WRRWC HIGH PRIORITY QUESTIONS

SENT TO DCTS VIA EMAIL 2/15/17

Question #1: The order of document completion seems to have an impact on the process. Can we receive a flow sheet that addresses the order in which things can be completed?

Response: DHS 36.13 describes the application process; including the application, admission agreement, and additional required documents. Because each admission process is consumer dependent and there is flexibility in how a county, tribe and/or region implements CCS, a flow chart would not be prudent to provide. The county, tribe and/or region should develop policies and procedures to describe how the program will be compliant with DHS 36.

Question #2: Does the application signature date equate to the admission date? Does the admissions/service agreement need to be signed on the same date application?

Response: The date of admission is the date of when the application for services is signed. The admissions agreement should be reviewed and signed as the same date of the application for services. DHS 36.13(1) states that any person seeking services under this chapter shall complete an application for services. 36.13(1)(m) identifies that an admission agreement that includes all of the following shall be signed by applicant at the time of application to CCS.

Question #3: If the application date is the admission date, then is it correct that the application date begins the 30-day clock to complete the assessment and recovery plan process? Is it 30 calendar days or 30 work days?

Response: The date of admission is the date of when the application for services is signed per DHS 36.16 (2) The Assessment Process and the Assessment Summary required under sub. (6) Shall be completed within 30 days of the receipt of an application for services. The 30 days are calendar days.

Question #4: Please define "determine the applicant's need" at time of application. For example, is it a diagnosis, functional impairment – group 1 or group 2, and functional screen? AND, is this information sufficient for the MHP to authorize services? What has to be done to document the applicant's need? Concern: For consumers transitioning from one program to another, we don't want to disrupt services yet we cannot bill for two programs at the same time. Clinically and ethically, we need to be able to authorize services during the assessment phase.

Response: DHS 36.13(1) states that once a person has completed an application, the CCS shall determine the applicant's need pursuant to DHS 36.14, which states that the program needs to use the department-approved functional screen to determine that the individual needs require more than outpatient counseling and less than community support program, and the individual has a mental health or substance use diagnosis, and a functional impairment from group 1 or group 2.

The Mental Health Professional and/or Substance Abuse Professional authorize the need for psychosocial rehabilitation and attest to that through the authorization of services DHS 36.15.

Activities that are completed to determine the applicant's need can be documented in the Mental Health Professional's authorization of services.

If you have individuals that need services immediately you may choose to provide services pending Determination of the Need for Psychosocial Rehabilitation Services as described in 36.13(2) or complete an Abbreviated Assessment as described in 36.15(5)

Question #5: What has to happen on the "date of application?" For example, 36.14(3) suggest if the functional screen can't be completed, the assessment has to be.

Response: On the "date of application" the application for services and admission agreement must be signed per 36.13(1) and (1m)Thereafter, there is no identified order or timeline; other than the 30 calendar days to complete the DHS 36 requirements for admission. County, tribe and/or region should have a policy and procedure that guides the CCS admission process. If the functional screen cannot be completed the assessment must be done.

Question #6: There are times when a consumer does not attend scheduled meetings or appointments. How can/should this be documented to evidence staff efforts to complete the process? Please give an example.

Response: If consumer participation, or lack thereof, is creating issues for staff to complete the assessment or service planning process and documents, staff efforts of outreach and missed appointments can be documented in progress notes. If the assessment summary and service plan are not completed within the 30 days, please refer to the CCS Website CCS – Correcting Files. https://www.dhs.wisconsin.gov/ccs/correcting-files.htm

Question #7: What signatures are required to authorize services and capture billing? Do they all have to be in the same document?

Response: The Mental Health Professional and, if needed, the Substance Abuse Professional shall sign the authorization of services detailed in 36.15. This authorization of services is a separate document from the functional screen, comprehensive assessment, and service plan.

Regarding billing refer to FAQ Reimbursement question #2 pasted below:

CCS programs may be reimbursed by Medicaid for services provided to meet the immediate needs of an applicant up until the point it is determined that the applicant does not need psychosocial rehabilitation services or should receive these services through a different program. In order for services to be reimbursed, the following conditions must be met (DHS 36.13, Wisconsin Administrative Code):
1. The member has a current physician prescription for psychosocial services.
2. The member seeking services has completed an application.
3. The applicant has signed an admission agreement.
4. An assessment of initial needs has been conducted as described in DHS 36.14(3)(a), Wisconsin Administrative Code.
5. A mental health professional has authorized services as evidenced by the signature of the mental health professional as required in DHS 36.15, Wisconsin Administrative Code.
6. The assessment of initial needs and the authorization for services have been documented.

Question #8: Does "the assessment" mean "the assessment process? If so, then the Assessment Summary would need to include everything described in 36.16 (1) – (5). Some counties currently distinguish between a document called the "Comprehensive Assessment" and the "Assessment Summary." Given this language, it seems all of the information should be in one document called the "Assessment Summary." Who is required to sign the assessment summary?

Response: There are two components to the comprehensive assessment in CCS. First is the **Assessment Process** (DHS 36.16) which requires the County, Tribe and/or Region to complete an assessment that is comprehensive and accurate per DHS 36.16 (3). A comprehensive assessment includes assessment of all the domains listed in DHS 36.16 (4) by the assessment criteria listed in DHS 36.16 (3) and is supported by consumer development and perspective and clinical assessment. The county, tribe and/or region should create a document that tangibly shows that a comprehensive assessment was completed as identified by the assessment process outlined in 36.16.

Second is the **Assessment Summary** outlined in DHS 36.16 (6) and shall include all of the required elements that incorporates period of time within which the assessment was conducted, information on which outcomes and service recommendations are based, desired outcomes and measurable goals desired by the consumer, names and relationship to the consumer of all individuals who participated in the assessment process, significant differences of opinion, and signatures of persons present at meetings. The county, tribe and/or region should create a document that provides all of the information outlined in 36.16 (6)

These two pieces are functionally different. The Comprehensive Assessment provides evidence of consultation with the consumer, treatment team and collateral information and is be developed with the recovery – focused, strengths – based approach which will support creating a person-centered plan. The Assessment Summary is developed to determine the course of treatment services for the service plan. The document must contain the signatures of persons present at meetings being summarized 36.16 (6)(f).

Counties, tribes and/or regions should have a policy and procedure that staff follow to complete the CCS Assessment Process and the Assessment Summary and how they will meet all the documentation requirements of DHS 36.16 and 36.16(6). In addition, counties, tribes and/or regions can decide if they want to have one document or separate documents for the Assessment Summary and the Comprehensive Assessment. However, if combined, each piece should be clearly labeled so they can be easily identified.

DHS 36.16 (5) describes the criteria for an abbreviated assessment. If the criteria listed are met the Assessment Process DHS 36.16 (3) may be abbreviated.

Question #9: How and where in the chart do we document/evidence that the consumer's input was considered in each of the assessment domains?

Response: This information should be captured and documented throughout the entire Assessment Process per DHS 36.16(2)(d). There is a need to show active engagement

throughout the process. If the consumer is participating in the assessment process then the consumer will sign the Assessment Summary

Question #10: Are updated consumer signatures required on the assessment summary/assessment and/or individualized service plan each time it is updated? Is there ever a time one would not need a signature on the plan? Example: Change in number of units being provided.

Response: The Assessment Summary document must contain the signatures of persons present at meetings being summarized 36.16 (6)(f). If the consumer participated in the meetings that gleaned the new information, then their signature is required. DHS 36.17 (3) states that the service plan for each consumer shall be reviewed and updated as the needs of the consumer change or at least every six months. If you have a conversation with one or more of the treatment team to make the change, DHS 36.17 (2m) (4)(b) states that an attendance roster shall be signed by each person, including recovery team members in attendance at each service planning meeting. 36.17 (2m)(c) states the completed service plan shall be signed by the consumer, a mental health or substance abuse profession and the service facilitator. If there is a change in treatment services, the consumer should be aware of these changes. The consumer's signature on the updated service plan would acknowledge this and show informed consent per DHS 94.03 and 94.04.

Question #11: Could updates to the assessment and plan be documented within the progress notes and then incorporated into the formal assessment and ISP updates at the 6 month mark?

Response: Updates to the Assessment Process, Assessment Summary and or the Service Plan cannot be documented in progress notes and then incorporated at the six month mark.

Question #12: Does the Comprehensive Assessment need to be completed "at the time of application" or within 30 days of receipt of application? Define "at the time of application?"

Response: The Comprehensive Assessment and Assessment Summary must be completed within 30 calendar days from the date of signature of the application. Neither needs to be done at the time of application. DHS 36.16 (5)(2) refers to the Abbreviated Assessment and the criteria that the consumer does not provide enough information necessary to complete a comprehensive assessment at the time of application. The Abbreviated Assessment would be appropriate if the consumer is unable, due to their mental health or substance use disorder, to give enough information at the time of application or during the assessment process.

Question #13: What participation is required of each role in regards to participation in the assessment and planning process? Consumer, Service Facilitator, MHP, SAP, etc. Example: MHP will not have the availability to attend all team meetings. Same applies to Psychiatrist who a consumer may identify as "on their team."

Response: The MH/SA Professional does not need to attend every assessment and services planning meeting, but they do need to review and sign all documents that they are required to

sign per 36.17. They also need to attend as many meetings as their staff functions (DHS 36.10 (2)(e) and their clinical roles require. DHS 36.03 (24) defines the "recovery team" as the group of individuals who are identified to participate in an assessment of the needs of the consumer, service planning and delivery, and evaluation of desired outcomes. Best practice would require that there needs to be evidence of active participation and engagement in the process from all team members.

Question #14: What are the elements of a "valid" physician prescription for CCS?

Response: CCS FAQ #1 under Physician Prescription states: Under Section 49.46(2)(b)6.Lm, Wisconsin Statutes, CCS requires a physician prescription. As indicated on page 5 of *Update* 2014-42, "Any individual seeking CCS must have a physician prescription to initiate services. The CCS provider must have a current prescription on file at all times." A current prescription is one that has not expired. The physician will determine the expiration date for the prescription for each member. Each CCS program is responsible for establishing review timelines to ensure the prescription is updated prior to its expiration. As long as there is a non-expired prescription on file for each member, a CCS program is in compliance. There is no specific terminology that needs to be used on the prescription.

Context for Question #15: DCTS direction provided.

The longstanding position is that services provided under the outpatient level of care, whether mental health, Chapter DHS 35 or substance abuse Chapter DHS 75.13 must be provided in either the main clinic or branch office. For unusual exceptions they would need to document the reason in the record to justify this. That opportunity for an exception is not intended as a practice of delivery of services outside of the clinic or branch setting. Unique circumstances documented in a non-patterned routine practice manner would be expected. Medicaid traditionally has had limits on locations of service delivery as well.

Question #15: Where is this documented and how would a CCS provider be aware of this?

Response: Generally, agencies and providers are expected to understand and work within their scope of practice and any license or certification requirements, including program requirements. These may be licenses, certifications, Administrative Rules and/or Statutes. When counties, tribes or regions contract with DHS 35 or DHS 75 agencies for services, they should work with the agencies and providers to understand the scope of practice and any license or certification requirements, including program requirements.

Question #16: What is the correct billing practice?
This response was provided on 10/12/2016

Response: Claims represent the actual service took place. In this case, a group service. The claim should indicate group.