Treatment and Supervision Documentation Guidelines for New Mexico Medicaid Providers

Learning Objectives

Participant will be able to:

1. Identify at least 4 important documentation elements of a treatment plan
2. Discuss and name at least 5 treatment and service record guidelines
3. List the requirements of a clinical supervisor in the State of New Mexico
4. Summarize at least 3 best practices of clinical supervision documentation

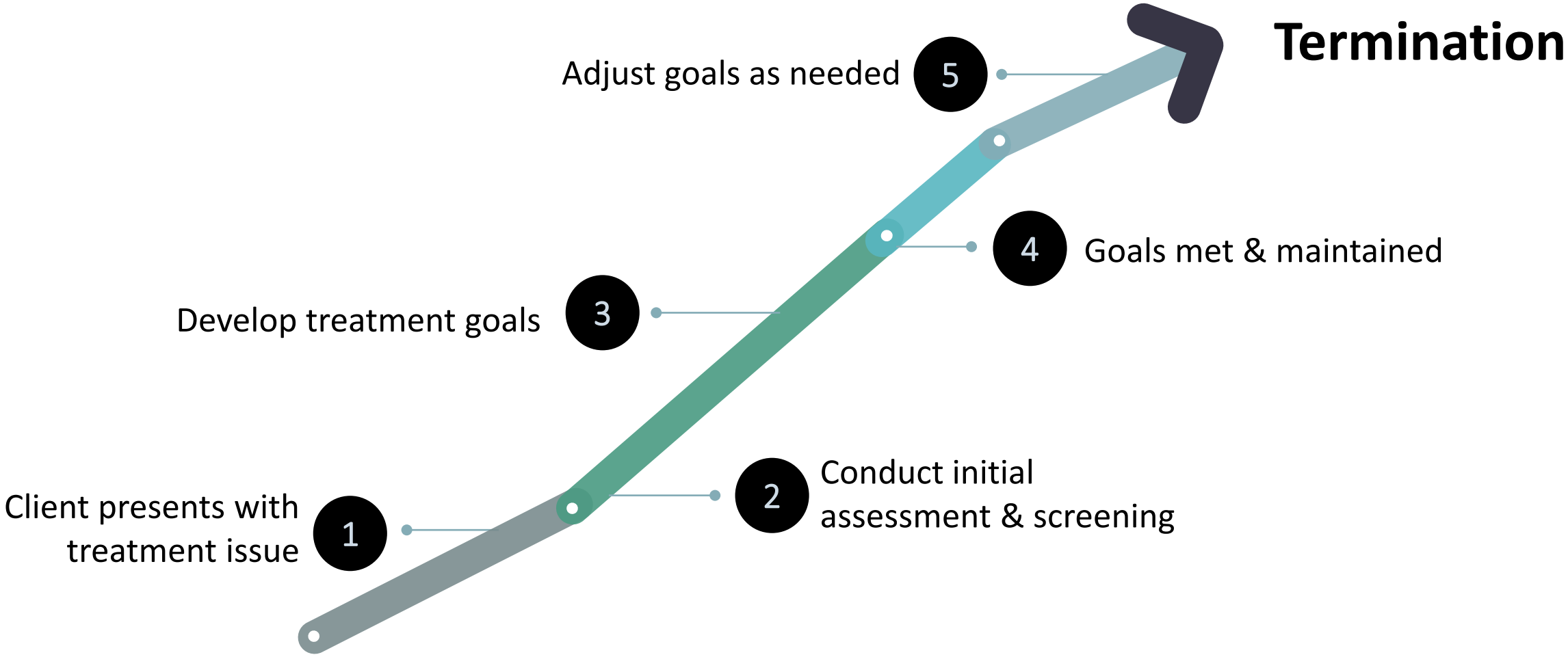
Treatment Documentation

Benefits of Strong Documentation

*"Consistent, current and complete documentation in the treatment record is an **essential component** of quality patient care."*

(National Committee for Quality Assurance [NCQA], n.d.)

Treatment Roadmap



Treatment or Service Plan Documentation

Elements of a Care Plan/Treatment Plan/ Individual Service Plan

All treatment plans should be **client-centered** and **strengths-based**. Essential components of a treatment plan include…

- Presenting Issue
- Specific Interventions and Modalities
- Barriers/Challenges
- Individualized Goals
- Supports/Strengths
- Cultural Considerations

When a Goal is Created Ask Yourself…

*"At the time of re-evaluation will the patient and I be able to know **unequivocally** if this goal has been met?"*

S.M.A.R.T. Goal Development

As you are collaborating to develop **client-centered goals**, ask yourself if the goals are...

S pecific

M easurable

A ttainable

R ealistic

T ime-based

(Doran, 1981)

Reasons to Use S.M.A.R.T. Goals

Higher client engagement

Greater adherence & improved outcomes

Identification of barriers & successes

Improved communication with other providers

Improved communication with MCO/MCE

Supports MNC determination & relevance to current situation

(Doran, 1981)

Developing Treatment Goals & Documenting Progress: Best Practices

Goals/objectives are written using the S.M.A.R.T. format

Document the date goals were initiated

Measurable goals that are adjustable over time to show incremental progress/regression

Documentation shows it's benefitting the client and meeting Medical Necessity Criteria

Discuss plans/interventions for ongoing sessions

Progress notes must be tied to specific goals/interventions

Progress Note Tips

Important Tips for Progress Note Documentation

- Always **double check** your spelling, punctuation, and fluency of the notes
- Notes should be **clear and concise**
- Do **not** use **"cookie cutter" notes** by copying previous notes
- Each note must be **original and specific** to that particular session
- The medical record must contain documentation showing the **differences** and the **needs** of the patient for each visit or encounter
- Exact **start and stop times** of the face-to-face service with patient present

Important Tips for Progress Notes Documentation

- Best practice is to write notes **concurrent** in session
- If unable to write notes in session, best practice for notes to be written **within 24 hours**
- Simply **changing** the date on the Electronic Health Record without reflecting what occurred during the actual visit is **not** acceptable
- Ensure Electronic Health Record accurately reflect the client's current needs and services

> ***"You may not add late signatures to medical records (beyond the short delay that occurs during the transcription process)."***
>
> (Centers for Medicare & Medicaid Services and the Medicare Learning Network, 2022)

Treatment and Service Record Guidelines

THESE GUIDELINES ARE ADOPTED FROM THE NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) GUIDELINES AND WILL ALSO INCLUDE OTHER NEW MEXICO SPECIFIC GUIDELINES.
IN THIS SECTION.

Treatment and Service Record Guidelines

1. Each page in the treatment plan/individual service plan/care plan contains the **patient's name or ID number**

2. Each record includes the patient's:
   - Address
   - Employer or school
   - Home and work telephone numbers
   - Emergency contacts
   - Marital or legal status
   - Appropriate consent forms and
   - Guardianship information (if relevant)

(NCQA, n.d.)

Treatment and Service Record Guidelines

3. All entries in the treatment record are **dated**; include the responsible clinician's **name, signature, professional degree**; and relevant identification number (if applicable)

4. The record is **legible** to someone other than the writer

5. **Medication allergies, adverse reactions, and relevant medical conditions** are clearly documented and dated
   - If the patient has no known allergies, history of adverse reactions or relevant medical conditions, this is prominently noted

(NCQA, n.d.)

Treatment and Service Record Guidelines

6. **Presenting problems**, including relevant **psychological and social conditions** affecting the patient's medical/psychiatric status and the **results** of a mental status exam

7. **Special status situations** such as imminent risk of harm, suicidal ideation, crisis plans documented, or elopement potential (when present) are prominently noted, documented, and revised in compliance with written protocols

8. Each record indicates what **medications have been prescribed**, dosages of each, the dates of initial prescription or refills, adherence to medication regiment and interventions, and documentation of medication education

(NCQA, n.d.)

Treatment and Service Record Guidelines

9 A **medical and psychiatric history** is documented, including previous treatment dates; practitioner identification, therapeutic interventions and responses; sources of clinical data, and relevant family information

For **children & adolescents**, please include past medical & psychiatric history (prenatal & perinatal events) and a complete developmental history (physical, psychological, social, intellectual, & academic)

For **patients 12 & older**, documentation should include **past & present use** of cigarettes, alcohol, and drug use (illicit, prescribed, and over-the counter) including if patient has substance use disorder, and there is evidence of Medication Assisted Treatment or discussion about it.

(NCQA, n.d.)

Treatment and Service Record Guidelines

10 A **DSM-5-TR/ICD 10 diagnosis** is documented and consistent with the presenting problems, history, mental status examination, and/or other assessment data

11 Treatment plans are **consistent** with diagnosis:

- Have **objective, measurable goals** with estimated time frame for goal attainment or problem resolution
- Include a preliminary **discharge** plan (if applicable)
- Include **continuity and coordination of care activities** between the primary clinician, consultants, ancillary practitioners, and health care institutions (as appropriate)

(NCQA, n.d.)

Treatment and Service Record Guidelines

12 **Informed consent** for medication and the **patient's understanding** of the treatment plan are documented

13 Progress notes describe the patient's **strengths** and **limitations** to achieving treatment plan goals/objectives and reflect treatment **interventions** that are **consistent** with goals/objectives

14 Documented **interventions** include continuity and coordination of care activities, dates of follow up appointments, and discharge plans

(NCQA, n.d.)

Frequently Asked Questions

1. What date(s) need to be on my session notes?

   You must have the date of service (DOS) and the date you actually sign the note. If you write and sign the note on the DOS, you will have the same date next to your signature as the DOS.

2. Can I use the scheduled appointment time on my notes?

   No. You must indicate the exact beginning and ending times of the session. Clients may be late or may end appointments early, so notes must indicate the face-to-face time with clients when you are rendering service, not just the scheduled appointment time.

3. What makes a good session note?

   - Clinical interventions are documented as well as client responses to interventions
   - Interventions are aligned with the treatment plan (support why that intervention was used)
   - Document what you plan to do in future sessions (not just “further sessions as needed”)

Treatment Documentation Resources

- **Treatment and Supervision Documentation Checklist**

- **New Mexico Administrative Code (NMAC), Section 8.321.2**
  https://www.hsd.state.nm.us/wp-content/uploads/FileLinks/5f2c7ec62d6f427eb1d7b4f710cb7367/8.321.2.pdf

- **Behavioral Health Policy and Billing Manual: For Providers Treating Medicaid Beneficiaries**
  https://www.hsd.state.nm.us/providers/behavioral-health-policy-and-billing-manual

Clinical Supervision Documentation for Medicaid Providers

Clinical Supervision Requirements For Non-Licensed Staff

What is Clinical Supervision

- Includes “observation, evaluation, feedback, facilitation of the supervisee’s self assessment, and acquisition of knowledge and skills”

- Provides “support, consultation, and oversight of patients’ treatment to include assessment of needs; diagnoses/differential diagnoses (MH, SA, and COD); clinical reasoning and case formulation; teaming with other stakeholders, treatment planning and implementation; refining treatment goals and outcomes; selecting interventions and supports; coordination of care; tracking and adjusting interventions”

- “Addresses the treatment staffs’ steps to ensure a client’s active involvement at all levels and that client voice and choice are clearly represented and documented”

- ”Assures that discharge planning starts at the initiation of treatment and is continually developed throughout treatment. The discharge plan assures ongoing support for the client’s continued recovery and success”

For full details visit: **Behavioral Health Policy and Billing Manual: For Providers Treating Medicaid Beneficiaries**

(New Mexico Human Services Department, 2021)

Clinical Supervision Requirements

- Clinical supervisor must be:
  - Approved by their respective professional licensing board as having met board requirements for clinical supervision. Please refer to **New Mexico Regulation and Licensing Department**
  - Have a minimum of 1 year documented supervisory experience and a minimum of 2 documented years of experience in clinical practice with the population for whom clinical supervision is being provided
- Supervision must be provided to all treatment staff a minimum of 4 hours a month
- Supervision can be in an individual or a group setting. Note: Individual supervision is required no less than 2 hours/month
- Must fulfill required documentation requirements

(New Mexico Human Services Department, 2021)

Supervision Documentation Required for Billing Medicaid Services

Requirements for Supervision Documentation

Supervision must be documented and include:

- Date of supervision session
- Name of supervisee or supervisees, if group supervision
- Duration/length of time in supervision
- Include ID numbers of patients discussed and outcome/next steps for each patient, if casing specific patients
- Any other content of the supervision session for their supervisee(s) which may include a professional development plan
- All documents pertaining to clinical supervision will be readily available to the supervisee

(New Mexico Human Services Department, 2021)

Clinical Supervision & Documentation Resources

- **Treatment and Supervision Documentation Checklist**

- **New Mexico Administrative Code (NMAC), Section 8.321.2**
  https://www.hsd.state.nm.us/wp-content/uploads/FileLinks/5f2c7ec62d6f427eb1d7b4f710cb7367/8.321.2.pdf

- **NM Behavioral Health Policy and Billing Manual: For Providers Treating Medicaid Beneficiaries**
  https://www.hsd.state.nm.us/providers/behavioral-health-policy-and-billing-manual

- **New Mexico Regulation and Licensing Department**
  https://www.rld.nm.gov/boards-and-commissions/individual-boards-and-commissions/

- **NM Behavioral Health Collaborative Clinical Supervision Implementation Guide**
  https://nmrecovery.org/wp-content/uploads/2022/10/Clinical-Supervision-Implementation-Guide-3.22.2019.pdf

- **ACES Best Practices in Clinical Supervision**
  https://acesonline.net/wp-content/uploads/2018/11/ACES-Best-Practices-in-Clinical-Supervision-2011.pdf

Thank you!

References

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- National Committee for Quality Assurance. (n.d.). *Guidelines for medical record documentation.* https://www.ncqa.org/wpcontent/uploads/2018/07/20180110_Guidelines_Medical_Record_Documentation.pdf