WRAPAROUND MILWAUKEE Policy & Procedure	Date Issued: 9/1/98	Reviewed: 11/15/10 By: PE Last Revision: 12/2/10	Section: ADMINISTRATION	Policy No: 025	Pages: 1 of 8 (7 Attachments)
☒ Wraparound ☒ Wraparound-REACH ☒ FISS ☒ Project O-Yeah	Effective Date: 1/1/11	Subject: **IN-HOME THERAPY**			

I. POLICY

It is the policy of Wraparound Milwaukee / REACH / O-YEAH and FISS Services that In-Home Therapy be available to all clients/families if deemed necessary by the Child & Family Team and as indicated in the Treatment Plan / Plan of Care / Future Plan. In-Home Therapy encompasses intensive, time-limited therapy services that are provided in the client's place of residence, family's home, or when necessary (***though rarely***), in a community-based setting (i.e., neutral ground, if the home setting is unsafe for the provision of services).

NOTE: This policy utilizes the term "Care Coordinator", which also applies to FISS Managers, REACH Care Coordinators and O-YEAH Transition Specialists. It also uses the terms "Child and Family Team" - which applies to any group of people that may be working with a family, "Plan of Care Meeting" – which also applies to any meeting that may occur to address the needs, strengths, progress, etc., of a family and "Plan of Care" - which also applies to Treatment Plan or the Future Plan for O-YEAH clients.

II. PROCEDURE

A. GENERAL CARE COORDINATOR RESPONSIBILITIES.

1. If In-Home services are being sought by the Child & Family Team, a REFERRAL FORM (*Wraparound Milwaukee / REACH / O-YEAH Provider Referral Form – see Attachment 1 and FISS Services Referral Form – see Attachment 2*) must be completed and given to the selected In-Home Therapy Provider prior to the provision of service.

2. A monthly Service Authorization Request (SAR) must then be completed by the Care Coordinator authorizing In-Home Therapy using the appropriate codes and rates as follows.
   - 5160 In-Home Lead $60.00 per hour
   - 5161 In-Home Aide $30.00 per hour

   Note: The authorization cap/limit for Code 5160 is 14 hours per month per client/family. The authorization cap/limit for Code 5161 is 12 hours per month per client/family.

3. For the initial visit, the Care Coordinator must accompany the In-Home Therapist to the home/residence of the family/youth. The Child & Family Team will determine if the Care Coordinator should accompany the In-Home Therapist to future home visits.

4. The Care Coordinator must invite the In-Home Provider to the Child & Family Team and Plan of Care meetings and, with the written consent of the parent/legal guardian/enrollee, provide the In-Home Therapist(s) with a current copy of the Plan of Care and all subsequent Plans of Care. The only exception to the Care Coordinator not being able to provide the In-Home Therapist with a copy of the Plan of Care is if the legal guardian/enrollee does not consent to do so. The Plan of Care must indicate what goals/needs the In-Home Therapist/Team is to specifically address, the specific methods of treatment the therapist(s) will be using and the expected time frame for meeting those needs.

B. IN-HOME PROVIDER CREDENTIALS / REQUIREMENTS/JOB DESCRIPTIONS.

1. **In-Home Leads (5160) and Aides (5161).**
   In-Home Leads (5160) and Aides (5161) must meet the credential/licensure requirements in effect at

the time of Agency/Provider application (*see relevant Service Description List / Universal Application Packet for credential/licensure requirements).* Credentials/licenses must be maintained/renewed per State regulatory and Wraparound Milwaukee expectations. Should State/Wraparound requirements change during the course of the provision of services, the Provider/Agency is expected to meet those expectations (*see Lead and Aide Job Descriptions – Attachments 3 & 4).*

C. SUPERVISION.

1. A Lead (5160) from the same Agency as the Case Aide, must supervise the Aide (5161).

2. An In-Home Case Aide cannot be authorized to independently provide services for a client/family. A Case Aide must always be part of a 5160/5161 Team.

D. SERVICE EXPECTATIONS / DESCRIPTIONS.

1. Intensive In-Home Therapy is generally a "**Family All**" systemic focused service, although individual and/or family counseling/psycho-therapy sessions are permissible. Identified needs, measurable goals and the intensity of treatment should be consistent with the assessment conducted on the child/family/enrollee and with the Plan of Care. Methods of intervention must meet professional standards of practice.

2. Services that are primarily social or recreational are **not** reimbursable. However, this should not be construed as implying that appropriate clinical interventions that employ social or recreational activities to augment the therapeutic process, such as play therapy, are not covered. The Plan of Care should be used to clearly identify the relationship of the planned interventions to the treatment goals and identified needs.

3. All services provided to the youth/enrollee must be directly related to the his/her emotional/behavioral challenges.

   Services provided to the enrollee's parents, caregivers (i.e., potential adoptive resources), siblings, or other individuals significantly involved with the enrollee are deemed appropriate as part of the In-Home Treatment when these services are required to directly affect the enrollee's functioning at home or in the community. Such services may include therapy necessary to deal with family issues related to the promotion of healthy functioning, behavior training with responsible adults to identify concerning behaviors and develop appropriate responses, supervision of the child and family members in the home setting to evaluate the effect of behavioral intervention approaches and provide feedback to the family on implementing these interventions, and minimal supportive interventions with family members or significant others which are necessary to ensure their ability to continue their participation in the In-Home Treatment process.

4. Interventions with family members that are primarily AODA focused (i.e. interventions directed solely at a parent's alcohol abuse) should be authorized under AODA treatment. However, when the intervention is with the majority of the family and is focusing on the way in which the parent's alcohol abuse is affecting the child/enrollee and/or contributing to the problem behaviors, this may be authorized under these guidelines. When alcohol and other drug abuse treatment issues are identified as part of the In-Home Treatment in the Plan of Care, an appropriately qualified AODA counselor must be a part of the In-Home team or may be the primary In-Home Therapist (if dual certified).

5. An In-Home Therapist should **NOT be authorized to work with the youth/enrollee and his/her treatment foster parents while the youth is in the treatment foster home**. The only exception to this would be if the treatment foster home were an adoptive resource. In-Home can be authorized

while the youth is in the treatment foster home if the In-Home Therapist is bringing the biological family/youth together to promote reunification, which is expected to occur within 60 to 90 days.

6. It is expected that over time the intensity of In-Home hours (Lead and Aide) would decrease, as the client/family becomes more empowered/stable.

E. CLIENT FILE / DOCUMENTATION / UTILIZATION GUIDELINES.

1. The In-Home Provider must maintain a record/chart on each client for which In-Home services are provided. This record/chart must be separate from the Care Coordinator's client chart. (*See Vendor Responsibilities & Guidelines Policy #054 for additional information regarding client chart expectations.)*

   Note: Questions have been raised regarding keeping separate charts for other family members if the primary In-Home Therapy is being done with that individual. <u>There should be only one chart per billable client/family</u>.

2. The record/chart must be assembled in an organized fashion, as follows:
   a. Sections should refer to the different documentation required, i.e., Progress Notes, Treatment Plans, Logs, etc.
   b. Notes should be in chronological order with the most current on top.
   c. The client's name should be indicated on the chart.

3. All records/charts should be maintained at the agency office in a secure cabinet/room. All client records/charts are considered confidential information and must be treated as such. All laws and requirements related to HIPAA (Health Insurance Portability and Accountability Act) must be implemented and followed.

4. The In-Home record/chart **<u>must</u>** contain the following:
   a. Wraparound Milwaukee, REACH, FISS or O-YEAH Services Provider Referral Form.
   b. Agency Consent to Treatment & Disclosure Form (the Agency must furnish their own).
   c.. A copy of the current and all past Plans of Care relevant to the timeframe that the client was served (unless otherwise indicated by the legal guardian), Plan of Care (POC)/Treatment Plan that reflects specific In-Home Therapy needs/goals, strategies and expected time frames for achievement for meeting those needs.
   d. In-Home Therapy Progress Notes (*see Attachment 5 and Sample Attachments 5A & 5B*).
   e. In-Home Therapy Service Logs (*see Attachment 6 and Sample 6A for Wraparound/REACH/O-YEAH and Attachment 7 for FISS*).
   f. Any relevant billing documentation.
   g. Agency Discharge Summary (if client has been discharged from therapy).
   h. Other significant items as needed (i.e., psychological reports, school reports, court reports,
   In- Home Agency social/mental health assessment, etc.).

   Note: An In-Home MD prescription is <u>not</u> needed. The sign-off by the psychologist/psychiatrist on the Plan of Care, which should reference the In-Home needs/goals/treatment, is sufficient.

5. The Provider shall retain all records/charts until the client becomes 19 years of age or until 7 years after treatment has been complete, whichever is longer. Termination of a Provider's participation in the Wraparound Provider Network does not terminate the Provider's responsibility to retain the records unless program-specific Management has approved an alternative arrangement for record retention and maintenance.

6. A Provider shall prepare and maintain truthful, accurate, complete, legible, and concise documentation. Progress Notes must be completed immediately after the service is provided. The Progress Note documentation must include the following:
   a. The In-Home Agency Name.
   b. The identity of the person(s) who provided the service to the recipient (i.e., therapist(s) signature(s) and credentials).
   c. The full name of the recipient(s).
   d. The name of the Care Coordinator / FISS Manager /Transition Specialist.
   e. The place/location where the service was provided.
   f. An accurate description of each service provided (i.e., check if billable or non-billable service and the code that was billed).
   g. The date(s) start and stop time (duration), and amount of time that service was provided (direct service and travel or no-show).
   h. A descriptive summary of the therapeutic intervention, session outcomes, client's response and plan for future sessions.
   i. The signatures (full name and credentials) of the Therapist(s) who provided the service. A signature is required after each entry.
      Note: Pre-signing of Progress Notes is considered fraudulent behavior and may be grounds for termination from any/all County Provider Networks and may prohibit any future contractual arrangements with Milwaukee County.
   j. The date that the note was written.

   The In-Home Therapy PROGRESS NOTE form is attached (s*ee Attachment 6*). **The use of this Progress Note form is MANDATORY**. Two samples of completed Progress Notes forms are also attached (*see Attachments 6A and 6B*).

7. For **every** client/collateral contact made **whether billable or not billable** there should be reference to that contact in a Progress Note, which should then be filed in the Progress Note area of the chart. **Monthly summaries are not acceptable.**

8. For those client/collateral contacts that are billable, documentation must be sufficient to be able to determine that the services provided correlate to what was billed under the authorized codes and authorized/approved hours.

9. An In-Home "Team" can be defined as a Lead (5160) and a Case Aide (5161) from the same Agency. This combination of Therapists is preferred and encouraged.

   When an In-Home "Team" is going in to see a client/family, the following guidelines apply:
   a. If a client/family is being seen by the "Team" **simultaneously** (i.e., same time, date, place), it is only necessary for the Primary Lead Therapist (5160) to write a Progress Note for that direct contact. The Progress Note must specify that the other team member was present and that person must also sign-off on the Progress Note under the "Co-Therapist Signature" area.
   b. If **individual** contacts (face-to-face, phone or collateral) are being made by either of the team members, this also needs to be documented, but a Co-Therapist's signature is not needed.

   If there is an In-Home "Team" providing services, the documentation from both Providers should be kept in the **same** designated In-Home client chart.

10. If a "Team" is not being used, a Lead (5160) providing services alone is permissible.

    Note: Only one Vendor should provide In-Home services to a family. It is not recommended to have multiple providers / agencies providing services to the family simultaneously, unless specifically therapeutically indicated.

11. **The use of "White Out" on the Progress Note and Log is <u>not permissible</u>**. If an error occurs, it must be crossed out with a single line and dated and initialed by the author of the Progress Note/Log (i.e., John was being ~~aggressive~~ 8/14/02-L.M.). Photocopying of blank Progress Notes with the Provider's Signature on them or stamped signatures is **<u>not permissible</u>**. All Progress Note entries / notes must have an original signature.

F. DOCUMENTATION FOR "NO SHOW".

1. A "No Show" is considered to be a missed appointment by the client/family (i.e., the client/family is not at home when the therapist arrives or the client/family never shows up at the designated meeting place).

2. To be able to bill <u>travel time</u> for a "No Show" this <u>must</u> be indicated in a Progress Note and the "No Show" line under the Billable Service area should be checked (*see Attachment 6B - Sample Progress Note for how to document a No Show*).

3. A situation may occur when a therapist(s) arrives at the home of a client/family and **a member of the Child and Family Team is present, but not the person/people that the appointment was originally scheduled with.** If the therapist(s) has a significant interaction with that Child and Family Team Member that **<u>relates</u>** to the care/treatment of the client/family, then the therapist(s) can bill for that interaction (*see Attachments 6B - Sample Progress Note*).

G. IN-HOME THERAPY SERVICE LOG DOCUMENTATION. (*Wraparound / REACH /O-YEAH Only*)

To verify **billable** client contact/services, the In-Home Provider **<u>must</u>** utilize the IN-HOME THERAPY SERVICE LOG (*see Attachment 7 and Sample 7A*); this must be done **<u>in addition</u>** to the Progress Note.

The Log should be filled out completely <u>after every billable client contact</u> and then **<u>the recipient of the service should sign off on the Log</u>** to verify that the service was provided. The Therapist should be carrying the Log to every session and acquiring <u>the signature of the therapy recipient at the session's end</u>. Completing the Log(s) in its/their entirety at the end of the month or several months past the sessions and expecting the recipient of services to recall all sessions <u>is not acceptable</u>. The information on the Log and Progress Note <u>must</u> be consistent with each other. Billable crisis/therapeutic phone calls and "No Show" situations must also be listed on the Log, but a client's signature for these contacts is **<u>not</u>** required. There must be documentation of these services in a Progress Note. This Log should be kept in the In-Home client chart and does not need to be submitted to the Care Coordinator unless requested. One Log per month should be maintained.

Note: Having the client pre-sign the In-Home Therapy Service Log is considered fraudulent behavior and may be grounds for termination from any/all County Provider Networks and may prohibit any future contractual arrangements with Milwaukee County.

H. IN-HOME PROVIDER LOG. (*FISS Only*)

In addition to the In-Home Progress Note, FISS Services requires the IN-HOME PROVIDER LOG (*see Attachment 8)* to be completed <u>on a monthly basis</u> and sent to the FISS Manager. Billable crisis/therapeutic phone calls and "No Show" situations must also be documented on the Provider Log.

FISS **<u>requires</u>** the Log to be attached to the Invoice when billing is submitted and the Agency must keep a copy in the client file. The Parent/Guardian and Provider must sign and date the Log <u>at the end of the month</u> in which the services were provided.

I. BILLING.

Reminder: When primarily providing Individual type In-Home Services to a family member (i.e., parent, sibling), Wraparound Milwaukee should be the payor of last resort. The parent's/sibling's other insurance (if any) should be initially pursued for payment of services.

1. The following codes/rates are to be used for In-Home billing:
   - 5160 In-Home Lead $60 per hour
   - 5161 In-Home Aide $30 per hour

2. You should bill for In-Home Services by the tenth of an hour (i.e., .1 equals 6 minutes, .2 equals 12 minutes, .3 equals 18 minutes, .4 equals 24 minutes, .5 equals 30 minutes, etc.).

3. Travel time to and from a client's home should be built into the hourly rate (i.e., if you travel 30 minutes to the clients home, see the client for 1 hour, and return travel is 30 minutes, you should be billing for a total of two (2) hours). Travel time can be incorporated under the same code you are using to bill for In-Home Services. **There is no separate travel code - up to one hour of travel time can be billed each way, but it** should not be assumed that the In-Home Therapist should bill an automatic one (1) hour of travel each way. Travel time can consist of the time to travel from the Provider's office to the client's home or from the previous appointment to the client's home. Travel time exceeding one hour one-way is **not** acceptable, as most Providers have offices in Milwaukee County and provide services to clients/families who live in Milwaukee County.

4. **For Wraparound Clients Only.**
   Guidelines for reimbursement for travel time and seeing youth who are residing in placements that are out of town (i.e., Homme Home, Eau Claire, or Group Homes in communities that are 1+ hours away) is referenced below.

   Reimbursement for up to 2 hours of travel time – one way, will be allowed in the following situations under the following guidelines:

   a. Therapist is traveling ALONE in the vehicle to see a youth in a placement that is 1+ hour away. (If the Therapist is also transporting a caregiver/family member to go visit the youth and a therapeutic conversation is occurring during the transport, then this time can be billed as face-to-face time versus travel time.)

      Reminder: Whenever a Provider is transporting any family member, a Transportation Consent Form should be signed and dated prior to the transport. The driver must have a valid/current driver's license with adequate insurance coverage.

      Guidelines for serving youth who are residing out of town are as follows:

      1) The need for this Therapist to maintain contact with this youth for therapeutic reasons must be specifically identified in the Plan of Care.
      2) Visits to the youth cannot occur more than 2 times per month.
      3) For auditing purposes, the Therapist must reference the out-of-town visit in the In-Home Progress Note. "Other" should be checked under the "Location" area of the Note and the out-of-town destination should be identified.

      Note: Providing In-Home Services to a youth in an out-of-town placement should be a rare occurrence.

5. Services you **CAN** bill for under the In-Home Codes consist of the following:
   a. Direct face-to-face contact/home visits - include travel time.
   b. Attendance at Plan of Care/Child & Family Team meetings - include travel time.
   c. Any involvement that you may have with the child in his school setting, if you are instructing

the teacher/teachers aid on techniques used to promote improved functioning in that setting (i.e., use of a behavioral modification program, establishing a reward program, teaching crisis techniques such as hands-on restraint or verbal crisis intervention techniques) - include travel time.

Note: In-Home Therapists/Aides should not be seeing youth in the school setting unless it is specifically identified within the POC, all Child & Family Team and school personnel are in agreement with the arrangement and the In-Home Therapist/Aide is specifically engaging in interventions as described in section E.3. above.

d. Other meetings (i.e., Residential Care Center meetings, Agency staffing, etc.) in which your input is necessary and requested to assure comprehensive/collaborative care. **The child and /or family must be present** at these meetings to be able to bill - include travel time.

e. Communication with the family/child over the phone that can be considered "therapeutic" (i.e., crisis/behavioral intervention, guidance/instructions as to the implementation of a treatment modality).

6. Services you **CANNOT** bill for under the In-Home codes consist of the following:
   a. Setting up appointments with the family.
   b. Sharing information with the Care Coordinator.
   c. Speaking with the family/child about issues of a more "general" nature versus a "specific" treatment issue.
   d. Meetings that you attend where the child/family may be discussed, but in which the child/family are **not** present.
   e. Conversations with other professionals regarding the client/family in which the child/family are **not** present.
7. Billing for "No Shows".
   a. You are allowed to bill **up to** a total of one hour for travel time for a "No Show" at the respective rate that you would be billing had you seen the client. If on a rare occasion, the client was scheduled to come to the In-Home Therapist's office for a particular therapy session and does not show, the Therapist **cannot** bill any time for this "No Show".
   b. Time billed for No Shows is included in the capitated hourly rate, which is 14 hours per month for 5160 and 12 hours per month for 5161.
   c. If two to three No Shows are occurring within a month, then the Child & Family Team should meet to discuss the issue. Excessive billing for No Shows on any one client will be questioned during auditing.

Note: It should not be presumed that you would automatically bill one hour of travel for a No Show. If it normally takes you 30 minutes to get to and from a client's home, then you would only bill for 30 minutes.

8. You must be approved through the Wraparound Provider Network and be listed in our Synthesis IT system for any and all potential services/codes that you may bill for prior to providing the service.

9. A Provider/Agency should not bill for services prior to there being complete/accurate documentation (i.e., Progress Notes and associated Logs).

J. AUDITING.

1. At the request of a person(s) authorized by the Wraparound Provider Network, Milwaukee County, State of Wisconsin or Federal Government, a Provider shall permit access to any requested records. Access shall include the opportunity to inspect, review, audit and reproduce the records.

2. The respective Program may refuse to pay claims and may recover previous payments made on claims where the Provider fails or refuses to prepare and maintain records or permit authorized department personnel to have access to records for purposes of disclosing, substantiating or otherwise

auditing the provision, nature, scope, quality, appropriateness and necessity of services which are the subject of claims or for purposes of determining Provider compliance with stated policy requirements.

K. SERVICE PROVISION BY SOLE PRACTITIONERS.

If a Sole Practitioner's In-Home Therapy office is based in their home/residence, they may not see clients in that home-based office location. If the Sole Practitioner decides to expand their practice to do other types of therapies (i.e., individual/family therapy – 5100, etc.), then the Sole Practitioner must acquire a community-based office site prior to requesting to provide these other types of services within the Provider Network.

General Note: In addition to the above Policy and Procedure, the Provider is also encouraged to revisit the Fee-For-Service Agreement entered into with the respective Program regarding additional obligations, compensation guidelines, case record requirements, insurance/indemnification/debarment issues, etc.

Reviewed & Approved by: Bruce Kamradt

Bruce Kamradt, Director

WRAPAROUND MILWAUKEE
In-Home Therapy Policy
Attachment 1

WRAPAROUND MILWAUKEE

PROVIDER REFERRAL FORM

Reminder: Providers please assure that the initial visit is done with the Care Coordinator.

Referral Completion Date _____

Referred by:

_____ _____
Name of Care Coordinator Name of Care Coordination Agency

Phone (___)_____ Pager (____)_____ Cell Phone (____)_____

Name of Provider/Agency being referred to:_____

Address _____

City _____ State_____ Zip _____

Name of Provider Contact Person _____ Phone (____)_____

1. **Service being requested**:_____ Service Code _____
   Frequency / Days & Times being requested: _____
2. **Service being requested**:_____ Service Code _____
   Frequency / Days & Times being requested: _____
3. **Service being requested**:_____Service Code _____
   Frequency / Days & Times being requested: _____
4. **Service being requested**:_____Service Code _____
   Frequency / Days & Times being requested: _____

Name of Client being Referred:_____ Phone (____)_____

Address _____

City_____ State_____ Zip_____

Name of associated WM Enrollee (if different than client being referred) _____

Relationship of Referred Client to WM Enrollee (if not the same – i.e., mother, sibling, etc.)_____

Client Lives With:_____ **Relationship:**_____

Ethnicity: ☐ African American ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Asian ☐ Other _____

Gender: ☐ Male ☐ Female **DOB**: _____ **SSN:** _____

Special Accommodation Needs, if any *(i.e., physical and sensory disabilities, medical needs, limitations, etc):*

_____

FAMILY/SCHOOL INFORMATION

Mother/Legal Guardian _____ Home Phone (____)_____

Address _____ Work Phone (____)_____

City_____ State_____ Zip _____

Father/Legal Guardian _____ Home Phone (____)_____

Address _____ Work Phone (____)_____

City_____ State _____ Zip _____

Other Emergency Contact _____ Home Phone (____)_____

Address _____ Work Phone (____)_____

City_____ State_____ Zip _____

Relationship to Client _____

Siblings/Children: (*Not required for transportation services if only transporting identified client.*)

1. _____ **DOB** _____

2. _____ **DOB** _____

3. _____ **DOB** _____

4. _____ **DOB** _____

School _____ ☐ Not Attending ☐ Not Enrolled ☐ N/A

Grade _____ **Special Education:** ☐ Yes ☐ No

GENERAL INFORMATION

Diagnosis: *(Required only if referring to medical or mental health providers.)*

_____

Currently on Medication? ☐ **Yes** ☐ **No** **If yes, what type?** _____

Strengths/Interests*:* (*Not required for transportation referrals.)*

_____

_____

_____

Needs/Reason for Referral: (*Not required for transportation referrals.)*

_____

_____

_____

Safety Concerns: _____

_____

_____

_____

.....

(For Provider Agency Use Only)

Date Referral was Received _____

FISS SERVICES

Behavioral Health Division

REFERRAL FORM FOR PROVIDERS OF SAFENOW

DATE:			
PROGRAM:	**FISS**		
REFERRED BY:		**AGENCY:**	St. Charles Youth & Family
		PHONE:	
PROVIDER:		**PHONE:**	
		FAX:	
INDIVIDUAL REFERRED:		**SOCIAL SECURITY #:**	
ADDRESS:			
TELEPHONE #:			
SEX:		**HERITAGE:**	
LIVES WITH:			

FAMILY INFORMATION

MOTHER'S NAME:		**HOME PHONE:**	
SS #:		**WORK PHONE:**	
ETHNICITY:		**ADDRESS:**	
FATHER'S NAME:		**HOME PHONE:**	
		WORK PHONE:	
		ADDRESS:	
CHILD(REN)/SIBLINGS:		**DOB:**	
		DOB:	
		DOB:	

		DOB:	
		DOB:	
		DOB:	
OTHER EMERGENCY CONTACT:		**TELEPHONE NUMBERS:**	

GENERAL INFORMATION

SCHOOL:	ENROLLED _____	NOT ENROLLED _____
GRADE:	SPECIAL ED: YES: _____	NO: _____
RECREATIONAL ACTIVITIES/INTERESTS:		
CURRENTLY ON MEDICATION:	YES: _____ NO: _____	
IF YES, WHAT TYPE:		

Narrative describing relevant information/family dynamics/safety concerns:
This is a FISS case.
Physical problems/special needs/limitations:
Goals of Services:
➢
➢
➢
➢
➢

PLEASE INFORM SSM OF CASE ASSIGNMENT WITHIN 24 HOURS

Authorized Services:			
Service Recipient	Intervention	**Service Code**	*Unit/Description*

In-Home Therapy Lead Team Member

JOB DESCRIPTION

(Service Code 5160)

I. Qualifications.

A. Credentials.

Individuals with the appropriate credentials as outlined below may provide In-Home Lead services for the Wraparound Milwaukee, FISS Services, REACH and O-YEAH programs.

In-Home Lead services can be provided by:

1. Wisconsin Licensed Practitioners Practicing Privately or in a Wisconsin Certified Clinic.
   - Licensed Clinical Social Worker.
   - Licensed Marriage and Family Therapist
   - Licensed Professional Counselor.
   - Licensed Psychologist.
   - Psychiatrist.
2. Music, Art, Dance Therapist with Wisconsin Psychotherapy License.
3. Other Qualified Professionals in a Certified Outpatient Psychotherapy Clinic.
   - Practitioner with a status Approval (3000 hour) Psychotherapy Letter issued by the Wisconsin Department of Health Services, Division of Quality Assurance (DHS, DQA).

Providers of in-Home Medicaid Lead services must also satisfactorily complete the Wraparound Milwaukee Practitioner credentialing process and have a National Provider Identifier NPI).

B. Documentation Requirements.

During the application process, agencies / individuals shall submit a copy of **one of** the following:

1. State of Wisconsin License or Certification as described above.
2. Letter from the Program Certification Unit of the State of Wisconsin Bureau of Quality Assurance verifying attainment of 3,000 clinical hours and status as a psychotherapist to provide services under supervision in a Certified Mental Health Clinic.
3. EDS letter verifying a Provider's Billing Status as a Master's Level Psychotherapist in a Certified Mental Health Clinic.

Additional Documentation Requirements:

1. Documents for Certified Professionals Practicing Privately as described under section 1.b. above, must submit a copy of the License of supervisory agent. If this individual is a Licensed Clinical Social Worker (other than a doctorate degree), include a resume that demonstrates 5 years of experience.
2. Copy of Outpatient Clinic License, if working in an Outpatient Psychotherapy Clinic (if not already on file).

II. Working Hours.

Flexible, including evening and possible weekend hours as determined by the needs of the client and program.

III. Supervision

If part of an In-Home "Team" (i.e., a Lead and Aide), the Lead must provide supervision to the Aide.

IV. Duties.

- Has knowledge of Wraparound/REACH/FISS/O-YEAH philosophy regarding the provision of services/care.
- Provides In-Home Therapy primarily in the client's home or as necessary in a community-based location.

- Demonstrates adherence to established goals, standards of care, rules and regulations within the In-Home Policy (#025), the individual's profession and the State of Wisconsin (i.e., mandatory reporting requirements).
- Applies knowledge and experience of relevant psychosocial practice assuring thorough assessment of strengths and needs with respect to all domains of family's life functioning.
- Observes and collects with fellow team members relevant data of psychosocial, developmental characteristics and family patterns of the referred youth.
- As appropriate, keeps team members and the Mobile Urgent Treatment Team (MUTT) informed of progress, setbacks or possible crisis situations.
- Communicates routinely with the Care Coordinator to assure comprehensive care.
- Participates in Family Team meetings/Plan of Care meetings led by the Care Coordinator in collaboration with families and their support systems. Assists in the development of the Plan of Care/Treatment Plan, identification of family strengths/needs and recommendations for goal revision as reflective of In-Home Therapy needs.
  Note: The Plan of Care/Treatment Plan must indicate what goals/needs the In-Home Therapist/Team members are to specifically address, the specific methods of therapy and expected time frame for achieving these goals and the Therapist/Team member's name(s). The In-Home Therapist should be signing the attendance sheet at the Plan of Care/Child & Family Team meetings
- Works individually or with a second Team member/In-Home Aide in therapeutically assisting families in the following:
  a. Skill development/coping strategies in a variety of life areas/life domains.
  b. Role models and teaches parenting skills, anger management, behavioral control, etc.
  c. All In-Home related "Needs" identified on the Plan of Care / Treatment Plan.
- Plans for discharge in collaboration with the youth and family team throughout the course of services.
- Utilizes clinical consultation and support from Physicians, Psychologists, and fellow team members as needed or required.
- Actively seeks resources, utilizes literature and ongoing inservice training to update knowledge base and improve practice. Participates in opportunities to enhance cultural competence and knowledge of various ethnic practices. Attends Integrated Provider Network orientations. Attends Integrated Provider Network monthly meetings as able.
- Is accessible, if needed, to the youth, family, and/or Care Coordinator according to the In-Home Policy.

In-Home Therapy Case Aide

JOB DESCRIPTION

(Service Codes 5161)

I. Qualifications

The In-Home Therapy Case Aide is always the second person on a two-person team. A Case Aide cannot provide services/engage in interventions that would be considered "psychotherapy". Only the Lead is qualified to engage in psychotherapeutic interventions.

A. Credentials.

The In-Home Aide must possess **one of** the following credentials:

1. An individual with a minimum of a BA/BS Degree in a behavioral health service, a registered nurse, an occupational therapist, a WMAP-certified AODA counselor or a professional with equivalent training **and** at least 1,000+ hours of supervised clinical experience working in a program whose primary clients are emotionally and behaviorally disturbed youth, children, and/or families.
2. An individual with minimum of 2,000+ hours of supervised clinical experience (without a degree) working in a program whose primary clients are emotionally and behaviorally disturbed youth, children and/or families.

B. Documentation Requirements.

Copy of the individual's degree. Proof of experience must be documented in one or more letters of reference supporting the supervised experience or a resume with written corroboration of prior experience by current employer.

II. Working Hours - Flexible, including evening and possible weekend hours as determined by the needs of the client and program.

III. Supervision – An Aide must be supervised by a Medicaid reimbursable Lead Therapist (see 5160).

IV. Duties.

- Has knowledge of Wraparound/REACH/FISS/O-YEAH philosophy regarding the provision of services/care.
- Demonstrates adherence to established goals, standards of care, rules and regulations within the In-Home Policy (#025), the individual's profession (if applicable) and the State of Wisconsin (i.e., mandatory reporting requirements).
- Provides In-Home therapy services primarily in the client's home or as necessary in a community-based location.
- Participates in Family Team meetings/Plan of Care meetings led by the Care Coordinator in collaboration with families and their support systems. Assists in the development of the Plan of Care / Treatment Plan and identifying families strengths and needs.
- Communicates routinely with the Care Coordinator to assure comprehensive care.
- Works collaboratively with a Lead In-Home Therapist in meeting the identified needs/goals of the family.
- Documents pertinent phone contacts and when functioning without the Lead In-Home Therapist documents family visits/interventions and community meetings per the policy and procedure.
- As appropriate, keeps team members and Mobile Urgent Treatment Team (MUTT) informed of progress, setbacks, or possible crisis situations.
- Actively participates in clinical staffings. Utilizes clinical consultation/supervision and support from Physicians, Psychologists and fellow team members as needed. Accepts feedback and direction from the Lead In-Home Therapist.
- Plans for discharge in collaboration with the child and family team throughout the course of services.
- Actively seeks resources, utilizes literature and ongoing inservice training to update therapeutic knowledge base. Participates in opportunities to enhance cultural competency and knowledge of various ethnic practices.
- Is accessible, if needed, to the youth, family and/or Care Coordinator according to the In-Home Policy.

WRAPAROUND MILWAUKEE
In Home Therapy Policy
Attachment 5

IN-HOME PROGRESS NOTE
WRAPAROUND/FISS/REACH/O-YEAH

Check One:
_____Wraparound
_____FISS
_____ REACH
_____ O-YEAH

In-Home Agency Name:_____

In-Home Therapist(s): _____

Client/Casehead: _____ **ID No.** _____

Care Coord./FISS Manager: _____

CODE:

____ 5160/H2033 In-Home Lead
____ 5161/H2033 In-Home Aide

_____Date of Visit/Contact
_____Time/Duration of Visit/Contact
_____Travel Time Billed
_____Contact Time Billed
_____ Total Time Billed

BILLABLE SERVICE

____ Face to Face
____ Therapeutic Crisis Phone Contact
____ Other Mtg. w/ Family / Parent
____ POC/Tx. Plan Meeting
____ School
____ No Show ***Travel Only***

NON-BILLABLE SERVICE

____ **Phone Contact Family / Collateral**
____ Mtg. Family / Client NOT Present
____ **No Show (Office)**
____ Other (Specify) _____

LOCATION: (Check One)

____**Client's Home** ____**School** ____**Office** _____**Other (Specify)**

Progress Note Summary: To include: specific recipient(s) names, summary of session including focus of session, therapeutic intervention, client's response and any plan for future sessions. Separate progress note entries are to be made for each contact.

Therapist's Signature: **Date:**

Co-Therapist's Signature: (if applicable) **Date:**

NOTE: Therapists must sign with full name and credentials. Pre-signing of progress notes is fraudulent behavior and may be terms for termination from any/all County Provider Networks and may prohibit any future contractual arrangements with the County.

WRAPAROUND MILWAUKEE
In-Home Policy
Attachment 5A

IN-HOME PROGRESS NOTE
WRAPAROUND / FISS

Check One:
X Wraparound
___ FISS

In-Home Agency Name: ABC Therapeutics
In-Home Therapist(s): Kathy Johnson MSW, Carla Mills OTR
Client/Casehead: Josh Smith ID No. 088-56-2359
Care Coord./FISS Manager: Joe Crain / Caring, Inc.

SAMPLE

CODE:
✓ 5160/H2033 In-Home Lead / Medicaid
✓ 5161/H2033 In-Home Aide

BILLABLE SERVICE
✓ Face to Face
___ Therapeutic Crisis Phone Contact
___ Other Mtg. w/ Family / Parent
___ POC/Tx. Plan Meeting
___ School
___ No Show *Travel Only*

NON-BILLABLE SERVICE
___ Phone Contact Family / Collateral
___ Mtg. Family / Client NOT Present
___ No Show (Office)
___ Other (Specify) _____

LOCATION: (Check One)
✓ Client's Home ___ School ___ Office ___ Other (Specify) _____

6/15/05 Date of Visit/Contact
2pm-4pm Time/Duration of Visit/Contact
1.0 Travel Time Billed
2.0 Contact Time Billed
3.0 Total Time Billed

Progress Note Summary: To include: specific recipient(s) names, summary of session including focus of session, therapeutic intervention, client's response and any plan for future sessions. Separate progress note entries are to be made for each contact.

Met with Josh, Marie-mother & Nickie-sister. Therapy session focused on Josh's aggressive behavior towards (M) & sibling. Family identified triggers of anger & current ways of dealing with anger outbursts. Began to discuss alternative methods of self expression that are less aggressive. Current triggers are: 1) Nickie using Josh's personal items, 2) (M) setting limits re: curfew & chores. Current coping strategies: 1) Josh lashes out physically, i.e.- punches, kicks. All family members were receptive to alternative ways of coping but did express concern that implementation may be difficult. This writer & co-therapist plan to meet with family on 6/22/05 to continue above discussion & begin to formalize a plan for behavioral change

Therapist's Signature: Kathy Johnson MSW Date: 6/15/05
Co-Therapist's Signature: (if applicable) Carla Mills OTR Date: 6/15/05

NOTE: Therapists must sign with full name and credentials. Pre-signing of progress notes is fraudulent behavior and may be terms for termination from any/all County Provider Networks and may prohibit any future contractual arrangements with the County.

WRAPAROUND MILWAUKEE
In-Home Policy
Attachment 5B

Check One:
✓ Wraparound
___ FISS

IN-HOME PROGRESS NOTE
WRAPAROUND / FISS

In-Home Agency Name: ABC Therapeutics
In-Home Therapist(s): Kathy Johnson MSW, Carla Mills OTR
Client/Casehead: Josh Smith **ID No.** 888-56-2350
Care Coord./FISS Manager: Joe Klein, Caring, Inc.

SAMPLE

CODE:
✓ 5160/H2033 In-Home Lead / Medicaid
✓ 5161/H2033 In-Home Aide
___

6/22/05 **Date of Visit/Contact**
2:30pm-2:45 **Time/Duration of Visit/Contact**
1.0 **Travel Time Billed**
0 **Contact Time Billed**
1.0 **Total Time Billed**

BILLABLE SERVICE
___ Face to Face
___ Therapeutic Crisis Phone Contact
___ Other Mtg. w/ Family / Parent
___ POC/Tx. Plan Meeting
___ School
✓ No Show ***Travel Only***

NON-BILLABLE SERVICE
___ Phone Contact Family / Collateral
___ Mtg. Family / Client NOT Present
___ No Show (Office)
___ Other (Specify) _____

LOCATION: (Check One)
✓ Client's Home ___ School ___ Office ___ Other (Specify) _____

Progress Note Summary To include: recipient(s) names, summary of session including focus of session, therapeutic intervention, client's response and any plan for future sessions. Separate progress note entries are to be made for each contact.

This writer & co-therapist Carla Mills arrived at the Smith residence at 2:30 pm for scheduled appt. After ringing the bell several times & placing a call into the home with no response, a message was left on voice mail & on the front door for family to contact therapist ASAP to reschedule visit.

Therapist's Signature: Kathy Johnson MSW **Date:** 6/22/05

Co-Therapist's Signature: (if applicable) Carla Mills OTR **Date:** 6/22/05

NOTE: Therapists must sign with full name and credentials. Pre-signing of progress notes is fraudulent behavior and may be terms for termination from any/all County Provider Networks and may prohibit any future contractual arrangements with the County.

WRAPAROUND MILWAUKEE
In-Home Therapy Policy
Attachment 6

WRAPAROUND MILWAUKEE
IN-HOME THERAPY SERVICE LOG

For the Month/Year

CLIENT'S NAME ______________________________ **ID No.** ______________

Date of Contact	**Person(s) Seen**	**In-Home Therapist(s) name(s) & code(s) being billed**	**Length of Session/ Session Time & Travel**	**Location**	**No Show** (X here if a No Show)	**Signature of Therapy Session Recipient** (Enrollee/Client signs if being seen with the family unit or individually; other recipients sign if being seen individually)	**Relationship to Client** (Indicate relationship if it's not the enrollee/client that has signed)
			Session Start Time/End Time Total Hours: Travel Time: Total Time:				
			Session Start Time/End Time Total Hours: Travel Time: Total Time:				
			Session Start Time/End Time Total Hours: Travel Time: Total Time:				
			Session Start Time/End Time Total Hours: Travel Time: Total Time:				
			Session Start Time/End Time Total Hours: Travel Time: Total Time:				
			Session Start Time/End Time Total Hours: Travel Time: Total Time:				
			Session Start Time/End Time Total Hours: Travel Time: Total Time:				
			Session Start Time/End Time Total Hours: Travel Time: Total Time:				

NOTE: Having the enrollee/client pre-sign the In-Home Log is fraudulent behavior and may be grounds for termination from any/all County Provider Networks and may prohibit any future contractual arrangements with the County.

WRAPAROUND MILWAUKEE
In-Home Therapy Policy
Attachment 6A

WRAPAROUND MILWAUKEE
IN-HOME THERAPY SERVICE LOG

CLIENT'S NAME Josh Smith **ID No.** OFS-56-2359

For the Month/Year 8/04

Date of Contact	Person(s) Seen	In-Home Therapist(s) name(s) & code(s) being billed	Length of Session/ Session Time & Travel	Location	No Show (X here if a No Show)	Signature of Therapy Session Recipient (Enrollee/Client signs if being seen with the family unit or individually; other recipients sign if being seen individually)	Relationship to Client (Indicate relationship if it's not the enrollee/client that has signed)
8/6/04	Josh Marie-(M) Nickie-Sister	Kathy Johnson 5160 Carla Mills 5161	Session Start Time/End Time 2-4 pm Total Hours: 2.0 Travel Time: 1.0 Total Time: 3.0	Client's Home		Josh Smith	
8/8/04	Josh Marie-(M)	Carla Mills 5161	Session Start Time/End Time 6-7 pm Total Hours: 1.0 Travel Time: 1.0 Total Time: 2.0	Client's Home		Josh Smith	
8/13/04	Josh Marie-(M) Nickie-Sister	Kathy Johnson 5160 Carla Mills 5161	Session Start Time/End Time 2-4 pm Total Hours: 2.0 Travel Time: 1.0 Total Time: 3.0	Client's Home		Josh Smith	
8/15/04	—	Kathy Johnson 5160 Carla Mills 5161	Session Start Time/End Time 2:30-2:45 pm Total Hours: 0 Travel Time: 1.0 Total Time: 1.0	—	X	—	
8/20/04	Josh Nickie-Sister	Carla Mills 5161	Session Start Time/End Time 6-7:30 pm Total Hours: 1.5 Travel Time: 1.0 Total Time: 2.5	Client's Home		Josh Smith	
8/22/04	Marie-(M)	Carla Mills 5161	Session Start Time/End Time 10-11 am Total Hours: 1.0 Travel Time: 1.0 Total Time: 2.0	Client's Home		Marie Smith	Mother
			Session Start Time/End Time Total Hours: Travel Time: Total Time:				
			Session Start Time/End Time Total Hours: Travel Time: Total Time:				

NOTE: Having the enrollee/client pre-sign the In-Home Log is fraudulent behavior and may be grounds for termination from any/all County Provider Networks and may prohibit any future contractual arrangements with the County.

WRAPAROUND MILWAUKEE
In Home Therapy Policy
Attachment 7

FISS SERVICE PROGRAM
In-Home Provider Log

Parent's Name: _____

Provider/Agency Name: _____

Service Provided: ☐ In-Home Lead (5160) ☐ In-Home Case Aide (5161)

FISS Worker: _____

For Services Provided During the Month/Year: _____

Goal(s): _____

Date	Time	Who Was Seen / What Was Accomplished

_____ _____ _____ _____

Parent/Guardian Signature Date Provider's Signature Date

Submit this form with Parent's Signature to FISS Worker on a monthly basis and attach copy to invoice.