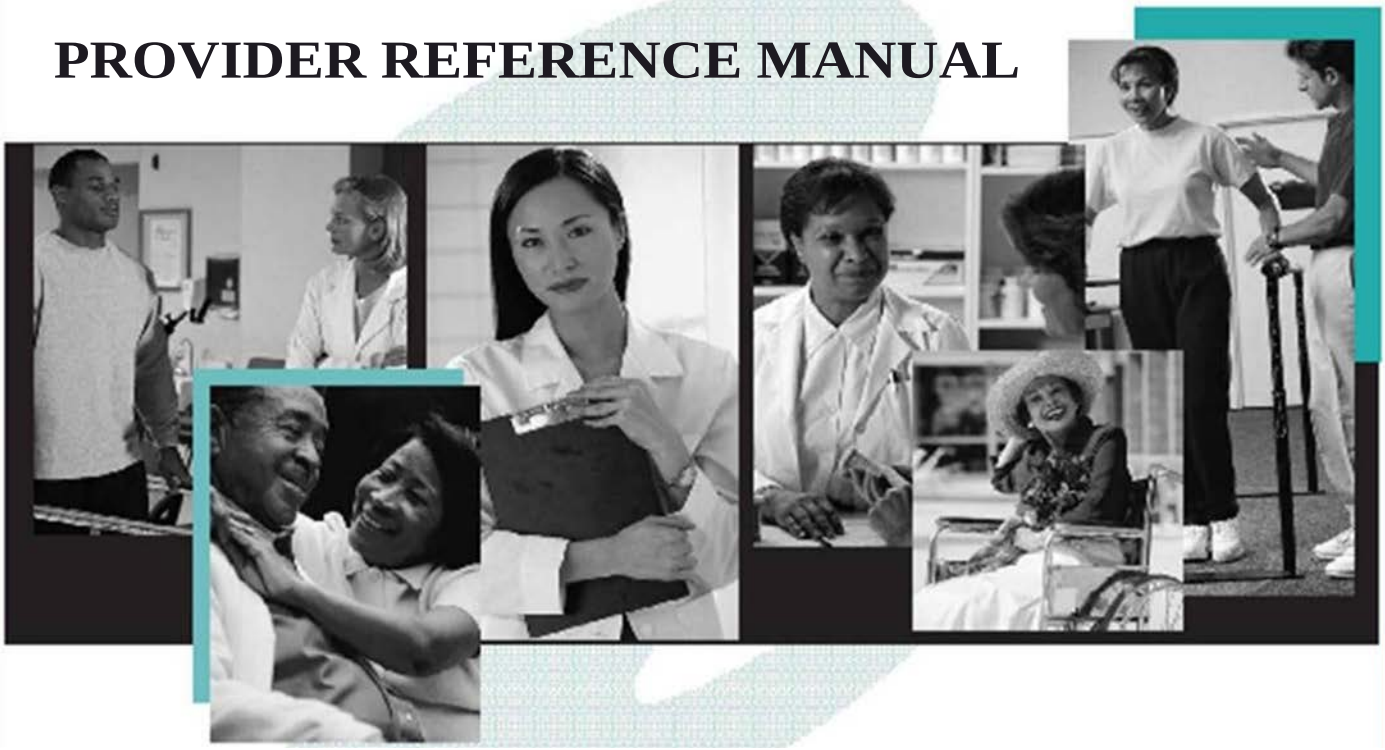
iCare

QUALITY, CHOICE,RESULTS

PROVIDER REFERENCE MANUAL



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INTRODUCTION

MISSION STATEMENT

The mission of Independent Care Health Plan (*i*Care) is to secure the wellness of persons with complex medical and behavioral conditions, respecting their dignity and the values of caring stakeholders.

COMPANY INFORMATION

Formed in 1994, Independent Care Health Plan receives funding from the State of Wisconsin Medicaid Program to coordinate healthcare services for individuals in the Southeastern Wisconsin Counties who receive Medicaid and Supplemental Security Income (SSI) benefits. A percentage of the membership has dual eligibility with Medicare as the primary insurer.

Independent Care also provides Medicare benefits and services to the dual eligible population in 22 Wisconsin counties.

Independent Care has 4 plans:

- The *i*Care SSI Medicaid Plan which is a Medicaid Health Maintenance Organization (HMO).
- The *i*Care Medicare Plan which is a Medicare Advantage Special Needs Plan (SNP).
- The *i*Care BagderCare Plan is in all Medicaid areas except Dane County
- The *i*Care Family Care Partnership Plan is in Milwaukee, Racine and Kenosha County.

The *i*Care population suffers from multiple medical co-morbidities further complicated by extensive social and behavioral needs. Through an integrated care management model, *i*Care works to identify and coordinate the home health, medical, dental, behavioral health, vision and prescription drug services its members need. The multidisciplinary care management team recognizes that social and behavioral factors impact the ability to provide successful medical treatment and improve quality of life. Independent Care members are treated with dignity and respect. We take pride in the diversity of our membership and consider cultural specific concerns when rendering services.

Independent Care contracts with providers interested and committed to serving individuals with special needs. We work hard to support our providers by sharing important information about *i*Care members and helping them follow through with intended treatment plans.

INTEGRATED CARE MANAGEMENT MODEL

Through the efforts of integrated care management, *i*Care Medicare, *i*Care Medicaid SSI, and BadgerCare Plus and Family Care Partnership seek to:

- Improve healthcare access
- Improve health outcomes and quality of life
- Improve communication
- Manage healthcare costs

Independent Care acts as a partner to complement the efforts of its physicians, hospitals, and ancillary providers to achieve these goals.
Independent Care's management process consists of the following components:

- Assessment
- Care planning
- Implementation of care plan
- Coordination of services
- Collaboration with members and providers
- Education
- Monitoring of needs
- Evaluation of plan
- Documentation

Care Coordinators (CC), Care Managers (CM) and RN Case Managers (RNCM) assist *i*Care Medicare SNP, Medicaid SSI, and Partnership members to meet their medical, behavioral health and social needs. They also work with hospital providers and physicians to assist in the discharge planning process to provide a smooth transition of care from one setting to the next.

When *i*Care is informed that your patient is experiencing a planned or unplanned transition in their care setting, we will contact you, and ask that you send a care plan consisting of any information that may assist in the members care in that setting. "Care Plan" is specifically defined by CMS as: a set of information about the patient that facilitates communication, collaboration and continuity of care across settings when a member experiences a transition. The care plan may contain, but is not limited to both medical and non-medical information, i.e., current problem list, medication regimen, allergies, advance directives, baseline physical and cognitive function, contact information for all professional care providers or practitioners and informal care providers. The care settings referred to include: home, inpatient hospital, home health care, acute care, skilled nursing facility, residential care and rehabilitation facility.

MEDICAL MANAGEMENT

Through *i*Care's integrated process of Care Coordination and Case Management, *i*Care believes members receive quality, cost effective medical care. Through the Medical Management Department, *i*Care provides the following for Badger Care members:

- Prior authorization
- Specialty referrals
- Discharge planning
- Disease management programs

Inpatient Admission Notification

Independent Care requires that all hospitals notify *i*Care by phone or fax within 24 hours of an admission (emergent or elective) or on the next business day. (**See Exhibit 1 – Inpatient Admission Notification Form**). This notification allows *i*Care to initiate early discharge planning.

*i*Care is also notified of Skilled Nursing Facility admissions. (**See Exhibit 2 – Nursing Home/Facility Prior Authorization Form**)

GENERAL INFORMATION

MAIN NUMBER
414-223-4847 or 800-777-4376

Please see individual department phone and fax numbers, below.

Behavioral Health and AODA Services
Phone: 1-855-893-0476
Fax: 414-231-1075

Claims/Appeals/Reconsiderations
Local: 414-231-1029
Fax: 414-231-1094
Out of Area: 877-333-6820

Eligibility and Provider Services
Local: 414-231-1029
Fax: 414-231-1094
Out of Area: 877-333-6820

Inpatient Admissions Notification
414-225-4760
Fax: 414-231-1075

Member Advocate
414-231-1076
Fax: 414-231-1090

Pharmacy
414-223-4847
Fax: 414-231-1092

Prior Authorization & Referrals
Fax: 414-231-1026

Provider Contracting
414-225-4701
Fax: 414-272-5618

Provider Services and Eligibility
Local: 414-231-1029
Fax: 414-231-1094
Out of Area: 877-333-6820

ELIGIBILITY

*i*CARE MEDICAID PLAN ELIGIBILITY CRITERIA

To enroll in the *i*Care Medicaid Program, SSI or Badger Care Plus Standard the recipient must:

Be a resident of one of these Wisconsin counties

Brown	Manitowoc	Shawano
Calumet	Marinette	Sheboygan
Dane	Milwaukee	Walworth
Dodge	Oconto	Washington
Fond du Lac	Outagamie	Waukesha
Jefferson	Ozaukee	Waupaca
Kenosha	Racine	Winnebago
Kewaunee		

- Meet the Supplemental Security Income (SSI) and SSI-related disability criteria as defined by the State of Wisconsin Medicaid program, or
- Meet the Badger Care eligibility criteria established by the State of Wisconsin.
- Be living in the community
    - Not living in an institution
    - Not living in a nursing home
    - Not participating in a Home and Community Based (HCBW) Waiver program.

It is imperative the provider verifies eligibility each time services are provided. For various reasons, T-19/Medicaid eligibility can change at any time.

Eligibility is administered by the State of Wisconsin and requires the following:

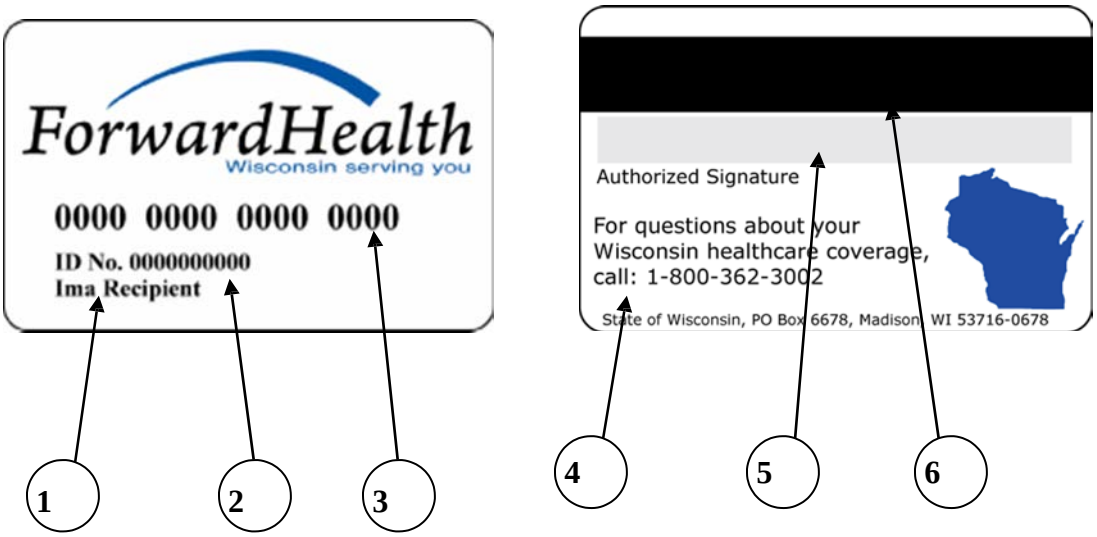
- Only certified Wisconsin Member Assistance (MA) providers are allowed to provide services to *i*Care Medicaid and BadgerCare Plus members.
- New Medicaid/BadgerCare Plus members are issued a ForwardHealth ID card (see below).
- The front of the cards display the recipient name, recipient Medicaid ID number and a unique 16-digit card number.
- The ForwardHealth cards offer providers an immediate and real-time eligibility Medicaid date and *i*Care designation when used with a point of service device or special computer software allowing access to the new eligibility verification system (EVS).
    - Providers may also verify a member's Medicaid eligibility status by calling **800-947-9627**.

CAREGIVER BACKGROUND CHECKS

All *i*Care contracted providers are required to comply with all applicable requirements of Wis. Admin. Code §§ DHS 12 and 13 relating to caregiver background checks. **Providers are required to provide documentation of compliance with these requirements to *i*Care at the point of applying for network provider status and periodically thereafter to validate continuing compliance.** Please refer to *i*Care's Caregiver Background Check Policy in the Exhibit Section of this Manual.

*i*Care reserves the right to decline to contract with, or to terminate the contract of any provider who cannot document that it is in compliance with the requirements of Wis. Admin. Code §§ DHS 12 and 13. The results of caregiver background checks shall be made available by the provider to *i*Care members consistent with the requirements of Wis. Admin. Code §§ DHS 12 and 13.

Medicaid ForwardHealth ID Card



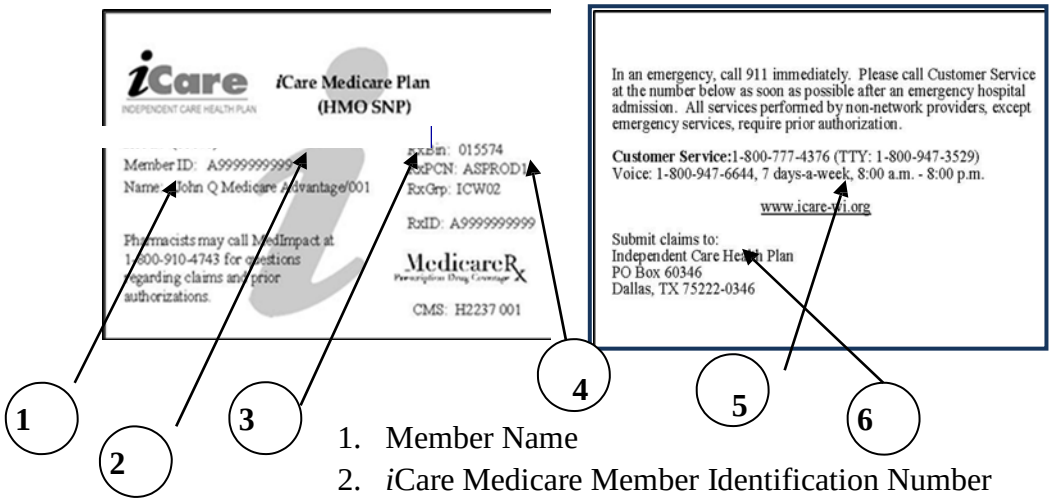
1. Recipient Name
2. Medicaid Identification Number
3. Unique Card Number (for internal use only)
4. Medicaid Recipient Services Telephone Number
5. Signature Space
6. Magnetic Strip

*i*CARE MEDICARE PLAN ELIGIBILITY CRITERIA

To be eligible for the *i*Care Medicare Plan, the enrollee must meet the following criteria:

- Must live in *i*Care's service area which includes the following counties:
  - Brown
  - Calumet
  - Dane
  - Kenosha
  - Kewaunee
  - Manitowoc
  - Menominee
  - Milwaukee
  - Oconto
  - Outagamie
  - Ozaukee
  - Racine
  - Shawano
  - Sheboygan
  - Walworth
  - Washington
  - Waukesha
  - Waupaca o
  - Winnebago
- Must have Medicare Part A and B
- Cannot have End-Stage Renal Disease (some exceptions may apply)
- Must be dual eligible with Medicaid and Medicare coverage
  - The Medicaid coverage can be Fee for Service or any other Medicaid coverage including *i*Care.

*i*Care Medicare ID Card



1. Member Name
2. *i*Care Medicare Member Identification Number
3. RxBin: Number
4. RxPCN: Number
5. *i*Care Medicare Member Services Telephone Number
6. *i*Care claims address

*i*CARE MEDICAID/BADGERCARE PLUS BENEFITS

MEDICAL ASSISTANCE BENEFITS

- The *i*Care Program provides the same medically necessary services as the Wisconsin Medical Assistance Program (WMAP) other than chiropractic care which is covered under the Fee for Service (FFS) program.
- *i*Care may go beyond WMAP services if it is warranted by the member's health condition.
- Refer to the Wisconsin Medical Assistance Program (WMAP) handbook for specific details of covered benefits.
    - The handbook is found on the Internet on the State of Wisconsin Medicaid website: http://dhs.wisconsin.gov/medicaid/INDEX.HTM

- Certified Wisconsin MA providers are required to provide services to all *i*Care members who present a valid Forward card issued by the State.

MEDICAID GENERAL SERVICES

*i*Care provides medically necessary Medicaid covered benefits through an approved provider when arranged through a Care Coordinator or Case Manager, with the exception of chiropractic services which are covered by the State of Wisconsin Medicaid Fee for Service Program. Some of the included Medicaid services are:

Physician

- Office and hospital visits
- Out-of-area routine care (referral required)
- Specialists (referral required only for Oral Surgery and Plastic Surgery)

General Hospital

- Inpatient
- Outpatient

Dental

- Emergency, preventive, restorative, endodontic, periodontics, removable prosthodontics, oral surgery

Vision

- Preventive (annual vision exam)
- Eyewear

Routine Physical and HealthCheck Exams

- Yearly and periodic check-ups
- HealthCheck exams and related services

Emergency/Urgent Care

Hearing Exams/Hearing Aids

Mental Health/Substance Abuse

- Inpatient/Outpatient

Nursing Home

- The first 90 days are covered

Vehicle Services

- Ambulance services for emergencies; (ambulance service for non-emergencies requires a Physician Certification Statement for Ambulance Transport)
- Specialized medical vehicles for medically necessary services
- Common carrier transport for medically necessary services

Durable Medical Equipment and Medical Supplies

Respiratory and Infusion Services

Home Health Services [Skilled Nursing and Personal Care Worker (PCW) services] Therapy

(Physical, Occupational, Speech, Cardiac and Pulmonary)

LONG-TERM CARE

When medically necessary, *i*Care Medicaid covers long-term care placement for up to 90 days. Nursing homes are responsible for notifying *i*Care of potential admissions to long-term care. (**See Exhibit 2 – Nursing Home/Facility Prior Authorization Form**) If an *i*Care member requires long-term care, he/she is automatically disenrolled from *i*Care after 90 days and continues Medicaid coverage with a Medicaid Fee for Service status. The facility is also obligated to notify the Social Security Administration (SSA) office that a member is in long-term care.

ORGAN TRANSPLANTS

*i*Care Medicaid covers kidney and cornea transplants only.

If an *i*Care member requires any other type of transplant the procedure must be preauthorized through the State of Wisconsin Medicaid Fee for Service (FFS) program. At the time of the transplant, the member is disenrolled from *i*Care Medicaid and reverts to the Medicaid FFS status effective the first of the month in which the transplant occurred.

EMERGENCY SERVICES

An emergency medical condition is defined by the State of Wisconsin as: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention could reasonably be expected to result in:

A. 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.

B. Serious impairment of bodily functions; or
C. Serious dysfunction of any bodily organ or part; or
D. With respect to a pregnant woman who is in active labor:
    1. Where there is inadequate time to effect a safe transfer to another hospital before delivery; or
    2. When a transfer may pose a threat to the health or safety of the woman or the unborn child
E. A psychiatric emergency involving a significant risk of serious harm to oneself or others.
F. A substance abuse emergency because there is significant harm to the enrollee or others, or there is likelihood of return to drug abuse without immediate treatment.
G. An emergency dental care situation which is defined as immediate service needed to relieve the patient from pain, an acute infection, swelling, trismus, fever, or trauma. In all emergency situations, the provider must document in the recipient's dental records the nature of the emergency.

URGENT CARE SERVICES

- An urgent medical situation is one that may require medical care but does not satisfy the emergency criteria.
- When in the area, members may contact their physician before requesting urgent care.
- If out-of-area urgent care services are required, the member notifies his or her Care Coordinator (CC) or Care Manager (CM) within 24 hours of receiving the services at: o **414-223-4847**
    - o **800-777-4376**
    - o **TTY 800-947-3529/Voice 800-947-6444**

OUT OF AREA SERVICES

If an emergency occurs outside the member's service area, the following procedures should be followed:

- For emergency and urgent care, the member should go to the nearest hospital.
- *i*Care is to be notified within 24 hours of receiving the service.

For *i*Care Medicare and *i*Care Medicaid, routine services performed out of the service area are subject to the Independent Care Health Plan pre-authorization rules and guidelines. Authorization rules and guidelines may be obtained by calling 414-223-4847.

*i*CARE MEDICARE PLAN BENEFITS

Services covered by the *i*Care Medicare plan include:

- Inpatient Hospital Care
- Inpatient Mental Health Care (up to 190 days in a Psychiatric Hospital in a lifetime)
- Skilled Nursing Facility (100 days are covered for each benefit period)
- Intermediate Care Facility
- Hospice (by a Medicare-certified Hospice)
- Home Health Care

Outpatient Care

- Annual Wellness Visit (for Medicare-covered-benefits)
- Doctor Office Visits (for Medicare-covered benefits)
- Chiropractic Services (for Medicare-covered benefits)
- Podiatry Services (for Medicare-covered benefits)
- Outpatient Mental Health Care (for Medicare-covered benefits)
- Outpatient Substance Abuse Care (for Medicare-covered benefits)
- Outpatient Services/Surgery (for Medicare-covered benefits)
- Crisis Intervention Mental Health Services (for Medicare-covered benefits)
- Outpatient Rehabilitation Services (for Medicare-covered benefits)
- Respiratory Care for Ventilator Dependent
- Independent Nursing Services

Emergency and Urgent Care Services

- Emergency Care (for Medicare-covered Emergency Room visits)
- Urgently Needed Care (for Medicare-covered Urgently Needed Care visits)
- Ambulance Services (for Medicare-covered Ambulance services)

Outpatient Medical Services and Supplies

- Durable Medical Equipment (for Medicare-covered items)
- Prosthetic Devices (for Medicare-covered items)
- Diabetes Self-Monitoring Training and Supplies
- Diagnostic Tests, X-Rays, and Lab Services (for Medicare-covered services)

Preventive Services

- Bone Mass Measurement (for Medicare-covered Bone Mass Measurement)
- Colorectal Screening Exams (for Medicare-covered Colorectal Screenings)
- Immunizations
- Mammograms (for Medicare-covered screening Mammograms)
- Pap Smears and Pelvic Exams (for Medicare-covered Pap Smears and Pelvic Exams)
- Prostate Cancer Screening Exams (for Medicare-covered Prostate Cancer Screening)
- Family Planning Services
- Outpatient Prescription Drugs

Additional Benefits

- Routine Physical Exams (for Medicare-covered benefits) Routine exams not covered
- Dental Services (for Medicare-covered Dental benefits) Preventive Dental not covered
- Hearing Services (routine hearing exams and aids not covered)
- Vision Services (for one pair of eyeglasses or contact lenses after cataract surgery)

HEALTH EDUCATION, PREVENTION AND WELLNESS PROGRAM

The purpose of *i*Care's health education program is to improve the health and well-being of members through multi-faceted outreach and education strategies.

*i*Care has implemented preventive health and promotion programs to assist members to develop healthy lifestyles. These programs are developed to include members' stages of change, when applicable, and reviewed on an annual basis.

Providers may refer patients into the health education programs. Providers should instruct their patients to contact their Care Coordinator (CC) or Care Manager (CM) at 414-223-4847.

Programs include:

- Tobacco Cessation Program for *i*Care Medicare, Medicaid, and BadgerCare Plus members
- Flu Immune Program – Influenza and Pneumonia Vaccination Program for *i*Care Medicare and/or *i*Care Medicaid SSI and BadgerCare Plus members
- HealthCheck for *i*Care Medicaid members under age 21, includes SSI and Badger Care

TOBACCO CESSATION PROGRAM

- Tobacco use is the most common avoidable cause of illness and death in the U.S.
- Most tobacco users want to quit (70% to 80% in surveys).

*i*Care has developed a Tobacco Cessation Initiative for all *i*Care members that currently use tobacco products. Members are routinely screened by staff for tobacco use history and offered tobacco cessation resources. *i*Care members are referred to programs such as the Wisconsin Tobacco QuitLine, Striving to Quit, and First Breath, a program for pregnant women. The programs offer an array of resources to include smoking cessation counseling, medications, self-help materials and incentives. For those that are not quite ready, the staff will continue to address tobacco use history with subsequent member interactions.

FLU AND PNEUMOCOCCAL VACCINES

*i*Care has been working with providers to increase availability and accessibility of the influenza (flu) and pneumococcal (pneumonia) vaccines for *i*Care Medicare or *i*Care Medicaid members. Each year, eligible *i*Care members have the opportunity to receive a flu shot or pneumonia vaccine from their physician, or other healthcare professional. *i*Care encourages physicians and other healthcare professionals to provide these vaccinations to *i*Care members. Please encourage members to receive these vaccinations during a scheduled visit or encourage the member to call 211 or contact their *i*Care

coordinator for another convenient location to receive these vaccines.

HEALTHCHECK PROGRAM

HealthCheck is a program that is mandated by federal Medicaid law to ensure that children in the State of Wisconsin are receiving periodic, comprehensive health screening exams. Nationally this program is known as the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. The program is intended to promote early detection and treatment of health conditions that could lead to chronic illness and disabilities in children.
The HealthCheck exam includes:

1. Comprehensive health and developmental history
    a. Health history
    b. Nutritional assessment
    c. Health education/anticipatory guidelines
    d. Developmental behavioral assessment
2. Physical assessment
    a. Unclothed physical exam and personal growth assessment
    b. Growth assessment
    c. Sexual development
3. Age-appropriate vision screen
4. Age-appropriate hearing screen
5. Oral assessment and evaluation services plus direct referral to a dentist
6. Appropriate immunizations
7. Appropriate laboratory test

All *i*Care Medicaid SSI and Badger Care members, under age 21 must receive one HealthCheck screening per year. Providers are required to perform and document all seven components of the HealthCheck exam. Comprehensive screens are billed using CPT codes with modifiers to indicate that a comprehensive HealthCheck screen was performed.

Modifier	Description	Allowable procedure codes	Allowable providers
UA *	Comprehensive HealthCheck screen results in a referral or follow up visit for diagnostic or corrective treatment	99381-99385 and 99391-99395	All HealthCheck providers, including HealthCheck nursing agencies.
EP	Service provided as part of [follow-up to] Medicaid early periodic screening diagnosis and treatment (EPSDT) program	99211-99215, T1002, T1029, T1017, and T1016	HealthCheck nursing agencies only
TS	Follow-up service [for lead inspection]	T1029	HealthCheck nursing agencies only

* Modifier “UA” is a national modifier that is state defined by Wisconsin Medicaid.

PREVENTIVE HEALTH GUIDELINES

*i*Care has adopted a set of preventive health guidelines that are recognized in the medical community to help prevent or delay serious health problems. The guidelines chosen are those adopted by the Agency for Healthcare Research Quality (AHRQ) from the U.S. Department of Health and Human Services (HHS). Unless another source is noted, they are evidence-based from the US Preventive Services Task Force (USPSTF) recommendations.

Access the Preventive Health Guidelines per AHRQ using the following link:

http://www.ahrq.gov/clinic/pocketgd/index.html

For immunizations *i*Care has chosen the Immunization Recommendations approved by the CDC, the American Academy of Family Practitioners (AAFP), the American College of Obstetricians and Gynecologists (ACOG), the American College of Physicians (ACP) and the American Academy of Pediatrics (AAP).

Included in the Recommendations are the following immunization schedules:

- Recommended Immunization Schedule for Persons Aged 0-6 Years
- Recommended Immunization Schedule for Persons Aged 7-18 Years
- Catch-up Immunization Schedule for Persons Aged 4 Months-18 Years who start late or who are more than 1 month behind
- Recommended Adult Immunization Schedule

PRENATAL CARE COORDINATION

Prenatal Care Coordination is available to assist high-risk recipients and their families to access medical, social, educational and other services related to pregnancy. The services are offered during the pregnancy and through the first 60 days following delivery.

Prenatal Care Coordination is available to *i*Care Medicaid and BadgerCare Plus members directly from the Wisconsin Medicaid Fee for Service program. *i*Care assists in the coordination of transportation and needed services. All claims should be submitted to Wisconsin Medicaid and recipient eligibility should be verified prior to delivering any services.

Prenatal Care Coordination services include:

- Outreach
- Initial assessment
- Care plan development
- Ongoing care coordination and monitoring
- Health education and nutrition counseling services

How *i*Care Medicaid helps:

- *i*Care member services will provide the MTM phone number for transportation services to and from medical visits.
- The *i*Care member's Care Coordinator (CC) or Care Manager (CM) works with the Prenatal Care Coordination staff to help coordinate needed services.
- For questions or assistance, contact the member's Care Coordinator at (414) 223-4847.

CUSTOMER SERVICE

TRANSPORTATION

Transportation for Medicaid-covered services and *i*Care-sponsored programs is provided for *i*Care Medicaid and BadgerCare Plus members. Transportation is covered for services deemed medically necessary as part of the care plan, supported by the prescribing physician and recommended by the *i*Care multidisciplinary team. Transportation can be in the form of bus, taxi or van service. When a member needs assistance in obtaining transportation to a medical appointment, they ***must*** call Medical Transportation Management, Inc. (MTM) *before* the transport takes place. Most Medicaid and BadgerCare Plus members may receive non-emergency medical transportation services through MTM, Inc., if they have no other way to arrange a ride. The number is 1-866-907-1494.

MTM requires a Level of Need (LON) form from providers. The member will bring the form to the provider's office for completion, or an *i*Care staff member might call the provider to make an "urgent" ride arrangement.

When a Family Care Partnership member needs transportation, they may call *i*Care at 414-223-4847 or 1-800-777-4376 for assistance.

SPECIALIZED MEDICAL VEHICLE (SMV)

- SMV requires a physician certification which identifies medical necessity. Certification is required for recipients who are legally blind or disabled to the extent that they cannot safely use private vehicles or mass transit services.
- The *i*Care Member Services Department verbally authorizes SMV transportation with the individual SMV provider.
- Members may not use SMV transportation to pick up prescription medication unless it's on the way to or way home from an approved SMV appointment.
- Most SMV companies are unable to manage same day rides.
- All SMV procedure codes require the use of a trip modifier. Providers will find the modifiers and the descriptions of the modifiers in Topic #1815 on the ForwardHealth website for T-19.

AMBULANCE SERVICES

Ambulance services are used primarily in emergency situations. In cases of an emergency, it is recommended to call 911. Any other requests, other than emergencies, would require a Physician Certification Statement for Ambulance Transport. Submit the Physician Certification Statement with the claim for Medicaid and BadgerCare Plus members. For additional information on Medicaid and BadgerCare Plus members go to www.ForwardHealth.wi.gov under Handbooks select Ambulance. Chapter 3 includes covered and noncovered services.

Ambulance providers bill the Transportation HMO, which is MTM for Medicaid, and BadgerCare Plus and the member cannot be billed. However, *i*Care does process the Medicaid Family Care Partnership non-emergency medical transport (NEMT) claims.

The Medicare program **does not** cover transportation services unless it is an inpatient stay and the patient requires an ambulance in order to move safely from one location to another. For example, a patient needs to go to another hospital that will provide a specific test. The cost of the ambulance transport is bundled into the service(s) the patient needed.

When an ambulance is medically necessary, Medicare will cover the service based on medical necessity among other requirements. For details regarding ambulance services for Medicare members see the CMS IOM Claims Processing Manual, 100-04 Chapter 15 at https://www.cms.gov/manuals

TRANSLATION REQUEST

*i*Care will work with the provider and the Interpreter/Translator Agency to make sure the member's rights are met during their appointment. When required, a provider makes their request for an interpreter to *i*Care. For an American Sign Language interpreter the agency needs 5-7 business days prior to the appointment to make arrangements. For other languages, the agency asks for at least 3 business days. Contact Customer Service at **414-223-4847 or toll free at 1-800-777-4376.**

Healthcare Provider Role

After a provider determines that an interpreter is needed for an *i*Care member, the following steps are taken:

1. Send a request for assistance to the Customer Service Mailbox at callcen@icare-wi.org include the following:
    a. Name of member
    b. Medicaid ID number
    c. Date of appointment/Length of time
    d. Provider name and phone number
    e. Contact name of person at the provider. Once an interpreter is available for the appointment, the contact person will receive the information from customer service.
2. If an interpreter is not available the provider's office will be notified via phone or e-mail.
3. If there is a cancellation of service, please provide more than a 24 hour notice to *i*Care.

Interpretation Agency Role

1. *i*Care contacts a contracted agency for an available interpreter.
2. The agency provides the name of the person that will be at the appointment.
3. *i*Care sends the Translator/Interpreter Payment Form to the agency.
    a. The interpreter takes the form to the appointment.
    b. The form must be completed and signed by the interpreter, hospital/clinic staff, and the hospital/clinic staff must print their name before a payment is made.
    c. The agency submits the invoice(s) and the payment form to *i*Care for payment. The address is:

    Independent Care Health Plan
    Attention: Accounts Payable
    1555 N. RiverCenter Dr. Suite 206
    Milwaukee, WI 53212

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

All Inpatient Mental Health and Alcohol or Other Drug Abuse (AODA) treatment services require prior authorization. Authorizations for most office based outpatient services are not required. However, we do require a form for notification of treatment and services for coordination of care and care management requirements for this level of service. **See Exhibit 1 for Inpatient Admission Notification Form.**

For Behavioral Health and AODA services, providers should call *i*Care at:

1-855-893-0476

Behavioral Health services that **require** prior notification or authorization include:

- Inpatient hospitalization
- Partial hospitalization
- Intensive outpatient program
- Psychological testing greater than 4 hours
- In-home treatment
- Community day treatment
- Crisis stabilization

Prior authorization and outpatient notification forms are available on the *i*Care provider website at http://www.icare-wi.org/providers/forms.aspx and can be obtained from an *i*Care behavioral health staff member.

OUTPATIENT MENTAL HEALTH PROCEDURE CODES

CPT codes are required on all outpatient mental health claims submitted on the CMS 1500 Health Insurance Claim Form. Claims or adjustments received without a CPT code are rejected.

For procedure codes that do not indicate a time increment, providers are required to use the rounding guidelines per the Common Procedural Terminology (CPT) Manual.

The ForwardHealth website lists the applicable CPT codes and modifiers for mental health services. Go to https://www.forwardhealth.wi.gov/WIPortal/Default.aspx and login with an ID and password to view the material. Providers may create an ID and password at any time.

SUBSTANCE ABUSE TREATMENT-HCPCS and CPT Codes

HCPCS and CPT codes are required on all outpatient substance abuse treatment claims submitted on the CMS 1500 Health Insurance Claim Form. Claims or corrected claims received without an HCPCS or CPT code are denied.

For procedure codes that do not indicate a time increment, providers are required to use the rounding guidelines per the most current CPT manual. Providers may find codes and applicable modifiers at https://www.forwardhealth.wi.gov/WIPortal/Default.aspx . For providers that submit claims on the CMS 1500 form below are procedures for psychiatric diagnostic or evaluative interview services.

Assessment services are limited to eight hours every rolling 12 months per member before PA is required under DHS 107.13(2)©4, Wisc. Admin. Code for the following services:

- Outpatient mental health benefits (procedure codes 90791 and 90792).
- Outpatient substance abuse treatment services (procedure codes 90791 and 90792).
- Adult mental health day treatment (procedure code H2012 with modifiers “HE” (mental health program) and “U6” (functional assessment).
- Substance abuse day treatment (procedure code H2012 with modifiers “HF” (substance abuse program) and “U6” (assessment).

OUTPATIENT THERAPY

Prior authorization is required for PT, OT, and SLP.

Comprehensive information about the member helps to establish the functional potential of the member and forms the basis for determining whether the member will benefit from the requested services. The provider faxes the completed therapy evaluation, plan of care, and signed physicians prescription along with the completed Therapy Prior Authorization form to 414-231-1026 to determine if the service is medically necessary.

Outpatient therapy will be authorized based on medical necessity. Services that are medically necessary are defined under Wis. Admin. Code § DHS 101.03(96m). The provider is responsible to assure that the services provided are covered under the Medicare or Medicaid benefit, whichever applies.

An approved PA request will be backdated to the initial therapy of the evaluation if the PA request is received within 14 calendar days of the initial therapy evaluation. *i*Care will not retro authorize any authorization requests submitted beyond 14 calendar days of the initial evaluation.

Continuing therapy requests may be requested when the member's need for therapy services is expected to exceed the maximum allowable treatment days authorized.

For continuing therapy requests, prior authorization must be obtained. PA requests for ongoing therapy will not be backdated. The provider must submit the completed Therapy Prior Authorization form as well as supporting clinical documentation to support medical necessity for ongoing therapy services.

A prior authorization request for continuing therapy services may be approved if the documentation provided establishes the following:

- Services are reasonably expected to be effective in achieving predictable and functional results for the member.
- Services are coordinated with the goals and activities of all other medical, educational, and vocational disciplines involved with the member.
- Services are cost-effective when compared with other available services that meet the member's treatment needs.
- Professional skills of a PT, OT, or SLP provider are required to meet the member's functional needs and therapy treatment needs.
- Treatment goals are reasonable given the member's current age and health status.
- Pertinent medical and social history is provided in sufficient detail to support that attainment of treatment goals would result in measurable and sustained benefit to the member.
- Frequency and duration of the requested services are based on the estimated length of time required for the member to realistically achieve the treatment goals.
- Medical diagnosis and problem statement (treatment diagnosis) identify the specific treatment needs of the member.

- Progress statements are objective, measurable, and demonstrate the desired outcome from the PT, OT, or SLP services in terms of functional improvements that can be generalized to settings outside the immediate treatment environment.
- Short-term objectives are realistic and attainable by the end of the requested PA.
- Long-term objectives describe the predicted functional changes expected by the end of the episode of care (not necessarily at the end of the requested PA).
- A plan to educate the recipient or caregiver and transition responsibility of the PT, OT, or SLP program.

PA requests are approved for varying periods of time based on the clinical justification submitted. The provider receives a copy of a PA decision notice when a PA request for a service is approved. Providers may then begin providing the approved service on the start date given.

An approved request means that the requested *service*, not necessarily the code, was approved. Providers are encouraged to review approved PA requests to confirm the services authorized and confirm the assigned start and end dates.

All claims for services are subject to the coverage and medical necessity guidelines provided by Medicare and Medicaid.

Medicare Guidelines for Outpatient Physical and Occupational Therapy Services (Local Coverage Determination 26884) can be found here.

Medicaid Guidelines can be found here.

PHARMACY SERVICES

GENERAL PHARMACY BENEFITS FOR *i*CARE MEDICAID

WI Medicaid Fee-for-Service (FFS) administers the pharmacy benefit for members enrolled in *i*Care Medicaid SSI and Badger Care. Please contact WI Medicaid FFS for information regarding the coverage of medications for these members.

GENERAL PHARMACY BENEFITS FOR *i*CARE MEDICARE

1. Prescription drug claims are administered through MedImpact Healthcare Systems, Inc. Point of Service on-line prescription processing is preferred. Pharmacies are expected to process claims at the time of dispensing. Claims exceeding 90 days from the date of dispensing are rejected by the on-line processing system.

2. Most prescription claims exceeding $900 are reviewed for accurate submission. Compounded prescription claims exceeding $50 are also reviewed for accurate pricing and submission. Compounded prescriptions must contain at least one Part D covered drug to qualify for coverage. Pharmacies should call MedImpact at **1-800-910-4743** for assistance with claims exceeding these amounts.

3. Pharmacy network contracting is managed by MedImpact. Pharmacies interested in becoming a network provider should contact MedImpact at **1-800-910-4743**.

4. Prior Authorizations for the *i*Care Medicare Pharmacy Benefit are processed by MedImpact. Providers may call MedImpact for additional information or to request a Medicare Part D Coverage Determination Request Form at **1-800-910-4743**.

5. For questions regarding eligibility and benefit coverage the *i*Care Pharmacy Services help- line is available:

   Monday through Friday from 8:30 am to 5:00 pm
   Call **414-223-4847** or **1-800-777-4376**

   If calling outside normal business hours, the *i*Care Pharmacy Services help-line is automatically forwarded to MedImpact for assistance.

DRUGS COVERED BY *i*CARE MEDICARE

*i*Care Medicare utilizes a formulary approved by CMS which includes both brand and generic Part D medications. The formulary may change slightly during the year as new drugs become available or new information is released regarding a drug's safety or efficacy.

Access the most current list of *i*Care Medicare covered drugs on the *i*Care website using the following link: http://www.icare-wi.org/providers/

In most cases, CMS requires that we notify all authorized prescribers and pharmacists 60 days prior to

removing a covered Part D drug from our formulary or changing the preferred status of a covered Part D drug. You may access our **60 Day Notice of Formulary Changes** on our website.

For certain medications, there are additional requirements for coverage or limits on the coverage. These are indicated within the formulary as **PA**, **ST**, or **QL**. See descriptions below for details.

Prior Authorization (PA): A prior authorization is required on certain drugs before they are covered. A Medicare Part D Coverage Determination Request Form (**See Exhibit 10 – Medicare D Coverage Determination Request Form**) can be faxed to MedImpact at **858- 790-7100**.
Step Therapy (ST): In some cases, a member is required to try one drug to treat a medical condition before another drug for that condition is covered.

Quantity Limit (QL): For certain drugs, the amount of the drug covered per prescription is limited or is limited for a defined period of time. In general, these match the recommended dosing parameters defined in package labeling and are implemented to encourage cost effective utilization and safety.

Generic Substitution: When a generic version of a brand name drug is available, network pharmacies automatically dispense the generic version unless the physician has indicated brand name is medically necessary. In most cases, brand name medically necessary medications also require prior authorization.

EXCEPTIONS TO *i*CARE MEDICARE COVERAGE LIMITS

When the medications on the *i*Care formulary used to treat a specific condition are not appropriate for a member, the provider may request coverage of a non-formulary Part D medication. This type of request is called a Formulary Exception. An exception may also be requested to the Step Therapy or Quantity Limit Restrictions. A Medicare Part D Coverage Determination Request Form (**See Exhibit 10 – Medicare D Coverage Determination Request Form**) can be faxed to MedImpact at **858-790-7100**. **Supporting medical information must be submitted with any exception request**.
Standard Coverage Determinations are completed within 72 hours. If waiting the standard time frame may seriously harm the health of the member or their ability to function, request an Expedited Coverage Determination. Expedited Coverage Determinations are completed within 24 hours.

***i*CARE MEDICARE TRANSITION POLICY**

New members to the *i*Care plan may be taking medications that are not on the *i*Care formulary or that are subject to certain restrictions such as Prior Authorization or Step Therapy. During the first 90 days of enrollment with *i*Care Medicare, we provide a temporary 30 day supply of a Part D medication to allow the member time to talk with the prescribing physician regarding the right course of action. You can either switch your patient to a different drug covered by our plan or ask us to make an exception and cover the current drug.

For members residing in a long term care facility, *i*Care provides up to a 31 day supply of medication during the first 90 days of enrollment with *i*Care Medicare. For residents of a long term care facility,

*i*Care allows a one-time emergency 31 day supply of a medication even when the member is past the first 90 days of enrollment with *i*Care Medicare.

For current enrollees affected by formulary changes from one coverage year to the next, *i*Care provides a transition process consistent with the transition process required for new enrollees beginning in the new contract year. The transition process applies to both drugs that are removed from our formulary from one contract year to the next, as well as to formulary drugs that remain on formulary but to which a new prior authorization or step therapy restriction is added from one contract year to the next.

After covering the temporary supply, *i*Care generally does not cover these medications again without a Prior Authorization. For more detailed information, please see the *i*Care Transition Process at http://www.icare-wi.org/

AUTHORIZATION FOR EARLY REFILLS DUE TO DOSAGE CHANGES, VACATION, LOSS, THEFT

- Approvals are granted for physician directed changes in dosage and directions as long as the change is reflected on a new prescription.
- Vacation supplies need to be approved by *i*Care. The *i*Care Medicare plan has a national network of pharmacies which gives members the flexibility to access prescriptions while traveling out of state.
- Early refill requests for theft and negligent loss may be subject to approval and monitoring by the prescribing physician. Overrides for early refills related to theft or negligent loss are only allowed once per coverage year.

***i*CARE MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM**

The Centers for Medicaid and Medicare Services (CMS) requires each Medicare plan that offers prescription drug coverage to have a Medication Therapy Program (MTM). At the request of CMS, the program targets members who have multiple chronic diseases, are taking multiple Part D covered drugs, and have high drug costs. CMS hopes these programs will help ensure optimum therapeutic outcomes for the targeted members through improved medication use and reduction in adverse medication events. *i*Care Medicare partners with Outcomes Pharmaceutical Health Care ("Outcomes"), the national leader in MTM services, to administer our MTM program.

"Outcomes" has an established network of specially trained personal pharmacists to provide MTM services for all of our Medicare members. As part of the *i*Care MTM program, each MTM-eligible member is invited to participate in an annual face-to-face consultation with a personal pharmacist to review and organize the member's medication usage and identify, resolve, and/or prevent medication-related problems. In addition, "Outcomes" also conducts retrospective analysis of prescription claims data to identify potential MTM interventions. Any possible interventions identified are sent to a network pharmacist with instructions and supporting documentation. "Outcomes" calls this the Targeted Intervention Program or "TIPs". TIPs generally focus on issues such as formulary, use of potentially inappropriate meds in the elderly, therapeutic duplication, and compliance. Issues identified during the complete medication review, as well as many of the TIPs, might require the

pharmacist to contact the prescriber for resolution.

The disease states and number of Part D medications targeted by the program may change from year to year. If there are questions regarding the *i*Care MTM Program, including whether or not a patient is involved with the *i*Care program, please call ***i*Care Pharmacy Services at 414-223-4847.**

CODES AND PROCEDURES REQUIRING NOTIFICATION OR PRIOR AUTHORIZATION

Admission Notification

As part of our commitment to medical management, Independent Care requires that all hospitals notify *i*Care by fax within 24 hours of an admission (emergent or elective) or on the next business day. (**See Exhibit 1 – Inpatient Admission Notification Form**).

*Prior Authorization of Skilled Nursing Home Days; Prior authorization is required by i*Care for approval of Skilled Nursing Facility days. **(See Exhibit 2 – Nursing Home/LTAC/IRF Prior Authorization Form)**

PRIOR AUTHORIZATION AND SPECIALTY REFERRALS

Prior authorization and specialty referral requirements have been revised to create efficiencies for both *i*Care and the providers. This list includes specific procedure codes to eliminate any confusion. The information regarding benefit coverage is for convenience only. *i*Care's goal is to work with providers to provide quality care for members. Upon receipt of all required information, urgent prior authorization requests are processed within two (2) business days and fourteen (14) days for all other service and procedure authorizations. A home health agency has 7 days from start of services to submit a PA request for new services. A modification to a PA must be received before the end of the certification period, and continuation of services must be submitted before the end of the certification period. (14 days prior to end of certification period). An *MD signature is required* on every PA request for continuation of services. *i*Care is conducting 100% in home assessments of PCW services and authorizations will not be approved without a current assessment.

The following is *i*Care's **Prior Procedure Specific Listing:**

- *i*Care Prior List (Spreadsheet)*i*Care Prior List (PDF)

PRIOR AUTHORIZATION REQUIREMENT- FORMS

The following *i*Care forms are used for the prior authorization and referral requests:

- General Prior Authorization Form– See **Exhibit 3**
- Home Health/PCW Prior Authorization Request Form– See **Exhibit 4**
- Physician Referral Form – See **Exhibit 5**
- Therapy Authorization Request Form – See **Exhibit 6**
- Hospice Prior Authorization Request Form– See **Exhibit 7**

The following information includes further instructions regarding authorization and/or documentation for specific situations:

ABORTION

When submitting an *i*Care Medicare or *i*Care Medicaid claim for reimbursement of an abortion, according to State Medicaid regulations a physician must attach a written certification statement, Form **HCF 1161,** attesting to one of the circumstances listed below.
In the case of rape or incest, the physician's claim must include evidence that the crime was reported to law enforcement authorities.

- The abortion is directly and medically necessary to save the life of the woman, provided that prior to the abortion the physician attests, based on his or her best clinical judgment, that the abortion meets this condition by signing a certification.
- In a case of sexual assault or incest, provided that prior to the abortion the physician attests to his or her belief that sexual assault or incest has occurred, by signing a written certification and provided that the crime has been reported to the laws enforcement authorities.
- 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, based on his or her best clinical judgment, that the abortion meets this condition by signing a certification.

HYSTERECTOMY

Except in the situations noted below, an Acknowledgement of Receipt of Hysterectomy Information, Form **HCF 1160,** must be completed prior to the surgery and attached to a paper claim form. Use the following link to access the fillable and printable form:

http://dhs.wisconsin.gov/forms/F0/F01160.doc

Providers may develop their own form as long as it includes all of the same information as found on Wisconsin Medicaid's form.
A hysterectomy may be covered *without* a valid acknowledgement form if one of the following circumstances applies:

- The recipient was already sterile. This may include menopause. (The physician is required to state the cause of sterility in the recipient's medical record.)
- The hysterectomy was required as the result of a life-threatening emergency situation, in which the physician determined that a prior acknowledgement 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 recipient eligibility and one of the following circumstances applied:
  1) The recipient was informed before the surgery that the procedure would make her permanently incapable of reproducing.
  2) The recipient was already sterile.
  3) The recipient was in a life-threatening emergency situation which required a hysterectomy.

For all of the exceptions above, the physician must 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.

*i*Care Medicaid does not cover a hysterectomy for the following:

- Uncomplicated fibroids
- Fallen uterus
- Retroverted uterus
- Purpose of sterilization

STERILIZATION

*i*Care reimbursement for sterilizations is dependent on providers fulfilling all Federal and State requirements cited below and satisfactory completion of a Sterilization Informed Consent form-Form **HCF 1164**.

Use the following link to access instructions and the form:

http://dhs.wisconsin.gov/forms/F0/F01164A.pdf

Use the following link to access the fillable and printable form:

http://dhs.wisconsin.gov/forms/F0/F01164.doc

There are no exceptions. Federal and state regulations require the following:

- The recipient is not institutionalized.
- The recipient is at least 21-years-old on the date the informed written consent is obtained.
- The recipient gives voluntary informed written consent for sterilization.
- The recipient is not mentally incompetent. Wisconsin Medicaid defines a "mentally incompetent" individual as a person who is declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purposes, unless the individual has been declared competent for purposes that include the ability to consent to sterilization.
- At least 30 days, excluding the consent and surgery dates, but not more than 180 days, must pass between the date of written consent and the sterilization date, except in the case of premature delivery or emergency abdominal surgery if:
  - In the case of premature delivery, the sterilization is performed at the time of premature delivery ***and*** written informed consent was given at least 30 days before the expected end date of delivery ***and*** at least 72 hours before the premature delivery. The 30 days excludes the consent and surgery dates.
  - The sterilization is performed during emergency abdominal surgery ***and*** at least 72 hours have passed since the recipient gave written informed consent for sterilization.

Sterilization Consent Form

- The recipient must give voluntary written consent on the federally required Sterilization Informed Consent Form.
- Sterilization coverage requires accurate and thorough completion of the consent form.

- The physician is responsible for obtaining consent. Any corrections to the form, once completed, must be signed by the physician and/or recipient, as appropriate.
- Signatures and signature dates of the recipient, physician, and the person obtaining the consent are mandatory. Providers' failure to comply with any of the sterilization requirements results in denial of the sterilization claims.
- To ensure reimbursement for sterilizations, providers are urged to use the Sterilization Informed Consent Form before all sterilizations (i.e., Medicaid and non-Medicaid recipients) in the event that the patient obtains Medicaid retroactive eligibility.
- Physicians must attach the completed consent form to a paper claim form to obtain reimbursement. Since an attachment is necessary, this claim cannot be submitted electronically.

HIV

As part of the Medicaid state reporting requirements, *i*Care requires physicians to supply written information regarding an *i*Care member's HIV status and treatment. *i*Care sends a letter to the physician requesting initial HIV information on an *i*Care member. Information requested includes:

- Date of diagnosis (if known)
- Date treatment began
- Is the member still taking medication?

*i*Care needs a signature from the physician within two weeks of the letter. This information is required by the State of Wisconsin and *i*Care and the physician must comply with the request according to the Medicaid reporting regulations.

CONCURRENT REVIEW

*i*Care RN Case Managers (RNCMs) conduct concurrent review of inpatient stays on a regular basis either by telephone or onsite visits. *i*Care RNCMs work closely with the hospital discharge planners in transitioning member care, as appropriate.

Concurrent review is the process of obtaining information from providers and facilities to determine the level of care required to meet the member's needs and to identify Case Management opportunities that focus on discharge planning. Inpatient utilization review is generally limited to nursing homes, questionable admissions and DRG outlier lengths of stay.

DISCHARGE PLANNING

Discharge planning is a multidisciplinary process to facilitate a member's transition between healthcare settings. Discharge planning promotes the appropriate level of care and services needed to foster as much independence as possible. The medical RNCM performs discharge planning for all acute hospitalizations and follows members in nursing homes for discharge needs.
Proactive discharge planning beginning before the hospital admission or during the initial review facilitates continuity of care and timely development of a discharge plan to coordinate services. RNCMs revise and update the care plan to reflect the member's transition of care needs.

DISEASE MANAGEMENT PROGRAM

Disease management involves education to change patient behaviors related to a defined condition and coordinates care among all providers along the health care continuum. It involves identifying individuals who are at risk for chronic disease and assisting them to manage their care to avoid or delay onset of acute episodes.

QUALITY IMPROVEMENT

Independent Care Health Plan is committed to the Centers for Medicare & Medicaid standards through HEDIS (Healthcare Effectiveness Data and Information Set), CAPHS (Consumer Assessment of Health Providers and Systems), and HOS (Health Outcome Survey) and Department of Health Services (DHS) Pay for Performance (P4P) indicators. *i*Care strives to provide medically necessary health care that is efficient, effective, safe, accessible, accountable and fair. CAPHS and HOS ask members to report on and evaluate their experiences with their healthcare providers. It is important that *i*Care's team of professionals along with the provider community, seek to improve the health of our members. It is also important to stay in communication with our members to make sure their needs are met.

Independent Care Health Plan's Quality Improvement (QI) Program provides structure and processes that enable *i*Care to carry out its mission and commitment to ongoing improvements to the quality of care and services, availability and access to care, and health status of our members. It is through this commitment of continuous quality improvement that we are able to produce positive health outcomes for our members.

The QI program is integrated throughout *i*Care's functional areas with each department accountable for reviewing procedures, systems, quality, cost and outcomes related to their areas of responsibility to ensure that they meet regulatory requirements, achieve business objectives and add value to our members and providers.

GOALS OF THE QUALITY IMPROVEMENT PROGRAM:

- Develop and maintain an integrated QI Program that provides structure for promoting and achieving excellence in all areas through continuous quality improvement.
- Use an ongoing, systematic approach to monitor, evaluate, and improve the quality, appropriateness, availability and accessibility of medical care and services to *i*Care members.
- Monitor the quality of care and services provided by participating providers, medical groups, organizational providers, and behavioral health providers and delegated entities to *i*Care members.
- Identify opportunities for improvement of the health status of our members through development and implementation of health promotion, preventive education programs and appropriate referrals.
- Allocate resources necessary to assist in quality improvement initiatives.

QUALITY IMPROVEMENT PROGRAM SCOPE

Includes:

- Member and Provider Satisfaction
- Network Adequacy and Access to Care
- Quality and Safety of Care and Services
- Utilization Management
- Credentialing and Re-credentialing
- Delegation Oversight
- Annual Quality Improvement Studies

CMS FIVE STAR PROGRAM

BACKGROUND/HISTORY

The Centers for Medicare & Medicaid Services (CMS) contracted with the National Committee for Quality Assurance (NCQA) to develop a strategy to evaluate the quality of care provided by SNPs. This strategy relies on a phased approach, beginning with defining and assessing desirable structural characteristics and followed by assessing processes and, eventually, outcomes. The evaluation approach includes several types of assessment.

- HEDIS® measures
- CAHPS measures
- HOS measures
- CMS specific measures
- DHS Pay for Performance measures
- Measures that evaluate structure and process requirements through submission of documentation

FOCUS OF QUALITY MEASURES

- Preventive care
- Up-to-date treatments for acute episodes of illness
- Chronic disease care
- Appropriate medication treatment

*i*CARE'S COMMITMENT TO QUALITY IMPROVEMENT

*i*Care is committed to the delivery of quality health care services to its members as measured by HEDIS, CAPHS, HOS, and Pay for Performance. HEDIS measures include measures regarding the completion of prevention and early detection measures as well as chronic disease management measures. CAPHS and HOS ask members to report on and evaluate their experience with their healthcare providers.

*i*Care's Quality Improvement Program works diligently with its network of providers to ensure the highest level of quality for our members. Our expectation is that through a collaborative effort outcomes will be continuously met.

ACCESS TO CARE

- Members are encouraged to select a primary care provider for BadgerCare Plus.
- Currently *i*Care has an open network of medical physicians.
- *i*Care utilizes the following access standards:
    - Preventive appointments – within 30 days
    - Urgent care – within 24 hours
    - Emergent care – immediate availability
    - Office wait times – within 30 minutes of appointment time
    - After hours coverage/access – 24 hours a day/7days a week
- *i*Care utilizes the following dental access guidelines:
    - New patient – within 90 days
    - Routine care – within 90 days
    - Emergent care – within 24-72 hours
- *i*Care provides interpretation services for members 24 hours a day, 7 days a week. Interpretation information can be found in this manual.
- *i*Care utilizes the following office wait time standards
    - Office wait times should not exceed 30 minutes after the schedules appointment time.
- Behavioral Health Access:
    - Wait times for routine office visit: 30 days or less
    - Follow up from an inpatient mental health stay: 30 days or less
    - The Behavioral Health line for UM is 1-855-893-0476.
- High Risk Prenatal Care - Wait time for appointments 2 weeks or less
- *i*Care has a Care Coordinator available for assistance 24 hours a day, 7 days a week. They can be reached at 414-223-4847 or 1-800-777-4376.
- Telephone access standards
    - *i*Care collects and performs analysis of performance against *i*Care's telephone access standards and reports the findings to the QIC and in its annual Quality Improvement Program Evaluation.

CONFIDENTIALITY
*i*Care complies with State and Federal confidentiality and privacy laws and regulations, including HIPAA.

MEDICAL RECORDS
When *i*Care requests copies of a member's medical records for purposes of determining whether benefits are payable (prior authorization requests, claims adjudication, utilization management, or grievances and appeals), *i*Care will not pay for medical records. As a health plan, HIPPA guidelines apply and a payment is not required under the law.

***i*Care's Annual Diagnoses Collection and Confirmation Project**
As part of *i*Care's contract with The Centers for Medicare & Medicaid Services (CMS), it is required to compile and report diagnostic profiles annually. This information *must* be obtained via a medical record review of individual member diagnoses that were treated or impacted within a claim (calendar) year. *i*Care has partnered with Cognisight to perform the annual collection of data and confirmation project. Cognisight's goal is to obtain a "complete diagnostic member profile", while attempting to minimize disruptions to your office workflow and staff. CMS will only accept submission of diagnoses when they are listed on an encounter note rather than on an active problem list, signed lab result or consult. This does not imply that a provider's documentation for the purposes of patient care is not sufficient, only that CMS has specific requirements to recognize existing diagnoses for a patient.

This information is time sensitive and a response is needed as soon as possible.

If you have additional questions, please contact Paul Kesselring, Account Manager, at Cognisight at 877-271-1657 ext. 8087 or Provider Network Development at NetDev@icare-wi.org

GRIEVANCES/APPEALS

- Members may submit verbal and/or written grievances for review and investigation.
- Members are provided an opportunity to appear in person before the Grievance Committee for formal (written) grievances.
- **Providers may also file an appeal or grievance on behalf of the member with the member's written consent.** Refer to the Reconsiderations and Appeals section of the manual for instructions.
- Members can receive assistance from the *i*Care Member Rights Specialist to file grievances.
- The Member Rights Specialist can be contacted at: **(414) 231-1076.**

CLAIMS PROCESS OVERVIEW

One of *i*Care's main goals is to facilitate the processing of provider claims in an efficient, accurate and timely manner. This section includes guidelines to ensure a payment system that is beneficial to both *i*Care and its providers. The timeframes included in this section apply to all providers unless otherwise agreed upon and included in the Provider's Service Agreement with *i*Care.

CLAIM SUBMISSION

*i*Care claims are processed by The Trizetto Group. The Trizetto Group uses an automated claims processing system. All claims should be submitted on a paper CMS 1500, UB-04 or an electronic equivalent claims form. Each claim must accurately include the information on the tables on the following pages:

iCare Requirements for Clean Claim (CMS 1500)

Box	Description	Comments
1a	Insured's ID Number	
2	Patient Name	
3	Birth Date and Sex	Date of birth must be valid date and not future date
5	Patient Address	
12	Patient's or Authorized Person's Signature and Date Signed	Acceptable alternatives: Unable to sign, signature on file, SOF, Computer generated, signature marked with "X", Authorization of File, Medicare/Medicaid Reclamation Claims, Transportation, Lodging
21	Diagnosis or Nature of Illness	
24a	Dates of Service	Claim must include one detail line, must be a valid date, From date cannot include a future date, cannot have a date span into the future, cannot span a calendar year
24b	Place of Service	Must be 2 characters
24d	Procedures, Services or Supplies	Must be at least 5 characters
24f	Charges	A negative amount will be neglected
24g	Days or Units	
24i/j	Taxonomy code and prefix	Must be present here or in Box 33b. Not required for SMV, personal care attendant, Blood bank or Community Care Organization. Prefix of PXC is required for all 5010 electronic submission, for paper submission either ZZ or blank is accepted.
24J (b)	NPI	Must be 10 numerical characters. Not required for SMV claims billed with POS 41,42,99
25	Federal Tax ID Number	Must be 9 numerical characters
28	Total Charge	Total charges must equal the sum of the line charges
31	Signature of Physician or Supplier Physician	Not required for SMV claims billed with POS 41,42,99
33	Physician/Provider's Name, Billing Address, Zip Code	
33a	Billing Physician/Provider NPI	Must be 10 numerical characters. Not required for SMV claims billed with POS 41, 42,99. The Medicaid provider must be certified as a billing provider.

33b	Taxonomy code and prefix	Must be present here or in Box 24i/24j. Not required for SMV, personal care attendant, Blood bank or Community Care Organization. Prefix of PXC is required for all 5010 electronic submission, for paper submission either ZZ or blank is accepted. For electronic submission: Loop Number 2310A-BILLING PROVIDER NAME, Segment PRV, ElementPRV02 =PXC, ElementPRZ03=value populated taxonomy code

iCare Requirements for Clean Claim (UB-04)

Box	Description	Comments
1	Provider Name and Address	
4	Bill Type	
5	Federal Tax ID	
6	Statement Covers Period	From and Through Dates of Claim
8b	Patient Name	
9a-e	Patient Address	
10	Date of Birth	
11	Patient Sex	
12	Admission Date	Required Inpatient, Home Health and SNF
14	Admission Type	Inpatient claims only
15	Admission Source	
17	Discharge Status	Not required for rural health or federally qualified clinics.
42	Revenue Codes	If Revenue code of 0022, 0023, 0024 is listed in box 42 and there is no entry box on 44, reject claim for RUGS code missing
44	HCPCS/Rate	Required based on Type of Bill
45	Service Date	
46	Service Units	
47	Total/Line Item Charges	Negative Amount: Claim will reject for "No Dollar Amount". Total Charges must equal the sum of the line item charges or claim will reject "Total charge does not match line charge totals". Total charges with claim with Revenue Codes 0022, 0023, 0024 may be zero.
49	Unlabeled	Required for ESRD claims. Entry is Y or N
56	NPI	
57a-57c	Other Provider ID	Required for ESRD claims
58a	Insured's Name	
59a	Relationship to Uninsured	
60a	Insured Identification Number	
67	Primary Diagnosis Code	Box 67A-67Q other diagnosis code - **Inpatient Required.** The hospital enters the full ICD codes for up to eight additional conditions if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. It may **not** duplicate the principal diagnosis listed in FL 67 as an additional or secondary diagnosis. **Outpatient Required.** The hospital enters the full ICD codes in FLs 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.
69	Admitting Diagnosis Code	Inpatient claims only

81a-d	Taxonomy Code	For Electronic Submissions: Loop Number 2000A_BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL, Segment PRV, element PRV02 =PXC, PRV03=value populated
Updated 9/30/2015		

ELECTRONIC CLAIMS SUBMISSION

Electronic Claims Submission offers an opportunity to save time and reduce costs. *i*Care partners with a leading claims submission provider, **Claimsnet.com**, to allow electronic claims submission.

- To register with **Claimsnet.com** for electronic claims submission via the internet, visit the following URL and click "Register:"
  http://www.claimsnet.com/icare
- Use the special *i*Care section of the Claimsnet website and avoid paying set-up or submission fees when submitting claims through **Claimsnet.com**.
- Immediately take advantage of on-line claims submission, real-time error reporting and payer updates.

Submit electronic claims with the National Provider Identifier (NPI) and the tax identification number. To request an electronic remittance (835 file) please submit the request with the provider's name, tax ID, NPI and the name of the contact person to NetDev@icare-wi.org.

MAILING ADDRESSES

Mail all *i*Care Medicare and *i*Care Medicaid paper claims to:

Independent Care Health Plan
P.O. Box 660346
Dallas, TX 75266-0346

For **CORRECTED CLAIMS: A "Corrected" claim must include all the correct information, including all correct service lines, that were included in the original claim. Any missing line items are assumed to be deleted as part of the correction.** Mark the claim as '**Corrected Claim**' and include the initial claim number on the claim and mail to:

- Independent Care Health Plan
  P.O. Box 660346
  Dallas, TX 75266-0346
  ATTN: Operations Department

CLAIMS FILING LIMITS

Providers have 60 days from the date of service to submit claims to *i*Care, unless otherwise stated in the provider's agreement. Providers are to submit all claims for services rendered where *i*Care Medicare is primary or *i*Care Medicaid is primary according to the terms of the contract. Timely filing limits apply to initial claim submissions, resubmissions and corrected claims.

*i*Care Medicaid secondary claims for the Medicare coinsurance, copayment and deductible amounts from Medicare coverage other than *i*Care, must be received by whichever is later:

- Within 90 days of the Medicare Remittance Advice (RA) date

- Within 365 days of the date of service

All other claims for which *i*Care Medicare is the secondary payer must be submitted with an RA from the primary payer within 365 days from date of service.

Medicare claims submitted beyond the timely filing limits are not eligible for payment and *i*Care members cannot be billed for the covered services. However, with the denied RA, *i*Care Medicaid can be billed and will cover within the payment limits, the deductible, coinsurance or copayment that would have been covered had the Medicare claim been submitted on time.

Medicare providers will have to submit the secondary claims by paper and include the Medicare RA from the other insurance carrier.

Medicaid claims submitted beyond the timely filing limits are not eligible for payment and *i*Care members cannot be billed for covered services.

FEE SCHEDULES

Each provider contract defines the fee schedule used to pay services provided by the contracted provider.

Direct questions regarding fee schedules to *i*Care Provider Services:

- Monday through Friday, 8:00-5:00
- ☐ Local: **414-231-1029**
- ☐ Out of Area: **1-877-333-6820**
- Email: providerservices@icare-wi.org

Direct questions regarding contracted rates to your *i*Care Network Development Representative:

- Monday through Friday 8:30-5:00 by phone or email

In most cases, *i*Care Medicare pays providers according to the CMS Medicare Fee for Service rates published by CMS at www.NGSMedicare.com and *i*Care Medicaid pays providers according to the State of Wisconsin Medicaid Fee for Service rates.

- Changes to the Medicare Fee for Service rates are effective as of the date National Government Services, LLC post the fee schedule changes at www.NGSMedicare.com .
- Changes to the State of Wisconsin Medicaid Fee For Service rates are recognized to be effective as of the date they posted to the State of Wisconsin Forward Health website or for provider specific rate changes, the business day after *i*Care is notified by the provider.

CLAIMS EDITING

*i*Care uses the McKesson ClaimCheck code auditing software solution. The ClaimCheck code auditing software solution is a clinically based software application used to insure consistent and accurate application of current coding guidelines, contractual requirements and medical policy. Edit rules are based on national guidelines and are widely accepted by the provider community. The categories of edits include:

- National Correct Coding Initiative

- Incidentals
- Multiple Surgeons
- Global Surgery
- New Visit
- Age & Gender
- Multiple Evaluation & Management Services

CO-PAYMENTS

***i*Care Medicare** members have co-payment requirements for facility emergency room services and medication.

- Medication copayments vary by coverage year.
- Certain *i*Care members may qualify for help from Medicare to pay for their medications (Low income subsidy or LIS).

***i*Care Medicaid** SSI and Badger Care members may have co-payments anywhere from $.50 - $3.00, please check the Forward Health website for specific member information.

- Bill chiropractic services, prescription drugs and select OTC drugs directly to the State Medicaid program.
- Payments for these services are made using Medicaid Fee for Service rates.

CHECKING THE STATUS OF A CLAIM

*i*Care has a provider portal available to check on claim status. For access information, please email NetDev@icare-wi.org and request a PIN for the *i*Care portal. A portal user guide is at our website www.icare-wi.org/providers

Alternatively, you may direct calls regarding claim status to *i*Care Customer Services:

- Monday through Friday, 8:00-5:00
- ☐ Local: **414-231-1029**
- ☐ Out of Area: **1-877-333-6820**
- Email: providerservices@icare-wi.org

EXPLANATION OF PAYMENT/REMITTANCE

Providers receive an Explanation of Payment (EOP) including each claim submitted to *i*Care. Separate Medicare EOPs and Medicaid EOPs along with separate checks are mailed twice a week for processed Medicare and Medicaid claims.

Direct questions regarding the EOP to *i*Care Provider Services:

- Monday through Friday, 8:00-5:00
- ☐ Local: **414-231-1029**
- ☐ Out of Area: **1-877-333-6820**
- Email: providerservices@icare-wi.org

BILLING *i*CARE MEMBERS

According to federal regulations, providers cannot hold a Medicaid recipient responsible for any commercial or Medicare cost-sharing amount such as coinsurance, copayment, or deductible. Therefore, a provider may not collect payment from a Medicaid recipient, or authorized person acting on behalf of the recipient for cost-sharing payments required by other health insurance sources. The provider should collect only the Medicaid copayment amount from the recipient.

Any provider who knowingly and willfully bills an enrollee for a Medicaid-covered service shall be guilty of a felony as defined in Section 1128B. (d)(1) [42 U.S.C.1320a-7b] of the Social Security Act.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) is necessary when a member is covered by more than one insurance carrier. With few exceptions, *i*Care Medicaid is the payer of last resort in most COB circumstances.

In order to process a claim when *i*Care is not the primary carrier, a **complete** Explanation of Benefits (EOB) from the primary insurer, including the Medicare Remittance Advice, must accompany a copy of the original claim.

If the member has both *i*Care Medicare and *i*Care Medicaid submit the original claim with the *i*Care Medicare identification number then both the *i*Care Medicare and *i*Care Medicaid claims process. A Medicare EOP is not needed. Refer to the ***i*Care Medicaid Coordination of Benefits with Medicare and Other Insurance** processing guidelines below.

*i*Care Medicaid Coordination of Benefits with Medicare and With Other Insurance

This section contains coordination information about the following services:

1. Outpatient facility services
2. Professional services
3. Inpatient facility services and Skilled Nursing facility services

1. Outpatient Facility Services

Medicare and *i*Care Medicaid

The coinsurance/copayment amount for outpatient facility services are reimbursed at the lower of:

- The Medicare allowed
  or
- The T-19 Published Medicaid Outpatient rate per visit or a specific *i*Care contracted rate (the Medicaid allowed) minus the Medicare payment amount

In addition the coinsurance/copayment payment amount, when added to the Medicare payment amount cannot exceed either:

- The Medicaid allowed amount

- The Medicare allowed amount

Because of the above comparison and adjustments *i*Care Medicaid does not always pay the full Medicare coinsurance/copayment amount.

Then any Medicare deductible amount is added to the above calculated amount for the total *i*Care Medicaid coordinated payment.

Other Insurance and *i*Care Medicaid

Outpatient facility services for *i*Care Medicaid members having other primary insurance are reimbursed at the difference between:

- The T-19 Published Medicaid Outpatient rate per visit or a specific *i*Care contracted rate and
- The other primary insurance payment

No secondary *i*Care Medicaid payment is made when the primary insurance payment exceeds the Medicaid allowed.

2. **Professional Services**

Medicare and *i*Care Medicaid (SSI and BadgerCare Plus)

The coinsurance/copayment amount for professional services is reimbursed at the lower of:

- The Medicare allowed or
- The Medicaid FFS Fee Schedule or a specific *i*Care contracted rate (the Medicaid allowed) minus the Medicare payment amount

In addition the coinsurance/copayment amount, when added to the Medicare payment amount cannot exceed either:

- The Medicaid allowed amount
- The Medicare allowed amount

Because of the above comparison and adjustments *i*Care Medicaid does not always pay the full Medicare coinsurance/copayment amount.

Note the following examples that demonstrate the above calculation and results:

***i*Care Medicaid Reimbursement for Coinsurance or Copayment of Medicare Part B Services**			
Explanation	**Example**		
	1	**2**	**3**
Provider billed amount	$120	$120	$120
Medicare allowed amount	$100	$100	$100
Medicaid allowed amount	$90	$110	$75
Medicare payment with $20 coinsurance	$80	$80	$80
*i*Care Medicaid payment	$10	$20	$0

See: http://dhfs.wisconsin.gov/medicaid2/handbooks/all-provider/coord/coord.pdf

Then any Medicare deductible amount is added to the above calculated amount for the total *i*Care Medicaid coordinated payment.

Other Insurance and *i*Care Medicaid (SSI and BadgerCare Plus)
Professional services for *i*Care Medicaid members having other primary insurance are reimbursed at the difference between:

- The T-19 FFS Fee Schedule Rate or a specific *i*Care contracted rate
- The other primary insurance payment

The maximum total payment the provider can receive from *i*Care and the other carrier is the Medicaid allowed amount for that service. No secondary *i*Care Medicaid payment is made when the primary insurance payment exceeds the Medicaid allowed.

3. **Inpatient facility services**

***i*Care Medicaid Reimbursement for Medicare Part A Covered Inpatient Services Provided to Dual Eligible Members**			
Explanation	**Example**		
	1	**2**	**3**
Provider's billed amount	$1200	$1200	$1200
Medicare allowed amount	$1000	$1000	$1000
Medicaid allowed amount	$1200	$750	$750
Medicare payment	$1000	$800	$500
Difference between Medicaid Allowed amount and Medicare-paid amount	**$200**	**<$-50>**	**$250**
Medicare coinsurance, copayment, and deductible	$0	$200	$500
***i*Care Medicaid Payment**	**$0**	**$0**	**$250**

Medicare and *i*Care Medicaid SSI and BadgerCare Plus
Inpatient facility services for *i*Care Medicaid members having Medicare are reimbursed at the applicable years' Medicare Deductible amount per benefit period.

The benefit period is the way Medicare measures the member's use of hospital and skilled nursing facilities. A benefit period begins the day the member is admitted to a hospital as inpatient or admitted to a skilled nursing facility. The benefit period ends when the member has not received hospital or skilled nursing care for 60 days in a row. (See **Skilled Nursing Facility** services below.)

Hospital care within the first 60 days of the benefit period is not eligible for additional Medicaid reimbursement, i.e. the deductible paid for the initial benefit period satisfies the *i*Care Medicaid liability until the next benefit period begins. If the member is discharged from a hospital, and is readmitted within 60 days, no additional Medicare or Medicaid payment will be made.

If the member goes into the hospital after one benefit period has ended (60 days after discharge), a new benefit period begins. The inpatient hospital deductible is paid for each benefit period, and is subject to the State's lesser of logic. There is no limit to the number of benefit periods the member can have.

For each benefit period, *i*Care Medicaid pays:

- For a hospital stay of 1-60 days – the applicable year's Medicare inpatient deductible amount
- For days 61-90 of a hospital stay – the applicable year's Medicare 61-90 day coinsurance rate times the number of days subject to the State's lesser of logic.
- For days 91-150 of a hospital stay –
  Medicare only covers up to 90 days of an inpatient stay then the member decides whether or not to use Medicare Reserve Day coverage (See **Reserve Days**, below**)** if days are still available. The provider contacts the member and indicates the decision on the facility claim.
  - If Medicare Reserve days are used Medicaid pays the applicable year's Medicare Reserve Day coinsurance rate times the number of days.
  - If Medicare Reserve days are NOT used Medicaid pays the Medicaid DRG for all remaining days over 90.
- When reserve days are used, for days beyond 150 days – the Medicaid DRG for all remaining days

To find the applicable year's inpatient deductible and coinsurance amounts use the following link to access the CMS website:

http://www.cms.hhs.gov/transmittals/downloads/R49GI.pdf

Reserve Days are defined as "Sixty days that Medicare will pay for when the member is put in a hospital for more than 90 days". These 60 **Reserve Days** can only be used once during the member's lifetime. For each lifetime Reserve Day, Medicare pays all covered costs except for a daily (Reserve Day) coinsurance amount.

Other Insurance and *i*Care Medicaid, SSI and BadgerCare Plus

Inpatient facility services for *i*Care Medicaid members having other primary insurance are reimbursed at the difference between:

- The calculated T-19 Medicaid DRG/per diem amount or a specific *i*Care contracted rate and
- The other primary insurance payment

No secondary *i*Care payment is made when other primary insurance payments exceed the calculated T-19 Medicaid DRG/per diem amount or a specific *i*Care Medicaid contracted rate.

Skilled Nursing Facility Services

*i*Care Medicaid pays:

- For days 1-20 – $0; Medicare covers up to the Medicare allowed for each day and there is no coinsurance
- For days 21-100 – the applicable year's Medicare SNF 21-100 day coinsurance rate times the number of days

- For days beyond 100, Medicaid is prime – either *i*Care Medicaid or Medicaid Fee for Service depending on the member's enrollment in *i*Care Medicaid.

When the *i*Care member has SNF services for 90 days the member is **disenrolled from *i*Care Medicaid at the end of that month**. After the end of the month the Medicaid member continues coverage with Medicaid Fee for Service.

- For charges beyond the end of the month, submit the claim to Medicaid Fee for Service.

For the applicable year's SNF day 21-100 coinsurance amount use the following link to access the CMS website:

http://www.cms.hhs.gov/transmittals/downloads/R49GI.pdf

CLAIM ERRORS

*i*Care strives to process submitted claims in a timely and accurate manner. Quality is a top priority. However, when claims processing and submission errors do occur, *i*Care's goal is to accurately resolve the situation as quickly as possible.

Claim processing errors are identified by either the provider or *i*Care.

Preferably, when a provider identifies a processing error, whether an overpayment, underpayment or wrong provider payment follow the *i*CARE RECONSIDERATION procedure outlined below.

Please do not refund the money or return the check to *i*Care.

RECONSIDERATIONS

An *i*Care Reconsideration is a request to review a processed claim when the provider or member (includes authorized representative, or in some cases their physician) does not agree with the processing outcome. This includes situations where the provider or member feels there is an:

- Incorrect denial
- Underpayment
- Overpayment
- Incorrect adjustment
- Wrong provider payment

The provider has 60 days from the date of the EOP to contact *i*Care with an *i*Care Reconsideration request. The request may be made via the phone, in a letter format by mail or by fax**.** When members appeal a *Medicaid* denial they have 45 days from the date of denial to request an appeal. When members appeal a *Medicare* denial they have 60 days from the date of denial to appeal.

EXPEDITED RECONSIDERATIONS

Reconsiderations can be standard or expedited. An expedited reconsideration may be justified based on the health of a member. A request for payment of a service already provided to a member is not eligible for review as an expedited reconsideration. A request for payment of a service already provided to a member is not eligible to be reviewed as an expedited reconsideration.
Expedited Reconsiderations are available only to the following:

- Member
- Member's authorized representative
- Physician (regardless of their affiliation with *i*Care)

*i*Care has no later than 72 hours from receiving the request to make a determination. If denied, request is treated like a standard reconsideration and goes through the process. Within 24 hours the member is notified orally by the Quality Improvement Specialist-Member Focus (QISMF) or designee that the request will be processed within the standard timeframe. A written notice is sent within 3 days of the oral notification. If the original denial is reversed, the benefit is authorized and the member or their representative is notified by phone within 72 hours. If the matter is not resolved the QISMF prepares a written explanation and forwards the file to the Independent Review Entity (IRE) within 72 hours of the adverse decision.

For an ***Expedited Reconsideration***, contact iCare by phone:

- Monday through Friday, 8:00-5:00
- ❒ Local: **414-231-1029**
- ❒ Out of Area: **1-877-333-6820**

To make an ***iCare Reconsideration*** request, contact *i*Care using one of the following methods:

1. By phone, call *i*Care Provider Services
   - Monday through Friday, 8:00-5:00
   - ❒ Local: **414-231-1029**
   - ❒ Out of Area: **1-877-333-6820**

2. By mail, use the following address:

   - Independent Care Health Plan
     P.O. Box 660346
     Dallas, TX 75266-0346
     ATTN: Operations Department

3. By Fax: **414-231-1094**, **Attn: Operations Department**

Regardless of the method used, all *i*Care Reconsideration requests must include:

- Member's name
- Member's identification number
  - For *i*Care Medicare the number assigned by *i*Care (C1111234567)

- For *i*Care Medicaid the number assigned by the State Medicaid program +01 (12345678901)
- Provider's name
- Date of service
- Service(s) to review
- Charge
- Payment
- Explanation why the claim decision should be reconsidered and what is expected
- Additional information to support the Review request

When complete request information is received, *i*Care Operations staff reviews the original claim submission, the request and all additional information provided. After research and benefit verification, a determination is made regarding whether or not the claim processed correctly. *i*Care has 60 days from the receipt of the reconsideration information to respond.

If the claim requires reprocessing or an adjustment (additional payment or recoupment), the claim is processed and the resulting Explanation of Payment (EOP) is *i*Care's response to the Reconsideration request.

If the reviewed claim processed correctly, *i*Care contacts the provider with an explanation of why the reviewed claim is correct as processed.

REFUNDS

Before sending a refund, please refer to the ***i*CARE RECONSIDERATION** section above. If at some point it is necessary for the provider to send a refund to *i*Care, please make the checks payable to: ***i*Care**. Include the following information:

- A complete explanation of why the money is being refunded
- Member name
- Member identification number for the related claim
- DOS
- Service rendered
- Copy of the EOP containing the payment being refunded

Mail the information and check to:

INDEPENDENT CARE HEALTH PLAN ATTN: FINANCE DIRECTOR
1555 N RIVERCENTER DRIVE, SUITE 206
MILWAUKEE WI 53212-3979

*i*Care then makes the necessary claim adjustments.

CLAIM APPEALS

*i*Care encourages the provider to request an *i*Care Medicare or Medicaid Reconsideration before going through the formal appeals process. See ***i*CARE RECONSIDERATION** section.

Appeal

A Provider's appeal is a formal process for the provider to disagree with or question an *i*Care claim denial or a reduction in the level of benefits. The provider makes an appeal to *i*Care to change a claim decision. The provider may also appeal on behalf of the member with their written consent.

A formal appeal must include all the following:

- A separate letter on the provider's letterhead for each appealed claim
- Sent within 60 days of the EOP date or if Reconsideration was submitted, within 60 days of the Reconsideration determination
- Addressed to *i*Care as instructed below
  - A letter or fax is acceptable
  - An email with an attachment of the scanned letterhead letter
- Clearly mark 'appeal' in the body of the letter
- Provider's name
- Date of service
- Date of payment or nonpayment date
- Member's name
- Member's identification number
  - Medicare claims, the *i*Care Medicare identification number (C1111234567)
  - Medicaid claims – identification number assigned by the State + 01 (12345678901)
  - BadgerCare Plus claims, identification number assigned by the State (12345678901)
- The reason the claim merits a review

Send claim appeals to the following address:

INDEPENDENT CARE HEALTH PLAN ATTN: OPERATIONS APPEALS
1555 N RIVERCENTER DRIVE, SUITE 206
MILWAUKEE WI 53212-3979

If the formal appeal is not sent within 60 days of the EOP date or the Reconsideration determination, the appeal is untimely and is denied and the claim decision is upheld.

If the appeal does not contain all the required parts of a formal appeal the document is considered an informal appeal and handled as an *i*Care Reconsideration request. See ***i*CARE RECONSIDERATION** section.

Tracers and resubmission of claims do not meet the criteria of a formal appeal and are handled as an *i*Care Reconsideration request.

Within 10 days of receiving a formal appeal, *i*Care sends the provider a letter acknowledging the receipt of the appeal. *i*Care has 45 days to review the claim decision and respond in writing with a final decision. *i*Care's decision is to either uphold or overturn the claim decision.

If the claim was processed correctly the claim decision is upheld and the appeal is denied. *i*Care contacts the provider with a written response that includes the reason the claim decision was upheld and instructions for submitting any further appeals.

If the claim was not processed correctly the claim decision is overturned and the appeal is approved. *i*Care adjusts/reprocesses the claim and the resulting EOP is the provider's response to the appeal.

Medicaid: If the provider is not satisfied with *i*Care*'s* response or if *i*Care fails to respond within 45 days of the receipt of the appeal, the provider may submit an appeal to DHS. This must be done within 60 days from the date of *i*Care's written decision notification or within 60 days of when *i*Care should have provided the decision notification.

Before filing a DHS appeal with the State the provider must file a formal appeal or a written informal appeal (an *i*Care Reconsideration request) with *i*Care.

Medicare: For further information refer to the **Medicare Managed Care Manual** – **Chapter 13** – Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals and refer to the section: Who May Request Reconsiderations.

Rules For	Reconsiderations	iCare Appeal	Next Level
Medicare:	• 60 day timely submission from EOP • *i*Care has 60 days to respond • Request can be sent by phone, fax or letter • Providers can appeal on behalf of the member with written consent	• 60 days from EOP or Reconsideration Determination • Incomplete Appeal is treated as reconsideration • Requires a formal letter • *i*Care acknowledges receipt in 10 days • *i*Care has 45 days to respond	• Contracted Provider- No further appeal rights • Non-contracted Provider- Medicare Independent Review Entity (IRE)
Medicaid (including LTC Wavier Services)	• 60 day timely submission from EOP • *i*Care has 60 days to respond • Request can be sent by phone, fax, or letter • Providers can appeal on behalf of the member with written consent	• 60 days from EOP or Reconsideration determination • Incomplete Appeal is treated as reconsideration • *i*Care acknowledges receipt in 10 days, • *i*Care has 45 days to respond	• DHS Appeal **Family Care Partnership Appeal to DHS** 1 West Wilson Street, Room 518 PO Box 7851 Madison, WI 63707-7851 **Medicaid/BadgerCare Plus** **Appeals to DHS** Managed Care Unit PO Box 6470 Madison, WI 53716-04701 **Fax Number:** 608-224-6318
Expedited Reconsideration	• Available only to the following: o Member o Member's Authorized Rep o Physician(regardless of iCare affiliation) • 60 days from the EOP date • Decision is made within 72 hours of the receipt of the expedited request • Within 24 hours the member is notified orally by the QISMF. Written notice within 3 days of the oral notification		If the matter is not resolved the Quality Improvement Specialist-Member Focus (QISMF) prepares the written explanation and forwards the file to the IRE within 72 hours of the adverse decision.

PROVIDER RIGHTS AND RESPONSIBILITIES

ACCESS TO CARE STANDARDS:

In order to provide members access to quality health care services, *i*Care has adopted standards for member waiting times at the provider facility and waiting times for appointment scheduling to assure that the services available to *i*Care members.

- *i*Care utilizes the following access standards:
  - Preventive appointments – within 30 days
  - Urgent care – within 24 hours
  - Emergent care – immediate availability
  - Office wait times – within 30 minutes of appointment time
  - After hours coverage/access – 24 hours a day/7days a week
- *i*Care utilizes the following dental access guidelines:
  - New patient – within 90 days
  - Routine care – within 90 days
  - Emergent care – within 24-72 hours
- *i*Care provides translation services for members 24 hours a day, 7 days a week.
- . *i*Care utilizes the following office wait time standards
  - Office wait times should not exceed 30 minutes after the scheduled appointment time.
- Behavioral Health Access:
  - Wait times for routine office visit: 30 days or less
  - Follow up from an inpatient mental health stay: 30 days or less
- High Risk Prenatal Care - Wait time for appointments 2 weeks or less

PROVIDER RIGHTS

- Provider may bill *i*Care for Medicare or Medicaid covered services.

  NOTE: Provider must obtain a referral or prior authorization when applicable. Please see the Medical Management section for complete details.

- Provider may bill a member for non-covered services only if the provider informs the member prior to performing that service that he or she will be responsible for payment because Medicare or Medicaid does not cover the service.

NOTE: Provider must obtain a written statement in advance verifying that the member has accepted liability for the service. The standard release form signed by the member at the time of the services or another type of acknowledgement relevant to *i*Care member liability must specifically state the admissions, services or procedures that are not covered by Medicare or Medicaid.

PROVIDER RESPONSIBILITIES

- Provider is required to obtain recipient eligibility information.

  NOTE: Possession of a Forward Card, ForwardHealth Card or Medicare Part A and/or Part B card does not guarantee eligibility.

- Provider accepts *i*Care reimbursement as payment in full except in cases where coordination of benefits applies.
- Provider is required to bill *i*Care for covered services provided to a recipient during periods of retroactive eligibility when notified that a recipient has received such eligibility.
- Provider and subcontractor shall not bill an *i*Care member for medically necessary services covered by Medicare or Medicaid and provided during the member's period of *i*Care enrollment.
- Provider and subcontractor shall not bill an *i*Care member for co-payments and/or premiums for medically necessary services covered by Medicare or Medicaid and provided during the member's period of *i*Care enrollment.

  NOTE: Any provider who knowingly and willfully bills a member for a Medicaid covered service shall be guilty of a felony, as defined in Section 1128B. (d)(1) [42 U.S.C.1320a-7b] of the Social Security Act. *i*Care shall report to the Department of Justice any violations of this act.

- Provider is prohibited from discriminating against *i*Care members. Provider's hours of operation must not discriminate against *i*Care members.
- Provider will document in the member's medical records whether or not the individual has executed an advance directive. Provider shall not discriminate in the provision of care or otherwise discriminate against a member based on whether or not the member has executed an advance directive.
- Provider shall ensure compliance with requirements of Wisconsin law (whether statutory or recognized by the courts of Wisconsin) respecting advance directives.
- With respect to the services provided to *i*Care members, provider is expected to observe and comply with all applicable Federal and State laws, rules or regulations in effect at the time services are provided, including health data and information privacy and security policies and any other standards and regulations as may be adopted or promulgated under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.
- All appeals and reconsiderations should be dated and submitted to *i*Care within 60 days of receipt of the *i*Care Explanation of Payment.

NOTE: For Medicaid appeals the provider may seek a final determination from the Department of Health Services (DHS). If *i*Care has not responded in writing within 45 days from the receipt of the request for the formal appeal, the provider will accept the DHS determination regarding appeals or disputed claims.

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Providers will notify *i*Care of new and changed information related to the provider's practice. Including but not limited to:

- Add provider to staff
- Provider retires or terminates
- New location or location moved
- Terminate a location
- NPI number
- Tax Identification number and corresponding W9
- Billing service change
- Billing address change

Send all changes to: NetDev@icare-wi.org

PROVIDER PREVENTABLE CONDITION

Providers must report all provider preventable conditions with claims for payment or member treatments, if payment would otherwise be made outside of provider preventable conditions.

Provider preventable conditions means a condition that meet either of the following criteria:

- Is a Healthcare Acquired Condition. A Healthcare Acquired Condition is a condition listed below occurring in any inpatient hospital setting:
  - Foreign object retained after surgery;
  - Air embolism;
  - Blood incompatibility;
  - Stage III and IV pressure ulcers;
  - Falls and trauma; including fractures, dislocations, intracranial injuries, crushing injuries, burns, other injuries;
  - Catheter-associated urinary tract infection (UTI);
  - Vascular catheter-associated infection;
  - Manifestations of poor glycemic control including diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity;
  - Surgical site infection following coronary artery bypass graft (CABG)- Mediastinitis;
  - Surgical site infection following bariatric surgery for obesity, including laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery;
  - Surgical site infection following certain orthopedic procedures including spine, neck, shoulder, and elbow;
  - Surgical site infection following cardiac implantable electronic device
  - Deep vein thrombosis (DVT) Pulmonary Embolism (PE) following total knee replacement or hip replacement with pediatric and obstetric exceptions; or Latrogenic pneumothorax with venous catheterization.
- Is an Other Provider-Preventable Condition –
  - An Other Provider-Preventable Condition is a condition occurring in any

health care setting that meets the following criteria:

- Is identified in the State plan;
- Has been found by the State, based upon a review of the medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
- Has a negative consequence for the beneficiary;
- Is auditable; and at a minimum includes:
    - Wrong surgical or other invasive procedure performed on a patient;
    - Surgical or other invasive procedure performed on the wrong body part;
    - Surgical or other invasive procedure performed on the wrong patient.

Member Rights

The following section contains the rights of all *i*Care Members as set forth by the Department of Health Services. Independent Care goes to great length to ensure that member's rights are protected. Please be familiar with the following:

Knowing About the Physician Incentive Plan

You have the right to ask if we have special financial arrangements with our physicians that can affect the use of referrals and other services you might need. To get this information, call our Customer Service Department at 1-800-777-4376 and request information about our physician payment arrangements.

Knowing Provider Credentials

You have the right to information about our providers including the provider's education, board certification, and recertification. To get this information, call our Customer Service Department at 1-800-777-4376.

Completing an Advance Directive, Living Will, or Power of Attorney for HealthCare

You have the right to make decisions about your medical care. You have the right to accept or refuse medical or surgical treatment. You have the right to plan and direct the types of health care you may get in the future if you become unable to express your wishes. You can let your doctor know about your wishes by completing an advance directive, living will, or power of attorney for health care. Contact your doctor for more information.

You have the right to file a grievance with the DHS Division of Quality Assurance if your advance directive, living will, or power of attorney wishes are not followed. You may request help in filing a grievance.

Rights to Medical Records

You have the right to ask for copies of your medical records from your provider(s). We can help you get copies of these records. Please call 1-800-777-4376 for help. Please note that you may have to pay to copy your medical records. You may correct inaccurate information in your medical records if your doctor agrees to the correction.

Your Member Rights

- You have the right to have an interpreter with you during any BadgerCare Plus covered service.
- You have the right to get the information provided in this member handbook in another language or format.

- You have the right to get health care services as provided for in federal and state law. All covered services must be available and accessible to you. When medically appropriate, services must be available 24 hours a day, seven days a week.
- You have the right to get information about treatment options including the right to request a second opinion.
- You have the right to make decisions about your health care.
- You have the right to be treated with dignity and respect.
- You have the right to be free from any form of restraint or seclusion used as a means of force, control, ease, or reprisal.

Your Member Civil Rights

Independent Care Health Plan provides covered services to all eligible members regardless of the following:

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

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

EXHIBITS

Note: All forms in this section are on the iCare website for providers to use as filled form at

www.icare-wi.org/providers/authorizations

Exhibit 1

Inpatient Admission Notification Form

INDEPENDENT CARE HEALTH PLAN

INPATIENT ADMISSION NOTIFICATION

This form is for providing notification for inpatient stays at time of admit; if you are inquiring if a CPT code or procedure needs authorization please utilize the general PA form which can be obtained from our website www.icare-wi.org

Independent Care Health Plan (*i*Care**)** needs to be notified of all inpatient stays **within one (1) business day** of the admission. Failure to adhere to *i*Care's notification policy may result in delay or denial of payment of the related hospital claim.

Please complete all requested information on this form and fax to *i*Care at FAX# 414-231-1075.

If you have any questions about this form please contact *i*Care at (414)223-4847. Submission of the notification of an admission is not a guarantee of coverage or payment of the reported service.

MEMBER INFORMATION:

Name: _____ Medicare#: _____

DOB: _____ Medicaid#: _____

ADMISSION INFORMATION:

Admission Date: _____ Discharge Date: _____ Time: _____ Room #: _____

Type of Admission: (check one) ☐ Emergency ☐ Elective ☐ Observation

Admitting Hospital: _____ Hospital Phone #: _____

Facility NPI #: _____ Facility Address: _____

Admitting MD: _____ Admitting MD's Phone #: _____

Admitting Dx: _____ ICD10 Code: _____

******iCare will not authorize PA requests without ICD 10 codes after 09/30/2015******

Designated Contact Person: _____ Title: _____

========== DO NOT WRITE BELOW THIS LINE ==========

Notification #: _____

1555 N. RiverCenter Dr. Suite 206 Milwaukee, WI 53212
Phone Number: (800)777-4376 Fax 414-231-1026 www.icare-wi.org

Revised 9/2015

Exhibit 2

Nursing Home/LTAC/IRF Prior Authorization

INDEPENDENT CARE HEALTH PLAN

SUB-ACUTE FACILITY PRIOR AUTHORIZATION

This form is for requesting Prior Authorization for Inpatient Rehabilitation Facilities (IPR), Long-Term Acute Care Facilities (LTAC), and Skilled Nursing Facilities (SNF) stays.

Independent Care Health Plan (*i*Care) reviews all admissions for medical necessity and appropriateness of level of care. In order to conduct these reviews on a timely basis, policy REQUIRES the facility to request authorization from *i*Care **at least one (1) business day PRIOR** to tentative admission date. Prior authorization needs to be approved by *i*Care **BEFORE** admission to facility. Failure to adhere to *i*Care's authorization policy may result in delay or denial of payment of the related facility claim.

Please complete all requested information on this form and fax to *i*Care at FAX# 414-231-1026. Submission of the prior authorization request for an admission is not a guarantee of coverage or payment of the reported service.

REQUIRED INFORMATION*

MEMBER INFORMATION:

Member Name: _____ DOB: _____

Medicare#: _____ Medicaid#: _____

ADMISSION INFORMATION:

Are you requesting a Medicare stay? YES ____ (dates of hospital stay_____ to _____) NO ____

Primary Admit Dx: _____ ICD10 Code: _____

********i***Care will not authorize PA requests without ICD 10 codes after 09/30/2015****

Admission Date: _____ Admitting From: _____

Admitting Facility: _____ Facility NPI #: _____

Phone: **(**_____) _____ Fax: **(**_____) _____

Please attach the following to help facilitate an appropriate determination in a timely manner:

1) History and Physical (H&P)
2) Therapy Notes
3) Supporting clinical documentation

*Prior Authorization request will not be determined if required information section is incomplete.

========== DO NOT WRITE BELOW THIS LINE ==========

Medicare Authorization #:_____ Medicaid Authorization #:_____

1555 N. RiverCenter Dr. Suite 206 Milwaukee, WI 53212
Phone Number: (800)777-4376 Fax 414-231-1026 www.icare-wi.org

Revised 9/2015

Exhibit 3

General Prior Authorization Request

iCare
INDEPENDENT CARE HEALTH PLAN

GENERAL PRIOR AUTHORIZATION REQUEST

PLEASE NOTE: Receipt of an approved prior authorization does not guarantee payment by *i*Care. Benefits are determined based on the dates that the services are rendered. Please fill out this form completely and fax to **(414)231-1026**. An incomplete form may delay processing and/or claims payment.

Today's date: _____

MEMBER INFORMATION:

Name: _____ DOB: _____

Medicare: _____ Medicaid:_____

SSN: _____ Phone #:_____

ICD10: _____ Diagnosis: _____

******iCare will not authorize PA requests without ICD 10 codes after 09/30/2015******

Please check appropriate box:

- ❒ DME
- ❒ Elective Inpatient Procedure
- ❒ Outpatient Procedure
- ❒ Modification to authorization #: _____

CPT Code: (1) _____ Procedure: _____

(2) _____ Procedure: _____

(3) _____ Procedure: _____

Date Scheduled: _____ Performing MD/Provider: _____ NPI #: _____

PA Contact: _____ Phone #: _____ Fax #: _____

FOR iCare USE ONLY:

1555 N. RiverCenter Dr. Suite 206 Milwaukee, WI 53212
Phone Number: (800)777-4376 Fax 414-231-1026 www.icare-wi.org

Revised 9/2015

Exhibit 4

Home Health/PCW Prior Authorization Request

iCare
INDEPENDENT CARE HEALTH PLAN

HOME HEALTH/PCW PRIOR AUTHORIZATION REQUEST

PLEASE NOTE: Receipt of an approved prior authorization does not guarantee payment by *i*Care. Benefits are determined based on the dates that the services are rendered. Please fill out this form completely and fax to **(414)231-1026**. An incomplete form may delay processing and/or claim(s) payment. ***i*Care conducts in home PCW assessments and authorizations will not be approved without a current assessment.**

MEMBER INFORMATION:

Name: _____ DOB: _____

Medicare: _____ Medicaid:_____

SSN: _____ Phone #:_____

Today's date: _____

NPI #: _____ Provider: _____

ICD10: _____ Diagnosis: _____

******iCare will not authorize PA requests without ICD 10 codes after 09/30/2015******

PA Contact: _____ Phone #: _____ Fax #: _____

Please check appropriate box:

Certification/Recertification Dates: _____

- ❒ New Services
- ❒ Modification of Authorization #: _____
- ❒ Home Health/Aide Visit
- ❒ Social Worker/MSW
- ❒ Personal Care Worker/PCW
- ❒ Home Health/Therapy (PT, OT, SLP)
- ❒ Home Health/Skilled Nurse Visit

Procedure Code: _____ Description: _____Quantity: _____
Procedure Code: _____ Description: _____Quantity: _____
Procedure Code: _____ Description: _____Quantity: _____
Procedure Code: _____ Description: _____Quantity: _____
PCW travel time # of units: _____ Is travel time included in above quantity? ❒Yes ❒No
PCW lives with member? ❒Yes ❒ No
PCW Address_____ Relationship to member_____
Comments: _____

FOR iCare USE ONLY:

1555 N. RiverCenter Dr. Suite 206 Milwaukee, WI 53212
Phone Number: (800)777-4376 Fax 414-231-1026 *www.icare-wi.org*

Revised 9/2015

Exhibit 5

Physician Request Form

iCare
INDEPENDENT CARE HEALTH PLAN

Physician Referral Request Form

PLEASE NOTE: Receipt of an approved prior authorization does not guarantee payment by *i*Care. Benefits are determined based on the dates that the services are rendered. Please fill out this form completely and fax to **(414)231-1026**. An incomplete form may delay processing and/or claims payment.

MEMBER INFORMATION:

Name: _____ DOB: _____

Medicare: _____ Medicaid:_____

SSN: _____ Phone #:_____

Today's date: _____ Check Specialty: ❒ Oral Surgery
❒ Plastic Surgery

Services Requested:

❒ One Time Consult ❒ Consult and Treat (please list dates) _____

ICD10: _____ Diagnosis: _____

******iCare will not authorize PA requests without ICD 10 codes after 09/30/2015******

Referring Physician	**Referred To**
Name:	Name:
Address:	Address:
City: Zip Code:	City: Zip Code:
Phone:	Phone:
Fax:	Fax:

PA Contact: _____ Phone #: _____ Fax #: _____

FOR iCare USE ONLY:

1555 N. RiverCenter Dr. Suite 206 Milwaukee, WI 53212
Phone Number: (800)777-4376 Fax 414-231-1026 www.icare-wi.org

Revised 10/2015

Exhibit 6

Therapy Prior Authorization Request

INDEPENDENT CARE HEALTH PLAN

THERAPY PRIOR AUTHORIZATION REQUEST

PLEASE NOTE: Receipt of an approved prior authorization does not guarantee payment by *i*Care. Benefits are determined based on the dates that the services are rendered. Please fill out this form completely and fax to **(414)231-1026**. An incomplete form may delay processing and/or claim(s) payment.

MEMBER INFORMATION:

Name: _____ DOB: _____

Medicare: _____ Medicaid:_____

SSN: _____ Phone #:_____

Today's date: _____

Date of Evaluation: _____ ICD10: _____ Diagnosis:_____

******iCare will not authorize PA requests without ICD 10 codes after 09/30/2015******

Facility/Provider: _____ NPI #: _____

PA Contact: _____ Phone #: _____ Fax #: _____

Please check appropriate box

❒ New Services
(Must provide initial eval and signed MD order)

❒ Modification to Authorization # _____
(Must provide clinical documentation & revised treatment plan to support request)

PT # of visits _____ OT # of visits _____ SLP # of visits _____

If this service is being performed at a SNF

Is the member ❒ Outpatient ❒ Inpatient

Are you trying to obtain a Medicare B authorization? ❒ Yes ❒ No
(Medicare A does not require authorization)

❒ Cardiac Rehab ❒ Pulmonary Rehab ❒ Lymphedema Therapy

Procedure Code: _____ Description: _____ Quantity _____

Procedure Code: _____ Description: _____ Quantity _____

Procedure Code: _____ Description: _____ Quantity _____

FOR iCare USE ONLY:

1555 N. RiverCenter Dr. Suite 206 Milwaukee, WI 53212
Phone Number: (800)777-4376 Fax 414-231-1026 www.icare-wi.org

Revised 1/2016

Exhibit 7

Hospice Prior Authorization Request

iCare
INDEPENDENT CARE HEALTH PLAN

HOSPICE PRIOR AUTHORIZATION REQUEST

PLEASE NOTE: Receipt of an approved prior authorization does not guarantee payment by *i*Care. Benefits are determined based on the dates that the services are rendered. Please fill out this form completely and fax to **(414)231-1026**. An incomplete form may delay processing and/or claim(s) payment.

MEMBER INFORMATION:

Name: _____ DOB: _____

Medicare: _____ Medicaid:_____

SSN: _____ Phone #:_____

Today's date: _____

NPI #: _____ Provider: _____

ICD10: _____ Diagnosis:_____

******iCare will not authorize PA requests without ICD 10 codes after 09/30/2015******

PA Contact: _____ Phone #: _____ Fax #: _____

Please check appropriate box:

❒ New Services

❒ Continuation of Services

Certification/Recertification Dates: _____

NOTE: Procedure Codes Required:

Procedure Code: _____ Description: _____ Quantity: _____

Procedure Code: _____ Description: _____ Quantity: _____

Procedure Code: _____ Description: _____ Quantity: _____

Procedure Code: _____ Description: _____ Quantity: _____

FOR iCare USE ONLY:

1555 N. RiverCenter Dr. Suite 206 Milwaukee, WI 53212
Phone Number: (800)777-4376 Fax 414-231-1026 www.icare-wi.org

Revised 9/2015

Exhibit 8

Outpatient Behavioral Health Prior Authorization Request

iCare
INDEPENDENT CARE HEALTH PLAN

OUTPATIENT BEHAVIORAL HEALTH PRIOR AUTHORIZATION REQUEST

PLEASE NOTE: Receipt of an approved prior authorization does not guarantee payment by *i*Care. Benefits are determined based on the dates that the services are rendered. Please fill out this form completely and fax to **(414)231-1026** within 1 business day of the initial treatment day. An incomplete form may delay processing and/or claims payment. An initial clinical review is due within 24 hours of notification of initiation of services.

Today's date: _____

MEMBER INFORMATION:

Name: _____ DOB: _____

Medicare: _____ Medicaid: _____

SSN: _____ Phone #:_____

ICD10: _____ Diagnosis: _____

******iCare will not authorize PA requests without ICD 10 codes after 09/30/2015******

Planned Dates of Treatment: _____

Facility or Performing Provider: _____ NPI #: _____

Facility Address: _____

PA Contact: _____ Phone #: _____ Fax #: _____

Please check appropriate box:

In order to process request clinical documentation supporting medical necessity is required.

- ❒ Partial hospitalization (PHP)
- ❒ Intensive Outpatient Therapy (IOP)
- ❒ Community Day Treatment Program
- ❒ Crisis Stabilization/Diversion
- ❒ In Home Psychotherapy
- ❒ Psychological Testing > 4 hours
- ❒ Modification to authorization #: _____

Please provide procedure codes & quantity of units (use visits for in home psychotherapy only)

Procedure Code: (1) _____ Quantity of Units/visits: _____

(2) _____ Quantity of Units/visits: _____

(3) _____ Quantity of Units/visits: _____

1555 N. RiverCenter Dr. Suite 206 Milwaukee, WI 53212
Phone Number: (800)777-4376 Fax 414-231-1026 www.icare-wi.org

Revision 9/2015

Exhibit 9

Behavioral Health Inpatient Prior Authorization Request

INDEPENDENT CARE HEALTH PLAN

BEHAVIOR HEALTH INPATIENT ADMISSION AUTHORIZATION REQUEST

This form is for providing notification for inpatient stays at time of admit; if you are inquiring if a CPT code or procedure needs authorization please utilize the general PA form which can be obtained from our website www.icare-wi.org

Independent Care Health Plan (*i*Care**)** needs to be notified of all inpatient stays **within one (1) business day** of the admission. Failure to adhere to *i*Care's notification policy may result in delay or denial of payment of the related hospital claim.

Please complete all requested information on this form and fax to *i*Care at FAX# 414-231-1075.

If you have any questions about this form please contact *i*Care at (414)223-4847. Submission of the notification of an admission is not a guarantee of coverage or payment of the reported service.

MEMBER INFORMATION:

Name: _____ DOB: _____

Medicare: _____ Medicaid:_____

SSN: _____ Phone #:_____

ADMISSION INFORMATION:

Admission Date: _____ Time: _____ Room #: _____

Type of Inpatient Admission: Emergency Detention _____ Voluntary _____

Admitting Facility: _____ Facility Phone #: _____

Facility NPI #: _____ Facility Address: _____

Admitting Provider: _____

Admitting Dx: _____ICD10 Code: _____

******iCare will not authorize PA requests without ICD 10 codes after 09/30/2015*****

Designated Contact Person: _____ Title: _____

Phone: (_____) _____ Fax: (_____) _____

========== DO NOT WRITE BELOW THIS LINE ==========

Authorization #: _____

1555 N. RiverCenter Dr. Suite 206 Milwaukee, WI 53212
Phone Number: (800)777-4376 Fax 414-231-1075 www.icare-wi.org

Exhibit 10

Medicare Part D Coverage Determination Request Form

10680 Treena Street Suite 500
San Diego, CA 92131

Phone: (800) 788-2949
Fax: (858) 790-7100

Medicare Part D Coverage Determination Request Form

This form **cannot** be used to request:

- Medicare non-covered drugs, including fertility drugs, drugs prescribed for weight loss, weight gain or hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).

Plan Name:

Patient Information		**Prescriber Information**		
Patient Name:		Prescriber Name:		
Member ID#		DEA#		
Address:		Address:		
City:	State	City:		State:
Home Phone:	Zip:	Office Phone#	Office Fax:	Zip:
Sex (circle): M F	DOB:	Contact Person:		

Diagnosis and Medical Information			
Medication:	Directions for use: (Frequency & Strength):		
☐ New Prescription OR Date Therapy Initiated**:**	Expected Length of Therapy: Route of Administration	Qty:	
		Qty per month:	
Height/Weight:	Drug Allergies:	Diagnosis:	
Prescriber's Signature:	MD Specialty	Date:	

Rationale for Exception Request or Prior Authorization
FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION

☐ Alternate drug(s) contraindicated or previously tried, but with adverse outcome (i.e., toxicity, allergy, or therapeutic failure)
- **Specify below**: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s);

☐ Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change
- **Specify below**: Anticipated significant adverse clinical outcome

☐ Medical need for different dosage form and/or higher dosage
- **Specify below**: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason

☐ Prior Authorization: Prior Authorization guidelines or Step Requirements
Exception Request (ME, FE, QE, CF, CE):
- **Specify below**: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome

☐ Medical Exception (ME) – Enrollee would suffer adverse events if subject to the PA requirement
☐ Formulary Exception (FE) – Medication not on the plan's list of covered drugs
☐ Quantity Exception (QE) – For a quantity different from the number of doses available under a dose restriction
☐ Compound Formulary Exception (CF) – Review for a nonformulary compound
☐ Copay Tier Exception (CE) – Reduction in the member's copay/cost sharing

Other:_____ ☐ Explain below

REQUIRED EXPLANATION: _____

_____

Request for Expedited Review

☐ REQUEST FOR EXPEDITED REVIEW [24 HOURS]
- BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

Information on this form is protected Health Information and subject to all privacy and security regulations under HIPAA

Exhibit 11

Caregiver Background Check Policy

INDEPENDENT CARE HEALTH PLAN

CAREGIVER BACKGROUND CHECK POLICY

POLICY:
In the interest of the safety and welfare of its members, it is *i*Care's policy to require all contracted organizational providers to perform Caregiver Background Checks (CBC) as required by Wis. Adm. Code §DHS 12 and 13. Background checks are completed by *i*Care contracted agencies or employing providers. No exceptions to this requirement are allowed. Procedures for verification of compliance with this requirement are conducted by *i*Care staff as outlined below.

*i*Care maintains the ability to terminate provider agreements with any provider if the MCO deems it is unsafe based on the findings of past criminal convictions stated in the results of the caregiver background check.

PROCESS:

I. Initial contracting.

1. Boilerplate contracts for Long Term Care (LTC) agencies will include requirements for the agency to conduct background checks on all employed or engaged individual service providers who meet the DHS definition of caregivers as required by Wis. Adm. Code §DHS 12 and 13. Prior to contracting as an *i*Care LTC provider, agencies will be required to attest to and to provide documentation of required CBC.

2. A list of current employees, volunteers, and nonclient residents who are subject to Caregiver Background checks will be required prior to the execution of the Provider Service Agreement. The Credentialing Department will request evidence of the background check for a sample of the employees. The following documents are required:

    a. DHS Background Information Disclosure Statement: Dated and signed by the employee (DHS F 82064A)
    b. Copy of the Department of Justice (DOJ) Crime Information Bureau (CIB) report
    c. Copy of the WI DHS Response to Care Giver Background Check report

3. If Provider is unable to provide evidence of background checks for the identified sample, within 21 business days Network Development will not proceed with the contracting process.
4. Network Development staff will be responsible for ensuring that this attestation and current employee information and evidence of verification is collected and provided in writing to the Credentialing Department for tracking and monitoring purposes.
5. Verbal attestations will not meet the requirements of this policy.

II. Re-verification.

As part of the ongoing quality monitoring process, the Credentialing Department will perform annual verification audit for up to 10% of the contracted LTC providers.

III. Non-compliance

1. Failure to comply with required caregiver background checks will result in the development of an action plan that will include termination of the contractual agreement if the problem is not corrected in the designated time frame.