

Affected Programs: BadgerCare Plus, Medicaid

To: Advance Practice Nurse Prescribers with Psychiatric Specialty, Behavioral Treatment Providers, Case Management Providers, Intensive In-Home Mental Health and Substance Abuse Treatment Services for Children Providers, Master's Level Psychotherapists, Nurse Practitioners, Occupational Therapists, Outpatient Mental Health Clinics, Outpatient Substance Abuse Clinics, Physical Therapists, Physician Assistants, Physician Clinics, Physicians, Psychologists, Qualified Treatment Trainees, Speech-Language Pathologists, Substance Abuse Counselors, HMOs and Other Managed Care Programs

New and Clarified Policy for the Behavioral Treatment Benefit

This *ForwardHealth Update* clarifies behavioral treatment benefit policy previously published and provides new information related to the behavioral treatment benefit.

This *ForwardHealth Update* clarifies behavioral treatment benefit policy previously published in the December 2015 *Update* (2015-62), titled "New ForwardHealth Behavioral Treatment Benefit," and the October 2015 *Update* (2015-55), titled "Provider Enrollment for the New Behavioral Treatment Benefit." In addition, this *Update* provides new information related to the behavioral treatment benefit. The information in this *Update* will be published in the Behavioral Treatment Benefit service area of the Online Handbook on the ForwardHealth Portal at www.forwardhealth.wi.gov/. Providers are reminded that they are responsible for keeping current with ForwardHealth policy and billing information as indicated in the Online Handbook.

Provider Enrollment

To avoid confusion during the enrollment process and when submitting claims, behavioral treatment providers are encouraged to enroll in a single provider specialty when enrolling in Wisconsin Medicaid. For example, a provider who enrolls as a behavioral treatment licensed supervisor is not required to also enroll as a focused treatment licensed supervisor.

When selecting a provider specialty, providers should consider the enrollment criteria found on the Provider Enrollment Information page of the Portal, the allowable level(s) of service for the specialty, and the billing status of the specialty. The Provider Enrollment Information page can be accessed by clicking the Become a Provider link on the home page of the Portal.

Refer to Attachment 1 of this *Update* for information on the different behavioral treatment provider specialties.

Providers wishing to change specialties can refer to the ForwardHealth Portal Demographic Maintenance Tool User Guide, which is available via the Portal User Guides link on the Provider home page of the Portal. Providers may also contact the Portal Helpdesk at 866-908-1363 for assistance.

Changes to Provider Enrollment Criteria

ForwardHealth is implementing the following changes to the enrollment criteria for therapist level practitioners:

- Providers enrolling as behavioral treatment therapists or focused treatment therapists under the master's or bachelor's degree qualifications are no longer required to have completed their degree in certain fields of study.
- Providers enrolling as behavioral treatment therapists or focused treatment therapists under the Board Certified

Assistant Behavior Analyst (BCaBA) qualification are no longer required to separately demonstrate 400 hours of experience.

- Providers enrolling as focused treatment therapists under the Registered Behavior Technician (RBT) qualification are now required to have completed 2,000 hours of documented training and supervised experience delivering a Wisconsin-approved treatment model.

All other enrollment criteria for therapist level practitioners remain the same:

- **Behavioral Treatment Therapist** — A healthcare professional is required to meet one of the following criteria to enroll in Wisconsin Medicaid as a behavioral treatment therapist:
 - ✓ Be a BCaBA with certification from the Behavior Analyst Certification Board (BACB).
 - ✓ Hold a master's degree from an accredited university and have, and attest to, 400 hours of documented training and supervised experience delivering a Wisconsin-approved treatment model.
 - ✓ Hold a bachelor's degree from an accredited university and have, and attest to, 2,000 hours of documented training and supervised experience delivering a Wisconsin-approved treatment model.
- **Focused Treatment Therapist** — A healthcare professional is required to meet one of the following criteria to enroll in Wisconsin Medicaid as a focused treatment therapist:
 - ✓ Be a BCaBA with certification from the BACB.
 - ✓ Hold a master's degree from an accredited university and have, and attest to, 400 hours of documented training and supervised experience delivering a Wisconsin-approved treatment model.
 - ✓ Hold a bachelor's degree from an accredited university and have, and attest to, 2,000 hours of documented training and supervised experience delivering a Wisconsin-approved treatment model.
 - ✓ Be an RBT and have, and attest to, 2,000 hours of documented training and supervised experience delivering a Wisconsin-approved treatment model.

Changes to Documentation Requirements

ForwardHealth continues to require documentation of the qualifications and experience of providers who are applying for enrollment in Wisconsin Medicaid. Effective December 17, 2015, the following changes have been made to the format required for this documentation.

Licensed Supervisor and Therapist Experience

Providers are required to submit to ForwardHealth, via the Portal, a letter or document stating their total hours of experience. This letter or document must be signed by the provider, by a current or prior employer of the provider, or by the provider's supervisor. This required format applies to both documentation of experience delivering treatment and documentation of experience supervising treatment. Providers are no longer required to provide subtotals of experience by individual patient, dates of service (DOS), dates of employment, or other category.

Technician Education

Providers are no longer required to submit a copy of their high school diploma or the equivalent; however, providers are still required to attest to their completion of high school or the equivalent when completing the enrollment application. Providers are required to produce documentation upon request from the Department of Health Services or federal auditors.

Therapist Education

Behavioral treatment therapists or focused treatment therapists who are enrolling under the master's or bachelor's degree qualification are required to submit documentation of degree completion. Documentation can be either a degree or transcript.

Variance of Enrollment Criteria

Any provider who is interested in enrollment with ForwardHealth as a certain provider specialty but does not meet the published enrollment criteria for that provider specialty may request a variance. The provider is required to provide the following information to ForwardHealth:

- The requested provider specialty

- The specific enrollment requirement for which the variance is requested
- The alternative qualification that is proposed to replace the previous requirement
- Documentation of the training, education, experience, or credential that supports the proposed qualification
- The time period for which the waiver or variance is requested
- Reason(s) for the request
- Contact information

Providers should mail completed variance requests to the following address:

Division of Health Care Access and Accountability
 Bureau of Benefits Management
 PO Box 309
 Madison WI 53701-0309

ForwardHealth may require additional information prior to processing the request.

ForwardHealth will examine each request individually and issue a decision based on certain factors, including need, compliance history, and public safety. The fact that exceptions have been approved for other providers does not constitute evidence of need. When reviewing a variance request, ForwardHealth must determine the following in order to approve the request:

- The variance will not adversely affect the health, safety, or welfare of a member.
- Strict enforcement of the rule would result in unreasonable hardship on a member, **or** a proposed alternative to the rule is in the interest of better care or management.
- The variance will comply with all state and federal statutes or regulations, ForwardHealth requirements, and any other regulatory requirements for ForwardHealth coverage.

Enrollment Applications Require Supervisor's National Provider Identifier

Provider enrollment applications for therapists and technicians must include the National Provider Identifier (NPI) of the therapist's or technician's supervisor within the Declaration of Supervision area of the online form. Therapists or technicians who change agencies can update the NPI to that of a supervisor at the new agency by accessing the demographic maintenance tool available on the secure Provider area of the Portal. Refer to the ForwardHealth Portal Demographic Maintenance Tool User Guide available via the Portal User Guides link on the Provider home page of the Portal for additional information.

The supervisor is required to be Medicaid-enrolled as either a behavioral treatment licensed supervisor or focused treatment licensed supervisor before the therapist's or technician's application can be processed. Furthermore, the enrollment application must include the NPI of a behavioral treatment licensed supervisor, because focused treatment licensed supervisors may not supervise comprehensive treatment.

Establishing a Portal Account

To submit prior authorization (PA) requests and claims to ForwardHealth on the Portal, supervisors are required to have an administrative account under their behavioral treatment enrollment.

Adding Multiple Organizations or Enrollments

Providers are reminded that Portal users with an administrative account (e.g., billing providers such as behavioral treatment licensed supervisors) may add multiple organizations to an existing Portal account. This feature offers the convenience of managing multiple organizations — or multiple enrollments — within one Portal account as an alternative to creating separate Portal accounts for each organization or enrollment. This means behavioral treatment agencies with multiple billing providers can manage each enrollment through a single administrative account.

Refer to the ForwardHealth Provider Portal Account User Guide available via the Portal User Guides link on the Provider home page of the Portal for information on how to establish an account or how to add an organization (or another enrollment) to an existing Portal account. Providers may also contact the Portal Helpdesk at 866-908-1363 for assistance.

As a reminder, all billing and rendering providers indicated on PA requests or claims for behavioral treatment services are required to be enrolled as behavioral treatment providers. Any other ForwardHealth enrollment (e.g., outpatient mental health) is not an allowable biller or renderer for behavioral treatment services.

Covered Services

The primary goal of behavioral treatment is to prepare members and their families for successful long-term participation in normative settings and activities at home, in school, and in the community. Intensive, early intervention behavioral treatment is appropriate to “close the developmental gap” in young children. Providers developing plans of care (POCs) for early developmental delays should indicate specific, measurable goals that build toward this outcome.

ForwardHealth expects early, comprehensive behavioral treatment to result in meaningful progress for the member, such as:

- Substantial improvement on age-normed cognitive, communicative, and adaptive performance measures in comparison to same-age peers.
- Reduction in interfering behaviors that allows the member to commence or return to participation in normative activities.
- Increased independence as evidenced by decreased need for direct support and monitoring by parents, guardians, or paid staff.

As the member approaches more age-typical functioning, such as successful participation in group learning and social activities with minimal to no support, fewer hours of treatment are appropriate to allow the member more

opportunities for normative community participation. The POC should include treatment in settings and at a frequency that is likely to result in desired gains.

Behavioral treatment is also appropriate to address behaviors that prevent the member from living in the least restrictive, appropriate community setting. For members with ongoing, significant behavioral needs for whom early intervention is no longer appropriate, treatment should result in skill acquisition and behavioral improvement that allows the member to transition to a system of care without ongoing behavioral treatment (e.g., family, personal care, supported employment). Providers developing POCs for these members should prioritize the following:

- Addressing behavioral challenges that are preventing other professionals and caregivers from teaching new skills or supporting the member’s day-to-day functioning
- Enhancing the member’s safety
- Preparing the member for his or her next living or occupational environment

The plan must include an anticipated timeline with time or skill acquisition benchmarks that will result in a progressive transition to the member’s next system of care.

Comprehensive Behavioral Treatment

ForwardHealth reimburses comprehensive behavioral treatment services under federal Early Periodic Screening, Diagnosis, and Treatment (EPSDT) authority. Early Periodic Screening Diagnosis and Treatment authority limits services to ForwardHealth members under 21 years of age. Prior authorization requests and claim submissions for comprehensive behavioral treatment for members 21 years of age or older will not be accepted by ForwardHealth.

Services Covered as Family Adaptive Behavior Treatment Guidance

Both team meetings and family treatment guidance are covered under Family Adaptive Behavior Treatment Guidance. ForwardHealth covers both of these related, but distinct, services. In recognition of the different intents of each of these services, ForwardHealth is providing the

following clarifications regarding the appropriate goals and allowable providers for team meetings and family treatment guidance.

Team Meetings

ForwardHealth covers team meeting services in which licensed supervisors or treatment therapists meet with a member's parent(s) or caregiver(s) and the behavioral treatment team to discuss the member's progress and help the team and caregivers learn how to:

- Identify behavioral problems.
- Implement treatment strategies to minimize destructive behavior.
- Participate in the treatment of the member.

ForwardHealth covers team meeting services under *Current Procedural Terminology* (CPT) code 0370T (Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional [without the patient present]). Procedure code 0370T is used with modifier AM (Physician, team member service) in addition to modifier TG (Comprehensive level of service) or TF (Focused level of service), as appropriate. As indicated in the code description, the service is delivered without the member present. ForwardHealth defines "present" to mean actively participating in activities related to the service.

Refer to Attachment 2 for additional information related to submitting procedure code 0370T for team meeting services including required modifiers, renderers, coding guidelines, documentation requirements, and PA limits.

Although a specific time requirement is not part of the procedure code description, the service is valued at 60–75 minutes of provider and caregiver time discussing the member's progress and engaging in learning objectives. The team meeting is not intended to be a brief check-in with staff or caregivers; therefore, team meetings that are less than 45 minutes are not reimbursable by BadgerCare Plus and Medicaid.

In order for team meeting services to be reimbursable, providers are required to document all of the following:

- Goals resulting from the meeting
- Learning objectives that were targeted
- Length of the meeting
- Names of the parents, caregivers, and team members who were present:
 - ✓ Comprehensive — In addition to the parents or caregivers, a licensed supervisor or treatment therapist and other treatment team member(s) must be present in order for the meeting to qualify as a team meeting
 - ✓ Focused — In addition to the parents or caregivers, a licensed supervisor and other treatment team member(s) must be present in order for the meeting to qualify as a team meeting
- Outcome of the learning objectives
- Renderer's signature

Team meetings that occur no more frequently than once per week are reimbursed, as long as a PA request is received from ForwardHealth. Team meeting services must be requested as a separate line item on the PA request.

Regardless of the number of participants, the team meeting is reimbursed once per member per DOS. Either the licensed supervisor or treatment therapist — who must be documented as present and leading the meeting — is required to be indicated as the rendering provider on the claim. Team meeting services are not intended to satisfy the ForwardHealth direct patient observation requirements for licensed supervisors or to include activities directly involving the member, such as demonstration protocols or coaching family members in the implementation of a protocol, as these activities are consistent with other available services covered under the behavioral treatment benefit.

Family Treatment Guidance

ForwardHealth covers family treatment guidance when performed by a licensed supervisor and when the purpose of the therapy is teaching family members and caregivers about treatment protocols without the member present. This service must include specific measurable goals.

ForwardHealth covers family treatment guidance under CPT procedure code 0370T. Procedure code 0370T is used with

modifier TG or TF, as appropriate. As indicated in the code definition, the service is delivered without the member present. ForwardHealth defines “present” to mean actively participating in activities related to the service. Family treatment guidance is not intended to satisfy the ForwardHealth direct patient observation requirements for licensed supervisors or to include activities directly involving the member, such as demonstration protocols or coaching family members in the implementation of a protocol, as these activities are consistent with other available services covered under the behavioral treatment benefit.

Refer to Attachment 2 for additional information related to submitting procedure code 0370T for family treatment guidance including required modifiers, renderers, coding guidelines, documentation requirements, and PA limits.

Although a specific time requirement is not part of the procedure code definition, the service is valued at 60–75 minutes of provider and caregiver time with complexity of specific and measurable family goals to be addressed. Family treatment guidance is not intended to be a brief check-in with staff or caregivers; therefore, family treatment guidance that is less than 45 minutes is not reimbursable by ForwardHealth.

In order for family treatment guidance to be reimbursable, providers are required to document all of the following:

- Date of service
- Information collected from the family
- Information shared with the family
- Length of the meeting, including time in and out
- Measurable family goals addressed
- Names of the licensed supervisor and family members or caregivers who were present
- Update of family goals resulting from the family treatment guidance session
- Renderer’s signature

ForwardHealth requires PA for family treatment guidance. Providers are required to request family treatment guidance as a separate line item on the PA request. Regardless of the number of participants, family treatment guidance is

reimbursed once per member per DOS. The licensed supervisor is required to be indicated as the rendering provider on the claim.

Changes to Procedure Codes for Continuous Individualized One-on-One Treatment During a Group Session

Effective for DOS on and after September 1, 2016, providers should no longer use procedure codes 0366T (Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time) and 0367T (Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; each additional 30 minutes of technician time [List separately in addition to code for primary procedure]) on claims for behavioral treatment services; instead, providers should use procedure codes 0364T (Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; first 30 minutes of technician time), 0365T (Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; each additional 30 minutes of technician time [List separately in addition to code for primary procedure]), 0368T (Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional with one patient; first 30 minutes of patient face-to-face time), or 0369T (Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional with one patient; each additional 30 minutes of patient face-to-face time [List separately in addition to code for primary procedure]) in accordance with published policy, regardless of whether the member is alone or participating in a group. Claims for behavioral treatment submitted using procedure codes 0366T or 0367T will not be reimbursed.

This change in procedure codes to use for continuous individualized one-on-one treatment during a group session is due to inconsistency in the use of procedure codes 0366T and 0367T and does not indicate a change in coverage policy. ForwardHealth continues to cover individualized one-on-one treatment delivered by a single provider to a single

member during a group session. Group therapy that involves a single provider treating multiple members concurrently during a single session (one-to-many approach) is **not** a covered service under behavioral treatment.

Prior Authorization

Comprehensive behavioral treatment, focused behavioral treatment, behavioral treatment with protocol modification, family treatment guidance, and team meetings all require PA.

Completing the Behavioral Treatment Attachment Form

Prior authorization requests for behavioral treatment require completion of the Prior Authorization/Behavioral Treatment Attachment (PA/BTA), F-01629 (12/15), to document clinical information about the member and the proposed POC. Providers are required to ensure that the PA/BTA is correct and complete; providers may only indicate “See attached” when the form or instructions indicate that this is a valid entry. When noting “See attached,” the information requested on the PA/BTA must be easily located and adequately answered in the attached information. The PA request will be returned if the attached information is unclear, incomplete, or difficult for a PA reviewer to locate.

Prior Authorization Requirements

Only licensed supervisors may be listed as the billing or rendering provider on a PA request. The renderer listed on the Prior Authorization Request Form (PA/RF), F-11018 (05/13), must match the supervising professional in the POC.

Providers should submit a POC consistent with their clinical recommendations for the member. The treatment hours requested on the PA/RF should reflect the number of weekly treatment hours that will be provided, based on member and staff availability. ForwardHealth may approve the plan as requested or may approve a lesser level of service than requested based on the documentation submitted. ForwardHealth will deny PA requests that do not meet approval criteria or that do not establish medical necessity for the requested service.

Backdating of Prior Authorization Requests

Initial PA requests for behavioral treatment may be backdated to a date prior to ForwardHealth’s initial receipt of the request in limited circumstances. Generally, a request for backdating may be approved if **all** of the following conditions are met:

- The provider specifically requests backdating in writing on the PA request.
- The PA request includes clinical justification for beginning the service before the PA was granted.
- The PA request is received by ForwardHealth within 14 calendar days of the start of the provision of services.

Behavioral treatment providers may request PA back to the date of eligibility for members who receive retroactive enrollment in Wisconsin Medicaid or BadgerCare Plus; however, services will not be authorized for dates prior to the date the member’s medical provider prescribed or ordered the services. Providers are required to submit a PA request and receive approval from ForwardHealth before submitting a claim for behavioral treatment services.

When Prior Authorization Is Required for Assessment Services

Behavior identification assessment services generally do not require PA. One assessment is covered every six months per member for the provider submitting the behavioral treatment PA request. If more frequent assessments are needed, the provider is required to submit a PA amendment request. If the member changes providers, a different licensed supervisor may conduct his or her own assessment without submitting a PA request.

Follow-up assessments, which allow the licensed supervisor to finalize or fine-tune the baseline results or POC, may be conducted only when they occur within 60 days of the behavior identification assessment. A provider is required to submit a PA amendment request to conduct a follow-up assessment more than 60 days after a behavior identification assessment.

When submitting a PA amendment to request authorization of assessment services, providers are required to indicate **each** procedure code that will be used to submit claims for the service as a separate line item on the PA/RF.

Treatment Scope and Intensity

The scope of treatment goals and intensity of treatment hours should be consistent with the member's current needs. For members with prior behavior treatment, the scope and intensity of the proposed POC should be consistent with the member's demonstrated rate of skill acquisition, skill maintenance, and generalization of skills, and should be reasonably likely to result in desired gains.

Age-Normed Standardized Testing

Prior authorization requests for comprehensive behavioral treatment must include standardized age-normed testing results in the areas of cognition, communication, and life skills to establish the member's baseline developmental level prior to the provision of treatment. ForwardHealth requires age-normed tests to meet the following standards:

- The member's age is within the test's published age range.
- The test is administered by a qualified professional, following standard administration procedures.
- The test is published and has been subject to rigorous psychometric evaluation and age-norming procedures.
- The test measures one or more specific areas of individual performance (e.g., cognition, communication, adaptive behavior).
- Scores (composite or subscales) are reported as standard scores, percentiles, or age scores.

ForwardHealth does not routinely require annual re-testing on age-normed measures but may require periodic re-assessments when needed to establish the medical necessity of a requested service.

Treatment for School-Age Members

If the member is intellectually and behaviorally capable of learning and/or socializing with same-age peers, the POC must allow regular and appropriate participation in school or other settings that support interaction with typically

developing same-age peers, consistent with the member's abilities.

If the member is temporarily participating in behavioral treatment in lieu of regular school attendance, the POC must include a plan for returning to full-time attendance. The plan must include an anticipated timeline with time or skill acquisition benchmarks that will trigger each step-down in treatment hours.

Because professional educators and homeschooling parents are responsible for teaching academic content to children 6 years of age and older, ForwardHealth will not authorize POC or reimburse behavioral treatment providers for providing educational instruction to these members.

If disruptive behaviors or deficits in prerequisite skills are impeding the member's successful participation in school, ForwardHealth may authorize and reimburse treatment that addresses these behaviors and skills. If treatment goals appear to be academic in nature but address prerequisite skills that support the member's general functioning, the goals may be evaluated for medical necessity based on the member's unique needs and the rationale given by the provider. The fact that a goal appears on a teaching curriculum and is within scope for a behavioral treatment therapist to teach does not make the goal medically necessary.

Plans of care for members under 6 years of age may include goals that support the development of foundation learning skills and general knowledge, such as skills that appear on school readiness checklists, provided the goals are appropriate for the member's age and assessed needs.

Including Documentation of Disruptive Behaviors, When Applicable

When disruptive behaviors are identified through the clinical assessment or record review for either comprehensive or focused treatment, these behaviors must be documented in the POC that is submitted as part of the PA request. As part of the behavioral assessment, the provider is required to include the following:

- A clear definition of the concerning behavior
- The baseline level (frequency, rate, duration, latency, and/or interresponse times) of the behavior and rationale for treating it immediately
- The causes or functions of the behavior (for new members, this may indicate the hypothesized function)

Behavior reduction goals must be included in the POC, and the POC must identify skill acquisition goals that are expected to address skill deficits underlying the behavior. Mastery criteria for behavior goals should reflect behavior that is, at most, age-typical or, at least, manageable for caregivers.

When the member's disruptive behavior may be related to a co-morbid medical or mental health condition, the provider's assessment and POC must explain how the condition will be treated or otherwise addressed alongside the proposed behavioral treatment. A recent consultation to evaluate the member's medication needs may be requested.

If the problem behavior persists despite treatment, a thorough functional analysis of the problem behavior may be required for subsequent PA requests.

Meeting Supervision Requirements

Consistent with Wis. Admin. Code § DHS 101.03(173), professional supervision involves intermittent face-to-face contact between supervisor and assistant and a regular review of the assistant's work by the supervisor, including general clinical guidance that may apply to multiple members. Each treatment therapist must be supervised by a licensed supervisor via weekly face-to-face or indirect contact and monthly face-to-face supervision. Each behavioral treatment technician is required to be supervised face-to-face by either a treatment therapist or licensed supervisor at least once a month.

In addition, direct oversight (i.e., direct case supervision) of treatment implementation for each member's treatment program is required. Treatment supervisors (either licensed supervisors or treatment therapists) are required to observe, demonstrate, and guide the team of service providers during

delivery of each member's treatment for a minimum of one hour and a maximum of two hours for every 10 hours of direct treatment provided, averaged over a calendar month. Providers are required to document exceptional circumstances that require direct oversight in excess of the maximum.

Note: Time spent by a supervisor observing treatment performed by a team member may fulfill the requirement for professional supervision and direct case supervision.

The licensed supervisor is also required to directly observe the member for at least one hour every 60–75 days, as noted in the Approval Criteria for Initial Prior Authorization Requests topic (topic #19038) in the Approval Criteria chapter of the Prior Authorization section of the Behavioral Treatment Benefit service area of the Online Handbook. The one-hour minimum observation requirement every 60–75 days is counted from the first DOS the member received direct treatment from the provider. These visits must be documented by a detailed progress note or report and by claims submitted by the licensed supervisor for behavior assessment, behavioral treatment, or protocol modification.

The intent of this case supervision is for the licensed supervisor to be actively and solely engaged in member-focused activities, such as demonstrating protocols, coaching staff, assessing or observing member skills, or providing direct treatment. Progress notes must include descriptions of these activities in order to meet this requirement. Incidental observation of the member that may occur while the licensed supervisor provides family treatment guidance to parents or caregivers does not meet this requirement.

Including Family/Caregiver Goals in the Plan of Care

Behavioral treatment frequently seeks to make behavior more manageable for caregivers. This involves both modification of the member's behavior and enhancement of caregiver skills. For children and adult members with legal guardians, ForwardHealth expects the family and/or caregivers to be included in treatment planning and POC goals. The provider's initial assessment of the member must

include reports from the family and/or caregivers about the member's current behavioral challenges and other treatment needs. The POC must include goals for the family and/or caregivers to learn how to follow protocols for managing behavior or teaching new skills. Teaching the member's family and/or caregivers about treatment protocols without the member present, demonstrating protocols involving the member, and coaching the family and/or caregivers in the implementation of a protocol may all be billed using the appropriate CPT codes.

Specific, measurable goals for the family and/or caregivers must be included in all POC that include family treatment guidance as a requested service. Initial goals may focus on family participation, communication, and compliance with treatment policies and procedures. However, the purpose of family training is to help family members improve their behavior management skills and reduce the need for treatment and other supports. Goals should be individualized for the member's family or caregivers and may address a range of areas including, but not limited to:

- Increasing the accuracy and consistency of behavior plan implementation.
- Increasing the frequency and duration of successful family and community participation.
- Reducing the frequency and duration of the member's disruptive behavior outside of sessions.
- Teaching the member common adaptive skills.

Family goals must be appropriate and specific, with measurable baselines and mastery criteria.

Any PA request for continued family treatment guidance must summarize progress on family goals documented in specific, measurable, objective terms. Progress that is indicated by descriptive terms, such as "better," "improved," "calmer," "less/more," or "longer" are not measurable and will not be accepted by ForwardHealth. If the family has made limited or no progress by the end of the authorization period, a subsequent POC must clearly identify barriers to progress and propose a corrective action plan. Refer to the Approval Criteria for Initial Prior Authorization Requests topic (topic #19038) in the Approval Criteria chapter of the

Prior Authorization section of the Behavioral Treatment Benefit service area of the Online Handbook for additional details.

Required Medical Examinations

ForwardHealth requires a medical examination and referral for treatment prior to authorizing behavioral treatment for members of all ages, including adults. Any qualified medical provider who can address the specific health issues highlighted on the PA/BTA can complete the examination and write the prescription for behavioral treatment. The qualified medical provider must be enrolled with Wisconsin Medicaid.

Prescribing/Referring/Ordering Providers Must Be Medicaid-Enrolled

As a reminder, all physicians and other health care professionals who prescribe, refer, or order services for ForwardHealth members within their legally defined scope of practice are required to be enrolled in Wisconsin Medicaid. Behavioral treatment services for ForwardHealth members must be prescribed or ordered by a Medicaid-enrolled physician or other health care professional.

The prescribing, referring, or ordering provider whose information is submitted on the PA request or claim for behavioral treatment services must match the prescribing provider on the prescription for behavioral treatment services.

Refer to the Prescribing/Referring/Ordering Providers information on the Provider Enrollment Information page of the Portal for additional information on prescribing/referring/ordering providers. Providers can also refer to the Affordable Care Act link on the Provider Enrollment Information page for previously published *ForwardHealth Updates* about services that are prescribed, referred, or ordered.

Submission of Treatment Schedules

In addition to following the guidelines described in the Approval Criteria for Initial Prior Authorization Requests topic (topic #19038), providers are advised to submit

alternate proposed schedules if a change in the member's schedule is anticipated within the authorization period (e.g., school year versus summer schedule).

Discharge Criteria and Transition Planning

Prior authorization requests for behavioral treatment must include discharge criteria that clearly describe a realistic range of outcomes, including lack of progress, which may result in discharge from treatment. Refer to the Approval Criteria for Initial Prior Authorization Requests topic (topic #19038) for detailed guidelines. Standard discharge criteria should be shared with members at the beginning of treatment to assist them with long-term planning.

Initial PA requests must include the provider's standard discharge criteria. Subsequent PA requests must include a transition plan that is updated based on the member's rate and magnitude of progress. Transition plans should identify the anticipated system(s) of care (e.g., school, personal care) that will support the member following the current course of behavioral treatment; the plans should include an anticipated timeline with time or skill acquisition benchmarks that will result in a progressive transition to the next system of care.

Prior Authorization for Members with Commercial Insurance as Primary Coverage

ForwardHealth is authorizing behavioral treatment units in terms of the CPT or Healthcare Common Procedure Coding System (HCPCS) procedure code required by the member's primary insurance for each service. Providers should continue to include the CPT or HCPCS procedure code required for the member's primary insurance on the PA request submitted to ForwardHealth.

Prior Authorization Amendments

Providers may submit a Prior Authorization Amendment Request, F-11042 (07/12), to ForwardHealth when changing from the commercial procedure code set to the Medicaid-allowable procedure code set (codes 0359T–0361T, 0364T–0365T, 0368T–0370T) after a member's commercial insurance benefits have been exhausted. For additional

information related to PA amendments, refer to the Amendments topic (topic #431) in the Follow-Up to Decisions chapter of the Prior Authorization section of the Behavioral Treatment Benefit service area of the Online Handbook.

The Commercial Health Insurance section of this *Update* includes additional information regarding when the member reaches his or her maximum annual commercial insurance benefit for behavioral treatment.

Claim Submission

Only licensed supervisors will be reimbursed for claims submitted to ForwardHealth for behavioral treatment services.

When submitting claims for behavioral treatment services, providers are required to indicate the licensed supervisor overseeing the member's POC as the billing provider and indicate the licensed supervisor, treatment therapist, or treatment technician who rendered the service to the member as the rendering provider. Each detail line on the claim requires a rendering provider number. Licensed supervisors other than the one indicated on the member's POC may temporarily render services for the member to accommodate a leave of absence (e.g., due to illness), but the original licensed supervisor should still be indicated as the billing provider.

Managed Care

The behavioral treatment benefit is administered fee-for-service for all Medicaid-enrolled members who demonstrate medical necessity for covered services. The behavioral treatment benefit is "carved out" of managed care organizations, which include BadgerCare Plus and Medicaid Supplemental Security Income (SSI) HMOs and special managed care plans. Special managed care plans include Children Come First, Wraparound Milwaukee, Care4Kids, Family Care, the Program of All Inclusive Care for the Elderly (PACE), and the Family Care Partnership Program.

Commercial Health Insurance

When a member is enrolled in both a commercial health insurance plan and BadgerCare Plus or Wisconsin Medicaid, the provider is required to submit claims to commercial health insurance sources before submitting claims to ForwardHealth. Even when a member has a known deductible or cost share, primary insurance must process the claim prior to submission to ForwardHealth. The outcome of the primary insurance claim submission, regardless of payment status, is required for secondary claims processing by ForwardHealth.

ForwardHealth recognizes that commercial insurance policies and procedure codes for behavioral treatment do not always match ForwardHealth policies and procedure codes. For example, some commercial insurers use a single procedure code for billing all behavioral treatment services, regardless of the specific service rendered, the skill level of the renderer, or the number of renderers billed concurrently.

When coordinating commercial insurance and Medicaid benefits, providers are required to bill the commercial health insurance plan **according to the commercial insurer's policies and designated procedure codes, modifiers, and units billed**. Do not use modifiers TG or TF when submitting claims to the commercial insurer. After receiving the claims processing outcome (i.e., Remittance Advice) from the commercial insurer, the provider may submit a claim to ForwardHealth for consideration of any remaining balance, **using the same procedure codes, modifiers, and units billed on the original commercial insurance claim**. Refer to the 1500 Health Insurance Claim Form Completion Instructions topic (topic #17797) in the Submission chapter of the Claims section of the Online Handbook for additional information.

ForwardHealth recognizes the following CPT or HCPCS procedure codes when allowed by commercial health insurance companies for reimbursement of behavioral treatment services:

- 90791 (Psychiatric diagnostic evaluation)
- 97532 (Development of cognitive skills to improve attention, memory, problem solving [includes

compensatory training], direct [one-on-one] patient contact, each 15 minutes)

- H0031 (Mental health assessment, by non-physician)
- H0032 (Mental health service plan development by non-physician)
- H2012 (Behavioral health day treatment, per hour)
- H2014 (Skills training and development, per 15 minutes)
- H2019 (Therapeutic behavioral services, per 15 minutes)

ForwardHealth does not use billing crosswalks between commercial insurance procedure codes and ForwardHealth's allowable procedure codes in any benefit areas. Coordination of benefits claims are paid using the procedure code billed to commercial insurance, based on ForwardHealth's maximum allowable fee schedule, which is the standard, statewide, maximum rate that can be paid for a procedure code.

Note: The requirement for providers to submit claims to commercial insurance companies according to the commercial insurer's coding guidance does not waive other ForwardHealth program requirements. These requirements (e.g., provider qualifications, medical necessity, documentation requirements) are still in effect. ForwardHealth will not reimburse providers for services that do not meet program requirements.

Claims for Services Denied or Not Covered by Commercial Health Insurance

If a correct and complete claim for behavioral treatment was denied by a commercial health insurance company, the provider may submit a claim to ForwardHealth for those services. Providers are required to have an approved PA request from ForwardHealth for behavioral treatment for the DOS indicated on the claim in order for the treatment to be considered for reimbursement.

ForwardHealth will not reimburse claims denied by commercial health insurance due to billing errors or when the provider was out of the commercial insurer's network of providers. ForwardHealth will only coordinate benefits when members use a provider in their commercial insurer's network.

ForwardHealth will consider reimbursement of claims denied by commercial health insurance when behavioral treatment is not a covered benefit under the member's plan and/or when the member has reached his or her maximum annual benefit for behavioral treatment.

Some commercial health insurance carriers will not process claims for behavioral treatment/Applied Behavior Analysis services when the service is excluded from the member's benefit plan. These carriers will typically issue an Administrative Denial Letter to the provider. This letter must be retained in the member's file.

When behavioral treatment is excluded from commercial health insurance coverage and/or when the member has reached his or her maximum annual benefit, the provider is encouraged to bill ForwardHealth using the adaptive behavior treatment procedure codes allowable under ForwardHealth policy. For members with commercial health insurance, every claim for behavioral treatment must be submitted to ForwardHealth using the claim adjustment reason code that best describes the carrier's reason for non-payment. The Administrative Denial Letter must be retained in the member's file to substantiate the claim adjustment reason code or other insurance indicator that was submitted on the claim. Refer to the Other Insurance Indicators topic (topic #605) in the Commercial Health Insurance chapter of the Coordination of Benefits section of the Online Handbook for more information. Copies of the Administrative Denial Letter should **not** be sent to ForwardHealth.

Note: Commercial health insurance benefit plans change on a regular basis. In order to comply with Wisconsin state statutes, providers are required to validate a member's coverage when the plan year changes and update the member's file accordingly.

Discovery of Commercial Insurance After Payment by ForwardHealth

If, after paying a claim for behavioral treatment, ForwardHealth discovers that the member had commercial health insurance coverage on the DOS included on the

claim, ForwardHealth will submit an invoice to the provider for the previously paid claim. The provider is required to seek reimbursement from the commercial health insurer upon receipt of this invoice using **the commercial insurer's policies and designated procedure codes, modifiers, and units billed**. Refer to the Purpose of Provider-Based Billing topic (topic #660) in the Provider-Based Billing chapter of the Coordination of Benefits section of the Online Handbook for more information.

Resources

As a reminder, the Behavioral Treatment Benefit service area of the Online Handbook is now available on the Portal. The Online Handbook provides current policy and billing information for the behavioral treatment benefit in one centralized place.

To begin using the Behavioral Treatment Benefit service area of the Online Handbook:

- Go to the ForwardHealth Portal home page at www.forwardhealth.wi.gov/.
- Select the Online Handbooks link from the Provider links on the left side of the Portal home page.
- Select BadgerCare Plus and Medicaid from the "Choose a program" dropdown menu on the upper right side of the page.
- Select the Behavioral Treatment Benefit from the "Choose a service area" drop-down menu located on the upper right side of the page.
- Click the applicable section to see a list of chapters and topics available for selection.

Once a topic is clicked, information will be displayed. Each topic is assigned a topic number, displayed above the topic title, for reference. A topic number may be entered into the Advanced Search tool to locate the corresponding topic.

A link to the updated ForwardHealth Desktop Reference for Behavioral Treatment Providers is available on the New Behavioral Treatment Benefit page of the Portal, which can be accessed via the Provider-specific Resources link on the Providers home page. This updated document contains links to numerous ForwardHealth resources available for the

behavioral treatment benefit, including information about how to establish a secure Provider account on the Portal, provider enrollment, PA, and claim submission.

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 AIDS Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at 800-947-9627 or visit our website at www.forwardhealth.wi.gov/.

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This *Update* was issued on 8/3/2016 and information contained in this *Update* was incorporated into the Online Handbook on 9/7/2016.

ATTACHMENT 1

Behavioral Treatment Provider Specialties

The following table lists the different behavioral treatment provider specialties, allowable levels of service, and billing status.

Provider Specialty	Allowable Levels of Service	Billing Status
Behavioral Treatment Licensed Supervisor	Comprehensive and Focused	Billing and Rendering
Behavioral Treatment Therapist	Comprehensive and Focused	Rendering Only
Behavioral Treatment Technician	Comprehensive Only	Rendering Only
Focused Treatment Licensed Supervisor	Focused Only	Billing and Rendering
Focused Treatment Therapist	Focused Only	Rendering Only

ATTACHMENT 2

Procedure Code Guidance

The following tables list information for *Current Procedural Terminology* (CPT) procedure code 0370T when submitting claims under the behavioral treatment benefit. The information in these tables has been updated and replaces the information published in the December 2015 *ForwardHealth Update* (2015-62), titled “New ForwardHealth Behavioral Treatment Benefit.”

The following table indicates required modifiers, renderers, coding guidelines, documentation requirements, and prior authorization (PA) limits when using procedure code 0370T for **team meeting services**.

Code	Code Description	Required Modifier(s)	Renderer	National NCCI, MUE*, and CPT Coding Guidelines (<i>Note: Subject to Industry Change</i>)	Required Documentation	Prior Authorization Limits
0370T	Family adaptive behavior treatment guidance , administered by physician or other qualified health care professional (without the patient present)	AM (Physician, team member service), in addition to TG (Comprehensive level of service) or TF (Focused level of service)	Licensed supervisor or treatment therapist	MUE=1 <ul style="list-style-type: none"> This is not a time-based service. The service is face to face with parent or caregiver. The member is not present. 	<ul style="list-style-type: none"> Time in/time out Name of the parents, caregivers, and team members present Learning objectives that were targeted Outcome of the learning objectives Goals resulting from the meeting Renderer’s signature 	PA required

* NCCI (National Correct Coding Initiative)
MUE (Medically Unlikely Edits)

The following table indicates required modifiers, renderers, coding guidelines, documentation requirements, and PA limits when using procedure code 0370T for **family treatment guidance**.

Code	Code Description	Required Modifier	Renderer	National NCCI, MUE, and CPT Coding Guidelines (Note: Subject to Industry Change)	Required Documentation	Prior Authorization Limits
0370T	Family adaptive behavior treatment guidance , administered by physician or other qualified health care professional (without the patient present)	TG or TF	Licensed supervisor	MUE=1 <ul style="list-style-type: none"> This is not a time-based service. The service is face to face with parent or caregiver. The member is not present. 	<ul style="list-style-type: none"> Time in/time out Names of the licensed supervisor and family members or caregivers present Measurable family goals addressed Information collected from family Information shared with family Updates to Plan of Care or family goals resulting from the family treatment guidance session Renderer's signature 	PA required