

Affected Programs: BadgerCare Plus, Medicaid

To: Adult Mental Health Day Treatment Providers, Advanced Practice Nurse Prescribers with Psychiatric Specialty, Child/Adolescent Day Treatment Providers, Crisis Intervention Providers, Community Support Programs, 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, Psychiatrists, Psychologists, Qualified Treatment Trainees, Substance Abuse Counselors, Substance Abuse Day Treatment Providers, HMOs and Other Managed Care Programs

Changes to the Comprehensive Community Services Benefit as a Result of the Wisconsin 2013-15 Biennial Budget

The Wisconsin 2013-15 biennial budget (Act 20) authorized the Department of Health Services to increase funding for Comprehensive Community Services (CCS) programs. As a result, effective for dates of service on and after July 1, 2014, ForwardHealth will provide both the federal and non-federal share of Medicaid and BadgerCare Plus program costs to counties and tribes that operate regional CCS programs.

This *ForwardHealth Update* provides the following information regarding ForwardHealth's implementation of this budget initiative:

- The process for counties and tribes to become Medicaid-enrolled as regional CCS providers.
- Changes to the Medicaid and BadgerCare Plus CCS benefit for both regional and non-regional CCS providers.
- Changes to the reimbursement process for Medicaid and BadgerCare Plus program costs for both regional and non-regional CCS providers.

The Wisconsin 2013-15 biennial budget (Act 20) authorized the Department of Health Services (DHS) to increase funding for Comprehensive Community Services (CCS) programs. As a result, effective for dates of service (DOS)

on and after July 1, 2014, ForwardHealth will provide both the federal and non-federal share of Medicaid and BadgerCare Plus program costs to counties and tribes that operate regional CCS programs. Counties and tribes may continue to operate CCS programs on a non-regional basis and will continue to be eligible only for the federal share of Medicaid and BadgerCare Plus program costs.

To implement the CCS budget initiative, effective for DOS on and after July 1, 2014, ForwardHealth is making changes to the Medicaid provider enrollment process, the CCS benefit, and the reimbursement process for both regional and non-regional CCS programs.

Comprehensive Community Service Providers

Regional CCS providers are counties or tribes that operate a regional CCS program under one of the four regional service models detailed below. ForwardHealth will provide the federal and non-federal share of Medicaid and BadgerCare Plus program costs to regional CCS providers.

Non-regional CCS providers are counties or tribes that operate a CCS program within their own county or tribe on a non-regional basis. ForwardHealth will continue to

provide only the federal share of Medicaid and BadgerCare Plus program costs to non-regional CCS providers.

Regional CCS providers must operate their CCS programs under one of the following four regional service models defined by the DHS Division of Mental Health and Substance Abuse Services (DMHSAS):

- Population-Based Model — A single county with a population exceeding 350,000 residents operates a regional CCS program within its own county borders or a single tribe, regardless of population size, operates a regional CCS program within its tribe.
- Shared Services Model — Multiple counties/tribes partner together to operate a regional CCS program across their counties/tribes; a lead county or tribe is *not* identified.
- Multi-County Model — Multiple counties/tribes partner together to operate a regional CCS program across their counties/tribes; a lead county or tribe is identified.
- 51.42 Model — Multiple counties that have partnered together to form a separate 51.42 legal entity operate a regional CCS program through the 51.42 entity.

Throughout this *ForwardHealth Update* the term “regional CCS program” will be used to refer to any or all of the regional service models indicated above, unless specified.

Additional information about the four regional service models is available on the DHS Web site at: www.dhs.wisconsin.gov/publications/P0/P00602.pdf.

Steps to Become a Medicaid-Enrolled Regional CCS Provider

To operate a regional CCS program, counties and tribes must first complete the following three steps:

Division of Mental Health and Substance Abuse Services Approval

Counties and tribes must obtain approval of their proposed regional CCS program from the DMHSAS. Through the DMHSAS approval process, the DMHSAS confirms that

the proposed regional CCS program meets the requirements of the regional service model under which it will operate.

For more information about the DMHSAS approval process, refer to DMHSAS Info Memo 2014-01 (“Request for Approval: Comprehensive Community Services (CCS) Regional Service Model”) available on the CCS Expansion page of the DHS Web site at: www.dhs.wisconsin.gov/dsl_info/InfoMemos/DMHSAS/CY2014/2014-01InfoMemo.pdf.

Division of Quality Assurance Certification

Counties and tribes that have received DMHSAS approval to operate a regional CCS program under the population-based, multi-county, or 51.42 models are required to obtain a single DHS Division of Quality Assurance (DQA) certification for the regional CCS program. Counties and tribes that have received DMHSAS approval to operate under the shared services model are required to obtain separate DQA certifications for each county or tribe within the region. Through the DQA certification process, the DQA confirms that the proposed regional CCS program meets all requirements within DHS 36, Wis. Admin. Code.

For more information about DQA certification or to request an initial certification application packet, refer to the DHS Web site at: www.dhs.wisconsin.gov/CCS/ApplicationforCertification.htm.

Medicaid Enrollment

Following DMHSAS approval and DQA certification, counties and tribes must enroll with ForwardHealth in the Medicaid program as a regional CCS provider based on the following requirements for each regional service model:

- Population-Based Model — The single county or single tribe within the region must enroll.
- Shared Services Model — Each county or tribe within the region must enroll separately.
- Multi-County Model — Each county or tribe within the region must enroll separately.
- 51.42 Model — The 51.42 entity must enroll; individual counties within the 51.42 region do not need to separately enroll.

Providers who have multiple Medicaid enrollments will be required to provide a unique taxonomy on their CCS enrollment.

Counties and tribes that are already enrolled in the Medicaid program as CCS providers do not need to re-enroll as regional CCS providers but do still need to complete DMHSAS approval and DQA certification. After these existing CCS providers receive DMHSAS approval and DQA certification, ForwardHealth will complete direct outreach to the providers to update their existing enrollment file. In the future, ForwardHealth will be notified by the DQA of any changes to the provider's regional CCS program and will automatically update the provider's Medicaid enrollment file.

Counties and tribes that are not already enrolled in the Medicaid program as CCS providers must complete a Medicaid enrollment application. Medicaid enrollment will require an application fee per Affordable Care Act requirements. This fee is federally mandated and may be adjusted annually. The fee is used to offset the cost of conducting federally mandated screening activities. The enrollment fee may be included in the reconciliation at the end of the year.

To access the Medicaid enrollment application on the Portal, providers should follow these steps:

1. Access the Portal at www.forwardhealth.wi.gov/.
2. Select the Become a Provider link on the left side of the Portal home page. The Provider Enrollment Information home page will be displayed.
3. On the upper left side of the Provider Enrollment Information home page, select the Start or Continue Your Enrollment Application link.
4. In the box titled, "To Start a New Medicaid Enrollment," select the Medicaid Provider Enrollment Application link.

The earliest possible effective date for Medicaid enrollment is the DQA certification date.

Non-regional CCS Providers

Medicaid enrollment requirements are not changing for counties and tribes that choose to operate non-regional CCS programs.

Counties and tribes currently enrolled as CCS providers that choose to continue to operate a non-regional CCS program are required to provide a new taxonomy.

Regional Start Date Guidelines

For the purpose of implementing the CCS budget initiative, ForwardHealth has defined a rollout period from July 1, 2014, through December 31, 2015. Any change to a regional CCS program during the rollout period will require the region to update its DMHSAS approval and DQA certification prior to the effective date of the change (see Steps to Become a Medicaid-enrolled CCS Provider section of this *Update* for appropriate steps). A change could include the addition or removal of a county/tribe or counties/tribes to the region or a change in the regional service model under which the region operates. During the rollout period, the following guidelines will apply:

- Regions may begin operation on the later of July 1, 2014, or the effective date of Medicaid enrollment.
- From July 1, 2014, through December 31, 2014, an existing region may make one addition of a county/tribe or counties/tribes to the region during this time. The revised region must begin operation on the first of a month.
- Existing regions may also add a county/tribe or counties/tribes effective for January 1, 2015.
- During the calendar year 2015, existing regions may make one addition of a county/tribe or counties/tribes to the region. The revised region must begin operation on the first day of a month.
- Counties or tribes may voluntarily leave a region only at the beginning of a calendar year. This applies to all dates of regional operation. *Note:* As with all providers, a county or tribe may be involuntarily decertified by DQA (subject to appeal rights) for failing to meet program requirements. The county or tribe will be excluded from the CCS region on the date

ForwardHealth is notified. If a county or tribe is involuntarily decertified for failing to meet program requirements, the remaining counties/tribes within the region must update their DMHSAS approval and DQA certification.

- Beginning January 1, 2016, counties/tribes may only be voluntarily added or removed from an existing region effective for January 1 of each calendar year.

Comprehensive Community Services Benefit

Comprehensive Community Service programs provide and arrange for the provision of psychosocial rehabilitation services. 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. All services must be non-institutional and fall within the definition of rehabilitative services as defined in 42 CFR 440.130(d). Members across the lifespan (minors, adults, and elders) can receive CCS.

Members enrolled in the Medicaid or BadgerCare Plus programs are eligible for CCS enrollment. All services provided under the CCS benefit are reimbursed fee-for-service regardless of whether the member is enrolled in a BadgerCare Plus HMO, a Medicaid Supplemental Security Income (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. Health care providers may refer potential members to their county or tribal human services department. Each county or tribe determines its access point for CCS and has policies and procedures on referral and screening for the program. Once members are evaluated through the functional screen, the members are informed of the services for which they are eligible and referred to those services in the manner the county or tribe has established.

Program Requirements

A CCS program must meet the requirements in DHS Chapter 36, Wis. Admin. Code, for services to be reimbursed by Medicaid. Key requirements include:

- DHS 36.13 — Any individual seeking CCS must complete a CCS application for the CCS program and sign an admission agreement. The CCS program must determine the individual's need for psychosocial rehabilitation services based on DHS 36.14.
- DHS 36.14 — The CCS program is available to individuals who, based on a DHS-approved functional screen, need more than outpatient counseling, but less than the services provided by the Community Support Program (CSP) benefit. Any individual seeking CCS must have a mental health or substance abuse diagnosis and a functional impairment that interferes with or limits one or more major life activities. If a CCS program determines that an individual needs CCS, it must conduct a comprehensive assessment under DHS 36.16.
- DHS 36.15 — All services must be authorized by the CCS program before a service is provided to a CCS member (and submitted for reimbursement). Services do not need to be prior authorized by ForwardHealth.
- DHS 36.16 and 36.17 — All CCS members must receive an assessment and have a service plan. The assessment and service plan must be completed within 30 days from the CCS application date. All CCS members must have a recovery team. All services provided must be documented in the member's service plan.
- DHS 36.18 — All CCS members must have a service record that contains information about his or her needs, outcomes, and progress. The service record includes the assessment, service plans, authorization of services statements, member requests, service delivery information, medication information, consent forms, legal documents, discharge information, and anything else that is appropriate.

Services provided under the CCS benefit must meet the following additional ForwardHealth requirements to be reimbursed:

- 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.
- Members cannot be enrolled in both CCS and CSP at the same time per Wis. Stats. 49.45(30e), DHS 107.13(7), Wis. Admin. Code, and DHS 36.14, Wis. Admin. Code.
- Comprehensive Community Services providers can provide services directly or may contract with other qualified providers to provide all or some of the services covered under the CCS benefit per DHS 105.257, Wis. Admin. Code. However, the Medicaid-enrolled provider retains all legal and fiscal responsibility for the services provided by contractors. ForwardHealth sends provider materials to Medicaid-enrolled providers only. It is the Medicaid-enrolled provider's responsibility to ensure that contractors are qualified to provide services and maintain records in accordance with the requirements for the provision of services. The Medicaid-enrolled provider is responsible for ensuring that contractors meet all program requirements and receive copies of ForwardHealth publications.

Covered Services

Both regional and non-regional CCS programs must serve all CCS eligible members. A CCS program must provide all services covered under the CCS benefit that a member needs as determined by the assessment of all the domains in DHS 36.16(4), Wis. Admin. Code. The CCS Service Array describes the services covered under the CCS benefit. Please refer to the CCS Service Array in Attachment 1 of this *Update*. Comprehensive Community Services programs may not deny a member access to CCS by claiming that the CCS program does not provide a service that is covered under the CCS benefit. If a CCS program does not provide a service that is covered under the CCS benefit, the CCS program must determine a way to provide a service that meets the needs of the member.

For members enrolled in a CCS program, the following services must be provided through the CCS program if needed by the member and cannot be reimbursed separately under any other Medicaid or BadgerCare Plus benefit per DHS 107.13(7), Wis. Admin. Code:

- Outpatient psychotherapy including outpatient psychotherapy services for children provided in the home.
- Adult mental health day treatment.

Additionally, members enrolled in a CCS program cannot also be enrolled in the targeted case management benefit.

For members enrolled in a CCS program, all other services covered under the CCS benefit not described above can be provided either through the CCS program or, if covered under another Medicaid or BadgerCare Plus benefit, through that other Medicaid or BadgerCare Plus benefit. An example of a service that can be provided either through a CCS program or through another Medicaid or BadgerCare Plus benefit is medication management provided by a psychiatrist.

Non-traditional Psychosocial Rehabilitative Services

Non-traditional psychosocial rehabilitative services are described in CCS Service Array category #14 titled, "Non-Traditional or Other Approved Services." Non-traditional psychosocial rehabilitative services or other approved services are identified for specific members and are expected to accomplish treatment ends that traditional behavioral health services have not.

Non-traditional psychosocial rehabilitative services are not allowable unless they:

- Are medically necessary and documented as defined in DHS 101.03(96m), Wis. Admin. Code.
- Have a psychosocial rehabilitative purpose.
- Are not recreational activities.
- Are not otherwise available to the member.

Non-traditional CCS services must follow the principles and standards for determining costs outlined in 2 CFR 225 (formerly Office of Management and Budget Circular A-87).

Prior to providing any non-traditional services, the CCS provider is required to complete and submit the Comprehensive Community Services/Non-Traditional Services Approval form, F-01270 (07/14), to obtain approval. Refer to Attachment 2 for a copy of the Comprehensive Community Services/Non-Traditional Services Approval form.

Non-traditional services must have specified, reasonable time frames, and successful outcomes that are reviewed regularly by the service facilitator as described in CCS Service Array category #3 titled, “Service Facilitation.” Non-traditional services will be discontinued if measurable goals are not met in a reasonable time frame.

Non-covered Services

The following services are not covered under the CCS benefit (*Note:* Some of these services may be covered under other Medicaid and BadgerCare Plus benefits):

- Intensive In-home Mental Health and Substance Abuse Treatment Services for Children covered under the HealthCheck “Other Services” benefit.
- Child/Adolescent Day Treatment covered under the HealthCheck “Other Services” benefit.
- Crisis Intervention benefit — The CCS program can coordinate a member’s crisis services, but cannot actually provide crisis services.
- Community Support Programs (CSP) benefit — Members may not be enrolled in both CCS and CSP at the same time.
- Targeted case management benefit — Members may not be enrolled in both CCS and TCM at the same time.
- Narcotic Treatment benefit (opioid treatment programs) — The CCS program covers substance abuse services as defined in the CCS Service Array. Substance abuse counseling is covered under CCS Service Array category #13 titled, “Substance Abuse Treatment.”
- Non-emergency Medical Transportation benefit — The CCS program does not cover time spent solely to transport members. Members should use the Non-emergency Medical Transportation benefit for transportation services. However, a CCS provider may provide a service covered under the CCS Service Array to a member while traveling with the member.
- Services to members residing in Residential Care Centers.
- Autism services.
- Developmental disability services.
- Learning disorder services.
- Respite care.
- Sheltered workshop.
- Job development — The CCS program does not cover activities related to finding a member a specific job. The CCS program covers employment-related skill training as defined in the CCS Service Array category #9 titled, “Employment-Related Skill Training.”
- Clubhouses — The CCS program does not cover time spent by a member working in a clubhouse. The CCS program covers time spent by clubhouse staff in providing psychosocial rehabilitation services, as defined in the CCS Service Array, for members.
- Operating While Intoxicated assessments.
- Urine analysis and drug screening.
- Prescription drug dispensing — The CCS program does not cover solely the dispensing of prescription drugs. The CCS program covers medication management services as defined in CCS Service Array category #5 titled, “Medication Management.”
- Detoxification services.
 - ✓ Medically managed inpatient.
 - ✓ Medically monitored residential.
 - ✓ Ambulatory.
- Residential intoxication monitoring services.
- Medically managed inpatient treatment services.
- Case management services provided under DHS 107.32, Wis. Admin. Code, by a provider not enrolled

in accordance with DHS 105.255, Wis. Admin. Code, to provide services.

- Services provided to a resident of an intermediate care facility, skilled nursing facility or an institution for mental diseases, or to a hospital patient unless the services are performed to prepare the member for discharge from the facility to reside in the community.
- Services performed by volunteers, except that out-of-pocket expenses incurred by volunteers in performing services may be covered. Comprehensive Community Services programs may use volunteers to support the activities of CCS staff. Before a volunteer may work independently with a member or family member, the CCS program must conduct a background check on the volunteer. Each volunteer must be supervised by a qualified staff member and receive orientation and training. See DHS 36.10, Wis. Admin. Code, for more information.
- Services that are not rehabilitative, including services that are primarily recreation-oriented.
- Legal advocacy performed by an attorney or paralegal.

Prior Authorization

Prior authorization by ForwardHealth is not required for the CCS benefit.

Copayment

Providers are prohibited from collecting copayments from members for services covered under the CCS benefit.

Documentation Requirements

Comprehensive Community Services providers must maintain documentation in accordance with DHS 36.18 and DHS 106, Wis. Admin. Code and other applicable laws and rules. The provider must be able to produce documentation upon request from DHS, single audit firms, or federal auditors.

To support interim claims, providers should indicate whether the service provided was face-to-face service and also the service length.

Refer to Attachment 3 for documentation requirements for all mental health and substance abuse providers, including CCS.

Reimbursement of CCS Program Costs

Overview

Reimbursement of CCS program costs consists of the following:

- Interim claims submission and reimbursement — The process throughout the calendar year during which CCS providers submit interim health care claims to ForwardHealth and receive interim reimbursement.
- Cost reporting/Cost reconciliation — The process following the end of the calendar year during which CCS providers report to ForwardHealth the total cost of operating their CCS program for the calendar year and ForwardHealth adjusts the total interim reimbursement to reflect full reimbursement for allowable Medicaid costs.

Important CCS Cost Category Concepts and Definitions

ForwardHealth is aligning cost definitions across all county administered Medicaid programs that rely on cost-based reimbursement. These cost categories are important for proper interim claim submission and cost reporting/cost reconciliation purposes.

Direct Costs and General Overhead Costs

Comprehensive Community Services program costs consist of *direct costs* and *general overhead costs* which are described below.

- Direct costs — These are costs that support direct program operation. Direct costs can include:
 - ✓ Service delivery time — Time spent by an allowable service provider providing a service identified on the CCS Service Array. This includes time providing both face-to-face and non-face-to-face services identified on the CCS Service Array. Allowable service providers are described in DHS 36.10(2)(g), Wis. Admin. Code.

- ✓ Provider travel time — Time for a service provider to travel to provide a CCS service to a member.
- ✓ Documentation time — Time after service delivery for a service provider to complete a member's progress note/case note/medical record or otherwise document service delivery.
- ✓ Staff training time directly related to CCS.
- ✓ A CCS supervisor's time supervising other CCS staff. (*Note:* A CCS supervisor could also spend a portion of his or her time as an allowable service provider providing a service identified on the CCS Service Array. This time would represent service delivery time, not supervision time.)
- ✓ Comprehensive Community Service administrator's time spent on general CCS administration.
- ✓ Time spent by staff not described in DHS 36.10(2)(g), Wis. Admin. Code, directly supporting the CCS program.
- ✓ Non-staff costs that directly contribute to the CCS program (e.g., CCS training materials and CCS supplies).
- ✓ All other direct CCS program support costs.
- General overhead costs — These are costs that reflect central services related to overall agency operations that are allocable to all agency programs including CCS.
Common examples of general overhead costs include:
 - ✓ Accounting.
 - ✓ Billing.
 - ✓ Financial.
 - ✓ Human resources.
 - ✓ Legal.
 - ✓ Plant maintenance.
 - ✓ Agency administrator.
 - ✓ Agency director.
 - ✓ Software.
 - ✓ Lease and rental.
 - ✓ Utilities costs.

Interim Claim Submission and Reimbursement

Effective for DOS on and after July 1, 2014, ForwardHealth will reimburse interim claims for CCS based on statewide interim rates. Previously, ForwardHealth reimbursed interim claims for CCS based on rates developed by each county/tribe.

Statewide interim rates for CCS will vary based on the type of professional providing the service and on whether the service was provided as an individual service or as a group service. The same interim rates apply to services provided by county/tribe staff and contracted staff. Refer to Attachment 4 for the statewide interim rates. Following the CCS rollout period, the interim rates may be adjusted on an annual basis. Comprehensive Community Services programs will be notified via the ForwardHealth Portal if CCS rates change.

Providers can only submit interim claims for reimbursement for the following types of direct costs, as defined previously:

- Service delivery time.
- Provider travel time.
- Documentation time.

A CCS provider may have higher or lower total program costs than the statewide interim rates for CCS services. Providers are required to indicate their usual and customary charge on claim details when submitting claims. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to the program's benefits through Medicaid or BadgerCare Plus. For providers using a sliding scale, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid or BadgerCare program patients. For providers who have not established usual and customary charges, the charge should be reasonably related to the provider's cost for providing the service.

The usual and customary charge should represent the expected actual costs of providing the service regardless if it

is greater than or less than the interim rate. Comprehensive Community Services providers should not simply bill the interim rate. The difference between the actual costs and the interim payments will be accounted for during the cost reporting and cost reconciliation process and may result in either a payment or recoupment to the county/tribe.

Providers are encouraged to submit claims on a timely basis. Timely claim submission ensures consistent cash flow to the CCS program and accurate cost reporting at the end of the calendar year.

How to Submit Interim Claims

General Requirements

Providers can submit claims in the following ways:

- Electronically using the 837 Health Care Claim: Professional transaction.
- On paper using the 1500 Health Insurance Claim Form (dated 08/05).
- Via the ForwardHealth Portal.

When submitting an interim claim for CCS services, providers are required to include the National Provider Identifier of the Medicaid-enrolled prescribing/referring/ordering provider. Refer to the Claims for Services Prescribed, Referred or Ordered topic (topic #15737) of the Submission chapter of the Claims section of the Online Handbook for more information.

Each unit of time submitted on the interim claim represents 15 minutes of service. A unit of time has been reached when a provider has completed 51 percent of the designated time unit.

Billing and Rendering Providers

A single billing provider must be identified for each interim claim and a single rendering provider must be identified for each interim claim detail. The billing and rendering provider information submitted on each interim claim will be used to assign each interim claim detail to a specific county, tribe, or 51.42 entity for cost reporting and reconciliation purposes.

Billing and rendering providers are defined as follows:

- Billing provider — The county, tribe, or 51.42 entity that submits the claim.
- Rendering provider — The county, tribe, or 51.42 entity that incurred the direct cost of delivering the service. This may or may not be the same as the county, tribe, or 51.42 entity in which the member resides. The county, tribe, or 51.42 entity incurs the direct cost if (1) its employed staff rendered the service directly and the county, tribe, or 51.42 entity did not receive reimbursement for the service from another entity or (2) it incurred the cost of a contract with another public or private entity that rendered the service (which could include another county or tribe within its region).

For regional providers, the billing and rendering provider depends on the regional service model under which the CCS program operates:

- Population Based Model — The single county/tribe within the region must be identified as both the billing and rendering provider on all interim claim details.
- Shared Services Model — The county/tribe within the region that incurred the direct cost of delivering the service being submitted on the interim claim must be identified as both the billing and rendering provider on all interim claim details.
- Multi-County Model — The lead county/tribe must be identified as the billing provider on all interim claims for the region. The county/tribe within the region that incurred the direct cost of delivering the service being submitted on the interim claim detail must be identified as the rendering provider on that detail. *Note:* Each detail can only include a single rendering provider.
- 51.42 Model — The 51.42 entity must be identified as both the billing and rendering provider on all interim claim details.

For non-regional CCS providers, the non-regional CCS provider must be identified as both the billing and rendering provider on all interim claim details.

Claims for Service Delivery Time and Documentation Time

In order to submit claims for service delivery time and documentation time, both the service delivery time and documentation time must be clearly documented in the member's medical record. Documentation should include the specific service provided and the specific time period spent documenting the service. Effective for DOS on and after July 1, 2014, providers are required to submit Healthcare Common Procedure Coding System procedure code H2017 (Psychosocial rehabilitation services, per 15 minutes) for all service delivery time and documentation time including service delivery time and documentation time provided in a residential setting. Previously, providers were required to submit procedure code H2018 (Psychosocial rehabilitation services, per diem). Providers can no longer use procedure code H2018.

On the claim detail for service delivery time and documentation time, CCS providers are required to include the following modifiers:

- In the first modifier position, the appropriate professional provider type modifier (e.g., MD, PhD, Masters, Bachelors) from Attachment 4.
- In the second modifier position, the appropriate modifier from Attachment 4 to indicate whether the service was provided as an individual or group service.

Claim details for which the DOS and both modifiers are the same should be combined into one detail on the claim. For these claim details, time should be added up and rounded to the nearest 15-minute unit, per CPT rounding guidelines.

Refer to Attachment 4 for modifiers, descriptions, and statewide interim rates. See Attachment 5 for a crosswalk between the service providers specified in DHS 36.10(2)(g), Wis. Admin. Code, and the provider type modifiers specified in Attachment 4.

Providers are required to indicate the appropriate place of service (POS) on the claim. Allowable POS codes for CCS services are included in Attachment 6.

Claims for Provider Travel Time

In order to submit provider travel time on interim claims, the time and distance traveled in miles must be documented in the member's medical record. Providers are required to use *Current Procedural Terminology* procedure code 99199 (Unlisted special service, procedure, or report) when submitting claim details for travel. Units must be rounded to the closest 15-minute unit, per CPT rounding guidelines. Provider travel time must be submitted on the same claim as the professional service in order to be reimbursable.

On the claim detail for provider travel time, CCS providers are required to include the following modifiers:

- In the first modifier position, the appropriate professional provider type modifier from Attachment 4 to identify the type of professional who is traveling.
- In the second modifier position, the appropriate modifier from Attachment 4 to indicate whether the professional is traveling to provide an individual service or a group service.
- In the third modifier position, modifier "U3" to indicate that the unit of service represents provider travel time.

Provider travel time to a group service should be submitted on the claim for each member in the group.

Claim details for which the DOS and all modifiers are the same should be combined into one detail on the claim. For these claim details, time should be added up and rounded to the nearest 15-minute unit.

Refer to Attachment 4 for modifiers, descriptions, and statewide interim rates. See Attachment 5 for a crosswalk between the service providers specified in DHS 36.10(2)(g), Wis. Admin. Code, and the provider type modifiers specified in Attachment 4.

Providers should use POS code "99" for all provider travel time.

Note: Units of provider travel time will be included as part of the cost reporting and cost reconciliation process.

Interim Claim Reimbursement

Regional CCS providers will receive the federal and non-federal share of the statewide interim rate for each claim submitted. Non-regional CCS providers will receive only the federal share of the statewide interim rate.

CCS Cost Reporting and Reconciliation Process Guidelines

Cost reporting and cost reconciliation will occur following the end of each calendar year. *Cost reporting* is defined as the work conducted by each county/tribe or region to fulfill state and federal financial reporting requirements, whereas *cost reconciliation* represents activities completed by ForwardHealth that results in either payment to, or recoupment from, the county/tribe or region to fulfill CCS cost-based reimbursement under the program.

Guidelines for CCS Regional Structures

The following are general guidelines related to proper claim submission and cost reporting for CCS regions and participating counties/tribes under the CCS program, effective for DOS on and after July 1, 2014. A CCS Cost Reporting and Reconciliation Manual is currently being developed and will be distributed to CCS programs. The manual will include more detailed cost reporting and reconciliation guidelines.

General Cost Reporting Guidelines

Regions may only operate under one regional service model during each cost reporting and cost reconciliation period. For example, a single region may not operate under a Multi-County Model that uses a lead biller to submit certain interim claims for reimbursement, while at the same time operating under a Shared Services Model to submit other interim claims. Additionally, a county/tribe may not participate in multiple CCS regions simultaneously.

- Cost reports for CCS regions will represent the summation of county and/or tribal costs. This means

that each region must disaggregate costs at the individual county or tribe level.

- ✓ In a population-based region, one cost report will be submitted.
- ✓ In a shared services region, each county or tribe will submit its own cost report.
- ✓ In a multi-county region, each county or tribe will be provided a section on a regional cost report to report its individual county or tribal costs.
- ✓ In a 51.42 region, one cost report will be submitted. The DHS will work with each 51.42 region individually on the details required for cost reporting.
- If a county or tribe participating in a CCS region wishes to claim direct or general overhead costs for reconciliation purposes, then these costs must appear in that county's or tribe's cost report, or county/tribal-specific section of the regional cost report.
- Counties/tribes can only report general overhead costs if direct costs and billed service units are reported for that county or tribe. In other words, the county or tribe must incur at least one direct cost in order to report general overhead costs. General overhead costs function as an add-on to the direct service unit cost.
- On the cost report, counties/tribes are required to clearly state their actual direct costs and general overhead costs that relate to each county's or tribe's interim claims.
 - ✓ Actual general overhead cost allocations, not budgeted estimates, will be needed for cost reporting.
 - ✓ Allowable allocation methods include allocations based on staff time reporting, full time equivalents related to CCS, and other allocation methods as allowed in 2 CFR 225 (formerly Office of Management and Budget Circular A-87).
 - ✓ Reported direct costs and general overhead costs within a cost report must align with units of service submitted on interim claims. For example, reported costs per county/tribe must have corresponding direct service units billed for proper reconciliation.

- Outlier costs will be reviewed for reasonableness and may lead to future policy on per member limits for the CCS program.
- Comprehensive Community Services are subject to audit.

Regional Contractual Arrangements

Counties/tribes have the flexibility to enter into contractual arrangements for service provision either among regional county or tribal entities or with non-county or tribal contractors. Additionally, a region may contract with a county or tribe outside of the region for services. This outside county or tribe will be treated as the subcontracted county or tribe and will not have a county or tribal section on the contracting region's cost report.

If there is a contractual relationship that a county or tribe intends to have reflected in the cost reporting and financial reconciliation process, then certain coding rules must be followed. Specifically, where contracts exist, the interim claims submission would use the rendering provider number on claim details to attribute those interim claim detail costs to the county or tribe that incurred costs associated with those contracted units.

Cost Reconciliation Periods

Cost reporting and cost reconciliations for all DOS within calendar year 2014 will occur following the end of the calendar year. For DOS from January 1, 2014, through June 30, 2014, ForwardHealth will use the previous cost reconciliation process. For DOS between July 1, 2014, and December 31, 2014, ForwardHealth will use a revised cost reconciliation process based on the policy described in this *Update*.

If a county/tribe regionalizes after July 1, 2014, then the cost reconciliation for DOS between July 1, 2014, and December 31, 2014, will include the following two periods:

- The period from July 1, 2014, to the effective date of regionalization.
- The period from the effective date of regionalization to December 31, 2014.

If a county/tribe regionalizes after July 1, 2014, and adds an additional county/tribe or counties/tribes prior to the end of the year, then the cost reconciliation for DOS between July 1, 2014, and December 31, 2014, will include the following three periods:

- The period from July 1, 2014, to the effective date of regionalization.
- The period from the effective date of regionalization to the effective date of the addition.
- The period from the effective date of the addition to December 31, 2014.

For example, if a region begins on August 1, 2014, and adds counties/tribes on October 1, 2014, the three reconciliation periods would be July 1, 2014, through July 31, 2014 (as a non-regional county), August 1, 2014, through September 30, 2014 (as the initial region), and October 1, 2014, through December 31, 2014 (as the revised region).

Calendar year 2015 reconciliations will be broken down into periods according to the start date of the region (for start dates within calendar year 2015) and to modifications made to the region during the calendar year.

Calendar year 2016 reconciliations will not be broken down into periods, as changes will only be allowed on a calendar year basis beginning January 1, 2016.

Note: Calendar year 2013 cost reconciliations are not affected by the changes due to the CCS budget initiative.

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 Health Care Access and Accountability, 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, Wisconsin DHS.

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

P-1250

ATTACHMENT 1

Comprehensive Community Services Program — Service Array

The Comprehensive Community Services (CCS) program provides individuals with psychosocial rehabilitation services. All CCS programs must provide the services covered under the CCS benefit that a member needs as determined by the assessment of all the domains in DHS 36.16(4), Wis. Admin. Code. The service array describes the services that are covered under the CCS benefit. All services must be in compliance with DHS 36, Wis. Admin. Code. All services should be person-centered and developed in partnership with the member. The assessment domains included in DHS 36.16(4), Wis. Admin. Code, are: (a) life satisfaction, (b) basic needs, (c) social network and family involvement, (d) community living skills, (e) housing issues, (f) employment, (g) education, (h) finances and benefits, (i) mental health, (j) physical health, (k) substance use, (L) trauma and significant life stressors, (m) medications, (n) crisis prevention and management, (o) legal status, and (p) any other domain identified by the CCS program.

Service Category (Most Applicable DHS Wis. Admin. Code Sections)	Allowable Services	Allowable Provider Types
1. Screening and Assessment (DHS 36.03, 36.13-36.16, Wis. Admin. Code)	<p>Screening and assessment services include: completion of initial and annual functional screens, and completion of the initial comprehensive assessment and ongoing assessments as needed. The assessment must cover all the domains, including substance use, which may include using the Uniform Placement Criteria or the American Society of Addiction Medicine Criteria. The assessment must address the strengths, needs, recovery goals, priorities, preferences, values, and lifestyle of the member and identify how to evaluate progress toward the member's desired outcomes.</p> <p>Assessments for minors must address the minor's and family's strengths, needs, recovery and/or resilience goals, priorities, preferences, values, and lifestyle of the member including an assessment of the relationships between the minor and his or her family. Assessments for minors should be age (developmentally) appropriate.</p>	<p>Providers described in DHS 36.10(2)(g)1-22, Wis. Admin. Code.* ‡</p> <p>All providers are required to act within their scope of practice.</p>

Service Category (Most Applicable DHS Wis. Admin. Code Sections)	Allowable Services	Allowable Provider Types
<p>2. Service Planning (DHS 36.03, 36.16(7), 36.17, Wis. Admin. Code)</p>	<p>Service planning includes the development of a written plan of the psychosocial rehabilitation services that will be provided or arranged for the member. All services must be authorized by a mental health professional and a substance abuse professional if substance abuse services will be provided. The service plan is based on the assessed needs of the member. It must include measurable goals and the type and frequency of data that will be used to measure progress toward the desired outcomes. It must be completed within 30 days of the member's application for CCS services. The completed service plan must be signed by the member, a mental health or substance abuse professional and the service facilitator.</p> <p>The service plan must be reviewed and updated based on the needs of the member or at least every six months. The review must include an assessment of the progress toward goals and member satisfaction with the services. The service plan review must be facilitated by the service facilitator in collaboration with the member and the recovery team.</p>	<p>Providers described in DHS 36.10(2)(g)1-22, Wis. Admin. Code.* ‡</p> <p>All providers are required to act within their scope of practice.</p>
<p>3. Service Facilitation (DHS 36.03, 36.10(2)(e)4, 36.17, Wis. Admin. Code)</p>	<p>Service facilitation includes activities that ensure the member receives: assessment services, service planning, service delivery, and supportive activities in an appropriate and timely manner. It also includes ensuring the service plan and service delivery for each member is coordinated, monitored, and designed to support the member in a manner that helps the member achieve the highest possible level of independent functioning. Service facilitation includes assisting the member in self-advocacy and helping the member obtain other necessary services such as medical, dental, legal, financial and housing services.</p> <p>Service facilitation for minors includes advocating, and assisting the minor's family in advocating, for the minor to obtain necessary services. When working with a minor, service facilitation that is designed to support the family must be directly related to the assessed needs of the minor.</p> <p>Service facilitation includes coordinating a member's crisis services, but not actually providing crisis services. Crisis services are provided by DHS 34, Wis. Admin. Code, certified programs.</p> <p>All services should be culturally, linguistically, and age (developmentally) appropriate.</p>	<p>Providers described in DHS 36.10(2)(g)1-21, Wis. Admin. Code.* ‡</p> <p>All providers are required to act within their scope of practice.</p>

Service Category (Most Applicable DHS Wis. Admin. Code Sections)	Allowable Services	Allowable Provider Types
4. Diagnostic Evaluations	<p>Diagnostic evaluations include specialized evaluations needed by the member including, but not limited to neuropsychological, geropsychiatric, specialized trauma, and eating disorder evaluations. For minors, diagnostic evaluations can also include functional behavioral evaluations and adolescent alcohol/drug assessment intervention programs.</p> <p>The CCS program does not cover evaluations for autism, developmental disabilities, or learning disabilities.</p>	<p>Providers described in DHS 36.10(2)(g)1-14, Wis. Admin. Code.*</p> <p>All providers are required to be licensed/certified and acting within their scope of practice.</p>
5. Medication Management	<p>Medication management services for prescribers include:</p> <ul style="list-style-type: none"> • Diagnosing and specifying target symptoms. • Prescribing medication to alleviate the identified symptoms. • Monitoring changes in the member’s symptoms and tolerability of side effects. • Reviewing data, including other medications, used to make medication decisions. <p>Prescribers may also provide all services the non-prescribers can provide as noted below.</p>	<p>Providers described in DHS 36.10(2)(g)1-3, 7-8, and 11, Wis. Admin. Code.</p> <p>All providers are required to be licensed/certified and acting within their scope of practice.</p>
	<p>Medication management services for non-prescribers include:</p> <ul style="list-style-type: none"> • Supporting the member in taking his or her medications. • Increasing the member’s understanding of the benefits of medication and the symptoms it is treating. • Monitoring changes in the member’s symptoms and tolerability of side effects. 	<p>Providers described in DHS 36.10(2)(g)1-22, Wis. Admin. Code.* ‡</p> <p>All providers are required to act within their scope of practice.</p>
6. Physical Health Monitoring	<p>Physical health monitoring services focus on how the member’s mental health and/or substance abuse issues impact his or her ability to monitor and manage physical health and health risks.</p> <p>Physical health monitoring services include activities related to the monitoring and management of a member’s physical health. Services may include assisting and training the member and the member’s family to identify symptoms of physical health conditions, monitor physical health medications and treatments, and to develop health monitoring and management skills.</p>	<p>Providers described in DHS 36.10(2)(g)1-22, Wis. Admin. Code.* ‡</p> <p>All providers are required to act within their scope of practice.</p>

Service Category (Most Applicable DHS Wis. Admin. Code Sections)	Allowable Services	Allowable Provider Types
7. Peer Support	<p>Peer support services include a wide range of supports to assist the member and the member’s family with mental health and/or substance abuse issues in the recovery process. These services promote wellness, self-direction, and recovery by enhancing the skills and abilities of members to meet their chosen goals. The services also help members negotiate the mental health and/or substance abuse systems with dignity, and without trauma. Through a mutually empowering relationship, Certified Peer Specialists and members work as equals toward living in recovery.</p>	<p>Providers described in DHS 36.10(2)(g)20, Wis. Admin. Code.* ‡</p> <p><i>Reminder:</i> All CCS peer specialists are required to be Wisconsin Certified Peer Specialists as noted by the “‡” throughout the array.</p> <p>All providers are required to act within their scope of practice.</p>
8. Individual Skill Development and Enhancement	<p>Individual skill development and enhancement services include training in communication, interpersonal skills, problem solving, decision-making, self-regulation, conflict resolution, and other specific needs identified in the member’s service plan. Services also include training in daily living skills related to personal care, household tasks, financial management, transportation, shopping, parenting, accessing and connecting to community resources and services (including health care services), and other specific daily living needs identified in the member’s service plan.</p> <p>Services provided to minors should also focus on improving integration into and interaction with the minor’s family, school, community, and other social networks. Services include assisting the minor’s family in gaining skills to assist the minor with individual skill development and enhancement. Services that are designed to support the family must be directly related to the assessed needs of the minor.</p> <p>Skill training may be provided by various methods, including but not limited to modeling, monitoring, mentoring, supervision, assistance, and cueing. Skill training may be provided individually or in a group setting.</p>	<p>Providers described in DHS 36.10(2)(g)1-22, Wis. Admin. Code.* ‡</p> <p>All providers are required to act within their scope of practice.</p>

Service Category (Most Applicable DHS Wis. Admin. Code Sections)	Allowable Services	Allowable Provider Types
9. Employment-Related Skill Training	<p>Employment-related skill training services address the member’s illness or symptom-related problems in finding, securing, and keeping a job. Services may include, but are not limited to: employment and education assessments; assistance in accessing or participating in educational and employment-related services; education about appropriate job-related behaviors; assistance with job preparation activities such as personal hygiene, clothing, and transportation; on-site employment evaluation and feedback sessions to identify and manage work-related symptoms; assistance with work-related crises; and individual therapeutic support.</p> <p>The CCS program does not cover time spent by the member working in a clubhouse. The CCS program covers time spent by clubhouse staff in providing psychosocial rehabilitation services, as defined in the service array, for the member if those services are identified in the member’s service plan.</p>	<p>Providers described in DHS 36.10(2)(g)1-22, Wis. Admin. Code.* ‡</p> <p>All providers are required to act within their scope of practice.</p>
10. Individual and/or Family Psychoeducation**	<p>Psychoeducation services include:</p> <ul style="list-style-type: none"> • Providing education and information resources about the member’s mental health and/or substance abuse issues. • Skills training. • Problem solving. • Ongoing guidance about managing and coping with mental health and/or substance abuse issues. • Social and emotional support for dealing with mental health and/or substance abuse issues. <p>Psychoeducation may be provided individually or in a group setting to the member or the member’s family and natural supports (i.e., anyone the member identifies as being supportive in his or her recovery and/or resilience process). Psychoeducation is not psychotherapy.</p> <p>Family psychoeducation must be provided for the direct benefit of the member. Consultation to family members for treatment of their issues not related to the member is not included as part of family psychoeducation. Family psychoeducation may include anticipatory guidance when the member is a minor.</p> <p>If psychoeducation is provided without the other components of the Wellness Management and Recovery service array category (#11), it should be included under this service category.</p>	<p>Providers described in DHS 36.10(2)(g)1-22, Wis. Admin. Code.* ‡</p> <p>All providers are required to act within their scope of practice.</p>

Service Category (Most Applicable DHS Wis. Admin. Code Sections)	Allowable Services	Allowable Provider Types
<p>11. Wellness Management and Recovery**/ Recovery Support Services</p>	<p>Wellness management and recovery services, which are generally provided as mental health services, include empowering members to manage their mental health and/or substance abuse issues, helping them develop their own goals, and teaching them the knowledge and skills necessary to help them make informed treatment decisions. These services include: psychoeducation; behavioral tailoring; relapse prevention; development of a recovery action plan; recovery and/or resilience training; treatment strategies; social support building; and coping skills. Services can be taught using motivational, educational, and cognitive-behavioral strategies.</p> <p>If psychoeducation is provided without the other components of wellness management and recovery, it should be included under the Individual and/or Family Psychoeducation service array category (#10).</p> <p>Recovery support services, which are generally provided as substance abuse services, include emotional, informational, instrumental, and affiliated support. Services include assisting the member in increasing engagement in treatment, developing appropriate coping strategies, and providing aftercare and assertive continuing care. Continuing care includes relapse prevention support and periodic follow-ups and is designed to provide less intensive services as the member progresses in recovery.</p>	<p>Providers described in DHS 36.10(2)(g)1-22, Wis. Admin. Code. * ‡</p> <p>All providers are required to act within their scope of practice.</p>
<p>12. Psychotherapy</p>	<p>Psychotherapy includes the diagnosis and treatment of mental, emotional, or behavioral disorders, conditions, or addictions through the application of methods derived from established psychological or systemic principles for the purpose of assisting people in modifying their behaviors, cognitions, emotions, and other personal characteristics, which may include the purpose of understanding unconscious processes or intrapersonal, interpersonal, or psychosocial dynamics.</p> <p>Psychotherapy may be provided in an individual or group setting.</p>	<p>Providers described in DHS 36.10(2)(g)1-10, 14, 22, Wis. Admin. Code.*</p> <p>All providers are required to be licensed/certified and acting within their scope of practice.</p>

Service Category (Most Applicable DHS Wis. Admin. Code Sections)	Allowable Services	Allowable Provider Types
13. Substance Abuse Treatment	<p>Substance abuse treatment services include day treatment (DHS 75.12, Wis. Admin. Code) and outpatient substance abuse counseling (DHS 75.13, Wis. Admin. Code). Substance abuse treatment services can be in an individual or group setting.</p> <p>The other categories in the service array also include psychosocial rehabilitation substance abuse services that support members in their recovery.</p> <p>The CCS program does not cover Operating While Intoxicated assessments, urine analysis and drug screening, detoxification services, medically managed inpatient treatment services, or narcotic treatment services (opioid treatment programs). Some of these services may be covered under Medicaid and BadgerCare Plus outside the CCS program.</p>	<p>Providers described in DHS 36.10(2)(g) 1, 2 (with knowledge of addiction treatment), 4 (with knowledge of psychopharmacology and addiction treatment) and 16, Wis. Admin. Code.</p> <p>Substance abuse professionals include:</p> <ul style="list-style-type: none"> • Certified Substance Abuse Counselor. • Substance Abuse Counselor. • Substance Abuse Counselor in Training. • Marriage & Family Therapy, Professional Counseling & Social Worker Examining Board (MPSW) 1.09 specialty. <p>All providers are required to be licensed/certified and acting within their scope of practice.</p>

Service Category (Most Applicable DHS Wis. Admin. Code Sections)	Allowable Services	Allowable Provider Types
14. Non-Traditional or Other Approved Services	<p>Non-traditional services or other approved services are identified for specific members and are expected to accomplish treatment ends that traditional behavioral health services have not. Non-traditional services billed to the CCS program must:</p> <ul style="list-style-type: none"> • Have a psychosocial rehabilitative purpose. • Not be merely recreational activities. • Not otherwise be available to the member. <p>The medical necessity of non-traditional services must be documented in the member’s records and through assessed needs in the member’s service plan. Documentation must include the psychosocial rehabilitative benefits. The service plan must document the corresponding measurable goals of the non-traditional service. Non-traditional or other approved services must have specified, reasonable time frames and successful outcomes that are reviewed regularly by the service facilitator. Non-traditional services will be discontinued if measurable goals are not met in a reasonable time frame.</p>	<p>Provider types as requested and approved by ForwardHealth.</p> <p>All providers are required to act within their scope of practice.</p>

* Type I Qualified Treatment Trainees (QTTs) are described in DHS 36.10(2)(g)22, Wis. Admin. Code, (clinical students) and Type II QTTs are described in DHS 36.10(2)(g)9, Wis. Admin. Code, (certified social workers, certified advance practice social workers, and certified independent social workers). Type I and Type II QTTs are required to be working through a DHS 35, Wis. Admin. Code, certified outpatient clinic. For purposes of the CCS program, all clinical students are required to be Type I QTTs.

** Information for these service categories is based on information provided by the federal Substance Abuse and Mental Health Services Administration.

‡ DHS 36.10(2)(g)20, Wis. Admin. Code, describes peer specialists. For purposes of the CCS program, all CCS peer specialists are required to be Wisconsin Certified Peer Specialists. Individuals who are not Wisconsin Certified Peer Specialists could potentially act as rehabilitation workers if they meet the requirements described in DHS 36.10(2)(g)21, Wis. Admin. Code. Refer to the service array for which services rehabilitation workers can provide.

ATTACHMENT 2

Comprehensive Community Services / Non-Traditional Services Approval

(A copy of the “Comprehensive Community Services / Non-Traditional Services Approval” is located on the following page.)

**FORWARDHEALTH
COMPREHENSIVE COMMUNITY SERVICES / NON-TRADITIONAL SERVICES APPROVAL**

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (DHS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

The use of this form is mandatory when requesting approval for Comprehensive Community Services (CCS) non-traditional services.

Non-traditional psychosocial rehabilitative services fall under the definition of CCS Service Array category #14, titled "Non-Traditional or Other Approved Services." Non-traditional psychosocial rehabilitative services or other approved services are identified for specific members and are expected to accomplish treatment ends that traditional behavioral health services have not.

This form must be completed and e-mailed to VEDSCCSSupport@wisconsin.gov and approved by ForwardHealth before submitting claims for these services. A response indicating approval or denial will be provided within 30 calendar days after receipt of all required information. The form must be completed for each member every calendar year in order to continue receiving approval for the services requested. This form must be e-mailed in a secure manner.

CCS County / Tribe Region

Name — CCS Program Contact Person

Telephone Number — CCS Program Contact Person

E-mail Address — CCS Program Contact Person

Calendar Year for Implementation of Non-traditional Service

Name — CCS Member

CCS Member ID

1. Describe the proposed non-traditional services. Provide links to Web sites or other supporting documentation describing the service.

2. Verify that the non-traditional psychosocial rehabilitative service is medically necessary and documented as defined in DHS 101.03 (96m), Wis. Admin. Code.

3. Describe the psychosocial rehabilitative purpose of the non-traditional service and verify that it is not merely a recreational activity.

4. Describe the professional level and credentials of the county/tribal staff or contractor who will deliver the non-traditional service.

5. Verify that the service is not otherwise available to the member through available, traditional services on the CCS service array and explain why the traditional services will not meet the needs of the member.

6. Describe the goals and outcomes of the service and the timeframe within which these outcomes are to be achieved.

SIGNATURE — CCS Program Representative	Date Signed
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Name — CCS Program Representative (Printed)

SIGNATURE — Medicaid Behavioral Health Analyst	Approved / Not Approved
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Name — Medicaid Behavioral Health Analyst (Printed)	Decision Date
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Reason for Denial

ATTACHMENT 3

Mental Health and Substance Abuse Services Documentation Requirements

Providers are responsible for meeting medical and financial documentation requirements. Refer to DHS 106.02(9)(a), Wis. Admin. Code, for preparation and maintenance documentation requirements and DHS 106.02(9)(c), Wis. Admin. Code, for financial record documentation requirements.

The following are the medical record documentation requirements (DHS 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 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, 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 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, 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).
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 member, including any prescriptions and plans of care or treatment provided).
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.

ATTACHMENT 4

Procedure Code Information for the Comprehensive Community Services Benefit

The following table lists the procedure code and modifiers that providers are required to use when submitting interim claims for service delivery time and documentation time.

Procedure Code	Procedure Code Description	Professional Provider Type and Modifier		Individual Service vs. Group Service and Modifier		State-Wide Interim Rate (Per 15 Minutes)
H2017	Psychosocial Rehabilitation Services, per 15 minutes	M.D.	UA	Individual	U5	\$53.57
				Group	HQ	\$13.39
		Ph.D.	HP	Individual	U5	\$40.00
				Group	HQ	\$10.00
		Bachelors degree level	HN	Individual	U5	\$21.43
				Group	HQ	\$5.36
		Masters degree level	HO	Individual	U5	\$32.14
				Group	HQ	\$8.04
		Advanced Practice Nurse Prescriber with Psychiatric Specialty	UB	Individual	U5	\$53.57
				Group	HQ	\$13.39
		Registered Nurse	TD	Individual	U5	\$21.43
				Group	HQ	\$5.36
		Certified Peer Specialist	U8	Individual	U5	\$13.97
				Group	HQ	\$3.49
		Rehabilitation Worker	U9	Individual	U5	\$13.97
				Group	HQ	\$3.49
		Associate Degree	UD	Individual	U5	\$13.97
				Group	HQ	\$3.49
		Qualified Treatment Trainee Type 1	U7	Individual	U5	\$32.14
				Group	HQ	\$8.04
Qualified Treatment Trainee Type 2	U6	Individual	U5	\$32.14		
		Group	HQ	\$8.04		
Other Provider Type	UC	Individual	U5	\$13.97		
		Group	HQ	\$3.49		

The following table lists the procedure code and modifiers that providers are required to use when submitting interim claims for provider travel time.

Procedure Code	Procedure Code Description	Professional Provider Type and Modifier		Individual Service vs. Group Service and Modifier		Required Modifier (Travel)	State-Wide Interim Rates (Per 15 Minutes)
99199	Unlisted special service, procedure, or report	M.D.	UA	Individual	U5	U3	\$53.57
				Group	HQ	U3	\$13.39
		Ph.D.	HP	Individual	U5	U3	\$40.00
				Group	HQ	U3	\$10.00
		Bachelors degree level	HN	Individual	U5	U3	\$21.43
				Group	HQ	U3	\$5.36
		Masters degree level	HO	Individual	U5	U3	\$32.14
				Group	HQ	U3	\$8.04
		Advanced Practice Nurse Prescriber with Psychiatric Specialty	UB	Individual	U5	U3	\$53.57
				Group	HQ	U3	\$13.39
		Registered Nurse	TD	Individual	U5	U3	\$21.43
				Group	HQ	U3	\$5.36
		Certified Peer Specialist	U8	Individual	U5	U3	\$13.97
				Group	HQ	U3	\$3.49
		Rehab Worker	U9	Individual	U5	U3	\$13.97
				Group	HQ	U3	\$3.49
		Associate Degree	UD	Individual	U5	U3	\$13.97
				Group	HQ	U3	\$3.49
		Qualified Treatment Trainee Type 1	U7	Individual	U5	U3	\$32.14
				Group	HQ	U3	\$8.04
		Qualified Treatment Trainee Type 2	U6	Individual	U5	U3	\$32.14
				Group	HQ	U3	\$8.04
		Other Provider Type	UC	Individual	U5	U3	\$13.97
				Group	HQ	U3	\$3.49

ATTACHMENT 5

Professional Type Crosswalk for the Comprehensive Community Services Benefit

The table below provides a crosswalk for professional types in DHS 36, Wis. Admin. Code, to the Standardized Professional Type that should be used for billing Comprehensive Community Services (CCS). See DHS 36.10(2)(g), Wis. Admin. Code, for additional guidance regarding required experience, licenses, and fields in which degrees should be earned to qualify under each CCS professional type.

Professional Type Specified in DHS 36.10(2)(g)1-22, Wis. Admin. Code	Standardized Professional Type
1. Psychiatrists	M.D.
2. Physicians	M.D.
3. Psychiatric residents	M.D.
4. Psychologists	Ph.D.
5. Licensed clinical social workers ¹	Masters
6. Licensed professional counselors and licensed marriage and family therapists ¹	Masters or Ph.D.
7. Adult psychiatric and mental health nurse practitioners	Masters
8. Advanced practice nurse prescribers	APNP
9. Certified social workers, certified advance practice social workers, and certified independent social workers ³	Masters (includes Type II Qualified Treatment Trainees)
10. Psychology residents	Ph.D.
11. Physician assistants	APNP
12. Registered nurses	RN
13. Occupational therapists	Bachelors, Masters or Ph.D.
14. Master's level clinicians	Masters
15. Other professionals	Bachelors, Masters or Ph.D.
16. Alcohol and drug abuse counselors ²	Associate Degree, Bachelors or Masters
17. Specialists in specific areas of therapeutic assistance, such as recreational and music therapists	Associate Degree, Bachelors or Masters
18. Certified occupational therapy assistants	Associate Degree
19. Licensed practical nurses	Associate Degree
20. Certified Peer specialists ¹	Certified Peer Specialist
21. Rehabilitation workers	Rehabilitation Worker
22. Clinical Students ³	Type I Qualified Treatment Trainees

¹ Note that this professional type description has been updated from what appears in DHS 36.10(2)(g), Wis. Admin. Code. DHS 36.10(2)(g), Wis. Admin. Code, describes "licensed clinical social workers" as "licensed independent clinical social workers"; "licensed professional counselors and licensed marriage and family therapists" as "professional counselors and marriage and family therapists"; and "certified peer specialists" as "peer specialists". The professional type descriptions have been updated in this table to align with the current descriptions used in practice.

² Substance Abuse Counselors, Certified Substance Abuse Counselors, Substance Abuse Counselors in Training, and individuals that meet the requirement of Marriage & Family Therapy, Professional Counseling & Social Worker Examining Board (MPSW) 1.09 are considered part of DHS 36.10(2)(g)16.

³ Refer to Attachment 7 of this *ForwardHealth Update* for more information on qualified treatment trainees.

ATTACHMENT 6

Place of Service Codes for the Comprehensive Community Services Benefit

Allowable place of service (POS) codes for the Comprehensive Community Services (CCS) benefit are listed in the following table.

Place of Service Codes and Descriptions			
Code	Description	Code	Description
01	Pharmacy	23	Emergency Room — Hospital
03	School	26	Military Treatment Facility
04	Homeless Shelter	31	Skilled Nursing Facility
05	Indian Health Service Free-standing Facility	32	Nursing Facility
06	Indian Health Service Provider-based Facility	33	Custodial Care Facility
07	Tribal 638 Free-standing Facility	34	Hospice
08	Tribal 638 Provider-based Facility	49	Independent Clinic
11	Office	50	Federally Qualified Health Center
12	Home	51	Inpatient Psychiatric Facility
13	Assisted Living Facility	52	Psychiatric Facility-Partial Hospitalization
14	Group Home	53	Community Mental Health Center
15	Mobile Unit	55	Residential Substance Abuse Treatment Facility
16	Temporary Lodging	56	Psychiatric Residential Treatment Center
18	Place of Employment-Worksite	57	Non-residential Substance Abuse Treatment Facility
20	Urgent Care Facility	71	Public Health Clinic
21	Inpatient Hospital	72	Rural Health Clinic
22	Outpatient Hospital	99	Other Place of Service

Notes regarding place of service codes:

- Comprehensive Community Services provided to a resident of an intermediate care facility, skilled nursing facility, institution for mental diseases, hospital, or other institutional facility are only covered if provided to prepare the CCS member for discharge from the facility to reside in the community.
- Comprehensive Community Services do not cover any services provided to members residing in Residential Care Centers.
- If staff in a CCS program is providing CCS covered services to a member while traveling with the member or attending a health appointment with the member, providers should use POS code 99.
- Although CCS can be provided in certain residential facilities, room and board is not allowable for CCS.

ATTACHMENT 7

Comprehensive Community Services Reimbursement of Qualified Treatment Trainees

Comprehensive Community Services cover services rendered by two types of qualified treatment trainees (QTTs). Qualified treatment trainees can only work with DHS 35, Wis. Admin. Code, certified outpatient mental health clinics. Type I QTTs are defined in DHS 35.03(17m)(a), Wis. Admin. Code, as “A graduate student who is enrolled in an accredited institution in psychology, counseling, marriage and family therapy, social work, nursing or a closely related field.” Type 1 QTTs are covered under CCS provider type DHS 36.10(2)(g)22, Wis. Admin. Code, which is for clinical students. Services rendered by Type I QTTs are only billable if the QTT is working through a DHS 35, Wis. Admin. Code, certified clinic that is contracted by the CCS program to provide services. For the purposes of CCS, all clinical students are required to be Type I QTTs.

Type 2 QTTs are defined in DHS 35.03(17m)(b), Wis. Admin. Code, as “A person with a graduate degree from an accredited institution and course work in psychology, counseling, marriage and family therapy, social work, nursing or a closely related field who has not yet completed the applicable supervised practice requirements described under ch. MPSW 4, 12, or 16, or Psy 2 as applicable.” Type II QTTs are covered under CCS provider type DHS 36.10(2)(g)9, Wis. Admin. Code, which is for certified social workers, certified advance practice social workers, and certified independent social workers. Services rendered by Type II QTTs are only billable if the QTT is working through a DHS 35, Wis. Admin. Code, certified clinic that is contracted by the CCS program to provide services.

Supervision

Types I and II QTTs are required to follow all supervision requirements detailed in the following sources:

- Requirements specified in DHS 35 and 36, Wis. Admin. Code.
- Requirements published in the ForwardHealth Online Handbook under the benefit in which services are provided.
- All applicable Wisconsin Department of Safety and Professional Services regulations.

Comprehensive Community Services providers should refer to the November 2012 *ForwardHealth Update* (2012-64), titled “Policy Changes for Services Rendered by Qualified Treatment Trainees,” for policy associated with CCS coverage of QTTs.