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February 2013
Training Objectives

• APS Healthcare Introduction

• Utilization Review Process

• Overview of Medical Necessity

• Clinical Documentation for Utilization Review

• APS Healthcare—APS CareConnection®
• APS Healthcare is a national specialty healthcare management company in 24 states & Puerto Rico.

• APS Healthcare has been contracted with the State of Maine since September 1, 2007 as a Behavioral Health Administrative Service Organization (ASO). APS’ service center is located in South Portland.
• APS conducts Prior Authorization, Utilization Management, Member Services, Provider Services, Quality Management for:
  • MaineCare mental health services
  • State grant funded adult mental health services
  • Nursing facility screenings for mental illness, intellectual disabilities and other related conditions (PASRR)
  • Long term supported employment utilization management
  • Mental health services for Baxter Fund class members
Goals of the APS Healthcare Program

• 1. Improve outcomes of behavioral health services

• 2. Reduce the costs and increase the value of MaineCare funded services

• 3. Ensure State of Maine compliance with Federal & other legal requirements
Utilization Review Process

• APS Care Managers are independently licensed professionals with years of experience working in the provider community of Maine

• Care Managers are cross-trained but have primary responsibility for service-specific areas

• Care Manager use MaineCare Rule and providers’ clinical documentation to make determinations

• Internal Quality Assurance measures include routine peer consultation among Care Managers

• Clinical back-up and supervision is provided on-site by the Clinical Director and Medical Director
Effective February 15, 2013 APS Healthcare will be conducting utilization review for new admissions to Intensive Outpatient Programs

- This will include Mental Health IOP and Substance Abuse IOP

- IOP will be a prior authorized service. Prior Authorizations should be done *prior to the service beginning*, and include info provided by the referral source. Prior Authorization is for a maximum of a seven day period
  - *The purpose of a Prior Authorization is to establish clinical support for this level of service, as opposed to a higher or lower level of service. It is important to include other treatments tried and why IOP is the appropriate level of care at this time*

- A Continued Stay Review must be entered *every 7 days* until services end

- A discharge review is required in CareConnection®
Medical Necessity

Definition of Medical Necessity from the MaineCare Benefits Manual, Chapter 1

Medical Necessity or Medically Necessary services are those reasonably necessary medical and remedial services that are:

▪ provided in an appropriate setting;

▪ recognized as standard medical care, based on national standards for best practices and safe, effective, quality care;

▪ required for the diagnosis, prevention and/or treatment of illness, disability, infirmity or impairment and which are necessary to improve, restore or maintain health and well-being;

▪ MaineCare covered service (subject to age, eligibility, and coverage restrictions as specified in other Sections of this manual as well as Prevention, Health Promotion and Optional Treatment requirements as detailed in Chapter II, Section 94 of this Manual);

▪ performed by enrolled providers within their scope of licensure and/or certification; and

▪ provided within the regulations of this Manual
Clinical Documentation

Provider responsibilities:

• To create a thread between diagnosis, current presentation, treatment strategies, treatment progress, the benefit of the service, and the discharge criteria and plan

• To write review requests that enable the reader to have a current clinical snap-shot of the member related to the goals and progress of the service requested, and that supports the continuing service
A clinical summary that supports in the Prior Authorization should include:

• Demographic (age, gender, family composition, geography)

• Reason for referral: symptoms and behaviors, (including duration/intensity) and level of functioning

• Treatment history

• Social history/environment

• Strengths and exceptions

• Clinical rationale—why this level of service is indicated at this time

• Discharge criteria, plan and timeline—how will progress be measured, and what measurable outcomes will be achieved
Multi-axial Assessment

- ICD9 is used as it is consistent with the federal Medicaid requirements
- Please update date of most recent assessment
- Use the dark blue box to find the ICD9 code. Search by DSM code or descriptor
- Primary diagnosis
- Co-Occurring dx relates to mental health/substance abuse diagnosis
- Axis III text box is for medical issues
- Axis IV Psychosocial stressors—the dropdown menu asks for mild, moderate or severe descriptors
- Axis V Global Assessment of Functioning is a free text field. Please identify how the GAF has changed since last review
Symptoms and Behaviors

• Assessment Tools:
  • not needed for MH IOP
  • For substance abuse, complete the ASAM field and *be sure to update the date of the most current assessment at the top of the Assessment Tools section*

• Agency Involvement—please select all providers to the best of your knowledge

• Family Social Involvement—update all supports that apply and rate overall support of family and natural supports
Medications

- All medications, both psychiatric and medical, should be entered with the medication type

- In Additional Medication Info field, please indicate:
  
  • Names of any meds that have been discontinued since the last review, and any med changes that are planned in the near future but are not listed as current
  
  • A brief description of what meds will be stabilized at discharge, if known or planned
Clinical Indicators

• Use this page to describe *history* of symptoms/behaviors, check all that apply and indicate severity and history

• Since we also need a current snap-shot of symptoms/behaviors in the last 5-7 days, save this info for entering later into the Additional Information page
• Please complete the following fields:

• Is member receiving integrated MH/SA services?

• How long has member been receiving this service?

• Number of ER or crisis episodes within last 12 months?

• Number of Inpatient Admissions in Last 12 months (For either MH or SA)?
Treatment Plan

- Describe member’s strengths and skills—click on all that apply

- Fill in all sections with a *brief* summary or note (most of these fields address expectations, supports, or barriers in treatment)
Tip—Be Brief! Some of these fields allow only a limited number of characters.

- Problem statement—Behaviors/symptoms, frequency, duration, the settings or triggers when the problem occurs
- Long-term goal—At the end of IOP what change in symptoms/behaviors will be reduced or eliminated, at what functional or behavioral level will the client/member be?
- Short-term goal—Goals for the next 7 days. Describe the goal more in terms of the treatment, rather than the symptoms/behavior/functioning
- Progress since last review. Describe in a way that threads back through goals and presenting problems
- Interventions: Within IOP, identify some sub-interventions, including teaching skills, specific treatment modalities, or providers that are recommended in the goals sections. E.g.; Clinical risk assessment—1x daily; DBT group-1 hour/3x weekly; Individual therapy—1 hour/4x weekly

Each time you extend the service, please update all of these fields. If a treatment goal is no longer active, please indicate that either in the goal box as “Not Active” or the progress box as “Goal met.” You may also delete the goal altogether, as it will be in prior CSRs for reference.
Transition Discharge Plan

- What is specific discharge plan and date? Identify barriers to discharge
- Check boxes that apply for anticipated step down services. If you know the date of the 1st appointment, please include it
- Plan for Transition Discharge. This is an important field, and it is needed in every review. Please include the following:
  - Specific but brief description of what symptoms/behaviors/functioning will be improved.
  - How will progress be measured?
  - How will the frequency or intensity of the interventions be phased out or reduced over time?
  - What services will be recommended after discharge?
  - What are the current or expected barriers for discharge?
  - If another service is recommended, what is the status of the referrals?
  - If the client/member will be discharged into the care of a caregiver, who are those supports (not by name, but generally describe the relationship; e.g., biological parents, foster family, adult sibling)?
  - If discharge is planned before treatment goals are achieved, or if discharge is happening unexpectedly or against advice of provider, please explain.
Additional Information

• Include a brief summary of the progress in the past 7 days with a focus on the risk/safety issues and the behaviors that precipitated the service

• Plans for the upcoming review period

• Factors that are impacting treatment (negatively or positively) and how those will be addressed

• If a discharge had been planned for the prior review period and it is decided that the member needs to continue, please explain the barriers or new factors that contribute to that

• There is a tendency for providers to describe the client/member’s history in detail or to describe the client/member or family’s needs in this field in detail. If the need for this level of service has already been established, we only need a brief description of history if it directly impacts this episode of care.
Additional Information

- Treatment Progress menu—select progress in last 7 days

- In the text box, please describe the progress in terms of:
  
  - *How is IOP benefiting the member?*
  
  - If progress is minimal, briefly describe factors or barriers
  
  - In what areas the member has progressed and in what areas progress is slower or not happening?
  
  - Have there been or will there be any adjustments to the delivery of service that will support progress?
  
  - Has there been a change in the family’s knowledge, skills, or ability to support member during or after treatment?
APS Contact Information
1-866-521-0027

• **Option 1 Provider Relations**
  • for technical support or to make administrative changes

• **Option 3 Member Services**
  • you may give this phone number to the member/family if they have questions about an authorization

• **Option 4 Clinical Care Manager**
  • questions about clinical documentation

• **Email:** mainecare-prov@apshealthcare.com