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NEW FORWARDHEALTH RESIDENTIAL FACILITY SUBSTANCE USE DISORDER TREATMENT BENEFIT

For dates of service (DOS) on and after February 1, 2020, ForwardHealth will begin coverage of the new residential facility substance use disorder (SUD) treatment benefit for BadgerCare Plus and Medicaid members. This ForwardHealth Update offers policy information for covered and noncovered services, prior authorization (PA), claims submission, and reimbursement.

Overview

Wisconsin Medicaid has covered a variety of treatment options for members with SUDs, but substance use treatment provided in a residential, setting was not covered. This coverage gap prevented access to residential facility SUD treatment services and continuity of care. This new residential facility SUD treatment benefit was created in response to the coverage gap.

The 2015-2017 Biennium Budget authorized Medicaid to cover residential treatment through two program types: facilities certified under DHS 75.11, medically-monitored residential treatment, and DHS 75.14, transitional residential treatment.

In May, 2017, Medicaid implemented limited residential facility SUD treatment services under the Comprehensive Community Services Program. These services were subject to the Institution for Mental Disease (IMD) exclusion, which was created in 1965. The IMD exclusion is a clause in the Medicaid program that prohibits federal funding for services provided in facilities with more than 16 beds for members aged 21-64. Because two-thirds of the DQA-certified residential facility SUD treatment facilities in Wisconsin are considered IMDs, the existing benefit has afforded limited capacity to address the needs of Medicaid members.

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The new residential substance use disorder treatment benefit has been developed under a 1115 demonstration waiver, which allows Wisconsin Medicaid to claim federal funding for services provided in IMDs. All certified DHS 75.11 Medically Monitored Residential Treatment and 75.14 Transitional Residential Treatment facilities in Wisconsin will be eligible to take part in the new residential facility SUD treatment benefit, regardless of IMD designation.

Covered Services

The residential facility SUD benefit is available to members of all ages.

The ForwardHealth residential facility SUD treatment benefit covers the following services designed to treat one or more substance use disorders. Residential facility SUD treatment services must be provided in a 24-hour, supervised, clinically and medically necessary facility. Residential facility SUD treatment will be provided at two levels of intensity by DQA-certified Medically Monitored Residential Treatment Facilities (high intensity) and/or Transitional Residential Treatment Facilities (low intensity). All of the following services are reimbursed as part of the residential facility SUD daily rate.

Comprehensive Evaluation and Treatment Planning

Comprehensive assessment of the member is required to be completed no more than 30 days prior to or within 4 days of the member's admission to the residential treatment facility to identify the member's unique medical conditions, mental health conditions, psychological state, personality, addictive behavior patterns, wellness and nutritional needs, and spiritual needs. This information provides the basis for the documented individualized treatment plan. Throughout the member's residential treatment, ongoing re-evaluation and adjustments to the documented treatment plan are required in response to changes in the member's condition.

Monitoring and Management

Residential treatment services include ongoing monitoring of the member's well-being and skill development as the member works toward recovery. Based on individual needs, this may include monitoring and/or

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administration of prescribed medications, withdrawal management, physical health monitoring, wellness management and recovery, individual skill development and enhancement, and peer support.

Counseling and Psychoeducation

Treatment services include individual or group counseling, as well as individual and/or family psychoeducation. The amount of counseling and psychoeducation should be based on the unique needs of the member and family and guided by ASAM or similar practice standards for the requested level of treatment services. High intensity treatment requires 20 or more hours per week of counseling and psychoeducation for each member. Low intensity treatment requires 6 or more hours per week of counseling and psychoeducation for each member.

Discharge and Aftercare Planning

Discharge planning must meet all requirements as described in ch. DHS 75. A comprehensive aftercare plan must be part of the treatment planning process and part of the discharge planning.

Preparation of an effective aftercare plan should begin shortly after admission. For members living in an environment hostile to addiction recovery, such as homeless members, planning for aftercare housing must begin immediately. .

Successful treatment can be defined along multiple parameters including, but not limited to the following:

- The member completes treatment goals as set up by the residential facility in addition to completing length of stay as recommended by providers.
- The member meets American Society of Addiction Medicine (ASAM) criteria for discharge in addition to completing length of stay as recommended by providers.

The goal of aftercare planning is to identify the member's expected needs for ongoing recovery and the available resources in the community to address those needs. The member must be involved in the process and have a thorough understanding of the plan. The elements of a successful and comprehensive aftercare plan include:

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- Planning for available services upon discharge (for example, intensive outpatient program, individual counseling or group counseling, medication management, and attendance at recovery support group meetings)
- Confirming living arrangements that will promote recovery and reduce chances of relapse
- Providing housing resources available to help the member in their transition back to the community if needed
- Providing emergency and counseling contact information for the member
- Overdose prevention plan, if applicable, including continuation of MAT and provision of emergency medication to treat overdoses

Failure to develop an adequate plan of care for discharge may result in a denial of authorization for additional days of service. Member discharge in this case, including inappropriate service termination, regardless of ForwardHealth reimbursement, may result in department action regarding provider certification status or other actions.

Drug Testing

Medically necessary drug testing is included in the residential facility SUD treatment benefit to monitor and reinforce treatment gains, as appropriate to the member's individual treatment plan. ForwardHealth will **not** separately reimburse providers for medically necessary drug testing if there is a residential facility SUD claim for the DOS on the claim. All claims are subject to post-payment review.

Behavioral Health and Medical Services for Co-Occurring Disorders

Co-occurring disorders refer to the simultaneous presence of symptoms of medical and/or mental health and substance use disorders, which may result in greater impairments in functioning. Providers are expected to integrate treatment needs for members with co-occurring medical, mental health, and substance use disorders. This may include services delivered by appropriately credentialed staff at the residential SUD facility or care collaboration with outside providers.

Care Collaboration with Concurrent Service Providers

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If the member is continuing a course of medical or mental health initiated prior to admission, or if the member requires specialty care that is outside the scope of care expected of residential SUD treatment providers, access to needed care must be provided. Collaboration between the residential SUD treatment provider and each concurrent service provider is required and must be documented in the member's medical record. The residential SUD treatment provider must document their collaboration with each concurrent service provider in the member's medical record. The documentation must include services the member is receiving from the other provider and the current schedule or frequency of services. This will ensure better coordination of care and prevent duplication of services.

ForwardHealth will allow for the concurrent delivery of residential SUD treatment services with medically necessary, non-duplicative medical and mental health services, per Wis. Admin. Code § DHS 101.03(96m).

Related Services

These services are not part of coverage policy and not included in the rate for this benefit but are frequently provided on a concurrent basis and may be integrated with residential SUD services.

Medication-Assisted Treatment

Medication-assisted treatment (MAT) must be available to members who require it. MAT is the use of Food and Drug Administration (FDA)-approved medications in combination with counseling and behavioral therapies to offer a "whole patient" approach to the treatment of substance use disorders. Residential facility SUD treatment providers must support the member's continued use of their MAT medication, either by providing the medication on-site or enabling access to the medication off-site.

BadgerCare Plus and Medicaid covers narcotic treatment-related medical service under the narcotic treatment benefit and covers medication under the pharmacy benefit. Each part of MAT is required to be submitted on separate claims.

Non-Emergency Medical Transportation

As a reminder, members may use the non-emergency medical transportation (NEMT) benefit for transportation to the residential facility

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and for transportation to outside medical appointments during residential treatment. NEMT is not included as a part of the residential facility SUD benefit but is available to Medicaid and BadgerCare Plus members to facilitate their treatment. Visit the DHS NEMT webpage for more information about this benefit.

Emergency Services

There are no PA requirements in emergency situations as defined by Wis. Admin. Code § DHS 101.03(52). Emergency services are **only** reimbursed if they are covered services.

Noncovered Services

ForwardHealth will not reimburse noncovered services, which include:

- Detoxification. ForwardHealth expects that any detoxification required has already been provided before starting a residential facility treatment program. Refer to Wis. Admin. Code § DHS 75.07 for more information on detoxification.
- Services that are recreational, social, academic, or unrelated to the direct treatment of the substance use disorder.
- Services delivered outside the parameters of the PA.

For more information about noncovered services, refer to Wis. Admin. Code § DHS 101.03(103) and DHS ch. 107.

Individuals detained by legal process are not eligible for the residential facility SUD treatment benefit since they are not eligible for full Wisconsin Medicaid benefits. Providers can refer to the Online Handbook topic #278 for more information on people detained by legal process.

Services Not Separately Reimbursable

Room and board expenses are not part of the daily rate for the residential facility SUD treatment benefit. Room and board expenses are also not a covered service by ForwardHealth. In addition, medically necessary drug testing is included in the residential facility SUD treatment daily rate and is not separately reimbursable.

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Documentation Retention

Wisconsin Admin. Code DHS chs. 75, 83, 92, and 94, and 42 C.F.R. Part 2 require residential facility SUD treatment providers to keep documentation.

Providers are reminded that they must follow documentation retention requirements, per Wis. Admin Code § DHS 106.02(9). Information about those requirements are explained in the following Online Handbook topics:

- Financial Records topic (#201)
- Medical Records topic (#202)
- Preparation and Maintenance of Records topic (#203)
- Record Retention topic (#204)
- Availability of Records to Authorized Personnel topic (#1640)

Providers are required to produce and/or submit documentation to ForwardHealth upon request. ForwardHealth may deny or recoup payment for services that fail to meet this requirement. Refusal to produce documentation may result in sanctions, including but not limited to termination from the Medicaid program.

Benefit Requirements

To meet program requirements, a covered service must be provided by a qualified Medicaid-enrolled provider to an enrolled member. The service must meet all applicable program requirements. These program requirements include, but are not limited to, medical necessity, PA, claims submission, and documentation requirements.

Residential facility SUD treatment providers must admit members who take medications for substance use disorder (for example, FDA-approved methadone, buprenorphine, and naltrexone) and mental health disorders. Residential facility SUD treatment providers must also be able to support the member continuing to use prescribed medication including their MAT medication, either by providing the medication on-site or enabling access to the medication off-site. Services provided must address the member's individual needs, as documented in the treatment plan. Services provided must also meet the definition of medical necessity.

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Prior Authorization

ForwardHealth has established clinical criteria for PA requests for residential facility SUD treatment effective for DOS on or after February 1, 2020.

All residential facility SUD treatment services require PA. PA for initial admission will be granted for up to 15 days based on diagnostic and ASAM criteria. PA for initial admission may be extended up to 30 days with the submission of a PA amendment request or subsequent PA request that includes a comprehensive biopsychosocial assessment, plan of care, and a discharge and aftercare plan that meets approval criteria. Continued treatment may be authorized beyond 30 days for no greater than 7 days at a time for high intensity treatment and no greater than 30 days at a time for low intensity treatment. Exceptions may be granted for pregnant or post-partum members up to 60 days after the child's birth.

Prior Authorization Approval Criteria

Every PA request is reviewed to evaluate whether or not the requested service meets the Wisconsin Administrative Code's definition of 'medically necessary' as well as other criteria.

The Prior Authorization/Residential Substance Use Disorder Treatment Attachment (PA/RFSUD) allows a provider to document the clinical information used to determine whether the standards of medical necessity are met for the requested service. ForwardHealth considers certain factors when determining whether to approve or deny a PA request pursuant to Wis. Admin. Code § DHS 107.02(3). It is crucial that providers include all necessary information on the PA/RFSUD (F-XXXX).

Submitted documentation must provide the justification for the service requested specific to the member's current condition and needs. Pursuant to Wis. Admin. Code § DHS 101.03(96m), medically necessary is a service under ch. DHS 107 that meets certain criteria. Providers are also required to prepare, submit and maintain written documents that are complete, accurate, legible, and based on the current needs of the member (DHS 106). Each PA is evaluated on its own merits and medical necessity is established on an individual basis.

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Prior Authorization Requirements for Initial Requests for all Residential Facility SUD Treatment Provider Specialties

An initial PA request is the first request to ForwardHealth for a member for an episode of residential SUD treatment. This includes instances when the member's residential facility SUD treatment is already in progress but covered by a payer other than Medicaid. The initial assessment of the member to determine the appropriateness of residential treatment admission must be completed by a credentialed counselor, clinician, certified addiction registered nurse, psychologist, or physician that refers the member for residential treatment familiar with ASAM treatment criteria, which may include licensed professionals working at the residential SUD treatment facility. Requests for initial admission for either high intensity or low intensity treatment may be approved for up to 15 days.

In all cases, the PA request for admission to a residential treatment facility must be submitted by the enrolled residential facility SUD provider. The following information is required to make a determination of medical necessity for an initial PA request:

- A completed Prior Authorization Request Form (PA/RF)
- A completed Prior Authorization Residential Substance Use Disorder Treatment (PA/RFSUD) form, which includes:
  - Diagnostic evaluation
  - ASAM criteria
  - Treatment readiness

Diagnostic Evaluation

The diagnosing clinician must identify each of the member's symptoms from the diagnostic criteria listed in the current Diagnostic and Statistical Manual (DSM) for SUDs. Typically, the member must meet the diagnostic criteria for a moderate or severe substance use disorder to be eligible for residential treatment. The diagnosing clinician must specify the substances used by the member and severity of symptoms associated with each substance.

ASAM Criteria

Providers must submit an assessment of the member's ASAM level of functioning and severity as described in the current edition of *The ASAM*

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Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. The assessment must include:

- A brief narrative description for each ASAM dimension
- The member's risk rating for each ASAM dimension to specify severity of needs and treatment priorities
- The member's level of care rating for each ASAM dimension to specify the least restrictive intensity of services needed to address each dimension

As a reminder, the member should utilize the least restrictive level of care that results in progress. If it is determined that the member meets a less restrictive level of care than residential treatment, those services should be utilized first. If the member has already utilized services in a less restrictive level of care and no further progress has been made, the member may be placed in residential treatment. Some members may meet the criteria for direct admission into residential treatment without requiring less restrictive treatment, depending on the severity of symptoms and member's individual circumstances.

Treatment Readiness

For admission to a residential treatment program, the provider completing the PA/RFSUD must do all of the following:

- Establish that the member is not in need of services for acute withdrawal or intoxication from drugs or alcohol.
- Indicate whether the member is seeking treatment voluntarily or involuntarily. For example, the member may be seeking treatment exclusively in response to a requirement placed by another entity (such as a court or family member) or the member may be seeking treatment exclusively of their own volition. This condition is not intended to exclude members from residential facility SUD treatment but may result in a request for additional documentation to support the medical necessity of the request.
- Establish that the member has attempted professionally-supervised treatment in the past or has a demonstrated need for structure and intensity of treatment that is not available in a less restrictive level of care.

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- Establish that the member is not be experiencing acute psychiatric or medical symptoms that require a greater level of care than the requested level of service.

Prior Authorization Requirements for Requests to Extend Services for Initial 30 Days for all Residential Facility SUD Treatment Provider Specialties

Following admission to the treatment facility, providers may submit a PA amendment request to extend the member's residential treatment to up to 30 days from the date of initial admission. The amendment must be submitted prior to the expiration of the current, initial authorization for residential treatment and must include the provider's completed comprehensive biopsychosocial assessment, individualized plan of care, and discharge and aftercare plan. In the event the provider does not submit the amendment prior to expiration of the current PA, a new PA request must be submitted for consideration. PAs will not be backdated to cover the gap of services due to untimely submissions. The following information is required with the PA extension request:

- A completed PA Amendment Request form or new PA Request
- Provider's comprehensive biopsychosocial assessment
- Plan of care
- Discharge criteria and aftercare plan

Prior Authorization Amendment Request Form

Complete all required fields on the PA Amendment Request form, including the following:

- In Element 9, indicate the desired end date for the PA. This may be up to 30 calendar days from the date of admission.
- In Element 10, indicate "Change Grant or Expiration Date."
- In Element 11, include the note "Extend initial stay to 30 days" with any other desired information.

Provider's Comprehensive Biopsychosocial Assessment

The provider must submit a comprehensive biopsychosocial assessment of the member, which may be completed following the member's admission for residential facility SUD treatment. The assessment must include:

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- History of the present episode
- Personal and social history (for example, school, work, military service, relationships)
- Family and developmental history.
- Alcohol, tobacco, other drug use, and addictive behavior history
- Past treatment history for substance abuse
- Medical conditions
- Mental health conditions or psychological state (i.e. depression, anxiety, or trauma)
- Potential obstacles to successful residential treatment.

Plan of Care

The provider must submit a plan of care, also known as a treatment plan or protocol, which meets all requirements described in DHS 75. The plan of care must address the member's priority needs, based on the ASAM assessment, and must identify the specific, measurable outcomes used to evaluate progress and treatment success. The plan of care must also identify any diagnosed mental health conditions or psychiatric symptoms observed or reported by the member, and the plan for integrating and addressing these conditions in treatment.

If the member has medical needs or requires medication-assisted treatment (MAT), the plan of care must specify how these medical conditions will be addressed, including a plan for obtaining MAT, if needed.

Discharge Planning and Aftercare Plan

The provider must begin preparing an effective aftercare plan shortly after admission to identify the anticipated needs of the member and available resources in the community to address the member's needs related to ongoing recovery. This plan must be complete prior to PA submissions to extend services. The member and the member's family, when applicable, must be involved in the process and have a thorough understanding of the plan. The provider must submit a comprehensive aftercare plan that includes the following:

- Planning for available services upon discharge (for example, intensive outpatient program, individual counseling or group

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counseling, medication management, and attendance at recovery support group meetings)
- Confirming living arrangements that will promote recovery and reduce chances of relapse
- Providing housing resources available to help the member in their transition back to the community if needed
- Providing emergency and counseling contact information for the member
- Overdose prevention plan, if applicable, including continuation of MAT and provision of emergency medication to treat overdoses

ForwardHealth recognizes that the provider may continue to develop and modify the initial aftercare plan during the remainder of the member's treatment stay. However, providers are advised that all requests to extend the member's stay in residential treatment will require a comprehensive aftercare plan and evidence of timely efforts to develop an effective plan, such as dates of member meetings, phone contacts, etc. It is necessary for the provider to develop an adequate discharge plan.

Failure to develop an adequate plan of care for discharge may result in a denial of authorization for additional days of service. Member discharge in this case, including inappropriate service termination, regardless of ForwardHealth reimbursement, may result in department action regarding provider certification status or other actions.

PA Requirements for Requests to Extend Services beyond 30 Days for all Residential Facility SUD Treatment Provider Specialties

A PA amendment may be submitted to request an extension of services under the initial PA number for continued stay at the ASAM-indicated residential level of care. The provider must submit the amendment request before the current PA expires to prevent a gap in services. In the event the amendment is not submitted timely, a new PA request must be submitted. PAs will not be backdated to cover gaps of services due to untimely submissions.

Following the initial 30 days of residential treatment, requests for Clinically Managed High Intensity Residential Services may be extended for up to 7 days per amendment request. Typically, the maximum length of continued

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stay at this level of care is 3 months. Exceptions may be granted for pregnant or post-partum members up to 60 days after the child's birth.

Following the initial 30 days of residential treatment, requests for Clinically Managed Low Intensity Residential Services may be extended for up to 30 days per amendment request. Typically, the maximum length of continued stay at this level of care is one year.

For requests to extend services at either level of care, the following information is required to make a determination of medical necessity for a PA amendment request:

- A completed Prior Authorization Amendment Request form
- All treatment plan reviews
- Updated ASAM criteria
- Updated plan of care
- Clinical rationale for continued stay
- Updated comprehensive aftercare plan

Prior Authorization Amendment Request

Complete all required fields on the PA Amendment Request form, including the following:

- In Element 9, indicate the desired end date for the PA. For high intensity treatment, this may be up to 7 days from the current expiration date. For low intensity treatment, this may be up to 30 days from the current expiration date.
- In Element 10, indicate "Change Grant or Expiration Date."
- In Element 11, include the note "Additional 7 days requested" or "Additional 30 days requested" with any other desired information.

Treatment Plan Reviews

Providers must submit all treatment plan reviews completed since the last PA request. Documentation must include the date of each review, the individual completing the review, and narrative descriptions of changes and progress toward goals.

Updated ASAM Criteria

Providers must submit an updated assessment of the member's level of functioning and severity using the ASAM criteria. Include brief narrative descriptions, risk ratings, and level of care ratings for each of the six ASAM dimensions. Provider may utilize Section NN of the PA/RFSUD

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form to report the updated information, or may provide it in another format as long as all required information in included.

Updated Plan of Care

Provider must submit an updated plan of care. Identify any new or modified goals and changes to the treatment protocol.

Clinical Rationale for Continued Stay

Provider must submit a clear clinical rationale for continued stay beyond the authorized expiration date. Identify barriers to discharge, all corrective actions attempted including timeline, and the plan to resolve barriers.

Updated Comprehensive Aftercare Plan

Provider must submit the member's current comprehensive aftercare plan that includes the following:

- Planning for available services upon discharge (for example, intensive outpatient program, individual counseling or group counseling, medication management, and attendance at recovery support group meetings)
- Confirming living arrangements that will promote recovery and reduce chances of relapse
- Providing housing resources available to help the member in their transition back to the community if needed
- Providing emergency and counseling contact information for the member
- Overdose prevention plan, if applicable, including continuation of MAT and provision of emergency medication to treat overdoses

Providers must include a timeline of efforts to develop and ensure the adequacy of the aftercare plan (for example, dates of member meetings, phone contacts, etc.). Providers are responsible for helping the member to actively pursue appropriate living arrangement to avoid continued treatment when the member no longer meets criteria for the current level of care, other than needing an adequate recovery environment. It is necessary for the provider to develop an adequate discharge plan.

Failure to develop a suitable plan of care for discharge may result in a denial of authorization for additional days of service. Patient discharge in this case, including inappropriate service termination, regardless of

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ForwardHealth reimbursement, may result in department action regarding provider certification status or other actions.

Prior Authorization Requests to Continue Services at a Different Level of Care

Services provided following an authorized extension of a placement should continue to be delivered at the frequency and intensity consistent with ASAM and DHS 75 for the designated level of care. If the member's needed frequency or intensity of care changes during the authorization period, the provider must submit a PA amendment to end the current authorization, and may submit new PA at the appropriate level of care for the member's needs. Providers are expected to submit a PA amendment within 48 hours of the member no longer meeting ASAM criteria for the currently authorized level of care.

Forms and Attachments

The following forms must be included as part of the PA request for residential facility SUD treatment.

- A completed Prior Authorization Request Form (PA/RF), F-11018 (05/13)
- A completed Prior Authorization/Residential Substance Use Disorder Treatment Attachment (PA/RFSUD), F-XXXX (X/19)

Note: Providers must utilize the fillable PDF from the Portal until Portal entry is available.

Submission Options

Residential facility SUD treatment providers may submit PA requests for residential facility SUD treatment services using any of the following methods:

- **ForwardHealth Portal** — PA requests may be submitted on the ForwardHealth Portal at www.forwardhealth.wi.gov/.
- **Fax** — Prior authorization requests may be faxed to 608-221-8616.
- **Mail** — Prior authorization requests may be mailed to the following address:

  ForwardHealth

  Prior Authorization

Ste 88

313 Blettner Blvd.

Madison WI 53784

For specific information about each of these submission options, providers should refer to the Submission Options chapter of the Online Handbook.

Providers are encouraged to utilize the ForwardHealth Portal to reduce the likelihood of errors on the PA submission. In the event that documentation related to the PA is being faxed or mailed to ForwardHealth, it is the provider's responsibility to include the PA number and other member identifying information to ensure that the attachments are easily identified and assigned to the PA. Providers are reminded of their responsibility to submit complete and accurate prior authorization requests. Incomplete submissions may result in delays to receiving a final decision on the request.

Authorization Dates

The requested start date for services on PA requests cannot precede the date of the diagnostic evaluation and ASAM evaluation.

PA requests may not be backdated to a date that is earlier than the initial date of the PA request submission, except in limited circumstances.

Requests for backdating may be approved up to 14 calendar days from the date of submission if all of the following conditions are met:

- The provider specifically requests backdating in writing on the PA request.
- The request includes clinical justification for beginning the service before the PA was granted, including the evaluation report.
- The request includes justification as to why the PA could not be submitted immediately before or after the member was admitted.
- ForwardHealth receives the request within 14 calendar days of the start of the provision of services.

Prior Authorization Status Inquiries

Providers may ask about the status of a PA request through one of the following methods, using the 10-digit PA number received following submission of a PA request:

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- Logging into the ForwardHealth Portal and visiting the Prior Authorization page
- Accessing WiCall at 800-947-3544
- Calling Provider Services at 800-947-9627

Refer to the Prior Authorization section of the Physician service area of the Online Handbook for more information on PA status and decisions.

Reimbursement Not Available

Wisconsin Medicaid may decline to reimburse a provider for a service that has been prior authorized if one or more of the following applies:

- The service authorized on the approved PA request is not the service provided.
- The service is not provided within the grant and expiration dates on the approved PA request.
- The member is not eligible for the service on the date the service is provided.
- The provider is not enrolled in Wisconsin Medicaid on the date the service is provided.
- The service is not billed according to service-specific claim instructions.
- The provider does not meet other program requirements.

Collecting Payment From Members

Providers may not collect payment from a member for a service requiring PA under any of the following circumstances:

- The provider did not submit a PA request before the service was provided.
- The service was provided before the PA grant date or after the PA expiration date.
- The provider obtained an approved PA request but did not meet other program requirements.
- The service was provided before a decision was made, the member did not accept responsibility for the payment of the service before the service was provided, and the PA request was denied.

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Coordination of Benefits

Commercial Health Insurance

When a member is enrolled in both a commercial health insurance plan and BadgerCare Plus or Wisconsin Medicaid, the provider is required to submit claims to commercial health insurance sources before submitting claims to ForwardHealth. This is done by following the process in the Exhausting Commercial Health Insurance Sources topic (topic #596) of the Commercial Health Insurance chapter of the Coordination of Benefits section of the Online Handbook.

Even when a member has a known deductible or cost share, primary insurance must process the claim before submission to ForwardHealth. The outcome of the primary insurance claim, regardless of payment status, is required for ForwardHealth to process secondary claims.

When coordinating commercial insurance and Medicaid benefits, providers are required to bill the commercial health insurance plan **according to the commercial insurer's policies and designated procedure codes, modifiers, and units billed**. After receiving the claims processing outcome (for example, Remittance Advice) from the commercial insurer, the provider may submit a claim to ForwardHealth for consideration of any remaining balance, **using the other insurance indicator or completing the Explanation of Medical Benefits form as applicable**. Refer to the UB-04 (CMS 1450) Claim Form Instructions for Residential Facility Substance Use Disorder Treatment Services in the Submission chapter of the Claims section of the Online Handbook for more information.

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

Note: The requirement for providers to submit claims to commercial insurance companies according to the commercial insurer's coding guidance does not waive other ForwardHealth program requirements. These requirements (for example, provider qualifications, medical

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necessity, and documentation requirements) are still in effect. ForwardHealth will not reimburse providers for services that do not meet program requirements.

Claims for Services Denied or Not Covered by Commercial Health Insurance

If commercial health insurance denies or recoups payment for services that are covered by BadgerCare Plus and Wisconsin Medicaid, the provider may submit a claim for those services. To allow payment in this situation, providers are encouraged to follow the requirements (e.g., request PA before providing the service for covered services that require PA). If the requirements are followed, ForwardHealth may reimburse for the service up to the allowed amount (less any payments made by other health insurance sources).

Note: The provider is required to show that a correct and complete claim was denied by the commercial health insurance company for a reason other than that the provider was out of network.

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

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

Note: Commercial health insurance benefit plans change on a regular basis. To follow Wisconsin state statutes, providers are required to confirm a member's coverage when the plan year changes and to update the member's file with any changes.

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Discovery of Commercial Insurance After Payment by ForwardHealth

If, after paying a claim for residential facility SUD treatment, ForwardHealth discovers the member had commercial health insurance coverage on the DOS included on the claim, ForwardHealth will send an invoice to the provider for the paid claim. The provider is required to seek reimbursement from the commercial health insurer upon receipt of this invoice using **the commercial insurer's policies and designated procedure codes, modifiers, and units billed.** Refer to the Purpose of Provider-Based Billing topic (#660) of the Online Handbook for more information.

Medicare

State law limits reimbursement for coinsurance and copayment of Medicare Part B-covered services provided to dual eligibles and Qualified Medicare Beneficiary-Only members.

Total payment for a Medicare Part B-covered service (that is, any amount paid by other health insurance sources, any copayment or spenddown amounts paid by the member, and any amount paid by Wisconsin Medicaid) may not exceed the Medicare-allowed amount. Therefore, Medicaid reimbursement for coinsurance or copayment of a Medicare Part B-covered service is the lesser of the following:

- The Medicare-allowed amount less any amount paid by other health insurance sources and any copayment or spenddown amounts paid by the member.
- The Medicaid-allowed amount less any amount paid by other health insurance sources and any copayment or spenddown amounts paid by the member.

For more information on reimbursing crossover claims with Medicare, visit the Reimbursement for Crossover Claims topic (#686) in the ForwardHealth Online Handbook.

Claim Submission

ForwardHealth reimburses only for services that are medically necessary as defined under Wis. Admin. Code § DHS 101.03(96m). ForwardHealth

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may deny or recoup payment if a service does not meet Medicaid medical necessity requirements. Claims must be billed using the UB-04 claim form for institutional claims, and must include one revenue code and at least one procedure code.

The use of *Healthcare Common Procedure Coding System (HCPCS)* procedure codes and applicable modifiers is required on all claims. Claims or claims adjustments received without a valid HCPCS code and corresponding modifier will be denied.

Information on claims submission to ForwardHealth is found in the ForwardHealth Online Handbook.

Procedure Codes and Modifiers

Effective for DOS on and after February 1, 2020, residential facility SUD treatment providers must include revenue code 1002 (Behavioral health accommodations residential-chemical dependency) on claims and claim adjustments with the procedure code, H0017.

Prior Authorization is required for all claims submissions.

Claims or claim adjustments submitted to ForwardHealth for residential facility SUD treatment services must have a modifier to indicate the type of treatment (complex/high tech or intermediate levels of care) that was provided. Each line of detail on a claim or claim adjustment requires a modifier. Claims and claim adjustments without the required modifier will be denied.

Providers should bill only one type of service, either clinically managed low intensity residential services or clinically managed high intensity residential services, per claim. Providers may include additional revenue codes on the claim but ForwardHealth will only reimburse the established daily rate.

Allowable modifiers for claims submission for procedure code H0017 are listed below:

- Only the Clinically Managed High Intensity Residential Services provider specialty of the residential facility SUD Treatment provider type will be able to use the modifier, TG (Complex/high tech level of care).

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- Only the Clinically Managed Low Intensity Residential Services provider specialty of the residential facility SUD provider type will be able to use the modifier, TF (Intermediate level of care).

Reimbursement

Residential facility SUD treatment benefit services are reimbursed fee-for-service for BadgerCare Plus or Medicaid members enrolled as fee-for service. Services provided to members enrolled in a Medicaid or BadgerCare Plus HMO or MCO will be reimbursed by the HMO or MCO, and the amount of the reimbursement will be determined by the contract or agreement between the provider and the HMO or MCO.

Services will be reimbursed via a daily maximum fee rate. Initial screening and assessments completed by the residential facility SUD treatment provider to a member who was admitted to the facility will be included in the daily rate. These services are considered part of the bundled treatment services that are reimbursed via the established daily max fee. Maximum allowable fees are based on various factors, including a review of usual and customary charges submitted, the Wisconsin State Legislature’s Medicaid budgetary constraints, and other relevant economic limitations. Maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law.

Refer to the ForwardHealth maximum fee schedule for residential facility SUD treatment services.

Member Information

Retroactive Medicaid Enrollment

Retroactive enrollment occurs when an individual applies for BadgerCare Plus or Medicaid and enrollment is granted with an effective date before the date the enrollment determination was made. A member’s enrollment may be backdated to allow retroactive coverage for medical bills incurred before the date of application. The retroactive enrollment period may be backdated up to three months before the month of application if all enrollment requirements were met during the period. Enrollment may be backdated more than three months if there were delays in determining

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enrollment. Enrollment may also be backdated if court orders, fair hearings, or appeals were involved.

Wisconsin Admin. Code § DHS 104.01(11) gives members that get retroactive enrollment the right to ask for the return of payments made to a Medicaid-enrolled provider for covered services during retroactive enrollment. A Medicaid-enrolled provider is required to submit claims to ForwardHealth for covered services provided to a member during retroactive enrollment. Medicaid cannot directly refund the member.

If a service that requires PA was performed during the member's retroactive enrollment, the provider is required to submit a PA request as soon as the member's eligibility is granted and obtain approval from ForwardHealth **before** submitting the claim.

If a provider receives reimbursement from Medicaid for a service provided to a retroactively enrolled member and the member has paid for the service, the provider is required to reimburse the member or authorized person acting on behalf of the member for the full amount that the member paid for the service.

If a claim cannot be filed within 365 days of the DOS due to a delay in the determination of a member's retroactive enrollment, the provider is required to submit the claim to Timely Filing within 180 days of the date the retroactive enrollment is entered into Wisconsin's Enrollment Verification System (EVS) (if the services provided during retroactive enrollment were covered).

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Member Enrollment Verification

Providers must always verify a member's enrollment before submitting a PA request and before each DOS to which they are providing services. By verifying a member's enrollment, providers confirm enrollment for the current date of service (since a member's enrollment status may change). Verification of member enrollment also allows providers to notice any limits to the member's coverage.

ForwardHealth will not authorize backdated services due to the provider's delay in checking eligibility.

Providers can access Wisconsin's EVS to get the most current enrollment information through the following methods:

- ForwardHealth Portal
- WiCall, the ForwardHealth automated voice response system, which gives responses to questions about claim status (800-947-3544)
- Commercial enrollment verification vendors
- The 270/271 Health Care Eligibility/Benefit Inquiry and Information Response transactions
- Provider Services (800-947-9627)

Each enrollment verification method lets providers check the following:

- Member enrollment in a ForwardHealth program(s)
- State-contracted managed care organization (MCO) enrollment
- Medicare enrollment
- Any other commercial health insurance coverage
- Exemption from copayments for BadgerCare Plus members

Note: The EVS does not indicate other government programs secondary to ForwardHealth. Providers cannot charge a member, or authorized person acting on behalf of the member, for verifying their enrollment.

Copayments

Residential facility SUD treatment services are exempt from copayments. Providers are prohibited from collecting copayments from members for services covered under the residential facility SUD treatment benefit.

Managed Care

ForwardHealth anticipates that most members receiving services through the residential facility SUD benefit will be enrolled in an HMO. ForwardHealth contracts with BadgerCare Plus and Medicaid SSI HMOs to provide medically necessary covered services, including residential facility SUD treatment services. HMOs then contract with individual providers. These providers are required to also be enrolled with Wisconsin Medicaid before they can provide services to members.

After completing the ForwardHealth provider enrollment process, residential facility SUD treatment providers interested in participating in a

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Medicaid SSI or BadgerCare Plus HMO's network should contact the HMO for more information about credentialing and contracting prior to providing services to members enrolled in that HMO. HMOs may have different prior authorization processes and claim submission processes than ForwardHealth. For managed care policy, contact the appropriate managed care organization. Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The residential facility SUD treatment benefit is not covered under Family Care or Family Care Partnership. Members of those programs would access this benefit via fee-for-service Medicaid.

Refer to the Managed Care section of the Physician service area of the Online Handbook for more information on Medicaid managed care. Providers can also refer to the Managed Care Organization area of the ForwardHealth Portal at https://www.forwardhealth.wi.gov/WIPortal/ to access key HMO information.

Policy Information

To ensure adherence to program requirements, providers should verify that they have the most current sources of policy information. It is critical that providers and staff have access to these documents:

- **Wisconsin Administrative Code**—Wis. Admin. Code chs. DHS 101–108 are the rules regarding Medicaid administration.
- **Wisconsin Statutes**—Wis. Stat. §§ 49 provides the legal framework for Wisconsin Medicaid.
- **ForwardHealth Online Handbook**—the Online Handbook contains policy information for all providers.

ATTACHMENT A

Services Included and Excluded from the RFSUD Treatment Benefit

SEPARATELY REIMBURSABLE SERVICES	SERVICES THAT ARE NOT SEPARATELY REIMBURSABLE
Initial screening and assessments completed by a separate Medicaid-enrolled behavioral health provider prior to making a referral to treatment by a Residential Facility SUD Treatment provider. The Medicaid-enrolled behavioral health provider must bill this service separately under the outpatient mental health benefit.	Initial screening and assessments completed by the residential facility SUD treatment provider to a member who was admitted to the facility. These services are considered part of the bundled treatment services that are reimbursed via the established daily max fee.
Initial screening and assessments completed by a residential facility SUD treatment provider to a member who was not admitted to the facility. The residential facility SUD treatment provider must bill this service separately under the Outpatient Mental Health benefit.	Room and board expenses are not covered by ForwardHealth or Wisconsin Medicaid.
Narcotic treatment-related medical services, including methadone testing, are reimbursed under the narcotic treatment benefit.	Substance abuse counseling and psychoeducation services are considered part of the bundled treatment services that are reimbursed via the established daily max fee.
Medication, including MAT, is reimbursed under the pharmacy benefit.	Drug testing (excluding methadone testing provided under the narcotic treatment benefit) is considered part of the bundled treatment services that are reimbursed via the established daily max fee.