Care Wisconsin Provider Manual

Revised: August, 2017

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SECTION 1: INTRODUCTION

Purpose of Provider Manual
The Care Wisconsin Provider Manual serves as a reference for information for providers participating in the Family Care or Family Care Partnership Provider Networks. In this Manual are policies, procedures, regulations and guidelines established by the Wisconsin Department of Health Services (DHS), the Centers for Medicare and Medicaid Services (CMS) and Care Wisconsin that govern our Provider Network.

We welcome your ideas on how we can improve the usefulness of this Manual; please contact Care Wisconsin at 1-800-963-0035 with your suggestions.

Updates and Revisions
The Care Wisconsin Provider Manual is and always will be a work in progress since content can change at any time. You can always find the most current version on our website, www.carewisc.org

Nondiscrimination in Provider Selection and Contracting
Care Wisconsin focuses provider network development on top priorities to fill network gaps and measures to best manage available resources. When electing new providers Care Wisconsin does not discriminate in terms of reimbursement, service to high-risk populations, specialities in conditions requiring costly treatment, or indemnification of any provider acting within the scope of his or her license or certification under applicable state law. A managed care organization is not required to contract with providers beyond the number necessary to meet the needs of its members. If Care Wisconsin declines to include an individual or group of providers in its network, we will provide the affected provider(s) with written notice of the decision; including the reason the providers were denied participation the network.

Nondiscrimination in Employment
The services provided for our Family Care Partnership and Family Care members include federal and state funds. Care Wisconsin and its subcontractors (and their subcontractors) are required to comply with federal and state laws regarding equal opportunity and nondiscrimination in employment and service delivery. This includes the Americans with Disabilities Act of 1990, 42 U.S.C., Section 12101, and all related, applicable regulations. We agree not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, gender, physical condition, developmental disability as defined in § 51.01(5), sexual orientation or national origin. This includes, but is not be limited to, employment practices, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship.

Care Wisconsin and its subcontractors are also required to provide equal opportunity for members with Limited English Proficiency (LEP) and provide language access services to populations of persons with LEP who are eligible to be served by provider or subcontractor.

Other related laws that Care Wisconsin and its providers and subcontractors must comply with include Title VI and VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, the Civil Rights Act of 1991, Title VI and XVI of the Public Health Service Act, the Age Discrimination in Employment Act of 1967, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981, Personal

Responsibility and Work Opportunity Act of 1996, Title I, II and III of the American with Disabilities Act (ADA) of 1990, Wisconsin Fair Employment Act Section 111.31-111.395 and s.16.765 Wis., Stats., and ADM 50.

Prohibition of Interference with Health Care Professionals' Advice to Members
Care Wisconsin respects the patient/provider relationship and does not restrict or prohibit a health care professional, acting within the lawful scope of their practice, from providing advice to a patient that is a member of Care Wisconsin.

SECTION 2: OVERVIEW AND MODEL OF CARE

Our Mission
To promote the quality of life of our communities by empowering others and working together to creatively solve unique health and long term care needs. To operate on a sustainable financial basis through growth and continuous improvement. Our culture is based on integrity, accountability, and treating our members, partners and each other with dignity and respect.

Care Wisconsin Overview
Care Wisconsin is a nonprofit care management organization that matches frail seniors and people with physical and intellectual disabilities to the health and long-term care services they need. Since 1976, we've been helping our members live as independently as possible. We manage Family Care and Family Care Partnership, two of Wisconsin's public health and long-term care programs.

To ensure members of our programs have choices, flexibility and access to high-quality services, we build strong provider networks. Members can have Care Wisconsin coordinate services or self-direct services as needed.

Our care model makes us unique. We place members at the center of care and develop personalized service plans to ensure each member's needs are met. By empowering members to be active partners in their service plan, the focus is on achieving personal goals, prevention, continuous monitoring, early intervention, and flexibility.

A similar collaborative approach is taken for family members, guardians, advocates, providers and government agencies.

Care Wisconsin Programs and Service Area

Program Goals
The key goals of the Family Care and Family Care Partnership programs are to:

- Maximize the ability of members to live in the setting of their choice, to participate in community life, and to be engaged in the decision-making process regarding their own care.
- Promote and maintain a high level of interdisciplinary collaboration in the development of care plans that are based on unique member outcomes and team assessments.
- Promote the development and use of natural supports as much as possible to foster a high level of independence.
- Provide members with quality community-based long-term support services that are cost-effective, socially responsible and assure good stewardship of taxpayer dollars.

Program Descriptions
Care Wisconsin's Family Care and Family Care Partnership Programs use a member-centered approach to provide long-term care services to adults with physical or developmental disabilities and disabilities associated with aging. Member-centeredness focuses on listening to members, eliciting their outcomes, and assessment of social and clinical needs by professional staff to determine how best to provide services. Respect for diversity, supporting choice and promoting quality of life are additional values embedded in the core values outlined above. Care Wisconsin is a managed care organization, meaning that member outcomes and assessed needs for services

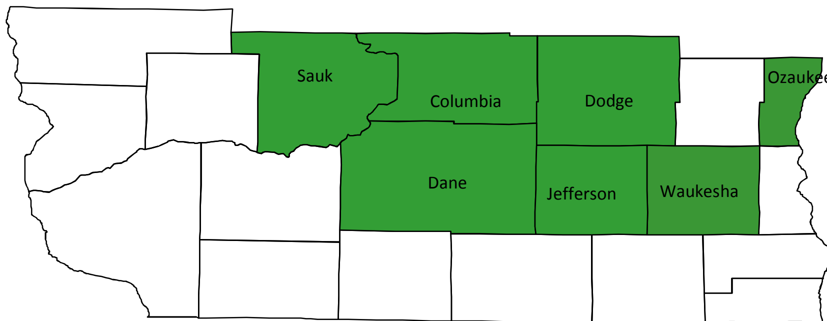
are provided in a manner that is equitable and sustainable for all members served. An interdisciplinary team uses a resource allocation decision-making process (RAD) to determine services that promote the attainment of member outcomes and goals to meet assessed needs. Services are also coordinated with the member's health care providers, as appropriate. More information on the RAD process can be found on Page 2-5.

Family Care Program
Family Care offers Medicaid, home and community-based long-term care services, as well as the support of a local Care Wisconsin care team. Care teams include the member, a care manager/social worker and a registered nurse. Please see the Program Benefits Chart on Page 5-1.

Family Care Service Region

Family Care Partnership Program
Care Wisconsin care teams partner with local doctors and other service providers to coordinate health and long-term care for adults who qualify for nursing home care, yet wish to remain independent.

Members receive all covered long-term care services in the basic Family Care package, plus all health and medical services, and prescription drugs. (Please see the Program Benefits Chart on Page 5-1.) Family Care Partnership is a Wisconsin Family Care and Medicare Advantage Special Needs program. In addition to the member, care teams include a care manager/social worker, a registered nurse and a nurse practitioner.



Partnership Service Region

Interdisciplinary Team Composition

	Family Care	Family Care Partnership
Model of Care	• Provides coverage of community-based long-term care services when necessary • Coordinates with acute and primary care health services, but does not fund these services	• Provides coverage of community-based long-term care services when necessary • Provides coverage of acute and primary health care services
Team Composition	Two social service Care Managers and 1 RN Care Manager serves approximately 80 members.	A Registered Nurse and Social Worker with the member being an integral part of the team. Each team will work with approximately 80 members. The NP will not be assigned to a team, but will work with specific clinics.

Core Competencies

Clinical Core Competencies

- Care management integrating health and long-term care.
- Effective resource allocation for providing services to people with chronic conditions and long-term care needs.
- Self-directed care teams interacting through a unique, clinically-driven, interdisciplinary process with the member at the center.
- Direct delivery of long-term care services to people in functional decline.

Operational Core Competencies

- Partnering effectively to integrate health and long-term care services across service delivery systems.
- Management of high risk, high cost and/or chronically-ill members while achieving quality of care and financial stability.
- Ability to be flexible and nimble in growing infrastructure and operations.

Quality and Customer Satisfaction

Part of Care Wisconsin's mission is to promote continual improvement. To that end, Care Wisconsin has a structured Quality Management program built on a model that incorporates the following primary functions:

- **Discovery**: collecting data and direct member experience information in order to assess the ongoing implementation of the program, identifying strengths and opportunities for improvement
- **Remediation**: taking action to remedy specific problems or concerns that arise
- **Continuous Improvement**: utilizing data and quality information to engage in actions that lead to continuous improvement

A wide array of quality data are collected, monitored and reported annually to the Wisconsin Department of Health Services, the Centers for Medicare and Medicaid and other regulatory bodies. Much of the data are collected in standardized ways to promote comparisons among Managed Care Organizations and Health Plans. Quality audits are performed by external agencies that include MetaStar, CMS, HEDIS auditors, and Medicare Validation Audits. Quality data are also available on the Care Wisconsin website to support transparency and public accountability of the quality of services and outcomes for the people Care Wisconsin supports.

Care Management

Care Wisconsin's care managers work closely with the member, the member's family, the member's Primary Care Provider, and other health care providers to facilitate communication about the member, as well as to ensure that the member understands his or her health care treatment plan.

Resource Allocation Decision (RAD) Method

Care Wisconsin staff help members achieve their personal goals or outcomes, and take into consideration cost when planning member care and choosing providers to meet member needs. To do this, members and their care teams use a utilization management process called the Resource Allocation Decision (RAD) method. The RAD method identifies the most efficient and appropriate ways to meet member needs and help support member outcomes. Together, the member and the care team develop a Member Centered Plan (MCP) that summarizes the member's needs and outcomes, and the services to address them.

SECTION 3: CARE WISCONSIN CONTACT INFORMATION AND LOCATIONS

Claims Questions

A. **Non-Pharmacy Claims Questions**
1-855-878-6699
Monday through Friday, 8:00 a.m. to 11:30 a.m. and noon to 4:00 p.m.
At any other times leave a detailed message and your call will be returned within two (2) business days.

B. **Pharmacy Claims Questions**
EnvisionRx: 1-844-550-6814
Prior authorizations and any other pharmacy claims information.

Member-Related Incidents and Authorizations

Care Wisconsin encourages open communication on all issues related to services and our members. If uou have a member-related question or concern, your first contact should always be the member's care team. Please see the chart below for telephone numbers of local Family Care and Family Care Partnership care teams. If you are not able to reach the care team, please contact Care Wisconsin's local program managers.

Prior authorization is required for all home and community-based (long-term) services, and claims will not be paid without specific authorization. Please contact a member's Care Wisconsin care team to receive prior authorization for these services. If you need assistance contacting a member's care team, please call Customer Service at 1-800-963-0035.

For select procedures and services under Partnership and other services under Family Care, go to https://www.carewisc.org/authorizations for a complete list of prior authorization and notification requirements, as well as prior authorization forms and instructions for submission.

Regular business hours are Mon.-Fri., 8:00 a.m. to 4:30 p.m., Central Time. After business hours, you can reach the on-call staff for both the Family Care and Partnership programs on evenings, weekends and holidays by calling 1-800-963-0035.

Member Eligibility and Enrollment Verification

If you need to determine a member's eligibility, call Care Wisconsin's Customer Service Department at 1-800-963-0035 for verification. Since Family Care or Partnership members can enroll in, or disenroll from Care Wisconsin at any time during the month, Providers are reminded to always verify member enrollment prior to providing services. (Additionally, providers may also access information through WiCall (ForwardHealth's Automated Voice Response system) at 1-800-947-3544, through the ForwardHealth portal, or by calling the Care Wisconsin Provider Help Desk at 1-855-878-6699.)

Contracting Questions

Questions related to a provider agreement or contract can be answered by calling the Provider Services Department at 1-800-963-0035.

Care Wisconsin Regional and County Offices

Office Location	Office Address	General Office Phone and Family Care Phone SSI Phone-See Carewisc.org For Contact Information	Family Care Partnership Phone	Fax
Dane County (Madison):				
Central Administrative Offices	1617 Sherman Ave. PO Box 14017 Madison, WI 53708-0017	(608) 240-0020 1-800-963-0035	NA	(608) 245-3077
Family Care Partnership Team Offices	1617 Sherman Ave. PO Box 14017 Madison, WI 53708-0017	(608) 240-0020 1-800-963-0035	(608) 240-0020 1-800 963-0035	(608) 246-8428
County Office Location	**Office Address**	**General Office Phone and Family Care Phone SSI Phone-See Carewisc.org For Contact Information**	**Family Care Partnership Phone**	**Fax**
Brown County (Family Care)	2321 San Luis Place Green Bay, WI 54304	(844) 503-5073	NA	(920) 940-6101
Clark County (Family Care and SSI)	450 Hewett St. Neillsville, WI 54456	(855) 830-7908	NA	(608) 245-3416
Columbia County (Family Care, Partnership and SSI)	1432 East Wisconsin St. Portage, WI 53901	(866) 561-2682	(866) 561-2683	(608) 210-4759
Dodge County (Family Care, Partnership and SSI)	1659 North Spring St. Suite 102 P.O. Box 147 Beaver Dam, WI 53916	(877) 496-4412	(877) 496-4413	(608) 210-4794
Door County (Family Care)	14 S. 3rd Ave Sturgeon Bay, WI 54235	(844) 503-5074	NA	(920) 940-6103
Eau Claire County (Family Care)	Suite 400 3430 Oakwood Mall Dr. Eau Claire, WI 54701	(888) 508-5055	NA	(715) 598-5367
Green Lake County (Family Care)	610 South St., Unit B PO Box 695 Green Lake, WI 54941-0695	(877) 496-3854	NA	(608) 210-4806
Iowa County (Family Care)	123 North Iowa St. Dodgeville, WI 53533	(888) 508-5056	NA	(608) 383-6001
Jefferson County (Family Care, Partnership and SSI)	37 South Water St. East Fort Atkinson, WI 53538-2052	(877) 496-3851	(877) 496-3852	(608) 210-4848
La Crosse County (Family Care and SSI)	325 3rd St South La Crosse, WI 54601-4049	(855) 408-3687	NA	(608) 210-4616
Marinette County (Family Care)	3900 Hall Ave. Suites C & G Marinette, WI 54143	(844) 503-5075	NA	(920) 940-6105
Ozaukee County (Family Care, Partnership and SSI)	11019 N Towne Square Rd. Suite 6 Mequon, WI 53092	(855) 410-5672	(855) 410-5672	(608) 245-3417

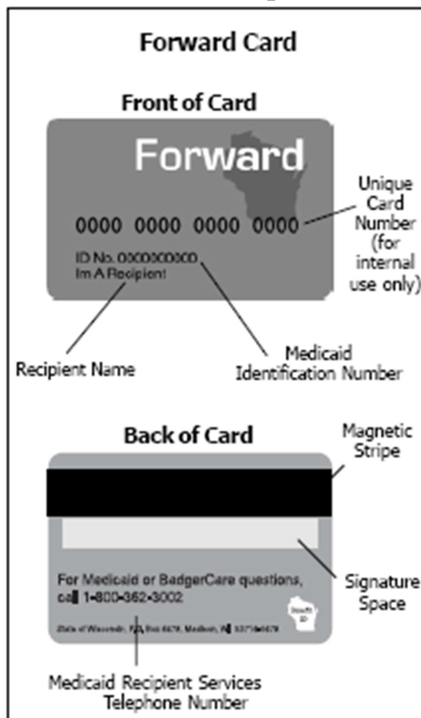
Office Location	Office Address	General Office Phone and Family Care Phone SSI Phone-See Carewisc.org For Contact Information	Family Care Partnership Phone	Fax
Shawano County (Family Care)	300 East Green Bay St. Shawano, WI 54166	(844) 475-9189	NA	(920) 940-6107
Sheboygan County (Family Care)	2124 Kohler Memorial Dr. Suite 210 Sheboygan, WI 53081	(855) 410-3995	NA	(608) 245-3418
Vernon County (Family Care and SSI)	117 W Court St Viroqua, WI 54665	(844) 241-6311	NA	(608) 210-4115
Walworth County (Family Care)	47 S Wisconsin St., Suite C Elkhorn, WI 53121	(855) 410-5674	NA	(608) 245-3419
Washington County (Family Care)	2364 West Washington St. West Bend, WI 53095	(866) 293-0608	NA	(608) 210-4645
Waukesha County (Family Care and Partnership)	N19 W24075 Riverwood Dr., Suite 110 Waukesha, WI 53188	(866) 530-2295	(866) 530-2295	(608) 210-4708
Waushara County (Family Care)	203 S. 16th Ct. P.O. Box 1135 Wautoma, WI 54982	(877) 496-3844	NA	(608) 210-4659

SECTION 4: MEMBER INFORMATION

Member Identification
Members' eligibility for Family Care Partnership or Family Care can be established by looking at the identification card the member presents when she or he arrives for services.

Family Care members are not issued a Care Wisconsin identification card. They are issued a Forward ID card by the Wisconsin Medical Assistance Program, which is used for non-Family Care items and services, specifically acute and primary services such as medical appointments, hospitalizations, eyeglasses, podiatry, and dentistry (see chart in section 5 – Member Benefits). See example of Forward ID card below. This is the standard state-issued Medicaid Card. Medicaid is also known as Medical Assistance, MA, or Title 19. It is possible for a Family Care member to have other coverage that is primary to Medicaid – Medicaid is always the "payer of last resort" – so be sure to check. For example, a person can be enrolled in Family Care through Care Wisconsin and can have Medicare or private insurance coverage outside of Care Wisconsin.

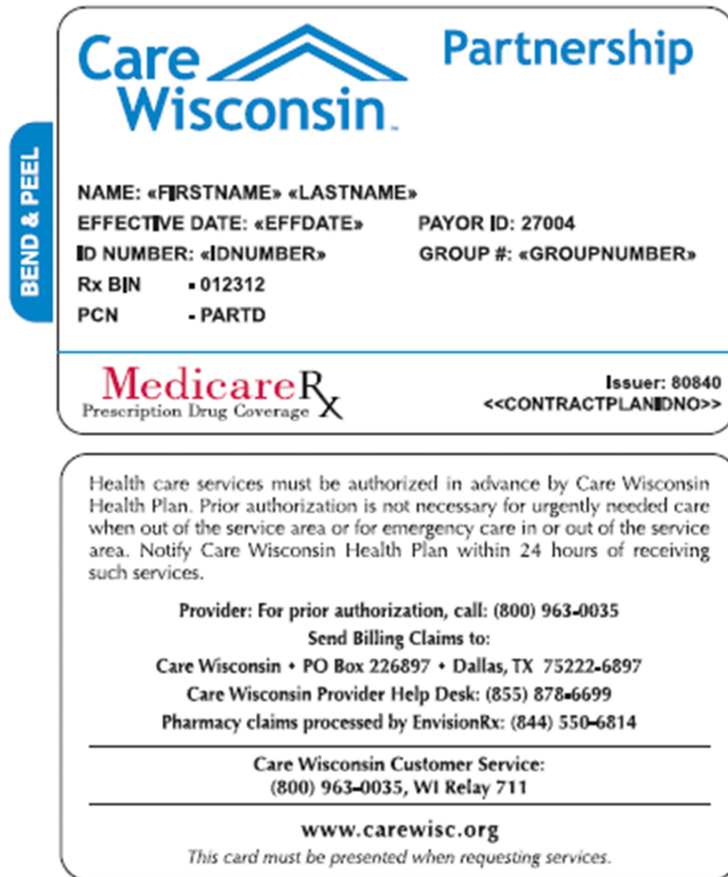
Forward Card Example



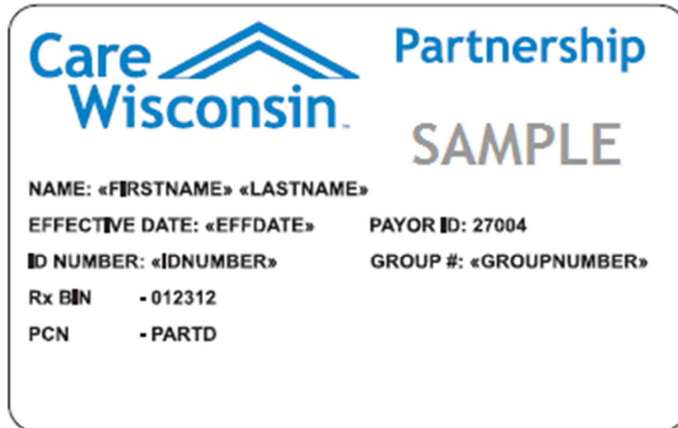
Family Care Partnership members are issued a Care Wisconsin identification card (see samples on pages 4-2 and 4-3). Family Care Partnership members are not issued a Forward ID Card by the Wisconsin Medical Assistance Program, as the Care Wisconsin identification card replaces that. Under the Family Care Partnership program, Medicare and/or Medicaid are no longer responsible for claims for dually-eligible members enrolled with Care Wisconsin. All claims should be sent to Care Wisconsin Health Plan (CWHP). Please refer to "Claims Submission Address" in Section 3 of this Manual.

Care Wisconsin Identification Cards
Family Care Partnership combines Medicare and Medicaid benefits. When a person enrolls in Family Care Partnership through Care Wisconsin and has both Medicare and Medicaid, we say that person is "dually-eligible." Dually-eligible Care Wisconsin members present a Care Wisconsin identification card. A very small number of Family Care Partnership members enrolled in Care Wisconsin have only Medicaid. These members will present a slightly different Care Wisconsin identification card – it does not display the Medicare logo displayed on the card issued to dual-eligible members

Care Wisconsin Identification Card Example for a Family Care Partnership Dually-Eligible Member



Care Wisconsin Identification Card Example for a Family Care Partnership Medicaid Only Member



Health care services must be authorized in advance by Care Wisconsin Health Plan. Prior authorization is not necessary for urgently needed care when out of the service area or for emergency care in or out of the service area. Notify Care Wisconsin Health Plan within 24 hours of receiving such services.

Provider: For prior authorization, call: (800) 963-0035
Send Billing Claims to:
Care Wisconsin • PO Box 226897 • Dallas, TX 75222-6897
Care Wisconsin Provider Help Desk: (855) 878-6699
Pharmacy claims processed by EnvisionRx: (844) 550-6814

Care Wisconsin Customer Service:
(800) 963-0035, WI Relay 711

www.carewisc.org
This card must be presented when requesting services.

Member Disenrollment
A member may voluntarily disenroll from Care Wisconsin at any time. Typically, Care Wisconsin coverage of services will end as of 12:00 midnight on the final day of enrollment. If a Family Care Partnership member is confined as an inpatient in a hospital on the date of disenrollment, Care Wisconsin will continue to cover the inpatient hospital stay until the former member is discharged from the hospital.

Members lose Care Wisconsin eligibility when they are admitted to an Institute for Mental Disease (IMD) and are between the age of 21 years and 65 years old. Members who are incarcerated more than 24 hours are disenrolled the day of admission or incarceration.

SECTION 5: MEMBER BENEFITS

Family Care Benefits
Care Wisconsin's Family Care Program provides long-term care services covered by Wisconsin Medicaid as well as services covered by Wisconsin's Home and Community-Based Waiver (HBCW) and other waiver services.

Family Care Partnership Benefits
Care Wisconsin's Family Care Partnership Program provides all of the benefits covered in Family Care, plus Wisconsin Medicaid-covered services, including primary and acute care. For Family Care Partnership members who are dually-eligible for Medicare (Part A and Part B) and Medicaid, Care Wisconsin also covers all Medicare Part A, B and D services through its fully-integrated Medicare Advantage Special Needs Plans (SNPs). Family Care Partnership Medicare-covered services include CMS's national coverage decisions and published coverage decisions of local carriers and intermediaries. Care Wisconsin informs health care providers, in writing, of new coverage decisions.

Member Benefits Chart
The chart below outlines the Care Wisconsin member benefits (effective April 1, 2015) depending on whether a member is enrolled in Family Care Partnership or Family Care. More detailed information is available by contacting the member's Care Wisconsin Care Team. All health care services must be medically necessary and provided in accordance with professionally recognized standards of care.

Wisconsin Department of Health Services

Services Included in IRIS, Family Care, Partnership and PACE

Family Care Partnership & PACE (Program of All Inclusive Care for the Elderly)			
Family Care			
IRIS			
Home and Community Based Waiver Services	Medicaid Card Services - LTC Services	Acute/Primary Medicaid Services	Medicare Services
• Adaptive Aids (general and vehicle) • Adult Day Care • Care/Case Management [1] • Communication Aids/Interpreter Services • Consultative Clinical and Therapeutic Services for Caregivers [1] • Consumer Education and Training • Counseling and Therapeutic Resources • Customized Goods and Services [2] • Daily Living Skills Training • Day Services/Treatment • Financial Management Services [1] • Fiscal Employer Agent [2] • Home Modifications • Housing Counseling • IRIS Consultant Agency Provider [2] • Live-In Caregiver [2] • Meals: home delivered • Personal Emergency Response System Services • Prevocational Services • Relocation Services Residential Services (Adult Family Home, Community-Based Residential Facility [1], Certified Residential Care Apartment Complex • Respite Care • Self-Directed Personal Care • Skilled Nursing (amounts above what's available with Medicaid card) • Specialized Medical Equipment and Supplies • Specialized Transportation • Support Broker • Supported Employment • Supportive Home Care • Training Services for Unpaid Caregivers [1] • Vocational Futures Planning	• Alcohol and Other Drug Abuse Day Treatment Services (in all settings except hospital-based) • Community Support Program • Durable Medical Equipment, except for hearing aids and prosthetics • Home Health • Medical Supplies • Mental Health Day Treatment Services (in all settings) • Mental Health Services, except those provided by a physician or on an inpatient basis • Nursing Facility (all stays including Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) and Institution for Mental Disease. IMD not covered between ages 21-64) • Nursing Services (including respiratory care, intermittent and private duty nursing) • Occupational Therapy (in all settings except for inpatient hospital) • Personal Care • Physical Therapy (in all settings except for inpatient hospital) • Speech and Language Pathology Services (in all settings except for inpatient hospital) • Transportation to receive non-emergency medical care (except Ambulance)	• Physician services • Laboratory and x-ray services • Inpatient hospital • Outpatient hospital services • EPSDT (under 21) • Family planning services and supplies • Federally-qualified health center services • Rural health clinic services • Nurse midwife services • Certified nurse practitioner services • Prescribed drugs (very limited if Medicare eligible. Medicare Part D would cover most outpatient drugs) • Diagnostic, screening, preventive and rehabilitation services • Clinic services • Primary care case management services • Dental services, dentures • Dialysis service • Hospice care • Prosthetic devices, eyeglasses • TB–related services • Other specific medical and remedial care • Inpatient mental health • Chiropractic services • Podiatry services • Outpatient mental health provided by a physician • Outpatient substance abuse provided by a physician • Outpatient surgery • Ambulance services • Emergency care • Urgent care • Diagnostic services • Hearing services • Vision services	Medicare Part A (Hospital), Part B (Medical), and Part D (Prescription Drugs) • Ambulance services • Ambulatory surgical centers • Blood • Durable Medical Equipment, Prosthetics, Orthotics and Supplies • Cardiac rehab • Chiropractic services - extremely limited (Only service covered is manipulation of the spine to correct a minor dislocation, called "subluxation") • Diabetes supplies • Diagnostic tests, x-rays and lab services • Physician services • Emergency and urgent care services • Home health care if homebound and need skilled nursing or therapy services • Hospice care • Inpatient hospital care • Inpatient mental health care • Outpatient mental health care • Outpatient hospital services, including outpatient surgery • Limited post-hospital skilled nursing facility if daily skilled nursing and/or rehabilitation services needed • Physical/speech/occupational therapy • Podiatry services, limited to treatment of injuries or diseases of the foot, no routine care • Prescription drugs, including drugs covered under Medicare Part A, Part B, and Part D • Very limited dental, hearing and vision services, excluding all dental services except where necessary to the provision of other, covered medical services, also excluding routine eye care and hearing exams and hearing aids. Eyeglasses and contacts limited to one pair after cataract surgery, • Substance abuse treatment (outpatient) • Various preventive services, screenings, vaccinations, and yearly wellness visit.

[1] Family Care only [2] IRIS only

IRIS participants access Medicaid LTC card services and acute/primary services with their Medicaid card. Family Care members access acute/primary services with their Medicaid card. Individuals enrolled in IRIS or Family Care may also be eligible for Medicare.

P-00570 (04/2015)

Use of Network Providers
Members must use Care Wisconsin network providers to get covered services, except in limited cases. Examples of when it is permissible to use out-of-network providers include:

- Emergency care,
- Urgently needed care when our network is not available, or
- Out of service area dialysis.

Co-payment, Coinsurance, Deductible
Most covered services in Family Care and Family Care Partnership are provided with no member co-payment, coinsurance, or deductible. The only exception is Medicare Part D co-pays for the covered drugs and supplies of our dually-eligible Family Care Partnership members. Providers are prohibited from balance-billing Family Care or Family Care Partnership members for covered services.

Benefit Exclusions
Some services are excluded from coverage under the Family Care and Family Care Partnership Programs. For information and questions on service exclusions, please contact the member's Care Wisconsin care team. In addition to specific excluded services, Care Wisconsin may deny coverage if:

- The service is not medically necessary;
- The service is not a covered benefit; or
- The member is not enrolled in Care Wisconsin's Family Care or Family Care Partnership program at the time the services are provided.

Emergency Services
For Family Care Partnership members, medically necessary emergency services are covered within and outside of Care Wisconsin's service area. In the event of an emergency, the member should seek immediate care or call 911. Prior authorization is not required.

Emergency Services are defined as covered inpatient and outpatient services that are: (a) furnished by a provider that is qualified to furnish these services under Title 19 of the Social Security Act; and (b) needed to evaluate or stabilize an emergency medical condition. An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Post-Stabilization Care Services
Care Wisconsin's Family Care Partnership Program also covers post-stabilization care services. Post-stabilization care services are covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or to improve or resolve the member's condition if Care Wisconsin did not respond to a request for pre-approval within one hour, Care Wisconsin could not be contacted, or a Care Wisconsin

representative and the treating physician could not reach an agreement concerning the member's care and a Care Wisconsin physician is not available for consultation.

Urgently Needed Care

Care Wisconsin covers urgent care services for Family Care Partnership members. Urgent care is medically necessary care that is required by an illness or accidental injury that is not life-threatening and will not result in further disability but has the potential to develop such a threat if treatment is delayed longer than twenty-four (24) hours. Urgent care services are typically provided when a member is temporarily absent from Care Wisconsin's service area or, under unusual and extraordinary circumstances, provided when the member is in the service area but Care Wisconsin's provider network is temporarily unavailable or inaccessible and when the services are medically necessary and immediately required a) as a result of an unforeseen illness, injury, or condition; and b) it was not reasonable, given the circumstances, to obtain the services through Care Wisconsin's contracted provider network.

Notification of Emergency Services and Urgently Needed Care

Members are encouraged to notify Care Wisconsin as soon as possible after receiving urgently needed, emergency, or post-stabilization health services. Hospitals that contract with Care Wisconsin are required to notify Care Wisconsin when a member is admitted to the hospital.

Renal Dialysis Services

For Family Care Partnership members who are within the service area, Care Wisconsin covers renal dialysis services provided by a network provider. Out-of-area renal dialysis services are also covered within the United States if furnished by a Medicare-certified renal dialysis facility while a member is temporarily outside of the service area.

Drugs

Care Wisconsin provides coverage for drugs in the Family Care Partnership Program as described in the Care Wisconsin Formulary.

SECTION 6: PROVIDER INFORMATION

Provider Network

"Providers" are individuals or organizations that are contracted to participate in Care Wisconsin's network and offer health, medical and long-term care services to Care Wisconsin members. In many cases, providers must be licensed and/or certified by Medicare, Medicaid and/or various other state agencies and programs in order to be eligible to furnish services to our members. Network providers agree to follow Care Wisconsin policies, procedures and guidelines.

Care Wisconsin ensures members have access to qualified providers who have agreed to a number of member protections and other legal requirements in the provider contract. Therefore, Care Wisconsin members are required to obtain services from network providers except in an emergency. Our goal is to offer Care Wisconsin members a broad range of providers who can help them achieve their individual outcomes. Whenever possible, Care Wisconsin wants to offer members choices among available providers.

In addition to offering member choice of providers, Care Wisconsin encourages and fosters cultural competency among providers. Care Wisconsin and participating network providers shall honor and support member beliefs, and be sensitive to cultural diversity. This includes members with limited English proficiency and diverse cultural and ethnic backgrounds. Contracted providers shall collaborate with Care Wisconsin in fostering in staff/provider attitudes and interpersonal communication styles to respect member cultural backgrounds.

The quality and integrity of Care Wisconsin's provider network is established through provider credentialing, utilization management and ongoing quality improvement initiatives.

Becoming a Network Provider

If you are interested in participating in Care Wisconsin's Provider Network, please call 1-800-963-0035, or visit the Care Wiscoinsin website at www.carewisc.org and click on the Joining Our Network Quick Link. You will be provided with information about our programs and forwarded any information that our organization needs to determine your qualifications for becoming a contracted provider. These documents may include:

- A Provider Information Form or Application
- A Residential Provider Profile (residential providers only)
- W-9
- Credentialing Application (for providers of certain service types)
- Caregiver Background Check Packet for Employers or Sole Proprietor
- Proof of Insurance (see required insurance information below)
- Medicare Participation Letter
- NPI

Provider Insurance Requirements

Care Wisconsin verifies that all potential providers have current insurance policies as appropriate per the grid below, "Insurance Required by Business Model and Select Provider Types." Potential providers submit to Care Wisconsin a copy of a current insurance certificate/liability certificate. The insurance listed on the certificate must be both appropriate and current. Per the Agreement for Services, the provider must submit to Care Wisconsin an updated certificate each year.

Insurance Coverage Minimums 03/01/16

Type of Service	Interaction with CW Members	Employees?	Professional Liability	General Liability	Auto Liability	Workers Comp.
Non-Residential Services	Work Directly with CW Members	No Employees: Self Employed	$500,000	$500,000	$500,000 for owned, non-owned, & leased vehicles	No
		Employees: Fewer than 25	$500,000	$500,000	$500,000 for owned, non-owned, & leased vehicles	Required
		Employees: 25 or More	$1 Million + $1 Million Umbrella	$1 Million + $1 Million Umbrella	$1 Million for owned, non-owned, & leased vehicles	Required
	Do not Work Directly with CW Members	No Employees: Self Employed	No	$500,000	$500,000 for owned, non-owned, & leased vehicles	No
		Employees: Fewer than 25	No	$500,000	$500,000 for owned, non-owned, & leased vehicles	Required
		Employees: 25 or More	No	$1 Million + $1 Million Umbrella	$1 Million for owned, non-owned, & leased vehicles	Required
Type of Service	**Facility Type**	**Criteria**	**Professional Liability**	**General Liability**	**Auto Liability**	**Workers Comp.**
Residential Facility	AFH: Owner-Occupied	Owner Lives in the AFH	$500,000 per occurrence / $500,000 general aggregate limit. *Not required if caring only for family members*	$500,000 per occurrence / $500,000 general aggregate limit. *Not required if caring only for family members*	$100,000/$300,000 for leased and owned vehicles; $1 Million for hired and non-owned vehicles	No
	CBRF, RCAC, and all other AFH	Fewer than 100 Beds (all facilities combined)	$1Million per occurrence/ $2 Million general aggregate + $1 Million Umbrella liability	$1Million per occurrence/ $2 Million general aggregate + $1 Million Umbrella liability	$1 Million for owned, non-owned, & leased vehicles	Required
		More than 100 Beds (all facilities combined)	$1Million/$2 Million + $5 Million Umbrella	$1Million/$2 Million + $5 Million Umbrella	$1 Million for owned, non-owned, & leased vehicles	Required

Provider Directory

The Care Wisconsin Provider Directory contains a listing of our network providers; it is published every three years and updates are issued periodically. You may view the searchable or PDF version of the Provider Directory online at www.carewisc.org. If you do not have access to the online version of the Directory and would like a hard copy, please contact the Care Wisconsin Provider Services Department and a hard copy will be mailed to you.

Please note that a listing in the Provider Directory does not necessarily mean that all of a provider's services are covered under a member's benefit plan, or that any specific provider's services are part of a member's individual service plan. Care Wisconsin cannot guarantee continued affiliation with any provider. If a member requires services that a provider is unable to render, the member should be referred only to another Care Wisconsin network provider. It is important to always contact the member's Interdisciplinary Team (IDT, or care team) before coordinating services for a member with another provider in order to assure the services are a covered benefit and approved by the care team.

Provider Agreements
Both the Centers for Medicare and Medicaid (CMS) and the Wisconsin Department of Health Services (DHS) require Care Wisconsin to maintain a network of providers that is supported by written agreements, and both specify a number of provisions that must be included in these agreements. For most providers, such a written agreement is a full contract. In addition, certain kinds of providers must also sign a Business Associate Agreement, designed to ensure a member's privacy.

Providers' Subcontracts
If a contracted Care Wisconsin network provider subcontracts with another individual or entity to provide any of the items or services included in the Care Wisconsin contract with the provider, the provider shall require that individual or entity to meet the requirements as outlined in 42 CFR 422.504 (i)(3)-(4).

Provider Responsibilities

- Comply with the terms of your contract or agreement.
- Providers shall not differentiate or discriminate in the treatment of members on the basis of race, sex, color, age, religion, marital status, veteran status, sexual orientation, national origin, disability, health status, or source of payment and shall observe, protect, and promote the rights of members as members and any other category protected by law.
- Request a member's insurance card before services are provided; Care Wisconsin Health Plan (Family Care Partnership) or Forward Health identification card (non-covered Family Care services.)
- Verify the accuracy of the demographic and insurance information you have for members.
- Contact Care Wisconsin Customer Service at 1-800-963-0035 to verify a member's eligibility and benefit limitations.
- Contact Customer Service if you become aware of incorrect member information.
- Notify Customer Service of any of the Reportable Changes (see Reportable Changes in this section, page 10.)
- Follow the expectations included in contracted Scopes of Service when applicable within a provider's contracted services.
- Refer members seeking options counseling to their local county Aging and Disabilities Resource Center (ADRC).

Protected Health Information (PHI)
Care Wisconsin is, and requires its providers to be committed to using and disclosing Protected Health Information (PHI) in compliance with the Privacy Rule (45 C.F.R. Parts 160 and 164) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This commitment includes password protection or encryption of any external email communication to Care Wisconsin that contains PHI. Because of the risk of inappropriate disclosure, Care Wisconsin requests that providers not email PHI to Care Wisconsin unless necessary.

In working with Care Wisconsin, providers and their employees and subcontractors may have access to confidential and/or proprietary information. Such information may include but not be limited to medical records, staff compensation, and certain proprietary and management

information concerning both organizations. Any providers or employees or subcontractors assigned to perform services or who otherwise have access to such information will be made aware of the confidential nature of such information and will receive training and education on protecting confidentiality.

Primary Care Provider Responsibilities

- Establish and maintain a strong physician/patient relationship; assume responsibility for the health care of members who select you as their primary care physician.
- Review and monitor member's compliance with medication and prescribed treatments.
- Assist members with Advance Directives, if necessary.
- Work with Care Wisconsin care team members to coordinate care with skilled nursing facilities, home health providers, hospitals, therapy services, and other health care professionals.
- Collaborate with Care Wisconsin care team to provide effective and timely care management; communicate in a timely manner with care team members about medical management issues.
- Avoid duplication of services.
- Collaborate with the Care Wisconsin Nurse Practitioner to provide effective medication management that is cost effective and avoids both over and under medication.
- Evaluate and treat acute and chronic illness.
- Provide preventive care, screening services and routine maintenance checks as appropriate and indicated.
- Coordinate and oversee care provided by others and provide advice, opinions, and perspectives to Care Wisconsin members.
- Communicate with specialists involved in a members' care.
- Ensure that the exchange of member health care information among treating providers is handled in a confidential manner.
- Use respectful communication in all interactions with Care Wisconsin members and care team staff.
- Recognize that conflict may occasionally arise between Care Wisconsin and providers, or Care Wisconsin and members, and that conflict should be resolved within the parameters of the grievance or appeals processes outlined in the applicable Care Wisconsin document.
- Ensure that Care Wisconsin members with limited English proficiency or reading skills, diverse cultural or ethnic backgrounds, or physical or mental disabilities understand their treatment plans.
- Refrain from comments or advice on payment or insurance coverage issues. Refer members with coverage questions or concerns to their Care Wisconsin care team.
- Ensure that Care Wisconsin members receive information needed to participate fully in their own care (e.g., medication management, use of medical equipment, potential complications and symptoms that should be communicated to provider, patient education, etc.).

Notice of Primary Care Provider Status Change
Primary Care Providers must notify Care Wisconsin of status changes by calling Care Wisconsin at 1-800-963-0083, or completing the change forms available on our website at www.carewisc.org so that Care Wisconsin can fulfill its obligations under its contracts with DHS and CMS. Status changes include changing from an open to closed practice, retirement, transfer, resignation, termination, or leave of absence, relocation, and the like.

A status change may require a Primary Care Provider to assist Care Wisconsin in transitioning member care. The provider or practice are responsible for informing members that care will be transferred to another Primary Care Provider, and for transferring records and treatment plans to the new Primary Care Provider.

Care Wisconsin will assist members in transferring care, and will notify members of material provider status changes.

Records Retention
The Provider shall retain, preserve, maintain and make available upon request all books and records relating to the performance of its obligations under their contract, including paper and electronic claim forms as stipulated in Article XII.A, Member Records, and Article XIV.F, Records Retention of the Health Plan and MCO’s contract with DHS. Access to this information shall be limited to persons who, or agencies which, require the information in order to perform their duties related to Care Wisconsin’s contract with CMS and DHS.

Provider will retain records for no less than ten (10) years following the end of this contract period. Records involving matters that are the subject of any litigation, claim, financial management review or audit shall be retained for a period of not less than ten (10) years following the termination of the litigation, claim financial management review or audit.
The only exceptions to the record retention requirements above are the following:

a. If any litigation, claim, financial management review, or audit is started before the expiration of the 10-year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved and final action taken.
b. Records for real property and equipment acquired with Federal funds shall be retained for ten (10) years after final disposition.

Care Wisconsin Family Care Partnership Interdisciplinary Care Team Responsibilities

- Work closely with all care providers, including physicians, to develop and maintain appropriate care plans for our members.
- Communicate any significant changes in a member’s health situation to the primary care provider in a timely fashion.
- The Care Wisconsin Nurse Practitioner collaborates closely with the primary care provider in medical management of the member, providing in-home primary care as appropriate, carefully monitoring medication management and implementing the medical care plan across care settings.
- Provide continuity of care for our members over time and across different care settings.
- Coordinate or provide all of the services that are covered in our benefit package in an integrated and cost effective way.
- Always communicate with providers and members in a respectful way.

Specialist Provider Responsibilities

- Coordinate all member care through the Primary Care Provider and the Care Wisconsin Care Team.
- Provide advice and recommendations to member, member's family, and Primary Care Provider.
- Work with Care Wisconsin Care Team to ensure appropriate utilization of health care services and improve quality of care.
- Actively facilitate care coordination by communicating openly and directly with the Care Wisconsin Care team and Primary Care Providers.
- Avoid duplication of services, including diagnostic and laboratory testing.
- If need arises for consultation with another network provider, coordinate through the Care Wisconsin Care Team.

Hospital Responsibilities-Medicare Outpatient Observation Notice (MOON)

All Care Wisconsin participating hospitals and critical care hospitals (CAH) must comply with the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) 42 U.S.C. §1395cc(a)(1)(Y), which requires hospitals to provide written and oral notice, within 36 hours, to patients who are in observation or other outpatient status for more than 24 hours. The notice must explain the reason that the patient/member is an outpatient (and not an admitted inpatient) and describe the implications of that status both for cost-sharing in the hospital and for subsequent "eligibility for coverage" in a skilled nursing facility (SNF). For a copy of the final rule and guidance for implementation, visit: Federal Register-IPPS-NOTICE Act Final Rule https://www.federalregister.gov/articles/2016/08/22/2016-18476/medicare-programs-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-etc

Care Wisconsin Health Plan Responsibilities

- Assist providers in meeting Care Wisconsin Health Plan's expectations.
- Pay claims in a timely, efficient and accurate manner.
- Provide due process to provider if a member complaint or grievance is initiated, or when a provider requests an appeal of Care Wisconsin Health Plan decisions.
- Maintain a grievance and appeal process that responds in a timely and appropriate manner to members and providers.
- Provide each Family Care Partnership member with a Care Wisconsin Health Plan identification card (members with Family Care present their Forward Health identification card).
- Confirm member eligibility or ineligibility by calling the Care Wisconsin Customer Service Department at 1-800-963-0035.
- Correct member information when made aware of incorrect information.

Network Participation Standards for Health and Long-Term Care Providers

Care Wisconsin uses a variety of mechanisms to confirm providers' qualifications to serve our members. We *credential* health care providers, either as facilities or organizations, or as practitioners. We also establish minimum participation requirements for Long-Term Care (LTC) providers and contract only with those providers who satisfy the requirements.

In addition, Care Wisconsin expects providers to demonstrate sensitivity to cultural diversity and to persons with disabilities by honoring members' beliefs and fostering in staff attitudes and interpersonal communication styles that respect members' cultural backgrounds.

Credentialing of Health Care Providers
Care Wisconsin's credentialing standards are established to meet the requirements of Care Wisconsin's contracts with CMS and DHS. Although Care Wisconsin delegates some credentialing activities to recognized credentialing programs, Care Wisconsin always retains the right and the obligation to accept or reject the recommendations of our credentialing delegates.

When a provider contracts with Care Wisconsin, Care Wisconsin will let the provider know whether or not the Uniform Credentialing Application must be completed. It is possible credentialing may be handled by one of Care Wisconsin's credentialing delegates. Information acquired through the credentialing and re-credentialing processes is considered confidential. Care Wisconsin staff and credentialing delegates with access to the files are responsible for ensuring the information remains confidential, except as otherwise provided by law. The release of any information acquired through these processes is prohibited without a provider's written consent. If a law enforcement agency or other government agency seeks provider information, a legal opinion is sought prior to the release of such information.

Care Wisconsin may not contract with, or use any providers, including their employees and subcontractors, who are excluded from participation in any federal or state health care programs. Upon obtaining information or receiving information from CMS, DHS or from another verifiable source, Care Wisconsin is required to exclude from participation all persons or entities that could be included in any of the following categories:

- Entities That Could Be Excluded Under s. 1128(b)(8) of the Social Security Act.
- Entities That Have a Direct or Indirect Substantial Contractual Relationship with an Individual or Entity Listed which could be excluded under s. 1128(b)(8) of the Social Security Act.
- Entities That Employ, Contract With, or Contract Through Any Individual or Entity That is Excluded From Participation in Medicaid under ss. 1128 or 1128A, for the Provision (Directly or Indirectly) of Health Care, Utilization Review, Medical Social Work or Administrative Services.

Care Wisconsin monitors Medicare and Medicaid sanctions and grievances against health care professionals. Care Wisconsin also monitors those who opt out of accepting federal reimbursement from Medicare and resolution of beneficiary grievances. Further, Care Wisconsin checks the Wisconsin Department of Regulation and Licensing website monthly to determine if any plan providers have had actions taken against their licenses. If Care Wisconsin becomes aware of conditions at a site that suggest compromised safety or other concerns related to the delivery of care, Care Wisconsin conducts a site visit to assess the site and identify corrective action.

Care Wisconsin's Medical Advisory, Peer Review and Credentialing Committee (MAPRCC), which oversees Care Wisconsin's credentialing program, includes members appointed by Care Wisconsin management and physicians outside of Care Wisconsin and is chaired by Care Wisconsin's Chief Medical Officer. The MAPRCC establishes and implements credentialing and re-credentialing policies and procedures, reviews credentialing and re-credentialing applications, reviews recommendations from the delegated credentialing entities, and performs related peer

reviews as needed. The MAPRCC has authority to approve or deny provider credentialing and re-credentialing applications.

The MAPRCC reviews and updates our credentialing and re-credentialing policies and procedures annually. Care Wisconsin's credentialing policies and procedures may also be changed at the discretion of Care Wisconsin's Board of Directors. Care Wisconsin will adopt any change in legal, regulatory, or accreditation requirements automatically as of the requirement's effective date and such changes will be effective for all new and existing providers upon that date.

Facilities and Organizational Providers
Care Wisconsin credentials the following types of organizations and facilities:
- Ambulatory surgery centers
- Home health agencies
- Hospice programs
- Hospitals
- Skilled nursing facilities

Facilities and organizational providers must provide the following information to Care Wisconsin at least every three (3) years, and whenever such information changes:
- Legal name, address, facility type and facility contact person
- Documented verification of licensure in the state of Wisconsin
- Attestation of compliance with state and federal requirements
- Copies of facility's general and malpractice liability insurance face sheets
- Documented verification of facility's accreditation(s)
- A practioner roster and all facility locations

The facility's Medicare and Medicaid sanction history is reviewed, and malpractice liability insurance coverage is verified. Information is cross-checked on the Wisconsin Department of Regulation and Licensing website and on the Health and Human Services (HHS) Office of Inspector General website.

For accredited facilities, Care Wisconsin, and/or its credentialing delegates, will verify whether the facility has been approved by recognized accrediting bodies by requesting and reviewing the certificate or letter of accreditation. Care Wiscosnin, and/or its credentialing delegates, verify the facility has met all state and federal licensing and regulatory requirements. Care Wisconsin and its credentialing delegates recognize accreditation by the following accreditation bodies:
- JCAHO: Joint Commission on Accreditation of Healthcare Organization
- HFAP: Healthcare Facilities Accreditation Program
- AAAHC: Accreditation Association for Ambulatory Health Care
- CARF: Commission on Accreditation of Rehabilitation Facilities
- CHAP: Community Health Accreditation Program

Further, Care Wisconsin requires submission of the following for the specific facility types noted:
- Findings of the two most recent surveys from the DHS Division of Quality Assurance (DQA) for skilled nursing facilities and home health agencies.
- A copy of the On-line Survey and Certification and Report 3 (OSCAR) for skilled nursing facilities.

If a facility is not accredited, Care Wisconsin requires the completion of the Site Quality Evaluation, which is a self-reported assessment of any facility not accredited at the time of initial credentialing and re-credentialing.

Practitioners
Care Wisconsin credentials the following types of practitioners:

- Physicians (MDs and DOs)
- Podiatrists (DPMs)
- Chiropractors
- Doctors of Optometry (ODs)
- Mental health providers
- Audiologists
- Clinical psychologists
- Other licensed independent providers who treat members outside the inpatient setting

Initial Credentialing
Initial credentialing is based on an application and process that includes verification of information from primary and secondary sources and, confirmation of eligibility for payment under Medicare and Wisconsin Medicaid. Practitioners applying for network participation with Care Wisconsin must complete an application and attestation. Applicants must provide the following information with the application:

- Signed Authorization for Release of Information form.
- Completed curriculum vitae form or equivalent information provided.
- Copy of current malpractice declaration with amounts and dates of coverage.
- Copy of current Drug Enforcement Agency (DEA) licensure, as applicable.

Primary Source Verification
Care Wisconsin, and/or its credentialing delegates, verify all provider credentials in accordance with CMS standards for primary source verification. Applicants must cooperate to ensure Care Wisconsin and/or its credentialing delegates are able to obtain all documents needed to satisfy primary source verification requirements, including, but not limited to:

- State of Wisconsin license
- Education, training and board certification (as applicable)
- Verification of current DEA certificate (if applicable)

Practitioners for Whom Credentialing is Not Required
Not all plan providers are subject to credentialing. Those who are not subject to credentialing include:

- Non-traditional practitioners who are included in the Provider Network but, by virtue of the service they provide, are not required to be Medicare or Medicaid certified.
- Health care professionals who are permitted to deliver services only under the direct supervision of another practitioner, including but not limited to physician's assistants, nurse practitioners, students, residents, and fellows.
- Hospital-based health care professionals who deliver services to members only in the inpatient hospital setting with no outpatient follow-up.

Practitioner Re-credentialing
Care Wisconsin, and/or its credentialing delegates, will re-credential plan providers at least every three years. Any provider not re-credentialed within thirty-six (36) months of the previous credential approval is considered to be out of compliance with our policy.

Care Wisconsin, and/or its credentialing delegates, send each Network Provider a re-credentialing application requesting updated professional information. The re-credentialing application must contain all required information and must be signed before it is returned to Care Wisconsin. Incomplete applications will be returned to applicants.

Reportable Changes
Practitioners must notify Care Wisconsin when a practice is opening in a new location at least 30 days before the new location opens.

Practitioners must notify Care Wisconsin of changes in the following:

- Any limitations in ability to perform the functions of the position with or without accommodation,
- History of loss of license and/or felony convictions, and
- History of loss or limitation of privileges or disciplinary actions.
- State of Wisconsin license
- Education, training and board certification (as applicable)
- Verification of current DEA certificate (if applicable)
- Hospital privileges (if applicable)
- Copy of malpractice insurance face sheet showing current, adequate coverage
- History of malpractice claims or denial of professional liability
- Loss of Medicare and/or Wisconsin Medicaid certification
- Changes or updates to the practitioner roster, or changes in facility locations.

Qualifications of Long-Term Care Providers
Certain providers of LTC services are credentialed as health care providers. Certain others, such as residential facilities, must be licensed and/or certified by Medicare and/or the state of Wisconsin. Care Wisconsin adopts existing, mandated standards, such as criminal background checks, for certain LTC provider types. Appropriate insurance coverage is also required.

Care Wisconsin operates a Provider Quality Committee (PQC), the purpose of which is to monitor the quality of care our members receive. PQC works with Provider Services and managers across both Family Care and Family Care Partnership to determine the best course of action to engage providers in making improvements in both the provider's system and in Care Wisconsin's systems, as appropriate.

To report any changes in your practice, please go to our website at www.carewisc.org and click on the Providers tab to access the forms provided under the Change/Update Your Information link.

SECTION 7: SERVICE STANDARDS & EXPECTATIONS

Access Standards
All Care Wisconsin members have the right to receive timely access to medically necessary health care services. Care Wisconsin's Quality Improvement (QI) Committee approves member access standards and reviews Network Providers' compliance with the standards on an annual basis.

Care Wisconsin members with life-threatening emergencies will have immediate access to care without prior authorization from Care Wisconsin. Members may receive emergency care from participating or Out-of-Network Providers at hospitals within or outside of Care Wisconsin's service area. This care is available twenty-four hours a day, seven days a week.

Care Wisconsin has established the following standards for timely access to care:

- 30 days for an appointment with a Primary Care Provider (PCP)
- 30 days for a follow-up appointment with a Mental Health provider after an inpatient mental health stay
- 90 days for an appointment with a dental provider for routine dental care
- 2 weeks for medically necessary high risk prenatal care
- Wait time at care facilities is not to exceed 30 minutes
- Physicians "on call" for network Primary Care Providers and Specialist Providers are subject to Care Wisconsin's access standards.
- Physicians and behavioral health providers must ensure there is a system in place for providing after-hours accessibility, and must inform members how to access care after hours. After-hours calls should be returned within one (1) hour.
- All providers are required to provide members with an emergency telephone number for use after regular office hours. Members should also be provided with a written summary about how to access care after hours.

How to Access Utilization Management Criteria
Physicians and nurses at Care Wisconsin use clinical criteria, based on medical necessity, to make coverage decisions. If you are seeing a Care Wisconsin member and have questions regarding the criteria used, you may call Care Wisconsin to request information regarding the criteria.

Care Wisconsin Guide to Pre-certification, Notification, and Concurrent Review

Hospital Responsibilities

Hospital responsibilities include:

- Pre-certify all elective admissions/surgeries.
- Notify Care Wisconsin on date of admission or within 24 hours of the first business day of admission.
- Cooperate with concurrent review activities, both by telephone and on-site.

Skilled Nursing Facility Responsibilities

Skilled Nursing Facility responsibilities include:

- Pre-certify all admissions.
- Notify Care Wisconsin of admission within 24 hours or the first business day of admission.

- Cooperate with concurrent review activities, both by telephone and on-site.

Home Health Agency Responsibilities

Home Health Agency responsibilities include:

- Pre-certify all services.
- Notify Care Wisconsin within 48 hours or within 2 business days of providing home health services.

Pre-certification of Hospital Admissions

Based on medical diagnoses, information, or proposed surgery, Care Wisconsin will:

- Authorize coverage for a length of stay based on clinical protocols.
- Notify the member of the number of days authorized for elective admissions by letter.
- Notify the Physician of concurrent review for those admissions with no specific length of stay.
- Follow the admission with the hospital's utilization review department if the member is not discharged within the pre-certified period of time. The admission will be reviewed for medical necessity and intensity of service.
- If not available through the hospital utilization review department, contact the provider for additional information to determine if additional days should be covered or denied. The decision will be based on medical necessity for an acute care setting. Alternate settings and/or appropriate home health services will be explored for members who do not meet criteria for continued coverage of acute care.

The **provider,** not the member, is responsible to pre-certify an admission to the hospital for medical and/or surgical treatment.

Second Opinions

Care Wisconsin members are covered for a second opinion within the Provider Network.

Prior Approval

Coverage for Care Wisconsin members is provided in accordance with Medicare and/or Medicaid criteria and guidelines. Procedures that do not meet Medicare and/or Medicaid criteria and guidelines are not covered by Care Wisconsin. To ensure coverage, services must be:

- Obtained from a Network Provider, unless the Member's Care Wisconsin Interdisciplinary Team provides prior approval for the member to obtain care from an Out-of-Network Provider, as outlined below,
- Approved in advance by the member's Care Wisconsin Interdisciplinary Team, except in a medical Emergency. For additional informationon Care Wisconsin's prior authorization requirements, go to https://www.carewisc.org/authorizations

Prior Authorization for Out-of-Network Providers
Care Wisconsin's Chief Medical Officer will consider approval of prior authorization requests for Out-of-Network Providers only if **all** of the following requirements are met:

- The services are medically necessary.
- The services are a covered benefit.
- The services are not available from a Network Provider.
- The services will be provided by a Care Wisconsin approved Out-of-Network Provider.

Contact Care Wisconsin before a member is referred to an Out-of-Network Provider.

New Technology
Care Wisconsin will follow Medicare's coverage determinations for new technology.

Quality Improvement Program
Care Wisconsin administration supports a Quality Management Program that includes assessment, monitoring, and improvement of both operational and clinical services. Data are collected from a variety of sources, case management software, claims, the Medicare Health Outcomes Survey (HOS), customer service feedback via Medicare Consumer Assessment of Health Plans Study (CAHPS), and provider surveys. Care Wisconsin utilizes Quality Management committees and work groups to develop and implement quality improvement interventions based upon analyzed data findings. Outcome measures of specific quality improvement interventions are monitored and compared to internal and/or external benchmarks. Interventions are developed and changed, when necessary, based on outcomes analysis.

Outcomes are reported to Care Wisconsin Leadership, CMS regional office,). Required CMS disclosures include, but are not limited to, the following:

- Quality and performance indicators regarding enrollee satisfaction.
- Quality and performance indicators regarding health outcomes.

The Care Wisconsin Board of Directors is responsible for overseeing the activities of Care Wisconsin. The Quality Management program has been delegated by the Board to Care Wisconsin's Chief Executive Officer.

The Quality Improvement Steering Committee:
Provides general oversight of QI-related activities, maintains organization-wide integration of processes related to quality improvement, shares QI information, and distributes summary reports.

- Reviews and approves methods for evaluation and ongoing monitoring of operational and clinical aspects of care.
- Reviews and evaluates findings, approves interventions and corrections, and makes recommendations.
- Ensures follow-up of interventions and corrections.
- Reviews and approves practice guidelines and performance monitoring of practice guidelines and quality indicators.
- Develops, measures, and assesses clinical initiatives.
- Provides recommendations and reviews policies and procedures related to QI activities.
- Reviews information about member appeal and grievance activities and provides recommendations as appropriate.
- Reviews data regarding critical incidents and provides recommendations as appropriate.
- Reviews various subcommittee reports and provides recommendations as appropriate.
- Annually reviews and approves QI program description, evaluation, and work plan.

SECTION 8: MEMBER RIGHTS AND RESPONSIBILITIES

Care Wisconsin members receive a list of their rights and responsibilities upon enrollment.

Direct Access to Preventive Care (Partnership Program)

Care Wisconsin members have direct access to preventive health care services. Members have access to the following services from a Network Provider without the need for a referral:

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests and pelvic exams as long as you get them from a network provider.
- Flu shots **and** pneumonia vaccines as long as you get them from a network provider.
- Urgently needed care from in-network providers, or from out-of-network providers when network providers are temporarily unavailable or inaccessible, e.g., when you are temporarily out of the plan's service area.
- Family planning services.

Member Rights

1.) **We must provide information in a way that works for the member**.

2.) **We must treat a member with dignity, respect, and fairness at all times**. Members have the right:
   - To get compassionate, considerate care from Care Wisconsin staff and providers.
   - To get your care in a safe, clean environment.
   - To not have to do work or perform services for Care Wisconsin.
   - To be encouraged and helped in talking to Care Wisconsin staff about changes in policy that you think should be made or services that you think should be provided.
   - To be encouraged to exercise rights as a member of Care Wisconsin.
   - To be free from discrimination. Care Wisconsin and providers must obey laws to protect members from discrimination or unfair treatment. We do not discriminate based on a person's race, mental or physical disability, religion, gender, sexual orientation, health, ethnicity, creed (beliefs), age, national origin, or source of payment.
   - To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. This means a member has the right to be free from being restrained or forced to be alone in order to make the member behave in a certain way or to punish because someone finds it useful.
   - To be free from abuse, neglect, and financial exploitation.
     - **Abuse** can be physical, emotional, financial or sexual. Abuse can also be if someone gives the member a treatment such as medication, or experimental research without their informed consent.

     - **Neglect** is when a caregiver fails to provide care, services, or supervision which creates significant risk of danger to the individual. Self-neglect is when an individual who is responsible for his or her own care fails to obtain adequate care, including food, shelter, clothing, or medical or dental care.

     - **Financial exploitation** can be fraud, enticement or coercion, theft, misconduct by a fiscal agent, identity theft, forgery, or unauthorized use of financial transaction cards including credit, debit, ATM and similar cards.

What can a member do if they are experiencing abuse, neglect, or financial exploitation? The care team is available to talk with members about issues that you feel may be abuse, neglect, or financial exploitation. They can help members with reporting or securing services for safety. Members should always call 911 in an emergency.

If you feel that you or someone you know is a victim of abuse, neglect or financial exploitation, you can contact Adult Protective Services. Adult Protective Services help protect the safety of seniors and adults-at-risk who have experienced abuse, neglect or exploitation. They also help when a person is unable to look after his or her own safety due to a health condition or disability.

You may call the following numbers to report incidents of witnessed or suspected abuse:

- If a life-threatening emergency, call 911.
- Call the Care Team at 1-800-963-0035, 8 a.m. to 4:30 p.m., Monday-Friday.
- For assistance after-hours, on weekends and holidays, call the same number.

3.) **We must ensure that members get timely access to your covered services**. As a member of Care Wisconsin, members have a right to receive services listed in their care plan as they need them. The care team will arrange for covered services. The care team will also coordinate with health care providers. Examples of these are doctors, dentists, and podiatrists.

4.) **We must protect the privacy of personal health information**. If you have questions or concerns about the privacy of personal health information, please call 1-800-963-0035.

5.) **We must give members access to their medical records**.

6.) **We must give members information about Care Wisconsin, our network of providers, and available services**.

7.) **We must support a member's right to make decisions about their services**.

- Members have a right to know about all of their choices. This includes all of the options available, what they cost, risks associated with those options, and whether they are covered by Family Care. Members can also suggest other services they think would meet their needs.
- Members have the right to say "no" to any recommended care or services.
- Members have the right to get second medical opinions.
- Members have the right to give instructions about what they want done if unable to make decisions for themselves. They have the right to say what they want to happen if in this situation. Members can develop an "**advance directive**."
- Members have the right to file a grievance or appeal if you are dissatisfied with your care or services.

Member Responsibilities

Please reference the Member Handbook on Care Wisconsin's website www.carewisc.org

Advance Directives
Care Wisconsin is required to have written policies and procedures regarding Advance Directives, and to inform all members of their rights with respect to Advance Directives. We encourage all members to discuss their wishes with their Primary Care Provider, or another member of their care team. Physicians and other health care providers must document, in a prominent part of the member's current medical record, whether or not the member has executed an advance directive. However, a member cannot be discriminated against based on the status of an executed advance directive.

Member Rights and Responsibilities Relative to Advance Directives

- A member has the right to receive medical care regardless of whether he or she has an Advance Directive.
- Members have the right to cancel or change Advance Directives at any time.
- Members have the right to obtain concise information about different types of Advance Directives, and when an Advance Directive will take effect.
- Members are expected to discuss Advance Directives with their Primary Care Provider and family members, friends, and others involved in the member's health care.
- Members must comply with State and Federal laws regarding having Advance Directive documents witnessed and notarized.
- Members should keep Advance Directives in a safe place that is known to and accessible to family members and/or other responsible individuals.
- Members should provide copies of Advance Directives to their Primary Care Provider, family members, friends, and others involved in the member's health care.
- Members should inform Physicians and other health care providers if they have Advance Directives.

Physicians and Other Health Care Providers' Responsibilities Relative to Advance Directives

- Physicians and other health care providers must comply with all applicable State and Federal laws related to Advance Directives.
- Physicians and other health care providers must ask adult members if they have Advance Directives, and include existing Advance Directives in the member's medical record.
- Physicians and other health care providers cannot require members to have Advance Directives in order to receive medical care, and cannot prevent members from having an advance directive.
- Physicians and other health care providers must not execute Advance Directives until the member is no longer able to give informed consent.
- Physicians and other health care providers must maintain written policies regarding Advance Directives for their office staff.

Members Rights for Appeal & Grievance
Care Wisconsin members have the right to grieve or appeal any action or inaction that the member perceives as having a negative impact on them. Members, their legal representative, or, with member's permission, a provider involved in the member's care has the right to assist the member or file a grievance or appeal for the member. An "action" is any of the following:

- The denial of functional eligibility as a result of administration of the long-term care functional screen, including a change from nursing home level of care to non-nursing home level of care.
- The denial or limited authorization of a requested service that falls within the benefit package, including the type or level of service.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service that falls within the benefit package.
- The failure to provide services and support items included in the member's member-centered plan in a timely manner, as defined by the Wisconsin Department of Health Services (DHS).
- The failure of the MCO to act within the timeframes of this article for resolution of grievances or appeals.
- The development of a member-centered plan that is unacceptable to the member because any of the following apply:
  - The plan is contrary to a member's wishes insofar as it requires the member to live in a place that is unacceptable to the member.
  - The plan does not provide sufficient care, treatment or support to meet the member's needs and support the member's identified outcomes.
  - The plan requires the member to accept care, treatment or support items that are unnecessarily restrictive or unwanted by the member.
- Notification by the MCO of a decision made in response to a member's appeal that is enterly or partially adverse to the member.

An "action" is not:

- A change in provider.
- A change in the rate the MCO pays a provider.
- A termination of a service that was authorized for a limited number of units of service or duration of a service.
- An adverse action that is the result of a change in state or federal law; however, a member does have the right to a State fair hearing in regard to whether he/she is a member of the group impacted by the change.
- The denial of authorization or payment for a service or item that is not inside the benefit package.

What are Appeals and Grievances?
An **appeal** is a formal request to reconsider a decision or an action that Care Wisconsin informs the member they intend to make (i.e. denial of a requested service, reduction or termination of an existing service, denial in full or part to pay for a service, etc.). When this type of action is proposed the Care Wisconsin Care Team Staff, working with the member, is required to send a Notice of Action (NOA) letter to the member explaining the action.

An appeal of an action must be filed within 45 calendar days of receipt of the NOA. If the member wants a service to continue during the appeal process, the appeal must be filed before the effective date on the NOA. However, if Care Wisconsin's proposed action is upheld in the appeal process, the member may be liable for the cost of any continued benefits.

A **grievance** is an expression of dissatisfaction to either Care Wisconsin or the State of Wisconsin about something other than an action (i.e. poor quality of service, does not feel respected by staff, etc.). If a member wants to file a grievance it can be either oral or written and

should begin by contacting their Care Team Staff or the Care Wisconsin Member Rights Specialist. A grievance can be submitted at any time with no time limits.

How can Members File an Appeal or Grievance
If a member is not satisfied with a decision regarding a service or support, the member is encouraged to contact the Care Team Staff and/or the Care Wisconsin Member Rights Specialist to discuss the situation and review the member's options. In addition, Member Rights Specialist can be available to provide the member assistance in the process of filing for an appeal or grievance including completion of paperwork when assistance is requested.

Care Wisconsin:
Members, or their representatives, can contact the Care Wisconsin Member Rights Specialist toll-free at 1-800-963-0035 (TTY: WI Relay 711).

Members can also send a grievance or appeal letter to:
Care Wisconsin
Member Rights Specialist
P.O. Box 14017
Madison, WI 53708-0017

Additional information on appeals and grievances can be found on the Care Wisconsin Web site:
Family Care: https://www.carewisc.org/familycare/grievanceappeals-familycare

Partnership: *(For Medicare and Medicaid)*
https://www.carewisc.org/partnership/medicareandmedicaid-partnership/grievanceappeals

Partnership: *(For Medicaid only)*
https://www.carewisc.org/partnership/medicaid-partnership/grievanceappeals

SECTION 9: RESIDENTIAL PROVIDERS

Residential services include Adult Family Homes (AFHs), Community Based Residential Facilities (CBRFs), and Certified Residential Care Apartment Complexes (RCACs). Care Wisconsin utilizes a a tiered contracted rate methodology for settingresidential rates for each facility..

Residential Placement Process

Member needs are assessed by their Interdisciplinary Team. Once an assessment has been completed and the determination made for the appropriate residential setting, the team submits a request to the Provider Services Department. The Residential Admissions Representative assigned to a member's county identifies providers who have availability and ability to safely and effectively provide service in a cost-effective manner to aid the member in achieving successful outcomes based upon that member's care plan. Those options are then presented to the Interdisciplinary Team who shares the information with the member, schedules assessments and facility tours, communicates with the member to identify the chosen provider (if more than one option is available) and schedules a move date.

Prior to a move date being scheduled, the Residential Admissions Representative contacts the selected residential provider to confirm the tier level for the member.. The Interdisciplinary Team will enter a Service Authorization at the appropriate tier level and a move can be completed.

Excessive Damage to a Residential Facility Caused by a Member

Residential Facility shall develop written policies that apply to all the facility's residents whose neglect or failure to adhere to the rules of the facility results in excessive damage to the facility. The residential facility shall require eligible residents to read and sign an agreement of compliance with the facility's policies and rules, clearly communicating a resident's rights, privileges and obligations with respect to functioning safely and in consideration of other residents, employees and visitors to the facility.

Residential Facility shall monitor Care Wisconsin member's use of mobility aids including, but not limited to motorized wheelchairs and scooters and shall promptly inform Member's Interdisciplinary Team in the event a Member's ability to safely and competently use such equipment appears to be impaired.

Residential Facility shall make reasonable physical adaptations (wide-angle mirrors for sharp corners, door/wall guards, etc.) to the facility to minimize the opportunity for collisions and physical damage.

Residential Facility and Interdisciplinary Team shall document efforts to ensure member safety and safety of others in a member's vicinity.

The Residential Facility agrees not to hold Care Wisconsin members responsible for the cost of Reasonable Wear and Tear. However, if a member is responsible for excessive damage to the residential facility due to member's failure to adhere to the rules of the facility, the residential facility may hold the Care Wisconsin member responsible for the cost of the excessive damage after documented efforts have failed to resolve member's failure to adhere to the rules of the facility. Facility agrees not to hold Care Wisconsin responsible for the cost of excessive damage.

Shared Room Rates
Room and board rates are standardized amounts for all members. Care Wisconsin uses previous year HUD Room and Board rates. If a Care Wisconsin member is placed in a unit that is intended for 2 residents or has a shared address or unit number, the room and board portion of the daily rate will be adjusted to pay 100% of the board portion and 50% of the room portion of the daily rate.

Bedhold Payments
Care Wisconsin reimburses contracted residential providers for member leaves of absence from the residential facility when the absence meets the following criteria.:

- Vacation and family visits
- If the absence and payment of the bedhold have been approved in advance by the InterDisciplinary Team

Approved bedholds are reimbursed at 75% of the member's current daily care and supervision rate. Members are responsible for payment of their daily room and board rate during all periods of absence without regard to whether or not there is an approved bedhold.

Federal Medicaid regulations do not permit payment of bedholds when members are receiving the following Medicaid covered services: inpatient hospital, nursing home, ICF-MR and DD Center. Care Wisconsin will not approve or pay for bedhold when members are receiving these services.

Respite for Residents of an AFH
Owner-Occupied (respite provided in the owner's AFH) – Paid to Owner at 100% of usual Care & Supervision rate for the member. Owner pays respite provider at whatever rate owner has negotiated with respite provider. Member responsible for 100% of the room and board payment to Care Wisconsin, and Care Wisconsin in turn pays that amount in full to the AFH owner.

Owner-Occupied (respite provided outside the owner's AFH) – Paid to external respite provider at 100% of external provider's contracted rate with Care Wisconsin. Member responsible for 100% of the room and board payment to Care Wisconsin, and Care Wisconsin in turn pays that amount in full to the AFH owner.

SECTION 10: PROVIDER BILLING AND REPORTING

Care Wisconsin First, Inc. and Care Wisconsin Health Plan, Inc.
In most cases, your contract with Care Wisconsin is for members of both Care Wisconsin programs, Family Care and Family Care Partnership, but it is important for you to know that these programs are operated by different Care Wisconsin business entities. Family Care is operated by Care Wisconsin First, Inc. Care Wisconsin Health Plan, Inc., a sole member of Care Wisconsin First, Inc., operates the Family Care Partnership program.

Federal Funds
The provider acknowledges that payments received from Care Wisconsin to provide services to Care Wisconsin members are, in whole or in part, from Federal funds. Therefore, provider and provider's subcontractors are subject to certain laws that are applicable to individuals and entities receiving Federal funds.

Prompt Payment
Care Wisconsin encourages providers to submit claims (bills or invoices) for authorized covered services as soon as possible. The timely filing limit is sixty (60) days from the date of service for Family Care and Family Care Partnership. Claims received after this time period may be rejected for payment.

Claim Submission and Reimbursement
Claims should be submitted on the appropriate claim form. For many services, this will be a CMS 1500 Claim Form (outpatient services) or a UB92 Claim Form (inpatient services). For other services, providers may submit claims on an alternative form approved by Care Wisconsin. Claims must be complete and accurate, as required by Medicare and/or Wisconsin Medicaid and Care Wisconsin claim submission instructions. Claims forms and instructions can be found on Care Wisconsin's website at www.carewisc.org.

Claims (Non-Pharmacy) must be submitted to:

Care Wisconsin
P.O. Box 226897
Dallas, TX 75222-6897

Pharmacy Claims must be submitted:
All of our pharmacy claims should be submitted to EnvisionRx electronically.

PROVIDERS SERVING FAMILY CARE PARTNERSHIP MEMBERS:

- **PLEASE DO NOT SUBMIT CLAIMS FOR COVERED SERVICES TO MEDICARE OR MEDICAID. DOING SO WILL DELAY YOUR PAYMENT**.

PROVIDERS SERVING FAMILY CARE MEMBERS:

- **WHEN PROVIDING SERVICES TO MEMBERS WHO HAVE BOTH MEDICARE AND MEDICAID, CLAIMS FOR MEDICARE-COVERED SERVICES MUST FIRST BE SUBMITTED TO MEDICARE.**

Providers cannot bill members for covered services, or for the balance remaining if the fee is greater than the contractually agreed-upon fee. Care Wisconsin will reimburse providers according to the terms and conditions of the contract between Care Wisconsin and each provider, if the claim meets the filing requirements, the service is in the member's benefit plan and the member was eligible for Family Care or Family Care Partnership on the date the service was provided. Subject to these conditions, Care Wisconsin will reimburse providers even if Care Wisconsin is no longer under contract with Medicare or Wisconsin Medicaid, so long as the date of service occurred before the applicable contract ended.

Coordination of Benefits

Definition
Coordination of benefits is the process used to determine whether Care Wisconsin is the primary or secondary payer on claims submitted on behalf of Care Wisconsin members.

Coordination of Benefit Rules for Care Wisconsin Family Care Partnership Program Members

- If the member is 65-years or older, and has coverage under an employer group health plan through either the member's current employment, or the employment of a spouse or partner, that coverage pays first. This rule applies to health plans of employers with 20 or more employees.
- If the member is under age 65 and entitled to Medicare due to disability (other than end-stage renal disease), is a Care Wisconsin member, and has group health coverage through an employer with 2 to 99 employees, either through the member's own employment or the employment of a family member, Care Wisconsin pays first. The group health plan will pay first if the employer has 100 or more employees.
- If the member is eligible for Medicare solely on the basis of end-stage renal disease (ESRD) and is covered under an employer group health plan, the employer plan is primary for the first thirty (30) months.
- Care Wisconsin is the secondary payer for work-related illnesses or injuries, or veteran's benefits for treatment of service-connected disabilities.
- Care Wisconsin follows the same guidelines as Medicare.

Subrogation
If there is the potential for third-party responsibility, Care Wisconsin will pay claims first according to benefits available. Care Wisconsin will then pursue subrogation against the responsible person, insurer, or organization. Care Wisconsin *requires* network providers to submit all claims for a member to Care Wisconsin.

Provider Payment Inquiries
Questions concerning claim status, adjustments, or requests for claim review should be directed to the Care Wisconsin Provider Help Desk at 1-855-878-6699.

Provider Review Process for Medicare Covered Services for Family Care Partnership
This process is to be used to appeal Care Wisconsin determinations relative to claim denials, payments, fees, contract terminations, medical necessity, and prior authorization for Medicare Covered Services for Family Care Partnership program members. Care Wisconsin providers must appeal within six (6) months after receiving an initial denial or partial payment of a claim.

The provider may call the Care Wisconsin Provider Help Desk at 1-855-878-6699. The Provider Help Desk will help answer provider questions, and/or will route the call to the appropriate department.

All appeals related to denials based on medical necessity will be reviewed by Care Wisconsin's Chief Medical Officer. Requests for review of prior authorization or denials based on medical necessity should be put in writing and mailed to:

Care Wisconsin
ATTN: Chief Medical Officer
PO Box 14017
Madison, WI 53708-0017

All other appeals must be put in writing and mailed to:

Care Wisconsin
Claims Appeals
PO Box 14017
Madison, WI 53708-0017

Care Wisconsin will respond to provider appeals within forty-five (45) calendar days of receipt of the request for review. The response will be in writing.

Provider Appeals

A. Network Participation Appeals

1. In the event the Care Wisconsin Medical Advisory Committee ("MAC") fails to approve the credentials of an applicant seeking approval to participate in Care Wisconsin's provider network, or Care Wisconsin's Provider Services Department (PSD) suspends or terminates a provider's existing agreement to provide services based on quality deficiencies or lack of network need, Care Wisconsin's PSD provides written notice to the affected individual or organization of the reason for not granting approval for participation, or for suspending or terminating such approval.
2. The written notice is sent within thirty (30) days of the date of the MAC's or PSD's decision.
3. The written notice includes:
    a. The reason(s) for the action
    b. The affected provider's right to appeal the process and the process and timing to request a hearing.
        (1) Generally speaking, the provider is given sixty (60) days from the date of the written notice to file a written appeal to Care Wisconsin's PSD.
        (2) The Care Wisconsin MAC or PSD considers and acts upon the provider's appeal within thirty (30) days of receipt of the appeal by the PSD.
        (3) The PSD notifies the provider in writing of the MAC's or PSD's decision regarding his or her appeal within fourteen (14) days of the date of the decision.

B. Residential Provider Holds

1. In the event the Care Wisconsin Provider Quality Committee (PQC) places a hold on admissions to a contracted residential provider, Care Wisconsin's PSD provides written notice to the affected residential provider, including the reason for the hold.

2. The written notice is sent within thirty (30) days of the date of the PQC decision.
   a. The written notice will include:
      i. The reason(s) for the action
      ii. The effective date of the action
      iii. The changes that the residential provider must make before Care Wisconsin will consider removing the hold

3. Should the residential provider choose to act to recover from this action, it must provide Care Wisconsin with an action plan and timeline for correcting the reason for the hold.

4. The Care Wisconsin PQC works with the residential provider to develop a plan for monitoring and evaluating the residential provider's progress toward the identified improvement plan.

5. Should the residential provider wish to appeal this action, the residential provider is expected to provide written notification of the appeal and meet with the PQC to discuss the hold.

6. Care Wisconsin acts on such appeals within thirty (30) days of receipt of the appeal, and provides written notification to the residential provider of the appeal decision within fourteen (14) days of the decision date.

C. Contracted Provider Appeals

1. Provider Appeals for Medicaid and Long-Term Care Services
   a. All providers must appeal first to Care Wisconsin if they disagree with Care Wisconsin's payment or non-payment of a claim. Care Wisconsin responds to such appeals within forty-five (45) days.
   b. Care Wisconsin must inform providers in writing of Care Wisconsin's decision to pay or deny the original claims, including:
      (i) A specific explanation of the payment amount or specific reason for non-payment.
      (ii) A statement explaining the appeal process and the provider's rights and responsibilities in appealing Care Wisconsin's determination by submitting a separate letter or form which:
         a) Is clearly marked "appeal";
         b) Contains the provider's name, date of service, date of billing, date of rejection, and reason(s) claim merits reconsideration for each appeal; and,
         c) Is submitted to the Care Wisconsin claims manager at:

            Attn: Claims Manager
            Care Wisconsin
            PO Box 14017
            Madison, WI 53708-0017

      (iii) The name of the person and/or function at Care Wisconsin to whom provider appeals should be submitted.

(iv) An explanation of the process the provider should follow when appealing Care Wisconsin's decision:

(v) A statement advising providers of their right to appeal to DHS if Care Wisconsin fails to respond to the appeal within forty-five (45) days or if the provider is not satisfied with Care Wisconsin's response to the request for reconsideration.

Appeals to DHS are submitted in writing within sixty (60) days of Care Wisconsin's final decision, or in the case of no response, within sixty (60) days from the forty-five (45) day timeline allotted to Care Wisconsin to respond, to:

Provider Appeals Investigator
Division of Long-Term Care
1 West Wilson Street, Room 518
P.O. Box 7851
Madison, WI 53707-7851

c. Care Wisconsin accepts written appeals from providers within sixty (60) days of Care Wisconsin's initial payment and/or non-payment notice. Care Wisconsin responds in writing within forty-five (45) days from the date of receipt of the request for reconsideration. If Care Wisconsin fails to respond within forty-five (45) days, or if the provider is not satisfied with Care Wisconsin's response, the provider may seek a final determination from DHS.

d. After a provider has appealed to Care Wisconsin as described above, and the provider disputes the determination, the provider may appeal to DHS for the final determination. Appeals must be submitted to DHS within sixty (60) days of the date of written notification of Care Wisconsin's final decision resulting from a request for reconsideration, or, if Care Wisconsin fails to respond, within sixty (60) days from the forty-five (45) day timeline allotted to Care Wisconsin to respond. In exceptional cases, DHS may override Care Wisconsin's time limit for the submission of claims and appeals. DHS will not exercise its authority in this regard unreasonably. DHS will accept written comments from all parties to the dispute prior to making a final decision. DHS has forty-five (45) days from the date of receipt of all written comments to inform the provider and Care Wisconsin of the final decision. If DHS's decision is in favor of the provider, Care Wisconsin will pay provider(s) within forty-five (45) days of notification of DHS's final determination. Care Wisconsin must accept DHS's determination regarding appeals of Care Wisconsin's actions concerning disputed claims.

e. Along with the Quarterly Report (as specified in Care Wisconsin's current contract with DHS) Care Wisconsin shall submit to DHS a provider appeal log as follows:
   (i) Name of the provider
   (ii) Type of service
   (iii) Date of service
   (iv) Amount of the claim
   (v) Date of receipt of the appeal
   (vi) Appeal decision by Care Wisconsin, and
   (vii) Reason for the decision

2. Claim Appeals Process
    a. Each piece of correspondence received by the Care Wisconsin Provider Services or Claims Departments is evaluated to determine if it is an appeal. All Care Wisconsin providers can appeal claims.
    b. Correspondence is considered an appeal when it follows the format described in section 1b (ii) above.
    c. Each appeal is logged into the Provider Communication Log and the Appeal Log.
    d. The Care Wisconsin Provider Services or Claims Department researches and makes a decision on each appeal. The Department Manager, Claims Director, Executive Vice President, and/or Medical Director are consulted on the decision, if necessary.
    e. A letter, including the provider's DHS appeal rights, is sent in response to each appeal. A copy of this letter is filed, along with the original appeal documents, in the Appeals File.
    f. The decision is logged in the Provider Communication Log and the Appeal Log.
    g. The Quarterly Appeals Log is evaluated by management to determine if there are any systems or operational issues that are causing appeals.

3. Appeals for Medicare services are covered under the Centers for Medicare and Medicaid Services (CMS) Medicare Advantage/Part D contracts with Care Wisconsin for the Partnership program.

D. Non-contracted Provider Appeals

1. When a non-contracted provider requests, in writing, a reconsideration of a denied claim, Care Wisconsin requests a completed “Waiver of Liability Statement” on which the provider agrees that he/she will not bill the member regardless of the outcome of the appeal.
2. The non-contracted provider's request for consideration must be filed within sixty (60) calendar days from the date of the notice of the organization determination.
3. Care Wisconsin documents reasonable efforts to secure the necessary Waiver of Liability form. Care Wisconsin requests the form twice within thirty (30) days of receipt of the request for reconsideration.
4. If the form is not received after sixty (60) days from the date the request for reconsideration was received, Care Wisconsin does not review the claim.
5. Care Wisconsin forwards the case to the independent review entity contracted by CMS with a request for dismissal.
6. Care Wisconsin complies with the independent review entity's process for reconsiderations that fail to meet provider-as-party requirements.

E. Provider Communication Log

1. Care Wisconsin logs all incoming Provider Help Desk calls through the VPrime Call Tracker. All appropriate information gathered during the call is logged in the Call Tracker, including provider, member, question and resolution. Care Wisconsin Claims Department leadership runs reports on a monthly basis which outlines all calls. These reports are analyzed each month to determine if any system or operational improvements, or additional training of staff is needed.

APPENDIX A: GLOSSARY

Advance Directive – An advance directive is a legal document that describes, in writing, a person's choices about the treatments she or he wants or does not want or about how health care decisions should be made for him or her if she or he becomes incapacitated and cannot express his or her wishes.

Agreement for Services – The contract between Care Wisconsin First, Inc. or Care Wisconsin Health Plan and a provider to provide health and/or long-term care services to persons enrolled in Care Wisconsin's Family Care or Family Care Partnership program.

Ambulatory Surgery Center – Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.

Care Management – Individualized assessment and care planning, authorizing, arranging and coordinating service in the Individual Service Plan (ISP, as defined below) and periodic reassessment and updates of the ISP. Care management also includes assistance in filing complaints and grievances and obtaining advocacy services.

Care Team – See "Interdisciplinary Team."

Centers for Medicare and Medicaid Services (CMS) – CMS is a federal agency within the U.S. Department of Health and Human Services that administers the Medicare and Medicaid programs. CMS contracts with Care Wisconsin Health Plan, a Medicare Advantage Special Needs Plan.

Chief Medical Officer – A physician who monitors and reviews the utilization of covered services by Care Wisconsin Health Plan members and also responsible for oversight of clinical quality.

Critical Incident – a circumstance, event, or condition resulting from action or inaction that is either:

a) associated with suspected abuse, neglect and financial exploitation, other crime, or a violation of member rights, or any unplanned unapproved use of restrictive measures;
b) or that:
    i. resulted in serious harm to the health, safety or well-being of a member, or
    ii. resulted in serious harm to the health, safety or well-being of another person as a result of the member's actions; or
    iii. resulted in substantial loss in the value of the personal or real property of a member or of another person as a result of the member's actions, or
    iv. resulted in the unexpected death of a member; or
    v. posed an immediate or serious risk to the health, safety, or well being of a member, but did not cause harm because of chance or preventive intervention.

Culturally Competent Health Care – Care that incorporates the values of honoring Members' beliefs; being sensitive to cultural diversity, including members with limited English proficiency and diverse cultural and ethnic backgrounds, and; fostering in staff/providers attitudes and interpersonal communication styles which respect Members' cultural backgrounds.

Department of Health Services (DHS) – The state agency responsible for protecting and promoting the health and safety of the people of Wisconsin.

Emergency Medical Condition – A medical emergency includes severe pain, an injury, sudden illness, or suddenly worsening illness that would cause a reasonably prudent layperson to expect that delay in treatment may cause serious danger to the person's health if he/she does not get immediate medical care.

Evidence of Coverage – A document that Care Wisconsin Health Plan issues to Family Care Partnership members which describes the benefits to which members are entitled. It explains a member's coverage.

Health Risk Assessment – A health assessment completed with the member upon enrollment. It provides information for care management planning based on the member's current health status. It is used to assist in identifying members with serious and complex health conditions.

Inpatient Status – A hospital stay longer than 24 hours.

Individual Service Plan (ISP) – A document that lists services and supports, paid or unpaid, provided or arranged by the MCO to address all needs identified in the functional screen and comprehensive assessment and all services and supports provided that are consistent with the Member-Centered Plan and the nature and severity of the member's identified needs. The ISP identifies the types of services or supports authorized by the interdisciplinary team (IDT), the amount, the frequency and duration of each service (e.g., start and stop date), and the provider(s) that will furnish each service. It is a supplement to the Member-Centered Plan document. (Also see "Member-Centered Plan".)

Interdisciplinary Team (IDT) – The individuals identified by the MCO to provide care management services to members.

Maintenance or Supportive Care – Services provided to a member after the acute phase of an illness or injury has passed and maximum therapeutic benefit has occurred. These services are provided to a member whose recovery has plateaued, slowed, or ceased, when only minimum rehabilitative gains can be demonstrated with continued care. Care Wisconsin Health Plan makes the determination of what constitutes maintenance or supportive care after careful review of the member's case history and treatment plan submitted by a health care provider.

Managed Care Organization (MCO) – an entity that the DHS has certified as having capacity for financial solvency and stability and which has agreed to make certain services available to members for payment.

Medically Necessary – As determined by Care Wisconsin, a health care service that is required to identify or treat a member's illness or injury. The service must be:

- Consistent with the symptom(s) or diagnosis and treatment of the illness or injury.
- Furnished for an appropriate duration and frequency and in accordance with accepted medical practice and Care Wisconsin Health Plan protocols to treat that illness or injury.
- Not solely for the member's convenience or the convenience of the physician, hospital, or other health care provider.

- The most appropriate service or location for providing such service that can be safely provided to the member and accomplishes the desired end result in the most economical manner.
- Supported by information contained in the member's medical record and from other relevant sources.
- Services or supplies that meet the following: (1) they are appropriate and necessary for symptoms, diagnosis, or treatment of the medical condition; (2) they are provided for the diagnosis or direct care and treatment of medical conditions; (3) they meet the standards of good medical practice within the medical community in the service area: (4) they are NOT should be inserted, I assume primarily for the convenience of the patient or provider; (5) they are the most appropriate level or supply of service that can safely be provided.

Medically Necessary – Services, as determined by Care Wisconsin, that are required to prevent, identify or treat a Member's illness, injury or disability and that meet the following standards:

- Are consistent with prevention, diagnoses or treatment of the Member's illness, injury or disability;
- Are provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;
- Are appropriate with regard to generally accepted standards of medical practice;
- Are not medically contraindicated with regard to the member's diagnoses, symptom, general medical condition or
- other medically necessary services being provided to the member;
- Are of proven medical value or usefulness and not experimental in nature;
- Are not duplicative with respect to other services being provided to the Member;
- Are not solely for the convenience of the Member, the member's family or a provider;
- With respect to prior authorization of a service and other prospective coverage determinations, are cost-effective compared to an alternative medically necessary service which is reasonably accessible to the member; and
- Is the most appropriate supply or level of service that can safely and effectively be provided to the member.

Member – An individual entitled to receive long-term care (LTC) and/or health care services who has voluntarily enrolled in Care Wisconsin's Family Care or Family Care Partnership program.

Member-Centered Plan (MCP) – Means a record that documents a process by which the member and the IDT further identify, define and prioritize a member's long-term care outcomes initially identified in the Comprehensive Assessment and identify, define and prioritize quality of life outcomes important to the member. The MCP establishes how the member's strengths, skills and resources and informal and community resources identified in the Comprehensive Assessment, and services and supports available through the MCO benefit and identified in the ISP, will be used to achieve the outcomes identified and defined by the member. The MCP identifies the person(s) on the IDT responsible for tracking of steps/supports related to achieving these outcomes. The ISP is a part of the Member-Centered Plan.

Network Hospital – A hospital with which Care Wisconsin has an Agreement for Services for the provision of hospital services to members.

Network Physician – A licensed doctor of medicine or osteopathy with which Care Wisconsin has an Agreement for Services for the provision of medical services to members.

Network Provider – A provider with which Care Wisconsin contracts to provide or arrange for health and/or long-term care services for members. May also be referred to as a "subcontractor" or "MCO Provider."

Observation Status – A short-term hospital stay, classified as outpatient, for the purpose of evaluation or minimal treatment, as determined by the admitting physician.

Out-of-Area or Out-of Network Services – Services provided outside of Care Wisconsin's Service Area only for treatment of an Emergency Medical Condition or Urgently Needed Care.

Outpatient – Services a patient receives without staying overnight. May also be to as ambulatory, clinic or ancillary services.

Post-Stabilization Care Services – Services related to an Emergency Medical Condition that are either: (a) provided after a member is stabilized in order to maintain the stabilized condition; or (b) provided to improve or resolve the member's condition.

Primary Care Provider – Any contracted network provider who is designated by the health plan as a primary care care provider whose primary care specialty is family practice, general internal medicine, pediatric medicine, or geriatric medicine and who has agreed to work within the parameters of Care Wisconsin's model of care. The Primary Care Provider, who, in collaboration with a member's IDT, is responsible for knowing the member's complete medical history, performing routine health care duties, and referring the member to a Specialist when necessary.

Provider Network – All health and long-term care providers who have executed contracts with Care Wisconsin to provide or arrange specified services for members.

Prior Authorization – The process of obtaining authorization from a member's IDT for specific services, procedures or items prior to the provision of such services, procedures or items.

Service Area – The geographic area in which Care Wisconsin has been authorized by CMS or DHS to offer its programs.

Specialist – A physician who practices in a branch of medical science that is not primary care.

Subcontractor/MCO Provider – A service provider that Care Wisconsin has an Agreement for Services with to provide specified services to Care Wisconsin's members.

Urgently Needed Care – Medically Necessary care that is required by an illness or accidental injury that is not life-threatening and will not result in further disability but has the potential to develop such a threat if treatment is delayed longer than twenty-four (24) hours. Covered Services when a member is temporarily out of the Service Area and that are Medically Necessary and immediately needed as a result of an unforeseen illness, accident, or injury, and when it is not reasonable to obtain services from a Network Provider, or no Network Provider is available to provide the neededservices at the time the services are needed.

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