

Affected Programs: BadgerCare Plus, Medicaid

To: Advanced Practice Nurse Prescribers with Psychiatric Specialty, Community Recovery Services Providers, Comprehensive Community Service Providers, Intensive In-Home Mental Health and Substance Abuse Treatment Services for Children Providers, Master's Level Psychotherapists, Outpatient Mental Health Clinics, Outpatient Substance Abuse Clinics, Psychologists, Qualified Treatment Trainees, Substance Abuse Counselors, HMOs and Other Managed Care Programs

New and Clarified Coverage Policy for Psychosocial Rehabilitation Programs

This *ForwardHealth Update* announces new and clarified coverage policy for psychosocial rehabilitation programs effective for dates of service (DOS) on and after July 1, 2018.

New policy for psychosocial rehabilitation programs includes the following:

- A coverage change for non-traditional services under the Comprehensive Community Services (CCS) benefit.
- A billing change requiring all Community Recovery Services (CRS) to be documented and submitted on claims in 15-minute units.
- An eligibility change where members will no longer be required to be at or below 150 percent of the Federal Poverty Level (FPL) in order to be eligible for CRS.

Psychosocial rehabilitation services are provided to members to help them:

- Better manage the symptoms of their mental health and/or substance abuse conditions
- Increase independence
- Achieve effective levels of functioning in the community and at home
- Reduce the incidence and duration of institutional care

These services are covered under the CRS, CCS, and Community Support Program (CSP) service areas. This

Update details changes to psychosocial rehabilitation services for CCS and CRS.

Policy from this *Update* will be added to the ForwardHealth Online Handbook in early July. For current policy and billing information specific to psychosocial rehabilitation programs, providers should refer to the ForwardHealth Online Handbook at www.forwardhealth.wi.gov/.

CCS

Non-Traditional or Other Approved Services

The “non-traditional services or other approved services” category will no longer be included in the CCS program service array. As a reminder, psychosocial rehabilitation services are services and supportive activities that assist members with mental health and/or substance abuse conditions to achieve their highest possible level of independent functioning, stability, and independence and to facilitate recovery. They must be tailored to address the specific mental health and/or substance abuse treatment needs of the individual member and must be provided by staff with the appropriate training and experience. CCS programs that have considered delivering services under the “non-traditional” category in the past should consider how these services may be covered under existing services on the

CCS program service array when delivered by trained staff and tailored to meet the assessed needs of the member. ForwardHealth will continue to reimburse CCS programs for medically necessary psychosocial rehabilitation services provided by qualified staff under the service descriptions in categories #1–13 of the CCS program service array.

Refer to the Covered Services topic (topic #17137) of the Covered Services and Requirements chapter of the Covered and Noncovered Services section of the Comprehensive Community Services service area of the Online Handbook for a description of the services covered under the CCS benefit.

CRS

Psychosocial rehabilitation services delivered by CRS programs for all Medicaid members who have a need for these services will now be covered by ForwardHealth with the following changes:

- All CRS services must be documented and submitted on claims in 15-minute units.
- Members will no longer be required to be at or below 150 percent of the FPL in order to be eligible for CRS.

This *Update* does not change psychosocial rehabilitation services that are covered under the CRS benefit.

Psychosocial rehabilitation services delivered under the CRS benefit were previously covered as a Home and Community Based Services (HCBS) waiver program.

CRS programs must continue to be certified by the state Division of Care and Treatment Services (DCTS) prior to enrolling as a Medicaid provider.

Claim Submission

All CRS services must be documented and submitted on claims in 15-minute units. Services reimbursed on a per diem basis are no longer allowable. For community living supportive services, providers should continue to indicate Healthcare Common Procedure Coding System (HCPCS) procedure code H0043 with modifier U8 to indicate the 15-

minute increment. HCPCS code H0043 with modifier U9 will no longer be reimbursed. CRS programs that are currently billing on a per diem basis can refer to existing templates for developing 15-minute claims submission and documentation processes on the Comprehensive Community Services website at www.dhs.wisconsin.gov/ccs/expansion/ccsresidentialratesettingguidance.pdf. CRS programs should note that these templates are shared for informational purposes only and have not been developed specifically for CRS. Use of these templates are not CRS program requirements since other methods may be used to ensure residential service providers are appropriately documenting services provided to CRS members.

Providers are reminded to continue to submit claims according to their current claim submission instructions.

Reimbursement

Effective for claims processed on and after July 1, 2018, the reimbursement rate for procedure code H0043 will be \$17.77 per 15-minute unit. A CRS provider may have higher or lower total program costs than the statewide reimbursement rate. Providers are required to indicate their usual and customary charge on claim details when submitting claims. The usual and customary charge should represent the expected actual costs of providing the service regardless of whether it is greater than or less than the reimbursement rate. CRS providers should not simply bill the reimbursement rate. The difference between the actual costs and the reimbursement rate payments is accounted for during the cost reporting and cost reconciliation process and may result in either a payment or recoupment to the CRS provider.

Program Requirements

A state-approved service plan is still required and must be updated at least **every six months** and as needed when there is significant change in the member's circumstances. Previously, service plans were required to be updated every 12 months. Other program requirements remain in effect.

Member Enrollment

To be eligible for CRS, members must:

- Be eligible and enrolled in a full-benefit BadgerCare Plus or Medicaid plan.
- Meet CRS functional eligibility criteria (as determined by a Wisconsin Department of Health Services [DHS]-approved functional screen).
- Reside in the home or community.
- Have an approved service plan.

Members will no longer be required to have countable income at or below 150 percent of the FPL.

The CRS benefit will continue to use Wisconsin's Functional Eligibility Screen for Adult Mental Health & Alcohol and Other Drug Abuse (Co-occurring) services, or the Children's Functional Screen in performing the independent evaluation of needs-based criteria. The functional screen must be performed by a trained, DHS-certified screen administrator and must be completed prior to the CRS program providing services for the member.

Assessment Process

The assessment process should incorporate the consumer's unique perspective and own words about how they view their recovery, experience, challenges, strengths, resources and needs in each of the assessment domains. The consumer's assessment should identify factors that influence outcomes, goals, and methods for addressing them. Cultural and environmental supports should be identified and incorporated as they affect identified goals and desired outcomes and preferred methods for achieving the identified goals. A consumer's assessment should be updated as new information becomes available or at least every six months as part of the service planning process.

The assessment should include the following domains:

- Life satisfaction
- Basic needs
- Social network and family involvement
- Community living skills
- Housing issues

- Employment
- Education
- Finances and benefits
- Mental health
- Physical health
- Substance use
- Trauma and significant life stressors
- Medications
- Crisis prevention and management
- Legal status

Service Planning Process

A service plan must be developed based on an objective face-to-face assessment using a person-centered process in consultation with the member. The person-centered planning process must address the member's physical and mental health support needs, strengths, preferences, and desired outcomes, and must identify which CRS-specific services the member needs. This process is completed by a county or tribal case manager who meets DHS and DCTS requirements. The service plan must be signed and dated by the member, and then approved by DHS. The county or tribal certifying agency can use the Individual Service Plan – Community Recovery Services (CRS) form, F-00202 (08/2016), for this purpose or a locally developed form that has been approved in advance by DHS and DCTS. The service plan must be reviewed, revised, and signed by the member at least every six months and as needed when there is significant change in the member's circumstances. A CRS provider cannot be reimbursed for services provided prior to the effective date of the member's service plan.

Enrollment Verification

Member enrollment issues are the primary reason claims are denied. To reduce claim denials, providers should **always** verify a member's enrollment before providing services, both to determine enrollment for the current date (since a member's enrollment status may change) and to discover any limitations to the member's coverage. Providers may want to verify the member's enrollment a second time before submitting a claim to find out whether the member's enrollment information has changed since the appointment.

Providers can access Wisconsin’s Enrollment Verification System (EVS) to receive the most current enrollment information through the following methods:

- ForwardHealth Portal
- WiCall, Wisconsin’s Automated Voice Response system
- Commercial enrollment verification vendors
- 270/271 transactions
- Provider Services

Providers cannot charge a member, or authorized person acting on behalf of the member, for verifying his or her enrollment.

The EVS does not indicate other government programs that are secondary to Wisconsin Medicaid.

Note: Providers are no longer required to review medical status codes to determine member eligibility for CRS.

Clarification of Covered Services

Supported Employment

This service covers activities to assist individuals in addressing or managing the symptoms and behaviors associated with severe and persistent mental illness that may be barriers to obtaining and maintaining competitive employment. Services may include, but are not limited to, assistance in accessing or participating in educational and employment-related services; education about appropriate job-related behaviors; assistance in learning employment-related skills such as performing personal hygiene and grooming, securing appropriate clothing, and arranging transportation to employment; on-site employment evaluation and feedback sessions to identify and manage work-related symptoms; assistance with work-related crises; and individual therapeutic support.

Supported employment does not include interventions to train an individual on how to do a specific work task. For example, training an individual on a five-step work process of assembling a product is not psychosocial rehabilitation, nor is providing guidance on the order of activities to process a customer order. However, training the individual

on methods to focus on the work process despite experiencing symptoms of a mental health condition (e.g., auditory hallucinations or marked anxiety) are covered as psychosocial rehabilitative services.

Services follow the Individual Placement and Support (IPS) model recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) to be an evidence-based practice. Employment-related services are integrated with mental health treatment and planning. Choices and decisions about work and needed services are individualized based on the person’s preferences, strengths, and experiences.

CRS programs should continue to deliver supported employment services aligned with the IPS model; however, CRS programs may only deliver mental health treatment and support components of the IPS model. All vocational-specific components of IPS must be provided by vocational rehabilitation providers in coordination with the CRS program staff.

Supported employment covers time spent by an individual’s CRS treatment team with an individual’s vocational rehabilitation counselor to coordinate service plans.

Refer to the following table for the components of the IPS model and Medicaid coverage guidance.

Components of Individual Placement and Support Model		
Services	Components	Covered by Wisconsin Medicaid?
Mental Health Treatment and Supports	Mental Health Assessment	Yes
	Service Facilitation	Yes
	Other Mental Health Focused Psychosocial Rehabilitation	Yes

Components of Individual Placement and Support Model		
Services	Components	Covered by Wisconsin Medicaid?
Vocational Services	Vocational Assessment	No
	Job Development	No
	Job Placement	No
	Job Coaching	No

Daily and Monthly Limits

Daily and monthly service limits for the CRS benefit will be eliminated. Services must be provided according to the individual’s assessed needs and must be described in the service plan.

Provider Qualifications

All CRS program staff must be qualified to provide CRS and meet training curriculum standards developed by DHS and DCTS.

Documentation Requirements

General Mental Health and Substance Abuse Documentation Requirements

Providers are responsible for meeting medical and financial documentation requirements. Refer to Wis. Admin. Code § 106.02(9)(a), for preparation and maintenance documentation requirements and Wis. Admin. Code § 106.02(9)(c), for financial record documentation requirements. Lack of such documentation will be considered grounds for denial of claims and may result in recoupment of payments previously made.

Refer to the Attachment of this *Update* for mental health and substance abuse general documentation requirements that providers must follow.

CRS Documentation Requirements

CRS providers are responsible for meeting all documentation requirements. The Medicaid-enrolled county or tribal CRS provider must ensure that contracted staff create and

maintain documentation to substantiate claims for Medicaid reimbursement.

CRS Progress Record Documentation

A written progress record for each member should be created and signed and dated by the rendering provider. For each DOS for which a Medicaid claim is submitted, this record shall reflect which community living supportive services, supported employment, and/or peer support services, as enumerated in the member’s service plan, were provided to the member. The record shall also provide a clear indication that such services were rendered with a sufficiency of time as to substantiate the reimbursement requested. The record must reflect the outcome of the service rendered (i.e., it must be clear from the documentation that services are provided with service plan outcomes in mind). Documentation must support how the provider addressed any health and safety needs of the individual, including completing incident reports and outcomes. Finally, if travel is claimed, the provider is expected to keep detailed travel records in a contemporaneous manner to support the time claimed.

Information Regarding Managed Care Organizations

CCS and CRS psychosocial rehabilitation services are “carved out” of managed care benefits. All services provided under the CCS and CRS programs are reimbursed fee-for-service regardless of whether the member is enrolled in a BadgerCare Plus HMO, a Medicaid SSI HMO, or a special managed care program including Family Care, the Program of All-Inclusive Care for the Elderly (PACE), and the Family Care Partnership program.

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

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Medicaid Services, the Wisconsin Department of Health Services (DHS). The Wisconsin AIDS Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health, DHS.

For questions, call Provider Services at 800-947-9627 or visit our website at www.forwardhealth.wi.gov/.

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This *Update* was issued on 5/1/18 and information contained in this *Update* was incorporated into the Online Handbook on 7/2/18.

ATTACHMENT

Mental Health and Substance Abuse Services Documentation Requirements

The following are the medical record documentation requirements described in Wis. Admin. Code § DHS 106.02(9)(b) as they apply to all mental health and substance abuse services, including CRS. In each element, the applicable administrative code language is in parentheses. The provider is required to include the following written documentation in the member's medical record, as applicable:

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)
3. Assessments (clinical findings, studies ordered, or 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, which may include mood and affect, thought processes — principally orientation X3, dangerousness to others and self, and behavioral and motor observations — and other information that may be essential depending on presenting symptoms — thought processes other than orientation X3, attitude, judgment, memory, speech, thought content, perception, intellectual functioning, and general appearance (clinical findings and/or 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, which may include mental status, current living arrangements and social relationships, support system, current activities of daily living, current prescribed medications, current and recent substance abuse usage, current personal strengths, current vocational and educational status, and current religious attendance (clinical findings)
4. Treatment plans, which may include treatment goals that are expressed in functional terms that provide measurable indices of performance, planned intervention, mechanics of intervention (frequency, duration, responsible party[ies]) (disposition, recommendations, and instructions given to the member, including any prescriptions and plans of care or treatment provided)
5. Progress notes (therapies or other treatments administered) that provide data relative to accomplishment of the treatment goals in measurable terms and 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