



Targeted Case Management and the Wisconsin Birth to 3 Program

Birth to 3 Service Coordination

ForwardHealth Online Handbook [Topic #1690](#)

As defined in the Targeted Case Management Online Handbook, activities of the service coordinator and other personnel who provide case management services are covered when the Birth to 3 Program is enrolled as a case management provider (or is part of a county department that is a Wisconsin Medicaid-enrolled program).

Providers are required to comply with Medicaid requirements (Wis. Admin. Code chs. [DHS 101-108](#), and this service area of the Online Handbook) **AND** Birth to 3 early intervention services rules (Wis. Admin. Code ch. [DHS 90](#)) when billing for case management services provided under the Birth to 3 Program.

Per § [DHS 105.51 \(2\)](#), case managers performing assessments and case planning must meet both of the following requirements:

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

Per § [DHS 90.11](#), the following requirements are needed to act as a Birth to 3 service coordinator:

- A service coordinator shall have at least one year of supervised experience working with families with special needs and have demonstrated knowledge and understanding about:
 - Children in the age group birth to 3 who are eligible for the program.
 - Part C and the federal implementing regulations, 34 CFR pt. 303, and this chapter.
 - The nature and scope of services available under the Birth to 3 Program and how these are financed.
- The service coordinator may be a person from the list of qualified personnel in § [DHS 90.08\(3\) \(b\)](#), another person with experience and training indicated under [sub. 1](#), or a parent facilitator.





Case Management Requirements

ForwardHealth Online Handbook [Topic #1675](#)

- Although hour limits on ongoing monitoring are not established, ongoing monitoring can only be billed once for any given calendar month unless the member's county of residence changes. If the member's county of residence changes, Medicaid may reimburse a second claim for ongoing monitoring to an enrolled case management agency in the new county of residence. Medicaid does not reimburse more than two providers for ongoing monitoring occurring in any month. If a child is enrolled in more than one program where case management is a service, then the programs must decide which program will take the lead on case management and bill Medicaid for those services.
- Medicaid does not reimburse the costs associated with ongoing monitoring and service coordination by more than one identifiable, individual case manager except in the case of a qualified, temporary replacement used when the designated case manager is unavailable due to illness, vacation, death, or client crisis.

Assessments

ForwardHealth Online Handbook [Topic #1695](#)

Case managers must perform a written comprehensive assessment of a person's abilities, deficits, and needs. Case managers should use persons from relevant disciplines to document service gaps and unmet needs. All services appropriate to the member's needs, regardless of availability or accessibility of providers, must be included in this comprehensive assessment.

Per § [DHS 90.03](#), the Birth to 3 Program also has requirements when assessments are conducted with children and families.

- Assessment means the initial and ongoing procedures used by qualified personnel and family members, following determination of eligibility, to determine an eligible child's unique strengths and needs and the nature and extent of early intervention services required by the child and the child's family to meet those needs.
- Individual Family Service Plan (IFSP) planning process means the process to develop the IFSP, which begins with the family's first contacts with the Birth to 3 Program, including the evaluation of the child's abilities to determine eligibility; identification and assessment of



the eligible child's unique needs; at a family's option, family-directed assessment of the family's strengths, resources, concerns and priorities; development of the written IFSP; implementation of the plan; planning for transition to other programs or services; and ongoing review and revision of the written plan.

Ongoing Monitoring and Service Coordination Contacts

ForwardHealth Online Handbook [Topic #1685](#)

Ongoing case management services include face-to-face and telephone contacts with members for the purpose of assessing or reassessing needs, or planning or monitoring services. This also includes face-to-face and telephone contact with collaterals (anyone who has direct supportive contacts with the member). Collaterals include paid providers, family members, guardians, housemates, school representatives, friends, volunteers, and others involved with the member. Document all collateral contacts. Collateral contacts include case management staff time spent on case-specific staffing and formal case consultation with the unit supervisor and other professionals regarding the needs of a specific member. Only the case manager's travel time is covered when providing the covered case management service.

Frequency of Ongoing Monitoring and Contact

ForwardHealth Online Handbook [Topic # 1678](#)

There are different requirements for contact frequency for children enrolled in the Birth to 3 Program and for TCM. If case management is to be billed for ongoing monitoring and service coordination, then the frequency must meet the Medicaid requirements.

As part of the care planning process, the provider is required to discuss and document the frequency of ongoing contacts and monitoring with the member (and the member's collaterals if appropriate). The case manager must note the rationale for the frequency of monitoring in the member's record if the frequency of monitoring is less than the following:

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



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

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

Per § [DHS 90.10](#), there are required points of contact for children and families during the year.

- **Periodic review.** A review of an IFSP shall take place every six months or more frequently if warranted or a parent requests it. The review shall be carried out at a meeting or by other means acceptable to the parent and other participants and shall involve at least the parent or parents and the service coordinator, other family members if requested by a parent, and an advocate or other person from outside the family if requested by a parent. If conditions warrant, provision shall be made to include persons directly involved in conducting the evaluation and assessment and, as appropriate, persons providing services to the child or family. The purpose of the review is to determine: (1) the progress being made toward achieving the planned outcomes and (2) whether modification or revision of the planned outcomes or services is necessary.
- **Annual meeting.** At least annually, the service coordinator shall convene a meeting at which the IFSP shall be evaluated and, as appropriate, revised.
- **Service coordination activities** include:
 - Coordinating the performance of evaluation and assessments.
 - Facilitating and participating in development, review, and evaluation of the IFSP.
 - Assisting parents in identifying available service providers.
 - Facilitating access to services and coordinating and monitoring the timely provision of services.
 - Informing parents of the availability of advocacy services.
 - Coordinating with medical and other health care providers.
 - Facilitating the development of transition plans.





Target Group Populations

In addition to meeting other enrollment requirements in the case management service area, members must belong to at least one of the two target populations, per Wis. Stat. § [49.45\(25\)](#), and be served by a Medicaid-enrolled case management provider that elected to serve members in the corresponding target populations.

Children who are eligible for Birth to 3 are in Group B target population. However, under Group B, there are multiple options for families with children who may be eligible to receive TCM services.

ForwardHealth Online Handbook [Topic #1673](#)

Group B Target Populations

The Group B target populations include:

- Families with a child or children at risk of serious physical, mental, or emotional dysfunction (also referred to as family case management). This target population has five subgroups:
 - Families with a child or children with special health care needs, including children with lead poisoning
 - Families with a child or children who is/are at risk of maltreatment
 - Families with a child or children involved in the juvenile justice system
 - Families where the primary caregiver has a mental illness, developmental disability, or substance abuse disorder
 - Families where the mother required PNCC services
- Children enrolled in a Birth to 3 Program under Wis. Admin. Code ch. [DHS 90](#).
- Children with asthma.
- Individuals infected with tuberculosis.
- Women ages 45 to 64.

Per § [DHS 90.08](#), children are being referred to the Birth to 3 Program through an informed network.

- If the primary referral source suspects that an infant or toddler has a developmental delay, the primary referral source shall conduct or request a formal screening to determine if there is reason to refer the child for an evaluation.



- If the primary referral source has reasonable cause to believe that a child has a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay or has a developmental delay, the primary referral source shall refer the child for an evaluation. The primary referral source shall ensure that referral for evaluation is made no more than two working days after a child has been identified.

QUESTION: When can a county bill TCM services for children referred to the Birth to 3 Program?

Counties may bill TCM for children in the Group B target population for children referred to the Birth to 3 Program if the child meets the requirements for the Group B target population and the requirements for case management have been met.

Here are some scenarios that detail the most common progressions from referral to enrollment in the Birth to 3 Program:

Scenario One: A child is referred to the Birth to 3 Program with a suspected delay in development. The child receives a developmental screen but does not proceed to evaluations and assessments. The county **would not** bill for TCM services up to that point because the child would not meet the requirements for the Group B target population.

Scenario Two: A child is referred to the Birth to 3 Program with a suspected delay in development. The child receives appropriate evaluations and assessments but does not meet eligibility criteria for the Birth to 3 Program. The county would bill for TCM services up to that point if all the case management requirements have been met for the child under Group B target population ([for families with children with special health care needs](#)).

Scenario Three: A child is referred to the Birth to 3 Program with a suspected delay in development. The child receives appropriate evaluations and assessments, meets the eligibility criteria for the Birth to 3 Program, and is enrolled in the program by the family. The county would bill for TCM services ongoing for the child under Group B target population ([for children eligible for the Birth to 3 Program](#)).

Scenario Four: A child is referred to the Birth to 3 Program with a suspected delay in development. The child receives appropriate evaluations and assessments, meets the eligibility criteria for the Birth to 3 Program, and is not enrolled in the program by the family. The county would bill for TCM services up to that point if all case management requirements have been





met for the child under Group B target population ([for children eligible for the Birth to 3 Program](#)).

ForwardHealth Portal Resources

Fee Schedules

ForwardHealth Online Handbook [Topic #897](#)

For most services, Wisconsin BadgerCare Plus reimburses providers the lesser of the billed amount or the maximum allowable fee established by the Department of Health Services (DHS) based on legislative directives. The amounts established by DHS are published in fee schedules available to all providers and other interested parties.

Providers are encouraged to use the Interactive Max Fee tool on the ForwardHealth Portal to review maximum fee schedules as well as billing rules and restrictions.

Trainings

ForwardHealth Online Handbook [Trainings](#)

There are multiple types of trainings available on the ForwardHealth Portal. These trainings are accessible to all providers. You may also sign up to receive regular communication via an [email subscription](#).

Resources

ForwardHealth [Provider Resources](#)

You will find links to Portal user guides, online handbooks, provider-specific resources, and contact information resources available to providers in the “Provider” area of the Portal.