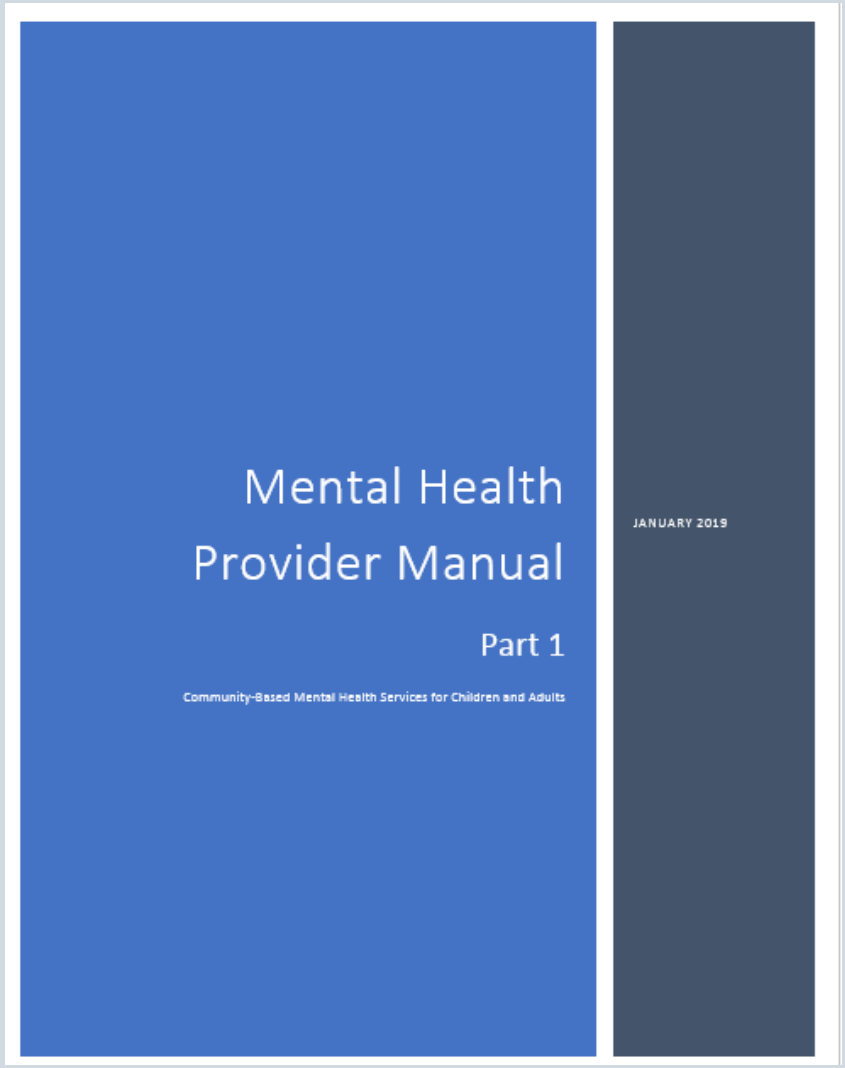
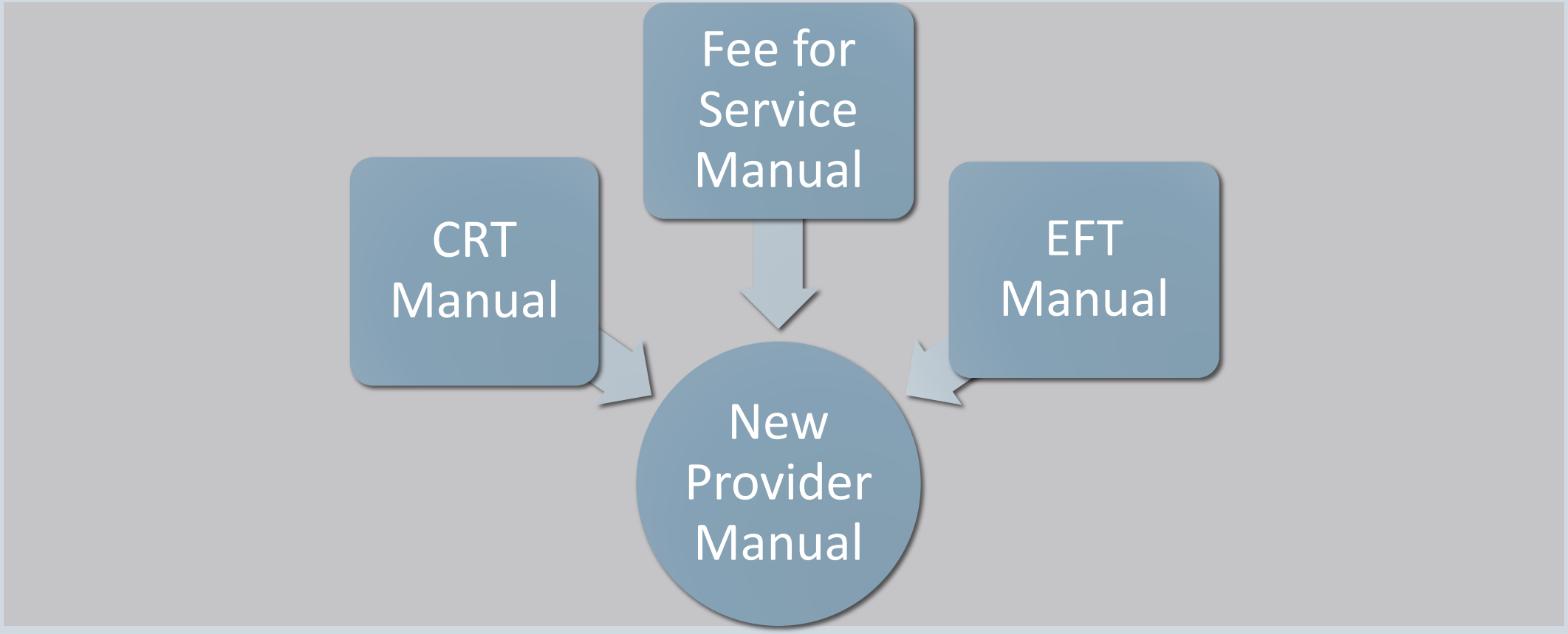


Policy and Procedure Impacts

Multiple Manuals Combined Into One



Notable Policy Impacts

Place of Service Limitations were eliminated

Concurrent billing issues were alleviated

Set **minimum standards** for documentation for all services

Threshold billing parameters set for services to qualify as a billable

Bolstering the Assessment Process

- All clients, **child and adult must be reassessed every two years**
- **All assessments must have a face to face component** by a Master's level, **or BA level intern** providing clinical services through a formal internship as part of a clinical Master's level program, non-licensed, rostered clinical staff may provide therapy services, including clinical assessment under supervised billing rules

Child and Adolescent Needs and Strengths tool (CANS)

- **CANS** for all children/youth accessing IHCBS (CANS has replaced the CBCL for this purpose)
- CANS is the chosen standardized tool for CYF Value-Based Payment and agencies should be working toward broad adoption throughout 2019

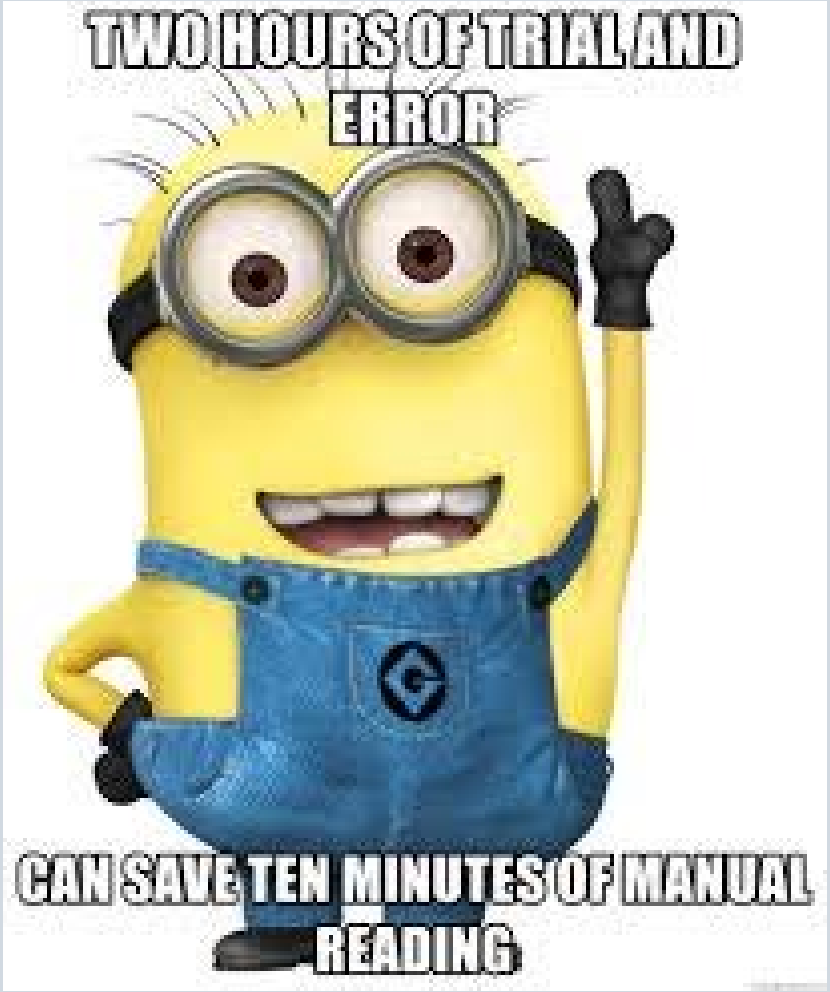

TWO HOURS OF TRIAL AND ERROR
CAN SAVE TEN MINUTES OF MANUAL READING

Table of Contents is your friend

CONTENTS

All Covered Services Have A Standard Layout

3.11 DAY SERVICES

Target Group: Individuals in CRT

DEFINITION

Community-based services may be provided in a Day Service environment, where group recovery activities are provided to adults in a milieu that promotes wellness, empowerment, a sense of community, personal responsibility, self-esteem and hope. These activities are client-centered. Day Services should provide socialization, daily skills development and crisis support, and promote self-advocacy. These services can be provided by peer providers if employed by the agency, or by clinical staff.

CONDITIONS OF COVERAGE

Days Services are not eligible to draw down the case rate as a stand-alone service. Day Services are reserved for adults in CRT who are receiving other qualifying mental health services.

DOCUMENTATION REQUIREMENTS

A chronological log of all Day Services encounter data which identifies the client, service provided, person delivering service, the date of service, place of service, and duration of time. Indication in the monthly summary note that the client received a Day Service.

STAFF QUALIFICATIONS

The service must be provided by staff of the Designated Agency/Specialized Services Agency, Peer Providers, or a qualified provider subcontracted by the Designated Agency/Specialized Services Agency who, based on their education, training, or experience, is authorized by the Designated Agency's/Specialized Services Agency's Medical Director as competent to provide the service.

Each Service States Whether it Counts Towards Case Rate Billing and the Threshold to Qualify

3.9 COMMUNITY SUPPORTS

CONDITIONS OF COVERAGE

For group community support, there must be no less than one staff member to every four (4) individuals present.

The minimum duration for a Community Support service encounter to be allowable for case rate billing is 15 minutes accumulated in one day.

Community supports do not include

- daily living and social skills interventions that are provided through the nursing facility Medicaid per diem,
- vocational and educational service activities.

Transportation that includes goal-oriented community support time with the individual can be coded as an encounter.

The service must be authorized in the consumer's Individualized Plan of Care[25].

Services Not Qualifying for Caseload Count -Example

3.10 SUPPORTED EMPLOYMENT

CONDITIONS OF COVERAGE

Supported employment services must be delivered in conjunction with one or more covered services listed in Section 3.1. Encounter data is required, however this service alone does not qualify to draw down the case rate regardless of duration.

Supported employment must be authorized in the consumer's Individualized Plan of Care. For specifics please see Individualized Plan of Care (IPC) Timelines and Required Components in Section 4.5 Care Planning of this document.

3.3 FACILITY-BASED CRISIS STABILIZATION AND SUPPORT SERVICES

All Covered Services Detail the Documentation Required to Support the Service

CONDITIONS OF COVERAGE

Crisis stabilization and support services must be provided under the supervision of a Medicaid-enrolled physician or licensed mental health practitioner affiliated with the DA. This service is allowable for case rate billing without a prescription in the individual treatment plan.

The minimum encounter to be allowable for case rate billing is defined as completion of intake into the facility. Staff will continue to document one encounter per day of Crisis Stabilization and Support Services until discharge.

DOCUMENTATION REQUIREMENTS

Crisis stabilization and support service needs must be documented upon admission, per shift and/or per 8-hour period of crisis stabilization, and upon discharge for all emergency community support services. Services requiring a qualified provider under supervised billing guidelines must be documented by the qualified provider following appropriate service documentation guidelines (i.e.: Medication Consultation, Individual Therapy, etc.)

If crisis stabilization and support service admission and discharge occur within the course of an 8-hour period, documentation may abbreviate admission, shift, and discharge information into a summary overview note to reflect the brief course of care.

Crisis stabilization and support services must include, in summary form:

Admission Documentation

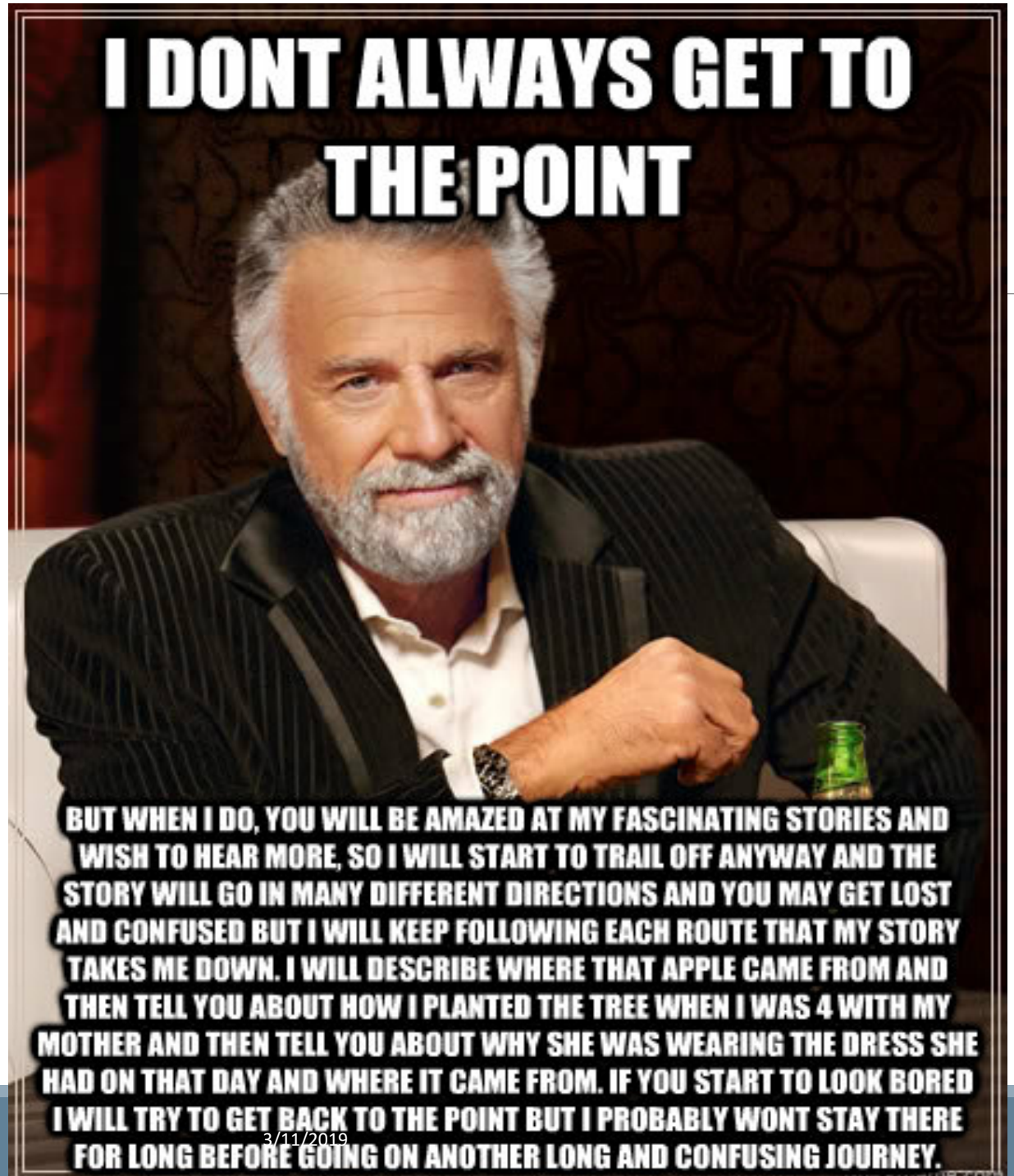
- A description of the precipitant crisis or behavioral/psychiatric decompensation (e.g. observation of behavior supporting crisis stabilization).
- An assessment of treatment needs or anticipated benefits of proactive clinical intervention.
- A plan for treatment (e.g. issues to be addressed or discussed).
- Level of Care Utilization System (LOCUS)

Per shift and/or 8-hour period of ongoing crisis stabilization

- A log or record of observations made of the individual (e.g. behavioral or psychiatric indicators for ongoing crisis stabilization).
- A log or record of the interventions used and the individual's response.
- The clinician's assessment of the issues/situation/risks.
- An ongoing plan for crisis stabilization.

Where can I find service information boiled down for quick reference?

Provider Manual Section 4.7



- 4.7 Documentation Requirements
  - General Requirements

Billing Criteria	Minimum Clinical Documentation Required	Encounter Data to Support Clinical Documentation	Provider Qualifications
A01 --SERVICE PLANNING AND COORDINATION			
Target Population: All Global Commitment to Health Enrollees **Minimum duration for payment:** **15 min** accumulated in one day **Billable Encounter:** Yes	**Monthly Summary Note** -Clinical intervention used -Summary of major content or intervention themes consistent with treatment goals; -Observations made of the individual or responses to interventions; -Assessment of progress toward treatment goal; -Ongoing Needs for continued intervention and plan. *If more than one service is provided during the month, only one progress note containing all the services provided for that individual is required*	**Chronological log of all Service Planning and Coordination services provided** Multiple service coordination contacts in one day by the same provider for the same client can be gathered into one service encounter log. All encounter data must include: -Client Identification -Name of Service -Staff Providing Service -Date of Service -Duration of Service -Location of Service	Vermont Medicaid-enrolled provider consistent with their licensed scope of practice or by a DA/SSA staff member who, based on their education, training, or experience, is determined competent to provide the covered service by the Medical Director of the DA/SSA and whose work is directly supervised by a qualifying provider.

Is Group Living a service that qualifies to bill the case rate?

Where are the two places in the manual to find this answer?

Standardized Crisis Bed Service Documentation

- Crisis bed service encounters are documented in days and are counted as a service once there is completion of the intake
- Crisis bed service encounter includes Service Coordination and Community Supports, therefore these services do not require documentation by crisis bed staff separate from the shift note or additional MSR submission of A01 or B01 codes during the client stay
- Therapy or medication services which require a licensed clinician medical provider must be documented separately and signed by the staff providing that service in line with all clinical documentation standards including supervised billing if applicable
- There are no longer any limitations with concurrent billing while clients are in the crisis bed. If a case manager takes a client out they should document that time. If a therapist sees the client, or a psychiatrist for a med check they must document that time as an encounter and provide a clinical note that is signed.

Standardized Adult Residential/ Group Living Service Documentation

- ❑Adult residential service encounters are documented in days
- ❑Adult residential service encounter includes Service Coordination and Community Supports, therefore these services do not require documentation by residential staff separate from the shift note or additional MSR submission of A01 or B01 codes by residential staff during the client stay
- ❑Therapy or medication services which require a licensed clinician medical provider must be documented separately and signed by the staff providing that service in line with all clinical documentation standards including supervised billing if applicable
- ❑There are no longer any limitations with concurrent billing while clients are in the residential setting. If a case manager takes a client out they should document that time.

(This is important as it may be the only qualifying service for the month!)

General Service Provision Rules

Section 4 Covers the General Service Provision Guidelines

- 4. DA/SSA DELIVERY SYSTEM REQUIREMENTS
- 4.1 ELIGIBLE PROVIDERS
- 4.2 MEMBER GRIEVANCE AND APPEALS
- 4.3 ACCESS TO CARE
- 4.4 SCREENING AND ASSESSMENT
- 4.5 CARE PLANNING
- 4.6 PROVIDER OWNED AND CONTROLLED RESIDENTIAL SETTINGS
- 4.7 DOCUMENTATION REQUIREMENTS
- 4.8 COLLABORATION AND INTEGRATION WITH OTHER PROVIDERS

Treatment Plans

IPC Components were reviewed, streamlined and aligned across programs

Section 4.5

The IPC must contain the following components:

Goals: A statement of the overall, long term desired results of service interventions, expressed in the individual's words as much as possible.

In addition the goals should reflect evaluation and/or other assessments, and at least one goal must reflect mental health treatment needs.

Objectives: The action steps that help people move toward realizing their long-term goals and describe the specific changes in behavior, function and/or status that would indicate progress toward the long-term goal;

are observable, measurable and achievable, using language that is understandable for the person served;

include specific time frames for achieving/assessing progress.

Interventions: A description of the actions used to achieve each objective. For each intervention identify

who- The responsible person or role providing the intervention. This could include staff, family and/or natural support network;

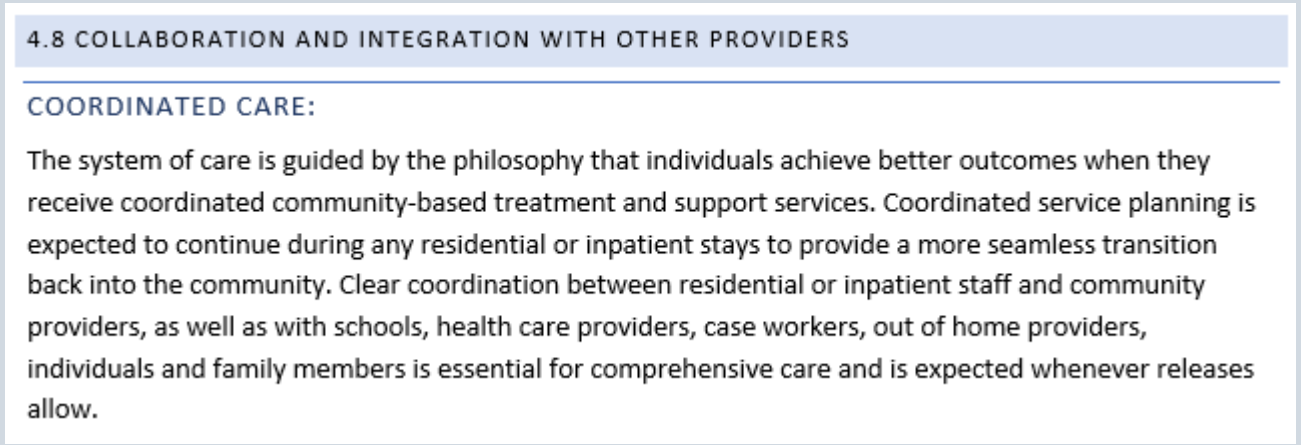
what- The specific service to be provided;

when- The frequency and duration. It is acceptable to identify a range of treatment frequency for planned services or interventions. PRN or "as needed" frequency should be reserved for emergent or episodic service delivery.

Crisis plan: When indicated, a proactive crisis plan or WRAP (using Copeland's Wellness Recovery Action Plan) will be developed with the individual in collaboration with their identified family or support persons as requested.

Collaboration and Integration

Guidance on the expectations for coordinating care when releases allow can be found in SECTION 4.8



4.8 COLLABORATION AND INTEGRATION WITH OTHER PROVIDERS

COORDINATED CARE:

The system of care is guided by the philosophy that individuals achieve better outcomes when they receive coordinated community-based treatment and support services. Coordinated service planning is expected to continue during any residential or inpatient stays to provide a more seamless transition back into the community. Clear coordination between residential or inpatient staff and community providers, as well as with schools, health care providers, case workers, out of home providers, individuals and family members is essential for comprehensive care and is expected whenever releases allow.

If a client is an inpatient or residential setting, can the sending DA bill for Service Coordination provided to that individual during that time?

If an individual served by CRT in one agency receives outpatient therapy at a different DA/SSA, can both agencies count that individual toward their monthly case rate, or is it only whoever bills first in the month?