Federal and Minnesota Regulations

Documentation standards for MH-TCM services come from more than one sources, and include: Federal law, a CMS program manual, CMS policy letters, Minnesota Statute, Minnesota Rule, DHS MHCP Provider Manual, DHS Rules and Bulletins. MCO contracts with providers may have specific additional documentation standards for contracted providers.

Minnesota has built a substantial portion of its services to persons with serious mental illnesses or serious and persistent mental illness on reimbursement from Medicaid (known as M.A., or Medical Assistance in Minnesota). In part, this is where the federal standards apply.

Medicaid is a joint federal and state program that funds health case for persons who are poor or disabled. Federal regulations establish the basic health services parameters of what can be reimbursed under the program and the core reimbursement requirements. Federal regulations change both by congressional action and issuance of regulations from the federal Center for Medicare and Medicaid Services (CMS). CMS provides guidance to states through the publication of the State Medicaid Manual (not to be confused with Minnesota's Health Care Programs Provider Manual) and enforces regulations through audits conducted by the federal Office of the Inspector General.

The CMS "State Medicaid Manual," section 4302.2 specifically addresses the documentation requirements for claiming Medicaid TCM, and in part states*: Expenditures are made on behalf of eligible recipients included in the target group (i.e. there must be an identifiable charge related to an identifiable service provided to a recipient . . . . Payment for services is made following the receipt of a valid provider claim. Providers must maintain case records which indicate all contacts with and on behalf of recipients. The case records must document . . . the nature, extent, or units of service, and the place of service delivery.*

Also, section 2500.2(A) of the CMS "State Medicaid Manual" generally instructs States to: *Report only expenditures for which all supporting documentation, in readily reviewable form, has been compiled and which is immediately available when the claim is filed. Your supporting documentation includes at a minimum the following: date of service, name of recipient, Medicaid identification number, name of provider agency and person providing the service, nature, extent or units of service, and the place of service.*

Minnesota must comply with federal regulations in order to receive Federal Financial Participation (FFP) and documentation is crucial to compliance.

Documentation must support the qualifying MH-TCM services provided to an eligible recipient.

In accordance with MA and state record keeping requirements, health service records, including the MH-TCM client record/file, must be developed and maintained as a condition of payment by MHCP. Each occurrence of a health service must be documented in the client's health record. MHCP funds paid for health care not documented in the health service record are subject to monetary recovery.

All MHCP service records must contain the following information when applicable. There may also be other record obligations specific to providers of a particular service:

- The record must be legible at a minimum to the individual providing care
- The recipient's name must be on each page of the recipient's record
- Each entry in the health service record must contain:
  - The date on which the entry is made
  - The date or dates on which the health service is provided
  - The length of time spent with the recipient, if the amount paid for the service depends on time spent
  - The signature and title of the person from whom the recipient received the service
  - Reportage of the recipient's progress or response to treatment, and the changes in the treatment or diagnosis
  - When applicable, the countersignature of the vendor or supervisor as required under Minnesota Rules 9505.0170 to 9505.0475
  - Documentation of supervision by the supervisor
- The record must state:
  - The recipient's case history and health condition as determined by the vendor's examination or assessment
  - The results of all diagnostic tests and examinations
  - The diagnosis resulting from the examination.
- The record must contain reports of consultations that are ordered for the recipient
- The record must contain the recipient's plan of care (ICSP), individual treatment plan, or individual program plan.

Additionally, the start and stop times must be entered for services that are paid based on a unit of time.