Child Care Coordination Services

wisconsin Medicaid and BadgerCare

Information for Providers

Department of Health and Family Services

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Preface

The Wisconsin Medicaid and BadgerCare Child Care Coordination Services Handbook is issued to child care coordination 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. BadgerCare extends Medicaid coverage to uninsured children and parents with incomes at or below 185% (as of January 2001) 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 handbook for detailed information on the methods of verifying eligibility.

Handbook Organization

The Child Care Coordination Services Handbook consists of the following chapters:

- General Information.
- Covered Services and Related Limitations.
- Billing Information.

In addition to the Child Care Coordination 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 - 456 -- Public Health.

Wisconsin Law and Regulation

- Law: Wisconsin Statutes: Sections 49.43 - 49.497 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, to provide health claims processing, communications, and other related services.

General Information

To obtain the program's goals, it is critical that providers have the ability to offer all three components of the child care coordination benefit, not just the assessment, to eligible recipients.

Wisconsin Medicaid added the child care coordination (CCC) benefit under the authority of 1995 Wisconsin Act 303. The benefit extends Medicaid prenatal care coordination (PNCC) services to include CCC services for recipients in Milwaukee County.

Definition of the Child Care Coordination Benefit

Child care coordination services help a recipient and, when appropriate, the recipient's family gain access to and coordinate a full array of services, including necessary medical, social, educational, vocational, and other services. Wisconsin Medicaid CCC services are available to Medicaid recipients in Milwaukee County who either:

- Receive an initial risk assessment within eight weeks following the birth of a child.
- Received Medicaid PNCC services, if they receive the initial risk assessment within six months following delivery.

Recipients qualify for care coordination services until the child's seventh birthday.

Child care coordination services include all of the following:

- Initial assessment.
- Care plan development.
- Ongoing care coordination and monitoring.

Wisconsin Medicaid does *not* cover direct service provision as part of the CCC benefit.

Child Care Coordination Goal

The CCC benefit extends the Medicaid PNCC benefit in Milwaukee County. The goals of the CCC benefit are to promote positive parenting, improve child health outcomes, and prevent child abuse and neglect.

The main objectives for obtaining these goals include the following:

- Improving family functioning.
- Improving parenting skills and positive parenting outcomes.
- Increasing recipients' understanding of infant and child development.
- Increasing recipients' access to and appropriate use of the health care delivery system.
- Improving employment outcomes.
- Encouraging planned pregnancies.
- Improving future birth outcomes.

Child care coordination services do not end with the completion of the initial assessment, unless the assessment determines the recipient does not need further assistance. To obtain the program's goals, it is critical that providers have the ability to offer all three components of the CCC benefit, not just the assessment, to eligible recipients.

- ***Care Coordination Provider -*** the entity that meets the requirements as a certified care coordination provider (refer to the Prenatal Care Coordination Handbook), is assigned the Medicaid billing provider number, and has legal liability for the provision of care coordination services.

- ***Care Coordinator -*** the individual who is providing care coordination services to recipients.

Scope of Service

The policies in this handbook govern services as defined in ss. 49.46(2)(b)12m, Wis. Stats. Please refer to the Covered Services and Related Limitations chapter of this handbook for more information on covered services and related limitations.

Provider Information

Provider Eligibility and Certification

All Medicaid-certified PNCC providers in Milwaukee County are automatically certified to provide CCC services.

Subcontracting for Child Care Coordination Services

Medicaid-certified PNCC providers may subcontract with agencies not certified by Medicaid for CCC services. 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 subcontractor provides services and maintains records in accordance with the Medicaid requirements for the provision of CCC 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 (Medicaid).

For more information on recordkeeping as it relates to CCC services, refer to Recordkeeping in the Covered Services and Related Limitations chapter of this handbook. Please refer to the Recipient 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 subcontractors:

- 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 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 subcontracted agency may bill Wisconsin Medicaid using the certified provider's Medicaid number, Wisconsin Medicaid only reimburses the certified provider.

The Medicaid-certified provider retains all legal and fiscal responsibility for the services provided by subcontractors.

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 (EVS) 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.

Medicaid Managed Care Coverage

Child care coordination is not covered by state-contracted Medicaid HMOs or special managed care programs (such as programs for people with disabilities). Therefore, bill CCC services directly to Wisconsin Medicaid for recipients enrolled in these programs.

Copayment

Child care coordination services are not subject to recipient copayment.

Freedom of Choice

For recipients, participation in the CCC program is voluntary. The recipient voluntarily participates in the program by maintaining contact with and receiving services from the care coordination provider. The care coordination provider may not "lock-in" recipients or deny the recipients' freedom to choose providers. Recipients may participate, to the full extent of their ability, in all decisions regarding appropriate services and providers.

Covered Services and Related Limitations

Refer to the Medicaid Guidelines and Performance Measurements for Child Care Coordination (Appendix 7 of this handbook) for detailed information about the benefit's operational standards and performance measurements.

This chapter outlines the Medicaid-approved services, conditions, and limitations for child care coordination (CCC) services. Child care coordination services include all of the following:

- Initial assessment.
- Care plan development.
- Ongoing care coordination and monitoring.

Wisconsin Medicaid does *not* cover direct service provision as part of the CCC benefit.

Note: Providers should be prepared to offer all three components of the CCC benefit, not just the initial assessment, to eligible recipients.

Refer to the Medicaid Guidelines and Performance Measurements for Child Care Coordination (Appendix 7 of this handbook) for detailed information about the benefit's operational standards and performance measurements. Providers are encouraged to use the guidelines to help ensure that quality services are provided and activities are directed toward the program's objectives and goals as stated in the General Information chapter of this handbook.

Wisconsin Medicaid also uses the guidelines to monitor the administration of the benefit.

Initial Assessment

Providers are required to administer an initial, comprehensive risk assessment to all recipients, including recipients who received PNCC services. The purpose of this assessment is to determine the needs and strengths of the recipients. The Department of Health and Family Services' (DHFS)-approved tool is the Family Questionnaire (Appendix 8 of this handbook).

Complete *every* section on the Family Questionnaire unless the recipient objects to a particular section.

The Family Questionnaire must be:

- Reviewed and finalized in a face-to-face contact with the recipient.
- Signed and dated by the agency staff member who completed the questionnaire.

The person administering the Family Questionnaire must be an employee of the Medicaid-certified care coordination agency or an employee of an agency under contract to the care coordination agency.

Qualified professionals are required to review and initial all Family Questionnaires completed by paraprofessional staff.

According to HFS 105.52, Wis. Admin. Code, types of qualified professionals include:

- A nurse practitioner licensed as a certified nurse pursuant to s. 441.06, Wis. Stats., and currently certified by the American Nurses' Association, the National Board of Pediatric Nurse Practitioners and Associates or the Nurses' Association of the American College of Obstetricians and Gynecologists' Certification Corporation.
- A nurse midwife certified under HFS 105.201, Wis. Admin. Code.
- A public health nurse meeting the qualifications of HFS 139.08, Wis. Admin. Code.
- A physician licensed under ch. 448, Wis. Stats., to practice medicine or osteopathy.
- A physician assistant certified under ch. 448, Wis. Stats.
- A dietitian certified or eligible for registration by the Commission on Dietetic Registration of the American Dietetic

Association with at least two years of community health experience. (Per proposed rule change, the following is also acceptable: A dietician certified by the State of Wisconsin [CD] or registered by the American Dietetic Association [RD] with at least two years of community health experience.)

- A certified nurse with at least two years of experience in maternity nursing and/or community health service.
- A social worker with at least a bachelor's degree and two years of experience in a health care or family services program.
- A health educator with a master's degree in health education and at least two years of experience in community health services.

Wisconsin Medicaid reimburses for the administration of the Family Questionnaire regardless of the recipient's score. Recipients may be reassessed at any time, but providers need only readminister the entire Family Questionnaire if the recipient's situation changes significantly.

Wisconsin Medicaid will reimburse only one comprehensive assessment per 365 days.

Providers may obtain copies of the Family Questionnaire at no cost by writing to:

Division of Health Care Financing
Bureau of Fee-for-Service Health Care Benefits
Attn: Forms Manager
P.O. Box 309
Madison, WI 53701-0309

When requesting the Family Questionnaire, note the form number DOH 1118 on the request.

Care Plan Development

Wisconsin Medicaid will reimburse care planning as a CCC service when provided by qualified staff. Care planning includes developing *and* implementing the care plan.

Wisconsin Medicaid will reimburse the development of a care plan for recipients who score 70 or more points on the Family Questionnaire. A completed questionnaire must predate the care plan.

Medicaid reimburses for the development of one care plan per recipient, per 365 days. (Wisconsin Medicaid reimburses for updates to the care plan under the ongoing care coordination and monitoring procedure code.)

The care coordinator is required to develop an individualized care plan for each eligible recipient. Medicaid does not require a specific care plan format, but the care plan must be:

- Developed (or reviewed) and signed or initialed by a qualified professional.
- In writing.
- Based on the results of the Family Questionnaire.

Note: Providers should note in the care plan if the recipient does not want to address issues identified in the Family Questionnaire.

Refer to Appendix 11 of this handbook for a blank model of a care plan. Providers are not required to use the sample.

To ensure the recipient's needs are met, the care plan must:

- Identify needs, problems, necessary services, necessary referrals, and frequency of monitoring.
- Include an array of services regardless of funding sources.

To the maximum extent possible, include the recipient in the development and any subsequent revisions of the care plan. Include family members and other supportive persons as appropriate. The recipient and care coordinator who developed the care plan are required to sign and date the plan.

The care coordinator is required to develop an individualized care plan for each eligible recipient.

Ongoing Care Coordination and Monitoring

A collateral is anyone who has direct supportive contact with the recipient, such as a family member, friend, service provider, guardian, housemate, or school official.

Ongoing care coordination and monitoring activities must be based on the recipient's written care plan. Wisconsin Medicaid will not cover ongoing care coordination and monitoring services that are not based on the recipient's care plan.

Ongoing care coordination and monitoring is a covered CCC service for recipients who score 70 or more points on the Family Questionnaire. Except for urgent care situations, providers are required to complete the Family Questionnaire and a care plan for each recipient prior to providing ongoing care coordination and monitoring services. Providers may offer ongoing care coordination services on the same date they completed the Family Questionnaire and care plan.

Activities for Ongoing Care Coordination and Monitoring

Covered activities include the following:

- Recipient contacts.
- Collateral contacts.
- Information and referral.
- Assessment and care plan updates.
- Recordkeeping.

Recipient Contacts

Recipient contacts may be face-to-face, by telephone, or in writing, as appropriate. Wisconsin Medicaid does not cover recipient contacts for the direct provision of services. Wisconsin Medicaid reimburses for the provision of many medical services under other Medicaid benefits.

Wisconsin Medicaid does not limit the number of contacts providers may have with a recipient.

Family Members
Wisconsin Medicaid covers care coordination services provided to Medicaid-eligible family members. Services to non-Medicaid-eligible family members (including mothers who become ineligible for Medicaid) are covered only as outlined below. The need for care coordination services provided to family members must be identified in the recipient's care plan and must be directly related to meeting the goals and objectives of the benefit.

Family Members Not Eligible for Medicaid
Providers may assist a non-Medicaid-eligible family member in locating and accessing services only if the service is directly related to addressing the needs of the eligible recipient.

For example, the provider is providing services to a family of four. The mother, the baby and the grandmother are all eligible for Medicaid. The baby's father is not. The baby has special health care needs. Wisconsin Medicaid will cover care coordination services related to assisting the father in locating and accessing educational resources necessary to help him better meet the baby's needs. However, Medicaid would not cover care coordination activities related to assisting the father in accessing needed substance abuse treatment services for himself.

Collateral Contacts

A collateral is anyone who has direct supportive contact with the recipient, such as a family member, friend, service provider, guardian, housemate, or school official. Since the purpose of contacts with a collateral is to mobilize services and support on behalf of the recipient, the provider is required to identify the role of the collateral in the recipient's care plan.

Collateral contacts also include time spent on client-specific meetings and formal case consultations with other professionals or supervisors. Do not include time spent discussing or meeting on non-client-specific or general program issues.

Wisconsin Medicaid will reimburse collateral contacts even if there is no recipient contact during the month for which the provider is billing.

Information and Referral

Information and referral means providing recipients with current information about available resources and programs to help recipients gain access to needed services. Providers are required to ensure follow up on all referrals within two weeks, unless otherwise stated. Wisconsin Medicaid reimburses information and referral under ongoing care coordination and monitoring.

Please refer to Appendix 9 of this handbook for a model of a Referral Form.

Refer to Appendix 13 of this handbook for general information on HealthCheck screens and Appendix 14 for the HealthCheck screening schedule.

Appendix 15 of this handbook includes a list of resources that providers and recipients may consult.

Assessment and Care Plan Updates

Providers may update the Pregnancy Questionnaire and care plan, and administer other assessment tools, when necessary. Wisconsin Medicaid reimburses these activities as ongoing care coordination and monitoring services.

Assessment Updates

Providers may update the Family Questionnaire as frequently as needed. Providers may also administer other assessment instruments periodically, if appropriate, to determine the child's (or mother's) progress toward meeting basic developmental milestones or program goals. For example, the assessment tools may include Denver Developmental, Wisconsin Child Protective Services Risk Management System, or the HOME Screening tool.

Use the ongoing care coordination and monitoring procedure code (W7097) when billing for updates to the Family Questionnaire and/or administration of other assessments.

Care Plan Updates

Providers are required to review and update the care plan at least every 60 days, or earlier if the recipient's needs change, during the first year of the child's life. Thereafter, providers should review and update the care plan at least every 180 days. If necessary, providers should update the recipient's care plan during each visit.

The provider and the recipient are required to sign and date all updates to the care plan. The provider may initial updates to the care plan if a signature page is included in the recipient's file. Providers are required to keep signed copies of the updates in the recipient's file.

Use the ongoing care coordination and monitoring procedure code (W7097) when billing for updates to the care plan.

Providers are required to review and update the care plan at least every 60 days, or earlier if the recipient's needs change, during the first year of the child's life.

Recordkeeping

Wisconsin Medicaid considers recordkeeping a reimbursable ongoing care coordination and monitoring activity. Reimbursable recordkeeping activities include time spent on the following:

- Updating care plans.
- Documenting recipient and collateral contacts.
- Preparing and responding to correspondence to and for recipients and collaterals.
- Documenting the recipient's activities in relation to the care plan.

Wisconsin Medicaid reimburses for recordkeeping only if a recipient or collateral contact occurred during the month for which the provider is billing.

If a recipient or collateral contact occurs on the last day of the month, the provider may bill Medicaid for the documentation of the contact in the following month (e.g., if the contact occurred on June 30, the provider may bill for the contact with the July contacts). Wisconsin Medicaid will only allow this exception if the provider documents the contact no later than the next business day.

Provision of Services in Urgent Situations

When ongoing care coordination services are provided in an urgent situation (e.g., the family is homeless or lacks food), the provider is required to:

- Document the nature of the urgent situation.
- Complete the Family Questionnaire and care plan as soon as possible but no later than 30 days following the actions taken to alleviate the urgent situation.

Note: Providers may offer ongoing care coordination services to recipients in urgent situations, but Wisconsin Medicaid will not reimburse for these services when they are provided to recipients who score fewer than 70 points on the Family Questionnaire.

As part of the care planning process, the care coordinator is required to discuss and document the frequency of ongoing contacts and monitoring with the recipient (and the recipient's collaterals, if appropriate).

Frequency of Ongoing Monitoring

As part of the care planning process, the provider is required to discuss and document the frequency of ongoing contacts and monitoring with the recipient (and the recipient's collaterals, if appropriate). The care coordinator is required to note the rationale for contacts that are less frequent than the following:

- A contact (face-to-face or telephone) with the recipient every 30 days, if the recipient has a child aged 6 months or less.
- A face-to-face contact with the recipient every 60 days, if the recipient has a child aged 12 months or less.
- A face-to-face or telephone contact with the recipient every 90 days after the first year of the child's life.

When the recipient is a child under age 18 who is living with the parent(s) or guardian, the provider satisfies the recipient contact requirements if the face-to-face contact is with either the recipient or with the custodial parent(s) or guardian.

Recipient Records

According to HFS 106.02(9), Wis. Admin. Code, all providers are required to prepare and maintain truthful, accurate, complete, legible, and concise documentation and records. Providers may keep records in written or electronic formats. If providers keep electronic records, they are required to have hard copies available for review and audit.

As defined in HFS 105.52(5), Wis. Admin. Code, the recipient's file must include the following documents, as appropriate:

- The recipient's completed Family Questionnaire. The Family Questionnaire must be scored, signed, and dated.
- The recipient's care plan, signed and dated as required. The provider may initial the care plan if a signature page is included in the recipient's record.
- A log that clearly and concisely documents all care coordination activities. All entries must be signed and dated.
- Completed consent document(s) for release of information.
- A written record of all recipient-specific care coordination and monitoring activities. The record must include documentation of the following information:
  1. The recipient's name.
  2. The date of the contact.
  3. The full name and title of the person who made the contact.
  4. A clear description of the reason and nature of the contact.
  5. The results of the contact.
  6. The length of time of the contact (the number of minutes or the exact time; for example, 9:15-10:05 a.m.).
  7. Where or how the contact was made.
- Referrals and follow up.
- All pertinent correspondence relating to coordination of the recipient's care.

The following are general guidelines for documentation of activities:

- Maintain accurate and legible documentation.

- Correct errors with caution. Do not erase or obliterate errors in established records. Instead, draw a line through the error so the words remain legible. Sign or initial and date the correction.
- Arrange the file in logical order if possible, so that documents can easily be reviewed and audited.
- Ensure that all entries are signed and dated and in chronological order. Initials are acceptable if the recipient's file includes a page bearing the provider's full name and signature.
- Keep documentation concise, but descriptive and pertinent. The notation for each entry should be reasonably reflective of the length of time documented for the activity.
  For example, an entry stating, "Called Recipient X to remind her of baby's HealthCheck appointment" should not have a length of time of one hour.
  A more reasonable notation would state: "Called Recipient X to remind her of baby's upcoming HealthCheck appointment. Made sure that she knew the name and location of the clinic and knew the name of the pediatrician. Answered Recipient X's questions regarding the appointment, transportation arrangement, and child care for her other children. Provided her with the name and telephone numbers of several transportation and day care providers in the area. Made plans with the recipient for a follow-up home visit."
- If unusual abbreviations and symbols are used routinely (e.g., abbreviations pertaining to internal policy or personal shorthand codes), maintain a key describing each one.

Please refer to Appendix 12 of this handbook for a completed sample time log form.

Safeguarding Recipient Information

State and federal laws require that the personal information of all Medicaid recipients be safeguarded. However, when providing care coordination services, providers may need to obtain or release recipient information on behalf of the recipient. To comply with state and federal laws, providers may release recipient-specific information if:

- The recipient has granted written authorization to the provider.
- The recipient has signed and dated the authorization.

In cases where more stringent laws govern the release of certain personal information, providers are required to comply with those laws. It is the provider's responsibility to be aware of patient confidentiality laws.

For a model of a release of information form, please consult the Informed Consent to Release/Obtain Health Care Information form in Appendix 10 of this handbook.

Please refer to HFS 104.01(3), Wis. Admin. Code, and to the Provider Rights and Responsibilities section of the All-Provider Handbook for additional information on maintenance and confidentiality of Medicaid recipient records.

Duplication of Services

Child Care Coordinators

A recipient should not require CCC services from more than one provider. Although Medicaid does not deny claims for concurrent services, both providers are notified of the overlap. It is the providers' responsibility to eliminate the overlap by communicating with the family and with each other to determine which provider will continue to provide CCC services.

Other Care Coordinators

When multiple family members have care coordinators (case managers), the care plan must identify the role of each care coordinator. Coordinators may not duplicate services. This requirement applies whether or not Medicaid

A recipient should not require child care coordination services from more than one provider.

covers the other care coordinator's services. The need for more than one service coordinator in the family must be reassessed after 12 months. The family's preferences concerning which care coordinator should provide services must be considered when the care coordinators' roles overlap.

If a family is involved in the child welfare system, the child care coordination provider may not bill Wisconsin Medicaid for ongoing care coordination services.

Coordinating Prenatal Care Coordination Services and Child Care Coordination Services

The Wisconsin Medicaid PNCC benefit covers the period of pregnancy through the 60th day (the postpartum period) following delivery. During the postpartum period, CCC providers may be reimbursed through the CCC benefit for administering the Family Questionnaire and developing a care plan. However, providers may not bill Wisconsin Medicaid for ongoing CCC services (W7097) provided to recipients receiving PNCC services, except as outlined here.

Wisconsin Medicaid covers ongoing CCC services provided to a recipient receiving PNCC services if the following information is documented in the recipient's record:

- The recipient's care plan specifically addresses the need for both services at the same time, as demonstrated in the following two examples:
  Example 1: A recipient receiving PNCC services has just given birth to healthy twins. However, the recipient is a 19-year-old, first-time mother who moves frequently and is sometimes homeless. At present, she lives with an abusive partner who is often absent for days at a time. She receives little or no emotional support from family members and is not sure she is happy with twins.
  In this example, the prenatal care coordinator may decide (with the recipient) to include the child care coordinator during the postpartum period because of the recipient's immediate and significant needs.
  Example 2: A recipient receiving CCC services becomes pregnant. The recipient has a child who is at high risk for child abuse and/or neglect, has a history of gestational diabetes, poor nutrition, and other significant medical problems. The recipient also has a history of poor compliance with prenatal medical appointments and advice.
  In this situation, the child care coordinator may decide (in consultation with the recipient) that the expertise of a prenatal care coordinator is also appropriate.
- The recipient's care plan includes a clear delineation of the role of each care coordinator (regardless of whether the care coordinators are employed by the same or different agencies). The care coordinators should decide, along with the recipient, which care coordinator will provide or follow up on which services.
- The services provided by the care coordinators are not duplicative.
- The recipient's care plan addresses the frequency of contacts between the care coordinators. The care coordinators must have a face-to-face or telephone contact to discuss the recipient's progress every 60 days, at a minimum. The need for ongoing joint care coordination should be reassessed during that time.

Child Care Coordination and Child Welfare

Wisconsin Medicaid covers CCC services provided to families who are undergoing a child protective services investigation or initial assessment. These families are not yet receiving ongoing child welfare case management services.

If a family is involved in the child welfare system, the CCC provider may not bill Wisconsin Medicaid for ongoing care coordination services. However, Wisconsin Medicaid will cover two concurrent visits

between the CCC provider and the Safety Services or ongoing case management provider if the family is receiving either:

- Services from a Safety Services provider under contract with the Bureau of Milwaukee Child Welfare.
- Ongoing case management services through the child welfare system.

Providers are required to consult with the family and the Safety Services or ongoing case management provider regarding the necessity and timing of concurrent visits. Providers are required to document the reason for the joint visits.

Providers are encouraged to develop referral protocols and maintain working relationships with the Safety Services and child protective services providers in their service areas.

Referrals From the Child Welfare System

In some cases, families will be identified by the child welfare system, including Safety Services, prior to receiving CCC services. The CCC provider may accept these referrals in the following situations:

- The family meets the eligibility criteria for the benefit.
- The family became involved with the child welfare system, including Safety Services, within eight weeks following the birth of the baby, regardless of the age of the child at the time of the referral.

Reduction or Termination of Ongoing Care Coordination Services

If a provider needs to reduce or terminate ongoing care coordination services for any reason, the provider should notify the recipient in advance and document this in the recipient's record. A decision that services can be reduced or terminated should be mutually agreed upon by the provider and recipient. The recipient's file must include a statement, signed and dated by the recipient, indicating agreement with the decision to terminate services. Changes in the care plan should always be discussed with the recipient/guardian/parent.

In circumstances when the provider is unable to obtain a signature from the recipient for the termination of services (for example, the recipient consistently misses meetings with the provider and does not follow through on referrals, but indicates she wants to continue receiving CCC services), the recipient's file must include documentation of all attempts to contact the recipient through telephone logs and returned or certified mail. The provider is encouraged to provide the recipient with the names and addresses of other CCC providers.

If a provider terminates ongoing CCC services for any reason, the recipient's case is closed. However, there is no limit to the number of times a provider may reopen a recipient's case. The provider is required to document in the recipient's record why the case has been closed and reopened.

There is no limit to the number of times a provider may reopen a recipient's case.

Other Limitations

The following related limitations apply to CCC services in addition to the other limitations stated in this handbook:

1. Child care coordination services are available to recipients who are inpatients in hospital or nursing facilities if:

    - The services do not duplicate discharge planning services that the hospital or nursing facility is required to provide.
    - The service is provided during the 30 days prior to discharge.

2. Wisconsin Medicaid will only reimburse ongoing care coordination and monitoring services *once* per recipient per month of service. The units billed are the sum of the time for the month.

Noncovered Services

The following services are not covered under the Medicaid CCC benefit:

1. The provision of diagnostic, treatment, or other direct services. Direct services include, but are not limited to, diagnosis of a physical or mental illness and administration of medications.
2. Recipient vocational training.
3. Legal advocacy by an attorney or paralegal.
4. Ongoing care coordination and monitoring services which are not based on the recipient's current care plan.
5. Ongoing care coordination and monitoring services which are not necessary to meet the CCC benefit goals.
6. Transportation (provider or recipient mileage or travel time).
7. Interpreter services.
8. Missed appointments (no shows).

Billing Information

Claim Submission

Wisconsin Medicaid must receive properly completed claims within 365 days from the date the service was provided.

All claims, whether electronic or paper, are subject to the same Medicaid processing and legal requirements.

Electronic Billing

Child care coordination (CCC) providers are encouraged to submit claims electronically. Electronic claims submission:

- Reduces processing time.
- Eliminates manual handling of claims.
- Reduces both billing and processing errors.

Wisconsin Medicaid provides free software for billing electronically. For more information on electronic billing:

- Refer to the Claims Submission section of the All-Provider Handbook.
- Contact the Electronic Media Claims (EMC) Department at (608) 221-4746. Ask to speak with an EMC coordinator.

If you are currently using the free software and have technical questions, please contact Wisconsin Medicaid's software customer service at (800) 822-8050.

Paper Claim Submission

Providers submitting paper claims are required to use the HCFA 1500 claim form (dated 12/90). Appendices 2 and 3 of this handbook contain completed samples of HCFA 1500 claim forms for CCC services. Refer to Appendix 1 of this handbook for HCFA 1500 claim form completion instructions.

Wisconsin Medicaid denies claims for CCC services submitted on any paper claim form other than the HCFA 1500 claim form.

Wisconsin Medicaid does not provide the HCFA 1500 claim form. Providers may obtain these forms from any vendor that sells federal forms.

Where to Send Your Claims

Mail completed HCFA 1500 claim forms for reimbursement to the following address:

Wisconsin Medicaid
Claims and Adjustments Unit
6406 Bridge Road
Madison, WI 53784-0002

Claim Submission Deadline

Wisconsin Medicaid must receive properly completed claims within 365 days from the date the service was provided. This policy applies to all initial claim submissions, resubmissions, and adjustment requests.

Exceptions to the 365-day claim submission deadline and requirements for submission to Late Billing Appeals can be found in the Claims Submission section of the All-Provider Handbook. Providers may access the handbook on-line at *www.dhfs.state.wi.us/medicaid/*.

Recipient Identification

Care coordinators are required to use the mother's Medicaid ID number when billing for CCC services.

If the mother becomes ineligible for Wisconsin Medicaid while receiving CCC services, providers may bill Wisconsin Medicaid for those services using the eligible child's Medicaid ID number. Providers are required to document in the recipient's file the reason for using the child's Medicaid ID number when billing for CCC services.

Billed Amounts

Providers are required to bill their usual and customary charge for the service performed. The usual and customary charge is the provider's charge for providing the same

service to persons not entitled to Wisconsin Medicaid benefits. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid patients.

Providers may not discriminate against Wisconsin Medicaid recipients by charging Medicaid a higher fee for the same service than that charged to a private-pay patient. For providers who have not established usual and customary charges, the charge should be reasonably related to the provider's cost to provide the service.

Reimbursement

Providers are reimbursed at the lesser of their usual and customary charge or the maximum allowable fee established by the Department of Health and Family Services (DHFS).

The maximum allowable fee is the amount Wisconsin Medicaid will pay a provider for an allowable procedure code. Refer to Appendix 16 of this handbook for a copy of the Wisconsin Medicaid maximum allowable fee schedule for CCC services.

To obtain subsequent maximum allowable fee schedules, or to ensure you have the most recent fee schedule, you may:

- Purchase a paper schedule by writing to:

  Wisconsin Medicaid
  Provider Maintenance
  6406 Bridge Road
  Madison, WI 53784-0006

  Providers may contact Provider Services at (800) 947-9627 or (608) 221-9883 for the cost of the fee schedule.

- Download an electronic version from Wisconsin Medicaid's Web site using directions located in the Claims Submission section of the All-Provider Handbook. Wisconsin Medicaid's Web site is located at *www.dhfs.state.wi.us/medicaid/*.

Procedure Codes

All claims submitted to Wisconsin Medicaid must include procedure codes. Allowable HCFA Common Procedure Coding System (HCPCS) codes for CCC services are listed in

It is vital that you use the correct procedure codes, diagnosis codes, and modifiers when billing for CCC services:

Procedure Codes

- W7095 Risk Assessment - Child Care Coordination.
- W7096 Initial Care Plan Development - Child Care Coordination.
- W7097 Ongoing Child Care Coordination and Monitoring.

Diagnosis Codes

- V61.8 Other specified family circumstances.
- V61.9 Unspecified family circumstances.

Use V61.8 when billing for:

- Recipients who score 70 or more points on the Family Questionnaire (initial risk assessment).
- When billing procedure codes W7096 or W7097.

Use V61.9 when billing for:

- Recipients who score fewer than 70 points on the Family Questionnaire.

Remember to use a modifier to indicate the recipient's risk assessment score when billing for procedure code W7095. Please refer to Appendix 4 of this handbook for the appropriate modifiers.

the shaded box on the previous page and in Appendix 4 of this handbook. Claims or adjustments received without the appropriate HCPCS codes are denied.

Diagnosis Codes

Claims submitted for CCC services must include either diagnosis code V61.8 (other specified family circumstances) or V61.9 (unspecified family circumstances).

Claims submitted for risk assessments (procedure code W7095) must include a modifier indicating the recipient's total risk assessment score.

Use diagnosis code:

- V61.8 when billing on behalf of recipients who score 70 points or more on the Family Questionnaire (i.e., those who are determined eligible to receive services).
- V61.8 when billing procedure codes W7096 and W7097.
- V61.9 when billing on behalf of recipients who score fewer than 70 points (i.e., those who are assessed but determined ineligible to receive services).

Wisconsin Medicaid will deny claims if providers use other diagnosis codes when billing for CCC services.

Time Units

When billing for risk assessment (W7095) and initial care plan development (W7096), always bill for one unit.

Round time units to the nearest tenth of an hour when billing for ongoing care coordination and monitoring (W7097).

Refer to Appendix 6 of this handbook for more information on rounding guidelines for CCC services.

Modifiers

Claims submitted for risk assessments (procedure code W7095) must include a modifier indicating the recipient's total risk assessment score.

Allowable modifiers are located in Appendix 4 of this handbook. Claims for risk assessments that do not include the appropriate modifier are denied.

Follow-Up to Claim Submission

The provider is responsible for initiating follow-up procedures on claims submitted to Wisconsin Medicaid. Processed claims appear on the Remittance and Status (R/S) Report either as 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.

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 ongoing care coordination time which may have been omitted from the original claim, providers are required to file an Adjustment Request Form.

Appendix 1

National HCFA 1500 Claim Form Completion Instructions for Child Care Coordination 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.

Providers are not required to bill commercial health insurance for child care coordination services.

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 ID 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 ID 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 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)

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)

Appendix 1
(Continued)

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 appropriate diagnosis code as follows:

- Enter V61.8 (other specified family circumstances) if the Family Questionnaire indicates the recipient to be high risk (a score of 70 or more points on the Family Questionnaire). Procedure codes W7096 and W7097 are only allowable if V61.8 is indicated.
- Enter V61.9 (unspecified family circumstances) if the Family Questionnaire indicates the recipient is not high risk (a score of fewer than 70 points on the Family Questionnaire).

Element 22 — Medicaid Resubmission (not required)

Element 23 —- Prior Authorization Number (not required)

Element 24A — Date(s) of Service

For ongoing care coordination and monitoring (W7097), if the service was performed on more than one date of service within the month, indicate the last date the service was performed. If billing for more than one month of activities, use one detail line for each month's activities with the date of service determined as described below. Refer to Appendix 2 of this handbook for a completed sample claim form that shows more than one month's activities billed on the same claim form.

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.
- When billing for two, three, or four dates of service on the same detail line, enter the last date of service in MM/DD/YY or MM/DD/YYYY format in the "From" field.

Element 24B — Place of Service

Enter the appropriate Medicaid single-digit place of service (POS) code for each service. Enter 0 (other) if the place of service occurred in more than one location. Refer to Appendix 5 of this handbook for Medicaid-allowable POS codes.

Element 24C — Type of Service

Enter "9" as the single-digit type of service code.

Appendix 1
(Continued)

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character procedure code (refer to Appendix 4 of this handbook for a list of Medicaid-allowable procedure codes). Claims received without an appropriate procedure code are denied by Wisconsin Medicaid.

Modifiers

Enter the appropriate two digit procedure code modifier in the "Modifier" column of Element 24D when billing for the initial risk assessment (Family Questionnaire). Refer to Appendix 4 of this handbook for definitions of modifiers.

Element 24E — Diagnosis Code

Enter the number (1, 2, 3, or 4) 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 appropriate number of hours billed on each line. Round to the nearest 0.1 hour. Appendix 6 of this handbook lists the rules for rounding. Always enter "1.0" when billing procedure codes W7095 and W7096.

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

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 (R/S) 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.

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 2

HCFA 1500 Claim Form Completed Sample

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [P] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

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

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YYYY SEX M [ ] F [X]

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

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

CITY: Anytown STATE: WI

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

CITY STATE

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

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

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

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

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V61.8 . 3. . 2. . 4. .

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 06 22 98		0	9	W7095	30	1	XX XX	1.0				
2 06 22 98		0	9	W7096		1	XX XX	1.0				
3 06 28 98		0	9	W7097		1	XX XX	4.5				
4 07 12 98		0	9	W7097		1	XX XX	1				
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 123JED

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

28. TOTAL CHARGE $ XXX.XX

29. AMOUNT PAID $

30. BALANCE DUE $ XXX.XX

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

I.M.Authorized MM/DD/YYYY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 87654321

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Appendix

Appendix 3

HCFA 1500 Claim Form Completed Sample - Risk Assessment Only

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

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

CITY: Anytown STATE: WI

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

CITY STATE

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

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

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

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

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED _____

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

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

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V61.9 3. ___

2. ___ 4. ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 06 22 98		0	9	W7095	05		XX XX	1.0				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: 123JED

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

28. TOTAL CHARGE $ XXX.XX

29. AMOUNT PAID $

30. BALANCE DUE $ XXX.XX

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

I.M.Authorized MM/DD/YYYY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 87654321

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

Appendix

Appendix 4

Medicaid-Allowable Procedure Codes and Modifiers for Child Care Coordination Services

Procedure Codes

Procedure	Description
W7095	Risk Assessment - Child Care Coordination (See modifiers below)
W7096	Initial Care Plan Development - Child Care Coordination
W7097	Ongoing Child Care Coordination and Monitoring

Risk Assessment (Family Questionnaire) Score Modifier

The risk assessment (Family Questionnaire) must be billed using the appropriate two-digit modifier to indicate the recipient's total risk assessment score. Claims for risk assessments that are submitted without a modifier are denied. The modifiers in the gray cells represent modifiers for recipients who do not qualify for child care coordination (CCC) services. Providers do not need to use modifiers with other CCC procedure codes.

Score	Modifier	Score	Modifier	Score	Modifier	Score	Modifier
00-09	00	80-89	08	160-169	16	240-249	24
10-19	01	90-99	09	170-179	17	250-259	25
20-29	02	100-109	10	180-189	18	260-269	26
30-39	03	110-119	11	190-199	19	270-279	27
40-49	04	120-129	12	200-209	20	280-289	28
50-59	05	130-139	13	210-219	21	290-299	29
60-69	06	140-149	14	220-229	22	300 or greater	30
70-79	07	150-159	15	230-239	23		

Appendix 5

Medicaid-Allowable Place of Service Codes and Type of Service Code for Child Care Coordination Services

PLACE OF SERVICE (POS) CODES

POS	Description
0	Other
1	Inpatient Hospital
3	Office or Clinic
4	Home

Enter 0 (other) if the place of service occurred in more than one location.

TYPE OF SERVICE (TOS) CODE

TOS	Description
9	Other

Appendix 6

Rounding Guidelines for Child Care Coordination Services

Time units are calculated based on rounding accumulated hours of service for the month to the nearest tenth of an hour.

The following chart illustrates the rules of rounding and gives the appropriate billing unit:

Accumulated 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.	

A unit of service (1.0) for ongoing child care coordination and monitoring services (W7097) is one hour. Use the chart above to determine the appropriate unit when billing for a fraction of an hour. For example, bill 1.8 units to represent 1 hour and 45 minutes of ongoing care coordination services.

Do not use these guidelines when billing for procedure codes W7095 (risk assessment) or W7096 (care plan development). Always enter "1.0" unit for these procedure codes. Wisconsin Medicaid does not reimburse these procedure codes by the hour.

Appendix 7

Medicaid Guidelines and Performance Measurements for Child Care Coordination

The following pages provide guidelines with which child care coordination (CCC) agencies are required to comply when providing CCC services. The document is divided into four sections:

I. Child Care Coordination Administration.
II. Family Questionnaire Administration.
III. Care Plan Development.
IV. Ongoing Child Care Coordination and Monitoring.

Benefit guidelines are listed in the left-hand column of each page, while performance measurements are in the right-hand column. Wisconsin Medicaid uses the performance measurements to determine if the provider is complying with the benefit guidelines. If a guideline is not met, the provider is required to have written documentation that it has a reasonable alternative in place.

I. Child Care Coordination Administration

GUIDELINE The provider must:	PERFORMANCE MEASUREMENT
I.A. Develop a plan which addresses the hiring and ongoing support and training of staff who can provide quality services that are family-centered and culturally appropriate.	**I.A.** The provider's plan to hire, support, and train staff to provide services that are family-centered and culturally appropriate must be documented and available for review. Documentation of staff training includes the name of the employee, date of training, and the employee's signature.
I.B. Develop and implement an outreach plan to inform potentially eligible pregnant women and families with newborns (eight weeks or younger) about the availability of CCC services. At a minimum, the plan must: • Identify the provider's target population (for example, teens only, all eligible families in the county, families in specific ZIP codes). • Outline the strategies that will be used to inform eligible recipients, the local community, social service providers, schools, local health care providers, and other appropriate agencies and organizations about the availability of CCC services. Outreach efforts could also include community presentations, informational brochures, posters, billboards, television ads, or newspaper articles.	**I.B.** The provider is required to have an outreach plan available for review. The plan also must be specific to the target population and address strategies to inform eligible pregnant women about CCC services.
I.C. Establish written procedures to ensure that care coordinators include recipients, to the full extent of their ability, in all decisions regarding appropriate services and providers.	**I.C.** Written procedures that meet the stated guidelines are available for review.
I.D. Develop and implement internal policies and procedures for ensuring that quality services are provided in accordance with Medicaid rules. At a minimum, these policies and procedures address: • Patient confidentiality. These policies must include clear statements regarding the type of information that can be released, the time period for which the authorization is valid, and the agencies or individuals to whom the information can be released.	**I.D.** Written policies and procedures that meet the stated guidelines are available for review. Documentation of all activities that meet the stated guidelines is also available for review. Provider records indicate paraprofessional supervision every 90 days, at a minimum.

GUIDELINE (I.D. Cont.)	PERFORMANCE MEASUREMENT
• Accuracy, legibility, and completeness of records (for example, the accurate scoring of Family Questionnaires, the legibility of care plans and other written information, and documentation of all contacts with, or on behalf of, a recipient). • Procedures to ensure that priorities established in individual care plans are addressed in a timely manner. • Procedures to ensure that recipients are offered services that are sufficient in intensity. The procedures must include well-defined criteria for increasing or decreasing the intensity of services. • Procedures to ensure that timely and appropriate referrals are made and there is follow up on all referrals. Unless otherwise stated, follow up on referrals must be made within two weeks of the referral. • Ongoing staff training and support, including adequate supervision and support of paraprofessionals. Provide face-to-face supervision of paraprofessionals every 90 days, at a minimum. • Appropriate staff-to-client ratio. Ensure that care coordinators have an adequate amount of time to spend with each family. The number of clients per care coordinator will vary depending on the needs of the families on their caseload. • The provision of services by culturally competent staff. • The provision of services that are family-centered. • Procedures to ensure that staff are following the provider's policies and procedures for the provision of services. The policies and procedures must clearly identify: • The staff responsible for oversight of the policies and procedures. • Steps for prioritizing, monitoring, and correcting problem areas.	

Appendix

GUIDELINE	PERFORMANCE MEASUREMENT
I.E. Develop written procedures and policies for determining when cases are to be closed (for example, the recipient no longer lives in the county, or the recipient has accomplished all identified goals).	**I.E.** The provider has written procedures and policies for determining when cases are to be closed.
I.F. Establish written procedures to ensure that a qualified professional reviews and signs all assessments completed by paraprofessional staff.	**I.F.** The provider has written procedures requiring the review by and signature of qualified professionals for all Family Questionnaires completed by paraprofessionals.
I.G. Develop a written plan for providing timely, non-disruptive, translator services for recipients who are hearing impaired and for recipients who do not speak or understand English. If the provider does not have an interpreter on staff, the provider must maintain a current list of interpreters who are "on call" to provide interpreter services. Do not use family members as interpreters when administering Family Questionnaires or for the initial care plan development. Do not use children as interpreters.	**I.G.** The provider has a written plan that meets the stated guidelines available for review. If the interpreter is not a staff member, the agency has a current list of "on call" interpreters available for review.
I.H. Develop written procedures for scheduling recipients for the initial assessment, initial care plan development, and for ongoing care coordination and monitoring services. The schedule should allow adequate time with each individual to address her problems, develop a plan of action, and provide information, if necessary. If possible, schedule the initial assessment within 10 working days after the request for a service or after receiving a referral. The procedures must also include guidelines for staff regarding the time frame within which the initial contact must be scheduled after the Family Questionnaire and care plan are completed.	**I.H.** Written procedures that clearly outline the provider's plans for scheduling the initial assessment, the initial care plan development, and ongoing care coordination and monitoring services must be available for review.
I.I. Develop written procedures for following up with recipients who fail to keep appointments (care coordination, social service, medical or other appointments). Include time frames within which the recipient must be contacted and the steps designed to help the recipient keep future appointments.	**I.I.** Written procedures that meet the stated guidelines are available for review.

GUIDELINE

I.J. Maintain a current list of appropriate community resources (for referral purposes). The list includes, but is not limited to, the following services and agencies:

- Adoption.
- AIDS/HIV.
- Adult protective services.
- Alcohol, tobacco, and other drug abuse.
- Child welfare services.
- Children with special health care needs program.
- Day care centers.
- Domestic/family violence.
- Early childhood intervention programs (for example, Head Start, Birth to 3).
- Education.
- Employment/job training.
- Family planning.
- Food pantries/other food services.
- Special Supplemental Food Program for Women, Infants, and Children (WIC) programs.
- Housing and shelters for the homeless.
- Legal assistance.
- Social services (e.g., family/marriage counseling, family support services, clothing for newborns).
- Parenting education (including fathers).
- Perinatal loss/grief counseling.
- Respite/family resource centers.
- Transportation.

The list(s) must include the description of services offered, name of agency, address, telephone number, contact person, and any costs associated with the services.

PERFORMANCE MEASUREMENT

I.J. A current list of appropriate community resources - including, but not limited to, the services and agencies stated in the guidelines - and addresses, telephone numbers, and any associated costs is on file.

GUIDELINE	PERFORMANCE MEASUREMENT
I.K. Establish working relationships (for the purpose of referrals) with key community agencies, social services providers, HMOs, and Medicaid primary care providers. If possible, develop written agreements that address the specific procedures to be followed for making referrals and for obtaining information on the outcome of the referrals from these agencies and providers. Ensure that staff is aware of these agreements. Medicaid HMOs are required to sign a Memorandum of Understanding (MOU) with all prenatal care coordination providers in their service area. The MOUs address the provision of services to pregnant women. As appropriate, work with the HMOs to expand the cooperative agreement beyond the postpartum period.	**I.K.** The provider's file includes written agreements or documentation that show that the provider has made good faith efforts to develop effective working relationships with key health and social services providers.
I.L. Establish written procedures regarding the release of recipient-specific information. Recipients may sign a general release of information. However, providers must obtain specific approval to release sensitive information about the recipient.	**I.L.** The provider has written policies regarding the release of recipient-specific information. The policies specifically address the release of sensitive information.

II. FAMILY QUESTIONNAIRE ADMINISTRATION

The provider must administer the Medicaid-approved assessment tool (the Family Questionnaire) to determine eligibility for the benefit. The assessment tool is designed to identify the recipient's strengths and needs. In addition to the Family Questionnaire, the provider may use any commercial or self-designed form to conduct a more detailed assessment.

All recipients must have a completed copy of the Family Questionnaire in their file.

Note: The Family Questionnaire includes several questions to which the recipient may object. Prior to administering the Family Questionnaire, explain the assessment and care planning process, acknowledge the intrusiveness of some of the questions and explain why you need to ask the questions. If necessary, share your agency's confidentiality policies with the recipient, including who will have access to the information provided.

GUIDELINE
The provider must:

II.A. Administer and score the Family Questionnaire in its entirety unless the recipient objects to a particular question or section, or the information is unavailable.

II.B. Review and finalize the Family Questionnaire in a face-to-face meeting with the recipient. The staff completing the Family Questionnaire must sign and date it. A qualified professional must review and sign all Family Questionnaires completed by paraprofessional staff.

II.C. Inform recipients who score 70 or more points on the Family Questionnaire that they are eligible to receive CCC services.

If the recipient is not interested in receiving services, try to determine the reason. Give the recipient a written copy of the agency's address and telephone number and ask the recipient to call or stop by if she changes her mind.

II.D. Inform recipients who score less than 70 points on the Family Questionnaire that they are not eligible to receive CCC services.

Based on the recipient's identified needs, refer her to other community resources as appropriate. Give the recipient with a written copy of the agency's telephone number and ask her to call or stop by if she has a significant negative change in her family, medical, social, or economic status within six months after the initial assessment.

PERFORMANCE MEASUREMENT

II.A. The recipient's file includes a completed and scored Family Questionnaire. If the questionnaire is not completed in its entirety, there is documentation that explains why.

II.B. The recipient's file includes documentation that the Family Questionnaire was reviewed and finalized in a face-to-face visit. The Family Questionnaire is signed and dated. The recipient's file also includes documentation that a qualified professional reviewed and signed all Family Questionnaires completed by paraprofessional staff.

II.C. The recipient's file documents that the recipient was offered CCC services.

If the recipient is not interested in receiving services, the reason is documented. The file includes documentation that the recipient received a written copy of the provider's address and telephone number and was asked to call if she changes her mind about receiving services.

II.D. The recipient's file includes documentation that the recipient was referred to other community resources as appropriate. The file also documents that the recipient was asked to contact the provider if she has a significant negative change in her family, medical, social, or economic status within six months.

Changes to the Family Questionnaire are legible and clearly identified. The Family Questionnaire is signed and dated.

GUIDELINE (II.D. Cont.)	PERFORMANCE MEASUREMENT
Also, the provider may reassess the recipient if someone, such as a health care professional, a school, or a social worker, refers her back to the provider within six months of the initial assessment.	
The provider may use the same Family Questionnaire if the reassessment or update is within 12 months of the initial assessment. Changes to the Family Questionnaire must be clearly identified (for example, use of different color ink, cross out old response). Do not erase or totally obliterate the original response.	
Re-sign and date the Family Questionnaire.	
II.E. Use a new Family Questionnaire for assessments administered after 12 months of the initial assessment.	**II.E.** The recipient's file includes a new Family Questionnaire if more than 12 months have elapsed since the initial assessment.

III. CARE PLAN DEVELOPMENT

The Family Questionnaire must be completed prior to the development of the care plan. The provider is not required to use a specific care plan format. However, the care plan must be based on the results of the Family Questionnaire.

As appropriate, the activities outlined in the care plan must be aimed at the following:

- Improving family functioning.
- Improving parenting skills and positive parenting outcomes.
- Increasing recipients' understanding of infant and child development.
- Increasing recipients' access to and appropriate use of the health care delivery system.
- Improving employment outcomes.
- Encouraging planned pregnancies.
- Improving future birth outcomes.

GUIDELINE The provider must:	PERFORMANCE MEASUREMENT
III.A. Develop a written individualized care plan for each recipient scoring 70 or more points on the Family Questionnaire. Develop only one care plan for each recipient.	**III.A.** The recipient's file includes an individualized care plan if the recipient scored 70 or more points on the Family Questionnaire.
III.B. Include the recipient in the development and any subsequent revisions of the care plan. Include family members and other supportive persons as appropriate.	**III.B.** The recipient's file includes documentation that the recipient and, when appropriate, the recipient's family and other supportive persons actively participated in the development of the care plan.
The recipient and provider who developed the care plan must sign and date the plan.	The recipient and provider have signed the care plan.
III.C. Inform the recipient that the care plan can be changed at any time, and as often as necessary. Provide the recipient with information on how to request changes to the care plan, including the name and telephone number of the person to contact to initiate the change.	**III.C.** The recipient's file includes documentation of the stated guideline.
III.D. Ensure that the care plan includes the following: • Identification and prioritization of strengths and problems identified during the initial assessment. • Identification and prioritization of all services to be arranged with the recipient, including the names of the service providers (including health care providers). • A description of the recipient's informal support system, including collaterals, and activities planned to strengthen it if necessary.	**III.D.** The recipient's file includes a care plan that meets the stated guidelines. If necessary, the care plan identifies all of the care coordinators involved with the family, addresses the role of each care coordinator, and addresses the frequency of contacts between the care coordinators.

GUIDELINE (III.D. Cont.)	PERFORMANCE MEASUREMENT
• Appropriate referrals and planned follow up. • Expected outcome of each referral. • Progress or resolution of identified priorities. • Documentation of unmet needs and gaps in service. • Planned frequency, time, and place of contacts with the recipient. • Identification of individuals who participated in the care plan development. • The recipient's responsibility in the plan's implementation. If there are other care coordinators involved with the family, the care plan must: • Identify the role of each care coordinator. • Address any needed collaboration or coordination. • Address, at least every 60 days, the frequency of contacts between the care coordinators. This requirement applies whether or not Medicaid covers the other care coordinator's services. The family's preferences concerning which care coordinator should provide services must be considered when the care coordinators' roles overlap. The need for more than one care coordinator in the family must be reassessed every 12 months.	
III.E. At a minimum, review and update the recipient's care plan every 60 days for the first year of the child's life. Thereafter, review and update the care plan at least every 180 days. If necessary, update the recipient's care plan during each visit. All updates to the care plan must be dated and signed or initialed by the provider and the recipient.	**III.E.** The recipient's file includes documentation that the care plan was updated at least every 60 days for the first year of the child's life and reviewed and updated a minimum of every 180 days thereafter. All updates to the care plan are dated and signed or initialed by the provider and the recipient.
III.F. Provide the recipient with the written name and telephone number of: • The person who will provide the ongoing care coordination services. If necessary, introduce the recipient to the care coordinator if he or she is different from the person who administered the assessment and developed the care plan. • The person to contact in urgent situations or as backup when the care coordinator is unavailable.	**III.F.** The recipient's file includes a copy of, or documentation stating that the provider gave to the recipient, written information identifying the name and telephone number of the care coordinator and of the person to contact as backup.

IV. ONGOING CHILD CARE COORDINATION AND MONITORING

All recipients must have a care plan in their file that predates the delivery of ongoing CCC services, except for in urgent situations. In such cases, the provider is required to document the urgent situation. The provider is required to document all recipient and collateral contacts. The documentation must include the following:

- The recipient's name.
- The date of the contact.
- The full name and title of the person who made the contact.
- A clear description of the reason for and nature of the contact.
- The length of time of the contact (the number of minutes or the exact time; for example, 9:15-10:05 a.m.).
- Where or how the contact was made.

Ongoing CCC services must be based on the care plan.

GUIDELINE	PERFORMANCE MEASUREMENT
IV.A. On an ongoing basis, the provider must: • Determine which services identified in the care plan have been or are being delivered. • Determine if the services are adequate for the recipient's needs. • Provide supportive contact to ensure that the recipient is able to access services, is actually receiving services, or is engaging in activities specified in the care plan. • Monitor the recipient and the family's satisfaction with the service. • Ask the recipient to evaluate the quality, relevance, and desirability of the services to which she or her family have been referred. • Identify changes in the family's circumstances that would require an adjustment in the care plan.	**IV.A.** The recipient's file includes documentation that indicates the provider offered ongoing services as stated.
IV.B. Provide the recipient with information on community resources and referrals to other agencies when appropriate. Whenever possible, provide written referrals. Written referrals must include: • The care coordinator's name, address, and telephone number. • The recipient's name. • The date that the referral is made. • The name, address, and telephone number of the agency/provider to which the recipient is being referred. • The reason for the referral.	**IV.B.** The recipient's file indicates that the provider made available information on community resources and provided referrals as appropriate. A copy of all written referrals is maintained (or noted if verbal) in the recipient's file.

Appendix

GUIDELINE	PERFORMANCE MEASUREMENT
IV.C. When referring the recipient for services, the care coordinator must: • Ensure that the recipient understands the reason and need for the referral. • Inform the recipient of all available options for obtaining the needed service. • Explain any costs involved or limitation in the service. • Assist the recipient in learning how to access the service for which the referral was made, including the appropriate use of contact name, telephone number, and address. • Follow up with the service agency, including appropriate advocacy on behalf of the recipient to ensure that services are provided. Follow up on referrals within two weeks unless otherwise dictated by the urgency of the circumstance.	**IV.C.** The recipient's file includes copies of referrals, consent for release of information, and documentation of the coordinator's follow-up on all referrals with the recipient and the service provider.
IV.D. Ensure that the intensity and frequency of contacts with the recipient corresponds to the level of need and/or risk identified by the Family Questionnaire. For example, schedule frequent face-to-face visits if the family is in crisis, if there is violence in the home, or if the mother is a first-time parent with no support system. If necessary, call or visit the recipient daily or weekly. At a minimum: • Contact (face-to-face or telephone) the recipient every 30 days in the first 6 months. • Make face-to-face contact with the recipient every 60 days during the first year. • Contact (face-to-face or telephone) the recipient every 90 days in subsequent years. Document the reason for less frequent contacts in the recipient's file.	**IV.D.** The recipient's file includes documentation that contacts with the recipient correspond to the level of need/risk and includes the date, time, location, and length of recipient contact, progress and/or resolution of identified problems and signature of a professional reviewer. The recipient's file includes documentation supporting contacts with the recipient that are less frequent than the stated guidelines.

GUIDELINE	PERFORMANCE MEASUREMENT
ACTIVITIES AIMED AT IMPROVING FAMILY FUNCTIONING	**ACTIVITIES AIMED AT IMPROVING FAMILY FUNCTIONING**
The care coordinator must:	
IV.E. Assist the recipient in identifying neighborhood activities and support groups that will enhance family functioning. Follow up with the recipient to determine if participation occurred.	**IV.E.** The recipient's file includes documentation of activities and the groups identified for participation by the recipient and the care coordinator. The file includes documentation of participation.
IV.F. Encourage the recipient to establish safe behaviors. Activities to encourage safe behaviors include, but are not limited to, the following: • Assisting the recipient in obtaining a home safety checklist. • Assisting the recipient in evaluating the risk for injuries in the home and other settings where her children spend a significant amount of time. • Helping the recipient plan changes in the home to establish a safe environment for infants and young children. • Encouraging the recipient to conduct a home safety checklist at each new residence and at least annually. • Assisting the recipient as needed to access safety projects, including properly installed smoke detectors. In the case of rental property, assist the recipient in contacting and following up with the landlord if necessary.	**IV.F.** The recipient's file documents all safety-related assistance, including deficiencies found and plans for corrective action. The file also includes documentation of referrals and related follow-up, including any contact with the recipient's landlord.
IV.G. Assist the recipient in obtaining services to learn about and improve life skills, such as: • Consumer skills, including self-advocacy. • Home and money management, including resources for food, food budgeting, preparation, and storage. • Arranging appropriate and inexpensive family leisure activities.	**IV.G.** The recipient's file includes documentation relative to assisting the recipient in obtaining services to learn about and improve life skills, and all referrals and follow-up.

GUIDELINE	PERFORMANCE MEASUREMENT
ACTIVITIES AIMED AT IMPROVING PARENTING SKILLS AND POSITIVE PARENTING OUTCOMES	**ACTIVITIES AIMED AT IMPROVING PARENTING SKILLS AND POSITIVE PARENTING OUTCOMES**
The provider must establish written protocols for: • Assessing potential/actual child abuse. • Meeting the legal reporting requirements. • The frequency and intensity of monitoring those families identified at risk for abuse.	The recipient's file includes documentation relative to assisting the recipient in obtaining services to learn about and improve life skills and all referrals and follow-up.
The provider must:	
IV.H. Assess the recipient's interpersonal relationships with the infant/child, her partner, and other family members living in the home. The assessment should include, but is not limited to, the recipient's strengths, weaknesses, support system, social environment, stresses, attitude toward the infant/other children, and past experiences with parenting. Refer the recipient for psychosocial services as appropriate. Ensure timely follow-up.	**IV.H.** The recipient's file includes documentation of assessment, problems noted, and referrals made. The file also includes documentation that the care coordinator followed up with the recipient to confirm that the referrals resulted in appointments.
IV.I. Immediately refer the recipient to a qualified professional if the recipient exhibits behavior that may be dangerous to herself or others. Situations requiring immediate referral must be documented in the recipient's file. Specifically document all known referrals to the child welfare system. Within 24 hours of making the referral, confirm that the recipient has made the appointment(s).	**IV.I.** The recipient's file includes documentation of the specific concern or behavior noted, a copy of referrals made (including specific documentation of known referrals to the child welfare system), and outcome of the referrals. The file also includes documentation that, within 24 hours of making the referral, the care coordinator followed up with the recipient to confirm that the referrals resulted in appointments.
IV.J. As appropriate, provide referrals for parenting education that will: • Educate the recipient about normal developmental milestones. • Help the recipient identify the early signs associated with potential developmental delays and/or emotional problems. • Help the recipient develop positive parenting skills. • Help the recipient provide a nurturing environment for her children. • Help the recipient develop the necessary skills to become a self-advocate and to advocate on her children's behalf.	**IV.J.** The recipient's file includes documentation of referral for parenting education and all contacts with parenting support services. Changes in parenting behavior are documented in the recipient's file.

GUIDELINE (IV.J. Cont.)	PERFORMANCE MEASUREMENT
Monitor type and frequency of parenting support and training. Follow up with the recipient to determine if she is receiving services.	
ACTIVITIES AIMED AT INCREASING RECIPIENTS' UNDERSTANDING OF INFANT/ CHILD DEVELOPMENT	**ACTIVITIES AIMED AT INCREASING RECIPIENTS' UNDERSTANDING OF INFANT/ CHILD DEVELOPMENT**
The care coordinator must:	
IV.K. Assess the recipient's knowledge and understanding about nutrition and infant/child feeding practices and how these factors affect growth and development. This screening is required to begin with the first visit and is required to be followed up with periodic assessments. Refer the recipient to a qualified professional if knowledge deficiencies are found in any of the following topics: • Infant's hunger/fullness cues. • Infant nutrition and appropriate feeding practices. • Successful breastfeeding. • Food and/or formula preparation and storage. • Meal pattern and feeding practices for infants, toddlers, and preschool children. • Dangers of eating non-food substances (pica) and of folk remedies. • Nutrition to reduce the effects of lead poisoning (e.g., calcium-rich and iron-rich foods).	**IV.K.** The recipient's file includes documentation of the assessment, information provided to the recipient, and any follow-up done by the care coordinator relative to the recipient's increased understanding of infant/child development.
Ensure timely follow-up on referrals.	
IV.L. Assess the recipient's knowledge regarding basic child health and development. Refer the recipient to a qualified professional if deficiencies are found in any of the following areas: • Bathing, skin care, diaper rash. • Normal growth and development, including developmental milestones (for example, toilet training), and vision, hearing, speech, and motor development. • Child nurturing and stimulation. • Effects of secondhand smoke on infant/ child health.	**IV.L.** The recipient's file includes documentation of identified health education needs, the information provided, referrals given, and follow-up.

GUIDELINE
(IV.L. Cont.)

- Taking temperature, treatment of nausea, vomiting, fever, or dehydration.
- Injury prevention and safety, including use of car seats, falls, choking, sleep positions, and poisoning.

Ensure timely follow-up on referrals.

IV.M. Assess the recipient's knowledge of the steps involved in obtaining appropriate and reliable child care. Provide information or refer the recipient for assistance if deficiencies are found in the following areas:

- Knowledge regarding available resources for checking provider references.
- Evaluating child care settings for safety.
- Obtaining financial assistance for child care.
- Appropriate monitoring of the child care provider.
- Reporting suspected child abuse or neglect by the child care provider.

ACTIVITIES AIMED AT INCREASING ACCESS TO AND USE OF PRIMARY HEALTH CARE SERVICES

The care coordinator must:

IV.N. Assist the recipient in accessing and appropriately using the health care delivery system. For example, ensure that the recipient:

- Can identify the family's primary care physician(s) or clinic and HMO if appropriate.
- Has health care providers' telephone numbers and addresses and knows where to find them.
- Knows the proper procedures for obtaining medical information or health care after hours.
- Understands how to obtain speciality care, for example, mental health/substance abuse (alcohol and other drug abuse) treatment or speech therapy.
- Knows when to use the hospital emergency room.

PERFORMANCE MEASUREMENT

IV.M. The recipient's file includes documentation of the assessment, information provided, referrals given, and follow-up.

ACTIVITIES AIMED AT INCREASING ACCESS TO AND USE OF PRIMARY HEALTH CARE SERVICES

IV.N. The recipient's file includes documentation of recipient's knowledge, deficiencies, and information provided as stated in the guidelines.

GUIDELINE (IV.N. Cont.)	PERFORMANCE MEASUREMENT
• Knows how to schedule, reschedule, and cancel appointments.	
Assist the recipient in obtaining information as appropriate.	
IV.O. Assess the recipient's awareness of the importance of timely immunizations and regular dental and well-child checkups (HealthCheck). Determine the recipient's compliance with the visit schedules for these services. Assist the recipient in obtaining services as appropriate.	**IV.O.** The recipient's file includes documentation of the child's immunization, dental, and HealthCheck compliance status.
Reassess the recipient's compliance with the recommended schedules on an ongoing basis.	If deficiencies are found, file includes documentation of referrals, appointments made, and follow up to bring family into compliance.
IV.P. Assess the recipient's awareness of the effects of lead poisoning. Assist the recipient as needed to receive recommended blood lead tests and necessary follow up services.	**IV.P.** The recipient's file includes dates and results of lead tests and follow up for any elevated lead test results.
IV.Q. Refer the recipient for additional support, assistance, and specific training to learn how to care for her child if the child is identified as having a birth defect or a special health care need.	**IV.Q.** The recipient's file includes documentation of the identified problem, referrals given, and follow up.
ACTIVITIES AIMED AT IMPROVING EMPLOYMENT OUTCOMES	**ACTIVITIES AIMED AT IMPROVING EMPLOYMENT OUTCOMES**
IV.R. Help the recipient identify employment goals and barriers to obtaining or maintaining employment. Address the following areas with the recipient: • Transportation problems. • Medical problems of family members. • Child day care and/or health care needs. • Appropriate conflict/grievance procedures. • Job preparation and interview skills. • Appropriate attire. • Job training or retraining needs. • Educational needs.	**IV.R.** Recipient's file includes documentation of employment status and/or barriers to employment and, as appropriate, indicates referral to the appropriate agency for assistance in obtaining necessary services to support employment.
Assist the recipient in obtaining services as appropriate.	

GUIDELINE	PERFORMANCE MEASUREMENT
ACTIVITIES AIMED AT ENCOURAGING PLANNED PREGNANCIES	**ACTIVITIES AIMED AT ENCOURAGING PLANNED PREGNANCIES**
IV.S. Assess the recipient's self-esteem, assertiveness, and empowerment regarding family planning decisions. Help the recipient determine what referrals or other actions are needed.	**IV.S.** The recipient's file includes documentation of referral, information provided, and any follow-up.
IV.T. Assess the recipient's knowledge of the following: • Family planning practices/methods. • Prevention of sexually transmitted diseases. • Continuity of basic primary and reproductive health care, including the need for mammograms and routine pap smears. Provide the recipient with necessary referrals, and ensure timely and appropriate follow-up on all referrals.	**IV.T.** The recipient's file includes written documentation of assessment and referrals related to family planning and basic health issues of the mother.
ACTIVITIES AIMED AT IMPROVING FUTURE BIRTH OUTCOMES	**ACTIVITIES AIMED AT IMPROVING FUTURE BIRTH OUTCOMES**
IV.U. Refer the recipient to the WIC program, if appropriate. Ensure timely follow up.	**IV.U.** The recipient's file includes documentation of a WIC referral and appropriate follow-up.
IV.V. Assess the recipient's knowledge of the need for early and ongoing prenatal care, the importance of not smoking during pregnancy, and the importance of planned pregnancies. Provide the recipient with necessary referrals, and ensure timely and appropriate follow-up on all referrals.	**IV.V.** The recipient's file includes documentation of the assessment and any referrals made.

Appendix 8

Family Questionnaire (Child Risk Assessment)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health
DOH 1118 (3/98)

☞ = INITIAL SCREENING QUESTIONS

FAMILY QUESTIONNAIRE

A. GENERAL INFORMATION

1. Mother's Name and Address: *[Please print.]*

   _____
   Mother's Last Name First Middle

   _____
   Street Address

   _____
   City State Zip Code

2. Mother's date of birth: _____

☞ 3. **Mother's age:** _____ < 18 = (70)
18 – 20 = (15)

4. Mother's Medicaid ID#:
   _____

5. HMO Name:
   _____

6. Primary Care Doctor/Clinic Name(s):
   _____
   _____
   If none or unable to answer = (10)

7. Infant's Name:
   _____
   Infant's Sex:
   ❒ Female
   ❒ Male

☞ 8. **Birth Weight:** _____
If very low birth weight < 3.3 lbs. (1500 grams) = (70)
If low birth weight < 5.5 lbs. (2500 grams) = (30)
If birth weight > 10 lbs. (4540 grams) = (10)

☞ 9. **Birth Date:** _____
If pre-term (gestational age < 37 weeks) = (70)

10. Home telephone number: _____
    ❒ No phone, or phone is often disconnected. = (15)

11. How can we contact you?
    _____

12. Are other agency staff visiting your home?
    ❒ No
    ❒ Yes
    If yes, please list if known: _____
    _____
    _____
    _____
    _____

B. EMPLOYMENT

1. Are you employed?
   ❒ No
   ❒ Yes
   If yes, what is your occupation?
   _____

2. If you are employed, how many hours do you usually work in a week? _____

3. What shift? (days, evenings, nights) _____

4. Do you feel your child care arrangements are safe and nurturing?
   ❒ No = (15)
   ❒ Yes

5. If returning to work/school, when will you go back?
   _____

☞ 6. **What was the last grade you finished?** _____
8th grade or less = (40)
> 8th grade but < 12th grade = (15)

7. What are your sources of income? *(Please check all that apply.)*
   ❒ Parents
   ❒ Job
   ❒ Partner/spouse
   ❒ Unemployment benefits
   ❒ Child support payments
   ❒ Other: _____

Key: > = *greater than*
< = *less than*

Points (subtotal) _____

Appendix

Appendix 8
(Continued)

C. FAMILY FUNCTIONING

1. Are you:
   - ❒ Married
   - ❒ Single (includes, never married, separated, divorced, widowed) = (15)

☞ 2. **Do you speak English?**
   - ❒ Very well
   - ❒ A little = (10)
   - ❒ Not at all = (15)

☞ 3. **Do you read English?**
   - ❒ Very well
   - ❒ A little = (10)
   - ❒ Not at all = (15)

4. If of school age now, are you enrolled and do you attend school regularly?
   - ❒ No = (10)
   - ❒ Yes
   - ❒ I am working on GED or have completed it
   - ❒ I have dropped out = (10)

☞ 5. **Have you in the past, or are you currently, receiving special or exceptional education services?**
   - ❒ No
   - ❒ Yes = (10)

☞ 6. **How many children do you have?** _____
   - If first child = (10)
   - If > 4 children = (40)
   - If > 2 children and mother is < 18 = (40)

☞ 7 **Within the last 12 months, have any of your children been taken away from you?**
   - ❒ No
   - ❒ Yes
   - If yes, how many? _____ = (40)

☞ 8. **Where do you live?**
   - ❒ House/Mobile Home
   - ❒ Apartment Mobile Home
   - ❒ With friends = (10)
   - ❒ With other family members = (10)
   - ❒ Homeless (including shelter, hotel/motel) = (70)
   - ❒ Other, specify: _____

9. Who is currently living in your home?

Name	Age	Relationship

10. Where you live now, do you have the following?

Yes	No	
❒	❒	Running water
❒	❒	Hot water
❒	❒	Working appliances (stove, refrigerator)
❒	❒	Working bathroom/bathing facilities
❒	❒	Working smoke detector
❒	❒	Working fire extinguisher

Each No = (5) Total points ____

☞ 11. **Is there chipping paint inside/outside your home?**
   - ❒ No
   - ❒ Yes = (10)

12. How many times have you moved in the last year?
   _____ > 2 times = (20)

13. Do you think you will need to move in the next 12 months?
   - ❒ No
   - ❒ Yes

14. How long have you been living in the present neighborhood?

15. What do you think of your neighborhood?
   - ❒ It's a good place to live
   - ❒ It's an okay place to live
   - ❒ It's a bad place to live

16. What is the best thing about your neighborhood?
   _____
   _____

17. What is the worst thing about your neighborhood?
   _____
   _____

18. In the past two years, has your neighborhood become:
   - ❒ A better place to live
   - ❒ Stayed the same
   - ❒ A bad place to live

Key: > = *greater than*
< = *less than*

2

Points *(subtotal)* _____

Appendix

Appendix 8
(Continued)

19. Do your children have a safe play area both inside and outside the home?
    - ❒ No to either = (5)
    - ❒ Yes

20. If not at home, where else can they play? *(Please check all that apply.)*
    - ❒ Relatives ❒ Nowhere = (15)
    - ❒ Park ❒ School playground
    - ❒ Community Center ❒ Other: _____

21. Have you witnessed acts of violence in your neighborhood? If so, please describe these acts and the impressions they had on you:
    _____
    _____
    _____
    _____
    _____

22. Does your family own an automobile?
    - ❒ No
    - ❒ Yes

23. If yes, what is the condition of the automobile?
    - ❒ Good
    - ❒ Average
    - ❒ Below Average

24. If you do not have an automobile, how do you get around?
    - ❒ Get a ride from friends/relatives
    - ❒ Use public transportation
    - ❒ Walk
    - ❒ Other: _____

25. How often do you have problems getting transportation?
    - ❒ Never
    - ❒ Occasionally
    - ❒ Most of the time = (10)

26. If you use a car, does everyone use car seats or seat belts?
    - ❒ Always
    - ❒ Sometimes
    - ❒ Never = (5)

    Explain: _____
    _____

D. HEALTH

1. Where do you go for your regular health care (e.g., checkups, shots)?
    - ❒ Family doctor/primary care provider/clinic
    - ❒ Emergency room = (10)
    - ❒ Other: _____

2. Have any of your children been hospitalized in the past 6 months?
    - ❒ No
    - ❒ Yes = (10)

    If yes, for what types of problem(s):
    _____
    _____
    _____
    _____

3. Have your children between 6 months and 6 years of age been tested for lead poisoning?
    - ❒ No = (5)
    - ❒ Yes
    - ❒ Don't know = (5)
    - ❒ Not applicable *(Skip to #6)*

4. If yes, have you received the results?
    - ❒ No = (5)
    - ❒ Yes

5. If the results require follow-up, has this occurred?
    - ❒ No = (5)
    - ❒ Yes

6. Do you have a record of your children's immunizations?
    - ❒ No = (5)
    - ❒ Yes

7. If your child(ren) are 3 years or older, are they seeing a dentist?
    - ❒ No = (5)
    - ❒ Yes
    - ❒ Not applicable

☞ 8. **How many months pregnant were you when you started seeing a medical provider (doctor, nurse practitioner, nurse midwife) for prenatal care?**

    _____ weeks or _____ months

    13-15 weeks = (5) 15-23 weeks = (10) > 24 weeks = (20)

☞ 9. **Did you receive prenatal care coordination services during this pregnancy?**
    - ❒ No
    - ❒ Yes = (70)

Key: > = greater than
< = less than

3

Points (subtotal) _____

Appendix

Appendix 8
(Continued)

☞ **10. How was your health during this pregnancy?**
- ❒ Fine, no problems
- ❒ Some problems (e.g., nausea, tiredness)
- ❒ Serious problems (e.g., high blood pressure, diabetes) = (10)

Explain: _____

☞ **11. Did your baby stay in a "special care" nursery for more than one day?**
- ❒ No
- ❒ Yes = (10)

If yes, how many? _____

☞ **12. Was this pregnancy:**
- ❒ Planned
- ❒ Unplanned = (5)
- ❒ Result of sexual assault = (40)

☞ **13. How do you feel now that the baby is born?**
- ❒ Happy
- ❒ Unsure--a little bit happy, a little bit unhappy=(10)
- ❒ Very upset about it = (20)

☞ **14. How does the father of the baby (or your partner) feel about the newborn?**
- ❒ Happy
- ❒ Unsure--a little bit happy, a little bit unhappy=(10)
- ❒ Very upset about it = (20)

☞ **15. Do you have any history of prenatal or postpartum depression, raging, or "scary" thoughts about the baby?**
- ❒ No
- ❒ Yes = (40)

16. Do you plan to have another baby?
- ❒ No
- ❒ Yes

If yes, how soon? _____

17. Are you currently using birth control?
- ❒ No
- ❒ Yes

18. Do you understand how to use the product?
- ❒ No = (5)
- ❒ Yes

19. Have you experienced any problems getting the necessary supplies, medication or services?
- ❒ No
- ❒ Yes = (5)

☞ **20. Do you, or your children receive SSI benefits or special services for a health problem?**
- ❒ No
- ❒ Yes = (20)

If yes, who? _____

What services? _____

If receiving mental health related services = (50)

21. Are you or your children in a WIC Program?
- ❒ No
- ❒ Yes

If yes, where?

_____

_____

22. How are you currently feeding your baby?
- ❒ Breast-feed
- ❒ Bottle feed
- ❒ Both breast and bottle

23. At what age do you plan to start feeding cereal/baby food to your new baby?
- ❒ Birth-3 months = (5)
- ❒ 4-6 months
- ❒ I don't know = (5)

24. Are any of your children on a special diet or receiving special foods or drinks?
- ❒ No
- ❒ Yes = (5)

If yes, what?

_____

_____

☞ **25. Do you or your children ever eat non-food items, (e.g., dirt, sand, starch, paint chips)?**
- ❒ No
- ❒ Yes = (20)

☞ **26. Do you sometimes run out of food before you are able to buy more?**
- ❒ No
- ❒ Yes = (10)

Key: > = greater than
< = less than

4

Points (*máximo*) _____

Appendix 8
(Continued)

E. PARENTING ATTITUDES/SKILLS

☞ 1. **How do you feel about the way you were raised as a child?**
- ❒ Very positive: I had a happy childhood: my parents were very caring
- ❒ Okay; my parents tried to do their best; parents caring
- ❒ Negative: I received no nurturing **= (10)**
- ❒ Very negative. I was punished frequently and received little or no nurturing **= (40)**

2. If you plan to parent differently than you were raised, how much support/encouragement will you get from your family/friends?
- ❒ A lot
- ❒ A little
- ❒ Very little **= (10)**
- ❒ None **= (20)**

3. When you want advice about parenting, who do you go to? *[Please check all that apply.]*
- ❒ Parents
- ❒ Friends
- ❒ Doctor/nurse
- ❒ Community "helping organizations"
- ❒ I don't have anyone to ask **= (10)**
- ❒ "It comes naturally" **= (10)**
- ❒ Grandparents/family
- ❒ Father of the child/partner
- ❒ Books/magazines

☞ 4. **Do you ever feel your infant cries or is demanding "on purpose" or just to "irritate you"?**
- ❒ No
- ❒ Yes **= (40)**

If yes, please explain:_____

5. At what age do you think your baby will:
- ❒ Be potty trained _____
- ❒ Sleep all night _____
- ❒ Begin to walk _____

If answer is unrealistic **= (15)**

6. Do you have an adequate supply or access to toys, books, games, or other play equipment?
- ❒ No
- ❒ Yes

7. When your children are playing or having fun, do you join them?
- ❒ Most of the time
- ❒ Occasionally **= (5)**
- ❒ Rarely **= (10)**

8. How helpful is the child's father (or your partner) in raising this child and other children in your household?
- ❒ Very helpful
- ❒ Helps when requested to help
- ❒ Not helpful **= (10)**

9. Finish this sentence.
I think my/our children are:_____
_____
_____
_____

Use of strong negatives such as, interfere with my activities, too demanding, too much work, ugly, stupid, bad. **= (20)**

F. TOBACCO, ALCOHOL AND OTHER DRUGS

1. Do you or anyone else in your household smoke?
- ❒ No
- ❒ Yes

2. If yes, do you have "rules" governing when and where not to smoke?
- ❒ No **= (20)**
- ❒ Yes

I need to ask you a few questions about drinking and drug use. It will help us take better care of you and your children. Be sure to include beer, wine and liquor in your answers to these questions.

3. How many drinks does it take to make you feel high?_____ **> 2 = (20)**
- ❒ I never drink

4. How much can you hold? _____ **> 2 = (20)**
- ❒ I never drink
- ❒ I don't know

5. Have people annoyed you by criticizing your drinking?
- ❒ No
- ❒ Yes **= (20)**
- ❒ I never drink

Key: > = greater than
< = less than

5

Points (subtotal) _____

Appendix

Appendix 8
(Continued)

6. Have you ever felt you ought to cut down on your drinking?
   - ❒ No
   - ❒ Yes = (20)
   - ❒ I never drink

7. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?
   - ❒ No
   - ❒ Yes = (20)
   - ❒ I never drink

☞ 8. **In the past 12 months, have you injected a non-prescribed drug or used any other street drugs (e.g., marijuana, hash, cocaine, heroin, crack, amphetamines)?**
   - ❒ No
   - ❒ Yes = (70)

☞ 9. **Does anyone who is involved in caring for your children abuse alcohol or other drugs?**
   - ❒ No
   - ❒ Yes = (20)

   If yes, explain: _____

G. PERSONAL SUPPORT/COPING SKILLS

☞ 1. **How do you deal with stress and anger?** *[Please check all that apply.]*
   - ❒ Talk it out
   - ❒ Calm down by taking a walk, doing some activity
   - ❒ Not talk about it at all = (5)
   - ❒ Take it out on somebody by yelling = (5)
   - ❒ Get violent (e.g., hitting, threatening with object or weapon) = (50)
   - ❒ Have a drink or get high to calm my nerves = (20)
   - ❒ Other: _____

☞ 2. **How does the father of the baby (or your partner) deal with stress and anger?** *[Please check all that apply.]*
   - ❒ Talk it out
   - ❒ Calm down by taking a walk, doing some activity
   - ❒ Not talk about it at all = (5)
   - ❒ Take it out on somebody by yelling = (5)
   - ❒ Get violent (e.g., hitting, threatening with object or weapon) = (50)
   - ❒ Have a drink or get high to calm his nerves = (20)
   - ❒ Other: _____

☞ 3. **Have you, or your children, ever been emotionally or verbally abused by the father of the baby, your partner, or someone close to you?**
   - ❒ No
   - ❒ Yes = (20)

☞ 4. **Does the father of the baby (or your partner) physically, verbally, or emotionally, abuse you or your children?**
   - ❒ No
   - ❒ Yes = (70)

☞ 5. **Have you or other household members been raped or forced to have sex against your/their will?**
   - ❒ No
   - ❒ Yes = (30)

☞ 6. **Does the abuser(s) still have access to you or your children?**
   - ❒ No
   - ❒ Yes = (40)

7. Has anyone in your immediate household (parent, spouse, partner, sibling) been incarcerated/jailed for a crime in the past year or more than 3 times in the past 5 years?
   - ❒ No
   - ❒ Yes = (40)

8. Are you afraid of the father of the baby, your partner or anyone else in your household?
   - ❒ No
   - ❒ Yes = (20)

9. Is there a gun in your home?
   - ❒ No
   - ❒ Yes = (10)

10. If yes, are the guns unloaded and stored in a locked place?
    - ❒ No = (15)
    - ❒ Yes

11. How many people do you know well enough to visit with in your neighborhood?

    _____

    - ❒ None = (5)

12. How often do you spend time with friends or relatives?

    _____

    - ❒ Never = (10)

Key: > = greater than
< = less than

Points (subtotal) _____

Appendix 8
(Continued)

☞ **13. Do you have someone you can talk with when you need to?**
- ❒ No = (20)
- ❒ Yes

14. Do you find yourself feeling lonely?
- ❒ Quite often
- ❒ Sometimes
- ❒ Almost never

15. Is there anyone you can count on in case of an emergency?
- ❒ No = (10)
- ❒ Yes

16. Is there someone who could help you for as long as you needed their help?
- ❒ No
- ❒ Yes

17. Are you known or do you think of yourself as a resource to others?
- ❒ No
- ❒ Yes

18. How often do you go to neighborhood activities such as spiritual ceremonies, support groups or "club" functions?
- ❒ Never = (5)

19. How would you describe yourself to someone who does not know you?

_____
_____
_____
_____
_____

20. Does your family have special traditions that they observe?
- ❒ No
- ❒ Yes

If yes, explain:

_____
_____
_____

☞ **21. Tell me about your family's strengths.**

_____
_____
_____
_____
_____

- ❒ None = (10)

22. Which of these things worry you a lot? *(Check the ones that are big problems.)*
- ❒ Money problems = (2)
- ❒ Transportation = (2)
- ❒ My job = (2)
- ❒ My partner's job, or unemployment = (2)
- ❒ Caring for this baby/my other children = (2)
- ❒ Housing problems/getting evicted = (2)
- ❒ Getting child care = (2)
- ❒ My physical or mental health/safety = (2)
- ❒ My drinking/drug use = (2)
- ❒ My partner's drinking or drug use = (2)
- ❒ My relationship with my partner = (2)
- ❒ My child's relationship with his/her father = (2)
- ❒ My partner is in jail = (2)

23. Would you like more help or information with any of these things?
- ❒ Discipline
- ❒ Child development
- ❒ Parenting skills
- ❒ Playing with your children
- ❒ Health Issues
- ❒ Employment Training
- ❒ Coping with stress
- ❒ Family planning/Pregnancy prevention
- ❒ Community resources for parents

_____
Staff Signature/Assessment Date

_____
Staff Signature/Reassessment Date

Key: > = *greater than*
< = *less than*

7

Points *(subtotal)*_____
Total *(all pages)*_____

Appendix

Appendix 9

Referral Form (Sample Format)

Client's Name: _____ Date of Referral: _____
Medicaid ID Number:_____ Address_____
Birthdate:_____ _____
Telephone Number:_____ _____

Referral To: [*Service provider's name, address, and telephone number*]

_____

_____

_____

Referred By: [*Service provider's name, address, and telephone number*]

_____

_____

_____

Reason for Referral:_____

_____

_____

_____

Authorization: I, _____ [*Client's Name*], give my permission to _____ [*Service Provider's Name*], to release this information to _____ [*Care Coordination Provider's Name*]. The information is to be used to assist me in monitoring and coordinating my health care and social service needs.

Signature of client/parent or guardian: _____

Date: _____

Service Provider's Reply (summary of findings, diagnosis, recommendations, comments, as appropriate):

Signature: _____ Date: _____

Appendix

Appendix 10

Informed Consent to Release/Obtain Health Care Information Form (Sample Format)

Agency Name: _____ Telephone #: _____

Address: _____

_____

Client's Name: _____ Medicaid ID #: _____

Address: _____ Date of Birth: _____

_____

Telephone Number: _____

I, _____ (*print client's name*), give consent for _____ (*print name of care coordination provider)* to release health/social services information to, and obtain information from, _____ (*print name of other provider/agency to which, or from which, you are requesting information)* for the person named above. The information is to be used to assist me in monitoring and coordinating health care and social services.

The information to be disclosed includes:

_____

_____

_____

Do not disclose the following information:

_____

_____

_____

This authorization shall be valid from the signature date until _____ *(print the date)*, and may be revoked by me at any time (except as it has already been used).

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Appendix

Appendix 11

Care Plan (Sample Format)

The following is a sample care plan. Care coordinators are required to base each care plan on the results of the Family Questionnaire, but are not restricted to a specific format. Please note again this is a sample, not a required format.

Recipient's Name_____
Medicaid Number_____
WIC Site_____

Initial Assessment Date_____
Date of Family Plan Development_____
Total Points from Family Questionnaire_____

Questionnaire Categories	Critical Elements	Family Plan (Including Goals and Expected Outcomes)
A. General Information Total Possible Points (235) Actual Points_____	Age of mom_____ HMO_____ MD_____ Phone_____	
B. Employment Total Possible Points (55) Actual Points_____ PRIORITY (according to points or recipient's preference) #_____	Employed Y N Childcare Y N On W-2? Y N	
C. Family Functioning Total Possible Points (320) Actual Points_____ PRIORITY (according to points or recipient's preference) #_____	English literacy Y N Demonstrates ability to care for all children Y N With safe, maintained home (rate on a scale of 0-5) + 0 1 2 3 4 5 - Out-of-home placement of children Y N Transient/homelessness Y N Transportation Y N	
D. Parenting Attitudes/Skills Total Possible Points (165) Actual Points_____ PRIORITY (according to points or recipient's preference) #_____	Demonstrates nurturing behaviors (rate on a scale of 0-5) + 0 1 2 3 4 5 - Past history of abuse/neglect of children Y N Foster home placement Y N Abuse/neglect of mother as a child Y N	

Questionnaire Categories	Critical Elements	Family Plan (Including Goals and Expected Outcomes)
F. AODTA (Alcohol and Other Drug and Tobacco Abuse) Total Possible Points (210) Actual Points_____ PRIORITY (according to points or recipient's preference) #_____	Past history of AODTA abuse? Y N Smokes Y N Household smoke Y N Alcohol use Y N Other substance abuse Y N	
G. Personal Support/Coping Skills Total Possible Points (481) Actual Points_____ PRIORITY (according to points or recipient's preference) #_____	(Rate on a scale of 0-5) Stress management + 0 1 2 3 4 5 - Family abuse + 0 1 2 3 4 5 - Personal support + 0 1 2 3 4 5 - Community support systems + 0 1 2 3 4 5 - Family support + 0 1 2 3 4 5 -	
Date of Care Plan Updates:	**Referrals/Follow-up:**	**Collateral Contacts:**

Signature of Mother_____ **Date**_____
Signature of Care Coordinator_____ **Date**_____

Family Members and/or Other Supportive Persons Involved in the Care Plan Development:

_____
_____
_____
_____
_____

Appendix 12

Child Care Coordination Monthly Time Log for Ongoing Care Coordination and Monitoring (Completed Sample Format)

Client (Last, First, MI): Recipient, Im A. **Month:** 06 **Year:** 1999

Wisconsin Medicaid ID Number: 1234567890

Agency: Care Coordination Agency

Care Coordinator--
Name: Jayne Smith
Title: Care Coordinator

Description Codes (to be used in the second column below)
RF=Recipient Contact - Face-to-Face **CF=Collateral Contact - Face-to-Face**
RT=Recipient Contact - Telephone **CT=Collateral Contact - Telephone**
S=Staffing/Consultations **R=Record-Keeping**

Date	Code	Place of Service	Hours	Minutes	Documentation of Activities
6/4/1999	RT	Office	1	00	Called Recipient X to remind her of baby's upcoming HealthCheck appointment. Made sure she knew the clinic's name and location and the pediatrician's name. Answered Recipient X's questions regarding the appointment, transportation arrangement and child care for her other children. Provided her with the name and telephone numbers of several transportation and day care providers in the area. Made plans with the recipient for a follow-up home visit. *J.S., Care Coordinator*
6/9/1999	RF	Recipient Home		45	Visited Recipient X at home. Followed up on HealthCheck visit and previous referrals. Reminded recipient about WIC visit. Reminded recipient about community food pantry. Discussed child care and transportation options for recipient. *J.S., Care Coordinator*
6/16/1999	S/RF	Office	1	45	Called several local charities to help family get clothing. Also called several agencies looking for respite care. Found agency and arranged for ongoing respite care. Provided recipient with written referral for respite care and name and address of Wehelp Clothing Organization. *J.S., Care Coordinator*
6/28/1999	R	Office		15	Chart notations, preparation of appointment schedule for client. *J.S., Care Coordinator*

Monthly Total 3 hrs., 45 min.

Total Units 3.8
Refer to Appendix 6 of this handbook for rounding guidelines

Appendix 13
HealthCheck General Information

HealthCheck is Wisconsin Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Providers should encourage recipients to obtain regular HealthCheck services for their children. HealthCheck promotes early detection and treatment of health conditions that could lead to chronic illness and disabilities in children. HealthCheck screening exams are comprehensive and include the following components:

- A complete health and development history (including anticipatory guidance).
- A comprehensive unclothed physical examination.
- An age-appropriate vision screening examination.
- An age-appropriate hearing screening examination.
- An oral assessment and referral to a dentist for children, beginning at three years of age.
- The appropriate immunizations (according to age and health history).
- The appropriate laboratory tests (including blood lead level assessment when appropriate for age and risk).

For Medicaid recipients under 18 years of age, HealthCheck screens do not require a copayment. Recipients 18-20 years of age, who are not in a Medicaid HMO, pay a copayment. There is no copayment for recipients enrolled in a Medicaid HMO.

Recipients may call the Department of Health and Family Services (DHFS) Maternal and Child Health Hotline listed in Appendix 15 of this handbook for information about HealthCheck providers. Recipients enrolled in a Medicaid HMO should call their HMO.

Please refer to Appendix 14 of this handbook for the HealthCheck screening schedule.

Appendix 14
HealthCheck Visit Schedule

AGE	INFANCY						EARLY CHILDHOOD						LATE CHILDHOOD					ADOLESCENCE			
	Birth - 1 mo.	2 mos.	4 mos.	6 mos.	9 mos.	12 mos.	15 mos.	18 mos.	24 mos.	30 mos.	3 yrs.	4 yrs.	5 yrs.	6-7 yrs.	8-9 yrs.	10-11 yrs.	12-13 yrs.	14-15 yrs.	16-17 yrs.	18-19 yrs.	20-21 yrs.
I. Health Nutritional & Developmental Assessment																					
A. HISTORY	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
B. DEVEL/BEHAV. ASSESSMENT	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
C. HEALTH EDUC/ ANTICIPATORY GUIDE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
II. Physical Assessment																					
A. MEASUREMENTS																					
Height and Weight	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference	●	●	●	●	●	●	●	●	●												
Blood Pressure											●	●	●	●	●	●	●	●	●	●	●
B. UNCLOTHED PHYSICAL EXAM	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
C. SENSORY																					
Vision	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hearing	●	●	●	●	●	●	●	●	●	●	●	●	●	●			●		●		
D. DENTAL											●	●	●	●	●	●	●	●	●	●	●
III. Procedures																					
A. BLOOD LEAD TEST						●			●												
Pap Smear/Pelvic HIV	As Indicated																				
Tuberculin Test	As Indicated																				
Urinalysis	As Indicated																				

Key
● = to be performed

Recommended Childhood Immunization Schedule, United States

Vaccines are listed under routinely recommended ages. Bars indicate range of recommended ages for immunization. Any dose not given at the recommended age should be given as a "catch-up" immunization at any subsequent visit when indicated and feasible. Ovals indicate vaccines to be given if previously recommended doses were missed or given earlier than the recommended minimum age.

AGE	Birth	1 mo.	2 mos.	4 mos.	6 mos.	12 mos.	15 mos.	18 mos.	24 mos.	4-6 yrs.	11-12 yrs.	14-16 yrs.
VACCINE												
Hepatitis B	Hep B											
		Hep B			Hep B						Hep B	
Diptheria, Tetanus, Pertussis			DTaP	DTaP	DTaP		DTaP			DTaP	Td	
H. influenzae type b			Hib	Hib	Hib	Hib						
Polio			IPV	IPV	IPV					IPV		
Measles, Mumps, Rubella						MMR				MMR	MMR	
Varicella						VAR					VAR	
Hepatitis A									Hep A - in selected areas			

RECOMMENDED NUMBER OF SCREENINGS

HealthCheck should begin with a neonatal examination at birth whenever possible. Medicaid covers the following screenings:

- Birth to one year, 6 screenings.
- Age one to two years, 3 screenings.
- Age two to three years, 2 screenings.
- Age three to twenty-one years, 1 screening per year.

Appendix 15
Child Care Coordination Resource Guide

Resources Available Directly from State Agencies

1. Division of Health Care Financing Publications *- Available from the Division of Health Care Financing at the address listed below. There is no charge for the documents below.*

Title	Document #
Family Questionnaire	DOH 1118
Pregnancy Questionnaire (Risk Assessment Form)	HCF 1105
Guidance Manual for the Pregnancy Questionnaire	POH 1043
HealthCheck Brochure (Spanish)	POH 1007S
HealthCheck Brochure (Hmong)	POH 1007H
HealthCheck Brochure (English)	POH 1007
HealthCheck Poster (81/2 x 14)	POH 1041
HealthCheck Check Stuffer/Handbill	POH 1041A
HealthCheck Stickers	POH 1041C

Available from: Division of Health Care Financing
Bureau of Fee-for-Service Health Care Benefits
Attn: Forms Manager
P.O. Box 309
Madison, WI 53701-0309

2. Division of Public Health Publications *- Available from the Department of Health and Family Services Forms Center at the address listed on the next page. There is minimal or no charge for the documents below.*

Family Health Resource Catalog (a list of maternal and child health education materials)	PPH 4536
If I'm Pregnant, Can the Chemicals I Work with Harm my Baby?	PPH 7074
Child Growth Grid - Boy	DOH 4517
Child Growth Grid - Girl	DOH 4518
Caring for Your Baby: A Newborn and Infant Care Handbook	PPH 9321

Appendix

Appendix 15
(Continued)

Title	Document #
Caring for Your Baby: A Newborn and Infant Care Handbook (Spanish)	PPH 9321-S
Healthy Start Brochure (Spanish)	PPH 0054
Healthy Start Brochure (English)	PPH 0051
Healthy Start Poster (Spanish)	PPH 0055
Healthy Start Poster (English)	PPH 0051A

Available from: Department of Health and Family Services Forms Center
P.O. Box 7850
Madison, WI 53701-7850

Resources Available from Other Organizations

3. Children's Trust Fund - *There is no charge for these documents.*

- Information on child abuse and neglect

- Positive Parenting Kit (parenting booklet that gives insightful hints on how to "catch your kid being good")

Available from: Children's Trust Fund
110 E. Main St., Suite 614
Madison, WI 53703
(800) 262-9922 extension "KIDS" or (608) 266-6871

Hotline Phone Numbers

1. Wisconsin First Step/Children with Special Health Care Needs.....(800) 642-7837

2. Maternal and Child Health Hotline ..... (800) 722-2295
(Provides information on services for women and children throughout Wisconsin, including WIC, Healthy Start, and HealthCheck)

3. Wisconsin AIDS Hotline ..... (800) 334-2437
Milwaukee Area ..... (414) 273-2437

4. Wisconsin Medicaid Recipient Hotline ..... (800) 362-3002
Madison Area ..... (608) 221-5720

Appendix 16

Medicaid Maximum Fee Schedule for Child Care Coordination Services

The following reimbursement rates are effective as of July 1, 2000. The reimbursement rates are subject to change. To obtain the most current reimbursement rates in the future, providers may:

- Purchase a paper schedule by writing to:

  Wisconsin Medicaid
  Provider Maintenance
  6406 Bridge Road
  Madison, WI 53784-0006

- Download an electronic version from Wisconsin Medicaid's Web site at *www.dhfs.state.wi.us/medicaid/* using instructions found in the Claims Submission section of the All-Provider Handbook.

Maximum allowable fees are effective as of July 1, 2000.

Procedure Code	Procedure Description	Maximum Allowable Fee
W7095	Risk Assessment - Child Care Coordination	$52.54
W7096	Initial Care Plan Development - Child Care Coordination	$52.54
W7097	Ongoing Care Coordination and Monitoring	$42.04

Providers are required to bill their usual and customary charges for services provided.

Glossary of Common Terms

Adjustment

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

Allowed claim

A Medicaid or Medicare claim that has at least one service that is reimbursable.

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.

Child care coordination

Child care coordination services help a recipient and, when appropriate, the recipient's family, gain access to and coordinate a full array of services, including necessary medical, social, educational, vocational, and other services.

Collateral

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

Concurrent care

Evaluation and management services provided by two or more physicians to a recipient during an inpatient hospital or nursing home stay.

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 Health Care Financing Administration (HCFA) 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 Health Care Financing Administration (HCFA) and the U.S. Department of Health and Human Services (DHHS), assurances that the program is administered in conformity with federal law and HCFA policy.

DHFS

Wisconsin Department of Health and Family Services. The DHFS administers the Wisconsin Medicaid program. Its primary mission is to foster healthy, self-reliant 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.

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 and Internet access.
- Wisconsin Medicaid's Provider Services (telephone correspondents).
- Wisconsin Medicaid's Direct Information Access Line with Updates for Providers (Dial-Up).

Family-centered care

Family-centered care refers to a provider's or agency's ability to:

- Treat recipients with dignity and respect.
- Communicate and share information with recipients in ways that are affirming and useful.
- Allow recipients and their families to build on their strengths by participating in experiences that enhance feelings of control and independence.
- Collaborate between providers, recipients, and families in policy and program development, professional education, and delivery of care.

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.

HCFA

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

HCPCS

HCFA 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 Health Care Financing Administration (HCFA) 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. 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;
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.

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