Washington State Department of Social and Health Services

Transforming Lives

Behavioral Health Services Individual Service Plans

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Presented by:
Marc Bollinger, LISCW, CEO, Great Rivers BHO
Crystal Didier, MEd, Qualis Health
Kathy Robertson, MSW, CCO, Great Rivers BHO

Base Format Developed by:
David Reed, Office Chief, Division of Behavioral Health and Recovery
Marc Bollinger, LISCW, CEO, Great Rivers BHO
Crystal Didier, MEd, Qualis Health
Kathy Robertson, MSW, CCO, Great Rivers BHO

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Goals

- Participant will become familiar with Medicaid documentation rules.
- Participant will discover the importance of complete and detailed documentation as the foundation for coding, billing and quality of care for the client.
- Participant will learn how insufficient documentation leads to both poor client care and to improper payments.

The Golden Thread

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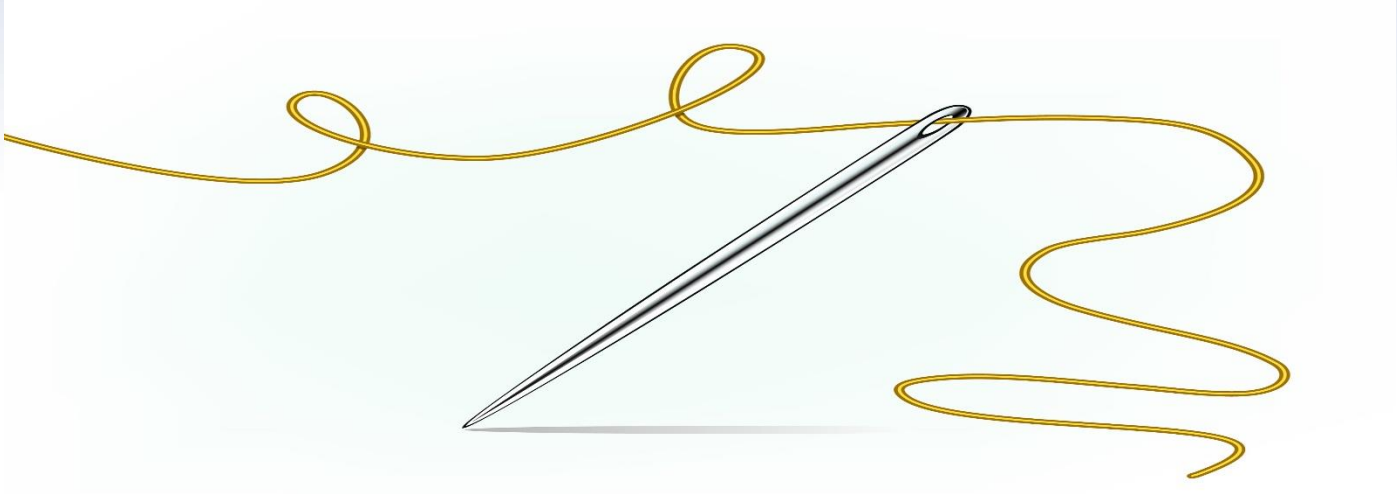
It is the Practitioner's responsibility to ensure that medical necessity is firmly established and that The Golden Thread is easy to follow within your documentation.



Medical Necessity

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- Requires that all services/interventions be directed at a medical problem/diagnosis and be necessary in order that the service can be billed
- A claims based model that requires that each service/encounter, on a *stand alone basis, reflects the necessity for that treatment intervention

* Stand alone means information in the service note should include pertinent past clinical information, dealing with the issue at hand, and making plans for future care such as referrals or follow up, based upon the care plan. Each service note needs to stand-alone completely.

Why Document Medical Necessity?

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Documentation is an important aspect of client care and is used to:

- Coordinate services and provides continuity of care among practitioners
- Furnish sufficient services
- Improve client care – provides a clinical service map
- Comply with regulations (Medicaid, Medicare and other Insurance)
- Support claims billed
- Reduce improper payments
- Medical record is a legal document

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Tests for Medical Necessity

- There must be a diagnosis: ICD 10
- The services ordered are considered reasonable and effective for the diagnosis
  - Directed at or relate to the symptoms of that diagnosis
  - Will make the symptoms or persons functioning get better or at least, not get worse
- The ordered services are covered under that person's benefit package (State Plan Services)

Golden Thread

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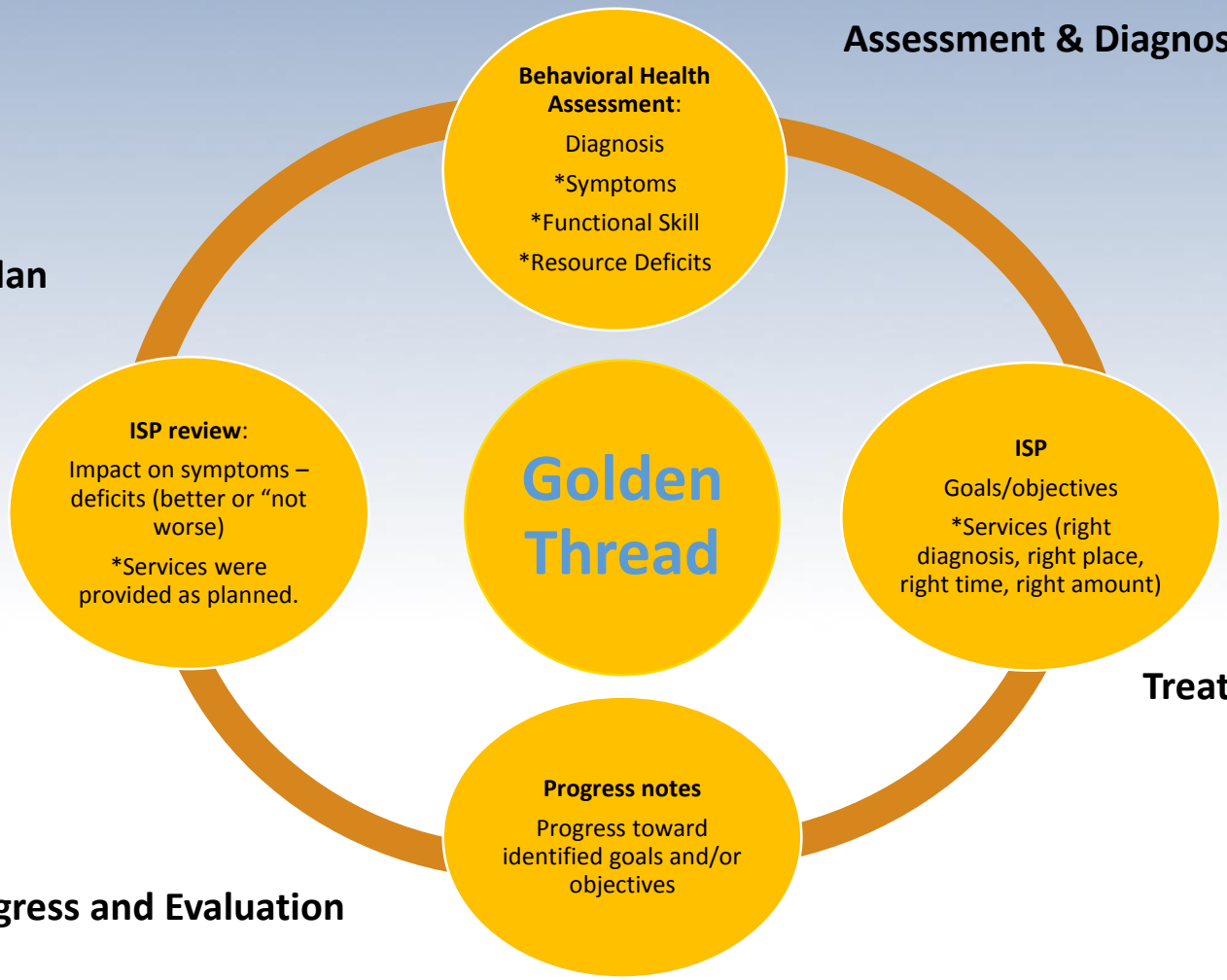

The Golden Thread

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- There are documented assessed needs
- Needs lead to specific goals
- There are treatment goals with measurable objectives
- There are specific interventions ordered by the practitioner
- Each intervention, is connected to the assessed need, ordered by the treatment plan, documents what occurred and the outcome

Difficulty Following The Golden Thread

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Assessment Deficits

- Diagnosis poorly supported
- Symptoms, behaviors and deficits under defined
  - No baseline against which to determine progress or lack

Individual Service Plan/Care Plan

- Goals and objectives unrelated to assessed needs/symptoms/behaviors and deficits (example: “comply with treatment”)

Progress Notes

- Documents “conversations” about events or mini-crisis
- Does not assess behavior change, (i.e. progress toward a goal or objective)
- Does not spell out specifics of intervention(s) used in session.

Components of the Golden Thread

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- Assessment
- Individual Service Plans (aka: Treatment plan, Care plan)
- Progress Notes

The Intake Assessment

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- Diagnosis with clinical rationale: how the diagnostic criteria are present in the person's life
  - Based on presenting problem (Reflect an understanding of unmet needs relating to symptoms and behaviors)
  - Data from client—their story and the client's desired outcome
  - Observation
- Safety or risks
- Client functioning
  - Evidence that the diagnosis/client condition, causes minimally, moderate distress or functional impairment in Life Domains
- Recommendation for treatment and level of care.

Individual Service (Treatment) Plan

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A Quality Plan should:

- be linked to needs identified in the assessment
- include desired outcomes relevant to the presenting problems and symptoms and utilize client's words (How client knows when they are ready for discharge)
- have a clear goal statement
- include measurable objectives (how will practitioner and client know when an objective is accomplished)
- use client strengths and skills as resources
- clearly describe interventions and service types
- identify staff and staff type. (The staff should be qualified to deliver the care)
- address frequency and duration of interventions

WAC Requirements

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WAC 388-877-0620

(1)The individual service plan must:

- (a) Be completed or approved by a professional appropriately credentialed or qualified to provide mental health, chemical dependency, and/or problem and pathological gambling services.
- (b) Address age, gender, cultural, strengths and/or disability issues identified by the individual or, if applicable, the individual's parent(s) or legal representative.
- (c) Be in a terminology that is understandable to the individual and the individual's family.
- (d) Document that the plan was mutually agreed upon and a copy was provided to the individual.
- (e) Demonstrate the individual's participation in the development of the plan.
- (f) Document participation of family or significant others, if participation is requested by the individual and is clinically appropriate.
- (g) Be strength-based.
- (h) Contain measurable goals or objectives, or both.
- (i) Be updated to address applicable changes in identified needs and achievement of goals and objectives.
- (2) If the individual service plan includes assignment of work to an individual, the assignment must have therapeutic value and meet all the requirements in (1) of this section.
- (3) When required by law, the agency must notify the required authority of a violation of a court order or nonparticipation in treatment, or both.

WAC Requirements

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WAC 388-877B-0420
Substance use disorder opiate substitution treatment services—Clinical record content and documentation requirements.

(2) In addition to the requirements in (1) of this section, an agency must ensure the following for each individual service plan. The individual service plan must:

- (a) Be personalized to the individual's unique treatment needs;
- (b) Include individual needs identified in the diagnOTPic and periodic reviews, addressing:
  - (i) All substance use needing treatment, including tobacco, if necessary;
  - (ii) The individual's bio-psychosocial problems;
  - (iii) The treatment goals;
  - (iv) Estimated dates or conditions for completion of each treatment goal; and
  - (v) Approaches to resolve the problem.
- (c) Document approval by a chemical dependency professional (CDP) if the staff member developing the plan is not a CDP.
- (d) Document that the plan has been reviewed with the individual.

WAC Requirements

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WAC 388-877B-0320
Substance use disorder outpatient treatment services—Clinical record content and documentation.

(2) In addition to the requirements in (1) of this section, an agency must ensure the following for each individual service plan. The individual service plan must:

(a) Be personalized to the individual's unique treatment needs;

(b) Include individual needs identified in the diagnostic and periodic reviews, addressing:

(i) All substance use needing treatment, including tobacco, if necessary;

(ii) The individual's bio-psychosocial problems;

(iii) Treatment goals;

(iv) Estimated dates or conditions for completion of each treatment goal; and

(v) Approaches to resolve the problem.

(c) Document approval by a chemical dependency professional (CDP) if the staff member developing the plan is not a CDP.

(d) Document that the plan was updated to reflect any changes in the individual's treatment needs, or as requested by the individual, at least once per month for the first three months, and at least quarterly thereafter.

(e) Document that the plan has been reviewed with the individual.

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WAC Requirements

WAC 388-877B-0220 - Substance use disorder residential treatment services—Clinical record content and documentation requirements.

- (2) In addition to the requirements in (1) of this section, an agency must ensure the following for each individual service plan. The individual service plan must:
- (a) Be personalized to the individual's unique treatment needs.
- (b) Be initiated with at least one goal identified by the individual during the initial assessment or at the first service session following the assessment.
- (c) Include individual needs identified in the diagnostic and periodic reviews, addressing:
- (i) All substance use needing treatment, including tobacco, if necessary;
- (ii) Patient bio-psychosocial problems;
- (iii) Treatment goals;
- (iv) Estimated dates or conditions for completion of each treatment goal; and
- (v) Approaches to resolve the problem.
- (d) Document approval by a chemical dependency professional (CDP) if the staff member developing the plan is not a CDP.
- (e) Document that the plan was updated to reflect any changes in the individual's treatment needs, status, and progress towards goals, or as requested by the individual, at least weekly.
- (f) Document that the plan has been reviewed with the individual

WAC Requirements - continued

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WAC 388-877B-0250
Substance use disorder residential treatment services requiring program-specific certification—Intensive inpatient services

- Complete the individual service plan within five days of admission.

WAC 388-877B-0260

- Substance use disorder residential treatment services requiring program-specific certification—Recovery house
- Conduct and document an individual service plan review at least monthly.

WAC 388-877B-0270

- Substance use disorder residential treatment services requiring program-specific certification—Long-term treatment services
- (5) Conduct and document an individual service plan review at least monthly.

Goals

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- Behavioral description of what the individual will do or achieve in measurable terms, directly related to the diagnosis and the presenting problem
- Often describe barriers to be resolved in order that the goal may be met
- Tied to discharge and transition planning

Example:

Individual's Goal: "I want to attain and maintain sobriety."

Treatment Goal: The individual will be able to reliably avoid use in his daily life and feel comfortable with his ability to refuse within the next month.

Goals

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Kathy's Goals in a Traditional Treatment Plan	*Kathy's Goals in a Person-Centered*
Patient will be med-compliant over next 3 months.	**I want to have enough energy to focus on my job. I don't want to feel dopey all the time.**
Patient will refrain from verbal and physical aggression	**I need to get along better with my co-workers. My boss said I could lose my job if I don't figure this out.**
Patient will increase insight regarding mental illness and demonstrate realistic expectations.	**I want to finish my General Education Diploma (GED) but I'm not sure where to start.**
Patient will decrease denial of substance abuse and achieve and maintain abstinence.	**I don't know how to cope with what I have been through. I need to figure out other ways of coping.**

Goals

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Example: Reduce auditory hallucinations from 7x to 1x per day for the next 12 months.

Example: Reduce oppositional and defiant behavior by following adult directions from 0x/day to 3x/day; increase prosocial behaviors with friends and family from 1x/day to 7x/day for the next 12 months.

Example: Increase attendance at school from 0 days to 3 days per week for the next 12 months.

Example of Case Management/Meds only treatment plan goal: to “stabilize” or to “maintain” symptoms, behaviors, housing, daily activities, etc; i.e., maintain current housing for the next 12 months.

Source: Santa Clara County Mental Health Department Documentation Manual March 2010

Objectives

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- Objectives are smaller, must be measurable (if Goal is not) steps for the client to accomplish on the road to his/her recovery (discharge goals)
  - Specific and focused
  - Can be step-by-step
  - 2 or 3 at most for each goal
  - Realistic and specific
  - Measurable – focused on measurable change or events within a specified time period. (Example: as evidence by an observable behavioral change, times per week, every time, etc.)
  - Try not to use words like "improve" or "increase" or "decrease" <u>unless they are tied to a measurement</u>. (Example: 3 times weekly, daily, rating scale (with scale defined)

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Key Elements of a Quality Objective

Person's Name	+	Action Word	+	What?	+	When	+	How Measured?	=	Objective
Marc		Will manage anxiety		By using the coping skill of deep breathing		Once a day in response to anxiety for 6 months		As reported by himself in Wellness Self Management group		Objective

Examples of Objectives:

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- **The objective goal is stated in positive terms**.
  Not: Tony quits hanging out all night.

Reframe as: Tony [person] comes home by curfew (10:00 p.m.) [what] on weekends [when], as measured by Tony and mom's self report during weekly family sessions [how measured].

- **The objective can be measured, observed or concretely described**.
  Not: Tony improves communication.

Reframe as: Tony [person] tells his mother where he will be and when he will be home Saturday night [what], as measured by Tony and mom's self report during weekly family sessions [how measured].

- **The objective has one expected outcome per goal/objective**.
  Not: Tony makes more friends and likes school.

Reframe as: Tony [person] increases his number of friends his age from zero to three [what], within the next three (3) months as reported by Tony during clinical sessions with his clinician [how measured].

Interventions

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- Interventions are the specific clinical actions providers will do to help the client achieve their objectives
- Must be linked to treatment plan goals and objectives
- Should be an activity and demonstrate what is occurring in the interaction with the client
- Must include the frequency and duration of the intervention

Tips:

- Staff will: use active verbs in describing what staff will do
- Time period: length of time you will do the above action
- Frequency: how often you will do it
- Type of treatment service to be provide (Group therapy, cognitive behavioral therapy, family therapy, individual therapy) and a reason for it

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Interventions - Examples

- Type of treatment service to be provide (Group therapy, cognitive behavioral therapy, family therapy, individual therapy) and a reason for it
  - Use Cognitive Behavioral Therapy (CBT) to assist individual in identifying relapse triggers 1x/week for 6 months
  - 1x/week for the next 6 months teach the client self-calming techniques to use during high stress activities through discussion modeling and role-play

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Interventions - Examples

- Example: Clinician will provide individual therapy 1x per week for 60 minutes and will utilize cognitive behavioral techniques to assist client in stabilizing their symptoms. The clinician will also link client to psychiatric services and community resources as needed for the next 12 months.

- Example: Case manager will provide socialization group 1x/week for 30 minutes for the next six (6) months; provide comprehensive community support services 1x/week for the next six (6) months. Link client to community resources as needed for the next 6 months.

Source: Santa Clara County Mental Health Department Documentation Manual March 2010

Treatment Plan - Examples

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Individual's Goal: "I want to attain and maintain sobriety"

Treatment Goal: Sally will be able to reliably avoid use in her daily life and feel comfortable with her ability to refuse within the next month.

Objective: Sally will learn five triggers for alcohol and drug use.

Intervention: 1x/week for the next 4 weeks clinician will utilize Cognitive Behavioral Therapy techniques to assist Sally in identify Sally's triggers for alcohol and drug use.

Treatment Planning Tips

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- The treatment plan is a "contract" with the client that outlines the course of therapy and expected achievements.
- Reviewer should see both a plan and a progress note describing the treatment planning process:
  - Summarize who participated, individual's level of participation/family involvement (critical for children/youth) and primary goals/objectives set, etc.
- Client should be given a copy of the plan
- Plan will be changed or updated as issues are resolved or new issues emerge.

Treatment Plan Reviews

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- At least every 6 months (or earlier depending on contract and WAC requirement) review diagnosis, goals, progress, new issues, etc.,
  - Analyze the effectiveness of the treatment strategy
  - Reevaluate client's commitment to treatment & relevancy of goals
  - Discuss progress or lack of progress and how the treatment strategy will be modified (if at all) in response
  - Document either in a progress note or on a separate form

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Treatment Plan Reviews continued

- Revised, update, or continue the treatment plan based on reassessment. Explain the reasons for your decisions.
  - If there is progress, consider next steps. Ready for discharge?
  - If there is no progress, revise goals, treatment strategy, diagnosis, etc., as needed
- Get new signatures to indicate continued agreement.
- Start the Golden Thread cycle over again

Frequent Treatment Plan Problems

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- Goals and objectives are the same as interventions
- Too many goals; plan too complicated
- Goals reflect provider concerns and needs rather than those of the client
- Too difficult to understand
- Goals do not address Medicaid billable services (not a requirement for all goals, but for reimbursable treatment plans there must be some Medicaid reimbursable goals identified.)
- Goals do not address the diagnosis, symptoms or need
- Goals are not identified in a strength based manner
- Goals are not linked to discharge or transition from care

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Example 1:

Category: 5 Family/Social/Housing

Problem: The patient has a diagnosis of opiate dependence. (Doesn't reflect how this impacts the patient)

Treatment Goal:

Long Term: Maintain abstinence from all unprescribed drugs and abstinence from any illicit drug use.

Short Term: To keep all scheduled appointments. To provide drug screens that show no evidence of substance use.

Objective: To increase social interactions to eliminate turmoil and guilt caused by not engaging in social activities with nephew(s). (Not clear why this is an objective? Does this guilt lead to substance use?)

1. Discuss activities that children would enjoy participating in.
2. Develop an agreement that reflects a consistent date at least once a month with parents and children.
3. Develop topics of discussion that are age appropriate to strengthen relationship and probe for more hobbies.

Intervention:

1. Writer will discuss age appropriate events and connecting certain values with the event(s).
2. Writer will discuss the rewards associated with spending time with identified family member.
3. Writer will receive routine updates regarding the status of this goal.

(None of the interventions indicate substance use treatment, dosing, and does not include frequency, duration or amount).

Example 1 - REVISED:

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Category: 5 Family/Social/Housing

Problem: The patient opioid addiction presents great stress on his family and jeopardizes his living situation.

Treatment Goal:

Long Term: Maintain abstinence from all unprescribed illegal drugs and abstinence from any illicit drug use to strengthen his relationship and stabilize his housing, through the use of Opiate Substitution Treatment.

Short Term: To participate in counseling and take his medications daily and provide drug screens on demand.

Objective: Increase social activities and become more involved in with his family lives. Current self rating is a 2 out of 10 (with 10 representing comfortable with family activities). At next review individual's goal is to increase comfort level to a 5. (Target Date: 5/20/2018)

1. Discuss activities the patient would feel comfortable participating in without triggering desire to use illegal substance use.
2. Identify a date when scheduled activities will occur.
3. Develop topics of discussion that are age appropriate to strengthen relationship and find one hobby that patient has in common with family and pursue.

Intervention:

1. Clinician provide individual counseling services once per week for 30 minutes over the next 90 days to identify how efforts to engage with his family has been going, assist in developing parenting skills, and assist patient identify solutions to substance use triggers during times with family.
2. Clinician will provide group counseling services designed to address movement toward abstinence of illegal drug use, 90 minute group sessions, 3x per week for the next 90 days.
3. Medical team will dispense dosing as prescribed by appropriate medical professional based on prescription, current dosing six (6) times per week and having one (1) carry.

Example 2:

Problem: Patient has limited friendships because he is very protective of his recovery

Diagnosis: F11.20- opioid dependence, uncomplicated

Long term goal: Patient will have a long term relationship and engage in healthy activities

Short term goal: Patient will make time to do things on his time off from work.

Progress since last plan: Initial plan

Objectives:

1. Patient needs to reach out to healthy people so he can engage in activities that support his positive momentum. Goal target date 9/15/17
2. Patient will call one person and make plans to do something. Goal target date 5/15/17
3. Patient will engage in at least one social activity a month. Goal target date 9/15/17

Interventions:

1. Patient has gained and maintained significant progress in all areas of his life
2. Patient needs to make this a priority
3. Counselor will check in with patient and help him to meet this goal by requiring check ins on progress.

Example 2 - REVISED

Problem: Patient (Clark) has an opioid addiction and has recently moved into the region. He has a limited support system and would like to have more friendships that are supportive of his recovery.

Long Term Goal: Clark will remain maintain abstinence from illicit drugs and have a number of healthy friends that are supportive of him and a positive influence on his recovery

Short Term Goal: Clark will maintain his recovery and improve his social life to support his recovery

Progress since last plan: Initial plan

Objectives:

1. Clark will identify 5 characteristics of potential friends and 5 places he will go that he could meet people that might be supportive of his recovery by 9/1/2017
2. Clark will obtain a phone list from addiction support meetings and call at least one person per day for the next 90 days. 9/1/2017
3. Clark will participate in one social activity per week for the next 90 days. 9/1/2017

Interventions:

1. Clinician will meet with Clark for individual counseling session, one time per week for 60 minutes, for the next 3 months to assist him in identifying how to develop more friendships that will be support his ongoing recovery.
2. Clinician will provide group therapy sessions three (3) times per week for 90 minutes for the next three (3) months to assist him in his recovery efforts.
3. Medical team will dispense dosing as prescribed by appropriate medical professional based on prescription, current dosing four (4) times per week and having three (3) carries. Dosing will occur for the next 3 months for a minimum of 3 minutes.

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Example 3:

Problem #1: Recurrent major depressive episodes
Client Statement of Strengths: Math and housing cleaning

Goal #1: Client to develop healthy beliefs about self and to reduce the overwhelming depressive symptoms

Objective 1: Client will reduce her DASS score for depression from 38 extremely severe to 20 moderate in the next 180 days.

Intervention 1: CBT and individual therapy. Psycho-education.

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Example 4:

Problem #1: I have an ADDICTION to alcohol and used this substance to cope with daily life. My addiction led to my poor choices that have negatively affected my life, and the lives around me.

Goal #1: To make positive choices that will lead to family reunification and obtainment of employment. Remain abstinent from drug/alcohol use for the next three (3) months as reflected in UA tracking.

Objective 1: I will learn three (3) alternative coping skills that can be used instead of turning back to my addiction. I will make a list of these coping skills and present them to group. Due May 5.

Objective 2: Share my thoughts of relapse with group and be open for feedback.

Objective 3: Complete a relapse prevention plan during the Relapse Prevention phase of treatment. I need to develop a relapse prevention/recovery maintenance plan. I need to work on prioritizing my recovery, gaining employment, and reuniting with family and friends.

Intervention 1: Clinician will provide group therapy for 90 minutes three times per week for the next three (3) months to support individual in their addiction recovery.

Intervention 2: Clinician will provide individual therapy for 60 minutes, two times per month for the next three (3) months to support individual in their addiction recovery.

Amending and Appending Documentation

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Behavioral Health Organizations and Behavioral Health Agencies must have a policy that outlines how amending and appending documentation can be completed that include:

- When and how to add and modify documentation
- Must be dated
- Indicate who made the modification
- What the modification included
- Reason for the modification

Amending and Appending Documentation

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Late entries, addendums, or corrections to a medical record are legitimate occurrences in documentation of clinical services. A late entry, an addendum or a correction to the medical record, bears the current date of that entry and is signed by the person making the addition or change.

Noridian Health Solutions 2016

Amending and Appending Documentation - Late Entry

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Late Entry: A late entry supplies additional information that was omitted from the original entry. The late entry bears the current date, is added as soon as possible, is written only if the person documenting has total recall of the omitted information and signs the late entry.

Example: A late entry following supervision review of a note might add additional information about the service provide *"The services was provided in the families home with the mother (Jane Doe) and father (Jon Doe) present. Marc Dollinger, LISCW, MD 06/15/09"*

Noridian Health Solutions 2016

Amending and Appending Documentation - Addendum

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Addendum: An addendum is used to provide information that was not available at the time of the original entry. The addendum should also be timely and bear the current date and reason for the addition or clarification of information being added to the medical record and be signed by the person making the addendum.

- Would typically be used with an E&M code to input additional clinical or medical information, such as lab results.

Noridian Health Solutions 2016

Amending and Appending Documentation - Correction

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Correction: When making a correction to the medical record, never write over, or otherwise obliterate the passage when an entry to a medical record is made in error. Draw a single line through the erroneous information, keeping the original entry legible. Sign or initial and date the deletion, stating the reason for correction above or in the margin. Document the correct information on the next line or space with the current date and time, making reference back to the original entry.

- Correction of electronic records should follow the same principles of tracking both the original entry and the correction with the current date, time, reason for the change and initials of person making the correction. When a hard copy is generated from an electronic record, both records must show the correction. Any corrected record submitted must make clear the specific change made, the date of the change, and the identity of the person making that entry.

Noridian Health Solutions 2016

What to do if you have questions

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- Clinicians should discuss questions with their supervisors
- Supervisors should discuss with their BHA Quality Managers
- BHA quality managers should discuss with the BHO Quality Manager
- BHO quality manager can email the SERI workgroup: cpt-seriinquiries@dshs.wa.gov

Again Why follow the Golden Thread?

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To ensure quality of client care and better outcomes

Possible Consequences from audits:

- Loss of employment
- Repayment of funds
- Fines
- Criminal charges
- Loss of contract
- Loss of ability to do business with Medicare and Medicaid

Avoid "Improper payments" caused by:

- Missing documentation
- Incomplete documentation
- Wrong codes for services
- Services not covered by Medicaid

Questions?

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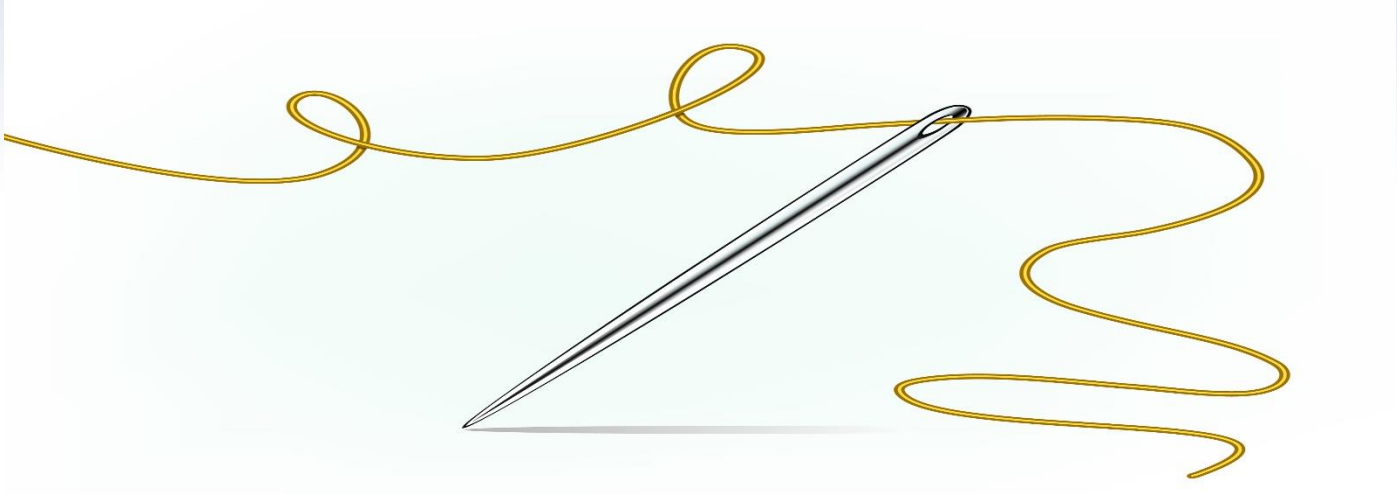
Remember:

It is the Practitioner's responsibility to ensure that medical necessity is firmly established and that The Golden Threat is easy to follow within your documentation.



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