47

48

MEDICAID/MEDICARE

OAR 410-120-1280
Billing

- (4) For Medicaid covered services, the provider must not:
- (a) Bill the Authority more than the provider's usual charge (see definitions) or the reimbursement specified in the applicable Authority program rules;
- (b) Bill the client for missed appointments. A missed appointment is not considered to be a distinct Medicaid service by the federal government and as such is not billable to the client or the Authority;
- (c) Bill the client for services or treatments that have been denied due to provider error, except as authorized under section (5) of these rules. Examples of provider error could be things such as required documentation not submitted for a prior authorization, or a prior authorization not submitted.
- (5) Providers may only bill a client or a financially responsible relative or representative of that client in the following situations:
- (a) The client did not inform the provider of their Oregon Health plan I.D., MCE I.D card, or third-party insurance card, or gave a name that did not match OHP I.D. at the time of or after a service was provided; and therefore, the provider could not bill the appropriate payer for reasons including but not limited to the lack of prior authorization, or because the time limit to submit the claim for payment has passed. The provider shall verify eligibility at the time of service pursuant to OAR 410-120-1140 and prior to billing or collection pursuant to OAR 410-120-1280 and document attempts to obtain coverage information prior to billing the client;
- (b) The client became eligible for benefits retroactively but did not meet all of the other criteria required to receive the service;

https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=278723

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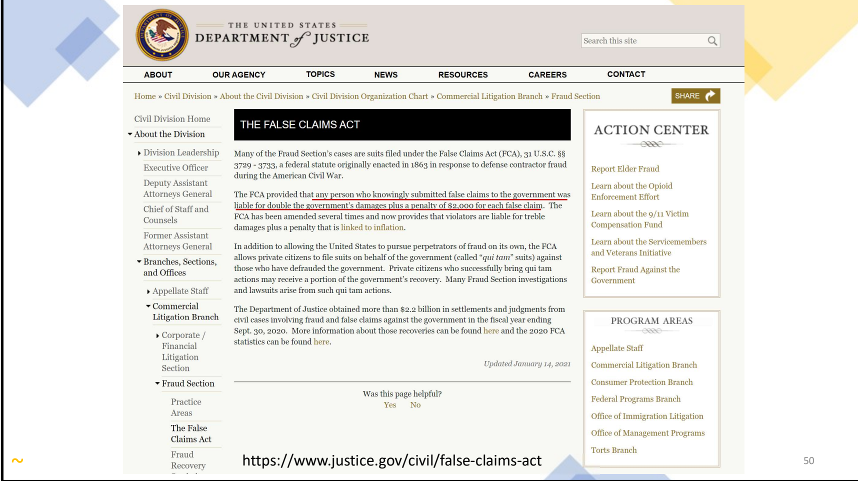

THE UNITED STATES DEPARTMENT of JUSTICE

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THE FALSE CLAIMS ACT

Many of the Fraud Section's cases are suits filed under the False Claims Act (FCA), 31 U.S.C. §§ 3729 - 3733, a federal statute originally enacted in 1863 in response to defense contractor fraud during the American Civil War.

The FCA provided that any person who knowingly submitted false claims to the government was liable for double the government's damages plus a penalty of $2,000 for each false claim. The FCA has been amended several times and now provides that violators are liable for treble damages plus a penalty that is linked to inflation.

In addition to allowing the United States to pursue perpetrators of fraud on its own, the FCA allows private citizens to file suits on behalf of the government (called "*qui tam*" suits) against those who have defrauded the government. Private citizens who successfully bring qui tam actions may receive a portion of the government's recovery. Many Fraud Section investigations and lawsuits arise from such qui tam actions.

The Department of Justice obtained more than $2.2 billion in settlements and judgments from civil cases involving fraud and false claims against the government in the fiscal year ending Sept. 30, 2020. More information about those recoveries can be found here and the 2020 FCA statistics can be found here.

Updated January 14, 2021

Was this page helpful?
Yes No

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Consumer Protection Branch
Federal Programs Branch
Office of Immigration Litigation
Office of Management Programs
Torts Branch

https://www.justice.gov/civil/false-claims-act

50

50

Health Care Fraud (Federal, State & Private)

1. Health Care Fraud, § 18 U.S.C. 1347. Section 1347 states:

- (a) Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice-
- (1) to defraud any health care benefit program; or
- (2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program, in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 10 years, or both….
- (b) With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.

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Health Care Fraud (Federal, State & Private)

2. False Statements Relating to Health Care Matters, 18 U.S.C. § 1035. Section 1035 states:

Whoever, in any matter involving a health care benefit program, knowingly and willfully—

(1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact; or

(2) makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 5 years, or both.

Example of content in training

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Health Care Wire Fraud (Federal, State & Private)

(18 U.S.C. § 1341). Section 1343 states:

- Whoever, having devised or intending to devise any scheme or artifice to defraud, or for obtaining money or property by means of false or fraudulent pretenses, representations, or promises, transmits or causes to be transmitted by means of wire, radio, or television communication in interstate or foreign commerce, any writings, signs, signals, pictures, or sounds for the purpose of executing such scheme or artifice, shall be fined under this title or imprisoned not more than 20 years, or both…

53

2020 ORS / Vol. 4 / Chapter 165 / Section 165.692

165.694 Aggregation of claims

165.696 Who may commence prosecution

165.690 Definitions for ORS 165.690, 165.692 and 165.694

165.692 Making false claim for health care payment

165.698 Notice of conviction

ORS 165.692[1]
Making false claim for health care payment

Text | News | Annotations | Related Statutes

A person commits the crime of making a false claim for health care payment when the person:

(1) Knowingly makes or causes to be made a claim for health care payment that contains any false statement or false representation of a material fact in order to receive a health care payment; **or**

(2) Knowingly conceals from or fails to disclose to a health care payor the occurrence of any event or the existence of any information with the intent to obtain a health care payment to which the person is not entitled, or to obtain or retain a health care payment in an amount greater than that to which the person is or was entitled. [1995 c.496 §2]

54

2020 ORS / Vol. 4 / Chapter 165 / Section 165.690

165.694 Aggregation of claims

165.696 Who may commence prosecution

165.690 Definitions for ORS 165.690, 165.692 and 165.694

165.692 Making false claim for health care payment

165.698 Notice of conviction

ORS 165.690[1]
Definitions for ORS 165.690, 165.692 and 165.694

Text | News | Annotations | Related Statutes

As used in ORS **165.690 (Definitions for ORS 165.690, 165.692 and 165.694)**, **165.692 (Making false claim for health care payment)** and **165.694 (Aggregation of claims)**:

(1) "Claim for health care payment" means any request or demand for a health care payment, whether made in the form of a bill, claim form, cost report, invoice, electronic transmission or any other document. "Claim for health care payment" does not include any statement by a person on an application for coverage under a contract or certificate of health care coverage issued by an insurer, health care service contractor, health maintenance organization or other legal entity that is self-insured and provides health care benefits to its employees.

(2) "Health care payment" means money paid in compensation for the delivery of specified health care services, whether under a contract, certificate or policy of insurance, by a health care payor.

(3) "Health care payor" means:

(a) Any insurance company authorized to provide health insurance in this state;

(b) A health maintenance organization;

(c) A health care service contractor;

(d) Any legal entity that is self-insured and provides benefits for health care services to its employees;

(e) Any legal entity responsible for handling claims for health care services under a state

Example of content in training

55

2020 ORS / Vol. 4 / Chapter 165 / Section 165.698

165.694 Aggregation of claims

165.696 Who may commence prosecution

165.690 Definitions for ORS 165.690, 165.692 and 165.694

165.692 Making false claim for health care payment

165.698 Notice of conviction

ORS 165.698[1]
Notice of conviction

Text | News | Annotations | Related Statutes

The prosecuting attorney shall notify the Oregon Health Authority and any appropriate licensing boards of the conviction of a person under ORS **165.692 (Making false claim for health care payment)**. [1995 c.496 §5; 2009 c.595 §111]

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If you don't have completed chart notes and are not engaged in a focused process to create, complete or re-create those chart notes in adequate form you can be required by law to repay claims made by commercial (i.e. private) Healthplans for payer reimbursement and spend up to 20 years in prison.

Bottom Line …. It's a real thing!

57

Professional liability insurance does NOT cover the legal service costs of a provider who is under investigation for allegations of criminal conduct

58

Ethical question

Example of content in training

Personal, private and sensitive information necessary to provide psychotherapy can be placed in psychotherapy notes.

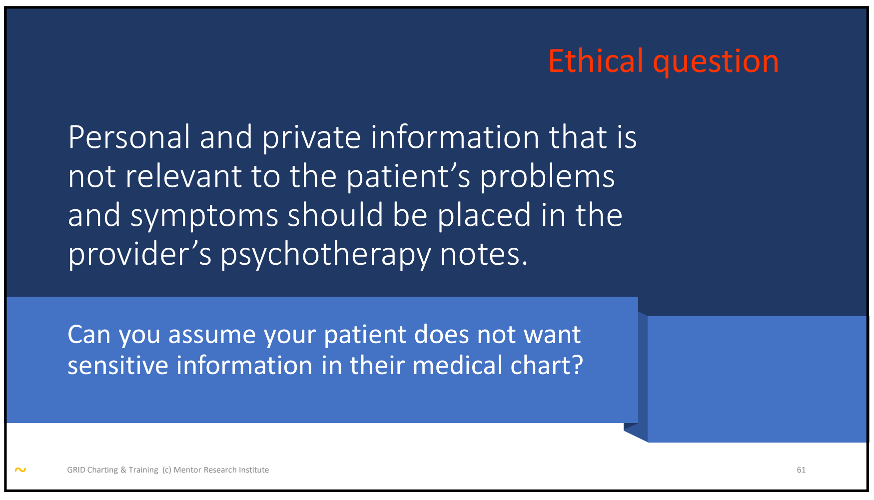
Do you have an ethical responsibility to keep personal, sensitive and private information out of a patient's medical record? Why?

59

Personal, private and sensitive information which describes a patient's problems and symptoms should be entered in the patient's medical chart in a way that protects patient privacy.

What goes in the Medical Chart?

60



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Psychotherapy Notes

Example of content in training

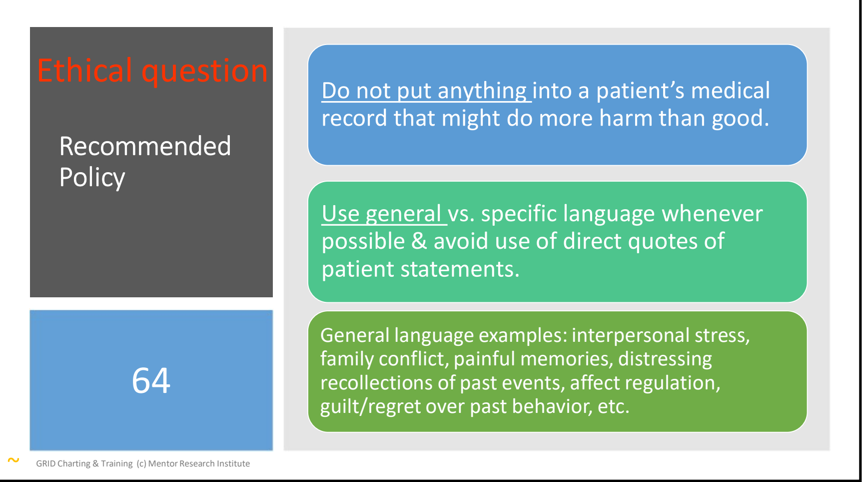
- Psychotherapy notes may include information that is in the Medical record and information that may become part of the medical record in the future. (augment the record.)
- "Psychotherapy Notes" are granted special protection under HIPAA due to the likelihood they contain particularly sensitive information, and also because they are the personal reflections of the patient or treating therapist.
- The primary purpose of psychotherapy notes is to help the psychotherapist recall the therapy discussion, session content, information that is not relevant that may become relevant, is little or no use to others not involved in the therapy at the time the notes were made.

62

Yale University Minimum Necessary Policy

- Medical staff must make a reasonable effort to disclose or use only the minimum necessary amount of protected health information in order to do their jobs. They **can disclose information requested by other health care providers if the information is necessary for treatment.**
- Physicians and providers who are directly involved in the care of the patient can see PHI. Providers can disclose to consulting physicians or for referrals, **but not to people who don't have clinical responsibilities.** Physicians must be careful about what they disclose to **other staff members**, such as **billing department workers** or providers not involved in the care of their patient.

63



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Important

The information placed in a patient's medical chart should be only the minimum necessary for the legitimate purposes for which the record may be examined.

An auditor's curiosity about details of the circumstances which create symptoms is not a legitimate purpose.

Example of content in training

65

Ethical question

The purpose of a medical chart is NOT to document as much as you can about a patient's personal and private life.

Is it ethical to put in all the sad details?
Not if your ethical goal is to avoid harm and protect privacy.

66

Ethical question

A chart note may be amended with excerpts from psychotherapy notes during or prior to an audit (or other legitimate request for information.)

Therapists are writing to 7 masters who have nothing to do with psychotherapy services

67

There are 7 oversight purposes for which charts may be examined. Each is external to psychotherapy, none relate to improvement in patients progress, outcomes, or satisfaction.

https://www.mentorresearch.org/value-psychotherapy-charting

Example of content in training

68

7 oversight purposes of chart notes provide no incremental improvement in patient progress, outcomes or satisfaction

1. Billing & claims information
2. Contractual requirements
3. Legal requirements
4. Ethical requirements
5. Clinical thoroughness
6. Medical necessity
7. Practice policies and patient rights requirements

69

6 internal practice purposes that provide no incremental improvement in treatment progress, outcomes or satisfaction

1. that a service was provided to justify charging a fee for that service.
2. that patient/s and psychotherapist discussed pertinent patient history and presenting problems for which services are requested and qualify for reimbursement.
3. pertinent aspects of patient functionality, symptoms, well-being, health, and risk factors which impact provision of an appropriate level of care.
4. information that allows the patient and psychotherapist to define when continuation or termination of care is appropriate.
5. any need for other or additional services.
6. the outcome of services provided.

70

Factors that may increase payer audits of mental health services.

- Annual session limits are no longer allowed.
- Mental health providers lag in adopting EHRs; their practice norms are not as easily analyzed as medical service codes.
- Medical necessity criteria are not well enough documented.
- Mental health professionals often do not meet payer's contract compliance requirements.
- Physicians advocate effectively and collaboratively for their bottom line; mental health professionals do not.
- Pandemic experience has increased public eagerness for psychotherapy services.
- Payers have financial pressures due to increases in overall healthcare expenditures: aging population, pandemic service demands, more medical service options of many types; payers may be motivated to audit mental health providers - who are vulnerable.

71

What is a Designated Record Set?

Example of content in training

- ...is a HIPAA privacy rule that defines the **designated record set** as a group of records maintained by or for a covered entity that may include patient medical and billing records; the enrollment, payment, claims, adjudication, and cases or medical management record systems maintained by or for a health plan; or information used in whole or in part to make care-related decisions.

Broader than a Legal Medical Record

72

What is a Legal Medical Record?

- Generally, the information used by the patient care team to make decisions about the treatment of a patient.

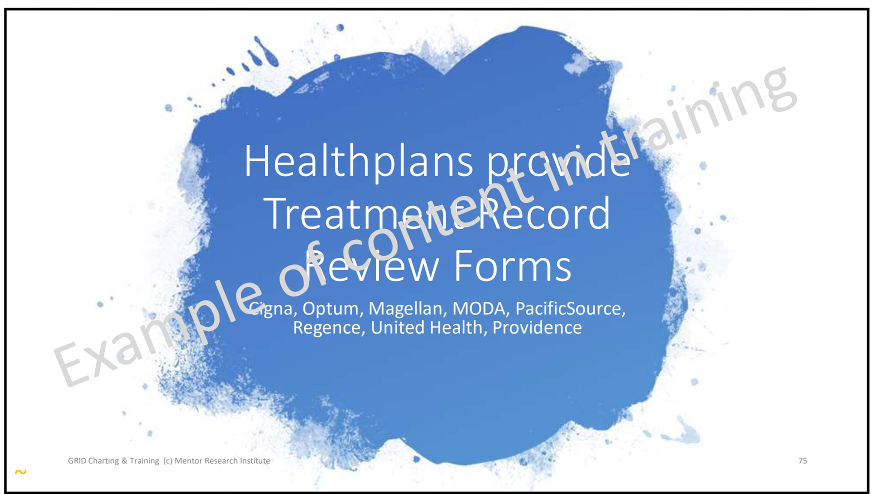
  Does not include billing data

73

4 Types of Audits

1. Risk Adjustment
2. Abuse Audits
3. Record Keeping
4. Medical Necessity & Appropriateness
   - Failure to document
   - 90837 letters "bring it on"

74



75

Treatment Record Keeping

Regence BlueCross BlueShield of Oregon

Record details: Revised 2021

1. All appointments, including the patient's name and date of contact
2. All entries should be legible, in chronological order and signed in ink with the provider's name and credentials
3. All treatment charts should be readily accessible and stored in a secure environment to protect patient confidentiality

Documentation should include, but is not limited to:

1. Presenting problem
2. Key demographic data
3. ICD-10 diagnosis code(s)
4. Full psychological and medical history
5. Treatment plan with measurable goals
6. Date and length of the therapy sessions
7. All diagnostic and treatment services provided or ordered
8. Summary of the patient's progress or lack of progress toward the treatment goals
9. Prescribing providers should document that noted positive benefits outweigh noted side effects

14. Mental status exam and current clinical status
15. Therapy session content, such as therapeutic interventions used and major themes discussed
16. DSM-5 diagnosis code is acceptable only as supplemental coding to the required ICD-10 diagnosis code
17. Complete developmental history for children and adolescents, including relevant prenatal and perinatal events
18. Current prescription medications, including the name, dosage, instructions for use and any side effects experienced
19. With patient consent, documentation of coordination of care with the primary care physician and other involved health care professionals
20. Substance use evaluation, including past and present use of cigarettes, alcohol, illicit, prescribed and/or over-the-counter drugs
21. Discharge plan for patients being treated in an inpatient setting, residential program, partial hospitalization/day treatment program or intensive outpatient program
22. Number of participants and relationship of the participants to the patient if it is conjoint or family therapy, as well as a summary of how the participants responded to the session

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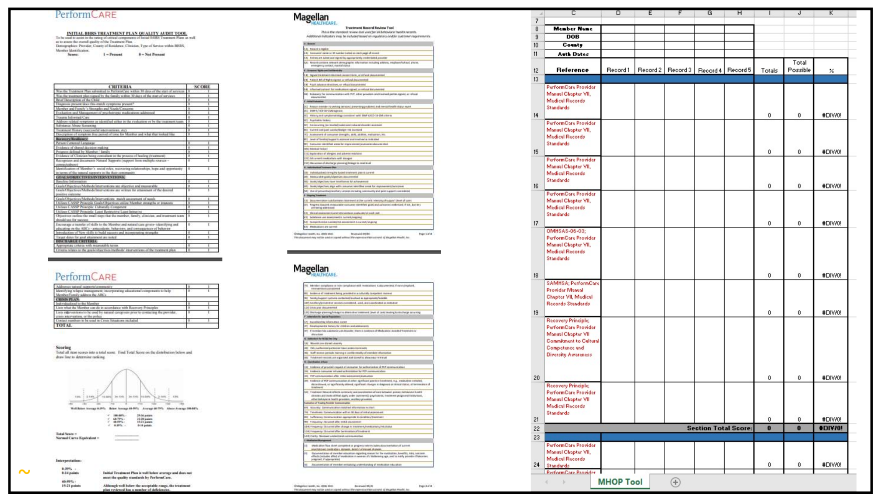

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PacificSource CCO Self Self-Audit Checklist

SELF-AUDIT CHECKLIST with OAR References			
Provider Name/Position/Credentials:			
Date:			
Checklist Item	Yes	No	Comments
Are records being retained for ten years after the date of services for which claims were made? [OAR 410-141-3520 (10)]			
Are your staff trained in recovery principles, motivational interviewing, integration, and trauma informed care? (CCO Contract, Exhibit M)			
Are non-priority members receiving an assessment within seven days of request and second appointment when clinically appropriate? [OAR 410-141-3515 (11)(c)(C)]			

Checklist Item	Chart # 1		Chart # 2		Chart # 3		Chart # 4		Chart # 5		Comments
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
Is there documentation indicating that the member has been informed of their rights and responsibilities? [OAR 410-120-1855 (1)(h)]											
Does documentation identify the service provider and their credentials? [OAR 410-172-0630 (2)(a)]											
Was a behavioral health assessment completed by a qualified mental health professional prior to the start of services? [OAR 410-120-0000 (31)]											
Are the services provided appropriate and consistent with the diagnosis identified in the behavioral health assessment? [OAR 410-172-0630 (2)(b)]											
When developing the member's Service Plan, are you assessing for Adverse Childhood Experiences (ACE), trauma, and resiliency in a culturally and linguistically appropriate manner, using a trauma informed framework? (CCO Contract, Exhibit M)											
Are the goals on the Service Plan specific and measurable? [OAR 410-172-0630 (2)(c)]											
Were services provided in accordance with an individualized Service Plan? [OAR 410-172-0630 (2)(c)]											
Were the services provided medically appropriate (see OAR 410-172-0630 for definition)? [OAR 410-120-1855 (1)(k)]											
Do service notes document the exact time of the encounter (i.e. no rounding up or down of the service time)? (False Claims Act)											
Do service notes document the specific service provided? [OAR 410-172-0620 (2)]											
Are all entries in the clinical record signed and dated by the provider? [OAR 410-172-0620 (2) and 410-172-0620 (4)]											
If applicable, are referrals documented? [OAR 410-120-1855 (1)(n)]											

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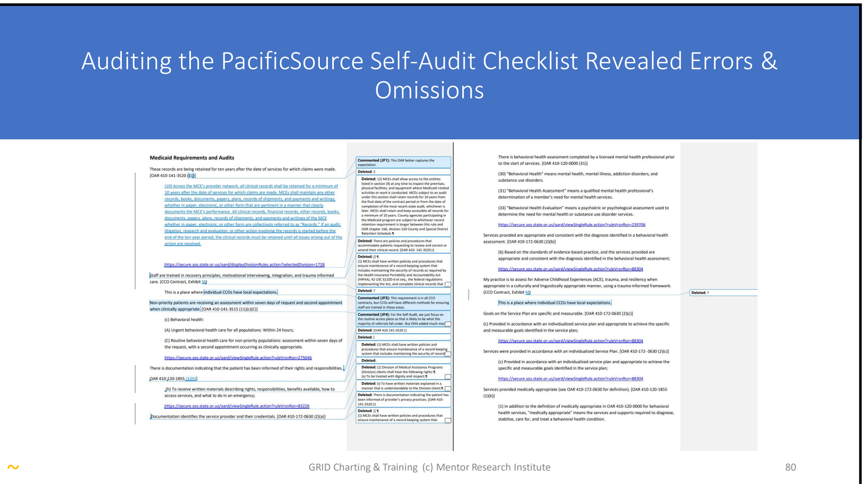

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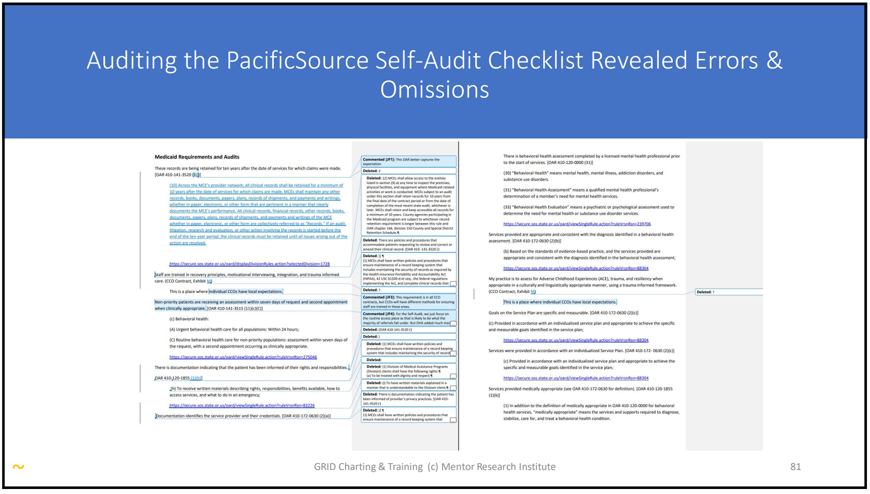
Auditing the PacificSource Self-Audit Checklist Revealed Errors & Omissions



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Auditing the PacificSource Self-Audit Checklist Revealed Errors & Omissions

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Auditing Self-Audit Checklists Reveals Errors & Omissions

1. Anyone who contracts with an Oregon Health Plan CCO must adhere to federal and State laws and regulations. (Punishable as a crime.)
2. CCOs are paid by the State of Oregon.
3. CCOs manage behavioral health services in accordance with State and Federal Law.
4. Public behavioral health departments have employees and are certified by the State to take OHP payment.
5. Private groups can form and contract with CCOs if they have a certificate of authority issued by the State of Oregon.
6. The State of Oregon contracts with individual providers because they do not have enough employees and working for some private groups suck; having case loads of 100 to 150 patients per provider.
7. CCOs are required to audit solo private practice providers. They send providers self-audits to place the burden on the solo practice providers.
8. Providers are auditing themselves using criteria that are incomplete, has errors, and misleads professionals into believing they are compliant.
9. CCOs are protecting their contracts, not the providers' practices.
10. Providers are struggling to understand the legal obligations.

Example of content in training

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- …self-audit checklists do not release psychotherapists from responsibility to validate that they are adhering to ALL external oversight requirements?

Did you know that …

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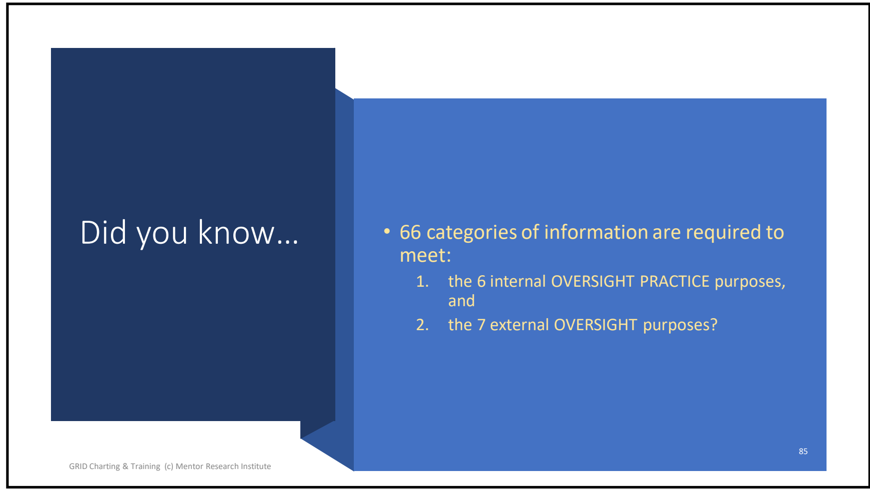

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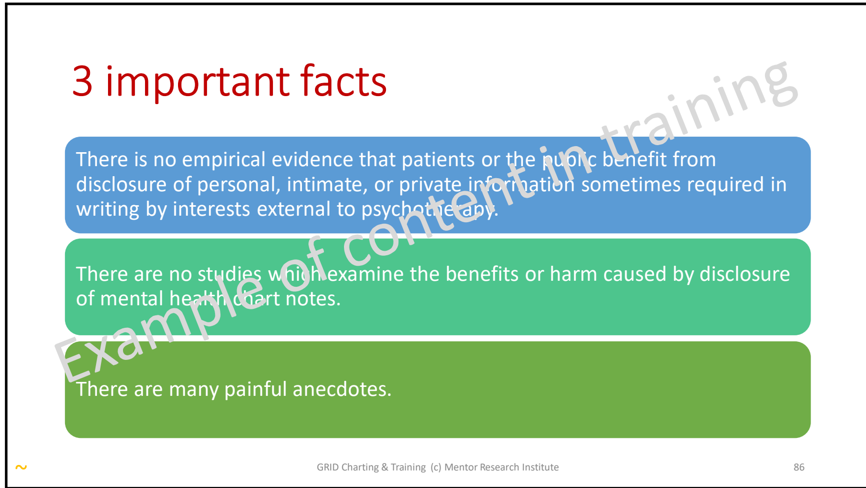

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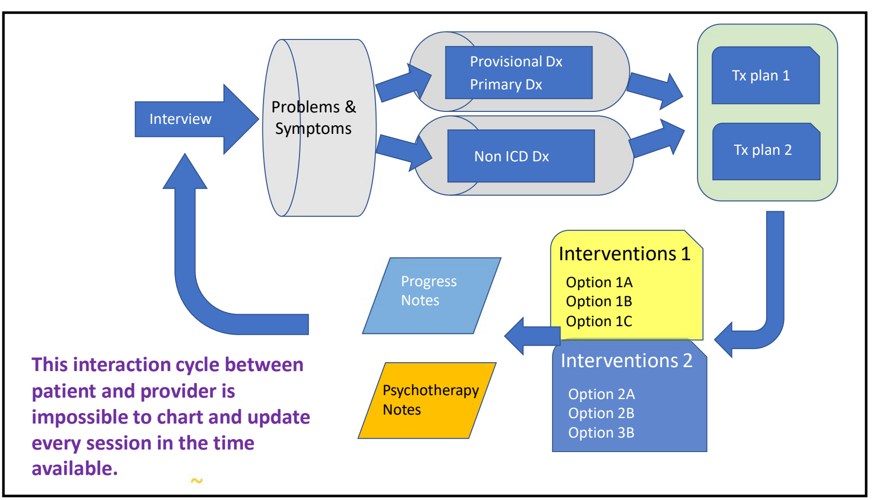

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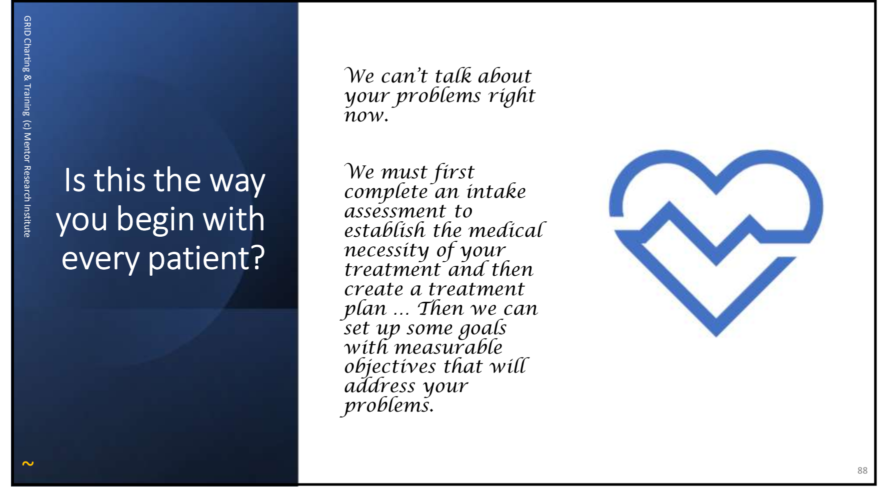

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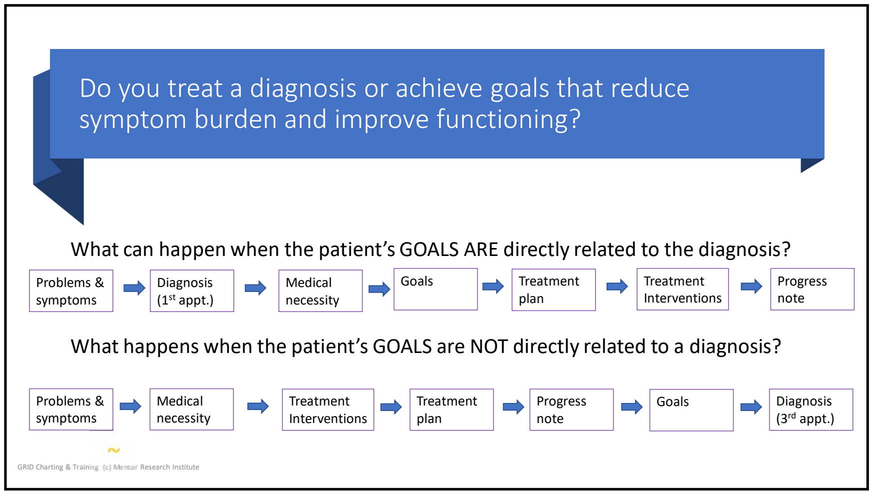

89

Why do Healthplans want personal, private and sensitive information.

Beginning in the 1970's

- Residential and inpatient treatment programs flourished.
- The cost of mental health care increased dramatically (uncontrolled).
- Healthplans insisted on reducing costs.
- The Joint Commission On Accreditation of Hospitals (JCAH) established accreditation standards for psychiatric facilities and substance abuse programs.

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There's a S.M.A.R.T. way to write management's goals and objectives

George T. Doran

A characteristic of management excel- lence is a climate in which company offi-

unique executive beliefs and philoso- phies. They are usually of a form that is continuous and long-term. For example: (1) Conduct all corporate activities with

find ways to deal with change and allow managers the freedom to reveal them- selves as individuals. These twin de- mands of managing change and satisfying human needs can be accomplished if, and only if, organizations educate their people in the "what" and "how" of writ- ing effective objectives.

It's important to understand the

Specific—target a specific area for im- provement.
Measurable—quantify or at least suggest an indicator of progress.
Assignable—specify who will do it.
Realistic—state what results can realisti- cally be achieved, given available re- sources.
Time-related—specify when the result(s) can be achieved.

Notice that these criteria don't say that all objectives must be quantified on all levels of management. In certain sit-

The Joint commission adopted a management by objectives policy developed to manage employees in companies.

91

91

S.M.A.R.T. charting was adopted by hospital business administrators to manage their employees and patients!

Cobbled together based on health care administrative needs totally unrelated to providing care to people with emotional or behavioral problems …

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93

What is the origin of "S.M.A.R.T."?

Finally, hold managers accountable for the proper match of their subordinates and their jobs. Require evidence of job fit in performance appraisals as foundation, to management by objectives and all efforts seeking improvement in productivity. And, when you encounter job mismatch, correct it. If you must, remove the employee, move him or her to a more suitable position, or, if that is impossible, seek assistance in outplacement.

People are expensive assets. If a manager has persons in the wrong job, require him to face up to the reality of it, or be penalized. The immorality lies in failing to tackle the problem, not in being soft about it. ■

94

S.M.A.R.T. Goals and Objectives Keep Being Changed by People with Perverse Incentives…

- **Specific:** Objectives need to be clear and specific, not general or vague. It's easier for a patient to complete objectives when they know exactly what they need to do.
- **Measurable:** Objectives need specific times, amounts or dates for completion so you and your patients can measure their progress.
- **Attainable:** Encourage patients to set goals and objectives they can meet. If their objectives are unrealistic, it may decrease their self-confidence or discourage them. However, goals and objectives should not be too easy either. Goals should be challenging but also realistic.
- **Relevant:** Goals and objectives should be relevant to the issues listed in the treatment plan. When patients complete objectives and reach their goals, they should be closer to the place they want to be in life and as a person.
- **Time-bound:** Goals and objectives must have a deadline. Goals might be considered short-term or long-term, while objectives need specific dates to meet. A deadline creates a sense of urgency which helps motivate clients.

95

Why do so many people use SMART charting?

96

97

Is this a real thing?

"I strongly encourage the use of SMART goals on Service Plans to be compliant with this OAR: Specific, Measurable, Achievable, Realistic, and Time-based. (the manager was referring to [OAR 410-172-0630 (2)(c)])"

Email communication with the behavioral health quality manager of an Oregon Coordinated Care Organization (CCO).

98

Quality of care (defined as efficiency and cost effectiveness) was evaluated based on adherence to a process like this for each patient:

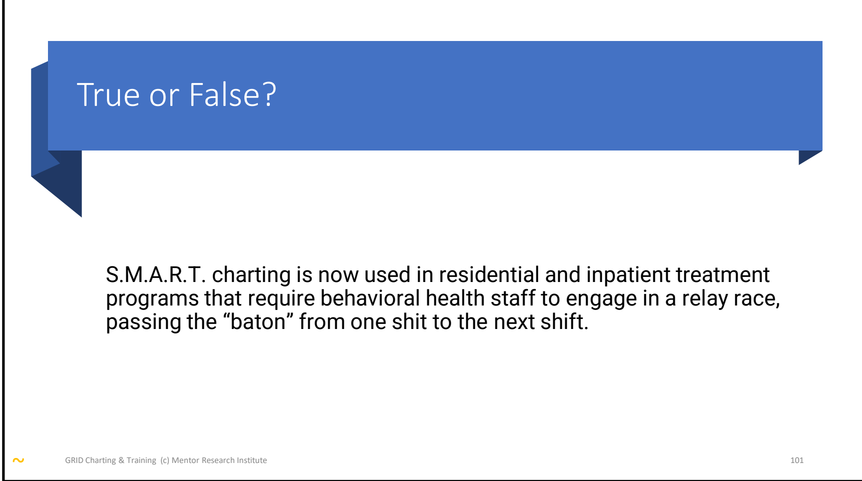
1. **S**tatements of clearly defined problems and needs
2. **M**easurable goals and objectives.
3. **A**chievable outcomes based on the frequency of care, treatment, and services.
4. **R**eports about those objectives sufficiently specific to evaluate the patient's progress, expressed in behavioral terms that specify measurable indices of progress.
5. **T**imely attention to goals and objectives, re-evaluated and, when necessary, revised; recorded at intervals established by organization policy.

99

True or False?

S.M.A.R.T. charting borrowed a concept based on the **management by objectives** (MBO) model created for the purpose of managing, supervising and removing employees who did not meet employers' performance objectives.

100



101

SMART Charting is not SMART

S.M.A.R.T. (Dorin, 1981)

Business (Manage By Objectives)

- Specific - targets and areas for improvement.
- Measurable - suggest indicators of progress.
- Assignable - specify who will do it
- Realistic – what can be achieved with resources.
- Time related – when results will be achieved.

S.M.A.R.T. (SAMSHA, 2021)

Business (Management by Objectives)

- Specific – Objective clearly states, so anyone reading it can understand, what will be done and who will do it.
- Measurable – Objective includes how the action will be measured. Measuring your objectives helps you determine if you are making progress. It keeps you on track and on schedule.
- Achievable – Objective is realistic given the realities faced in the community. Setting reasonable objectives helps set the project up for success
- Relevant – A relevant objective makes sense, that is, it fits the purpose of the grant, it fits the culture and structure of the community, and it addresses the vision of the project.
- Time-bound – Every objective has a specific timeline for completion.

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102

SMART is no longer SMART

SMART (Dorin, 1981)

Business (Manage By Objectives)

- Specific - targets and areas for improvement.
- Measurable - suggest indicators of progress.
- Assignable - specify who will do it
- Realistic – what can be achieved with resources.
- Time related – when results will be achieved.

SMART (Griswold, 2021)

Clinical (Opinion during CE)

- Specific - number and quantities for objectives.
- Measurable goals - behaviors and scores.
- Attainable - is it realistic?
- Relevant - related to a diagnosis.
- Time limited – deadlines to ensure clients are meeting targets.

SMART (SAMSHA, 2021)

Business (Management by Objectives)

- Specific – Objective clearly states, so anyone reading it can understand, what will be done and who will do it.
- Measurable – Objective includes how the action will be measured. Measuring your objectives helps you determine if you are making progress. It keeps you on track and on schedule.
- Achievable – Objective is realistic given the realities faced in the community. Setting reasonable objectives helps set the project up for success
- Relevant – A relevant objective makes sense, that is, it fits the purpose of the grant, it fits the culture and structure of the community, and it addresses the vision of the project.
- Time-bound – Every objective has a specific timeline for completion.

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103

True or False?

S.M.A.R.T. charting is now pushed as the defacto psychotherapy documentation standard for auditing by Healthplans and insurance payers.

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104

Can you create a bullet proof treatment record that would make an auditor swoon?

105

A bullet proof treatment record that would make an auditor swoon requires…

Example of content in training

1. A problem and symptoms list used to make a diagnosis that justifies treatment.
2. The treatment plan which includes a set of interventions, based on a provisional diagnosis, to treat problems and symptoms.
3. Interventions include sets of treatment options selected and used to treat problems and symptoms.
4. Progress notes are created to document treatment options that may be used and to measure change by observations, conversation and/or questionnaires.

106

The GOLDEN THREAD

Used almost exclusively by Community Behavioral Health Programs with a Certificate of Approval by the OHA

The "golden thread" refers to how the problems and symptoms from an assessment (interview and screening) lead to a provisional diagnosis and the initial treatment plan, which should then be reflected in the treatment and progress notes. This is a slight variation on SMART charting strategy.

107

Contrasting the Golden Thread with Reality

Golden Thread

- Intake assessment clearly identifies an appropriate clinical problem and corresponding diagnosis.

In Reality

- Ascertaining appropriate focal symptoms and/or problems can take weeks or months.
- The initial diagnosis is often uncertain, can take weeks to arrive at, and can change over time.

108

Golden Thread

- Each goal should have specific interventions prescribed that reflect best practices and evidenced-based treatments to help guide the client along the path to recovery.

In Reality

- Inpatient services require specific goals and interventions that can be assigned to a wide range of behavioral and mental health providers who work with the patient 24/7 in a controlled setting. Continuity of care requires specificity.
- Outpatient services provided by one person can be 32 hours of service over 8 months in an uncontrolled setting. Treatment approaches and goals can change between appointment.

109

Depression example

- Each note should lead into the next, demonstrating the client's progression through treatment.

- 0=Never... Depression has been a problem since last appointment.
- 1=Almost never... Depression has been a problem since last appointment.
- 2=Less than half the time... Depression has been a problem since last appointment.
- 3=Half the time... Depression has been a problem since last appointment.
- 4=More than half the time... Depression has been a problem since last appointment.
- 5=Almost every day... Depression has been a problem since last appointment.
- 6=Every day... Depression has been a problem since last appointment.

110

Ethical question

- The Golden Thread is important for compliance and reimbursement.
- The Golden Thread can also be an important tool for delivering quality care.

- There is no evidence to support this assertion.
- The Golden Thread is a myth formulated for inpatient treatment and imposed on outpatient treatment without evidence.

111

What contractors are part of UPIC nationally?

- Medicare Administrative **Contractors** (MACs),
- Supplemental Medical Review **Contractor** (SMRC),
- Recovery Audit **Contractors** (RACs), and the.
- Comprehensive Error Rate Testing (CERT) **Contractor**.

112

What triggers an RAC audit?

RAC looks for both overpayments made to patients (i.e. providers) and underpayments made to providers (by hospitals and groups).

1. While many **RAC audits** do uncover fraud, it is important to note that innocent mistakes or errors in documentation can also **trigger** an **audit**.
2. Private contractors will demand correction of the payment.

113

How are RACs paid?

- **Medicare** RACs are paid on a contingency fee basis, receiving a percentage of both the over- and underpayments they correct.
- **Medicare** RACs perform **audit** and recovery activities on a postpayment basis, and claims are reviewable up to 3 years from the date the claim was filed.

114

What is Medicaid Abuse

Ethical question

- **Medicaid abuse** occurs when a member or provider engages in activity that results in unnecessary cost, including services that are not necessary or services that do not meet the standards of care.
- Examples of **Medicaid abuse**: Billing for services that are not necessary.

115

Complaint referral to UPIC

- “Claims have been up-coded to obtain a higher reimbursement amount and appear to be fraudulent or abusive; “

Medicare Program Integrity Manual Chapter 1 - Medicare Improper Payments: Measuring, Correcting, and Preventing Overpayments and Underpayments

116

Complaint referral to UPIC

Ethical question

- "Potential misrepresentation with respect to the nature of the services rendered, charges for the services rendered, identity of the person receiving the services, identity of persons or doctor providing the services, dates of the services, etc.; "

Medicare Program Integrity Manual Chapter 1 - Medicare Improper Payments: Measuring, Correcting, and Preventing Overpayments and Underpayments

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117

Complaint referral to UPIC

- "Alleged submissions of claims for non-covered services are misrepresented as covered services, excluding demand bills and those with Advanced Beneficiary Notices (ABNs);"

Medicare Program Integrity Manual Chapter 1 - Medicare Improper Payments: Measuring, Correcting, and Preventing Overpayments and Underpayments

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118

Complaint referral to UPIC

- "Alleged alteration of claim history records to generate inappropriate payments;"

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119

What can auditors do?

- "When auditors conduct statistical sampling for overpayment estimation as specified in PIM chapter 8, they shall extrapolate the sampling results to the known universe of similar claims when calculating the projected overpayment or underpayment amount."

CMS guidelines as of October 2, 2020

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120

What can auditors do?

- “Auditors have the discretion to conduct the postpayment review onsite at the provider’s location.”

CMS guidelines as of October 2, 2020

121

"Progress Notes“ are…

- “…visit notes, encounter notes, Evaluation and Management documentation, office notes, face-to-face evaluation notes or any other type of record of the services provided by a physician or other licensed/certified medical professional (LCMP) in the medical record.”

CMS guidelines as of October 2, 2020

122

"Progress Notes“

Important

- “…may be in any form or format, hardcopy or electronic.”

Ethical question

CMS guidelines as of October 2, 2020

123

Important

- Template – “a.. tool/instrument/interface that assists in documenting a progress note.”

- CMS guidelines as of October 2, 2020

124

Auditors look for…

- "Patterns and trends that may indicate potential fraud."

CMS guidelines as of October 2, 2020

125

"The CERT reviewers shall review every line on the randomly selected claim that affects payment to determine if the following types of requirements are met:

1. Coding requirements;
2. Benefit category requirements;
3. The reasonable and necessary requirements."

CMS guidelines as of October 2, 2020

126

What are reasonable and necessary requirements?

127

This class of information does not qualify as psychotherapy note material.

- Progress notes and psychotherapy notes have important but distinct purposes. Psychotherapy notes are psychotherapists private notes taken down during sessions. They're used primarily as a memory aid and include information like your hypothesis on a potential diagnosis, observations, and impressions related to the patient's unique needs or circumstance.
- Progress notes, by contrast, are the official record of each therapy session. They're meant to be shared with other members of the patient's care team and insurers when requested. Progress notes include information such as diagnoses, interventions used, and progress toward treatment plan goals.

Example of content in training

128

"In certain situations, it is appropriate for contractors to up code or down code a claim (or items or services on a claim) and adjust the payment. When the medical record supports a higher or lower level code, the MACs, SMRC, CERT, UPICs and Recovery Auditors shall not deny the entire claim but instead shall adjust the code and adjust the payment."

CMS guidelines as of October 2, 2020

True or False?

"The False Claims Act ("FCA") provides, in pertinent part, that: (a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government;. . . or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,…"

- 31 U.S.C. § 3729.

Important

True or False?

Under Federal Law…

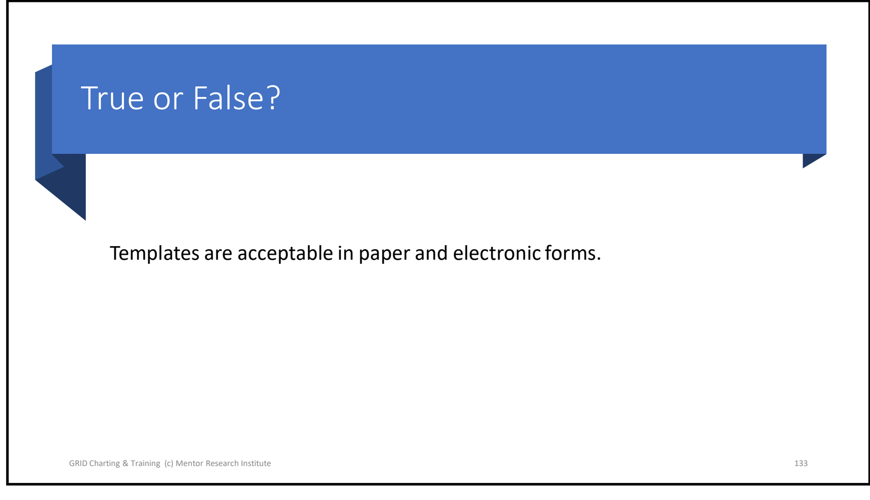
"(b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required."

- 31 U.S.C. 3729(b)

True or False?

Treatment plans are what the therapist plans to do in sessions and includes homework assignments to be given to clients.

There is no requirement to document that plan before the appointment in order to "steer" the appointment.



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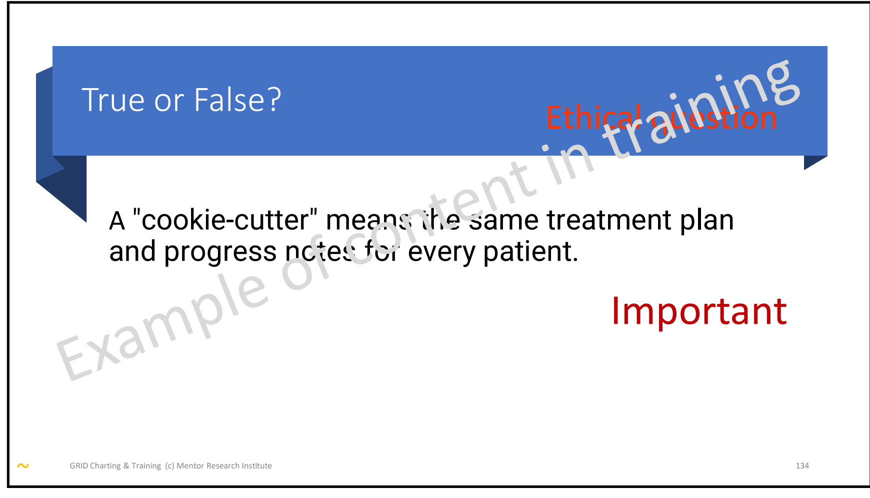

134

True or False?

You can document what you routinely do, even what you do in every session.

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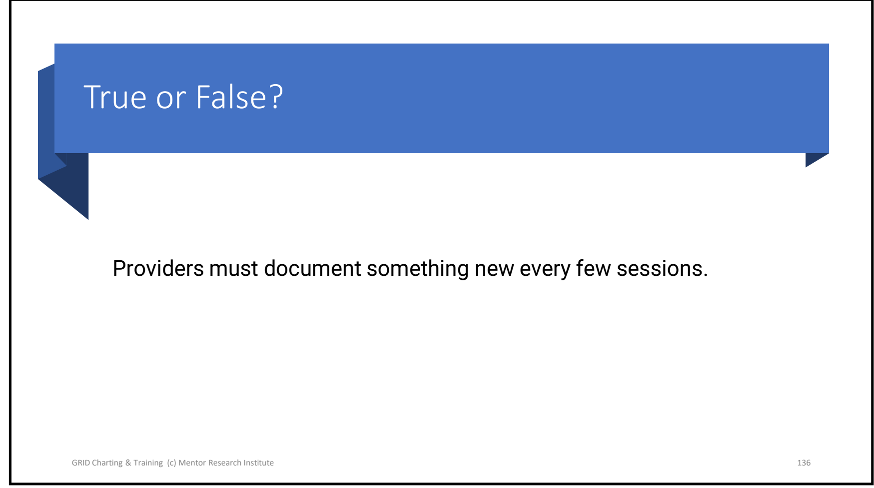

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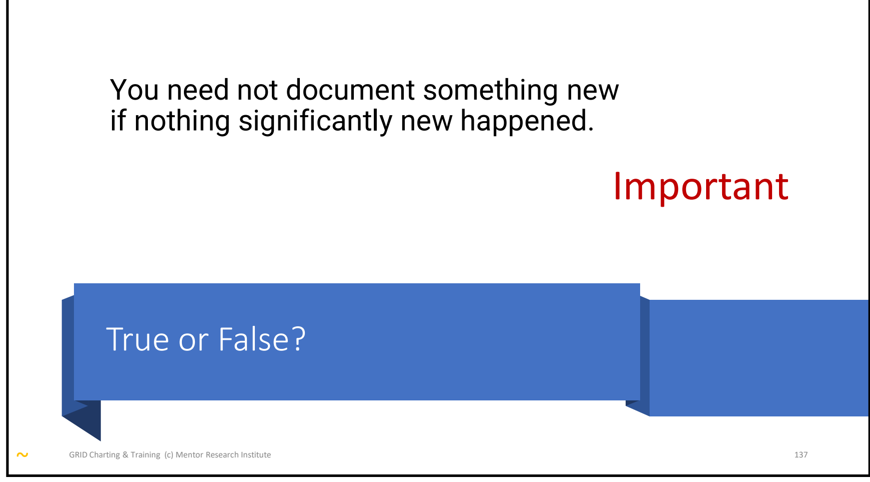

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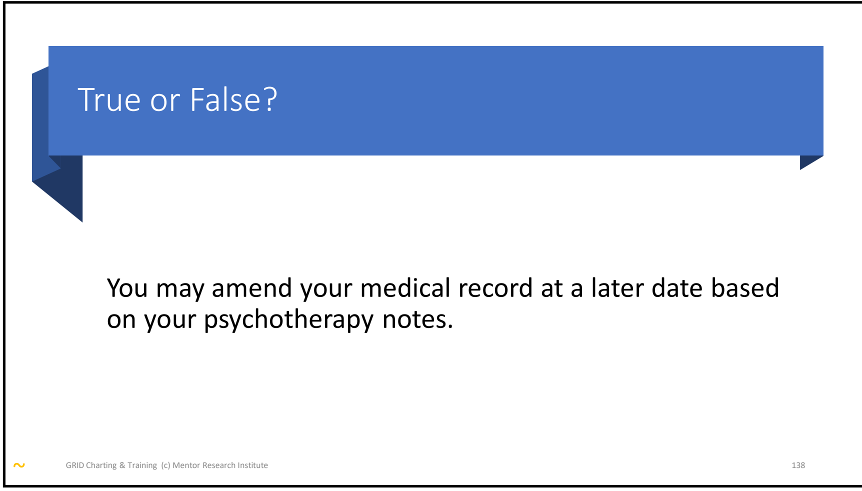

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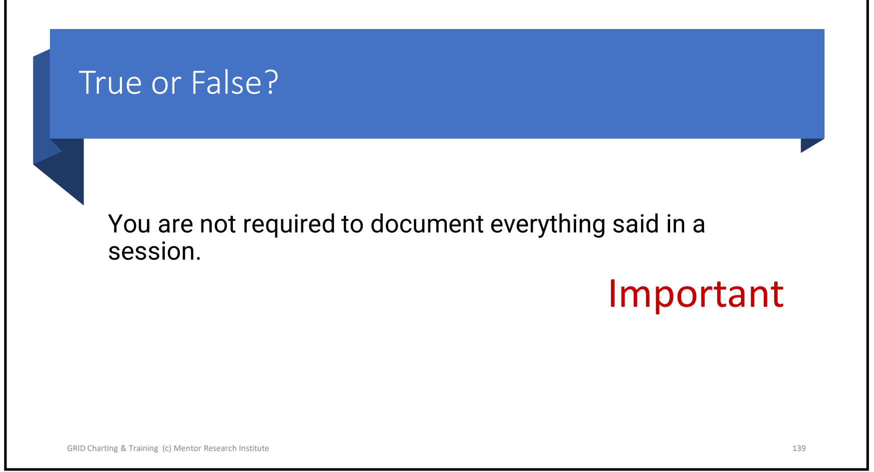

139

True or False?

You should document the patient's medical record everything..

1. that is legally required,
2. reasonably necessary to document the services provided, and
3. reasonably necessary to pass an audit.

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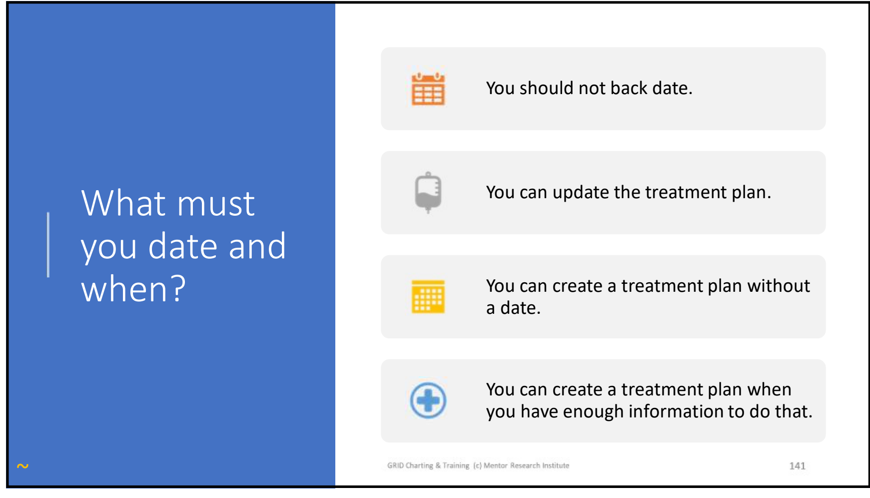

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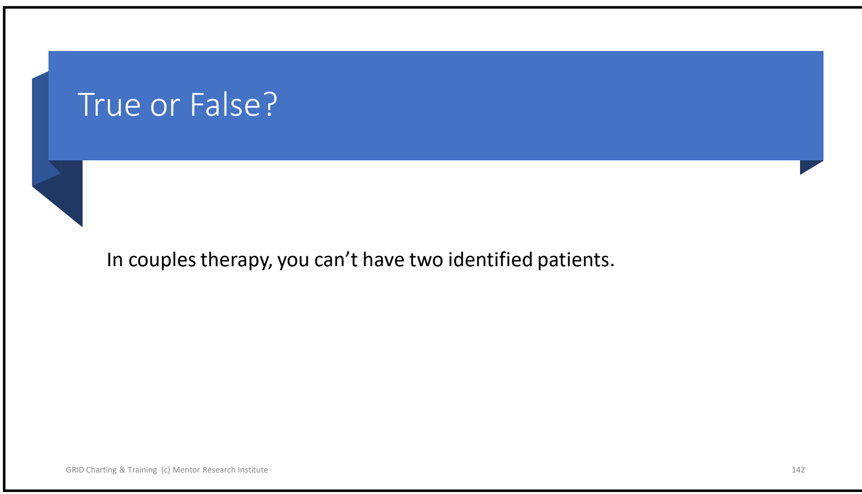

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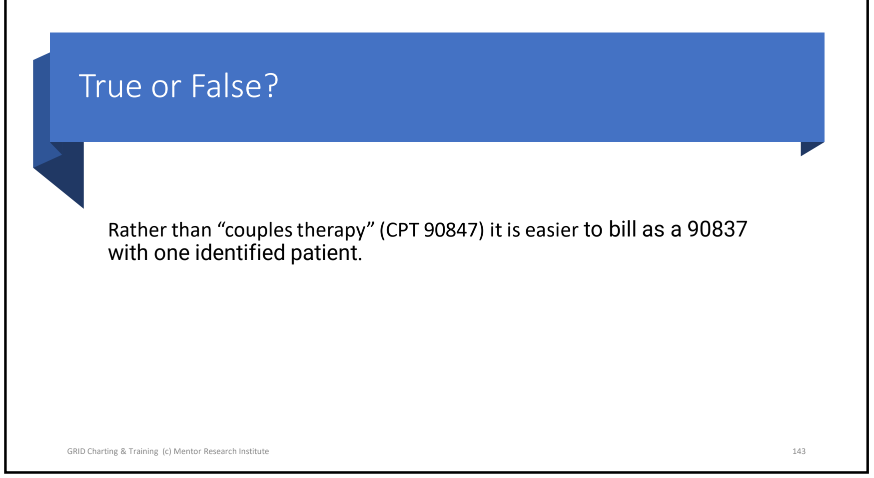

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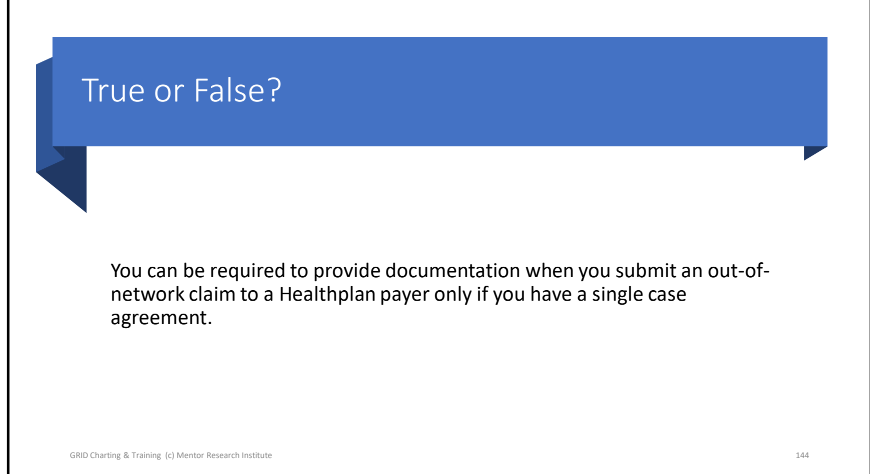

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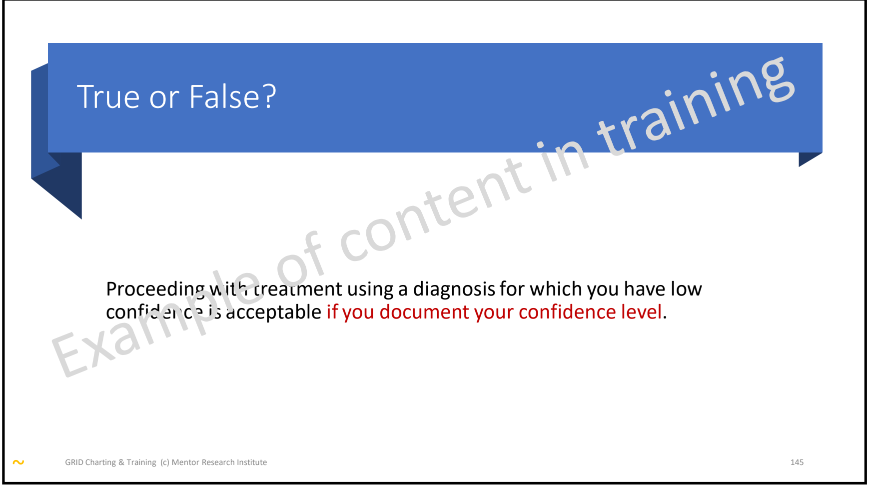

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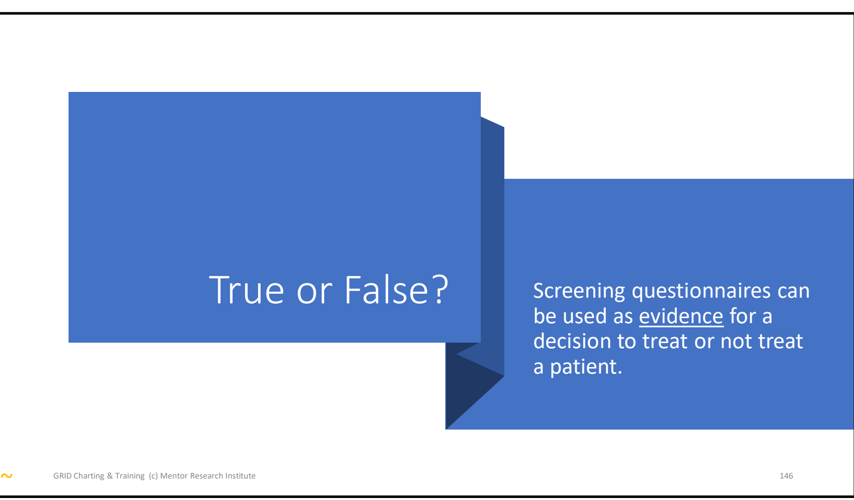

146

True or False?

You must have a documented treatment plan for all your patients in your medical record.

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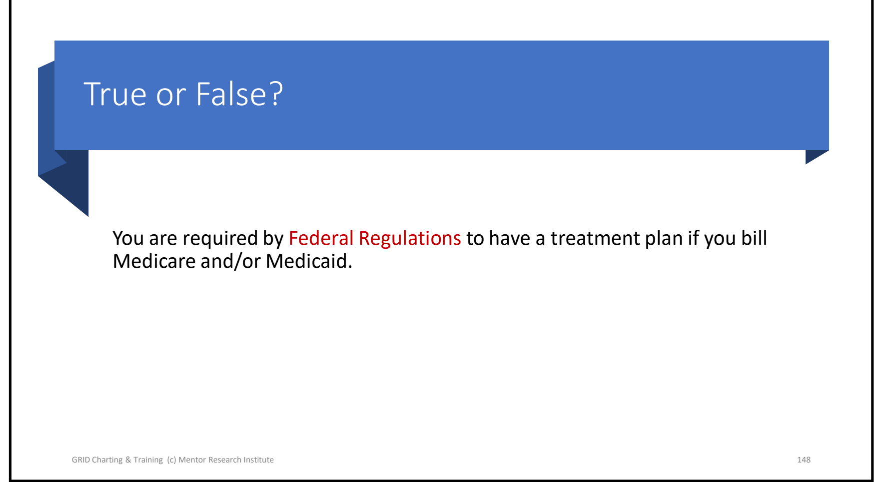

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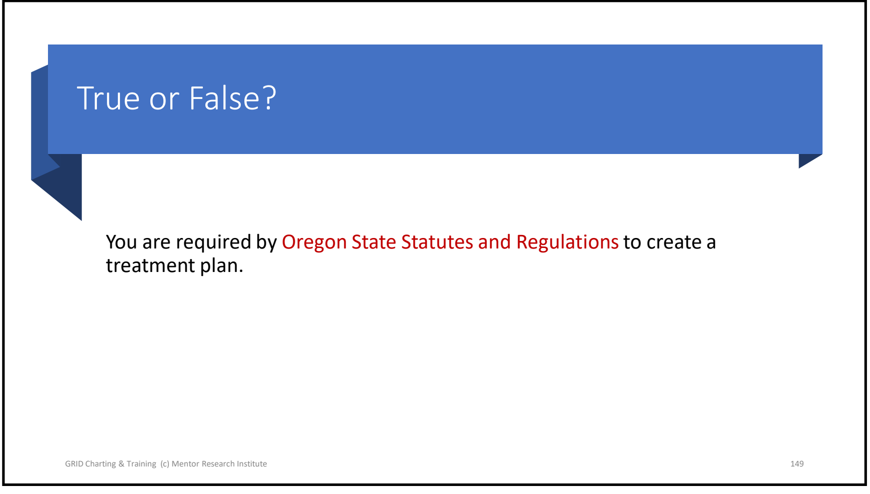

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Assertions others make about Tx plans without evidence:

- Treatment plans can help patients:
  - Avoid feeling overwhelmed by setting goals
  - Stay motivated, achieve more, boost self confidence feel more satisfied with treatment
  - Monitor progress and demonstrate t to clients
  - Demonstrate progress and need for treatment to insurance
  - Build rapport, as client/therapist collaborate on vision

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Restoring the "special ingredient" to charting

Meta-Objectives
Client-Centered focus
Gestalt shift
Perceptual shifting
Somatic therapy
Emotion focused, etc..

Therapist-Patient Alliance

GOAL
Reduce compulsive eating when anxious

OBJECTIVES
- Ct. will learn (and report using) 2 tools to deal with anxiety instead of eating
- Ct. will keep log of emotional eating, to gather info about behavior (triggers, frequency, progress)
- Ct. will report emotional eating no more than once weekly

INTERVENTIONS
- Weekly individual CBT therapy
- Explore history of disordered eating/secondary gains, help identify distorted cognitions and emotional triggers
- Teach ct. techniques to deal with anxiety, including mindfulness, meditation, journaling, breathing exercises, and progressive relaxation
- Therapist will help ct. write relapse prevention plan, outlining how to use new coping skills instead of eating

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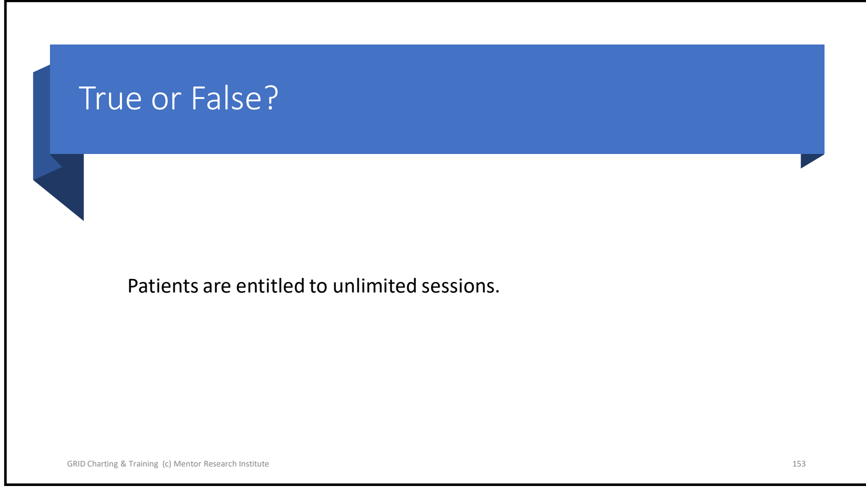

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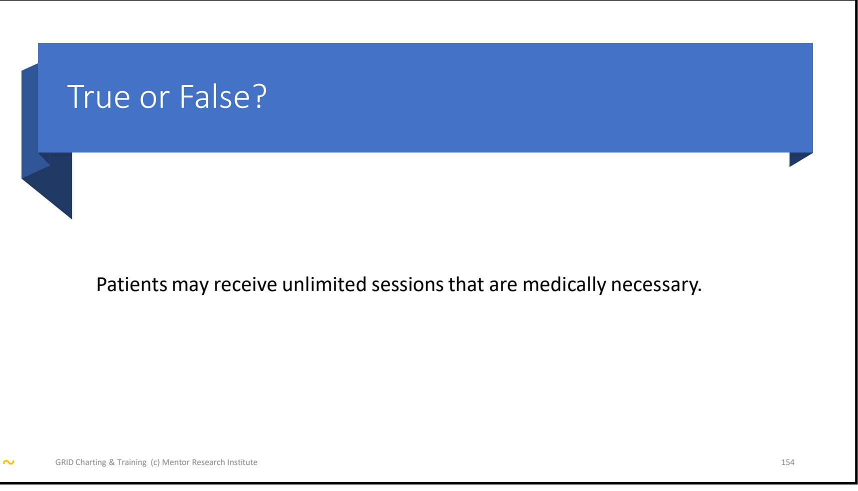

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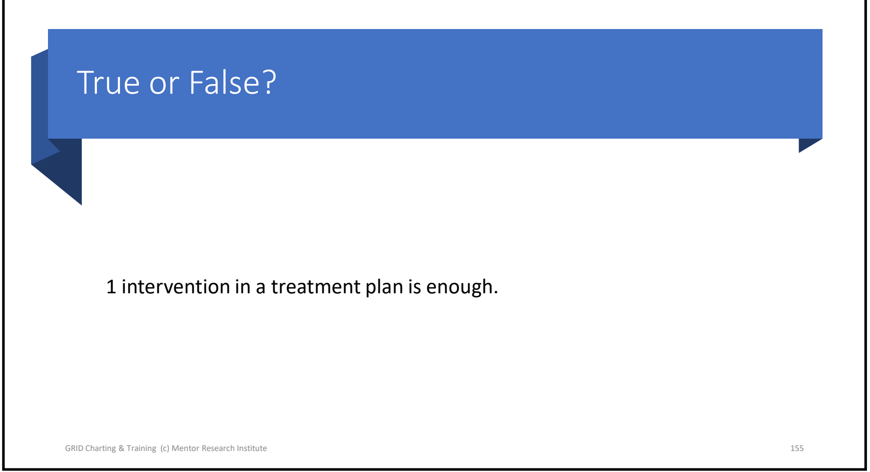

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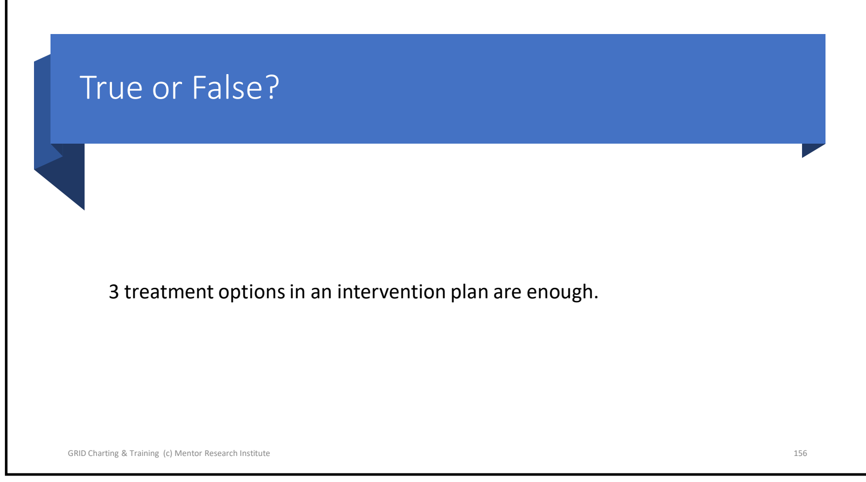

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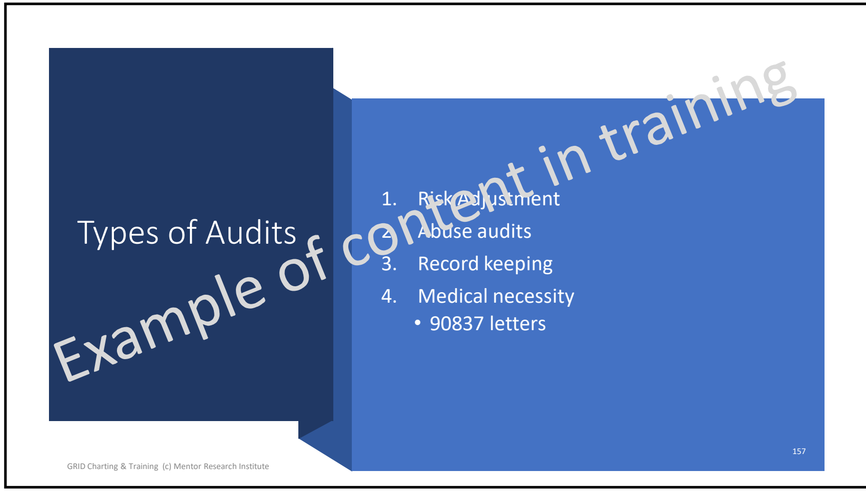

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Risk Adjustment Audits

- Conducted annually.
- Comes in a letter from a contractor acting on behalf HHS.
- Required by HHS to assess risk pool of insurers.
- It is not clear if there is any penalty or retribution if an individual provider does not comply.
- Do not provide information without the patient's permission.

158

What defines "medically necessary"? (According to CareOregon CCO)

Example of content in training

Please include the following documentation with every authorization request:

Current and valid **Mental Health Assessment** that includes:

- ☐ Clinical justification for the DSM 5 diagnosis that is a covered diagnosis on Oregon's prioritized list.
- ☐ Explanation of the medical need for the services.

Current and valid **Service Plan** that includes:

- ☐ Individualized plan that describes the member's condition and services that will be needed.
- ☐ Specific and measurable goal(s) of services.
- ☐ Expected outcome(s) and duration of the services.

A brief clinical reason for the request (entered here or as an attachment):

159

"Medically Necessary"
Providence Healthplan - Oregon

- Services that do not meet Medically Necessary criteria will not be covered.
  - Example: Your provider suggests a treatment using a machine that has not been approved for use in the United States. We probably would not pay for that treatment.
  - Example: You go to a hospital emergency room to have stitches removed, rather than wait for an appointment in your doctor's office. We would not pay for that visit.
  - Example: You stay an extra day in the Hospital only because the relative who will help you during recovery can't pick you up until the next morning. We may not pay for the extra day.
- Although a treatment was prescribed or performed by a Qualified Practitioner, it does not necessarily mean that it is Medically Necessary under our guidelines. Obtaining confirmation of coverage from Providence Health Plan beforehand is always recommended.

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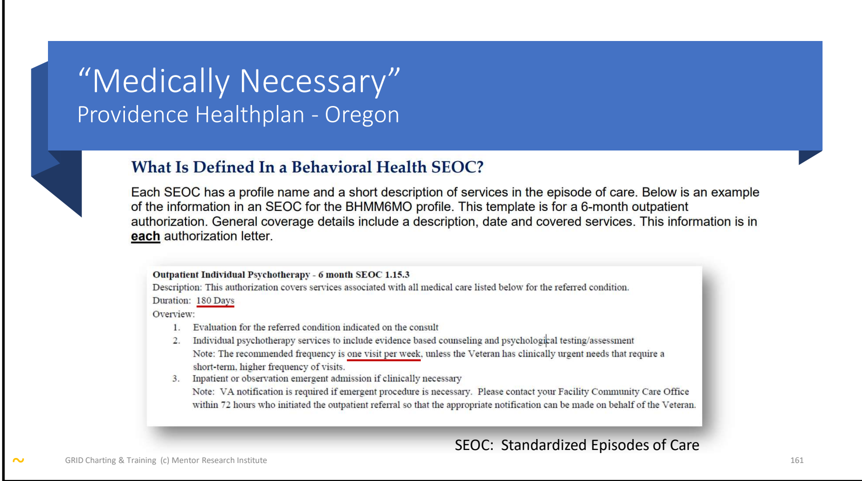

161

What defines "medically necessary"?

(According to CMS/Medicare)

Example of content in training

1. Medically appropriate services rendered or made available to a member for treatment of a behavioral, mental health or substance use disorders diagnosis.
2. Safe, effective and appropriate for the member based on standards of evidence-based practice generally recognized by the relevant scientific or professional community based on the best available evidence;
3. Appropriate and consistent with the diagnosis identified in the behavioral and mental health assessment;
4. Provided in accordance with an individualized service plan and appropriate to achieve the specific and measurable goals identified in the service plan;
5. Not provided solely for the convenience or preference of the member, the member's family, or the provider of the service item or supply;
6. Not provided solely for recreational purposes; Not provided solely for research and data collection;
7. Not provided solely for the purpose of fulfilling a legal requirement placed on the member; and
8. The most cost effective of the covered services that can be safely and effectively provided to a member.

162

"Medically Necessary"

Providence Healthplan - Oregon

MEDICALLY NECESSARY SERVICES

- We believe our Members are entitled to comprehensive medical care within the standards of good medical practice. Our medical directors and special committees of In-Network Providers determine which Services are Medically Necessary, as defined in section 12.

Providence Healthplan (2021) Standard Choice Network

https://www.providencehealthplan.com/-/media/providence/website/pdfs/indi-fam/2021/plan-contracts/providence-oregon-standard-choice-network.pdf

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What is medically necessary?

2. Safe, effective and appropriate for the member based on standards of evidence-based practice generally recognized by the relevant scientific or professional community based on the best available evidence;

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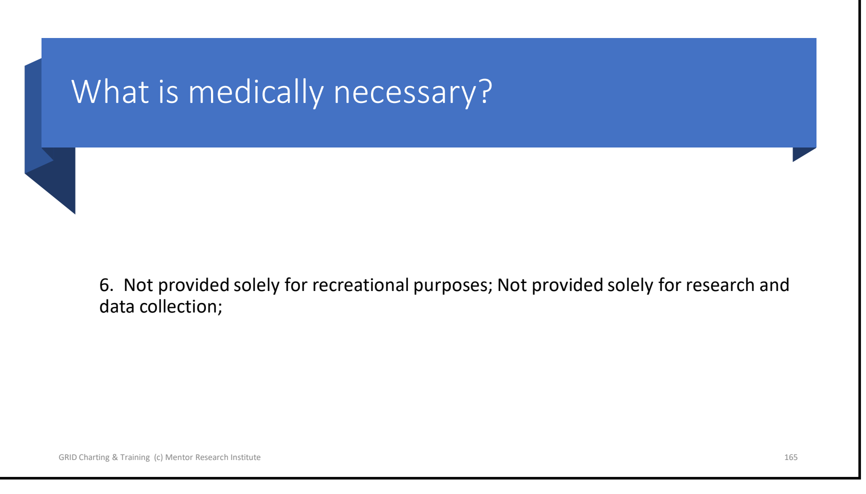

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What is medically necessary?

8. The most cost effective of the covered services that can be safely and effectively provided to a member.

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What is a “Special Investigations Unit?

- Looking for evidence of fraud or abuse.
- Therapists have less ability to avoid providing information.
- Can follow or replace regular reviews.

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How do you respond to a request for audit if you are out of network?

- Out of network means you have no contract with the insurance payer.
- The contract is between the patient and the payer.
- The patient must give you a release to send the records.
- The patient may be denied reimbursements or further reimbursement.

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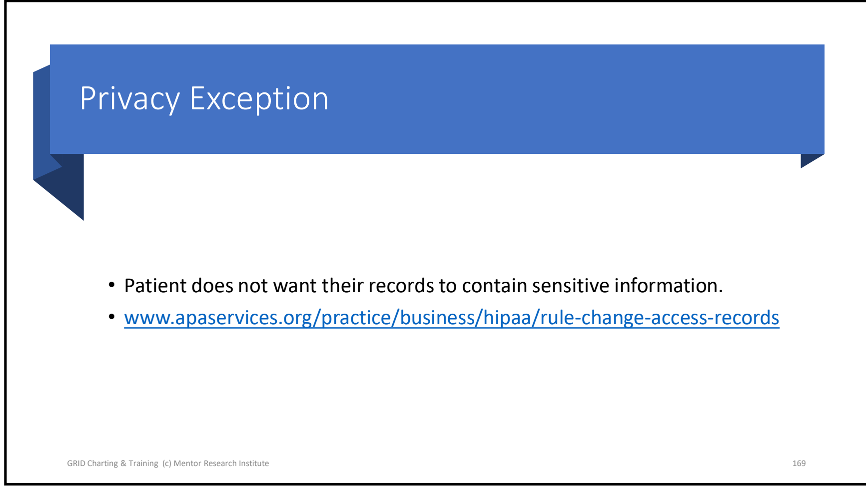

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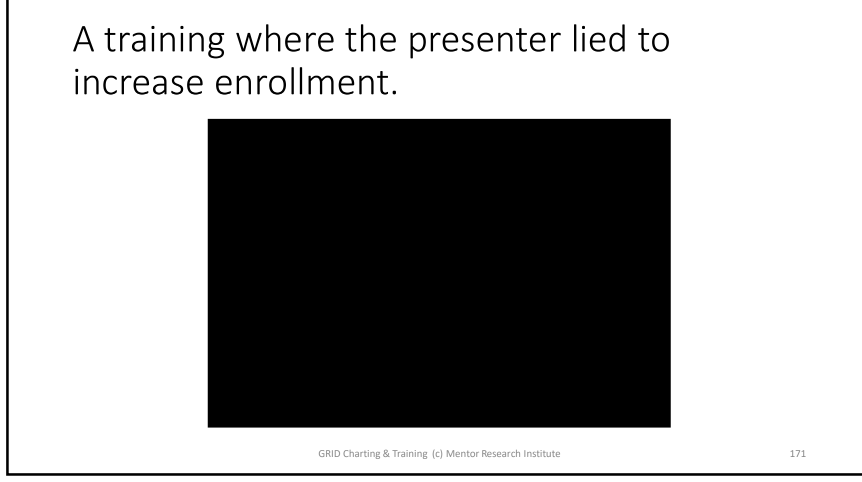

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