



Wisconsin Medicaid Behavioral Treatment Provider Training

November 4, 2015

Wisconsin Department of Health Services
Division of Health Care Access and Accountability
Division of Long Term Care



Agenda

- Introduction and Welcome
- Behavioral Treatment Benefit Overview
- Provider Enrollment Criteria and Process
- Member Enrollment Verification
- Clinical Prior Authorization Criteria
- Prior Authorization Submission on the Portal
- Claims Submission on the Portal
- Reimbursement Methodology
- Transition Plan for Current Waiver Participants
- Recap of available resources; Q & A

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Information in this presentation is current as of November 4, 2015 and is subject to change pending negotiations with the federal Centers for Medicare and Medicaid Services (CMS).

This presentation does not constitute official ForwardHealth policy, which will be published in a forthcoming *ForwardHealth Update*.

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Behavioral Treatment Benefit Overview

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CMS Guidance

In July 2014, the Centers for Medicare and Medicaid Services (CMS) issued guidance that requires states to provide coverage of Autism Spectrum Disorder (ASD) treatment services as a state plan benefit.

Coverage of treatment services for Medicaid members with behavioral treatment needs, including autism spectrum disorders, is moving from the Children's Long-Term Support (CLTS) Waiver Program to ForwardHealth.

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Eligible Members

Behavioral treatment services are available to Medicaid (including the Katie Beckett program), and BadgerCare Plus members.

- Eligibility requirements for Medicaid and BadgerCare Plus are not changing.
- Children on the CLTS Waiver Program are Medicaid members.
 - Medicaid eligibility will be maintained during the transition of behavioral treatment services from the CLTS Waiver program to ForwardHealth.

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Behavioral Treatment Services

CLTS Waiver Program Treatment Levels and Limits

- Intensive, Consultative, and Ongoing
- Hard limits on age of eligible members, duration of treatment, required number of hours.

ForwardHealth Treatment Levels

- Comprehensive – High-intensity, early-intervention treatment designed to address multiple aspects of development and behavior in young children.
- Focused – Fewer hours of treatment to address specific behaviors or skill deficits.

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Behavioral Treatment Services (cont.)

Behavioral treatment services are professional services and may be provided in the home, community, or provider office.

Behavioral treatment services are authorized via prior authorization (PA):

- Member-specific
- Medically necessary
- Evidence-based treatment modalities

Behavioral treatment services must be provided by a Medicaid-enrolled behavioral treatment provider.

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Behavioral Treatment Providers

Must be Medicaid enrolled as a Behavioral Treatment Provider to submit PA requests and receive reimbursement from ForwardHealth.

- 3-Tier Provider Model for Comprehensive Level Treatment
 - Behavioral Treatment Licensed Supervisor
 - Behavioral Treatment Therapist
 - Behavior Treatment Technician
- 2-Tier Provider Model for Focused Level Treatment
 - Focused Treatment Licensed Supervisor
 - Focused Treatment Therapist

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Behavioral Treatment Claims Policy

ForwardHealth using T-code procedure codes to represent services on professional claims.

- Use modifiers to signify comprehensive (TG) or focused (TF) service.
- Use place of service “home” for community locations.
- Identify the actual rendering provider of the service using the National Provider Identifier (NPI) or Medicaid ID.

ForwardHealth will coordinate benefits with commercial payers that cover behavioral treatment services.

- Medicaid is payer of last resort.
- Commercial insurance may require different procedure codes to submit claims for behavioral treatment services.

Behavioral Treatment Benefit *Update* coming December 2015.

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Provider Enrollment

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Provider Enrollment Criteria

- Beginning November 16, 2015, certain licensed and/or certified medical professionals and other paraprofessionals will be able to enroll in Wisconsin Medicaid as a behavioral treatment provider in preparation for ForwardHealth's coverage of behavioral treatment services, including services for treatment of autism spectrum disorder.
- Licensed/certified medical professionals who are already enrolled in Wisconsin Medicaid will be required to complete a separate enrollment as a behavioral treatment provider in order to provide covered behavioral treatment services to ForwardHealth members.

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Provider Specialties

ForwardHealth is establishing the following provider specialties that reflect the existing multi-tiered paraprofessional delivery model commonly used by Wisconsin behavioral treatment providers:

- Behavioral treatment licensed supervisor
- Behavioral treatment therapist
- Behavioral treatment technician
- Focused treatment licensed supervisor
- Focused treatment therapist

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Provider Specialties

- Licensed/certified medical professionals and qualifying paraprofessionals should choose the most appropriate enrollment for his or her qualifications.
- Each professional or paraprofessional is encouraged to enroll in a single provider specialty but may enroll in two provider specialties to reflect his or her professional duties.
- Detailed enrollment information will be located on the Provider Enrollment Information page of the ForwardHealth Portal at www.forwardhealth.wi.gov/

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Provider Specialty	Behavioral Treatment Licensed Supervisor	Behavioral Treatment Therapist	Behavioral Treatment Technician	Focused Treatment Licensed Supervisor	Focused Treatment Therapist
Enrollment Criteria	<p>Is required to be certified to do one of the following:</p> <ul style="list-style-type: none"> Supervise provision of ABA: Must be a Wisconsin-licensed behavior analyst Supervise provision of ESDM: Must be a Wisconsin-licensed psychiatrist, psychologist, behavior analyst, clinical social worker, professional counselor, or marriage and family therapist, AND must hold an ESDM certificate from the University of California, Davis program <p>In addition, a behavioral treatment licensed supervisor is required to have, and attest to, at least 4,000 hours of documented experience as a supervisor of less experienced clinicians delivering the approved treatment model for the target population.</p>	<p>Must meet at least one of the following criteria:</p> <ul style="list-style-type: none"> Be a Board Certified Assistant Behavior Analyst (BCaBA) and have 400 hours of documented training and supervised experience delivering a Wisconsin-approved treatment model Hold a master's degree in psychology, counseling, marriage and family therapy, social work, education, or a behavioral sciences field and have 400 hours of documented training and supervised experience delivering a Wisconsin-approved treatment model Hold a bachelor's degree in psychology, counseling, marriage and family therapy, social work, education, or a behavioral sciences field and have 2,000 hours of documented training and supervised experience delivering a Wisconsin-approved treatment model 	<p>Must meet all of the following criteria:</p> <ul style="list-style-type: none"> Be at least 18 years old Have earned a high school diploma or a General Educational Development (GED) certificate <p>In addition, a behavioral treatment technician is required to have a Registered Behavior Technician (RBT) certification from the BACB or 40 hours of training administered by a supervising provider.</p>	<p>Must meet all of the following criteria:</p> <ul style="list-style-type: none"> Be a Wisconsin-licensed psychiatrist, psychologist, behavior analyst, clinical social worker, professional counselor, or marriage and family therapist Act within the scope of his or her training and experience, including at least 2,000 hours of supervised experience in a Wisconsin-approved treatment model 	<p>Must meet at least one of the following criteria:</p> <ul style="list-style-type: none"> Be a Board Certified Assistant Behavior Analyst (BCaBA) with 400 hours of documented training and supervised experience delivering a Wisconsin-approved focused treatment model Hold at least a master's degree in psychology, counseling, marriage and family therapy, social work, education, or a behavioral sciences field with 400 hours of documented training and supervised experience delivering a Wisconsin-approved focused treatment model Hold a bachelor's degree in psychology, counseling, marriage and family therapy, social work, education, or a behavioral sciences field with 2,000 hours of documented training and supervised experience delivering a Wisconsin-approved focused treatment model Be a Registered Behavior Technician from the Behavior Analyst Certification Board (BACB) with 3,000 hours of documented training and supervised experience delivering a Wisconsin-approved treatment model
Enrollment Category	Billing/rendering provider	Rendering provider only	Rendering provider only	Billing/rendering provider	Rendering provider only
Type(s) of Treatment	May provide both comprehensive and focused treatment	May provide both comprehensive and focused treatment	May provide comprehensive treatment only	May provide focused treatment only	May provide focused treatment only
Documentation Requirements (required during the enrollment process)	<ul style="list-style-type: none"> The DSPS License number Documentation denoting required hours of supervisory experience Copy of the ESDM certificate, if applicable 	<ul style="list-style-type: none"> Copy of the Behavior Analyst Certification Board (BACB) certificate, if applicable Documentation denoting required hours of supervised experience 	<ul style="list-style-type: none"> Copy of the Behavior Analyst Certification Board (BACB) certificate Copy of the high school diploma or GED certificate 	<ul style="list-style-type: none"> The DSPS License number Documentation denoting required hours of supervised experience 	<ul style="list-style-type: none"> Copy of the Behavior Analyst Certification Board (BACB) certificate, if applicable Degree from appropriate institution, if applicable Documentation denoting required hours of supervised experience




Provider Enrollment on the ForwardHealth Portal

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Provider Enrollment on the Portal

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[Enrollment](#)
[Claims](#)
[Prior Authorization](#)
[Remittance Advices](#)
[Trade Files](#)
[HealthCheck](#)
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[Account](#)
[Contact Information](#)
[Online Handbooks](#)
[Site Map](#)
[Certification](#)
[User Guides](#)

You are logged in with NPI: 1639245558, Taxonomy Number: 282N00000X, Zip Code: 53709 - 1234, Financial Payer: Medicaid


[Enrollment Criteria](#)

Provider Enrollment Information

[Home](#)

To be reimbursed for services provided to members enrolled in Wisconsin Medicaid, BadgerCare Plus, or SeniorCare, providers are required to be enrolled in Wisconsin Medicaid as described in [DHS 105](#), Wis. Admin. Code.

Personally identifiable information about Medicaid providers, persons with ownership or control interest in the provider, managing employees, agents, or other provider personnel is only used for purposes directly related to Medicaid administration, such as determining the enrollment of providers and monitoring providers for waste, fraud, and abuse. All information provided is protected under federal and/or state confidentiality laws. Failure to supply the information requested by the application may result in denial of Medicaid payment for the services.

To be enrolled in Wisconsin Medicaid, providers are required to complete the application process. Failure to complete the enrollment application process will cause a delay, and may cause denial, of enrollment. As part of the enrollment application, providers are required to sign a provider agreement with the Department of Health Services (DHS). Providers sign the provider agreement electronically by selecting the box acknowledging and agreeing to the terms of the agreement. By electronically signing the provider agreement, the provider attests that the provider and each person employed by the provider, for the purpose of providing services, holds all licenses or similar entitlements and meets other requirements specified in [DHS 101 through DHS 109](#), Wis. Admin. Code, and required by federal or state statute, regulation, or rule for the provision of the service.

The provider's enrollment in Wisconsin Medicaid may be terminated by the provider as specified in [DHS 106.05](#), Wis. Admin. Code, or by the DHS upon grounds set forth in [DHS 106.06](#), Wis. Admin. Code.

The provider agreement remains in effect as long as the provider is enrolled in Wisconsin Medicaid.

[Start or Continue Your Enrollment Application](#)

[Medicaid Criteria](#)

- [Home](#)
- [Affordable Care Act](#)
- [Border-Status Providers](#)
- [Categories of Enrollment](#)
- [Change in Ownership](#)
- [Effective Date of Medicaid Enrollment](#)
- [Enrollment Application and Tracking Process](#)
- [Express Enrollment](#)
- [In-State Emergency Providers](#)
- [Information for Specific Provider Types](#)
- [Multiple Locations and Services](#)
- [Notice of Enrollment Decision](#)
- [Out-of-State Providers](#)
- [Out-of-State Youth Program](#)
- [Prescribing/Referring/Ordering Providers](#)
- [Provider Addresses](#)
- [Provider Enrollment Application Fee](#)
- [Provider Identification](#)
- [Re-enrollment](#)

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Provider Enrollment on the Portal


- Providers may begin the online enrollment process by selecting the Become a Provider link from the Portal Home page or the secure Providers page. This link leads to the Provider Enrollment Information page.
- The Provider Enrollment Information page contains links to important enrollment information as well as the link to the online enrollment tool, titled “Start or Continue Your Enrollment Application.”
- To use the online enrollment tool, providers need to answer questions and fill in the necessary information by navigating through a series of pages using the Previous and Next buttons.

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Provider Enrollment on the Portal

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[Enrollment](#)
[Claims](#)
[Prior Authorization](#)
[Remittance Advices](#)
[Trade Files](#)
[HealthCheck](#)
[Max Fee Home](#)
[Account](#)
[Contact Information](#)
[Online Handbooks](#)
[Site Map](#)
[Certification](#)
[User](#)

You are logged in with NPI: 1639245558, Taxonomy Number: 282N00000X, Zip Code: 53709 - 1234, Financial Payer: Medicaid


[Certification Home Page](#)

To Start a New Medicaid Enrollment

- Select the link below to start the enrollment process.
- Applicants have the ability to save their application and return later to finish.

[Medicaid/Border Status Provider Enrollment Application](#)

To Start a New ADAP Enrollment

- Select the link below to start the enrollment process.
- Medicaid-enrolled providers must complete a separate application to be an ADAP provider.

[ADAP Provider Enrollment Application](#)

To Start a New Prescribing/Referring/Ordering Enrollment

- Select the link below to start the enrollment process.
- Applicants have the ability to save their application and return later to finish.

[Medicaid Prescribing/Referring/Ordering Provider Enrollment Application](#)

To Start a New In-State Emergency/Out-of-State Enrollment

- Select the link below to start the enrollment process.
- Applicants have the ability to save their application and return later to finish.

[Medicaid In-State Emergency/Out-of-State Enrollment Application](#)

To Continue a Previous Medicaid Enrollment

- Enter your Enrollment Key and Password and select Login.
- Enrollment process will start from the beginning; however, previously entered data will be displayed for review.
- ADAP enrollment cannot be completed in this section. Please start a new ADAP Provider Certification Application to enroll as an ADAP provider.

Enrollment Key

Password

Login

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Provider Enrollment for Licensure

Before starting the application process:

- Have your NPI/Taxonomy code
- Have your mailing, service location, prior authorization and financial addresses.
- Have your tax I.D. or SSN available.
- Any required licensure.

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Provider Enrollment for Non-Licensure

Before starting the application process:

- Have your mailing, service location, prior authorization and financial addresses.
- Have your supervisor's address and his or her effective date of enrollment.
- Any required supporting documentation for uploading.

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Provider Enrollment on the Portal

- The Provider Agreement must be signed, dated, and sent to ForwardHealth electronically. Providers will have the opportunity to print the Provider Agreement for their records.
- Supporting documentation may be uploaded with the electronic application.
- Providers should note the Application Tracking Number (ATN) assigned to their enrollment request.
- Providers may track the status of their enrollment requests via the Enrollment Tracking Search tool. Providers will need the ATN assigned to the application to perform this search.
- The Provider Agreement and information regarding supporting documentation, if required, is displayed at the end of the application.

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An Introduction to Member Enrollment Verification

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General Functionality

- A user must be granted secure Portal access to member enrollment information.
- Providers access member enrollment information via the Enrollment page.
- All enrollment-related panels will time-out after 30 minutes of inactivity.
- Refer to the Enrollment Verification (EV) User Guides for detailed information on how to perform member EV and for guidance understanding the information within each panel.

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Member Enrollment Verification

- One of the following combinations of information is required along with the to and from date of service:
 - Member identification number.
 - Social Security number (SSN) and date of birth.
 - Member first/last name and date of birth.
- For best results, enter the minimum amount of required information.
- The verification tracking number for the enrollment verification inquiry is displayed in a yellow box. Providers should keep a record of this number as proof of the inquiry.

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Member Enrollment Verification

- If your inquiry cannot be processed with the information entered, an error message will display stating why the inquiry failed.
- If the member is not eligible for services during the time period searched, the message “***No rows found***” will display in the Benefit Plan panel.
- The message “***No rows found***” may also display if the member information used for the search does not exactly match the member information on file (e.g., last name).

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Member Enrollment Verification

- If you are certain the member for whom you are performing the inquiry is eligible for benefits but cannot locate the enrollment record, check to make sure that you are logged in under the correct payer account. You may also try changing your search parameters.
- If the enrollment verification results reflect that the member is eligible under more than one benefit plan, providers should consider the most comprehensive benefit plan for purposes of copayment and services allowed. This also includes limited benefit plans.
- Providers are strongly encouraged to check enrollment on the date of service prior to providing services to the member.
- Providers may contact Provider Services with questions regarding member enrollment.

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Member Enrollment Verification

For your reference, the enrollment verification tracking number 122770000B verifies the enrollment information below only for the following time frame of 01/01/2012 through 09/30/2012.

Search Results

Member Information

Member ID	4110657741	Name	SALLY S STANDARD
Date of Birth	07/14/1999	County	Dane
Medicare ID		Address	DO NOT USE/CHANGE COTTAGE GROVE WI, 53527

Benefit Plan

Payer	Benefit Plan	Effective Date	End Date
MEDICAID	BC+ Standard Plan (No Copay)	01/01/2012	09/30/2012

Lockin

Category of Service	Effective Date	End Date	Provider Name	Provider Phone	Referral
Hospice	07/01/2012	09/30/2012	HOSPICE TRAINING	(920)322-1144	

Non-Emergency Transportation Services Enrollment

Provider Name	Effective Date	End Date
LOGISTICARE SOLUTIONS LLC	01/01/2012	09/30/2012

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Clinical Prior Authorization (PA) Criteria & Claim Codes

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Purpose of Prior Authorization

The PA process is ForwardHealth's method for assessing the *medical necessity* of a requested service.

A service may be considered *medically necessary* when it is the most *appropriate, clinically effective, cost-effective* plan of care *for this member at this time (DHS 101)*.

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Clinical Criteria for PA Approval

- *Diagnostic Evaluation*
- *Previous Treatment History*
- *Medical Evaluation*
- *Standardized Testing*
- *Behavioral Treatment Team*
- *Plan of Care*
- *Progress Summary (re-authorization)*
- *Care Collaboration*
- *Supporting Documentation*

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Diagnostic Evaluation

- Comprehensive – evaluation within 1 year of initial PA request; or within 1 year of start of current course of treatment (if member has been continuously enrolled in a treatment program prior to PA request)
- Focused – if diagnostic evaluation is older than one year, provider's assessment report should include provider's clinical impression of member's diagnosis
- Differential diagnosis - For members with complex conditions, good quality differential diagnosis is required

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Medical Evaluation

- Physical exam required within 12 months of PA request; must update annually
- Include information from member's medical provider regarding medical factors that might impact the member's participation and/or expected outcomes from behavioral treatment
 - Hearing, vision, various medical concerns like seizures, sleep, digestive problems, attention problems, depression, anxiety
- **Prescription:** medical provider's order *must* indicate hours per week and number of weeks/months

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Standardized Testing

- Standardized testing provides a *baseline*, which may be used later to assess progress.
- Testing may be included in behavior identification assessment (0359T), which can usually be billed to Medicaid without PA. Providers may also report test results from school or Birth to 3.
- Comprehensive – age-normed, standardized assessments of cognition, communication, life skills
- Focused - standardized tools that measure specific skill limitations and/or FBA for problem behaviors

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Behavioral Treatment Team

- Licensed supervisors should see the member at least once every 60 days, and no later than every 75 days.
- Specify the type of staff who will provide direct services.
- Unlicensed staff must receive regular supervision from qualified clinical supervisors. Provide details about frequency, mode, and provider of supervision.
- Provide details on the team's training and accommodations for members who are dual-language learners.

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Plan of Care

- Must indicate *treatment modality, time period, and measurable goals*. May use your existing format.
- Goals must be related to assessed needs.
 - If assessment noted behavioral challenges, include a goal related to addressing the behavior.
 - If assessment noted that parents are struggling with strategies, include a goal related to parent education.
- Include a plan for family education and involvement, which includes more than being present for team meetings and sessions. Family goals may be included.

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Progress Summary

Provide a narrative summary of progress and measurement of behavior change during the authorization period. Evidence of progress may include:

- increased IQ / cognitive gains
- closing the developmental gap with a norm-group of same-age peers
- mastery of treatment goals identified on the treatment plan
- functional behavioral change that is sustained over time and generalizes to activities and settings outside of treatment sessions

If there has been minimal to no progress, identify barriers to progress and a corrective plan of action.

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Care Collaboration

- Identify the person in your agency who will coordinate collaboration with other providers.
- Identify school, therapies, and other relevant supports the member is receiving.
- Specify your plan for communicating and collaborating with each entity (e.g., weekly emails, monthly phone check in, attendance at team meeting every other month, etc.).

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Supporting Documents

- Prescription for treatment
- IFSPs and IEPs
- Treatment & school schedule
- Discharge criteria and transition plan
 - Standard discharge criteria at beginning of treatment
 - Use clear, face-valid indicators
 - Transition plan should be individualized over time
 - “Resolution of all symptoms” is not the only reason for discharge

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CPT Claim Codes

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CPT Codes

- Services may be requested and billed using the Current Procedural Terminology (CPT) temporary code set designed specifically for Adaptive Behavior Assessment and Treatment.
- Per coding guidelines, these codes are applicable to individuals of any age with autism spectrum disorders (ASDs) or conditions associated with deficient adaptive or maladaptive behaviors.
- ForwardHealth is required to follow NCCI guidelines.

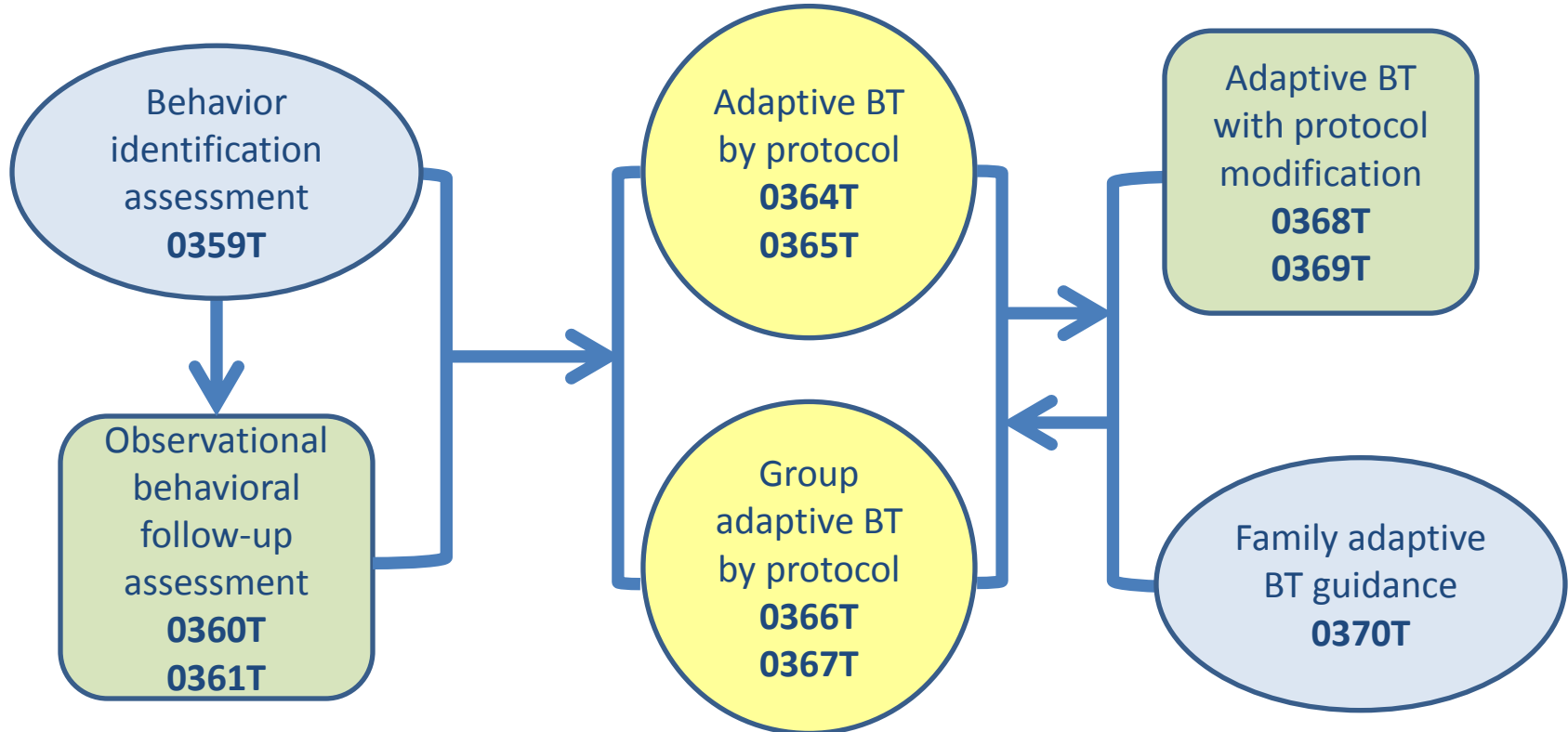
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CPT Codes for Behavioral Treatment

Assessment Codes

Treatment Codes





CPT Code Handout

	Renderer	Billing Unit	Service Requirements	Required Documentation	PA Limits
0359T Behavior Identification Assessment	Licensed Supervisor	1 unit	<ul style="list-style-type: none"> Member present (for observation) Interview, record review, testing, plan of care, report preparation, meet with family 	<ul style="list-style-type: none"> Time in/time out Names of staff & caregiver(s) present Place of service Assessment report Plan of care Renderer signature 	PA required only for re-assessment of member within 6 months of provider's prior assessment
0360T/0361T Follow-Up Assessment	Licensed Supervisor or Treatment Therapist	30 minute units Maximum 2 hours per day	<ul style="list-style-type: none"> Member present Assessment activities Face-to-face 	<ul style="list-style-type: none"> Time in/time out Names of staff & caregiver(s) present Place of service Assessments completed Renderer signature 	PA required only for follow-up assessment more than 2 months after 0359T date of service
0364T/0365T 0366T/0367T Behavior Treatment by Protocol	any level of BT provider	30 minute units	<ul style="list-style-type: none"> Member present Treatment activities per POC Face-to-face, 1:1 	<ul style="list-style-type: none"> Time in/time out Names of staff & caregiver(s) present Place of service Goals addressed Data collected re goals Renderer signature 	PA required
0368T/0369T Protocol Modification	Licensed Supervisor or Treatment Therapist	30 minute units	<ul style="list-style-type: none"> Member present Face-to-face guidance of staff or caregiver actively engaged in protocol delivery Face-to-face; 1:1 	<ul style="list-style-type: none"> Time in/time out Names of staff & caregiver(s) present Narrative description of observations, changes implemented or feedback provided, and outcome of changes/feedback Renderer signature 	PA required
0370T Family Treatment Guidance	Licensed Supervisor	1 unit	<ul style="list-style-type: none"> Parent(s)/caregivers present; member not required to be present Face-to-face <p>Note: Staff other than billing provider may be present, but their time is not reportable</p>	<ul style="list-style-type: none"> Time in/time out Names of staff & caregiver(s) present Information collected from family Information shared with family Updates to POC or family goals, if any Renderer signature 	PA required



Requesting Units on a PA

For Members with Medicaid or BadgerCare Plus only

- Request the number of family treatment guidance units (0370T)
- Total all other requested treatment units; request as one amount, using code 0365T
- Use modifier TG for comprehensive, TF for focused
- Remember that treatment units are 30 minutes

For Members with Commercial Insurance + Medicaid or BadgerCare Plus

- Request the desired number of units using the procedure code(s) used by the member's primary insurance
- Use modifier TG for comprehensive, TF for focused

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PA Standards

- Verify member enrollment before submitting a PA.
- Most initial requests will be for 6 months.
- ForwardHealth will not approve more hours than ordered on the medical provider's prescription.
- ForwardHealth will not approve a start date earlier than the date of PA submission OR the date of the prescription.
- For comprehensive treatment, ForwardHealth will not approve more than 40 hours per week x number of weeks.

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PA Standards

- At the beginning of comprehensive treatment, ForwardHealth will authorize a minimum of 20 hours of treatment per week.
- Following a period of comprehensive treatment at 20+ hours per week, fewer than 20 hours per week may be approved as part of a planned reduction in hours.

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PA Standards

- ForwardHealth will not authorize treatment in excess of 45 hours per week, *inclusive of other interventions*, including but not limited to school and outside therapies.
- If the member has been continuously enrolled in a behavioral treatment program prior to the PA request for more than 45 hours per week, inclusive of other interventions, the PA may be approved with guidance to reduce hours to the 45 hour (inclusive) limit over the course of an authorization period.

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Prior Authorization on the Portal

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Prior Authorization Determination

- For the service to be eligible for reimbursement, PA must be obtained before providing the services.
- Renewal requests are required to prevent a lapse in coverage or reimbursement for ongoing services. These requests must be received by ForwardHealth *prior to the expiration date* of the previous PA request.
- A new PA request must be submitted if:
 - A provider's billing provider changes.
 - A member requests a provider change that results in a change in billing providers.
 - A member's enrollment status changes and there is not a valid PA on file for the member's current plan.

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Methods of Prior Authorization Submission

- ForwardHealth secure Portal account
- Mail to:
ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784
- Fax to: 608-221-8616
- 278 Health Care Service Review — Request for Review and Response (HIPAA transaction)

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General Prior Authorization Information

- All PAs, regardless of whether they are submitted on paper or electronically, are accessible via the Portal.
- All PA's have a grant/expiration date. Services must be used between these dates.
- All Pa's have 2 parts to be completed: PA Request Form and the Clinical attachments.
- Once you have submitted your PA, you will receive a PA number. Use the number as a reference when contacting ForwardHealth.
- If a PA needs a clarification or correction, the PA will be returned.
- You will receive a Returned Provider Review letter stating the information needed. Only return the portion of the pa that is to be corrected, not the entire PA. Do so as soon as possible.

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Decision Notices and Returned Provider Review Letters

- Decision notices and returned provider review letters are available via the Portal.
- Providers submitting PA requests via the Portal will receive the documents via the Portal.
- If the provider submitted a PA request via mail or fax and the provider has a Portal account, the documents will be sent to the provider via the Portal as well as by mail. (Decision notices and returned letters are sent to the address indicated in the provider's file as his or her PA address.)

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Portal Prior Authorization Attachments

- By completing PA requests through the Portal, providers can be assured that they have submitted the appropriate PA attachments.
- Almost all PA attachments can be completed and submitted on the Portal.
- ForwardHealth recommends completing the PA attachment online to reduce the chance of the PA request being returned for clerical errors.
- To save time, providers may copy and paste information from plans of care and other medical documentation into the appropriate fields on the PA attachment. Providers can also take advantage of the Additional Information field at the end of the PA attachment.

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General Portal Prior Authorization Information

- When using the Portal, providers may save a partially completed PA request without losing entered data. Providers must either complete or re-save a saved PA within 30 days or it is deleted.
- Providers access saved PA requests by selecting the Complete a Saved PA Request link from the Prior Authorization page.
- The Portal PA screens will time out after 55 minutes. There is a button that will pop up to allow another hour of use.

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Changing a PA Request from Suspended to Pending

- Providers have the option of changing a PA request from “Suspended — Provider Sending Info” to “Pending” if the provider determined that supporting documentation will not be submitted by *mail or fax*.
- Changing the status to “Pending” will allow the PA request to be processed without supporting documentation.
- If the option to *upload* supporting documentation was selected in error, providers should upload a letter stating that they do not intend to submit supporting documentation and request the PA be processed without it.

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PA Record



- The PA record below is in "APPROVED" status.
- To view the decision on this approved PA select "View PA Decision Notice" located in the PA Information section. If you wish to submit an amendment request for this PA, select "Amend this PA" located at the bottom of the page.

PA Information

PA Number 5113050001 Media Type WEB
 First Name MARY Member ID 1110560117
 Last Name MEDICAID Date of Birth 10/01/1938
 PA Status APPROVED [View PA Decision Notice](#)
 Amendment Status
 Process Type 133 - Transplants

Program Medicaid
 HealthCheck Other Service No Start Date - SOI
 Requested Start Date 12/01/2011 First Date of Treatment - SOI
 Primary Diagnosis Code 4280 Description CONGESTIVE HEART FAILURE UNS
 Secondary Diagnosis Code Description
 National Provider Identifier- Name - Prescribing/Referring/
 Prescribing/Referring/Ordering Provider Ordering Provider

Line Item Information

Line Item	Status	Service Code	Units Requested	Dollars Requested	Units Authorized	Dollars Authorized	Grant Date	Expiration Date
01	APPROVED	3751	1.000	\$10,000.00	1.000	\$0.00	12/01/2011	12/31/2011
02	APPROVED	0810	1.000	\$5,000.00	1.000	\$0.00	12/01/2011	12/31/2011

Select row above to display a different line item's data below.

Line Item 01

Status APPROVED

Rendering Provider ID 1639245558 NPI

Prescribing Provider ID

Service Code Type ICD

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Supporting Documentation

- If supporting documentation needs to be mailed or faxed, the Print PA Cover Sheet panel will display instructions to complete a cover sheet to accompany the documentation. The cover sheet is also available via the Print PA cover sheet link on the Prior Authorization page.
- Providers should submit only the cover sheet along with the supporting documentation.

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PA Record

- The PA record below is in "SUSPENDED - PROVIDER SENDING INFO" status.

PA Information

PA Number 5112770002 Media Type WEB
First Name MEDICAID Member ID 4201042010
Last Name JACKSON Date of Birth 11/12/1999
PA Status SUSPENDED - PROVIDER SENDING INFO
Amendment Status
Process Type 120 - Home Care
Program Medicaid
HealthCheck Other Service No Start Date - SOI
Requested Start Date 09/30/2011 First Date of Treatment - SOI
Primary Diagnosis Code 436 Description CVA
Secondary Diagnosis Code Description
Referring Physician's Name Referring Provider ID

Line Item Information

Line Item	Status	Service Code	Units Requested	Dollars Requested	Units Authorized	Dollars Authorized	Grant Date	Expiration Date
01	PENDING	T1021	50.000	\$1,500.00	0.000	\$0.00		

Select row above to display a different line item's data below.

Line Item 01
Status PENDING
Rendering Provider ID 1427014270 NPI
Prescribing Provider ID
Service Code Type Procedure Code
Service Code T1021
Service Code Description HHA 1/D, 5D/WK X 10WK
Tooth Area of the Oral Cavity
Modifiers UF
Place of Service 12
Units Requested 50.000 Dollars Requested \$1,500.00
Units Authorized 0.000 Dollars Authorized \$0.00
Units Remaining 0.000 Dollars Remaining \$0.00
Grant Date
Expiration Date

Change Prior Authorization Status

☐ Check this box to change PA status from "Suspended" to "Pending". Enter text below to explain or comment on why the PA can be processed.

Comments (Optional)

Submit

Previous Exit

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Prior Authorization Status

- Approved
- Approved with Modifications
- Denied
- Returned — Provider Review
- Pending — Fiscal Agent Review
- Pending — State Review
- Suspended — Provider Sending Information
- Inactive

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Overview of Review Process: Clerical and Clinical

Clerical Review

- The first step of the review process includes the review of provider, member, diagnosis, and treatment information.
- PAs completed on the ForwardHealth Portal have upfront edits for this information.
- Portal submission allows for fewer clerical errors due to upfront editing.
- Clerical errors and omissions are responsible for the majority of PA returns.
- PAs returned for corrections or additional information can cause delays in PA approval and services to members.

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Overview of Review Process:

Clerical and Clinical

Clinical Review

- After verifying the completeness and accuracy of the Prior Authorization Request Form (PA/RF), F-11018, the PA request is reviewed to evaluate whether or not each service being requested meets Wisconsin Medicaid's definition of "medically necessary" as well as other criteria.
- Medical necessity is based on information submitted by the provider.
- Documentation must be complete and accurate.
- Provider is required to provide justification for the service.
- Information must be specific to the member's current condition and needs.

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Prior Authorization Amendments

- Providers may amend approved PAs via the Amend an Approved PA on the Portal or via a paper amendment request form.
- Reasons to amend an approved PA:
 - to temporarily modify a members frequency of service when there is a short term change in the members medical condition.
 - to change the rendering provider information when the billing provider stays the same.
 - to change the member's ForwardHealth identification number.
 - to add or change a procedure code.

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Reasons for Clerical-Based Returns

- Incomplete/incorrect forms (clerical errors).
- Provider enrollment (EOB code 0172).
- Member is not enrolled for date of service requested (EOB code 0D40).
- Provider taxonomy is missing or incorrect (EOB code 0B13).
- The modifier listed is not valid for the date of service (EOB code 0859).

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Reasons for Clinical-Based Returns

- A signature is requested on attachments.
- Clinical information for services is requested.
- Provider asked to document treatment goals and objectives.
- Provider asked to document whether or not service was provided previously.
- The services do not match physician orders.
- Provider asked to submit clinical information sufficient for clinical request.

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Portal Claims

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General Claims Functionality

- All claims, regardless of whether they are submitted on paper or electronically, will appear in the secure Claims area of the Portal.
- A user must be granted secure Portal access to the claims functionality.
- Providers access claims functionality via the Claims page. Users may also view a limited number of recently submitted claims via the Providers page.
- In addition, providers may adjust, copy, and void paid claims and resubmit denied claims.
- All claims-related panels will time-out after 30 minutes of inactivity.
- Refer to the Claims Submission User Guides for detailed information on how to complete and submit a claim on the Portal using Direct Data Entry (DDE).

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Accessing Claims Information

- Any claim dating back three years through present date can be located by selecting Claim search on the Claims page.
- Providers search for claims by entering data into at least one of the parameter fields.
- The more parameters completed, the narrower the search.
- Providers can navigate through multiple pages of results by using the page numbers at the bottom of the screen or by modifying the sort by selecting any of the column headers.
- Click on any claim to select it. The claim detail will be displayed.
- Once a claim is selected, the provider can either work on that claim or navigate back to the Claims page and perform another claim search.

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Portal Claim Image

Wisconsin serving you

Home Search Providers Enrollment **Claims** Prior Authorization Remittance Advices Trade Files HealthCheck Max Fee Home Account Contact Information Online Handbooks Site Map Certification User Guides

You are logged in with NPI: 1639245558, Taxonomy Number: 282N00000X, Zip Code: 53709 - 1234, Financial Payer: Medicaid Search

[Claims](#) » [Professional](#)

Next Search By: ICN

Professional Claim

Required fields are indicated with an asterisk (*).

ICN 5911348001002 Rendering Provider 1639245558 NPI

Provider ID 1639245558 NPI Referring Provider 1

Member ID* 5110615357 Referring Provider 2

Last Name TRAINING Medicare Disclaimer no disclaimer

First Name, MI SUSAN Other Insurance Indicator

Date of Birth 08/12/1945

Patient Account # Total Charge* \$205.00

Medical Record Number Other Insurance Amount \$0.00

SOI Date Total Amount Paid \$55.67

[Diagnosis](#) [Condition](#) [Medicare](#) [Anesthesia](#) [Other Insurance](#)

Detail

Line Number	From Date of Service	To Date of Service	Procedure Code	Mod1	Mod2	Mod3	Mod4	Status	Units	Charge
1	12/10/2011	12/10/2011	97022	GO				PAY	1.00	\$61.00
2	12/10/2011	12/10/2011	97110	GO				PAY	1.00	\$144.00

Select row above to update -or- click Add button below.

Line Number Rendering Provider

From Date of Service Referring Provider 1

To Date of Service Referring Provider 2

Procedure Code Ordering Provider

Modifiers

Diagnosis Code Pointers

Units

Charge Status

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Portal Claim Image

Diagnosis Code Pointers

Units

Charge

Place of Service Code [Search]

Emergency

Family Planning

Notes

Status

Allowed Amount

CoPay Amount

Professional Service Description

[Delete](#) [Add](#)

[NDCs for JCode](#)

Medicare Information(Detail)

Line Number	1	Medicare Deductible	<input type="text"/>	\$0.00	+
Medicare Date Paid	<input type="text"/>	Medicare Coinsurance	<input type="text"/>	\$0.00	+
Medicare Paid Amount	<input type="text"/>	Psychiatric Reduction	<input type="text"/>	\$0.00	+
Medicare Non Covered Charge	<input type="text"/>	Medicare Copayment	<input type="text"/>	\$0.00	+
		Remaining Patient Liability*	<input type="text"/>	\$0.00	=

Attachments

*** No rows found ***

Select row above to update -or- click Add button below.

Attachment Control Number

Description

[Delete](#) [Add](#)

Adjustment Information

Original ICN	Date Adjusted	Claim Status
2211348001008	12/14/2011	PAY

Claim Status Information

Claim Status	PAY
Claim ICN	5911348001002
Paid Date	12/14/2011

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Final Claim Panel

Claim Status Information

Claim Status

PAY

Claim ICN

5911348001002

Paid Date

12/14/2011

Paid Amount

\$55.67

EOB Information

Detail Number	Code	Description
0	9817	Billing provider number was used to adjudicate the service(s)
1	9817	Billing provider number was used to adjudicate the service(s)
1	9918	Pricing Adjustment - Maximum allowable fee pricing applied.
2	9817	Billing provider number was used to adjudicate the service(s)
2	9918	Pricing Adjustment - Maximum allowable fee pricing applied.

Cancel

Adjust

Void

Copy claim

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Rate Structure

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Reimbursement

Current CLTS Waiver Reimbursement:

- Single procedure code
- Statewide flat fee of 5.63
- Providers bill for units of time spent conducting delivering direct treatment, supervision, traveling, conducting family meetings, etc...
- Statewide rate set the same for SPC 512 (similar to proposed comprehensive) and SPC 512.10 (similar to proposed focused)



Reimbursement

Proposed Benefit Rate Structure:

- Utilize the full series of available procedure codes to differentiate between assessments, direct treatment, protocol modification (supervision), and family meetings
- Assign reimbursement rate for each procedure code that reflects the service being delivered and the provider level expected to deliver the service
- Incorporate travel costs into the service delivery rate
- Account for differences in delivery models between comprehensive and focused treatment



Reimbursement

Sources of Information:

- CLTS Waiver program reimbursement rate and claims history for behavioral treatment
- Other state MA reimbursement methodology and rates for behavioral treatment
- Wisconsin MA reimbursement and claims history for similar services (e.g. mental health treatment, psychosocial rehabilitation, and therapy)
- Cost analysis provided by Wisconsin behavioral treatment providers



Transition Plan for Current Waiver Participants

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Transition Plan Overview

- Children enrolled with CLTS Waiver Program currently receiving autism treatment services that must transition to ForwardHealth.
- Waiver agencies are working with the Department to implement the transition plan.
- In November, 2015, CLTS Waiver Program providers of ABA and ESDM autism treatment services will receive a transition schedule from the Waiver agency.
 - The schedule relates to when the Department requests providers to submit a PA request to ForwardHealth for the child.

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Transition Plan Overview (cont.)

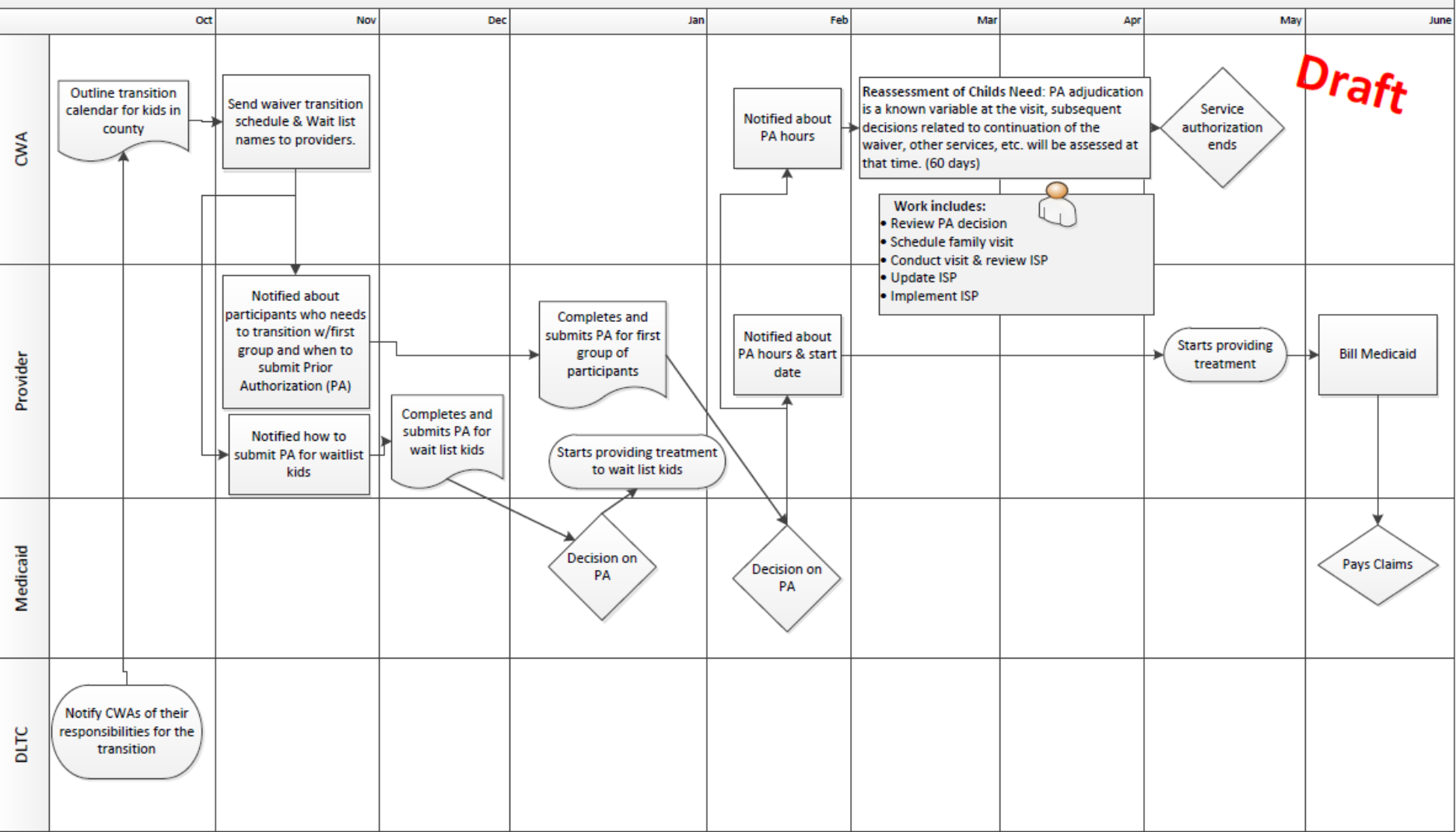
Each child is assigned a transition month between May and October 2016 by the Department.

Behavioral treatment providers should submit PA requests to ForwardHealth between January and June 2016 for services to begin in May to October 2016

- Services will not be authorized in advance of the child's scheduled transition date.

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Process flow for 1st group of CLTS Waiver Participants and Wait list kids



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Provider's Role in the Transition

- Adhere to Prior Authorization (PA) request timelines.
 - Notify waiver agency of concerns regarding the timeline for a particular child.
- Keep in contact with waiver agency and families regarding PA status.
- Providers who choose not to participate in the ForwardHealth behavioral treatment benefit should notify the waiver agency and refer the child to another behavioral treatment provider.

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CLTS Waiver Program 2016

CLTS Waivers will continue to provide an array of supports and services to meet children's assessed needs.

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Questions?

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