wisconsin Medicaid update and BadgerCare

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Wisconsin Medicaid and BadgerCare Information for Providers

To:

- Child Adolescent Day Treatment Providers
- County Mental Health Coordinators
- County Substance Abuse Coordinators
- Master's Level Psychotherapists
- Mental Health Day Treatment Providers
- Mental Health/ Substance Abuse Clinics
- Psychiatrists
- Psychologists
- Substance Abuse Day Treatment Providers
- HMOs and Other Managed Care Programs

Medical Record Documentation Requirements for Mental Health and Substance Abuse Services

This *Wisconsin Medicaid and BadgerCare Update* clarifies Wisconsin Medicaid's medical record documentation requirements for mental health and substance abuse services.

Documentation — General Requirements for All Providers

Medical record documentation must be kept in each recipient's record as required under HFS 106.02(9), Wis. Admin. Code. Refer to the Attachment of this *Wisconsin Medicaid and BadgerCare Update* for documentation requirements as they apply to mental health and substance abuse providers. This information was published previously in the July 1999 *Update* (99-40), titled "Mental health and substance abuse outpatient services in the home or community." For general information on preparing and maintaining records, refer to the Provider Rights and Responsibilities section of the All-Provider Handbook.

Medical records kept electronically are subject to the same requirements as those maintained on paper. In addition, the following requirements apply:

- Mental health and substance abuse service providers are required to have a paper or electronic back-up system for electronic medical records. This could include having files saved on disk or CD-ROM in case of computer failure.
- For audits conducted by the Division of Health Care Financing, providers are required to produce paper copies of electronic records.
- Mental health and substance abuse service providers are required to have safeguards to prevent unauthorized access to the records.

Medicaid Record Retention Requirements Reminder

Documentation of Medicaid services performed must be retained by providers for a period of not less than *five years* as required under HFS 106.02(9)(e)2, Wis. Admin. Code.

Utilizing Medical Record Documentation for Prior Authorization Requests

If the provider follows medical documentation requirements as required under HFS 106.02(9), Wis. Admin. Code, he or she can submit selected existing medical documentation with a prior authorization (PA) request. For example, as supportive documentation, the current treatment plan could be attached rather than rewritten on the PA attachment.

Information Regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *dhfs.wisconsin.gov/medicaid/*.

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ATTACHMENT
Mental Health and Substance Abuse Services Documentation Requirements

The following is Wisconsin Medicaid's medical record documentation requirements (HFS 106.02[9][b], Wis. Admin. Code) as they apply to all mental health and substance abuse services. In each element, the applicable administrative code language is in parentheses. The provider is required to include in the recipient's medical record the following written documentation, as applicable:

General Information

1. Date, department or office of the provider, as applicable, and provider name and profession.
2. Presenting Problem (chief medical complaint or purpose of the service or services).

Assessments

3. Assessments (clinical findings, studies ordered, diagnosis or medical impression).
   a. Intake note signed by the therapist (clinical findings).
   b. Information about past treatment, such as where it occurred, for how long, and by whom (clinical findings).
   c. Mental status exam, including mood and affect, thought processes — principally orientation X3, dangerousness to others and self, and behavioral and motor observations. Other information that may be essential depending on presenting symptoms includes thought processes other than orientation X3, attitude, judgment, memory, speech, thought content, perception, intellectual functioning, and general appearance (clinical findings/diagnosis or medical impression).
   d. Biopsychosocial history, which may include, depending on the situation, educational or vocational history, developmental history, medical history, significant past events, religious history, substance abuse history, past mental health treatment, criminal and legal history, significant past relationships and prominent influences, behavioral history, financial history, and overall life adjustment (clinical findings).
   e. Psychological, neuropsychological, functional, cognitive, behavioral, and/or developmental testing as indicated (studies ordered).
   f. Current status, including mental status, current living arrangements and social relationships, support system, current activities of daily living, current and recent substance abuse usage, current personal strengths, current vocational and educational status, and current religious attendance (clinical findings).

Treatment Plans

4. Treatment plans, including treatment goals, which are expressed in behavioral terms that provide measurable indices of performance, planned intervention, mechanics of intervention (frequency, duration, responsible party[ies]) (disposition, recommendations, and instructions given to the recipient, including any prescriptions and plans of care or treatment provided).

Progress Notes

5. Progress notes (therapies or other treatments administered) must provide data relative to accomplishment of the treatment goals in measurable terms. Progress notes also must 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.