Purpose Statement:
"Optimize the health of our members through the Cooperative’s pooling of health-related resources."
Dear Provider:

We are pleased that your organization is a participant in the Group Health Cooperative of Eau Claire network of healthcare providers. We are committed to providing you with current and accurate information.

This provider manual has been developed as a resource for the following member populations administered by the Cooperative:

- Group Health Cooperative of Eau Claire BadgerCare Plus
- Group Health Cooperative of Eau Claire Medicaid SSI
- BadgerCare Plus
- Medicaid SSI

Updates to this manual will take place periodically and will be available online. If you have any questions on updates or anything contained in this manual, please do not hesitate to call our Provider Relations Department.

Included in this manual is a list of our Administrative Departments that will be happy to help you with specific questions or concerns. We truly understand your need to have your questions answered in a clear and timely manner. We look forward to a mutually beneficial partnership. Please visit our website at group-health.com.

Sincerely,

Mark J. Peterson, CHC
Director Government Programs
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ADMINISTRATIVE CONTACTS

Group Health Cooperative of Eau Claire Contacts for Providers

Call our Provider Services Department for:
- Patient Benefits, Coverage or Eligibility
- Patient Concerns
- Claims Status
- Billing & / Or Payment Procedures
- Medicaid Enrollment, Membership, Eligibility
- Electronic Billing
- Provider Log-In Assistance

PROVIDER SERVICES DEPARTMENT
(715) 552-4333 or (866) 563-3020
Fax Number: (715) 836-7683

Call our Health Management Department for:
- Prior Authorizations (inpatient admissions, referrals, elective surgery, etc.)
- Mental Health/AODA Questions or Authorizations

HEALTH MANAGEMENT DEPARTMENT
(715) 552-7200 or (800) 218-1745
Fax Number: (715) 552-7202

Call our Provider Relations Department for:
- Information on joining our network
- Contractual Arrangements such as fee schedule or reimbursement
- Changes to your Tax ID, Office, Address, additional locations/clinics

PROVIDER RELATIONS DEPARTMENT
(715) 552-4300 or (888) 203-7770

Call our Credentialing Department for:
- Prior Authorizations (inpatient admissions, referrals, elective surgery, etc.)
- Mental Health/AODA Questions or Authorizations

CREDENTIALING DEPARTMENT
(715) 552-4300 or (888) 203-7770

Call our Quality Improvement Department for:
- Questions or requests for information on Quality Improvement Activities

QUALITY IMPROVEMENT DEPARTMENT
(715) 552-4300 or (888) 203-7770
SECTION 1 | CLAIMS INFORMATION

CLAIMS SUBMISSION
In order to facilitate timely payment of claims submitted to the Cooperative, please utilize the appropriate claim forms and follow standard submission guidelines for your provider type.

Submit all claims to: Group Health Cooperative of Eau Claire
P.O. Box 3217
Eau Claire, WI 54702-3217

Questions regarding the processing of your claims may be directed to the Provider Services department at the Cooperative. You can reach Provider Services directly at (715) 552-4333 or (866) 563 3020. Staff is available Monday-Friday, 8 a.m. to 5 p.m., to answer questions regarding how your claims are processed.

We do not issue Providers a special identification number for billing purposes. However, each Member has a unique member identification number.

Claims submitted after one year from the date of services will be denied unless otherwise stated in the Provider Services Agreement.

The Cooperative utilizes payment rationale based on various coding sources including but not limited to CPT, HCPCS, ICD-9, ICD-10 and CMS/CCI (Correct Coding Initiative) edits.

ELECTRONIC CLAIM SUBMISSION - CLEARINGHOUSES
To expedite payment to you, the Cooperative encourages electronic billing whenever possible. Our most common Payor ID number is 95192. The Cooperative works with six clearinghouses: Emdeon, SDS (Smart Data Solutions), Cvikota Company, Relay Health, SSI Group, Inc., and G4 Health Systems. In addition, the Cooperative exchanges electronic remittance advice with five clearinghouses: Cvikota, Relay Health, Gateway EDI LLC, Rycan Technologies, Inc., and G4 Health Systems. Since many clearinghouses work together, please check with your clearinghouse if you do not see it listed above.

Note:
• Providers are not required to utilize a clearinghouse.
• The Cooperative does not charge claim submissions fees for a direct connection.
• Clearinghouses may charge a fee. It is the provider’s responsibility to discuss these potential fees with the clearinghouse.

The Cooperative has a simple one-page form to trade basic information on establishing a direct connect. Please call the Cooperative’s Provider Services at (866) 563-3020 to obtain the Electronic Claims Setup form or follow the link below. No paperwork (including this form) is necessary to submit claims through a clearinghouse. Electronic Claims Submission form.

In addition, the Cooperative has a setup form available for the following types of electronic transactions:
• Electronic Remittance Advice form
• Eligibility Benefit Inquiry and Response form

Contact the Cooperative’s Provider Services at (866) 563-3020 for more information.
ELECTRONIC CLAIM SUBMISSION - QUICKCLAIM
The Cooperative has made an electronic claim submission software program available to contracted providers; QuickClaim is a claims submission program powered by Smart Data Solutions (SDS). This program combines direct online data entry and automation, allowing providers to submit HIPAA complaint claims directly to the Cooperative at no cost to the provider. This solution eliminates paper claims, reduces costs and shortens claims processing turnaround time.

To access QuickClaim: group-health.com/QuickClaim

BALANCE BILLING / COPAYMENT INFORMATION
Provider (with the exception of collecting co-payments) may not bill, charge, collect a deposit from, seek remuneration from, or have any recourse against a Cooperative Member for covered benefits.

Under state and federal laws, if a provider inappropriately collects payment from an enrolled member, or authorized person acting on behalf of the member, that provider may be subject to program sanctions, termination of Medicaid certification, and/or be fined, imprisoned or both.

However, a member may request a non-covered service, a covered service for which authorization was denied (or modified), or a service that is not covered under the member’s limited benefit category. The charge for these services may be collected from the member if the following conditions are met prior to the delivery of that service:

• The member accepts responsibility for payment.
• The provider and member make payment arrangements for the service.

Providers are strongly encouraged to obtain a written statement in advance, documenting that the member has accepted responsibility for the payment of the service. This statement should be signed and dated by the member.

Furthermore, the service must be separate or distinct from a related, covered service.

PAYER OF LAST RESORT
Following Wisconsin Fee-For-Service Medicaid guidelines, BadgerCare Plus and Medicaid SSI HMOs are the payer of last resort for any covered services. Therefore, the provider is required to make a reasonable effort to exhaust all of the member’s other health insurance sources before submitting claims to the Cooperative.

SUBROGATION AND RECOUPMENT
Effective with dates of service on or after January 1, 2016, the Wisconsin Department of Health Services (DHS) is requiring HMOs to ensure that all other payor sources are exhausted prior to issuing payment on claims for Medicaid members. While this has been longstanding Federal and State policy to ensure the continued solvency of the program, there are several noteworthy changes that will affect all providers in how claims are billed to and paid by the Cooperative, some of which we are hopeful will eliminate some of the administrative burden associated with benefits coordination. Much of this was driven by changes/clarifications in the Deficit Reduction Act.

• Relinquishment forms are no longer necessary. The Cooperative will no longer require (or accept) relinquishment forms to be submitted in order to issue payment on claims where other insurance (like third party liability) may be involved. Instead, however, we will be requiring a copy or verification of any denial (EOB, etc.) from other insurance prior to issuing payment. This is a direct result of changes mandated in the DHS-HMO contract. Providers will be required to bill other applicable insurance sources and receive a denial prior to the Cooperative issuing payment on a claim.
• **Third party liability.** In cases of disputed liability (e.g., a worker’s compensation claim that the carrier is denying, claims being actively litigated, etc.), the Cooperative will only require one denial before related claims will process for payment (again, without the need for submission of relinquishment forms each time). For example, if we are notified of a possible worker’s compensation claim involving an injury to a member’s neck, and with the initial billing the provider submits documentation that the claim is disputed (e.g., denied by the worker’s compensation insurance), then the Cooperative will process and pay subsequent neck claims that are related without requiring a relinquishment form or additional EOBs/proof of denial. However, in cases of undisputed third party liability claims, such as a worker’s compensation claim that has been accepted by the insurance and for which medical payments are being issued, the Cooperative will be required to treat the worker’s compensation insurance as primary and coordinate benefits accordingly.

• **Medical payments coverage is not considered third party liability for purposes of DHS 106.** Any coverage for medical payments that is available and issuable without regard to liability is considered primary to Medicaid payment. This includes a Medicaid members’ own auto or other liability policy that includes medical payment provisions separate from liability-related payments. For example, many auto insurance policies include $10,000 of medical payments coverage that is issued to their insured regardless of fault. What this means is that if a Medicaid member is involved in an auto or other accident, the Cooperative will be pending claims or denying claims for coordination of benefits until the medical payments coverage is exhausted, unless we have verification that it has been issued. Importantly, in situations where the medical payments coverage has been issued to a Medicaid member and the payment is itemized/attributable to specific claims, the Cooperative will be denying payment of those claims. Providers will be expected to seek recovery directly from the member.

• **Providers are expected to code for liability.** In cases of auto accidents, worker’s compensation, etc., providers will be expected to code claims for liability in accordance with CMS guidance and TPL/COB clarifications under the Deficit Reduction Act (please see: https://www.medicaid.gov/federal-policy-guidance/downloads/faq-09-04-2014.pdf). While we appreciate that this can be challenging, it will also help expedite payments to you by not pending claims unnecessarily.

Recoupments/Refunds

• ALL recoupment and refund requests MUST comply with Wisconsin Administrative Code DHS §106. Requests should be reviewed for compliance prior to submission to the Cooperative.
• Requests found to be in violation of Wis. Adm. Code will be denied and returned to the provider.
• Violations will be reported as required under the Cooperative’s contract with the Department of Health Services.

**COORDINATION OF BENEFITS**

If a member carries other insurance through more than one insurer, the Cooperative will coordinate the benefits to ensure maximum coverage without duplication of payments.

Provider must submit claims to the primary insurance before submitting to the Cooperative. Following the primary insurance determination, a copy of the original claim form and a copy of the primary insurance Remittance Advice (RA) must be submitted to the Cooperative for secondary benefit determination (regardless of balance due). Provider must submit the documents within 90 days from the date on the primary RA.

If the Provider fails to comply or is unaware of the primary insurance, claims for which the Cooperative is secondary will be denied. This denial reason will print on the Provider’s RA.
If primary insurance is discovered after charges have been processed and both the Cooperative and the primary insurance make payment, the Provider may have an overpayment and will be required to return the balance to the Cooperative.

If the Cooperative discovers a primary insurance after charges have been processed, the Cooperative will reverse its original payment. The adjustment will be reflected on the Provider’s RA.

If the primary insurance denies a claim because of lack of information, the Cooperative will also deny. In the event the denial was due to the member’s lack of compliance in responding to the primary insurance request for additional information, the Cooperative may reconsider the denial based on the following process: the provider must make, and document, three attempts (verbal or written) to the member indicating they must become compliant in providing the missing information in order for the primary insurance to process. There must be at least one week between contacts attempts. Provider must submit documentation of these outreach efforts and if the member is not following through, documentation of the outreach attempts can be resubmitted with the claim, documenting in box 19 of the CMS-1500 “non-compliant”. In the case where the claim is submitted on a UB, notation of “non compliant” can be documented anywhere on the claim form.

- If member has Medicare and/or other insurance, complete information must be on the CMS-1500 claim or UB-04 claim for the claim to be processed efficiently.
- On the CMS-1500 claim, box 11d should be checked “Yes” if there is any other insurance information. If box 11d is checked “Yes”, boxes 9a – 9d on the CMS-1500 claim must be completed with the other insurance information. (See sample CMS-1500 claim form).
- On the UB-04 claim, box 50 is completed if there is any other insurance information. (See sample UB-04 claim form).
- Other insurance remittance advice needs to accompany each CMS-1500 claim and UB-04 claim where other insurance is indicated on the claim.

For any questions regarding Coordination of Benefits, call Provider Services at (866) 563-3020.

**CORRECTED CLAIMS**

Corrected claims can be submitted on the appropriate claim form with “correction/resubmission” identified in box 19 on the UB-04 and written or stamped on the CMS-1500. Claims that are corrected and/or resubmitted to the Cooperative are subject to the claim appeal time frame identified in the Claim Appeal Process section of this Provider Manual or as identified in the Provider Service Agreement.

Send or fax paper claims to:

Group Health Cooperative of Eau Claire  
P.O. Box 3217  
Eau Claire, WI  54702-3217  
Fax: (715) 836-7683
CMS-1500 FORM INFORMATION

The Cooperative claims processing system is designed to process standard health insurance claim forms (CMS-1500) using CPT-4 Procedure Codes or Healthcare Common Procedure Coding System (HCPCS) with appropriate modifiers and ICD-9-CM or ICD-10 Diagnosis Codes.

The Cooperative requires a compliant red form be used. Required information must be filled in completely, accurately, and legibly. If the information is inaccurate or incomplete, your claim cannot be processed and will not be considered a “clean claim”. A clean claim has all the necessary data elements, (such as timely filing) on industry standard paper forms (CMS-1500 or UB-04, or their successor forms), or by electronic format, with no defect or impropriety. A submission which does not include all the necessary information, or for which the Cooperative must request additional information (for example, medical records, other coverage information, or subrogation information) is not a clean claim until the Cooperative receives the needed information.

A clean CMS-1500 claim is considered to have the following data elements (numbered as shown on claim form):

1. Type (SSN or ID)
1a. Insured’s Identification Number (Social Security or Member ID Number)
2. Patient’s Complete Name (to include middle initial when appropriate)
3. Patient’s Birth Date
4. Insured’s Name
5. Patient’s Complete Address
6. Insured’s Address
7. Other Insurance Information (if applicable)
9a. Other Insurance Policy or Group Number (if applicable, also complete 9b & 9d)
10. X Appropriate Box if Related to Employment/Auto Accident/Other
11d. Is there another health benefit plan?
17. Name of Referring Physician or Other Source
17b. Referring NPI
21. Diagnosis or Nature of Illness or Injury
24a. Date(s) of Service
24b. Place of Service
24d. Procedures, Services, or Supplies (CPT/HCPCS to include modifier when appropriate)
24e. Number of Diagnosis Code Listed in Box 21 Related to Service
24f. $ Charges
24g. Days or Units
24j. Rendering Provider NPI
25. Federal Tax ID Number
26. Patient’s Account Number
27. Accept Assignment?
28. Total Charge
29. Amount Paid
31. Attending Physician or Supplier Information
32. Service Facility
33. Complete billing provider information to include name, address, city, state, zip code +4 and telephone number
33a. Billing Provider NPI
33b. Taxonomy

Note: Please utilize the appropriate claims form and follow standard Medicaid submission guidelines for your industry and/or provider type.
SAMPLE CMS-1500 CLAIM FORM
BILLING AND REIMBURSEMENT OF PROFESSIONAL SURGICAL SERVICES

Note: The majority of the following information is based upon ForwardHealth Guidelines and is therefore subject to change. Please check the Wisconsin Department of Health Services ForwardHealth Portal website. Information not taken from ForwardHealth is noted*.

All surgical services must be BadgerCare Plus and Medicaid SSI covered procedures in order for them to be considered for reimbursement.

Reimbursement will never be in excess of the maximum daily reimbursement rate.

All surgical procedure codes must be submitted on a CMS-1500 claim form with appropriate modifiers when applicable.

The procedure may also require prior authorization by the Cooperative. Please see the Prior Authorization section of this manual.

All surgical services are subject to the Cooperative code review and may require the support of medical records for payment to occur. If medical records are not submitted with the claim and they are needed for a code review, the claim will be denied using ANSI Code 16. Please review your contractual requirements for re-submission of claims to ensure resubmitted claims are filed timely.

**Surgical Procedures**

Surgical procedures performed by the same physician, for the same member, on the same date of service (DOS) must be submitted on the same claim form. Surgeries that are billed on separate claim forms will be denied.

Reimbursement for most surgical procedures includes preoperative and postoperative care days. Preoperative and postoperative surgical care includes the preoperative evaluation or consultation, postsurgical E&M services (i.e., hospital visits, office visits), suture, and cast removal.

Although E&M services pertaining to the surgery for DOS during the preoperative and postoperative care days are not covered, an E&M service may be reimbursed if it was provided in response to a different diagnosis.

**Co-Surgeons**

The Cooperative reimburses each surgeon according to the ForwardHealth Guidelines. Attach supporting clinical documentation (such as an operative report) clearly marked “co-surgeon” to each surgeon’s paper claim to demonstrate medical necessity. Use modifier “62” on each surgeon’s procedures.

**Surgical Assistants**

The Cooperative reimburses services performed by surgical assistants according to the ForwardHealth Guidelines. To receive reimbursement for surgical assistants, indicate the surgery procedure code with modifier “80” (assistant surgeon) on the claim. The Cooperative reimburses surgical assistants only for those surgeries that are listed in the physician services fee schedule with modifier “80.”

**Bilateral Surgeries**

Bilateral surgical procedures are reimbursed according to the ForwardHealth Guidelines.
Multiple Surgeries
Multiple surgical procedures performed by the same physician for the same member during the same surgical session are reimbursed according to the ForwardHealth Guidelines.

If bilateral surgical procedures and multiple procedures are done during the same operative session by the same physician, the surgical procedure with the highest billed amount will be reimbursed as the primary procedure.*

The Cooperative permits full payments for surgeries that are performed on the same DOS but at different surgical sessions. For example, if a provider performs sterilization on the same DOS as a delivery, the provider may be reimbursed without reductions for both procedures if performed at different times (and if all of the billing requirements were met for the sterilization).

To obtain full reimbursement, submit a claim for all the surgeries performed on the same DOS that are being billed for the member. Then submit additional supporting documentation clarifying that the surgeries were performed in separate surgical sessions.

Note: Most diagnostic and certain vascular injections and radiological procedures are not subject to the multiple surgery reimbursement limits. Call Provider Services for more information about whether a specific procedure code is subject to these reimbursement limits.

Multiple Births
Reimbursement for multiple births is dependent on the circumstances of the deliveries. Multiple births are reimbursed according to the ForwardHealth Guidelines.

Preoperative and Postoperative Care
Reimbursement for certain surgical procedures includes the preoperative and postoperative care days associated with that procedure. Preoperative and postoperative surgical care includes the preoperative evaluation or consultation, postsurgical E&M services (i.e., hospital visits, office visits), suture, and cast removal.

All primary surgeons, surgical assistants, and co-surgeons are subject to the same preoperative and postoperative care limitations for each procedure. For surgical services in which a preoperative period applies, the preoperative period is typically three days. Claims for services which fall within the range of established pre-care and post-care days for the procedure(s) being performed are denied unless they indicate a circumstance or diagnosis code unrelated to the surgical procedure.

For the number of preoperative and postoperative care days applied to a specific procedure code, call Provider Services.
OBSTETRICS (OB) CODING

Whether a clinic bills for individual OB visits, delivery and/or postpartum care; or as a prenatal package or global billing for OB care, the clinic will be reimbursed up to the maximum amount of the appropriate prenatal package or global billing. As a general guideline, the Cooperative does not reimburse a global OB fee if the patient was a member less than 4 months prior to delivery. To meet reporting requirements for the Wisconsin BadgerCare Plus and Medicaid SSI Managed Care Program, it is necessary to collect information regarding the frequency of ongoing prenatal care. To help achieve this, Providers must submit the dates of individual OB visits, including the CPT and ICD-9 codes, when billing a prenatal package or global billing.

Coding 1st OB or 6-week postpartum visits as a HealthCheck:
If a BadgerCare Plus or Medicaid SSI patient is under 21 years old, the 1st OB or 6-week postpartum visit may be an ideal opportunity to complete a HealthCheck screen on a patient in this age group. Many of the required components of a HealthCheck screen are completed as part of these OB visits. (Note: Only one HealthCheck screen per year is allowed for this age group).

The following guidelines address the billing of 1st OB or 6-week postpartum visits as HealthChecks:

1st OB VISIT: Code a 99384-99385 and use V20.2 as the primary diagnosis (ICD-9) code and V22.2 as the secondary (ICD-9) code.

6-Week Postpartum Visit: If all of the OB care including prenatal care, delivery and postpartum care were provided, bill the global billing (59400 for vaginal delivery, 59510 for C-section delivery) using the date of delivery. Then using the date of the 6-week postpartum visit, code the visit at the appropriate level (99384 /99385). Otherwise, code for the appropriate services provided using the CPT code for the 6-week postpartum visit.

For Initial Antepartum Care Visits, use appropriate E & M Code(s):
99204Prenatal Visit – New Patient / 1st Visit
99213Detailed Prenatal Exam / 2nd Visit – Record zero charge

For Subsequent Prenatal Office Visits until the patient delivers, use:
99213Prenatal Visit – Record zero charge

After the patient delivers, code the appropriate level OB Code or Global Billing:
59425Prenatal Package (4-6 visits)
59426Prenatal Package (7 or more visits)
59430Postpartum Care Only
59409Vaginal Delivery Only
59410Vaginal Delivery Including Postpartum Care
59514Cesarean Delivery Only
59515Cesarean Delivery Including Postpartum Care

Global Billing for OB Care:
59400Vaginal Delivery with Antepartum and Postpartum Care
59510Cesarean Delivery with Antepartum and Postpartum Care
59610Vaginal Delivery after previous C-section with Antepartum and Postpartum Care
59618Routine OB care including Antepartum care, C-section and Postpartum Care following attempted vaginal delivery after previous C-section
Billing Postpartum as HealthCheck:
99384-99385 Use when billing global or NOT billing global package

Note: EVERY PRENATAL VISIT must be coded to meet Medicaid reporting requirements regarding prenatal care. Please refer to Forward Health Topic #1251.

Antepartum Care Claims Submission Guide

<table>
<thead>
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<th>Total Visit(s)</th>
<th>Procedure Code and Description</th>
<th>Modifier and Description</th>
<th>Qty</th>
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<tr>
<td>1</td>
<td>99204 Office or other outpatient visit for the evaluation and management of a new patient ... Usually, the presenting problem(s) is of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.</td>
<td>TH (Obstetrical treatment/services, prenatal or postpartum)</td>
<td>1.0</td>
</tr>
<tr>
<td>2</td>
<td>99204</td>
<td>TH</td>
<td>1.0</td>
</tr>
<tr>
<td>2</td>
<td>99213 Office or other outpatient visit for the evaluation and management of an established patient ... Usually, the presenting problem(s) is of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.</td>
<td>TH</td>
<td>1.0</td>
</tr>
<tr>
<td>3</td>
<td>99204</td>
<td>TH</td>
<td>1.0</td>
</tr>
<tr>
<td>3</td>
<td>99213</td>
<td>TH</td>
<td>2.0</td>
</tr>
<tr>
<td>4-6</td>
<td>59425 Antepartum care only; 4-6 visits</td>
<td></td>
<td>1.0</td>
</tr>
<tr>
<td>7+</td>
<td>59426 7 or more visits</td>
<td></td>
<td>1.0</td>
</tr>
</tbody>
</table>
OB Billing Flow Chart

Is patient Group Health/ BadgerCare Plus or SSI at the time of delivery?

- **Yes**
  - If other insurance is primary, bill them first; then bill Group Health along with the primary EOB
  - Has patient been a member greater than 4 months?
    - **Yes**
      - Bill appropriate CPT code for services rendered.
      - (See OB Coding page for further Assistance)
    - **No**
      - Bill CPT 59510 or 59400 as appropriate

- **No**
  - Has this patient ever been to Group Health/ BadgerCare Plus or SSI?
    - **Yes**
      - Please bill the appropriate party/payor for services rendered.
    - **No**
      - Are there charges for routine OB visits while Group Health member?
        - **Yes**
          - Please bill the appropriate party/payor for services rendered.
        - **No**
          - Bill according to appropriate CPT Package or individual services

Did provider provide all services necessary to qualify for global charge?

- **Yes**
  - Bill appropriate CPT code for services rendered.
  - (See OB Coding page for further Assistance)
- **No**
  - Bill CPT 59510 or 59400 as appropriate
**UB-04 INFORMATION**

UB-04 claim completion is required for inpatient and outpatient services billed by hospitals, skilled nursing facilities, home health agencies and other institutional providers. The data elements are listed as fields on the claim form.

Required information must be filled in completely, accurately, and legibly. If the information is inaccurate or incomplete, your claim cannot be processed and will not be considered a “clean claim”. A clean claim has all the necessary data elements, such as timely filing on industry standard paper forms (CMS-1500 or UB-04, or their successor forms), or by electronic format, with no defect or impropriety. A submission which does not include all the necessary information, or for which the Cooperative must request additional information (for example, medical records, other coverage information, or subrogation information) is not a clean claim until the Cooperative receives the needed information.

A clean UB04 claim is considered to have the following data elements (numbered as shown on claim form):

1. Complete provider information to include name, address, city, state, zip code +4 and telephone number
2. Type of Bill
3. Patient’s Account Number
4. Date(s) of Service
5. Federal Tax ID Number
6. Patient’s Complete Name (to include middle initial when appropriate)
7. Patient’s Complete Address
8. Admission Hour (2-digit hour only)
9. Type
10. SRC (Source of Admission)
11. Discharge Hour (2-digit hour only)
12. Discharge Status
13. Condition Codes
14. Occurrence Codes & Dates
15. Accident Status
16. Revenue Codes
17. Revenue Code Description (optional)
18. HCPCS/CPT Code corresponding to Rev Code in element 42
19. Service Date
20. Days or Units
21. Total Charges
22. Other Insurance Information (if applicable)
23. Amount Paid Prior
24. Balance Due (optional)
25. NPI
26. Insured’s Name
27. Patient Identification Number (ForwardHealth, Social Security or ID Number)
28. Principle Diagnosis
29. Diagnosis or Nature of Illness or Injury Present on Admission Indicator (POA)
30. DRG Number (only on inpatient claims)
31. E-Codes – External Cause of Injury (when appropriate)
32. Attending Provider’s NPI
33. Taxonomy

**Note:** Please utilize the appropriate claims form and follow standard Medicaid submission guidelines for your INDUSTRY AND/OR PROVIDER type.
SAMPLE UB-04 CLAIM FORM
STERILIZATION CONSENT FORM REQUIREMENTS

“Sterilization” means any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing. This does not cover medical procedures that, while they may have the effect of producing sterility, have an entirely different purpose, such as removal of a cancerous uterus or prostate gland.

There must be 30 full days between the date of the consult and the date of the surgery.

Note: Payment cannot be made to providers of associated services (hospital, anesthesiologists, pathologists, radiologists) unless the consent form is completed in an accurate and timely manner. If this requirement is not followed, DHS will make recoupment from the Cooperative that will subsequently be recouped from the clinic.

The ForwardHealth “Consent for Sterilization” state mandated consent form and instructions for completion are available on the Department of Health Services website. This form must be completed for all Wisconsin BadgerCare Plus and Medicaid SSI members.

The following requirements are necessary before the sterilization can be performed:

1. The patient has voluntarily given his/her consent to be sterilized.
2. The patient was at least 21 years of age on the date consent was obtained.
3. At least 30 days, but no more than 180 days, have passed between the date of the informed consent and the date of sterilization. With the following exceptions:
   a. In the case of emergency abdominal surgery where the patient signs an informed consent at least 72 hours prior to an emergency abdominal surgery, or,
   b. In the case of premature labor where the patient has received informed consent at least 30 days prior to the expected date of confinement. The physician must indicate the expected date of confinement on the consent form.
4. The patient is mentally competent.
5. The patient is not an institutionalized person.
6. The dates on the consent form cannot be altered.
7. DHS provides a consent form and no other is to be used in substitution.
8. The provider will send a signed copy of the Sterilization Consent Form to:
   Group Health Cooperative of Eau Claire
   P.O. Box 3217
   Eau Claire, WI 54702
   Attention: Sterilization Consent
9. The original signed Sterilization Consent Form must remain in the patient’s medical record.
HYSTERECTOMY CONSENT FORM REQUIREMENTS

Wisconsin Medicaid does not cover hysterectomies for the purposes of sterilization (i.e. rendering the patient permanently incapable of reproduction) nor for medical purposes which by themselves do not mandate a hysterectomy (such as uncomplicated fibroids, fallen uterus and retroverted uterus).

An Acknowledgment of Receipt of Hysterectomy Information form must be completed prior to a covered hysterectomy, except in the circumstances noted below. The form must be attached to the CMS-1500 Health Insurance Claim Form.

A hysterectomy may be covered without a valid acknowledgment form if one of the following circumstances applies:

- The member was already sterile. Sterility may include menopause. (The physician is required to state the cause of sterility in the member’s medical record.)
- The hysterectomy was required as the result of a life-threatening emergency situation in which the physician determined that a prior acknowledgment of receipt of hysterectomy information was not possible. (The physician is required to describe the nature of the emergency.)
- The hysterectomy was performed during a period of retroactive member eligibility and one of the following circumstances applied:
  - The member was informed before the surgery that the procedure would make her permanently incapable of reproducing.
  - The member was already sterile.
  - The member was in a life-threatening emergency situation which required a hysterectomy.

For all of the exceptions previously listed, the physician is required to identify, in writing, the applicable circumstance and attach the signed and dated documentation to the paper claim. (A copy of the preoperative history/physical exam and operative report is usually sufficient.)

Note: Payment cannot be made to providers of associated services (hospital, anesthesiologist, pathologists, and radiologists) unless the “Acknowledgment of Receipt of Hysterectomy Information” form is filled out accurately and in a timely manner. DHS will make recoupment from Group Health that will subsequently be recouped from the clinic.

The ForwardHealth “Acknowledgment of Receipt of Hysterectomy Information” state mandated form and instructions for completion are available on the Department of Health Services website at [http://www.dhs.wisconsin.gov/forms/index.htm](http://www.dhs.wisconsin.gov/forms/index.htm). This form must be completed for all Wisconsin BadgerCare Plus and Medicaid SSI members.
ABORTION CERTIFICATION STATEMENT REQUIREMENTS
When an abortion meets the following criteria for coverage, all other medically necessary related services are also covered. Complications arising from an abortion, whether the abortion was covered or not, are also a covered service. Services incidental to a non-covered abortion are not covered. Such services include, but are not limited to any of the following services when directly related to the performance of a non-covered abortion: laboratory testing and interpretation, ultrasound services, recovery room services, routine follow-up visits, and transportation (transportation to prenatal visits is covered).

Criteria for coverage:

1. The abortion is directly and medically necessary to save the life of the woman, provided that prior to the abortion the physician attests in a signed, written statement, based on his or her best clinical judgment, that the abortion meets this condition.

2. In a case of sexual assault or incest, provided that prior to the abortion the physician attests in a signed, written statement, to his or her belief that sexual assault or incest has occurred, and provided that the crime has been reported to law enforcement authorities.

3. Due to a medical condition existing prior to the abortion, the physician determines that the abortion is directly and medically necessary to prevent grave, long-lasting physical health damage to the woman, provided that prior to the abortion, the physician attests in a signed, written statement, based on his or her best clinical judgment, that the abortion meets this condition.

The ForwardHealth “Abortion Information Provision Certification” state mandated form is available on the Department of Health Services website at http://www.dhs.wisconsin.gov/forms/index.htm. This form must be completed for all Wisconsin BadgerCare Plus and Medicaid SSI members.

In the case of rape or incest, the physician must include evidence that the crime was reported to law enforcement authorities.

The Certification Statement Form must be faxed to the Cooperative's Health Management Department at (715) 552-7202 along with progress notes and any law enforcement documentation. The Cooperative will forward this information to the State for final decision regarding coverage. Once the State has made their recommendations, the Cooperative will notify the physician’s office of their decision.

Approved services must be scheduled at a Wisconsin Medicaid Certified facility.
CLAIM APPEAL PROCESS

If you have questions or if you are dissatisfied with the payment/denial reflected on your Provider Remittance Advice, you may request an informal review of payment within 60 days from the initial payment/denial determination notice. To do this, please contact the Cooperative’s Provider Services at (866) 563-3020. If your concern is not settled to your satisfaction, you may also appeal in writing within 60 days from the initial payment/denial determination notice, or as outlined in the Provider Services Agreement.

The appeal must contain the member’s name and BadgerCare Plus or Medicaid SSI ID number, the provider’s name, date of service, date of billing, and date of rejection and reason for reconsideration. If your appeal is medical in nature (i.e. emergency, medical necessity and/or prior authorization related) you must submit medical records with your appeal.

Clearly indicate on the letter and the addressed envelope:

Group Health Cooperative of Eau Claire
Attn: Provider Appeals
PO Box 3217
Eau Claire, WI 54702-3217
Fax: (715) 836-7683

All BadgerCare Plus and Medicaid SSI providers must appeal first to the HMO and then to the Department if they disagree with the HMO’s payment or nonpayment of a claim. If the health plan fails to respond to your appeal within 45 days or if you are not satisfied with the response to your appeal, you may appeal to the Department in writing within 60 days of the final decision or in the case of no response, within 60 days from the 45 day timeline allotted to the HMO to respond. Providers must use the Department’s form when submitting a provider appeal for State review and all elements of the form must be completed at the time the form is submitted (i.e. medical records for appeal regarding medical necessity). This form is available at the following website: http://dhs.wisconsin.gov/forms/F1/F12022.doc.

Forms must be sent to:

ForwardHealth
Managed Care Appeals
PO Box 6470
Madison, WI 53716-6470
### Example of Provider Remittance Advice

<table>
<thead>
<tr>
<th>PROBLEM NAME</th>
<th>ADDRESS 1</th>
<th>ADDRESS 2</th>
<th>ADDRESS 3</th>
<th>PROVIDER NO.</th>
<th>TAX I.D.</th>
<th>PAY DATE</th>
<th>CHECK NO.</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>XXXX XXXX X</td>
<td>9999999999</td>
<td>XXXX</td>
<td>TOTAL</td>
<td>000000</td>
<td>000000</td>
<td>000000</td>
<td>000000</td>
<td>0000</td>
</tr>
<tr>
<td>PT CONTROL NUMBER</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PROD TYPE/GHC ID#</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ANSI CODE DESCRIPTION FOR DENIAL/PAYMENT**

<table>
<thead>
<tr>
<th>LOCATION TOTAL</th>
<th>CHECK TOTAL</th>
<th>Net Payment</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>000000</td>
<td>000000</td>
<td>0000</td>
<td></td>
</tr>
</tbody>
</table>

RIGHT TO REVIEW AND APPEAL: If you have questions or if you are dissatisfied with the payment/denial reflected on this Explanation of Benefits, you may request an informal review of payment within 60 days from the initial payment/denial determination notice. To do this, please contact Provider Services at 1-866-563-3020.

RIGHT TO REVIEW AND APPEAL FOR BADGER CARE PLUS AND MEDICAID SSI RECIPIENTS: If you have questions or if you are dissatisfied with the payment/denial reflected on this Explanation of Benefits, you may request an informal review of payment within 60 days from the initial payment/denial determination notice. To do this, please contact Provider Services at 1-866-563-3020. If your concern is not settled to your satisfaction, you may also appeal in writing within 60 days from the initial payment/denial determination notice.

The appeal must contain the member's name and Badger Care Plus and/or Medicaid SSI ID number, the provider's name, date of service, date of billing, date of rejection and reason for reconsideration. If your appeal is medical in nature (i.e., emergency, medical necessity and/or prior authorization related) you must submit medical records with your appeal. Clearly indicate on the letter and the addressed envelope ATTENTION: PROVIDER APPEALS P.O. Box 3217 Eau Claire, WI 54702-3217.

All Badger Care Plus and Medicaid SSI providers must appeal first to the HMO and then to the Department if they disagree with the HMO's payment or non-payment of a claim.

If the health plan fails to respond to your appeal within 45 days or if you are not satisfied with the response to your appeal, you may appeal to the Department in writing within 60 days of the decision or, in the case of no response, within 60 days from the 45 day timeline allotted to the HMO to respond. Providers must use the Department's form when submitting a provider appeal for State review and all elements of the form must be completed at the time the form is submitted (i.e., medical records for appeal regarding medical necessity).

This form is available at the following website: [http://dhs.wisconsin.gov/forms/F1/F12022.doc](http://dhs.wisconsin.gov/forms/F1/F12022.doc).

Forms must be sent to:
- Badger Care Plus and Medicaid SSI Managed Care Unit
- P.O. Box 6470
- Madison, WI 53716-0470

P.O. Box 3217, Eau Claire, WI 54702-3217 Phone 715-552-4300 FAX 715-836-7683 888-203-7770
CLAIMS CODING SECTION
Accurate claims submission will allow for a more timely payment of claims.

Group Health Cooperative utilizes several policies for reimbursement of services rendered to our members. If you have claim related questions please contact Provider Services at (866) 563-3020. The intent of this information is to provide an overview of the claims processing policies related to correct coding and reimbursement. Because this information does not address every reimbursement situation, we will use reasonable discretion to construe and utilize all claims processing policies to services that were rendered to our members. Several factors are involved that relate to reimbursement, including but not limited to a member’s benefit coverage, legislative mandates and other primary insurance. The Cooperative claims processing policies may change at any time.

Providers are to bill in full. Payment will be reduced appropriately upon receipt of the claim. It is the responsibility of the provider to notify the Cooperative of any billing changes within 30 days of the change. The Cooperative reserves the right to reprocess and recoup any claims that were processed erroneously due to a billing change.

Below is a list of commonly billed modifiers and the Cooperative’s claims processing policies. Please be advised that this is not an all-inclusive list. If you have a question on a reimbursement policy, please contact Provider Services at (866) 563-3020.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Cooperative Claims Processing Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Increased procedural services</td>
<td>When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, and severity of patient’s condition, physical and mental effort required).</td>
</tr>
<tr>
<td>23</td>
<td>Unusual anesthesia</td>
<td>Does not impact reimbursement</td>
</tr>
<tr>
<td>24</td>
<td>Unrelated evaluation and management service by the same physician during a postoperative period</td>
<td>Documentation must support reasons for visit unrelated to the original procedure.</td>
</tr>
<tr>
<td>25</td>
<td>Significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure or other service</td>
<td>E&amp;M services appended with the modifier -25 are considered for reimbursement when the documentation supports: • the complaint or problem stands alone as a billable service • the key components of the E&amp;M service were met • either a different diagnosis for a significant portion of the visit, or if the diagnosis is the same, there was extra work that significantly extended beyond the pre-service work associated with the procedural code.</td>
</tr>
<tr>
<td>Modifier</td>
<td>Description</td>
<td>Cooperative Claims Processing Policy</td>
</tr>
<tr>
<td>----------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>26</td>
<td>Professional component</td>
<td>Do not bill global fee in addition to a Professional Component</td>
</tr>
<tr>
<td>TC</td>
<td>Technical component</td>
<td>Do not bill global fee in addition to a Technical Component</td>
</tr>
<tr>
<td>32</td>
<td>Mandated services</td>
<td>Not reimbursable</td>
</tr>
<tr>
<td>47</td>
<td>Anesthesia by surgeon</td>
<td>Does not impact reimbursement</td>
</tr>
<tr>
<td>50</td>
<td>Bilateral procedure</td>
<td>Reimbursed at Forward Health Fee</td>
</tr>
<tr>
<td>51</td>
<td>Multiple procedures</td>
<td>Highest dollar amount billed considered primary procedure and is reimbursed at 100% of Forward Health fee, Secondary procedure reimbursed at 50% of Forward Health fee, Tertiary at 25% of Forward Health fee and all subsequent reimbursed at 13% of Forward Health fee.</td>
</tr>
<tr>
<td>52</td>
<td>Reduced services</td>
<td>Reimbursed at 50%</td>
</tr>
<tr>
<td>53</td>
<td>Discontinued procedure after anesthesia induction (physician charges)</td>
<td>Reimbursed at 50%</td>
</tr>
<tr>
<td>54</td>
<td>Surgical care only</td>
<td>Reimbursed at 80%</td>
</tr>
<tr>
<td>55</td>
<td>Postoperative management only</td>
<td>Reimbursed at 20%</td>
</tr>
<tr>
<td>56</td>
<td>Preoperative management only</td>
<td>Not covered (included in surgical care)</td>
</tr>
<tr>
<td>57</td>
<td>Decision for surgery</td>
<td>An E&amp;M service that resulted in the initial decision to perform a major surgery (90 day global) may be identified by adding modifier 57 to the appropriate E&amp;M level.</td>
</tr>
<tr>
<td>58</td>
<td>Staged or related procedure or service by the same physician during postoperative period</td>
<td>Does not impact reimbursement</td>
</tr>
<tr>
<td>59</td>
<td>Distinct procedural service</td>
<td>Requires review. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion or separate injury, etc.</td>
</tr>
<tr>
<td>62</td>
<td>Two surgeons (i.e. co-surgery)</td>
<td>Each surgeon reimbursed according to the Forward Health Fee Schedule.</td>
</tr>
<tr>
<td>63</td>
<td>Procedure performed on infants less than 4 kgs.</td>
<td>Does not impact reimbursement</td>
</tr>
<tr>
<td>66</td>
<td>Surgical team</td>
<td>Does not impact reimbursement</td>
</tr>
<tr>
<td>Modifier</td>
<td>Description</td>
<td>Cooperative Claims Processing Policy</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>74</td>
<td>Discontinued outpatient hospital/ASC procedure after anesthesia administration. (For physician reporting of a discontinued procedure, see modifier 53)</td>
<td>Does not impact reimbursement</td>
</tr>
<tr>
<td>76</td>
<td>Repeat procedure by same physician</td>
<td>Does not impact reimbursement</td>
</tr>
<tr>
<td>77</td>
<td>Repeat procedure by another physician</td>
<td>Does not impact reimbursement</td>
</tr>
<tr>
<td>79</td>
<td>Unrelated procedure or service during the postoperative period</td>
<td>Does not impact reimbursement</td>
</tr>
<tr>
<td>80</td>
<td>Assistant surgeon MD</td>
<td>Reimbursed at Forward Health fee. Assistants at surgery are covered when an assistant is considered medically necessary and appropriate. Documentation must support why assistant was needed.</td>
</tr>
<tr>
<td>82</td>
<td>Assistant surgeon (when qualified resident not available)</td>
<td>Reimbursed at Forward Health fee. Assistants at surgery are covered when an assistant is considered medically necessary and appropriate. Documentation must support why assistant was needed.</td>
</tr>
<tr>
<td>90</td>
<td>Reference (outside) laboratory</td>
<td>Does not impact reimbursement</td>
</tr>
<tr>
<td>91</td>
<td>Repeat clinical diagnostic laboratory test</td>
<td>In the course of treatment of the patient it may be necessary to repeat the same laboratory test on the same day to obtain subsequent test results. This modifier is not appropriate when different specimens from different anatomical sites are tested.</td>
</tr>
<tr>
<td>99</td>
<td>Multiple modifiers</td>
<td>Does not impact reimbursement</td>
</tr>
<tr>
<td>AA</td>
<td>Anesthesia services performed personally by anesthesiologist</td>
<td>Does not impact reimbursement</td>
</tr>
<tr>
<td>AS</td>
<td>Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery</td>
<td>Reimbursed at Forward Health fee. Assistants at surgery are covered when an assistant is considered medically necessary and appropriate. Documentation must support why assistant was needed.</td>
</tr>
<tr>
<td>P1</td>
<td>A normal healthy patient (anesthesia modifier)</td>
<td>Does not impact reimbursement</td>
</tr>
<tr>
<td>P2</td>
<td>A patient with mild systemic disease (anesthesia modifier)</td>
<td>Does not impact reimbursement</td>
</tr>
<tr>
<td>P3</td>
<td>A patient with severe systemic disease (anesthesia modifier)</td>
<td>Provider may bill one additional unit when appropriate</td>
</tr>
<tr>
<td>Modifier</td>
<td>Description</td>
<td>Cooperative Claims Processing Policy</td>
</tr>
<tr>
<td>----------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>P4</td>
<td>A patient with severe systemic disease that is a constant threat to life (anesthesia modifier)</td>
<td>Provider may bill two additional units when appropriate</td>
</tr>
<tr>
<td>P5</td>
<td>A moribund patient who is not expected to survive without the operation (anesthesia modifier)</td>
<td>Provider may bill three additional units when appropriate</td>
</tr>
<tr>
<td>P6</td>
<td>A declared brain-dead patient whose organs are being removed for donor purposes</td>
<td>Does not impact reimbursement</td>
</tr>
<tr>
<td>QK</td>
<td>Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals</td>
<td>Reimbursed at Forward Health fee</td>
</tr>
<tr>
<td>QX</td>
<td>CRNA service: with medical direction by a physician</td>
<td>Reimbursed at Forward Health fee</td>
</tr>
<tr>
<td>QY</td>
<td>Anesthesiologist medically directs one CRNA</td>
<td>Reimbursed at Forward Health fee</td>
</tr>
<tr>
<td>QZ</td>
<td>CRNA service: without medical direction by a physician</td>
<td>Does not impact reimbursement</td>
</tr>
</tbody>
</table>

**Supporting Notes Are Required For The Following:**
- 59 modifier
- 62 modifier
- 66 modifier
- Corrected claims
- Prolonged services (99354-99355, 99356-99357, 99358-99359)
- Unlisted CPT codes

**Supporting Notes May Be Required For The Following:**
- 22 modifier
- 24 modifier
- 25 modifier
- Consultation codes (99241-99245, 99251-99255)

This is not an all-inclusive list. Notes may be requested for other services and or other modifiers. Category III codes are not reimbursable.

**Separate Procedures**
If provided as part of a more comprehensive procedure, “separate procedure” codes should not be submitted with their related and more comprehensive codes, unless the code meets criteria of modifier 59 and is billed with modifier 59 and accompanied by medical notes.
SECTION 2 – CREDENTIALING

The Cooperative is proud of the professionals and facilities that make up the network of healthcare providers. Providers and facilities must meet rigorous credentialing standards in order to be included in the provider network. Once credentialed, providers and facilities must be re-credentialed every three years in order to meet our credentialing standards.

The Cooperative is accredited by the Accreditation Association for Ambulatory Healthcare, Inc. (AAAHC). Providers and facilities are reviewed against the standards set by AAAHC, including a current valid license, clinical privileges, valid DEA or CDS certification, educational background (including board certification), work history, malpractice history, professional liability, claims history, and accreditation status. Site visits are required for all primary care, OB/GYN, behavioral health clinics and a percentage of specialty clinics and other service providers. The purpose of the site visit is to ensure that the facility meets basic quality expectations and clinical processes are in place to provide our members quality care. This process is also an avenue that allows the contracted provider and the Cooperative to develop a relationship that will lead to increased member participation in their care, and provides an opportunity for education and communication. The Cooperative wishes to be a collaborative partner in the provision of health services.

Questions or requests for information should be directed to the Quality Improvement Manager at the Administrative Offices at P.O. Box 3217, 2503 N. Hillcrest Parkway, Eau Claire WI 54702, or call (888) 203-7770.

Your comments and recommendations are always welcome.

Note: In some instances, credentialing is delegated. Please contact the Cooperative Credentialing Coordinator/QI Specialist toll free at (888) 203-7770 for clarification.

CREDENTIALING GUIDELINES:

• The Cooperative will not pay claims to a provider who is not fully credentialed at the time services are provided to the Cooperative members. Group Health expects that you will not bill the Cooperative members who are seen prior to credentialing and approved affiliation.

• Credentialing applications must contain complete and accurate information before submission to the Cooperative. Applications with incomplete information will be returned and providers instructed to re-submit with an updated signature and date.

  • Initial Credentialing Application

  • Recredentialing Form

Providers requesting affiliation should have their completed application to the Cooperative at least ten weeks prior to scheduling the Cooperative members as patients. This is to allow the Cooperative adequate time to process the application and complete all the required primary source verification.

  • The Cooperative currently credentials physicians (MD, DO, oral surgeon), dentists, podiatrists, audiologists, optometrists, chiropractors, therapists (physical, occupational, speech) and other licensed independent providers (e.g. NP, PA, CRNA, CNM, mid-level mental health practitioners, clinical psychologists, social workers, counselors, CADC’s, CSAC’s, QTT’s etc.), with whom the Cooperative contracts who treat members outside of the inpatient setting.
In addition, any provider who disaffiliates from the Cooperative’s network (whether voluntarily or through termination) is subject to credentialing if they apply to re-affiliate.

- For Locum Tenens, the Cooperative requires prior written/telephone notification if the Locum Tenens will be providing services for less than 60 consecutive days.

- If the Locum Tenens will be providing services for more than 60 consecutive days, the Cooperative requires full credentialing.

- The Cooperative’s Management Team grants final approval. The Credentialing Committee meets monthly to help expedite provider credentialing and affiliation. Providers will be notified with a letter stating the Cooperative’s Committee decision and effective date.

The Cooperative will re-credential Network providers every three years. Any provider not credentialed within 36 months from previous credentialing approval date will no longer be considered part of the provider network.
SECTION 3 - QUALITY IMPROVEMENT

Quality Improvement is an integrated process throughout the Cooperative organization. The Mission Statement for the Cooperative Quality Improvement program is:

“To objectively and systematically identify opportunities for improvement and to continuously assess the effect of improvement activities in order to meet or exceed internal and external customer expectations.”

This statement provides specific direction regarding the focus of quality improvement for the Cooperative. In order to satisfy the goals of this mission statement, we feel that all the Cooperative providers and facilities must collaborate with and embrace the activities of quality improvement. Such activities include satisfaction surveys, population and random sample based studies, and participation in multi-disciplinary teams for problem solving. These activities allow the organization to continuously improve upon processes of healthcare delivery in order to ensure that we are providing our members with highest quality of care in a cost-effective manner.

Activities of quality improvement programs in HMOs are critically reviewed by organizations such as the Accreditation Association for Ambulatory Healthcare, Inc. (AAAHC) or National Committee for Quality Assurance (NCQA). We recognize that consumers demand that organizations such as ours are held accountable for the services that are provided. Accreditation by organizations such as AAAHC or NCQA provides the consumer with assurances that the HMO has appropriate quality improvement structures in place and that those activities have a positive impact on healthcare delivery.

HealthCare Effectiveness Data and Information Set (HEDIS)
The Cooperative uses HealthCare Effectiveness Data and Information Set (HEDIS) as both a clinical and service reporting tool. Each year employers and consumer groups use this tool to compare the performance of HMOs. HEDIS is the most widely used health care quality measurement tool in the United States. HEDIS reporting includes 80 measures related access to services and preventive care across 5 domains:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Relative Resource Use
- Health Plan Descriptive Information

By analyzing this information, we are able to identify areas for improvement in serving our members. The healthcare Provider’s role in supplying this data is extremely important! Thorough medical records along with appropriately billed claims have a large impact on the quality of data being we are reporting. We continuously work to strengthen our relationships within the provider community so that our combined efforts can make a positive impact on the quality of data obtained and most importantly, the quality of care our members are receiving.

State of Wisconsin Medicaid Quality Requirements
In addition to using HEDIS measurement reporting, the Wisconsin BadgerCare /Medicaid SSI Managed Care Program requires that participating HMOs have effective quality improvement structures in place. As part of the State of Wisconsin BadgerCare /Medicaid SSI program and HMO relationship, HMOs are required to provide the state with accurate encounter data within specified time frames. This data is collated and reported annually by the State of Wisconsin. Indicator data is reported in the following areas: Women’s Healthcare; Child Healthcare; Acute and Chronic Condition; Mental Health; Preventive Care and Other Healthcare.
The Cooperative continuously works with the Department of Health Services of Wisconsin (DHS) on performance initiatives. The Department of Health Services has developed Quality Requirements for health plans managing BadgerCare and SSI populations. The Quality Requirements are chosen based on clinical need, high risk, high cost and measures that require increased performance.

BadgerCare and Medicaid SSI Quality Requirements:
- Anti-depressant Medication Management
- Breast Cancer Screening
- Childhood Immunization Status
- Comprehensive Diabetes Care
- Emergency Department Use
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Outpatient follow up after a hospital stay for mental health or substance abuse
- Prenatal and Post-partum Care
- Tobacco Cessation

Please note: The State of Wisconsin reviews and reissues current BadgerCare and Medicaid SSI Quality Requirements each year. Information in the listing above is current as of October 2014. Please contact the Quality Improvement department for more information regarding this data.

Information from quality improvement activities is actively shared with our providers and staff. We encourage constructive feedback and are available as a resource for quality improvement activities of Cooperative providers and facilities. Questions or requests for information should be directed to the Quality Improvement department at the Administrative Offices at P.O. Box 3217, 2503 N. Hillcrest Parkway, Eau Claire WI 54702 (715) 552-4300 or (888) 203-7770.

**Waiting and Appointment Scheduling Standards:**

The following is the Cooperative’s expectations for providers regarding accessibility of care and services to all members regardless of payer type:

- **Primary Care/Preventive Care:** Within 3 weeks of request
- **Specialty Care:** Within 5 weeks of request
- **Behavioral Health Care:** Within 5 weeks of request
- **Urgent Care:** Within 30 days of request upon discharge from inpatient stay
- **Emergent Care:** 24-48 hours
- **Office Waiting Time:** Immediate face-to-face
- **Office Waiting Time:** Within 30 minutes

The Cooperative recognizes that delays may be unavoidable. It is the responsibility of the provider to notify the member of unusual delays and offer alternatives.
SECTION 4 – MEMBER RIGHTS & RESPONSIBILITIES

Badgercare Plus and Medicaid SSI Members Have The Right To:
✓ Receive services in accordance with Federal and State civil rights and limited English proficiency (LEP) requirements, including, but not limited to:
  o Asking for an interpreter and having one provided to them during any covered service. The Cooperative and all contracted providers are required to provide professional interpretation services on-site to members at no cost. Family members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality is critical.
  o Receiving care, referrals and/or recommendations for services in the same manner (including timeliness, amount, duration, and scope) as all other Cooperative members or patients, regardless of insurance coverage.
  o Obtaining care at a facility and/or location that is physically accessible as well as accessible for individuals with hearing and/or vision impairments.
  o Receiving all medically necessary, covered services and having services provided to all eligible members regardless of:
    • Age
    • Race
    • Religion
    • Color
    • Disability
    • Sex
    • Sexual orientation
    • National origin
    • Marital status
    • Arrest or conviction record
    • Military participation

✓ Receive the information provided in their member handbook and/or any provider handouts or documentation in another language or another format.
✓ Receive healthcare services as provided for in Federal and State law. All covered services must be available and accessible to members, including hours of operation that do not discriminate against BadgerCare Plus and/or Medicaid SSI members. When medically appropriate, services must be available 24 hours a day, seven days a week.
✓ Receive information about treatment options, including the right to request a second opinion.
✓ Make decisions about their healthcare.
✓ Be treated with dignity and respect.
✓ Be free from any form of restraint or seclusion used as a means of force, control, ease or reprisal.
✓ Receive all the benefits to which they are entitled under their plan.
✓ Receive quality healthcare through their Primary Care Clinic and other Cooperative providers in a timely manner and in a medically appropriate setting.
✓ Considerate, courteous and respectful care. This includes obtaining culturally-competent services which recognize members’ beliefs, address cultural differences in a competent manner, and foster behaviors that address interpersonal communication styles that respect members’ cultural backgrounds.
✓ Privacy and confidentiality concerning their medical care. All communication and records pertaining to their care shall be treated as confidential in accordance with Federal and State law.

✓ Obtain complete, current information concerning a diagnosis, treatment and prognosis from a physician or other provider in terms that they can reasonably be expected to understand. When it is not advisable to give such information to the member, the information will be made available to an appropriate person on the member’s behalf.

✓ Receive from a physician or other provider information necessary to give informed consent prior to the start of any procedure or treatment.

✓ Refuse treatment to the extent permitted by law and to be informed of the medical consequences of that decision.

✓ Receive written documentation regarding rules and regulations of their healthcare benefits.

✓ Expect their Primary Care Clinic to coordinate and monitor their care.

✓ Express their concerns, make a complaint, or file a grievance with the Cooperative and/or the right to file a complaint with the State of Wisconsin Department of Health Services (DHS); or appeal to the Social Security Administration; or appeal to the Office of the Railroad Retirement Board if they are a railroad annuitant.

✓ Designate an individual to make treatment decisions on their behalf in the event that they are unable to do so.

✓ Receive direct access to in-network women’s health specialists for females seeking routine and preventive services.

The following are additional rights members have in relation to their protected health information in accordance with the Cooperative’s Notice of Privacy Practices and Federal and State law:

✓ Right to See or Copy Protected Health Information: Patients have the right to see or copy records used to make decisions about their health plan services. It will not include information needed for civil, criminal, administrative actions and proceedings, or psychotherapy notes, except in certain circumstances. The Cooperative may ask that the request be in writing and to provide the specific information needed to fulfill the request. A reasonable, cost-based fee may be charged to cover the processing and mailing cost of the request.

✓ Right to Correct Information Believed to be Incorrect or Incomplete: Patients have the right to request an amendment any protected health information. All requests for amendments must be in writing. In certain cases, the Cooperative may deny the request, if it did not create the original information. All denials will be made in writing and will indicate how a patient can respond if they disagree.

✓ Right to Request a List of Who Was Given Their Information and Why: Patients have the right to have the Cooperative provide them with a list of times when their medical information was disclosed for any purpose other than treatment, payment, or healthcare operations, national security purposes, or for any listing already provided to them. All requests must be in writing. The patient is required to provide the Cooperative with the specific information needed to fulfill the request, with specific dates required. This requirement applies for six years from the date of the disclosure. If a list is requested more than once in a 12-month period, a reasonable, cost-based fee may be charged to cover the processing and mailing costs.
 ✓ Right to Request Restrictions: Patients have the right to request restrictions on the way their medical information is used or disclosed for treatment, payment, or healthcare operations. However, the Cooperative is not required to agree to these restrictions. All requests must be made in writing.

 ✓ Right to Confidential Communications: Patients have the right to reasonable requests to communicate with them about their medical information by alternative means or to alternative locations. The request will be evaluated and the patient will be notified if it can be done. All requests must be made in writing. Patients are not required to provide a reason for this request.

 ✓ Right to Contact Information: Patients have the right to exercise any of the rights described above by contacting the Cooperative’s Compliance Officer. All requests must be made in writing.

**MEMBERS HAVE THE RESPONSIBILITY TO:**

 ✓ Select their Primary Care Clinic from the Cooperative’s Provider Directory. Primary Care Clinics will coordinate and monitor their member’s healthcare needs.

 ✓ Use the Cooperative’s providers, hospitals, laboratories or other diagnostic facilities whenever possible, unless members are in an emergency situation.

 ✓ Provide complete and honest information about their healthcare status.

 ✓ Report unexpected changes in their medical condition to their medical providers, and make it known whether or not they understand the contemplated course of action and what is expected of them.

 ✓ Keep appointments and notify the medical office of their cancellation.

 ✓ Notify the Cooperative whenever they change their address or phone number so that records may be updated.

 ✓ Read and understand their Member Handbook and covered benefits.

 ✓ Provide accurate and complete information to the Cooperative about other healthcare coverage and/or insurance benefits they may carry for coordination of benefits purposes.
SECTION 5 – ENROLLMENT & ELIGIBILITY INFORMATION

Eligibility
Group Health covers the following groups of Medicaid HMO Members and their corresponding group numbers:

- Group Health BadgerCare Plus Standard Plan (7100-7299)
- Group Health BadgerCare Plus Childless Adults (7005)
- Group Health Medicaid SSI (6000-6299 & 6500-6799)
- BadgerCare Plus Standard Plan (7600-7799)
- BadgerCare Plus Childless Adults (7505)
- Medicaid SSI (6300-6302)

Income eligibility for these programs varies by family size and program type. Enrollment Specialists are trained to explain benefits, eligibility and the application process. Medicaid SSI Plan recipients receive benefits and coverage comparable to the BadgerCare Plus Standard Plan and are eligible for Medicaid due to their eligibility for SSI (Supplemental Security Income) for limited income and resources.

All Members may choose their own HMO or work with the HMO Enrollment Specialist to choose the best one for their needs. They may choose an HMO at any time during the enrollment process. All eligible members of the member’s family must choose the same HMO. However, individuals within a family may be eligible for an exemption from enrollment.

Following is the enrollment process:

1. Members residing in an HMO service area receive an HMO enrollment packet. The packet has an enrollment form, a list of available HMOs, and instructions on how to choose an HMO and how to find out if a provider is affiliated with an HMO.

2. If the member does not choose an HMO within two weeks of receiving the enrollment packet, s/he receives a reminder card. Members in areas with only one available HMO do not have to enroll in an HMO, unless the zip code has been designated rural mandatory by DHS.

3. If the member has not selected an HMO after four weeks, and resides in a mandatory enrollment zip code area, s/he will be assigned an HMO. A letter explaining the assignment will be sent to him/her. S/he will receive another enrollment form and have an opportunity to change the assigned HMO.

4. S/he will then receive a notice confirming enrollment in the assigned or selected HMO for the following month. The member has up to three months to change HMOs, once enrolled. This is the open enrollment period. After the initial three months, the member is locked into the HMO and cannot change for nine months. If your member has questions about HMO enrollment, s/he should contact the Enrollment Specialist at (800) 291-2002.

The Member Services Department attempts to call all new members within one month of their enrollment. Staff presents an overview of the plan benefits and procedures and, if necessary, assists new members in selecting a primary care provider.

Exemptions: A member may qualify for an exemption from HMO enrollment if s/he meets certain criteria, such as a chronic illness, high-risk third trimester pregnancy, or continuity of care concerns, etc.
If the member believes s/he has a valid reason for exemption, s/he should call the HMO Enrollment Specialist at (800) 291-2002. The number is also in the enrollment materials s/he receives.

**Change of Circumstances:** Members who lose BadgerCare Plus and Medicaid SSI eligibility, but become eligible again, may be automatically re-enrolled in their previous HMO.

If the member’s eligibility is re-established after a Restrictive Reenrollment Period (RRP), s/he will be automatically re-enrolled in the previous HMO, unless the HMO is no longer accepting reassignments.

After six months, or if the HMO is no longer accepting reassignments or has exceeded its enrollment level, s/he will receive an enrollment packet, and the enrollment process will start over.

**IDENTIFICATION OF GROUP HEALTH MEMBERS**
Group Health BadgerCare Plus, Group Health Medicaid SSI and BadgerCare Plus members do not receive Insurance Identification cards from the Cooperative. BadgerCare Plus and Medicaid SSI members are required to carry and present their ForwardHealth card (issued by Department of Health Services) when seeking services.

![DHS ForwardHealth Card](image)

**IT IS ESSENTIAL THAT MEDICAID PROVIDERS VERIFY ENROLLMENT PRIOR TO EACH DATE OF SERVICE.**

The secure area of the ForwardHealth Portal offers real-time member enrollment verification for all ForwardHealth programs. All Portal users can use this tool to determine the benefit plan(s) in which the member is enrolled or if the member is enrolled in a state-contracted managed care program (for BadgerCare Plus and Medicaid members). The ForwardHealth Portal website can be found at [www.ForwardHealth.wi.gov/](http://www.ForwardHealth.wi.gov/) and is available 24 hours a day, seven days a week.

Providers may also contact WiCall (formerly known as ForwardHealth Automatic Voice Response) at (800) 947-3544 for enrollment verification. WiCall is available 24 hours a day, seven days a week.

To verify enrollment and benefits for Group Health Cooperative members, contact the Cooperative Provider Services department directly at (715) 552-4333 or (866) 563-3020. Representatives are available from 8:00 a.m. to 5:00 p.m. Monday through Friday.
Providers can also verify eligibility and benefit plan (i.e. Standard or SSI) for Cooperative members via the secure online eligibility website* for providers. Primary care clinic assignment and other insurance information are also available via provider login. The Group Health website can be found at www.group-health.com/ and is available 24 hours a day, seven days a week.

*If you do not currently have online eligibility access, please contact the Provider Services department at (866) 563-3020 to establish an account. Execution of a Confidentiality Agreement is required for initial set-up.

Note: In emergency situations, providers are required to treat the patient for medically necessary emergency care regardless of HMO affiliation. The provider should then bill the HMO that the patient is affiliated with. The State of Wisconsin requires that HMO’s reimburse for medically necessary emergency services. The patient should be instructed to follow-up with their HMO.

DISENROLLMENT
Members are automatically disenrolled from the HMO program if:
1. Their medical status code changes to a BadgerCare Plus subprogram that does not require enrollment in an HMO.
2. They become eligible for Medicare (applies to BadgerCare Plus only, not SSI).
3. They lose eligibility.
4. They move out of the HMO’s service area.

Members who move out of the HMO service area receive a new packet showing the HMO(s) available in the new area and the enrollment process begins again. If no HMO covers the member’s new area, s/he remains fee-for-service.
### Service

<table>
<thead>
<tr>
<th>Service</th>
<th>BadgerCare Plus Standard Plan and Medicaid SSI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance</td>
<td>Full coverage of emergency transportation to and from a BadgerCare Plus covered service with no copayment. Non-emergent ambulance transportation may be arranged by Medical Transportation Manager (MTM). Please call them for information.</td>
</tr>
<tr>
<td>Ambulatory Surgery Centers</td>
<td>Coverage of certain surgical procedures and related lab services.</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>Group Health Cooperative does not cover chiropractic services. You may receive chiropractic services from any chiropractor who will accept your Forward Health ID card.</td>
</tr>
<tr>
<td>Dental/Oral Surgery/TMJ</td>
<td>You may get dental services from any dentist who will accept your Forward Health ID card. Your dental services are provided by the State, not the Cooperative. Please show your Forward Health ID card to the dentist. A dental emergency is an immediate dental service needed to treat dental pain, swelling, fever, infection or injury to the teeth. For help with a dental emergency, call 1-800-362-3002 (toll-free).</td>
</tr>
<tr>
<td>Disposable Medical Supplies (DMS)</td>
<td>Full coverage with no copayment.</td>
</tr>
<tr>
<td>Drugs</td>
<td>You may get your drugs from any pharmacy that will accept your Forward Health ID card. Your prescriptions and certain over the counter items are provided by the State, not the Cooperative. Please show your Forward Health ID card to the pharmacy.</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>Full coverage with no copayment. Rental items are not subject to copayment.</td>
</tr>
<tr>
<td>End Stage Renal Disease (ESRD)</td>
<td>Full coverage with no copayment.</td>
</tr>
<tr>
<td>HealthCheck screenings for Children</td>
<td>Full coverage of HealthCheck screenings and other services for individuals 20 years and under. Your child should receive a health check at the following ages:</td>
</tr>
<tr>
<td></td>
<td>• Birth • 6 Months • 15 Months • 30 Months • 2 Months • 9 Months • 18 Months • 4 Months • 12 Months • 24 Months</td>
</tr>
<tr>
<td></td>
<td>3 years old through the age of 20 should receive a yearly HealthCheck. No Copayment.</td>
</tr>
<tr>
<td>Service</td>
<td>BadgerCare Plus Standard Plan and Medicaid SSI</td>
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<tr>
<td>Hearing Services</td>
<td>Full coverage with no copayment. No copayment for hearing aid batteries.</td>
</tr>
<tr>
<td>Home Care Services – Home Health, Private Duty Nursing (PDN), and Personal care.</td>
<td>Full coverage of private duty nursing, home health care, personal care with no copayment.</td>
</tr>
<tr>
<td>Hospice</td>
<td>Full coverage with no copayment.</td>
</tr>
<tr>
<td>Hospital - Inpatient</td>
<td>Full coverage with no copayment.</td>
</tr>
<tr>
<td>Hospital - Outpatient</td>
<td>Full coverage with no copayment.</td>
</tr>
<tr>
<td>Hospital – Outpatient Emergency Room</td>
<td>Full coverage with no copayment.</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse Treatment</td>
<td>Full coverage with no copayment.</td>
</tr>
<tr>
<td>Nursing Home Services</td>
<td>Full coverage with no copayment.</td>
</tr>
<tr>
<td>Physician</td>
<td>Full coverage including laboratory and radiology with no copayment.</td>
</tr>
<tr>
<td>Podiatry</td>
<td>Full coverage with no copayment.</td>
</tr>
<tr>
<td>Prenatal /Maternity Care</td>
<td>Full coverage with no copayment. Includes Prenatal Care Coordination (PNCC) and preventive mental health and substance abuse screening and counseling for women at risk of mental health or substance abuse problems.</td>
</tr>
<tr>
<td>Reproductive Health</td>
<td>Full coverage, excluding infertility treatments, reversal of voluntary sterilization and surrogate parenting and related services, including but not limited to artificial insemination, obstetrical care, labor or delivery, prescription and OTC drugs.</td>
</tr>
<tr>
<td>Routine Vision</td>
<td>Full coverage including eye glasses with no copayment.</td>
</tr>
<tr>
<td>Therapy - Physical Therapy, Occupational Therapy and Speech and Language Pathology</td>
<td>Full coverage with no copayment.</td>
</tr>
<tr>
<td>Transportation (Non-emergent) Specialized Medical Vehicle (SMV), Common Carrier</td>
<td>All non-emergent medical transportation is arranged through Medical Transportation Manager (MTM). Please call them for information</td>
</tr>
</tbody>
</table>
SECTION 7 - HEALTH MANAGEMENT REVIEWS FOR MEDICAL NECESSITY

OVERVIEW OF HEALTH MANAGEMENT PROGRAM
The Health Management program has been designed to facilitate the appropriate, efficient and cost-effective management of our members’ healthcare. While cost and other resource issues are considered as part of a responsible decision-making process, our Health Management staff, including the clinicians who make health management-related decisions and those who supervise them, make decisions based on the clinical appropriateness of the care or service. Ongoing analysis of under and over utilization will be performed.

Our Health Management staff is not rewarded for issuing denials of coverage or service, and is not given any financial incentives for health management decisions that are intended to reward inappropriate restrictions of care, or result in the under-utilization of services.

Reviews for medical necessity are based on currently available clinical information including:
- clinical outcome studies in peer-reviewed published medical literature,
- regulatory status of the technology,
- evidence-based guidelines of public health and health research agencies,
- evidence-based guidelines and positions of leading national health professional organizations,
- views of physicians practicing in relevant clinical areas, and
- other relevant factors

We expressly reserve the right to revise these conclusions as clinical information changes, and welcome further relevant information. Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their providers will need to consult the member’s benefit plan to determine if there are exclusions or other benefit limitations applicable to approved services or supplies. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (i.e. will be paid for) for a particular member. The member’s benefit plan determines the extent and limitations of coverage. In addition, coverage may be defined by applicable legal requirements of the State of Wisconsin, the Federal Government or Center for Medicare and Medicaid Services (CMS) (for Medicare and Medicaid members). This is in no way to imply that providers are not prohibited from advocating for member resources.

DEFINITIONS

**Concurrent Review:** A collaborative process with hospital staff and/or attending physicians to provide information necessary for inpatient management. Information is transmitted by telephone or fax unless the anticipated length of stay for the patients' diagnosis is lengthened. In these cases, on-site review may be necessary.

**Prior Authorization:** Written approval (generally based on medical necessity) for a referral, admission, or service by the Cooperative prior to services being rendered. Payment for services is dependent on other non-medical criteria such as the benefits associated with a member’s specific plan and coverage eligibility.

**Medically Necessary:** A service, treatment, procedure, equipment, drug, device, or supply provided by a network hospital, physician, or other health care provider that is required to identify or treat a member’s illness or injury. That which is medically necessary is determined by the Cooperative using the following criteria: is consistent with symptom(s) or diagnosis and treatment of the member’s illness or injury; is not primarily for the convenience of the member, physician, hospital, or other health care provider; is the most appropriate service, treatment, procedure, equipment, drug, device, or supply
which can be safely provided to the member and accomplishes the desired result in the most
cost-effective manner.

Non-Network Provider (or “out-of-network”): the group of non-contracted physicians, providers,
clinics, and facilities outside the Cooperative’s service area and/or those which do not have a
contractual relationship with the Cooperative. The most current provider directory lists the
Cooperative’s network providers. All services, except emergency services, received from any non-
network provider require prior authorization from the Cooperative.

Practice Group: An organized group of physicians that have joined together in a defined structure to
facilitate the care of members between primary care and specialty care.

Primary Care Clinic: a clinic contracted to provide primary care services to Cooperative members.
The member must choose a primary care clinic for their care. Each member may have a different
primary care clinic.

Primary Care Provider: a Wisconsin-licensed network provider who is contracted to provide primary
care services to members. The primary care provider evaluates the member’s total health needs
and provides personal medical care in one or more medical fields. When medically needed, he/she
preserves continuity of care. He/she is also in charge of coordinating other provider health services and
refers the member to other contracted providers as appropriate to the member. Primary care providers
include the following: Family Practice, Internal Medicine, Pediatric, and OB/GYN physicians.

Receipt Date: Determined by the date marked as received by the Health Management Department when
received by mail or by the date received and date stamped by fax in the Health Management Department.

INPATIENT MANAGEMENT FACILITIES

All hospital admissions*, inpatient rehabilitation facility admissions (including inpatient pulmonary
rehabilitation admissions), non-emergent intra-facility admissions (transfers), and long term care
and skilled nursing facility care (including out-of-network admissions) are reviewed for medical
appropriateness of admission and continued stay. Notification of an inpatient admission by the
hospital can serve as a trigger for the Health Management nurse consultant to assess, in partnership
with the contracted facility, the need for discharge planning or case management.

*Medical appropriateness for hospital admission associated with labor and delivery charges is only required if discharge is
greater than two (2) days following vaginal delivery or is greater than four (4) days following cesarean delivery. No notification
of inpatient admission by hospital is needed if admission is less than or equal to these time-frames.

Concurrent Review

Concurrent Review of inpatient management is a collaborative process with hospital staff and/or
attending physicians to provide concurrent review by telephone or fax. On-site review may be
necessary in some situations where the anticipated length of stay for the patient’s diagnosis is
lengthened. The concurrent review process includes, but is not limited to, the following components:

• The Cooperative nurse consultants provide concurrent review of medical records and are
  available to assist with members’ care management or discharge planning needs;

• When appropriate, the nurse consultant will work with members and families to explain health
  management decisions and facilitate discharge planning.

1The group of non-contracted physicians, providers, clinics, and facilities outside the Cooperative’s service area and/or those which
do not have a contractual relationship with the Cooperative. The most current provider directory lists the Cooperative’s network
providers. All services, except emergency services, received from any non-network provider require prior authorization from the
Cooperative.
Authorization for services does not guarantee payment for services. Payment for services is dependent on other non-medical criteria such as the benefits associated with a member’s specific plan and eligibility issues.

- Nurse Consultants use clinical decision support criteria to evaluate medical necessity and appropriateness of care;
- Potential quality issues identified during concurrent review are reported to the Group Health Medical Director and, if found to be significant, to the Group Health Quality Improvement Committee.

Discharge Planning
Evaluation of discharge planning opportunities begins with the initial notification that an inpatient admission is being contemplated, or has occurred. In order to facilitate an individualized discharge plan that effectively promotes the efficient use of medical resources in the most appropriate clinical setting, nurse consultants collect information from a variety of sources such as medical records, the patient, physician interaction and input from hospital nursing and discharge planning staff. Nurse consultants identify patients whose diagnosis, intensive treatment requirements or co-morbidity factors make them likely candidates for intense discharge planning or specialized case management.

SERVICES REQUIRING PRIOR AUTHORIZATION
When authorization is required, the facility, ancillary provider or physician rendering the services must verify with the Cooperative’s Provider Services that authorization has been approved before the services are performed. Requests will be evaluated for medical necessity using evidence-based guidelines as available.

All services requiring event authorization must have authorization prior to delivery or, as in the case of an emergency inpatient admission, the next business day.

In the case of an emergent medical need for an event authorized service, an event service request with clinical justification of the emergent need, must be faxed to the Health Management Department as soon as possible before the services are performed. Please indicate on your request the need for an emergent review.

Note: Retroactive event authorization requests will not be granted unless there is a compelling medical reason for consideration. At no time will a retroactive review event authorization be approved for a time span greater than two weeks prior to the receipt date of the retroactive review request to the Health Management Department. All requests shall be sent to the Health Management Department by fax or by mail with appropriate documentation to determine medical necessity. This includes the inpatient admission authorizations and notifications and discharge notifications.

EMERGENCY DEPARTMENT SERVICES
Written approval (generally based on medical necessity) for a referral, admission, or service by the Cooperative prior to services being rendered. Payment for services is dependent on other non-medical criteria such as the benefits associated with a member’s specific plan and coverage eligibility.

Medically necessary means a service, treatment, procedure, equipment, drug, device, or supply provided by a plan hospital, physician, or other healthcare provider that is required to identify or treat a member’s illness or injury. That which is determined by the Cooperative to be: consistent with symptom(s) or diagnosis and treatment of the member’s illness or injury; not primarily for the convenience of the member, physician, hospital, or other healthcare provider; most appropriate service, treatment, procedure, equipment, drug, device or supply, which can be safely provided to the member and accomplishes the desired result in the most cost effective manner.

Receipt date shall be determined by the date marked as received by the Health Management when received by mail or by the date received and date stamped by fax if received by fax in the Health Management Department.
Group Health instructs all Group Health HMO patients to call their primary care clinic during regular office hours or the Cooperative Nurse Triage Line at (800) 586-5473 after clinic hours, before proceeding to the emergency department, unless there is an “emergency medical condition” defined by the State of Wisconsin as:

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could reasonably be expected to result in:

A. Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy.
B. Serious impairment of bodily functions.
C. Serious dysfunction of any bodily organ or part.
D. Or, with respect to a pregnant woman in active labor:
   a. There is inadequate time to affect a safe transfer to another hospital before delivery.
   b. The transfer may pose a threat to health and safety of the woman or the unborn child.

Other emergency situations as stated:
A. A psychiatric emergency involving a significant risk of serious harm to oneself or others.
B. A substance abuse (alcohol or other drug abuse) emergency exists if there is a significant risk of serious harm to a member or others, or there is a likelihood of return to drug abuse without immediate treatment.
C. Emergency dental care is defined as an immediate service needed to relieve the patient from pain, an acute infection, swelling, truism, fever, or trauma. In all emergency situations, the managed care program must document the nature of the emergency in the recipient’s dental records.

In the absence of a finding by the Cooperative’s Chief Medical Officer of justifying circumstances, including serious jeopardy to the health of the woman or her unborn child, obstetrical delivery of a child or children outside of the service area during or after the ninth (9th) month of pregnancy will not constitute an emergency medical condition.

SEE APPENDIX A FOR HEALTH MANAGEMENT AUTHORIZATION FORMS
SECTION 8 - BEHAVIORAL HEALTH & ALCOHOL AND OTHER DRUG ABUSE (AODA) SERVICES

SERVICE AREAS

The behavioral health and chemical dependency service areas of the Cooperative are referred to as Region 1 and Region 2. When a primary care provider or a member themselves, determines that behavioral health or AODA services (either inpatient or outpatient) are needed, they must adhere to the following:

Region 1 services are for BadgerCare Plus members who reside in the counties of Barron, Chippewa and Eau Claire. These services are provided directly by Vantage Point Clinic and can be reached at 715-834-3171 or 715-832-5454 to schedule services.

Region 2 services are for BadgerCare Plus members who reside outside of Barron, Chippewa and Eau Claire counties and all the Cooperative commercial and Medicaid SSI members. These services are not provided directly by Vantage Point Clinic. Members and the providers who serve them should contact Group Health Cooperative’s Health Management Department at (800) 218-1745 for all authorization and referral needs.

SERVICES REQUIRING PRIOR AUTHORIZATION

Subsequent outpatient psychiatric, mental health and AODA visits
If after six visits (including the intake visit), the provider determines that additional outpatient treatment/services are necessary, the provider must receive prior authorization from the Cooperative’s Health Management Department.

Inpatient & Outpatient Psychological Testing
All authorization requests for inpatient and outpatient psychological testing must be obtained prior to members receiving the service and can be requested from the Cooperative’s Health Management Department.

Day Treatment/Partial Hospitalization and Transitional Care
All authorization requests for Day Treatment / Partial Hospitalization and Transitional Care must be obtained prior to members receiving the service and must be requested from the Cooperative’s Health Management Department.

Medication Management
Authorization is not required when medication management is provided by a contracted provider. Medication management visits are not included in the initial six visits cited above in the “Outpatient psychiatric, mental health and AODA” section. Psychotherapy, in conjunction with medication management, is subject to the 6 visit outpatient guideline. Prior to the 7th visit, authorization for additional visits must be authorized.

Inpatient Care
In the event of an emergency admission, notification including clinical information supporting the need for admission is required on the next business day. A target length of stay will be determined and communicated to the provider. Additional clinical information (concurrent review) may be needed to assess length of stays that are longer than the initial authorization. Clinician-to-clinician reviews may be conducted during concurrent review. Review and planning of further care should occur prior to expiration of any current authorization. Concurrent reviews generally occur during normal business hours. Notification of discharge date and discharge plan is required at the time of discharge.
Authorization for admission services does not guarantee payment for services. Payment for services is dependent on other non-medical criteria such as the benefits associated with the member’s plan and eligibility issues. Authorization guidelines must be followed even if Group Health is secondary to another insurance plan, including Medicare.

SERVICES NOT REQUIRING PRIOR AUTHORIZATION

Region 2 Initial outpatient psychiatric, mental health and AODA visits
Authorization for outpatient services in Region 2 will not require initial authorization requests by participating providers. Network providers may see new patients for up to six visits per calendar year, including the intake, without authorization. This automatic authorization is only given to providers with active credentialing and provider participation status who are seeing Group Health Cooperative members.

SEE APPENDIX B FOR BEHAVIORAL HEALTH AND AODA AUTHORIZATION FORMS

Retroactive event authorizations for services will not be granted unless there is a compelling reason for consideration. At no time will a retroactive event authorization be approved for a time span greater than two weeks prior to the receipt date.
SECTION 9 – AUTHORIZATION GUIDELINES

Authorization for services does not guarantee payment for services. Payment for services is dependent on other non-medical criteria such as the benefits associated with a member’s specific plan and eligibility issues. Authorization guidelines must be followed even if the Cooperative is secondary to another insurance plan, including Medicare.

Retroactive event authorizations for services will not be granted unless there is a compelling reason for consideration. At no time will a retroactive event authorization be approved for a time span greater than two weeks prior to the receipt date.

Note: If a member receives services that require an approved authorization by the Cooperative and such authorization is not obtained, or the prior authorization was denied because services were not deemed medically necessary, all services (including out-of-network and future related services and/or follow-up care related to the services) will be denied. This includes any ancillary, facility, and/or professional charges.

Authorization forms are located in Appendix A of this manual. Behavioral Health authorization forms are located in Appendix B of this manual.

All Facility Admissions

Prior authorization is required for all facility admissions including:
- non-emergent hospital admissions,
- rehabilitation facility admissions,
- skilled nursing facility admissions,
- sub-acute care admissions,
- behavioral health admissions, and
- swing bed admissions

Additional clinical information may be needed to assess length of stays that are prolonged after the initial length of stay authorization approval (Concurrent Review). Use the ‘Notification Request for Admission Form’ located in Appendix A.

Note:
For Emergency Admissions, next business day notification and notification of discharge date at time of discharge are required. Additional clinical information may be needed to assess length of stays that are prolonged after the initial length of stay authorization approval (Concurrent Review). Use ‘Notification Request for Admission Form’ located in Appendix A.

Prior Authorization for hospital admission associated with labor and delivery charges is only required if discharge is greater than two (2) days following vaginal delivery or is greater than four (4) days following cesarean delivery. No notification of inpatient admission by hospital is needed if admission is less than or equal to these timeframes.

Alternative Medicine Services

Alternative medicine specialists including massage therapists, acupuncturists, and/or herbal therapists are non-covered benefits for all plans. No services will be authorized or paid for.
Ambulance Transportation
Prior authorization is required for ambulance transportation (both air & ground) that is not due to an emergency, prior to the scheduling of the transfer. Use the ‘Request for Service Event Authorization Form’ located in Appendix A.

Behavioral Health & Alcohol and Other Drug Abuse (AODA)
The behavioral health and AODA service areas of the Cooperative are referred to as Region 1 and Region 2. When a primary care provider or a member themselves, determines that behavioral health or AODA services (either inpatient or outpatient) are needed, they must adhere to the following:

Region 1 services are for BadgerCare Plus members who reside in the counties of Barron, Chippewa and Eau Claire. These services are provided directly by Vantage Point Clinic and can be reached at 715-834-3171 or 715-832-5454 to schedule services.

Region 2 services are for BadgerCare Plus members who reside outside of Barron, Chippewa and Eau Claire counties and all Cooperative commercial and Medicaid SSI members. These services are not provided directly by Vantage Point Clinic. Members and the providers who serve them should contact Group Health Cooperative’s Health Management Department at (800) 218-1745 for all authorization and referral needs.

• No authorization is required for the first six visits (counting the initial evaluation) for outpatient mental health and/or AODA counseling.
• Authorization is required prior to any:
  o Day Treatment,
  o In-Home Therapy (including autism)
  o Inpatient and/or partial inpatient hospitalization

Use the appropriate Behavioral Health Authorization Form(s) located in Appendix B.

Eyeglasses (BadgerCare Plus and/or Medicaid SSI only)
Prior authorization is required if a prescription change occurs resulting in the need for replacement of eyeglasses beyond the benefit of two pair within the member’s annual membership year. Use the ‘Service Event Authorization Form’ located in Appendix A.

Home Health
• Home Health Services require prior authorization
• Prior Authorization is no longer required for Palliative Care and Hospice Services

Non-Emergent Surgeries and Procedures
Prior authorization is required for the following non-emergent surgeries & procedures:
• Abortion
• Bone conduction hearing implants
• Cancer Clinical Trials
• Corneal Transplants / Keratoplasty
• Circumcision not performed within one week of birth
• Dental anesthesia procedures or oral surgery not performed in an office setting (dental anesthesia not performed in an office setting for children 5 years old and under does not require prior authorization)
• Essure sterilization not performed in a doctor’s office
• Gastric surgery for obesity (including consults, testing, and assessments prior to surgery)
• Hyperbaric Oxygen Chamber Treatment
• Intra-discal electrothermal annuloplasty (IDET)
• Non-cardiac radiofrequency ablation for the treatment of chronic pain
• Organ transplant including bone marrow transplant/stem cell transplant
• Pain management services in an outpatient clinic and outpatient hospital setting (see May 2017 update)
• Plastic or reconstructive surgery including but not limited to: blepharoplasty; ptosis repair, panniculectomy, reduction mammoplasty, breast implant removal, rhinoplasty, seotoplasty, scar revision
• Podiatric surgery not performed in the doctor’s office or Skilled Nursing Facility
• Sclerotherapy/Endovenous Ablation
• Temporomandibular joint (TMJ) treatment
• Uvulopalatopharyngoplasty (UVPP, UPPP)
• Unlisted CPT or Category III procedure code, or previously unlisted CPT or Category III codes that now have a permanent code

Use the ‘Request for Service Event Authorization Form’ located in Appendix A.

**Out-of-Network Referral Requests**

Any request for a member to obtain professional services from an out-of-network provider must be authorized by the Cooperative Health Management Department. Use the 'Event Authorization for Out-of-Network Referral Form' located in Appendix A.

**Outpatient Laboratory**

Prior authorization is required for any genetic testing such as DNA testing except:
• when billed in conjunction with amnioncentesis or;
• when provided in conjunction with Bone Marrow Biopsy

Use the ‘Request for Service Event Authorization Form’ located in Appendix A.

**Outpatient Psychological Testing**

All authorization requests for outpatient psychological testing must be obtained prior to members receiving the service and can be requested from the Cooperative’s Health Management Department. Use the appropriate authorization form(s) located in Appendix B.

**Outpatient Radiology**

Prior authorization is required for the following outpatient scans (i.e. not performed at the time of an emergency department visit, emergency department service, inpatient stay or observation stay)
• MRI
• PET Scans / SPECT Scans
• CT Scans / CTA Scans
• Cardiac CT Scans for calcium scoring

Use the ‘Request for Service Event Authorization Form’ located in Appendix A.

**Outpatient Therapies**

Medically necessary outpatient therapy (when a covered benefit) must be prescribed by a physician.

**Physical Therapy & Occupational Therapy**

Prior authorization from the Cooperative is not required for the first six outpatient visits, including the initial evaluation, for physical therapy and occupational therapy. All therapies must be medically necessary. If upon review medical necessity criteria are not met, the Cooperative may recoup payment for non-medically necessary services. If additional visits beyond the first six are needed, prior authorization is required before the seventh visit. Use the PT/OT Request form.
Speech Therapy
Prior authorization is required for speech therapy. Many commercial benefit plans do not cover Speech Therapy. If speech therapy is a covered benefit, prior authorization is required for any subsequent visits after the initial evaluation.

Use the Speech Therapy Request form.

Cardiac Rehabilitation & Pulmonary Rehabilitation
Prior authorization is required for Pulmonary and Cardiac Rehabilitation prior to any services being rendered.

Use the Cardiac & Pulmonary Rehabilitation Request form.

Prosthetics and Durable Medical Equipment (DME)
Prior authorization is required for the following:

- Continuous Passive Motion Device (CPM)
- All other DME rental beyond 30 days or accumulated $300 rental charges per item (authorization is not needed for nebulizers),
- New or used DME purchases over $300 billed per item (authorization is not needed for nebulizers), and
- External and implantable infusion pump and supplies, including insulin infusion pump

If the coverage criteria is not met for a DME item over $300 in billed charges and/or rentals over 30 days, there will also be no coverage for supplies related to the unauthorized/denied items.

Use the ‘Request for DME Authorization Form’ located in Appendix A.

Specialized Pharmacy Services
Prior authorization is required for the following Specialized Pharmacy Services:

- All outpatient injections or infusions of medications with billed charges of $500 and above, excluding cancer chemotherapy, and drugs administered in conjunction with diagnostic or radiographic testing if the testing itself does not require prior authorization,
- Any drugs or therapies used in the diagnosis or the treatment of infertility, and
- Enteral nutrition and related supplies
- Off-label drug use

Use the ‘Request for Service Event Authorization Form’ located in Appendix A.

Note: Group Health Cooperative’s reviews for medical necessity are based on review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). Group Health Cooperative expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their providers will need to consult the member’s benefit plan to determine if there are exclusions or other benefit limitations applicable to approved services or supplies. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (i.e. will be paid for by Group Health Cooperative) for a particular member. The member’s benefit plan determines the extent and limitations of coverage. In addition, coverage may be defined by applicable legal requirements of the State of Wisconsin, the Federal government or CMS (for Medicare and Medicaid members).
SECTION 10 - PROVISIONS FOR INTERPRETERS/TRANSLATORS

As a contracted provider, access to interpreters conversant in languages spoken by the population in the provider’s contracted service areas must be available at all times. Family members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality is critical.

Interpreters are to be scheduled at the same time the appointment is made by the appointment clerk.

In the case of an emergency, or if interpreters are not available in the clinic, local interpreters must be contacted to assist by phone or in person if possible.

When scheduling an appointment at a referral office you will need to inquire if they have appropriate staff to interpret for the patient. If not, it is the responsibility of the referring primary care provider’s office to call the appropriate interpreter/translators’ office to request an interpreter to accompany the patient to their appointment.

It is the responsibility of the patient to schedule future interpreter appointments, cancel any appointments arranged, or reschedule any appointments made by the referring provider’s office.

It is the responsibility of the provider of healthcare to pay for this service.

**Note:** Documentation is to be made in the patient’s medical record of all efforts made to schedule an interpreter.

Assistance in locating translation/interpretation services is available online at the Wisconsin Department of Human Services website at www.dhs.wi.gov and specifically on the Limited English Proficiency Resources link at http://www.dhs.wisconsin.gov/civilrights/LEPresources.HTM.
SECTION 11 - TRANSPORTATION FOR WISCONSIN BADGERCARE PLUS & MEDICAID SSI MEMBERS

The State of Wisconsin Department of Health Services (DHS) requires that HMOs assure transportation for all BadgerCare Plus and Medicaid SSI members who have no means of transportation for medical appointments or emergencies.

Non-Emergency Transportation:
The HMO Representative will educate the member on how to arrange for transportation to a BadgerCare Plus or Medicaid SSI covered facility/service. The member will need to contact Medical Transportation Management Inc. (MTM Inc.) at (866) 907-1493 (TTY: 1-800-855-2880).

Ambulance Transportation:
An ambulance is only used in a life-threatening emergency or if there is no other means of transportation. For all non-emergent ambulance transportation the member will need to contact Medical Transportation Management Inc. (MTM Inc.) at (866) 907-1493 (TTY: 1-800-855-2880).
SECTION 12 - HEALTHCHECK INFORMATION
HealthCheck is a preventive health checkup program for members under the age of 21. The HealthCheck program covers complete health checkups. These checkups are very important for those under 21.

The HealthCheck checkup includes:
- Health and developmental history (including anticipatory guidance).
- Unclothed physical examination.
- Vision screening.
- Hearing screening.
- Dental screening and a referral to a dentist beginning at age one.
- Immunizations appropriate for age (shots).
- Blood and urine lab tests (including blood lead level testing when appropriate for age).

TARGET LEVELS
There are State and Federal requirements that your clinic/organization must achieve the target level of at least 80% of allowable HealthCheck screenings. A recipient is limited, based on their age, to the following number of comprehensive screenings for a consecutive 12 month period:

- Birth to first birthday, 6 screenings
- First birthday to second birthday, 3 screenings
- Second birthday to third birthday, 2 screenings
- Third birthday through the age of 20, 1 screening per year.

WAITING TIMES
There are maximum allowable waiting times for completing HealthCheck screens, based on the age of the recipient, as follows (per the Wisconsin BadgerCare Plus and Medicaid SSI HMO Contract):

"Provide Comprehensive HealthCheck screens upon request. The HMO must provide a HealthCheck screen within 60 days (if a screen is due according to the periodicity schedule) for members over one year of age for which a parent or guardian of a member requests a Comprehensive HealthCheck screen. If the screen is not due within 30 days, then the HMO must schedule the appointment in accordance with the periodicity schedule.

The HMO must provide a Comprehensive HealthCheck screen within 30 days (if a screen is due according to the periodicity schedule) for members up to one year of age for which a parent or guardian of a member requests a Comprehensive HealthCheck screen. If the screen is not due within 30 days, then the HMO must schedule the appointment in accordance with the periodicity schedule."

COMPONENTS
The provider must assess and document all of the age-specific components in order for the visit to be recognized and billed as a complete HealthCheck screen/exam. Visit http://www.cdc.gov/vaccines/schedules/index.html for the current immunization periodicity chart.

DOCUMENTATION
Documentation in the medical record must reflect that all of the required components for a comprehensive HealthCheck screening were completed. For more information and resources for HealthCheck providers, please refer to the ForwardHealth Online Portal here.
SECTION 13 – DHS BADGERCARE PLUS & MEDICAID SSI CONTACT INFORMATION

FORWARDHEALTH TELEPHONE HOTLINES

ForwardHealth Provider Service Call Center: (800) 947-9627
Available Monday through Friday, 7:00 a.m. - 6:00 p.m. (Central Time, with the exception of state-observed holidays).

Medical providers should call Provider Service for enrollment, policy, and billing questions.

ForwardHealth Member Service: (800) 362-3002
Available Monday through Friday, 7:00 a.m. - 6:00 p.m. (Central Time, with the exception of state-observed holidays).

Members should call Member Service for enrollment and benefit information. Members should not be referred to Provider Services.

SeniorCare Hotline: (800) 657-2038
Available Monday through Friday, 8:00 a.m. - 6:00 p.m. (Central Time, with the exception of state-observed holidays).

Participants should call the SeniorCare Hotline for enrollment, renewal, and general benefit information. Medical providers working with SeniorCare should call Provider Services.

Electronic Data Interchange (EDI) Help Desk: (866) 416-4979
Available Monday through Friday, 8:30 a.m. - 4:30 p.m. (Central Time, with the exception of state-observed holidays).

The EDI Helpdesk assists anyone interested in becoming a trading partner with getting started and provides ongoing support pertaining to electronic transactions, companion documents, and PES software.

ForwardHealth Portal Help Desk: (866) 908-1363
Available Monday through Friday, 8:30 a.m. - 4:30 p.m. (Central Time, with the exception of state-observed holidays).

Providers and trading partners may call the ForwardHealth Portal Helpdesk with technical questions on Portal functions, including their Portal accounts, registrations, passwords, and submissions through the Portal.

WiCall Automated Voice Response (AVR) System: (800) 947-3544
Available 24 hours a day, seven days a week. WiCall is an AVR system that allows providers with touch-tone telephones direct access to enrollment verification, claim status, Pa status, and CheckWrite information.

Written Inquiries
Available 24 hours a day, seven days a week. Individuals are able to contact ForwardHealth through the ForwardHealth Portal by entering the relevant inquiry information, including selecting the preferred method of response (i.e., telephone call or e-mail). Inquiries will be responded to by the preferred method of response indicated with five business days.
SECTION 14 – FRAUD, WASTE & ABUSE

It is the policy of the Cooperative to comply with all applicable Federal and State laws pertaining to fraud, waste and abuse in Federal healthcare programs. All contracted entities and business associates of the Cooperative are also required to act in compliance with all federal and state laws that address fraud, waste and abuse in federal healthcare programs such as Medicare and Medicaid.

DEFINITIONS OF FRAUD, WASTE AND ABUSE

Fraud:
A person makes a material statement of fact. The statement is false and the person making the statement knows that it is false. The person making the false statement intends to deceive or mislead the person to whom the statement was made with the expectation of receiving something of value. The person to whom the false statement is made is expected to rely on the statement to his or her detriment.

Waste:
Overutilization of items or services or other practices that result in unnecessary cost.

Abuse:
Any activity that unjustly robs the health care system but does not constitute fraud. In abuse, a provider or consumer may obtain money or health care services to which he/she is not entitled, but there is not the intent to deceive that is necessary for fraud to have occurred. This includes provision of services that are not medically necessary.

EXAMPLES OF FEDERAL AND STATE FWA LAWS

A. Federal False Claims Laws
   1. False Claims Act (31 U.S.C. Sections 3729-3733)
      a. The federal False Claims Act makes it a crime for any person or organization who:
         i. Knowingly files a false or fraudulent claim for payments to Medicare, Medicaid or other federally funded health care program;
         ii. Knowingly uses a false record or statement to obtain payment on a false or fraudulent claim from Medicare, Medicaid or other federally funded health care program; or
         iii. Conspires to defraud Medicare, Medicaid or other federally funded health care program by attempting to have a false or fraudulent claim paid.
      b. “Knowingly” means:
         i. Having actual knowledge that the information on the claim is false;
         ii. Deliberately ignoring whether the claim is true or false; or
         iii. Seeking payment recklessly without caring whether or not the claim is true or false.
      c. Examples of potential false claims include knowingly billing Medicaid for services that were not provided, submitting inaccurate or misleading claims for actual services provided, or making false statements to obtain payment for services.
      d. Any person or entity found liable under the False Claims Act is, generally, subject to civil money penalties. Penalties can be between $5,500 and $11,000 per claim plus three times the amount paid for each false claim. The courts can also impose criminal penalties against individuals and organizations for intentional violations of the False Claims Act.
e. The False Claims Act allows individuals with original information about fraud involving federal health care programs to file a complaint under seal with a federal court. The government investigates the complaint and may elect to pursue the case in its own name or decide not to pursue the case. If the government decides not to pursue the case, the person who filed the action has the right to continue with the case on his or her own.

2. Program Fraud Civil Remedies Act (31 U.S.C. Sections 3801-3812)
   a. The Program Fraud Civil Remedies Act ("PFCRA") creates administrative remedies for making false claims and false statements. These penalties are separate from and in addition to any liability that may be enforced under the federal False Claims Act.
   b. The PFCRA imposes liability on people or entities that file a claim that they know or have reason to know:
      i. Is false, fictitious, or fraudulent
      ii. Includes or is supported by any written statement that contains false, fictitious, or fraudulent information;
      iii. Includes or is supported by a written statement that omits a material fact, which causes the statement to be false, fictitious, or fraudulent, and the person or entity submitting the statement has a duty to include the omitted fact; or
      iv. Is payment for property or services not provided as claimed.
   c. A violation of this section of the PFCRA is subject to penalties of $5,000 for each wrongfully filed claim, plus twice the amount of any unlawful claim that has been paid.
   d. A person or entity violates the PFCRA if they submit a written statement that they know or should know:
      i. states a material fact that is false, fictitious or fraudulent
      ii. Omits a material fact that they had a duty to include; the omission caused the statement to be false, fictitious, or fraudulent, and the statement contained a certification of accuracy.
   e. A violation of this section of the PFCRA is subject to a civil penalty of up to $5,000 in addition to any other remedy allowed under other laws.

B. State False Claims Laws
   1. Medicaid Fraud Statute, s. 49.49 (1), Wis. Stats.
      a. This state Medicaid fraud statute prohibits any person from:
         i. Knowingly and willfully making or causing to be made a false statement or misrepresentation of a material fact in a claim for Medicaid benefits or payments.
         ii. Knowingly and willfully making or causing to be made a false statement or misrepresentation of a material fact for use in determining rights to Medicaid benefits or payments.
         iii. Having knowledge of an act affecting the initial or continued right to Medicaid benefits or payments or the initial, or continued right to Medicaid benefits or payments of any other individual on whose behalf someone has applied for or is receiving the benefits or payments, concealing or failing to disclose such event with an intent to fraudulently secure Medicaid benefits or payments whether in a greater amount or quantity than is due or when no benefit or payment is authorized.
         iv. Making a claim for Medicaid benefits or payments for the use or benefit of another, and after receiving the benefit or payment, knowingly and willfully converting it or any part of it to a use other than for the use and benefit of the intended person.
v. Anyone found guilty of the above may be imprisoned for up to six years, and fined not more than $25,000, plus three times the amount of actual damages.

Note: the above laws are not exhaustive, merely a representation of certain FWA laws that may apply to any given circumstance. Please contact your Compliance Department and/or legal counsel for more detailed compliance guidance. Both civil and criminal penalties may apply.

Anti-Retaliation Protections
The Cooperative has a zero tolerance policy against retaliation to protect those who report fraud, waste or abuse concerns, in good faith, from adverse action. Anyone who has concerns about retaliation should contact the Group Health Compliance Department immediately. The federal False Claims Act and Wisconsin statutes also protect those who report concerns.

To report instances of fraud, waste or abuse, or to report suspected retaliatory actions please call the Cooperative’s Compliance Department toll free at (888) 203-7770.
APPENDIX A
HEALTH MANAGEMENT FORMS
Please indicate the type of rehabilitation you are requesting:

☐ Cardiac  ☐ Pulmonary

Patient's Name: __________________________ DOB: ___________ ID# ________________

Ordering Physician: __________________________ Clinic: __________________________

Rehabilitation Provider: __________________________ Tax ID: _________ NPI: ________________

Name/Specialty/Clinic

Phone: __________________________ Fax: __________________________

Diagnosis: __________________________ ICD-10: ________________

Is this a Worker’s Comp or accident case?  ☐ Yes  ☐ No

Dates of service requested: __________________________

Number of visits requested: __________________________

Provider Contact Name __________________________ Phone # ___________ Fax # ___________ Date ___________

Prior authorization is required prior to any services being rendered. Services must be prescribed by a
Physician to be considered a covered benefit.

Privacy and Confidentiality:
The information within this fax message is intended for the recipient(s) only. If you have received this fax in error, please
contact us at (715) 552-4300 and destroy this document received. State and Federal Law prohibits any unauthorized
use of this information. Thank you for your cooperation.
Request Form

DME Authorization

Patient’s Name: ________________________________________ DOB: ______________ ID# ___________________

Prescribing Provider: ____________________________________ Tax ID: ____________ Fax# ____________________

Name/Clinic

DME Provider: ____________________________________________ Tax ID: ____________ NPI: ___________________

Phone: __________________________ Fax: ____________________

Diagnosis: ______________________________________________ ICD-10: __________________

DME Item 1: _____________________________________________ HCPCS: ______________

☐ Purchase ☐ Rental Start Date ____________ End Date _______________

DME Item 2: _____________________________________________ HCPCS: ______________

☐ Purchase ☐ Rental Start Date ____________ End Date _______________

DME Item 3: _____________________________________________ HCPCS: ______________

☐ Purchase ☐ Rental Start Date ____________ End Date _______________

DME Item 4: _____________________________________________ HCPCS: ______________

☐ Purchase ☐ Rental Start Date ____________ End Date _______________

Please submit clinical documentation to support medical necessity for requested item.

Please indicate if any of the following is suspected to be a cause of the indicated need for the service:

☐ MVA ☐ Liability ☐ Workers’ Compensation ☐ Indicate if this is an emergent request

Please note: In the case of an emergent medical need for a service event authorized service, a service event request with clinical justification of the emergent need must be faxed to the Health Management Department as soon as possible before the services are performed. Please indicate on your request the need for an emergent review.

Provider Contact Name __________________________ Phone # __________________________ Fax # ______________ Date ______________

Please refer to the Provider Manual for specific information regarding the need for service event authorizations.

Privacy and Confidentiality:
The information within this fax message is intended for the recipient(s) only. If you have received this fax in error, please contact us at (715) 552-4300 and destroy this document received. State and Federal Law prohibits any unauthorized use of this information. Thank you for your cooperation.
### Request Form

#### Home Health Authorization

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<th>Patient’s Name:</th>
<th>DOB:</th>
<th>ID#:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orderng Physician:</td>
<td>Tax ID:</td>
<td>Fax#:</td>
</tr>
<tr>
<td>Home Health Provider:</td>
<td>Tax ID:</td>
<td>NPI:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Fax:</td>
<td></td>
</tr>
</tbody>
</table>

**Diagnosis:**

<table>
<thead>
<tr>
<th>ICD-10:</th>
</tr>
</thead>
</table>

**Please provide clinical information for justification of need for service along with 485 or 486**

<table>
<thead>
<tr>
<th>Admission Date:</th>
</tr>
</thead>
</table>

**Skilled Nursing Frequency:**

**Please indicate additional services and frequency being provided:**

- [ ] Home Health Aid  
  Frequency: _____________________
- [ ] Personal Care Worker  
  Frequency: _____________________
- [ ] Physical Therapy  
  Frequency: _____________________
- [ ] Occupational Therapy  
  Frequency: _____________________
- [ ] Speech Therapy  
  Frequency: _____________________

**Projected End Date of Service:**

**Please indicate if any of the following is suspected to be a cause of the indicated need for the medication:**

- [ ] MVA  
- [ ] Liability  
- [ ] Workers’ Compensation  
- [ ] Indicate if this is an emergent request

**Please note:** In the case of an emergent medical need for a service event authorized service, a service event request with clinical justification of the emergent need must be faxed to the Health Management Department as soon as possible before the services are performed. Please indicate on your request the need for an emergent review.

---

**Provider Contact Name**  
**Phone #**  
**Fax #**  
**Date**

**Please refer to the Provider Manual for specific information regarding the need for service event authorizations.**

---

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Request Form

Admission Event Authorization

Patients Name: ___________________________ DOB: ______ ID# ___________________________

Admitting Physician: ___________________________ Name/Clinic

Facility: ___________________________ Tax ID: ___________ NPI: ___________

Name of Facility

Procedure: ___________________________ CPT Code: ___________

Admitting Diagnosis: ___________________________

ICD-10: ________________

Admission Date: ___________________________

Was this an emergency admission? ☐ Yes ☐ No

Bed Type (Check One):
- Medical
- ICU/CCU
- OB
- Rehab
- Swing
- Surgical
- NICU
- Peds
- Observation

Mother/Maternal Child Information

<table>
<thead>
<tr>
<th>Mother</th>
<th>Please Indicate:</th>
<th>Maternal Child</th>
<th>Please Indicate:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Date:</td>
<td></td>
<td>Date of Birth and time:</td>
<td></td>
</tr>
<tr>
<td>Anticipated Discharge Date:</td>
<td></td>
<td>Anticipated Date of Discharge:</td>
<td></td>
</tr>
<tr>
<td>Method of Delivery:</td>
<td></td>
<td>Birth Weight:</td>
<td></td>
</tr>
<tr>
<td>Admitting Provider:</td>
<td></td>
<td>Apgar at 1 minute:</td>
<td></td>
</tr>
<tr>
<td>Delivery Provider:</td>
<td></td>
<td>Apgar at 5 minutes:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gestational Age:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Feeding Type:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Birth Status:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gender (check one): ☐ Male ☐ Female</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Full Name, if available:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pediatric Provider:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Birth Order:</td>
<td></td>
</tr>
</tbody>
</table>

Please indicate if any of the following is suspected to be a cause of the indicated need for the admission:
- MVA
- Liability
- Workers’ Compensation

Provider Contact Name

Phone #

Fax #

Date

Group Health Cooperative Health Management Response:

Based on information provided this admission will be approved for _______ days.

Target Date of Discharge: _______

Signature, Date: ___________________________

Please note: The facility must notify Health Management upon discharge of patient or by the Target date indicated above. If the patient’s stay is over the target discharge date the facility representative must call Health Management with clinical information regarding the admission. If assistance with discharge planning services is needed please feel free to call Health Management at (715) 552-7200 or (888) 203-7770.

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group-health.com | p. 715.552.4300 or 888.203.7770 | f. 715.552.7202

GHC14231
Patient’s Name: ___________________________ DOB: ________ ID# ______________________________

Referring Provider: ________________________ Tax ID: _______ Fax#: ___________________________
Name/Clinic

Refer to Provider: _________________________ Tax ID: _______ NPI: _____________________________
Name/Specialty/Clinic

Phone: __________________________ Fax: __________________________

Diagnosis: __________________________________________________________ ICD-10:______________

Please indicate the reason for requesting this out of practice group or out of network referral (Please Select One):
☐ Specialty not available within the Cooperative’s network of contracted providers.
☐ Patient has been under the care of this physician for ___ years for this diagnosis.
☐ Other - Please specify: _________________________________________________________________

Please send clinical information to assist in the decision for the need of this referral. This referral request is limited to one of the following and will expire on: ________ (Request cannot exceed greater than 90 days from the date signed below)

Projected Appointment Date: ______________________________

Please select one:
☐ Surgical consult only one visit:
☐ Evaluation and recommendations to the Primary Clinician One visit only
☐ Consultation and Treatment of the specific condition listed above as needed and limited to _____ visits. (Indicate number of visits.)
☐ Surgical follow up as needed and limited to ______ visits (Indicate number of visits.)
☐ Renewal for extended Medical Management of the indicated diagnosis as above and limited to _____ visits. (Indicate number of visits.)

Please indicate if any of the following is suspected to be a cause of the indicated need for the medication:
☐ MVA ☐ Liability ☐ Workers’ Compensation ☐ Indicate if this is an emergent request

Please note: In the case of an emergent medical need for a service event authorized service, a service event request with clinical justification of the emergent need must be faxed to the Health Management Department as soon as possible before the services are performed. Please indicate on your request the need for an emergent review.

Provider Contact Name ___________________________________________________________________
Phone # __________ Fax # __________________________ Date ________________________

Please refer to the Provider Manual for specific information regarding our network referrals.

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GHC14232
Please indicate the type of therapy you are requesting (For speech therapy, please use specific form):

☐ Physical   ☐ Occupational

Patient’s Name: ________________________ DOB: ___________ ID# ________________________

Ordering Physician: ________________________ Clinic: __________________________________

Therapy Provider: ________________________ Tax ID: ___________ NPI: ______________________

Name/Specialty/Clinic

Phone: ________________________ Fax: ________________________

Diagnosis: ________________________ ICD-10: ___________ Date of Initial Eval: ___________

Is this a Worker’s Comp or accident case?   ☐ Yes   ☐ No

Dates of service requested: ________________________

Number of visits requested: ________________________

PLEASE SEND EVALUATION AND MOST RECENT PROGRESS NOTE FOR FIRST REQUEST ONLY. ADDITIONAL REQUESTS WILL NEED ONLY THE MOST RECENT VISIT NOTE. THERAPY REQUESTS MUST INCLUDE THE ENTIRE SCORING SCALE INCLUDING THE STANDARD SCORES AND THE MEMBER’S SCORE.

Provider Contact Name ________________________ Phone # ________________________ Fax # ________________________ Date

Prior authorization is not required for the initial evaluation and next five visits (first six visits) per calendar year. If additional visits are needed, authorization is required prior to the seventh visit. Services must be prescribed by a Physician to be considered a covered benefit.

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Patient’s Name: ___________________________  DOB: _________  ID#: __________________

Referring Provider: ___________________________  Tax ID: _________  Fax#: __________________

Name/Clinic

Refer to Provider: ___________________________  Tax ID: _________  NPI: __________

Name/Specialty/Clinic

Phone: ___________________________  Fax: ___________________________

Diagnosis: ___________________________________________________________  ICD-10: __________

ICD-10 Procedure Code requesting: ___________________________  Description: ___________________________

CPT Procedure Code requesting: ___________________________  Description: ___________________________

**Please provide clinical information for justification of need for service.**

Place of Service: __________________________________________________________

Projected Date of Service: __________________________________________________

Projected End Date of Service: ______________________________________________

Please select one:

☐ Anticipate Outpatient service only.

☐ Anticipate Observations stay for _____ hours.

☐ Anticipate Inpatient Admission for _____ days.

Please indicate if any of the following is suspected to be a cause of the indicated need for the medication:

☐ MVA  ☐ Liability  ☐ Workers’ Compensation  ☐ Indicate if this is an emergent request

**Please note:** In the case of an emergent medical need for a service event authorized service, a service event request with clinical justification of the emergent need must be faxed to the Health Management Department as soon as possible before the services are performed. Please indicate on your request the need for an emergent review.

______  _______  _______  _______

Provider Contact Name  Phone #  Fax #  Date

Please refer to the Provider Manual for specific information regarding the need for service event authorization.

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Prior Authorization Form
Speech Therapy

Patient’s Name: ____________________________ DOB: ________ ID#_____________________

Ordering Physician: ____________________________ Clinic: _______________________________________

Therapy Provider: ____________________________ Tax ID: ________ NPI: __________________________

Name/Specialty/Clinic

Phone: ____________________________ Fax: ____________________________

Diagnosis: ____________________________ ICD-10: __________ Date of Initial Eval: __________

Is this a Worker’s Comp or accident case?  ☐ Yes  ☐ No

Dates of service requested: __________________________________________________________

Number of visits requested: __________________________________________________________

PLEASE SEND EVALUATION FOR FIRST REQUEST ONLY. ADDITIONAL REQUESTS WILL NEED ONLY THE
MOST RECENT VISIT NOTE. THERAPY REQUESTS MUST INCLUDE THE ENTIRE SCORING SCALE
INCLUDING THE STANDARD SCORES AND THE MEMBER’S SCORE.

Provider Contact Name          Phone #            Fax #                Date

A Speech Therapy Request Form will be required after the initial evaluation. If additional visits are needed,
authorization is required prior to continuing. Services must be prescribed by a Physician to be considered a
covered benefit.

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contact us at (715) 552-4300 and destroy this document received. State and Federal Law prohibits any unauthorized
use of this information. Thank you for your cooperation.
Member Name: _______________________________ DOB: ___________   ID#: ______________

Provider Name: _______________________________ Fed#: ___________  NPI#: ______________

Ordering Physician: ____________________________________________

Diagnosis Code: ___________________________ CPT Code: ___________________________
(please send a copy of the doctors order with this request.)

Type of Pain:

**Acute postoperative pain** (choose those that apply):

- [ ] Less than or equal to 30 days since surgery
- [ ] Pain unresponsive to parenteral or oral pain medication
- [ ] Other clinical information

**Chronic intractable pain** (choose those that apply):

- [ ] Initial application
- [ ] Pain Greater or equal to 3 mos: [ ] yes or [ ] no (choose one)

**Ongoing application** (choose those that apply):

- [ ] 30-day TENS trial completed
- [ ] Reduction in pain during trial
- [ ] TENS reevaluation documented
- [ ] TENDS unit to be used at least once daily
- [ ] Other clinical information

**Etiology of pain amenable to TENS treatment** (choose one):

- [ ] Musculoskeletal
- [ ] Neurogenic
- [ ] Other clinical information

**Continued pain after** (choose those that apply):

- [ ] Pain medications
- [ ] Pain reliever modalities
- [ ] Other clinical information

**Treatment area** (choose those that apply):

- [ ] Treatment across a joint
- [ ] Large area of pain
- [ ] Adipose tissue interferes with conduction
- [ ] Treating two separate areas with two leads simultaneously
- [ ] Failed 2 lead unit trial
- [ ] None of the above
APPENDIX B
HEALTH MANAGEMENT FORMS
Patient's Name: ___________________________ DOB: ______ ID# ______________________
Provider: ________________________________      NPI: ____________________________
Admission Date: ___/___/___  Discharge Date: ___/___/___  Discharged to: ___________________

*Please attach discharge summary and fax to (715) 852-5755.

Discharge Medications:

Follow-up Appointments:

Other Pertinent Information:

The submission of supporting clinical documentation/plan of care is required with this form.

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Authorization Request Form  
Behavioral Health Inpatient Admission

Patient’s Name: _______________________________ DOB: __/__/___ ID# ______________________

*Attach H&P and clinical information including medications and fax all to (715) 852-5755.

Note: Discharge summary including follow up care information is required at time of discharge.

Diagnosis Code(s):                         Type of Admission

□ Chapter 51/Emergency Detention
□ Mental Health
□ Detox

Date of Admission __/__/__                Estimated Length of Stay: _____            Actual D/C Date: __/__/__

Brief Summary of Current Clinical Status/Admission Information:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Provider Name: ________________________________________________________________________
Facility Name: ______________________________ NPI: __________________
Address: __________________________________________ Tax ID: __________________

Contact Name: ___________________________ Phone: __________________ Fax: _____________

The submission of supporting clinical documentation/plan of care is required with this form.

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An intake evaluation must be completed before a request for testing will be considered. Testing for learning disability, attention deficit disorders and disability evaluations is not covered. Rating scales, checklists, inventories and questionnaires are not reimbursed as testing.

Patient’s Name: _______________________________________       DOB: __/__/__         ID# _____________________

*Please attach a copy of the psychological intake and fax all to (715) 852-5755.

Diagnosis Code(s): Has the patient had previous testing? ☐Yes ☐No

__________________________
__________________________

If yes, when? _____/_____/

What specific questions will be answered by the evaluation?
1. _________________________________________________________________________________________________
2. _________________________________________________________________________________________________
3. _________________________________________________________________________________________________

Describe how the evaluation will help to implement the treatment plan:

___________________________________________________________________________________________________
___________________________________________________________________________________________________

Describe what other strategies/treatments have failed:

___________________________________________________________________________________________________
___________________________________________________________________________________________________

Specify the proposed measures and rationale for use:

Measure Name: __________________________ CPT Code: _________ Hours: _________
Rationale: ________________________________________________________________

Measure Name: __________________________ CPT Code: _________ Hours: _________
Rationale: ________________________________________________________________

Measure Name: __________________________ CPT Code: _________ Hours: _________
Rationale: ________________________________________________________________

Measure Name: __________________________ CPT Code: _________ Hours: _________
Rationale: ________________________________________________________________

Measure Name: __________________________ CPT Code: _________ Hours: _________
Rationale: ________________________________________________________________

Provider Name: ________________________________________________________________________________

Facility Name: __________________________ NPI: __________________

Address: ____________________________________________________________ Tax ID: __________________

Contact Name: __________________________ Phone: __________________ Fax: __________________

The submission of supporting clinical documentation/plan of care is required with this form.

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Authorization Request Form
Behavioral Health Outpatient Treatment

Patient’s Name: _______________________________________      DOB: __ / __ / __ ID#: __________

*Please attach clinical information/progress notes, current medications, and therapeutic goals.

Intensive in home therapy requires that a health check screening has been completed within the past 12 months. Intensive outpatient and Intensive in home levels of care require authorization prior to initiating services. Outpatient therapy does not require prior authorization until the initial six visits of the calendar year have been exhausted.

### Diagnosis Code(s):

[Diagnosis Code(s)]

<table>
<thead>
<tr>
<th>Diagnosis Code(s)</th>
<th>Patient Regularly Participates: □ Yes □ No</th>
</tr>
</thead>
</table>

Date of First Visit: __ / __ / __

Number of Visits this calendar year: ________

Anticipated Discharge Date: ________________

Start Date: _____________________________

### Type of Service:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Frequency:</th>
<th># Visits Requested:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Individual Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Family Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Group Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Intensive</td>
<td>Hours/week:</td>
<td>(4-12 hours/week)</td>
</tr>
<tr>
<td>□ Intensive In-Home</td>
<td>Hours/week:</td>
<td>(4-8 hours/week)</td>
</tr>
</tbody>
</table>

### Brief Summary of Current Clinical Status:


### Criteria for Termination:


Provider Name:  __________________________________________________________________________________

Facility Name: __________________________________________________________        NPI: __________________

Address: _______________________________________________________________  Tax ID: __________________

Contact Name: ______________________________________    Phone: _________________ Fax: ________________

The submission of supporting clinical documentation/plan of care is required with this form.

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Authorization Request Form
Day Treatment/Partial Hospitalization

Patient’s Name: ___________________________ DOB: __/__/__ ID# ___________________________

*Please attach clinical information including medications and fax all to (715) 852-5755.

Diagnosis Code(s):

Date of Admission __/__/__

Estimated Length of Stay: _________

□ Mental Health □ AODA

Past Levels of Care Attempted
Outpatient? If yes, when and where: __________________________________________________________

Inpatient? If yes, when and where: __________________________________________________________

Provider Name: ____________________________________________________________________________

Facility Name: ___________________________________________ NPI: _____________________________

Address: ___________________________________________ Tax ID: _____________________________

Contact Name ____________________________________________________________

Phone: ___________________ Fax: _____________________

Health Check screening documentation is required with this request. Members without a Health Check screening performed within the past 12 months will not be approved for this service. General follow up or problem focused appointments with a primary care provider do not qualify as a Health Check.

The submission of supporting clinical documentation/plan of care is required with this form.

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APPENDIX C
COUNTY HANDBOOK
COORDINATION OF PRIMARY CARE MOU’S

Health Plans are required by the Department of Human Services to ensure the coordination of care for their members. Because of this requirement, Group Health Cooperative asks Counties and Primary Care Clinics (PCC) to address the coordination of care for HealthCheck exams with a signed Memorandum of Understanding (MOU).

Negotiating an MOU is strictly between the County and Clinic, and either party may decline to sign. However, having an MOU in place encourages the coordination of care of the member, eliminates the duplication of services, and saves time and money.

• A signed MOU is only required when the County submits claims for HealthCheck exams. MOUs must be in place between the County Department and member’s Primary Care Clinic (PCC) before the County will be reimbursed for HealthCheck exams. Either fax a copy of the signed MOU to Group Health at: (715) 836-7683; or mail a copy to: Provider Relations, P.O. Box 3217, Eau Claire, WI 54702-3217.

• An MOU is NOT required between the County and PCC if the County only performs components of the HealthCheck Exam (e.g. immunizations, blood lead screens, dental fluoride varnish, etc.) and does not perform the HealthCheck exam.

COVERED SERVICES & CARVED-OUT SERVICES

Contracted Covered Services Provided by Counties and Reimbursed by the HMO:

Group Health Cooperative of Eau Claire may contract for the following services performed by County Departments. Please refer to your Provider Services Agreement to determine which services will be reimbursed by Group Health Cooperative of Eau Claire.

• Behavioral Health: Outpatient Services
• Alcohol or Drug Abuse (AODA): Outpatient Services
• Birth-to-Three: therapies (PT, OT & ST) & medical services
• HealthCheck exams
• Immunizations
• Blood Lead Testing screens
• Dental Fluoride Varnish
• Home Health Care services
• Nursing Home Care: “skilled” nursing & therapies.

Carved Out Services (Fee-for-service):

The following services are not covered by the HMO, but are reimbursed by the state on a fee-for-service basis, or as otherwise noted:

• Community Services Program (CSP) benefits
• School Based Services (SBS)
• Prenatal Care Coordination (PNCC) services
• Targeted Case Management (TCM) services
• Comprehensive Community Services (CCS)
• Crisis Intervention services: the HMO will coordinate care with Crisis Intervention. The County provides follow-up covered services within the service area and transition members into behavioral health and AODA treatment, when appropriate. The HMO does not reimburse for out-of-network services ordered by the certified Crisis Intervention Agency, unless prior authorization is received from the HMO.

• Environmental lead inspections
• Pharmacy services and some drug-related supplies
• Provider administered drugs
• Non-emergency medical transportation is coordinated and provided by the state’s contracted transportation broker (Medical Transportation Management Inc. (MTM Inc.) This includes transportation provided by common carrier, SMV, or stretcher/ non-emergency ambulance transportation.

COORDINATION OF PRENATAL CARE

Group Health Cooperative’s Health Management Department works with women of childbearing age to ensure appropriate interconception and prenatal care. Our goal is promoting the best outcome for both mother and baby.

High Risk pregnancies are identified through McKesson Risk Manager software. In addition, the State of Wisconsin provides a monthly list of all women who may be at risk for a poor birth outcome and are enrolled in the Health Plan.

Once identified, members are contacted by a member of the Group Health Prenatal Team. The Prenatal Team consists of a Registered Nurse with expertise in the area of Maternal and Child Health, a Licensed Practical Nurse and a Clinical Nurse Assistant. All pregnant women receive a letter informing them of the PNCC Program available to them in their county.

Once the member is contacted, a comprehensive maternity assessment is completed. High risk members have regular contacts by our staff to assist them in obtaining appropriate prenatal care. These activities may include assisting with other family needs, and assisting the health care professionals in meeting the healthcare and educational needs of the member.

The Prenatal Team will collaborate with the County’s PNCC staff to coordinate care. Both infant and mother are followed through the first year of life and beyond if needed.

Coordination of Care between the County and HMO

It is important for Counties and HMOs to coordinate care and work together to ensure healthy outcomes for their members and members. The successful provision of services requires cooperation, coordination and communication between the HMO and the PNCC. Coordination of care can improve communication between all members of the health care team; encourage the timely sharing of information; avoid duplication of services; support care plans; and offer resources to each other. A PNCC Coordination of Care MOU or Addendum to Service Agreement is required between the PNCC Agency and Group Health Cooperative of Eau Claire. Please contact the Provider Relations department (866) 563-3020 to verify execution of document.
HMO Role - Health Management
The HMO’s Health Management Department identifies high risk members of childbearing age during
and following pregnancy. The team includes nurses that specialize in the area of maternal and child
health and work with members that require intensive Case Management. The HMO’s Care Management
activities also address other family needs such as providing education, newborn follow-up, encouraging
HealthChecks, providing information about transportation, and communicating issues and needs to
their member’s other health care professionals.

HEALTHCHECK EXAM
Group Health Cooperative of Eau Claire may contract for HealthCheck exams performed by the
County. Please refer to the Provider Services Agreement to determine if these services will be
reimbursed by Group Health Cooperative of Eau Claire.

IMMUNIZATIONS & VACCINES
Group Health Cooperative of Eau Claire may contract for immunizations and vaccines provided by
the County. Please refer to the Provider Services Agreement to determine if these services will be
reimbursed by Group Health Cooperative of Eau Claire.

Covered Vaccines
BadgerCare Plus covers the preventive vaccines which are normally covered under HealthChecks. For
a complete list of covered vaccines, corresponding codes and immunization schedules please refer to
the ForwardHealth website at: http://www.forwardhealth.wi.gov

Certain vaccines that are commonly combined, such as MMR or DTaP, are not reimbursed separately
unless there is a medically necessary reason to administer each vaccine separately, which is
documented in the member’s medical record.

“Vaccines for Children” (VFC) Program
The federal program “Vaccines for Children” (VFC) provides vaccines at no cost to public and private
providers who give immunizations to eligible children, including those enrolled in BadgerCare Plus and
Medicaid SSI. County Departments that provide immunizations should submit their claims (including
those provided through the VFC program) with the appropriate vaccine procedure code. Only the
administration component (and not the vaccine itself) is reimbursed in the VFC Program.

BLOOD LEAD SCREENS
Group Health Cooperative of Eau Claire may contract for blood lead screens provided by the County.
Please refer to the Provider Services Agreement to determine if these services will be reimbursed by
Group Health Cooperative of Eau Claire.

In order to perform on-site blood lead testing, providers must hold a CLIA certificate of waiver (or
higher complexity CLIA certification level) and meet the following guidelines:

• Participate in a proficiency testing (PT) program administered by the Wisconsin State Laboratory
  of Hygiene (WSLH) or another CMS-approved PT program. This program is currently available at
  no cost to the participants. For additional information about proficiency testing, contact the
  Wisconsin State Laboratory of Hygiene at (608) 224-6252.

• Report all blood lead testing results, regardless of the lead level, to the Wisconsin Children’s Lead
  Poisoning Prevention Program (WCLPPP) as required.
TOPICAL FLUORIDE VARNISH
Group Health Cooperative of Eau Claire may contract for dental fluoride varnish services provided by the County. Please refer to the Provider Services Agreement to determine if these services will be reimbursed by Group Health Cooperative of Eau Claire.

Topical applications of fluoride may be provided by nurses and dental hygienists employed by certified HealthCheck nursing agencies.

- Nurses may provide topical fluoride applications at a HealthCheck nursing agency under a physician’s order or agency’s protocol.
- Dental hygienists may provide topical fluoride applications at a HealthCheck nursing agency under a dentist or physician’s order, or agency protocol.
- Over-the-Counter Fluoride treatments are NOT covered.

EMERGENCY DETENTION ADMISSIONS
This section discusses the coordination of services between County Agencies and HMOs for substance abuse and behavioral health coverage, and defines responsibilities for the admission and billing of services provided to members enrolled in BadgerCare Plus or Medicaid SSI Managed Care.

It is important for Counties and HMOs to coordinate care and work together to ensure healthy outcomes for their members. The successful provision of services requires cooperation, coordination and communication between the HMO and the County. Coordination of care can improve communication between all members of the health care team; encourage the timely sharing of information; avoid duplication of services; support care plans; and offer resources to each other. A Behavioral Health Coordination of Care MOU or Addendum to Service Agreement is required between the County and Group Health Cooperative of Eau Claire. Please contact the Provider Relations department (866) 563-3020 to verify execution of document.

Emergency Detention Admissions
For admissions that result from an Emergency Detention, the member’s healthcare coverage should be verified and the HMO informed of the admission within the first 72 hours (three business days plus any intervening weekend days and/or holidays). The County should contact the HMO to discuss authorization and treatment plan options, as soon as they become aware of the admission.

The HMO is responsible for the cost of Emergency Detention and court-related mental health/substance abuse treatment, including involuntary commitment provided out-of-network. Treatment provided by out-of-network providers will be covered only if the time needed to obtain treatment in-network would have risked permanent damage to the enrollee’s health or safety, or the health or safety of others.

For Other Admissions (other than Emergency Detentions)
The County must contact the HMO prior to the member’s admission to discuss authorization and treatment plan options. As part of the case management responsibilities, the HMO may suggest alternate care options.

Placement
The County Agency and HMO staff will work together to ensure the most appropriate placement and services are provided to the member. The County and/or corporation counsel are responsible for informing the judge of the HMO’s network recommendations.
• If the individual is enrolled in a Medicaid HMO at the time of admission, the HMO is responsible for care provided during the first 72 hours (three business days plus any intervening weekend days and/or legal holidays) when there is a statement of Emergency Detention (ED) or detention order. During this period of time, care is deemed medically necessary. The HMO is responsible for court-ordered treatment beyond the mandatory 72 hours and any intervening weekend days or holidays, if they are involved in the discharge planning at an out-of-network facility, or if additional care is provided at a network facility.

• If the individual is not enrolled in a Medicaid Program at the time of admission, the admitting facility will submit a Medicaid application regardless of expected length of stay. Medicaid fee-for-service remains the payer for the duration of the stay, even if the individual subsequently enrolls in the HMO.

MEDICAL SERVICES & THERAPIES: BIRTH-TO-THREE PROGRAM

Group Health Cooperative of Eau Claire may contract for therapies (PT, OT & SLT) provided by the County. Please refer to the Provider Services Agreement to determine if these services will be reimbursed by Group Health Cooperative of Eau Claire.

Covered Services
Birth-to-Three services for HMO members are reimbursed by the state on a “fee-for-service” basis, except for medically necessary services and therapies. When contracted, the HMO reimburses the following services for children enrolled in the Birth-to-Three Program.

• Physical Therapy (PT), Occupational Therapy (OT) and Speech Language Therapy (SLT)
• Certain medical services for diagnosis and evaluation purposes
• Audiology testing

*Prior authorization may be required for therapies and certain medical services associated with the Birth-to-Three Program. Please refer to the Authorization Guidelines section of this Handbook for more information.

Non-Covered Services
The following services are not reimbursed by the HMO:

• Special instruction, family training, counseling and home visits
• Social work
• Non-emergency medical transportation
• Targeted case management