Ethical Considerations & Overview of Center for Medicare & Medicaid Services (CMS) Clinical Documentation Requirements

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Presenters

Samantha Fryer, MBA, CPHQ & Chris Labreche, BCBA

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Samantha Fryer

- MBA, Certified Professional in Healthcare Quality (CPHQ)
- 10+ years working with at-risk populations including children, youth, adults, and aging adults
- Operated in behavioral health care settings from outpatient wellness centers up to psychiatric crisis residential
- Extensive healthcare accreditation experience
- Providing clinical documentation training and expertise for 7+ years

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Chris Labreche

- MA SpEd
- Board Certified Behavior Analyst
- 13 years' experience working with children, adolescents, and adults diagnosed with Autism Spectrum Disorder
- Extensive training experience in ABA implementation
- 10+ years in the field of Applied Behavior Analysis

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Agenda

- Designated Medical Record Set
- Definitions
- Medical Necessity
- CMS Clinical Documentation Standards
- Management of Medical Records
- Documenting Parent Training Goals
- Billable services

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Course Objectives

- Participants will be able to define the components of a Designated Record Set, Medical Record, and Electronic Health Record
- Participants will be able to differentiate between examples of appropriate and not-appropriate clinical documentation
- Participants will be able to relate best practices in clinical documentation to the BACB Professional & Ethical Compliance Code for Behavior Analysts
- Participants will demonstrate an understanding of the importance of client consent to treatment and incorporating client voice in treatment

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Designated Record Set

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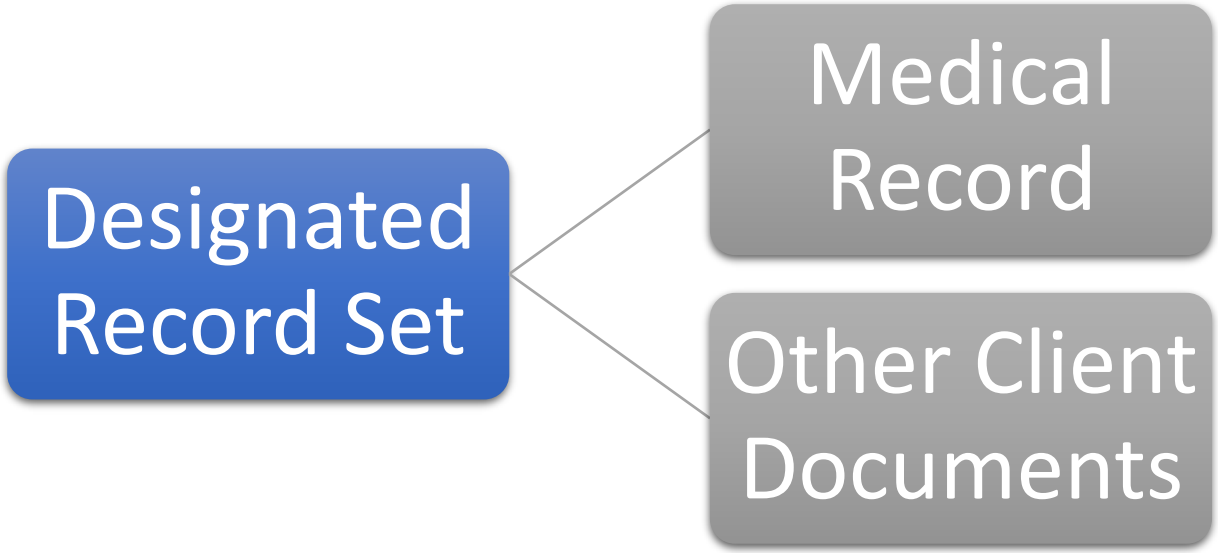
Client Record Set



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Definitions

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Designated Record Set (DRS)

A group of records that include protected health information (PHI) and that is maintained, collected, used or disseminated by, or for, a covered entity

Used to make decisions about the client's/patient's treatment

Used for claims adjudication and other nontreatment plan operations

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DRS Components

- Referral Records
- Scheduling Records
- Customer Service Records
- Complaints & Grievances
- Reportable Events
- Claims and Billing
- Client Billing Statements
- Legal Medical Record

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Legal Medical Record

Is a subset of the DRS focused on the treatment rendered, responses to treatment rendered, and all clinical work conducted.

Collection of information regarding a client and their health care that is created and maintained by provider and/or health care organization

Entries are made by a person who has knowledge of the acts, events, opinions, or diagnoses relating to the client/patient, and made at or around the time indicated in the documentation

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The Importance of a Medical Record

Provides clinical detail to support continuity of treatment within and across episodes of care.

Medical Records can be requested by clients at any time and are mutually owned by the client and the provider.

Medical Records are what is left after a service or episode of care, as the clinical documentation memorializes the services.

Healthcare Provider Entities are legally required to maintain medical records, and Legal Medical Records can be requested and subpoenaed.

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Medical Record Components

- Consent to Treatment
- Client Information Forms
- Treatment Authorizations
- Intake Report
- Assessment Report
- Progress Report(s)
- Treatment Plans
- Transition Report(s)
- Discharge Report
- Encounter/Session Notes
- Authorizations to Disclose
- Disclosures

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Electronic Health Record

An electronic version of a client's medical history, that is maintained by the provider over time, and may include all of the key administrative clinical data relevant to that persons care under a particular provider, including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports

(Source: Centers for Medicare & Medicaid Services)

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Signature & Credential

A signature and credential (e.g., John Doe, LCSW; Jane Doe BCBA) identifies the author or the responsible party who takes ownership of and attests to the information contained in a record entry or document.

Most often, this is the individual that rendered the healthcare service being signed.

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Authentication

The process that ensures that users are who they say they are. The aim is to prevent unauthorized people from accessing data or using another person's identity to sign documents.

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Protected Health Information (PHI)

Individually identifiable health information that is transmitted or maintained in any medium.

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Medical Necessity

The determination by a healthcare professional as to what medical services are required for a specific client in order for them to return to the most realistic level of functioning possible.

Services are Medically Necessary when:

- Treatment goals are achievable
- Interventions are likely to increase the ability of the client to be able to live more independently, and those interventions require a behavioral health professional/practitioner to provide them.
- Goals/objectives are not better addressed by other services (examples: Day Rehab, School, Special Education, etc.)

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Medical Necessity

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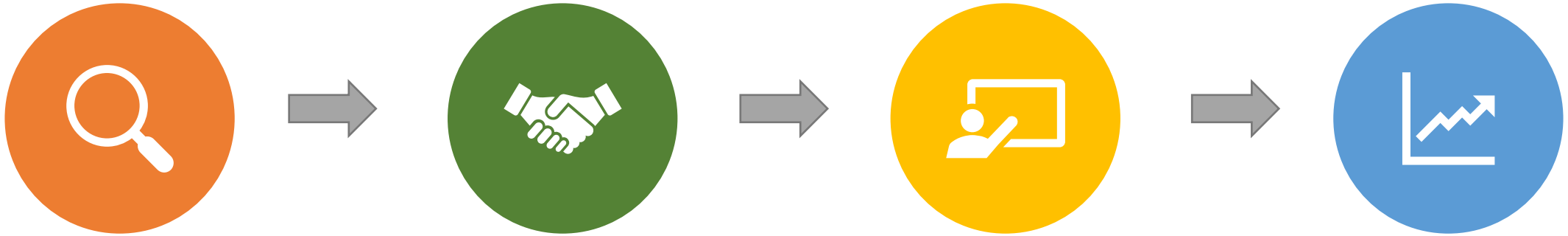
The Process of Medical Necessity



ASSESSMENT

WHAT DEFICITS EXIST?

PLAN DEVELOPMENT

WHAT INTERVENTIONS WILL DECREASE OR LIMIT THE DEFICITS?

TREATMENT

IMPLEMENT THE INTERVENTIONS AS PLANNED

ONGOING ASSESSMENT & PROGRESS REPORTING

NOW WHAT DEFICITS EXIST? HAVE THE PRIOR DEFICITS IMPROVED?

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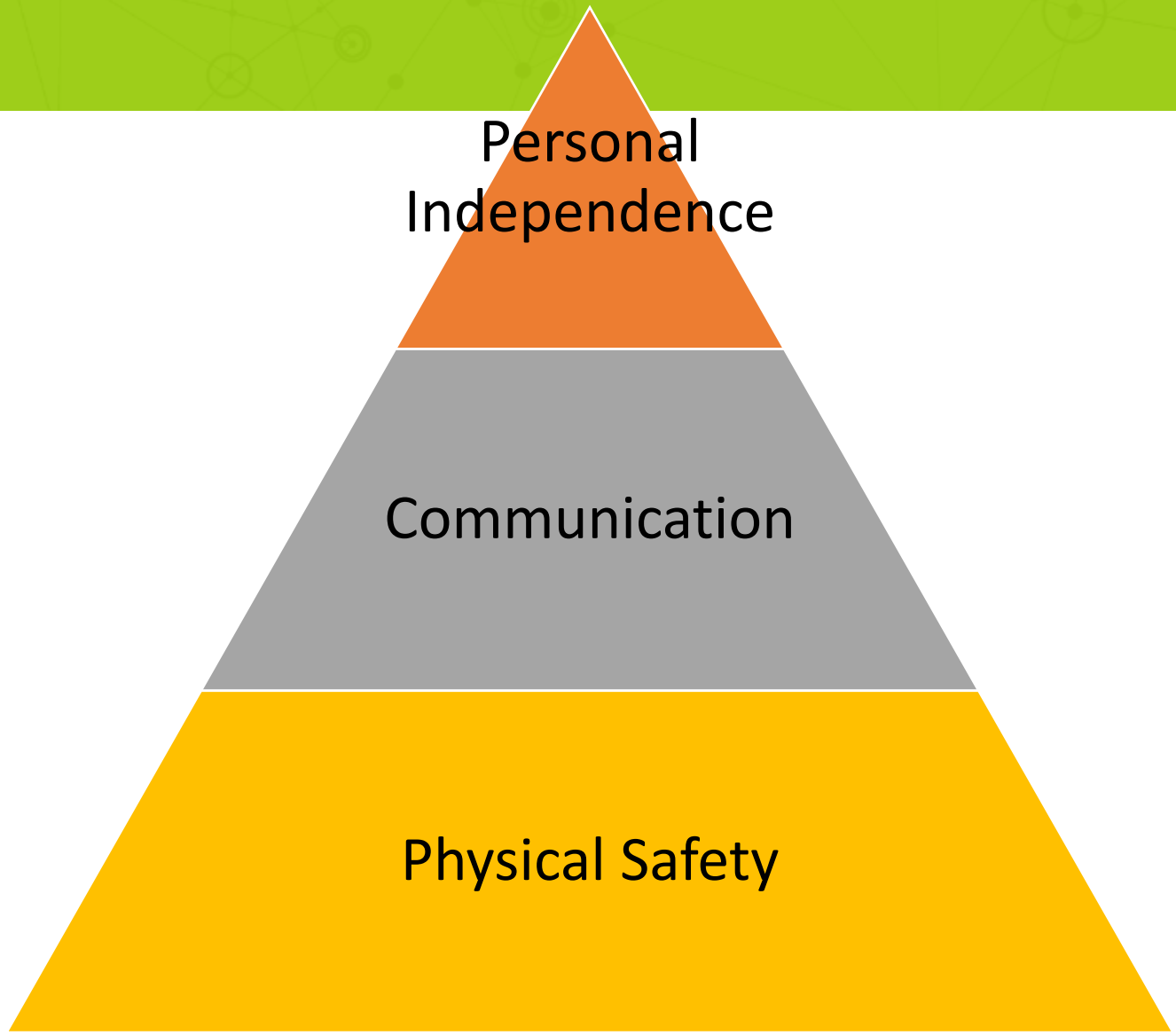
Hierarchy of Medical Necessity



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Example- CHORES

- Do kids who don't do chores have significant medical challenges or risks? No.
- What is the medical VALUE that the "chores" you're working on with your clients bring to the client?
  - For younger clients, this may be following instructions (listener responding)
  - For teenagers….wait, teens aren't supposed to do chores.
  - For adult clients, this may be Activities of Daily Living
- So instead of calling them Chores, we as medical professionals need to be calling them what they are: Activities of Daily Living, Following Instructions (listener responding)
- Do individuals who don't follow instructions or complete ADLs have significant medical challenges or risks? Yes!

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Q & A

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CMS Clinical Documentation Standards

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The Value of Clinical Documentation

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Imagine you are injured in an accident:

You work with your Doctor and PT for 6 months on an exercise and medication regiment that decreases your pain and begins to build back your strength.

You move out of the area and get a new doctor. Your new doctor requests records from your prior doctor, and you find out that the notes taken didn't contain much detail.

Your new doctor does not know what your medication history was or what your current meds are, and they have no record of what worked and didn't work to build your strength.

Now you have to start all over!

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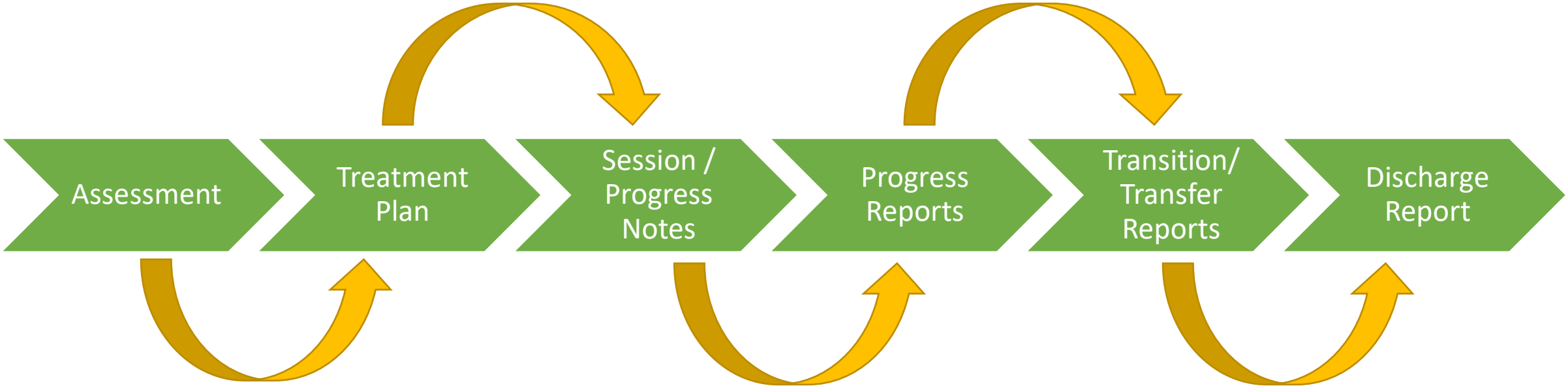
The Golden Thread of Clinical Documentation



That “golden thread” is Medical Necessity!

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Professional & Ethical Compliance Code for Behavior Analysts

2.13 Accuracy in Billing Reports

- Behavior analysts accurately state the nature of the services provided, the fees or charges, the identity of the provider, relevant outcomes, and other required descriptive data.

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Report Accuracy

- All clinical reports are part of the Medical Record and must reflect what occurs in treatment
- It is a risk to the clinician and provider if billed hours and hours reported in a progress or other report are not aligned

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Documenting Clinical Reports

Clinical Reports serve three functions:

- Assessment of clinical need
- Report of progress made
- Recommendations for additional treatment

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Documenting Clinical Reports

1

Use the templates – they were created to support medical necessity

2

Always include the clinical rationale

3

Base everything in Medical Necessity

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Report - Examples

SUBJECTIVE & GENERALIZED	ANALYSIS	OBJECTIVE, CONCRETE, SPECIFIC
Additional supervision hours are recommended based on assessment, client profile, and medical-necessity. Supervision hours will be used to provide adequate supervision of treatment and update treatment plan as necessary.	*This clinical rationale is too vague. What specifically is the clinical need that indicates the recommendation of additional supervision?* *As is, this is closer to a general description of what a clinical rationale is, rather than an actual clinical rationale related to a specific client's treatment.*	*Additional supervision hours are recommended based on client's increased aggression as evidenced by data reported in behavior domain. Supervision hours are needed to complete updated functional behavior assessment and behavior intervention plan, model interventions for clinical staff, and provide intensive parent coaching focused on behavior management.*

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Documenting Sessions

Session Notes are the evidence of a provider's services to or on behalf of a client and relate to the client's progress in treatment.

Notes are filed in the clinical record and must contain the clinical interventions to support the medical necessity of each service and its relevance to the Treatment Plan.

In order to submit a service for reimbursement, there must be a complete and filed Session Note for that service. Reimbursement submission is attestation that a Session Note has been completed, filed, and meets medical necessity.

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Session Documentation Requirements

(Title 17 and CMS)

- Client Name
- Date of Service
- Session Start & End Time
- Number of Units / Duration
- Service Location
- Procedure Code
- Practitioner Name, Credential
- Practitioner Signature
- Responsible Adult Printed Name
- Responsible Adult Signature
- Description of Service:
- Clients current clinical status (evidenced by the client's symptoms)
  - Statement summarizing the interventions implemented during the session
  - Statement summarizing client's response to the interventions
  - Statement summarizing client's progress towards treatment goals

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Sample Note Template

Client Name:		**Date of Service:**	
Medical Record Number (MRN):		**Session Start Time:**	
Location of Service:	☐ Office/Clinic ☐ Home ☐ Community ☐ School ☐ Phone ☐ Other: _____	**Session End Time:**	
Also Present:	☐ Parent ☐ SLP ☐ OT ☐ Other: _____	**Total duration of Session:**	
Procedure Code: _____		☐ **Direct**	☐ **Indirect**

Purpose of Session:	(Please include the reason for and the purpose of the appointment/session. Should also include why it is needed)
Treatment Goals Addressed	(Please indicate which treatment goals from the treatment plan were targeted during the service)
Description of Service	(Each session note must include a description of what clinical intervention took place during the session, client's degree of participation, and client's response to the intervention)

Practitioner Attestation: My signature below certifies that I have completed the above tasks as part of the client's treatment and care.

PRINT Practitioner Name & Credentials	**Practitioner Signature**	**Date**

Parent/Guardian/Client (if over 18) Attestation:
My signature below certifies that my child received services at the date/time stated above.

Client/Parent/Guardian PRINTED Name	**Client/Parent/Guardian Signature**	**Date**

Pertinent Session Information

Description of Service & Clinical Interventions

Signatures

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Documenting Direct Sessions

Direct Service Session Documentation should include:

- Reason for the contact.
- Assessment of client's current clinical or behavioral presentation.
- Relevant history.
- **Specific clinical interventions by provider, per type of service and scope of practice.**
- **Client's response to interventions.**
- **Plans, next steps, and/or clinical decisions.**
- Unresolved issues from previous contacts, if applicable.
- If little or no progress toward goals/objectives is being made, describe why. Include date of next planned contact and/or next clinician action. Address any issues of risk.

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Documenting Indirect Sessions

- Indirect Service Session Documentation should include:
  - **Specific clinical interventions by provider, per type of service and scope of practice.**
  - Response from collateral contacts.
  - Unresolved issues from previous contacts, if applicable.
  - Address any issues of risk.
  - Plans, next steps, and/or clinical decisions.
  - Include date of next planned contact, clinician actions and referrals made, if applicable.

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Key Elements of a Session Note Narrative

- What the Clinician observed
- What the Clinician did and WHY (Clinical Interventions)
- How the Client Responded to the Interventions
- What the Clinician will do Next

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Example: Direct H2019

When BT arrived client was sitting at a table with other children for snack time. Client engaged in the session with BT. Client's preferred item during session was legos. Ran Expressive Communication, Receptive communication, and Pragmatic Communication goals. Client responded independently to Expressive Communication Goals at a rate of 40%, and with prompts at a rate of 65%. Client responded independently to Receptive Communication Goals at a rate of 30%, and with prompts at a rate of 40%. Client responded independently to Pragmatic Communication Goals at a rate of 20%, and with prompts at a rate of 40%.

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Example: Direct H2019

- RBT entered home and greeted client. Client made eye contact but did not reciprocate greeting. Client required physical prompting when using the AAC system after being presented with a choice between two amounts of time for an activity. RBT observed client verbally manding “yes” during preference programs when he didn’t want an item. Used error correction by still giving the client the item and then using full verbal prompting for client to mand “done.” Took data on laughing without a clear antecedent as unspecified behavior. On incorrect trials of looking both ways before crossing the street, RBT noticed that client would look to the left and require prompting to look to the right. RBT noticed client imitating her during play or imitating sounds of her coughing/sniffing. RBT would repeat tasks during play and use physical prompting to block action. RBT was unable to block imitation of coughing or other sounds. RBT was also unable to use full physical prompting to block imitating during instances of sitting too far away from client. RBT used a token system to reinforce the blocking imitation program. Next session RBT will continue working on blocking more instances of physical imitating.

Branch Name	Current Data Point	Current Phase
Tolerating Changes in Routine	100.00%	Intervention
Mand with AAC	66.67%	Intervention
Vocal mand 'help'	100.00%	Intervention
Go to ___ and sit down	88.89%	Maintenance
Looking both ways when crossing the street	25.00%	Intervention
Respond to 'come here' from 10 feet away, indoors	100.00%	Intervention
Preferences: respond with 'yes'	80.00%	Intervention
Follow any functional 3-step direction	72.73%	Intervention
Imitation Blocking	83.33%	Intervention
Engage in non-preferred activity for 5 minutes	3.00	Intervention
Unspecified behavior	1.37	Intervention
Elopement (rate per hour)	0.46	Intervention

- What the Clinician observed
- What the Clinician did and WHY (Clinical Interventions)
- How the Client Responded to the Interventions
- What the Clinician will do Next

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Examples: Direct Overlap

- Consultant overlapped session at client's home with new RBT on the case. Consultant ran the majority of session in order to model for RBT session structure, behavior management of client and ensuring client safety at all times. Consultant utilized behavior skills training to explain lessons for RBT, model how to implement lessons prior to RBT running them, and providing feedback for lessons including attending, holding hands, waiting, and coloring/attending to classroom instruction. Consultant modeled utilizing a token economy for lessons including attending and coloring. Consultant answered RBT questions regarding programming and addressed questions that RBT had regarding when to prompt client to join the classroom activity (details).
  - Need an evaluation of client and documentation of how client responded.
- Supervisor overlapped home session with RBT, client, and grandparents present. Supervisor and RBT discussed programs currently in maintenance and progressed maintenance targets and retired programs that have been in maintenance for the required period. Supervisor had RBT run gross motor imitation due to slow acquisition; client was able to independently respond to SD independently 50% of opportunities. Consultant progressed targets for lessons and probed maintenance for targets that are not maintaining according to data and updates notes accordingly.
  - Need an evaluation of client and plan for next steps

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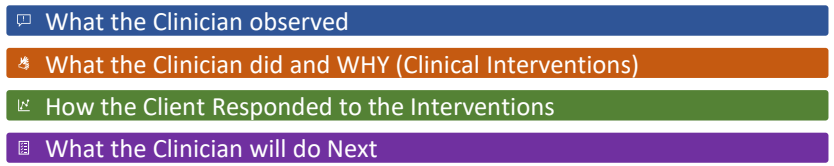

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Example: Direct Supervision

- Parent, Client, Sibling, BCAT, and Consultant present for session. Mother of client reported concerns regarding client's behavior in the community. Parent reports that client is hitting her outside in the community, parent told consultant that she has seen this behavior for the past two weeks. Consultant modeled treatment implementation goals to BCAT and provided feedback when BCAT implemented goals with client. Consultant observed 5 occurrences of "stop it"(inappropriate request) behavior that is being tracked in baseline. Consultant observed functional communication, client independently requested for escape three times, and requested independently for access 11 times and 2times prompted. Client was observed asking for help 8 times dependently and1 time prompted. Consultant observed social gestures in natural trial teaching(NT), client got 100%. Client got 0% in receptive commands taught in NT, client needed a model prompt to end in a correct prompt. Consultant observed client get 100% in current drink from cup target. Client got 100% in receptive function ran in random rotation (RR) taught in discrete trial teaching(DTT) and 100% in tacts ran in RR taught in DTT. Client got 100% in sharing target ran in NT. Client got 100% across the gender identification and pronouns maintenance targets ran. Client is maintaining previously mastered targets. Consultant to follow-up with BCBA regarding parent report of client hitting parent in the community for past 2-weeks.

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Example: Direct Supervision

- Purpose of today's visit was to observe client during non-preferred task. Client engaged in tantrum behaviors during non-preferred task including screaming that he did not want to play, flipped the table and kicked his feet on the ground. BI told the client that he needed to take two turns to escape the task. The client continued to engage in the tantrum behaviors and the BI reminded him of the reinforcer. The client continued to need reminders to clean up from the table flipping and the game going on the floor and to take his turn once the game was complete. Upon the tasks being completed the BI provided praise for completing the task and the client ignored the praise and exited the task. Client also engaged in profanity during this tantrum.
  Next steps: Conduct a FAST on the client's tantrum behaviors and continue to monitor the client's behaviors during sessions

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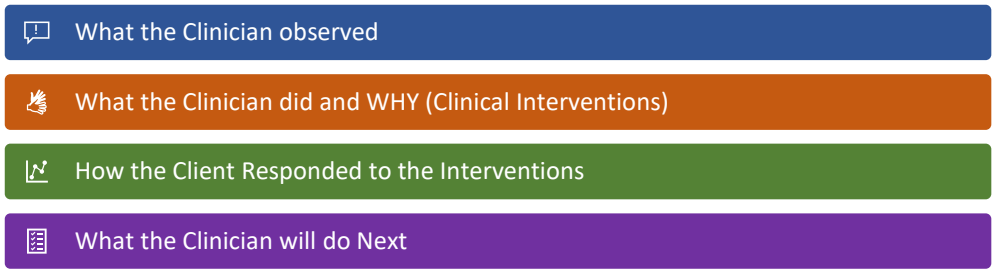
Example: Indirect Supervision

- BCBA added a goal for asking for a break due to an increase in the client's aggressive behaviors during session (aggressive behavior has increased by 50% over the last 4-weeks). During a discussion with the client's parents it had been identified that the client had more aggressive behaviors with his parents. Therefore, this BCBA developed the following parent training goals and scheduled parent training sessions for the next three weeks.
  - Parent Training Goal 1:
  - Parent Training Goals 2:



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Duration of Session

- The Duration of the session will also dictate how much information needs to be provided in the note.

- For a 1-unit session, a quick note about what you spent 15-minutes on is sufficient (if it's a medically necessary clinical intervention)

- For a 12-unit session, there needs to be enough documentation and outline of what clinical intervention(s) took place for 3-hours.
  - Non-Examples: Conducted an overlap, updated progress report, updated targets

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Management of Medical Records

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Copying & Pasting & Corrections to Documentation

"Copy and Paste Notes" occurs when a note (individual, group, etc.) is worded exactly like or similar to previous entries in the record, which is considered a misrepresentation of the medical necessity requirement. State of California considers this fraud.

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Information that should never be copied:

- Information from one client's chart into another client's chart (even if they are immediate family)

- Information from one service to another service/session, even if for the same client.

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Corrections & Amendments

When an error is made in a record entry, the original entry must **not** be removed, and the inaccurate information must remain accessible. Entries should **never** be deleted.

To correct an error, the correction must include the reason for the correction, and the correction amendment entry must be dated and signed by the person making the revision.

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An author is responsible for the content of their documentation whether it is original or copied and pasted

The author should:

- Review the notes for accuracy, completeness and relevance;
- Ensure that the documentation is in the correct patient's record;
- Confirm that all information has been updated; and
- Exclude unnecessary or redundant information.

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Professional & Ethical Compliance Code for Behavior Analysts

2.11 Records and Data

- (a) Behavior analysts create, maintain, disseminate, store, retain, and dispose of records and data relating to their research, practice, and other work in accordance with applicable laws, regulations, and policies; in a manner that permits compliance with the requirements of this Code; and in a manner that allows for appropriate transition of service oversight at any moment in time.
- (b) Behavior analysts must retain records and data for at least seven (7) years and as otherwise required by law

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Retention and Destruction of Medical Records

All Medical Records are retained for at least as long as required by state and federal law and regulations require

BHPN: 10 years after discharge, or 1 year after the client turns age 18, whichever is longer.

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PHI

Protected **NOT** withheld

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Professional & Ethical Compliance Code for Behavior Analysts

2.06 Maintaining Confidentiality.

- (a) Behavior analysts have a primary obligation and take reasonable precautions to protect the confidentiality of those with whom they work or consult, recognizing that confidentiality may be established by law, organizational rules, or professional or scientific relationships.
- (b) Behavior analysts discuss confidentiality at the outset of the relationship and thereafter as new circumstances may warrant.
- (c) In order to minimize intrusions on privacy, behavior analysts include only information germane to the purpose for which the communication is made in written, oral, and electronic reports, consultations, and other avenues.
- (d) Behavior analysts discuss confidential information obtained in clinical or consulting relationships, or evaluative data concerning clients, students, research participants, supervisees, and employees, only for appropriate scientific or professional purposes and only with persons clearly concerned with such matters.
- (e) Behavior analysts must not share or create situations likely to result in the sharing of any identifying information (written, photographic, or video) about current clients and supervisees within social media contexts.

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Privacy in Documentation

- When you reference another patient / client or family, protect that person's confidentiality.
- Events involving multiple patient / client /families must have one Reportable Event Form written for each participant/family.
- Professionals may be referenced by name and title.

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Professional & Ethical Compliance Code for Behavior Analysts

2.08 Disclosures

- Behavior analysts never disclose confidential information without the consent of the client, except as mandated by law, or where permitted by law for a valid purpose, such as
  - (1) to provide needed professional services to the client,
  - (2) to obtain appropriate professional consultations,
  - (3) to protect the client or others from harm, or
  - (4) to obtain payment for services, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose. Behavior analysts recognize that parameters of consent for disclosure should be acquired at the outset of any defined relationship and is an ongoing procedure throughout the duration of the professional relationship.

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Client Access to Protected Health Information

All clients will have the ability to review, inspect and/or obtain a copy of their PHI in their medical record.

A client does not have the right to immediate access to his/her medical records under the HIPAA Privacy Rule. (Source: HRSA)

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Professional & Ethical Compliance Code for Behavior Analysts

3.05 Consent-Client Records

- Behavior analysts obtain the written consent of the client before obtaining or disclosing client records from or to other sources, for assessment purposes.

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Release of Protected Health Information

- HIPAA covers not just about privacy it is also about portability
- Any treating provider can request treatment or assessment information for the purpose of treating the client
- A release is not needed under the circumstances when the information is needed to treat the client in the medical model

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Documenting Parent Training Goals

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Documenting Parent / Caregiver Education Goals

- Goals for parent training or education must be specific and measurable in the same way a goal would be for a client

- Goals for parent training or education must be medically necessary for the client.

- Attending a monthly meeting or observing an ABA session for 15 minutes is a poor rationalization for supervision or parent training

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Documenting Parent / Caregiver Education Goals

- Participation in treatment is an expectation for ABA programs
- Goals should be individualized to the caregivers' and clients' needs
- Various caregivers may need different goals based on their specific needs for education and training

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Examples of Parent Training Goals

- "In response to Jameel engaging in tantrum behavior, caregivers will implement an extinction procedure as outlined in the behavior intervention plan to fidelity in 90% opportunities at home and in the community"

- "In response to Courtney stating she needs to urinate or defecate, caregivers will follow the toileting task analysis with Courtney using least-to-most prompting in 100% opportunities across three different environments."

- "In response to Carlos entering his social skills group, caregivers will take data on Carlos's skill acquisition goals to compare with data taken by the BT with at least 80% inter-observer reliability twice per week."

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Examples of Parent Training Goals

- Fernando's parents will implement the forced choice strategy to fidelity in 90% of opportunities.

- Utilizing the protocol provided by the treatment team, Andre's caregivers will conduct the Echoic-to-Mand-Stimulus-Control-Transfer-Procedure with 80% accuracy across 5 different reinforcers.

- When transitioning her off screen time, Sofia's parents will (a) set a visual timer to indicate the approaching transition and (b) give Sofia an additional 5 minutes of screen time in response to the first appropriate request for "more time" if requested in absence of maladaptive behavior

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Billable Services

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Billable & Non-Billable Services

All services (including non-billable ones) should have a clinical note to document the work completed, even if it is not billed for, to ensure a complete clinical record.

Only services rendered with a medically necessary clinical intervention are Billable.

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Comments and Questions

After this event, you will receive an email with a link to an evaluation of the course. To receive credit for this event through the BACB, please complete the evaluation and you'll receive an immediate confirmation and follow up email with all information necessary to receive credit.

Please make sure to check your junk / spam / filter folder as occasionally the emails with the evaluations get trapped there!

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