

STATE OF WISCONSIN  
Department of Health Services  
Division of Mental Health and Substance  
Abuse Services  
Division of Health Care Access and  
Accountability

DMHSAS / DHCAA Memo Series 2009- 02  
February 20, 2009  
**Re: Revision** to DSL Numbered Memo 2003-04:  
Admission and Billing Procedures for Medicaid /  
Covered Youth Admitted to Mendota Mental Health  
Institute and Winnebago Mental Health Institute

To: Area Administrators / Human Service Area Coordinators  
Bureau Directors  
County Departments of Community Programs Directors  
County Departments of Developmental Disabilities Services Directors  
County Departments of Human Services Directors  
County Departments of Social Services Directors  
County Corporation Counsels  
County Economic Support Workers  
County Judges  
County Mental Health / AODA Coordinators  
County Sheriffs  
BadgerCare Plus and Medicaid SSI HMOs  
Mendota Mental Health Institute / Winnebago Mental Health Institute Directors  
Licensing Chiefs / Section Chiefs  
Tribal Chairpersons/Human Services Facilitators

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Division of Mental Health and Substance Abuse Services

Jason Helgerson  
Medicaid Director  
Division of Health Care Access and Accountability

## **Document Summary**

The purpose of this memo is to update the admission and billing procedures for Medicaid-covered youth admitted to Mendota Mental Health Institute and Winnebago Mental Health Institute.

## **Background**

In CY 2002, a state and county workgroup was formed to identify and resolve issues related to youth admitted to Mendota Mental Health Institute (MMHI) and Winnebago Mental Health Institute (WMHI). The result was DSL Numbered Memo 2003-04. Issues and concerns have been raised again so this numbered memo has been revised based on input from another state and county workgroup.

Some county departments of human services and community programs continue to be billed for some services / care provided to some Medicaid-eligible youth admitted to MMHI or WMHI. These county agencies are questioning why youth eligible for Medicaid are becoming their responsibility for payment when in the past services at these facilities were paid by Medicaid.

The Division of Mental Health and Substance Abuse Services, in partnership with the Division of Health Care Access and Accountability, is revising DSL Numbered Memo 2003-04 to clarify unresolved issues and again inform all stakeholders of the admission and billing procedures.

Youth (defined herein as persons under the age of 21 years) admitted to one of the two state mental health institutes, Mendota Mental Health Institute (MMHI) or Winnebago Mental Health Institute (WMHI), are funded primarily by Medicaid fee-for-service (FFS), BadgerCare Plus and Medicaid SSI managed care, or third party insurance. Since the beginning of Medicaid managed care in 1984, the Department of Health Services (DHS) has contracted with Health Maintenance Organizations (HMOs) to manage the health care needs, including mental health, of Medicaid members who are enrolled in a HMO.

For those youth enrolled in a BadgerCare Plus and Medicaid SSI HMO at the time of admission to MMHI or WMHI, the HMO must pay for care provided during the first 72 hours (three business days plus any intervening weekend days and / or legal holidays) when there is a signed statement of emergency detention or detention order. For those youth not enrolled in a BadgerCare Plus and Medicaid SSI HMO at the time of admission, Medicaid FFS or other third-party insurance covers the cost of medically necessary care at MMHI and WMHI. Medicaid fee-for-service remains the payer if the youth enters MMHI or WMHI under the fee-for-service system and is subsequently enrolled in the HMO during his or her stay at the institute.

Article III.F. (“Mental Health and Substance Abuse Coverage Requirements / Coordination of Services with Community Agencies”) of the contract between the Department and the HMO specifies the HMO’s responsibilities for the provision of mental health and substance abuse services. Additional information can be found on the ForwardHealth web page: [Wisconsin Medicaid Managed Care, What's New: References and Tools](#). The contract between DHS and the HMOs requires the HMO to make a good faith effort to develop a Memorandum of Understanding (MOU) or contract with each of the county agencies responsible for these services in the HMO’s service area, and to sign the MOU or contract every two years as part of their Department certification. It is important for counties and the HMOs to coordinate and work together to ensure necessary and appropriate services are provided to youth and families enrolled in BadgerCare Plus and Medicaid SSI HMOs. As per this numbered memo, county agencies are also required to make a good faith effort to sign a contract or an MOU with the HMOs in their service area.

County departments of community programs / human services are responsible for providing the necessary mental health, developmental disability, and alcohol and other drug abuse services to the extent required in ch. 51, Wis. Stats. This includes inpatient psychiatric services such as the care and treatment provided by MMHI and WMHI, provided pursuant to an emergency detention, court order, or application for admission.

After a youth has been admitted to a state institute, medical necessity reviews will be done on a regular basis. HMOs perform reviews during the inpatient stay for their members; Medicaid FFS reviews are retrospective for those in Medicaid FFS. The review process can result in a determination that the placement is no longer Medicaid covered due to a lack of medical necessity of inpatient hospital care. If this determination is made, further payments from BadgerCare Plus and Medicaid SSI HMOs are denied, and Medicaid FFS recoupments are made retrospectively. However, for BadgerCare Plus and Medicaid SSI HMO members, the first three business days (72 hours), plus any intervening weekends and / or holidays, always meet the medical necessity rule provided that there is a signed statement of emergency detention or detention order.

## **Medical necessity**

Medical necessity as stated in HFS 101.03(96m) Wis. Adm. Code means a Medicaid service under ch. HFS 107 that is:

- I. Required to prevent, identify, or treat a recipient's illness, injury or disability; and
- II. Meets the following standards:
  - Is consistent with recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
  - Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;
  - Is appropriate with regard to generally accepted standards of medical practice;
  - Is not medically contraindicated with regards to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
  - Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;
  - Is not duplicative with respect to other services being provided to the recipient;
  - Is not solely for the convenience of the recipient, the recipient's family or a provider;
  - With regard to prior authorization of a service and to other prospective coverage determinations made by the department;
    - Is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
    - Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

Below are the updated procedures for admissions of youth to the state institutions.

## Procedures for Admission by Application

- I. The statutes (Wis. Stat. § 51.13) provide for admissions to inpatient treatment facilities based upon application of the youth or parent, provided that the facility agrees there is opportunity for court review and, if the county department is to be responsible for the cost of treatment and the county department director approves.
- II. Federal [42 CFR 441.152] and state [HFS 107.13(1)(b)] regulations require providers to conduct and document a Certificate Of Need (CON) assessment for all members under the age of 21 who are admitted to a psychiatric or substance abuse Institution for Mental Disease Services (IMD) for elective / urgent or emergency psychiatric or substance abuse treatment services. As specified in 42 CFR Part 441.153, elective / urgent admissions require an independent team to complete the elective / urgent CON assessment. Providers are required to complete and document an emergency CON assessment within 14 days of admission for emergency admissions. Detailed information on Certification of Need (CON) requirements, including forms, can be found in the Covered Services and Requirements Section of the [Wisconsin Medicaid Hospital Inpatient Services Handbook](#) on the ForwardHealth website.
- III. Before a county agency (case manager / child welfare) staff person pursues an admission by application of a youth to MMHI or WMHI, the county staff person must determine if the youth has Medicaid coverage and whether the youth is enrolled in a BadgerCare Plus and Medicaid SSI HMO or is Medicaid fee-for-service (FFS). This may be done by:
  - contacting the county income maintenance (IM) worker,
  - by using either the online [ForwardHealth Portal](#) or
  - calling WiCall at telephone: 1-800-947-3544 to access Medicaid eligibility and HMO enrollment information 24 hours a day, seven days a week.  
(Formerly Medicaid Automated Voice Response [AVR])

A listing of county contacts for Institutions for Mental Diseases (IMD) is available on the DHS webpage: [Directory of Income Maintenance \(IM\) Agencies](#). These are the income maintenance (IM) workers that county agencies want MMHI / WMHI staff to contact about Medicaid eligibility issues for their residents. If a youth who is not a Medicaid member is admitted to an IMD, the IMD should submit a Medicaid application regardless of the expected length of stay.

- IV. If the youth has Medicaid coverage or other third party insurance that covers inpatient psychiatric services, and is expected to remain for 30 days or more; an application for Institutional Medicaid should be submitted after admission. The youth, the youth's parent, or the Superintendent of the IMD may sign the application. Any third party insurance that covers the youth should be reported on the Medicaid application to facilitate the coordination of benefits. Medicaid will only cover those services that are determined to be medically necessary.
- V. If a youth is enrolled in a BadgerCare Plus or Medicaid SSI HMO and is expected to be admitted in the IMD for less than 30 days, she or he will be considered temporarily absent from the home and it is expected that the HMO will pay for the medically

necessary care as long as all of the procedures in this memo and contract requirements are followed.

- VI. If the county fails to follow the procedures outlined in the memo for coordinating with the HMO about the youth's care, then the county is responsible for the costs.

## HMO

- I. If the youth is enrolled in a BadgerCare Plus or Medicaid SSI HMO, the HMO is responsible for insuring that all medically necessary treatment is made available. The HMO determines whether to provide the treatment within their network of providers or outside their network, such as at MMHI or WMHI. For these youth, the county (case manager / child welfare) staff person must contact the HMO to determine whether the HMO will authorize inpatient mental health services. If the HMO does not approve inpatient treatment, the HMO must take responsibility for ensuring that medically necessary treatment is provided. Contact information should be outlined in the Memorandum of Understanding (MOU) or contract between the county and HMO. County staff can find the mental health contact number for each HMO on the ForwardHealth web page: [HMO Mental Health Contact Numbers for the Wisconsin Medicaid and BadgerCare HMO Program](#). HMOs may authorize and pay for less restrictive care and counties should work with the HMOs to determine what treatment is in the best interest of the youth. Counties may be liable for the cost of care if a youth is admitted by application without authorization by the HMO to a facility outside the HMO's provider network. However, the HMO member or another person on the HMO member's behalf may contest the HMO's refusal to authorize care outside the HMO's provider network, and if that contest is successful, the HMO may be required to pay for care provided by a provider outside the HMO's provider network (DHS and HMO contract, Article IX – "Complaint, Grievance, and Appeal Procedures").
- II. If the HMO approves inpatient treatment, they decide whether to use one of their in-network facilities or to use MMHI or WMHI. According to State Statute, MMHI and WMHI may not contract with the BadgerCare Plus and Medicaid SSI HMOs. The HMO will pay for an admission by application to MMHI or WMHI under the following conditions:
  - The HMO does not have an in-plan facility bed available that will meet the youth's needs.
  - The HMO determines that MMHI or WMHI is the best placement for the youth; or,
  - Until it is possible and clinically appropriate to transfer the youth to an in-plan facility.
- III. If, after admission to MMHI or WMHI, the HMO determines further inpatient treatment lacks medical necessity, the member should be discharged. Staff at the institute will notify the county contact person immediately. The county and the HMO must communicate and work together regarding discharge planning and follow-up treatment. The HMO is responsible for all medically necessary outpatient follow-up treatment.
- IV. When there is a signed emergency detention statement or detention order, care for the first 72 hours, plus any intervening weekend days and / or legal holidays, is automatically deemed medically necessary, and the youth's HMO is required to pay for the care, regardless whether the HMO authorizes any stay at MMHI or WMHI beyond the emergency detention.

## **FFS**

If the youth is eligible for Medicaid FFS, the youth can be admitted by application to any Medicaid-certified inpatient psychiatric facility, including MMHI and WMHI, if the facility agrees. Admissions of FFS members are subject to the same CON requirements as discussed above. Hospitalizations of all youth admitted to MMHI or WMHI who have Medicaid FFS coverage undergo a retrospective review of medical necessity on a regular basis. Medicaid recoups payment after a claim is paid if the stay did not meet either CON or medical necessity requirements. If Medicaid recoupment is made from the state institutes, the counties will not be billed for the services provided to the youth.

## Procedures for Court-Ordered and Emergency Admission

- I. A youth may be placed at MMHI or WMHI under an Emergency Detention (ED) through either a three-party petition or through a detention by law enforcement officials.
- II. When there is a signed emergency detention statement or detention order, care for the first 72 hours, plus any intervening weekend days and / or legal holidays, is automatically deemed medically necessary, and the youth's HMO is required to pay for the care, regardless whether the HMO authorizes any stay at MMHI or WMHI beyond the emergency detention.
- III. When a youth is admitted to MMHI or WMHI under an ED, staff at the institute must contact the county agency (DHS or DCP) contact person (case manager / child welfare worker) within 24 hours, exclusive of weekends or legal holidays. The county agency is responsible to inform MMHI and WMHI of the name of their contact person to be notified in these situations. See the Word fillable Form # F21231 on the DHS Forms website: [County Agency Contracts Regarding Children at MMHI and WMHI](#).
- IV. During the admission process institute staff are expected to attempt to determine the potential funding source for the youth. These could be Medicaid FFS, BadgerCare Plus / Medicaid SSI HMO, third party insurance or other potential funding sources. Institute staff are required to provide this information to the county contact person when they notify the county of the admission.
- V. The county agency board authorizer (the person responsible at the county level for authorizing hospital admissions) is expected to verify the funding source. If it appears the youth is eligible for Medicaid, the county agency (case manager/child welfare) staff person should contact either the county income maintenance (IM) worker, or use either the [ForwardHealth Portal](#) website or by calling WiCall at telephone: 1-800-947-3544 to verify whether the youth is in Medicaid FFS or in a BadgerCare Plus and Medicaid SSI HMO (formerly Medicaid Automated Voice Response [AVR]).
- VI. Federal [42 CFR 441.152] and state [HFS 107.13] regulations require providers to conduct and document a Certificate Of Need (CON) assessment for all members under the age of 21 who are admitted to a psychiatric or substance abuse Institution for Mental Disease Services (IMD) for elective / urgent or emergency psychiatric or substance abuse treatment services. As specified in 42 CFR Part 441.153, elective / urgent admissions require an independent team to complete the elective / urgent CON assessment. Providers are required to complete and document an emergency CON assessment within 14 days of admission for emergency admissions. Detailed information on Certification of Need (CON) requirements, including forms, can be found in the Covered Services and Requirements Section of the Wisconsin Medicaid Hospital Inpatient Services Handbook found at the ForwardHealth web page: [Covered and Noncovered Services](#).
- VII. If the parents of a youth admitted to MMHI or WMHI are not cooperative in providing the necessary information for DHS to bill third-party insurance or Medicaid, the parents and county of residence will be responsible for payment of the bill.
- VIII. If the youth is enrolled in a BadgerCare Plus or Medicaid SSI HMO, the county (case manager / child welfare) worker must contact the HMO as soon as possible after

admission or within the period agreed upon in the county and HMO's MOU. The mental health contact number for each HMO on the ForwardHealth web page: [HMO Mental Health Contact Numbers for the Wisconsin Medicaid and BadgerCare HMO Program](#). The HMO is responsible for treatment at an Institute after the first three business days (72 hours plus any intervening weekend days and / or legal holidays) only if notified of the emergency treatment within that period and given the opportunity to provide the care through its own network, or if the HMO has approved the Institute stay. The county agency (case manager / child welfare) worker is expected to find out where the HMO would like the youth placed if continued hospitalization is needed after this period. If the county worker fails to contact the HMO to authorize care within this period, the county is liable for the cost of care beyond this period.

- IX. The county agency (case manager / child welfare) worker should inform the county corporation counsel of the placement facility in the HMO provider network that should be used after the first 72 hours (three business days plus any intervening weekend days and / or legal holidays). The corporation counsel and / or the county agency are responsible for informing the judge who presides over the probable cause hearing of the HMO's placement recommendation. The HMO may submit an alternative treatment plan for the county to submit at the probable cause hearing. The HMO must submit the name of an in-plan facility willing to treat the member if the court rejects the alternative treatment plan and the court orders the member to receive an inpatient evaluation. The HMO is responsible to make the referral to their network provider, make sure a bed is available and arrange transportation, unless secure transportation is necessary. The Court should be informed of all placement recommendations at the Probable Cause Hearing.
- X. If the youth requires inpatient psychiatric care after the first 72 hours (plus Saturday, Sunday and legal holidays) and the HMO has not agreed to have the youth remain in MMHI or WMHI, the youth should be transferred to the in-plan facility the HMO has designated, unless the court orders that the youth remain at MMHI or WMHI. The HMO is not liable for the member's court-ordered evaluation and treatment if the HMO provided the name of an in-plan facility and the court ordered the evaluation at an out-of-plan facility (2008-2009 contract between DHS and HMOs, Article III, F, 10, e). The HMO is responsible to arrange and complete all necessary application information for the in-plan facility.
- XI. The contract between DHS and the HMO states that if the county can document that it attempted to notify the designated primary HMO contact during the required time period but did not succeed, or if the HMO was given the opportunity but failed to provide the county with the name of an inpatient facility, then the HMO cannot deny payment for court-ordered care beyond the first 72 hours (plus Saturday, Sunday and legal holidays). The county must be sure to document all contacts with HMOs for authorizations, including the dates, times, names, numbers attempted to contact, and outcomes. If a youth is admitted over a weekend at a state institute, staff at the institute must Fax a copy of the ED and admission note to the county and HMO on Monday morning to ensure notification of the HMO for this youth.
- XII. If the youth requires secure transportation by local law enforcement officials from the state institute to the HMO's in-network facility, the county will arrange and pay for

transportation. Non-secure transportation from the state institute to the in-network facility will be arranged and paid for by the HMO as specified in their contract with the Department for BadgerCare Plus and Medicaid SSI – Standard Plan members only (common carrier transportation is not a covered benefit for Benchmark Plan members); however, ambulance transportation in emergency situations is covered for both Standard and Benchmark Plan members. When common carrier transportation is appropriate, the county will arrange and pay for this service, and then the Medicaid program reimburses the county for BadgerCare Plus and Medicaid SSI – Standard Plan members only. In Milwaukee County, the HMO arranges for common carrier transportation for Standard Plan members, and then the Medicaid program reimburses the HMO.

## Summary of Responsibilities by Party in the Admission Procedures

### I. County Staff Responsibilities

- A. When a separate department of social services (DSS) and department of community programs (DCP) exist in a county, it is critical that the DSS staff communicate with the DCP staff when:
  - 1. they are working with a youth and his / her family and
  - 2. the youth is detained at, ordered, or admitted by application to WMHI or MMHI.

The reason for this is that often the child welfare worker at DSS is the responsible staff person to assist the youth and his / her family with the admission and is the central contact point at the county level to monitor the placement and work with the institute staff on discharge planning.

- B. However, it is the responsibility of the DCP to pay for the care and treatment at the state institutes if there are no other funding sources and the DCP does not provide an alternate placement. Therefore, it is very important for the DSS worker to keep the DCP informed of any placement plans of youth at the state institutes. It is suggested that the two county agencies develop a Memorandum of Understanding (MOU) detailing the responsibilities of both agencies regarding these types of situations.
- C. For any admission by application of a youth that is being considered, the responsible county agency needs to determine if the youth is enrolled in a BadgerCare Plus or Medicaid SSI HMO and to contact that HMO for authorization and planning prior to admitting the youth. As part of their case management responsibilities, the HMO may suggest alternate care options. County agency (case manager / child welfare) staff and HMO staff should work together to ensure the most appropriate placement and services are provided to the youth and his / her family.
- D. It is the responsibility of the county to provide a contact for the HMO to facilitate follow-up care. This contact could be identified in the MOU between the County and the HMO. Counties are liable for the cost of care if they do not follow the treatment plan for the youth developed by the HMO. It is suggested that county agencies and HMOs include language in their MOU on how the two agencies will work together on admissions by application.
- E. The Department's Division of Health Care Access and Accountability will maintain an updated list of mental health contacts for each of the HMOs on the Department's website at: [HMO Mental Health Contact Numbers for the Wisconsin Medicaid and BadgerCare HMO Program](#). Counties with questions may contact the Division of Health Care Access and Accountability at telephone: (608) 266-8922 and request the Bureau of Benefits Management.
- F. When a youth is admitted to one of the state institutes under an Emergency Detention (ED), the county department (DSS / DCP / DHS) or the corporation counsel must determine if the youth is covered by private health insurance, Medicaid FFS or a HMO, and which HMO, during the first 72 hours (first three business days plus any

intervening weekend days and / or legal holidays) after admission. Staff can do this by contacting the county income maintenance (IM) worker, or by using the [ForwardHealth Portal](#) website or by calling WiCall at telephone: 1-800-947-3544. The county department or the corporation counsel must also determine placement options in the HMO provider network during the first 72 hours (three business days plus intervening weekend days and/or legal holidays) and inform the Court of the treatment options available at which the HMO would authorize payment. The county department should meet with their corporation counsel to establish a policy on how they will inform the Court of all necessary information.

- G. Counties are requested to submit to MMHI and WMHI the names of their employees who serve as contact person for admission notification, who is responsible for coordinating with the HMO, and who is the case manager for treatment and discharge planning. The person responsible for case management and discharge planning could change with each youth admitted so the county department must inform the facility within 24 hours, exclusive of weekends and holidays, of who this person is for each admission.

Information for the contact person for admission notification and for the person responsible for coordinating with the HMO should be submitted to MMHI and WMHI using Form # F21231. This form can be updated as needed. See the Word fillable Form # F21231 on the DHS Forms website: [County Agency Contracts Regarding Children at MMHI and WMHI](#).

A listing of IM workers at county agencies that MMHI/WMHI staff should call about Medicaid eligibility issues is available on the DHS web page: [Directory of Income Maintenance \(IM\) Agencies](#).

- H. County departments should make a “good faith” effort to negotiate an MOU with the HMOs who serve their county and be familiar with what the BadgerCare Plus and Medicaid SSI HMOs are required to cover. If counties have general questions regarding HMO contract requirements, they may contact the Division of Health Care Access and Accountability and requesting the Bureau of Benefits Management by telephone: (608) 266-8922. In addition, counties may seek assistance from the HMOs listed on the ForwardHealth web page: [Managed Care Contacts: BadgerCare Plus and Medicaid SSI HMOs](#).
- I. Staff of the county department need to inform the county judge that the county will be liable for the cost of placement if the Court is given the HMO provider network information, with placement recommendations, and the Court orders placement at another facility.
- J. County (case manager / child welfare) staff needs to promptly review the monthly HSRS report submitted by MMHI and WMHI. Any discrepancies will be resolved by contacting the admission office at MMHI and WMHI. The HSRS report and the monthly County Board billing use the same INSIGHT database.
- K. If a youth is under an involuntary status at either MMHI or WMHI and must be transported to another facility in the HMO’s provider network, it is the responsibility

of the county to arrange and pay for secure transportation using local law enforcement officials or common carrier transportation (in all counties other than Milwaukee). If common carrier transportation is used, the county will be reimbursed by the Medicaid program for the cost of this service for BadgerCare Plus – Standard Plan and Medicaid SSI members.

- L. In the situation of a youth enrolled in Medicaid FFS being admitted by application to an IMD, the county agency is responsible for providing a completed Elective / Urgent CON prior to the time of admission. See Attachment 1 regarding CON requirements.
- M. If a HMO member is transferred from an out-of-network facility to an in-network facility in non-secure transportation, then the county is not responsible for completing the admission paperwork for the facility.

## II. **MMHI and WMHI Responsibilities**

- A. MMHI and WMHI staff are responsible for having a correctly completed Certification of Need (CON). The facility may request / require a county agency or outside provider to complete the form for admissions by application. For a youth who applies for Medicaid while in the facility, the certification must be made by the team responsible for the plan of care and must cover any period before application for which claims are made.
- B. In the situation of a youth enrolled in Medicaid FFS being admitted under an emergency detention to an MMHI or WMHI, the facility is responsible completing an Emergent CON within 14 days of the admission. When a youth is being transferred to one of the institutes, even if from another institute for mental disease (IMD), a CON is required. The agency responsible for completing the CON is determined based upon whether the admission is under an emergency detention or otherwise. When a youth becomes eligible for Medicaid after admission or is made retroactively eligible for any part of the period during which the youth is at an institute, the institute is responsible for completing the Emergent CON. If Medicaid is applied for during the stay in the institute, the CON must be completed by the institute at the time the application for Medicaid is made.
- C. For Emergency Detentions, staff at MMHI and WMHI will determine upon admission if a youth is in a BadgerCare Plus or Medicaid SSI HMO, Medicaid FFS, or private pay and will provide verbal notification to the county contact and the HMO, if applicable, on all admissions within 24 hours, exclusive of weekends and legal holidays.
- D. If the youth is enrolled in a BadgerCare Plus or Medicaid SSI HMO, staff at MMHI and WMHI will communicate necessary clinical information to the HMO to support medical necessity as soon as possible and on an on-going basis to facilitate care coordination.  
If a youth, who is not a Medicaid member, is admitted to an Institution for Mental Diseases (IMD), such as MMHI or WMHI, the IMD should submit a Medicaid application regardless of the expected length of stay.

- E. Staff at MMHI and WMHI will notify the county contact verbally, by the close of the next business day, when a HMO denies payment because they have determined the services are not medically necessary.
- F. Staff at MMHI and WMHI will enter the appropriate State Board Code. The State Board Code will determine whether or not the county will be billed for the services. In the event the HMO does not authorize services, the State Board Code will be changed to a Billable Status and Bureau of Fiscal Services (BFS) will be notified to bill the county.
- G. Staff at MMHI and WMHI will submit monthly HSRS reports to the appropriate county contact. The report includes all county clients grouped as Billable or Unbillable depending upon the State Board Code.

### III. **BadgerCare Plus and Medicaid SSI HMO Responsibilities**

- A. The BadgerCare Plus or Medicaid SSI HMO is responsible for making a “good faith” effort to negotiate a Memorandum of Understanding (MOU) or a contract with the county agencies in the HMO’s service area. MOUs or contracts must be signed every two years as part of certification. If no changes have occurred, then both the county and the HMO must sign off that no changes have occurred and documentation must be submitted to the Department during certification (2008-2009 contract between DHS and HMOs, Article III, F, 14).
- B. BadgerCare Plus and Medicaid SSI HMOs are responsible for funding the first 72 hours (three business days plus any intervening weekend days and / or holidays) if a youth is placed in a facility under an emergency detention (ED) based on a detention order or statement of emergency detention. During this period of time, care is deemed medically necessary.
- C. If the court does not order the youth held after the probable cause hearing, it is the HMO’s responsibility to work with the county to recommend follow-up care and provide the treatment within the HMO network.
- D. HMOs are responsible for court-ordered treatment beyond the mandatory 72 hours and any intervening weekend days or holidays if they are notified of the treatment within the 72 hours and if they are given the opportunity to provide such care within their network, or if they provide the additional care in one of their facilities for the period of time they receive a capitation payment.
- E. If a youth is in need of non-secure transportation from an out-of-network treatment facility to an in-network facility, the HMO is responsible for arranging and paying the transportation as specified in their contract with the Department (2008-2009 contract between DHS and HMOs, Article III, F, 12). When common carrier transportation is appropriate, the county is responsible for arranging and paying, but is reimbursed by the Medicaid program for this service for BadgerCare Plus and Medicaid SSI – Standard Plan Members. In Milwaukee County, the HMO is responsible for arranging and paying for common carrier transportation for BadgerCare Plus – Standard Plan and Medicaid SSI members, and then the Medicaid program

reimburses the HMO for this service. Ambulance transportation in emergency situations is covered for both Standard and Benchmark Plan HMO members.

## **Procedures for State Institute Providers to Appeal to HMOs**

When the provider determines that appealing the denial is appropriate, an appeal will be made to the HMO as soon as possible after receiving the written notice of denial of payment from the HMO.

When state institute providers are denied payment for services provided to a HMO member, the Department's Division of Mental Health and Substance Abuse Services will assist the institute in an appeal to the HMO. The provider appeal must first be made directly to the HMO within 60 days of the denial of payment.

If the HMO fails to respond to the provider within 45 days, or the provider is not satisfied with the HMO's response, an appeal can be made to the Department for a final decision. This appeal must be made within 60 days of the notification of the HMO's decision. The address for this appeal is:

BadgerCare Plus and Medicaid SSI  
Managed Care Unit  
P. O. Box 6470  
Madison, WI 53716-0470

The HMO appeal process for providers may be found in Article III, G (“Provider Appeals”) of the current HMO contract, available at the ForwardHealth web page: [References And Tools](#).

Institutes having general BadgerCare Plus and Medicaid SSI HMO contract questions may contact the Division of Health Care Access and Accountability at telephone: (608) 266-8922 and request the Bureau of Benefits Management.

## **Procedures for County Agencies to Appeal to DHS**

If a county agency believes they incorrectly received a bill for services provided at MMHI or WHMI for youth under the age of 21 years, they must first determine that all requirements of this memo have been adhered to and that every other appeal avenue has been exhausted. If the county agency still believes they have been unjustly billed for services, they can appeal to the Administrator of the Division of Mental Health and Substance Abuse Services. This appeal must be in writing, signed by the county agency director, and must outline in precise terms why they believe the appeal is justified. The Administrator or designee will respond within 30 days.

Address to appeal is:

Administrator  
Division of Mental Health and Substance Abuse  
One West Wilson Street  
P. O. Box 7851  
Madison, WI 53707-7851

## **Training**

DHS staff will schedule a teleconference to discuss and answer questions on the contents of this memo in March or April of 2009. At the teleconference, participants will be able to ask specific questions regarding the admission and billing procedures for Medicaid-covered youth admitted or seeking admission to one of the state mental health institutes. In the near future, additional information will be shared with all stakeholder groups indicating the time, dates, and locations of the meeting.

If you have questions before the meeting, contact the individuals listed below.

### **REGIONAL OFFICE CONTACT:**

Area Administrators and Human Service Area Coordinators

### **CENTRAL OFFICE CONTACT:**

MMHI: Amy Bersing  
Telephone: (608-301-1357)

WMHI: Beverly Pezewski  
Telephone: (920-235-4910)

DHCAA: Makalah Wagner  
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