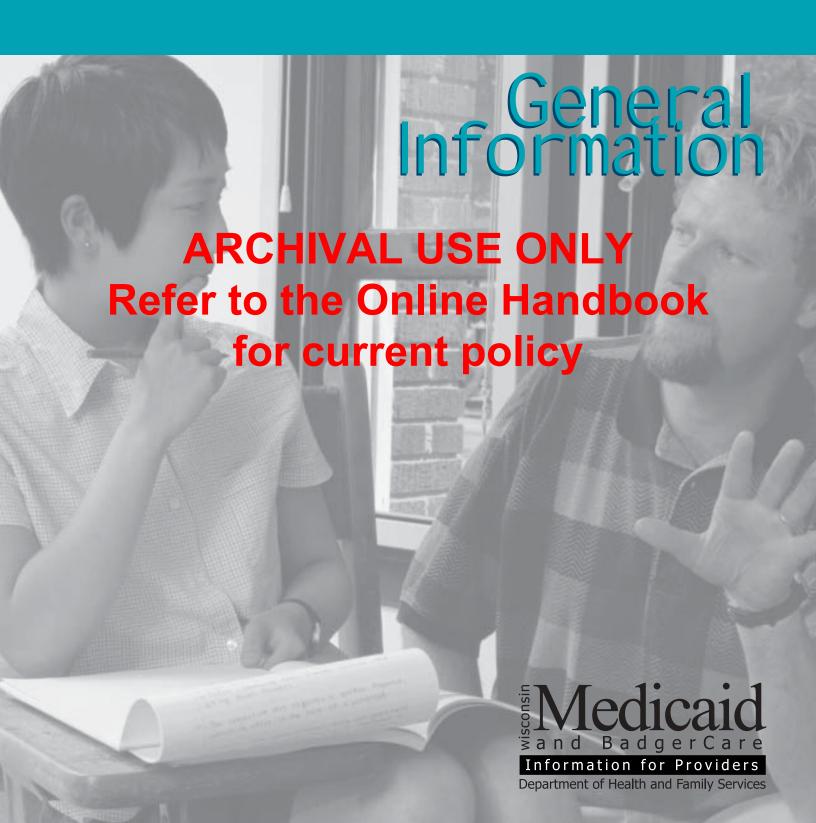
Case Management Services



Important Telephone Numbers

The Wisconsin Medicaid Eligibility Verification System (EVS) is available through the following resources to verify checkwrite information, claim status, prior authorization status, provider certification, and/or recipient eligibility.

Service	Information Available	Telephone Number	Hours
Automated Voice Response (AVR) System (Computerized voice response to provider inquiries.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	(800) 947-3544 (608) 221-4247 (Madison area)	24 hours a day/ 7 days a week
Personal Computer Software and Magnetic Stripe Card Readers	Recipient Eligibility*	Refer to Provider Resources section of the All-Provider Handbook for a list of commercial eligibility verification vendors.	24 hours a day/ 7 days a week
Provider Services (Correspondents assist with questions.)	Checkwrite Information Claim Status Prior Authorization Status Provider Certification Recipient Eligibility*	(800) 947-9627 (608) 221-9883 ent policy	Policy/Billing and Eligibility: 8:30 a.m 4:30 p.m. (M, W-F) 9:30 a.m 4:30 p.m. (T) Pharmacy: 8:30 a.m 6:00 p.m. (M, W-F) 9:30 a.m 6:00 p.m. (T)
Direct Information Access Line with Updates for Providers (Dial-Up) (Software communications package and modem.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	Call (608) 221-4746 for more information.	7:00 a.m 6:00 p.m. (M-F)
Recipient Services (Recipients or persons calling on behalf of recipients only.)	Recipient Eligibility Medicaid-Certified Providers General Medicaid Information	(800) 362-3002 (608) 221-5720	7:30 a.m 5:00 p.m. (M-F)

^{*} Please use the information exactly as it appears on the recipient's identification card or the EVS to complete the patient information section on claims and other documentation. Recipient eligibility information available through the EVS includes:

- Dates of eligibility.
- Medicaid managed care program name and telephone number.
- Privately purchased managed care or other commercial health insurance coverage.
- Medicare coverage.
- Lock-In Program status.
- Limited benefit information.

Table of Contents

Preface	ხ
Provider Information	7
Provider Eligibility and Certification	7
General Requirements	
Private, Nonprofit Entities That May Be Certified	
Public Entities That May Be Certified	
General Qualifications of Staff Providing Case Management Services	
Qualifications for Performing Assessments and Case Plans	
Determining a Human Services-Related Field	
Qualifications for Providing Ongoing Monitoring and Service Coordination	
Subcontracting for Case Management Services	
Terms of Reimbursement	
Provider Responsibilities	
Provider Sanctions	
Recipient Information	11
Recipient Information Recipient Eligibility RCHIVAL USE ONLY	11
Eligibility Categories Copayment Contine Unline Handbook	11
Copayment Refer to the Offine Hariobook	11
Freedom of Choice	11
Case Management for Recipients Enrolled in	
Medicaid-Contracted Managed Care Programs	
Medicaid-Contracted HMOs	
Special Managed Care Programs	
Family Care	
Community Support Programs	∣∠
Appendix	13
1. General Program Revenue "Matching" Fund Requirements	15
2. Guidelines for the Coordination of Services Between Medicaid-Contracted HMOs and	
Medicaid Case Management Agencies	
3. Wisconsin Medicaid Case Management Agency Self-Audit Checklist	19
Glossary of Common Terms	23
Index	27

Preface

The Wisconsin Medicaid and BadgerCare Case Management Handbook is issued to case management providers who are Wisconsin Medicaid certified. It contains information that applies to *fee-for-service* Medicaid providers. The Medicaid information in the handbook applies to both Medicaid and BadgerCare.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid and BadgerCare. As of January 2003, BadgerCare extends Medicaid coverage to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. BadgerCare recipients receive the same health benefits as Wisconsin Medicaid recipients and their health care is administered through the same delivery system.

Medicaid and BadgerCare recipients enrolled in state-contracted HMOs are entitled to at least the same benefits as fee-for-service recipients; however, HMOs may establish their own requirements regarding prior authorization, billing, etc. If you are an HMO network provider, contact your managed care organization regarding its requirements. Information contained in this and other Medicaid publications is used by the DHCF to resolve disputes regarding covered benefits that cannot be handled internally by HMOs under managed care arrangements.

Verifying Eligibility

Wisconsin Medicaid providers should always verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage. Wisconsin Medicaid's Eligibility Verification System (EVS) provides eligibility information that providers can access a number of ways.

Refer to the Important Telephone Numbers page at the beginning of this section for detailed information on the methods of verifying eligibility.

Handbook Organization

The Case Management Handbook consists of the following sections:

- General Information.
- Covered and Noncovered Services.
- Billing.

In addition to the Case Management Handbook, each Medicaid-certified provider is issued a copy of the All-Provider Handbook. The All-Provider Handbook includes the following sections:

- Claims Submission.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Prior Authorization.
- Provider Certification.
- Provider Resources.
- Provider Rights and Responsibilities.
- Recipient Rights and Responsibilities.

Legal Framework of Wisconsin Medicaid and BadgerCare

The following laws and regulations provide the legal framework for Wisconsin Medicaid and BadgerCare:

Federal Law and Regulation

- Law: United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
- Regulation: Title 42 CFR Parts 430-498 Public Health.

Wisconsin Law and Regulation

- Law: Wisconsin Statutes: Sections 49.43-49.499 and 49.665.
- Regulation: Wisconsin Administrative Code, Chapters HFS 101-108.

Handbooks and Wisconsin Medicaid and BadgerCare Updates further interpret and implement these laws and regulations.

Handbooks and *Updates*, maximum allowable fee schedules, helpful telephone numbers and addresses, and much more information about Wisconsin Medicaid and BadgerCare are available at the following Web sites:

www.dhfs.state.wi.us/medicaid/ www.dhfs.state.wi.us/badgercare/.

Medicaid Fiscal Agent

The DHFS contracts with a fiscal agent, which is currently EDS.

Provider Information

Provider Eligibility and Certification

General Requirements

Under HFS 105.51, Wis.

Admin. Code, Wisconsin

management providers.

entities electing to

participate as case

Medicaid certifies qualified

Under HFS 105.51, Wis. Admin. Code, Wisconsin Medicaid certifies qualified entities electing to participate as case management providers. To become certified, providers must have:

- Qualified staff, as identified in this section.
- The ability to deliver all case management elements, as identified in the Covered and Noncovered Services section of this handbook.

Throughout this handbook, three different names are used to signify who may provide case management services. These names are *not* interchangeable. The following list defines the three types of entities:

- Case Management Provider denotes the entity that meets the requirements as a certified case management provider and is assigned the Medicaid billing provider number.
- Case Management Agency organizations with whom the provider contracts.
- Case Manager individual who is providing case management services to recipients.

Private, Nonprofit Entities That May Be Certified

The following private, nonprofit entities are eligible for certification:

1. Independent Living Centers, as defined under s. 46.96(1)(ah), Wis. Stats.

 Private, nonprofit agencies funded by the Department of Health and Family Services (DHFS) under s. 252.12(2)(a)8, Wis. Stats., for purposes of providing life care services to persons diagnosed as having Human Immunodeficiency Virus.

Public Entities That May Be Certified

Any of the following public entities (as defined by the relevant state statutes) are eligible to be certified case management providers:

- 1. County or tribal departments of community programs (51.42 and 51.42/.437 boards).
- County or tribal departments of social services.
- 3. County or tribal departments of human services.
- 4. County or tribal aging units.
- County or tribal departments of developmental disabilities services (51.437 boards).
 - 6. County/tribal, city, village, town, or combined city/county/tribal public health agency, and multiple county/tribal health departments (as defined under s. 251.02, Wis. Stats.).

Per HFS 105.51(7), Wis. Admin. Code, public entities are eligible for case management certification if the local government has elected to participate in this service. Also, the local government must have state statutory authority to operate community programs necessary for the population(s) to assure effective monitoring and coordination of these critical services.

To provide case management services, the case management provider's county, village, or town board of supervisors, city council, or Indian tribal government must elect to provide the services [s. 49.45(25), Wis. Stats.]. Therefore, at any time, a county, city, village, town, or tribal government may send notice of termination of, or amendment to, participation as a case management provider to Wisconsin Medicaid. Such notice supersedes any prior action by the case management provider within the county, city, village, town, or tribal jurisdiction.

Eligible private, nonprofit entities do not need approval from a county, village, or town board of supervisors, city council, or tribal agency.

General Qualifications of Staff Providing Case **Management Services**

Qualifications for Performing Assessments and Case Plans

As defined in HFS 105.51(2), Wis. Admin. Code, case managers performing assessments and case planning must meet both of the following requirements:

- Knowledge of the local service delivery system, the target group's needs, the need for integrated services, and the resources available or needing to be developed.
- A degree in a human services-related field and one year of supervised experience, or two years of supervised experience working with people in the target population, or an equivalent combination of training and experience.

The certified case management provider is responsible for ensuring that its own or subcontracted staff meet these requirements.

Determining a Human Services-Related Field

Wisconsin Medicaid rules do not define a human services-related field. Since degree requirements vary, case management providers must review the prospective case manager's records to identify the amount of course work completed in areas relevant to case management. Some examples of relevant course work might be human development, long term care, and psychology.

Case management providers must look at training, experience, or a combination of training and experience to make a determination of equivalency to the standards. For the purposes of meeting these requirements, a registered nurse with a bachelor's degree in nursing is considered to have a degree in a human services-related field.

Qualifications for Providing Ongoing Monitoring and Service Coordination

Case managers providing ongoing monitoring and service coordination must have knowledge of the following:

- Local service delivery system.
- Target population's needs.
- Need for integrated services.
- Resources available or needing development.

Case managers typically gain such knowledge through one year of supervised experience working with people in the designated target populations.

For example, a certified alcohol and other drug abuse (AODA) counselor qualifies to provide case management services for a person with alcohol or drug dependence. However, for an elderly recipient, that AODA counselor may not qualify to perform case management services. The case management provider must The certified case management provider is responsible for ensuring that its own or subcontracted staff meet these requirements.

have available on request its policies and procedures for determining an individual case manager's qualifications, as well as documentation of its case manager's qualifications. A case management provider must make and document any determination of qualifications based on equivalency using written guidelines and procedures. The certified case management provider is responsible for the determination of equivalence for its own or subcontracted staff.

Subcontracting for Case Management Services

It is the certified provider's

responsibility to ensure that

the subcontractor provides

records in accordance with

the Medicaid requirements

for the provision of case

management services.

services and maintains

Medicaid-certified case management providers may contract with noncertified case management agencies for any case management service. However, the Medicaid-certified provider retains all legal and fiscal responsibility for the services provided by subcontractors.

It is the certified provider's responsibility to ensure that the contractor provides services and maintains records in accordance with the Medicaid requirements for the provision of case management services. According to HFS 105.02(6)(a), Wis. Admin. Code, the following records must be maintained:

Contracts or agreements with persons or organizations for the furnishing of items or services, payment for which may be made in whole or in part, directly or indirectly, by MA.

For more information on recordkeeping as it relates to case management services, refer to the Covered and Noncovered Services section of this handbook. Please refer to the Provider Rights and Responsibilities section of the All-Provider Handbook for additional information on required recordkeeping.

The Medicaid-certified provider is responsible for ensuring that its contractors:

- Meet all program requirements.
- Receive copies of Medicaid handbooks and other appropriate materials.

Wisconsin Medicaid sends provider materials to Medicaid-certified providers only, unless materials are specifically requested by individuals or agencies who are not certified by Wisconsin Medicaid. Published issues of Wisconsin Medicaid and BadgerCare Updates, the All-Provider Handbook, this handbook, and other provider publications may be reviewed and downloaded online at www.dhfs.state.wi.us/medicaid/.

Although the contracted case management agency may submit claims to Wisconsin Medicaid using the certified provider's Medicaid number if the provider has authorized this, Wisconsin Medicaid only reimburses the certified provider.

andbook Scope of Service

The policies in this handbook govern all services provided within the standards defined in s. 49.45(25), Wis. Stats., and HFS 105.51 and 107.32, Wis. Admin. Code. Refer to the Covered and Noncovered Services section of this handbook for covered services and related limitations.

Terms of Reimbursement

Medicaid reimbursement is based on a uniform, contracted hourly rate set by Wisconsin Medicaid. This hourly rate applies to all services provided by the certified case management provider or by agencies or individuals contracted by that provider for case management services. The provider receives the federal share of the hourly contracted rate from Wisconsin Medicaid for all hours of allowable service.

Refer to Appendix 1 of this section for clarification on the federal share and general program revenue "matching" and related services. Refer to the Billing section of this handbook for billing instructions.

Provider Responsibilities

Refer to the Provider Rights and Responsibilities section of the All-Provider Handbook for specific responsibilities as a certified provider, including:

- Additional state and federal requirements.
- Fair treatment of the recipient.
- Grounds for provider sanctions.
- Maintenance of records.
- Recipient requests for noncovered
- Services rendered to a recipient during periods of retroactive eligibility.

Provider Sanctions

According to HFS 106.09(2), Wis. Admin. Code, the certified case management provider is liable for the entire amount of an audit adjustment or disallowance attributed to the provider by the federal government or DHFS.

Refer to Appendix 3 of this section for a Wisconsin Medicaid Case Manangement Self-Audit Checklist. This checklist was developed as a guide to assist Wisconsin Medicaid case management providers in assessing their level of compliance with Wisconsin Medicaid case management policies and procedures. The use of this checklist is strictly voluntary. Refer to the Provider Rights and Responsibilities section of the All-Provider Handbook for additional requirements.

Refer to the Provider Rights and Responsibilities section of the All-Provider Handbook for specific responsibilities as a certified provider.

Recipient Information

Recipient Eligibility

Wisconsin Medicaid providers should *always* verify a recipient's eligibility before delivering services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage. Wisconsin Medicaid's Eligibility Verification System provides eligibility information that providers can access a number of ways.

Refer to the Important Telephone Numbers page at the beginning of this handbook for detailed information on the methods of verifying eligibility. Refer to the Provider Resources section of the All-Provider Handbook for more information about these methods of verifying recipient eligibility.

For recipients, participation in

the case management

recipient voluntarily

participates in case

program is voluntary. The

management services by

maintaining contact with and

receiving services from the

case management agency.

Eligibility Categories

Wisconsin Medicaid classifies recipients into one of several eligibility categories, including special benefit categories. These categories allow for a differentiation in benefit coverage. Refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook for more information about special benefit categories.

Case management is *not* a separately payable service when provided to nursing home recipients, except within 30 days before nursing home discharge.

Case management is *not* a benefit for Qualified Medicare Beneficiary-only (QMB-only) recipients. Qualified Medicare Beneficiary-only recipients are eligible for Medicaid payment of the coinsurance and deductibles for Medicare-covered services only. Medicare does not cover case management services; therefore, Wisconsin Medicaid denies claims submitted for QMB-only recipients.

Copayment

Case management services are not subject to recipient copayments.

Freedom of Choice

For recipients, participation in the case management program is voluntary. The recipient voluntarily participates in case management services by maintaining contact with and receiving services from the case management agency. The case management provider may not "lock-in" recipients or deny the recipient's freedom to choose providers. Recipients may participate, to the full extent of their ability, in all decisions regarding appropriate services and providers. For ongoing monitoring and service coordination, there is one, individual case manager known by and available to the recipient or guardian.

For a recipient receiving case management services, the following people may choose and, if necessary, request a change in the case manager who is performing ongoing monitoring and service coordination (subject to the case management provider's or agency's capacity to provide services under HFS 107.32(2), Wis. Admin. Code:

- The recipient.
- The recipient's parents, if the recipient is a minor child.
- A guardian, if the recipient has been judged incompetent by the courts.

The case manager and recipient/parent/ guardian must discuss case plan changes and mutually agree to reduce or terminate services. If the case management provider or agency needs to reduce or terminate services for any reason, the case manager must notify the recipient in advance and document this in the record.

Case Management for Recipients Enrolled in Medicaid-Contracted **Managed Care Programs**

Medicaid-Contracted HMOs

Wisconsin Medicaid covers case management services on a fee-for-service basis for recipients enrolled in a Medicaid-contracted HMO, including Independent Care (commonly referred to as iCare) in Milwaukee. Since Medicaid-contracted HMOs and case management providers are responsible for coordinating care to recipients, Wisconsin Medicaid has developed guidelines to address the roles and responsibilities of each entity.

Refer to Appendix 2 of this section for coordination of services guidelines between HMOs and case management providers.

Special Managed Care Programs

The following special managed care programs include case management as a covered service; therefore, case management may not be billed separately to Wisconsin Medicaid for persons enrolled in these programs:

- Children Come First (CCF).
- Community Care for the Elderly.
- Community Health Partnership.
- Community Living Alliance.
- Elder Care Options.
- Wraparound Milwaukee (WAM).

Refer to the Medicaid Web site at www.dhfs.state.wi.us/medicaid/ for further updates to this list of special managed care programs.

For more information on case management for recipients enrolled in these special managed care programs, please contact the special managed care program directly.

Refer to the Provider Resources section of the All-Provider Handbook for information on identifying a recipient's managed care status.

Family Care

Wisconsin Medicaid does not separately cover case management services for recipients enrolled in Family Care. For more information on case management services for recipients enrolled in Family Care, contact the care management organization (CMO). A list of CMOs is included in the Family Care Guide, which can be found on the Medicaid Web site at www.dhfs.state.wi.us/medicaid/.

Community Support Programs

Wisconsin Medicaid does not reimburse case management providers for case management services provided to recipients receiving Medicaid-reimbursed community support program (CSP) services. Case management services provided to CSP recipients should be billed under the Medicaid CSP benefit, not the case management benefit. Information on CSP services can be found in the Wisconsin Medicaid Community Support Program Handbook.

Wisconsin Medicaid covers case management services on a fee-forservice basis for recipients enrolled in a Medicaidcontracted HMO, including **Independent Care** (commonly referred to as iCare) in Milwaukee.

Appendix

Appendix 1

General Program Revenue "Matching" Fund Requirements

Wisconsin Medicaid is funded by a combination of state/local and federal funds. In order for the state to collect the approximately 60% federal share, Wisconsin Medicaid has to secure approximately 40% as the state share. For Medicaid case management, existing state and local funding constitutes this state match. This could be county tax levy, Community Options Program funds, Family Support monies, Alzheimer's Caregiver Support funds, Life Care Services Program funds under s. 252.12, Wis. Stats., funding for Independent Living Centers under s. 46.96, Wis. Stats., or any state general program revenue (GPR) aids allocated to county agencies administering case management services to eligible recipients.

Medicaid-certified case management agencies must have sufficient state or local funding to serve as the nonfederal share of case management reimbursement and must maintain an audit trail to document expenditures for eligible recipients.

There are two limitations on funds allowable for matching funds:

- 1. Federal monies cannot be used to match the federal share of Medicaid dollars, unless the federal funds are authorized for this purpose.
- 2. Local funds already being used to match other federal funds cannot be used as a match for case management. Examples of this include:
 - The same local funds cannot be claimed as a match for community support program services and case management.
 - The same local funds may not be claimed as a match for maternal/child health block grants and case management.

for current policy

Appendix 2

Guidelines for the Coordination of Services Between Medicaid-Contracted HMOs and Medicaid Case Management Agencies

The purpose of this attachment is to identify the roles and responsibilities of Medicaid-contracted HMOs and case management agencies when they are working with common recipients. This same language is also incorporated as an addendum to the HMO contract to ensure that both HMOs and case management providers have the same language available to them.

HMO Rights and Responsibilities

- 1. The HMO must designate at least one individual to serve as a contact person for case management providers. If the HMO chooses to designate more than one contact person, the HMO must identify the target populations for which each contact person is responsible.
- 2. The HMO may make referrals to case management agencies when they identify a recipient from an eligible target population who they believe could benefit from case management services.
- 3. If the recipient or case manager requests the HMO to conduct an assessment, the HMO determines whether there are signs and symptoms indicating the need for an assessment. If the HMO finds that an assessment is needed, the HMO determines the most appropriate level for an assessment to be conducted (e.g., primary care physician, specialist, etc.). If the HMO determines that no assessment is needed, the HMO documents the rationale for this decision.
- 4. The HMO must determine the need for medical treatment of those services covered under the HMO contract based on the results of the assessment and the medical necessity of the treatment recommended.
- 5. The HMO case management liaison, or other appropriate staff as designated by the HMO, must participate in case planning with the case management agency, unless no services provided through the HMO are required:

ior current policy

- The case planning may be done through telephone contact or means of communication other than attending a formal case planning meeting.
- The HMO must informally discuss differences in opinion regarding the HMO's determination of treatment needs if requested by the recipient or case manager.
- The HMO case management liaison and the case manager must discuss who is responsible for ensuring that the recipient receives the services authorized by and provided through the HMO.
- The HMO's role in the case planning may be limited to a confirmation of the services the HMO authorizes if the recipient and case manager find these acceptable.

Case Management Agency Rights and Responsibilities

- 1. The case management provider is responsible for initiating contact with the HMO to coordinate services to recipient(s) they have in common and providing the HMO with the name and telephone number of the case manager(s).
- 2. If the HMO refers a recipient to the case management provider, the case management provider must conduct an initial screening based on their usual procedures and policies. The case management provider must determine whether or not they will provide case management services and notify the HMO of this decision.
- 3. The case manager must complete a comprehensive assessment of the recipient's needs according to the requirements in the Case Management Services Handbook. This includes a review of the recipient's physical and dental health needs.

- 4. If the case manager requires copies of the recipient's medical records, the case manager must obtain the records directly from the service provider, not the HMO.
- 5. The case manager must identify whether the recipient has additional service or treatment needs. As a part of this process, the case manager and the recipient may seek additional assessment of conditions that the HMO may be expected to treat under the terms of its contract, if the HMO determines there are specific signs and symptoms indicating the need for an assessment.
- The case management provider may not determine the need for specific medical care covered under the HMO contract, nor may the case manager make referrals directly to specific providers of medical care covered through the HMO.
- 7. The case manager must complete a comprehensive case plan according to the Case Management Services Handbook's requirements. The plan must include the medical services the recipient requires as determined by the HMO.
- 8. If the case manager specifically requests the HMO liaison to attend a planning meeting in person, the case management provider must reimburse the HMO for the costs associated with attending the planning meeting. These are allowable costs for case management reimbursement through Wisconsin Medicaid.

Nothing in these guidelines precludes the HMO and the case management agency from entering into a formal contract or Memorandum of Understanding to address issues not outlined here.

Appendix 3

Wisconsin Medicaid Case Management Agency Self-Audit Checklist

This form is a self-audit checklist for case management policies only. Refer to the Provider Rights and Responsibilities section of the All-Provider Handbook for additional provider requirements. Use of this form is strictly voluntary.

Recipient:	Date:		
Agency:	Checklist comple	eted by:	
1. AGENCY REQUIREMENTS		YES	NO
The agency has accurately designated the target population(s) it will	be serving.		
Written procedures are in place for determining and documenting a caqualifications.	Ü		
Agency is in compliance with the Provider Rights and Responsibilities Provider Handbook.			
A signature page is in the recipient's file, if initials are used in the doc	umentation.		
2. RECIPIENT INFORMATION			
The client is Medicaid eligible and meets the definition of one or more populations the agency has elected to serve.			
The person is not receiving Medicaid-covered hospital or nursing hom time the case management services are being provided, except when	e services at the		
For severely emotionally disturbed (SED) persons under age 21, there documentation of the three-member team's (including a psychiatrist of SED finding or the evidence that the child has been admitted to an inproject under s. 46.56, Wis. Stats.	or psychologist)		
3. ASSESSMENT			
The following information, as appropriate, is completed and in the rec			
a. Recipient identifying information (for example, the "Face Shee			
 Record of physical and mental health assessments and consident potential for rehabilitation. 			
c. A review of the recipient's performance in carrying out activities such as mobility levels, personal care, household chores, personal the amount of assistance required.			
d. Social interactive skills and activities.			
e. Record of psychiatric symptomatology and mental and emotion	nal status.		
 f. Identification of social relationships and support (informal care family, friends, volunteers; formal service providers; significan relationships; social environments). 	·		
 g. A description of the recipient's physical environment, especially home mobility and accessibility. 	y regarding in-		
h. In-depth financial resource analysis, including identification of with, insurance, veteran's benefits, and other sources of financial			
 i. Vocational and educational status and daily structure, if approfor employment; educational/vocational needs; appropriateness of educational, rehabilitational, and vocational programs). 	priate (prognosis		
j. Legal status, if appropriate (guardian relationships, involvement	nt with the legal		

system)

Appendix 3 (Continued)

3. ASSESSMENT (CONT.)	YES	NO
k. For any recipient under age 21 identified as SED, a record of the multi-		
disciplinary team evaluation required under s. 49.45(25), Wis. Stats.		
I. The recipient's need for housing, residential support, adaptive equipment, and		
assistance with decision making.		
m. Assessment of drug and/or alcohol use and misuse for recipients indicating		
possible alcohol and drug dependency.		
n. Accessibility to community resources that the recipient needs or wants.		
o. For families with children at risk, an assessment of other family members, as		
appropriate.		
p. For families with children at risk, an assessment of family functioning.		
q. For families with children at risk, identification of other case managers working	,	
with the family and their responsibilities.		
4. CASE PLAN DEVELOPMENT		<u> </u>
The recipient's file contains a written case plan identifying the short- and long-term go		
the following information (for families with children at risk, the plan should address the	e Medicaid-	
eligible child and services to other Medicaid-eligible family members): a. Problems identified during the assessment.		l
b. Goals to be achieved.		
 Identification of formal services to be arranged for the recipient, including names of the service providers and costs. 		
d. Development of a support system, including a description of the recipient's		
informal support system. To the Online Handbook		
e. Identification of individuals who participated in developing the plan of care.		
f. Schedule of initiation and frequency of various services arranged.		
g. Documentation of unmet needs and gaps in service.		
h. For families with children at risk, identification of how services will be		
coordinated by multiple case managers working with the family (if applicable).		
i. Frequency of monitoring by the case manager.		
j. The case plan is signed and dated. Each update to the case plan must be		
signed and dated.		
5. ONGOING MONITORING AND SERVICE COORDINATION		
a. For ongoing monitoring and service coordination, there is one, identified		
individual who serves as the case manager and is known and available to the		
recipient.		
b. All recipient collateral contacts, including travel time incurred to provide case		
management services, are recorded in the case file.		
c. All record keeping necessary for case planning, coordination, and service		
monitoring is recorded in the recipient's file. d. There has been at least one documented recipient or collateral contact, case-		
d. There has been at least one documented recipient or collateral contact, case- specific staffing, or formal case consultation during a month when time was		
billed for record keeping.		
e. The case manager has monitored the recipient and collaterals according to the		
frequency identified in the case plan.		
f. The case manager has signed (or initialed) and dated all entries in the		
recipient's file.		

Appendix 3 (Continued)

6. DISCHARGE PLANNING	YES	NO
a. Discharge-related case management services billed on a recipient's behalf	who	
has entered a hospital inpatient unit, nursing facility, or ICF/MR (following	j an	
initial assessment or case plan) have been billed under procedure code W	7062.	
b. Discharge planning services were provided within 30 days of discharge.		
c. Services billed as discharge planning do not duplicate discharge planning		
services that the institution normally is expected to provide as part of inpa	atient	
services.		
7. MAINTENANCE OF CASE RECORDS		
A written record of all monitoring and quality assurance activities is included in the	e recipient's file	and
has the following:		
a. Name of recipient.		
b. The full name and title of the person who made the contact. If initials are		
in the case records, the file includes a signature page showing the full nar	ne.	
c. The content of the contact.		
d. Why the contact was made.		
e. How much time was spent.		
f. The date the contact was made.		
g. Where the contact was made.		
8. BILLING REQUIREMENTS		
One of the following activities has been performed prior to billing for targeted case	se management:	
 Face-to-face and telephone contacts with the recipient: 	K	
 To assess or reassess needs. 		
 To plan or monitor services to ensure access or adequacy of services. 	ces.	
To monitor recipient satisfaction with care.		
b. Face-to-face and telephone contact with collaterals (paid providers, family	,	
members, guardians, housemates, school representatives, friends, volunte	eers,	
or others involved with the client):		
 To mobilize services and support. 		
 To educate collateral of the needs, goals, and services identified in 	ı the	
plan.		
 To advocate on behalf of the recipient. 		
 To evaluate/coordinate services in the plan. 		
 To monitor collateral satisfaction or participation in recipient care. 		
9. NONBILLABLE SERVICES		
Wisconsin Medicaid does not cover the following as Medicaid case management s	ervices:	
a. Diagnosis, evaluation, or treatment of a physical, dental, or mental illness		
b. Monitoring of clinical symptoms.		
c. Administration of medication.		
d. Recipient education and training.		
e. Legal advocacy by an attorney or paralegal.		
f. Provision of supportive home care, home health care, or personal care.		
g. Information and referral services which are not based on a recipient's plan	n of	
care.	. 5.	

Appendix 3 (Continued)

9. NO	NBILLABLE SERVICES (CONT.)	YES	NO
h.	Ongoing monitoring to a resident of a Medicaid-funded hospital, SNF, ICF, or ICF-MR, except for the 30 days before discharge.		
i.	Case management to Medicaid waiver recipients, except for the first month of waiver eligibility.		
j.	Duplicative discharge planning from an institution.		
k.	Services other than case management covered under Wisconsin Medicaid.		
I.	For Group A target populations, more than one assessment or case plan per year with no change in county of residence.		
m.	For Group A target populations, more than two assessments or case plans per year with a change in county of residence.		
n.	For Group B target populations, more than two assessments or case plans per year.		
0.	Costs for more than one case manager (unless there is a qualified temporary replacement).		
p.	Services during periods in which the recipient was not Medicaid eligible, including periods of time when a recipient is detained by the legal process, is in jail or other secure detention, or when an individual 22 to 64 years of age is in an IMD.		
q.	Interpreter services.		
r.	Case management to recipients enrolled in Family Care, special managed care programs, or a community support program (CSP).		
S.	Any service not specifically listed as covered in the Case Management Services Handbook.		

NOTE: In sections 1 through 8 of this checklist, the answers should be "yes." Answers to section 9 should be "no." for current policy

Glossary of Common Terms

Adjustment

A modified or changed claim that was originally allowed, at least in part, by Wisconsin Medicaid.

BadgerCare

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or "crowding out" private insurance.

BadgerCare benefits are identical to the benefits and services covered by Wisconsin Medicaid and recipients' health care is administered through the same delivery system.

CMS

Centers for Medicare and Medicaid Services. An agency housed within the U.S. Department of Health and Human Services (DHHS), CMS administers Medicare, Medicaid, related quality assurance programs, and other programs. Formerly known as the Health Care Financing Administration (HCFA).

Collateral

A collateral is anyone who has direct supportive contacts with the recipient. Collaterals include family members, friends, service providers, guardians, housemates, or school officials.

CPT

Current Procedural Terminology. A listing of descriptive terms and codes for reporting medical, surgical, therapeutic, and diagnostic procedures. These codes are developed, updated, and published annually by the American Medical Association and adopted for billing purposes by the Centers for Medicare and Medicaid Services (CMS) and Wisconsin Medicaid.

DHCF

Division of Health Care Financing. The DHCF administers Wisconsin Medicaid for the Department of Health and Family Services (DHFS) under statutory provisions, administrative rules, and the state's Medicaid plan. The state's Medicaid plan is a comprehensive description of the state's Medicaid

program that provides the Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of Health and Human Services (DHHS), assurances that the program is administered in conformity with federal law and CMS policy.

DHFS

Wisconsin Department of Health and Family Services. The DHFS administers the Wisconsin Medicaid program. Its primary mission is to foster healthy, selfreliant individuals and families by promoting independence and community responsibility; strengthening families; encouraging healthy behaviors; protecting vulnerable children, adults, and families; preventing individual and social problems; and providing services of value to taxpayers.

DHHS

Department of Health and Human Services. The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

The DHHS includes more than 300 programs, covering a wide spectrum of activities, including overseeing Medicare and Medicaid; medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; and providing financial assistance for low-income families.

DOS

for current

Date of service. The calendar date on which a specific medical service is performed.

Emergency services

Those services which are necessary to prevent the death or serious impairment of the health of the individual. (For the Medicaid managed care definition of emergency, refer to the Managed Care Guide or the Medicaid managed care contract.)

EOB

Explanation of Benefits. Appears on the providers' Remittance and Status (R/S) Report and informs Medicaid providers of the status of or action taken on their claims.

Glossary (Continued)

EVS

Eligibility Verification System. The EVS allows providers to verify recipient eligibility prior to providing services. Providers may access recipient eligibility information through the following methods:

- Wisconsin Medicaid's Automated Voice Response (AVR) system.
- Commercial magnetic stripe card readers.
- Commercial personal computer software or Internet access.
- Wisconsin Medicaid's Provider Services (telephone correspondents).
- Wisconsin Medicaid's Direct Information Access Line with Updates for Providers (Dial-Up).

Fee-for-service

The traditional health care payment system under which physicians and other providers receive a payment for each unit of service provided rather than a capitation payment for each recipient.

Fiscal agent

The Department of Health and Family Services (DHFS) contracts with Electronic Data Systems (EDS) to provide health claims processing services for Wisconsin Medicaid, including provider certification, claims payment, provider services, and recipient services. The fiscal agent also issues identification cards to recipients, publishes information for providers and recipients, and maintains the Wisconsin Medicaid Web site.

HCPCS

Healthcare Common Procedure Coding System. A listing of services, procedures, and supplies offered by physicians and other providers. HCPCS includes Current Procedural Terminology (CPT) codes, national alphanumeric codes, and local alphanumeric codes. The national codes are developed by the Centers for Medicare and Medicaid (CMS) in order to supplement CPT codes.

HMO

Health Maintenance Organization. Provides health care services to enrolled recipients.

ICD-9-CM

International Classification of Diseases, Ninth Revision, Clinical Modification. Nomenclature for all medical diagnoses required for billing. Available through the American Hospital Association.

Maximum allowable fee schedule

A listing of all procedure codes allowed by Wisconsin Medicaid for a provider type and Wisconsin Medicaid's maximum allowable fee for each procedure code.

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for people with disabilities, people 65 years and older, children and their caretakers, and pregnant women who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Medicaid is also known as the Medical Assistance Program, Title XIX, or T19.

Medically necessary

According to HFS 101.03(96m), Wis. Admin. Code, a Medicaid service that is:

- (a) Required to prevent, identify or treat a recipient's illness, injury or disability; and
- (b) Meets the following standards:
 - 1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
 - 2. Is provided consistent with standards of acceptable quality of care applicable to type of service, the type of provider and the setting in which the service is provided;
 - 3. Is appropriate with regard to generally accepted standards of medical practice;
 - 4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;

Glossary (Continued)

- 5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;
- 6. Is not duplicative with respect to other services being provided to the recipient;
- 7. Is not solely for the convenience of the recipient, the recipient's family or a provider;
- 8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
- 9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

POS

Place of service. A single-digit code which identifies where the service was performed.

R/S Report

Remittance and Status Report. A statement generated by the Medicaid fiscal agent to inform providers regarding the processing of their claims.

TOS

Type of service. A single-digit code which identifies the general category of a procedure code.

Audit, 10 Case Manangement Self-Audit Checklist, 10, 19

Certification, 7 Private, nonprofit entities, 7 Providers, 7 Requirements, 7 Public entities, 7 Subcontracted staff, 9 Provider responsibilities for, 9

Contracted hourly rate, 9

Eligibility categories, 11 Qualified Medicare Beneficiary (QMB)-only recipients, 11

Eligibility Verification System, 11

Federal share, 15

Freedom to choose providers, 11

General program revenue "matching," 15

Medicaid-contracted HMOs, 12 Coordination of services guidelines, 17

Qualified staff, 8

Case Management Services



Important Telephone Numbers

The Wisconsin Medicaid Eligibility Verification System (EVS) is available through the following resources to verify checkwrite information, claim status, prior authorization status, provider certification, and/or recipient eligibility.

Service	Information Available	Telephone Number	Hours
Automated Voice Response (AVR) System (Computerized voice response to provider inquiries.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	(800) 947-3544 (608) 221-4247 (Madison area)	24 hours a day/ 7 days a week
Personal Computer Software and Magnetic Stripe Card Readers	Recipient Eligibility*	Refer to Provider Resources section of the All-Provider Handbook for a list of commercial eligibility verification vendors.	24 hours a day/ 7 days a week
Provider Services (Correspondents assist with questions.)	Checkwrite Information Claim Status Prior Authorization Status Provider Certification Recipient Eligibility*	(800) 947-9627 (608) 221-9883 ent policy	Policy/Billing and Eligibility: 8:30 a.m 4:30 p.m. (M, W-F) 9:30 a.m 4:30 p.m. (T) Pharmacy: 8:30 a.m 6:00 p.m. (M, W-F) 9:30 a.m 6:00 p.m. (T)
Direct Information Access Line with Updates for Providers (Dial-Up) (Software communications package and modem.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	Call (608) 221-4746 for more information.	7:00 a.m 6:00 p.m. (M-F)
Recipient Services (Recipients or persons calling on behalf of recipients only.)	Recipient Eligibility Medicaid-Certified Providers General Medicaid Information	(800) 362-3002 (608) 221-5720	7:30 a.m 5:00 p.m. (M-F)

^{*} Please use the information exactly as it appears on the recipient's identification card or the EVS to complete the patient information section on claims and other documentation. Recipient eligibility information available through the EVS includes:

- Dates of eligibility.
- Medicaid managed care program name and telephone number.
- Privately purchased managed care or other commercial health insurance coverage.
- Medicare coverage.
- Lock-In Program status.
- Limited benefit information.

Table of Contents

Preface
Introduction
Definition of Case Management
Target Populations
Selection of Target Population Target Population Description Group A Target Populations Group B Target Populations 1 Eligibility Determinations and Case Management Assessments
General Policy for Assessments and Case Plans
Frequency of Comprehensive Assessments and Case Plans for Group A Target Populations
Assessment Policy1
Required Components
Case Plan Development 1
Required Components
Ongoing Monitoring and Service Coordination1
What Is Ongoing Monitoring and Service Coordination?

Ongoing Review of the Case Plan by the Single Designated Case Manager	21
Case-Specific Staffing and Meetings with Unit Supervisors	
Information and Referral	
Case Management on Behalf of Family Members Who Are Not Medicaid Eligible	
Court-Related Service Coordination and Medicaid Case Management	22
Duplication of Services	
Case Management Services Provided to Children in Out-of-Home Placement	23
Covered Case Management Activities	23
County Staff Providing Case Management Services to Children in Out-of-Home	
Placement	23
Institutional Discharge Planning	25
Maintenance of Case Records	27
Maintenance of Case Records Guidance	27
Complete Case Note Example	
Incomplete Case Note Example	
Common Questions and Answers	
Noncovered Services	29
Noncovered ServicesOther LimitationsARCH.V.ASE.O.NY	29
Other LimitationsA.K.U.H.I.V.AIU.S.EU.N.I.Y	29
Appendix Refer to the Online Handbook	31
Target Population Codes and Procedure Codes for Case Management Services	33
 Case Management Target Population "Change Request" Form 	35 35
Wisconsin Medicaid Case Management Recipient Face Sheet Sample	
4. Sample Completed Wisconsin Medicaid Case Management Case Plan	
 Sample Completed Wisconsin Medicald Gase Management Gase Flands Sample Completed Monthly Log for Ongoing Monitoring and Service Coordination 	
6. Birth to 3 Service Coordination and Wisconsin Medicaid Case Management	
7. All Target Populations Court-Related Service Coordination	10
and Medicaid Case Management	45
Local Health Department Coordination and Medicaid Case Management	
9. Group B Target Populations Eligibility Requirements and Required Documentation	
10. Definitions of Illnesses and Disabilities	
11. Common Questions About Medicaid Case Management	
Glossary of Common Terms	
Glossary or Common Terms	J7
Index	63

Preface

The Wisconsin Medicaid and BadgerCare Case Management Handbook is issued to case management providers who are Wisconsin Medicaid certified. It contains information that applies to *fee-for-service* Medicaid providers. The Medicaid information in the handbook applies to both Medicaid and BadgerCare.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid and BadgerCare. As of January 2003, BadgerCare extends Medicaid coverage to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. BadgerCare recipients receive the same health benefits as Wisconsin Medicaid recipients and their health care is administered through the same delivery system.

Medicaid and BadgerCare recipients enrolled in state-contracted HMOs are entitled to at least the same benefits as fee-for-service recipients; however, HMOs may establish their own requirements regarding prior authorization, billing, etc. If you are an HMO network provider, contact your managed care organization regarding its requirements. Information contained in this and other Medicaid publications is used by the DHCF to resolve disputes regarding covered benefits that cannot be handled internally by HMOs under managed care arrangements.

Verifying Eligibility

Wisconsin Medicaid providers should always verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage. Wisconsin Medicaid's Eligibility Verification System (EVS) provides eligibility information that providers can access a number of ways.

Refer to the Important Telephone Numbers page at the beginning of this section for detailed information on the methods of verifying eligibility.

Handbook Organization

The Case Management Handbook consists of the following sections:

- General Information.
- Covered and Noncovered Services.
- Billing.

In addition to the Case Management Handbook, each Medicaid-certified provider is issued a copy of the All-Provider Handbook. The All-Provider Handbook includes the following sections:

- Claims Submission.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Prior Authorization.
- Provider Certification.
- Provider Resources.
- Provider Rights and Responsibilities.
- Recipient Rights and Responsibilities.

Legal Framework of Wisconsin Medicaid and BadgerCare

The following laws and regulations provide the legal framework for Wisconsin Medicaid and BadgerCare:

Federal Law and Regulation

- Law: United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
- Regulation: Title 42 CFR Parts 430-498 Public Health.

Wisconsin Law and Regulation

- Law: Wisconsin Statutes: Sections 49.43-49.499 and 49.665.
- Regulation: Wisconsin Administrative Code, Chapters HFS 101-108.

Handbooks and Wisconsin Medicaid and BadgerCare Updates further interpret and implement these laws and regulations.

Handbooks and *Updates*, maximum allowable fee schedules, helpful telephone numbers and addresses, and much more information about

Wisconsin Medicaid and BadgerCare are available at the following Web sites:

www.dhfs.state.wi.us/medicaid/ www.dhfs.state.wi.us/badgercare/.

Medicaid Fiscal Agent

The DHFS contracts with a fiscal agent, which is currently EDS.

Introduction

Definition of Case Management

Case management includes gaining access to or coordinating non-Medicaid services as well as Medicaid services.

Per HFS 107.32(1)(a)1, Wis. Admin. Code, case management services assist recipients and, when appropriate, their families *gain access* to and *coordinate* a full array of services, including medical, social, educational, vocational, and other services. These case management services include all of the following:

- Assessment [HFS 107.32(1)(b), Wis. Admin. Code].
- Case plan development [HFS 107.32(1)(c), Wis. Admin. Code].
- Ongoing monitoring and service coordination [HFS 107.32,(1)(d), Wis. Admin. Code].

Case Management and Non-Medicaid Services

Case management includes gaining access to or coordinating non-Medicaid services as well as Medicaid services. Examples of gaining access to or coordinating non-Medicaid services include, but are not limited to:

- Assisting recipients in accessing energy assistance.
- Assisting recipients in accessing housing.
- Assisting recipients in accessing legal advocacy.
- Assisting recipients in accessing social services.
- Setting up a volunteer/supportive home care worker to take a recipient shopping.

Case Management Does Not Include Service Provision

Wisconsin Medicaid does not cover service provision as part of the case management

benefit. The following are examples of activities *not* covered as case management services. (Wisconsin Medicaid may cover some of these activities under another Medicaid benefit. Example: some skill training may be covered under the community support program benefit.) Activities not covered as case management services include, but are not limited to:

- Medication set-up.
- Money management.
- Skill training.
- Taking a client shopping.
- Transporting clients (except as noted in Appendix 11 of this section).

Birth to 3 Service Coordination and Medicaid Case Management

Refer to Appendix 6 of this section for more information about Birth to 3 service coordination and Medicaid case management.

Local Health Departments and Medicaid Case Management

Refer to Appendix 8 of this section for information about assessments, case plans, and ongoing monitoring and service coordination for local health departments providing case management services.

Target Populations

Selection of Target Population

Eligible public entities

and independent living

centers may serve all

populations; however,

in their certification

cover.

providers must indicate

paperwork which target

populations they plan to

Medicaid target

Eligible public entities and independent living centers may serve all Medicaid target populations; however, providers must indicate in their certification paperwork which target populations they plan to cover. Private, nonprofit entities funded under s. 252.12(2)(a)8, Wis. Stats., are eligible for Medicaid reimbursement for case management services provided only to persons diagnosed with Human Immunodeficiency Virus (HIV).

After the initial certification process, during which initial target population selection(s) is made, providers may add or delete target populations anytime by completing the Target Population Change Request Form subject to the following provisions:

1. Providers *adding* target population(s) 2 must specify if they want the population added retroactive to the first day of the calendar quarter or when Wisconsin 3 Medicaid receives the form.

keter to the

2. Providers *subtracting* population(s) must specify if they want the subtraction(s) effective when Wisconsin Medicaid receives the form, or at a date after Wisconsin Medicaid receives the form, as specified on the form.

Refer to Appendix 2 of this section for the Target Population Change Request Form.

Target Population Description

In addition to meeting the eligibility requirements in the General Information section of this handbook, Medicaid recipients must belong to at least one of the following target populations, per s. 49.45(25), Wis. Stats.,

and be served by a Medicaid-certified case management provider that elected to serve recipients in the corresponding target populations.

Note:

For the purposes of identifying which policies apply to which populations, the target populations are divided by when they were authorized in Wisconsin Statutes. Group A target populations refer to those populations authorized in statutes *before* July 29, 1995. Group B target populations refer to those populations authorized in the 1995-97 budget and effective on and after July 29, 1995.

Group A Target Populations

The Group A target populations include all of the following:

- 1. Persons age 65 or over.
- 2. Persons with a physician's diagnosis of Alzheimer's disease or related dementia, as defined under s. 46.87(1)(a), Wis. Stats.
- 3. Persons who can be defined as having:
 - ✓ A developmental disability, as defined under s. 51.01(5)(a), Wis. Stats.
 - ✓ A chronic mental illness, as defined under s. 51.01(3g), Wis. Stats., and who are age 21 or over.
 - ✓ A physical or sensory disability, as defined in HFS 101.03 (122m), Wis. Admin. Code.
 - ✓ An alcohol or drug dependency, as defined under s. 51.01(1m) or (8), Wis. Stats., respectively.
- 4. Persons diagnosed as having HIV infection, as defined under s. 252.01 (2), Wis. Stats.
- 5. Persons who are severely emotionally disturbed (SED) and under age 21, as defined under s. 49.45(25)(a), Wis. Stats.

In order for a recipient to be considered SED, one of the following must occur:

- A three-person team of mental health experts (one must be a psychiatrist or psychologist) appointed by the provider must find that the child is SED. The finding and activities leading to the determination that a child is SED are not covered as part of Medicaid case management services. Providers must document and retain these findings in the client's clinical record.
- The recipient meets the requirements under s. 46.56, Wis. Stats. This makes the recipient eligible for admission to an Integrated Services Project as a child with severe emotional and behavioral problems.

Refer to Appendix 10 of this section for definitions of the above illnesses and disabilities.

Group B Target Populations

The Group B target populations include all of the following:

- 1. Families with a child/children at risk of serious physical, mental, or emotional dysfunction (also referred to as family case management). This target population has five subgroups:
 - Families with a child/children with special health care needs, including children with lead poisoning.
 - Families with a child/children who is/ are at risk of maltreatment.
 - Families with a child/children involved in the juvenile justice system.
 - Families where the primary caregiver has a mental illness, developmental disability, or substance abuse disorder.
 - Families where the mother required prenatal care coordination services.
- Children enrolled in a Birth to 3 program under HFS 90. Wis. Admin. Code.
- Children with asthma.

- Individuals infected with tuberculosis.
- Women age 45 to 64.

Refer to Appendix 9 of this section for Group B target population eligibility requirements, required documentation, and target population definitions.

Refer to Appendix 1 of this section for target population codes and procedure codes for case management services.

Eligibility **Determinations and** Case Management Assessments

Case managers may complete some components of the comprehensive assessment as part of a determination that a recipient meets any target populations' eligibility criteria. Bill the time for completing this as part of the case management assessment when the person is found eligible for case management. If the recipient is found not eligible for case management in any of the target populations, Wisconsin Medicaid will not cover the assessment. In addition, Wisconsin Medicaid does not reimburse for the three-person team determination that a child is SED.

Case managers may complete some components of the comprehensive assessment as part of a determination that a recipient meets any target populations' eligibility criteria.

General Policy for Assessments and Case Plans

Frequency of Comprehensive Assessments and Case Plans for Group A Target Populations

Wisconsin Medicaid covers:

- 1. Only one comprehensive assessment and one case plan development per recipient, per calendar year for Group A target populations unless the recipient's county of residence changes. If the recipient's county of residence changes, Wisconsin Medicaid covers a second assessment or case plan from a certified case management provider in the recipient's new county of residence.
- No more than two comprehensive
 assessments and case plans per calendar
 year even if the recipient's county of
 residence changes more than once.

Frequency of Comprehensive Assessments and Case Plans for Group B Target Populations

Wisconsin Medicaid covers up to two comprehensive case management assessments and the development of two case plans per calendar year for the Group B target populations even when recipients have not changed county of residence. The recipient's record must indicate the rationale for a new comprehensive assessment. Wisconsin Medicaid does not cover more than two comprehensive assessments and/or case plans per calendar year, even if the recipient subsequently changes county of residence.

Comprehensive Assessment Versus Ongoing Evaluation

The comprehensive assessment is the assessment of all components described in HFS 107.32(1)(b), Wis. Admin. Code, and in the Assessment Policy chapter of this section. Wisconsin Medicaid may cover the time spent by all the individuals participating in that assessment.

The ongoing evaluation is the review of the case plan or of the recipient's status. This activity must be performed by the single designated case manager and may be billed as ongoing monitoring and service coordination.

Assessments and Case Plans Must Predate Ongoing Monitoring and Service Coordination

A complete assessment and case plan must predate any covered ongoing monitoring and service coordination, except in emergency situations. Providers need not have billed Wisconsin Medicaid for either an assessment or a case plan prior to billing for ongoing monitoring and service coordination. Providers meet Medicaid requirements if the assessment is complete and a current case plan meeting the standards for Medicaid reimbursement is in the recipient's file. Wisconsin Medicaid defines "current" within the context of applicable departmental statutes, rules, and guidelines for the agencies or programs performing case management, if any.

When ongoing care coordination services are provided in an urgent situation, the provider is required to:

• Document the nature of the urgent situation.

A complete assessment and case plan must predate any covered ongoing monitoring and service coordination, except in emergency situations. Complete the assessment and case plan as soon as possible but no later than 60 days following the actions taken to alleviate the urgent situation.

Due to the public health risk presented by tuberculosis (TB)-infected recipients, Wisconsin Medicaid covers ongoing monitoring and service coordination for up to 90 days before completion of an assessment and case plan for recipients in the TB target population. Providers must complete the assessment and case plan as soon as possible, but not later than 90 days following the start of case management.

Performing Assessments and Case Plans

Wisconsin Medicaid allows for more than one individual to complete the comprehensive case management assessment and to prepare the case plan.

Wisconsin Medicaid covers services provided by any individual involved in case management assessment if the following requirements are met:

- The individual meets the qualifications in the General Information section of this handbook for performing case management assessments.
- The case record documents the participation of each individual in the assessment process.
- The case management agency incurred a cost for that individual providing the assessment.

Wisconsin Medicaid covers services provided by any individual involved in case planning if the following requirements are met:

- The case record documents the individual's participation in the case planning process.
- The case management agency incurred a cost for that individual providing the case planning service.

Wisconsin Medicaid covers some assessment or case planning activities under other Medicaid benefits. In this case, bill the activity to the other benefit. For example, if a Medicaid-certified occupational therapist (OT) conducts an assessment of adult activities of daily living which meets the Medicaid-covered services requirements for OT, Wisconsin Medicaid covers the services as OT services only, not as case management services.

Case managers must calculate the time spent on assessment and case planning for a recipient meeting these requirements and bill using the appropriate code from Appendix 1 of this section. Since Wisconsin Medicaid reimburses assessments and case plans only once or twice per year (depending on the target population), providers are required to bill all assessment time together and all case planning time together.

Wisconsin Medicaid allows for more than one individual to complete the comprehensive case management assessment and to prepare the case plan.

Assessment Policy

Required Components

Per HFS 107.32(1)(b), Wis. Admin. Code, case managers must perform a written comprehensive assessment of a person's abilities, deficits, and needs. Use persons from relevant disciplines to document service gaps and unmet needs. All services appropriate to the recipient's needs, regardless of availability or accessibility of providers, must be included in this comprehensive assessment.

Include any of the following as appropriate services regardless of whether they are covered by Wisconsin Medicaid or not:

- Educational.
- Medical.

Per HFS 105.51, Wis.

Admin. Code.

certified case

management

providers are

three case

management

components

section.

described in this

required to offer all

- Rehabilitative.
- Social.
- Vocational.

Per HFS 105.51, Wis. Admin. Code, certified case management providers are required to offer all three case management components described in this section. However, not all recipients assessed need case management. Based on the assessment, the case management agency may determine that further case management is not appropriate for a given recipient.

The individual(s) performing the assessment must document the following information in writing:

- Recipient identifying information.
- Record of physical and dental health assessments and consideration of potential for rehabilitation.
- A review of the recipient's performance in carrying out activities of daily living (ADLs) (e.g., mobility levels, personal care, household chores, personal business, and the amount of assistance required).
- Social interactive skills and activities.

- Record of psychiatric symptomatology and mental and emotional status.
- Identification of social relationships and support (e.g., informal caregivers, family, friends, volunteers, formal service providers, significant issues in relationships, social environments).
- A description of the recipient's physical environment, especially regarding inhome mobility and accessibility.
- In-depth financial resource analysis, including identification of and coordination with insurance, veterans' benefits, and other sources of financial assistance.
- The recipient's need for housing, residential support, adaptive equipment, and assistance with decision making.
- Vocational and educational status and daily structure, if appropriate (e.g., prognosis for employment; educational/vocational needs; appropriateness/availability of educational, rehabilitation, and vocational programs).
- Legal status, if appropriate (e.g., guardian relationships, involvement with the legal system).
- For any recipient identified as a person who is severely emotionally disturbed under age 21, a record of the multidisciplinary team evaluation required under s. 49.45(25), Wis. Stats., or evidence of his/her admission to an integrated services program meeting the requirements of s. 46.56, Wis. Stats.
- Access to community resources that the recipient needs or wants.
- Assessment of drug and/or alcohol use and misuse for recipients identified as alcohol or drug dependent or both.

All assessments must meet the standards for Community Options Program (COP) assessments, as defined in s. 46.27(6), Wis. Stats. Wisconsin Medicaid does not require providers to use a specific assessment tool.

To obtain a copy of the Department of Health and Family Services' COP Model Long-Term Care Assessment Tool, write:

Bureau of Aging and Long Term Care Resources Division of Supportive Living Room 450 P.O. Box 7851 Madison, WI 53707-7851

Additional Assessment Requirements for Families with a Child at Risk of Physical, Mental, or Emotional **Dysfunction (Group B** Target Population)

In addition to completing the 14 required assessment components described in this section for the identified at-risk child, the assessment for families with a child at risk of physical, mental, or emotional dysfunction must also include the following components:

- 1. Assessment of the primary caregiver's needs, when that person's condition (e.g., mental illness, substance abuse disorder, or maltreatment) is the primary reason for the child being at risk. The assessment must include those components of the comprehensive assessment that are applicable to the caregiver's situation. This component of the assessment is not necessary if the caregiver already has a Medicaid case manager.
- Assessment of the needs of the family's other child(ren) when the conditions placing the identified child at risk might also place the other child(ren) at risk (e.g., maltreatment). The assessment must include only those components of the comprehensive assessment applicable to the other child(ren). Where components of the assessment apply equally to the identified at-risk child and other child(ren)

in the family, do not duplicate these components in the assessments of the family's other child(ren) (e.g., needs of the primary caregiver). This component of the assessment is not necessary if the other child(ren) already has/have a Medicaid case manager.

- Assessment of the family's functioning as a system as it impacts the family's ability to provide for the identified at-risk child's needs and the family's other child(ren) deemed at risk after further assessment. The following are examples of factors for further assessment:
 - Family communication whether family communication is open, clear, and effective, or interfering with healthy family functioning.
 - Family organization and structure — within the family, whether appropriate boundaries exist between adults and children, or if the family is cohesive and organized, or unstable and chaotic.
 - Family relationships whether relationships are satisfying, how emotions are expressed, and if there is a history of violence.
 - Family decision-making if the family has an effective problemsolving process.
 - Family resources/support how the family uses formal and informal community resources, and what support is available to the family.
 - Family integration into the community — whether the family is isolated or involved with the community.
 - Family demographics how work, housing, child care, or health issues impact the family, and how the family handles stress from these factors.
- Identification of other case managers who are working with members of the family and their activities with the family.

The assessment must include those components of the comprehensive assessment that are applicable to the caregiver's situation. This component of the assessment is not necessary if the caregiver already has a Medicaid case manager.

Assessment Guidance

Assessments for Children and Adolescents (Group A and B Target Populations)

Some COP assessment components use language more applicable to adults. Case managers must interpret the assessment components in a manner consistent with the recipient's needs. Educational needs, for instance, may include an infant's need for cognitive stimulation by the caregivers, even when "formal" education is not required. The safety of the physical environment may require, for example, outlet plugs in homes with toddlers.

A variety of children's assessment instruments evaluate the child's progress toward basic developmental milestones (Denver II, Wisconsin Model for Ongoing Child Protective Services) and measure all or some of the following areas:

- Learning/cognitive development.
- Mobility/physical development.
- Self direction/social and emotional development.

Wisconsin Medicaid considers these assessment instruments to meet the requirements for reviewing the recipient's performance while performing ADLs and his/ her social status and skills. In the absence of other psychiatric symptoms which require further professional evaluation, these assessment instruments also meet the requirements to evaluate mental and emotional status.

Self-care/adaptive activities. Nine Handbook

Receptive and expressive language/ communication. CURRENT POLICY

Case managers must interpret the assessment components in a manner consistent with the recipient's needs.

Case Plan Development

To the maximum extent possible, the case plan development is a group process involving the recipient, family or other support system, and case manager.

Required Components

Following the assessment and determination of case management needs, the case manager develops a written plan of care (case plan) to address the recipient's needs and, if appropriate, to enable the recipient to live in the community. To the maximum extent possible, the case plan development is a group process involving the recipient, family or other support system, and case manager. This negotiated agreement of short and long term care objectives include:

- Development of a support system, including a description of the recipient's informal support system.
- Documentation of unfulfilled needs and gaps in service.
- Goals to be achieved.
- Identification of all formal services arranged for the recipient, including costs and the service provider's names.
- Identification of individuals who participated in the case plan development.
- Problems identified during the assessment.
- Schedules of initiation and frequency of the various services available to the recipient.

For every recipient receiving case management services, the written case plan must guide the case management services. Refer to Appendix 4 of this section for a completed sample case plan form. Providers may create their own form, as long as their created form contains the same information as Appendix 4. The case manager must sign and date the case plan.

Additional Case Plan Requirements for Families with a Child at Risk of Physical, Mental, or Emotional Dysfunction (Group B)

For family case management, the case plan must address the case plan components above as they apply to the needs assessment of the identified at-risk child, Medicaid-eligible caregivers, and the family's other Medicaid-eligible children.

Also, when multiple family members have case managers, the case plan must identify how the activities of the various case managers are coordinated. Services may not be duplicated. This policy applies even if the other case manager's services are not related to the specific conditions placing the identified child at risk. The family's preferences concerning which case manager should provide different services must be considered when the case managers' roles overlap.

Frequency of Case Plan Reviews

At a minimum, the case manager must review the case plan in writing every six months. If the individuals developing the case plan decide to review the case plan more frequently, the case manager must document this in the case plan. This review must include input from the case manager and the recipient or parent/guardian or both and must be documented in the recipient's record. The case manager and recipient or parent/guardian may agree to include other persons. The case manager must sign or initial and date all updates to the case plan.

Ongoing Monitoring and Service Coordination

What Is Ongoing Monitoring and Service Coordination?

According to HFS 107.32(1)(d), Wis. Admin. Code, ongoing case management services include:

Wisconsin Medicaid

does not cover

record keeping

unless there was

also a recipient or

collateral face-to-

face or telephone

contact during the

calendar month.

- Face-to-face and telephone contacts with recipients for the purpose of assessing or reassessing needs, or planning or monitoring services. This includes the case manager's travel time when providing the covered case management service.
- Face-to-face and telephone contact with collaterals when mobilizing services and support, advocating on behalf of a specific Medicaid-eligible recipient, educating collaterals on recipient needs and the goals and services specified in the plan, and evaluating and coordinating services specified in the plan. Collaterals include paid providers, family members, guardians, housemates, school representatives, friends, volunteers, and others involved with the recipient.

Document *all* collateral contacts. This includes travel time incurred when providing the covered case management service. 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 recipient.

- Record keeping as necessary for case planning, coordination, and service monitoring. Record keeping includes all of the following:
 - Entering notes about case activity into the recipient file.
 - ✓ Gathering data.
 - Preparing and responding to correspondence with recipients and collaterals.

- ✓ Preparing application forms for supportive home care, Community Options Program (COP), Community Integration Program I (CIP-IA), Community Integration Program II (CIP-IB), family support, and other community-based care programs.
- Preparing court reports.
- ✓ Updating case plans.

Case managers must document all time spent on the above services in the case record. Wisconsin Medicaid does not cover record keeping unless there was also a recipient or collateral face-to-face or telephone contact during the calendar month.

For ongoing monitoring and service coordination, the case manager does all of the following:

- Determines on an ongoing basis which services identified in the case plan have been or are being delivered.
- Determines if the services are adequate for the recipient's needs.
- Provides supportive contact to ensure that the recipient is able to access services, is actually receiving services, or is engaging in activities specified in the case plan.
- Monitors recipient and family satisfaction and participation.
- Identifies any change in the recipient's condition that would require an adjustment in the case plan.

This monitoring function may include independent monitoring for purposes of evaluating quality assurance.

For ongoing monitoring and service coordination, the case manager must:

 Monitor services to ensure that quality service is provided and to evaluate whether a particular service is effectively meeting the recipient's needs.

- Periodically, observe the actual delivery of services.
- Periodically, have the recipient evaluate the quality, relevance, and desirability of the services he or she is receiving.
- Record all monitoring and quality assurance activities and place the original records in the recipient's file.

Single, Designated Case Manager for Ongoing Monitoring

For purposes of ongoing monitoring, the recipient must have a single, designated case manager. Wisconsin Medicaid covers ongoing monitoring on the recipient's behalf provided by the single, designated case manager only. However, if the designated case manager is unavailable due to illness, vacation, or client crisis, Wisconsin Medicaid covers the time spent by a qualified temporary replacement providing ongoing monitoring services on the recipient's behalf. The reason for the substitution must be documented in the recipient's record.

Persons in both Group A and Group B target populations (refer to the Target Population chapter of this section for more information) are eligible for ongoing monitoring and service coordination (if they are Medicaid eligible on the date of this service), provided that all of the following apply:

- The recipient is eligible for and receiving services, in addition to case management, from an agency or through Wisconsin Medicaid which enables the recipient to live in a community setting.
- A case plan for this person is in the agency's files.
- The person is not receiving Medicaidcovered hospital or nursing home services at the time the case management services are being provided, except that institutional discharge planning may be

reimbursed as described in the Institutional Discharge Planning chapter in this section.

Frequency of Ongoing Monitoring

As part of the case planning process, the case manager must discuss and document the frequency of ongoing monitoring with the recipient/parent/guardian. This must include an indication of the frequency of contact with all of the following:

- Recipient.
- Parents/guardians.
- Collaterals, if applicable. Collaterals are other family, friends, providers, or anyone instrumental to the care plan.

The case manager must note the rationale for the frequency of monitoring in the recipient's record if the frequency of monitoring is less than the following:

- A face-to-face recipient/family/guardian contact every three months.
- A face-to-face or telephone contact with the recipient/family/guardian or a face-toface, telephone, or written contact with a collateral contact every month.

The case manager must base the rationale for the frequency of ongoing monitoring on one or more of the following factors:

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

Wisconsin Medicaid covers ongoing monitoring on the recipient's behalf provided by the single, designated case manager only.

Ongoing Review of the Case Plan by the Single Designated Case Manager

Wisconsin Medicaid reimburses:

Wisconsin Medicaid

expects the single,

manager to review

appropriateness on

an ongoing basis

needed changes.

and make any

designated case

the case plan's

- Comprehensive assessments only once per calendar year for Group A target populations, unless the recipient changes county of residence. Even if the recipient's county of residence changes more than once, Wisconsin Medicaid will not cover more than two assessments or case plans per calendar year.
- Comprehensive assessments two times per calendar year for Group B target populations.

However, Wisconsin Medicaid expects the single, designated case manager to review the case plan's appropriateness on an ongoing basis and make any needed changes. The case manager must sign or initial and date all changes to the case plan. The case manager may include this review in the monthly billings for ongoing monitoring and service coordination.

Case-Specific Staffing and Meetings with Unit Supervisors

HFS 107.32(1)(d), Wis. Admin. Code, includes case-specific staffing and meetings with unit supervisors in the definition of collateral contacts when the recipient's issues are discussed. Wisconsin Medicaid covers these activities under case management even if no other collateral or recipient contacts occurred during the month. Wisconsin Medicaid does not cover staffing or supervision time which is not client-specific as a case management service.

Information and Referral

Wisconsin Medicaid considers information and referral a covered case management service. Information and referral means providing recipients with information about available resources and programs as part of the process of helping recipients gain access to services. Case managers must inform recipients if the service has a cost. If the service is covered by Wisconsin Medicaid, provide the recipient with copayment information, if appropriate. Case managers should ensure timely follow-up on all referrals.

Case Management on Behalf of Family Members Who Are Not Medicaid Eligible

Wisconsin Medicaid covers case management with a family member not eligible for Wisconsin Medicaid (on a recipient's behalf) when:

- The case manager assists the family member to gain access to services and resources which are required because of the recipient's condition. For example, a Medicaid-eligible child is eligible for case management because of cerebral palsy. The parent needs to find specialized transportation so the child, who uses a power wheelchair, can receive treatment services. Wisconsin Medicaid covers the case manager assisting the parent in locating an appropriate transportation provider, even if the parent is not Medicaid eligible.
- The family member would not require access to the services or resources if the recipient did not have the condition that makes him or her eligible for case management. For example, a Medicaid-eligible child is found to be eligible for case management because of cerebral palsy. The parent requires education to learn about the disability and how to best care for the child.

Wisconsin Medicaid reimburses a case manager for assisting the parent in accessing an education group.

Wisconsin Medicaid does not cover a case manager assisting a family member not eligible for Wisconsin Medicaid gain access to services that the family member would require even in the absence of the Medicaid recipient's eligibility for case management services. For example, a Medicaid-eligible child is eligible for case management because of risk of abuse. The parent is found to require substance abuse treatment. Wisconsin Medicaid does not cover the case manager assisting a non-Medicaideligible parent to obtain substance abuse treatment, even though it might indirectly reduce the child's risk. The substance abuse treatment meets the parent's primary treatment needs.

When the other family member is Medicaid eligible, Wisconsin Medicaid covers those activities identified on the family case plan aimed at the other family member's service needs. This occurs even if the activities do not directly benefit the at-risk child in the family.

Court-Related Service Coordination and **Medicaid Case** Management

Refer to Appendix 7 of this section for detailed information about court-related service coordination and Medicaid case management.

Duplication of Services

Wisconsin Medicaid ordinarily covers only one family case manager per family. If more than one Medicaid-eligible child in a family is considered at risk, the single family case manager is responsible for assessing the needs of all of these children. If multiple case managers are providing case management to the family, these case managers must communicate with the family and with each

other to determine which provider will provide the family case management.

A family may have a child at risk of physical, mental, or emotional dysfunction while another family member is part of another eligible case management target population. This is highly likely when the parent's condition puts the child at risk, e.g., a parent with a mental illness or developmental disability. Since each case manager requires different knowledge, both case managers may remain involved with the individuals and family.

Wisconsin Medicaid covers both a family case manager and other case managers working with family members only if documentation shows that their activities have been coordinated through the case planning process to avoid duplication of efforts.

A given child may be eligible for case management under more than one target population, e.g., as a child at risk and as a child with developmental disabilities. The child's needs may bring that child in contact with multiple agencies eligible to provide case management, e.g., the Birth to 3 Program and local health department. However, Wisconsin Medicaid covers only one case manager for that individual child. Wisconsin Medicaid expects providers to communicate with each other and the family to determine which agency will submit claims to Wisconsin Medicaid for case management activities.

Submit claims for family case management under the Medicaid identification number of an at-risk child.

Refer to Appendix 11 of this section for more information on potential duplication of services between targeted case management, HealthCheck outreach and case management, and prenatal care coordination.

Wisconsin Medicaid covers both a family case manager and other case managers working with family members only if documentation shows that their activities have been coordinated through the case planning process to avoid duplication of efforts.

Case Management Services Provided to Children in Out-of-Home **Placement**

Covered Case Management Activities

Medicaid-covered case management services for children in out-of-home placement who are determined eligible for Title IV-E are limited to activities that relate to the assessment, case planning, and monitoring of medical care needs.

Medical care needs include all services that may be covered under Wisconsin Medicaid. Wisconsin Medicaid does not cover case management activities that relate directly to the provision of foster care benefits and services. For example, Wisconsin Medicaid may cover case management activities related to finding a mental health provider, scheduling an appointment, and arranging for transportation to the appointment. However, case management activities related to making child placement arrangements or arranging for transportation to a new foster home would not be covered because they relate directly to the administration of the foster care program.

Wisconsin Medicaid will reimburse the state Division of Children and Family Services for case management services provided to children in foster care who are determined to be ineligible for federal foster care payments. Providers should not submit case management claims for these children. Although these claims may be reimbursed initially, they would be subject to recoupment.

County Staff Providing Case Management Services to Children in Out-of-Home Placement

Wisconsin Medicaid covers case management services provided by the following categories of county staff:

- Court-attached juvenile workers.
- **Department of Community Programs** staff.
- Department of Developmental Disabilities Services staff.
- Department of Human Services staff for public health, mental health, substance abuse, or developmental disabilities services.

However, Wisconsin Medicaid may cover case management services provided by private agencies under contract with the county. For example, Wisconsin Medicaid may reimburse a county that contracts with an outpatient mental health clinic when the clinic staff provides covered case management services.

Wisconsin Medicaid will reimburse the state Division of Children and Family Services for case management services provided to children in foster care who are determined to be ineligible for federal foster care payments.

Institutional Discharge Planning

If the recipient enters an inpatient hospital, nursing facility, or intermediate care facility for the mentally retarded, Wisconsin Medicaid covers case management for up to 30 days prior to discharge from the institutional setting. Institutional discharge planning may not duplicate discharge planning services that the institution normally is expected to provide as part of inpatient services.

However, Wisconsin Medicaid does cover case management services for individuals on convalescent leave from an IMD.

An IMD is a hospital or nursing home primarily for the care and treatment of persons with a mental illness. A psychiatric unit of a general hospital is *not* an IMD.

Wisconsin Medicaid does not allow expenditures for services to an individual who is a resident of an institution for mental disease (IMD) unless either of the following is true:

- 1. The person is under 21 years of age or over 64 years of age.
- 2. The person was a resident of the IMD immediately before turning 21 years of age and has been a resident since turning 21.

Refer to the Online Handbook for current policy

covers case management for up to 30 days prior to discharge from the institutional setting.

Wisconsin Medicaid

Maintenance of Case Records

It is the certified case management provider's responsibility to comply with the standards for monthly logs for ongoing monitoring and service coordination outlined in Appendix 5 of this section, whether for its own or subcontracted staff.

According to HFS 106.02(9) and 107.32(1)(d), Wis. Admin. Code, providers must maintain case records, in writing or in electronic format that can be reduced to writing, which indicate all case management contacts with, and on behalf of, recipients. The case manager or individuals providing assessment (W7051) and case planning (W7061) must individually list the services in the case record. The case records must document the following:

- Name of recipient.
- The full name and title of the person who made the contact. Additionally, 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.
- What the content of the contact was.
- Why the contact was made.
- How much time was spent.
- The date the contact was made.
- Where the contact was made.

Refer to Appendix 5 of this section for a completed sample monthly log for ongoing monitoring and service coordination. Providers may create their own form, as long as their created form contains the same information as Appendix 5. It is the certified case management provider's responsibility to comply with the standards for monthly logs for ongoing monitoring and service coordination outlined in Appendix 5 of this section, whether for its own or subcontracted staff.

Maintenance of Case Records Guidance

Complete Case Note Example

The following example includes the minimum requirements for case notes.

ABC County Case Management log notes

Recipient: John Doe

Case Manager: Sue Smith, MSW

01/01/03

Consultation with county personal care provider at county office regarding personal care services for client since he is having problems performing all cares. Supervising nurse from personal care agency will set up appointment with client to do assessment within the next week.

Will talk to her after the assessment to see if Mr. Doe qualifies for personal care.

15 minutes

Sue Smith, MSW

Incomplete Case Note Example

The following example does not meet the minimum requirements for case notes.

ABC County Case Management log notes

Recipient: John Doe

Case Manager: Sue Smith, MSW

Visit with John Doe. There was a problem with his home care service.

The preceding example does not clearly establish that case management was performed or that the service was linked to a case plan.

Refer to Appendices 3 and 5 of this section for samples of record keeping forms. Providers may create their own forms, as long as their created forms contain the same information as the forms in Appendices 3 and 5 of this section.

Common Questions and Answers

Appendix 11 of this section contains some commonly asked questions with their answers about case management. The question topics include these six areas:

- Billing split travel time.
- HealthCheck Outreach case management.
- Other service providers and case management.
- Prenatal care coordination and case management.
- "Targeted case management."
- Transportation services.

Noncovered Services

Noncovered Services

Refer to the Covered and Noncovered Services section of the All-Provider Handbook for further information regarding noncovered Wisconsin Medicaid services.

According to HFS 107.32(3)(a) or (b), Wis. Admin. Code, Wisconsin Medicaid does not cover the following services as Medicaid case management benefits:

- Diagnosis, evaluation, or treatment of a physical, dental, or mental illness.
 (However, Wisconsin Medicaid considers referral to these services as a component of case management services.)
- 2. Monitoring of clinical symptoms.
- 3. Administration of medications.
- 4. Client education and training.
- 5. Legal advocacy by an attorney or paralegal.
- 6. Provision of supportive home care or personal care.
- Information and referral services which are not based on a recipient's current plan of care.
- Services other than case management that are covered elsewhere by Wisconsin Medicaid when performed by persons who are certified or certifiable with Wisconsin Medicaid for that service. For example, services provided by home health agencies, psychotherapists, occupational therapists, etc., whose services can be billed and paid for as therapy (or evaluation) may not be billed as case management. Wisconsin Medicaid does not cover staffing and other involvement in assessments or case plans by these professionals, unless they cannot be covered by Wisconsin Medicaid as a service other than case management.

Refer to the Covered and Noncovered Services section of the All-Provider Handbook for further information regarding noncovered Wisconsin Medicaid services.

Other Limitations

The following are related limitations under the case management benefit:

- Ongoing monitoring and service coordination is not covered for recipients residing in hospitals, intermediate care, or skilled nursing facilities. These facilities are expected to provide these services as part of their reimbursement.
- Ongoing monitoring services for recipients in home and community-based waiver programs after the first month of waiver eligibility. Under the case management benefit, Wisconsin Medicaid covers ongoing monitoring during the first month of waiver eligibility.
- 3. Institutional discharge planning is covered if:
 - The services do not duplicate the discharge planning services that the hospital, intermediate care, or nursing facility is expected to provide as part of inpatient services.
 - The service is provided within the 30 days prior to discharge from the facility.
- 4. For recipients in Group A target populations, Wisconsin Medicaid does not cover more than one assessment or case plan development per recipient, per calendar year, unless the recipient's county of residence changes. If the county of residence changes, Wisconsin Medicaid covers a second assessment or case plan for a certified case management agency in the new county of residence. Wisconsin Medicaid does not cover more than two assessments or case plans per year for recipients in target populations A or B.
- Although Wisconsin Medicaid does not establish hour limits on ongoing monitoring, it can only be billed once for

any given calendar month, unless the recipient's county of residence changes. If the recipient's county of residence changes, Wisconsin Medicaid may reimburse a second claim for ongoing monitoring to a certified case management agency in the new county of residence. Wisconsin Medicaid does not reimburse more than two providers for ongoing monitoring occurring in any month.

The costs associated with ongoing monitoring and service coordination by more than one identifiable, individual case manager except in the case of a qualified, temporary replacement used when the designated case manager is unavailable due to illness, vacation, death, or client crisis.



Appendix 1

Target Population Codes and Procedure Codes for Case Management Services

Target Population Codes

Providers of case management services are required to indicate one of the following target population codes in Element 21 of the National CMS 1500 claim form. In all cases, target population codes ending in the letter B are intended to identify recipients who are receiving funding for any portion of their case management services through Community Options Program (COP).

Target Population Codes

Code Description	1	Code	Description
01A Developmen	ntally Disabled	45B	Women Age 45-64, COP
01B Developmen	ntally Disabled, COP	57A	Physically or Sensory Disabled
03A Birth to 3		57B	Physically or Sensory Disabled, COP
O3B Birth to 3, C	COP	58A	Age 65 or over
18A Alcohol and	l Other Drug Abuse	58B	Age 65 or over, COP
18B Alcohol and	l Other Drug Abuse, COP	64A ON	Under Age 21 and Severely
31A Chronically	Mentally Ill	ao Han	Emotionally Disturbed
31B Chronically	Mentally Ill, COP	64B	Under Age 21 and Severely
36A Alzheimer's	s Disease of Current	policy	Emotionally Disturbed, COP
Related Der	mentia	72A	Asthma
36B Alzheimer's	s Disease or	72B	Asthma, COP
Related Der	mentia, COP	88A	Families with child at risk
44A TB		88B	Families with child at risk, COP
44B TB, COP		92A	HIV
45A Women Age	e 45-64	92B	HIV-COP

Procedure Codes

Procedure	Description
Code	
W7051	Assessment
W7061	Case Planning
W7062	Institutional Discharge Planning
W7071	Ongoing Monitoring and Service Coordination

Appendix 2

Case Management Target Population "Change Request" Form

Please send this form to:

Wisconsin Medicaid Provider Maintenance 6406 Bridge Rd

Madison WI 53784-0006

Please note that you may add target populations at any time. If you add a target population, specify whether you want the population added retroactive to the first day of the calendar quarter or when Wisconsin Medicaid receives this form. You may also subtract target populations at any time. If you subtract a population, the subtraction is effective when Wisconsin Medicaid receives this form or at a date after Wisconsin Medicaid receives this form, as specified on this form.

NAME:	TTLE:
ADDRESS:	
COUNTY: Pl	ROVIDER NUMBER:
SIGNATURE: ARCHIVAL U	DATE SIGNED:
By signing this form, I am indicating to the Division of Health C County Board of Supervisors or Indian Tribal Government as rec	
Indicate populations you will be adding or subtracting:	ADDING OR SUBTRACTING
Persons who are age 65 or older	() ()
Persons who have a diagnosis of Alzheimer's disease or related dementia	()
Persons with a physical or sensory disability	() ()
Persons with a developmental disability	
Persons with a chronic mental illness	()
Persons with alcohol and/or drug dependency	
Persons who are severely emotionally disturbed and are under the	ne age of 21 ()
Persons diagnosed as having Human Immunodeficiency Virus in	fection () ()
Families with child at risk of serious physical, mental,	
or emotional dysfunction	()
Children enrolled in a Birth to 3 program	()
Children with asthma	()
Persons infected with tuberculosis	()
Women age 45-64	() ()
Complete one of the following:	
1. EFFECTIVE UPON RECEIPT? Y N	
or	
2. EFFECTIVE ON:	_
(Specify date)	

Appendix 3

Wisconsin Medicaid Case Management **Recipient Face Sheet Sample**

Agency Name:		_ Case Manager:				
Date Completed:		_				
	Genera	al Information				
Name		Telephone Number				
Address		Birth Date				
Target Group		Medicaid Identificat	tion Number			
Other Insurance Income and/or Income So		e Source	Source			
	Emergency (Contact Information	1			
Guardian's Name	Emergency Contac	Emergency Contact's Name				
Telephone Number—Guardia	ARCHIVAL	Telephone Numbe	r—Emergency Cor	ntact		
Address	fer to the O	Address	ndhook			
	Other Cor	ntact Information				
	Name	Addi	ress	Telephone Number		
Primary Care Physician						
Primary Medical Contact						
НМО						
Pharmacy						
Hospital Preference						
Other Support						
	Case F	Plan Summary				
Service	Provider's Name	Telephone Number	Frequency and Hours of Contact	Funding Source		

CLIENT: Im A. Recipient	Wisconsin Medicaid #: 1234567890	Case Manager: Im A. Case Manager, MSW
-------------------------	----------------------------------	---------------------------------------

CASE PLAN PARTICIPANTS: Im A. Recipient's daughter, Case Manager

PROBLEM	GOALS/OUTCOME	SERVICE TYPE	UNIT COST*	PROVIDER	UNITS OF SERVICE	S
Recipient is recovering from a broken left hip and cannot ambulate without assistance.	Independent ambulation (within six weeks)	Physical therapy	xxx.xx	Wisconsin Medicaid, PT- certified provider	2 PT appointments per week-6 weeks	2/2 4/1
Recipient has no means of transportation to medical appointments.	Access to all medical appointments	Medical transport services	xxx.xx	Safe-T Transport	As needed	On(
Recipient is unable to manage her medications.	Evaluation of all meds and support for proper intake of all meds by 3-1	RN visit and evaluation with RX	xxx.xx	Visiting nurses	2 visits	2/2 3/1
Recipient cannot perform her own personal care, i.e., bathing, dressing, toileting.	Assistance and instruction to meet personal care needs	Personal Care	*****E	Wisconsin Medicaid service provider	7 days/wk. 1 hr. a.m., 1 hr. p.m.	Onç
Recipient has no assistive devices in her home.	Occupational therapy evaluation for assistive devices at home by 3-5	Occupational therapy	xxx.xx	Wisconsin Medicaid, OT- certified provider	1 evaluation 1 installation	2/2 3/5
		for currer	it poi	lCy		

Sample Completed Wisconsin Medicaid Case Management Case Plan

Appendix 4

^{*}State, if applicable, "Medicaid reimbursement" and indicate copayment amount when appropriate. (Form continued on the back of this page.)

	234567890			Case Manager – Name: Sue Smith		
Coun						
	Agency: ABC County			Title: MSW		
	s (to be used					
-				ateral Contact – Face to Face S = Staffing/Consultation		
•	•		CI = Colla	ateral Contact – Telephone R = Record Keeping		
			Minutes	Documentation of Activities (sign or initial each entry)		
Jue		Hours	wiiilutes	Documentation of Activities (sign of initial each entry)		
	County Office		15	Consultation with county personal care provider at county office regarding arrangi personal care service for client, John Doe, since he is having problems performing Supervising nurse, Jessie Jones, from ABC personal care agency will set up appoin with client to do assessment within the next week. Will talk to her after the assess to see if Mr. Doe qualifies for personal care.		
			AR	CHIVAL USE ONLY		
		R	efer t	o the Online Handbook		
				for current policy		
				Total Units:		
))	ry Cone to Pr de	ry Contact – Telephone e to Provide Services u de Place of Service	Service County Office	ry Contact – Telephone e to Provide Services under BF de Place of Service County Office ARC Refer to		

Sample Completed Monthly Log for Ongoing Monitoring and Service

Appendix 5

Coordination

Appendix 6

Birth to 3 Service Coordination and Wisconsin Medicaid Case Management

Wisconsin Medicaid covers activities of the service coordinator and other personnel who provide case management services when the Birth to 3 program is certified as a Medicaid case management provider (or is part of a county department which is a Medicaid-certified program).

Providers must comply with Medicaid requirements (HFS 101-108, Wis. Admin. Code, this handbook, the Wisconsin Medicaid All-Provider Handbook) and Birth to 3 early intervention services rules (HFS 90, Wis. Admin. Code) when billing for case management services provided under the Birth to 3 Program. These documents describe the covered services and requirements needed to bill for these services.

The following highlights Medicaid case management policies about recipient eligibility, provider qualifications, and covered services. This information is only advisory. Refer to this handbook for complete coverage of Medicaid case management policy.

Examples of Billable Medicaid Case Management Activities and Related Limitations

- 1. Wisconsin Medicaid limits billable Medicaid case management services to Medicaid-eligible recipients who meet one of the target group definitions listed in the Target Populations chapter of this section. All children enrolled in the Birth to 3 Program are eligible for case management.
- 2. Providers may submit claims to Wisconsin Medicaid for the following case management activities when performed by the service coordinator. Also, the provider must meet the qualifications under HFS 105.51(2)(b) and HFS 90.11(1)(c), Wis. Admin. Code:
 - The activities of the service coordinator when arranging for an eligible child's evaluation and assessment (HFS 90, Wis. Admin. Code).
 - Developing, writing, monitoring, and evaluating the written Individualized Family Service Plan (IFSP).
 - Providing service coordination activities.
- 3. The time of providers qualified to provide early intervention services, as defined by HFS 90, Wis. Admin. Code, who participate in assessments, IFSP development, or annual review of the IFSP is billable if the certified case management provider pays for the provider's time involved and it is not billable as another Medicaid service.
- 4. When compiling an eligible child's medical history, the case manager should request any dental history information and note this as a part of the review of the child's medical and health records.
- The case plan must list goals, outcomes, and specific services that are directly related to the recipient's unmet needs or gaps in services identified in the assessment. The Birth to 3 Program meets all the requirements for case plan development if the program follows the procedures in HFS 90 and HFS 101-108, Wis. Admin. Code, and Wisconsin Medicaid provider handbooks, and records the required information in the IFSP and/or the child's early intervention record.
- 6. A complete assessment and case plan must predate any billed ongoing monitoring and service coordination, except in urgent situations. In urgent situations, complete the assessment and case plan within 30 days of initiating service coordination.

- 7. Providers may submit claims for record keeping time if it is noted in the early intervention record and there was contact with the family (collateral) or child (recipient) during the billable month.
- 8. Providers may submit claims for the service coordination time spent assisting the family locate and access services identified in the IFSP as ongoing service coordination if:
 - The other services relate to supporting the child's needs.
 - The other services relate to supporting the recipient's family needs to enable the recipient to gain access to necessary services identified in the IFSP (e.g., coordination with medical services, locating a specialized day care or respite services).

Appendix 7

All Target Populations Court-Related Service Coordination and Medicaid Case Management

Recipients Become Court Involved in a Variety of Ways

Medicaid-eligible recipients receiving case management services may become involved with the court system in many ways:

- As a child in need of protective services.
- As an individual who requires guardianship and protective services.
- As an individual believed or found to require civil commitment to treatment services.
- As an individual who has been accused of, or found guilty of, a criminal offense or a juvenile alleged or adjudicated delinquent for an act that would be a crime if committed by an adult.

Covered Court-Related Services

The court's actions have an impact on the services available to the recipient. The court may order the recipient to receive certain services. Wisconsin Medicaid covers case management activities related to the court system when they are necessary for one of the following reasons:

- Advise the court on the recipient's service needs.
- Coordinate the court orders with other requirements the recipient is obligated to meet.
- Assist the recipient in participating in the legal process and comply with the order of the court.

These activities may include the preparation of reports to the court, communication (face-to-face, telephone, or written) with court personnel, actual court appearances, and activities to ensure compliance with the court order.

or current boll

Covered case management activities must be identified in the recipient's treatment plan, and the case manager must revise the treatment plan or indicate through notes in the recipient's record the reason for the court involvement and the activities required by the case manager as a result of the court involvement.

Limitations on Court-Related Services

Wisconsin Medicaid does not cover case management services for individuals in hospitals or nursing homes, except for the 30 days prior to discharge from the facility. Therefore, Wisconsin Medicaid does not cover any of these court-related activities (e.g., WATTS reviews) when a recipient is in one of these facilities, unless they are discharged within 30 days of the date of service.

Wisconsin Medicaid does not provide coverage to persons detained by legal process. Therefore, Wisconsin Medicaid does not cover any of these court-related services on days when an adult is in jail or a youth is in secure detention. Jailed individuals who have Huber work-release privileges are not eligible for Medicaid services. Exception: Individuals who have Huber privileges to provide care for a family member in the home are eligible for Medicaid services.

The case manager ensures that the court is aware of the recipient's treatment needs and available resources. Wisconsin Medicaid does not cover case management activities when case managers may be acting in the capacity of legal counsel or attorney.

Case Management Examples

The following are examples of case management activities covered by Wisconsin Medicaid when provided to eligible recipients:

- 1. Reporting assessment findings that meet the criteria for comprehensive case management assessments. Examples of recipients who may be receiving court-related services include the following:
 - Children believed to be in need of protective services.
 - Individuals believed to be in need of guardianship services.

This reporting could be a written report to the court or an actual court appearance.

- 2. Participating in dispositional/commitment hearings, when the case manager is required to do one of the following:
 - Advise the court on the services required by, and/or available to, the recipient.
 - Assist the recipient in understanding the court orders and participating in the dispositional process.
- 3. Preparing reports to the court periodically as required.
- 4. Providing activities necessary to recruit and retain a guardian or guardian ad litem for a recipient when the court orders a guardian.

The recruitment must be specific to recipients for whom the case management provider is claiming reimbursement. If one or more case managers meet with a group of potential guardians, or individuals who have agreed to be guardians, and there are two or more identified recipients for whom guardians are being recruited, the case manager's(s') time should be equally divided and billed on behalf of the different recipients. Recruitment activities include, but are not limited to:

- Preparing informational literature for a guardian.
- Meetings with potential guardians, or individuals who have agreed to be guardians, to explain the position's roles and responsibilities. or current policy
- Providing ongoing assistance to the guardian so the guardian can fulfill the position's responsibilities. This may include educating the guardian on the recipient's service needs, the service system in general, and the condition or conditions leading to the recipient requiring guardianship. This also includes assisting the guardian in completing any required reports to the court.
- Activities necessary to recruit and retain payees when a payee is required by the Social Security Administration.

Allowable activities are those identified above for guardian recruitment and retention. Wisconsin Medicaid does not cover the provision of payee services directly to the recipient as a case management service.

Appendix 8

Local Health Department Coordination and Medicaid Case Management

This appendix is a guide for local health departments providing case management services. It highlights the natural fit between public health nursing practice and Medicaid case management requirements.

Introduction

All Wisconsin local health departments are required to provide a general public health nursing program, as specified in s. 250.06 and s. 251.04(8), Wis. Stats. Every local health department requires a public health nurse. Public health nurses promote and protect the health of individuals, families, and the community using knowledge from nursing, social, and public health sciences. Health departments may vary in their resource capacity to directly provide case management services. However, it is important for other case management providers to understand the role and nature of preventive and therapeutic services provided by local health departments for the purposes of coordinating and assuring recipient access to health services.

Assessments

Case management assessments must include all required components, as identified in HFS 107.32(1)(b), Wis. Admin. Code, and in the Assessment Policy chapter of this section. If certain components are not applicable, e.g., no legal involvements, the provider must indicate this in the recipient's record.

The Wisconsin Department of Regulation and Licensing issues licenses to all qualified nurses in Wisconsin under Ch. 441, Wis. Stats. In addition, the Wisconsin Department of Health and Family Services (DHFS) requires that any nurse who practices as a public health nurse in a local health department must meet the standards of the DHFS as set forth in HFS 139, Wis. Admin. Code. The contemporary scope of public health nursing practice is defined in HFS 140.04(1)(a), Wis. Admin. Code. A public health nurse's practice is interdisciplinary and characterized by use of the nursing process, which is a systematic process for:

- Assessing actual and potential health needs generally consistent with the components identified in HFS 107.32(1)(b), Wis. Admin. Code, and in the Assessment Policy chapter of this section.
- Developing plans of care to meet actual and potential recipient needs.
- Carrying out or assuring effective, efficient, and equitable plans in collaboration with other health disciplines and service providers.
- Evaluating plans of care to determine results and benefits to the recipient.

Case Plans

The case plan requirements are outlined in HFS 107.32 (1) (c), Wis. Admin. Code, and in the Case Plan Development chapter of this section. Public health case managers must identify all formal services arranged for the recipient, not just those provided through the local health department. It is important to identify who, beside the public health nurse, will provide services and when these services will be initiated.

Ongoing Monitoring and Service Coordination

Since public health case managers provide services to the recipient and family as well as conducting case management activities, care must be taken not to submit claims for "direct" services as case management. Case management includes those activities required to help a recipient and the recipient's family gain access to, coordinate, or monitor

necessary medical, social, educational, vocational, and other services. The following are not allowable as case management activities:

- Providing counseling on good health practices, parenting, nutrition, and self care.
- Providing education to the recipient and family about a disease, disease transmission, and the drug treatment.
- Administering tuberculosis tests or medication (including directly observed therapy).
- Providing other direct health care services.

Medicaid-covered case management activities include arranging for the recipient, or the Medicaid-eligible members of the recipient's family, to receive any of the above services from another provider (as indicated in the case plan).

Wisconsin Medicaid allows the following case management activities when included in the case plan:

- Monitoring whether the services on the case plan are meeting the recipient's needs and modifying the plan as needed. This may include direct observation of the recipient receiving services from other providers.
- 2. Providing information and referral to community resources, as identified in the case plan.
- 3. Providing client-specific advocacy necessary to assist the recipient and the family in gaining access to services and resources identified on the case plan.
- 4. Having face-to-face, telephone, or written contacts with collaterals including care providers, informal support persons, and others involved with the family — for the purpose of implementing the case plan and monitoring the recipient's response to services.
- 5. Holding client-specific staffings and formal case supervision.

Appendix 9

Group B Target Populations Eligibility Requirements and Required Documentation

Families with Children at Risk of Physical, Mental, or Emotional Dysfunction

This target population includes five subgroups. They are described in this section. "Child" is defined as an individual under age 21. Case management services for this group are sometimes referred to as "family case management."

1. Families with a Child with Special Health Care Needs

Children Included in This Category

A child with a special health care need exhibits biological or environmental characteristics associated with a heightened probability of developing a chronic physical, developmental, behavioral, or emotional condition. This special health care need requires health or health-related services of a type or amount beyond that generally required by children.

The following are examples of conditions that cause a child to be considered a child with special health care needs when they meet the criteria outlined in the required documentation section:

- Congenital conditions, e.g., cerebral palsy, spina bifida, congenital heart disease.
- Acquired illnesses or injuries, e.g., spinal cord injury, intracranial injury. Children with lead poisoning are eligible under this category if the child has a blood lead level of > 20ug/dL (venous) or persistent (at least three months duration) blood lead levels of 15-19ug/dL (venous).
- Behavioral health conditions, e.g., substance abuse, attention deficit disorder.
- Chronic health conditions, e.g., seizure disorders, juvenile diabetes.
 Physical or sensory disorders, e.g., sensorineural hearing loss.

for current policy **Required Documentation**

The record must contain documentation from a physician that the child's condition:

- Is severe enough to restrict the child's growth, physical or emotional development, or ability to engage in usual activities.
- Has been, or is, likely to persist for at least 12 months.
- Is of sufficient complexity to require specialized health care services. A licensed, Medicaid-certified psychologist may create the documentation for a child with an emotional disturbance.

The above documentation is not a requirement for children with lead poisoning. The required documentation for children with lead poisoning is the blood lead test results from a health care provider and information that supports the need for ongoing service coordination and monitoring.

2. Families with a Child Who Is at Risk of Maltreatment

Required Documentation

The county agency responsible for child protective services documents a finding that abuse or neglect has or is likely to occur. The county makes this finding through the use of a structured assessment tool, which assesses all of the following:

- The manner in which the caregiver(s) parents the child.
- The child's current level of daily functioning.
- The caregiver's(s') level of functioning (including mental health functioning).

Appendix 9 (Continued)

- The family's functioning, ability to cope with current stressors, and the resources available to help the family cope.
- The risk of maltreatment to other children in the family.
- Past allegations of maltreatment.

3. Families with Children Involved in the Juvenile Justice System

Required Documentation

Documentation that the youth is at risk of, involved in, or alleged to be involved in antisocial behavior. Documentation is one of the following:

- The youth has been referred to juvenile court intake because he/she is either alleged or adjudicated delinquent under s.938.12. Wis. Stats.
- The youth is an alleged or adjudicated juvenile in need of protection or services (JIPS) under s. 938.13(4), (6), (6m), (7), (9), or (12), Wis. Stats.

Typically, although not required, the referral is made via one of two forms: Court Referral — Juvenile (Law Enforcement Referrals) or Court Referral — Juvenile (non-Law Enforcement Referrals).

4. Families Where the Primary Caregiver Has a Mental Illness, Developmental Disability, or Substance Abuse Disorder

Required Documentation

The caregiver has a diagnosis of a developmental disability, alcohol or other drug abuse or dependence, or mental illness. A qualified professional must make the diagnosis. In addition to this diagnosis, the case management agency documents that the caregiver's disability restricts the child's physical or emotional development or ability to engage in usual activities. Refer to the Online Handbook

5. Families Where the Mother Required Prenatal Care Coordination (PNCC) **Services**

Required Documentation

Documentation needed for eligibility includes one of the following:

- Evidence that the mother was involved in a Medicaid PNCC program.
- A completed Medicaid PNCC risk assessment showing that the mother was at risk for an adverse pregnancy outcome (even though the woman may not have participated in the PNCC program).

In addition, the provider must document that coordination activities continue to be required to ensure the best possible health outcome for the child.

Children Enrolled in a Birth to 3 Program Certified Under HFS 90, Wis. Admin. Code **Required Documentation**

The child is eligible to participate in the Birth to 3 Program according to criteria in HFS 90.08, Wis. Admin. Code.

Children with Asthma

Children Included in This Category

This population consists of asthmatic individuals under 21 years of age.

Appendix 9 (Continued)

Required Documentation

Documentation needed for eligibility includes all of the following:

- A physician's diagnosis of asthma.
- Documentation that the severity of the asthma is moderate to severe, requiring active management to ensure the best possible clinical outcome.

Individuals Infected with Tuberculosis (TB)

Recipients Included in This Category

There is no age limit on this group.

Required Documentation

Documentation needed for eligibility includes *one* of the following:

- A positive TB skin test. (If the skin test was done more than six months before the date case management was initiated, the provider must document that the recipient has not been treated or still requires treatment.)
- A positive sputum culture for the TB organism within the past six months.
- A physician's certification that the individual requires TB-related drug/or surgical therapy (even when the TB test is negative).
- A physician's order for testing to confirm the presence (or absence) of the TB organism.
- A TB-related diagnosis by a physician.

Women Age 45 to 64 ARC

Recipients Included in This Category

This group includes women age 45 to 64 who may be unaware of the importance of obtaining regular preventive health care services and the resources available to access those services.

CHIVAL USE ONLY

Required Documentation

Documentation needed for eligibility includes all of the following:

- Documentation of age.
- Documentation that recipient is not a nursing home resident.
- Documentation that recipient is not obtaining regular preventative health care services.

In addition, the provider must document that the woman needs assistance in identifying and accessing needed preventive health care services (such as screenings for breast and cervical cancer, depression, osteoporosis, diabetes, and high blood pressure) and other community resources.

Appendix 10

Definitions of Illnesses and Disabilities

Illness and **Statute Reference**

Definition

Developmentally Disabled 51.01(5)(a), Wis. Stats.

"A disability attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi Syndrome, mental retardation, or another neurological condition closely related to mental retardation or requiring treatment similar to that required for mental retardation, which has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the afflicted individual. 'Developmental disability' does not include senility which is primarily caused by the process of aging or the infirmities of aging."

Alcoholism

51.01(1m), Wis. Stats.

"A disease which is characterized by the dependency of a person on the drug alcohol, to the extent that the person's health is substantially impaired or endangered or his or her social or economic functioning is substantially disrupted."

Drug Dependent 51.01(8), Wis.Stats. "A person who uses one or more drugs to the extent that the person's health is substantially impaired or his or her social or economic functioning is substantially disrupted."

Chronic Mental Illness 51.01(3g), Wis. Stats.

"A mental illness which is severe in degree and persistent in duration, which causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life, which may lead to an inability to maintain stable adjustment and independent functioning without long-term treatment and support which may be of lifelong duration. 'Chronic mental illness' includes schizophrenia as well as a wide spectrum of psychotic and other severely disabling psychiatric diagnostic categories, but does not include infirmities of aging or a primary diagnosis of mental retardation or of alcohol or drug dependence."

Alzheimer's Disease 46.87(1)(a), Wis. Stats. "A degenerative disease of the central nervous system characterized especially by premature senile mental deterioration, and also includes any other irreversible deterioration of intellectual faculties without concomitant emotional disturbance resulting from organic brain disorder."

101.03(122m), Wis. Stats.

Physically or Sensory Disabled "A condition which affects a person's physical or sensory functioning by limiting his or her mobility or ability to see or hear, is the result of injury, disease or congenital deficiency, and significantly interferes with or limits one or more major life activities and the performance of major personal or social roles."

49.45(25)(a), Wis. Stats.

Severely Emotionally Disturbed "An individual under 21 years of age who has emotional or behavioral problems that are severe in degree; are expected to persist for at least one year; substantially interfere with the individual's functioning in his or her family, school, or community and with his or her ability to cope with ordinary demands of life; and cause the individual to need services from 2 or more agencies or organization that provide social services or services or treatment for mental health, juvenile justice, child welfare, special education, or health."

Severely Emotionally Disturbed "Case management services under this subsection may not be provided to a person under the category of severely emotionally disturbed child unless any of the following is true: (continued) 49.45(25)(a), Wis. Stats.

- A team of mental health experts appointed by the case management provider determine that the person is a severely emotionally disturbed child. The team shall consist of at least three members. The case management provider shall appoint at least one member of the team who is a licensed psychologist or a physician specializing in psychiatry. The case management provider shall appoint at least two members of the team who are members of the professions of school psychologist, school social worker, registered nurse, social worker, child care worker, occupational therapist, or teacher of emotionally disturbed children. The case management provider shall appoint as a member of the team at least one person who personally participated in a psychological evaluation of the child.
- 2. A service coordination agency has determined under Section 46.56 (8) (d) that the person is a child with emotional and behavioral disabilities that meet the requirements under 46.56 (1) (c) 1. to 4."

Appendix 11

Common Questions About Medicaid Case Management

This appendix contains frequently asked questions and answers about Medicaid case management.

1. If I transport a recipient to case management services, is this covered as case management?

On occasion, case managers are expected to accompany recipients to services. The purpose is both to ensure that the service provider is aware of the overall case plan and to monitor the services the provider is delivering. If the case manager transports the recipient on these occasions, Wisconsin Medicaid covers this transportation under case management.

2. How do I bill split travel time when case management is not the only service provided?

When a case manager travels to a recipient's home and provides both case management and other services, the travel time must be prorated so that only the appropriate portion of travel is claimed as case management.

> For example, the case manager must travel one half-hour each way to a recipient's house and provide one half-hour of case management and one half-hour of assistance with personal tasks (which is not case management). Bill only half of the travel time (one half-hour) to case management.

for current policy

Wisconsin Medicaid may cover the remainder of the travel time if both of the following apply:

- The other service is Medicaid covered.
- The policies for that service allow travel time to be separately reimbursable.

For example, a provider travels one half-hour each way to a recipient's house. The provider provides one half-hour of case management and one and a half hours of in-home psychotherapy. Since travel time is billable with in-home psychotherapy, the provider should bill 15 minutes of the travel to case management and 45 minutes to in-home psychotherapy.

If the case manager travels to a location, such as a group home, where he or she sees more than one recipient, the case management time should be allocated on a prorated basis to the different recipients.

> For example, the case manager must travel one half-hour each way to see two recipients at one site. One half-hour of travel should be billed on behalf of each recipient.

Appendix 11 (Continued)

3. Let's say I travel to a recipient's residence, but I don't make contact with the recipient. Does Wisconsin Medicaid cover travel time if there is no billable service?

No. If a case manager travels to see a recipient or collateral, but does not actually make a contact (because the person was not home or available), Wisconsin Medicaid does not cover that travel time. Travel time is only covered when it is provided as a part of a covered service. Since no service took place, the travel time is not covered.

4. I'm a service provider, but not a case management provider. Can I become a case management provider?

Yes. Wisconsin Medicaid does not prohibit providers of other services (whether Medicaid covered or not) from being case managers. For instance, staff of a day treatment program or a sheltered workshop may be case managers. However, the case manager must not bill services which are associated with his/her role as a service provider as Medicaid case management.

For example, a provider of in-home treatment for a child with severe emotional disturbance is also providing case management. As the child's case manager, the provider completes the comprehensive case management assessment and also convenes an interagency team to complete the case plan. Wisconsin Medicaid covers these activities under case management. In-home treatment is one of the services identified on the case plan. The in-home team develops a treatment plan for the in-home services. Wisconsin Medicaid does not cover this treatment plan's development under case management.

Similarly, Wisconsin Medicaid does not cover the documentation of the in-home treatment as case management. This documentation is considered part of the in-home service. Only documentation of the case management activities in support of the case management case plan are covered as case management documentation time.

If case management is a component of the other services being provided and included in the Medicaid payment for that service, do not separately bill it under case management.

5. I have seen case management referred to as "targeted case management." Why?

Wisconsin Medicaid sometimes uses the term targeted case management to refer to the case management provided to certain populations as described in HFS 107.32, Wis. Admin. Code, and in this handbook. This is because case management is a covered service for *only certain target populations*.

6. What is HealthCheck Outreach case management?

Wisconsin Medicaid also reimburses certain agencies to ensure that HealthCheck-eligible recipients (individuals under 21 years of age) receive their HealthCheck screens according to the periodicity schedule and obtain referrals to services recommended because of the screen. This is referred to as HealthCheck Outreach and Case Management. If the same agency provides HealthCheck Outreach and case management and targeted case management, bill the service as targeted case management. Why? Ensuring access to HealthCheck screens and related necessary services is a component of targeted case management.

Appendix 11 (Continued)

7. If HealthCheck Outreach and case management are provided by a different agency from the agency providing targeted case management, who does Wisconsin Medicaid pay?

Wisconsin Medicaid covers services by both agencies for their activities only if the activities are not duplicative. The targeted case manager must ensure that the activities are coordinated. The purpose of HealthCheck Outreach and Case Management is to get the child screened and make referrals based on the screening. Targeted case management coordinates a broader array of services identified in the child's case plan.

What is Prenatal Care Coordination (PNCC)? Who is eligible for PNCC?

Women who are pregnant with a high risk of an adverse birth outcome are eligible for Medicaid PNCC services. The PNCC agency is responsible for ensuring that the woman gets necessary prenatal care and also addressing other issues which might put the woman at risk (e.g., substance abuse, domestic abuse).

How do PNCC and targeted case management work together?

Wisconsin Medicaid reimburses both the PNCC agency and the targeted case management agency for providing services to the same recipient at the same time if the services are not duplicative. Since PNCC is time limited (to 60 days after the birth), the targeted case manager must take responsibility for coordinating the two agencies' efforts to avoid duplication of effort. The targeted case manager and the PNCC case manager must decide, along with the recipient, which agency will provide what services.

> For example, a woman with a significant history of substance abuse is admitted to a PNCC program because of the risk of an adverse birth outcome. The woman has a Medicaid case manager because of her substance abuse disorder. The "targeted" case manager has been working with the woman to help her find treatment and is also working on housing and nutrition needs.

> After the woman's admission to the PNCC program, the targeted case manager revises the woman's case plan to identify her involvement with PNCC and the need to coordinate efforts with the PNCC agency. The targeted case manager meets with the PNCC staff and discusses their responsibilities with the recipient. The targeted case manager continues to work with the recipient on accessing substance abuse treatment and on housing issues. The PNCC agency works on accessing prenatal care, educating the recipient on perinatal health issues, and addressing nutrition needs.

Glossary of Common Terms

Adjustment

A modified or changed claim that was originally allowed, at least in part, by Wisconsin Medicaid.

BadgerCare

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or "crowding out" private insurance.

BadgerCare benefits are identical to the benefits and services covered by Wisconsin Medicaid and recipients' health care is administered through the same delivery system.

CMS

Centers for Medicare and Medicaid Services. An agency housed within the U.S. Department of Health and Human Services (DHHS), CMS administers Medicare, Medicaid, related quality assurance programs, and other programs. Formerly known as the Health Care Financing Administration (HCFA). or current

Collateral

A collateral is anyone who has direct supportive contacts with the recipient. Collaterals include family members, friends, service providers, guardians, housemates, or school officials.

CPT

Current Procedural Terminology. A listing of descriptive terms and codes for reporting medical, surgical, therapeutic, and diagnostic procedures. These codes are developed, updated, and published annually by the American Medical Association and adopted for billing purposes by the Centers for Medicare and Medicaid Services (CMS) and Wisconsin Medicaid.

DHCF

Division of Health Care Financing. The DHCF administers Wisconsin Medicaid for the Department of Health and Family Services (DHFS) under statutory provisions, administrative rules, and the state's Medicaid plan. The state's Medicaid plan is a comprehensive description of the state's Medicaid

program that provides the Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of Health and Human Services (DHHS), assurances that the program is administered in conformity with federal law and CMS policy.

DHFS

Wisconsin Department of Health and Family Services. The DHFS administers the Wisconsin Medicaid program. Its primary mission is to foster healthy, selfreliant individuals and families by promoting independence and community responsibility; strengthening families; encouraging healthy behaviors; protecting vulnerable children, adults, and families; preventing individual and social problems; and providing services of value to taxpayers.

DHHS

Department of Health and Human Services. The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

The DHHS includes more than 300 programs, covering a wide spectrum of activities, including overseeing Medicare and Medicaid; medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; and providing financial assistance for low-income families.

DOS

Date of service. The calendar date on which a specific medical service is performed.

Emergency services

Those services which are necessary to prevent the death or serious impairment of the health of the individual. (For the Medicaid managed care definition of emergency, refer to the Managed Care Guide or the Medicaid managed care contract.)

EOB

Explanation of Benefits. Appears on the providers' Remittance and Status (R/S) Report and informs Medicaid providers of the status of or action taken on their claims.

Glossary (Continued)

EVS

Eligibility Verification System. The EVS allows providers to verify recipient eligibility prior to providing services. Providers may access recipient eligibility information through the following methods:

- Wisconsin Medicaid's Automated Voice Response (AVR) system.
- Commercial magnetic stripe card readers.
- Commercial personal computer software or Internet access.
- Wisconsin Medicaid's Provider Services (telephone correspondents).
- Wisconsin Medicaid's Direct Information Access Line with Updates for Providers (Dial-Up).

Fee-for-service

The traditional health care payment system under which physicians and other providers receive a payment for each unit of service provided rather than a capitation payment for each recipient.

Fiscal agent

The Department of Health and Family Services (DHFS) contracts with Electronic Data Systems (EDS) to provide health claims processing services for Wisconsin Medicaid, including provider certification, claims payment, provider services, and recipient services. The fiscal agent also issues identification CUITEN cards to recipients, publishes information for providers and recipients, and maintains the Wisconsin Medicaid Web site.

HCPCS

Healthcare Common Procedure Coding System. A listing of services, procedures, and supplies offered by physicians and other providers. HCPCS includes Current Procedural Terminology (CPT) codes, national alphanumeric codes, and local alphanumeric codes. The national codes are developed by the Centers for Medicare and Medicaid Services (CMS) in order to supplement CPT codes.

HMO

Health Maintenance Organization. Provides health care services to enrolled recipients.

ICD-9-CM

International Classification of Diseases, Ninth Revision, Clinical Modification. Nomenclature for all medical diagnoses required for billing. Available through the American Hospital Association.

Maximum allowable fee schedule

A listing of all procedure codes allowed by Wisconsin Medicaid for a provider type and Wisconsin Medicaid's maximum allowable fee for each procedure code.

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for people with disabilities, people 65 years and older, children and their caretakers, and pregnant women who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Medicaid is also known as the Medical Assistance Program, Title XIX, or T19.

Medically necessary

According to HFS 101.03(96m), Wis. Admin. Code, a Medicaid service that is:

- (a) Required to prevent, identify or treat a recipient's illness, injury or disability; and
- (b) Meets the following standards:
 - 1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
 - 2. Is provided consistent with standards of acceptable quality of care applicable to type of service, the type of provider and the setting in which the service is provided;
 - 3. Is appropriate with regard to generally accepted standards of medical practice;
 - 4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
 - 5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;
 - 6. Is not duplicative with respect to other services being provided to the recipient;
 - 7. Is not solely for the convenience of the recipient, the recipient's family or a provider;

Glossary (Continued)

- 8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
- 9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

POS

Place of service. A single-digit code which identifies where the service was performed.

R/S Report

Remittance and Status Report. A statement generated by the Medicaid fiscal agent to inform providers regarding the processing of their claims.

TOS

Type of service. A single-digit code which identifies the general category of a procedure code.

ndex

Assessments, 11 components, 15 for children and adolescents, 15 frequency, 11

Birth to 3 service coordination and Medicaid case management, 7

Case management, 19 Covered case management services, 19 Duplication of Services, 22 Family members who are not Medicaid-eligible, HealthCheck outreach case management, 56 Prenatal Care Coordination services, 50 Case notes, 27 Case plan, frequency, 17 required components 17 Case plan, 11 Case records, 27 Collateral contacts, 19

Eligibility determinations, 10

Family member not eligible for Wisconsin Medicaid, 21

Frequency of assessments and case plans, 11 for children and adolescents, 15 Frequency of comprehensive assessments, 11

HealthCheck outreach, 22 Information and referral, 21 Institutional discharge planning, 25

Local health departments and Medicaid case management, 7

Minimum requirements for case notes, 27

Ongoing monitoring and service coordination, 19 single, designated case manager, 20

Prenatal care coordination, 22, 67

Target population, 9 Target population change request form, 9 Target population codes, 10 ARCHIVAL US Transporting clients, 7 Travel time, 55 Court-related service coordination, 22 the Online billing, 55 clock if there is no billable service, 56 for current policy

Case Management Services



Important Telephone Numbers

The Wisconsin Medicaid Eligibility Verification System (EVS) is available through the following resources to verify checkwrite information, claim status, prior authorization status, provider certification, and/or recipient eligibility.

Service	Information Available	Telephone Number	Hours
Automated Voice Response (AVR) System (Computerized voice response to provider inquiries.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	(800) 947-3544 (608) 221-4247 (Madison area)	24 hours a day/ 7 days a week
Personal Computer Software and Magnetic Stripe Card Readers	Recipient Eligibility*	Refer to Provider Resources section of the All-Provider Handbook for a list of commercial eligibility verification vendors.	24 hours a day/ 7 days a week
Provider Services (Correspondents assist with questions.)	Checkwrite Information Claim Status Prior Authorization Status Provider Certification Recipient Eligibility*	(800) 947-9627 (608) 221-9883 ent policy	Policy/Billing and Eligibility: 8:30 a.m 4:30 p.m. (M, W-F) 9:30 a.m 4:30 p.m. (T) Pharmacy: 8:30 a.m 6:00 p.m. (M, W-F) 9:30 a.m 6:00 p.m. (T)
Direct Information Access Line with Updates for Providers (Dial-Up) (Software communications package and modem.)	Checkwrite Information Claim Status Prior Authorization Status Recipient Eligibility*	Call (608) 221-4746 for more information.	7:00 a.m 6:00 p.m. (M-F)
Recipient Services (Recipients or persons calling on behalf of recipients only.)	Recipient Eligibility Medicaid-Certified Providers General Medicaid Information	(800) 362-3002 (608) 221-5720	7:30 a.m 5:00 p.m. (M-F)

^{*} Please use the information exactly as it appears on the recipient's identification card or the EVS to complete the patient information section on claims and other documentation. Recipient eligibility information available through the EVS includes:

- Dates of eligibility.
- Medicaid managed care program name and telephone number.
- Privately purchased managed care or other commercial health insurance coverage.
- Medicare coverage.
- Lock-In Program status.
- Limited benefit information.

Table of Contents

Preface	5
Claims Submission	7
Billed Amounts	7
Paper Claims Submission	
Paperless Claims Submission	
Submission of Claims	
Target Population Codes	
Procedure Codes	
Place of Service Codes	
Type of Service Codes	
Follow-Up to Claims Submission	9
Appendix	11
 Sample Completed CMS 1500 Claim for Case Management Services National CMS 1500 Claim Form Completion Instructions 	
for Case Management Services	15
for Case Management Services	19
Glossary of Common Terms For current policy	21
Index	25

Preface

The Wisconsin Medicaid and BadgerCare Case Management Handbook is issued to case management providers who are Wisconsin Medicaid certified. It contains information that applies to *fee-for-service* Medicaid providers. The Medicaid information in the handbook applies to both Medicaid and BadgerCare.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing (DHCF) is directly responsible for managing Wisconsin Medicaid and BadgerCare. As of January 2003, BadgerCare extends Medicaid coverage to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. BadgerCare recipients receive the same health benefits as Wisconsin Medicaid recipients and their health care is administered through the same delivery system.

Medicaid and BadgerCare recipients enrolled in state-contracted HMOs are entitled to at least the same benefits as fee-for-service recipients; however, HMOs may establish their own requirements regarding prior authorization, billing, etc. If you are an HMO network provider, contact your managed care organization regarding its requirements. Information contained in this and other Medicaid publications is used by the DHCF to resolve disputes regarding covered benefits that cannot be handled internally by HMOs under managed care arrangements.

Verifying Eligibility

Wisconsin Medicaid providers should always verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage. Wisconsin Medicaid's Eligibility Verification System (EVS) provides eligibility information that providers can access a number of ways.

Refer to the Important Telephone Numbers page at the beginning of this section for detailed information on the methods of verifying eligibility.

Handbook Organization

The Case Management Handbook consists of the following sections:

- General Information.
- Covered and Noncovered Services.
- Billing.

In addition to the Case Management Handbook, each Medicaid-certified provider is issued a copy of the All-Provider Handbook. The All-Provider Handbook includes the following sections:

- Claims Submission.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Prior Authorization.
- Provider Certification.
- Provider Resources.
- Provider Rights and Responsibilities.
- Recipient Rights and Responsibilities.

Legal Framework of Wisconsin Medicaid and BadgerCare

The following laws and regulations provide the legal framework for Wisconsin Medicaid and BadgerCare:

Federal Law and Regulation

- Law: United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
- Regulation: Title 42 CFR Parts 430-498 Public Health.

Wisconsin Law and Regulation

- Law: Wisconsin Statutes: Sections 49.43-49.499 and 49.665.
- Regulation: Wisconsin Administrative Code, Chapters HFS 101-108.

Handbooks and Wisconsin Medicaid and BadgerCare Updates further interpret and implement these laws and regulations.

Handbooks and *Updates*, maximum allowable fee schedules, helpful telephone numbers and addresses, and much more information about Wisconsin Medicaid and BadgerCare are available at the following Web sites:

www.dhfs.state.wi.us/medicaid/ www.dhfs.state.wi.us/badgercare/.

Medicaid Fiscal Agent

The DHFS contracts with a fiscal agent, which is currently EDS.

Claims Submission

Billed Amounts

Claims submitted
electronically have the
same legal requirements
as paper claims and are
subject to the same
processing requirements.

Case management providers must always bill Wisconsin Medicaid their usual and customary charge for services provided. The usual and customary charge is the amount the provider charges for the same service when provided to private-pay recipients. Providers who do not have a usual and customary charge must bill Wisconsin Medicaid the estimated cost for services provided. Providers must not discriminate against recipients by charging a higher fee for the same service than is charged to a private-pay patient.

Paper Claims Submission

Submit claims for case management services on the National CMS 1500 claim form. Refer to Appendices 1 and 2 of this section for a sample form and completion instructions.

Wisconsin Medicaid does not provide the CMS 1500 claim form. The form may be obtained from any federal form supplier.

Mail completed claims for payment to:

Wisconsin Medicaid Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002

For ongoing monitoring and service coordination, case management providers must accrue billable time during a month and bill only *once* per recipient, per month.

Wisconsin Medicaid allows more than one month's services on a single claim, but each month's ongoing monitoring and service coordination must appear on a separate detail line. Reimbursement is limited to staff time paid for by the case management provider.

Paperless Claims Submission

As an alternative to submission of paper claims, Wisconsin Medicaid processes claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted electronically have the same legal requirements as paper claims and are subject to the same processing requirements. Providers submitting electronically usually reduce their claims submission errors and processing time. For additional information on alternative claims submission, contact:

Wisconsin Medicaid Electronic Media Claims 6406 Bridge Rd Madison WI 53784-0009 (608) 221-4746

Submission of Claims

Wisconsin Medicaid must receive all claims for services provided to eligible Medicaid recipients within 365 days from the date of service. This policy applies to all initial claims submissions, resubmissions, and adjustment requests.

Refer to the Claims Submission section of the All-Provider Handbook for information about exceptions to the claims submission deadline and submission requirements to Late Billing Appeals.

Refer to the Covered and Noncovered Services section of this handbook for more information about case management covered services.

Target Population Codes

The case management claim must identify the recipient's "target populations" in Element 21 of the claim form.

Refer to the Covered and Noncovered Services section of this handbook for a listing of allowable target population codes. In all cases, target population codes ending in the letter "B" are used to identify recipients receiving funding through the Community Options Program (COP) for any of the case management functions in a given month.

Note:

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) coding structure is *not* used to identify or describe the target populations.

Procedure Codes

Wisconsin Medicaid denies submitted claims that do not have allowable Healthcare Common Procedure Coding System (HCPCS) procedure codes. Refer to the Covered and Noncovered Services section of this handbook for a listing of allowable procedure codes.

Bill ongoing monitoring and service coordination only once per month. On individual dates of service, case managers may either record their actual time (e.g., 3 minutes, 45 minutes) or accumulate the time spent on case management services on that day and round to the nearest one-tenth hour.

On a monthly basis, case managers must add up the time for the individual dates of service. If actual time was recorded on individual dates of service, round the accumulated time at the end of the month to the nearest one-tenth hour. Refer to Appendix 3 of this section for rounding guidelines.

For example, a case manager has billable contacts on three days during a month: a 1 hour and 15 minute meeting with a recipient (including travel and recording time), a 10 minute phone call with a collateral (refer to the Covered/Noncovered Services section of this handbook for a definition of a collateral), and another 20 minute phone call with a collateral.

If the case manager records actual time, these are accumulated at the end of the month to 1 hour and 45 minutes and billed to Wisconsin Medicaid as 1.8 units of service. If these are rounded on individual days (to 1.3 units, .2 units, and .4 units), they are accumulated at the end of the month and billed to Wisconsin Medicaid as 1.9 units of service. Refer to Appendix 3 of this section for more information on rounding guidelines for units of service.

Place of Service Codes

Place of service (POS), Element 24B, is always "0" (other), except when billing for institutional discharge planning. Refer to Appendix 3 of this section for a list of allowable POS codes. Refer to Appendix 2 of this section for claim form completion instructions.

Type of Service Codes

Type of service, Element 24C, is always "9" (other medical service) on the claim form. Refer to Appendix 2 of this section for claim form completion instructions.

Wisconsin Medicaid denies submitted claims that do not have allowable Healthcare Common **Procedure Coding System** (HCPCS) procedure codes.

Follow-Up to Claims Submission

The provider is responsible for initiating follow-up procedures on claims submitted to Wisconsin Medicaid. Processed claims appear on the Remittance and Status Report as either paid, pending, or denied. Wisconsin Medicaid will take no further action on a denied claim until the provider corrects the information and resubmits the claim for processing.

Because of the claim filing deadline (365 days from the date of service), it is critical that the case management provider understand these follow-up procedures.

If a claim was paid incorrectly, the provider is responsible for submitting an Adjustment Request Form to Wisconsin Medicaid. Refer to the Claims Submission section of the All-Provider Handbook for more information on filing Adjustment Request Forms.

To be reimbursed for additional case management time that may have been omitted from the original claim, providers are required to file an Adjustment Request Form.

Wisconsin Medicaid will take no further action on a denied claim until the provider corrects the information and resubmits the claim for processing.



Appendix 1

Sample Completed CMS 1500 Claim for Case Management Services

APPROVED OMB-0938-0008

PICA					F	EALTH INS	SURANC	E CL	.AIM	FOF	RM		PICA	
MEDICARE MEDICA	AID CHAMPUS	(CHAMPVA	GROUP		CA OTHER	1a. INSURED'	S I.D. NU	MBER		(FOR PF	ROGRAM IN 17	TEM 1)
(Medicare #) P (Medica	d #) (Sponsor's S	SSN)	(VA File #)	(SSN or	ID) (K LUNG SSN) (ID)		123	4567	7890				
PATIENT'S NAME (Last Nar	ne, First Name, Middle I	Initial)	. 3	MM DD	RTH DATE	SEX	4. INSURED'S	NAME (Last Na	me, First	Name,	Middle I	nitial)	
Recipient, Im A.														
5. PATIENT'S ADDRESS (No., Street)				5. PATIENT REL			7. INSURED'S ADDRESS (No., Street)							
609 Willow St.			OTATE	Self Spor		d Other	l out						122:3	
Anytown	W	/ I	STATE 8	. PATIENT STA	_		CITY						STAT	Έ
P CODE			ode)	Single	Married	Other	ZID CODE			TELE	DUONI	- (INICI I	IDE ABEA CO	ODE)
				Employed	Full-Time	Part-Time	ZIP CODE TELEPHONE (INCLUDE AREA CODE						JUE)	
55555 (XXX) XXX-XXXX O OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				Student Student 11. INSURED'S POLICY GROUP OR FECA NUMBER										
OTHER INSURED'S POLIC	OR GROUP NUMBER	3	a	a, EMPLOYMENT? (CURRENT OR PREVIOUS)			a. INSURED'S	DATE_C	F BIRTI	Н			SEX	
				YES NO			MM	DD	YY		М		F [٦
OTHER INSURED'S DATE	OF BIRTH SEX	×	b	. AUTO ACCIDE	ENT?	PLACE (State)	b. EMPLOYER	'S NAME	ORSC	CHOOL N	IAME			
MM DD YY	м	F			YES	NO								
EMPLOYER'S NAME OR SO	HOOL NAME		c	OTHER ACCID	DENT?		c. INSURANCE	PLAN I	NAME C	R PROG	BRAM N	AME		
					YES	NO								
INSURANCE PLAN NAME O	R PROGRAM NAME		1	0d. RESERVED	FOR LOCAL	USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?							
	D D LOV OF FORT	FORE CT	AND PRINTS	OLOHBIO TI	CODIA		YES		NO				mplete item 9	
. PATIENT'S OR AUTHORIZ	D BACK OF FORM BE ED PERSON'S SIGNA	TURE I au	thorize the re	lease of any med	ical or other in	formation necessary		medical	benefits				FURE I author sician or supp	
to process this claim. I also below.	request payment of gove	rnment ber	nefits either to	myself or to the	party who acce	epts assignment	services de						* *	
SIGNED	<i></i>	11	$\cup \sqcap$	DATE	L	JOE	SIGNED	ľ						
DATE OF CURRENT:	ILLNESS (First symptor	m) OR	15 IE		HAD SAME OF	R SIMILAR ILLNESS.		TIENT	INARI E	TO WO	SK IN C	LIBBEN	T OCCUPATI	ON
MM DD : YY 💨	INJURY (Accident) OR PREGNANCY(LMP)	or 1	G	VE FIRST DATE	MM DI	Y LEINESS.	5. 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO							
NAME OF REFERRING PH	17a. l.	D. NUMBER OF	REFERRING	PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES					3				
							FROM TO YY							
. RESERVED FOR LOCAL (ISE		tor	CHI	ren	t poli	20. OUTSIDE LAB? \$ CHARGES							
	-			<u> </u>		POII	YES NO							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS				,3 OR 4 TO ITEN	M 24E BY LIN	E)	22. MEDICAID RESUBMISSION ORIGINAL REF. NO.							
64A			3.	L		▼			1					
							23. PRIOR AUTHORIZATION NUMBER							
<u> </u>			4.			7 -				T 71 T				
DATE(S) OF SERV	ICE _{To} Place			D S, SERVICES, C		DIAGNOSIS	F			H EPSDT	- '	J	RESERVED	FOR
From Y MM MM DD YY MM	DD YY Service	of	(Explain CPT/HCPCS	Unusual Circums MODIFIE	stances) R	CODE	\$ CHARG	ES	OR UNITS	Family Plan	EMG	СОВ	LOCAL U	
2 02 02	0	9	W705		57100 200 200 200 200 200 200 200 200 200	1	XXX	XX	1.0				-	
2 02 02			11100		11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1	41/1/1	43/1	1.0					
2 15 02	0	9	W706	1	00 to	1	XXX	$\mathbf{X}\mathbf{X}$	1.0					
					- 3				1 0					
2 15 02	0	9	W707	1		1	XXX	XX	1.0					
		100			10 to									
		(p) 641 7 - 52 11 - 52 11 - 52 11 - 52 11 - 52			10.5 10.5 10.5 10.5 10.5 10.5 10.5 10.5									
	i	700		1 1					1					
	i								ļ					
	<u>. l</u>			1 !										
. FEDERAL TAX I.D. NUMBI	R SSN EIN	26 P	ATIENT'S AC	COLINT NO	27 ACCE	PT ASSIGNMENT?	28. TOTAL CH	ADCE	1	9. AMOL	INT DA	ID	30. BALANCI	E DUIT
LUCIAL TAX I.U. NUIVIBI	JOIN EIN	20. 77	THEN I S AU	COUNT NO.	(For go	PT ASSIGNMENT? vt. claims, see back)	1				PA נאוכ !	ן טי	\$ XXX	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAME AND A				DRESS OF FAC		E SERVICES WERE								
INCLUDING DEGREES OF	CREDENTIALS			other than home			& PHONE	#				_,	00, 00	
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)							I.M. I							
							1 W. V				_			
I M Anthonizad MM/DD/YY							Anytown, WI 55555 86754321							

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

Appendix 2

National CMS 1500 Claim Form Completion Instructions for Case Management Services

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

Note: Medicaid providers should *always* verify recipient eligibility before rendering services.

Element 1 — Program Block/Claim Sort Indicator

Enter claim sort indicator "P" in the Medicaid check box for the service billed.

Element 1a — Insured's I.D. Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 2 — Patient's Name

Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 3 — Patient's Birth Date, Patient's Sex

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

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

Enter the complete address of the recipient's place of residence.

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

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

Do not enter anything in this element.

Mother/Baby Claims

A provider may submit claims for an infant if the infant is 10 days old or less on the date of service (DOS) and the mother of the infant is a Medicaid recipient. To bill for an infant using the mother's Medicaid identification number, enter the following:

Element 1A: Enter the mother's 10-digit Medicaid identification number.

Element 2: Enter the mother's last name followed by "newborn."

Element 3: Enter the *infant's* date of birth.

Element 4: Enter the mother's name followed by

"mom" in parentheses.

Element 21: Indicate the secondary or lesser diagnosis code "M11" in fields 2, 3, or 4.

Appendix 2 (Continued)

Element 10 — Is Patient's Condition Related to (not required)

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

Elements 12 and 13 — Authorized Person's Signature (not required)

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

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

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

Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source (not required)

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

Element 19 — Reserved for Local Use (not required)

Element 20 — Outside Lab? (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

Enter the three-digit target population code for each target population to which the recipient belongs. Refer to the Covered and Noncovered Services section of this handbook for a list of target population codes.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number (not required) Handbook

Element 24A — Date(s) of Service or current policy

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- For assessments and case planning, if the service was performed on more than one date of service, indicate the last date of service on the claim form.
- For ongoing monitoring and service coordination, if the service was performed on more than one date of service within the month, indicate the last date the service was performed in each month as the date of service on the claim form.

Although a given month's ongoing monitoring may only be billed once, more than one month's ongoing monitoring may be billed on a single claim form. In that case, use one detail line for each month's ongoing monitoring with the date of service determined as described above.

Element 24B — Place of Service

Enter the appropriate Medicaid single-digit place of service (POS) code for each service. The POS code will be "0," except when billing for discharge planning.

Element 24C — Type of Service

Enter "9" for the type of service code. (Type of service is always "other medical service.")

Appendix 2 (Continued)

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character procedure code. Refer to the Covered and Noncovered Services section of this handbook for a list of allowable procedure codes.

Element 24E — Diagnosis Code

Enter the target population code or enter the line number that corresponds to the appropriate diagnosis code listed in Element 21.

Element 24F — \$Charges

Enter the total charge for each line item.

Element 24G — Days or Units

Enter the total number of hours billed on each line item. Round to the nearest one tenth hour.

Element 24H — EPSDT/Family Planning

Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. Enter an "F" for each family planning procedure. Enter a "B" if **both** HealthCheck and family planning services were provided. If HealthCheck or family planning do not apply, leave this element blank.

Online Handbook

Element 24I — EMG (not required)

Element 24J — COB (not required)

Element 24K — Reserved for Local Use (not required)

Element 25 — Federal Tax I.D. Number (not required)

Element 26 — Patient's Account No. (optional)

Provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the Remittance and Status Report.

Element 27 — Accept Assignment? (not required)

Element 28 — Total Charge

Enter the total charges for this claim.

Element 29 — Amount Paid (not required)

Element 30 - Balance Due

Enter the balance due. This will be the same amount as appears in Element 28.

Appendix 2 (Continued)

Element 31 — Signature of Physician or Supplier

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

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

Element 32 — Name and Address of Facility Where Services Were Rendered (not required)

Element 33 — Physician's, Supplier's Billing Name, Address, ZIP Code, and Phone #

Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

Appendix 3

Rounding Guidelines and Allowable Place of Service Codes

The following chart illustrates the rules of rounding and gives the appropriate billing unit(s). Refer to the Claims Submission chapter of this section for more information about how to bill for case management services.

Billing in One-Tenth Hour Increments

Time (in minutes)	Unit(s) Billed				
1 - 6	.1				
7 - 12	.2				
13 - 18	.3				
19 - 24	.4				
25 - 30	.5				
31 - 36	.6				
37 - 42	.7				
43 - 48	.8				
49 - 54	.9				
55 - 60	1.0				
	etc.				

ARCHIVAL USE ONLY Refer to the Online Handbook for current policy

The following chart lists the allowable place of service codes.

Place of Service Codes

Code	Description
0	Other
1	Inpatient Hospital
7	Nursing Home
8	Skilled Nursing Facility

Glossary of Common Terms

Adjustment

A modified or changed claim that was originally allowed, at least in part, by Wisconsin Medicaid.

BadgerCare

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI to uninsured children and parents with incomes at or below 185% of the federal poverty level and who meet other program requirements. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or "crowding out" private insurance.

BadgerCare benefits are identical to the benefits and services covered by Wisconsin Medicaid and recipients' health care is administered through the same delivery system.

CMS

Centers for Medicare and Medicaid Services. An agency housed within the U.S. Department of Health and Human Services (DHHS), CMS administers Medicare, Medicaid, related quality assurance programs, and other programs. Formerly known as the Health Care Financing Administration (HCFA).

Collateral

A collateral is anyone who has direct supportive contacts with the recipient. Collaterals include family members, friends, service providers, guardians, housemates, or school officials.

CPT

Current Procedural Terminology. A listing of descriptive terms and codes for reporting medical, surgical, therapeutic, and diagnostic procedures. These codes are developed, updated, and published annually by the American Medical Association and adopted for billing purposes by the Centers for Medicare and Medicaid Services (CMS) and Wisconsin Medicaid.

DHCF

Division of Health Care Financing. The DHCF administers Wisconsin Medicaid for the Department of Health and Family Services (DHFS) under statutory provisions, administrative rules, and the state's Medicaid plan. The state's Medicaid plan is a comprehensive description of the state's Medicaid

program that provides the Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of Health and Human Services (DHHS), assurances that the program is administered in conformity with federal law and CMS policy.

DHFS

Wisconsin Department of Health and Family Services. The DHFS administers the Wisconsin Medicaid program. Its primary mission is to foster healthy, selfreliant individuals and families by promoting independence and community responsibility; strengthening families; encouraging healthy behaviors; protecting vulnerable children, adults, and families; preventing individual and social problems; and providing services of value to taxpayers.

DHHS

Department of Health and Human Services. The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

The DHHS includes more than 300 programs, covering a wide spectrum of activities, including overseeing Medicare and Medicaid; medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; and providing financial assistance for low-income families.

DOS

for current

Date of service. The calendar date on which a specific medical service is performed.

Emergency services

Those services which are necessary to prevent the death or serious impairment of the health of the individual. (For the Medicaid managed care definition of emergency, refer to the Managed Care Guide or the Medicaid managed care contract.)

EOB

Explanation of Benefits. Appears on the providers' Remittance and Status (R/S) Report and informs Medicaid providers of the status of or action taken on their claims.

Glossary (Continued)

EVS

Eligibility Verification System. The EVS allows providers to verify recipient eligibility prior to providing services. Providers may access recipient eligibility information through the following methods:

- Wisconsin Medicaid's Automated Voice Response (AVR) system.
- Commercial magnetic stripe card readers.
- Commercial personal computer software or Internet access.
- Wisconsin Medicaid's Provider Services (telephone correspondents).
- Wisconsin Medicaid's Direct Information Access Line with Updates for Providers (Dial-Up).

Fee-for-service

The traditional health care payment system under which physicians and other providers receive a payment for each unit of service provided rather than a capitation payment for each recipient.

Fiscal agent

The Department of Health and Family Services (DHFS) contracts with Electronic Data Systems (EDS) to provide health claims processing services for + Wisconsin Medicaid, including provider certification. claims payment, provider services, and recipient services. The fiscal agent also issues identification cards to recipients, publishes information for providers and recipients, and maintains the Wisconsin Medicaid Web site.

HCPCS

Healthcare Common Procedure Coding System. A listing of services, procedures, and supplies offered by physicians and other providers. HCPCS includes Current Procedural Terminology (CPT) codes, national alphanumeric codes, and local alphanumeric codes. The national codes are developed by the Centers for Medicare and Medicaid Services (CMS) in order to supplement CPT codes.

HMO

Health Maintenance Organization. Provides health care services to enrolled recipients.

ICD-9-CM

International Classification of Diseases, Ninth Revision, Clinical Modification. Nomenclature for all medical diagnoses required for billing. Available through the American Hospital Association.

Maximum allowable fee schedule

A listing of all procedure codes allowed by Wisconsin Medicaid for a provider type and Wisconsin Medicaid's maximum allowable fee for each procedure code.

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for people with disabilities, people 65 years and older, children and their caretakers, and pregnant women who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Medicaid is also known as the Medical Assistance Program, Title XIX, or T19.

Medically necessary

According to HFS 101.03(96m), Wis. Admin. Code, a Medicaid service that is:

- (a) Required to prevent, identify or treat a recipient's illness, injury or disability; and
- (b) Meets the following standards:
 - 1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
 - 2. Is provided consistent with standards of acceptable quality of care applicable to type of service, the type of provider and the setting in which the service is provided;
 - 3. Is appropriate with regard to generally accepted standards of medical practice;
 - Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;

Glossary (Continued)

- 5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;
- 6. Is not duplicative with respect to other services being provided to the recipient;
- 7. Is not solely for the convenience of the recipient, the recipient's family or a provider;
- 8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
- 9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

POS

Place of service. A single-digit code which identifies where the service was performed.

R/S Report

Remittance and Status Report. A statement generated by the Medicaid fiscal agent to inform providers regarding the processing of their claims.

TOS

Type of service. A single-digit code which identifies the general category of a procedure code.

Index

Billable contacts, 8

Billed amounts, 7

Claim form completion, 7 Claim filing deadline, 7 Claims submitted electronically, 7 National CMS 1500 claim form, 7, 13, 15

Healthcare Common Procedure Coding System (HCPCS) procedure codes, 8

Place of service codes, 8

Remittance and Status Report, 9

Rounding guidelines, 8, 19

Target population codes, 8

Type of service codes, 8

Usual and customary charge, ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy