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A. TYPE OF HANDBOOK

Part H, Division V, Community Support Program (CSP), is the service specific portion of the Wisconsin Medical Assistance Provider Handbook. It is the fifth division of Part H, the Mental Health Handbook, which includes information for all mental health services. Division V includes information for CSP providers regarding provider eligibility criteria, recipient eligibility criteria, covered services, and billing instructions. Division V is intended to be used in conjunction with Part A of the Wisconsin Medical Assistance Provider Handbook which includes general policy guidelines, regulations, and billing information applicable to all types of providers certified in the Wisconsin Medical Assistance Program (WMAP).

B. INTRODUCTION

Community Support Program - Purpose

The purpose of Community Support Programs (CSPs) is to provide individuals with chronic (e.g., long term) mental illness with effective and easily accessible treatment, rehabilitation, and support services. CSP services are provided in the community, where recipients live and work, as opposed to in clinics or institutions. It is thought that by helping long-term mentally ill persons better manage the symptoms of their mental illness, fewer institutional placements will be needed.

Community Support Program - Definition

S. HSS 63.029, Wis. Adm. Code defines a CSP as "a coordinated care and treatment program which provides a range of treatment, rehabilitation, and support services through an identified treatment program and staff to ensure ongoing therapeutic involvement, individualized treatment, rehabilitation, and support services in the community for persons with chronic mental illness."

Chronic mental illness is defined as "a mental illness which is severe in degree and persistent in duration, which causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life, which may lead to an inability to maintain stable adjustment and independent functioning without long-term treatment and support and which may be of lifelong duration. Chronic mental illness includes schizophrenia as well as a wide spectrum of psychotic and other severely disabling psychiatric diagnostic categories, but does not include organic mental disorders or a primary diagnosis of mental retardation or of alcohol or drug dependence" [s.HSS 63.02(7), Wis. Adm. Code].

C. PROVIDER INFORMATION

Provider Eligibility and Certification

CSP providers are required to be certified by the Division of Community Services (DCS) of the Department of Health and Social Services (DHSS), fulfilling the State regulations set forth in ch. HSS 63, Wis. Adm. Code. The CSP standards became effective May 1, 1989. CSP providers are surveyed on-site every two years by a team of DHSS Division of Community Services surveyors and mental health professionals to ensure that standards continue to be met.

In order to be certifiable by the WMAP, CSP providers must be certified by the DCS under ch. HSS 63, Wis. Adm. Code, and must meet the staffing requirements in s. HSS 63.06, Wis. Adm. Code. In addition, CSP mental health technicians must meet the requirements in s. HSS 105.255, Wis. Adm. Code.

Any CSP whose certification through the DHSS Division of Community Services is terminated, suspended, or denied is not eligible for WMAP certification.

C. PROVIDER INFORMATION (continued)

Mental Health Technician Training and Education Requirements
For WMAP reimbursement, a mental health technician must meet the following training and education requirements:

1. A minimum of 1,000 hours of supervised work experience with the long-term mentally ill.

2. At least one of the following:

   a. Satisfactorily completed the educational curriculum developed by the DHSS; or

   b. Be certified by the American Occupational Therapy Association as an occupational therapy assistant; or

   c. Be a Licensed Practical Nurse (LPN) under s.441.10, Stats.; or

   d. Have satisfied the training requirements under s. HSS 133.17(4) Wis. Adm. Code for a home health aide; or

   e. Be included in the registry of persons under s.HSS 129.10, Wis. Adm. Code, who have completed a nurse's assistant training and testing program or only a testing program; or

   f. Have satisfied the requirements under s.HSS 105.17(3)(a)1. Wis. Adm. Code, to provide personal care services and has completed an additional 1,000 hours of supervised work experience with long-term mentally ill persons.

3. A mental health technician providing CSP services who does not meet the requirements above must meet these requirements within one year following the effective date of the CSP's WMAP certification or the mental health technician's date of employment by the CSP, whichever is later. If this requirement is not met, the CSP may no longer bill for the mental health technician' services. However, the CSP may bill for the mental health technician's services during the one year period.

Application for Certification
For information regarding <u>certification by the Division of Community Services</u>, under ch. HSS 63, Wis. Adm. Code, providers must contact:

CSP Unit
Office of Mental Health
Division of Community Services
Post Office Box 7851
Madison, WI 53707

For information regarding <u>WMAP certification under s. HSS 105.255 Wis. Adm. Code</u>, providers must contact:

EDS
Attn: Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

C. PROVIDER INFORMATION (continued)

Billing and Non-Billing Provider Numbers
A provider number is issued to all qualified CSPs certified with the WMAP. The individuals providing service within the CSP do not need to be individually certified.

In most counties, the county 51.42 board is the WMAP certified CSP. In several counties, the 51.42 board contracts with qualified CSPs. In these counties, both the county 51.42 board and the contracted agency must be certified with the WMAP.

When the 51.42 board is the CSP, a billing/performing provider number is issued to the 51.42 board, that number is used to bill the WMAP and no additional provider number is required on the claim form.

In counties where the 51.42 board contracts with qualified CSPs, the 51.42 board is issued a billing provider number and the contracted CSP is issued a non-billing/performing provider number. Both the billing provider number and the non-billing/performing provider number are required on the claim form, but reimbursement is made only to the 51.42 board.

The CSP must bill for Clozapine Management using only the billing provider number. The CSP may use the patient account field (element 26 of the HCFA 1500 claim form) to identify the performing CSP in those counties where there are a number of programs contracting with the county to provide CSP services.

Refer to Appendix 1 in this handbook for instructions on completion of the National HCFA 1500 claim form and the proper use of billing and non-billing provider numbers. Refer to Section II of Part A of the WMAP Provider Handbook for additional information on types of provider numbers.

Scope of Service
The policies in Part H, Division V govern all CSP services provided within the scope of the practice of the profession as defined in s. 49.46(2)(b)6.f, Wis. Stats. and s. HSS 107.13(6), Wis. Adm. Code. Covered services and related limitations are enumerated in Section II of this handbook.

Reimbursement

CSP Services
Reimbursement is made to the county 51.42 board based on a maximum allowable fee per hour for CSP services provided to Medical Assistance recipients. Providers are reimbursed the federal share of the lessor of the maximum allowable fee or the billed amount. The county 51.42 board is responsible for providing the state matching funds for CSP services. This match must come from non-federal funds available to the county. No state General Purpose Revenue (GPR) dollars are allocated to CSPs. Providers are responsible for maintaining an audit trail to document their expenditure and contribution of funds.

Clozapine Management
The WMAP reimburses the CSP a predetermined fee per seven-day period for all allowable Clozapine Management services delivered over the course of one week. CSPs are reimbursed for Clozapine Management only once per seven-day period. All necessary Clozapine Management services, as listed in Section II-G of this handbook, are included in the one weekly payment for Clozapine Management, regardless of the actual number of services provided.

C. PROVIDER INFORMATION (continued)

CSPs receive the full WMAP reimbursement (federal share plus state match) for Clozapine Management services. Counties are not required to provide the non-federal match for these services when they are reimbursed as Clozapine Management.

Reimbursement for Clozapine Management services is made to the county identified as the billing provider. However, the county receives the full share of the Medical Assistance reimbursement for these services. When the county is not the performing provider of the Clozapine Management services, the county must pass through the full payment for the Clozapine Management services to the performing CSP. The county is not responsible for local matching funds for this service.

Provider Responsibilities
Specific responsibilities as a provider under the WMAP are stated in Section IV of Part A of the WMAP Provider Handbook. This section should be referenced for detailed information regarding fair treatment of the recipient, maintenance of records, recipient requests for noncovered services, services rendered to a recipient during periods of retroactive eligibility, grounds for provider sanctions, and additional state and federal requirements.

D. RECIPIENT INFORMATION

Eligibility For Medical Assistance
Recipients meeting eligibility criteria for Medical Assistance are issued Medical Assistance identification cards. The identification cards include the recipient's name, date of birth, 10-digit Medical Assistance identification number, medical status code, and an indicator of private health insurance coverage, HMO coverage, and Medicare coverage.

Medical Assistance identification cards are sent to recipients on a monthly basis. All Medical Assistance identification cards are valid only through the end of the month in which they are issued. It is important that the provider or the designated agent check a recipient's Medical Assistance identification card prior to providing service to determine if the recipient is currently eligible and if there are any limitations to the recipient's coverage.

Section V-C of Part A of the WMAP Provider Handbook provides detailed information regarding eligibility for Medical Assistance, Medical Assistance identification cards, temporary cards, restricted cards, and how to verify eligibility. Section V-C of Part A must be reviewed carefully by the provider before services are rendered. A sample Medical Assistance identification card can be found in Appendix 7 of Part A of the WMAP Provider Handbook.

Medical Status
Medical Assistance recipients are classified into one of several eligibility categories. These categories allow for a differentiation of benefit coverage. Refer to Section V-D of Part A of the Provider Handbook for additional information regarding medical status.

Recipients Eligible for CSP Services
CSP is a benefit for Medical Assistance recipients 18 years of age or over. Recipients enrolled in WMAP-contracted HMOs are not eligible for Medical Assistance CSP services. All eligible recipients must meet the criteria for admission set forth in s. HSS 63.08, Wis Adm. Code.

D. RECIPIENT INFORMATION (continued)

Recipients Enrolled in WMAP-Contracted HMOs

WMAP recipients enrolled in WMAP-contracted HMOs receive a yellow Medical Assistance identification card. This card has a six-character code in the "Other Coverage" column designating the recipient's HMO. These codes are defined in Appendices 20, 21, and 22 of Part A of the WMAP Provider Handbook. Providers must always check the recipient's current Medical Assistance identification card for HMO coverage before providing services.

WMAP-contracted HMOs do not cover CSP services. However, Medical Assistance recipients who are enrolled, or eligible for enrollment, in a WMAP-contracted HMO and who meet the criteria for admission to a CSP are eligible for disenrollment or exemption from the HMO.

In order for disenrollment to occur, the HMO must submit a disenrollment request to the Bureau of Health Care Financing (BHCF) Contract Monitor that specifies the recipient's name and 10-digit Medical Assistance identification number. This must include a statement from a WMAP-certified medical or mental health provider, or a community support program, indicating eligibility to participate in that program or indicating participation in that program, if it has already begun. This disenrollment will be effective the first day of the month in which participation began or is to begin.

The recipient may ask for an exemption from HMO enrollment, either before or after they are enrolled in an HMO. If the recipient is not yet in an HMO when the exemption is requested, they will be temporarily exempted until the request is either approved or denied. If the recipient is enrolled in an HMO when they apply for exemption, they will remain in the HMO until the month following approval of the exemption.

In order to apply for an exemption from HMO enrollment, the recipient must contact the HMO specialist at their county Department of Social (or Human) Services.

Any services provided to the recipient by CSP providers before the effective date of the HMO exemption or disenrollment are not covered by the HMO or the WMAP. Claims submitted to EDS for these services will be denied.

Copayment

CSP and Clozapine Management services are exempt from recipient copayment.

A. COVERED CSP SERVICES

The CSP services indicated below are covered by the WMAP when prescribed by a physician. All CSP services billed to the WMAP must be identified in the treatment plan except for assessments and treatment planning, case management, and services which must be provided on an emergency basis. The treatment plan must be reviewed and signed by the CSP psychiatrist. Services are reimbursable by the WMAP only if the recipient's treatment plan is written and updated in accordance with the requirements of HSS 63.10(2).

When billing the WMAP, providers may include travel time necessary to provide services away from the CSP office and time spent documenting the services provided.

Telephone contacts are only billable when they involve a crisis intervention or emergency service or when they are specifically identified in the treatment plan as a necessary element of the recipient's treatment. For instance, if identified in the treatment plan, the CSP may bill for calling a recipient in the mornings for the first two weeks of a new job to make sure that the recipient is getting prepared for work and making appropriate plans for traveling to the job.

Each service is reimbursable only if provided by staff allowed to perform that service. Refer to Appendix 7 of this handbook for the qualification descriptions of CSP staff for each level of service. Within each service, separate procedure codes are defined for each of the appropriate levels of staff qualifications. See Appendix 4 of this handbook for a listing of procedure codes and allowable staff for each service. Please refer to Appendix 5 of this handbook for a list of the appropriate place of service codes for each service.

CSP Assessments and Treatment Planning
This service includes:

- Initial assessment
- In-depth assessment
- Treatment plan development and case review to evaluate and revise the current treatment program

The criteria for initial assessment, in-depth assessments, and treatment plans are listed in s. HSS 63.10, Wis. Adm. Code.

The WMAP will only cover services delivered to a recipient after he or she has been formally admitted to the CSP. Only one staff member can bill the WMAP for an assessment, treatment plan, or case review when multiple CSP staff are present.

The referring or prescribing physician must be indicated on all claims submitted for CSP assessment and treatment planning. This may be the CSP's psychiatrist.

CSP Transition to Community Living
Minimal CSP services may be provided to individuals who are inpatients in a hospital or nursing home. However, CSP services are not reimbursable when delivered to individuals 21-64 years of age who are in a hospital or nursing home designated as an institution for mental disease (IMDs). CSP Transition to Community Living procedure codes must be used to bill for any services provided to recipients who are hospital or nursing home inpatients. These services include:

1. Meetings with the recipient during a hospital or nursing home stay to maintain continuity of contact with the CSP treatment team and to evaluate the recipient's progress towards discharge.

A. COVERED CSP SERVICES (continued)

2. Meetings in the hospital or nursing home with the recipient to discuss plans for discharge.

3. Any other covered CSP services (including case management) performed with, or on behalf of, an institutionalized client by qualified CSP staff.

CSP Routine Psychiatric Services
This service includes:

1. Psychiatric evaluations performed by a psychiatrist.

2. Psychological evaluations performed by a psychologist.

3. Individual and family psychotherapy [as defined in s. HSS 101.03(145), Wis. Adm. Code].

CSP Medication Prescription and Administration
This service includes:

1. Prescription of medication related to the psychiatric illness by a psychiatrist.

2. Administration of medication related to the psychiatric illness.

3. Medication checks and evaluation of appropriateness of current medication regimen, including the monitoring of side effects.

4. Administration and assistance in taking other medications if the need for supervision is related to the person's mental illness (e.g., the recipient is not using insulin appropriately).

CSP medication prescription and administration may be billed only by psychiatrists and registered nurses. Medication administration may be billed by psychiatrists or registered nurses. Medication prescription may be billed only by psychiatrists. CSP staff cannot be paid for other medical procedures (e.g., changing dressings on a wound).

CSP Symptom Management or Supportive Psychotherapy
This service includes:

1. Ongoing monitoring of the recipient's mental illness symptoms and response to treatment.

2. Interventions with the recipient to help the recipient identify his or her mental illness symptoms.

3. Teaching of behavioral symptom management techniques to alleviate and manage symptoms not reduced by medication.

4. Assisting the recipient to adapt to and cope with internal and external stresses.

5. Face-to-face crisis intervention, including in-home or community care, to manage a recipient crisis. For example, in order to prevent hospitalization, a recipient who becomes acutely paranoid may need extensive staff supervision over a period of a number of days to ensure that the client does not harm him/herself or others.

6. Time spent in contact with a recipient via a 24-hour crisis line.

A. COVERED CSP SERVICES (continued)

CSP Case Management
This recipient-specific service includes:

1. Coordination efforts to ensure that required assessments, treatment plans, and case reviews involving other CSP staff and community agency staff occur as needed.

2. Coordination, follow up, and monitoring of referrals of the recipient to other community agencies.

3. Coordination of contracting for a specific recipient for specialized services (e.g., Alcohol and Other Drug Abuse [AODA] services which cannot be supplied by CSP staff).

4. Monitoring recipient's symptom status in order to determine the need for additional services or changes in the treatment plan.

5. Contact with other CSP staff which is necessary to ensure that the recipient's treatment plan is being properly implemented and services are coordinated within the program.

6. Coordinating the provision of emergency services during crisis periods. This is distinguished from CSP symptom management and supportive psychotherapy in that these services are not necessarily face-to-face. It is possible that more than one CSP staff may bill for a crisis intervention, with one providing face-to-face contact and one providing case management.

7. Advocating on behalf of the recipient for needed benefits and services other than legal advocacy (e.g., general relief, supplemental security income, housing subsidies, medical services, and food stamps).

8. Coordinating efforts to provide the support, consultation, and educational needs of the recipient's family or others in the support system (including efforts to provide information, education, and support).

The recipient's designated case manager may delegate some of these activities to other appropriate CSP staff. However, CSPs may not bill the WMAP for case management services performed by mental health technicians.

Advocacy or education that is not recipient specific is not covered by the WMAP.

CSP Employment Related Skill Training
This service includes:

1. Initial vocational and educational assessment.

2. Ongoing, on-site vocational assessment/evaluation/feedback sessions to identify symptoms or behaviors and to develop interventions with the recipient and employer that affect work.

3. Individual work-related symptom management.

4. On-the-job or work-related crisis intervention.

A. COVERED CSP SERVICES (continued)

5. Employment-related services, which are not job specific, to assist in gaining and utilizing skills necessary to undertake employment. This includes helping the recipient learn skills related to personal hygiene and grooming, securing appropriate clothing, wake-up services, and on-the-job supportive contacts. In addition, this includes assistance in helping the recipient to learn to arrange transportation.

Covered services are those which address the illness or symptom-related problems that the mental illness creates in securing and keeping a job.

CSP Psychosocial Rehabilitation
This service includes:

1. Individual interventions in social or recreational skill training to improve communication skills and facilitate appropriate interpersonal behavior.

2. Problem solving, support, and supervision related to activities of daily living to assist recipients to gain and utilize skills related to personal hygiene, household tasks, transportation utilization, and money management.

3. Accompanying the recipient to appointments in order to assist in gaining necessary services including:

   - medical and dental care
   - legal services
   - transportation services
   - living accommodation

The CSP may bill the WMAP for accompanying a recipient to an appointment only when:

- the services of a CSP provider are needed in order for the recipient to gain access to the services because of the recipient's psychiatric symptomatology; and

- the need for staff to accompany the recipient is identified in the recipient's treatment plan.

These services differ from CSP case management services since CSP staff will accompany the recipient to appointments for arranging these services (e.g., if a CSP staff member accompanies a recipient to the housing authority).

CSP Group Therapy
This service includes:

1. Psychotherapy groups as performed by a psychiatrist, psychologist, or master's level provider. The goals of the group must be consistent with the definition of psychotherapy in s. HSS 101.03(145), Wis. Adm. Code.

2. Medication education groups provided by an M.D. or R.N. focusing on educating clients about the role of and effects of medications in treating symptoms of mental illness. These groups must not be used solely for the purpose of group prescriptioı writing.

3. Employment related groups to focus on symptom management on-the-job, anxiety reduction, and education about appropriate job-related behaviors.

A. COVERED CSP SERVICES (continued)

4. Groups that offer specific skill training in communication, interpersonal skills, or parenting when these groups are identified in the treatment plan for the purpose of improving specific skills which are identified in the assessment as being inadequate.

5. Symptom management groups as performed by an M.D., Ph.D., master's level, or CSP professional. The goals of the group should be consistent with CSP symptom management or supportive psychotherapy.

NOTE: A group is defined as two to ten clients, at least one of whom is a recipient, who are concurrently receiving a service which is identified in this section as group therapy. The service must be specified in the recipient's treatment plan. No more than two CSP staff may bill the WMAP for services provided to the same group of recipients. If two CSP staff bill for recipients in the same group session, they must each bill for different recipients.

B. PLACE OF SERVICE

CSP services may be provided in a variety of settings. All services can be delivered at the CSP office, an outpatient hospital setting, the recipient's home, or other places of service (e.g., recipient's job site, a social security office, grocery store). In addition, transition to community living services may also be delivered at the hospital or nursing home where the recipient is residing. Refer to Appendix 5 of this handbook for a list of the allowable place of service codes for each service.

C. NON-CSP MENTAL HEALTH AND AODA SERVICES

The WMAP does not allow reimbursement for any other outpatient mental health services while a recipient is receiving WMAP reimbursed CSP services. This includes Medical Assistance case management and medical day treatment services. CSPs, as part of their case management function, should monitor the use of other outpatient mental health services by their clients. However, the WMAP allows reimbursement to providers for AODA services provided while a recipient is receiving CSP services.

D. CONTRACTING SERVICES

CSP standards are designed to encourage development of a comprehensive and integrated service delivery system. It is recognized, however, that there may be times when clients have specialized treatment needs that cannot be addressed by the CSP staff. In these cases, the CSP may contract with other qualified providers to deliver services. Contracting is appropriate only for psychiatric or psychotherapy services with a psychologist or Medical Assistance-certifiable psychotherapist in two situations: 1) When the recipient has an established relationship with the independent provider and it would be harmful to the recipient to terminate this relationship; or 2) When the recipient has highly specialized treatment needs (e.g., sexual abuse) which are not required to be provided by the CSP under HSS 63, Wis. Adm. Code. These services must meet the criteria for Routine Psychiatric Services or CSP Medication Prescription and Administration as defined in this section of the handbook. The service must be billed by the CSP.

Psychiatric or psychotherapy services may only be separately billed by non-CSP providers for CSP recipients when they are provided as professional services to recipients who are inpatients in a hospital or nursing home.

When the CSP is contracting with an independent psychotherapy provider, the recipient's medical record must justify the need to contract for the services. The recipient's CSP treatment plan must reflect how these services are integrated with the recipient's overall treatment, including how the independent therapist is involved in treatment planning and review. Additionally, the recipient's record must have copies of progress notes from the independent provider to document the services billed through the CSP. The CSP is responsible for insuring the adequacy and quality of these services.

E. DOCUMENTATION

The recipient's medical record must contain copies of assessments and treatment plans required under HSS 63 and updated according to these standards. The record must have signed and dated notes for all services billed to the WMAP (including those provided by any contracted therapist). The notes must contain sufficient documentation showing that:

- The service provided meets the criteria for the billable services as described in this section;
- The service was provided by the level of professional for which the billing occurred (e.g., CSP professional, Masters);
- The amount of service time reflects the time billed, including any allowed travel time:
- The service is one which is identified in the treatment plan (or is one of the services exempt from this requirement as outlined at the beginning of this section; and
- The service was provided on the billed date.

All notes must be signed by the provider who delivered the service and received reimbursement. For instance, if a CSP professional, a master's level clinical coordinator, and the CSP psychiatrist attended the treatment planning session and the procedure code appropriate for the psychiatrist was billed, then the progress note documenting the meeting must be signed by the psychiatrist, even if another staff member writes the note.

F. NONCOVERED CSP SERVICES

The following services are not covered benefits of the WMAP:

1. CSP services provided to State-contracted HMO enrollees;
2. Recreational therapy (activities which are primarily social or recreational in nature, such as attending a baseball game);
3. CSP services performed by volunteers;
4. Job-specific interventions, job training and job placement services (helping the recipient develop a resume, applying for a job, and job training or coaching);
5. Advocacy which is not client specific;
6. Staff performance of household tasks and chores, such as laundering clothes, housekeeping, and grocery shopping;
7. Time spent "on call" when not delivering services to a client; and
8. Outreach services to potential clients.

G. CLOZAPINE MANAGEMENT SERVICES

Introduction

Clozapine Management is a specialized care management service which may be required to ensure the safety of recipients who are using the psychoactive medication Clozapine. WMAP-certified CSPs may be separately reimbursed by the WMAP for Clozapine Management services provided to Medical Assistance recipients.

G. CLOZAPINE MANAGEMENT SERVICES (continued)

CSPs are not required to bill the care management services for recipients on Clozapine as Clozapine Management. All of the Clozapine Management services described in this section of the handbook may be billed as CSP services when provided and billed in accordance with CSP policy described in Section II-A of this handbook.

For instance, making sure the recipient receives their medication appropriately or discontinues medications if ordered by the physician can be billed as CSP Medication Administration and Management. Making sure that test results are reported to the pharmacy or physician, as appropriate, may be billed as CSP case management. CSPs may bill for these services as CSP services if they are identified in the treatment plan and are provided by allowable staff, as described in Section II-A of this handbook. When these services are billed as CSP services they are not subject to prior authorization. However, the county is reimbursed under the CSP Terms of Reimbursement which means that they receive only the federal share of the allowable reimbursement. When the services are billed as Clozapine Management, the CSP is reimbursed the full contracted rate as described below.

Conditions for Coverage of Clozapine Management
Clozapine Management is covered when all of the following conditions are met:

1. A physician prescribes the Clozapine Management services in writing. Although separate prescriptions are not required for Clozapine and Clozapine Management, the Clozapine Management service must be identified as a separately prescribed service from the drug itself.

2. The recipient is currently taking or has taken Clozapine within the past four weeks.

3. The recipient resides in a community-based (non-hospital or nursing home) setting.

4. The pharmacy dispensing Clozapine obtains prior authorization from the WMAP for reimbursement for Clozapine.

5. The CSP obtains prior authorization for Clozapine Management from the WMAP.

Refer to Section III of this handbook for information on prior authorization for Clozapine Management and to Section IV for billing information.

Components of Clozapine Management Services
The following components are part of the Clozapine Management service:

1. Ensure that the recipient has the required weekly white blood count testing. The provider may draw the blood or transport the recipient to a clinic, hospital, or laboratory to have the blood drawn, if necessary. The provider may travel to the recipient's residence, or other places in the community where the recipient is available, to perform this service, if necessary.

   The provider's transportation to and from the recipient's home or other community location to carry out any of the required services listed here are considered part of the weekly capitation payment for Clozapine Management.

2. Ensure that the blood test results are reported to the pharmacy dispensing the recipient's Clozapine in a timely fashion.

G. CLOZAPINE MANAGEMENT SERVICES (continued)

3. Ensure that abnormal blood test results are reported to the physician who prescribed the recipient's Clozapine.

4. Ensure that the recipient receives medications as scheduled, ensure that the recipient stops taking medication when blood test is abnormal, if so ordered by the physician, and receives any physician-prescribed follow-up care to ensure that the recipient's physical and mental well-being are maintained.

5. Make arrangements for the transition and coordination of the use of Clozapine and Clozapine Management services between different care locations.

6. Maintain records as described below.

Recordkeeping Requirements for Clozapine Management
The Clozapine Management records must be kept with the recipient's CSP record and must be clearly identified. This record must contain:

1. A face sheet identifying the recipient, to include the following information:

   - recipient's Medical Assistance identification number;
   - recipient's name;
   - recipient's current address;
   - recipient's psychiatric diagnosis;
   - name, address and telephone number of the physician prescribing Clozapine;
   - name, address and telephone number of the primary medical provider (if different than the prescribing physician);
   - name, address and telephone number of the pharmacy from which the recipient is receiving Clozapine;
   - address and telephone number of other locations at which the client may be receiving blood draw and at which the client may be located on a regular basis.

   The CSP face sheet may be used for this purpose if it contains all the information specified.

2. The CSP treatment plan must have a separate problem part indicating the manner in which the provider ensures that the covered services are provided (e.g., the plan indicates where and when blood will be drawn, whether the recipient will pick up medications at the pharmacy or whether they will be delivered by the provider). The plan should also specify signs or symptoms that might be associated with medical conditions resulting from side effects of the drug, or other signs or symptoms related to the recipient's mental illness, which should be reported to a qualified medical professional. The plan should indicate health care professionals responsible for oversight of the Clozapine Management services and indicate how often they will see the recipient. The plan should be reviewed every six months in accordance with the usual standards for CSPs.

3. Copies of all prior authorization requests for Clozapine and Clozapine Management.

G. CLOZAPINE MANAGEMENT SERVICES (continued)

4. Copies of physician's prescriptions for Clozapine and Clozapine Management.

5. Copies of laboratory results of white blood cell counts.

6. Signed and dated notes documenting all Clozapine Management services. The date of all blood draws should be indicated as well as who performed the blood draw. If the provider had to travel to provide services, the travel time should be indicated. Services provided to ensure that recipient received medically necessary care following an abnormal white blood cell count must be documented. The CSP should document the Clozapine Management services in the CSP record chronologically along with documentation of other CSP services. The Clozapine Management notes should be highlighted in a manner which makes them easily identifiable (i.e., a hand stamp).

H. NONCOVERED CLOZAPINE MANAGEMENT SERVICES

The following are not covered as Clozapine Management services:

1. Clozapine Management for recipients not authorized by the WMAP to receive Clozapine.

2. Clozapine Management which has not been prior authorized.

3. Clozapine Management for recipients residing in a nursing home or hospital on the date of service.

4. Care coordination, medical services or provider transportation not related to the recipient's use of Clozapine.

5. Recipient transportation costs to receive any WMAP reimbursed services. Recipient transportation to a physician's office or pharmacy is reimbursed in accordance with sec. HSS 107.23, Wis. Adm. Code. Such transportation, when provided by a specialized medical vehicle, is not covered unless the recipient has a disability which requires personal assistance in ambulating or the use of mechanical aids, such as a wheelchair or crutches. Recipient transportation by common carrier must be approved and paid for by the county agency responsible for Medical Assistance transportation services.

6. The performance of the white blood cell count. The white blood cell count must be performed and billed by a WMAP-certified laboratory in order to be reimbursed by the WMAP.

I. CLOZAPINE MANAGEMENT VERSUS CSP SERVICES

CSPs which provide Clozapine Management services must be extremely careful not to double bill the WMAP for services. This may happen when the CSP provides Clozapine Management services during the same encounter as when they provide WMAP allowable CSP services. In these cases, the CSP must document the amount of time that was spent on the CSP billable service separate from the time spent on the Clozapine Management service.

If the CSP staff travels to the recipient's home to perform Clozapine Management related services (e.g., transport the recipient to receive their weekly blood draw or draw the blood for the weekly white blood cell count), the CSP may <u>not</u> bill the WMAP for CSP-related travel time even if the CSP staff performed other CSP billable services during this visit (i.e., adult daily living skill training). In these cases, reimbursement for travel time is assumed to be included in the weekly reimbursement for Clozapine Management.

I. CLOZAPINE MANAGEMENT VERSUS CSP SERVICES (continued)

Ensuring that the recipient takes Clozapine as scheduled is also considered a Clozapine Management function and, therefore, should not be billable as a CSP service. Regular psychiatric medication management visits which are not exclusively related to Clozapine are not considered a part of the Clozapine Management service and may, therefore, be billed as a CSP service. CSPs are advised to make sure that coordination functions related to Clozapine Management are not billed as CSP case management. Although CSPs must not bill Clozapine Management related services as CSP services, these services must still be identified in the recipient's treatment plan.

A. CSP SERVICES

Community Support Program (CSP) services do not require prior authorization and do not count towards the $500/15 hour prior authorization threshold for mental health and Alcohol and Other Drug Abuse (AODA) services.

B. CLOZAPINE MANAGEMENT SERVICES

Requesting Prior Authorization for Clozapine Management
All Clozapine Management services must be prior authorized by the WMAP. The same Prior Authorization Clozapine Attachment (PA/CZA) may be used for requesting prior authorization for both Clozapine and Clozapine Management.

The CSP requesting Clozapine Management must obtain a copy of the PA/CZA which was used in requesting prior authorization for Clozapine and attach this to a Prior Authorization Request Form (PA/RF) for Clozapine Management. The prior authorization requests for Clozapine and Clozapine Management should be submitted together to EDS. A sample PA/RF for Clozapine Management is found in Appendix 9 of this handbook. Prescription orders dated within two months must accompany prior authorization requests.

Refer to Appendix 11 of this handbook for a sample PA/CZA, and to Appendix 10 for PA/CZA completion instructions.

Authorization Criteria
Clozapine Management is approved when requested if the recipient is approved for use of the drug and the recipient does not reside in a nursing facility. Clozapine is deemed appropriate for an individual with an ICD-9-CM diagnosis of 295.10-295.95, who has a documented history of failure of at least two psychotropic drugs. Lithium Carbonate should not be considered one of the two failed drugs. Failure includes:

- no improvement in functioning level;
- continuation of positive symptoms (hallucinations or delusions);
- severe side effects;
- tardive dyskinesia/dystonia.

The provider must fully complete the PA/CZA. Authorization is for a period of up to six months.

A. OTHER THIRD PARTY LIABILITY (TPL) COVERAGE

The Wisconsin Medical Assistance Program (WMAP) is the payer of last resort for any service covered by the WMAP. If the recipient is covered under third party insurance, the WMAP reimburses that portion of the allowable cost remaining after all other third party sources have been exhausted. Refer to Section IX-D of Part A of the WMAP Provider Handbook for more detailed information on services requiring third party billing, exceptions, and the "Other Insurance Discrepancy Report."

B. MEDICARE/ MEDICAL ASSISTANCE DUAL ENTITLEMENT

Recipients covered under both Medicare and Medical Assistance are referred to as dual-entitlees. Claims for Medicare covered services provided to dual-entitlees must be billed to Medicare prior to billing the WMAP. However, Community Support Programs (CSPs) are not a Medicare-covered service, and thus billing Medicare for dual entitlees is not required. A Medicare disclaimer code must be indicated on the claim if the recipient's Medical Assistance identification card indicates Medicare coverage. Refer to Appendix 1 of this handbook for detailed claim form instructions.

C. BILLED AMOUNTS

Providers must bill the WMAP their usual and customary charges for the actual number of hours of services provided, that charge being the amount charged by the provider for the same service when provided to private pay patients. Providers who do not have a usual and customary charge must bill the WMAP the estimated cost for services provided.

For providers using a sliding fee scale for specific services, usual and customary means the median of the individual provider's charge for the service when provided to non-Medical Assistance patients. Providers may not discriminate against Medical Assistance recipients by charging a higher fee for the service than is charged to a private pay patient.

Providers should refer to Appendix 1 of this handbook for complete billing instructions.

D. BILLING INCREMENTS

The CSP should bill in hourly units. CSPs may bill in one-tenth hour increments or round to the nearest half hour.

When a CSP is rounding to the nearest half hour and provides more than one service to a Medical Assistance recipient during a single encounter, the provider may bill for the total time, coding each 1/2 hour increment according to the service provided. If the time spent on various services provided are in less than 1/2 hour increments, the provider should bill the entire time to the service which is predominant.

Example: If a CSP professional spends one hour with a client, 1/2 hour of which is psychosocial rehabilitation and 1/2 hour of which is symptom management, the provider should bill as follows:

.5 Psychosocial rehabilitation (procedure code W8273)
.5 Symptom management (procedure code W8243)

Example: If a CSP professional spends 1/2 hour with a client, of which 10 minutes is employment related skill training, 15 minutes is psychosocial rehabilitation, and 5 minutes is symptom management, the provider should bill as follows:

.5 Psychosocial rehabilitation (procedure code W8273)

If a provider bills in one-tenth hour increments, each procedure should be billed separately.

E. CLOZAPINE MANAGEMENT

Providers must bill a quantity of "1" in element 24G of the HCFA 1500 claim form for each week of Clozapine Management services, regardless of the actual number of services provided. All claims for Clozapine Management must have the prior authorization number indicated in element 23 of the HCFA 1500 claim form. The date of service indicated in element 24a must be the last day of the calendar week on which service was actually provided.

F. CLAIM SUBMISSION

Paper Claim Submission

CSP and Clozapine Management services must be submitted using the National HCFA 1500 claim form. Sample claim forms and completion instructions can be found in Appendices 1 and 2 of this handbook.

CSP and Clozapine Management services submitted on any other form than the National HCFA 1500 claim form are denied.

The National HCFA 1500 claim form is not provided by the WMAP or EDS. It may be obtained from a number of forms suppliers. One such source is:

State Medical Society Services
Post Office Box 1109
Madison, WI 53701
(608) 257-6781 (Madison area)
1-800-362-9080 (toll-free)

Completed claims submitted for payment must be mailed to the following address:

EDS
6406 Bridge Road
Madison, WI 53784-0002

Paperless Claim Submission

As an alternative to submission of paper claims, EDS is able to process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted electronically have the same legal requirements as claims submitted on paper and are subjected to the same processing requirements as paper claims. Providers submitting electronically can reduce their claim submission errors. Free software and consultation services are provided. Additional information on alternative claim submission is available by contacting:

EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

Submission of Claims

All claims for services rendered to eligible WMAP recipients must be received by EDS within 365 days from the date the service was rendered. Claims for coinsurance and deductible for services rendered to recipients covered by both Medicare and Medical Assistance must be received by EDS within 365 days from the date of service, *or* within 90 days from the Medicare EOMB date, whichever is later. (Refer to Section IX of Part A of the WMAP Provider Handbook for exceptions to the 90-day extension.) This policy applies to all initial claim submissions, resubmissions, and adjustment requests.

G. DIAGNOSIS CODES

All CSP claims must have a primary diagnosis of one of the ICD-9-CM (International Classification of Diseases, 9th Edition, Clinical Modifications) codes listed in Appendix 3 of this handbook. Claims received without an allowable ICD-9-CM code as the primary diagnosis are denied.

The complete ICD-9-CM code book can be ordered from:

ICD-9-CM
Post Office Box 991
Ann Arbor, MI 48106

H. PROCEDURE CODES

HCFA Common Procedure Coding System (HCPCS) codes are required on all CSP claims. Claims or adjustments received without HCPCS codes are denied. Allowable HCPCS codes for CSP are included in Appendix 4 of this handbook.

I. FOLLOW-UP TO CLAIM SUBMISSION

It is the responsibility of the provider to initiate follow-up procedures on claims submitted to EDS. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Providers are advised that EDS will take no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to EDS. Section X of Part A of the WMAP Provider Handbook includes detailed information regarding:

- the Remittance and Status Report
- adjustments to paid claims
- return of overpayments
- duplicate payments
- denied claims
- Good Faith claims filing procedures