ForwardHealth
Wisconsin serving you

Update
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Affected Programs: BadgerCare Plus, Wisconsin Medicaid
To: Community Recovery Services, HMOs and Other Managed Care Programs

Introducing the Community Recovery Services Benefit

This *ForwardHealth Update* introduces the Community Recovery Services 1915(i) Home and Community Based Services benefit.

Overview

In 2006, the federal Deficit Reduction Act added Section 1915(i) to the U.S. Social Security Act, allowing states, at their option, to provide Home and Community Based Services (HCBS) under their regular state Medicaid plans. In response, the state of Wisconsin submitted a Medicaid State Plan Amendment (SPA) in 2009 creating the Community Recovery Services (CRS) Medicaid benefit.

Like other HCBS, the goal of CRS is to enable people with mental illness to live with maximum independence within the community, while at the same time offering these members more control over designing the services they receive. The opportunity to live in the community allows members to lead more productive lives, as they pursue a self-directed path toward recovery.

Under the umbrella of psychosocial rehabilitation, the CRS benefit covers the following three categories of service:

- Community Living Supportive Services (CLSS).
- Peer supports.
- Supported employment.

CRS Provider Certification

County and Tribal Agencies

BadgerCare Plus and Wisconsin Medicaid require county or tribal agencies interested in providing CRS to have certification specific to CRS. Community Recovery Services may not be billed under other Medicaid certifications. County and tribal agencies wishing to become CRS providers are required to apply and be approved by the state Department of Mental Health and Substance Abuse Services (DMHSAS), and then certified by Wisconsin Medicaid. Interested agencies should complete the County/Tribal Agency Application form, F-00203 (08/10), and submit it to DMHSAS using the address provided on the form. County/Tribal Agency Applications must comply with the CRS Agency Certification Standards, and Policy and Procedure Requirements dated December 21, 2009, issued as Attachment 1 to DMHSAS Action Memo Series 2009-10, titled "Community Recovery Services Certification Process." The County/Tribal Agency Application for CRS may be found at *dhs.wisconsin.gov/MH_BCMH/crs/index.htm.* The certifying agency's effective date for DMHSAS approval shall be the date an approvable application is received by the DMHSAS or, if the application as first received cannot be approved, the date upon which the additional materials required to make the application approvable are received.

Following approval by DMHSAS, a Medicaid certification packet will be mailed to the county or tribal agency by state Medicaid. Agencies must submit their completed Medicaid certification application by mail. Agencies are required to be certified by Wisconsin Medicaid to be reimbursed for CRS.

After the completed application for Medicaid certification is received, Wisconsin Medicaid sends county or tribal agencies a notice of certification confirmation. Certification through the Medicaid program for CRS is retroactive to the effective date the agency received from the DMHSAS.

Community Recovery Services providers will not be reimbursed for services provided prior to the date of their Medicaid certification.

Contracting for Community Recovery Services

Medicaid-certified CRS county and tribal providers may contract with other providers to deliver any part of their CRS. However, the Medicaid-certified CRS county or tribal provider retains all legal and fiscal responsibility for the services provided by contractors. Contracted CRS providers do not need to be individually certified by Wisconsin Medicaid.

ForwardHealth notifies Medicaid-certified CRS county and tribal providers of policy and procedure changes. It is the Medicaid-certified county or tribal provider's responsibility to ensure that their contracted service providers provide services and maintain records in accordance with the Medicaid requirements for the provision of CRS.

The Medicaid-certified CRS county or tribal provider is responsible for ensuring that its contractors:

- Meet all provider qualifications as outlined in the SPA.
- Are notified of changes to policies and procedures.
- Have a current license, or certification, or meet any of the following requirements (if applicable):
  - ✓ Adult Family Homes (3-4 Beds) — Licensed under ch. 50, Wis. Stats., s. DHS 88, Wis. Admin. Code.
  - ✓ Community Based Residential Facilities (CBRFs) — Licensed under ch. 50, Wis. Stats., certified under DHS 83, Wis. Admin. Code.
  - ✓ Residential Care Apartment Complexes (RCACs) — Certified under Wisconsin Statute ch. 50, Wis. Stats., and DHS 89, Wis. Admin. Code.
  - ✓ Supportive Home Care Agency — Licensed under ch. 50, Wis. Stats., certified under s. DHS 105.17, Wis. Admin. Code.
  - ✓ Supported Employment Specialist — Currently there are no statutory licensure or certification requirements.
  - ✓ Peer Specialists — Currently there are no statutory licensure or certification requirements; however, the employing agency is responsible for verifying that the peer specialist has completed a state-approved training course and passed a competency-based exam.

Each contracted CRS provider (i.e., the service provider with whom the Medicaid-certified county or tribal provider contracts for the provision of CRS) is required to complete the CRS Benefit Provider Agreement and Acknowledgement of Terms of Participation form, F-00312 or F-00312A. The Medicaid-certified CRS county or tribal provider shall retain such forms and renew them periodically as required.

All Medicaid-certified CRS county and tribal providers and contracted providers are required to follow all policies and procedures in the Online Handbook.

Member Eligibility for Community Recovery Services

Members

The process for determining CRS eligibility, the assessment, service plan, and service delivery must conform to the DMHSAS's CRS certification standards and meet the requirements of the approved Centers for Medicare and Medicaid Services' (CMS) 1915(i) HCBS SPA.

To be eligible for CRS, members must:

- Be eligible and enrolled in Medicaid or the BadgerCare Plus Standard Plan.
- Have countable income at or below 150 percent of the Federal Poverty Level (FPL).
- Meet CRS functional eligibility criteria.
- Reside in the home or community.
- Have a state-approved Individual Service Plan (ISP).

Eligibility for Medicaid or the BadgerCare Plus Standard Plan

In order to be eligible for CRS, members must be eligible and enrolled in Medicaid or the Standard Plan.

Income Eligibility

In order to be eligible for CRS, members must be at or below 150 percent of the FPL, as verified through the state Client Assistance for Reemployment and Economic Support (CARES) system.

Functional Eligibility Criteria

Eligibility for the CRS benefit must be determined through an independent evaluation of each individual according to the requirements of the federally approved 1915(i) HCBS SPA, and the proposed 42 CFR s. 441.556(a)(1) through (5) dated April 4, 2008. The CRS benefit will use Wisconsin's Functional Eligibility Screen for Adult Mental Health & Alcohol and Other Drug Abuse (Co-occurring) services, or the Children's Functional Screen in performing the independent evaluation of needs-based criteria. The Functional Screen tool has been updated to include CRS, and will indicate CRS eligibility if the member's unique circumstances match the benefit's criteria. The functional screen must be performed by a trained, Department of Health Services (DHS)-certified screen administrator.

Residence in Home or Community

The CRS benefit will be furnished to members who reside in their home or in the community, not in an institution.

Living arrangements that qualify for the CRS benefit include:

- The member's own home or apartment.
- Adult Family Homes.
- Residential Care Apartment Complexes.
- Community Based Residential Facilities.

Refer to Attachment 5 of this *ForwardHealth Update* for a complete list of allowable place of service (POS) codes for CRS.

Individual Service Plan Identifying a Need for at Least One Community Recovery Service

An ISP must be developed based on an objective face-to-face assessment using a person-centered process in consultation with the member, and others (at the option of the member). "Others" could include such people as the member's spouse, family, or legal representative. The person-centered planning process must identify the member's physical and mental health support needs, strengths, preferences, and desired outcomes, and must identify which CRS-specific services the member needs. It must take into account the extent of, and the need for, any family or other supports for the individual, and neither duplicate nor compel natural supports. It must also prevent the provision of unnecessary or inappropriate care and supports. This process is completed by a county or tribal case manager who meets the DHS/DMHSAS requirements as identified in the CMS-approved SPA. The ISP must be signed and dated by the member, and then approved by the state. The

certifying agency must use the Individual Service Plan — Community Recovery Services form, F-00202, for this purpose or a locally developed form that has been approved in advance by DHS/DMHSAS.

The ISP must be reviewed, revised, and signed by the member at least every 12 months and as needed when there is significant change in the member's circumstances.

A CRS provider cannot be reimbursed for services provided prior to the effective date of the member's ISP.

Members Enrolled in Managed Care

Wisconsin Medicaid and BadgerCare Plus members enrolled in state-contracted HMOs may qualify to receive CRS. These services are not part of the HMO's capitation rate. If a member is in need of CRS, they should be referred to their Medicaid-certified county or tribal provider. Members do not need an HMO enrollment exemption.

Initial Enrollment Verification for Community Recovery Services

After an individual has been identified as being potentially eligible for the CRS benefit based upon their functional and financial assessment, their county case manager will access the Program Participation System (PPS) to check the current status of their Medicaid or Standard Plan enrollment. To do so, the county case manager will use the PPS Search Page to find the member and access his or her Individual Summary page. Once the member record is located, the county case manager will enter CRS enrollment information for the member. The PPS checks the ForwardHealth interChange system to verify that the member is enrolled in Medicaid or the Standard Plan. If the member is enrolled but requires income or living arrangement verification, the county case manager must verify the information and indicate it in PPS when PPS prompts for it. Once CRS eligibility is entered and verified, the member's ISP packet for CRS is mailed to the state DMHSAS for consideration.

State DMHSAS staff will then access the Individual Summary page within PPS and review the CRS enrollment information. The state DMHSAS staff will either approve the ISP and enter the CRS enrollment begin date, or if the ISP is not approvable, will deny the application and provide a denial reason.

CRS enrollment data will be transmitted nightly from PPS to ForwardHealth interChange, and the member's interChange record will be updated to reflect enrollment in the CRS benefit plan. Monthly, PPS will automatically revalidate CRS eligibility and disenroll members from CRS who become ineligible.

If a member loses Medicaid or Standard Plan enrollment and regains Medicaid or Standard Plan enrollment at a later date, they may continue enrollment in CRS throughout, but services provided during the gap in coverage are not reimbursable. County case managers are responsible for re-enrolling participants in CRS when the need arises.

Note: Providers are required to verify enrollment in Medicaid or the Standard Plan before each service is provided to ensure that the member continues to be enrolled.

Covered Services

The CRS benefit makes psychosocial rehabilitative care available to enable a member to better manage the symptoms of his or her illness, to increase the likelihood of the member's independent, effective functioning in the community, and to reduce the incidence and duration of institutional treatment for mental illness.

The following are covered psychosocial rehabilitation services under the CRS benefit:

- Community Living Supportive Services.
- Peer Supports.
- Supported Employment.

Refer to Attachment 1 for a complete description of these services.

Service Limits

Daily and monthly service limits for the CRS are as follows:

- Community Living Supportive Services (per diem) — A daily limit of one per day, and a monthly limit of 28-31 days.
- Community Living Supportive Services (periodic) — Up to six hours (24 units) are allowed per day and a monthly limit of 180 hours (720 units).
- Supported Employment — Up to eight hours (32 units) per day and a monthly limit of 80 hours (320 units).
- Peer Supports — Up to eight hours (32 units) per day and 40 hours (160 units).

A unit is equal to 15 minutes. Service limits are for delivery time only and do not include travel time.

Supported Employment is covered for members age 14 and older.

Travel Time

A CRS worker's travel time of up to one hour (four units) to an allowed POS prior to the provision of service may be billed. A CRS worker's travel time of up to one hour (four units) subsequent to the provision of the service is also allowable. Reimbursement for travel time is limited to two hours (eight units) per unique service episode for each date of service (DOS), or per member for each DOS. Travel must be billed on the same claim form as the related service.

To bill for travel time, on a separate detail line enter the procedure code of the service rendered (e.g., H2023 [Supported employment, per 15 minutes]), add modifier "TU" to denote that this is a claim for travel, then enter the units.

Travel reimbursement is not allowable for per diem basis CLSS.

Where travel time is incurred to an allowable POS at which two or more CRS services are to be provided to the same member, for billing purposes it must be split between the services performed on a prorata basis. Each unique travel event may only be billed once, whether it be assigned to a single Healthcare Common Procedure Coding System (HCPCS) code, or prorated among multiple HCPCS codes.

Note: Travel time is separately reimbursable. Travel time should consist of the time to travel from the provider's office to the member's home or agreed upon location or from the previous appointment to the member's home or agreed upon location. Travel time is not allowable if the member is not home or at the agreed upon location, since there is no face-to-face contact. Travel time exceeding one hour each way is not reimbursable.

Refer to Attachment 6 for a complete list of billing limits for CRS.

Noncovered Services

The following services are not covered by BadgerCare Plus and Wisconsin Medicaid as CRS:

- Services provided to a resident of an intermediate care facility, skilled nursing facility, or Institute for Mental Disease or to patient of a hospital.
- Services performed by volunteers.
- Services that are primarily recreation oriented.
- Room and board costs.
- Vocational rehabilitation services.
- Case management.

- Services that do not meet DMHSAS certification standards.
- Services that duplicate other State Plan services (e.g. community support program, comprehensive community services, etc.) provided to the individual CRS participant.

Documentation Requirements

Refer to Attachment 2 for documentation requirements for CRS. For additional information regarding documentation requirements, refer to the Certification and Ongoing Responsibilities section of the Online Handbook.

Prior Authorization

Prior authorization is not required for CRS. However, the DMHSAS must approve the initial ISP prior to BadgerCare Plus or Medicaid reimbursement of services. Refer to the Initial Enrollment Verification for Community Recovery Services section of this *Update*.

Copayment

Providers are prohibited from collecting copayments from members for CRS.

Claims Submission

The reimbursement start date for eligible members shall be whichever occurs later: the Medicaid-certified county or tribal provider's CRS effective date, or the effective date of the member's state-approved ISP.

To receive reimbursement, claims and adjustment requests must be received within 365 days of the DOS. This deadline applies to claims, corrected claims, and adjustments to claims.

Coordination of Benefits

Generally, CRS benefits are not covered by commercial health insurance; therefore, providers do not need to bill commercial insurance or Medicare before submitting claims to ForwardHealth at this time.

Diagnosis Codes

All claims for reimbursement for CRS must contain a valid diagnosis code. Diagnoses must be from the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) coding structure. The required use of valid diagnosis codes includes the use of the most specific diagnosis codes. Valid, most specific diagnosis codes may have up to five digits. Claims submitted with three- or four-digit codes where four- and five-digit codes are available will be denied.

Procedure Codes and Modifiers

A HCPCS code is required on all CRS claims. Claims or adjustments received without a HCPCS code and corresponding modifier, if applicable, will be denied.

Refer to Attachment 3 for the allowable procedure codes and modifiers. These procedure codes represent 15 minutes of service, unless designated as per diem, in which case they represent a daily rate. Attachment 4 lists periodic unit guidelines.

Place of Service Codes

Allowable POS codes for CRS are enumerated in Attachment 5.

Electronic Claims Submission

Medicaid-certified county and tribal providers are encouraged to submit claims electronically, since electronic claims submission usually reduces claim errors and expedites reimbursement. Claims for CRS must be submitted on a professional claim using one of the following methods:

- 837 Health Care Claim: Professional transaction.
- Direct Data Entry on the ForwardHealth Portal.
- Provider Electronic Solutions (PES) software, which may be downloaded from the Portal. Providers may call the Electronic Data Interchange Helpdesk at (866) 416-4979 for assistance with downloading the PES software.

Paper Claims Submission

Paper claims for CRS must be submitted using the 1500 Health Insurance Claim Form. Claims for CRS submitted on any other claim form will be denied.

ForwardHealth does not provide the 1500 Health Insurance Claim Form. The form may be obtained from any federal forms supplier.

Refer to Attachment 7 for claim form instructions for CRS and Attachment 8 for a sample claim form.

Refer to the Claims section of the Online Handbook for more information about electronic and paper claims submission.

Reimbursement

On an interim basis, Wisconsin Medicaid pays a portion of the federal Medicaid share (federal financial participation [FFP]) of the maximum allowable fee for all covered CRS provided by Medicaid-certified county or tribal providers to members eligible on the DOS. Wisconsin Medicaid will only reimburse CRS provided on and after the effective date of the Medicaid-certified county or tribal provider's CRS application, and for Medicaid-eligible members on and after the effective date of the member's ISP. The federal share may change in October of each year, with some exceptions. Providers will be notified of changes in the FFP rate in future *Updates*.

Cost Settlement

Wisconsin Medicaid pays a percentage of the FFP of allowable service costs the county or tribal provider incurs in providing CRS. Each CRS-certified county or tribe is required to document the total allowable cost it has incurred for all CRS using a cost report form developed by DMHSAS. As required by the federal CMS, CRS county or tribal providers must certify these documented CRS costs by submitting an annual cost report. Cost reporting is necessary for the CRS-certified county or tribal provider to qualify for a percentage of the FFP provided by the state.

To be eligible for FFP, the non-federal share of the total allowable cost must be non-federally funded by state aid and local taxes. After the CRS-certified county or tribal provider submits the CRS cost report form, Wisconsin Medicaid reconciles interim payment to cost by recovering overpayments or making additional payments. Some CRS-certified county or tribal providers may receive an increase in reconciliation funding and others may see a decrease.

Total Medicaid reimbursement cannot exceed a percentage of FFP for the total allowable cost for an individual CRS-certified county or tribe.

Certification of Expenditures

To qualify for the full amount of federal Medicaid-matching funds provided by the state, CRS providers are required to certify sufficient expenditures. This demonstrates that a county or tribe's expenditures are at least equal to the full Medicaid reimbursement included in federal and non-federal funds. All CRS expenditures must be identified on the CRS cost report. This form will be provided to CRS-certified county or tribal providers by the DMHSAS. The DMHSAS will also provide detailed instructions to CRS-certified county or tribal providers regarding the cost report and certification of expenditures.

Under federal requirements, provider documentation verifying the amount of certified expenditures must be maintained by the CRS-certified county or tribal provider for at least five years.

Once the forms are ready, CRS-certified county or tribal providers will be able to access cost report forms, instructions, and deadlines via the Community Recovery Services Web site at *dhs.wisconsin.gov/MH_BCMH/crs/index.htm.*

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

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

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ATTACHMENT 1
Covered Community Recovery Services

This attachment details the specific services covered under the Community Recovery Services 1915(i) state plan benefit.

Psychosocial Rehabilitation Services

Community Living Supportive Services

This service covers activities necessary to allow individuals to live with maximum independence in community integrated housing. Activities are intended to assure successful community living through utilization of skills training, cueing and/or supervision as identified by the person-centered assessment. Community living supportive services consist of meal planning/preparation, household cleaning, personal hygiene, reminders for medications and monitoring symptoms and side effects, teaching parenting skills, community resource access and utilization, emotional regulation skills, crisis coping skills, shopping, transportation, recovery management skills and education, financial management, social and recreational activities, and developing and enhancing interpersonal skills. Community living supportive services tasks, such as meal planning, cleaning, etc., are not done for the individual, but rather they are delivered through training, cueing, and supervision to help the member become more independent in doing these tasks.

Wisconsin would make these services available in a variety of community locations that encompass residential, business, social, and recreational settings. Residential settings are limited to an individual's own apartment or house, supported apartment programs, adult family homes (AFH), residential care apartment complexes (RCAC), and community-based residential facilities (CBRFs) of from 5 to 16 beds (inclusive). The type of residential setting needed would be as agreed upon in the person-centered assessment. Individuals needing services in a CBRF setting would be those whose health and safety are at risk without 24-hour supervision. Payment is not made for room and board including the cost of building maintenance.

The services provided under 1915(i) will not be duplicative of other state plan services, including but not limited to personal care and transportation.

Peer Support

Individuals trained and certified as peer specialists serve as advocates and provide information and peer support for members in outpatient and other community settings. All members receiving 1915(i) peer-support services will reside in home and community settings. Certified peer specialists perform a wide range of tasks to assist members in regaining control over their own lives and over their own recovery process. Peer specialists function as role models demonstrating techniques in recovery and in ongoing coping skills through:

(a) Offering effective recovery-based services;
(b) Assisting members in finding self-help groups;
(c) Assisting members in obtaining services that suit that individual's recovery needs;
(d) Teaching problem solving techniques;
(e) Teaching members how to identify and combat negative self-talk and how to identify and overcome fears;
(f) Assisting members in building social skills in the community that will enhance integration opportunities;
(g) Lending their unique insight into mental illness and what makes recovery possible;

(h) Attending treatment team and crisis plan development meetings to promote member's use of self-directed recovery tools;
(i) Informing members about community and natural supports and how to utilize these in the recovery process; and
(j) Assisting members in developing empowerment skills through self-advocacy and stigma-busting activities.

Wisconsin 1915(i) Home and Community Based Services will not duplicate other state plan services.

Supported Employment

This service covers activities necessary to assist individuals to obtain and maintain competitive employment. This service may be provided by a supported employment program agency or individual employment specialist. The service will follow the Individual Placement and Support (IPS) model recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) to be an evidence-based practice. This model has been shown to be effective in helping individuals obtain and maintain competitive employment. This promotes recovery through a community integrated, socially valued role and increased financial independence. The core principles of this supported employment approach are as follows:

- Participation is based on member choice. No one is excluded because of prior work history, hospitalization history, substance use, symptoms, or other characteristics. No one is excluded who wants to participate.
- Supported employment is closely integrated with mental health treatment. Employment specialists meet frequently with the mental health treatment team to coordinate plans.
- Competitive employment is the goal. The focus is community jobs anyone can apply for that pay at least minimum wage, including part-time and full-time jobs.
- Job search starts soon after a member expresses an interest in working. There are no requirements for completing extensive pre-employment assessment and training, or intermediate work experiences (like pre-vocational work units, transitional employment, or sheltered workshops).
- Follow-along supports are continuous. Individualized supports to maintain employment continue as long as the member wants assistance.
- Consumer preferences are important. Choices and decisions about work and support are individualized based on the person's preferences, strengths, and experiences.

The service covers supported employment intake, assessment (not general 1915[i] intake and assessment), job development, job placement, work-related symptom management, employment crisis support, and follow-along supports by an employment specialist. It also covers employment specialist time spent with the individual's mental health treatment team and Vocational Rehabilitation (VR) counselor. The Wisconsin 1915(i) HCB services will not duplicate other State Plan services. The supported employment service does not include services available as defined in S4(a)(4) of the 1975 Amendments to the Education of the Handicapped Act (20 U.S.C. 1401[16], [17]), which otherwise are available to the individual through a state or local educational agency and vocational rehabilitation services, which are otherwise available to the individual through a program funded under S110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

ATTACHMENT 2
Community Recovery Services Documentation Requirements

Providers are responsible for meeting Medicaid's medical and financial documentation requirements. Refer to DHS 106.02(9)(a), Wis. Admin. Code, for preparation and maintenance documentation requirements and DHS 106.02(9)(c), Wis. Admin. Code, for financial record documentation requirements. Lack of such documentation will be considered grounds for denial of claims and may result in recoupment of payments previously made.

This attachment provides additional, Community Recovery Services (CRS)-specific guidelines related to the critical topic of documentation sufficiency. The statutes cited above outline the documentation requirements that form the underpinning of each and every claim for Medicaid reimbursement, regardless of benefit type. A potentially unique characteristic of the CRS benefit is that the majority of the services provided to members may be provided by contracted providers. It is incumbent upon the Medicaid-certified county or tribal provider to ensure that these contracted providers are faithfully creating and maintaining documentation of sufficient quality and quantity to substantiate claims for Medicaid reimbursement. In addition to CRS-specific forms, supporting documents, approval/denial letters, correspondence, and other documents specified in the State Plan Amendment (SPA) (including the Quality Improvement Strategy) and Department of Health Services/Division of Mental Health and Substance Abuse Services policy, the certified Medicaid agency (county or tribe) must maintain current evidence of the contracted entity's provider qualification standards including licensure or certification (if applicable), and the completed CRS Benefit Provider Agreement and Acknowledgement of Terms of Participation form, F-00312 or F-00312A.

Community Living Supportive Services — Per Diem and Periodic Basis

Broadly, the goal of Community Living Supportive Services (CLSS) is to enable eligible members to live with maximum independence in community integrated settings.

The expectation is that a written progress record, signed and dated by the rendering provider and clearly identifiable as relating to the individual member, will be created. For each date of service (DOS) for which a Medicaid claim is submitted, this record shall reflect which CLSS, as enumerated in the member's Individual Service Plan (ISP), were provided to the member. The record shall also provide a clear indication that such services were rendered with a sufficiency of time as to substantiate the reimbursement requested. The record must reflect the outcome of the service rendered (i.e., it must be clear from the documentation that services are provided with ISP outcomes in mind, including status and process). Documentation must support how the provider addressed any health and safety needs of the individual, including completing incident reports and outcomes. Documentation must also reflect the provision of medication reminders to the individual and the monitoring of signs and symptoms and side-effects. Incident reports are to be submitted to the county/tribal case manager for review and action as described in the SPA Quality Improvement Strategy. Finally, if travel is to be claimed, the expectation is that providers will keep detailed travel records in a contemporaneous manner to support the time claimed.

Supported Employment and Peer Support Services

The expectation is that a written progress record, signed and dated by the rendering provider and clearly identifiable as relating to the individual member, will be created. For each DOS for which a Medicaid claim is submitted, this record shall reflect which services, as enumerated in the member's ISP, were provided to the member. The record shall also provide a clear indication that such services were rendered with a sufficiency of time as to substantiate the reimbursement requested. The record must reflect the outcome of the service rendered (i.e., it must be clear from the documentation that services are provided with ISP outcomes in mind, including status and process). Documentation must support how the provider addressed any health and safety needs of the individual, including completing incident reports and outcomes. Incident reports are to be submitted to the county/tribe case manager for review and action as described in the SPA Quality Improvement Strategy. Finally, if travel is to be claimed, the expectation is that providers will keep detailed travel records in a contemporaneous manner to support the time claimed.

ATTACHMENT 3
Procedure Code Information for Community Recovery Services

The following table lists allowable Healthcare Common Procedure Coding System (HCPCS) codes and modifiers that Medicaid-certified county and tribal providers are required to use when submitting claims for Community Recovery Services.

Community Recovery Services Procedure Code Information			
HCPCS Code	**Description**	**Available Modifiers**	**Rate***
H0038	Peer services, per 15 minutes	TU (Travel Time)***	$9.78
H0043	Community Living Supportive Services	U9 (Per Diem)** U8 (Periodic)** TU (Travel Time)***	$125.00 per diem $5.00 periodic (15-minute increments)
H2023	Supported employment, per 15 minutes	TU (Travel Time)***	$11.51

* Actual reimbursement will vary based upon periodic changes in the following:

- The Federal Medical Assistance Percentage (FMAP).
- Federal or state fiscal programs that may impact the FMAP (such as the American Recovery and Reinvestment Act).
- (For State Fiscal Years 2010 and 2011) the percentage withheld from each claim payment to offset statutorily allowed state administrative costs.

** When submitting claims with procedure code H0043, providers are required to differentiate between per diem and periodic using modifiers "U9" and "U8," respectively. Claims submitted using procedure code H0043 must contain one or the other of these modifiers.

*** Travel time must be billed on the same claim form on which the underlying service is billed. To bill for travel time, on a separate detail line, enter the procedure code of the underlying service (e.g., H2023), and add modifier "TU" to denote that this is a claim for travel, then enter the units.

When billing for Community Living Supportive Services, providers may only bill travel time if they are providing the "Periodic" variation of this service. On a separate detail line of the claim form upon which the underlying service is billed, enter procedure code H0043, enter modifier "U8," enter modifier "TU," and then enter the units.

ATTACHMENT 4
Periodic Unit Guidelines for Community Recovery Services

Time units are calculated based on minutes of service. The following chart gives the appropriate billing unit for minutes of service.

Use the following guidelines for procedure codes H0038, H0043 (periodic modifier only), H2023, and travel (modifier "TU").

Time (Minutes)	Unit(s) Billed
1-15	1.0
16-30	2.0
31-45	3.0
46-60	4.0
61-75	5.0
76-90	6.0

ATTACHMENT 5
Allowable Place of Service Codes for Community Recovery Services

These tables list the allowable place of service (POS) codes that providers are required to use when submitting claims for Community Recovery Services (CRS).

The following table lists the allowable POS codes for Community Living Supportive Services (H0043-U9) — per diem basis.

Place of Service	
13	Assisted Living Facility
14	Group Home

The following table lists the allowable POS codes for Community Living Supportive Services (H0043-U8) — periodic basis.

Place of Service	
12	Home
13	Assisted Living Facility

The following table provides a crosswalk between the POS typically utilized by counties and tribes and what these facilities are considered for Medicaid billing purposes.

Common Name	Considered As	Place of Service Code
Community Based Residential Facility (CBRF)	Group Home	14
Adult Family Home (AFH)	Group Home	14
Residential Care Apartment Complex (RCAC)	Assisted Living Facility	13
Supported Apartment	Home	12

The following table lists the allowable POS codes for supported employment (H2023) and peer supports (H0038).

Place of Service	
03	School*
04	Homeless Shelter*
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*
11	Office*
12	Home
13	Assisted Living Facility
14	Group Home
16	Temporary Lodging
33	Custodial Care Facility*
50	Federally Qualified Health Center*
53	Community Mental Health Center*
55	Residential Substance Abuse Treatment Facility*
57	Non-residential Substance Abuse Treatment Facility*
71	Public Health Clinic*
72	Rural Health Clinic*
99	Other Place of Service**

* Travel reimbursement is not available for these POS codes.

** Community Recovery Services are reimbursed only when provided in a community setting. Services provided in an institution, such as a hospital, Institute for Mental Disease, or state institutes are not reimbursable.

ATTACHMENT 6
Billing Limits for Community Recovery Services

These tables list the billing limits for Community Recovery Services (CRS).

The following table lists the daily and monthly limits for each of the CRS service types.

Service	Daily Limit*	Monthly Limit*
Community Living Supportive Services (CLSS) – Per Diem	1	28-31
CLSS – Periodic	24	720
Supported Employment	32	320
Peer Supports	32	160

*Exclusive of travel. Stated in units of 15-minute increments except for CLSS — Per Diem, which is stated in days.

The following table lists the upper and lower age limits for CRS supported employment members.

Supported Employment Services	
14 Years of Age	Lower Limit
None	Upper Limit

The following table lists the upper and lower age limits for CRS peer supports members.

Peer Supports Services	
None	Lower Limit
None	Upper Limit

The following table lists the CRS which allow reimbursement for provider travel time*.

Service	Allow Travel Time?	Prior	Subsequent
CLSS — Per Diem	No		
CLSS — Periodic	Yes	X	X
Supported Employment	Yes	X	X
Peer Supports	Yes	X	X

* Travel time of up to one hour to an approved place of service prior to the provision of service may be billed using the CLSS periodic Healthcare Common Procedure Coding System code plus the "Travel" modifier. Travel time of up to one hour subsequent to the provision of the service is also allowable, and should be billed in a similar manner. Travel must be billed on the same claim form as the related service.

The following table provides guidance about which CRS may be billed on the same date of service to the same member.

Community Support Programs, Crisis Intervention, Comprehensive Community Services, and Community Recovery Services with same Date of Service	**Community Living Supportive Services Per Diem**	OR	**Community Living Supportive Services Periodic**	**Supported Employment**	**Peer Supports**
Crisis Intervention	Yes		Yes	Yes	Yes
CSP	Yes		Yes	Yes	Yes
CCS	Yes		Yes	Yes	Yes
CLSS Per Diem	N/A		No	Yes	Yes
CLSS Periodic	No		N/A	Yes	Yes
Supported Employment	Yes		Yes	N/A	Yes
Peer Supports	Yes		Yes	Yes	N/A

ATTACHMENT 7
1500 Health Insurance Claim Form Instructions for Community Recovery Services

Use the following claim form completion instructions, not the claim form's printed descriptions, to avoid denial or inaccurate claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so.

BadgerCare Plus members receive a ForwardHealth identification card when initially enrolled in BadgerCare Plus. Always verify a member's enrollment before providing nonemergency services to determine if there are any limitations on covered services and to obtain the correct spelling of the member's name. Refer to the Online Handbook in the Provider area of the ForwardHealth Portal at *www.forwardhealth.wi.gov/* for more information about verifying enrollment.

When submitting a claim with multiple pages, providers are required to indicate page numbers using the format "Page X of X" in the upper right corner of the claim form.

Submit completed paper claims to the following address:

ForwardHealth
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

Element 1 — Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Blk Lung, Other

Enter "X" in the Medicaid check box.

Element 1a — Insured's ID Number

Enter the member's identification number. Do not enter any other numbers or letters. Use the ForwardHealth card or Wisconsin's Enrollment Verification System (EVS) to obtain the correct member ID.

Element 2 — Patient's Name

Enter the member's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

Element 3 — Patient's Birth Date, Sex

Enter the member's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/CCYY format (e.g., February 3, 1955, would be 02/03/1955). Specify whether the member is male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name

Data is required in this element for Optical Character Recognition (OCR) processing. Any information populated by a provider's computer software is acceptable data for this element (e.g., "Same"). If computer software does not automatically complete this element, enter information such as the member's last name, first name, and middle initial.

Element 5 — Patient's Address

Enter the complete address of the member's place of residence, if known.

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name (not required)

Element 9a — Other Insured's Policy or Group Number (not required)

Element 9b — Other Insured's Date of Birth, Sex (not required)

Element 9c — Employer's Name or School Name (not required)

Element 9d — Insurance Plan Name or Program Name (not required)

Element 10a-10c — Is Patient's Condition Related to: (not required)

Element 10d — Reserved for Local Use (not required)

Element 11 — Insured's Policy Group or FECA Number (not required)

Element 11a — Insured's Date of Birth, Sex (not required)

Element 11b — Employer's Name or School Name (not required)

Element 11c — Insurance Plan Name or Program Name (not required)

Element 11d — Is there another Health Benefit Plan? (not required)

Element 12 — Patient's or Authorized Person's Signature (not required)

Element 13 — Insured's or Authorized Person's Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Element 17 — Name of Referring Provider or Other Source (not required)

Element 17a (not required)

Element 17b — NPI (not required)

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use (not required)

Element 20 — Outside Lab? $Charges (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

Enter a valid *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. The required use of valid diagnosis codes includes the use of the most specific diagnosis codes. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. The diagnosis description is not required.

ForwardHealth accepts up to eight diagnosis codes. To enter more than four diagnosis codes:

- Enter the fifth diagnosis code in the space *between* the first and third diagnosis codes.
- Enter the sixth diagnosis code in the space *between* the second and fourth diagnosis codes.
- Enter the seventh diagnosis code in the space to the right of the third diagnosis code.
- Enter the eighth diagnosis code in the space to the right of the fourth diagnosis code.

When entering fifth, sixth, seventh, and eighth diagnosis codes, do *not* number the diagnosis codes (e.g., do not include a "5." before the fifth diagnosis code).

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number (not required)

Element 24

The six service lines in Element 24 have been divided horizontally. Enter service information in the bottom, unshaded area of the six service lines. The horizontal division of each service line is not intended to allow the billing of 12 lines of service.

Element 24A — Date(s) of Service

Enter to and from dates of service (DOS) in MM/DD/YY or MM/DD/CCYY format. If the service was provided on only one DOS, enter the date under "From." Leave "To" blank or re-enter the "From" date.

If the service was provided on consecutive days, those dates may be indicated as a range of dates by entering the first date as the "From" DOS and the last date as the "To" DOS in MM/DD/YY or MM/DD/CCYY format. If multiple DOS are listed on a single detail line, then each DOS must contain the identical number of units of service. Billing on each claim must be limited to a single month.

A range of dates may be indicated only if the place of service (POS), the procedure code (and modifiers, if applicable), the charge, the units, and the rendering provider were identical for each DOS within the range. If either the number of units or POS varies, then report each service on a separate detail line.

Element 24B — Place of Service

Enter the appropriate two-digit POS code for each item used or service performed.

Element 24C — EMG (not required)

Enter a “Y” for each procedure performed as an emergency. If the procedure was not an emergency, leave this element blank.

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character procedure code. ForwardHealth denies claims received without an appropriate procedure code.

Modifiers

Enter the appropriate (up to four per procedure code) modifier(s) in the “Modifier” column of Element 24D.

Element 24E — Diagnosis Pointer

Enter the number(s) that corresponds to the appropriate ICD-9-CM diagnosis code(s) listed in Element 21. Up to four diagnosis pointers per detail may be indicated. Valid diagnosis pointers, digits 1 through 8, should *not* be separated by commas or spaces.

Element 24F — $ Charges

Enter the total charge for each line item.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter “00” in the cents area if the amount is a whole number.

Providers are to bill BadgerCare Plus their usual and customary charge. The usual and customary charge is the provider’s charge for providing the same service to persons not entitled to BadgerCare Plus benefits.

Element 24G — Days or Units

Enter the number of days or units.

Element 24H — EPSDT/Family Plan (not required)

Element 24I — ID Qual (not required)

Element 24J — Rendering Provider ID. # (not required)

Element 25 — Federal Tax ID Number (not required)

Element 26 — Patient's Account No. (not required)

Optional — Providers may enter up to 14 characters of the patient's internal office account number. This number will appear on the Remittance Advice and/or the 835 Health Care Claim Payment/Advice transaction.

Element 27 — Accept Assignment? (not required)

Element 28 — Total Charge

Enter the total charges for this claim. If submitting a multiple-page claim, enter the total charge for the claim (i.e., the sum of all details from all pages of the claim) *only on the last page of the claim*.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

Element 29 — Amount Paid (not required)

Element 30 — Balance Due

Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28. If submitting a multiple-page claim, enter the balance due for the claim (i.e., the sum of all details from all pages of the claim minus the amount paid by commercial insurance) *only on the last page of the claim*.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

Element 31 — Signature of Physician or Supplier, Including Degrees or Credentials

The provider or authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/CCYY format.

Note: The signature may be a computer-printed or typed name and date or a signature stamp with the date.

Element 32 — Service Facility Location Information (not required)

Element 32a — NPI (not required)

Element 32b (not required)

Element 33 — Billing Provider Info & Ph

Enter the name of the provider submitting the claim and the practice location address. The minimum requirement is the provider's name, street, city, state, and ZIP+4 code.

Element 33a — NPI

Enter the National Provider Identifier of the billing provider.

Element 33b

Enter qualifier “ZZ” followed by the 10-digit provider taxonomy code.

ATTACHMENT 8
Sample 1500 Health Insurance Claim Form for Community Recovery Services

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) **X** | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): **1234567890**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **Member, Im A.**

3. PATIENT'S BIRTH DATE MM DD YY: **MM DD YY** SEX M F **X**

4. INSURED'S NAME (Last Name, First Name, Middle Initial): **Member, Im A.**

5. PATIENT'S ADDRESS (No., Street): **609 Willow St**

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: **Anytown** STATE: **WI**

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: **55555** TELEPHONE (Include Area Code): **(XXX) XXX-XXXX**

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______ DATE ______

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. **296 90** 3. ______ 2. ______ 4. ______

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 05 10		12		H0043	U8	1	XXX XX	8		NPI	
2	10 05 10		12		H0043	U8 TU	1	XXX XX	4		NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: **1234JED**

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE: $ **XXX XX**

29. AMOUNT PAID: $ **XX XX**

30. BALANCE DUE: $ **XX XX**

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Provider **MM/DD/YY**

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

I.M. Provider
1 W Williams St
Anytown WI 55555-1234

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)