BadgerCare Plus & Medicaid SSI Provider Manual

2024

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

GHC24014

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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 ghc-ec.com/ElectronicClaimsSubmission 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
  ghc-ec.com/ElectronicRemittanceAdvice
- Eligibility Benefit Inquiry and Response form
  ghc-ec.com/EligibilityBenefitInquiry

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 https://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 (TPL). 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 primary payment is related to a subrogation issue, please reference the previous section titled Subrogation and Recoupment. 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. Each attempt

must be at least one week apart. 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. A "resubmission of a claim" or "reconsideration of a claim" is not considered a formal appeal.

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 DHS 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 submission and review 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.

Computer-assisted navigation using fluoroscopic images or CT/MRI images for surgical procedures is not separately reimbursable.

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 at https://www.dhs.wisconsin.gov/library/f-01164.htm. 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.

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 Cooperative will forward this information to DHS for final decision regarding coverage. Once DHS 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 (a "resubmission of a claim" or "reconsideration of a claim") within 60 days from the initial payment/denial determination notice. This is not considered a formal appeal and the Cooperative is required to complete the reconsideration process within 60 days. 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 submit a formal provider 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. The provider appeal form is located on the Cooperative's website at ghc-ec.com/ProviderAppealForm.

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 715-598-7538 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 DHS 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 WI DHS 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 are required to log in to the secure Provider Appeals portal at https://wi-appeals.entellitrak.com/ and enter their appeal information in an online form. Providers are required to submit appeals with legible copies of all supporting documentation as outlined in the Appeals to BadgerCare Plus HMOs and Medicaid SSI HMOs (#384) and Appeals to ForwardHealth (#385) topics of the ForwardHealth Online Handbook. The decision to overturn a denial must be clearly supported by the documentation the provider submits. Submitting incomplete or insufficient documentation may lead to ForwardHealth upholding the Cooperative's denial. Once the provider submits the appeal information in the portal, an email will be sent automatically to the Cooperative's Provider Appeal email distribution list requesting additional information related to the claim(s). Once notified, the Cooperative will have 14 calendar days to log in to the portal and provide the additional information.

EXAMPLE OF PROVIDER REMITTANCE ADVICE

Group Health Cooperative of Eau Claire
P.O. Box 3217
Eau Claire, WI 54702-3217

<<PROVIDER NAME>>
<<ADDRESS 1>>
<<ADDRESS 2>>
<<ADDRESS 3>>

Your name,<<**PROVIDER NAME**>>, and Tax ID have been verified by the IRS.

For questions on claims please call 715-552-4300
or 888-203-7770, or fax 715-836-7683
(Monday-Friday 7AM-6PM CST).

Tax ID: XXXX ***EPC Draft #:*** XX ***Payment Week:*** XX ***Payment Date:*** XX/XX/XXXX Page 1 of 2

Service Date	Proc/Rev Code (Modifiers)	Units	Explanation Code(s)	Total Charge	Allowed Amount	Contractual Adjustment	Other Coverage	Other Adjustment	Patient Obligation				Net Payment Amount
									Co-Ins	Co-Pay	Deductible	Non-Cov	
Claim Number: XXXXXXXXXXXXXX **Provider:** <<PROVIDER NAME>>					**Group ID:** XXXXXX **Patient Name:** XXXXXX **Patient Acct #:** XXXXXX				**Payment Reference Number:** XXXX **Subscriber Name:** XXXX **Patient ID:** XXXXXXX				
XXXXXXX	XXXXXXX	1	96, N448	$100.00	$0.00	$0.00	$0.00	$100.00	$0.00	$0.00	$0.00	$0.00	$0.00
XXXXXXX	XXXXXXX	1	96, N448	$100.00	$0.00	$0.00	$0.00	$100.00	$0.00	$0.00	$0.00	$0.00	$0.00
			Claim Total:	$200.00	$0.00	$0.00	$0.00	$200.00	$0.00	$0.00	$0.00	$0.00	$0.00

Statement Summary	Total Charge	Allowed Amount	Contractual Adjustment	Other Coverage	Other Adjustment	Patient Obligation				Net Payment Amount
Administered By						Co-Ins	Co-Pay	Deductible	Non-Cov	
Group Health Cooperative of Eau Claire	$200.00	$0.00	$0.00	$0.00	$200.00	$0.00	$0.00	$0.00	$0.00	$0.00

Explanation Code(s)

Code	Description
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.

Code values and definitions included here come from https://x12.org/codes

Switch to EFT today and enjoy many benefits including ease of use and reliable, timely receipt of payments! Enroll today at:
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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 (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, member identification number (Badger Care Plus ID, Medicaid SSI ID number, Medicare Advantage, or other as applicable), 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. All appeals should be mailed to:

Group Health Cooperative of Eau Claire
ATTENTION: PROVIDER APPEALS
P.O. Box 3217
Eau Claire, WI 54702-3217

All appeals will be resolved, and resolution sent in writing, within 45 days of receipt by Group Health Cooperative of Eau Claire.

BADGER CARE PLUS AND MEDICAID SSI ONLY: All Badger Care Plus and Medicaid SSI providers must appeal first to the HMO.

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 appeal the decision to the Department of Health Services through the Provider Appeals portal at https://wi-appeals.entellitrak.com/. Providers are required to submit appeals with legible copies of all supporting documentation as outlined in the Appeals to BadgerCare Plus HMOs and Medicaid SSI HMOs (#384) and Appeals to ForwardHealth (#385) topics of the ForwardHealth Online Handbook. The decision to overturn an HMO's/PIHP's denial must be clearly supported by the documentation the provider submits. Submitting incomplete or insufficient documentation may lead to ForwardHealth upholding the HMO's/PIHP's denial.

MEDICARE ADVANTAGE ONLY: If you are a non-contracted provider appealing a post-service claim denial for a Medicare Advantage plan, complete the Waiver of Liability form as required by section 50.1.1 of the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance. This can be found at Cooperative-Advantage.com.

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 that clinical processes are in place to provide our members with quality care. This process allows the contracted provider and the Cooperative to develop a relationship to best meet our members' needs. 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.
- 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.
- Providers can appeal a termination decision based on failure to meet quality standards within 30 days of receiving the termination notice. 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 (QI) PROGRAM

Scope

The QI Program is a comprehensive program that addresses the quality and safety of clinical care and the quality of services our members receive. Our culture, processes, and systems are structured to ensure our members receive high quality care and services. By monitoring member satisfaction, access and availability standards, quality of care concerns, and national quality metric results, care improvement opportunities are identified and implemented.

Goal

Our QI Program goal is to improve the quality of health care for our members by implementing QI activities to improve quality of care and services delivered across all care settings.

Provider Participation in QI Initiatives

To ensure the success of the QI Program, the Cooperative requires providers and practitioners to cooperate with all QI initiatives and allow the use of provider and/or practitioner performance data for QI initiatives. QI initiatives include but are not limited to access and

after-hours care surveys, collection, evaluation, and submission of data, satisfaction surveys, and participation in QI meetings, QI programs, and partnerships. Provider participation in these activities allow the Cooperative to continuously improve the quality and safety of clinical care, the quality of services, and member experience. Information from QI activities is actively shared with our providers and staff.

We encourage feedback on our QI Program and activities and are available as a resource for QI activities with our network providers. Questions or requests for information should be directed to the Cooperative's Provider Services Department at (715) 552-4333 or (866) 563-3020.

Cultural Competency Plan

The Cooperative is committed to establishing multicultural principles and practices throughout the organization to ensure health care and services meet the diverse needs of our members in accordance with the National Standards of Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. These needs include cultural, ethnic, and religious beliefs, language and communication preferences, and health literacy.

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/clas-education-and-training.

Continuity and Coordination of Care

The Cooperative's goal is to improve continuity and coordination of care for its members to reduce the risk of problems when members see multiple providers in different health care settings. We collaborate with our providers to identify and implement opportunities to facilitate continuity and coordination of care and ensure mechanisms are in place for timely and confidential exchange of health information between behavioral health providers and primary care providers, specialists, and health care delivery systems.
Online toolkits are available to our providers to improve continuity and coordination of care and communication between providers on our website at https://group-health.com/providers/quality-care-and-patient-safety.

HealthCare Effectiveness Data and Information Set (HEDIS)

Developed and maintained by the National Committee for Quality and Assurance (NCQA), the HealthCare Effectiveness Data and Information Set (HEDIS) is used as a set of performance measures to evaluate the Cooperative's performance. HEDIS includes measures related to 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

CAHPS surveys help the Cooperative identify strengths and weaknesses, determine where improvements are needed, and track progress over time. This tool is especially useful in

evaluating and improving the quality of our provider network. These surveys ask members about their experiences with the health plan and their providers. Members rate their primary care provider, their specialist provider, and the healthcare they receive from their providers.

Providers are also rated on how well they communicate including:

- How well they explained things?
- How well they listened?
- Did they show respect?
- Did they spend enough time?
- Did they coordinate care?

Member's experience with timely access to care is evaluated by the following questions:

- Did you get care as soon as needed when care was needed right away?
- Did you get a check-up/routine appointment as soon as needed?
- What was the ease of getting care, tests, or treatments?
- Were you able to get an appointment with a specialist as soon as needed?

Access and Appointment Wait Time Standards

All members have the right to receive timely access to medically necessary health care services. Providers must provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities. 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. Network providers shall offer hours of operation that are no less than the hours of operation offered to Commercial members or Medicaid Fee for Service.

Primary Care Provider Access Standards

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

Prenatal Care Provider and OB/GYN Provider Access Standards

Prenatal Care Providers 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. OB/GYN access will be no more than 30 days.

Behavioral Health Care Provider Access 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

Provider After-Hours Coverage for Members

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

Provider Right to Practice

The Cooperative will not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for the following:

a. The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
b. Any information the member needs to decide among all relevant treatment options.
c. The risks, benefits, and consequences of treatment or non-treatment.
d. The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Shared Decision-Making (SDM)

The Cooperative understands the importance of shared decision-making aids in providing information about treatment options and outcomes to members. SDM aids facilitate member and provider discussions on treatment decisions. Please visit our website at https://group-health.com/providers/quality-care-and-patient-safety for a list of evidence based shared decision-making resources and aids.

Quality Resources for Providers

The Cooperative supports providers to achieve our population health management goals by providing comparative quality information on our website at https://group-health.com/providers/quality-care-and-patient-safety.

SECTION 4 – MEMBER RIGHTS & RESPONSIBILITIES

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

MEMBER RIGHTS

1. **You have a right to get information in a way that works for you. This includes:**
   - Your right to have an interpreter with you during any BadgerCare Plus or Medicaid SSI covered service.
   - Your right to get this member handbook in another language or format.
2. **You have a right to be treated with dignity, respect, and fairness and with consideration for privacy. This includes:**
   - Your right to be free from discrimination. The Cooperative must obey laws that protect you from discrimination and unfair treatment. The Cooperative provides covered services to all eligible members regardless of the following:
     - Age
     - Color
     - Disability
     - National origin
     - Race
     - Sex
     - Religion
     - Sexual orientation
     - Gender identity
     - 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 that refer or recommend members for services shall do so in the same manner for all members.
   - Your right to be free from any form of restraint or seclusion used to coerce, discipline, be convenient, or retaliate. This means you have the right to be free from being restrained or forced to be alone to make you behave in a certain way, to punish you, or because someone finds it useful.
   - Your right to privacy. The Cooperative must follow laws protecting the privacy of your personal and health information. See the Cooperative's Notice of Privacy Practices for more information.
3. **You have the right to get health care services as provided for in federal and state law. This includes:**
   - Your right to have covered services be available and accessible to you when you need them. When medically appropriate, services must be available 24 hours a day, seven days a week.
4. **You have the right to participate with practitioners to make decisions about your health care. This includes:**
   - Your right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.

- Your right to accept or refuse medical or surgical treatment and participate in making decisions about your care.
- Your right to plan and direct the types of health care you may get in the future if you become unable to express your wishes. You can make these decisions by completing an **advance directive**, **living will**, or **power of attorney for health care**.
- Your right to a second opinion if you disagree with your provider's treatment recommendation. Call our Member Services Department for more information about how to get a second opinion.

5. **You have a right to know about our providers and any physician incentive plans the Cooperative uses. This includes:**
   - Your right to ask if the Cooperative has special financial arrangements (physician incentive plans) with our physicians that can affect the use of referrals and other services you might need. To get this information, call our Members Services Department at 715-552-4300 or 1-888-203-7770 (toll-free and request information about our physician payment arrangements.
   - Your right to request information about the Cooperative's providers, including the provider's education, board certification, and recertification. To get this information, call our Member Services at 715-552-4300 or 1-888-203-7770 (toll-free).
6. **You have a right to ask for copies of your medical records from your provider.**
   - You may correct inaccurate information in your medical records if your doctor agrees to the correction.
   - Call our Member Services at 715-552-4300 or 1-888-203-7770 (toll-free) for assistance with requesting a copy or change to your medical records. Please note that you may have to pay to copy your medical records.
7. **You have a right to be informed about any Medicaid covered benefits that are not available through the Cooperative because of moral or religious objection. This includes:**
   - Your right to be informed of how to access these services through ForwardHealth using your ForwardHealth card.
   - Your right to disenroll from the Cooperative if the Cooperative does not cover a service you want because of moral or religious objections.
8. **You have a right to file a complaint, grievance, or appeal if you are dissatisfied with your care or services. This includes:**
   - Your right to request a fair hearing if you are dissatisfied with the Cooperative's decision about your appeal or if the Cooperative does not respond to your appeal in a timely manner.
   - Your right to request a Department of Health Services grievance review if you are unhappy with Cooperative's decision about your grievance or if the Cooperative does not respond to your grievance in a timely manner.
9. **You have the right to receive information about the Cooperative, its services, its practitioners, providers, and member rights and responsibilities. This includes:**
   - Your right to know about any big changes with the Cooperative at least 30 days before the effective date of the change.
10. **You have a right to be free to exercise your rights without negative treatment by the Cooperative and its network providers. This includes:**
    - Your right to make recommendations about the Cooperative's Member Rights and Responsibilities policy.

MEMBER RESPONSIBILITIES

- You have a responsibility to supply information (to the extent possible) that the Cooperative and its practitioners and providers need in order to provide care.
- You have a responsibility to let the Cooperative know how best to contact and communicate with you. You have a responsibility to respond to communications from the Cooperative.
- You have a responsibility to follow plans and instructions for care that you have agreed to with your practitioners.
- You have a responsibility to understand your health problems and participate in creating mutually agreed-upon treatment goals, to the degree possible.

SECTION 5 – 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 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, United States Preventive Services Task Force, JNC 8, NHLBI , 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 our coverage policies 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 cannot advocate for member resources.

Population Health Management Programs
The Cooperative offers comprehensive population health management programs for members which include complex case management and disease management. A list of programs and how to enroll can be found on the Cooperative's website at https://group-health.com/members/tools-and-resources/health-and-wellness-programs.

SECTION 6 – PRIOR AUTHORIZATION GUIDELINES

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

SECTION 7 – 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 8 – 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 9 – HEALTHCHECK REQUIREMENTS

HealthCheck visits, also known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), ensure that children and young adults receive early detection and care, so that health problems are prevented or diagnosed and treated as early as possible.

HealthCheck Components
HealthCheck has three purposes:

1. To find and treat health problems for members younger than 21 years old.
2. To share information about special health services for members younger than 21 years old.
3. To make members younger than 21 years old eligible for some health care not otherwise covered.

The HealthCheck exam includes:

- Age appropriate immunizations (shots)
- Blood and urine lab tests
- Dental checks and a referral to a dentist beginning at 1-year-old
- Health and developmental history
- Hearing checks
- Head-to-toe physical exam
- Lead testing for children ages 1 and 2 years old and children under age 6 who have never had a lead test
- Vision checks

HealthCheck Periodicity Schedule

The schedule for completing HealthCheck visits is based on recommendations from the American Academy of Pediatrics (AAP) and is summarized in the following table.

Age Range	Number of Visits	Recommended Ages for Visits
Birth to first birthday	6	Birth 3-4 weeks 6-8 weeks 4 months 6 months 9 months
First birthday to second birthday	3	12 months 15 months 18 months
Second birthday to third birthday	2	2 years 2 ½ years
Third birthday to 21st birthday	1	Every other year, not to exceed once per year

Visit http://www.cdc.gov/vaccines/schedules/index.html for the immunization periodicity chart.

HealthCheck Documentation Requirements

The provider must assess, complete, and document in the medical record all components listed above for the visit to be recognized as a HealthCheck and billed with the appropriate procedure codes listed below. HealthCheck visits will not be reimbursed if all the required components are not completed.

HealthCheck Billing

HealthCheck visits must be billed with the procedure codes outlined in the following tables:

Code	Description
99381	Initial preventive medicine visit (age younger than 1 year)
99382	Initial preventive medicine visit (age 1 through 4 years)
99383	Initial preventive medicine visit (age 5 through 11 years)
99384	Initial preventive medicine visit (age 12 through 17 years)
99385	Initial preventive medicine visit (age 18 through 20 years)

Code	Description
99391	Periodic preventive medicine visit (age younger than 1 year)
99392	Periodic preventive medicine visit (age 1 through 4 years)
99393	Periodic preventive medicine visit (age 5 through 11 years)
99394	Periodic preventive medicine visit (age 12 through 17 years)
99395	Periodic preventive medicine visit (18 through 20 years)

If the HealthCheck visit results in a referral, add the UA modifier to the above procedure codes. More information and resources on HealthCheck can be found on the ForwardHealth

Online Portal.

Billing for the HealthCheck Visit when the Cooperative is Not the Primary Insurance

If the primary insurance pays in full, please notify the Cooperative by submitting a claim and an Explanation of Benefits (EOB) through your normal billing process. This allows us to give you credit for completing the HealthCheck.

SECTION 10 – 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 11 – 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.

Further, DHS OIG and DHS OIG's contracted Program Integrity vendors will conduct audits of the Cooperative's network providers utilizing the fee-for-service max fee tables when assigning value to services provided in the audit. Providers must collaborate with DHS OIG and DHS OIG's contracted Program Integrity vendors in the following ways related to Network Provider Audits:

- Responding to requests for all records in a timely manner as specified in any record request letters;
- Submitting rebuttal information to initial findings, if providers would like, for consideration by DHS OIG or DHS OIG's contract Program Integrity vendors. Providers must submit rebuttal documentation to DHS OIG or DHS OIG's contracted Program Integrity vendor by date specified in the preliminary findings letter or amended preliminary findings letter.

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/FWA Laws

1. False Claims Act [31 U.S.C. § § 3729-3733]

- This law establishes civil liability for offenses related to acts of false or fraudulent claims, records or statements to the government. No specific intent to defraud the government is required.
- It includes actual knowledge, as well as deliberate ignorance or reckless disregard for truth.

2. Physician Self-Referral Law [42 U.S.C. § 1395nn]

- This law prohibits providers from referring patients to receive health services payable to Medicare or Medicaid in which the provider or an immediate family member has a financial relationship.
- It is a strict liability law, which means proof of specific intent to violate law is not required.

3. Anti-Kickback Statute [42 U.S.C. § 1320a-7b(b)]

- This law prohibits knowing and willful offers, payments, solicitations or receipt of any remunerations in cash or kind, to induce or in return for referring an individual for the furnishing or arranging of any item or service for which payment may be made under a federal health care program.
- Remuneration means anything of value and can include gifts, under-market value for the services provided.

4. Exclusion Statute [42 U.S.C. § 1320a-7]

- All health care programs, individuals, and entities convicted of: Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare or Medicaid; patient abuse or neglect; felony convictions for other health-care-related fraud, theft, or other financial misconduct; and felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances are excluded from participation in the Federal health care programs.
- Excluded physicians may not bill directly for treating Medicare and Medicaid patients, nor may their services be billed indirectly through an employer or a

group practice.

5. Civil Monetary Penalties Law [42 USC § 1320a-7a]

   - Allows OIG to seek civil monetary penalties for conducting any kind of Fraud, Waste, or Abuse of Federal Health Care Programs

B. State False Claims Laws

1. Medicaid Fraud Statute, s. 49.49 and s. 946.91, 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. Individuals who observe activities or behavior that may violate the law in some manner and who report their observations to management or to governmental agencies are provided protection under certain laws.

1. The federal False Claims Act provides protection for those who file lawsuits as described above. The False Claims Act states that any employee who is discharged, demoted,

suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful actions taken as indicated above is entitled to recover damages. A person is entitled to "all relief necessary to make the employee whole," including reinstatement with the same seniority status, twice the amount of back pay (plus interest), and compensation for any other damages the employee suffered as a result of the discrimination. An employee can also be awarded litigation costs and reasonable attorneys' fees.

2. Wisconsin statute 146.997, Health Care Worker Protection, also protects health care workers who disclose any of the following to an appropriate individual or agency:

    a. Information that a health care facility or provider has violated any state law or rule or federal law or regulation;
    b. A situation in which the quality of care provided by, or by an employee of, the health care facility or provider violates established standards and poses a potential risk to public health or safety.
    c. A health care facility or provider cannot take disciplinary action against an individual who reports the above in good faith. A health care facility or provider who violates this statute shall be subject to not more than a $1,000 fine for a first violation.

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.