WRAPAROUND MILWAUKEE **POLICY & PROCEDURE**	Date Issued: **9/1/98**	Reviewed: **12/12/14** By: **PE** Last Revision: **12/12/14**	Section: **ADMINISTRATION**	Policy No: **025**	Pages: **1 of 8** (8Attachments)
☒ **Wraparound** ☒ **Wraparound-REACH** ☒ **FISS** ☒ **Project O-Yeah**	Effective Date: **1/1/15**	Subject: **IN-HOME THERAPY** (Mental Health and Substance Abuse-AODA)			

I. POLICY

It is the policy of Wraparound Milwaukee / REACH / O-YEAH and FISS Services that In-Home Therapy Services (service codes 5160, 5161 and 5167) 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 mental health and substance abuse 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 Coordinators. 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.

The In-Home agency shall develop and maintain a written description of the therapeutic approach, service model, and/or evidence based support for the service model, as well as a description of the intervals and methods used to determine whether continuation of services is warranted.

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 Synthesis-generated 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 as follows.
   - 5160 In-Home Lead
   - 5161 In-Home Aide
   - 5167 In-Home AODA

   Note: The authorization cap/limit for Code 5160 and 5167 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

In-Home Leads (5160), Aides (5161) and AODA (5167)
In-Home Leads (5160), Aides (5161) and AODA (5167) providers must meet the credential/licensure requirements in effect at the time of submission of the 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/AODA and Aide Job Descriptions – Attachments 3 & 4).*

C. SUPERVISION – (5160 and 5161 ONLY)

1. A Lead (5160) from the same Agency as the Aide, must supervise the Aide (5161).
2. An In-Home Aide cannot be authorized to independently provide services for a client/family. An In-Home 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 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 ttreatment when these services directly impact on 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, observation 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. When interventions with individual family members (other than the enrollee) are primarily/solely focused on that persons mental health or substance abuse issues, alternative service provisions should be considered, i.e. –use of a different Wraparound Service Code, billing of the service recipients HMO/private insurance.

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

foster home were an adoptive resource. In-Home can be authorized while the youth is in the foster home if the In-Home Therapist is bringing the biological family/youth together to promote reunification, which is expected to occur within 30 to 90 days.

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

E. CLIENT FILE / PROGRESS NOTES / 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 Provider Agency 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). The Plan of Care (POC)/Treatment Plan must reflect 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)*
   e. In-Home Therapy Signature/Service Logs (*see Attachment 6 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 Coordinator.
   e. The place/location where the service was provided and what program the client is associated with, i.e. – Wraparound, REACH, FISS, O'YEAH.
   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 the service was provided.
   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 use of the In-Home Progress Note (Attachment 5) is MANDATORY. Monthly summaries are not acceptable.

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.

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. **The use of "White Out" on the Progress Note and Log is not permissible**. 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 **not permissible**. All Progress Note entries / notes must have an original signature.

F. The In-Home "TEAM" and Related Documentation - (5160 and 5161 ONLY)

1. An In-Home "Team" can be defined as a Lead (5160) and an 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 the 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.

2. 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 permissible to have multiple providers / agencies providing services to the family simultaneously, unless specifically therapeutically indicated.

G. DOCUMENTATION FOR "NO SHOW"

1. A "No Show" is considered to be a missed In-Home Therapy appointment or Child and Family Team initiated scheduled meeting of any type 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 travel time for a "No Show" this must be indicated in a Progress Note and the "No Show" line under the Billable Service area must be checked. (Also see "No Show" Signature Log guidelines under Section H. below).

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 **relates** to the care/treatment of the client/family, then the therapist(s) can bill for that interaction.

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

To verify **billable** client contact/services, the In-Home Provider **must** utilize the **IN-HOME THERAPY SIGNATURE LOG** (*see Attachment 6*) this must be done **in addition** to the Progress Note.

The Log should be filled out completely after every billable client contact and then **the recipient of the service should sign off on the Log** to verify that the service was provided. The Therapist should be carrying the Log to every session and acquiring the signature of the therapy recipient at the session's end. Completing the Log(s) in its/their entirety at the end of the month or several months past the sessions is not acceptable. The information on the Log and Progress Note must 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 not required.** There must be documentation of these services in a Progress Note. The 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 Signature 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.

The use of the In-Home Therapy Signature Log is MANDATORY.

I. BILLING

1. In-Home Services and travel time **must** be billed in tenths of an hour. Use conversion chart below.

Minutes	Billing Unit	Minutes	Billing Unit
1-6 min	.1	31-36 min	.6
7-12 min	.2	37-42 min	.7
13-18 min	.3	43-48 min	.8
19-24 min	.4	49-54 min	.9
25-30 min	.5	55-60 min	1.0

2. 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. It is permissible to bill up to one hour of travel time each way, but it should not be assumed that the In-Home Therapist should automatically bill one (1) hour of travel each way.** Travel time exceeding one hour one-way will not be reimbursed as most Providers have offices in Milwaukee County and provide services to clients/families that live in Milwaukee County. Travel time consists 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. If you are traveling from one client's home to another client's home, the time it takes you to complete that trip should be divided between the two clients. Travel time cannot be billed from your last appointment if you are going home for the day. If you are returning to the office to make closure then travel time can be billed. (See I.6. below for information about billing for travel for "No Shows")

3. **Out-of-Town Travel** (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 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 the Therapist to maintain contact with a 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.

4. 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/teacher's aide 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 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 c. above. These school contacts must be time limited, i.e. – one or two sessions.

   d. Other meetings (i.e.- Residential Care Center meetings, Agency staffings, Court appearances, IEP mtgs.) in which your input is necessary **and requested by the Care Coordinator/family** to ensure 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).

5. 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/FISS Manager/Transition 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.
   f. Teleconferences/video conferencing in which you are at a remote location from where the Team is meeting. Exceptions to this limitation may be approved on a case-to-case basis by Wraparound Administration ONLY.

6. 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 reimbursed at the regular hourly rate.
   c. If two to three "No Shows" are occurring within a month, then the Child & Family Team must 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.

7. 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.

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

9. A "Provider Daily Billing Grid" is available for Provider or Agency use. (See Attachment #8-8B) This is an optional tool that can be implemented/used to ensure that service/travel time is correctly calculated/billed and that no crossover of time is occurring between clients/service provision with other clients in other networks.

   NOTE: The Provider Daily Billing Grid is an Excel document and must be filled out electronically for the fields to self populate. The electronic version of this tool is on the Wraparound website under the Provider Network tab – Frequently Used Vendor Forms – Provider Daily Billing Grid.

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
Provider Referral Form

Name: **Enrollee, Test**
DOB: 1/1/02 Ethnicity: Bi-racial
Gender: Female

Referral Date: 9/15/12
Care Coord:
Phone No(s): NULL

Current Placement:

Date	*Type*	*Location*

Contact Information

Youth	Test Enrollee	Ann Smith 9999 Any Street Milwaukee, WI 53201
Mother	Mary Enrollee	5858 S. 5th St. Milwaukee, WI 55555
Father	Joe Father	2323 S.44th Street Milwaukee, WI 53223

School Information

School	*Grade*	*Phone*	*ContactPerson*	*IEPDate*	
Auer Avenue	1st	222	me	4/1/11	
				Spec Ed Types	CD
				Spec Ed Types	N/A
				Spec Ed Types	OHI
Baraboo High School					
Bay View Middle/High School					
Bay View Middle/High School					
Bay View Middle/High School	12th				

Strengths/Interests

Strengths are

Needs/Reason for Referral

Needs are

Benchmarks / Desired Outcomes

Describe Any Safety Concerns
concerns are

Name of Provider/Agency Being Referred to:
me

Name of Agency Being Referred to
81106

NON-NETWORK Vendors only: Name of Vendor

Service Code Being Requested
code is

Service Code being Requestedd
5440

Service(s) Being Requested
being requ

Initial family contact needed by (date)

Initial appointment needed by (date)

Special Accommodation Needs, if any
asdlfjk

FISS SERVICES
Behavioral Health Division

REFERRAL FORM FOR PROVIDERS OF WRAPAROUND NETWORK

DATE:			
PROGRAM:	**FISS**		
REFERRED BY:		**AGENCY:**	St. Charles Youth & Family
		PHONE:	414-257-
			414-810-
PROVIDER:		**PHONE:**	
		FAX:	
INDIVIDUAL REFERRED:		**D.O.B.:**	
ADDRESS:			
TELEPHONE #:			
SEX:		**HERITAGE:**	
LIVES WITH:			

FAMILY INFORMATION

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

GENERAL INFORMATION

TARGET CHILD:

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:
Physical problems/special needs/limitations:
Goals of Services:
➢
➢
➢
➢
➢
➢
➢
PLEASE INFORM CASE MANAGER OF CASE ASSIGNMENT WITHIN 24 HOURS

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

WRAPAROUND MILWAUKEE / FISS SERVICES / REACH/O'YEAH

In-Home Therapy Lead/AODA Team Member

JOB DESCRIPTION

(Service Code 5160and 5167)

I. Qualifications

A. Credentials

In-Home Leads (5160), Aides (5161) and AODA (5167) providers must meet the credential/licensure requirements in effect at the time of submission of the 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.

II. Working Hours

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

III. Supervision (5160 and 5161 ONLY)

If part of an In-Home "Team" (i.e., a Lead – 5160 and Aide-5161), the Lead must provide supervision to the Aide as outlined in the In-Home Therapy Policy # 025.

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.
- 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 relevant data of psychosocial, developmental characteristics and family patterns of the referred service recipient.
- As appropriate, keeps the team members and the Mobile Urgent Treatment Team (MUTT) informed of progress, setbacks or possible crisis situations.
- Communicates routinely with the Care Coordinator/FISS Manager/Transition Coordinator to assure comprehensive care.
- Participates in Family Team meetings/Plan of Care meetings led by the Care Coordinator/FISS Manager/Transition Coord. 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 intelligence, and knowledge of various ethnic practices. Attends Wraparound Provider Network orientations/meetings/available trainings.
- Is accessible, as needed, to the youth, family, and/or Care Coordinator according to the In-Home Policy.

WRAPAROUND MILWAUKEE / FISS SERVICES / REACH/O'YEAH

In-Home Therapy Aide

JOB DESCRIPTION

(Service Codes 5161)

I. Qualifications

The In-Home Therapy Aide is always the second person on a two-person team. An 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 challenged 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 challenged 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/FISS Manager/Transition Coord. in collaboration with families and their support systems. Assists in the development of the Plan of Care / Treatment Plan and identifying the family's strengths and needs.
- Communicates routinely with the Care Coordinator/FISS Manager/Transition Coord. 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 intelligence 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 Progress Note	**Enrollee/Client Name:** _____ **ID #** (if applicable per the agency):
Agency Name: _____ **Provider Name(s):**	**Care Coord./FISS Manager/ Transition Coord. Name:**

Session Date	**Service Code:**	**Location**	**Service Type:** **Billable Services**	**Non-Billable Services**	**Program (Check one)**
	☐5160/H2033 In-Home Lead ☐5161/H2033 In-Home Aide ☐5167 In-Home - AODA ☐Other: _____	☐ Client's Home ☐ School ☐ Office ☐ Other – Specify:	☐Face to Face ☐POC/Treatment Plan Meeting ☐Therapeutic Crisis: Phone Contact ☐School Visit ☐Other Meeting with Family/Parent ☐No Show: Travel Only	☐Phone Contact Family/Collateral ☐No Show: Office Visit ☐Mtg - Family/Client NOT Present ☐Other – Specify:	☐Wraparound ☐REACH ☐FISS ☐O-YEAH

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 completed for each session/contact).

Signature	**Credentials**	**Date**
Provider:		
Co-Provider (if applicable):		

NOTE: Providers must sign with full name and credentials.

Wraparound Milwaukee
In-Home Signature Log
USE OF THIS LOG FOR IN-HOME SERVICES ONLY

Enrollee/Client Name: ____________________
ID # (if applicable per the agency):

Service Month/Year:

Agency Name: ____________________
Provider Name(s):

Service Code: ☐ 5160/H2033 In-Home Lead ☐ 5161/H2033 In-Home Aide ☐ 5167 In-Home AODA

Session Date	No Show (x)	Person(s) Seen / Relationship to Enrollee/Client	Actual Session Time + Actual Travel Time = Total Units	Location	Signature of Therapy Session Recipient (Enrollee/Client signs if being seen with the family unit or individually; other recipients sign if being seen individually)	Date Therapy Session Recipient Signed	Relationship to Enrollee/Client (Indicate relationship if it's not the enrollee/ client that has signed)
SAMPLE 03/04/2014	☐	John Smith (enrollee) Jane Smith (mother) Mary Smith (sister)	Travel Start Time: 8:00AM Session Start Time: 8:12AM Session End Time: 9:12AM Travel End Time: 9:36AM Total Units (Session + Travel): 1.6	☒ Client's Home ☐ School ☐ Office ☐ Other:	John Smith	Today's Date: 03/04/14	Self
	☐		Travel Start Time: Session Start Time: Session End Time: Travel End Time: Total Units (Session + Travel):	☐ Client's Home ☐ School ☐ Office ☐ Other:		Today's Date:	
	☐		Travel Start Time: Session Start Time: Session End Time: Travel End Time: Total Units (Session + Travel):	☐ Client's Home ☐ School ☐ Office ☐ Other:		Today's Date:	
	☐		Travel Start Time: Session Start Time: Session End Time: Travel End Time: Total Units (Session + Travel):	☐ Client's Home ☐ School ☐ Office ☐ Other:		Today's Date:	
	☐		Travel Start Time: Session Start Time: Session End Time: Travel End Time: Total Units (Session + Travel):	☐ Client's Home ☐ School ☐ Office ☐ Other:		Today's Date:	
	☐		Travel Start Time: Session Start Time: Session End Time: Travel End Time: Total Units (Session + Travel):	☐ Client's Home ☐ School ☐ Office ☐ Other:		Today's Date:	
	☐		Travel Start Time: Session Start Time: Session End Time: Travel End Time: Total Units (Session + Travel):	☐ Client's Home ☐ School ☐ Office ☐ Other:		Today's Date:	

1-6 minutes = 0.1 units, 7-12 minutes = 0.2 units,13- 18 minutes = 0.3 units, 19-24 minutes = 0.4 units, 25-30 minutes = 0.5 units, 31-36 minutes = 0.6 units, 37-42 minutes = 0.7 units, 43-48 minutes = 0.8 units, 49-54 minutes = 0.9 units,55- 60 minutes = 1.0 units

NOTE: Having the service recipient pre-sign the In-Home Session 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) ☐ In-Home -AODA (5167)

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.

WRAPAROUND MILWAUKEE
In-Home Therapy Policy
Attachment 8

Provider Daily Billing Grid Instructions

GENERAL

Please Enter details on all TABS including in Handwritten one sequentially.
Please enter actual time and don't round up or down. Excel sheet later will take care of this.
Example: Enter 9:24 AM if session started at 9:24 AM do not enter 9:15 AM or 9:30 AM.
Please save the template and make a copy for each month of service.

FOR EACH TAB

Tab **"PRINT for Daily Use"** Print this Grid, to be hand-filled daily. Enter details in areas enclosed by outline style below except comments and signature.

DSP's Must Print a Separate Grid for Each Day of Service. Please do not use same sheet for more than one day.

Tab **1-31 one for each day of the month** These Tabs will be used to enter the handwritten sheets into excel before submitting billing.

In these Tabs - only area marked by light blue color can be used to enter details except comments and signature. DSP and Supervisor MUST type their name and date attesting to completing and/or reviewing this form.

SPECIFIC INSTRUCTIONS PER ROW and COLUMN: MANUAL ENTRY REQUIRED (except #1)		
	Date (MM/DD/YY):	Enter date of Service
	Agency Name:	Enter Name of Agency
	Provider Name:	Enter the DSP (Provider) Name who is providing the services and filling the Grid.

A	**If No Show (enter N)**	If the entry is for a **No Show** enter **N** in this column and enter **Travel Start Time (col #3)** and **Travel End Time (col #6)** only in that row. See example in filled sample row # 4
B	**No Travel only Face to Face (enter F)**	If the entry is for a **Face to Face only (no tarvel)** enter **F** in this column and enter **Session Start time (col #4)** and **Session End Time (col #5)** only in that row. See example in filled sample row # 5
1	**#**	Serial Number - No Entry required.
2	**Client Initials**	Enter Client Initials: First Name, Last Name
3	**TRAVEL START Time** (Enter time with a colon (:) and then a space then enter AM or PM)	Enter ACTUAL Travel Start time. Format for the entry will be hour : minutes AM or PM - so one needs to enter the colon in between the actual time of the day and enter AM or PM after adding a space after minutes entry, example 9:02 AM.
4	**SESSION START Time** (Enter time with a colon (:) and then a space then enter AM or PM)	Enter ACTUAL Session Start time. Format for the entry will be hour : minutes AM or PM - so one need to enter the colon in between the actual time of the day and enter AM or PM after adding a space after minutes entry, example 9:22 AM.

Provider Daily Billing Grid Instructions

5	**SESSION END Time** (Enter time with a colon (:) and then a space then enter AM or PM)	Enter ACTUAL Session End time. Format for the entry will be hour : minutes AM or PM - so one needs to enter the colon in between the actual time of the day and enter AM or PM after adding a space after minutes entry, example 9:02 AM.
6	**Travel End Time** (Enter time with a colon (:) and then a space then enter AM or PM)	Enter ACTUAL Travel End time. Format for the entry will be hour : minutes AM or PM - so one needs to enter the colon in between the actual time of the day and enter AM or PM after adding a space after minutes entry, example 9:02 AM.
7	**Minimum Unit Value in Minutes** (Select one from the list)	Select from the list the Minimum Value of Unit increment per service description or network policies like 6 min, 15 min, etc. If no minimum units is prescribed select "other."
8	**Program** (select one from the list)	Select a Program or Network from the list. For non-DHHS network services Select "OTHER".
9	**Service Code**	Enter the correct Service Code of the Service being provided per Network policies or for other sources like T-19 enter T-19 or OTHER.
CALCULATED FIELDS BELOW - NO MANUAL ENTRY BY DSP.		
10	**Over-Lap**	Calculated Field - no entry required. This calculated field will show value "OL" if one row end time overlaps the start time of next row.
11	**Travel To**	Calculated Field - no entry required. This cell will show **Travel Time to** destination in minutes.
12	**Travel From**	Calculated Field - no entry required. This cell will show **Travel Time from** destination in minutes.
13	**Face-to-Face**	Calculated Field - no entry required. This cell will show **Face to Face Session time in** minutes.
14	**Travel Units**	Calculated Field - no entry required. This cell will show **travel minutes in units based on the minimum unit value in 7 above.**
15	**Face-to-Face Units**	Calculated Field - no entry required. This cell will show **face-to-face time in units based on the minimum unit value in 7 above.**
16	**Calculated Units**	**Total Estimated Billable Units:** Travel and/or Face-to-Face time.

Tab ***"Filled Sample Daily Sheet"*** Shows a filled sample of the sheet for reference (at far right end)

Wraparound Milw.
In-Home Ther. Pol.
Attachment 8A

Date(MM/DD/YY):
Agency Name:
Provider Name:

Instructions: Providers must utilize a new log for the specific date of service. Each client is listed on a separate row as displayed in the sample below. Documentation of the clients' applicable travel and session times must be recorded in a **sequential order** on the log. Please enter **ACTUAL TIME** not rounded time. Example if you started at 9:24 enter 9:24 not 9:30 or 9:15.

Please make entry in light Blue cells only.

												Minutes			UNITS		
A	B	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
If No Show (enter N)	*No Travel only Face to Face (enter F)*	#	*Client Initials*	*Travel Start Time* (Please enter time with : and space with **AM** or **PM**)	*Session Start Time (Please enter time with : and space with **AM** or **PM**)*	*Session End Time (Please enter time with : and space with **AM** or **PM**)*	*Travel End Time (Please enter time with : and space with **AM** or **PM**)*	*Minimum Unit value in Minutes (Select one from the list)*	*Program (select one from the list)*	*Service Code*	Over- lap	Travel to	Travel From	Face to face	Travel Units	Face to Face Units	Calculated units
N	F	SAMPLE	SC	8:02 AM	8:22 AM	9:30 AM	9:47 AM	6	Wraparound	5160		1:00	0:00	0:00	10	-	Billable Units
N		1	JS	8:13 AM	9:02 AM	10:14 AM	10:32 AM	6	Wraparound	5160		1:00	0:00	0:00	10	-	1.00
	F	2	TR	10:33 AM	11:04 AM	12:44 PM	1:04 PM	6	Wraparound	5160		0:00	0:00	1:40	-	17	1.70
		3	TW	11:22 AM	1:42 PM	2:02 PM	3:38 PM	6	Wraparound	5160	OL	1:00	1:00	0:20	20	3	2.30
N		4	MC	3:12 PM			3:46 PM	6	Wraparound	5160	OL	0:34	0:00	0:00	6	-	0.60
	F	5	OA		5:05 PM	7:11 PM		15	Other			0:00	0:00	2:06	-	8	8.00
		6										0:00	0:00	0:00	check the	-	#VALUE!
		7										0:00	0:00	0:00	check the	-	#VALUE!
		8										0:00	0:00	0:00	check the	-	#VALUE!
		9										0:00	0:00	0:00	check the	-	#VALUE!
		10										0:00	0:00	0:00	check the	-	#VALUE!
		11										0:00	0:00	0:00	Please check	-	#VALUE!
		12										0:00	0:00	0:00	Please check	-	#VALUE!

Comments:

SAMPLE PROVIDER DAILY BILLING GRID

Completed by - Provider Signature

Date

Supervisor Signature

Date

Provider Daily Billing Grid Time Unit Rounding Chart

Wraparound Milwaukee
In-Home Policy
Attachment 8B

# of Minutes	# of Units
1	0.1
2	0.1
3	0.1
4	0.1
5	0.1
6	0.1
7	0.2
8	0.2
9	0.2
10	0.2
11	0.2
12	0.2
13	0.3
14	0.3
15	0.3
16	0.3
17	0.3
18	0.3
19	0.4
20	0.4

# of Minutes	# of Units
21	0.4
22	0.4
23	0.4
24	0.4
25	0.5
26	0.5
27	0.5
28	0.5
29	0.5
30	0.5
31	0.6
32	0.6
33	0.6
34	0.6
35	0.6
36	0.6
37	0.7
38	0.7
39	0.7
40	0.7

# of Minutes	# of Units
41	0.7
42	0.7
43	0.8
44	0.8
45	0.8
46	0.8
47	0.8
48	0.8
49	0.9
50	0.9
51	0.9
52	0.9
53	0.9
54	0.9
55	1.0
56	1.0
57	1.0
58	1.0
59	1.0
60	1.0