New Minimum Fee Schedule for Home and Community-Based Services

The Wisconsin Department of Health Services (DHS) has created a minimum fee schedule (MFS) for home and community-based services (HCBS) in Wisconsin. The minimum fee schedule is a list of the minimum rates managed care organizations (MCO) can pay providers of certain adult long-term care services. This applies to:

- Supportive home care services
    - Agency
    - Member self-directed
- Residential facilities
    - 1-2 bed adult family homes (AFHs)—owner occupied and corporate owned
    - 3-4 bed AFHs
    - Residential care apartment complexes (RCACs)
    - Community based residential facilities (CBRFs)

The minimum rates are effective October 1, 2024. DHS has provided that managed care organizations (MCOs) are to pay all claims in accordance with the new rates for dates of service October 1 through November 30 that MCOs receive by November 30, by December 31, 2024. Thereafter claims will be paid in accordance with the new rates following normal timely filing requirements. iCare will make every effort to process claims at the new rate timely to avoid reprocessing of claims. Inclusa will be providing new authorizations that reflect a rate at or above the Minimum Fee Schedule with a start date of 10/1/2024 to avoid the need for claims reprocessing in most instances.

This change impacts both iCare Family Care (branded Inclusa) and Family Care Partnership (*i*Care) programs.

Family Care/Inclusa Authorizations:

Residential (AFH, RCAC, CBRF)

With the new MFS effective 10/1/2024, impacted residential authorizations will now require the addition of a procedure code and modifiers and must be updated.

The following information is required on these authorization types effective 10/1/2024

- Revenue Code
- Procedure Code
- Modifier 1
- Modifier 2
- Modifier 3 – 4 when applicable
- Member Tier from LTCFS
- Date LTCFS was calculated

The table below outlines the corresponding code structures.

DHS Medical Coding Changes for Family Care and Family Care Partnership Residential Services

Allowable Service Codes, Effective 10/1/2024:

Revenue Code	National Definition	Notes	Required Procedure Code	Required Modifiers
0240	All Inclusive Ancillary General Classification	Use for 1-2 Bed AFH.	T2031 (Assisted Living; Waiver, Per Diem)	-U1, U2, or U3 as the first modifier. -U5 or U6 as the second modifier. -U7 as the third modifier. -U4 as the fourth modifier if applicable.
0241	All Inclusive Ancillary Basic	Use for 3-4 Bed AFH.	T2031 (Assisted Living; Waiver, Per Diem)	-U1, U2, or U3 as the first modifier. -U5 or U6 as the second modifier. -U8 as the third modifier. -U4 as the fourth modifier if applicable.
0242	All Inclusive Ancillary Comprehensive	Use for a CBRF with 8 beds or fewer.	T2033 (Residential Care, Not Otherwise Specified, Waiver; Per Diem)	-U1, U2, or U3 as the first modifier. -U7 as the second modifier. -U4 as the third modifier if applicable.
0243	All Inclusive Ancillary Specialty	Use for a CBRF with more than 8 beds.	T2033 (Residential Care, Not Otherwise Specified, Waiver; Per Diem)	-U1, U2, or U3 as the first modifier. -U8 as the second modifier. -U4 as the third modifier if applicable.
0670	Outpatient Special Residence Charges General Classification	Use for a RCAC.	T2033 (Residential Care, Not Otherwise Specified, Waiver; Per Diem)	-U9 as the first modifier. -U4 as the second modifier if applicable.

Modifiers for Residential Care

Modifier	Notes for Modifier Usage
U1	Use to indicate that the member meets the criteria for Level of Need (Acuity) Tier 1, based on elements from the member's Long-Term Care Functional Screen.
U2	Use to indicate that the member meets the criteria for Level of Need (Acuity) Tier 2, based on elements from the member's Long-Term Care Functional Screen.
U3	Use to indicate that the member meets the criteria for Level of Need (Acuity) Tier 3, based on elements from the member's Long-Term Care Functional Screen.
U4	Use to indicate the member received 24-hour 1-on-1 (or greater) care.

U5	Use to indicate that the Adult Family Home is owner-occupied.
U6	Use to indicate that the Adult Family Home is corporate owned.
U7	For AFH, use to indicate 1-2 bed Adult Family Home. For CBRF, use for Community Based Residential Facilities with 5-8 beds.
U8	For AFH, use to indicate 3-4 bed Adult Family Home. For CBRF, use for Community Based Residential Facilities with 9 or more beds.
U9	For RCAC, use to indicate Residential Care Apartment Complex.

Provider Impact and Process Change:

To comply with the above changes, residential authorizations will end 9/30/2024 and new authorizations will be issued with a start date of 10/1/2024.

To properly implement the required MFS changes, Inclusa will resume the process of two separate residential authorizations (versus the current process of one all-inclusive authorization), one for room and board and one for care and supervision.

- **Room and Board:** Effective 10/1/2024, you will be issued a new room and board authorization that will end 1/31/2025. (Note: New authorizations will be issued effective 2/1/2025 based on the updated HUD rates and the member's ability to pay.)
    - Providers will receive an authorization with one of the following codes:
        - 0120: 1-2 bed AFH
        - 0130: 3-4 bed AFH
        - 0150: CBRF 8 beds or fewer
        - 0159: CBRF more than 8 beds
        - 0167: RCAC

- **Care and Supervision:** This authorization will reflect the MFS changes per the DHS Medical Coding Changes and corresponding rate structure as appropriate set forth by DHS.

Non-Residential-Supportive Home Care (SHC), including SHC Days, Self-Directed Supports (SDS) and Community Supported Living (CSL) services

The MFS changes for these services are effective 10/1/2024 as well.

For SHC (Quarter Hour) services, new authorizations will **NOT** be issued for the impacted authorizations as the rates will be updated on the existing authorization. Please ensure that claims submitted for dates of service on and after 10/1/2024 are billed with the new rate.

For SHC Days, SDS and CSL, authorizations **MAY** change with a start date effective 10/1/2024 if the rate is adjusted to ensure compliance with the Minimum Fee schedule.

Residential Claims Processing:

Please note these instructions pertain to your Care and Supervision authorization only (not room and board).

In order to meet these enhanced requirements, WPS is in the process of updating their system to accommodate both a revenue code and a procedure code.

Your Inclusa authorization will have the revenue code, procedure code and all modifiers based on the DHS Medical Coding listed above.

Providers must bill with the authorization number, revenue code, procedure code and modifiers on an institutional claim form.

The billed revenue code **MUST** match the authorized revenue code. If the revenue code on the claim does not match what is on the authorization, WPS will deny the claim back to the provider.