Unique Regulatory and Documentation Standards for Inpatient Behavioral Health

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John A. Coleman, MSW, ACSW
Vice President, Clinical Services
Why are Behavioral Health Standards Different From Other Inpatient Requirements?

- Behavioral Health does not follow predictable clinical pathways
  - Inpatient Psych. has been exempt from DRGs
  - Cause, effect, and treatment are more complex

- Special Conditions apply to
  - Freestanding Psychiatric Hospitals
  - “Exempt” Psychiatric Units
  - Inpatient Prospective Payment System (IPPS)

- Provider (Psychiatrist and other professionals) have the obligation to determine what treatment is "reasonable and necessary" for the patient.
“Reasonable and Necessary”

• Requires Physician Certification and Re-Certification

• Services provided under an *individualized* plan of treatment

• Services must be reasonably expected to improve the patient’s condition or result in diagnostic conclusions

• Services must be supervised and evaluated by a Physician
CMS Conditions of Participation (CoP)

**General Provisions**

482.2 Provision of Emergency Services

**Administration**

482.21 Compliance with Federal, State, and Local Laws
482.12 Governing Body
482.13 Patient Rights

See Handout – page 2
CMS Conditions of Participation (CoP)

Basic Hospital Functions

482.21 Quality Assurance
482.22 Medical Staff
482.23 Nursing Services
482.24 Medical Records
482.25 Pharmacy
482.26 Radiology
482.27 Laboratory
482.28 Food and Dietary
482.30 Utilization Review
482.41 Physical Environment
482.42 Infection Control
482.43 Discharge Planning
482.44 Organ Tissue and Eye Procurement
Optional Hospital Services

482.51 Surgical Services
482.52 Anesthesia
482.53 Nuclear Medicine
482.54 Outpatient Services
482.55 Emergency Services
482.56 Rehabilitation Services
482.57 Respiratory Care Services
CMS Conditions of Participation (CoP)

Requirements for Specialty Hospitals

482.60 Special Conditions: Psychiatric Hospitals
482.61 Medical Record Requirements: Psychiatric
482.62 Staffing Requirements: Psychiatric
482.66 Long Term Care

EMTALA/COBRA

489.20 Anti-Dumping and Emergency Transfer
<table>
<thead>
<tr>
<th>TAG NUMBER</th>
<th>REGULATION</th>
<th>GUIDANCE TO SURVEYORS</th>
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<tbody>
<tr>
<td>B103</td>
<td>§482.61 Condition of Participation: Special Health Record requirements for psychiatric hospitals. The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.</td>
<td>§482.61 GUIDANCE: The clinical record should provide information that indicates need for admission and treatment, treatment goals, changes in status of treatment and discharge planning, and follow-up and the outcomes experienced by patients. The structure and content of the individual patient's record must be an accurate functional representation of the actual experience of the individual in the facility. It must contain enough information to indicate that the facility knows the status of the patient, has adequate plans to intervene, and provides sufficient evidence of the effects of the intervention, and how their interventions served as a function of the outcomes experienced. You must be able to identify this through interviews with staff, and when possible with individuals being served, as well as through observations.</td>
</tr>
<tr>
<td>B104</td>
<td>Medical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is hospitalized.</td>
<td></td>
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<tr>
<td>B105</td>
<td>(1) The identification data must include the patient's legal status.</td>
<td>§482.61(a)(1) GUIDANCE: Definition: Legal Status is defined in the State statutes and dictates the circumstances under which the patient was admitted and/or is being treated - i.e., voluntary, involuntary, committed by court, evaluation and recertification are in accordance with state requirements. Determine through interview with hospital staff the terminology they use in defining &quot;legal status.&quot; If evaluation and recertification is required by the State, determine that legal documentation supporting the status is present. Changes in legal status should also be recorded with the date of change.</td>
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</tbody>
</table>
What Do CMS Conditions Obligate You To?

• All Hospitals participating in Medicare or Medicaid must fully comply with *all* CoP’s.

• Most State Licensure surveys utilize the CMS Conditions of Participation.
  • Joint Commission “Deemed Status”

• Being out-of-compliance with one or more *standards* requires a corrective action plan.

• Being out on a *condition* (CoP) means your hospital is in jeopardy of losing:
  • Medicare Funding
  • Medicaid Funding
  • License To Operate Hospital In Your State
One Standard Can Trigger Multiple Citations

Treatment plan goals not measurable

- Staffing: 482.62
  - Nursing Director
  - Medical Director
  - Sufficient # of staff
  - Qualified staff

- Governing Body: 482.12

- Discharge Planning: 482.43

- Medical Records: 482.61
Medical Record Special Condition
42 CFR 482.61

Assessments
• B104 through B117

Treatment Plan
• B118 through B124

Progress Notes
• B125 through B132

Discharge Plan and Summary
• B133 through B135
Assessments
B104 - B117

B104  History of Illness

B105  Legal Status

B106  Admitting Diagnosis

B107  Reasons for Admission to Hospital

B108  Psychosocial Assessment

B109  Neurological Exam
Psychiatric Evaluation

§482.61(b)

B110 Psychiatric Evaluation

B111 Completed within 60 hours of admission
B112 Includes Medical History
B113 Records mental status
B114 Notes onset of illness and circumstances leading to admission
B115 Describes patients attitudes and behaviors
B116 Estimate of intellectual function, memory, orientation
B117 Descriptive inventory of patient assets

See Handout – pages 3-6
Also pages 12-14
Admission Physical Examination
§482.61(a)(5)

**B109  Physical Examination**
- Thorough History and Physical upon admission
- Include all laboratory examinations
- Sufficient to cover all structural, functional, systemic, and metabolic disorders
- Past physical disorders
- Substance abuse
- Neurological screening to include testing of Cranial Nerves II-XII
- Look for signs of current illness
- Determine if psychiatric symptoms may be due to medical condition or substance-related disorder

*See Handout – pages 7-8*
Neurological Screening includes Cranial Nerves II-XII
§482.61(a)(5)

<table>
<thead>
<tr>
<th>CRANIAL NERVES: (Circle each test used)</th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>OLFACTORY I: Smells freshly burned match, fresh coffee, or alcohol swab</td>
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<td>r</td>
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<tr>
<td>OPTICAL II: Distinguishes number of fingers in central field. Distinguishes movements in peripheral field.</td>
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<td>OCULOMOTOR III: Gazes symmetrically up, down, sideways</td>
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<tr>
<td>TROCHLEAR IV: Distinguishes 1 from 2 point touch symmetrically on forehead, cheeks, and chin; chews symmetrically.</td>
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<tr>
<td>ABDUDENS VI:</td>
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<tr>
<td>TRIGEM V: Upper: frowns symmetrically</td>
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<td>r</td>
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<td>Lower: smiles symmetrically</td>
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<td>r</td>
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<td>FACIAL VII:</td>
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<tr>
<td>AUDITORY VII: Hears finger rubbing or snapping equally in both ears</td>
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<tr>
<td>GLOSSO-PHARYNGEAL IX: Has gag reflex</td>
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<td>VAGUS: Can make guttural sounds</td>
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<td>r</td>
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<tr>
<td>ACCESSORY XI: Shrugs shoulders symmetrically</td>
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<td>r</td>
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<tr>
<td>HYPOGLOSSAL XII: Can stick tongue out without tremors or fasolculations</td>
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</table>
General Guidelines for Assessments

• Distinguish *history-taking* from assessment
  • History is a un-interpreted data; a profile of significant symptoms or circumstances
  • Assessment is an evaluation of this data by a qualified clinician who then draws *conclusions* and *recommendations*.

• Give Supporting Evidence

• Summarize *conclusions* in an evaluation
  • Declare medical necessity
  • Severity of illness

• Offer specific *recommendations* for treatment
  • All major clinical disciplines and treatment modalities
  • Intensity of Service

*See Handout: Example – pages 12-13*
Treatment Planning
B118 – B125

B118 Each patient has individualized, comprehensive treatment plan

B119 Based on inventory of patient’s strengths and disabilities

Treatment Plan Must Include:
B120 Substantiated diagnosis
B121 Short-term and Long-range goals
B122 Specific treatment modalities
B123 Responsibilities of each member of the treatment team
B124 Adequate documentation to justify diagnosis and interventions
B125 Documentation of all active therapeutic efforts

See Handout – pages 15-16
Progress Notes
B126 - B132

**Progress Notes Required By:**
- B126  Physician
- B127  Nursing
- B128  Social Worker
- B129  Other significantly-involved disciplines

**B130** Frequency of notes sufficient for patients condition

**B131** Progress notes include recommendations for revisions in the treatment plan

**B132** Assess progress (or lack thereof) towards established treatment goals
B134  *Discharge Summary contains recommendations for appropriate services following discharge.*

- Aftercare appointments (complete with dates)
- Discharge medications
- Housing needs
- Financial needs relative to aftercare
- Recommended family resources/involvement
- Recreational and leisure needs

B135  *Brief summary of patient’s condition on discharge*

*See Handout – pages 9-10*
Special Condition Staffing – Psychiatric
42 CFR § 482.62

Sufficient and Qualified Personnel - B137 – B140

Medical Director and medical staff - B141 – B145

Nursing Services - B146 – B150
  • (masters-level RN)

Psychological Services - B151

Social Services - B152 – B155
  • (MSW leads social services)

Therapeutic Activities
B156 – B158
 Patient Rights
42 CFR § 482.13

A 751
Notice of Rights

A 752
Grievance Process

A 760
Pt. Involvement in Tx Plan

A 761
Advanced Directives

A 763
Privacy and Safety
• Right to safe environment

A 766
Confidentiality

A 767
Pt. Right to Access PHI

A 769-791
Seclusion & Restraint
References

• To obtain hard copy of Special Conditions of Participation for Psychiatric Units
  • See your Horizon Program Director

• To download a full set of Conditions of Participation
How Does Your Behavioral Health Unit Stand?

Tools at your disposal:

• Daily Concurrent Record Review
  • Make corrections while you still can

• Horizon Monthly Audit
  • Sample size for external review

• Horizon Annual Comprehensive Audit

• Horizon VP, Clinical Services
  • Site visits
  • Training
Questions?