Dear Provider:

The Care Wisconsin Provider Manual serves as a reference for information pertaining to the Care Wisconsin Medicaid SSI Program and Care Wisconsin’s relationship with providers. We are pleased your organization has elected to participate in the Care Wisconsin Provider Network.

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. The Manual is a work in progress since content can change at any time.

We welcome your ideas on how we can improve the usefulness of this Manual and enhance your provider network participation. You may find the most current version at www.carewisc.org.

Sincerely,

Care Wisconsin, Provider Services Team
MISSION AND VALUES

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.
Contents

SECTION 1 – ENROLLMENT & ELIGIBILITY INFORMATION .......................................................... 6
  Eligibility ........................................................................................................................................... 6
  Identification of Care Wisconsin Members .................................................................................. 7
  Disenrollment ................................................................................................................................. 8

SECTION 2 – SSI CARE MANAGEMENT ..................................................................................... 9

SECTION 3 – COVERED SERVICES AND AUTHORIZATIONS ................................................ 10
  Medical Management ................................................................................................................... 10
  How to obtain a prior authorization ............................................................................................ 10
  Review criteria and guidelines ..................................................................................................... 10
  Time frame for requests ............................................................................................................... 11
  Limits of prior authorization approval ......................................................................................... 11
  Inpatient Management ............................................................................................................... 12
  Behavioral Health ...................................................................................................................... 12
  HealthCheck ............................................................................................................................... 13

SECTION 4 - TRANSPORTATION .............................................................................................. 15

SECTION 5 – MEMBER RIGHTS AND RESPONSIBILITIES ..................................................... 16
  Care Wisconsin Medicaid SSI Members have the right to: ......................................................... 16
  Care Wisconsin Members’ Civil Rights .................................................................................... 17
  Care Wisconsin Members’ Privacy Rights ............................................................................... 17
  Care Wisconsin Medicaid SSI members have the responsibility to: .......................................... 18

SECTION 6 – PROVIDER RESPONSIBILITIES ........................................................................ 18
  Provisions for Interpreters/Translators ...................................................................................... 18
  Obtaining a Prior Authorization .................................................................................................. 19
  Advance Directives ...................................................................................................................... 19
  Eligibility (See also Member Enrollment and Eligibility Information) ....................................... 20
  Fraud, Waste & Abuse .................................................................................................................. 21
  Definitions of Fraud, Waste and Abuse ...................................................................................... 21
  Examples of Federal and State Fraud, Waste & Abuse Laws ..................................................... 21
  Anti-Retaliation Protections ......................................................................................................... 22
  Network Participation Standards for Health and Long-Term Care Providers ......................... 22

SECTION 7 – CLAIMS INFORMATION ...................................................................................... 23
  Claims Submission ...................................................................................................................... 23
SECTION 1 – ENROLLMENT & ELIGIBILITY INFORMATION

Eligibility

Medicaid SSI Plan recipients receive benefits and coverage comparable to the BadgerCare Plus Standard Plan and are eligible for Medicaid due to their eligibility for SSI (Supplemental Security Income) for limited income and resources.

Members may choose their own HMO or work with the HMO Enrollment Specialist to choose the best one for their needs. They may choose an HMO at any time during the enrollment process.

Following is the enrollment process:

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

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

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

4. S/he will then receive a notice confirming enrollment in the assigned or chosen HMO for the following month. The member has up to three months to change HMOs, once enrolled. This is the open enrollment period. After the initial three months, the member is locked into the HMO and cannot change for nine months. If your member has questions about HMO enrollment, s/he should contact the Enrollment Specialist at 1-800-291-2002.

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

Exemptions: A member may qualify for an exemption from HMO enrollment if s/he meets certain criteria, such as a chronic illness, high-risk third trimester pregnancy, or continuity of care concerns, etc. If the member believes s/he has a valid reason for exemption, s/he should call the HMO Enrollment Specialist at 1-800-291-2002. The number is also in the enrollment materials s/he receives.

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

If the member’s eligibility is re-established after a Restrictive Reenrollment Period (RRP), s/he will be automatically re-enrolled in the previous HMO, unless the HMO is no longer accepting reassignments. After six months, or if the HMO is no longer accepting reassignments or has exceeded its enrollment level, s/he will receive an enrollment packet, and the enrollment process will start over.
Identification of Care Wisconsin Members

Medicaid SSI members do not receive Insurance Identification cards from Care Wisconsin.

Medicaid SSI members are required to carry and present their ForwardHealth card (issued by Department of Health Services) when seeking services.

DHS ForwardHealth Card

1. Recipient Name
2. Medicaid Identification Number
3. Unique Card Number (for internal use only)
4. Medicaid Recipient Services Telephone Number
5. Signature Space
6. Magnetic Strip

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

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

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

Members are automatically disenrolled from the HMO program if:

- They lose Medicaid SSI eligibility
- They move out of the HMO’s service area

Members who move out of the HMO service area receive a new packet showing the HMO(s) available in the new area and the enrollment process begins again. If no HMO covers the member’s new area, s/he remains fee-for-service.
SECTION 2 – SSI CARE MANAGEMENT

Care Wisconsin’s Medicaid SSI Health Management program is designed to assist members to obtain the benefits and services that they need to maximize their health and well-being. Our Member Care Specialists and Nurse Care Managers communicate with members beginning with the time of the member’s enrollment to assist the member in taking advantage of the full range of services that our care management program entails, including the following:

- **Comprehensive Assessment**: assessment of medical, behavioral, and social needs conducted within 60 days of enrollment

- **Individualized Care Planning**: developed as an extension of the assessment process to include appropriate service utilization under the benefit plan, engagement of informal supports and assistance, initiation of differentiated care coordination services through CW

- **Differentiated Care Coordination**: differentiated protocol of frequency and intensity of care coordination contact and follow-up based upon our risk stratification protocol

- **Preventive Care Reminders**: individualized schedule of reminders for routine preventive services.

- **Service Satisfaction Check**: follow-up with members to ensure that needed therapies, services, and equipment were provided in a timely manner and that they have adequately met the identified needs of those members

- **Health Education and Disease Management Programs**: information provided to members relevant to their health status through audio and written materials, community program referrals, and telephonic consultation as a continuation of the assessment and care planning process

- **Care Wisconsin Nurse Call Line**: after-hours access to Nurse triage line to assist in decision-making regarding obtaining appropriate treatment

- **Care Transition Planning**: access to care management staff who will be facilitating discharge and admission transitions to ensure that all needs are identified and met to maximize the potential for success in meeting the goals for shifting from one level of care to another

Members will have access to our Member Care Line 24 hours a day. During business hours (8 a.m.-4:30 p.m. M-F), this line is staffed by our care coordination staff to address member questions regarding their Health Plan benefits and services. Our differentiated care coordination provides the opportunity for those members with more complex medical, behavioral, and social needs to work more intensively with one of our qualified Member Care Specialist or Nurse staff. After hours, including weekends and holidays, members will be able to leave messages and access a Nurse for urgent and emergency situations.

All Care Wisconsin Medicaid SSI members will be required to select a primary care provider (PCP). Our staff will assist members who do not currently have a PCP, and will assign one if members are unable to make selection themselves. Members are able to change their PCP by contacting our care management staff, as well.

This PCP selection is central to Care Wisconsin’s coordination of care model. Correspondence reflecting the care coordination activities and programs outlined above will be available to a member’s PCP and other key providers.
SECTION 3 – COVERED SERVICES AND AUTHORIZATIONS

Medical Management

Care Wisconsin uses a prior authorization process to review the provision of certain services, procedures, and tests in the context of healthcare management guidelines prior to the services being provided. This includes elective facility admissions, some services and procedures received on an outpatient basis, some durable medical equipment, as well as a few laboratory tests and radiological procedures. Go to www.carewisc.org/providers for a complete list of prior authorization requirements.

Reviews are done to confirm the following:

- Member eligibility
- Benefit coverage
- Compliance with the State of Wisconsin definition of medical necessity
- Appropriateness of setting
- Requirements for utilization of in-network and out-of-network facilities and professionals
- Identification of medical conditions and other concerns that might benefit from Care Wisconsin care management programs including concurrent review, discharge planning, disease management, and intensive case management.

How to obtain a prior authorization

Prior authorization guidelines, forms and instructions for submission are available at www.carewisc.org/providers.

See forms for specific instructions. You can facilitate the review and determination of your prior authorization request by completing the appropriate form in full. Forms are available at https://www.carewisc.org/authorizations. Please keep in mind that there should be sufficient information to make a thoughtful determination of medical necessity as well as to be able to sufficiently code the appropriate procedures and applicable diagnoses.

Review criteria and guidelines

Care Wisconsin uses the Wisconsin Medicaid guidelines which can be found at: www.forwardhealth.wi.gov/WIPortal as well as clinical guidelines criteria in our utilization review process. Providers may obtain the criteria used to respond to a specific service request by calling 1-800-963-0035.

Medical necessity: Care Wisconsin concurs with the definition of “medically necessary” as stated under Chapter DHS 101.03 of a medical assistance service listed in Chapter DHS 107 that is:

(a) Required to prevent, identify or treat a recipient's illness, injury or disability; and
(b) Meets the following standards:

1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
2. Is 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;
3. Is appropriate with regard to generally accepted standards of medical practice;
4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
5. Is of proven medical value or usefulness and, consistent with s. DHS 107.035, is not experimental in nature;
6. Is not duplicative with respect to other services being provided to the recipient;
7. Is not solely for the convenience of the recipient, the recipient's family or a provider;
8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

**Time frame for requests**

Requests for prior authorization should be submitted 14 business days prior to the date of an elective service, admission, or procedure. Care Wisconsin will make a decision within 14 days of receipt of a standard request, or within 3 business days of receipt of an urgent request. An urgent request is one in which the physician indicates or the HMO determines that following the ordinary time frame could jeopardize the member’s health or ability to regain maximum function. Care Wisconsin will communicate that decision within 2 business days of our determination.

**Limits of prior authorization approval**

Approval of a prior authorization request is based upon the assumption of member eligibility and benefit coverage at the time of service. It is up to the provider to ensure that coverage is in place at that time.
**Inpatient Management**

**Prior authorization and notification:** Hospital, Skilled Nursing Facility, LTAC responsibilities:

- Contact Care Wisconsin to obtain prior authorization for all elective admissions and procedures
- Notify Care Wisconsin on the date of admission or within one (business) day of admission, regardless of elective/emergency status
- Cooperate with Care Wisconsin concurrent review and discharge planning activities

**Concurrent review and Discharge planning:** Care Wisconsin care management staff will review ongoing treatment and progress of members who have been admitted to any facility, in conjunction with the facility’s utilization review, discharge planning, or other facility-designated staff. Reviews will be done with consideration of member’s initial presentation, diagnoses, plan of care, response to treatment, as well as discharge plans, including medical follow-up. Care Wisconsin care management will also include members, guardians, caregivers, and family members as appropriate in the discharge planning process.

**Behavioral Health**

Care Wisconsin has structured its prior authorization requirements for mental health and AODA services to (1) minimize barriers for members who are in need of and wish to obtain these services, and (2) minimize the disruption to those who are providing the vast majority of care through office-based treatment. We implement a notification system for ongoing outpatient office-based services for care coordination and the exchange of information that will be necessary in some instances to ensure better outcomes for a member. Prior authorization requirements do exist for non-emergent admissions to structured programs and any services which include an overnight stay. These and other services such as home-based services and extensive psychological testing reflect a higher level of need and of intensity of care management services. It is our belief that the additional review of these services with our care management staff will lead to the kind of collaborative efforts which will improve member outcomes.

- **Office-based Outpatient Care:** Care Wisconsin has no prior authorization or concurrent review requirement for office-based outpatient behavioral health treatment, with the exception of some psychological testing (testing batteries over four hours in length). A Behavioral Health Care Plan (see Outpatient Behavioral Health Treatment Services Notification/Prior Authorization form available at [www.carewisc.org/providers](http://www.carewisc.org/providers)) is required to be submitted prior to the 4th visit to any given provider within a 6 month period. This care plan allows Care Wisconsin care management staff to be more effective in their care coordination efforts, particularly with those members with high needs. Care Wisconsin requests that providers obtain a release of information from members at the onset of treatment to facilitate care coordination.

- **Psychological Testing:** Care Wisconsin requires prior authorization for inpatient or outpatient psychological testing expected to be more than 4 hours in length. Please use the Outpatient Behavioral Health Treatment Services Notification/Prior Authorization form available at [www.carewisc.org/providers](http://www.carewisc.org/providers).

- **Home-based Therapy:** Care Wisconsin requires prior authorization for home-based therapy. Please use the Outpatient Behavioral Health Treatment Services Notification/Prior Authorization form available at [www.carewisc.org/providers](http://www.carewisc.org/providers).
Behavioral Health Programs (Day Treatment/Partial Hospitalization/Intensive Outpatient): Care Wisconsin requires prior authorization and ongoing review of treatment provided and progress of members enrolled in behavioral health programs. Please use the Outpatient Behavioral Health Treatment Services Notification/Prior Authorization form available at www.carewisc.org/providers. A schedule of ongoing review will be developed depending upon the nature of the program. This schedule will be communicated by Care Wisconsin care management staff upon approval of the request for authorization.

Inpatient Services including Sub-Acute and Crisis Stabilization: Any service involving an overnight stay requires a prior authorization unless it is an emergency. Emergency admissions require notification of Care Wisconsin as soon as possible after admission. Please use the Inpatient Behavioral Health Treatment and Services Notification form available at www.carewisc.org/providers for prior authorization and for emergency admissions. Care Wisconsin care management staff will work with facilities to conduct concurrent review of members’ progress while in a facility and to collaborate in the discharge planning process to ensure that all necessary services are in place prior to that transition, minimizing the chances of an unplanned readmission.

HealthCheck

HealthCheck is Wisconsin’s name for the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program which was put into place to assure that all Medicaid-enrolled children receive periodic, comprehensive health screening exams resulting in the identification and provision of needed health care services.

HealthCheck services consist of a comprehensive health screening of all members younger than 21 years of age that includes all of the following:

- A comprehensive health and developmental history (including anticipatory guidance).
- A comprehensive unclothed physical exam.
- An age-appropriate vision screen.
- An age-appropriate hearing screen.
- An oral assessment plus referral to a dentist beginning at age 3.
- Appropriate immunizations (according to age and health history).
- Appropriate laboratory tests (including blood lead level testing when appropriate for age).

A HealthCheck screening examination may be distinguished from other preventive health care under Wisconsin Medicaid because HealthCheck includes a strong anticipatory guidance and health education component and a schedule for periodic examinations (based on recommendations by organizations that are recognized as authorities in the field of child and adolescent health). Medicaid SSI members under age 21 should receive annual HealthCheck examinations.
Wisconsin Medicaid has developed and makes available free of charge forms that meet the documentation requirements of the program. Use of these forms is optional. Many clinics/agencies have developed documentation systems which work well for them, and they are encouraged to continue to do this. It is required that documentation shows that all seven areas listed above have been assessed and is located in the member's medical record.

Additional information and resources for HealthCheck providers can be found through the ForwardHealth Portal for Providers in the Online Handbook at:

SECTION 4 - TRANSPORTATION

Care Wisconsin Medicaid SSI Members who request non-emergency medical transportation services should be directed to the transportation manager per the ForwardHealth Update at: www.forwardhealth.wi.gov/kw/pdf/2013-32.pdf. The member may also contact Medical Transportation Management Inc. (MTM Inc.) at 1-866-907-1493 (TTY: 1-800-855-2880).

Care Wisconsin covers emergency ambulance transportation for life-threatening emergencies. For all non-emergent ambulance transportation the member, please direct the member to contact Medical Transportation Management Inc. (MTM Inc.) at 1-866-907-1493 (TTY: 1-800-855-2880).
SECTION 5 – MEMBER RIGHTS AND RESPONSIBILITIES

All SSI members have rights. We adhere to the following member rights as stated in the SSI Member Handbook and listed below.

**Care Wisconsin Medicaid SSI Members have the right to:**

- Be treated with respect and dignity, with recognition of the need for privacy.
- Ask for an interpreter and have one provided to them during any Medicaid SSI covered service.
- Receive the information provided in their member handbook or any provider handouts or documentation in another language or format.
- Receive health care services as provided for in Federal and State law. All covered services must be available and accessible to the members. When medically appropriate, services must be available 24 hours a day, seven days a week.
- Receive information about treatment options including the right to request a second opinion.
- Make decisions about their health care.
- Be free from any form of restraint or seclusion used as means of force, control, ease or reprisal.
- Direct access to preventive health care services. Members have access to preventive services from a Network Provider without the need for a referral.
- Receive direct access to in-network women’s health specialists for females seeking routine and preventive services.
- Be provided with complete and accurate information about health care benefits, limitations and exclusions associated with coverage through Care Wisconsin.
- Receive assistance in a prompt, courteous, appropriate and culturally competent manner.
- Receive information about their diagnosis, prognosis, and treatment from their Primary Care Physician, in terms they understand.
- Expect Care Wisconsin will not interfere with a Network Provider’s discussion with them about treatment options, whether those options would be covered by Care Wisconsin or not.
- Have the option of referral to another provider if your provider objects to a treatment based on religious or moral grounds.
- Be provided with complete and accurate information on Network Providers in their benefit plan.
- Receive complete information from their Physician or other medical provider about any treatment they are given.
• Have their medical provider request their consent for all treatment, except in the case of an emergency where the member’s life is in serious danger and the member is unable to sign a consent form.

• Refuse treatment and to be advised of the probable consequences of the refusal.

• Choose an Advance Directive to designate the kind of care the member prefers to receive if the member becomes unable to express his/her wishes.

• Select a Primary Care Clinic of their choice from Care Wisconsin’s contracted Provider network.

• File a grievance or appeal about Care Wisconsin or a Network Provider without fear of retaliation, and to receive a response to the grievance in a timely manner.

• Receive records and information that pertains to them within a timely manner.

**Care Wisconsin Members’ Civil Rights**

Care Wisconsin provides covered services to all eligible members regardless of:

- Age
- Color
- Disability
- National Origin
- Race
- Sex

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

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

**Care Wisconsin Members’ Privacy Rights**

Care Wisconsin members have the right to privacy and confidentiality concerning their medical care. All communication and records pertaining to their care shall be treated as confidential in accordance with Federal and State law.

In addition, members have the right to:

- Get a copy of their health and claims records
Correct their health and claims records
- Request confidential communications with them
- Ask us to limit the information we share for treatment, payment or operations
- Get a list of those with whom we’ve shared their information
- Get a copy of the notice of privacy practices
- Choose someone to act on their behalf with regard to their health information
- File a complaint if they believe their privacy rights have been violated

Care Wisconsin Medicaid SSI members have the responsibility to:
- Confirm their covered benefits prior to receiving services.
- Select health care providers that are part of Care Wisconsin’s contracted network.
- Keep their scheduled appointments, or to cancel as appropriate.
- Seek clarification from their medical care provider if they have questions.
- Follow the advice of their Physicians and providers, and to be aware of the potential consequences if they do not follow the advice.
- Express their opinions, concerns, complaints, and grievances to Care Wisconsin.
- Provide information to their Physicians, providers, and Care Wisconsin to enable them to provide high quality, individualized care.
- Use emergency room services only for an illness or injury that appears to pose a serious threat to their health or life if not evaluated and treated immediately.
- Follow the treatment plan agreed upon by the member and the member’s Physician and/or other providers.
- Treat all providers and Care Wisconsin staff with courtesy and respect.
- Notify Care Wisconsin of any change in address.

SECTION 6 – PROVIDER RESPONSIBILITIES

Provisions for Interpreters/Translators

Providers must provide access to professional interpreters, including sign language, must be available at all times to support members with limited English proficiency. Family members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality is critical.
Interpreters are to be scheduled at the same time the appointment is made. In the case of an emergency, or if interpreters are not available in the clinic, local interpreters must be contacted to assist by phone or in person if possible.

It is the responsibility of the provider of healthcare to pay for this service. Documentation is to be made in the member medical record of all efforts made to schedule an interpreter.

Assistance in locating translation/interpretations services is available online at the Wisconsin Department of Human Services website on the Limited English Proficiency Resources link at www.dhs.wisconsin.gov/civilrights/LEPresources.HTM.

**Obtaining a Prior Authorization**

The Medicaid SSI Program offered by Care Wisconsin covers many health care benefits. Care Wisconsin requires prior authorization for select procedures and services. Go to www.carewisc.org/providers for a complete list of prior authorization requirements, as well as, prior authorization forms and instructions for submission.

Prior authorization guidelines, forms and instructions for submission of prior authorization can be found at www.carewisc.org/providers. You can facilitate the review and determination of your prior authorization request by completing the form in full. Please keep in mind that there should be sufficient information to make a thoughtful determination of medical necessity as well as to be able to sufficiently code the appropriate procedures and applicable diagnoses.

Care Wisconsin uses the Wisconsin Medicaid guidelines which can be found on the DHS ForwardHealth Portal at www.forwardhealth.wi.gov/WIPortal. Providers may obtain the criteria used to respond to a specific service request by calling 1-800-963-0035.

**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 (See also Member Rights and Responsibilities.) We encourage all members to discuss their wishes with their Primary Care Physician. 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.

- 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.
- Physician 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.

Eligibility (See also Member Enrollment and Eligibility Information)

Identification of Care Wisconsin Members:

Medicaid SSI members do not receive Insurance Identification cards from Care Wisconsin. Medicaid SSI members are required to carry and present their ForwardHealth card (issued by the Department of Health Services) when seeking services.

DHS ForwardHealth Card

![ForwardHealth Card Diagram]

1. Recipient Name
2. Medicaid Identification Number
3. Unique Card Number (for internal use only)
4. Medicaid Recipient Services Telephone Number
5. Signature Space
6. Magnetic Strip

Provider Responsibility:

• To verify enrollment prior to each date of service. The secure area of the ForwardHealth Portal offers real-time member enrollment verification for all ForwardHealth programs. All Portal users can use this tool to determine the benefit plan(s) in which the member is enrolled or if the member is enrolled in a state-contracted managed care program. The ForwardHealth Portal
website can be found at www.ForwardHealth.wi.gov and is available 24 hours a day, seven days a week.

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

**Fraud, Waste & Abuse**

Care Wisconsin fosters and ensures an organizational culture in which we promote the prevention, detection and resolution of violations of law. Care Wisconsin’s policy is to comply with all applicable Federal and State laws pertaining to fraud, waste and abuse in Federal healthcare programs. All contracted entities and business associates of Care Wisconsin are also required to act in compliance with these laws.

**Definitions of Fraud, Waste and Abuse**

**Fraud**: To deliberately deceive, trick, or cheat in order to gain an advantage or something of value. An example of fraud is when a provider knowingly bills for services that were not provided.

**Waste**: To use, consume, spend, or expend thoughtlessly or carelessly. An example may be poor utilization management practices.

**Abuse**: To use wrongly or improperly in a manner that is not consistent with acceptable practice. This is like fraud, except with abuse there is no intent to deliberately deceive, trick or cheat. An example of abuse is when a provider bills for a service that was not provided, and the provider was not aware the service was not provided due to lack of business controls to identify erroneous billing.

**Examples of Federal and State Fraud, Waste & Abuse Laws**

**The False Claims Act**: Prohibits knowingly presenting (or causing to be presented) a false or fraudulent claim or creating or using (or causing to be created or used) a false record for claim payment or approval by Medicare, Medicaid or the federal government.

**The Anti-Kickback Statute**: Provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward under Medicare, Medicaid or other federally funded health care programs.

**The Health Insurance Portability and Accountability Act (HIPAA)**: Minimizes waste by standardizing electronic health care transactions, records, and data.

**The Freedom of Information Act**: Promotes the continued existence of an informed citizenry.

**Stark Laws I and II**: Regulates physician incentives by prohibiting payments to induce the reduction or limitation of medically necessary services.
**Anti-Retaliation Protections**

Care Wisconsin does not tolerate retaliation against those who report fraud, waste or abuse concerns in good faith. Anyone who has concerns about retaliation should call the Care Wisconsin Compliance Hotline immediately at 608-245-3576. The federal False Claims Act and Wisconsin statutes also protect those who report concerns.

To report suspected fraud, waste or abuse or to report suspected retaliatory actions please call Care Wisconsin’s Compliance Hotline at 608-245-3576.

**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 providers and contract only with 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.
SECTION 7 – CLAIMS INFORMATION

Claims Submission

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

Submit all claims to:
Care Wisconsin
PO Box 226897
Dallas, TX 75222-6897

Questions regarding the processing of your claims may be directed to the Provider Help Desk at Care Wisconsin. You can reach the Provider Help desk directly at 1-855-878-6699. Staff are available Monday-Friday, 8 a.m. to 4 p.m. to answer questions regarding how your claims are processed.

Claims submitted after the timely filing guideline indicated in your Care Wisconsin contract will be denied.

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

Electronic Claim Submission - Clearinghouses

To expedite payment to you, Care Wisconsin encourages electronic billing whenever possible. Care Wisconsin works with Emdeon, and our Payor ID number is 27004.

Balance Billing Information

Providers may not bill, charge, collect a deposit from, seek remuneration from, or have any recourse against a Care Wisconsin member for covered benefits.

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

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

• The member accepts responsibility for payment.

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

Providers are strongly encouraged to obtain a written statement in advance, documenting that the member has accepted responsibility for the payment of the service.

Furthermore, the service must be separate or distinct from a related, covered service.
**Payor of Last Resort**

Following Wisconsin Fee-For-Service Medicaid guidelines, Medicaid SSI HMOs are the payor of last resort for any covered services. Therefore, the provider is required to make a reasonable effort to exhaust all of the member’s other health insurance sources before submitting claims to Care Wisconsin.

**Subrogation and Recoupment**

**General Information**

- All liability insurer medical coverage benefits are considered primary to Care Wisconsin payment of Medicaid claims as per Wisconsin Statutes, Medicaid is payor of last resort. Care Wisconsin reserves the legal right to process claims accordingly.

- Wisconsin Statutes Chapter 49 and Administrative Code DHS §106 govern how providers should submit liability claims and how Care Wisconsin reviews these claims for processing. Wisconsin law also protects Care Wisconsin’s right of subrogation.

- Care Wisconsin reserves all legal, statutory and contractual subrogation and recoupment rights related to paid claims and will enforce its right in all cases, unless waived in writing by Care Wisconsin.

**Claims Submissions**

- Unless the provider wants to relinquish on liability claims (see below), the provider must submit claims to the primary liability insurance before submitting to Care Wisconsin. Following the liability carrier’s payment/denial determination, a copy of the original liability insurer remittance advice must be submitted to Care Wisconsin, along with the original claim, for Care Wisconsin’s review and/or payment determination (regardless of balance due).

- If liability claims are submitted to Care Wisconsin without the liability carrier’s payment determination via the original remittance advice, the claims will be denied using the appropriate ANSI codes. The denial reason will be printed on Care Wisconsin’s remittance advice to the provider.

- All claims should be submitted with accident relatedness and/or appropriate E-Codes when a liability carrier may be involved (i.e.: initial treatment and all subsequent related treatment).

- In the event a provider fails to submit claims with the appropriate liability coding information, and/or the claims are adjudicated and the provider accepts the Medicaid payment, these claims become the property of Care Wisconsin to pursue any subrogation interest.

- Once a provider accepts the Medicaid payment from Care Wisconsin, even where liability of another party/payor exists, the provider can no longer pursue or accept a payment from the liability carrier or Medicaid recipient, pursuant to Wisconsin Administrative Code DHS §106.03(8). **This applies to all liability-related payments, even if claims had not been coded to indicate liability as stated above.**
Recoupments/Refunds

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

Refund Process

If you have been overpaid and would like to submit a refund, please use the Refund Form from www.carewisc.org/providers. Make your check payable to “Care Wisconsin”, and mail the Form along with your check to:

Care Wisconsin
Attn: Refunds
P.O. Box 14017
Madison, WI 53708-0017

Coordination of Benefits

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

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

If the Provider fails to comply or is unaware of the primary insurance, claims for which Care Wisconsin is secondary will be denied. This denial reason will print on the Provider’s RA.

If primary insurance is discovered after charges have been processed and both Care Wisconsin and the primary insurance make payment, the Provider may have an overpayment and will be required to return the balance to Care Wisconsin.

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

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

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

For any questions regarding Coordination of Benefits, call the Provider Help Desk at 1-855-878-6699.

**Corrected Claims**

Corrected claims can be submitted on the appropriate claim form with “Corrected Claim” written or stamped on the UB-04 or the CMS-1500. Claims that are corrected and/or resubmitted to Care Wisconsin are subject to the claim appeal time frame identified in the Claim Appeal Process section of this Provider Manual. Corrected claims should be sent to the normal claims address at:

**Care Wisconsin**
PO Box 226897
Dallas, TX 75222-6897

**CMS-1500 Form Information**

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

Care Wisconsin requires a compliant red form be used.

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

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

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

**UB-04 Information**

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

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

A clean UB-04 claim is considered to have the following data elements (numbered as shown on claim form):

1. Complete provider information to include name, address, city, state, zip code +4 and telephone number
2. Patient's Account Number
3. Type of Bill
4. Federal Tax ID Number
5. Date(s) of Service
6. Patient's Complete Name (to include middle initial when appropriate)
7. Patient's Complete Address
8. Patient's Birth Date
9. Admission Hour (2-digit hour only)
10. Type
11. SRC (Source of Admission)
12. Discharge Hour (2-digit hour only)
13. Discharge Status
14. Condition Codes
15. Accident Status
16. Occurrence Codes & Dates
17. Revenue Codes
43. Revenue Code Description (optional)
44. HCPCS/CPT Code corresponding to Rev Code in element 42
45. Service Date
46. Days or Units
47. Total Charges
50. Other Insurance Information (if applicable)
54. Amount Paid Prior
55. Balance Due (optional)
56. NPI
58. Insured's Name
60. Patient Identification Number (ForwardHealth, Social Security or ID Number)
66. Principle Diagnosis
67A-Q. Diagnosis or Nature of Illness or Injury Present on Admission Indicator (POA)
71. DRG Number (only on inpatient claims)
72. E-Codes – External Cause of Injury (when appropriate)
76-79. Attending Provider’s NPI
81cc. Taxonomy

Note: Please utilize the appropriate claims form and follow standard Medicaid submission guidelines for your INDUSTRY AND/OR PROVIDER type.

Sterilization Consent Form Requirements

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

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

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

The ForwardHealth “Consent for Sterilization” state mandated consent form and instructions for completion are available on the Department of Health Services website at www.dhs.wisconsin.gov/forms/index.htm. This form must be completed for all Wisconsin Medicaid SSI members.
The following requirements are necessary before the sterilization can be performed:

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

**Hysterectomy Consent Form Requirements**

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

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

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

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

- The member was in a life-threatening emergency situation which required a hysterectomy.

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

**Note:** Payment cannot be made to providers of associated services (hospital, anesthesiologist, pathologists, and radiologists) unless the "Acknowledgment of Receipt of Hysterectomy Information" form is filled out accurately and in a timely manner. DHS will make recoupment from Care Wisconsin that will subsequently be recouped from the provider(s).

The ForwardHealth “Acknowledgment of Receipt of Hysterectomy Information” state mandated form and instructions for completion are available on the Department of Health Services website at [www.dhs.wisconsin.gov/forms/index.htm](http://www.dhs.wisconsin.gov/forms/index.htm). This form must be completed for all Wisconsin Medicaid SSI members.

**Abortion Certification Statement Requirements**

When an abortion meets the following criteria for coverage, all other medically necessary related services are also covered. Complications arising from an abortion, whether the abortion was covered or not, are also a covered service. Services incidental to a non-covered abortion are not covered. Such services include, but are not limited to any of the following services when directly related to the performance of a non-covered abortion: laboratory testing and interpretation, ultrasound services, recovery room services, routine follow-up visits, and transportation (transportation to prenatal visits is covered).

**Criteria for coverage:**

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

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

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

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

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

The Certification Statement Form must be faxed to Care Wisconsin’s Claims Department at (608) 245-3340 along with progress notes and any law enforcement documentation. Care Wisconsin will forward
this information to the State for final decision regarding coverage. Once the State has made their recommendations, Care Wisconsin will notify the physician’s office of their decision.

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

**Claim Appeal Process**

If you have questions or if you are dissatisfied with the payment/denial reflected on your Provider Remittance Advice, you may request an informal review of payment within 60 days from the initial payment/denial determination notice. To do this, please contact Care Wisconsin’s Provider Help Desk at 1-855-878-6699. If your concern is not settled to your satisfaction, you may also file a formal appeal in writing within 60 days from the initial payment/denial determination notice.

To submit a formal appeal, please use the Appeals Form from the Care Wisconsin Website: http://www.carewisc.org/providers. If you do not use the Appeals Form, please note that the appeal must contain the member’s name and Medicaid SSI ID number, the provider's name, date of service, date of billing, and date of rejection and reason for reconsideration. If your appeal is medical in nature (i.e. emergency, medical necessity and/or prior authorization related) you must submit medical records with your appeal. If your appeal does not include all of the required information, it will be considered an informal appeal.

Clearly indicate “Appeal” on the letter and mail it to:

**Care Wisconsin**  
**Attn: Claims Department**  
**P.O. Box 14017**  
**Madison, WI  53708-0017**

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

Forms must be sent to:

**BadgerCare Plus and Medicaid SSI Managed Care Unit**  
**PO Box 6470**  
**Madison, WI 53716-6470**  
**Fax: 608-224-6318**
SECTION 8 - QUALITY

Quality Improvement is an integrated process throughout Care Wisconsin organization. Effective operation of the managed care programs depends on the performance of program staff, the operation of internal and external systems, the performance of contractors and cooperative teamwork among the member, caregivers, families, and the community. The Quality Management Program at Care Wisconsin is critical in ensuring quality in the care provided to members and for continuously striving to improve that care. The goals of the Quality Department are shaped by Care Wisconsin’s strategic goals and fall into one of the seven categories: member access, member-centered planning and service delivery, member safeguards, provider capacity and capability, member outcomes and satisfaction and system performance. Each goal has measurable indicators associated with the goal. Departmental goals are outlined in the annual quality plan.

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

Activities of quality improvement programs in HMOs are critically reviewed by external quality review organizations and accreditation organizations such as the Accreditation Association for Ambulatory Healthcare, Inc. (AAAHC) or National Committee for Quality Assurance (NCQA). Care Wisconsin is held accountable to assure appropriate quality improvement structures are in place and that those activities have a positive impact on healthcare delivery.

As part of the State of Wisconsin Medicaid SSI program and HMO relationship, Care Wisconsin is required to provide the state with accurate encounter data within specified time frames. These data are collated and reported annually by the State of Wisconsin. Indicator data are reported in the following areas: Women's Healthcare; Child Healthcare; Acute and Chronic Condition; Mental Health; Preventive Care and Other Healthcare. Using this information, we are able to identify areas for improvement in serving these populations. The healthcare Provider's role in supplying these data is extremely important! With accurate information, Care Wisconsin is able to provide better administrative support for Plan Providers.

Pay for Performance

Care Wisconsin works with the Department of Health Services of Wisconsin (DHS) on performance initiatives. The Department of Health Services has developed Pay for Performance initiatives for health plans managing SSI populations. The initiatives are chosen based on clinical need, high risk, high cost and measures that require increased performance. Providers are expected to support compliance with the expectations of Pay for Performance measures.

These measures may change somewhat from year to year, but include:

- Adult Access to Preventive Care
- Breast Cancer Screening
- Diabetes Screening Tests (HbA1c and LDL)
• Outpatient follow up after hospital stay at 7 and 30 days for mental health or substance abuse
• Initiation and Engagement in Treatment of Alcohol and drugs

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 Physician (PCP)
• 30 days for a follow-up appointment with a dental provider for routine dental care
• 2 weeks for medical necessary high risk prenatal care
• Wait time at care facilities is not to exceed 30 minutes
• Physicians “on call” for network Primary Care Physicians 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.

Care Wisconsin recognizes that delays may be unavoidable, and it is the responsibility of the provider to notify the member of unusual delays and offer alternatives.
SECTION 9 – CREDENTIALING

Care Wisconsin’s credentialing standards enable us to meet the requirements of our contract with the Wisconsin Department of Health Services (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 you contract with Care Wisconsin, we will let you know whether or not you must complete our Uniform Credentialing Application (found in Appendix C) since it is possible your credentialing may be handled by one of our credentialing delegates.

Information acquired through the credentialing and re-credentialing processes is considered confidential, and Care Wisconsin staff and credentialing delegates who have 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 Committee has authority to approve or deny provider credentialing and re-credentialing applications.

The Medical Advisory, Peer Review and Credentialing Committee (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 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 practitioner 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 Wisconsin 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 notes:

- Findings of the two most recent surveys from the DHS Division of Quality Assurance (DQA) for skilled nursing facilities and home health agencies.
- CASPER 3 and 4 Reports are requested and reviewed for skilled nursing facilities, home health agencies, Hospitals, and ambulatory surgical centers.

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)
- 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:

- 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) Board Certification (if applicable)

Practitioners for Whom Credentialing Is Not Required

Not all plan providers are subject to credentialing. Those who are not include:

- Non-traditional practitioners 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 permitted to deliver services only under the direct supervision of another practitioner, including but no 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-credentialled within 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 limitation in ability to perform the function 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

Questions or requests for information should be directed to the Provider Services Manager of Contract Administration at:

    P.O. Box 14017
    Madison, WI  53708-0017

    or call 608-240-0020 or 1-800-963-0035
SECTION 10 - CONTACT INFORMATION

Provider Help Desk: 1-855-878-6699
- Available Monday through Friday 8 am – 4 pm
- Providers should call this number for claims and billing questions.

Provider Contracting: 1-800-963-0035
- Available Monday through Friday 8 am - 4:30 pm
- Providers should call this number for any contracting questions.

Inpatient Admissions Notification:
- Care Wisconsin requires notification of all inpatient admissions. Providers should email notification to carewisconsinadmissions@carewisc.org.
- If providers need to contact Care Wisconsin care management staff directly regarding an inpatient admission for an SSI member then please phone 1-855-463-0026.

Prior Authorizations:
- Fax Prior Authorization forms or information to 608-210-4050.
- If you have a question regarding prior authorization, please leave a message through our prior authorization mailbox at 1-855-463-0026.

ForwardHealth Portal: www.forwardhealth.wi.gov/WIPortal/
- Providers should use the ForwardHealth Portal for any eligibility or enrollment questions.

ForwardHealth Portal Help Desk: 1-866-908-1363
- Providers and trading partners may call the Forward Health Portal Helpdesk with technical questions on Portal functions.

WiCall Automated Voice Response (AVR) System: 1-800-947-3544
- Available 24 hours a day, seven days a week. WiCall is an AVR system that allows providers direct access to enrollment verification.