



# MEDICAL ASSISTANCE BULLETIN

COMMONWEALTH OF PENNSYLVANIA • DEPARTMENT OF PUBLIC WELFARE

ISSUE DATE

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EFFECTIVE DATE

March 1, 2001

NUMBER

\* See Below

SUBJECT

Reminder to Providers Who Prescribe Behavioral Health Rehabilitation Services of Documentation Requirements.

BY

*Peg J. Dierkers*  
Peg J. Dierkers, Ph.D.  
Deputy Secretary for Medical Assistance Programs

## Purpose:

To remind all Medical Assistance (MA) enrolled prescribing providers, i.e., psychiatrists and licensed psychologists:

1. Of the requirement that they must provide appropriate medical information and documentation in order for the Department of Public Welfare (Department) to evaluate the medical necessity for Behavioral Health Rehabilitation Services (BHRS).
2. That when documentation fails to justify the medical necessity of the MA recipient's need for these services, a prospective denial of services or retrospective restitution of payment to the Department will occur.
3. To remind providers that they are responsible for prescribing medically necessary services based on individual's needs.
4. To inform MA enrolled prescribing providers that this bulletin does not change any requirements that have been set forth in previous MA bulletins related to BHRS services.

## Scope:

This MA bulletin applies to all enrolled MA providers who prescribe BHRS to MA enrolled children under 21 years of age and who are paid through the fee-for-service or behavioral health managed care delivery systems.

## Background

Effective March 1, 2001, the Department implemented a prior authorization process for Therapeutic Staff Support (TSS) services, which are a component of BHRS. Since that time, the Department has been sending documentation deficiency checklists to the service providers detailing problems related to specific documentation requirements for these services. Documentation deficiencies have been identified in all of the following areas: Psychiatric and Psychological Evaluations, treatment history, mental status examinations, child and family strengths, current services being utilized, new services being requested and information related to active treatment and coordination of care. The Department requires this information in order to determine the medical necessity for TSS services.

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COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The Appropriate toll-free number for your provider type

Visit the Office of Medical Assistance Programs website at [www.dpw.state.pa.us/omap](http://www.dpw.state.pa.us/omap)

**Discussion:**

After review of prior authorization requests for TSS services, the Department has determined the need to remind prescribing providers of the importance in providing clear, accurate, concise, and timely information and documentation in order to assist the Department in determining the medical necessity of request (for TSS).

**Procedure:**

The most recent face-to-face strengths-based Psychiatric or Psychological Evaluation or re-evaluation, a detailed treatment plan, a complete Plan of Care Summary, and the Interagency Services Planning Team (ISPT) meeting signature sheet are required in order for the Department to evaluate the medical necessity for requested TSS services.

At this time, the Department is reiterating that the prescribing provider must submit the required information in a manner that *allows* for a timely and efficient review of the request for TSS services through the Department's Prior Authorization process.

Evaluation of the of documentation will take the following three criteria into account:

1. Level of Care
2. Documentation supporting the need for services
3. Active Treatment

1. Level of Care: Level of care is the intensity of the requested services in relation to the degree of the individual's behavioral health needs. The intensity of service represents the number of hours per week requested for the prescribed service. The purpose of reviewing for level of care information is to determine if the service intensity being requested is consistent and appropriate for the child's safety and behavioral issues.

Documentation will be reviewed for evidence that the requested hours per week reflect the requested level of *therapeutic services* the child is to receive, any *safety issues* and the degree of psychiatric impairment. Therapeutic services are individual one-to-one, face-to-face interventions to treat a behavioral health need. Safety issues encompass any signs of endangerment or other catastrophic event that exacerbates the child's behavioral symptoms or impacts the parent's ability to manage the child's behavior. Degree of psychiatric impairment relates to diagnosis or severity of the individual's behavior health needs.

All requests are reviewed in relation to whether the request is an initial request or a continued care request. If the request for service is a continued care request, it is reviewed in relation to hours being the same, more or less than previously requested and in relation to the child's progress or lack thereof.

2. Documentation Supporting the Need for Services: Documentation is information, which supports the service requested. Submitted documentation will be reviewed for evidence that the information explains the rationale for why TSS services rather than other more traditional outpatient treatment services are being requested; describes how the TSS service is anticipated to assist with the child's needs; describes the child and family relationship and their integration into the community; provides a complete treatment history; a diagnosis; a detailed treatment plan with measurable goals and objectives; and any involvement of an interagency team.

Supporting documentation will be reviewed for evidence of the following:

*Psychiatric/Psychological Evaluation* is expected to outline specific elements of medical necessity and absence of need for psychiatric hospitalization. The evaluation includes a description of the child and the behavioral health problems he or she is experiencing, diagnoses in all Diagnostic Statistics Manual (DSM) five axes, current services being received, and a specific recommendation for TSS services, as well as a complete description of the child in relation to his family and community.

The documentation will be reviewed for evidence that the psychiatric/psychological evaluation includes, at a minimum:

- (a) *Identifying information* that fully describes the child:
    - i. Name
    - ii. Age
    - iii. Sex
    - iv. Race
    - v. Family Members
    - vi. Place of residence (family home, group home, RTF, etc.)
    - vii. Involvement with other child-serving systems, such as Children and Youth Services or Juvenile Justice
    - viii. School information, including but not limited to, current grade, grades repeated, eligibility for special education and educational programs previously or currently tried
    - ix. Developmental history, including relevant prenatal history, early milestones, identification of any early illnesses or injuries
  
  - (b) *Treatment History* that provides description of specific mental health or behavioral health rehabilitation services previously provided to the child including, but not limited to, inpatient psychiatric hospitalization, psychiatric partial hospitalization, outpatient clinic services, family-based mental health services, medications, residential treatment facility services, drug and alcohol services, mental retardation services, behavioral health rehabilitation services such as TSS and Mobile Therapy. The Treatment History is expected to include the child's response to treatment.
  
  - (c) *Mental Status Examination (performed during a face-to-face evaluation)* that includes evaluation and documentation of:
    - i. Presence/Absence of homicidal ideation
    - ii. Presence/Absence of suicidal ideation, which includes a plan, signs of self-injurious behavior, threats or attempts
    - iii. Presence/Absence of psychosis, which includes thought content, and any impairment of thinking secondary to mental retardation, developmental delays or organic causes.
      - a. Orientation to person, place and time.
      - b. Manner of Relating, which includes activity level, distractibility, inattentiveness, or aggressiveness.
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- c. Goals and ideas, which includes description of the child's, if age appropriate, ideas and understanding of the treatment goals, specific concerns, family relationships and desires for the future.

(d) *Child and Family Strengths:*

- i. The child's and family's strengths and resources
- ii. The situations, times, and places when the child functions effectively without support
- iii. Each family member's ability to support each other and the child in coping with the child's emotional disturbance
- iv. Inter-relationships between family members
- v. The other community supports used by the child and family, such as YMCA, Big Brothers, 4-H, etc.

(e) *Current Services:*

- i. List the types of services (mental health, mental retardation, drug and alcohol, etc.) and the frequency, location and length of time the child/family are receiving each service and the child/family's response to the services
- ii. If TSS or other behavioral health rehabilitation services are currently being provided to the child and family, include: all behavioral health rehabilitation services being provided (i.e., Mobile Therapy, Behavioral Specialist Consultant), settings where services are provided, intensity (frequency, length of time of each intervention, etc.), goals and objectives of the services, clinical relationship to other behavioral health rehabilitation service, and the child's response to treatment
- iii. Medication: If the child is receiving psychotropic medication, list the name of the medication, dosage, presence of side effects and effectiveness. If the child has a diagnosed disorder that is responsive to treatment by medication, but is not taking medication, explain why medication has/is not been used.

(f) *Diagnoses in all five axes:*

- i. Axis I – Major Mental Health Disorders, Drug and Alcohol problems\*
- ii. Axis II – Developmental Disorders, Personality Disorders\*
- iii. Axis III – Physical illnesses\*
- iv. Axis-IV – Psychosocial Stressors\*
- v. Axis V – Children's Global Assessment Scale\*

- There must be an entry for all axes. AT A MINIMUM, there should be a diagnosis in either Axis I or II. If no diagnosis applies for a particular axis, please identify with "N/A".

- (g) *Recommendation for TSS services* that specify the number of hours per week of TSS services determined to meet the child's behavioral health needs, specific settings in which TSS services will be provided, and specific interventions and goals to be achieved through delivery of TSS services.

(h) *Other Recommendations*

Other treatment recommendations, global and specific (e.g., other needed services, interventions for the team to consider; psychotropic medication referral or recommendation; additional assessment(s); community referral(s) and natural supports; consultation with primary care physician).

3. Active Treatment: Active Treatment documentation provides evidence that the child and family are receiving (or will receive if the requested service is approved) effective treatment for the child's behavioral health needs. This documentation will be reviewed for evidence of: caretaker and child participation in the development of the care plan; coordination of care; documentation of clinical improvement or a plan to achieve such improvement; specific goals and objectives for school, home and community-based TSS services and the use of medication if appropriate.

- (a) The treatment plan includes a summary of the goals, objectives, and behavioral interventions proposed to address the child's behavioral health issues in the environments in which the child exhibits a behavioral health treatment need; an explanation of the appropriate settings and time allocations for the TSS worker; and a description of any changes or updates from previous treatment plans in sufficient detail for the reviewer to fully understand the planned goals, objectives, and interventions and their clinical relationship to each other. The individualized treatment plan interventions are to be based on the child and family's strengths specific to the child/family and not on "typical" interventions used for a certain diagnosis. The supporting documentation will be reviewed for evidence that the treatment plan includes, at a minimum:
- i. *Specific goals for the child and family* and the services requested to meet the goals.
  - ii. *Measurable and/or observable objectives and target dates* to be reached by the child and family in order to meet the above identified goals, specific to the environment within which the child's interventions will occur (e.g., school, home, community setting, etc.).
  - iii. Specific interventions to be used in order to reach the identified objectives and goals, specific to the environment within which they will occur, identifying: the person performing the intervention(s), specific intervention(s) to be used, the setting where the intervention(s) should be used, and specific intervention(s) planned to encourage child and family independence in the management of the behavioral health interventions.
- (b) *Updating of previous treatment plans* to address progress (or lack thereof) toward accomplishment of previously identified goals and/or objectives, new interventions to be used to reach previously identified objectives and identification of new goals, objectives and interventions.
- (c) *Signature(s) of parent/guardian and child if 14 years of age or older* that signifies their input in the development of and agreement with the treatment plan. If a signature cannot be obtained, an explanation for why the signature is not present should be included.

- (d) Caretaker/Child Participation – Following Child and Adolescent Services System Program (CASSP) principles, services planned are expected to be child centered and family focused, with the family and the child participating in all stages of decision making and treatment planning. Evidence of this participation is reflected by including the parent and child in the evaluation process, at ISPT meetings, the development of the treatment plan and concurrence of the need for a TSS worker to deliver the planned interventions.
- (e) Coordination of Care – The CASSP principles involve a collaboration of multiple systems in order to build on the strengths of the child, family, and community. The collaboration is to result in use of the most appropriate, least restrictive, and least intrusive service available to meet the child and family's needs. Representatives from each system are to participate in goal development. The documentation will be reviewed for evidence of collaboration that includes, at a minimum:
  - (i) *An ISPT Meeting within 60 Days prior to Service Start Date.* Documentation provides evidence that the multi-system approach to treatment is being utilized currently for this child's services, unless this is an initial ISPT, and agreement or disagreement with the planned treatment by the parent, child, and all involved agencies including the county MH/MR representative.
  - (ii) Signature (or documentation of participation by phone) on the ISPT sign-in sheet (Attachment 1). If a signature cannot be obtained, an explanation for the reasons why the signature is not present should be included. Interventions discussed at ISPT meeting should also be included.
  - (iii) Plan of Care Summary to identify contact/responsible person for each service identified (including Children and Youth caseworker, juvenile probation officer, outpatient clinic, outpatient therapist, etc.)
- (f) Clinical Improvement – Clinical improvement is measured by attainment of, or movement towards attainment of, identified goals and objectives through evidence of ongoing assessment and monitoring of the status of progress must be documented.