BadgerCare Plus & Medicaid SSI

Provider Manual

Administered by:
Group Health Cooperative of Eau Claire
2503 North Hillcrest Parkway | Altoona, WI 54720
715.552.4300 or 888.203.7770
group-health.com

GHC21082

group health Cooperative™ of eau claire

Purpose Statement:

"Optimize the health of our members through the Cooperative's pooling of health-related resources."

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ADMINISTRATIVE CONTACTS

Group Health Cooperative of Eau Claire Contacts for Providers

Call our **Provider Services Department** for:

- Member Benefits, Coverage or Eligibility
- Member Concerns
- Claims Status
- Billing & 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

MEMBER SERVICES DEPARTMENT
(715) 552-4300 or (888) 203-7770

Call our **Health Management Department** for:

- Prior Authorizations (inpatient admissions, referrals, elective surgery, etc.)
- Behavioral Health/AODA Questions and 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, address, additional locations

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

Call our **Credentialing Department** for:

- Clinician information updates

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

Call our **Quality Improvement Department** 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 6 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-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 Payor ID number is 95192. The Cooperative works with most major clearinghouses.

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 this link: Electronic Claims Submission. No paperwork is necessary to submit claims through a clearinghouse

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

QuickClaim is a claims submission program powered by Smart Data Solutions (SDS) and is available to contracted providers. 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

Providers may not bill, charge, collect a deposit from, seek remuneration from, or have any recourse against a Medicaid 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.

A member may request a non-covered service, a covered service for which authorization was denied or a service that is not covered under the member's plan. 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 in writing.
- The provider and member make payment arrangements for the 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. The provider should note that this will also help expedite payments to 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. Provider must submit documentation of these outreach efforts 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.

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-10 Diagnosis Codes.

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, on industry standard paper 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.

Please utilize the appropriate claims form and follow standard Medicaid submission guidelines for your industry and/or provider type.

BILLING AND REIMBURSEMENT OF PROFESSIONAL SURGICAL SERVICES

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. 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.

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.

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 and modifiers if applicable clarifying that the surgeries were performed in separate surgical sessions.

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.

PAYMENT REDUCTIONS AND DOCUMENTATION REQUIREMENTS

The Cooperative utilizes payment rationale based on various coding sources including but not limited to CPT, HCPCS, ICD-10 and CMS/CCI (Correct Coding Initiative) edits. Accurate claims submission will allow for more timely payment of claims. If you have claim related questions, please contact Provider Services at (866) 563-3020.

Supporting documentation may be required for claims processing. Common examples of when notes would be required include prolonged services, unlisted codes, and corrected claims. The Cooperative reserves the right to request documentation either pre-payment or post-payment in order to verify correct coding of the claim.

Providers are to bill in full. The Cooperative will reduce payment appropriately based on the service type and modifier billed. See below list of modifiers that affect reimbursement.

Modifier	Description	Cooperative Claims Processing Policy
51	Multiple procedures	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.
52	Reduced services	Reimbursed at 50%
53	Discontinued procedure after anesthesia induction (physician charges)	Reimbursed at 50%
54	Surgical care only	Reimbursed at 80%
55	Postoperative management only	Reimbursed at 20%

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-10 codes, when billing a prenatal package or global billing. Please reference ForwardHealth Portal Guidelines for details on appropriate obstetrics coding.

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 UB-04 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.

Please utilize the appropriate claims form and follow standard Medicaid submission guidelines for your industry and/or provider type.

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 Wisconsin's Department of Human 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. 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

PROVIDER NAME
ADDRESS 1
ADDRESS 2
ADDRESS 3

group health Cooperative of eau claire

PROVIDER NO.
TAX I.D.
PAY DATE
CHECK NO.
PAGE 1

Patient's Name / Patient's Account No	Service Dates From	Service Dates To	Service Code	Charges	Provider Liability	Amount Not Covered	Patient Responsibility	Capitated	Net Payment	Notes
XXXX XXXXX X	9999999999		XXXXX	000000	000000				0000	NOTE
PT CONTROL NUMBER			TOTAL	000000	000000				0000	
PROD TYPE/GHC ID#										
ANSI CODE DESCRIPTION FOR DENIAL/PAYMENT										
LOCATION TOTAL				00000	00000				0000	
CHECK TOTAL				00000	00000				0000	

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 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:
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

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.

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 certification, educational background, board certification, work history, malpractice history, and accreditation status. Site visits may be required for 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 allows the contracted provider and the Cooperative to develop a relationship. The Cooperative wishes to be a collaborative partner in the provision of health services. Questions or requests for information should be directed to the Credentialing Department

The Cooperative also welcomes providers to consider an agreement for delegated credentialing. Please contact the Provider Relations Department for information and consideration.

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. The Cooperative expects that you will not bill the 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.
- Providers requesting affiliation should have their completed application to the Cooperative prior to scheduling the Cooperative members as patients. The Cooperative needs 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.
- 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 Credentialing Committee meets monthly to help expedite provider credentialing and affiliation. Providers will be notified with a letter stating the Credentialing Committee decision and effective date.
- The Cooperative will re-credential 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, 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 to ensure we are providing members with highest quality of care in a cost-effective manner.

Activities of the quality improvement program are critically reviewed by the Accreditation Association for Ambulatory Healthcare, Inc. (AAAHC). Members demand that organizations such as ours are held accountable for the services that are provided. Accreditation by AAAHC provides the member with assurance that the Cooperative has appropriate quality improvement structures in place that 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 measures related access to services and preventive care across five 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 with providers so that our combined efforts can make a positive impact on the quality of data obtained and, most importantly, the quality of care members are receive.

State of Wisconsin Medicaid Quality Requirements

In addition to using HEDIS measurement reporting, the Wisconsin BadgerCare/SSI Medicaid 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. 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.

The State of Wisconsin reviews and reissues current BadgerCare and SSI Medicaid Quality Requirements each year. Please contact the Quality Improvement department for more information.

Waiting and Appointment Scheduling Standards:

The following are 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 Within 30 days of request upon discharge from inpatient stay
Urgent Care:	24-48 hours
Emergent Care:	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

Members have the RIGHT to:

- **Receive full benefits**. Receive all the benefits to which they are entitled under their plan.
- **Quality and timely care**. Receive quality health care through their Primary Care Clinic and network providers in a timely manner and in a medically appropriate setting.
- **Respect**. Be treated with respect and with due consideration for his or her dignity and privacy.
- **Privacy of health information**. Privacy and confidentiality concerning their medical care in accordance with the Cooperative's Notice of Privacy Practices, including the following rights:
  - Access and inspect health information. Request to access and/or inspect your protected health information in a designated record set. Please see the Notice of Privacy Practices for more information.
  - Amendment of health information. Request to have protected health information in a designated record set amended. Please see the Notice of Privacy Practices for more information.
  - Accounting of disclosures. Receive an accounting of disclosures made by us of your protected health information after April 14, 2003. Please see the Notice of Privacy Practices for more information.
  - Restriction on disclosures. Request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. Please see the Notice of Privacy Practices for more information.
  - Copies of health information. If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526
  - Alternate communications. Request that communications from GHC be sent to an alternate location or by an alternate means. GHC will accommodate reasonable requests for such confidential communications. You are not required to give a reason for this request.
- **Freedom from seclusions and restraints**. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
- **Treatment options and alternatives**. Receive information on available treatment options and alternatives presented in a manner appropriate to the enrollee's condition and ability to understand.
- **Cultural competency and nondiscrimination in service delivery**. Receive benefit and other important communications in alternate formats if needed, including non-English languages and via use of auxiliary aids/devices, in accordance with the Language and Accessibility Policy and Nondiscrimination Statement.
- **Informed consent**. Receive from a physician or other provider information necessary to give informed consent prior to the start of any procedure or treatment.
- **Participation in health care decisions**. Participate in discussion regarding his or her health care and appropriate or medically necessary treatment options, including the right to refuse treatment regardless of cost or benefit coverage.
- **Refuse treatment**. Refuse treatment to the extent permitted by law and to be informed of the medical consequences of that decision (including refusal to participate in research).
- **Benefit Rules**. Receive written documentation regarding rules and regulations of their health care benefits.

- **Primary Care coordination**. Expect their Primary Care Clinic to coordinate and monitor their care.
- **Grievances and complaints**. Express their concerns, make a complaint, or file a grievance with Group Health Cooperative and/or the right to file a complaint with the State of Wisconsin, Office of the Commissioner of Insurance; WI Department of Health Services (DHS); and/or appeal to the Social Security Administration; and/or appeal to the Office of the Railroad Retirement Board if they are a railroad annuitant.
- **Powers of Attorney and Advance Directive**s. Designate an individual to make treatment decisions on their behalf in the event that they are unable to do so.
- **Direct access to certain care**. Receive direct access (without authorization or referral) to in-network women's health specialists for females seeking routine and preventive services, including mammography; and certain immunizations in an office setting (such as influenza and meningococcal).
- **Organization**: Right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities and make recommendations regarding the members rights and responsibilities policy.

Members have the RESPONSIBILITY to:

- **Select a network primary care provider**. Select their Primary Care Clinic from the Group Health Provider Directory. Primary Care Clinics will coordinate and monitor their member's health care needs.
- **Use the network for most services**. Use Group Health Cooperative providers, hospitals, laboratories or other diagnostic facilities whenever possible, unless members are in an emergency.
- **Provide accurate health information**. Provide complete and honest information about their health care status, including medications and allergies.
- **Report changes in health condition**. Report unexpected changes in their medical condition to their medical providers, and make it known whether they understand the contemplated course of action and what is expected of them.
- **Keep provider appointments**. Keep appointments and notify the medical office of their cancellation.
- **Notify us of demographic changes**. Notify Group Health Cooperative whenever they change their address or phone number so that records may be updated.
- **Read and understand their benefits**. Read and understand their Member Handbook, policy form/documents, authorization guidelines, and other benefit and coverage information.
- **Coordinate benefits**. Provide accurate and complete information to Group Health Cooperative about other health care coverage and/or insurance benefits they may carry.
- **Follow treatment plans**. Actively participate in care and follow the treatment plan recommended by their doctor.
- **Provide information on advance directives**. Notify the Cooperative and providers of any advance directives that may affect care.
- **Understand health problems**. to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Your Civil Rights:

Group Health Cooperative of Eau Claire provides covered services to all eligible members regardless of:

- Age
- Race
- Religion
- Color
- Disability
- Sex
- Sexual orientation
- National origin
- Marital status
- Arrest or conviction record
- Military participation

All medically necessary covered services are available and will be provided in the same manner to all members. All persons or organizations connected with the Cooperative who refer or recommend members for services shall do so in the same manner for all members.

Translating or interpreting services are available for those members who need them. This service is free.

SECTION 5 - HEALTH MANAGEMENT REVIEWS FOR MEDICAL NECESSITY

OVERVIEW OF HEALTH MANAGEMENT PROGRAM

The Health Management program is 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 of services is 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.

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 as the anticipated length of stay for the patients' diagnosis is lengthened.

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"): 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.

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 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. To preserve continuity of care, they also coordinate other provider health services and refer members to other contracted providers as appropriate. Primary care providers include the following: Family Practice, Internal Medicine, Pediatric, and OB/GYN physicians.

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

INPATIENT CARE – UTILIZATION MANAGEMENT

All admissions to a hospital, inpatient rehabilitation facility and skilled nursing facility are reviewed for medical appropriateness of admission and continued stay. Notification to the Health Management Department of an inpatient admission and non-emergent intra facility transfer is required. The Health Management staff will assess, in partnership with the facility, medical necessity of continued stay, assist in discharge planning and refer to case management services if appropriate.

Hospital admission notification associated with labor and delivery is only required if discharge is greater than two days following vaginal delivery or greater than four days following Cesarean delivery.

Concurrent Review

Concurrent Review for inpatient management is a collaborative process with hospital staff to provide concurrent review when the anticipated length of stay for the patient's diagnosis is lengthened. The concurrent review process may include, but is not limited to, the Cooperative staff providing review of medical records, discharge planning assistance, explaining health management decisions, and facilitating post-discharge care.

Authorization for services during concurrent review does not guarantee payment for services. Payment for services may be dependent on other non-medical criteria such as the benefits associated with a member's specific plan and eligibility issues.

- Health Management Staff use clinical decision support criteria to evaluate medical necessity and appropriateness of care;
- Potential quality issues identified during concurrent review are reported to the Cooperative's CMO and, if found to be significant, to the 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. To facilitate an individualized discharge plan that effectively promotes the efficient use of medical resources in the most appropriate clinical setting, health management staff collect information from a variety of sources such as medical records, the member, physician interaction and input from hospital nursing and discharge planning staff. Health management staff identify patients whose diagnosis, intensive treatment requirements or co-morbidity factors make them likely candidates for intense discharge planning or specialized case management by the Cooperative.

SERVICES REQUIRING PRIOR AUTHORIZATION

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. Requests will be evaluated for medical necessity using evidence-based guidelines as available. 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.

In the case of an urgent medical need for an event needing prior authorization, 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 urgent review.

Retroactive event authorization requests will not be granted unless there is a compelling medical reason for consideration. All requests shall be sent to the Health Management Department by fax or by mail with appropriate documentation to determine medical necessity, including the inpatient admission notifications and discharge notifications.

SECTION 6 - 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 member, 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 commercial and Medicaid SSI members. These services are not provided directly by Vantage Point Clinic. Members and the providers who serve this region should contact Group Health Cooperative's Health Management Department at (800) 218-1745 for all authorization and referral needs.

SERVICES REQUIRING PRIOR AUTHORIZATION

Retroactive event authorizations for services will not be granted unless there is a compelling reason for consideration.

Subsequent outpatient psychiatric, behavioral 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. 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

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 six-visit outpatient guideline, i.e. prior to the seventh psychotherapy visit, authorization must be received.

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. 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 the Cooperative 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.

SECTION 7 –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.

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.

The current Prior Authorization Guidelines are located on the Cooperative's website. Also, providers are encouraged to contact Provider Services to confirm if a service requires a prior authorization and if an authorization request has been received and/or completed.

Any request for a member to obtain professional services from an out-of-network provider must be authorized by the Cooperative. The referring provider or out of network provider should complete the required request form located on the website.

SECTION 8 - PROVISIONS FOR INTERPRETERS/TRANSLATORS

As a contracted provider, access to interpreters 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.

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.

It is the responsibility of the provider of healthcare to pay for interpreters.

Documentation is to be made in the patient's medical record of all efforts made to schedule an interpreter and if an interpreter was utilized

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 9 - 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 Cooperative 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. 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 10 - 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 member 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 member, 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.

SECTION 11 – 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) and Portal 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, Prior Authorization 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 12 – 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.

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.

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.