Acceptable HML Documentation

HIV STATUS

External Documentation Verification:

- Lab results
- Medical Records
- Documented Conversation with collateral service provider or MCO that can confirm lab results or have access to the medical record

Observation as a Verification:

- Substantiation or reports from a care provider, the Member, family members, or other third party sources that support the level of intensity of need and billing.
- Documentation of this observation would include Care Notes and a Plan of Care that reflect the intensity of the services needs to address the issue.
- This documentation of a Care Note and Plan of Care goal will maintain the billing rate for 90 days, until external documentation (above) can be obtained.

AIDS Institute Clinical Guidelines:

- CD4 (T-cells) testing is recommended at 12 weeks and every four months after initiation of ARV until CD4 is > 200 cells/mm3 on two measures.
- For those who are virally suppressed, CD4 testing is recommended at least every six months if CD4 is less than or equal to 300 cells/mm3.
- Every 12 months if CD4 >300 cells/mm3 and less than or equal to 500 cells/mm3.
- Optional if CD4 greater than 500 cells/mm3.
- Practitioners agree that a six month period of more aggressive care management is appropriate for an HIV+ member with a medium or high range viral load, even though they should be tested again within that period.
    - Quarterly for HIV+ persons with recent history of non-adherence, MH disorders, SU, poor social support, or other major medical conditions;
    - Every four months for most individuals after complete viral suppression;
    - Every six months for those with complete suppression for over one year and CD4 counts greater than 200 cells/mm3;
    - Note, when a person is failing virologically, testing is recommended within four weeks from a change in ARV, and at least every eight weeks until complete suppressed.

HOMELESSNESS

External Documentation Verification:

- Letter from shelter or other homeless housing program
- Hospital discharge summary
- Eviction notice
- Documentation from local Homeless Management Information System (HMIS)
- Member self-report

Observation as a Verification:

- Substantiation or reports from a care provider, the Member, family members, or other third party sources that support the level of intensity of need and billing.
- Documentation of this observation would include Care Notes and a Plan of Care that reflect the intensity of the services needs to address the issue.
- For Medium and Low Level billing categories, this observation would support 30 days of billing with supervisory approval. For High category of billing, this observation would support 90 days of billing, until external documentation (above) can be obtained.

Definition of Homelessness and HML Categories:

- *HUD Category 1 (High):* An individual who lacks a fixed, regular and adequate nighttime residence.
- *HUD Category 2 (Medium):* An individual or family who will imminently lose their housing.
- *Date Housed:* If High or Medium (Category 1 or 2), they will maintain that level of billing category for six months
- *If Category 1 or 2 and not housed:* they will maintain that level of billing category with appropriate observation documentation until housed or discharged from the program

INCARCERATION

External Documentation Verification:

- Release papers
- Documentation from parole or probation
- Documented conversation from collateral contact
- Print-out from Webcrims or other criminal justice database
- Letter from halfway house
- Member self-report

Observation as a Verification:

- Substantiation or reports from a care provider, the Member, family members, or other third party sources that support the level of intensity of need and billing.

- Documentation of this observation would include Care Notes and a Plan of Care that reflect the intensity of the services needs to address the issue.
- For Medium and Low Level billing categories, this observation would support 30 days of billing with supervisory approval. For High category of billing, this observation would support 90 days of billing, until external documentation (above) can be obtained.

Definition of Incarceration:

- Released from state prison or county jail after sentence is served.
- Member may be on probation or parole, but that is not required to meet the definition of incarceration.
- Incarceration would also include:
  - Detention or arrest for charges not adjudicated or sentenced
  - Violations or probation or parole
  - Released on bail awaiting arraignment
  - Other criminal justice status in which the person has an ongoing criminal justice issue requiring care management intervention

INPATIENT STAY FOR PHYSICAL ILLNESS

External Documentation Verification:

- Hospital discharge summary
- Documented progress note (including name, title, contact information of person on inpatient unit who verified patient's discharge date);
- Print out from PSYCKES
- RHIO alerts of inpatient admission
- MCO confirmation of admission

NOTE: Member self-report does **<u>not</u>** meet criteria as sufficient documentation

Observation as a Verification:

- Substantiation or reports from a care provider, the Member, family members, or other third party sources that support the level of intensity of need and billing category.
- Documentation of this observation would include Care Notes and a Plan of Care that reflect the intensity of the services needs to address the issue.
- For Medium and Low Level billing categories, this observation would support 30 days of billing with supervisory approval. For High categorQ y of billing, this observation would support 90 days of billing, until external documentation (above) can be obtained.

Definition of Inpatient Stay for Mental Illness:

- Inpatient admission, regardless of duration, that would require significant care coordination post discharge.

INPATIENT STAY FOR MENTAL ILLNESS

External Documentation Verification:

- Hospital discharge summary
- Documented progress note (including name, title, contact information of person on inpatient unit who verified patient's discharge date);
- Documentation of Mobile crisis episodes
- Print out from PSYCKES
- RHIO alerts of inpatient admission
- MCO confirmation of admission

NOTE: Member self-report does **not** meet criteria as sufficient documentation

Observation as a Verification:

- Substantiation or reports from a care provider, the Member, family members, or other third party sources that support the level of intensity of need and billing category.
- Documentation of this observation would include Care Notes and a Plan of Care that reflect the intensity of the services needs to address the issue.
- For Medium and Low Level billing categories, this observation would support 30 days of billing with supervisory approval. For High category of billing, this observation would support 90 days of billing, until external documentation (above) can be obtained.

Definition of Inpatient Stay for Mental Illness:

- Inpatient admission, regardless of duration, that would include CPEP under an observation status or other psychiatric emergency/respite programs.
- Inpatient admission for MI that includes a transfer to other units for complex needs, including physical health, would qualify as an inpatient stay for MI. For example, a member is admitted to a MH IP unit, then transferred to the medical floor, and discharged from a medical bed to community.

INPATIENT STAY FOR SUBSTANCE USE TREATMENT DISORDER

External Documentation Verification:

- Hospital or provider discharge summary
- Documented progress note (including name, title, contact information of person on inpatient unit who verified patient's discharge date);
- Print out from PSYCKES
- MCO confirmation
- Member self-report

Observation as a Verification:

- Substantiation or reports from a care provider, the Member, family members, or other third party sources that support the level of intensity of need and billing.
- Documentation of this observation would include Care Notes and a Plan of Care that reflect the intensity of the services needs to address the issue.
- For High category of billing, this observation would support 90 days of billing, until external documentation (above) can be obtained.

Definition of Inpatient Stay for Substance Abuse Treatment:

- Inpatient admission in a hospital or community based setting regardless of duration that could include detoxification services (medically managed, medically supervised or medically monitored, but not ambulatory detox), inpatient rehabilitation, residential stabilization and rehabilitation or other inpatient services as defined by OASAS.

SUBSTANCE USE DISORDER ACTIVE USE/FUNCTIONAL IMPAIRMENT – HIGH RATE ONLY

External Documentation Verification:

- Based on assessment and information gathered by the Care Coordinator from:
    - substance use providers
    - probation/parole
    - court ordered programs
    - domestic violence providers
    - local DSS
    - other sources.

Observation as a Verification:

- Substantiation or reports from a care provider, the Member, family members, or other third party sources that support the level of intensity of need and billing.
- Documentation of this observation would include Care Notes and a Plan of Care that reflect the intensity of the services needs to address the issue.
- For High category of billing, the documentation of care plan and progress notes would maintain the High category of billing for 90 or more days if, and only if, progress notes clearly document evidence of care management interventions to support SUD intervention. This includes motivational interviewing, education, referral and linkage to recovery coaching, and other peer supports. External documentation is preferred and every effort must be clearly documented, including specific efforts to engage the individual in harm reduction and safety planning.

Definition of SUD Active Use / Functional Impairment:

- Positive lab test for Opioids, Benzodiazepines, Cocaine, Amphetamines, or Barbiturates; OR

- Care Coordinator observation (with supervisor sign off) of continued use of drugs (including synthetic drugs) or alcohol with supervisor sign off
  OR
- MCO report of continued use of drugs or alcohol;
  AND
- Demonstration of a functional impairment including continued inability to maintain gainful employment
  OR
- Continued inability to achieve success in school
  OR
- Documentation from family and/or criminal courts that indicates domestic violence and/or child welfare involvement with the last 120 days
  OR
- Documentation indicating Drug Court involvement
  AND
- the presence of six or more criterion of SUD under the DSM-5 which must also include pharmacological criteria of tolerance and/or withdrawal