

APPENDIX 12 – Children’s Long Term Support Waiver

The CLTS Waiver Program provides a structure within which Medicaid funding is available to support children and youth who live at home or in the community and have substantial limitations, in multiple daily activities as a result of one or more of the following disabilities:

- Intellectual and/or developmental disabilities
- Severe emotional disturbances
- Physical disabilities

Service Descriptions:

Willing and qualified providers must adhere to the service description requirements as detailed in Chapter 4 of the Medicaid Home and Community-Based Services Waiver CLTSW Program Manual. The manual can be found at the following link <https://www.dhs.wisconsin.gov/publications/p02256.pdf>.

Billing:

Provider agrees to bill Wisconsin Physicians Services (WPS) Health Insurance for services performed.

Claims may be submitted via:

- A. Paper Claims (submission & billing questions – 877-298-1258):
 1. HCFA (CMS 1500)
 2. UB04 (CMS 1450)
 3. CLTS Waivers Claim Form
- B. Excel Spreadsheet Submission (set up & questions – FCWPS@wpsic.com)
- C. Electronic Filing (contact for EFT, ERA and electronic claim submission (PC-Ace) – 800-782-2680 option 2)

Claims must be received by WPS within 90 days of the date of service or 90 days from other carrier’s processed date. If denied by other carrier, an Explanation of Benefits (EOB) from the other carrier must be submitted with the claim.

If a claim is denied by WPS and Provider wants to dispute the denial, Provider will need to submit a claims resolution form to the Purchaser with supporting documentation (i.e. copy of EOB) and a reason for the request. When the review is completed, Purchaser will notify Provider of the result.

Website: <https://www.dhs.wisconsin.gov/clts/tpa.htm>

Payment:

For in-scope services, the contracted amount represents the CLTSW statewide rate, which is the maximum amount that can be paid for each service unit without an outlier rate. Services should be billed at the service provider’s usual and customary rate, if lower than the CLTSW statewide rate, and will be paid at the lower amount. For services that are exempt from the statewide rate schedule, providers are reimbursed at the lesser of their billed amount or the negotiated contract rate for the procedure. More information on the CLTSW statewide rates is available at <https://www.dhs.wisconsin.gov/hcbs/ratestructure.htm>.

Background Checks:

The CLTSW Program requires that the Purchaser has a staff listing with caregiver background check information as outlined in Appendix 7 from Provider. This documentation will need to be submitted to the Purchaser at the beginning of a new contract, upon each new staff hire and every 4 years as checks expire. Provider must maintain current documentation of completed criminal, caregiver and licensing background checks. This documentation must be accessible for further review by Purchaser.

Training:

The CLTSW Program requires that each Provider staff complete the necessary training outlined in the attached approved training log. This documentation will need to be submitted to the Purchaser for new employees by January 31st of the following year.

Incident Reporting:

Provider should adhere to requirements to report allegations of abuse, neglect and exploitation as detailed in Chapter 9 of the Home and Community Based Services Medicaid Waiver Manual. The following link outlines those requirements: <https://www.dhs.wisconsin.gov/waivermanual/waiverch09-08.pdf>.

APPENDIX 12 – CLTSW ORIENTATION AND TRAINING PROGRAM LOG

Vendor: «VendorName» Service(s) Provided: _____

TRAINING: Performed prior to the staff providing service independently for CLTSW:

- HCBWM - Chapter 8 – 8.5 Participant Rights: Restrictive Measures
- HCBWM - Chapter 9 – 9.6 Incident Reporting/Mandated Reporting
- Home and Community Based Waiver Manual (HCBWM)
 - Chapter 4. Allowable Services (pertaining to services provided)
 - 4.07 Participant Contributions – specific to service provided.
- HSS 92 – Confidentiality
- Specific Client Training/Information
- HCBWM – Appendix T (*Supportive Home Care and Respite Service Providers ONLY*)
- Training specific to the service provided, as outlined in Chapter 4 of the HCBWM:
<https://www.dhs.wisconsin.gov/publications/p02256.pdf>

Vendor Employee Names, Training Topic and Date of Training (please attach a separate sheet, if needed):

EMPLOYEE NAME	TRAINING TOPIC	DATE OF TRAINING

Please submit this form after initial training of new employees by January 31st of the following year.

Forms should be submitted to La Crosse County Human Services - Contract Unit at hscontractunit@lacrossecounty.org or 300 4th Street N, La Crosse, Wisconsin 54601.

Vendor Signature: _____ Date: _____

La Crosse County Program Signature _____ Date: _____