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ForwardHealth UPDATE

Wisconsin serving you

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NEW INTENSIVE OUTPATIENT PROGRAM BENEFIT

Beginning March 1, 2025, ForwardHealth will begin covering a non-residential programmatic treatment service called intensive outpatient program (IOP). Providers may enroll with Wisconsin Medicaid as IOP providers beginning November 1, 2024. They must be certified by the Wisconsin Department of Health Services' (DHS) Division of Quality Assurance (DQA) in order to enroll.

This ForwardHealth Update offers information about:

- The new IOP provider specialty.
- Provider enrollment.
- Covered services.
- Noncovered services.
- Prior authorization (PA).
- Reimbursement.
- Claims submission.
- Member information.

AFFECTED PROGRAMS
BadgerCare Plus, Medicaid

TO
Adult Mental Health Day Treatment Providers, Community Health Services, Community Support Programs, Crisis Intervention Providers, HealthCheck "Other Services" Providers, Hospital Providers, Outpatient Mental Health Clinics, Outpatient Substance Abuse Clinics, Rural Health Clinics, Substance Abuse Day Treatment Providers, Tribal Federally Qualified Health Clinics, HMOs and Other Managed Care Programs

The information provided in this ForwardHealth Update is published in accordance with Wis. Admin. Code § DHS 75.51.

WISCONSIN DEPARTMENT of HEALTH SERVICES

- Training.
- A new Intensive Outpatient Program service area in the Online Handbook.

Overview

The new IOP benefit will ensure member access to the full range of behavioral health services and continuity of care. This service component includes screening, assessment, and treatment for substance use disorder (SUD), mental health disorders, and co-occurring disorders. Treatment hours may total between 9–19 hours per week for members who are 18 years and older and 6–19 hours per week for members younger than 18 years old.

ForwardHealth created the IOP benefit in response to Wisconsin Admin. Code ch. DHS 75 revisions, effective in 2022.

New Intensive Outpatient Program Provider Specialty

Beginning November 1, 2024, the following providers must enroll with the new IOP provider specialty to be able to receive reimbursement:

- Community health centers
- Hospital-based programs
- Mental health and substance abuse agencies
- Rural health clinics
- Tribal federally qualified health clinics (FQHCs)

Provider Enrollment

Providers may enroll with Wisconsin Medicaid as IOP providers beginning November 1, 2024. ForwardHealth expects that enrolled providers will be able to provide and bill for covered services beginning March 1, 2025.

Mental health and substance abuse agencies may enroll as Wisconsin Medicaid providers to start the necessary process to provide covered IOP services to Medicaid or BadgerCare Plus members.

Facilities certified under Wis. Admin. Code § DHS 75.51 that are currently enrolled in Wisconsin Medicaid Outpatient are not required to re-enroll with the IOP provider specialty. However, these facilities should update their enrollment to the IOP provider specialty by referring to Section 24 Specialty Change Panel of the ForwardHealth Portal Demographic Maintenance Tool User Guide (PDF).

Providers may contact Provider Services at 800-947-9627 with questions about the enrollment process.

RESOURCES

ForwardHealth Portal Demographic Maintenance Tool User Guide (PDF)

The information provided in this ForwardHealth Update is published in accordance with Wis. Admin. Code § DHS 75.51.

Provider Enrollment Criteria

To be eligible for enrollment with Wisconsin Medicaid, providers who wish to deliver covered IOP services must be certified by DHS' DQA to practice in Wisconsin. Mental health and substance abuse agencies must obtain certification per Wis. Admin. Code § DHS 75.51 before beginning the enrollment process.

Wisconsin Medicaid Enrollment Process

Providers must be enrolled with Wisconsin Medicaid to be reimbursed for services provided to Medicaid or BadgerCare Plus members.

More enrollment information is available on the Provider Enrollment Information homepage on the ForwardHealth Portal. The **Information for Specific Provider Types** page provides enrollment information specific to mental health and substance abuse agencies.

Existing Medicaid-enrolled providers must apply as "new enrollees" when applying for the IOP category.

To enroll in Wisconsin Medicaid as an IOP provider, follow these steps:

1. Access the Portal.
2. From the Providers box, select the **Become a Provider** link. The Provider Enrollment Information page will display.
3. On the upper left side of the Provider Enrollment Information page, click the Start or Continue Your Enrollment Application link.
4. In the To Start a New Medicaid Enrollment box, click the Medicaid/Border Status Provider Enrollment Application link.
5. Click **Next** after reading the instructions. The enrollment wizard will open.
6. Complete the enrollment wizard by entering your information. Click **Next** to continue through each question.
7. On the Provider Type panel, select **Mental Health/Substance Abuse Clinics**.
8. On the Provider Specialty panel, select **Intensive Outpatient Program**.
9. Continue through the enrollment wizard panels to complete.

Once a provider starts the application process, they will have 10 business days to complete it. **If the application is not completed within 10 business days, the provider will need to start the application process over.**

RESOURCES

Division of Quality Assurance (DQA), Department of Health Services (DHS), Mental Health and Substance Abuse Program Certification (PDF)

The information provided in this ForwardHealth Update is published in accordance with Wis. Admin. Code § DHS 75.51.

Notice of Enrollment Decision

ForwardHealth usually notifies the provider of their enrollment status within 10 business days (and no longer than 90 days) after receiving the **complete** enrollment application.

If the application is approved, ForwardHealth will enroll the provider and send a welcome letter, including:

- A copy of the provider agreement.
- An attachment containing important information such as effective dates and the assigned provider type and specialty.

If the enrollment application is denied, ForwardHealth will send a letter to the applicant giving the reasons for the denial.

Enrollment Effective Date

The first effective date of a provider's enrollment will be based on the date ForwardHealth receives the complete and correct enrollment application materials.

ForwardHealth considers an application complete when all required information has been correctly submitted and all supplemental documents have been received.

The earliest possible effective date is the date the applicant submits their complete online provider enrollment application to ForwardHealth if the following statements are true:

- The applicant meets all applicable screening, licensure, certification, authorization, or other credential requirements on the date of submission.
- ForwardHealth receives all required supplemental documents within 30 calendar days of the date the application was submitted.

Note: To avoid a delay of the enrollment effective date, providers are encouraged to upload documents during the enrollment process.

If ForwardHealth receives required supplemental documents more than 30 calendar days after the provider has submitted their application, the provider's effective date will be the date on which ForwardHealth received all supplemental documents.

Establishing a Portal Account

Establishing a secure Provider Portal account allows providers to keep information current with ForwardHealth. Providers may update information,

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check a member's eligibility, and bill via the Portal. Providers may refer to the ForwardHealth Provider Portal Account User Guide (PDF) for steps to request secure Portal access.

Adding Multiple Organizations or Enrollments

Users with an administrative account can add multiple organizations to an existing Portal account with the Add Organization function. This feature offers the convenience of managing multiple organizations within one Provider Portal account as an alternative to creating separate accounts for each organization.

Providers may refer to the ForwardHealth Provider Portal Account User Guide for information on setting up Portal accounts.

Demographic Maintenance

Once enrolled, providers are responsible for updating their information, such as addresses and financial information, through the demographic maintenance tool.

The ForwardHealth Portal Demographic Maintenance Tool User Guide outlines information on how providers will use the demographic maintenance tool to update their information.

Covered Services

The IOP treatment benefit is available to eligible members of all ages who are enrolled in full-benefit BadgerCare Plus or Wisconsin Medicaid.

Members are eligible for this benefit if an assessment determines they have a documented need for mental health services, SUD services, or co-occurring treatment at the IOP intensity level.

Providers may offer IOP services via telehealth. Providers should refer to the Max Fee Schedules page for a complete list of services allowed under telehealth policy and the ForwardHealth Online Handbook Telehealth Policy topic #510 for information about when to use telehealth, allowable services, reimbursement, documentation requirements, allowable providers, and other requirements and restrictions.

Assessment, treatment planning, and treatment services are reimbursed as part of the IOP services rate. Each covered service is described below.

RESOURCES

- ForwardHealth Provider Portal Account User Guide (PDF)
- Maximum allowable fee schedules

QUICK LINKS

Telehealth Policy topic #510

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Assessment and Treatment Planning

Assessment and treatment planning services include completion of:

- Screening.
- Intake.
- Clinical assessment.
- Diagnosis.
- Treatment planning.

Clinical Assessment

As defined in Wis. Admin. Code § DHS 75.03(14), providers must complete a clinical assessment, which may use specific assessment tools, to determine the member's diagnosis and develop the treatment plan. The diagnosis must meet criteria in the current Diagnostic Statistical Manual of Mental Disorders.

The initial assessment of the member to determine the appropriateness of IOP treatment must be completed by a qualified clinician as outlined in the Qualified Clinicians subsection of this Update.

Biopsychosocial assessments and comprehensive mental health assessments must include:

- History of the present episode.
- Personal and social history (for example, school, work, military service, relationships).
- Family and developmental history.
- Alcohol, tobacco, other drug use, and addictive behavior history, such as impact on functioning and readiness for change.
- Legal history.
- Psychiatric history and mental health status examination.
- Treatment history for substance abuse and mental health.
- Medical history, formulation, diagnosis, survey of assets, vulnerabilities and supports, and treatment recommendations.

The American Society of Addiction Medicine (ASAM) biopsychosocial assessment must be completed no more than 30 days prior to the start of treatment services. The comprehensive mental health assessment must be completed no more than 90 days prior to the start of treatment services. For members receiving co-occurring SUD and mental health IOP treatment, a single assessment meeting the criteria above is acceptable.

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For all SUD and co-occurring IOP treatment, a qualified clinician **must apply** ASAM criteria to determine appropriate level of care and develop the treatment plan and goals. For mental health IOP treatment, a qualified clinician may use a standardized placement tool or provide clinical rationale to determine the level of care.

Throughout the member's behavioral health treatment, providers must complete ongoing re-assessment, treatment reviews, treatment plan updates, and continuing care plan updates as required by Wis. Admin. Code ch. DHS 75.

Treatment Services

Treatment services address a member's need for mental health, substance use services, or co-occurring treatment.

Treatment services for IOP may include:

- Case management.
- Family counseling/therapy.
- Group counseling/therapy.
- Individual counseling/therapy.
- Medication management.
- Nursing services.
- Psychoeducation.

IOP services require:

- 6–19 hours of treatment services per week for members under age 18.
- 9–19 hours of treatment services per week for members age 18 and up.

Providers must document why the number of treatment hours provided during a week is higher or lower than required. ForwardHealth will allow providers to "ramp up" or "step down" the number of treatment hours for brief periods of time when members transition between levels of care. However, if the number of treatment hours per week is consistently higher or lower than typically allowed by policy, the provider should re-evaluate whether the current treatment matches the member's demonstrated level of care needs.

Treatment Plan

Providers must have a plan of care, also known as a treatment plan or protocol, which meets all requirements described in Wis. Admin. Code ch. DHS 75.

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The plan of care must:

- Address the member's priority needs based on the clinical assessment.
- Identify specific, measurable outcomes.
- Identify any diagnosed substance use or mental health conditions or psychiatric symptoms seen or reported by the member.
- Identify the plan for integrating and addressing these conditions in treatment.

Per Wis. Admin. Code § DHS 75.51, providers must complete initial treatment plans after the assessment and before the second session. Treatment plans must be reviewed every 14 days. The member, or their legal guardian, is required to sign treatment plans with the primary counselor.

If the member has medical needs or requires medication-assisted treatment (MAT), the plan of care must:

- Specify how these medical conditions will be addressed, including a plan for obtaining MAT, if needed.
- Ensure all treatment responses, modalities used, methods, and place of treatment are person centered and respond to needs identified in the assessment.

Medication-Assisted Treatment

MAT for SUD must be available to members when indicated by their diagnosis and desired by the member. A formal MAT assessment must be completed by a qualified prescriber for members with a diagnosis that indicates the need for MAT. If the member refuses treatment, the provider must document with the member's signature that they made an informed decision.

IOP treatment providers must admit members and enable access to MAT medication for mental health or physical conditions. IOP treatment providers can either manage MAT at the facility or coordinate care outside the facility for the member to access. IOP treatment providers may not deny services to someone receiving MAT. This includes all forms of medications for opioid use disorder (MOUD), which may be provided via programs certified under Wis. Admin. Code § DHS 75.59 or by Medicaid-enrolled prescribers with experience and capabilities to provide MOUD.

Following admission with a signed release, the IOP treatment provider should collaborate with the prescriber regarding medications and the treatment process. The provider must support the member's continued use of the

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prescribed medication of their choice and in cooperation with the treatment plan recommendations of their treating physician.

Discharge and Continuing Care Plan

When a member is admitted, providers must prepare a discharge and continuing care plan to identify the expected needs of the member and available community resources that address the member's treatment and recovery.

The member and their family, when applicable, must be involved in the process and have a thorough understanding of the plan. The initial continuing care plan must include:

- Documented coordination with the member's care manager for the next level of care, which may include the member's HMO or managed care organization (MCO), psychosocial rehabilitation program, Medicaid health home, ongoing care manager, or other care manager.
- Planning for services upon discharge, such as individual counseling, group counseling, medication management, attendance at recovery support group meetings, and interim support plans, as needed.
- Confirmation of living arrangements that will encourage recovery and reduce the chances of relapse.
- Emergency and counseling contact information for the member.
- Overdose prevention plan, if applicable, such as continuation of MAT and provision of emergency medication to treat overdoses.

Providers may continue to develop and modify the initial continuing care plan during the rest of the member's treatment.

Qualified Clinicians

These clinicians are considered qualified to provide IOP assessment and treatment services:

- Advanced practice nurse prescribers
- Advanced practice social workers or independent social workers enrolled as certified psychotherapists, with signoff by their clinical supervisor
- Certified addiction registered nurses
- Licensed clinical substance abuse counselors or substance abuse counselors
- Licensed marriage and family therapists, licensed professional counselors, or licensed clinical social workers

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- Physician assistants familiar with behavioral health placement criteria
- Physicians familiar with behavioral health placement criteria
- Psychologists
- Qualified treatment trainees, with signoff by their clinical supervisor
- Registered nurses and licensed practical nurses
- Substance abuse counselors in training, with signoff by their clinical supervisor

Providers are expected to act within their license's scope of practice for services rendered.

> **Providers are expected to act within their license's scope of practice for services rendered.**

Separately Billable Services

IOP providers may bill for services not included in the bundled assessment and reimbursement rate such as language services for BadgerCare Plus and Medicaid members who are deaf or hard of hearing or who have limited English proficiency. Providers may refer to Interpretive Services topic #22917 for more information.

Related Services

Services rendered by other behavioral health provider types are not included in the bundled rate for IOP while a member is receiving IOP services. However, these services may be reimbursed separately **when they are determined to be medically necessary and non-duplicative** according to the coverage and reimbursement policies associated with each service, per Wis. Admin. Code § DHS 101.03(96m):

- Narcotic treatment services (NTS) as described in A Narcotic Treatment Service May Provide Only Services Directly Related to Narcotic Treatment topic #7979
- SUD health home services
- Outpatient SUD counseling for MOUD as required by federal or state rules
- Outpatient mental health services that are provided for a separate assessment, diagnosis, and treatment plan, unrelated to IOP treatment goals
- Low-intensity residential SUD treatment
- Non-emergency medical transportation

QUICK LINKS

- Interpretive Services topic #22917
- A Narcotic Treatment Service May Provide Only Services Directly Related to Narcotic Treatment topic #7979

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Noncovered Services

ForwardHealth will not reimburse providers for noncovered services, which include:

- Acute withdrawal management or detoxification concurrent with IOP treatment.
- Day treatment services concurrent with IOP.
- Outpatient SUD services concurrent with IOP, except for required counseling services provided by an opioid treatment program under the NTS benefit.
- High-intensity residential SUD treatment concurrent with IOP.
- Services that are recreational, social, academic, vocational, or unrelated to the direct treatment of the behavioral health diagnoses.
- Services delivered outside the parameters of the approved PA.

Prior Authorization

ForwardHealth established PA criteria for IOP services effective for dates of service (DOS) on and after March 1, 2025. A PA form will be available prior to March 1, 2025. Assessments covered under the IOP benefit do not require PA. All treatment services covered under the IOP benefit require PA.

PA requests for IOP services submitted through the Portal may be granted real-time PA review and approval, if all applicable PA criteria are met. This policy applies only to initial PA requests submitted through the Portal for covered services.

PA Requests and Grant Date

The grant (start) date of an approved or modified PA request is the first date services are authorized and may be reimbursed under that PA number. On a PA request, providers may request a specific date that they will begin providing services. If no grant date is requested or the grant date is illegible, the grant date will typically be the date ForwardHealth reviews the PA request.

Real-Time Review

Real-time review is available only for PA requests submitted via the Portal. Real-time review for PA requests reduces clerical errors, administrative burden for providers, and wait time for members.

In real-time review, the system checks if all necessary information is included in the PA request. The system will send the PA request to a consultant for

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manual review, also known as clinical review, if real-time review:

- Cannot determine whether the request meets all applicable PA criteria.
- Finds that the PA request does not meet PA criteria.

IOP providers may submit PA requests by fax and mail at this time, but these submissions will be subject to manual PA review. Providers must submit PA requests on the Portal for real-time review.

Regardless of how the PA request is submitted, providers are expected to complete all required fields and are encouraged to complete all optional fields on the required forms.

Initial PA Requests for Intensive Outpatient Program Treatment Through Real-Time Review and Approval on the Portal

An initial PA request is the first request to ForwardHealth for a member's IOP treatment episode. This may include instances when the member's IOP treatment is already in progress but is covered by a payer other than Wisconsin Medicaid. **Initial requests for up to eight weeks of treatment submitted via the Portal will go through a real-time review process.**

Attestation of Criteria for Substance Use Treatment PA Requests

The provider must attest to completing these clinical documents when submitting an initial PA request for real-time review for SUD only or co-occurring IOP treatment requests:

- A member's diagnosed substance use conditions
- ASAM level of care determination
- Individualized treatment plan
- MAT assessment, status, results, and recommendations

Attestation of Criteria for Mental Health Treatment PA Requests

For mental health only or co-occurring IOP treatment requests, the provider must attest to completing these clinical documents when submitting an initial PA request for real-time review:

- A comprehensive mental health assessment including history and current safety risks
- The member's diagnosed mental health conditions
- The assessment tool and score, if a specific tool was used
- Individualized treatment plan
- The assessment score or clinical rationale that substantiates the requested level of care

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Criteria for Real-Time Review Approval

When a PA request for IOP services meets real-time review criteria (including attestation of all applicable assessments), these forms will be automatically generated:

- Prior Authorization Request Form (PA/RF), F-11018 (05/2013)
- Prior Authorization/Intensive Outpatient Treatment Attachment (PA/IOP) form

When PA requests are entered on the Portal for IOP services, a PA/IOP panel will display for providers to complete.

Providers can find these forms on the Forms page of the Portal. For information about completing required forms and documentation for IOP services, providers may refer to the Prior Authorization section of the IOP Online Handbook and Supporting Clinical Documentation topic #449.

Criteria Not Met for Real-Time Review

PA requests will go through manual review and approval by a consultant if they are:

- PA requests that indicate a level of care other than IOP.
- PA requests submitted via mail or fax.
- Amendments to extend an existing PA request.

Criteria Not Met for Real-Time Approval

PA requests submitted through the Portal will be routed for manual review by a behavioral health clinician if they do not meet approval criteria but could be considered with additional clinical information.

Providers must submit required documentation with the PA request. For SUD or co-occurring IOP treatment requests, providers must attach the biopsychosocial assessment, the ASAM level of care determination, and the treatment plan to the request. For mental health or co-occurring IOP treatment requests, providers must attach the mental health assessment and treatment plan to the request.

These documents can be uploaded through the Portal and attached to the PA request.

NEW PA FORM

Prior Authorization/Intensive Outpatient Treatment Attachment (PA/IOP) form

QUICK LINKS

- Supporting Clinical Documentation topic #449
- Forms page

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REQUIRED ATTESTATION OF DOCUMENT COMPLETION FOR PRIOR AUTHORIZATION REQUESTS FOR INTENSIVE OUTPATIENT PROGRAM TREATMENT CLINICAL REVIEW			
	Substance Use Only	**Co-Occurring (Substance Use and Mental Health)**	**Mental Health Only**
ASAM level of care determination	Yes	Yes	No
Biopsychosocial assessment	Yes	Yes	No
Mental health assessment	No	Yes*	Yes
Treatment plan	Yes	Yes	Yes
Continuing care plan	Required for amendment requests only	Required for amendment requests only	Required for amendment requests only

*For members in co-occurring treatment, a single assessment report that addresses both SUD and mental health history and needs is acceptable.

Requirements for PA Amendments to Extend Intensive Outpatient Program Treatment

Providers may submit a PA amendment request to extend the member's medically necessary treatment beyond the last day of treatment listed on an existing PA. Amendment requests may be submitted for up to eight weeks per request. The amendment must be submitted before the expiration of the initial PA. The PA amendment must include:

- A completed Prior Authorization Amendment Request form, F-11042 (07/2012).
- All assessments:
  - Biopsychosocial assessment
  - ASAM level of care determination (as indicated)
  - Mental health assessment (as indicated)
  - Diagnosis and supporting documents
  - Any other assessments used to determine level of care and needs for treatment
- Plan of care/treatment plan with progress reports.
- Discharge criteria and a continuing care plan.

QUICK LINKS

Forms page

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If the amendment request is submitted after the expiration of the current PA, a new PA request must be submitted. A PA will not be backdated to cover a gap in services.

Timely Submission of PA Renewal Requests

To prevent a lapse in coverage or reimbursement for ongoing IOP services, ForwardHealth must receive renewal PA requests before the expiration date of the current PA. Providers are responsible for the timely submission of PA request renewals. Renewal requests will not be backdated for continuation of ongoing services.

Private Health Insurance as the Primary Payer

PA is required for certain Healthcare Common Procedure Coding System (HCPCS) procedure codes when a member's private health insurance is the primary payer. Providers should refer to the Procedure Codes for Claims When Private Health Insurance Is the Primary Payer section of this Update.

Claims Submission

ForwardHealth reimburses only for services that are medically necessary as defined under Wis. Admin. Code § DHS 101.03(96m). ForwardHealth may deny or recoup payment if a service does not meet Medicaid medical necessity requirements.

Providers are required to submit a professional claim form (1500 Health Insurance Claim Form [02/2012]), 837 Health Care Claim: Professional transaction, or Direct Data Entry on the Portal for IOP services.

If the member has other health insurance, including Medicare, providers should refer to the Medicaid as Payer of Last Resort topic #388.

HCPCS procedure codes and applicable modifiers are required on all claims. Claims or claim adjustments received without a valid HCPCS procedure code and corresponding modifier will be denied.

Procedure Code and Modifiers

Effective for DOS on and after March 1, 2025, providers will use HCPCS code H2019 (Therapeutic behavioral services, per 15 minutes) on claims for IOP services. Providers are required to use the U6 (Functional assessment) modifier when submitting claims for IOP assessment services.

QUICK LINKS

- Medicaid as Payer of Last Resort topic #388
- Maximum allowable fee schedule
- Trainings page

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PROCEDURE CODE	DESCRIPTION	PROGRAM MODIFIER	PA REQUIRED?
H2019	Therapeutic behavioral services, per 15 minutes	HE Mental health program	Yes
		HF Substance abuse program	Yes
		HH Integrated mental health/substance abuse program	Yes
		U6 Functional assessment	No

Each unit of time submitted on a claim represents 15 minutes of service. A unit of time is reached when a provider completes 51% of the designated time unit.

Place of Service Codes

Allowable place of service (POS) codes for the IOP benefit are listed in the following table. Not all of the POS codes listed in this table are allowable for each procedure code allowed in the IOP benefit. Providers are required to use the POS code that most accurately describes the place where the service(s) were rendered.

POS CODE	DESCRIPTION
02	Telehealth Provided Other Than in Patient's Home
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
09	Prison/Correctional Facility
10	Telehealth Provided in Patient's Home
11	Office
19	Off Campus—Outpatient Hospital
20	Urgent Care Facility

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POS CODE	DESCRIPTION
22	On Campus—Outpatient Hospital
23	Emergency Room—Hospital
26	Military Treatment Facility
49	Independent Clinic
50	Federally Qualified Health Center
57	Non-Residential Substance Abuse Treatment Facility
60	Mass Immunization Center
71	Public Health Clinic
72	Rural Health Clinic
99	Other Place of Service

Behavioral Health Modifiers for Telehealth Services

Providers should use informational behavioral health modifiers when they render telehealth services.

MODIFIER	DESCRIPTION
FQ*	A [telehealth] service was furnished using audio-only communication technology
FR*	A supervising practitioner was present through [a real-time] two-way, audio/video communication technology
GQ	Via asynchronous telecommunications system
GT	Via interactive audio and video telecommunication systems

*Use for behavioral health services only.

Procedure Codes for Claims When Commercial Health Insurance Is the Primary Payer

To coordinate benefits and reimbursement for members who also have commercial health insurance, ForwardHealth will allow providers to bill certain HCPCS procedure codes to commercial health insurance companies for IOP services in addition to other ForwardHealth-allowed codes:

- H0015 (Alcohol and/or drug services; intensive outpatient [treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan], including assessment, counseling; crisis intervention, and activity therapies or education)
- S9480 (Intensive outpatient psychiatric services, per diem)

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Providers are required to bill commercial health insurance first using the HCPCS code set specified by the member's commercial health insurer. After commercial health insurance has paid its portion, the provider may submit a claim to ForwardHealth along with a completed Explanation of Medical Benefits form, F-01234 (04/2018), using the same HCPCS procedure codes used on the commercial health insurance claim. Providers may refer to the Exhausting Commercial Health Insurance Sources topic #596 for information on how to submit claims to ForwardHealth when the member has commercial health insurance.

Reimbursement

Providers will be reimbursed for IOP services provided fee for service for all BadgerCare Plus and Medicaid members in 15-minute units for a bundle of services. Providers should refer to the fee schedule for reimbursement rates for IOP services.

FQHCs will be reimbursed at the prospective payment system rate.

Member Information

Copayments

IOP services are exempt from copays. Providers may not collect copays from members for IOP services.

Comprehensive Community Services Coordination

If members enrolled in a comprehensive community services (CCS) program are unable to access IOP through their CCS program, they may access services through the IOP benefit. Providers must include documentation explaining the member's inability to access IOP through their CCS program with the PA request.

CCS services may not duplicate case management provided by the IOP provider.

Training Available

ForwardHealth will provide a recorded video training at a later date with instructions for submitting PAs for IOP services. Providers and BadgerCare Plus or Medicaid HMOs will be able to find this video on the Trainings page of the Portal.

QUICK LINKS

- Forms page
- Exhausting Commerical Health Insurance Sources topic #596
- Fee schedule
- Trainings page

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New Online Handbook Service Area

ForwardHealth will add an Intensive Outpatient Program service area to the Online Handbook. This new service area is intended to be a library of current Medicaid requirements, including those unique to IOP providers. IOP providers may also refer to the Resources for Mental Health and Substance Abuse Providers page of the Portal for more information.

As a reminder, ForwardHealth expects all Medicaid providers to follow the policies outlined in these Online Handbook topics:

- Availability of Records to Authorized Personnel topic #1640
- Intermediate Sanctions topic #211
- Involuntary Termination topic #212
- Reporting Suspected Waste, Fraud, and Abuse topic #13277
- Sanctions for Collecting Payment From Members topic #213
- Withholding Payments topic #214

Documentation Retention

Providers are reminded that they must follow the documentation retention requirements per Wis. Admin. Code § DHS 106.02(9). Providers are required to produce or submit documentation, or both, to the DHS upon request. Per Wis. Stat. § 49.45(3)(f), providers of services shall maintain records as required by DHS for verification of provider claims for reimbursement. DHS may audit such records to verify the actual provision of services and the appropriateness and accuracy of claims. DHS may deny or recoup payment for services that fail to meet these requirements. Refusal to produce documentation may result in denial of submitted claims, recoupment of paid claims, application of intermediate sanctions, or termination from the Medicaid program.

QUICK LINKS

- Resources for Mental Health and Substance Abuse Providers page
- Availability of Records to Authorized Personnel topic #1640
- Intermediate Sanctions topic #211
- Involuntary Termination topic #212
- Reporting Suspected Waste, Fraud, and Abuse topic #13277
- Sanctions for Collecting Payment From Members topic #213
- Withholding Payments topic #214

The information provided in this ForwardHealth Update is published in accordance with Wis. Admin. Code § DHS 75.51.

Information Regarding Managed Care Organizations

This Update applies to mental health services and SUD services that members receive on a fee-for-service basis and through BadgerCare Plus, Medicaid SSI, and other managed care programs. For information about managed care implementation of the updated policy, contact the appropriate MCO. MCOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

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This Update was issued on 10/22/2024 and information contained in this Update was incorporated into the Online Handbook on 03/03/2025.