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Outpatient Behavioral Health Provider Training

*Provided by the Utilization Management
Department of Superior HealthPlan*

Superior's Clinical Program



- Focus:
 - Individualizes treatment strategies.
 - Promotes resiliency and recovery.
 - Uses evidence-based practices.
- Goal:
 - Support the provision and maintenance of a quality-oriented patient care environment.
- In an effort to meet the above standards, audits may be conducted for charts of members receiving behavioral health outpatient services.

Training Outline



- Behavioral Health Outpatient Audit Tool
- Specific, Measurable, Achievable, Relevant and Time-Bound (SMART) Goals
- Texas Medicaid Provider Procedures Manual
- Superior HealthPlan STAR, STAR+PLUS, CHIP & STAR Health and STAR Kids Provider Manual
- Benefit Exclusions
- Training Review and Helpful Resources
- Questions and Answers



Behavioral Health Outpatient Audit Tool

Audit Tool Overview



- Consists of seven categories:
 1. General Medical Record
 2. Initial Assessment and History
 3. Medications
 4. Coordination of Care
 5. Treatment Plan
 6. Progress Notes
 7. Authorization and Claims

Audit Tool Overview



- This is not a state audit. This is an internal retrospective review of charts of members receiving outpatient behavioral health services.
 - 80% = passing for each section and overall.
 - The quality of the information provided will be assessed, not just the presence of content.

Please note: Information provided should not be from a third-party provider (Texas Child Protective Services [CPS], Residential Treatment Center [RTC], Psychiatrist, etc.). Providers should have their own record of each category as applicable.

General Medical Record



- The general medical record must include all of the following. If any of the following are not applicable, this must be noted as such with detail.
- The medical record also must be legible to someone other than the writer.
 - Member name or ID number on each page of medical record
 - Member's address
 - Home and work telephone numbers, member's age, gender/sex, religious preferences and/or restrictions
 - Marital status
 - Legal status (voluntarily seeking services, court order, etc.)
 - Employer or school name
 - Emergency contact information
 - Guardianship information (always necessary for minors; for adults ages 18 and older, if applicable)
 - Preferred language and need for any interpreter services (use of an interpreter is documented, as applicable)
 - Presence or absence of any visual or hearing impairments

General Medical Record



- Includes:
 - Evidence of signed informed consent for treatment.
 - Policy and procedures (procedures for handling complaints, crisis situations, missed appointments, a policy for non-discrimination, etc.).
 - Disclosure of Information Form, including information about confidentiality and safeguarding of member information and records.
 - Signed acknowledgment of HIPAA Privacy Notice.
 - Evidence that an advance directive has been discussed (if 18 or older).
 - Signed Primary Care Physician (PCP) Release of Information Form (includes documentation if no consent is granted).
 - Signed release of information forms, as applicable.
- For a child/adolescent under 18 years of age:
 - Child's legal status and guardianship information.
 - Parent(s), legal guardian or caretaker(s) signed consent for the various treatments provided.

Initial Assessment and History



- A Psychiatric Diagnostic Evaluation is an integrated biopsychosocial assessment. For additional information on what should be included, please see the Medical Guidelines on the following slides. The following factors will be assessed:
 - Presenting problem(s).
 - Psychiatric history and relevant family information.
 - Relevant medical conditions (including pregnancy).
 - Medical history (including any serious accidents, operations, illnesses, discharge summaries and Emergency Room [ER] encounters).
 - Support systems, legal history, and educational history.
 - Member's race, religion, ethnicity, age, gender, sexual orientation and level of education.
 - Mental Status Exam.
 - Risk factors to include danger to self, danger to others, ability to care for self, affect, perceptual disturbances, cognitive functioning, and significant social history.
 - Substance Abuse Evaluation (10 years of age or older).
 - Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis.

Initial Assessment and History



- For a child/adolescent under 18 years of age, record reflects:
 - Active involvement of family, legal guardian or primary caretaker in the assessment of the member, unless contraindicated.
 - Assessment of school functioning.
 - Relevant prenatal and perinatal events.
 - Complete developmental history including physical, psychological, social, intellectual and academic.
- Psychiatric diagnostic evaluations (90791) are limited to once per member, per rolling year.
 - Same provider in the office, home, outpatient hospital or other settings, regardless of the number of professionals involved in the interview.
- Additional psychiatric diagnostic evaluations may be necessary with supporting documentation, including but not limited to:
 - A court order or a Department of Family and Protective Services (DFPS) directive.
 - If a major change of status occurs.
 - Subject to retrospective review for necessity. No prior authorization request is necessary.

Medications



- For prescribing providers, medication services will require the following information. For non-prescribing providers, this section is not applicable.
- Medical record requirements:
 - Current medications are listed along with the prescribing provider.
 - Allergies, adverse reactions or no known allergies are clearly documented in the medical record.
 - If taking medications with addictive potential and member has a history of substance abuse, there is a clear rationale provided (risk vs. benefit analysis).
 - If taking medications with addictive potential for a long-term period, there is a clear rationale provided (risk vs. benefit analysis).
 - If psychotropic medications are being prescribed, the dosage of each, the dates of initial prescriptions-and number of refills are documented within the medical record.
 - There is evidence of consistency among the signs, symptoms,-and diagnoses with prescribed medications.

Medications



- Medical record requirements (continued):
 - Documentation of member/guardian education regarding reason for medication prescribed, risks and possible side effects is included in medical record.
 - Medical record includes documentation of member verbalization or understanding medication education.
 - Medical record contains clear rationale regarding any changes in diagnoses, medications or dosage, and includes dates of these revisions.
 - If provider is prescribing a controlled substance, such as an ADHD medication, an Agreement for Long-Term Controlled Substance Prescription Form is present.
 - A Pre-Authorization for Medication Form is completed and submitted, when applicable.
 - Medical record includes lab tests results and consultation reports, when applicable.

Coordination of Care



- Medical record includes:
 - Evidence of continuity and coordination of care between behavioral health-care institutions, other outpatient behavioral health providers, ancillary providers and/or consultants, if applicable.
 - Evidence of coordination of care with the PCP or note if declined by the member.
 - If known or suspected physical health problems or disorders, evidence of referral to a PCP for examination or treatment, with the member's or the member's legal guardian's consent.
 - Initial and quarterly (or more frequently, if clinically indicated) summary reports of a member's behavioral health status (sent from the provider to the PCP), with the member's or the member's legal guardian's consent.
- For STAR Health members, complete initial and monthly summaries of behavioral services are posted on the Health Passport and made available to the PCP, targeted case management and psychosocial rehab providers.

Treatment Plan



- Individualized with a diagnosis consistent with symptoms and behavioral indicators.
- Objective short-term and long-term goals that are measurable with an established timeframe for goal attainment.
 - SMART goals: Specific, Measurable, Achievable, Relevant, Time-bound
- Include specific interventions and modality (i.e. group, individual, family/couples counseling).
- Include frequency and duration of services to be provided.
- Member, guardian and family (as appropriate) should participate in treatment planning.
- Treatment plan should be reviewed and updated when clinically appropriate, or at least every 6 months.

Treatment Plan Changes



- What will you do differently in treatment to support the member's progress?
- Regardless of progress or lack thereof, indicate any changes that have occurred in the member's status, treatment focus and clinical interventions.
- If there is no progress, ensure treatment plan goals have been updated to address lack of progress.

Progress Notes



- Progress notes must include:
 - Every claim requires a progress note that should include the date and start/end time of each session, the service code or type of service provided, diagnosis, treatment modality, as well as current symptom assessment and functional status documented.
 - Mental status exam is documented, as well as suicidal/homicidal risk assessment for each session.
 - Progress notes must include member's response to intervention including progress or lack of progress towards treatment plan goals/objectives and evidence of clinical interventions or techniques used by the provider, consistent with evidence-based modalities.
 - Documentation must include plans for further interventions and justification for continued care, including date of next appointment.

Progress Notes



- Discharge notes should be completed if member has been discharged from services and should document achievement of goals or necessary referrals to assist in final attainment of goals.
- Missed appointments should be documented, as well as the attempt to contact the member within 24 hours to reschedule the appointment.
- For an adult, evidence of family support system involvement is present, as appropriate.
- For a child/adolescent under 18 years of age, the record reflects the active involvement of the family, legal guardian or primary caretaker in the treatment of the member, unless contraindicated.

Progress Notes



- Family Psychotherapy (90846 for members 20 years of age or younger, 90847 for member of any age).
 - If provided, only the following specific relatives are allowed to participate:
 - Biological parent, foster parent or legal guardian.
 - Child.
 - Grandfather or grandmother.
 - Sibling biological, foster or kinship.
 - Uncle, aunt, nephew or niece.
 - First cousin or first cousin once removed.
 - Stepfather, stepmother, stepbrother or stepsister.

Authorization and Claims



- All claims and encounters should be sent to Superior within 95 days of the date of service.
- If individual psychotherapy and family psychotherapy are provided on the same day for the same member, the provider must bill a modifier to identify a separate and distinct service with documentation supporting the provision of the distinct services.
- If the member changed providers during the year, attempts to obtain complete information on the previous treatment history are documented.
- Psychotherapy (individual, family or group) is limited to 4 hours per member, per day.
- Medical record information is documented using the ICD-10 classifications, as well as the most current DSM classifications.



SMART Goals

*Specific, Measurable, Achievable, Relevant
and Time-Bound*

Specific



Who, What, When, Where and How

- Identify which specific clinical interventions you will use.
 - Example: If you indicate you will be addressing coping skills in treatment, identify specific types of coping skills (anger management, communication, etc.).

Measurable



Intensity, Frequency, Durations of Symptoms

- Indicate what sort of objective, quantifiable behavioral indicators will be used to determine if progress is being made in treatment.
- The measurable component will determine if the goal has been completed.
- Choose a quantitative format that best translates what treatment you are hoping to accomplish.
 - Example: “5 out of 7 days” vs. “60% of the time”

Achievable



Within Scope for Current Treatment Episode

- Is the treatment goal within the member's power or control?
- The member's developmental and intellectual abilities should be considered.
- Is what you are expecting something a productive, functional member of society would be able to do?
 - Example: Expecting a "100% reduction in aggression" (not realistic) vs. "An identified appropriate response to anger triggers in 3 out of 4 instances" (achievable).

Relevant



Should Align with Needs, Values and Objectives

- Is the treatment goal in alignment with member's needs, values and larger, long-term goals?
- At the end of treatment, how will the treatment goal continue to benefit the member?
 - Example: If member desires to set a goal for knitting, the provider should guide the member toward correlating the goal for knitting with decreasing anxiety, in order to maintain relevancy of the goal.

Time-bound



Timeframe to Achieve Identified Goals

- Time-bound or time-limited goals are based on time periods expected, according to best practice vs. ongoing therapy.
- Emphasize gaining the maximum benefit within a specified timeframe.

Discharge Criteria



- Discharge criteria should also adhere to the SMART model.
- Appropriate discharge planning begins on the first day of treatment.
 - How will you know when you are done?
 - How will the member, foster parent and/or CPS worker know when therapy is completed?
 - How will you know when the member is ready to terminate services?
 - What are the barriers preventing this enrollee from being ready to be discharged?
- Discharge planning may include referrals to other providers and/or agencies.



Texas Medicaid Provider Procedures Manual, Volume 2

*Behavioral Health and Case Management
Services Handbook - Chapter 4: Outpatient
Mental Health Services*

4.2.2 – Psychotherapy (Overview)



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- **Individual** – Focuses on a single member.
- **Group** – Involves one or more therapists working with several members at a time.
- **Family** – Focuses on the dynamic of the family where the goal is to strengthen the family's problem-solving and communication skills.
- Psychotherapy (individual, family or group) is limited to 4 hours per member, per day. Psychotherapy is limited to 30 individual, group
- If the member changes providers during the year, the new provider should make an attempt to obtain complete information on the member's previous treatment history.

4.2.2 – Psychotherapy (Documentation)



- Documentation for individual, family or group psychotherapy must be legible to someone other than the writer, and must include:
 - Identifying client information.
 - Provider name and identifier.
 - Current DSM diagnosis/es.
 - Current psychotropic medications.
 - Treatment plan, including measurable short-term goals, specific therapeutic intervention utilized, and measurable expected outcomes of therapy.
 - Number and type of services requested and anticipated dates that the service will be provided.
 - Indication of court-ordered or DFPS-directed services.
 - Clinical notes for each encounter must include functional status, focused mental status examination, if indicated; prognosis, progress; name, signature and credentials of person performing the service.

4.2.2.1 – Family Psychotherapy



- May be provided to Medicaid members 20 years of age and younger using procedure code 90846, or to members of any age using procedure code 90847.
- Only reimbursable for one Medicaid-eligible member per session, regardless of the number of family members present per session.
- For Medicaid members 20 years of age and younger, family psychotherapy may be provided to the child's parent(s), foster parent(s), or legal guardian without the child present, as clinically appropriate, using procedure code 90846.
 - Parent- or guardian-only sessions may be indicated when addressing sensitive topics such as parenting challenges or related stressors that would be inappropriate to discuss with the child present at the session.

4.2.2.1 – Family Psychotherapy



- Only the following specific relatives are allowed to participate:
 - Biological parent, foster parent or legal guardian.
 - Child.
 - Grandfather or grandmother.
 - Sibling (biological, foster or kinship).
 - Uncle, aunt, nephew or niece.
 - First cousin or first cousin once removed.
 - Stepfather, stepmother, stepbrother or stepsister.

4.4 – Medical Necessity



- All services require documentation to support the medical necessity of the service rendered, including mental health services.
 - The documentation must support the medical necessity of the treatment for its entire duration.
- Mental health services are subject to retrospective review to ensure that the documentation in the member's medical record supports the medical necessity of the services provided.

4.5 – Twelve-Hour System Limitation



- The following provider types are limited to a maximum combined total of 12 hours per provider, per day, regardless of the number of patients seen for outpatient mental health services:
 - Psychologist.
 - Advanced Practice Registered Nurse (APRN).
 - Physician Assistant (PA).
 - Licensed Clinical Social Worker (LCSW).
 - Licensed Marriage and Family Therapist (LMFT).
 - Licensed Professional Counselor (LPC).



Behavioral Health Services

*Superior HealthPlan STAR, CHIP, STAR+PLUS,
STAR Health and STAR Kids Provider Manual*

Behavioral Health Services Explained



- Behavioral health services are covered services for the treatment of mental or emotional disorders and substance use disorders.
- Superior has defined “behavioral health” as encompassing both acute and chronic psychiatric and substance use disorders, as referenced in the most recent International Classification of Diseases, 10th Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS).

Behavioral Health Services Explained



- Providers may reach out to their assigned Superior Provider Representative for available trainings on the following programs:
 - Trauma Focused-Cognitive Behavioral Therapy (TF-CBT).
 - Trauma Informed Care (TIC).
 - Parent-Child Interaction Therapy (PCIT).
 - Trust Based Relational Intervention (TBRI).
 - Child Parent Psychotherapy (CPP).

Coordination Between Behavioral Health and Physical Health Services



- Superior recognizes that communication is the link that unites all the service components and is a key element in any program's success.
 - To advance this objective, providers are required to obtain a consent for release of information from the member-permitting exchange of clinical information between the behavioral health provider and the member's physical health provider.
- If the member refuses to release the information, they should indicate their refusal on the Release of Information Form. In addition, the provider will document the reasons for refusal in the patient's medical record.

Coordination Between Behavioral Health and Physical Health Services



- Superior monitors compliance of the behavioral health providers to ensure a Release of Information Form has been signed by the member and/or the legally authorized representative.
- Superior also ensures that regular reports are sent to the PCP for members agreeing to the release of information.
- For participants in the STAR Health program, behavioral health providers can access document updates in the **Health Passport Form Coversheet (PDF)**, found on [Superior's Important Forms](#) webpage.

Medical Record Guidelines



- The following Medical Record Guidelines are outlined in the **Superior HealthPlan STAR, CHIP, STAR+PLUS, STAR Health and STAR Kids Provider Manual (PDF)** found on [Superior's Training and Manuals](#) webpage.
- Medical records may be on paper or electronic. Superior requires that records be maintained in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review.
- The records must reflect all aspects of patient care, including ancillary services. Superior may audit recordkeeping practices and individual member medical records in conjunction with its ongoing Quality Assessment and Performance Improvement (QAPI) Program activities, or as a result of member complaints.
 - Providers scoring less than 80% on medical record audits may be placed under a corrective action plan, may be subject to additional medical record reviews or may be referred to Superior's Quality Improvement Committee (QIC) for recommendations.

Medical Record Guidelines



- Medical Records are organized, consistent and easily retrieved at the time of each visit and must include:
 - Written policy regarding confidentiality and safeguarding of member information. Records are protected through secure storage with limited access.
 - Written procedure for release of information and obtaining consent for treatment. This includes providing records by the deadline of the request.
 - Each page in the record contains the patient's name or Medicaid ID number.
 - Personal/biographical data includes address, age, sex, employer, home and work telephone numbers, and marital status, as well as assessment of cultural and/or linguistic needs (preferred language, religious restrictions) or visual or hearing impairments.

Medical Record Guidelines



- Medical Records are organized, consistent and easily retrieved at the time of each visit and must include (continued):
 - All entries in the medical record contain author identification, are legible (to someone other than the writer), in ink and dated.
 - The history and physical exam records appropriate subjective and objective information for presenting complaints.
 - Problem list documenting significant illnesses, behavioral health and/or medical conditions. Unresolved problems from previous office visits are addressed in subsequent visits.

Medical Record Guidelines



- Medical records must include (continued):
 - Medication list that includes instructions to member regarding dosage, initial date of prescription and number of refills.
 - Medical allergies and adverse reactions, prominently documented in a uniformed location in the medical record. If no known allergy, NKA or NKDA is documented.
 - Easily identifiable past medical history, and includes any serious accidents, operations and/or illnesses. For children and adolescents (18 years of age and younger), past medical history relating to prenatal care, birth, any operations and/or childhood illnesses must be included.
 - Clearly documented clinical findings and evaluation for each visit, including appropriate treatment plan and follow-up schedule as indicated.
 - For members 10 years of age and older, appropriate notations concerning use of tobacco, alcohol and substance use.
 - Documentation of failure to keep an appointment.
 - "At risk" factors, including danger to self/others, ability to care for self, affect, perceptual disorders, cognitive functioning and/or significant social history.

Medical Record Guidelines



- Medical records must include (continued):
 - An assessment conducted at each visit relating to member status, symptoms and treatment progress. Documentation may indicate initial symptoms of behavioral health condition as decreased, increased or unchanged during treatment period.
 - Evidence of family involvement, as applicable, as well as evidence that family was included in treatment planning and therapy sessions, when appropriate.
 - Evidence of attempts by treating providers to communicate and coordinate behavioral health treatment with PCPs and other behavioral health providers. This should include, at a minimum, the documentation of attempts to provide member's behavioral health diagnosis(es), current symptoms, behavioral health medications, any pertinent lab work, assessment and current treatment plan.



Benefit Exclusions

Exclusions



- The following exclusions are not covered benefits for Texas Medicaid:
 - Psychoanalysis.
 - Multiple Family Group Psychotherapy (MFGP).
 - Marriage or couples counseling.
 - Narcosynthesis.
 - Biofeedback training as part of psychophysiological therapy.
 - Psychiatric day treatment programs.
 - Services provided by a psychiatric assistant, psychological assistant (excluding Master's level Licensed Psychological Associate [LPA]), or a licensed chemical dependency counselor.



Training Review and Helpful Resources

Review



- Superior conducts audits of members receiving outpatient behavioral health services from participating providers.
- The 7 categories of the Behavioral Health Outpatient Audit Tool are:
 1. General Medical Record
 2. Initial Assessment and History
 3. Medications
 4. Coordination of Care
 5. Treatment Plan
 6. Progress Notes
 7. Authorization and Claims

Review



- 80% is considered passing for each section of the audit, as well as overall.
- Criteria for the audit tool is derived from the Texas Medicaid Provider Procedures Manual and the **Superior HealthPlan STAR, CHIP, STAR+PLUS, STAR Health and STAR Kids Provider Manual (PDF)**.

Trauma-Informed Care (TIC) Alternative Payment Model



- Effective February 1, 2020, Superior launched a new Alternative Payment Model (APM) for behavioral health therapy providers serving STAR Health members.
- When a provider uses an approved evidenced-based, trauma-informed care modality to treat trauma-related behavioral health symptoms and issues, they can receive an additional 10% payment to their submitted claim.

Trauma-Informed Care (TIC) Alternative Payment Model



- There are 5 therapy modalities that will be recognized for this APM:
 1. **Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)** – Recognized as evidence-based and validated for use with children and adolescents.
 2. **Eye Movement Desensitization and Reprocessing (EMDR)** – Recognized as evidence-based, validated for use with adults.
 3. **Cognitive Processing Therapy (CPT)** – Recognized as evidence-based, primarily focused on adults.
 4. **Prolonged Exposure (PE)** – Recognized as evidence-based, validated for adolescents (PE-A) and adults.
 5. **Parent Child Interaction Therapy (PCIT)** – Recognized as evidence-based, validated for children ages 2-7.
- For any questions or more information on this APM, please contact your local Provider Representative. To access their information, visit the [Find My provider Representative](#) webpage.

Contacts



The contact email addresses for each Superior Provider Representatives are listed below, and on the next slide.

- **Bexar** – AM.SanAntonio@SuperiorHealthPlan.com
- **Central** – AM.Austin@SuperiorHealthPlan.com
- **Dallas** – AM.Dallas@SuperiorHealthPlan.com
- **El Paso** – AM.ElPaso@SuperiorHealthPlan.com
- **Harris** – AM.Houston@SuperiorHealthPlan.com
- **Hidalgo** – AM.Hidalgo@SuperiorHealthPlan.com
- **Lubbock** – AM.Lubbock@SuperiorHealthPlan.com
- **Jefferson** – AM.Houston@SuperiorHealthPlan.com

Contacts



Superior Provider Representative email addresses (continued):

- **Northeast** – AM.Dallas@SuperiorHealthPlan.com
- **Nueces** – AM.CorpusChristi@SuperiorHealthPlan.com
- **Tarrant** – AM.Dallas@SuperiorHealthPlan.com
- **Travis** – AM.Austin@SuperiorHealthPlan.com
- **West (1)** – AM.ElPaso@SuperiorHealthPlan.com
- **West (2)** – AM.Lubbock@SuperiorHealthPlan.com

Resources



- [Texas Medicaid Provider Procedures Manual](#), Volume 2: Behavioral Health and Case Management Services Handbook, Chapter 4, Outpatient Mental Health Services
- *Superior HealthPlan STAR, STAR+PLUS & STAR Health and STAR Kids Provider Manual (PDF)* Section 7 Behavioral Health Services, Behavioral Health Services explained on [Superior's Training and Manuals webpage](#)
- [Superior's Find Help webpage](#)
- [Superior's Behavioral Health webpage](#)
- [Superior's For Member webpage](#)
- [Superior's Quarterly Provider Meetings](#)



Questions and Answers

Let us know what we can do to help.

Thank you for attending!