Dane County CCS Claims for Services/ Progress Note Guidance

Progress Notes Defined by ForwardHealth

*Progress notes (therapies or other treatments administered) must provide **data relative to accomplishment of the treatment goals in measurable terms**. Progress notes must also document **significant events** that are related to the person's treatment plan and assessments and that contribute to an overall understanding of the person's ongoing level and quality of functioning*

Claims for Reimbursement Expectation excerpts from *DHS 106.03(2)(a)*

CONTENT

(a) *In the preparation of claims, the provider shall use, as applicable, diagnosis, place of service, type of service, procedure codes and other information specified by the department under s. DHS 108.02 (4) for identifying services billed on the claim.*

(c) *Whether submitted directly by the provider, by the provider's billing service or by another agent of the provider, **the truthfulness, completeness, timeliness and accuracy** of any claim are the sole responsibility of the provider.*

(d) *Every claim submitted shall be signed by the provider or by the provider's authorized agent, certifying to the accuracy and completeness of the claim and that services billed on the claim are consistent with the requirements of chs. DHS 101 to 108 and the department's instructions issued under s. DHS 108.02 (4).*

Provision of Services Expectation excerpts from DHS 106.02(9)

9) *MEDICAL AND FINANCIAL RECORDKEEPING AND DOCUMENTATION.*

(a) *Preparation and maintenance. A provider shall prepare and maintain truthful, accurate, complete, legible and concise documentation and medical and financial records… for specific services rendered to a recipient by a certified provider. In addition to the documentation and recordkeeping requirements specified in pars. (b) to (d), the provider's documentation, unless otherwise specifically contained in the recipient's medical record, shall include:*

1. *The full name of the recipient;*

2. *The identity of the person who provided the service to the recipient;*

3. *An accurate, complete and legible description of each service provided;*

4. *The purpose of and need for the services;*

5. *The quantity, level and supply of service provided;*

6. *The date of service;*

7. *The place where the service was provided; and*

8. *The pertinent financial records.*

(b) *Medical record content. A provider shall include in a recipient's medical record the following written documentation, as applicable:*

1. *Date, department or office of the provider, as applicable, and provider name and profession;*

2. *Chief medical complaint or purpose of the service or services;*

3. *Clinical findings;*

4. *Diagnosis or medical impression;*

5. *Studies ordered, such as laboratory or x-ray studies;*

6. *Therapies or other treatments administered;*

7. *Disposition, recommendations and instructions given to the recipient, including any prescriptions and plans of care or treatment provided; and*

8. *Prescriptions, plans of care and any other treatment plans for the recipient received from any other provider.*

Service Delivery Expectations from DHS 36

Service delivery information, including all of the following:

1. *Service facilitation notes and* ***progress notes****.*

2. *Records of referrals of the consumer to outside resources.*

3. Descriptions of significant events that are related to the consumer's service plan and contribute to an overall understanding of the consumer's ongoing level and quality of functioning.

4. Evidence of the consumer's progress, including response to services, changes in condition and changes in services provided.

5. Observation of changes in activity level or in physical, cognitive or emotional status *and details of any related referrals.*

6. *Case conference and consultation notes.*

7. Service provider notes in accordance with standard professional documentation practices.

8. *Reports of treatment, or other activities from outside resources that may be influential in the CCS's service planning.*

Dane County CCS Guidance for Progress Notes

Claims for Services / Progress Note Checklist

- ☐ I have been **authorized** to provide a service to the identified client as evidenced by a **current service authorization** in the DCDHS CCS module, an **action step in the client's CCS recovery plan** indicating how my services will assist client in reaching their recovery goal, and I have the appropriate **qualifications** to provide the authorized service.[1,4]
- ☐ Client name, date of service, time of service, place of service, and type of service are **true, accurate, and complete**.[2]
- ☐ I have documented an **accurate and complete description of the service/ intervention** I provided. [3]
- ☐ I have documented the **purpose and need for the service/ intervention** I provided.[3]
- ☐ The **service/ intervention** I provided **is an allowable CCS service**. [4]
- ☐ I have documented my **clinical findings**.[3]
- ☐ I have documented the **disposition of the client and their response to the intervention** I provided.[3]
- ☐ I have documented **my recommendations, instructions, and plan of care for the client.** [3]
- ☐ I have documented **data relative to the client's accomplishment of goals in measurable terms**. [5]
- ☐ I have claimed **true and accurate units of time** to deliver my service/ intervention, documentation time, and travel time (if applicable). [2,6]

[1] DHS 36.17
[2] DHS 106.03(2)
[3] DHS 106.02(9)
[4] Forward Health Covered Services
[5] Forward Health Medical Records
[6] Combating Fraud, Waste, and Abuse

TIPS FOR PROGRESS NOTE REVIEW

Ask agencies to use the DAP format so the content is easier to find within the note.

BASIC INFO TO LOOK FOR:

- Only direct services to the client (or family member in limited circumstances as allowed by the Service Array) as a means to assist with their recovery plan goals as it relates to the client's HM/SU diagnoses)
- Remember: The duration and frequency should be appropriate for the client's needs and stated goals, as well as consistent with the client's recovery plan and comprehensive assessment.
- Is it psychosocial rehabilitation (skill building)? **Only services found in the service array are billable services.**

D = DATA

Content of the "session" or "service" further **described**

Remember Seven Standards=who, what, where, when, why, how, how much

- **Who, When, & How Much…** indicated at top of progress note
- **Where** did the service occur? Location could be client's home, office, community, etc.

Most of the narrative is contained in answering **What, How, and Why……**

- **Why….Why did you do it? What was the purpose of the service?**
  ****It should always relate back to the goals the provider is tagged into on the recovery plan**
- **What…What happened? What did THE PROVIDER DO and**
- **How did the provider do it?** (action steps on recovery plan)
  - Specific approaches? Treatment modalities used?
  - Why was this approach, location, etc was chosen.
  - Interventions provided/attempted or any actions taken
  - Must be for direct benefit of client
    (for SF's indicated on RP & based on assessed need on CCS Assessment)

A = ASSESSMENT

What is the writer's assessment or understanding of how the session/meeting/visit went with the client?
How did the client respond to the interventions used?

P = PLAN

Based on the writer's assessment and observations, what is the plan? What is the client doing in the interim? What natural supports will be utilized? Is revision to the treatment necessary? Does the writer need to follow up with specific providers or team members? What is the writer doing next and when is the next session, meeting, etc.?

Evaluating the Quality of a DAP Progress Note

The following scoring grid can be used to evaluate the quality of progress notes with the goal being to improve the quality of notes over time with a standardized scoring system.

Item	Structural Item of the Progress Note	Score of 2	Score of 1	Score of 0	Score
1	Is the note structured in the DAP format, identifying each category? D - Data A - Assessment/Response P - Plan	Note is structured in the DAP format utilizing the DAP documentation format	Note does not utilize the exact DAP documentation format but does cover all categories.	Note is not structured in DAP format nor does it cover all of the categories.	
2(D)	Does the note have a clear statement of who was present, the purpose for the meeting, the intervention/activity connected to a treatment plan goal that took place using action words?	The note clearly indicates why the meeting occurred, interventions/ activities that took place linked to a treatment plan goal, using action words.	Either the purpose for the meeting was unclear or the activity was not linked to a treatment plan goal.	There is not an indication of the purpose for the meeting or linkage of activity to the treatment plan.	
3 (A)	Does the note contain the provider's assessment of consumer's disposition and response to the session/intervention? Does the note document any significant changes since last session? Does the note document MSE?	The note included an evaluative statement that was clear regarding response and participation, al.so utilized clients own words. The note includes MSE.	The note contains an evaluation of the consumer's disposition, response to session, and/or MSE but the statement is vague or general (e.g. client was satisfied with the session)	There is no indication of consumer's disposition, how consumer responded to the session, or what was achieved. There note does not document MSE.	
4 (P)	Does the note contain information regarding the plan moving forward? When is next scheduled meeting? What will be worked on?	The note contains a specific date for the next meeting and it also includes a brief statement about what will occur in the next session.	The note contains a follow up date or a brief discussion of what will occur in the next meeting, but not both.	There is no indication of a follow-up session or it is unclear when the two individuals will meet again and for what reason.	
				Total Score:	

Scoring	
8	a complete and adequate DAP note
4 - 7	likely an acceptable note, although there may be suggestions for improvement
0 - 3	the note is inadequate; improvement is needed prior to approval
Note: a score of "0" in categories 3 or 4 may also indicate an inadequate note, even if the total score is 5 or above	

Reasons Progress Notes Get Denied

- Progress note is a **duplicate note** (same author, same client, same date and time of service, same service billed).
- Progress note date/time **overlaps** with another progress note date/time from *same author*.
- Progress note date/time **overlaps** with another progress note date/time for the same client from *different author*.
- Progress note date/time has been **forward dated/timed** to future date/time from original signature date/time after an unlock request.
- Service provided is **not a billable service**, but was identified as a billable service by the author (i.e. leaving voicemails).
- Note is identified as an individual service, but the narrative indicates **group service**.
- Author is **not qualified** to provide identified service.
- Author is **not authorized** to provide identified service.
- **No** indication of actual **PSR (psychosocial rehabilitation) service** was provided in note.
- Service is **not authorized** in recovery plan.
- Client is **out of state**.
- Note entered **in the wrong client chart** (QA voids these progress notes).

How can I avoid my progress notes being denied?

- Know what services you are qualified to provide.
- Ensure your services are identified in the recovery plan.
- Ensure progress notes are entered and signed within 2 business days of the service [Timely Exchange of Information].
- Monitor your progress note entries by running your case note time report in the module.
- Know Forward Health rules about what can be billed and what is note billable.
- Ensure you document interventions you utilized during your services.
- **Utilize the unlock process and then opportunity QA Staff give you when they unlock your notes for fixes. After 2 unlock requests from QA Staff – if no fixes have been offered, the note will be denied.**
    - Reminder – QA Staff are unable to unlock notes once they have gone through the billing cycle (8th of the month) and may result in denials if fixes are unable to happen.

Other Helpful Hints:

- Our system automatically rejects claims for services provided when there is:
    - No current Physician Rx
    - No current Recovery Plan
    - Authorized services have reached their limit
- **Progress Notes** (therapies or other treatments administered) must provide data relative to accomplishment of the treatment goals in measurable terms. Progress notes also much document significant events that are related to the person's treatment plan and assessments and that contribute to overall understanding of the person's ongoing level and quality of functioning. [Forward Health]

Know your service array!

Generally Billable Services

Direct Consumer (or family member if allowed by service array) **Contact Psychosocial Rehabilitation Services** that are written into the Recovery Plan at the frequency written in plan if agency is authorized to provide that services.

Time spent at Recovery Team meetings for all CCS Staff on team (their service category, must identify in progress note it's a Recovery Team meeting, and client/ guardian must be present)

Travel time to meet with participant for approved services **IF** service was rendered.

Time spent to document your services.

Services do depend on who you are, your role on the team, what is authorized on the plan and what is documented in the progress notes….

Not Billable to CCS

**** Impacts ALL providers on team****

Participant does not have MA coverage

Physician prescription has expired

Authorizations within recovery plan are not approved or have expired

Participant is in jail or juvenile detention

Participant is in residential care center (youth)

Service documented has no indication of psychosocial rehabilitation services provided

Voicemails

Travel to participant's home when participant is not home

Supervision

Agency administrative tasks

Participant is enrolled in CSP and targeted case management,

Service Facilitators have some options for billable time that array providers do not have:

- Discharge planning (consumer is in IMD, hospital, SNF, Day Tx, PHP)
- Texts/ emails **IF** there is reciprocal communication and **IF** it reaches threshold for billable time (activities to ensure service delivery)
- Case Consult/ activities to ensure service delivery with team members

Combining Multiple Contacts into 1 Progress Note

Many Service Facilitators (SFs) are providing an array of services to their clients throughout the day and may be doing different tasks for the same client during various parts of the day. What is the best way to capture these various contacts in 1 progress note?

- It is important that SFs are being mindful of the times when they are working with their clients to ensure the times are captured in the narrative.

Best Way:

The best way to capture multiple contacts in the same day is to document the times at the top of the narrative. This way, when QA Specialists review overlapping notes, it shows that the times do not technically overlap with one another even though the notes will be flagged as an overlap.

Example: Same SF working with 2 different clients throughout the day.

Client	Service Array	Author	Event Dates	Narrative
Client1	Service Facilitation	DANE COUNTY CCS Jane Smith	8/2/2021 8:45a-10:15a (Service Time = 1 hr 30 min)	8:45a-8:55a; 2:00p-3:20p *then continue progress note in DAP format. D A P
Client2	Service Facilitation	DANE COUNTY CCS Jane Smith	8/2/2021 8:30a-9:00a (Service Time = 30 min)	8:30a-8:40a; 12:00p-12:20p *then continue progress note in DAP format. D A P

*the date/time of service should reflect the start time of working with/on behalf of the client.

How to Review Unlocked Notes

If a note has been unlocked by a supervisor or CCS QA staff, the provider will receive an email notification that a note has been unlocked. In order to see why a note has been unlocked, the provider will need to review this in the module.

Step 1: Sign into the module database and go to the module inbox messages (screenshot below).

Step 2: In the module inbox, the provider will receive a detailed message outlining which note was unlocked, who unlocked the note (please connect with the individual who unlocked the note if further clarification is needed) and what needs to be fixed.

A progress note has been unlocked.

Sarah ServiceFacilitator	**10/15/2020**
A progress note for client Starbucks, Sally (Client No: 922126) on 10/15/2020 08:00 AM in the CCS module was unlocked by **Sydney Kamp** for the following corrections: **Unlocked – Please review type of contact (currently mailing).** Click the requested correct to view the note.	

Step 3: The provider will click the **unlocking comment** (bold, blue lettering) and the module will take the provider directly to the note (there will be another pop-up when the provider goes to the note with the same info. as the module inbox message). The provider can then make the requested changes and resign the note.

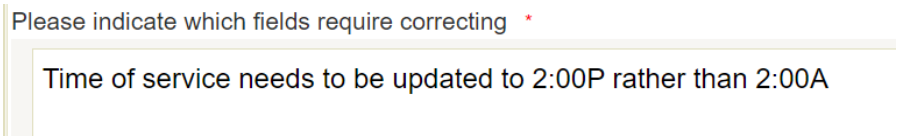
How to Request a Note to be Unlocked

If a provider notices something needs to be changed about a signed note (i.e. date/time of service, service length, adding/taking away travel, service type, etc.), the provider will need to request an unlock. The only piece of a note that cannot change is the narrative (clarifying information or additional content can only be added through an addendum). ***An unlock is not needed to add an addendum.***

Step 1: Sign into the module database, search the client and select the note that needs to be unlocked.

Step 2: The provider will need to state *why* the note needs to be unlocked. Put the unlock request in the box that states: *please indicate which fields require correcting* (screenshot below). It is best to be very specific in the request. Please see some examples below.

- Date of service needs to be updated to 9/20/20.
- Service time needs to be updated to 60 minutes rather than 45 minutes.



Step 3: Once a request has been put into the text box, the provider will click ***unlock*** at the bottom of the screen and this will prompt the supervisor or CCS QA staff to review the comment and unlock the note.

How Supervisors Unlock a Note after a Request

A provider/staff member may ask for an unlock request and this request will likely go directly to their supervisor. The supervisor will receive an email notification that a provider/staff member requested a note to be unlocked. The supervisor will need to review the unlock request in the CCS module to unlock the note.

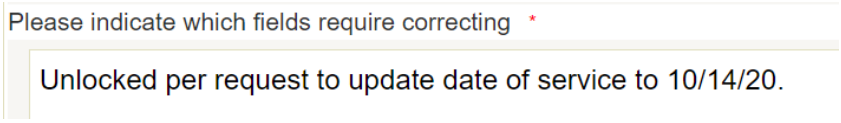
Step 1: Sign into the module database and go to the module inbox messages (screenshot below).

Step 2: Click on the message to review the unlock request. Below is an example of an unlock request message in module.

A progress note has been requested to be unlocked by Sarah ServiceFacilitator.

Sarah ServiceFacilitator	**10/15/2020**
Sarah ServiceFacilitator has requested a progress note for client Starbucks, Sally (Client No: 922126) on 10/15/2020 08:00 AM in the CCS module to be unlocked for corrections. **Reason for Unlock: I need to change the date to 10/14/20.** Click the link above to view the note.	

Step 3: The supervisor will click the **unlocking comment** (bold, blue lettering) and the module will take them directly to the note. The supervisor will be *required* to write an unlock comment, which is a statement that clarifies what needs to be changed about the progress note. It is best to provide clear directions on what needs to be updated/changed about the note as this statement is what the provider/staff member will see when reviewing the unlocked note.



Step 4: Once the unlock comment is put in the text box, the supervisor will click ***unlock*** at the bottom of the screen and the provider will be notified that a note has been unlocked in the module. The provider needs to follow the directions of "how to review unlocked notes" to read the unlock comments in the module.

How to Request a VOID

If a provider enters a progress note into the incorrect client chart, they will need to request a VOID. Reminder, VOIDs will only be done if a note is in the wrong client chart. If a note was entered incorrectly, such as a duplicate note or the wrong date/time, please use the unlock function to fix the information or use the addendum function to make any clarifications to the narrative or note.

When a note has been entered into the incorrect chart, please connect with QA Specialists, Erin Rodell and Sydney Kamp via email.

Step 1: Email Erin and Sydney: rodell.erin@danecounty.gov and kamp.sydney@danecounty.gov

Step 2: Please provide as much information as possible as it will help identify the correct note to send for the VOID request.

- Client Name and Number
- Date/Time of Progress Note
- Reason for VOID

Step 3: VOID requests will be completed at the end of the week.

How to Add an Addendum

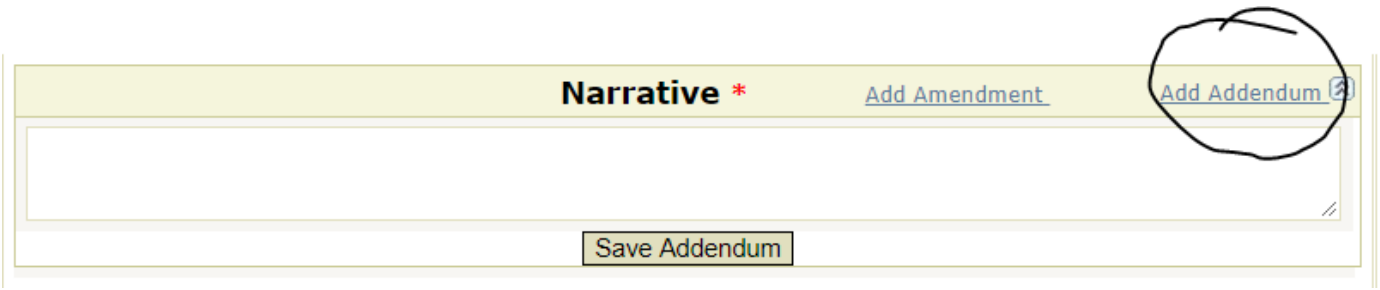
If a note requires clarifying information after it has been signed, this would be done through an addendum. Once a note is signed, the provider cannot change the narrative. ***An unlock is not needed to add an addendum.***

Step 1: Sign into the module database.

Step 2: Go to the note in the client's chart.

- **Reminder**: An addendum can be added when a note is signed or unsigned, but only the original signer of the note can add an addendum. Again, an unlock is not needed to add an addendum.

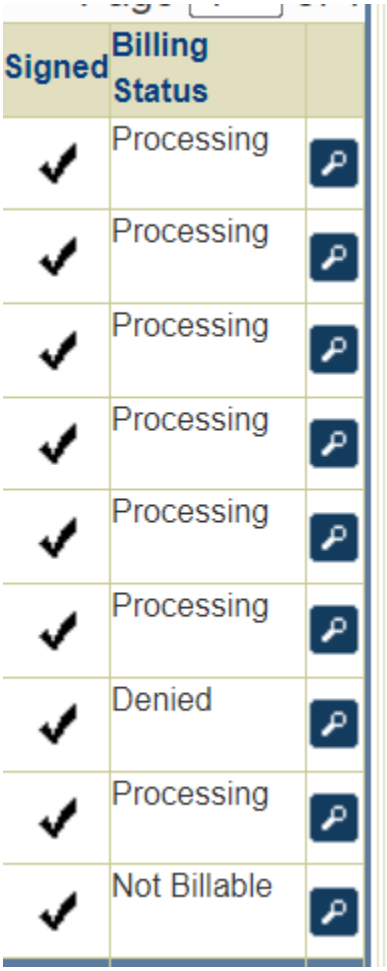
Step 3: Scroll down to the narrative section and click the hyperlink that states, "Add Addendum". From there, the provider can add additional clarifying information to the note.



Billing Status of Progress Notes

The module has a feature to allow providers to know the status of each note entered into the module. In the progress notes section of the module, providers will see a billing status next to each note.

Example from Module



Statuses

PN or Pending = These are claims that are still waiting to be Submitted to the County for processing.

SB or Submitted = These are claims that have been Submitted to the County and are ready for processing.

WD or Withdrawn = These are claims that will NOT by Submitted to the County and will not be processed.

XS or Excess = These are claims that have exceeded the Authorized number of hours and cannot be Submitted to the County unless the Authorization is increased.

DE or Denied = These are claims that have been Denied by the County, with the Reason for Denial being listed to explain why.

AD-DE or Administrative Denied = These are claims that have been Denied by Forward Health.

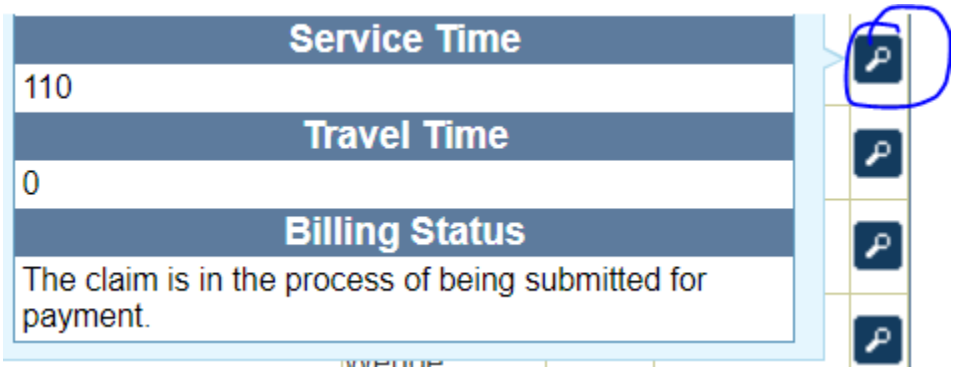
PC or Processing = These are claims that are being processed.

SB-STATE or Submitted to State = These are claims that have been Submitted to Forward Health.

AP or Approved = These are claims that have been Approved by Forward Health.

PD or Paid = These are claims that have been Paid by Forward Health.

The description of the billing status can also be found by hovering over the magnify glass next to the billing status.



Please note for denied notes, the module is not yet capable of providing the exact reason. Please locate that information in the billing module.

Group Services and Entering Notes

Curriculum: Submit a proposed curriculum to CCS Service Director, Jessica Gilbert prior to beginning group services. The QA team will review the curriculum and attempt to clear up any concerns ahead of time prior to claims being entered into the module.

Group Services in CCS: Maximum group size in CCS in 10 participants. It is import to clarify that "**support groups**" are **NOT** a billable service as they are not considered treatment. Other things to keep in mind:

- Be sure your group meets identified needs (as described in your group bio) and that the treatment provided relates directly to the assessed need of the clients you will be engaging with (both individually and in a broader sense).
- Before starting services be sure that goals/objectives/lessons/interventions are well documented in the client's recovery plan and action steps (work with client's SF).
- Review the hours of service that will need to be approved and act within the authorized time allotted.
- Discuss, determine and document how progress will be measured as well as in your progress notes.
- Remember that only time **providing direct staff intervention** is billable to CCS
- Clients within a treatment group can be working on different individual goals, as long as the group format/topic/objective is an appropriate intervention to assist the consumer with meeting their goals(s).

Billing/Documenting in the Module:

When you document a Group Service in a Progress Note, you are required to enter the number of CCS Clients and number of Non-CCS Clients in attendance. The easiest way to think about Group Billing, is that you will be paid a Fraction of your Unit Rate based on the **TOTAL NUMBER of Clients in attendance**.

- Example: If the Unit Rate is $22.50 per 15 minute increment, and there were 10 clients in attendance for a session, your documented progress note would pay out at $2.25 per 15 minute increment. The group facilitator would need to write a separate progress note for each CCS Client in the group.

If you have **multiple facilitators** for your group, the providers would need to separate the clients they bill for. So in the example of a 10 client group, Facilitator A would bill for 5 of the clients, and Facilitator B would bill for the other 5 clients.

The last thing to mention about Group Service is how to break down your times. In a progress note, you breakdown time by Service Time and Documentation Time. In order to ensure you are reimbursed fully for your group work, you must **sum up your documentation time for all the clients in your group**, and enter that number as the Documentation Time. Your Service Time would be the duration of the group.

- Example for a 10 Client Group:
  - Service Time = 1 Hour (length of group session)
  - Documentation Time = 100 Minutes (Avg. Doc Time X # of Clients in Group – if the average documentation time for each client is 10 minutes, you multiply that by the number of clients in the group – 10 for this example).
  - Travel Time = Full time it took you to travel to the group session for each client.

When you have less than 4 clients (CCS and Non-CCS), it's a bit trickier in terms of reimbursement. Groups of 4 or less clients will put your 'requested Group Rate' above the CCS Interim Group Rate (which assumes a group

of 4). This means your initial reimbursement will be the Interim Rate, and you will need to wait until Reconciliation to recoup the remainder of your rate. So groups of less than 4 would not pay in full for quite a while. If your group is 4 or more, though, you should be reimbursed fully.

Group Services Direct Service Provision Via Telehealth:

- Applies to group services that are currently covered under the CCS benefit.
- Providers must exercise professional judgment in determining whether services can be delivered appropriately and effectively via telehealth.
- Providers must obtain Informed Consent and discuss issues of privacy and confidentiality prior to providing telehealth services. If consent is verbal, verbal consent should be documented in the progress note (reminder – verbal consent is only valid for 10 days and there should be an Informed Consent for Telehealth in the central client file with Dane County).
- Providers should consider that there are additional privacy considerations that apply to CCS participants engaging in group treatment via telehealth. Telehealth services delivered via audio-only formats may afford more privacy for group members.

Progress Note Documentation for Telehealth Group Services:

- Type of Contact
  - = In-Person (using both audio and video telehealth)
  - = Phone (using telephone or audio only)
- Is this a telehealth Visit? **Yes**
- Type of Telehealth Visit – Select Audio-Visual or Audio-Only
- Place of Service – Select Telehealth Provided in Patient's Home or Telehealth Provided Other Than in Patient's Home
- Service Type = Group Service (designate the number of CCS and Non-CCS Clients)

All progress note narratives should include a statement that the service was provided via telehealth/telephone.

HIPAA-Compliant telehealth platforms are to be utilized.