

# Comprehensive Community Services (CCS)— Frequently Asked Questions

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## Provider Approval, Certification, and Enrollment

- 1. Once a CCS program receives approval from the Division of Mental Health and Substance Abuse Services (DMHSAS) and certification from the Division of Quality Assurance (DQA), how long will it take to become enrolled as a Medicaid provider?**

Once a CCS program has received approval and certification from DMHSAS and DQA, respectively, the program must be enrolled in Wisconsin Medicaid at [www.forwardhealth.wi.gov](http://www.forwardhealth.wi.gov). Medicaid enrollment can take up to 10 business days to process. If additional information is needed from the provider, it may take longer. As noted on page 3 of the June 2014 *ForwardHealth Update* (2014-42) titled, “Changes to the Comprehensive Community Services Benefit as a Result of the Wisconsin 2013-15 Biennial Budget,” the earliest possible effective date for Medicaid enrollment is the DQA certification date.

- 2. What steps does a CCS program need to take to create a taxonomy code?**

Wisconsin Medicaid’s fiscal agent, HP Enterprise Services, will work with new and existing CCS programs if there are questions about the taxonomy needed for CCS enrollment. Providers can review a list of taxonomies at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Taxonomy.html>.

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### **3. Does a CCS program that already has DQA certification need to complete a new DQA application for CCS regional expansion, or is the certification currently on file sufficient?**

DQA certification requirements for the CCS regional expansion are determined by the type of regional model and current certification status. If all of the counties/tribe(s) are DQA-certified CCS programs and in a Shared Services Model or Population Based Model, they will not have to apply again for certification. CCS programs currently DQA-certified in a Shared Services Model or Population Based Model will need to submit the letter of approval for the region from DMHSAS to DQA.

DQA's receipt of the DMHSAS approval letter will prompt DQA to provide the region with a "triage" letter identifying information needed to transition from a single county to a regional model. The letter will request a revised CCS plan to reflect implementation of regionalization. The assigned DQA surveyor will review the approval letter, the revised CCS plan, and information previously submitted to the Department of Health Services (DHS). The assigned surveyor may request additional information. Upon completion of the DQA review, a new program certificate will be issued indicating regional approval and the regional model type. For counties/tribes that are not currently DQA-certified CCS programs and part of a Shared Services Model or Population Based Model, an initial program certification application packet is required [refer to DQA publication P-00664, Comprehensive Community Services (CCS) Expansion: DQA Regional Model Review].

If the counties/tribe(s) are DQA-certified CCS programs but will be implementing a Multi-County Model, the counties/tribe(s) will need to reapply for certification because the certification needs to cover all counties/tribes in the region. Likewise, if the counties/tribe(s) are not currently DQA-certified CCS programs, an initial program certification application packet is required [refer to DQA publication P-00664].

## **Member Eligibility**

### **1. Does an individual have to be Medicaid eligible to receive CCS?**

No. [DHS Chapter 36](#), Wisconsin Administrative Code, does not require an individual to be Medicaid eligible to receive CCS services. Any individual who meets the CCS program eligibility requirements can participate in CCS. However, in order for Medicaid to reimburse for CCS services, the CCS member must be Medicaid eligible.

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### **2. Which Medicaid and BadgerCare Plus members are eligible for CCS?**

As noted on page 4 of *Update 2014-42*, all members enrolled in Medicaid or BadgerCare Plus programs are eligible for CCS enrollment as long as they meet the requirements for enrollment in CCS under [DHS Chapter 36](#), Wisconsin Administrative Code. However, it is important to note that the CCS program is not currently available to Wraparound Milwaukee members who receive services under the Medicaid Managed Care Benefit for Wraparound Milwaukee.

All services provided under the CCS benefit are reimbursed fee-for-service regardless of whether the member is enrolled in a BadgerCare Plus HMO, a Medicaid Supplemental Security Income (SSI) HMO, or a special managed care program including Family Care, the Program of All-Inclusive Care for the Elderly (PACE), and the Family Care Partnership Program.

### **3. What functional screen should a CCS program use for determining CCS eligibility for individuals of different ages?**

The Mental Health/Alcohol and Other Drug Abuse Functional Screen is used for individuals who are 18 years of age or older. The Children’s Long-Term Supports Functional Screen is used for children starting at birth through young adulthood (age 22). At this time, either screen may be used for individuals between 18 and 21 years of age.

### **4. Can a Medicaid or BadgerCare Plus member be enrolled in CCS and Family Care, or CCS and Family Care Partnership, or CCS and Include, Respect, I Self-Direct (IRIS) programs? How does the billing work when individuals are enrolled in multiple programs?**

As noted on page 4 of *Update 2014-42*, “[m]embers enrolled in the Medicaid or BadgerCare Plus programs are eligible for CCS enrollment. All services provided under the CCS benefit are reimbursed fee-for-service regardless of whether the member is enrolled in a BadgerCare Plus HMO, a Medicaid Supplemental Security Income (SSI) HMO, or a special managed care program including Family Care, the Program of All-Inclusive Care for the Elderly (PACE), and the Family Care Partnership Program.” Individuals in the IRIS program can also be in CCS. Since the programs are all distinct, counties/tribes should follow the billing procedures for each program.

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- 5. Does CCS provide developmental disability services? Is a person eligible for CCS if he or she only has a developmental disability?**

No. CCS does not provide developmental disability services. As noted on page 6 of *Update 2014-42*, developmental disability services are not covered by CCS. To be eligible for CCS, an individual must meet the requirements for enrollment in CCS under [DHS Chapter 36](#), Wisconsin Administrative Code. Individuals are not eligible for CCS based on their developmental disability. CCS is for individuals with mental health and/or substance abuse issues.

- 6. Can a Medicaid or BadgerCare Plus member be in both CCS and the Wraparound Milwaukee program?**

The CCS program is not currently available to Wraparound Milwaukee members who receive services under the Medicaid Managed Care Benefit for Wraparound Milwaukee. Wraparound Milwaukee includes case management as a covered service and, as a result, additional care coordination may not be billed separately at the same time through Medicaid. In addition, there are different enrollment criteria for Wraparound Milwaukee.

- 7. If a member who is interested in enrolling in CCS has an HMO attached to their Medicaid benefit, is exemption paperwork necessary?**

HMO exemption paperwork should not be filed in order to enroll members in CCS. CCS services are not covered by the HMOs, but are covered through ForwardHealth fee-for-service. This means the CCS programs must submit claims directly to ForwardHealth regardless of whether the member is enrolled in a managed care benefit or not.

### **Program and Service Delivery**

- 1. Do DQA-certified CCS programs have to do Person Centered Planning (PCP) in CCS?**

The CCS program is a recovery model which uses a person-centered planning approach. [DHS 36.16](#) and [36.17](#), Wisconsin Administrative Code, discuss how the CCS member should be involved in the assessment and service planning and delivery. Fidelity to the CCS program should include a PCP approach.

- 2. When should an individual be admitted to the CCS program? Does functional eligibility mean automatic enrollment in the CCS program?**

According to DHS 36.14, Wisconsin Administrative Code:

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Psychosocial rehabilitation services shall be available to individuals who are determined to require more than outpatient counseling but less than the services provided by a community support program under s. 51.421, Stats., and ch. DHS 63, as a result of a department-approved functional screen and meet all of the following criteria: **(1)** Has a diagnosis of a mental disorder or a substance use disorder. **(2)** Has a functional impairment that interferes with or limits one or more major life activities and results in needs for services that are described as ongoing, comprehensive and either high-intensity or low-intensity. Determination of a qualifying functional impairment is dependent upon whether the applicant meets one of the following descriptions: **(a)** ‘Group 1’. Persons in this group include children and adults in need of ongoing, high-intensity, comprehensive services who have diagnoses of a major mental disorder or substance-use disorder, and substantial needs for psychiatric, substance abuse, or addiction treatment. **(b)** ‘Group 2’. Persons in this group include children and adults in need of ongoing, low-intensity comprehensive services who have a diagnosed mental or substance-use disorder. These individuals generally function in a fairly independent and stable manner but may occasionally experience acute psychiatric crises.

Functional eligibility does not mean automatic enrollment in CCS. Once an individual is determined to be functionally eligible for CCS, the CCS program must complete an assessment of the individual to determine if the CCS program is appropriate. DHS 36.14(3)(c), Wisconsin Administrative Code, states, “If an applicant is determined to need psychosocial rehabilitation services, a comprehensive assessment shall be conducted....”

### **3. Under what circumstances may a CCS program deny CCS services to an individual?**

A CCS program may deny CCS services if the applicant is determined to not need psychosocial services or if it is determined that another program is more appropriate. An individual’s decision to participate in the program is always voluntary. Under DHS 36.14(3), Wisconsin Administrative Code, “if an applicant is determined to not need psychosocial rehabilitation services....The applicant shall be given written notice of the determination and referred to a non-CCS program. The applicant may submit a written request for a review of the determination to the department.”

DQA-certified CCS programs are able to limit enrollment in CCS to individuals with Medicaid only or, if serving those without Medicaid, up to their ability to financially provide services.

### **4. If a CCS region is using a Shared Services Model, can the program maintain individual, local CCS coordination committees as required by [DHS 36.09](#), Wisconsin**

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**Administrative Code, in each of the counties/tribe(s) to assist with access to services while also creating a larger CCS consumer committee with representatives from each county/tribe?**

Yes. In a Shared Services Model, it is the region's option to have both a local and a shared coordination committee. A shared coordination committee, by itself, is insufficient as each county/tribe must have a coordination committee. CCS programs are required to describe the coordination committee structure and function when applying for DMHSAS approval.

**5. Does DHS have any templates or suggestions for the assessment and progress note forms?**

DHS does not usually make recommendations on forms. At this time, DHS does not share or offer recommended tools other than those identified as components of evidence-based practices or that are required.

**6. A CCS program is required to complete the Mental Health/Alcohol and Other Drug Abuse Functional Screen on a yearly basis. Is the yearly requirement based on the actual date of the screen or the month of the screen? For example, if a screen was completed on March 3, 2013, is the CCS program required to complete the next screen by March 3, 2014, or March 31, 2014?**

The yearly requirement for screening is based on the month of the screen. In the example provided in the question, the yearly screen would need to be completed by March 31, 2014.

**7. Is medication monitoring billable under the CCS Service Array?**

CCS Service Array category #5 describes "Medication Management" and the types of medication management services that are covered by CCS. Medication management includes "monitoring changes in the member's symptoms and tolerability of side effects" and "supporting the member in taking his or her medications." CCS does not cover solely the dispensing and delivering of prescription drugs.

**8. When a service facilitator provides medication management, should the service be claimed on the CCS Service Array under service facilitation or medication management?**

Services should be claimed based on the service provided as described in the CCS Service Array. Services should not be claimed based on the type of staff providing the service. If staff is providing medication management, this would be claimed under CCS Service Array

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category #5 titled, “Medication Management.” If staff is providing service facilitation, this would be claimed under CCS Service Array category #3 titled, “Service Facilitation.” Providers must claim reimbursement by noting the appropriate professional level modifier for the staff providing the service.

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**9. Does a CCS program need to try all traditional services allowed under the CCS Service Array before trying non-traditional services?**

No, the CCS program needs only to try those traditional services that are potentially effective based on the member's assessment. If traditional services do not meet the needs of the CCS individual based on his or her assessment, then a non-traditional service may be considered to meet the individual's particular need(s). The assessment process provides information about the individual's need(s) and potential effective interventions. Prior to providing any non-traditional services, the CCS provider is required to complete and submit the Comprehensive Community Services/Non-Traditional Services Approval form, F-01270, to obtain approval. The form can be found at <http://www.dhs.wisconsin.gov/forms/F-0.asp>.

**10. Can a CCS program bill Medicaid for crisis services when an individual has not yet been admitted to the CCS program?**

As noted on page 6 of *Update 2014-42*, "The CCS program can coordinate a member's crisis services, but cannot actually provide crisis services." To qualify for Medicaid reimbursement, crisis services must be provided by Medicaid-enrolled providers. Medicaid reimbursement can only be claimed for Medicaid-enrolled individuals.

For those CCS programs that coordinate a member's crisis services, the program should bill for service facilitation (category #3 on the CCS Service Array). All other guidelines regarding the provision of CCS services would apply (member eligibility, provider type, documentation, etc.).

**11. How will providers be reimbursed for "diligent outreach efforts" to try and keep a member from being discharged from CCS under the guidelines in [DHS 36.17\(5\)](#), Wisconsin Administrative Code?**

For Medicaid-enrolled members, providers are only reimbursed for CCS services on the CCS Service Array that are authorized and in the member's CCS service plan.

**12. What is the anticipated length of stay in the CCS program, and how should individuals be transitioned out of CCS?**

There is no time limit in [DHS Chapter 36](#), Wisconsin Administrative Code, or Medicaid law for how long a member can be in CCS. According to DHS 36.17(5), Wisconsin Administrative Code:

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(5) DISCHARGE. (a) Discharge from the CCS shall be based on the discharge criteria in the service plan of the consumer unless any one of the following applies: **1.** The consumer no longer wants psychosocial rehabilitation services. **2.** The whereabouts of the consumer are unknown for at least 3 months despite diligent efforts to locate the consumer. **3.** The consumer refuses services from the CCS for at least 3 months despite diligent outreach efforts to engage the consumer. **4.** The consumer enters a long-term care facility for medical reasons and is unlikely to return to community living. **5.** The consumer is deceased. **6.** Psychosocial rehabilitation services are no longer needed.

After an individual is discharged from CCS, the individual should be supported as he or she transitions to services of less intensity that meet his or her needs. Services of less intensity are typically provided through outpatient treatment and/or targeted case management.

### **13. What training and credentialing do non-traditional service providers need?**

According to DHS 36.03(29), Wisconsin Administrative Code, a staff member “means a person employed by a county department, tribe, or contracted agency.” [DHS 36.12](#), Wisconsin Administrative Code, identifies specific training requirements for all staff. Non-traditional service providers must act within their scope of practice. Please see the Comprehensive Community Services/Non-Traditional Services Approval form, F-01270, for details on what information must be provided regarding non-traditional service providers. The form can be found at <http://www.dhs.wisconsin.gov/forms/F-0.asp>.

### **14. Update 2014-42 includes a provider type called “Other Provider Type.” When should that provider type be used?**

The “Other Provider Type” is for non-traditional service providers who don’t meet any of the other provider type criteria. See Attachments 4 and 5 in *Update 2014-42* for a list of provider types and criteria.

### **15. Can evidence-based practices (EBPs) be claimed? If so, under what service category should they be claimed?**

EBP’s are always encouraged. All services should be billed under the CCS Service Array category under which the service falls.

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### **16. For existing CCS participants, when must service plans be updated to account for the new CCS Service Array titles?**

According to DHS 36.17(3), Wisconsin Administrative Code, individual service plans “shall be reviewed and updated as the needs of the consumer change or at least every 6 months.” CCS programs can update the CCS Service Array titles when service plans are updated.

### **17. Does a psychiatrist need to sign the service plan?**

A psychiatrist does not need to sign the service plan.

DHS 36.15, Wisconsin Administrative Code, states:

(1) Before a service is provided to an applicant under s. DHS 36.13 (2) or 36.17, a mental health professional shall do all of the following: (a) Review and attest to the applicant’s need for psychosocial rehabilitation services and medical and supportive activities to address the desired recovery goals. (b) Assure that a statement authorizing the proposed psychosocial rehabilitation services under the standards set forth in par. (a) is provided and filed in the consumer service record. (2) If the applicant has or may have a substance-use disorder, a substance abuse professional shall also sign the authorization for services.

DHS 36.17(2m)(c), Wisconsin Administrative Code, states that “The completed service plan shall be signed by the consumer, a mental health or substance abuse professional and the service facilitator.” Mental health and substance abuse professionals are defined in [DHS 36.03](#), Wisconsin Administrative Code.

Please note that signing the service plan and providing a prescription for CCS are two separate requirements. The requirements for a CCS prescription are described in the Physician Prescription section of this FAQ document.

### **18. If an individual moves from one county/tribe to another in the CCS program, does the individual need a new functional screen and assessment?**

Per DMHSAS-defined CCS regional performance criteria, each regional CCS program, as a whole, is required to complete an initial and annual functional screen for each member enrolled in CCS:

- If the CCS region is a Shared Services Regional Model, the current CCS county will need to close the episode of care, and the new CCS county will need to complete a functional screen and open an episode of care.

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- If the CCS region is a Multi-County Regional Model, each county is under one CCS certification, and therefore a new functional screen will not need to be completed.
- If an individual is moving to a CCS county outside of the current CCS region, then the current CCS county will need to close the episode of care, and the new CCS county will need to complete a new functional screen and open an episode of care.

### **19. Can CCS programs look up individual histories and past Mental Health/Alcohol and Other Drug Abuse Functional Screens in the Program Participation System (PPS)?**

No. The functional screen and the PPS data systems are separate. However, past Mental Health/Alcohol and Other Drug Abuse Functional Screens can be viewed in the Functional Screen Information Access (FSIA) system. The FSIA system is where current functional screens are entered and past functional screens can be viewed. Go to <https://fsia.wisconsin.gov/#>, log in, and search for a past functional screen by member name and birth date.

### **20. How will the PPS allow reporting for a CCS region?**

Reporting as a region will be allowed starting in early 2015 after revisions to the PPS Mental Health (MH) data system are completed. Counties will have to request authorization through DHS to report PPS mental health data for a region. Once authorized, a single county may submit CCS data for multiple counties through its PPS MH system account. However, regions will still be required to identify which single county is responsible for each member served using a new data field that is being added to the PPS MH system. When these PPS MH data system revisions are completed, all CCS programs and counties will be notified.

### **21. Is medication delivery billable under the CCS Service Array?**

No. Medication delivery, as a stand-alone service, is not a covered and billable service in CCS. However, medication management, which may require travel, is a covered and billable service.

### **22. Does Medicaid pay for individuals to attend camps?**

Medicaid does not pay for individuals to attend camps. It will, however, reimburse for services on the CCS Service Array that are provided by CCS staff in a camp setting. All policy related to covered services, provider qualifications, and treatment documentation would still apply. Prior authorization is still required for any non-traditional services intended to be provided in a camp setting.

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### **23. Does all CCS staff need to be included on the on-site CCS staff roster, including contracted staff?**

Yes. DHS 36.03(29), Wisconsin Administrative Code, defines a staff member as “a person employed by a county department, tribe, or contracted agency.” Under [DHS 105.257](#) and [DHS Chapter 36](#), Wisconsin Administrative Code, DQA-certified CCS providers may provide services directly or may contract with other qualified providers to provide all or some of the CCS program.

### **24. What is the minimum level of education a substance abuse counselor has to have for CCS?**

According to [DHS 36.10\(2\)\(g\)\(16\)](#), Wisconsin Administrative Code, “Alcohol and drug abuse counselors shall be certified by the department of safety and professional services.” [Chapter SPS 161](#), Wisconsin Administrative Code, provides the educational requirements for certification as a clinical substance abuse counselor (CSAC), a substance abuse counselor (SAC), and a substance abuse counselor-in-training (SAC-T).

## **Physician Prescription**

### **1. CCS requires a current physician prescription to be on file at all times. What is considered a current physician prescription for CCS? Should the prescription be reviewed yearly? How detailed does the prescription have to be, and is there specific terminology that must be used?**

Under [Section 49.46\(2\)\(b\)6.Lm](#), Wisconsin Statutes, CCS requires a physician prescription. As indicated on page 5 of *Update 2014-42*, “Any individual seeking CCS must have a physician prescription to initiate services. The CCS provider must have a current prescription on file at all times.” A current prescription is one that has not expired. The physician will determine the expiration date for the prescription for each member. Each CCS program is responsible for establishing review timelines to ensure the prescription is updated prior to its expiration. As long as there is a non-expired prescription on file for each member, a CCS program is in compliance. There is no specific terminology that needs to be used on the prescription.

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- 2. For the purposes of meeting the CCS requirement of having a physician prescription, how is a physician defined?**

Under Section 49.43(9), Wisconsin Statutes, a physician “means a person licensed to practice medicine and surgery, and includes graduates of osteopathic colleges holding an unlimited license to practice medicine and surgery.” DHS 101.03(123), Wisconsin Administrative Code, expands on the definition. It states a physician “means a person licensed under ch. 448, Stats., to practice medicine and surgery, including a graduate of an osteopathic college who holds an unlimited license to practice medicine and surgery.”

- 3. Does the physician’s prescription need to be signed the day the DQA-certified CCS program starts claiming Medicaid reimbursement?**

The prescription must be signed on or before the first date of services claimed. For Medicaid, in order to claim reimbursement, a prescription must be signed and in the CCS member’s service record for the date services were provided.

### **Staff/Providers**

- 1. Where are the requirements for each provider type described?**

[DHS 36.10\(2\)\(g\)](#), Wisconsin Administrative Code, describes the qualifications for different provider types. Information is also included in *Update 2014-42*.

- 2. Can regional CCS programs utilize two people to fulfill the CCS Administrator function?**

Regardless of the regional model, a CCS program can allow multiple people to serve in a support role. It is possible for multiple management staff to provide support to the CCS program at a given time.

- 3. Can CCS staff/providers serve in multiple roles? For example, can a mental health and/or substance abuse professional also serve as the CCS Program Director? Can the CCS Program Director and the CCS Administrator be the same person?**

CCS staff/providers can serve in multiple roles as long as the staff/providers distinguish between the two functions and do not claim reimbursement for the same service hours in each role. Additionally, staff/providers must be qualified to perform each role, and the roles

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cannot be in conflict with each other. For example, the same person cannot provide a service while also being in charge of supervising the service.

**4. One of the professional level modifiers is Medical Doctor (M.D.). Does the M.D. modifier also include Doctors of Osteopathy (D.O.'s)?**

Yes, the M.D. modifier includes D.O.'s. Under Section 49.43(9), Wisconsin Statutes, a physician “means a person licensed to practice medicine and surgery, and includes graduates of osteopathic colleges holding an unlimited license to practice medicine and surgery.”

**5. One of the professional level modifiers is Doctor of Philosophy (Ph.D.). Does the Ph.D. modifier also include Doctors of Psychology (Psy.D.)?**

Yes, the Ph.D. modifier includes Psy.D.'s.

**6. What services can a peer specialist provide if the peer specialist is not certified?**

As noted on pages 17 and 21 of *Update 2014-42*, the CCS Service Array category #7 is “Peer Support.” Per *Update 2014-42*, peer support can only be provided by Certified Peer Specialists, and all peer specialists are required to be Wisconsin Certified Peer Specialists. Individuals who are not Wisconsin Certified Peer Specialists could potentially act as rehabilitation workers if they meet the requirements described in [DHS 36.10\(2\)\(g\)21](#), Wisconsin Administrative Code. Refer to the CCS Service Array for which services rehabilitation workers can provide.

If non-certified peer specialists also meet other provider type qualifications, they can provide any service on the CCS Service Array for which they are qualified. It is the responsibility of each CCS program to hire personnel that meet the qualifications and have competencies required of the position.

### **Documentation**

**1. Does the subcontracted providers' documentation need to be included in the records at the primary CCS office?**

Required service record documentation from all providers, including subcontractors, must be in a central location. DHS 36.18, Wisconsin Administrative Code, states, “The CCS shall maintain in a central location a service record for each consumer. Each record shall include sufficient information to demonstrate that the CCS has an accurate understanding of the

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consumer, the consumer’s needs, desired outcomes and progress toward goals.” DHS 36.18 describes all of the documentation that must be included in the member’s service record. Part of the service record includes the member’s CCS plan.

### 2. How long does a CCS program need to retain individual records?

As stated in the Record Retention topic (Topic #204) in the Comprehensive Community Services service area of the ForwardHealth Online Handbook, and as reflected in DHS 106.02(9), Wisconsin Administrative Code, “providers are required to retain documentation, including medical and financial records, for a period of not less than five years from the date of payment, except rural health clinics, which are required to retain records for a minimum of six years from the date of payment.” Per DHS 92.12, Wisconsin Administrative Code, records must be retained “for at least seven years after treatment has been completed, unless under this section they are to be retained for a longer period of time. In the case of a minor, records shall be retained until the person becomes 19 years of age or until seven years after treatment has been completed, whichever is longer....”

## Transportation and Travel Time

### 1. What types of travel and transportation are included in CCS?

CCS does not cover time spent solely to transport members. Members should use the Non-emergency Medical Transportation benefit for transportation services. However, CCS does cover services provided to a member while traveling with the member if those services are under the CCS Service Array.

If a provider is providing CCS services (as described in the CCS Service Array) to a member and happens to be in a car with him or her while providing services, then the provider would bill those services with place of service (POS) code 99, as noted on page 29 of *Update 2014-42*: “If staff in a CCS program is providing CCS covered services to a member while traveling with the member or attending a health appointment with the member, providers should use POS code 99.”

If a provider is traveling to a CCS member to provide CCS services, then the provider would use *Current Procedural Terminology* procedure code 99199 (Unlisted special service, procedure, or report) when submitting the claim. There is information about how to bill this time on pages 8-11 of *Update 2014-42*.

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- 2. Is time spent by a provider traveling to a CCS member to provide a CCS service reimbursable? If a member is not there and no services are provided, can the provider claim reimbursement for the travel time.**

In *Update 2014-42*, it states that time spent by a provider to travel to provide a CCS service to a member is reimbursable. Travel time must be submitted on the same claim as the professional service in order to be reimbursable. Therefore, a provider who travels to provide services to a member cannot claim reimbursement for the travel time if no services were provided because the member was not there.

### **Reimbursement**

- 1. Effective July 1, 2014, must CCS programs begin using the interim rates established by DHS and then do cost reconciliation after the end of each calendar year?**

Yes, CCS is using statewide interim rates for dates of service (DOS) on and after July 1, 2014. CCS will continue to complete cost settlements based on Medicaid-allowable costs.

- 2. Does a CCS program get reimbursed by Medicaid if it is later determined that an applicant does not need CCS services?**

CCS programs may be reimbursed by Medicaid for services provided to meet the immediate needs of an applicant up until the point it is determined that the applicant does not need psychosocial rehabilitation services or should receive these services through a different program. In order for services to be reimbursed, the following conditions must be met ([DHS 36.13](#), Wisconsin Administrative Code):

1. The member has a current physician prescription for psychosocial services.
2. The member seeking services has completed an application.
3. The applicant has signed an admission agreement.
4. An assessment of initial needs has been conducted as described in [DHS 36.14\(3\)\(a\)](#), Wisconsin Administrative Code.
5. A mental health professional has authorized services as evidenced by the signature of the mental health professional as required in DHS 36.15, Wisconsin Administrative Code.
6. The assessment of initial needs and the authorization for services have been documented.

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Medicaid will no longer pay for CCS services following the ineligible determination, as indicated under [DHS 36.14\(3\)\(b\)](#), Wisconsin Administrative Code: “If an applicant is determined to not need psychosocial rehabilitation services, no additional psychosocial rehabilitation services may be provided to the applicant by the CCS program. The applicant shall be given written notice of the determination and referred to a non-CCS program. The applicant may submit a written request for a review of the determination to the department.”

### **3. Can CCS regions contract with a third party to submit claims for reimbursement? Can the third-party contractor also provide services to CCS individuals?**

CCS regions may use a third party to submit CCS claims for reimbursement. The third-party biller should use the appropriate billing and rendering provider numbers for the region’s counties to facilitate the reconciliation process. The CCS region is still responsible for the accuracy of billable claims, regardless of who submits the claims. The third party may provide CCS services.

### **4. Can all providers bill during recovery team meetings?**

Yes. In order for a CCS provider to claim a service provided to a CCS member, the service must satisfy three criteria:

1. The service must be included in the service array found in Attachment 1 of *Update 2014-42*.
2. The service must be attributed to a specific CCS member.
3. The service must be documented as such.

Any eligible provider acting within the scope of his or her practice can bill for an allowable service under the CCS Program Service Array detailed in Attachment 1 of *Update 2014-42*. This includes a service attributed to a specific CCS member but provided in a setting with more than one provider present, such as a recovery team meeting. Documentation of the service provided must be maintained in the member’s record according to the documentation requirements detailed in Attachment 3 of *Update 2014-42*.

### **5. How does it work for data reporting and billing when you have a member who is in both CCS and a Coordinated Services Team (CST)?**

Since CST is not a Medicaid-reimbursed service, billing for a child who is in CCS and CST should occur as if the child was solely in the CCS program. Providers should follow the requirements for each program. Data reporting should occur in both programs. Providers should include the child on any CST data reporting in PPS for CCS reporting.

## **Comprehensive Community Services (CCS)— Frequently Asked Questions**

### **6. May providers claim reimbursement for documentation time?**

As noted on pages 8 and 10 of *Update* 2014-42, providers may submit interim claims for documentation time. Refer to the *Update* for more information about documentation time. Time spent on documentation should be noted in the member's record to provide justification for interim billing.

### **7. Will the new cost reconciliation tool for CCS be similar to the existing reconciliation tool, or will there be more detailed data elements required? As counties continue to develop CCS systems, they want to make sure that they are incorporating all of the data elements that will be needed for reconciliation.**

For DOS on and after July 1, 2014, the level of detail needed for CCS cost reconciliation will be consistent with the level of detail needed for the Wisconsin Medicaid Cost Reporting (WIMCR) reconciliation. The methodology used for CCS and WIMCR will be consistent, but CCS will continue to use a spreadsheet rather than the WIMCR Web tool in the near term. DHS is currently developing a Cost Reporting Manual that will be consistent with WIMCR methodologies. CCS programs will need to report direct costs by professional type, including CCS direct hours, CCS direct support hours, and non-CCS hours for each provider. This applies to CCS programs and their contracted staff.

### **8. As counties start and develop their CCS programs, how do counties ensure actual cost reconciliation when there is a potential for reduced productivity during the start-up phase?**

The CCS reconciliation process will continue to settle to the full cost-per-unit of service. If service units are low as the program begins, then we would expect the cost per unit to be higher to account for "direct support" and general overhead costs. It should be noted that while direct support and overhead costs may make up a higher than normal percentage of CCS costs during the start-up period, future CCS policies will use actual CCS data from across the state to set reasonable limits on non-service costs.

### **9. Can CCS regions have different rates for the same service in the CCS Service Array? For example, if a region has several counties/tribes with each one setting different, yet justifiable rates, should the CCS region claim reimbursement at each separate justifiable rate and then reconcile at the end of the year?**

Yes. The reconciliation process will account for rates that vary across the region because the reconciliation will account for the actual cost per unit.

## **Comprehensive Community Services (CCS)— Frequently Asked Questions**

### **10. Were the CCS Regional Trainings videotaped and, if so, when will they be available for counties to access?**

The trainings were videotaped. They can be accessed at <http://www.dhs.wisconsin.gov/ccs/expansion/index.htm>.

### **11. How do providers sign up to receive *ForwardHealth Updates* electronically?**

Following are the steps to sign up to receive *ForwardHealth Updates* electronically:

1. Go to [www.forwardhealth.wi.gov](http://www.forwardhealth.wi.gov).
2. On the top left-hand side of the home page, there is a section for providers. Click on the first link, which says “Register for E-mail Subscriptions.”
3. Fill in the information under “New Subscriber.”
4. Choose which subscriptions you want. If you just want CCS, choose that option.

### **12. Is medication monitoring billable under the CCS Service Array?**

CCS Service Array Category #5 describes “Medication Management” and the types of medication management services that are covered by CCS. Medication management includes “monitoring changes in the member’s symptoms and tolerability of side effects” and “supporting the member in taking his or her medications.” CCS does not cover solely the dispensing and delivering of prescription drugs.

### **13. When a service facilitator provides medication management, should the service be claimed on the CCS Service Array under service facilitation or medication management?**

Services should be claimed based on the service provided as described in the CCS Service Array. Services should not be claimed based on the type of staff providing the service. If staff is providing medication management, this would be claimed under CCS Service Array category #5 titled, “Medication Management.” If staff is providing service facilitation, this would be claimed under CCS Service Array category #3 titled, “Service Facilitation.” Providers must claim reimbursement by noting the appropriate professional level modifier for the staff providing the service.

## **Comprehensive Community Services (CCS)— Frequently Asked Questions**

### **14. Can a CCS program bill Medicaid for crisis services when an individual has not yet been admitted to the CCS program?**

As noted on page 6 of *Update 2014-42*, “The CCS program can coordinate a member’s crisis services, but cannot actually provide crisis services.” In order for crisis services to be reimbursed, they must be provided by Medicaid-enrolled providers. Medicaid reimbursement can only be claimed for Medicaid-enrolled individuals.

For those CCS programs that coordinate a member’s crisis services, the program should bill for service facilitation (category #3 on the CCS Service Array). All other guidelines regarding the provision of CCS services would apply (member eligibility, provider type, documentation, etc.).

### **15. How will providers be reimbursed for “diligent outreach efforts” to try and keep a member from being discharged from CCS under the guidelines in [DHS 36.17\(5\)](#), Wisconsin Administrative Code?**

For Medicaid-enrolled members, providers are only reimbursed for CCS services on the CCS Service Array that are authorized and in the member’s CCS service plan.

### **16. Does the establishment of statewide interim rates mean there is a limit on the per-unit cost that will be reimbursed during the cost reconciliation process?**

Statewide interim rates reflect the amount per unit that will be paid to CCS programs for their interim claims. CCS will continue to settle to full costs during reconciliation. Extreme outlier costs will require justification/explanation from the region. CCS programs may have different actual costs for the same service or provider type.

### **17. Can a CCS region use one National Provider Identifier to submit claims?**

Counties/tribes that are DQA-certified programs using a Shared Services Model or a Multi-County Regional Model will be required to set up a unique taxonomy number for each county/tribe through the Medicaid enrollment process.

### **18. Are CCS programs required to bill Medicare prior to billing Medicaid for CCS?**

No, programs do not need to bill Medicare prior to billing Medicaid for CCS. Medicare does not cover CCS services, and Wisconsin Medicaid has made the decision to pay claims for CCS services that are submitted directly to ForwardHealth.

## **Comprehensive Community Services (CCS)— Frequently Asked Questions**

- 19. Will a county/tribe receive full reimbursement (federal and local share) for administrative costs (teleconferences, organization meetings, application completion, etc.) incurred before July 1, 2014? What about start-up costs?**

**Updated January 20, 2016:** The Centers for Medicare and Medicaid Services (CMS) has confirmed to DHS that start-up costs, including start-up costs for CCS, are **not** a Medicaid allowable expense for cost reporting and related provider reimbursement. Start-up costs are defined as any program related cost incurred by a CCS provider prior to its designated DQA certification date. A CCS provider will receive full reimbursement for any Medicaid allowable program operation costs incurred on or after its DQA certification date.

### **Residential Treatment**

- 1. Are individuals in Community Based Residential Facilities (CBRFs) or Adult Family Homes (AFHs) eligible for CCS and full Medicaid reimbursement?**

Yes. Psychosocial rehabilitation services that are included in the CCS Service Array and are provided in a CBRF or AFH are fully Medicaid reimbursable for CCS Medicaid members. The CCS benefit only covers psychosocial rehabilitation since reimbursement for room and board is not available through the CCS benefit.

- 2. How can a CCS provider bill for services in residential settings now that there is no longer a residential rate?**

In order for a CCS provider to bill for a service provided to a CCS member, the service must satisfy three primary criteria, regardless of service environment:

- The service must be included in the CCS Program Service Array found in Attachment 1 of *Update 2014-42*.
- The service must be attributed to a specific CCS member.
- The service must be authorized as part of the member's service record and documented as required by [DHS Chapter 36](#), Wisconsin Administrative Code.

Notably, these requirements are generally applicable and will continue to be required in residential settings.

The per-unit method for billing residential CCS services takes into account members receiving a combination of individual and group services in a residential environment, which is documented in the member's service record.

## **Comprehensive Community Services (CCS)— Frequently Asked Questions**

In order for a CCS provider to bill for a group service, the provider must provide the service to at least two CCS members simultaneously, as is commonly the case in residential settings.

For example, if on a given day, a residential program staff member provides skill development and enhancement to a CCS member individually and also as part of a group of two or more CCS residents, the service provider would document the following in the member's service record:

- The length of time the CCS services were provided to the member individually.
- The length of time the CCS services were provided to the member in a group setting.

See the separate “Comprehensive Community Services (CCS) Residential Rate Setting Guidance” document for more details regarding billing for services in a residential setting. The guidance document provides information on establishing an individual and group billing rate, reimbursement of residential services costs, and appropriately documenting individual and group residential services. It also provides a sample residential rate setting method used by one county.

### **3. What constitutes a group service in a CBRF? For example if a staff member is providing individual skill development and enhancement to a particular CCS individual (e.g., teaching an individual to prepare a meal) and other people are present in the room, is that considered a group?**

In order for a CCS service to qualify as a group service, the service must meet the following criteria:

- The service must be included in the CCS Program Service Array found in Attachment 1 of *Update 2014-42*.
- The service must be provided to two or more members simultaneously.
- The service must be documented in each individual member's service record.

It is important to note that a group service may include CCS members and non-CCS members. CCS programs should only bill for services provided to CCS members who participated in group services. Non-CCS members should not be included on CCS claims. Additionally, if one CCS member participates in a group service with other non-CCS members, the service should still be considered a group service for the one CCS member.

## **Comprehensive Community Services (CCS)— Frequently Asked Questions**

- 4. Do staff have to document every 15 minutes with all CCS members in a CBRF? CCS members are free to come and go in CBRFs and staff may interact with none, some, or all during every 15-minute unit.**

Staff in residential facilities do not need to document every 15-minute interval for all CCS members in a day. However, staff are expected to document total service time provided to each CCS member served, rounded to the nearest 15-minute increment. According to [DHS 36.17](#) and [DHS 36.18](#), Wisconsin Administrative Code, the service plan must document each service that is provided to a CCS member. The service needs to be part of the member's CCS service plan and provided by the appropriate provider type listed for that service on the CCS Service Array. Additionally, CCS will only pay for services on the CCS Service Array. Only these services can be submitted to Medicaid for reimbursement.

- 5. Can Residential Care Centers (RCCs) bill Medicaid for services provided while a CCS member is transitioning out of an RCC?**

On pages 6 and 29 of *Update 2014-42*, it states that CCS does not cover **any** services provided to members residing in RCCs. This prohibition includes any discharge/transition services.