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

GHC22014

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

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DEPARTMENT CONTACTS

Group Health Cooperative of Eau Claire Department 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 Fax Number: (715) 836-7683
Call our **Utilization Management Department** for: • Prior authorization questions	**UTILIZATION MANAGEMENT** DEPARTMENT (715) 552-4333 or (866) 563-3020
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) 852-5706 Fax Number: (715) 598-7534
Call our **Credentialing Department** for: • Clinician information updates	**CREDENTIALING** DEPARTMENT (715) 852-2093 Fax Number: (715) 598-7534
Call our **Quality Improvement Department** for: • HEDIS Measures • Quality Reviews	**QUALITY IMPROVEMENT** DEPARTMENT (715) 552-4333 or (866) 563-3020 Fax Number: (715) 598-7530

SECTION 1 – CLAIMS INFORMATION

CLAIMS SUBMISSION

In order to facilitate timely payment of claims submitted to Group Health Cooperative of Eau Claire (the Cooperative), please utilize the appropriate claim forms and follow standard submission guidelines for your provider type.

Submit all claims via mail or fax to: Group Health Cooperative of Eau Claire
PO Box 3217
Eau Claire, WI 54702-3217
Fax: (715) 598-7525

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, 7 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.

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.

- 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.

If you are able to create x12 837 files, you can fill out the one-page form found on the Cooperative's website at https://group-health.com/getmedia/291d65db-f48a-4a4a-ab73-9af24c6d68e6/ElectronicClaimsSub837.pdf to work on establishing a direct connection. No paperwork (including this form) is necessary to submit claims through a clearinghouse and is the preferred method.

In addition, the Cooperative has a setup form available for the following types of electronic transactions:

- Electronic Remittance Advice form
  https://group-health.com/getmedia/c86f506d-0830-4ad9-bddb-b2821b9389a7/ElectronicTransfer835.pdf
- Eligibility Benefit Inquiry and Response form
  https://group-health.com/getmedia/32c0d859-d0ac-485a-b91a-96fff06f7994/EligibilityBenefitInquiry270-271.pdf

Contact the Cooperative's Provider Services at (715) 552-4333 or (866) 563-3020 for more information.

ELECTRONIC CLAIM SUBMISSION - QUICKCLAIM

The Cooperative has made an online claim submission software program available to contracted providers. QuickClaim is a claims submission program powered by Smart Data Solutions (SDS). If you have questions regarding the functionality of the QuickClaim system, please contact SDS at 855-297-4436 between 8 a.m.-5 p.m., Monday through Friday. If you have any questions regarding logging into the QuickClaim system, please call our Provider Services team at (715) 552-4333 or (866) 563-3020 between 7 a.m.-6 p.m., Monday through Friday. This program combines direct online data entry and automation, allowing providers to submit HIPAA compliant claims directly to the Cooperative at no cost to the provider. This solution eliminates paper claims, reduces costs, and shortens claims processing turnaround time.

QuickClaim can be accessed at http://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

The Wisconsin Department of Health Services (DHS) requires HMOs to ensure that all other payor sources are exhausted prior to issuing payment on claims for Medicaid members. This longstanding Federal and State policy is in place to ensure the continued solvency of the program and is driven by DHS 106, the Deficit Reduction Act, and the DHS-HMO Contract. These requirements affect how claims are billed to and paid by the Cooperative and should eliminate some of the administrative burden associated with benefits coordination.

- The Cooperative requires a copy or verification of any denial (EOB, etc.) from other insurance prior to issuing payment as outlined 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.

- 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 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 and the Cooperative has received an itemized listing of payments made from the carrier. Importantly, in situations where the medical payments coverage has been issued to a Medicaid member and the payment is itemized and/or attributable to specific claims, the Cooperative will be denying payment of those claims. Providers will be expected to seek recovery directly from the member.

- Third-party liability (TP). 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 a provider to submit one denial before related claims will be reconsidered. 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 additional EOBs or proof of denial. However, in cases of undisputed accident claims, such as worker's compensation 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.

- In cases of auto accidents, worker's compensation, etc., providers will be expected to code claims 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 by not pending claims unnecessarily.

- The Cooperative does not withhold payment pending third-party liability payment.

- Refund/recoupment requests must comply with Wisconsin Administrative Code DHS 106.03(8). Providers are allowed to bill a liability/worker's compensation carrier or Medicaid, but they cannot bill both at the same time for the same claims. In addition, once a provider accepts a Medicaid payment on a claim, that claim is considered paid in full, and the provider can no longer pursue or accept payment from another payer. If the Cooperative has made payment under the Medicaid plan and a provider later receives payment from the liability/worker's compensation carrier or the member's attorney, the provider must return the full payment to the carrier (or attorney) and inform the carrier (or attorney) that reimbursement is owed to the Cooperative. A copy of the original explanation of benefits form should be submitted with all refund/recoupment requests. Provider generated forms are not accepted.

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 (715) 552-4333 or (866) 563-3020.

CORRECTED CLAIMS

Corrected claims can be submitted on the appropriate claim form with "correction/ resubmission" identified in box 4 on the UB-04. The fourth digit of the type of bill code should be used to indicate a corrected claim. For CMS-1500 claims only, Box 19 would be used. 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) 598-7525

CMS-1500 FORM INFORMATION

The Cooperative's 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 ForwardHealthPortal 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 guidelines on the Cooperative's website at https://group-health.com/providers/prior-auth-guidelines.

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 resubmission 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 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.

Robotic Assist

Surgical techniques that involve a robotic surgical system are not a separately reimbursed service and the robotic assisted technique will be considered included as part of the primary surgical procedure.

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.

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 (715) 552-4333 or (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 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:
    Attention: Sterilization Consent
    Group Health Cooperative of Eau Claire
    P.O. Box 3217
    Eau Claire, WI 54702
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 the Cooperative 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 https://www.dhs.wisconsin.gov/library/f-01160.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 https://www.dhs.wisconsin.gov/forms/f4/f40117.pdf. 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 Cooperativewill 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 about a claim or if you are dissatisfied with the payment or denial reason 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 (715) 552-4333 or (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 name, BadgerCare Plus and/or Medicaid SSI ID number, the provider name, date of service, date of billing, date of rejection,

and reason for reconsideration. For your convenience, a provider appeal form can be located on the Cooperative's website at https://group-health.com/getmedia/f60c1176-f932-4a28-9408-029c7e388737/ProviderAppealForm.pdf.

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. Your appeal can be faxed to the attention of Provider Appeals at (715) 836-7683 or sent via regular mail to:

Attention: Provider Appeals
Group Health Cooperative of Eau Claire
PO Box 3217
Eau Claire, WI 54702-3217

All BadgerCare Plus and Medicaid SSI providers must appeal first to the HMO and then to the Department of Health Services 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 of Health Services 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: https://www.dhs.wisconsin.gov/library/f-12022.htm and must be faxed to (608) 224-6318 or mailed to:

BadgerCare Plus and Medicaid SSI
Managed Care Unit - Provider Appeal
PO Box 6470
Madison, WI 53716-0470

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

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 a member of the Council for Affordable Quality Healthcare (CAQH). CAQH is an online single entry national database that eliminates the need for providers to complete and submit multiple credentialing applications.

The Cooperative is accredited by the National Committee for Quality Assurance (NCQA). Providers and facilities are reviewed against the standards set by NCQA, including a current valid license, clinical privileges, valid DEA certification, educational background, board certification, work history, malpractice history, malpractice insurance, 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 at (715) 852-5706 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. Physicians and other healthcare providers who are members of CAQH are able to submit an initial credentialing application on the CAQH portal or provide the required information at recredentialing rather than completing several different credentialing applications for each payor. CAQH performs primary source verification of initial and recredentialing applications and delivers the complete credentialing file to the Cooperative for review. Additional information is available by contacting the Cooperative's Credentialing Department.
- 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:
  - Medical Doctors
  - Certified Nurse Anesthetists
  - Oral surgeons
  - Chiropractors
  - Osteopaths
  - Podiatrists
  - Nurse practitioners
  - Psychiatrists and other physicians

  - Doctoral or master's-level psychologists
  - Master's-level clinical social workers
  - Master's-level clinical nurse specialists or psychiatric nurse practitioners

  Any other practitioner who is licensed, certified, or registered by the state to practice independently (without direction or supervision) will also be credentialed.
- 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 36 months. Any provider not credentialed within 36 months from previous credentialing approval date will no longer be considered part of the provider network.
- Providers have a right to inquire about the status of their application.
- Providers have a right to review the information that was collected from outside sources for credentialing, not including references, recommendations or peer review protected information.
- Providers have a right to correct erroneous information on their credentialing application within 30 days of initial application by sending corrected information through CAQH.
- Providers can appeal a credentialing decision within 30 days of receiving a denial. Provider must send the appeal in writing to: ProviderRelations@group-health.com. A determination will be made by the Cooperative within 45 days of receipt of the appeal.

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 NCQA. Members demand that organizations such as ours are held accountable for the services that are provided. Accreditation by NCQA provides the member with assurance that the Cooperative has appropriate quality improvement structures in place that have a positive impact on

healthcare delivery.

Providers are expected to cooperate with the Cooperative's QI activities to improve the quality of care and services and member experience. Cooperation includes collection and evaluation of performance measurement data and participation in the organization's clinical and service measure QI programs and initiatives. The Cooperative may also use provider's performance data for quality improvement activities.

It is the Cooperative's policy to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs, in accordance with the National Standards of Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. The Cooperative has also aligned with the Wisconsin Department of Health Services initiatives in reducing health disparities. Culturally competent training is available to providers, and we work to ensure our entire network understands the different cultural and linguistic needs of our members.

To learn more about CLAS information and training, visit https://group-health.com/providers/quality-and-patient-safety.

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

On an annual basis, The Center for the Study of Services (CSS) conducts the CAHPS Survey. This consumer satisfaction survey is nationally accepted and is a mandatory component of the HEDIS data submission. The CAHPS survey in addition to the HEDIS data submission (health-related measures) assist employer groups (along with the individual health plans) in evaluating the various health plans' performance at the state, regional, and national level through a publication called *Quality Compass*.

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 Cooperative's Provider Services at (715) 552-4333 or (866) 563-3020.

Access Standards

All members have the right to receive timely access to medically necessary health care services. The Cooperative has established access standards and requires in-network providers to follow the access standards as outlined below. Access standards are reviewed annually. In-network providers are surveyed annually to evaluate compliance with the access standards.

Appointment Wait Time Standards

All providers are required to follow the Cooperative's appointment wait time standards. Members should be seen within 30 minutes of their scheduled appointment time. When care is unavoidably delayed, members must be notified of the delay and allowed to reschedule their appointment.

Primary Care Provider Standards

Service	Access Standard
Life-threatening emergencies	Immediate access
Urgent Care	Within 48 hours
Routine preventive exam	Within 30 days

Behavioral Health Care Provider Standards

Service	Access Standard
Life-threatening emergencies	Immediate access
Non life-threatening emergencies	Within 6 hours
Urgent Care	Within 48 hours
Initial routine care visit	Within 10 business days
Follow-up routine care	Within 30 days

Prenatal Care

Provider must provide medically necessary high-risk prenatal care within two weeks of the member's request for an appointment. Wait times for an appointment shall be no more than 30 days.

After Hours Coverage for Providers

Primary care providers and behavioral health providers must have process for ensuring after hours accessibility, and for informing their members how to access after hours care. After-hours patient telephone calls should be returned within one hour from the time placed by the patient.

SECTION 4 – MEMBER RIGHTS & RESPONSIBILITIES

The Member Rights & Responsibilities listed below are provided in the Member Handbook.

MEMBER RIGHTS

- You have the right to have an interpreter with you during any BadgerCare Plus or Medicaid SSI covered service.
- You have the right to get the information provided in this member handbook in another language or format.
- You have the right to get health care services as provided for in federal and state law. All covered services must be available and accessible to you. When medically appropriate, services must be available 24 hours a day, seven days a week.
- You have the right to get information about treatment options including the right to request a second opinion.
- You have the right to make decisions about your health care.
- You have the right to be treated with dignity and respect.
- You have the right to be free from any form of restraint or seclusion used as a means of force, control, ease, or reprisal.
- You have the right to be free to exercise your rights without adverse treatment by the Cooperative and its network providers.
- You may switch HMOs without cause during the first 90 days of enrollment into the Cooperative.
- You have the right to switch HMOs, without cause, if the State imposes sanctions or temporary management on the Cooperative.
- You have the right to receive information from the Cooperative regarding any significant changes with the Cooperative at least 30 days before the effective date of the change.
- You have the right to receive information about the Cooperative, its services, its practioners and providers, and member rights and responsibilities.
- You have the right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- You have the right to make recommendations regarding the Cooperative's member rights and responsibilities policy.
- You have the right to appeal decisions or voice complaints about the Cooperative or the care it provides.
- You have the right to disenroll from the Cooperative if:
    - You move out of the Cooperative's service area.
    - The Cooperative does not, for moral or religious objections, cover a service you want.
    - You need a related service performed at the same time, not all related services are available within the provider network and your PCP or another provider determines that receiving the services separately could put you at unnecessary risk.
    - Other reasons, including poor quality of care, lack of access to services covered under the contract or lack of access to providers experienced in dealing with your care needs.

MEMBER RESPONSIBILITIES

- You have a responsibility to follow plans and instructions for care that you have agreed to with your practitioner.
- You have a responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- You have a responsibility to read and understand your benefits, or call us if you have questions.
- You have a responsibility to select a primary care clinic/doctor from any in-network provider.
- You have a responsibility to use providers in the network, unless it is an emergency.
- You have a responsibility to provide us and your providers with complete and accurate information about your health.
- You have a responsibility to report changes in your health to your doctor and understand the care being provided to you.
- You have a responsibility to keep your scheduled appointments or call your provider if you need to cancel.
- You have a responsibility to contact us to update your address or phone number if it changes.
- You have a responsibility to provide us with complete information about other insurance you have.

YOUR CIVIL RIGHTS

The Cooperative provides covered services to all eligible members regardless of:

- Age
- Color
- Disability
- National origin
- Political beliefs
- Race
- Religion
- Sex
- Sexual orientation

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 – UTILIZATION MANAGEMENT REVIEWS FOR MEDICAL NECESSITY

OVERVIEW OF UTILIZATION MANAGEMENT PROGRAM

The Utilization 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 Utilization Management staff, including the clinicians who make utilization 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.

Medical necessity review is the process whereby covered services are reviewed to determine if they meet criteria for medical necessity and clinical appropriateness. As part of this review, national recognized, evidence-based standards and decision support tools/criteria sets and clinical practice guidelines are used to maintain quality of care, eliminate unnecessary care, and improve patient safety. The guidelines serve as a foundation and guide for ensuring the member's needs are being met according to evidence-based guidelines and that medical necessity determinations are being made consistently according to national evidence-based practice standards. A medical necessity review also considers the member's circumstances.

Our Utilization Management staff is not rewarded for issuing denials of coverage or service and is not given any financial incentives for health management decisions.

Medical necessity determinations are made using the following guidelines which are based on nationally recognized evidence-based clinical practice guidelines.

- InterQual medical necessity criteria sets and LOS data. These protocols are used to review selected procedures, DME, medical and behavioral health hospital admissions, AODA admissions, and subacute and rehabilitation admissions.
- Hayes Technologies for services that are experimental/investigational.
- Other national evidence-based practice guidelines that are used include but are not limited to the National Comprehensive Cancer Network, American College of Radiology Criteria sets, Untied States Preventive Services Task Force, JNC 8, NHLBI asthma guidelines, ACA-AHA guidelines, ADA guidelines American College of Obstetricians and Gynecologists, American Academy of Pediatrics, and American Academy of Family Practice.
- The Cooperative's Policy and Procedures are developed when there is no InterQual criteria set or Hayes recommendation for a service that is a covered benefit and there needs to be a medical necessity determination. These internal policies are developed based on nationally recognized evidence-based clinical practice guidelines.

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). 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: The process for obtaining an approval from the Cooperative that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by the Cooperative.

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: The primary care provider evaluates the member's total health needs and provides personal medical care in one or more medical fields. Primary care providers include the following: Family Practice, Internal Medicine, Pediatric, and OB/GYN physicians.

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 Utilization Management Department of an inpatient admission and non-emergent intra facility transfer is required by the next business day. The Utilization 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.

- Utilization 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.

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 prior authorization must have prior 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. When prior authorization is required, the facility, ancillary provider or physician rendering the services must verify with the Cooperative's Provider Services department that prior authorization has been approved before the services are performed.

SECTION 6 – BEHAVIORAL HEALTH & ALCOHOL AND OTHER DRUG ABUSE (AODA) SERVICES

SERVICES REQUIRING PRIOR AUTHORIZATION

A complete list of the prior authorization guidelines can be found on the Cooperative's website at https://group-health.com/providers/prior-auth-guidelines.

SECTION 7– PRIOR AUTHORIZATION GUIDELINES

Prior 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. Prior authorization guidelines must be followed even if the Cooperative is secondary to another insurance plan, including Medicare.

If a member receives services that require an approved prior authorization by the Cooperative and such prior 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 professional charges.

The current Prior Authorization Guidelines are located on the Cooperative's website. Also, providers are encouraged to contact Provider Services at (715) 552-4333 or (866) 563-3020 to confirm if a service requires a prior authorization and if a prior authorization request has been received and/or completed.

Any request for a member to obtain services from an out-of-network provider requires prior authorization 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 https://www.dhs.wisconsin.gov/ and specifically on

the Limited English Proficiency Resources link at https://www.dhs.wisconsin.gov/civil-rights/lep-resources.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 the Non-Emergency Medical Transportation (NEMT) Manager at (866) 907-1493 (TTY:711).

Ambulance Transportation:
An ambulance is only used in a life-threatening emergency. For all non-emergency medical transportation, the member should contact NEMT at (866) 907-1493 (TTY: 711).

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 Services for enrollment, policy, and billing questions.

ForwardHealth Member Service: (800) 362-3002

Available Monday through Friday, 8:00 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, trading partners, and other portal users may call the ForwardHealth Portal Helpdesk to report a Portal account security breach, improper Protected Health Information (PHI) use or disclosure, and 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 both Federal and State programs such as Medicare and Medicaid.

DEFINITIONS OF FRAUD, WASTE AND ABUSE (FWA)

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 the provider or consumer 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.

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.

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 make or cause to be made any false statement or representation of a material fact in any application for any benefit or payment.
         ii. Knowingly and willfully make or cause to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment.
         iii. Having knowledge of the occurrence of any event affecting the initial or continued right to any such benefit or payment or the initial or continued right to any such benefit or payment of any other individual on whose behalf someone has applied for or is receiving such benefit or payment, conceal or fail to disclose such event with an intent to fraudulently secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized.
         iv. Having made application to receive any such benefit or payment for the use or benefit of another, and having received it, knowingly and willfully convert such benefit or payment or any part thereof to a use other than for the use and benefit of such other person.

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 Cooperative's 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 (715) 852-5725.