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ForwardHealth UPDATE

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NEW REQUIREMENTS FOR CHILD CARE COORDINATION

Effective May 1, 2023, new requirements will apply to claims or claim adjustments submitted to ForwardHealth for reimbursement for child care coordination (CCC) services. Details are outlined below.

CCC is a care coordination benefit that provides covered services including assessment, care plan development, ongoing care coordination, and monitoring to eligible members in Milwaukee County and the city of Racine. The policy will continue to require an initial, comprehensive assessment to determine CCC benefit eligibility and the development of a care plan prior to the delivery of ongoing care coordination. There will be no changes to eligibility requirements for members currently receiving CCC services, but new claims requirements will apply to members that begin receiving CCC services through an assessment for dates of service (DOS) on or after May 1, 2023.

AFFECTED PROGRAMS
BadgerCare Plus, Medicaid

TO
Child Care Coordination Providers, Prenatal Care Coordination Providers, HMOs and Other Managed Care Programs

QUICK LINKS
Child Care Coordination service area of the ForwardHealth Online Handbook

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(44).

WISCONSIN DEPARTMENT of HEALTH SERVICES

Child Care Coordination Eligibility

For new members, an initial, comprehensive assessment must be administered by 8 weeks of age for claims to reimburse for CCC services, per Wis. Stat. § 49.45(44). Claims for DOS on or after May 1, 2023, must show a DOS indicating the initial comprehensive assessment was delivered within 8 weeks of birth to reimburse for ongoing CCC services. A member that did not receive an assessment within 8 weeks of birth is not eligible for CCC. Providers are responsible for referring and coordinating with other resources, including managed care, for members over 8 weeks of age that have not received an initial assessment within the eligibility timeframe. These new claims requirements will not apply to members that have received reimbursed CCC services for DOS prior to May 1, 2023.

Order of Service Provision

CCC policy requires the administration of an initial, comprehensive assessment prior to the development of a care plan and ongoing care coordination and monitoring. For new members receiving CCC services on or after May 1, 2023, the DOS on a claim for an initial, comprehensive assessment (Healthcare Common Procedure Coding System [HCPCS] procedure code T1016 [Case management, each 15 minutes] with modifier U1) must show that a comprehensive assessment was administered prior to the development of a care plan and ongoing care. Claims for CCC services not administered in this order will be denied.

The Ongoing Care Coordination and Monitoring topic (#990) of the ForwardHealth Online Handbook clarifies that providers may offer ongoing care coordination services on the same date that they complete the initial, comprehensive assessment and care plan development, and they can be billed on the same DOS (HCPCS procedure code T1016 with modifiers U1, U2, and U3).

New Child Care Coordination Modifier Requirement

For DOS on or after May 1, 2023, ForwardHealth will require a new modifier (UD) to indicate when ongoing care coordination was delivered in an urgent situation to a member under 8 weeks of age. More information on urgent situations can be found within the Ongoing Care Coordination and Monitoring topic (#990). ForwardHealth allows for ongoing care coordination to be delivered prior to an assessment and care plan in urgent situations to members otherwise eligible to receive CCC services. Providers must bill for ongoing care

TRAINING AVAILABLE

For details on the new requirements for claims and claim adjustments submitted to ForwardHealth for reimbursement for CCC services, providers may watch the Requirements for Child Care Coordination Training video on the Trainings page of the Portal.

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coordination in urgent situations to members under 8 weeks of age by billing HCPCS procedure code T1016 with modifiers U3 and UD, and subsequent DOS must indicate that an initial, comprehensive assessment (modifier U1) and care plan development (modifier U2) have been rendered to bill any additional CCC services.

Note: Comprehensive, initial assessments are required to be administered to members by 8 weeks of age to receive CCC services. Refer to the Child Care Coordination Eligibility section of this ForwardHealth Update for additional information.

LOCATION MODIFIERS		
MODIFIER	DESCRIPTION	NOTES
UB	CCC service provided in Milwaukee County	Indicate this modifier when the CCC service is provided in Milwaukee or Racine.
UC	CCC service provided in the city of Racine	Claims must indicate the location the CCC service was provided.
SERVICE TYPE MODIFIERS		
MODIFIER	DESCRIPTION	NOTES
U1	Comprehensive assessment	Indicate this modifier when submitting a claim for the initial, comprehensive assessment and subsequent comprehensive assessments (limited to one per 365 days).
U2	Care plan development	Indicate this modifier when submitting a claim for the initial care plan development and subsequent care plan development (limited to one per 365 days).
U3	Ongoing care coordination and monitoring	Indicate this modifier when submitting a claim for ongoing activities, **including**: • Updates to the assessment • Updates to the care plan

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OTHER MODIFIERS		
MODIFIER	DESCRIPTION	NOTES
UD (new)	Care coordination in an urgent situation	Indicate this modifier when submitting a claim for care coordination services delivered in an urgent situation to members under 8 weeks of age (T1016 with modifier U3 **and** UD).

Note: Providers are required to submit a minimum of two modifiers along with HCPCS procedure code T1016. One modifier identifies the location of where the CCC service was provided; the other modifier identifies the specific type of care coordination service provided. (Refer to the Modifiers topic [#974].) Additional modifiers (such as UD) may be required as needed.

Concurrent Billing

System requirements for claims with CCC concurrent services are being revised. For DOS on or after May 1, 2023, claims for concurrent CCC services will be denied. Concurrent billing is defined as two or more providers delivering CCC services to the same member within a specific period: 365 days for the comprehensive assessment and care plan development and the calendar month for ongoing care coordination and monitoring.

The limits are described in the following table.

TYPE OF SERVICE	REQUIREMENTS
Comprehensive Assessment (T1016 with modifier U1)	Limited to eight units per 365 days per member. Only one provider will receive reimbursement in a 365-day period. One comprehensive assessment is reimbursable per 365 days.
Care Plan Development (T1016 with modifier U2)	Limited to eight units per 365 days per member. Only one provider will receive reimbursement in a 365-day period. One comprehensive care plan is reimbursable per 365 days.
Ongoing Care Coordination and Monitoring (T1016 with modifier U3)	Limited to 40 units per month per member. Only one provider will receive reimbursement in a calendar month.

REMINDER

Claims are submitted once per month per the Limitations topic (#15397). Claims must be submitted **after** the services have been rendered for the entire month.

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Note: Assessments may be updated throughout the year but should be billed as ongoing care coordination (modifier U3) rather than as a comprehensive assessment (modifier U1). Care plans are required to be updated throughout the year but should be billed as ongoing care coordination (modifier U3) rather than care plan development (modifier U2).

Documentation Retention

Providers are reminded that they must follow the documentation retention requirements per Wis. Admin. Code § DHS 106.02(9). Providers are required to produce or submit documentation, or both, to the Wisconsin Department of Health Services (DHS) upon request. Per Wis. Stat. § 49.45(3)(f), providers of services shall maintain records as required by DHS for verification of provider claims for reimbursement. DHS may audit such records to verify the actual provision of services and the appropriateness and accuracy of claims. DHS may deny or recoup payment for services that fail to meet these requirements. Refusal to produce documentation may result in denial of submitted claims, recoupment of paid claims, application of intermediate sanctions, or termination from the Medicaid program.

Information Regarding Managed Care Organizations

This Update applies to CCC services that members receive on a fee-for-service basis. For information about managed care implementation of the updated policy, contact the appropriate managed care organization (MCO). MCOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

DID YOU KNOW?

Providers are encouraged to initially obtain information through the Portal, WiCall, and Provider Services. If these attempts are not successful, field representatives may be contacted for questions about policy or claim submission.

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