WISCONSIN DEPARTMENT of HEALTH SERVICES

# FAQs for Providers About Child Care Coordination Benefit Changes

This document contains answers to questions asked by providers during the DHS webinar on November 17, 2023, as well as key information from that presentation.

## About ForwardHealth Update 2023-38

**Q:** **What is ForwardHealth Update 2023-38?**

**A:** The Department of Health Services issued ForwardHealth Update 2023-38 to announce enrollment certification and claim submission process changes for prenatal care coordination providers billing for child care coordination services, which are only available to Medicaid members in Milwaukee County and in the City of Racine.

**Q:** **When does ForwardHealth Update 2023-38 take effect?**

**A:** ForwardHealth Update 2023-38 took effect on November 10, 2023.

### Enrollment Changes

**Q:** **What enrollment changes were announced for child care coordination services?**

**A:** ForwardHealth announced any prenatal care coordination agency approved for enrollment on or after November 10, 2023, will **not** be authorized to provide or bill for child care coordination services.

**Q:** **Are these enrollment changes temporary?**

**A:** These enrollment changes are permanent. FowardHealth will make an announcement if and when new providers will be accepted to deliver and bill for child care coordination services.

**Q:** **I am a new provider who enrolled after November 10, 2023. Are child care coordination requirements different for me?**

**A:** ForwardHealth is **not** accepting new providers to deliver and bill for child care coordination services as of November 10, 2023. This means you **cannot** provide or be reimbursed for child care coordination services.

**Q:** **My enrollment application is pending. Once approved, will I be able to provide child care coordination services**?

**A:** No. ForwardHealth and the Office of the Inspector General will contact providers who have pending applications on November 10, 2023, to confirm if they want to continue with their pending application to only deliver prenatal care coordination services. Before their application is processed for final review, providers who wish to continue with their application will be asked to complete a written attestation that they will not deliver child care coordination services.

**Q: My application is pending, but I no longer wish to render prenatal care coordination services. Can I discontinue my application and get my application fee refunded?**

**A:** Yes. If you no longer wish to move forward with your pending application, please tell ForwardHealth and the Office of the Inspector General when they contact you about your pending application. Once your application is closed, you will be able to have your application fee refunded by contacting Provider Services at 800-947-9627.

**Q: I was an enrolled provider before November 10, 2023. Do enrollment changes affect me?**

**A:** No. Enrollment changes do not affect prenatal care coordination providers who were enrolled and certified to provide child care coordination services before November 10, 2023.

**Q: My enrollment revalidation application was submitted and is pending. Can I still provide child care coordination services?**

**A:** Yes. You may provide services while your revalidation application is under review. If your revalidation is approved, the appropriate claims for those dates of service can be paid. If your revalidation is **not** approved, any claims submitted during that time period will **not** be paid.

**Q: My enrollment is up for revalidation soon. What do I need to know?**

**A:** You must revalidate your enrollment on time. Providers will receive a Provider Revalidation Notice in the mail from ForwardHealth when it is time for revalidation. This notice specifies your revalidation date, and you have 30 days from your revalidation date to submit your revalidation application. Providers who fail to submit their revalidation application by the deadline will be terminated from Wisconsin Medicaid. Please see Online Handbook Topic #8524 for more information on revalidation.

## Payment Integrity Review Changes and Reminders

**Q: What is payment integrity review?**

**A:** The Department of Health Services launched the payment integrity review program on April 1, 2023, to further safeguard the integrity of ForwardHealth by proactively reviewing claims prior to payment to ensure federal and state requirements are met.

**Q: Why is payment integrity review necessary?**

**A:** Payment integrity review seeks to identify practices that result in unnecessary program costs, like billing for services that were not rendered or lack documentation to support charges billed. This includes assessments, care planning, and care coordination procedure codes, regardless of the modifier or place of service.

**Q: What child care coordination procedure codes are reviewed through payment integrity review?**

**A:** Claims that will be reviewed include assessments, care planning, and care coordination procedure codes, regardless of the modifier or place of service.

**Q: I am certified to provide child care coordination services. What happens when I submit claims for these services?**

**A:** Your child care coordination claims will be suspended so you can attach records to your claim. The claim is then routed to the Office of the Inspector General review. Please remember to attach and submit all supporting records with your claim.

**Q: What types of records will I need to submit with child care coordination claims?**

**A:** If you are eligible to bill for child care coordination services, you will be expected to submit all applicable records and documents that substantiate the type of services being billed. These records should include but are not limited to:

- Family questionnaire
- Care plan
- Care coordination log
- Any additional service notes you maintain separately from the service log
- Copies of written referrals

**Q: My claim was suspended. When will it be released?**

**A:** If your claim was submitted without the required records, it will be suspended for 7 calendar days so you can attach and submit the necessary documentation.

**Q: I attached and submitted claim records. How long will the review take?**

**A:** Once you attach and submit claim records, your request will be routed to the Office of the Inspector General for review. Staff make it a priority to review claims as quickly as possible. Please note all claims are reviewed in the order received.

**Q: What happens if I do not submit the necessary records within 7 calendar days?**

**A:** The claim will be automatically denied. You can submit a new claim with the required attachments.

**Q: What resources are available to help me with payment integrity review?**

**A:** These resources were created to help you learn more about the payment integrity review purpose, requirements, and process:

- ForwardHealth Handbook Topic #22798
- ForwardHealth Update 2023-05
- Online, self-paced training
- Frequently Asked Questions

**Q: Can I be removed from payment integrity review?**

**A:** Yes. When 75% of a provider's reviewed claims over a three-month period are paid as submitted, the Office of Inspector General may consider removing the provider from payment integrity review.

# Covered Services

**Q: What is the difference between the family questionnaire, risk assessment, and comprehensive assessment?**

**A:** These are all terms that have been used to describe the start of services with the member. The comprehensive assessment and risk assessment are the same. The family questionnaire is a required form that you must complete as part of the comprehensive assessment.

**Q: How do I access the family questionnaire?**

**A:** The family questionnaire (F-01118) is available online. Please be sure to download and use the current version when you need it.

**Q: New clients know their family best. Am I allowed to give the family questionnaire to a parent or legal guardian to complete on their own?**

**A:** No. You must complete the family questionnaire with a parent or legal guardian in a face-to-face visit to ensure answers and scores are correct and accurately reflect the family's needs.

**Q: I assessed a child who did not meet the 70 points required on the family questionnaire to be eligible for child care coordination services. Can I still bill for the assessment?**

**A:** You can bill for the assessment following the diagnosis code guidance in FowardHealth Online Handbook Topic #976. However, you cannot bill for any additional child care coordination services for ineligible members.

**Q: I forgot to have the qualified professional sign and date the family questionnaire. It is now over a month old. What should I do?**

**A:** You cannot backdate any records. In this situation, the original appointment is not reimbursable because the proper signatures were not obtained. To address this error, the qualified professional must review the questionnaire and confirm it still accurately reflects the needs of the family through a face-to-face visit with a parent or legal guardian, and sign and date it at the appointment. The provider could submit a claim for this second visit because the family questionnaire was reviewed with the family **and** required signatures and dates were obtained.. Any other services provided can be reimbursed after you have a signed questionnaire.

**Q: The member's family questionnaire has not reached the 365-day renewal requirement. Do I still need to complete a new one?**

**A:** No. You only need to update a member's family questionnaire when it is due. ForwardHealth Handbook Topic #983 requires comprehensive assessments to be administered every 365 days. In addition, ForwardHealth Handbook Topic #991 clarifies that these assessments may be updated as frequently as needed, but should be billed as ongoing care coordination and monitoring using procedure code T1016 with modifier U3.

**Q: A new version of the family questionnaire was issued after the member's initial assessment. Do I need to conduct a new assessment before the renewal date?**

**A:** No. You do not need to conduct a new assessment before the renewal date.

**Q: A child who is older than 8 weeks of age is transferring to me from another agency. Is the child eligible for child care coordination services? If so, what documentation do I need to substantiate a claim?**

**A:** The member is eligible for services if the first agency completed and submitted a claim for the family questionnaire before the child turned 8 weeks of age. Before starting services, you are expected to validate a current or complete an updated family questionnaire and document it in the member's record. You also are expected to complete all new client paperwork with the family. This means you cannot use the other agency's paperwork, like the consent to treatment.

**Q: When the member family transfers to me, can I ask for a copy of their records?**

**A:** Yes. You can ask for a copy of prior records to better understand previously provided services.

## Care Planning

**Q: When do I need to update the care plan?**

**A:** According to ForwardHealth Handbook Topic #978 and #984, you must review and update care plans every 60 days for the first year of a child's life and every 180 days thereafter. The care plan can also be updated more frequently as needed for the member and should be billed as ongoing care coordination.

**Q: How do I document that I updated the care plan?**

**A:** While ForwardHealth does not have any specific instructions on how to best update the care plan, the Department of Health Services requires that you document any current care plan changes and sign/initial and date those changes. You do this to clearly state when the plan was reviewed or assessed and by whom.

## Logs and Notes

**Q: Are logs optional or required?**

**A:** According to ForwardHealth Handbook Topics #961 and #978, you are required to maintain a service log that clearly captures all care coordination activities as detailed in policy. You also must document the activities and details that occur during visits, including the coordination of any referrals. This can be documented in the log or a separate document such as the service note.

**Q: Can I bill for time spent researching community resources and keeping records for a member?**

**A:** We require that you maintain a list of community resources that you can use for referrals with all members. However, you may bill for researching community resources if you make a clear connection to a member and that member's specific goals. For example, we recommend that you maintain a list of food pantries. However, if a member's assessment shows that they need help finding food, you can research which food pantry is closest to that member and transportation options, such as bus routes, to help the member get to that food pantry. In your case notes, you should explain how long you spent on each of these activities, how they relate to the member's needs, and if resources were shared.

This research would be billed as ongoing care coordination and monitoring. Under ForwardHealth Handbook Topics #961, #978, #990, and #10857, ongoing care coordination and monitoring are billable in 15-minute increments up to 40 units (10 hours) total per month for each member. Most of your ongoing care coordination and monitoring time should be spent on actual contact with members and not on research or recordkeeping. Covered services under ongoing care coordination and monitoring include:

- Having actual contact with members or formal and informal collaterals.
- Providing members with information and referral services.
- Conducting recordkeeping, including updating care plans, documenting member and collateral contacts, preparing and responding to correspondence, and documenting member activities in relation to the care plan. **Recordkeeping is reimbursed only if a member or collateral contact occurred during the month for which the provider is billing.**

**Q: What can I bill for when I refer members to parenting and breastfeeding classes?**

**A:** You can bill for active care coordination for parenting and breastfeeding classes, if appropriate. For example, when referring a parent or legal guardian to a parenting class at a local library, covered care coordination may include:

- Notifying the member about the course during a date of service.
- Providing the member with a written referral for the course.
- Helping the member enroll in the course.
- Helping the member set up additional supports, such as transportation, needed to attend the course.
- Following-up with the member and the referenced provider after the course to confirm that the service met the needs of the member as detailed in the care plan goal and update the care plan accordingly.

However, the time a parent or legal guardian spends participating in the course is **not** considered active care coordination, which means you should **not** bill for this time.

## Billing and Noncovered Services

**Q: As the care coordinator, I forgot to have the member sign and date the last month's service log. Can I backdate it?**

**A:** No. You cannot backdate any records and so this session would not be covered. All records must be signed and dated on the actual date of service and before you submit claims to ForwardHealth.

**Q: I arrived at the family's home, but they were not there. Can I bill my time for a no show?**

**A:** No. You cannot bill for appointment cancellations or no shows as specified in ForwardHealth Online Handbook Topic #979.

**Q: I provided care coordination services to a member for 65 minutes. A friend told me that I could bill for the full 2 hours on that day. Is this true?**

**A:** No. You can only bill for the actual time you spent in the member's home providing covered services. In this case, you would bill 4 full units for the 60 minutes, and an additional .3 units for the remaining

5 minutes (for a total of 4.3 units), using the rounding guidance from ForwardHealth Online Handbook Topic #970.

**Q: I provide care coordination to two children who are siblings in the home. How do I correctly bill my time?**

**A:** You can only bill for the actual time spent providing care coordination to each member. In this scenario, you can only bill for the actual time you spent with each child in the home. Each 15 minutes is one unit. If you spent 90 minutes with Child A and 30 minutes with Child B, your claim should indicate 6 units for Child A and 2 units for Child B. Even though you were in the home for 2 hours, you **cannot** bill 8 units for both children.

**Q: I heard members are required to use all 10 hours of service every month, even if they do not want or need that many hours. Is this true?**

**A:** No. You should only provide the amount of services that members truly need and want. As a result, you are **not** allowed to require a minimum amount of services each month or force members to receive more services than they need or want.

**Q: Unfortunately, a member child recently passed away. Can I still provide care coordination to the parent or legal guardian and bill for those services?**

**A:** No. Since child care coordination services are billed through the member child's Medicaid ID, care coordination after the member's death is considered a noncovered service. In this situation, the agency should refer the family to other community and Medicaid resources, as appropriate. To help them be successful, please provide the parent or legal guardian with a written copy of contact information for these resources.

**Q: A family I help needs assistance with learning about proper nutrition and daily personal care, like bathing and dressing their child. Since I was a personal care worker with training in these skills, can I provide and bill for these services through child care coordination?**

**A:** No. Child care coordination services do not cover direct skilled or professional services. This this situation, you can only bill for covered services, such as actively coordinating the referral and access to the appropriate professional agencies.

**Q: A family I help is doing well with their main goals of shelter, food, and healthcare. They are now asking for help with coordinating extra services that would make their life better, like home remodeling and redesign. Is this covered?**

**A:** No. Child care coordination services are covered to provide active coordination and access to resources that address basic needs, such as medical, social, educational, and vocational services. Advanced needs, such as home remodeling and redesign, dating services, and legal assistance are **not** covered services. If the basic needs of members have been met, they are no longer eligible for child care coordination services and should be discharged.

**Q: Can I contract with a non-enrolled prenatal care coordination agency to provide services to members?**

**A:** You are discouraged from establishing contracts with non-enrolled providers. If you elect to contract with non-enrolled providers, you are responsible for the quality and accuracy of all services provided

and billed through the contract. This includes ensuring the non-enrolled contractor is complying with the enrolled provider's ForwardHealth agreement.

Any contracts you have with non-enrolled providers must comply with federal and state laws.

You also are prohibited from outsourcing services for a percentage billed or contracting with providers who have credible allegations of fraud, other fraud related investigations, or were involuntarily terminated from the Medicaid program.

## ForwardHealth Portal Tips

**Q:** **Where do I find the child care coordination provider handbook?**
**A:** ForwardHealth Portal handbooks are available online.

**Q:** **What is the difference between the prenatal care coordination and child care coordination resource pages? How do I access them?**
**A:** The prenatal care coordination resource page is available for prenatal care coordination agencies who are rendering prenatal care coordination services. The child care coordination resource page is available for prenatal care coordination agencies who are rendering child care coordination services.

## Contact Us

**Q:** **I am having trouble accessing or using the ForwardHealth Portal. Who do I call for help?**
**A:** For technology issues, please call the Portal Helpdesk at 866-908-1363. For all other questions, contact Provider Services at 800-947-9627

**Q:** **Who do I contact with questions about policy, program, and billing questions?**
**A:** If you have questions about ForwardHealth policy, program, and billing requirements, please contact Provider Services at 800-947-9627.

**Q:** **Who do I contact to report suspected fraud?**
**A:** To report suspected fraud in the child care coordination benefit or any program administered by the Department of Health Services, please contact the Office of the Inspector General at 877-865-3432 or www.reportfraud.wisconsin.gov.