Medicaid SSI HMO Care Management Benefit Billing and Reimbursement Guide

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1.0 Medicaid SSI Care Management Billing and Reimbursement

1.1 Introduction

The Medicaid SSI HMO Care Management Benefit Billing and Reimbursement Guide (Guide) provides billing and reimbursement information for health maintenance organizations (HMOs) providing care management services to Medicaid SSI members. HMOs must use this Guide in conjunction with the Contract for BadgerCare Plus and/or Medicaid SSI HMO Services (Contract) since the Guide does not include a description of the care management model nor does it include specific care management requirements and definitions.

Note: If there are conflicts between this Guide and the Contract, the requirements stated in the Contract will prevail.

1.2 Contract Language

Refer to the Contract, Article III.C., (Care Management Model for the Medicaid SSI Population) for the description and specific requirements of the SSI care management model, including model characteristics, infrastructure, and care management process.

1.3 Portal Location

This Guide is available on the ForwardHealth Portal on the Managed Care Organization Reimbursement and Capitation page (forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Reimbursement_and_Capitation/Home.htm.spage)

1.4 Eligible Population

The eligible population includes all SSI enrollees with exception of those members who are enrolled in Medicare Advantage.

1.5 Effective Date

The effective date for the information included in this Guide is January 1, 2018.

1.6 Questions

Questions or disputes associated with the encounter data pull can be sent to the Bureau of Rate Setting email box at DHSDMSBRS@dhs.wisconsin.gov.

Questions regarding the SSI Care Management model requirements and definitions can be sent to your Managed Care Analyst.

2.0 Reimbursable Care Management Activities

2.1 Reimbursable Activities

The Contract, Article III.B., describes the care management model required for all Medicaid SSI members. Care management activities are reimbursable when provided to, or on behalf of an identified member.

All care coordination activities must be identified in the member's individualized comprehensive care plan. HMOs must retain documentation to support all claimed services.

2.2 Non-Reimbursable Activities

Care management activities are billable only when the activities meet the criteria identified in the Contract and in this Guide. The SSI care management benefit does not include the direct delivery of health or social services. Rather, the benefit includes activities related to identifying and linking SSI members to needed health and social services.

The activities identified below are not reimbursable under the SSI care management benefit and should not be billed under the care management benefit. The activities include, but are not limited to:

- Member outreach and engagement.
- Care management activities not provided to, or on behalf of, an identified member.
- Care coordination and monitoring activities that are not identified in the member's comprehensive, individualized care plan.
- Case reviews for general quality assurance purposes.
- Care management activities provided by non-team members.
- Team meetings not specific to an identified member.
- Staff training.
- Wisconsin Interdisciplinary Care Team (WICT) team huddles.
- Activities that duplicate an integral and inseparable component of another covered Medicaid service (for example, hospital discharge planning).

HMOs must not submit a care management claim for calendar months in which the only activities are non-billable activities.

3.0 Allowable Codes

3.1 Valid Codes Required

HMOs are required to use valid and allowable codes for the SSI care management benefit. Wisconsin Medicaid and BadgerCare Plus recognize five Healthcare Common Procedure Coding System (HCPCS) procedure codes, two modifiers, and have limited restriction on allowable place of service codes.

3.2 Procedure Codes

Wisconsin Medicaid and BadgerCare Plus will reimburse Medicaid SSI HMOs for the following allowable HCPCS procedure codes for the SSI care management benefit:

- G9001 – Coordinated care fee; initial rate
- G9002 – Coordinated care fee; maintenance rate
- G9006 – Coordinated care fee; home monitoring
- G9007 – Coordinated care fee; scheduled team conference
- G9012 – Other specified case management services not elsewhere classified

Because these are national codes, they do not specifically describe Wisconsin's SSI care management benefit. Refer to Table 1 below for a crosswalk between the national HCPCS code description and the applicable activities under the SSI care management benefit.

3.3 Modifiers

HMOs are required to stratify individual members upon enrollment to assign each member to the most appropriate care management stratum and as an input to develop an individualized, comprehensive care plan. Refer to the Contract, Article III.B., for a description of needs stratification.

Effective January 1, 2018, HMOs will be required to indicate one of three strata when submitting claims for care management services: low, medium or high. The highest stratum is designated for members receiving care management from the Wisconsin Interdisciplinary Care Team (WICT). If the member is stratified to the:

- Lowest stratum – do not add a modifier.
- Medium stratum – add Modifier –TF (Intermediate level of care) as indicated.
- Highest stratum – add Modifier–TG (Complex/high tech level of care) as indicated. Refer to the Contract, Article III.B., for a description, structure, and functions of the WICT.

No More than One Stratum Modifier per Claim Detail
HMOs must periodically reassess whether members are assigned to the most appropriate stratum. If the member is placed in more than one stratum during the billable month, the HMO should select the stratum that represents the member's placement during the majority of the billing period. This requirement applies to procedure codes G9002 and G9012. For codes G9006 and G9007, indicate the member's stratum on the date of service.

When billing care management services that are allowed under telehealth, providers should use a telehealth modifier in addition to any other required benefit modifiers, as indicated in ForwardHealth Telehealth Policy (Online Handbook 510).

Refer to Table 1 below for a summary of the allowable benefit-specific procedure code and modifier combination.

3.4 Place of Service Codes (POS)

HMOs are required to use the nationally recognized POS code set for professional claims for the SSI care management benefit.

All valid POS codes are allowed for procedure codes G9001, G9002, G9007, and G9012. HMOs should use the most appropriate and specific code to represent the POS. When care management services are provided in multiple locations during the billing month, HMOs may bill using the most frequently occurring POS code, or use POS –99 (Other Place of Service).

When billing care management services that are allowed under telehealth, POS 02 or 10 should be used as appropriate along with a telehealth modifier in addition to any other required benefit modifiers as indicated in ForwardHealth Telehealth Policy (Online Handbook 510).

The POS code for procedure code G9006 is limited to the following codes:

- 04 – Homeless Shelter
- 12 – Home
- 14 – Group Home
- 16 – Temporary lodging

Refer to Table 1 below for a summary of the allowable POS codes.

3.5 Diagnosis Code

Wisconsin Medicaid does not require a specific diagnosis code for care management services. HMOs are required to use valid, nationally recognized ICD-CM diagnosis codes when billing care management services.

3.6 Care Management Activities and Allowable Codes

Table 1 provides a crosswalk between national code descriptions and SSI care management activities, indicates when a modifier is allowed, and identifies the allowable POS codes. Refer to the Reimbursement Policies section below for additional billing requirements.

Table 1 – Crosswalk of Care Management Activities to Allowable Codes

Procedure Code	National HCPCS Description	Examples of Care Management Activities	Valid Modifier	Place of Service (POS)
G9001	Coordinated care fee; initial rate	Use this code to bill for the following activities: ▪ Screening ▪ Information gathering and assessment ▪ Needs stratification ▪ Care team assignment ▪ Comprehensive care plan development Refer to the Contract for specific requirements related to each of these components	N/A	No Restriction
G9002	Coordinated care fee; maintenance rate	Use this code when billing for activities related to the implementation and maintenance of the care plan. Examples of these activities are as follows: ▪ Reviews and Updates to the Comprehensive Care Plan ▪ Care coordination ▪ Monitoring activities, including attending health care appointments with members, to ensure the care plan is implemented ▪ Periodic re-assessments of the member's needs ▪ Making and following up on referrals ▪ Time spent documenting care coordination activities	TF TG	No Restriction

Procedure Code	National HCPCS Description	Examples of Care Management Activities	Valid Modifier	Place of Service (POS)
		When these activities are attended in person and performed in the member's home, HMOs may bill procedure code G9006. Refer to the Contract for specific requirements related to reviewing and updating the comprehensive care plan.		
G9006	Coordinated care fee; home monitoring	Use this code when billing for home visits related to the implementation and maintenance of the member's care plan. Home visits are compensated for based on occurring in a member's place of residence and are limited to specified places of service. Refer to the Contract for specific requirements related to reviewing and updating the comprehensive care plan.	TF TG	POS limited to the following codes: ▪ 04–Homeless Shelter ▪ 12–Home ▪ 14–Group Home ▪ 16–Temporary lodging
G9007	Coordinated care fee; scheduled team conference	Use this code when billing for team conferences related to a specific member's care needs as identified in the member's care plan. Refer to the Contract for specific requirements related to reviewing and updating the comprehensive care plan.	TF TG	No Restriction
G9012	Other specified case management services not elsewhere classified	Use this code when billing for transitional care management activities (required after an inpatient hospital stay). Report **all** transitional care management activities, including team meetings and home visits, under Code G9012.	TF TG	No Restriction

Procedure Code	National HCPCS Description	Examples of Care Management Activities	Valid Modifier	Place of Service (POS)
		Examples of transitional care management activities are: ▪ Coordinating with hospital discharge staff to avoid duplication of activities ▪ Reviewing the hospital discharge instruction with the member ▪ Developing a transitional care plan or updating the comprehensive care plan to reflect transitional care needs ▪ Assisting members with follow-up health care visits ▪ Assessing the need for social and in-home formal and informal supports ▪ Any other facilitation of hospital-to-home transition, including related team meetings and home visits Refer to the Contract for additional requirements related to Transitional Care.		

4.0 Reimbursement Policies

4.1 Reimbursement Policies and Limitations

The Contract, Article III.B., includes the Contract requirements for providing care management services to SSI enrollees. HMOs must refer to the Contract in addition to the guidelines below when billing care management services. HMOs must retain documentation that supports the claimed services.

4.2 Units and Dates of Service

The unit of service for each allowable procedure code is always one. The date of service (DOS) varies, depending on the procedure code. Refer to the Additional Requirements section below for more DOS requirements, by procedure code.

4.3 Member Contacts

The HMO should make every effort to include the member in the care management process. In fact, to be billable, each procedure code includes a member contact element. If a member is unable to fully participate in a face-to-face or telephone contact, the HMO must document this information in the care plan (or other related document). To meet the requirement as a member contact, the documentation must include:

- The authorized representative's name and specific role in the care management process
- Whether the member's designation is time limited (for example, temporarily while the member recuperates from an illness).

4.4 Additional Requirements

Below are additional requirements for each allowable procedure code.

G9001 – Coordinated Care Fee; Initial Rate
The initial rate includes five components, including the development of the comprehensive care plan. HMOs should bill this code only if the following components are provided:

1. The initial screening and/or rescreening
2. Information gathering and assessment
3. Needs stratification
4. Care team assignment
5. Comprehensive care plan development

- Bill this code only if there is at least one member contact (face-to-face or telephone) during the care plan development process.
- HMOs may bill this code at least every 12 months, if appropriate.
- The date of service (DOS) is the date the comprehensive care plan is developed.
- Modifiers –TF and –TG are not valid with this code.

Refer to the Contract for information related to timeframes and modes of contacts.

G9002 – Coordinated Care Fee; Maintenance Rate
The maintenance rate includes all activities related to implementing and keeping the member's care plan up-to-date.

- This code is reimbursable for members with a comprehensive care plan.
- Bill this code only if there is at least one member contact (face-to-face, interactive video or telephone) during the calendar month for which the HMO is billing.
- The HMO may add Modifier –TF or –TG when billing on behalf of members assigned to the medium stratum or a WICT.

- If a WICT member declines to meet in-person, the WICT Core Team may offer a meeting by interactive video. If the WICT visit is performed via interactive video, and the decision is documented in the care plan, the service will qualify to be billed under this procedure code with a POS code and Modifier representing telehealth, along with stratum Modifier TG.

- HMOs may bill this code only once in a calendar month, regardless of modifier or POS.
- The DOS, POS, and modifier combination should use the last date of care management activity in the calendar month for claim submission.
- Procedure code G9002 is reimbursable in the same calendar month as codes G9001, G9006 and G9007.

Refer to the Contract for additional information related to the review and updates of the comprehensive care plan.

G9006 – Coordinated Care Fee; Home Monitoring

The home monitoring code is intended to represent care plan activities that occur in the member's place of residence. The reimbursement rate for this code accounts for travel for in-home visits. It is not to be used for telehealth visits.

- This code is reimbursable for members with a comprehensive care plan.
- Bill this code only if the home visit resulted in a face-to-face contact with the member or the member's authorized representative.
- Reimbursement for this code is limited to POS, 04, 12, 14, and 16. POS 02 and 10 are not appropriate for this code.
- The HMO may add Modifier –TF or –TG when billing on behalf of members assigned to the medium stratum or a WICT.
- The DOS is the date of the home visit.
- There is no limit on the number of times this code is billed in a calendar month. However, reimbursement is limited to a unit of one per DOS.
- Procedure code G9006 is reimbursable in the same calendar month as codes G9001, G9002 and G9007.

G9007 – Coordinated Care Fee; Scheduled Team Conference

This code represents team conferences scheduled to discuss a specific member's care needs, as identified in her or his comprehensive care plan.

- This code does not include brief team huddles and impromptu gatherings.
- HMOs may bill this code only if the following individuals participate in the team conference:
  - The member and/or their authorized representative
  - At least one representative of the member's care management team
  - Health or community care provider(s) instrumental to the implementation of the member's care plan (for example, community agency representative or health care professional).

Team conferences do not have to be face-to-face; but to be billable all required participants must be present at the meeting.

- Reimbursement for this code is limited to four units per member, per calendar month, regardless of modifier.
- The DOS is the date of the scheduled conference.
- The HMO may add Modifier –TF or –TG when billing on behalf of members assigned to the medium stratum or a WICT.
- Procedure code G9007 is reimbursable in the same calendar month as codes G9001, G9002 and G9006.

G9012 – Coordinated Care Fee; Other Specified Case Management Services not Elsewhere Classified

This unspecified code represents the required transitional care management activities that the HMO must provide following an inpatient hospitalization.

- Bill this code only if there is at least one member contact (face-to-face or telephone) related to transitional care management following an inpatient hospitalization.
- Reimbursement for this code is limited to one unit per member, per hospital discharge, regardless of modifier
- The DOS is the last date of transitional care activity.
- The HMO may add Modifier –TF or –TG when billing on behalf of members assigned to the medium stratum or a WICT.
- Other care management services (G9001, G9002, G9006 and G9007) are not reimbursable during the same calendar month as transitional care.
- If the required transitional care management activities include: the initial screening; information gathering and assessment; needs stratification; care team assignment; and comprehensive care plan development, the HMO should bill G9001 instead of G9012.

Refer to the Contract for additional requirements related to transitional care management.

5.0 Reimbursement Terms and Amounts

5.1 Introduction

HMOs should bill their usual and customary fee for care management services. Wisconsin Medicaid and BadgerCare Plus will reimburse the lower of the amount billed or the Medicaid established fee for each allowable code. HMOs are not required to bill a member's other insurance for this benefit since these activities are typically not covered by other insurance. HMOs must not charge a member copayment for this benefit.

5.2 Maximum Allowable Fees

Table 2 lists the maximum allowable fees, including an enhanced reimbursement fee for services provided to members assigned to a WICT. For each code, the unit of service is one and the reimbursement is a flat rate.

Table 2 – Maximum Allowable Fees

Rates Effective for Dates of Service on and after January 1, 2017				
Procedure Code	**Unit of Service**	**Maximum Allowable Fee (Flat Fee for all Codes)**		
		Without Modifier (Low Stratum)	**Modifier -TF (Medium Stratum)**	**Modifier -TG (WICT Related Activities)**
G9001	The unit of service is 1 (one), regardless of the number of hours and the number of staff contributing to the screening, information gathering and the care plan development.	$292.00		N/A
G9002	The unit of service is 1 (one), regardless of the number of hours of care coordination activity during the billable month.	$48.84		$73.26
G9006	The unit of service is 1 (one) per member, per DOS, regardless of the number of visits to the member's home on a particular date, the length of the visit(s), or the number of individuals involved in the visit.	$54.84		$82.26
G9007	The unit of service is 1 (one), regardless of the number of care management staff involved or the length of the conference.	$33.62		$50.43
G9012	The unit of service is 1 (one), regardless of the number of hours of transitional care management activities.	$127.19		$190.79

Change Log

Date	Version	Description of Change
01/01/2026	2.2	Updated: • Section 1.2 - Citation for contract language was corrected • Subsection numbers under 3.0 Allowable Codes • Section 3.3 Modifiers - added language for Telehealth • Section 3.4 Place of Service - added language for Telehealth • Section 3.6 *Table 1 Crosswalk of Care Management Activities to Allowable Codes* Updated language under code G9002 to clarify home visits and G9006 to include information on Home Visits. • Section 4.4 Code G9001 - rescreening added to initial screening • Section 4.4 Code G9002 - added language regarding WICT Telehealth coverage and clarification of billing date • Section 4.4 Code G9006 - added language regarding clarification of the intent of Home Monitoring
2/6/2024	2.1	• Updated section 1.4 Eligible Population • Updated section 1.6 Questions • Updated section 4.4 Additional Requirements (G9001) • Added Change Log
01/01/2018	1.0	• First version