ForwardHealth
Wisconsin serving you

Update
April 2018

No. 2018-13

Affected Programs: BadgerCare Plus, Medicaid
To: Case Management Providers, HMOs and Other Managed Care Programs

Former Health Care Connections Benefit Redesigned and Renamed as Case Management for Children with Medical Complexity

This *ForwardHealth Update* announces a redesign and name change of a Wisconsin Medicaid and BadgerCare Plus benefit, formerly referred to as Health Care Connections (HCC), to Case Management for Children with Medical Complexity. The name change and benefit redesign are effective retroactively for dates of service (DOS) on and after September 1, 2017.

Background

HCC was a voluntary Wisconsin Medicaid and BadgerCare Plus benefit that provided comprehensive case management services to assist children with chronic and complex health care needs in locating and coordinating services to address their medical and community care needs.

Between 2014 and 2017, the Wisconsin Department of Health Services (DHS) and its partners, the Children's Hospital of Wisconsin and UW Health-American Family Children's Hospital, implemented a federally funded grant program to test a pediatric provider and reimbursement model for the care of children with medical complexity (CMC) and high resource utilization.

DHS used the results of the grant evaluation to drive the redesign of the HCC benefit delivery and payment model, with the expanded goals for improving patient care, reducing avoidable health care utilization, and improving the quality of life of members and their families.

Benefit Overview

Case management is one aspect of an integrated approach to providing comprehensive, integrated care to CMC. CMC is one of the target groups covered under the Medicaid-targeted case management benefit. Targeted case management services are defined as services to assist members and, when appropriate, their families in gaining access to and coordinating a full array of services, including medical, social, educational, vocational, and other services. Case management services do not include the direct provision of care provision.

Note: As a reminder, other relevant ForwardHealth policies and procedures apply to this benefit. Refer to the Case Management, Targeted service area of the ForwardHealth Online Handbook at *www.forwardhealth.wi.gov/* for additional details.

Provider Enrollment

Medicaid-enrolled hospitals with pediatric medical and surgical specialty areas are eligible to enroll in Wisconsin Medicaid as a provider of Case Management for Children with Medical Complexity. Additionally, the hospital is required to have:

- The ability to support full integration of psychosocial and clinical care.
- Sufficient documentation that demonstrates staff has adequate knowledge and experience to provide

comprehensive and specialized case management services to children with complex medical and psychosocial needs.
- Referral and/or effective working relationships with key health care and other service providers that are essential to the care of children with complex medical and psychosocial needs (for example, primary care team, private duty nurses, specialists and sub-specialists, and community and social service organizations).

Staff Qualifications

To provide comprehensive and specialized case management services, staff providing case management services for CMC are required to have adequate knowledge and experience of the following:
- Local service delivery system
- Needs of the population
- Available resources (or the gaps in resources)

Core Team Requirements

The hospital provider is required to identify a core team of health care professionals who are knowledgeable about the care and needs of CMC and high-resource utilization, local health care, and social services delivery systems. Core team members may include the following staff:
- Advance practice provider (e.g., nurse practitioners or physician assistants)
- Paraprofessionals (serving as care coordination assistants)
- Physicians
- Registered nurses (RNs)
- Social workers

A physician or advance practice provider is required to be an integral part of all teams. The core team may include care coordination assistants to assist professional staff in coordinating care for the member. The primary case manager or care coordinator cannot be a paraprofessional.

Eligible Members

Children under age 26 diagnosed with chronic health conditions are eligible to receive case management services under this benefit if the child meets both of the following health condition criteria:
- Involves three or more organ systems
- Requires three or more medical or surgical specialists

Additionally, during the preceding year (i.e., 12 months), the child had at least one of the following utilization criteria:
- One or more hospital admissions totaling five or more days
- Ten or more visits to tertiary clinics (clinic visits count only if they are with a medical or surgical subspecialist)

Children too young to have met the above utilization criteria may still be eligible if they meet the above health condition criteria and both of the following are true:
- The child had a stay in a hospital totaling five or more days.
- Clinicians anticipate that the child will continue to be an intensive user of health resources without comprehensive care management services and care coordination.

Providers are required to retain documentation showing the member's:
- Eligibility for case management services for CMC.
- Need for comprehensive care management services to attain or maintain stability and optimal health status. (This includes care coordination to prevent progression of the disease, deterioration, or gaps in care.)
- Voluntary consent to program enrollment. (A statement regarding the member's acceptance meets this criteria.)

Members Not Eligible

Care management services are not available to the following:
- Inmates of public institutions
- Members between the ages of 21 and 26 who are served in institutions for mental disease
- Members who are inpatients and are not within 180 days of a hospital discharge (*Note:* Members are expected to be in the inpatient setting for more than 180 days from the initiation of case management services.)

Members' Freedom of Choice

Members may receive covered services from any willing Medicaid-enrolled provider, unless they are enrolled in a state-contracted managed care organization (MCO) or assigned to the Pharmacy Services Lock-In Program.

Members have the freedom to choose any qualified case management provider. Providers may not "lock-in" members or deny members' freedom to choose their care providers. Further, members are allowed to participate to the full extent of their ability in all decisions regarding appropriate services and providers. For more information, providers may refer to the Freedom of Choice topic (topic #247) of the Enrollment Rights chapter of the Member Information section of the Case Management, Targeted service area of the Online Handbook.

The case manager and member (or the member's parent, guardian, or caregiver) are required to discuss care plan changes and mutually agree to reduce or terminate services. If the case management provider needs to reduce or terminate services for any reason, the case manager is required to notify the member in advance and document this in the record.

Case Management Services Are Voluntary

Providers cannot compel a member to accept case management services. For members, participation in the case management program is voluntary. Members have the right to refuse case management services at any time. The member voluntarily participates in case management services by maintaining contact with and receiving services from the case management agency. If a member declines services, the provider is required to document the refusal in the care plan.

Covered Services

The Case Management for Children with Medical Complexity benefit covers the following services:

- A comprehensive assessment and periodic reassessment of the member's needs
- The development (and periodic revision) of a member-centric care plan
- Ongoing monitoring and service coordination

Comprehensive Assessment

Case management services include a comprehensive assessment to determine the member's need for any medical, educational, social, or other services. The assessment could include:

- Taking the member's history.
- Identifying the member's needs and strengths.
- Gathering information from other sources such as family members, medical providers, social workers, and educators.

The assessment must be documented in writing. Periodic assessments are covered as ongoing monitoring and service coordination.

Care Plan Development

Following the assessment, the case manager is required to develop a written care plan that is based on the information collected as part of the comprehensive assessment. At a minimum, the care plan must:

- Specify the goals and actions to address the medical, social, educational, and any other identified need.
- Identify a course of action to respond to the member's assessed needs.
- Include timeframes for initiating and/or completing the identified actions.

A physician or advance practice provider is required to have a face-to-face visit with the member, as part of the care plan development. To the maximum extent possible, the provider is required to ensure that the member (or the member's parent, guardian, or caregiver) is actively involved in the development of the care plan.

At a minimum, care plans must be reviewed and updated every six months, or as the member's needs change.

Periodic reviews and updates of the care plan are covered as ongoing monitoring and service coordination.

Ongoing Monitoring and Service Coordination

Following the development of the care plan, members are assigned to a care team with an identified primary point of contact.

Ongoing monitoring and service coordination includes:

- Periodic reassessment of need.
- Periodic review and updating of the care plan.
- Referrals and related activities (e.g., assisting with the scheduling of appointments), such as ensuring referrals are coordinated and effective by:
  - ✓ Obtaining verbal and/or written release of information, as appropriate.
  - ✓ Providing written referrals that include the reason for the referral, if necessary.
  - ✓ Informing members whether or not the service has a cost, including if there will be a copayment.
  - ✓ Assisting the member in gaining access to the needed service, if necessary.
  - ✓ Tracking, following up, and documenting the results of referrals.
  - ✓ Closing referrals when the service has been initiated.
  - ✓ Communicating with the member, and others when necessary, to ensure the referral met the intended need.
- Monitoring and follow-up activities, including:
  - ✓ Activities that are necessary to implement the care plan.
  - ✓ Ongoing supportive contacts to ensure that the member is able to access services and/or is receiving the services and care specified in the care plan. Ongoing supportive contacts must include (as appropriate):
    - Arranging acute care visits.
    - Attending specialty appointments.
    - Making rounds during the member's inpatient stay.
    - Following up with the member within three business days of a hospital discharge.
  - ✓ Periodic assessment of member satisfaction and participation.
  - ✓ Contacts with the member, the member's family, service providers, and other collaterals to determine if there are changes in the member's health or psychosocial needs that would necessitate a care plan review or update.
  - ✓ Conducting monitoring activities as frequently as necessary, including at least one annual monitoring activity to determine whether or not the following conditions are met:
    - Services are being provided in accordance with the member's care plan.
    - Services in the care plan are adequate.
    - Changes in the needs or status of the member are reflected in the care plan. Monitoring and follow-up activities include making any necessary adjustments in the care plan and service arrangements with providers.

Ongoing monitoring and service coordination activities include face-to-face, telephone, or written contacts with, or on behalf of, the member.

Primary Point of Contact

For ongoing monitoring and service coordination, the provider is required to identify a primary point of contact for members and ensure that members are given the information they need to contact the team when necessary. Care coordination teams consisting of an RN and care coordination assistant dyad have been shown to be effective in meeting members' primary coordination needs, as well as serving as the primary point of contact for families.

Frequency of Ongoing Monitoring

ForwardHealth does not have a frequency of contact requirement for case management services provided to CMC; however, the case manager is required to discuss and document the proposed frequency of contacts with the member (or the member's parent, guardian, or caregiver). This discussion must include the frequency of contacts with the member, care providers instrumental to the

implementation of the care plan, and other individuals directly related to mobilizing services and support on behalf of the member.

If the frequency of member contacts will be less than a monthly visit or reciprocal contact, the case manager is required to note the reason in the member's record. The case manager should consider the following when discussing the frequency of ongoing monitoring:

- The stability or frailty of the member's health
- The member's or family's ability to direct needed care and services
- The strength of supports in the home or the member's informal supports
- Stability of, and satisfaction with, service care staff (e.g., is there a history of high staff turnover?)
- Stability of the care plan (e.g., is there a history of numerous plan changes?)

Contacts with Non-Members

Face-to-face and telephone contacts with collaterals are covered to the extent that those contacts are directly related to:

- Identifying the member's needs and care.
- Helping the member access services.
- Identifying needs and supports to assist the member in obtaining services.
- Providing useful feedback to case managers.
- Alerting case managers to changes in the member's needs.

Collaterals include service providers and other individuals who are instrumental to addressing the member's needs or who have direct supportive contacts with the member. Collaterals could include paid providers, family members, guardians, school representatives, volunteers, and others involved with the member. Collateral contacts include case management staff time spent on case-specific staffing and formal case consultation with the unit supervisor and other professionals regarding the needs of a specific member.

The role of collaterals must be identified in the care plan or other member-specific documentation.

Case Management During an Inpatient Stay

Case management services may be provided during an inpatient stay but are limited to the 180 days prior to the member's discharge. Case management services are not available to members who are not within 180 days of discharge.

Discharge Planning

Case management activities must be coordinated with, and should not duplicate, institutional discharge planning. Targeted case management services are covered only if the activities are distinctly different and are not duplicative of the discharge planning activities typically covered as part of the hospital reimbursement.

Noncovered Services

Case management services do not include services that constitute the direct delivery of the underlying medical, educational, social, or other services to which a member has been referred. Further, case management services do not include activities that are an integral and inseparable component of another Medicaid-covered service.

For additional information related to noncovered services, refer to the Noncovered Services chapter of the Covered and Noncovered Services section of the Case Management, Targeted service area of the Online Handbook.

Duplication of Services

Non-Duplication Across Agencies

Members should not receive case management/care coordination services from more than one case management provider. Providers are required to make every effort to determine if there are other case management providers working with the member. If other case management providers are identified, it is the hospital's responsibility to communicate with the member and with the other agency/provider to eliminate duplication, reduce

fragmentation, and to ensure there are no gaps in care. The family's preferences concerning which agency should provide services must be considered when the roles overlap.

This requirement applies whether or not ForwardHealth covers the other case manager's services. The need for more than one service coordinator in the family must be reassessed after one year (i.e., 12 months).

Providing Services to More Than One Family Member

Wisconsin Medicaid ordinarily reimburses only one family case manager/team per family. If more than one child in a family meets the criteria for case management services for CMC, the provider may submit claims for each child only if there is clear documentation that each child requires a separate care plan, and the ensuing case management activities are not duplicative.

When multiple case managers/teams are providing case management to the family, these case managers are required to communicate with the family and with each other to avoid service duplication.

Documenting Overlap

A family case manager and other case managers working with family members are covered only if documentation shows that their activities have been coordinated through the care planning process to avoid duplication of efforts. The documentation should include the following information:

- The need for more than one case manager for the child/family
- The identification of the other case management provider or team
- Evidence that the member was included in any decision-making
- The member's care plan includes a clear delineation of the role of each care coordinator (regardless of whether the care coordinators are employed by the same or different agencies)
- Ongoing communication and frequency of contacts between the care coordinators, including the need to periodically assess the need for continued involvement of both providers

Documentation Requirements

Case Management Documentation

Providers are required to maintain case records for each member receiving case management services. The case records must document all of the following:

- The member's name
- The full name and title of the person who made the contact (If initials are used in the case records, the file must contain a signature page showing the full name of the person who initialed the record.)
- The nature and content of the contact and whether or not the goals specified in the care plan have been achieved
- The date the contact was made
- Where the contact was made
- How much time was spent
- Whether the member declined services in the care plan
- The need for, and occurrences of, coordination with other case managers
- A timeline for obtaining needed services
- A timeline for re-evaluation of the care plan

Refer to the Provider Enrollment and Ongoing Responsibilities section in the Case Management, Targeted service area of the Online Handbook for additional documentation and other requirements.

Reporting Requirements

To monitor and evaluate the Case Management for Children with Medical Complexity program, ForwardHealth may require the hospital provider to collect and report certain information to ForwardHealth. To the extent possible, ForwardHealth will use its own paid claims data for monitoring and evaluation and will only rely on the hospital provider for data not available through the claim system. Providers are required to respond to data requests as a condition of continued participation in the Case

Management for Children with Medical Complexity program.

In addition, providers participating in the program are required to submit monthly enrollment and patient-staffing reports, as well as annual member satisfaction surveys to DHS.

Monthly Enrollment Report

The hospital provider is required to submit a cumulative enrollment report to DHS on a monthly basis that includes the following elements:

- Member last name
- Member first name
- Member date of birth
- Member Medicaid ID
- Enrollment date
- Discharge date
- Discharge reason
- Referral date
- Referral type
- Inpatient admission date
- Inpatient discharge date
- Post-discharge contact indicator
- Eligibility criteria attestation indicator

Patient-Staffing Summary Report

The hospital provider is required to submit a patient caseload and staffing summary to DHS on a monthly basis. The report must include the following elements:

- Number of all currently enrolled members
- Number of currently enrolled Wisconsin Medicaid members
- Staff type (e.g., physician, advance practice provider, RN)
- Number of individual staff
- Staff full-time equivalent

The patient-staffing report may be submitted with the monthly enrollment report.

Member Satisfaction Survey

The hospital provider is required to conduct annual member satisfaction surveys. The purpose of the survey is to obtain feedback from each member regarding their satisfaction with the assistance and support received from the program. Providers may be required to periodically share the survey and the survey results with DHS. Hospital providers are required to document any action taken to improve services or the approach to care based on feedback received from members.

ForwardHealth may collaborate with the hospital provider to change reporting requirements at any time. Providers may be required to submit additional data to ForwardHealth upon request.

Claim Submission

Allowable Claim Types

Claims for case management services must be submitted on a professional claim form. Providers may submit claims for allowable case management activities via any of the following:

- The 1500 Health Insurance Claim Form (02/12)
- The 837 Health Care Claim: Professional electronic transaction
- Direct Data Entry on the ForwardHealth Portal
- Provider Electronic Solutions claims submission software

Claims for case management services submitted on any other claim format will be denied.

Allowable Procedure Codes

All claims submitted to ForwardHealth for case management services provided to CMC must include one of the following allowable Healthcare Common Procedure Coding System (HCPCS) procedure codes:

- G0506 (Comprehensive assessment of and care planning for patients requiring chronic care management services [list separately in addition to primary monthly care management service]) represents

the comprehensive assessment and care planning that is required for case management services.

- T2023 (Targeted case management; per month) represents the ongoing monthly management of the member.

Claims or adjustment requests received without the appropriate HCPCS codes will be denied. Refer to the Attachment of this *Update* for specific coverage policy limitations.

Dates of Service

Providers should adhere to the following guidelines when determining the DOS to indicate on the professional claim:

- For activities related to the comprehensive assessment and care plan development (indicated by HCPCS procedure code G0506), the DOS is the date the care plan is completed.
- For activities related to ongoing care coordination and monitoring (indicated by HCPCS procedure code T2023), indicate the last date the service was performed in the month as the DOS on the claim form.

Note: The actual DOS must be identified when documenting each case management activity.

Diagnosis Codes

ForwardHealth does not require a specific diagnosis code for case management services provided to CMC; however, providers are required to use valid, nationally recognized *International Classification of Diseases, 10th Revision, Clinical Modification* diagnosis codes when submitting claims.

Place of Service

Providers should use a valid two-digit place of service (POS) code to indicate the setting in which services were provided. If services occurred in multiple settings, providers may bill using the most frequently occurring POS code.

Note: The actual POS must be indicated when documenting each case management activity.

Units of Service

The unit of service for each CMC benefit-allowable HCPCS code is one. Claims submitted with more than one unit of service on a detail will be denied.

Reimbursement

Comprehensive Assessment and Care Planning

Providers receive a flat fee per eligible child for the completion of a comprehensive assessment and care planning that meets the coverage criteria, including a face-to-face contact with a physician or advance practice provider as part of the care planning process.

These activities are reimbursable only for members who meet the criteria of a child with medical complexity and who agree to participate. Members agree to participate by actively engaging in the care plan development process.

Periodic reassessments and reviews and updates of the care plan are reimbursable as part of the ongoing monitoring and service coordination activities.

Ongoing Monitoring and Service Coordination Activities

Ongoing case management activities are reimbursable for eligible members who have a completed care plan. Services are reimbursable only if an individual on the member's core team has at least one face-to-face or reciprocal telephone or written contact with the member (or the member's parent, guardian, or caregiver) during the billable month.

Billing the Usual and Customary Charge

Providers are required to bill their usual and customary charge for case management services provided to CMC. Reimbursement is either the lesser of the usual and customary charge or the maximum allowable fee established.

Copayment

Case management services are not subject to copayment; however, members are still responsible for applicable cost

sharing for other Medicaid and BadgerCare Plus services they receive.

Information Regarding Managed Care Organizations

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

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 Medicaid Services, the 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, DHS.

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

P-1250

ATTACHMENT
Allowable Procedure Codes for Eligible Children with Medical Complexity

The table below includes information for allowable Healthcare Common Procedure Coding System (HCPCS) procedure codes G0506 and T2023 for Case Management for Children with Medical Complexity.

HCPCS Procedure Codes for Targeted Case Management Services for Eligible Pediatric Members with Medical Complexity			
HCPCS Code	**Description**	**Use**	**Limitations**
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)	This code must be used when billing for activities related to the initial, comprehensive assessment and completion of the care plan.	• Limited to one unit of service every (rolling) three years, per provider, per member. • Not reimbursable for dates of service (DOS) in the same calendar month for the same provider and member as T2023.
T2023	Targeted case management, per month	Targeted case management, ongoing care coordination, referral, monitoring and follow-up activities.	• Limited to one unit of service per calendar month, per provider, per member. • Not reimbursable for DOS in the same calendar month for the same provider and member as G0506.