Service Plans


RULES
IMPLIED
WRITTEN
CODE
FEDERAL
SAFETY
LAWMAKERS
CRIMINA
AUTHOR
PENALTIES
PHILOSOPHY
STANDAI
SOCIAL
REFORM
LOCAL
ENVIRONMENTAL
CRIMINAL
PERMITS
REGULATIONS
COURT
STATUTES
GOVERNMENT
POLICIES
FOLLOW
ENFORCE

410-172-0620
Documentation Standards

(1) OHP providers shall maintain records that fully support the extent of services for which payment has been requested and provide the records to the Division upon request.

(2) All records shall document the specific service provided, the number of services comprising the service provided, the extent of the service provided, the dates on which the service was provided, and the individual who provided the service.

(3) Clinical records shall document the recipient's diagnosis and the medical need for the service.

(4) The record shall be annotated each time a service is provided and be signed or initialed by the individual providing the service.

(5) Information contained in the record shall be appropriate in quality and quantity to meet the professional standards applicable to the provider and any additional standards for documentation found in these rules, other Division rules, and pertinent contracts.

(6) For AMH certified providers, in addition to meeting the requirements in this rule, clinical documentation for behavioral health services shall also comply with the requirements in OAR 309-019-0135 through OAR 309-019-0140, and clinical documentation standards for substance use disorder services shall comply with OAR 309-018-0140 through OAR 309-018-0150.

RULES

309-019-0140 Service Plan

1) The service plan shall be a written, individualized plan designed to improve the individual's condition to the point where the individual's continued participation in the program or level of care is no longer necessary. The service plan is included in the individual's service record and shall:

(a) Be started prior to rendering of services;

(b) Reflect the assessment;

(c) Address areas of concern identified in the assessment that the individual agrees to address;

(d) When applicable, document the ASAM Level of Care placement. When there is a discrepancy document the individual's preferred ASAM Level of Care placement;

(e) Include a safety plan when the assessment indicates risk to the health and safety of the individual or to others and be updated as circumstances change. The safety plan may be a separate document from the service plan;

(f) Include the participation of the individual and family members, as applicable;

(g) Be completed and signed by qualified program staff as follows:

(A) A QMHP in mental health programs;

(B) Supervisory or treatment staff in substance use disorders treatment programs; and

(C) Supervisory or treatment staff in problem gambling treatment programs.

(h) For mental health services, a QMHP who meets the qualifications of a Clinical Supervisor shall recommend the services and supports by signing the service plan within ten business days of the start of services; and

(i) A QMHP who meets the qualifications of a Clinical Supervisor shall approve the service plan at least annually for each individual receiving mental health services for one or more continuous years.

(2) At minimum, each service plan shall include:

(a) Treatment objectives that are:

(A) Individualized to meet the assessed needs of the individual;

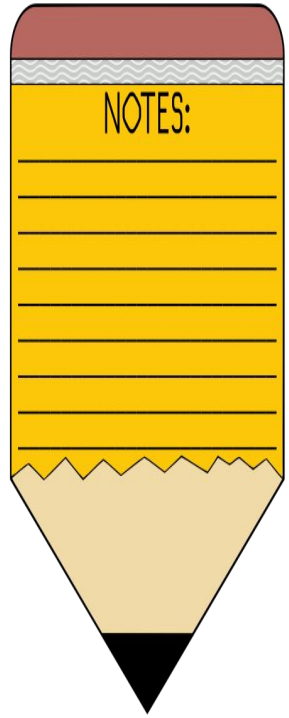
(B) Measurable for the purpose of evaluating individual progress, including a baseline evaluation.

(b) The specific services and supports that shall be used to meet the treatment objectives;

(c) Expected frequency of each type of planned service or support; and

(d) A schedule for re-evaluating the service plan.

*



NOTES

(3) Providers shall document each service and support in a service note to include:

(a) The specific services rendered;

(b) The specific service plan objectives being addressed by the services provided;

(c) The date, time of service, and the actual amount of time the services were rendered;

(d) The personnel rendering the services, including their name, credentials, and signature;

(e) The setting in which the services were rendered; and

(f) Periodic updates describing the individual's progress.

LET'S START WITH THE BASICS

- **GOALS**
  - A GENERAL STATEMENT OF WHAT THE PATIENT WISHES TO ACCOMPLISH. SHOULD BE IN THEIR WORDS.
- **OBJECTIVES: SYMPTOM REDUCTION AND/OR INCREASING FUNCTIONALITY. HAS TO BE MEASURABLE WITH A BASELINE AND TARGET.**
  - SHOULD BE WRITTEN IN LANGUAGE THAT IS UNDERSTANDABLE TO THE CLIENT
    - NOT THIS:
      - "UTILIZE GESTALT FRAMEWORK AND THEORY TO HELP THE CLIENT RECOVER AS A WHOLE PERSON AND SEE PROXIMITY, SIMILARITY, CONTINUITY, CONNECTEDNESS, AND CLOSURE AS PRINCIPLES TO HEALING"
- **INTERVENTIONS**

REMEMBER THE MEDICAL NECESSITY PIECE?

ICD-10 (DSM-V) diagnosis, impairments as a result of the said diagnosis, and **what interventions you're providing to alleviate symptoms and improve functioning**.

Medical necessity is based on "evidence based clinical standards of care". This means that there is evidence to support a course of treatment based on a set of symptoms or other diagnostic results. Not all diagnoses for all procedures are considered medically necessary.

What are the three components of medical necessity?

A medical necessity criterion has three components: diagnosis, impairment and intervention. Medical Necessity is determined through the assessment process by the following factors (Title 9, Section 1830.205):

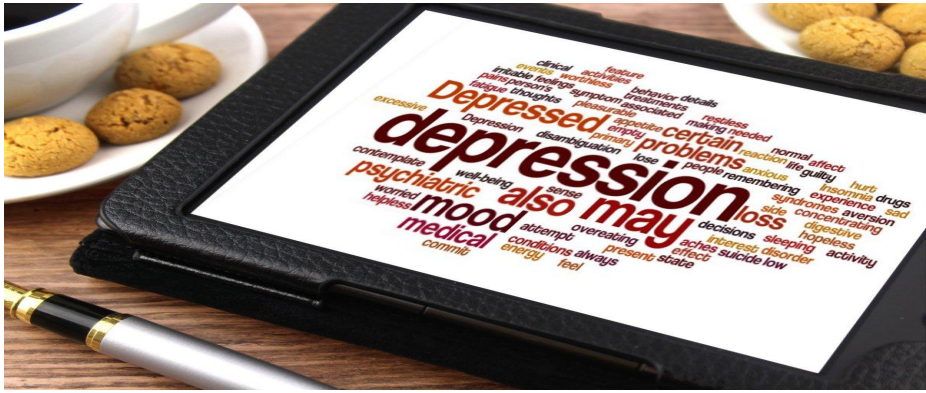
Medical necessity requires that all services/interventions be directed at a medical diagnosis and be necessary in order that the service can be billed.

What are the symptoms?

What are the impairments to daily living?

What is the diagnosis and do the symptoms support this?

What are the interventions to enhance the skill and decrease the symptomatology?



WE SHOULD BE WORKING ON EITHER

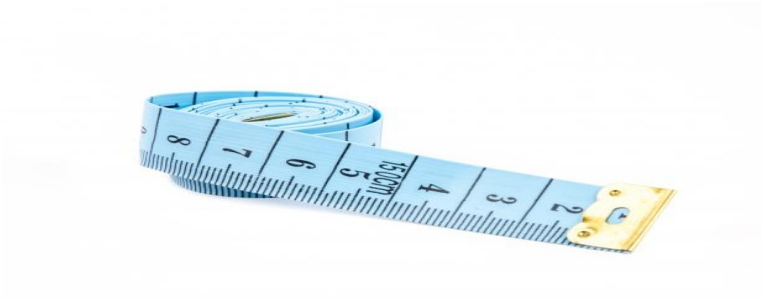
REDUCING SYMPTOMATOLOGY

OR

INCREASING FUNCTIONALITY

THIS IS BEST PRACTICE FOR DOCUMENTATION!

- NO NEED TO WRITE OBJECTIVES TO MATCH WHAT THE CLINICIAN DOES (ex: CBT/ DBT).
- SHOULD BE WRITING OBJECTIVES TO ADDRESS THE SYMPTOMS AND FUNCTIONAL DEFICITS OF THE CLIENT.
- FIDELITY PROGRAM OBJECTIVES FOLLOW THE ADVICE OF YOUR AUDITORS. STILL HAVE TO FOLLOW THE OAR'S.
    - TREATMENT OBJECTIVES THAT ARE:
    - (A) INDIVIDUALIZED TO MEET THE ASSESSED NEEDS OF THE INDIVIDUAL;
    - (B) MEASURABLE FOR THE PURPOSE OF EVALUATING INDIVIDUAL PROGRESS, INCLUDING A BASELINE EVALUATION.



GOALS SHOULD BE

SPECIFIC
MEASUREABLE
ATTAINABLE
RELEVANT

Specific - Who and What?

Measurable - By how much?

Achievable - Can this be completed?

Realistic - Is this a objective that makes sense to the individual?

Timely - Is there a timeframe for completion? (Measures progress)

S	Specific
M	Measurable
A	Attainable
R	Relevant
T	Time-bound
E	Exciting
R	Reward

S.M.A.R.T. OBJECTIVES

Specific - be thoughtful and specific about what the client wants to focus on.

Measurable - Make the objective measurable so that progress can continue to be monitored

Achievable - Choose objective that are realistic and manageable

Relevant - Make sure the objective is something that aligns with the individual's vision.

Time-bound - Define the time-frame target date to achieve the objective.


Progress

Suggested template:

Objectives:

CLIENT WILL (*INCREASE, DECREASE) (FUNCTIONALITY, SYMPTOM, OTHER PROTECTIVE FACTOR)* FROM _____ TIMES A (DAY/WEEK/MONTH), TO _____ TIMES A (DAY/WEEK/MONTH)

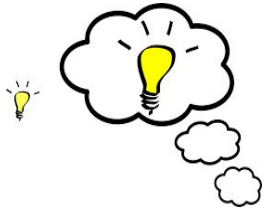
EXAMPLE of Baseline

A baseline is a starting point to know how effective the intervention was.

Example - Child has on average four outbursts per day.

Example - Individual cannot get out of bed five out of seven days per week due to low energy, feelings of sadness and overwhelming grief.

EXAMPLES of Good Starts



- Child will learn 2 skills within 60 days to reduce daily outbursts.
- Client will be able to increase ability to get out of bed from 5 days per week to 4 days per week within 30 days.
  - **Ways to enhance this Objective?**
  - **Are there symptoms getting in the way of getting out of bed?**

Avoid:
Decrease anxiety
Practice Affirmations
Reduce panic attacks
Demonstrate healthy sleep patterns

MORE EXAMPLES

More Examples

Client will practice learned communication skills and engage in positive conversations with her friends without name calling 3 out of 5 engagements over a period of 30 days.

Client will journal daily to identify a minimum of 2 positive traits about himself.

Client will decrease feelings of sadness from 5 out of 7 days to 4 out of 7 days within 30 days

*

MORE

- LEARN HOW TO BUDGET/BALANCE CHECK BOOK/DEVELOP A SAVINGS PLAN
- MOVE FROM NOT COOKING TO LEARNING HOW TO COOK 3 DAYS PER WEEK
- MOVE FROM NOT USING ANY TO LEARNING AND PRACTICING THREE EMOTION REGULATION SKILLS

LET'S WORK THESE INTO OBJECTIVES

CLIENT HAS INTRUSIVE DISTRESSING RECOLLECTIONS OF THE EVENT/MEMORY. THEY REPORT OF HAVING DEPRESSED MOODS, INSOMNIA, FATIGUE, ANHEDONIA, RESTLESS, POOR CONCENTRATION, IRRITABLE MOODS, ANGER, AND STRESS.

OBJECTIVE IDEAS….

LET'S REVIEW

- LEARN 3-4 COPING SKILLS TO HELP IMPROVE ANXIETY AND DEPRESSION

(REPORTS FEELING ANXIOUS NEARLY EVERY DAY. CLIENT REPORTS DIFFICULTIES SLEEPING, FIDGETING, FEELING NERVOUS, ANXIOUS, AND ON EDGE. REPORTS FEELINGS OF SADNESS, IRRITABILITY, LOSS OF INTEREST IN SOME ACTIVITIES, SUCH AS GAMES HE USED TO ENJOY, AND PERIODS OF LOW SELF-ESTEEM)

- LEARN DISTRESS TOLERANCE SKILLS (Can this be more specific?)

(CLIENT REPORTS EXPERIENCING DEPRESSION SYMPTOMS EVERY DAY. CLIENT EXPERIENCES EXCESSIVE ANXIETY AND WORRY OCCURRING MORE DAYS THAN NOT FOR AT LEAST SIX MONTHS, WHERE SHE FINDS IT DIFFICULT TO CONTROL WORRY AND FEELS RESTLESS, IS EASILY FATIGUED, HAS DIFFICULTY CONCENTRATING AND TROUBLE WITH SLEEP. CLIENT REPORTS DISTRESSING DREAMS, MEMORIES, FLASHBACKS, TRIGGERS, AVOIDANCE OF TRIGGERS, NEGATIVE ALTERATIONS IN COGNITION AND MOOD ASSOCIATED WITH THE TRAUMA)

LET'S CREATE

- WILL LEARN AND EFFECTIVELY UTILIZE 2-3 COPING SKILLS TO MANAGE IMPULSIVITY

(HIS ANGER IS VERY EASILY TRIGGERED AND WHEN HE GETS ANGRY HE WILL HIT/KICK/BITE CLASSMATES/FOSTER SIBLINGS/ADULTS, CUSS, AND THROW THINGS. HE IS VERY OPPOSITIONAL, DOES NOT FOLLOW DIRECTION MOST OF THE TIME, NEVER STOPS TALKING AND IS IN CONSTANT MOTION.)

INTERVENTIONS

INTERVENTIONS ALWAYS NEED FREQUENCY, DURATION AND SPECIFIC TYPE OF SERVICE, IN ADDITION TO CREDENTIALS OF PROVIDER FOR THE SERVICE. ONE CAN'T WRITE "INDIVIDUAL THERAPY" OR "WEEKLY SESSIONS".

- ONE NEEDS TO WRITE SOMETHING LIKE, "60 MINUTES WEEKLY IND THERAPY X12 WEEKS PROVIDED BY QMHP"
- UPON SERVICE PLAN UPDATE, IF A STATED INTERVENTION HASN'T BEEN USED, BEST TO REMOVE IT/END DATE IT IN TX PLUS

Frequency 1 time per week or 1 time per month or 1 time per day

Duration 60 min each or 30 minutes each or 3 hours each

Service - 1:1 individual therapy, or group therapy or care coordination or med management

Credential QMHA or QMHP or LMP or Peer Support or CADC

Putting it all together

- 1:1 individual therapy one time per week for 60 minutes each provided by a QMHP
- Group therapy 3 times per week for 75 minutes each provided by a QMHP
- Medication management one time per month for 20 minutes each provided by a LMP
- Care coordination two times per month for 15 minutes each provided by a QMHA
- Skills training one time per week for 30 minutes each provided by a Peer Support Staff

INTERVENTION EXAMPLES

- -REFERRAL TO HEALTH CLINIC FOR SCREENING (Include frequency/ duration of service)
- -CASE MGMT TO ASSIST WITH HOUSING AND INSURANCE 30 MIN TWICE A WEEK FOR 180 DAYS PROVIDED BY QMHA
- Individual Therapy 60 mins/ week; for 3 months*
- -SUPPORTED EMPLOYMENT COMMUNITY BASED SUPPORTS AND BENEFITS COUNSELING AS NEEDED UP TO 2 HOURS PER WEEK AND 3 MONTHS PROVIDED BY QMHA **(SUPPORTED EMPLOYMENT)**
- Skills Training (Include frequency/ duration of service)
- Groups (Include frequency/ duration of service)

Consequences of poor Documentation

Something to Think About

FINDINGS BASED On 2021/2022 AUDITS

- SERVICE PLANS:
  - NOT COMPLETED PRIOR TO START OF SERVICES
  - DID NOT CONTAIN PARTICIPATION OF MEMBERS AND/OR FAMILY
  - OBJECTIVES DID NOT CONTAIN A BASELINE
  - PLANS DID NOT LIST THE FREQUENCY AND DURATION OF EACH SERVICE
  - SERVICES NOT ADDED TO PLANS
  - SIGNATURES NOT OBTAINED WITHIN TIMEFRAME OR DID NOT HAVE CREDENTIALS
  - OBJECTIVES WERE NOT MEASURABLE 119/208= 57.2%
  - SERVICE PLAN DID NOT REFLECT THE ASSESSMENT

HEALTH AND THE OFFICE OF INSPECTOR GENERAL (OIG)

- MAY 2022- OIG REQUESTS 1.1 MILLION IN OVERPAYMENTS FROM A NEW YORK PROVIDER FOR PSYCHOTHERAPY.
- SPRING 2022 SEMI ANNUAL REPORT- 3 BILLION IN RECOVERIES, 320 CRIMINAL ENFORCEMENTS, 320 CIVIL ACTIONS, EXCLUDED 1043 INDIVIDUALS
- SEPTEMBER 2021- OPPORTUNITIES EXIST TO STRENGTHEN EVALUATION AND OVERSIGHT OF TELEHEALTH FOR BEHAVIORAL HEALTH IN MEDICAID.

Oregon Mental Health Facility Settles

On March 1, 2016, Cascadia **Behavioral Health**, Inc. (Cascadia), **Oregon**, entered into a $92,052.78 settlement agreement with **OIG**.

Is an OIG investigation serious?

An investigation looks into possible violations of law, regulation, or policy; consequently, the OIG conducts criminal, civil, and/or administrative investigations. The results may lead to criminal sanctions, civil penalties, or administrative actions against individual(s), contractors, companies, or their staff.

chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://oig.hhs.gov/reports-and-publications/archives/semiannual/2022/fall-sar-2022.pdf

Results for the Semiannual Reporting Period During this semiannual reporting period (April 1, 2022, through September 30, 2022), we issued 68 audit reports and 29 evaluation reports.

Our audit work identified $62.9 million in expected recoveries as well as $612.6 million in questioned costs (costs questioned by OIG because of an alleged violation, **costs not supported by adequate documentation, o**r expenditures of funds for which intended purposes were unnecessary or unreasonable).

Our audit work also identified $117 million in potential savings for HHS— funds that could be saved if HHS implemented all of OIG's audit recommendations. During this reporting period, OIG made 309 new audit and evaluation recommendations crucial to encouraging positive change in HHS programs.

Meanwhile, HHS OpDivs implemented 130 prior recommendations, resulting in positive impacts for HHS programs and enrollees. Statistic FY 2022 (10/1/2021–9/30/2022)

114 Audit Reports Issued 114

43 Evaluations Issued 43

Expected Audit Recoveries $1,199,088,845

Questioned Costs $2,173,082,045

Potential Savings $279,087,234

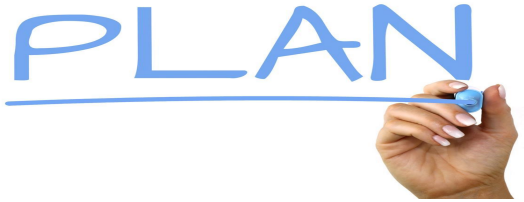
445 New Audit and Evaluation Recommendations

424 Recommendations Implemented by HHS OpDivs

Expected Investigative Recoveries $2.73 billion Criminal Actions

Criminal Actions 710

Civil Actions 736



OIG Strategic Plan

HHS-OIG Strategic Plan OIG's Strategic Plan outlines the approach to protecting the integrity of HHS programs. The plan has three key goals:

(1) to fight fraud, waste, and abuse;

(2) to promote quality, safety, and value in HHS programs and for HHS beneficiaries; and

(3) to advance excellence and innovation.

These goals drive OIG's work planning for audits and evaluations as well as OIG's approach to enforcement. These goals also serve as a starting point for OIG's assessment of its own effectiveness.

QUESTIONS