Western Region Integrated Care
Comprehensive Community Services
(CCS)

Provider Documentation Expectations

LA CROSSE COUNTY (Lead County)
HUMAN SERVICES DEPARTMENT
300 4TH ST N
PO BOX 4002
LA CROSSE WI 54602-4002

CCSsups@lacrossecounty.org

Updated 03.2024 RR

Contents

What happens in case management programs before a service is purchased?

1. A comprehensive assessment is done by a case manager or service facilitator (SF) with each consumer at enrollment and is updated annually thereafter. Many domains/areas of the consumer's life are explored and strengths and needs within each domain are identified.

   The assessment sets the stage for all purchase services in that it demonstrates:
   - That due to the impact from a mental health and/or substance use disorder the consumer requires assistance to achieve independent functioning
   - The specific needs that require assistance
   - The consumer's priority in what order issues are addressed

2. A Service Plan is formed by the consumer and their Recovery Team. The plan explores the consumer's goals and details the services that will be purchased by the program in those areas of need that were identified in the assessment. The recovery team is made up of the SF, the consumer, a Mental Health Professional, a Substance Abuse Professional as needed, peer support specialist as needed, anyone else the consumer requests (family, friends, or other natural supports), and venders involved. Some of the recovery planning process can or will occur in person, via the phone, or by email. The SF will ensure everyone is involved as some point even if they are in involved in the face-to-face meeting.

   During the planning process, the team addresses the following:
   - What did the consumer accomplish in the last 6-month period?
   - What are the consumer's goals or objectives for the next six months?
   - How will these objectives be measured?
   - Does the comprehensive assessment indicate the consumer needs assistance in order to achieve their goals?
   - Specific interventions that will address who and how team members will assist the consumer in meeting the objectives.
   - The circumstances, as determined by the consumer and recovery team, that would suggest the consumer would no longer need formal services and would be ready for discharge from the program

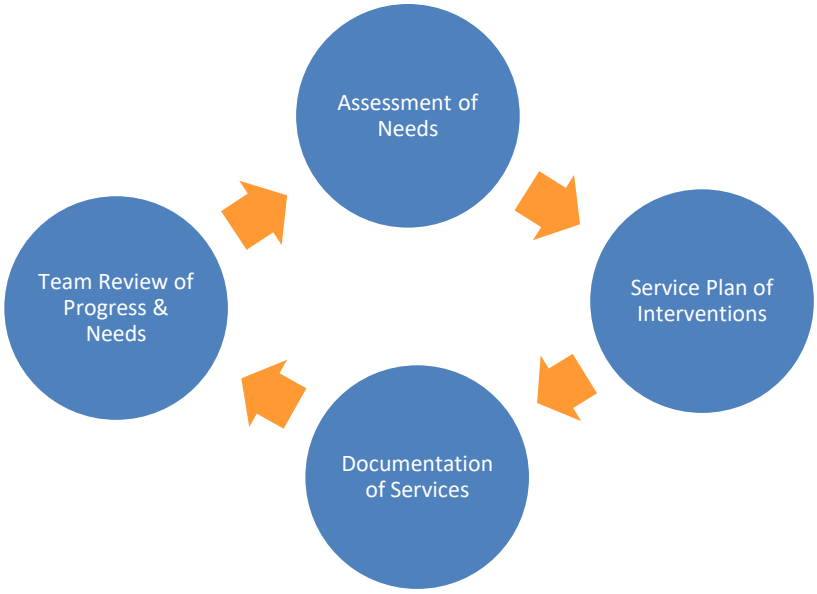
3. A referral is then made to your organization for a specific, goal oriented, and time limited service if the Recovery Team chooses you to provide the necessary intervention. You should expect that the referral and the service plan clearly outline and tell you why the consumer needs your assistance and what the desired outcome of your service is. The plan could also give you some clear guidance on what tasks need to be completed to achieve the desired outcome. This will specifically be listed in the interventions section of the recovery plan. The focus of the plans and the resulting service provision should be recovery focused and outcome based.

   - Please continue to ask questions until you believe you firmly understand why they were referred and what they are hoping to achieve.
   - Please provide feedback if you feel like your agency cannot provide the intervention or have additional ideas that your agency could provide to meet the objective.

- It is the team's responsibility to ensure the service that you are providing is in line with the objectives and interventions out lined on the recovery plan.
- It is **your responsibility to have an updated service plan** and not to bill for any services that are not on a valid and approved plan.
- The team's ultimate goal is to 'work ourselves out of a job' as it relates to this person's need for services.
- If a consumer is not currently action oriented/actively engaged in their recovery, the hope is that the service providers and the entire treatment team are assisting the consumer in finding ways to become more action oriented while respecting consumer choice.
- Maintenance or habilitative services are not the focus of the service delivery. The services should **not** be a 'do for' kind of service but have a psycho-educational focus that leads to increased functioning.
- As a member of the treatment team, you may request a team meeting to discuss and revise the service plan to address any progress or barriers that come up during service delivery.
- The communication process of clarifying any questions about the plan, interventions, or the desired outcomes is first with the case manager/Service Facilitator of the case, then the Mental Health professional. If after outreaching to those 2 professionals you still are not sure what your role is then feel free to call the program supervisor for further clarification.

4. At the end of the 6 month period, or if the needs change, the plan will be reviewed and updated. The SF, the consumer, and the rest of the recovery team will start planning 6 weeks in advance of the plan being due, assessing the last 6 months achievements and progress, reviewing the current assessed needs, and determining what is working and what is not in regards to assisting the consumers in meeting their desired outcomes.

Your documentation: Your documentation is a critical part of overall assessment and outcome based model. It needs to show what you are doing with the consumer to help them achieve the goal listed on their Recovery Plan. We call this the 'Golden Thread of Treatment'. We want to be able to pick up a person's chart, look at the assessment, their recovery plan, and all the progress notes documenting the services provider and see the continuous 'golden thread' that is woven through all of these documents. They all need to match up and be consistent in regards to the services we are providing and the information we are documenting about that service.



What documentation is needed from a contracted provider?

Documentation is required for all service that are billed to the CCS program. Service provider notes must be in accordance with standard professional documentation practices. Documentation must reflect how the activity relates to the reason the individual was referred to you. Use the service plan as your road map. Everything you do with a consumer needs to lead back to the objectives and interventions out lined on the recovery plan. The clinical content of your note needs to match what you really did and needs to match what was 'authorized' on the plan.

The following needs to be part of your documentation:

- ❑ When (date & specific start and stop time of service)
- ❑ Where were services provided (home, agency office, community, telehealth, etc)
- ❑ Type of Session (individual, group)
- ❑ Type of Contact (in-person, audio-visual telehealth, audio only telehealth, text-based message, etc)
- ❑ Type of Service Provided (service array - Skill Development, Wellness, Therapy, Medication, etc)
- ❑ Consumer objective (from approved service plan)
- ❑ How did consumer present? (appearance, affect)
- ❑ Interventions used (must be clearly obvious as to how this intervention relates to the objective and what you provided clinically to create change)
- ❑ Consumer Response to interventions (how did they respond to your intention service intervention)
- ❑ Any assignments/tasks given to consumer
- ❑ Any follow-up needed to be done by staff
- ❑ Duration of Service (breakout: direct face-to-face, documentation, travel, non-billable)
- ❑ Provider Name with Credentials (RW, Associates, BA, MA, etc)
- ❑ Provider Signature (physical signature or an electronic signature that meets state and federal statutes)

The emphasis of each progress note must include:

1. Measurable data relative to the accomplishment (or lack thereof) to the treatment objectives on the service plan
2. Significant events that provide an overall understanding of the person's ongoing level of independent functioning and quality of living

CCS Progress Note Anatomy & Required Elements

Insert Agency Name Here
CCS Progress Note

Consumer Name: ✦**Who** is the consumer?

Date of Service: ✦ **When** did the service occur?

CCS Service Array Category: ✦**Service Array:** service provided as authorized on the service plan

Location of Service: ✦ **Where** did the service occur? Home, Office, AFH, Community, etc

Type of Contact: ✦**Type of Contact:** Individual, Group, Team Meeting, Phone Call, etc

County Facilitator: Click here to enter text.

✦ **Specific Time & Duration of Service:** includes start & end time, and total minutes of service

Direct Service		Billing Summary	
Start	1:45 PM	45	Direct Service (min)
End	2:30 PM	15	Documentation (min)
Documentation		0	Non-Billable (min)
Start	3:30 PM	**4**	**Units of Direct Service**
End	3:45 PM		
Non-Billable			
Total Minutes	0		
Travel		17	Travel (Min)
Miles Traveled	10	**1**	**Units of Travel**
Minutes Traveled	17		

✦ **Travel for Service:** include both time and miles traveled

✦**Billing Claims:** total up the number of minutes and round to the nearest unit. Break out: Travel & Direct Service times (Face time + Documentation). Non-billable category is suggested/optional

Specific CCS Goal/Treatment Objective Addressed with Consumer:

✦ **Treatment Objective Addressed in Session:** must reference at least one treatment objective from the approved CCS service plan

What did staff do to assist the consumer today to address this goal/objective?

✦**Staff Interventions** Intentional service & action provided by the staff to help consumer meet their treatment objective

How was the consumer able to demonstrate growth/progress towards accomplishing the goal/objective? Describe consumer response to staff intervention.

✦**Progress Statement** is consumer showing progress? What was consumer response to staff? Any new barriers to address?

Additional Information (consumer presentation, observations, significant events impacting functioning level, follow up needed, etc):

✦**Functioning Level Statement:** what else is going on in their life? What is their general functioning level or quality of life like?

Print Name & Credentials: ✦ **Provider Name & Credentials (Printed/Legible)**

Provider Signature and Date: ✦ **Provider Signature & Date** Signatures must be a physical signature or a locked & encrypted digital signature with date stamp. Text boxes, drawing tools, or pictures of signatures are not acceptable forms of signatures

Service Locations

The location of the CCS service should reflect where the consumer was during the session/contact. A consumer's service plan may indicate or limit where a service may occur. Medicaid has a list of standard options for billing purposes that include:

Location Code	General Description
02 – Telehealth Provided to a Location Other than the Client's Home	Use when a client participates in the service via telehealth, but is not in their own home (e.g. coffee shop, program office, etc)
03 – School	Use when a client is participating in service at the school during the school operating hours. **School based services need explicit prior approval from both school and CCS team in order to use this location.*
10 – Telehealth Provided to a Client's Home	Use when a client participates in the service via telehealth within their identified home environment *(there is no requirement that it is their legal address, proof of residency, etc)*
11 – Office	Use when client is in an professional office setting (e.g. your agency, another agency, county building, doctor's office, etc)
12 – Home	Use when meeting the client within their home *(there is no requirement that it is their legal address, proof of residency, etc)*
14 – Group Home	Use when meeting the client at a group home, CBRF (community based-residential facility), AFH (adult family home), etc
99 – Other Place of Service	Use when meeting the client in a community setting or multiple settings through the session (e.g. library, coffee shop, store, traveling in a vehicle, etc)

Other locations/Institutional Settings: There are additional location codes for institutional settings such as: skilled nursing facility, hospital (in-patient), in-patient psychiatric facility, jail/detention facility, etc. In general, when the consumer is at one of these locations, CCS services are not billable. These locations may be billable to CCS when the service is a discharge service plan team meeting that is preparing the client to discharge back to their home within the next 30 days. Consult with the county treatment team on the specific situation as each facility location has different guidance.

- In the case of a minor/child, if the child consumer is in an institutional setting, services provided to caregivers are also non-billable due to the child's location status.

Telehealth Hybrid Session: If there is a service plan team meeting that is held in a mixed format of both in-person and virtually, the location code used is how you are interacting with the consumer. E.g. if you are in-person with the consumer use the appropriate in-person code. If you are seeing the consumer through an audio-visual platform use the appropriate telehealth location code.

Traveling: If a staff member is providing a CCS covered service while in a vehicle, the staff should use 99 – Other Place of Service.

Telehealth Requirements

CCS is able to utilize telehealth for services when it is medically appropriate.

Telehealth is when technology is used to conduct an interaction that is 2-way, interactive, real-time, and functionally equivalent to a face-to-face encounter. Telehealth does not include any form or written or text based exchange to include email, texts, or chats. Phone calls, or audio-only telehealth, has additional restrictions by Medicaid and may or may not be allowed under various program statute rules.

Requirements for the use of telehealth:

- The service is functionally equivalent to an in-person service for the consumer (The service and quality of service via telehealth needs to be comparable as if it were provided face-to-face)
- Providers are required to follow federal laws to ensure consumer privacy and security. This may include ensuring that:
    - The location from which the service is delivered via telehealth protects privacy and confidentiality of consumer information and communications.
    - The platforms used to connect the consumer to the telehealth visit are secure and HIPPA compliant
- Both the consumer and the provider must agree for a service to be performed via telehealth. Each agency must have their own signed consent agreement that meets the requirements listed in further detail below.
- The Consumer has the option to refuse telehealth at any time without it affecting their right to future treatment. The services should then be performed in-person, or referred to another service provider.
- The Provider has the right to decline the use of telehealth for any reason. The services should then be performed in-person, or the agency should refer consumers to another provider

Consent for Telehealth Guidelines

Each agency should develop and implement their own consent for telehealth that is reviewed and signed by the consumer. This consent agreement should be reviewed when an provider admits a consumer and at least on an annual basis. These methods must comply with all federal/state regulations and guidelines.

The consent for telehealth agreement needs to reflect:

- The consumer understanding of their right to decline services provided via telehealth without it impacting their future services
- The benefits and risks associated with telehealth to include privacy and confidentiality
- What to do in the event the telehealth connection fails or is not stable

Progress Note Documentation

- Documentation requirements for a telehealth service are the same as for an in-person visit and must accurately reflect the service provided.
- Documentation must identify the service delivery mode when provided via telehealth & document the following:
    - Whether the service was provided via audio-visual telehealth, audio-only telehealth, or in-person
    - Whether the service was provided synchronously or asynchronously (Note: Only synchronous (two-way, real-time, interactive communications) is reimbursable under telehealth)

- Additional information for which documentation is recommended, but not required, includes:
    - Provider location (for example, clinic [city/name], home, other)
    - Consumer location (for example, clinic [city/name], home)
    - All participants, as well as their roles and actions during the encounter (This could apply if, for example, a consumer presents at a clinic and receives telehealth services from a provider at a different location.)

Audio-Only Guidelines (e.g. Phone Calls) for CCS

- Whenever possible, telehealth services should include both an audio and visual component.
- Audio only telehealth may be used in limited circumstances where audio-visual telehealth is not possible due to consumer preference or technology limitations.
- The phone call service must still be functionally equivalent to an in-person service (as if you were there in person)
    - Note: A service requires a two-way, interactive exchange. Leaving a voicemail or listening to a voicemail is not billable.
- Documentation should include that the service was provided via audio-only telehealth.

When a Provider or Consumer is Out of State:

- ForwardHealth does not limit where members can receive telehealth services
- If the consumer is located outside of Wisconsin during a telehealth visit and still maintains Wisconsin Medicaid, the provider must follow all applicable state laws and practice standards for the state in which the consumer is located during the telehealth visit
- If the provider is located outside of Wisconsin, the provider must follow all applicable state laws and practice standards for the state in which the consumer is located during the telehealth visit

Reference: Permanent Telehealth Coverage Policy and Billing Guidelines (wi.gov)

Note Content & Service Delivery

CCS provides medical treatment services to its consumers in order to improve a person's functioning related to their mental health or substance use condition. CCS staff are paid from Medicaid insurance in the same way as a medical treatment provider (e.g. think of a doctor, nurse, dentist, etc). The difference is that Comprehensive *Community* Services allows these treatment level services to occur outside of a clinic or office setting within a person's home or the community they live in.

As such, contacts and interactions with a consumer must demonstrate a clinical treatment level of service within progress notes. There are 3 main requirements to capture in a CCS Progress Note:

1. Description of events and interventions that are related to the consumer's treatment plan
    a. Interventions must have a direct intention to treat the mental health/substance use need
    b. Interventions must have the focus of promoting ability to function on their own
    c. Interventions must be located in the most natural setting possible (home, community)
2. Measurable evidence of the consumer's progress during service delivery. This can include the consumer's response to services and noticeable changes in their condition during the service.
3. Significant events that contribute to an overall understanding of the person's ongoing level and quality of functioning, which may include changes in activity level, physical condition, cognitive condition, and/or emotional status.

When providing descriptions of events and progress, staff should use specific objective language and not use subjective language. Examples being "…had escalated behaviors…" vs "began yelling loudly and punching walls", "practiced coping skills" vs "practiced 4-square breathing technique".

The example note template referenced in this document can provide one example of how to capture this information in a written note narrative. Some agencies utilize a treatment note acronym to assist staff in capturing these elements (e.g. DAP, SMIRP, SOAP, STARS, TARP, etc). WRIC does not require a uniform progress note as long as all required elements are included on the progress note.

If any of the required elements of the progress notes are missing or unclear, a staff or agency may not be paid for their services, or may be asked to pay funds back to Medicaid during an audit recoupment process.

It is the responsibility of each agency to ensure their staff are adequately trained to write notes to Medicaid treatment standards.

Non-Covered/Non-Billable Services

There are very few guidelines around notes for non-billable services. It is encouraged that non-billable notes are completed and submitted to provide an ongoing understanding of the person's ongoing level of independent functioning and quality of living.

Common Non-Covered/Non-Billable Services Include:

- Missed/Cancelled Appointments
  - If the consumer or parent/guardian is not present the service cannot be billed.
- Text-Based Communications (text message, email, etc)
  - CCS requires a live interaction with consumers
- Indirect Services: Observations, Research, Scheduling Appointments
- Recreation-Oriented Activities & Camps
  - Per DHS, services cannot be primarily diversional in nature such as services which act as social or recreational outlets for the recipient. CCS is a medical treatment program and must demonstrate that a clinical treatment service was provided to address a diagnosed condition
- Transportation
  - The purpose of a session may not be primarily for transportation purposes.
  - CCS services may assist consumers in learning how to access or problem solve meeting transportation needs such as: learning to access public transportation or taxi services, utilizing Medicaid funded transportation services (MTM, Veyo), problem solving with friends, family, or other natural supports
  - CCS may provide an approved service array while traveling with a consumer, however the purpose of the session may not be primarily for transportation purposes.
- Crisis Intervention
  - CCS may support with utilizing coping strategies during a crisis, or help prompt a consumer to follow their crisis plan. However CCS does not provide on-call or unscheduled crisis intervention services. Each county has a crisis response program to assist with this need.
- Academic Supports
  - CCS services cannot replace what should be provided by a school district through a general education, an Individualized Education Plan (IEP), or 504 plan that a school would implement to remove barriers to learning due to a child's disability.
  - In practical terms, CCS cannot provide tutoring or homework assistance. CCS also has specific rules around what is allowable when a child is in school (or should be in school).
- Services Provided by Other Programs
  - There are a variety of different supports within the county and the community. Some common services may include: day treatment, respite, long-term disability services, sheltered workshops, supervised family visitation, housing assistance, crisis intervention, detoxification, medical care services, etc

Group Service Notes

Within the CCS program, a group service is when a staff member is supporting more than one participant at the same time. The group members may not all be CCS consumers (e.g. group members may be from CCS, CLTS, Family Care, DVR, private pay, community members, etc). If a staff member's responsibility, focus and attention is divided between more than one consumer, then the service is a group.

Group services cannot exceed 10 group members per staff member (i.e. a group service is 2-10 members).

If a group service is provided, the staff must write a separate note for each participant. The section of the note that describes "what was done in session today" may be the same for group participants if the same activities were done with all group members. The section of the note that describes "how the consumer was able to demonstrate growth/progress during the session" will need to be unique to each group member based upon their specific service plan treatment objectives.

The service delivery start/stop time, may be the same for all group members.

Time Billing Requirements

1.	**Direct Service**			**Billing Summary**
	Start	1:45 PM	45	Direct Service (min)
	End	2:30 PM	15	Documentation (min)
	Documentation		**4**	**Units of Direct Service**
2.	Start	3:30 PM		
	End	3:45 PM		
3.	**Non-Billable**			
	Total Minutes	0		
4.	**Travel**		17	Travel (Min)
	Miles Traveled	10	**1**	**Units of Travel**
	Minutes Traveled	17		

Start and End Time

When recording the specific start and stop time of a service, you need to separate out the direct service time from the documentation time.

1) Direct Service Time is the Face to Face time that you are meeting with a consumer (i.e. service delivery)
   a) The start and stop time of the direct service needs to be converted into minutes.

2) Documentation Time is the time that you are writing up the note for the service provided.
   a) The start and stop time of the documentation needs to be converted in to minutes
   b) Documentation should include the specific service provided and the specific time period spent documenting the service

The minutes of the Direct Service and Documentation should be added together and rounded to the nearest unit (i.e. quarter hour increment).

Non-Billable Time

3) There is no guidance for claiming non-billable time. Many agencies may claim non-billable time to help account for a staff member's time, and for considerations in fiscal decisions

Travel

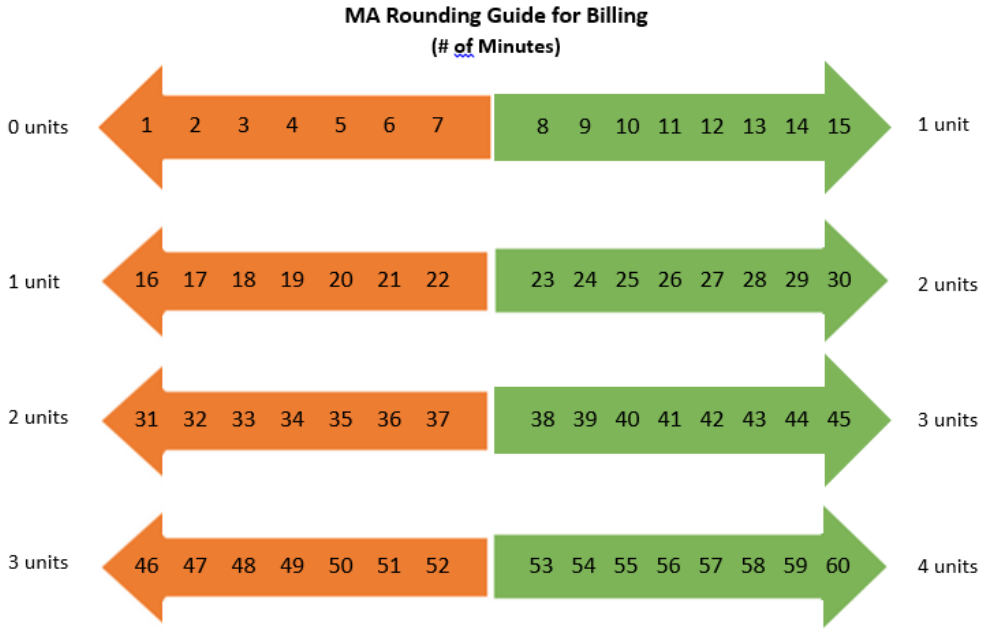
4) Travel miles and minutes need to be recorded on the progress note.
   a) Travel time is the time that a vendor is in the car driving to/from the service they will provide the consumer. If a consumer is in the car, it is not travel time
   b) The travel minutes need to be converted to units of travel (i.e. 1 unit = quarter hour increments)
   c) Travel time must be submitted on the same claim as the face to face service delivery to be reimbursable.
   d) If there is no billable face-to-face service with the consumer, travel time cannot be billed.

Multiple Services on the Same Date:

   a) Accounting for billable time for multiple services on the same date to the same consumer has additional rules for invoicing. Please reference the Invoicing section of the document

Medicaid Rounding Guides

After the total minutes has been calculated, the time is rounded off to the nearest 15-minute increment. For Medicaid the rounding rule is the service must exceed 51% to round up to the next unit. In practical terms, a service must be longer than 7 minutes in order to round up to 1 unit (15 minutes). The below charts help summary the rounding rules:



Units	Actual Time (Minutes)	Rounded Time
0	0 – 7 min	0 min
1	8 – 22 min	15 min
2	23 – 37 min	30 min
3	38 – 52 min	45 min
4	53 – 67 min	60 min (1 hour)
5	68 – 82 min	75 min (1 hour, 15 min)
6	83 – 97 min	90 min (1 hour, 30 min)
7	98 – 112 min	105 min (1 hour 45 min)
8	113 – 127 min	120 min (2 hours)

Travel Time

In CCS, travel time is when a staff member is driving to or from a consumer contact but the consumer is not in the vehicle. When a consumer is in the vehicle with a staff member, that time may be considered as direct service (face-to-face time). *Note: Medicaid travel billing rules are often different than agency mileage reimbursement rules.

CCS providers may bill a consumer's Medicaid insurance for travel to and/or from an in-person direct contact service that is medically necessary as described and authorized in the consumer's service plan.

a. Travel billing claims must include total time travel and total distance in miles traveled clearly documented in the consumer's chart.

b. Total time traveled for each consumer must be added up before rounding to the nearest 15-minute unit per CPT rounding guidelines.

c. Group Travel: provider travel time to a group service should be submitted on the claim for each member in the group. CCS defines group as more than one recipient of services and may include members from other programs and/or funding sources (e.g. CCS, CLTS, Family Care, etc)

d. Travel claims must be submitted in conjunction with the in-person direct service contact documentation and invoice claims.

e. If there is no in-person direct service contact, travel time is non-billable. Travel cannot be billed for a telehealth service. Providers may document any non-billable travel for record keeping purposes.

To preserve integrity and stewardship of Medicaid resources and in effort to prevent engagement in wasteful or abusive billing for travel, CCS service providers who chose to bill for travel costs will bill from closest originating location to the consumer's service location.

a. Waste of Medicaid funds includes activities that result in costs due to inefficiencies such as no clinically justified need for the travel or session, travel costs primarily serve the purpose of transportation and not for psychosocial rehabilitative services, etc.

b. Abuse of Medicaid funds includes activities that result in costs due to "bending the rules" such as time claimed is not supported by documentation, intentionally taking the longer route to claim a higher reimbursement, billing for a different service type (i.e. service array category or group vs 1:1) to receive a higher reimbursement rate, billing for services that are not medically necessary or approved on the consumer's recovery plan, billing a consumer's Medicaid insurance for a provider's own personal business, etc.

WRIC CCS does not support the Medicaid reimbursement for a staff member's normal commute to a workplace setting.

a. Providers cannot claim the costs of driving a vehicle between their home and their regular place of work. These costs are personal commuting expenses. Providers cannot claim commuting expenses no matter how far their home is from their regular place of work.
b. Primary or regular place of work is the location that a provider ordinally spends time conducting services. This may include an agency office building, agency satellite office building, a staff member's home office, or other regular workplace location. Leased or rented office spaces are considered satellite offices for the purposes of this guidance.

i. Home Office: If provider has an office in their home that serves as their primary place of business, the provider may claim travel time between their home and a direct consumer service.

ii. Two places of work/Traveling between satellite offices: If a provider works at two places in the same day, they may claim the time of getting from one workplace to the other. The provider must have a business need or service at both workplace locations and not simply travel past one workplace to commute to a secondary workplace.

c. If for some personal reason the provider does not go directly from one service location to another, a provider cannot bill to the consumer's Medicaid insurance for the provider's own personal business travel.

In general, travel may be authorized within the WRIC consortium or where the primary place of work is within a neighboring county to the WRIC consortium. Limited exceptions to this rule must have a case specific clinical need that is discussed within the treatment team, WRIC-CCS Program leadership, and potentially Division of Medicaid Services prior to being authorized. These exceptions will be documented in the consumer's record and reviewed on a regular basis.

Providers may be asked to pay back monies received to WRIC or the Division of Medicaid Services if improper billing has been determined as part of an audit or investigation.

a. Providers or entities suspect of engaging in fraudulent or abusive Medicaid billing practices may be reported to the Office of the Inspector General for investigation.

Requirements for Signatures on CCS Documentation

Documentation for CCS, including all assessments, service plans, and progress notes must be signed by the provider completing the service or a designee that has authority to sign in place of the provider (e.g. supervisor).

Signatures that will be accepted on client/consumer medical records are:

1. A Physical Signature placed on a printed document

2. An Electronic Signature:
    a. That is Applied to the document either via:
        i. Electronic Health Record system:
            a. That requires a confidential log-in and password for each user
            b. That displays a typed signature or unique personal identification code with date & time stamp

        ii. Digital Signature applied by the use of a stylus on a digital writing pad

    b. AND an also meets the requirements of:
        i. Only the provider has control of applying their unique digital signature
        ii. Once the digital signature is applied, the document contents or signature cannot be changed or altered in any way
        iii. The agency/provider has a written policy of maintaining and ensuring electronic records are kept confidential through an encryption software that is compliant with HIPAA standards
        iv. The program which applies the digital signature complies with the Health Information Technology Set of Standards (45 CFR Part 170)
        v. An annual electronic security risk assessment audit is completed to ensure electronic records are securely protected by HIPAA standards

    c. Common Occurrences that are Not Acceptable Electronic Signatures for Medical Records:
        i. Typing a provider name on a Word document
        ii. Utilizing the "Fill & Sign" Feature of Adobe Acrobat DC (basic version)
        iii. Copy & Paste a text box or picture with a signature

****** "Reimbursement for services paid to providers who do not meet all electronic signature requirements may be subject to recoupment." ******

References:

1. Forward Health; Comprehensive Community Services Handbook: Billing & Claims; Ch. 7 Provider Enrollment and Ongoing Responsibilities, Requirements for Use of Electronic Signatures, Topic #16157

2. US Department of Health and Human Services; 45 Code of Federal Regulations Part 142.310: Security and Electronic Signature Standards

Example Progress Note Template

Insert Agency Name Here
CCS Progress Note

Consumer Name: Click here to enter text.

Date of Service: Enter a date.

CCS Service Array: Choose an item.

Provider Location: Choose an item.

ConsumerLocation: Choose an item.

Type of Contact: Choose an item.

County Facilitator: Click here to enter text.

Direct Service		Billing Summary	
Start	1:45 PM	45	Direct Service (min)
End	2:30 PM	15	Documentation (min)
Documentation		**4**	**Units of Direct Service**
Start	3:30 PM		
End	3:45 PM		
Non-Billable			
Total Minutes	0		
Travel		17	Travel (Min)
Miles Traveled	10	**1**	**Units of Travel**
Minutes Traveled	17		

(double click on above table to edit)

Specific CCS Goal/Treatment Objective Addressed with Consumer:
Click or tap here to enter text.

What did staff do to assist the consumer today to address this goal/objective?
Click or tap here to enter text.

How was the consumer able to demonstrate growth/progress towards accomplishing the goal/objective? Describe consumer response to staff intervention.

Click or tap here to enter text.

Additional Information (consumer presentation, observations, significant events impacting functioning level, follow up needed, etc):
Click or tap here to enter text.

Print Name & Credentials: Click here to enter text.

Provider Signature and Date:

Examples of Progress Note Content

Community-Based Note

Staff met with client at the office for weekly individual session. Client was dressed and groomed appropriately and had slight smile when greeting staff. Session held to provide client with 1:1 skill development services to support use of 2 positive coping skills each week when feeling anxious. Staff explored client use of coping skills during the week. Client reported using deep breathing one time and found it was not helpful. Staff discussed utilizing silent counting to center self when anxious. Client did not think it would work but agreed to try. Staff assisted client by practicing. Staff accompanied client to common area to engage with peers, and practice using silent counting. Client had some challenges as they avoided engaging with peers and stood at outside edge of room. Client shared they were not ready to engage with peers. Staff and client discussed trying to engage with peers again next week.

Billing Time: 5 units Individual Skill Development & Enhancement
60 min direct service (1:00-2:00 PM); 15 min documentation (2:00-2:15 PM)

Susan Smith, BA

Residential Note

First Shift: 7am-3pm

9:00-9:15am	Medication Management: Staff had to wake resident up to remind them to take medications. Staff discussed with resident importance of taking medications at same time each day. Staff and resident problem solved methods to wake-up around same time every day. Resident to try setting alarm on cell phone for tomorrow. JD, RW
10:00am-10:20am	Individual Skills: Staff attempted to work with resident on laundry. Resident became upset when washing machine was in use by another resident. Resident was cussing and went to room of other resident. Staff intervened and assisted with moderating discussion between residents to work together to develop a laundry plan. JD, RW
2:30pm – 2:48pm	Wellness: Resident approached staff to seek feedback and process new relationship with boyfriend. Resident felt boyfriend was making demands of resident that made her feel uncomfortable. Staff and resident discussed healthy boundaries in relationships and role-played ways resident could stand up for herself when talking with boyfriend next. JD, RW
Billing Summary	1 unit Medication Management (15 min service, 4 min documentation) 2 unit Individual Skill Development (20 min service, 4 min documentation) 1 unit Wellness Management (18 min service, 4 min documentation) *Johanna Dearing,* RW

Billing Invoice Process & Checklist

- Staff must be credentialed and approved to provide Medicaid treatment Services under the CCS program benefit prior to beginning to bill for services (reference Provider Handbook for credentialling requirements).

- Progress notes and invoices should be submitted to HSInvoices@lacrossecounty.org by the 5th of the following month or no later than 60 days from the last date of service, or payment may be permanently denied.

- For WRIC-CCS you must use a WRIC approved fiscal invoice to submit your claims. Invoices that are submitted on unapproved invoice forms will not be processes, and be returned to the vendor to re-submit on an approved invoice.

- Fiscal/QA team will review and process invoices submitted on a first come/first serve basis based on date and time stamp of submission.

- QA team is expected to start the initial review within 15 days of receipt of invoice.

- QA team will review invoices and progress notes for functional errors and communicate with the vendor if corrections are needed. Vendors are expected to review, correct, and re-submit invoices and notes prior to QA completing the fiscal submission process.

- Common examples of issues:
  - **All billing providers must be rostered with the CCS program and have required personnel documentation on file** in order to process billing for Medicaid (i.e. performing provider roster completed – background checks, copies of degrees, training logs, reference checks, etc).
  - **Progress notes and invoice MUST MATCH** or will be sent back for corrections and will not be paid until corrected.

- All corrections must be within the 60 days or invoice will not be paid.

- If an invoice claim is clean (needing no corrections), the process to approve and pay vendors takes approximately 6-8 weeks from time of submission. If an invoice or progress notes are in need of corrections, that timeline will be longer, dependent upon the agency's response time to submit the corrections.
  - Providers should be aware and make financial plans to not be solely dependent upon Medicaid reimbursement to reduce impacts to agency cashflow needs.
  - It is highly recommended that agency's have their own internal quality assurance process to review invoices before they are submitted.

Required Elements of an Invoice:

- ☐ Organization Name
- ☐ Organization Address
- ☐ Billing Contact Name
- ☐ Billing Contact Telephone Number
- ☐ Invoice Number (The invoice number needs to be unique for each invoice and is created by the agency)
- ☐ Invoice Date (Date that the invoice is created)
- ☐ Program (Funding Source) – CCS
- ☐ Consumer Name (First and Last Name)
- ☐ Service information (requires a new line on the invoice for each service)
    - Date
    - Service description
    - Individual or Group service modifier
    - Service Location modifier
    - Type of Contact modifier
    - Service units
        - Direct service and documentation units with service array item listed)
        - Travel units (time in units spent by provider traveling to and from CCS service with CCS client)
    - Contracted Unit Rate for the appropriate service
    - Name of individual who provided the service
    - Degree Type for individual who provided the service (ex. Associates, Bachelors, Masters, PhD, MD)
- ☐ Invoice total will automatically populate

Provider Name:	ENTER AGENCY INFO HERE
Provider Address:	
Provider City/State/Zip:	
Provider Contact Name:	
Provider Phone Number:	

Invoice Date:

Invoice Number:

SUBMT TO: La Crosse County Human Services
Attn: HS Fiscal Services
300 4th Street North
La Crosse, WI 54602
EMAIL: hsinvoices@lacrossecounty.org

Services for the Month of:

Total Amount Billed for Services: $ 431.80

Program (Funding Source)	Participant Name (Client)	Date of Service	Service Description (CCS-Include travel separately)	Individual or Group	Service Location	Type of Contact	Service Units (CCS = Qthr)	Contract Rate	Amount Billed	Performing Provider / Clinician Name	Credentials (Degree) of Provider
CCS	**EXAMPLE** John Doe	01/05/22	Diagnostic Evaluations	Individual	12 Home	Face-to-Face	5	$ 21.59	$ 107.95	Sarah Morschauser	Bachelors
CCS	**EXAMPLE** John Doe	01/16/22	Wellness Management & Recovery Services: Service Planning	Individual	10 Telehealth: Consumer in Home	Audio-Visual	5	$ 21.59	$ 107.95	Sarah Morschauser	Bachelors
	EXAMPLE John Doe	01/10/22	Psychoeducation: Service Planning	Individual	02 Telehealth: Consumer at Other Location	Audio only	5	$ 21.59	$ 107.95	Sarah Morschauser	rw
	EXAMPLE John Doe	01/15/22	Individual Skill Development & Enhancement	Individual	11 Office	Face-to-Face	5	$ 21.59	$ 107.95	Sarah Morschauser	Masters
	EXAMPLE John Doe	01/23/22	Psychotherapy	Group	11 Office				$ -		

Invoicing Scenarios:

- ☐ Face to Face Service & Documentation is on different dates:
  - If service delivery and documentation are completed on the same date of service, it should be combined into one detail on the invoice
  - If service delivery and documentation are completed on different date of services, there should be separate claims on the invoice (documentation would still be whatever service array category as the service provided)

- ☐ Multiple Services on the same date of service:
  - Providing the same service on the same date by the same provider to the same consumer must be combined together before rounding to the nearest unit
    - *Example: 8 minutes of individual skills in the morning and 9 minutes of individual skills in the evening to the same consumer is a total of 17 minutes of service for the day (8+9=17).*
  - Providing different services on the same date by the same provider to the same consumer are separated by service array type.
    - *Example 8 minutes of individual skills, followed by a 45 minute team meeting is two separate notes and invoice entries. 8 minutes ISDE, 45 minutes service plan/team meeting.*

- ☐ Which Invoice Service Description category type do I use?
  - Reference the CCS service plan. There will be language similar to "Vendor of …". Most authorizations will cover: direct service (face-to-face and documentation), telehealth (face-to-face equivalent), service plan/team meetings, and travel.
    - *Example: you may be authorized Individual Skill Development and Enhancement. Your invoice may have lines reflecting:*
      - *ISDE – direct service*
      - *ISDE – travel*
      - *ISDE – telehealth*
      - *ISDE – service plan meeting*
      - *ISDE – service plan meeting – travel*

Reviews & Audits

Several persons and entities may review the notes you write.

- Consumers, Family members, and Guardians have a right to review any information in their medical record including your progress notes
- WRIC Staff: Service Facilitators and Mental Health Professionals will review your notes to ensure the services are appropriately meeting the consumer's assessed needs
- Quality Assurance (QA) & Fiscal: will review your notes to ensure that data points are present in order to process billing with Medicaid
- Court & Legal Systems: notes may be reviewed as part of a court proceding to determine a person's competency or safety, to investigate misconduct allegations, or other purposes
- State Department Division of Care and Treatment Services: may review notes to ensure consumer needs are being aquately meet
- State Department of Quality Assurance: will audit note samples to ensure all documentation and service requirements are met.
- Office of the Inspector General: will audit note samples to ensure that Medicaid fund are being spent appropriately on medical treatment services.

Inadequate documentation may result in denied payment, fines, fees, or requirement to pay back funds to Medicaid, WRIC CCS, and/or consumers.

Common Mistakes to Self-Audit on:

- Ensuring you are authorized to provide the service. Staff can only bill for services once authorized on a valid Medicaid treatment plan. No plan, no service.
- Progress Notes lack intention. It's not clear what the staff did or why they did it
- Service Interventions described are not approved or medically needed.
    - If the interventions are not approved on a Medicaid treatment plan, they are not allowable or reimbursable for payment.
    - CCS cannot provide services that are based upon the convenience of a consumer, family member, or provider; they have been determined as *needed* not simply *wanted.*
    - CCS cannot provide services that serve as social diversions (i.e. being the consumer's social outlet/friend, or respite/daycare replacement).
- Progress Notes are observation based. CCS pays for intentional, interactive services. The consumer must be part of the service intervention in order for it to be billable.
- Services are not provided by qualified staff.
    - The staff member providing the services has proof that they are appropriately trained, have degrees/credentials to provide the services within their scope of practice, engage in clinical supervision to receive guidance on clinical treatment services.
- Copy & Paste notes. CCS services need to demonstrate a unique interactive exchange with each contact. There are times when notes may look similar, however a person's presentation and progress should change with each service contact.
- Time Math. Calculating specific minutes from clock times and rounding errors are very common.
- Transposing Errors. It is also very common to make mistakes when creating invoices and making mistakes when copying information from progress notes.

References

- Forward Health: Medicaid Services: Comprehensive Community Services
  - Provider Responsbilities
  - Covered and Non-Covered Services
  - Claims & Reimbursements
- US Department of Health and Human Services; 45 Code of Federal Regulations Part 142.310: Security and Electronic Signature Standards
- Wisconsin Statute Code Chapter DHS 36: Comprehensive Community Services
- Wisconsin Statute Code Chapter DHS 107: Covered Services

Additional Resources, Guides, and Trainings are available on the WRIC Sharepoint Site. For access talk to your agency supervisor.

Staff Acknolwedgement Form

PROVIDER PACKET
DOCUMENTATION EXPECTATIONS

I, _____ of _____ acknowledge that I have received
(Print name of Individual) (Print name of organization)

a copy of the;

_____ WRIC Provider Packet
_____ WRIC Provider Documentation Expectations Packet
_____ WRIC Clinical Supervision Expectations Packet

I have reviewed and understand the information enclosed.

_____ Date_____
(signature)

Return to your agency supervisor to be submitted to WRIC Administration

Updated 03.2024 RR