



DIVISION OF MEDICAL SERVICES PROVIDER BULLETIN

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PSYCHOTHERAPY BULLETIN PHYSICIAN (PSYCHIATRIST), PSYCHOLOGIST, PCNS, LCSW, LPC, FQHC, RHC

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PROVIDER PARTICIPATION

To be eligible for participation in the Missouri Medicaid psychiatric/psychology/counseling/clinical social work program, a provider must meet the licensing criteria specified for his or her profession and be an enrolled Medicaid provider. The enrolled Medicaid provider, Physician (Psychiatrist), Psychologist, Psychiatric Clinical Nurse Specialist (PCNS), Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), Federally Qualified Health Care (FQHC), Rural Health Clinic (RHC), shall agree to:

- Keep any records necessary to disclose the extent of services the provider furnishes to recipients; and
- On request furnish to the Medicaid agency or State Medicaid Fraud Control Unit any information regarding payments claimed by the provider for furnishing services under the managed health care plan or fee-for-service.

DOCUMENTATION REQUIREMENTS FOR PSYCHIATRIC/PSYCHOLOGY/COUNSELING/CLINICAL SOCIAL WORK SERVICES

Documentation must be in narrative form, fully describing each session billed. A check-off list or pre-established form will not be accepted as sole documentation. Progress notes shall be written and maintained in the recipient's medical record for each date of service for which a

claim is filed. Progress notes for psychiatric/psychology/counseling/clinical social work services shall specify:

- First and last name of recipient:
 - When family therapy is furnished, each member of the family included in the session must be identified. Description of immediate issue addressed in therapy, identification of underlying roles, conflicts or patterns, and description of therapist intervention;
 - When group therapy is furnished, each service shall include the number of group members present, description of immediate issue addressed in therapy, identification of underlying roles, conflicts or patterns, and description of therapist intervention and progress towards goals;
- The specific service(s) rendered;
- Name of person who provided the service;
- The date (month/day/year) and actual begin and end time (e.g., 4:00-4:30 p.m.) taken to deliver the service;
- The setting in which the service was rendered;
- Recipient's report of recent symptoms and behaviors related to their diagnosis and treatment plan goals;
- Therapist interventions for that visit and recipient's response; and
- The recipient's progress towards one (1) or more goals stated in the treatment plan.

PLAN OF TREATMENT DOCUMENTATION

A plan of treatment is a required document in the overall record of the recipient.

A treatment plan must be developed by the provider based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the recipient's situation and reflects the need for psychiatric/psychological/counseling/clinical social work services. If the service is for a child who is in the legal custody of the Children's Division (formerly known as Division of Family Services, Children's Services section), a copy of the treatment plan shall be provided to the Children's Division in order for the provider to retain reimbursement for the covered service(s).

Documentation required by Missouri Medicaid does not replace or negate documentation/reports required by the Children's Division for individuals in their care or custody. Providers are expected to comply with policies and procedures established by the Children's Division.

The treatment plan shall be individualized to reflect the recipient's unique needs and goals.

The plan shall include, but is not limited to, the following:

- Measurable goals and outcomes;
- Services, support, and actions to accomplish each goal/outcome. This includes services and supports and the staff member responsible, as well as action steps of the recipient and other supports (family, social, peer and other natural supports);
- Involvement of family, when indicated;

- Identification of other agencies working with the recipient, plans for coordinating with other agencies;
- Identification of medications, which have been prescribed, where applicable;

- Services needed beyond the scope of the organization or program that are being addressed by referral or services at another community organization, where applicable;
- Projected time frame for the completion of each goal/outcome; and
- Estimated completion/discharge date for the level of care.

PLAN OF TREATMENT REVIEW

The treatment plan shall be reviewed on a periodic basis to evaluate progress towards treatment goals and outcomes and to update the plan.

Each person shall directly participate in the review of his or her individualized treatment plan.

The frequency of treatment plan reviews shall be based upon the recipient's level of care or other applicable program rules. The occurrence of a crisis or significant clinical event may require a further review and modification of the treatment plan.

The individualized treatment plan shall be updated and changed as indicated.

Each treatment plan update shall include the therapist's assessment of current symptoms and behaviors related to diagnosis, progress to treatment goals, justification of changed or new diagnosis, response to other concurrent treatments such as family or group therapy and medications.

The therapist's plan for continuing treatment and/or termination from therapy and aftercare shall be considerations expressed in each treatment plan update.

DIAGNOSTIC ASSESSMENT

A diagnostic assessment from a Medicaid enrolled provider shall be documented in the recipient's case record. The diagnostic assessment shall assist in ensuring an appropriate level of care, identifying necessary services, developing an individualized treatment plan, and documenting the following:

- Statement of needs, goals, and treatment expectations from the individual requesting services. The family's perceptions are also obtained, when appropriate and available;
- Presenting situations/problem and referral source;
- History of previous psychiatric and/or substance abuse treatment including number and type of admissions;
- Current medications and identifications of any medication allergies and adverse reactions;
- Recent alcohol and drug use for at least the past thirty (30) days and, when indicated, a substance abuse history that includes duration, patterns, and consequences of use;
- Current psychiatric symptoms;

- Family, social, legal, and vocational/educational status and functioning. The collection and assessment of historical data is also required unless short-term crisis intervention or detoxification are the only services being provided;
- Current use of resources and services from other community agencies;

- Personal and social resources and strengths, including the availability and use of family, social, peer and other natural supports; and
- Multi-axis diagnosis or diagnostic impression in accordance with the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association or the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD9-CM). The ICD9-CM is required on the treatment plan for billing purposes.

INTERACTIVE THERAPY DOCUMENTATION

When interactive therapy is billed, the provider must document the need for this service and the type of equipment, devices, or other mechanism of equipment used.

AFTERCARE PLAN

When care is completed, the aftercare plan shall include, but is not limited to, the following:

- Dates begin and end;
- Frequency and duration of visits;
- Target symptoms/behaviors addressed;
- Interventions;
- Progress to goals achieved;
- Final diagnosis; and
- Final recommendations including further services and providers, if needed, and activities to promote further recovery.

For all medically necessary covered services, a writing of all stipulated documentation elements referenced in this bulletin are an essential and integral part of the service itself. No service has been performed if documentation requirements are not met. No service will be reimbursed if documentation requirements are not met.

RETENTION OF RECORDS

Medicaid providers must retain for six (6) years, from the date of service, fiscal and medical records that coincide with and fully document services billed to the Medicaid Agency, and must furnish or make the records available for inspection or audit by the Department of Social Services or its representative upon request. Failure to furnish, reveal and retain adequate documentation for services billed to the Medicaid Program may result in recovery of the payments for those services not adequately documented and may result in sanctions to the provider's participation in the Medicaid Program. This policy continues to apply in the event of the provider's discontinuance as an actively participating Medicaid provider through change of ownership or any other circumstance.

Provider Bulletins are available on the DMS Website at <http://www.dss.mo.gov/dms/pages/bulletins.htm>. Bulletins will remain on this site only until incorporated into the [provider manuals](#) as appropriate, then deleted.

Missouri Medicaid News: Providers and other interested parties are urged to go to the DMS Website at <http://dss.missouri.gov/dms/subscribe/MedNewsSubscribe.htm> to subscribe to the listserve to receive automatic notifications of provider bulletins, provider manual updates, and other official Missouri Medicaid communications via e-mail.

MC+ Managed Care: The information contained in this bulletin applies to coverage for:

- MC+ Fee-for-Service
- Medicaid Fee-for-Service
- Select MC+ Managed Care Services

Questions regarding MC+ Managed Care benefits should be directed to the patient's MC+ Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the red MC+ card or by calling the Interactive Voice Response (IVR) System at 1-800-392-0938 and using Option One.

Provider Communications Hotline
800-392-0938 or 573-751-2896