

# Not Just Another Number...Individualized Treatment Planning in Mental Health

This summer, the Department of Justice (DOJ) announced that Allegiance Health Management, Inc. agreed to pay more than \$1.7 million to settle false claims allegations that they submitted, and caused other hospitals to submit, claims to Medicare for outpatient mental health services that were not medically reasonable or necessary. Allegiance entered into arrangements with hospitals in the southeastern United States to provide intensive outpatient psychotherapy (IOP) services to patients on behalf of the hospitals. At each of the hospitals, Allegiance established an Inspirations Outpatient Counseling Center at which Allegiance employees and those acting under the direction and control of Allegiance were responsible for, among other things, identifying potential patients, creating patient treatment plans, and performing IOP services.



It was under these arrangements, the Department of Justice alleged that one or more of the hospitals submitted false claims for IOP services. The claims were alleged to be false because the treatment plans were not individualized and the services were not reasonable and medically necessary. Patients passed time in treatment by playing bingo and watching television, among other recreational activities, however, **“therapy comprised primarily of activity, social or recreational therapy” does not constitute medically necessary psychiatric services.**

## The allegations were that the services did not qualify for Medicare reimbursement because:

- The patient’s medical condition(s) did not require IOP,
- Treatment was not provided according to an individualized treatment plan designed to help patients address their specific mental health issues and reach achievable goals,
- The patient’s progress was not sufficiently tracked or documented,
- An inappropriate level of treatment was provided, and/or
- The “therapy was primarily recreational or diversional in nature, and was not therapeutic.”

The Office of Inspector General (OIG) has, in previous years (2003, 2010), investigated and reported on the lack of medical necessity in mental health treatment in nursing homes and in community mental health centers. **Treatment plans and the lack of medical necessity is not a new issue, but it is again the focus of OIG and CMS review and investigation.**

The Allegiance settlement may herald more government reviews and investigations of outpatient and inpatient behavioral health treatment. Although the Allegiance settlement addresses treatment plans for outpatient mental health services, CMS has given Recovery Audit Contractors (RACs) the “go ahead” to audit the medical necessity of inpatient psychiatric facilities (see Compliance Alert – Inpatient Psych Services and RAC – Oct 2017 on the Corporate Integrity SharePoint site). Additionally, Medicare Administrative Contractors (MACs) are reviewing mental health services under the new CMS medical review strategy “targeted probe and educate” (see Compliance Alert – Probe and Educate – Oct 2017 on the Corporate Integrity SharePoint site).

All programs and providers should be vigilant to make sure that treatment plans and services are medically appropriate and necessary (see Treatment Plan Reminders on the next page) and take proactive measures to perform internal reviews of records and provide education on any identified areas for improvement.

# TREATMENT PLAN

## Reminders



- The services ordered and provided should be indicative of the patient’s medical condition(s).
- The therapy(ies) provided cannot be primarily recreational or diversional in nature.
- All treatment plans must be individualized for each patient and provide for medically necessary services only.
- Treatment plans should be designed to help patients address their specific mental health issues and reach achievable goals.
- The patient’s progress should be sufficiently tracked and documented.
  - Do the progress notes relate to the goals of the treatment plan? Do they include precise statements of progress?
  - Do the notes give a clear picture of the patient’s progress, or lack thereof, during the course of hospitalization?
  - Are all providers who are involved in active treatment modalities/interventions of the patient documenting progress?
  - In reviewing the patient’s progress, are aftercare/discharge plans being evaluated?
  - Does the medical record documentation support the patient’s current level of care and treatment?
- Documentation must record pertinent facts, findings, and observations about a patient’s health history, including past and present illnesses, examinations, tests, treatments, and outcomes.
- Documentation should not be “canned” or uninformative, such as the following statements:
  - “condition will be improved with treatment”
  - “patient slept well”
  - “no complaints”
  - “concur with the evaluation performed today” [by physician in conjunction with documentation by a mid-level provider]
  - [patient] “seen and agree”

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## Interesting Reads



Deena J. Tampi, MSN, MBA-HCA, RN, Executive Vice President, Clinical Services, Diamond Healthcare Corporation co-authored the following article: *Cannabinoids for the treatment of behavioral and psychological symptoms of dementia.*

*“There is evidence to suggest that cannabinoids can reduce neurodegeneration, neuroinflammation and have neuroprotective effects through the activation of the CB1 and CB2 receptors” [read more](#)*



Shelly F. Greenfield, MD, MPH, President, American Academy of Addiction Psychiatry authored: *Women and Opioid Use Disorders*

*“For every woman who dies of a prescription overdose, at least 30 women go to the emergency department for prescription opioid misuse or poisonings. The death rate from heroin overdoses among women is twice that of men” [read more](#)*