



## My Choice Wisconsin BadgerCare Plus Provider Handbook

Phone: 414-755-3619 Toll-Free 855-530-6790 TTY:711 Fax: 414-755-4410  
[www.mychoicewi.org](http://www.mychoicewi.org)

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## About My Choice Wisconsin Health Plan

My Choice Wisconsin Health Plan, part of the My Choice Wisconsin Inc. family, is a Wisconsin insurance company contracted with the Wisconsin Department of Health Services (DHS) to provide healthcare coverage for BadgerCare Plus populations in Wisconsin. For the most up-to-date listing of our service area counties, please refer to our website at [mychoicewi.org/badgercare-plus/program-locations/](http://mychoicewi.org/badgercare-plus/program-locations/).

At My Choice Wisconsin Health Plan, we believe that our providers should be spending their time practicing medicine, not managing through unnecessary insurance company "red tape." We strive to make our administrative requirements simple and clear, and we are firm in our commitment to consistently "do the right thing" on behalf of all those that we serve.

With My Choice Wisconsin Health Plan, you will get personalized service from someone you know, in your community, who is focused entirely on the needs of small businesses and Medicaid program administration.

Our company only serves Wisconsin, and our office and administrative services are handled **locally**. You will work with people right here in southeast Wisconsin for all your needs, including:

- Provider Relations and Contracting
- Medical Management, Case Management, and Disease Management
- Customer Service
- Claims Administration

We encourage your comments and suggestions about our program, and appreciate your partnership.

Our My Choice Wisconsin Core Values:



**Service** – We are committed to service excellence through continuous improvement.

**Equity** – We believe everyone deserves fair and impartial treatment.

**Respect** – We value the rights, wishes and traditions of others. We are accountable and stand behind our commitments.

**Vision** – We aspire to a sustainable future through innovation and a commitment to quality.

**Empowerment** – We help our members take ownership of their health and embrace self-advocacy.

**About the Policies in This Provider Manual** -The policies in this manual may be revised from time to time. The latest version will be published on the My Choice Wisconsin website at [mychoicewi.org/providers/resource-library/](http://mychoicewi.org/providers/resource-library/).

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## CONTACT LIST

<p><b>Customer Service</b></p> <p><i>All departments may be accessed through customer service. Service hours: Monday - Friday, 8:00 am to 5:00 pm.</i></p> <p>Phone: 414-755-3619 or 855-530-6790 Fax: 414-755-4410 Email: <a href="mailto:customerservice@trilogyhealthinsurance.com">customerservice@trilogyhealthinsurance.com</a></p> <p>Providers needing My Choice Wisconsin Health Plan's BIN &amp; PCN numbers to file pharmacy claims may call ForwardHealth at 800-947-9627</p>	<p><b>Medicaid Member Advocate</b></p> <p>Phone: 855-530-6790 Fax: 414-755-4410 Email: <a href="mailto:advocate@trilogyhealthinsurance.com">advocate@trilogyhealthinsurance.com</a></p> <p><b>24 hour Emergency Line:</b> 855-530-6790</p>				
<p><b>Provider Relations and Contracting</b></p> <p>Phone: 414-755-3619 or 855-530-6790 Fax: 414-755-4410 Email: <a href="mailto:providerrelations@trilogyhealthinsurance.com">providerrelations@trilogyhealthinsurance.com</a></p>	<p><b>Medical and Behavioral Health Claim Appeals</b></p> <p>My Choice Wisconsin Health Plan Health Insurance Provider Appeals Department P.O. Box 70491 Milwaukee, WI 53207 Fax: 414-755-4410</p>				
<p><b>Claim Submission</b></p> <p><b>Medical and Behavioral Health Claims</b></p> <p>Mail: My Choice Wisconsin Health Plan Health Networks P.O. Box 1171 Milwaukee, WI 53201 EDI Payer ID: 62777</p> <p><b>Vision Claims (EyeQuest of Wisconsin)</b></p> <p>EyeQuest of WI - Claims P.O. Box 433 Milwaukee, WI 53201-0433</p> <p>Phone: 844-824-2014 Fax: 888-696-9552</p> <p><b>Dental Claims (DentaQuest of Wisconsin)</b></p> <p>DentaQuest of WI - Claims P.O. Box 2906 Milwaukee, WI 53201-2906</p> <p>Phone: 855-453-5287 Electronic: via DentaQuest's website (<a href="http://www.dentaquest.com">www.dentaquest.com</a>)</p>	<p><b>Dental/Vision Appeals</b></p> <p>DentaQuest Attention: Appeals Department Department P.O. 2906 Milwaukee, WI 53201-2906 Fax: 262-834-3452</p> <p>EyeQuest Attention: Appeals Department Department P.O. 2906 Milwaukee, WI 53201-2906 Phone: 844-824-2014 Email: <a href="mailto:VisionCGA@dentaquest.com">VisionCGA@dentaquest.com</a></p> <p><b>Prior Authorization</b></p> <p><b>Medical and Behavioral Health</b></p> <p>Phone: 414-755-3619 or 855-530-6790 Fax: 414-771-1159 Email: <a href="mailto:medicalmanagement@trilogyhealthinsurance.com">medicalmanagement@trilogyhealthinsurance.com</a> Forms: <a href="https://mychoicewi.org/providers/authorizations/">https://mychoicewi.org/providers/authorizations/</a></p> <p><b>Behavioral Health</b></p> <p>Phone: 855-530-6790 Fax: 608-245-3097 Forms for Prior Authorization of Behavioral Health services are available on the website at <a href="https://mychoicewi.org/providers/resource-library/">https://mychoicewi.org/providers/resource-library/</a></p> <table border="0" style="width: 100%;"> <tr> <td style="vertical-align: top;"><b>Dental (DentaQuest)</b></td> <td style="vertical-align: top;"><b>Vision (EyeQuest)</b></td> </tr> <tr> <td>Phone: 855-453-5287 Fax: 262-834-3450</td> <td>Phone: 884-824-2014 Fax: 888-696-9552</td> </tr> </table>	<b>Dental (DentaQuest)</b>	<b>Vision (EyeQuest)</b>	Phone: 855-453-5287 Fax: 262-834-3450	Phone: 884-824-2014 Fax: 888-696-9552
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## ELIGIBILITY

Medicaid recipients may lose eligibility to participate in a Medicaid program and/or may change their HMO affiliation. Providers should always verify eligibility status and health insurance enrollment prior to delivering service to ensure that the patient is eligible for benefits and is a member of My Choice Wisconsin Health Plan. My Choice Wisconsin Health Plan enrolls members who are in BadgerCare Plus.

My Choice Wisconsin Health Plan does not issue its own identification cards to its members. Providers should utilize the ForwardHealth Card issued to BadgerCare Plus recipients when they become eligible for benefits. Each individual family member receives his or her own individual ID number and card.



The ForwardHealth card includes the member's name, 10-digit Medicaid ID number, magnetic stripe, signature panel, and the EDS Recipient Services telephone number. The card also has a unique 16-digit card number on the front. This number is for internal use only and is not used for billing. The card does not need to be signed to be valid, although adult members are encouraged to sign their cards. Providers may use the signature as another means of identification.

ForwardHealth cards contain no eligibility dates. Recipients are instructed to keep their ID card if they lose eligibility in case they become eligible for BadgerCare Plus again. It is possible a member will present a card when he or she is not eligible; therefore, it is essential providers confirm eligibility before providing services.

Members who lose their card or have it stolen or damaged may get a free replacement by calling EDS Recipient Services at 800-362-3002 and asking for a replacement card.

Providers may see a patient who has a temporary or presumptive eligibility card. These are issued on green and beige paper respectively. Patients who present with these cards are not My Choice Wisconsin Health Plan members but are covered under Medicaid Fee for Service. Providers are encouraged to make a copy of members' ID cards and retain them in the patient file.

### **Checking Eligibility under the State System**

Providers may check eligibility through the State's systems in the following manner:

- Through the ForwardHealth Portal <https://www.forwardhealth.wi.gov/WIPortal/> if you have a provider account.
- Calling WiCall, the state's automated voice response system by calling 800-947-3544.
- Calling the State Provider Services line at 800-947-9627 from 7 am to 6 pm Monday-Friday.

Using the state system is the most accurate, up to date information on eligibility.

Wisconsin Medicaid, from time to time, will retroactively terminate an individual's eligibility for services. When that happens, My Choice Wisconsin Health Plan will recoup money paid for these members. The provider should then re-bill Medicaid or the HMO the member was retroactively assigned to at the time of service.

### **Checking Eligibility through My Choice Wisconsin Health Plan**

Call Customer Service at 414-755-3619 or 855-530-6790 from 8:00 am to 5:00 pm Monday through Friday.

## **PRIMARY CARE PHYSICIAN (PCP) ASSIGNMENT**

In addition to eligibility for Medicaid and enrollment in My Choice Wisconsin Health Plan, Primary Care Physicians (PCP) should check to make sure they are the assigned PCP prior to rendering services.

My Choice Wisconsin Health Plan believes that the patient-PCP relationship is vital to quality of care and requires all members to have a PCP. Knowing who the PCP is can be important when trying to coordinate care between health care providers, or performing case, or disease management and getting information back to the current PCP. All My Choice Wisconsin Health Plan members are required to have a PCP on record.

### **PCP Selection**

All Medicaid recipients are given the option to select a PCP at the time of enrollment with My Choice Wisconsin Health Plan. They are sent a selection form with their Member Welcome material along with a self-addressed stamped envelope. They may either return the form or call Customer Service to make their selection.

### **PCP Auto-Assignment**

If a member does not select a PCP within 30 days of receiving that form, they are auto-assigned a PCP. PCPs are selected based on the zip code of the member and zip code of the PCP. The member is then notified by mail of the PCP assignment and informed of their ability, and the process, to change to a different PCP.

### **PCP Changes**

My Choice Wisconsin Health Plan members are allowed to change their PCP as desired by contacting Customer Service. If a PCP office calls to verify they are the PCP and it is found that they are not, the PCP cannot be changed without speaking directly to the Case Head. However, My Choice Wisconsin Health Plan makes a form available to its PCP offices that may be completed by the member and faxed in at the time of the visit. In either case the change is effective immediately and the PCP may see the member.

The PCP Change form should be faxed to 414-755-4410.

For transportation, members should be directed to call the State transportation agent Medical Transportation Management Inc. (MTM, Inc.) at 866-907-1493 or TTY 866-288-3133. MTM is open between 7:00 am and 6:00 pm Monday through Friday. My Choice Wisconsin Health Plan does not arrange transportation.

## **PRIOR AUTHORIZATION GUIDELINES (Medical)**

***NOTE: Specific behavioral health authorization guidelines are included in this section under appropriate headings.***

### **Services Delivered in Home**

Services to be delivered in a home setting require a face-to-face assessment as part of the authorization request. These services include home health, durable medical equipment/durable medical supplies, physical, speech and occupational therapies, and personal care worker services. Refer to the appropriate authorization request form for more information.

### **Women's Access to Reproductive Care**

- My Choice Wisconsin Health Plan BadgerCare Plus female members may self-refer to an in-network OB/GYN provider for routine annual gynecological exams, pregnancy, and any other OB/GYN medical related issues or may select an OB/GYN as a Primary Care Provider
- My Choice Wisconsin Health Plan BadgerCare Plus female members may self-refer to any Medicaid Family Planning provider

### **Pregnancy Notification**

We ask that you call and notify us as soon as possible in the member's pregnancy so that we can initiate pre-natal Case Management services. This will also allow us to put in a tentative authorization for the estimated date of delivery. My Choice Wisconsin Health Plan is committed to working with you and our members to ensure healthy birth outcomes. Providers are asked to use the My Choice Wisconsin Health Plan Pregnancy Notification Form on page 32 for this purpose. Please complete and fax to 414-771-1159.

### **Dietary Consultations**

Dietary consultations are approved with a PCP's written order for a limit of five visits within six months. If more visits are required, a treatment plan with a prior authorization request must be submitted for review by My Choice Wisconsin Health Plan's Medical Director.

### **Out of Network Providers**

My Choice Wisconsin Health Plan believes in preserving continuity of care for our members and providing them with the most appropriate specialty services. Authorization for services provided by non-network physicians are normally considered for approval in the following instances:

- The out of network physician performed prior invasive medical care, which necessitates that the same physician provide the follow-up care, or
- There are no in-network member physicians that can provide the necessary service(s)

If you have any concerns or you would like us to consider an out of network provider based on your patient's special needs, call us at 414-755-3619 or 855-530-6790 and select the Medical Management option.

## PRIOR AUTHORIZATION (PA) REQUIREMENTS (MEDICAL)

Services requiring prior authorization:

Inpatient Authorizations
Acute Hospital-Medical or Surgical – within 48 hours or the next business day
<b>Any</b> Elective Admission – 5 days in advance
<b>Any</b> Emergency Admission – within 48 hours or the next business day
Long Term Acute Care (LTAC)
Newborn stay <b>beyond</b> the Mother's stay
OB related medical stays due to OB complications
Rehabilitation Facility – free standing or hospital floor
Skilled Nursing Facility (SNF)

Procedures/Services
Transplants (including evaluation) (facility obtains the authorization)
Hospice Care – in any Setting
Abortions – must meet State criteria and include consent
Advanced Imaging Services – CT, MRI, MR, PET
Audiological Testing for hearing instrumentation
Bariatric Evaluation and Surgery
Blepharoplasty
Botox Injections
Capsule Endoscopy
Cardiac Imaging
Cochlear Implant
Cosmetic, Plastic or Reconstructive Surgery or procedure except for cancer diagnosis
Court – Ordered Services
Dermabrasion
Dental Procedures under General Anesthesia < 5 years of age

Ancillary Services
Air Ambulance or Ambulance for Non-Emergency Transportation
DME or DMS > \$500 per line item: including Prosthetics and Orthotics
Home Care Service(s): <ul style="list-style-type: none"> <li>• Skilled Nursing Visits</li> <li>• Hospice</li> <li>• Personal Care Worker</li> <li>• Wound Care, including Wound Vacs</li> </ul>
Outpatient Therapy Services or Rehabilitation ( <b>after evaluation</b> ) (up to 3 modalities of treatment are allowed at the time of an evaluation): <ul style="list-style-type: none"> <li>• Birth to Three Program</li> <li>• Occupational Rehabilitation</li> <li>• Physical Therapy</li> <li>• Speech Therapy</li> </ul>
Infertility and impotence services
Injectable medications or Specialty Drugs not covered under the State's Pharmacy benefit (including but not limited to 17P)
Mammoplasty – reduction or augmentation unless a cancer diagnosis
OB Ultrasound – 2 are allowed in 9 months. Any additional require authorization with the exception of those ordered by a Perinatologist
Pain Management Evaluations and Procedures
Pectus excavatum/carinatum Services
Penile Prosthesis
Rhinoplasty
Screening for CT Colonoscopy
Sclerotherapy or surgery for varicose veins
Septoplasty
Sleep Studies – with the exception of those ordered by a Pulmonologist

<b>Potentially Experimental or Investigational Services or Procedures</b>
Gynecomastia Surgery
HealthCheck other services
Hearing Aid: must use State required vendor
Hysterectomy requires the acknowledgement of consent form
Implantable devices including contraceptives

Sterilization – Male or Female – also requires informed consent
TMJ Evaluation and Surgery
Ultraviolet (UV) Therapy
Vagal Nerve Stimulator Implant Surgery
Vaginal Construction
Wearable Cardioverter Defibrillator
Weight Management Services > 5 visits in a year

## PRIOR AUTHORIZATION (PA) REQUIREMENTS (BEHAVIORAL HEALTH)

### Services Not Requiring Prior Authorization:

**Narcotic Treatment Services.** Prior authorization is not required for Narcotic Treatment Services that are considered a covered benefit. This automatic authorization is only given to providers with active credentialing and provider participation status who are seeing My Choice Wisconsin Health Plan members.

**Initial Outpatient Mental Health and AODA Visits.** Network providers may see new patients for Outpatient Mental Health and AODA services without an authorization when the service is considered a covered benefit. This automatic authorization is only given to providers with active credentialing and provider participation status who are seeing My Choice Wisconsin Health Plan members.

### Services Requiring Prior Authorization:

**Intensive In-Home Mental Health Therapy.** Authorization must be obtained prior to receiving services.

**Day Treatment/Partial Hospitalization and Transitional Care.** All authorization requests for Day Treatment/Partial Hospitalization and Transitional Care must be obtained prior to receiving the service.

**Outpatient Neuropsychological and Psychological Testing.** All authorization requests for outpatient neuro/psychological testing must be obtained prior to members receiving the service. Neuro/psychological testing done on an inpatient basis does not require prior authorization. Brief testing measures such as rating scales, checklists, and inventories are not reimbursed as testing and should be included as part of the initial intake.

**Medication Management.** Authorization is not required when medication management is provided by a contracted provider (MD, PA, NP) including Suboxone treatment.

**Inpatient Care.** In the event of an emergency admission, notification including clinical information supporting the need for admission is required on the next business day. A target length of stay will be determined and communicated to the provider. Additional clinical information (concurrent review) may be needed to assess length of stays that are longer than the initial authorization. Clinician-to-clinician reviews may be conducted during concurrent review. Review and planning of further care should occur prior to expiration of any current authorization. Concurrent reviews generally occur during normal business hours. Notification of discharge date and discharge plan is required at the time of discharge.

**Services provided by non-network Providers.**

### Emergency Detention Admissions

For admissions that result from an Emergency Detention, the member's healthcare coverage should be verified and the HMO informed of the admission within the first 72 hours (three business days plus any intervening weekend days and/or holidays). The County should contact the HMO to discuss authorization and treatment plan options, as soon as they become aware of the admission.

The HMO is responsible for the cost of Emergency Detention and court-related mental health/substance abuse treatment, including involuntary commitment provided out-of-network. Treatment provided by out-of-network providers will be covered only if the time need to obtain treatment in-network would have risked permanent damage to the enrollee's health or safety, or the health or safety of others.

#### **Other Admissions (other than Emergency Detentions)**

Notify the HMO prior to the member's admission to discuss authorization and treatment plan options. As part of the case management responsibilities, the HMO may suggest alternate care options.

***Services that require prior authorization should not be started prior to the determination of coverage*** (approval or denial of the prior authorization) for non-emergency services. Non-emergency treatment started prior to the determination of coverage will be performed at the financial risk of the provider office. If coverage is denied, the treating provider may be financially responsible.

#### **Exceptions to the Prior Authorization Requirement**

No prior authorization is needed for professional charges during an inpatient stay. This includes the doctors, lab services, radiologists, pathologists, anesthesiologists, etc. Only the hospital needs the prior authorization.

No prior authorization is required if My Choice Wisconsin Health Plan is paying secondary to other insurance coverage.

No prior authorization is required for a newborn unless the baby is in the hospital longer than the mother.

#### **Emergency or Urgent Authorizations**

In an **emergency** situation, the need to prior authorize services is waived. These services will be reviewed retrospectively for **medical necessity**. My Choice Wisconsin Health Plan defines Emergency and Medical Necessity as defined in the DHS Contract between My Choice Wisconsin Health Plan and the Department of Health Services.

***"Emergency"*** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge on health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part
- With respect to a pregnant woman who is in active labor—that there is adequate time to affect a safe transfer to another hospital before delivery or that transfer may pose a threat to the health or safety of the woman or the unborn child
- A psychiatric emergency involving a significant risk or serious harm to oneself or others
- A substance abuse emergency exists if there is significant risk of serious harm to a member or others, or there is likelihood of return to substance abuse without immediate treatment

***"Medically necessary"*** means a medical assistance service, item or supply defined in HFS 101.03 (96m) as a medical assistance service under Ch. HFS 107 that meets the following standards:

- Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability
- Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided
- Is appropriate with regard to generally accepted standards of medical practice
- Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient
- Is of proven medical value or usefulness and, consistent with s. DHS 107.035, is not experimental in nature
- Is not duplicative with respect to other services being provided to the recipient
- Is not solely for the convenience of the recipient, the recipient's family, or a provider
- With respect to prior authorization of a service and to other prospective coverage determinations made by

the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient

- Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient

### **Emergency Admissions**

Emergency admissions, defined as those situations in which the patient requires immediate medical intervention, do not require prior authorization. However, My Choice Wisconsin Health Plan should be notified by the admitting facility within 24 hours following admission or by the next business day if on a weekend or holiday.

My Choice Wisconsin Health Plan should be notified within 24 hours of an emergency admission or by next business day by the admitting facility. Information required includes:

- Patient's name and member number
- Admitting diagnosis
- Treatment plan
- Date of admission

Emergency review will be done retrospectively at the time the admission review is done by the Utilization Management staff. Determination will be made regarding compliance with established criteria. In cases where the criteria are met, the admission may be authorized, and the facility notified of the approval.

In cases where criteria compliance is questionable or not met, the admitting physician will be contacted for further information. If, after speaking with the admitting physician, criteria are still not met, the case is referred to the My Choice Wisconsin Health Plan Medical Director who will discuss the case with the physician personally.

Final determination is made by the My Choice Wisconsin Health Plan Medical Director.

### **Prior Day Admissions**

Day prior admissions for procedures are **not** a covered benefit unless the physician can document an expected **improved outcome** from the day prior admission. Requests for day prior admission are evaluated on a case-by-case basis by My Choice Wisconsin Health Plan. The admitting physician must provide supporting documentation. If the extra day meets designated criteria for inpatient stay, the day prior to admission will be approved. If the extra day does not meet the designated criteria, the My Choice Wisconsin Health Plan Medical Director will review the request and make a final decision.

### **Delivery and Length of Stay**

Postpartum length of stay is based on the type of delivery and other services provided. Postpartum discharge will be routinely assumed to occur at two days for vaginal delivery, and at four days for cesarean delivery. Postpartum tubal ligations should be done within 24 hours of delivery. Total length of stay for delivery with postpartum tubal ligations should not exceed 48 hours.

### **Anesthesiology**

Anesthesiologists providing surgical anesthesia do not need a separate authorization. They will be covered under the inpatient authorization obtained by the facility and claims will not be denied for lack of prior authorization.

Anesthesiologists providing pain management outside of a surgical setting do require prior authorization.

### **Home Health Care**

Home health agencies should initiate the authorization request. Submit signed physician orders and the home health agency's assessment (including an in-person assessment) with the completed authorization form. My Choice Wisconsin Health Plan will review the request, and make a determination based on medical necessity. Please note that custodial care is not covered.

### **PT/OT/ST**

After an initial evaluation, a signed physician request and a copy of the initial evaluation (including an in-person assessment) with a plan of care should be submitted with the appropriate form requesting authorization. An initial

evaluation and any modality performed on the same day do not require an authorization. Any future services do require authorization and should not be performed until an approved authorization request is received.

## PRIOR AUTHORIZATION SUBMISSION

All authorizations will be reviewed by the Medical Management staff using criteria established by the State of Wisconsin Medicaid guidelines and Milliman Care Guidelines. If documentation is incomplete, the request for authorization will be denied administratively. ***You must receive confirmation of approval prior to performing a service.***

The authorization will be approved as a covered benefit if the requested service and submitted documentation is consistent with clinical guidelines. If the requested service requires the determination of medical necessity or the appropriateness of care, the request will be referred to one of My Choice Wisconsin Health Plan's Medical Directors for review and determination. All decisions to deny or reduce the duration, amount, or scope of a requested authorization must be reviewed and signed off by a Medical Director. The Medical Director who makes the decision on a denial or reduction in services will have the appropriate clinical expertise in an area relevant to the member's condition or disease.

***NO PRIOR AUTHORIZATION from My Choice Wisconsin Health Plan is needed when other insurance is primary.***

### Time Frames

Authorization requests should be made 7 to 10 working days prior to an elective admission or outpatient procedure, and within 24 to 48 hours after emergency admissions.

If expedited service is required for an authorization, please contact My Choice Wisconsin Health Plan and let us know by calling 414-755-3619 or 855-530-6790.

Determination will be made within 2 working days unless the nature of the admission or procedure requires review of medical records. The Medical Management staff will make every effort to expedite the review process and many times determination will be made the same day as the request.

***Urgent*** prior authorization requests will be determined and the provider notified within one working day.

***Urgent or Emergent*** Prior Authorizations, unless defined otherwise by a state are defined as those requests for services to treat situations which involve the resolution of acute pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury that a prudent layperson, possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted in serious jeopardy
- Serious impairment to such person's bodily functions
- Serious dysfunction of any bodily organ or part of such person
- Serious disfigurement of such person

### **Notification**

The notification of the determination of a request for authorization is communicated in writing to the treating provider as expeditiously as the member's condition requires:

- 1) Within 14 days of the receipt of the request (with one 14-day extension if it is determined that additional information is required to make a determination), or
- 2) Within 3 working days if the physician indicates or My Choice Wisconsin Health Plan determines that following the ordinary time frame could jeopardize the member's health or ability to regain maximum function.

In the case of denial of an authorization request or failure of the Utilization Management staff to make a determination within required timeframes, a letter is sent to both the member and provider indicating the service that is being denied, the criteria used to make the determination, appeal rights and procedures to both My Choice Wisconsin Health Plan and the Department of Health Services.

My Choice Wisconsin Health Plan shall provide to the provider and the member, upon request, a copy of the review criteria utilized in benefit determination and the qualifications of the medical professional that made the determination to deny it.

**No requests for prior authorization are approved immediately. All requests are reviewed prior to determination of approval. You may be required to submit medical records.**

### **Retrospective Review or Post Service**

All urgent or emergent prior authorization will be reviewed retrospectively.

The provider must send in the appropriate documentation marked "Retrospective Review" along with all necessary documents to be reviewed after treatment has been provided. The retrospective review is completed by the nurse to determine coverage and to certify that the services were urgent or emergent in nature. The clinical criteria utilized in the retrospective review are the same criteria utilized in the prior authorization process to determine medical necessity and appropriateness of care. All decisions to deny, or reduce the duration, amount or scope of a requested authorization must be reviewed and signed off by a Medical Director. The Medical Director who makes the decision on a denial or reduction in services will have the appropriate clinical expertise in an area relevant to the member's condition or disease.

### **Time Frames for Retrospective Review or Post Service**

All retrospective reviews shall be determined within thirty (30) working days from the initiation of the UM process unless a more stringent standard applies per regulation. Provider notification of denied or reduced determinations will be made within two (2) working days of the decision by My Choice Wisconsin Health Plan.

### **Checking the Status of an Authorization**

Prior to receiving notification, the Primary Care Physicians or person requesting Authorization may call My Choice Wisconsin Health Plan at 414-755-3619 or 855-530-6790 and speak with the Medical Management Staff.

## **SERVICES WITH SPECIAL REGULATIONS, PRIOR AUTHORIZATION OR CONSENT REQUIREMENTS**

### **Abortion**

No prior authorization is required; however, documentation of the following must accompany claim submission. The abortion must be directly and medically necessary to save the life of the mother. The physician must attest that based on his or her best clinical judgment that the abortion meets this condition. There should be a statement to that effect when a claim for an abortion is submitted.

Abortions are covered 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 certification, and provided that the crime has been reported to the law enforcement authorities.

Abortions are covered if, 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 mother, provided that prior to the abortion, the physician attests, based on his or her best clinical judgment that the abortion meets this condition.

Services performed in connection with the abortion such as lab work, ultrasound, etc. are not covered unless the abortion is performed under the guidelines and restrictions above. However, treatment for complications arising due to an abortion is covered regardless of whether the abortion itself is covered or not.

My Choice Wisconsin Health Plan complies with Wisconsin Statute 20.927 which stipulates that physicians must affix to their claims for reimbursement written certification attesting to the direct medical necessity of the abortion or his or her belief that sexual assault or incest has occurred and has been reported to law enforcement authorities.

Abortion services are also subject to prior consent as defined below.

### **Mifeprex**

No prior authorization is required; however, documentation of the following must accompany claim submission. Administration of Mifeprex (morning after pill) follows the same rules as for Abortions. Wisconsin Medicaid Reimburses for Mifeprex (known as RU-486 in Europe) under the same coverage policy that it reimburses other surgical or medical abortion. Only physicians may obtain and dispense Mifeprex.

Provider must attach to each claim a completed Abortion Certification Statement that includes information showing the situation is one in which Wisconsin Medicaid covers abortion.

### **Consent for Abortion or Mifeprex**

A woman's consent to an abortion (including administration of Mifeprex) is not considered informed consent unless at least 24 hours prior to an abortion a physician has, in person, orally provided the woman with certain information specified in the statute. That information includes, among other things, the following:

- Medical risks associated with the woman's pregnancy
- Details of the abortion method that would be used
- Medical risks associated with a specific abortion procedure
- Any other information that a reasonable patient would consider material and relevant to a decision of whether or not to carry a child to birth or to undergo an abortion

Claims submitted with no Consent Form or Abortion Certification Statement on file will be denied.

### **Sterilization**

Prior authorization is needed for sterilization procedures for both males and females. Sterilization (rendering an individual incapable of reproducing) is covered under Medicaid when it is the primary purpose of a surgical procedure under strict federal and state requirements.

A completed informed consent form must be submitted with the claim in addition to obtaining prior authorization in order for the claim to be paid. To consent to sterilization, the following conditions must apply:

- Individual must be 21 years old at the time consent is given
- Individual must not have been declared mentally incompetent by federal, state, or local court for any purposes unless that individual has been declared competent for the purpose of consenting to sterilization
- Individual is not institutionalized

Individual has voluntarily given informed consent as follows:

- At least 30 days, but not more than 180 days have passed between the date of informed consent and surgery (except in the case of premature delivery or emergency abdominal surgery)

- An individual may be sterilized at the time of premature delivery if informed consent was given at least 30 days before the expected date of delivery and at least 72 hours have passed since informed consent for sterilization was given
- In the case of emergency, abdominal surgery informed consent was given at least 72 hours prior to the surgery

### **Sterilization by Hysterectomy or Hysteroscopy**

Patient Consent Form is needed for hysterectomies or hysteroscopies.

Hysterectomy performed ONLY to produce sterility is covered if:

- The individual providing the information for the hysterectomy has informed the individual orally and in writing that the procedure will render her permanently incapable of reproducing
- The individual has signed and dated a written acknowledgement of receipt of that information prior to the hysterectomy being performed

Hysterectomy may be performed on an individual who was already sterile and whose physician has provided written documentation, including a statement of the reason for sterility, with the claim form or requiring a hysterectomy due to a life-threatening situation in which the physician determines that prior acknowledgement is not possible (the physician performing the operation shall provide written documentation including a description of the nature of the emergency with the claim form).

Before reimbursement for either Sterilization or Hysterectomy is made, My Choice Wisconsin Health Plan must have:

- Completed consent form <https://www.dhs.wisconsin.gov/forms/F0/F01164.docx>
- Acknowledgement of receipt of hysterectomy information or a physician's certification form for hysterectomy performed without prior acknowledgement of receipt of hysterectomy information

## **CLAIM SUBMISSION – GENERAL INFORMATION**

### **Checking Claim Status**

The status of submitted claims may be obtained by calling 414-755-3619 or 855-530-6790 and speaking with the Customer Service Staff. When speaking with a Customer Service Representative, we ask that you limit the number of claims you are calling on to 5 at one time. We need to do this in order to ensure that other callers receive prompt attention. Claims will be paid or denied within 30 days of receipt. For larger projects related to claims please contact provider relations at 855-530-6790 or [providerrelations@trilogyhealthinsurance.com](mailto:providerrelations@trilogyhealthinsurance.com).

### **Coding**

My Choice Wisconsin Health Plan requires claims to be billed in compliance with required Wisconsin Medicaid instructions for your specific services as described in the online provider handbooks and published provider updates which may be accessed through the Forward Health Portal <https://www.forwardhealth.wi.gov/WIPortal/>. Online handbooks specify allowable provider types, procedure and/or diagnosis codes, modifiers, unit limits, and related information to be used when billing specific services.

In addition, claims will be processed in compliance with the provider type/specialty, place of service, modifiers, and procedure codes specified in the Medicaid fee schedule which also may be accessed through the Forward Health Portal.

Prior Authorization requirements listed on the Forward Health Portal refer to Medicaid Fee for Service claims. My Choice Wisconsin Health Plan's requirements may be different. Please refer to the Prior Authorization section of this manual for My Choice Wisconsin Health Plan's requirements.

### **Coordination of Benefits**

My Choice Wisconsin Health Plan will deny claims if it is determined that the member has other insurance as their primary carrier. My Choice Wisconsin Health Plan requires a copy of the EOB (Explanation of Benefits) or electronic

submission of other insurance payments showing a denial or payment from the primary insurance carrier before payment will be considered or coordinated.

- Only services covered by Medicaid are payable regardless of other insurance coverage
- My Choice Wisconsin Health Plan will consider the Medicaid allowable for the entire claim and the entire amount paid by the primary insurance when calculating secondary payment. If the primary insurance paid more than Medicaid allowable for the entire claim no additional money will be paid.

### **Electronic Claim Submission**

HIPAA X12 standards, version **5010** regulates the electronic transmission of specific health care transactions and became effective in 2012. Covered entities, such as health plans (including My Choice Wisconsin Health Plan), health care clearinghouses, and health care providers, are required to conform to **HIPAA 5010** standards. Therefore, all electronic claims submitted to My Choice Wisconsin Health Plan must be submitted in compliance with HIPAA 5010 standards. Claims must be submitted within 120 days of the date of service or the timeframe specified within the providers' contract.

Claims may be submitted electronically. Use Payer ID 62777.

### **Overpayments**

Pursuant to 42 CFR s. 438.608 My Choice Wisconsin Health Plan must recover all overpayments made to network providers, and further require providers to return overpayments within 60 days of identification by the provider or notice of overpayment by My Choice Wisconsin Health Plan. Overpayments may occur due to changes in primary insurance coverage, member eligibility, provider billing errors, health plan payment error, post payment audits, or similar reasons. My Choice Wisconsin Health Plan may request refunds in writing but reserves the right to offset overpayments against, or deduct or recoup overpayments from, any other payments My Choice Wisconsin Health Plan owes to provider. Failure of the provider to refund overpayments either when requested by My Choice Wisconsin Health Plan or identified by the provider will result in recoupment of funds or further collection activities.

### **Paper Claim Submission**

Paper claims submitted to My Choice Wisconsin Health Plan must be complete and contain all information required to process the claim and comply with Wisconsin Medicaid standards. Claims must be submitted within 120 days of the date of service or the timeframe specified within the providers' contract.

Claims with attachments and paper claims must be submitted to:

My Choice Wisconsin Health Plan  
P.O. Box 1171  
Milwaukee, WI 53201

### **Resubmission of Corrected Claims**

Providers may resubmit a claim that has been corrected or modified from the original submission via the normal claim submission process within 60 days of original payment/denial or the timeframe specified within the providers' contract. Resubmitted claims should not be sent to the provider appeals address.

Electronic submission: Payer ID 62777. Paper claims or claims with attachments should be mailed to: My Choice Wisconsin Health Plan, P.O. Box 1171, Milwaukee, WI 53201

ELECTRONIC REPLACEMENT/CORRECTED CLAIM SUBMISSIONS. The My Choice Wisconsin Health Plan Health Insurance claim system recognizes claim submission types on electronic claims by the frequency code submitted. The ANSI X12 837 claim format allows you to submit changes to claims that were not included on the original adjudication. Please refer to the 837 Implementation Guides for explanation and usage of claim frequency codes.

### **Supportive Documentation**

Providers must submit additional information and/or documents when billing the following services.

**Abortion:** My Choice Wisconsin Health Plan complies with Wisconsin Statute 20.927 which stipulates that physicians must submit written certification attesting to the direct medical necessity of the abortion or his or her belief that sexual assault or incest has occurred and has been reported to law enforcement when submitting claim. Abortion claims must also be submitted with a completed informed consent form.

**Hospice Services:** HMOs are required to have hospice providers submit form F-01008 Notification of Hospice Benefit Election with the first claim.

**Hysterectomies:** Hysterectomy may be performed on an individual who was already sterile and whose physician has provided written documentation, including a statement of the reason for sterility, with the claim form or requiring a hysterectomy due to a life-threatening situation in which the physician determines that prior acknowledgement is not possible (the physician performing the operation shall provide written documentation including a description of the nature of the emergency with the claim form)

Before reimbursement for either Sterilization or Hysterectomy is made My Choice Wisconsin Health Plan must have:

- A signed informed consent form
- Acknowledgement of receipt of hysterectomy information or a physician's certification form for hysterectomy performed without prior acknowledgement of receipt of hysterectomy information

**Sterilization:** A completed informed consent form must be submitted with the claim for sterilization in addition to obtaining prior authorization for the claim to be paid.

### **Timely Filing**

Claims should be submitted to My Choice Wisconsin Health Plan within 120 days of the date of service or of discharge or the timeframe specified within the providers' contract. Timely filing limits will vary by contractual agreement with My Choice Wisconsin Health Plan.

### **Timely Filing When My Choice Wisconsin Health Plan is Secondary Payer**

When My Choice Wisconsin Health Plan is the secondary payer due to other insurance coverage, the provider must submit the claim along with the EOB or explanation that payment from the primary carrier was sought first. My Choice Wisconsin Health Plan will allow 120 days from the date of the primary carrier's EOB, or the providers' contracted limits.

## **CLAIM SUBMISSION – SPECIFIC CLAIM TYPES**

Specific billing requirements included in this section of the manual are not all inclusive and are presented for quick reference and reminders for commonly billed services.

### **Anesthesiologists**

Anesthesiologists providing surgical anesthesia do not need a separate authorization. They will be covered under the inpatient authorization and claims will not be denied for lack of prior authorization. Anesthesiologists providing pain management outside of a surgical setting, do require prior authorization (see the Prior Authorization section of this manual).

### **Behavioral Health**

My Choice Wisconsin Health Plan requires providers to bill mental health and substance abuse services in accordance with published service specific provider online handbooks available on the Forward Health Web Portal. Such handbooks specify billable provider types/specialties, modifiers, allowable places of service and other informative coding specifications.

## **ForwardHealth Clarification of Coverage of IOP and PHP for Hospital Providers**

Wisconsin Medicaid covers a continuum of non-inpatient behavioral health services, including Intensive Outpatient Programs (IOP) and Partial Hospitalization Programs (PHP). WI Medicaid covers these programs, when medically necessary, for all full-benefit Medicaid members and requires all contracted BadgerCare Plus and Medicaid SSI health plans (HMOs) to cover these services. Relevant coverage policies and requirements for these services are described in Wis. Admin Code chs. DHS 105 and 107 and the ForwardHealth Online Handbook. In most cases, the services provided in an IOP are covered in accordance with published policy for outpatient mental health services or outpatient substance abuse services. For more intensive services, the IOP provider would be certified as a day treatment program and provide services under the day treatment policy. The services provided in a PHP are always covered in accordance with published policy for mental health or substance abuse day treatment.

Wisconsin Medicaid covers medically necessary IOPs and PHPs provided by certified hospitals when delivered in accordance with all program requirements.

### **IOP Services**

When providing “outpatient mental health” or “outpatient substance abuse treatment,” including most IOPs, hospitals may submit claims for the service using the UB-04 claim form and the appropriate revenue and procedure codes. The services must be provided within the licensed hospital. The WI Medicaid Claims and Encounter systems are configured to accept revenue codes 0905 and 0906 submitted with the appropriate HCPCS procedure codes.

### **PHP/Day Treatment Services**

When providing day treatment services, including PHPs, hospitals must adhere to published policy requirements for “adult mental health day treatment” and “substance abuse day treatment.” These requirements include provider certification as a day treatment program by the Wisconsin Division of Quality Assurance and submission of health care claims on a 1500 Health Insurance Claim form using HCPCS code H2012. Institutional claims on the UB-04 claim form using revenue codes 0912 and 0913 are not reimbursable by WI Medicaid, but the day treatment services themselves remain covered and reimbursable when claims are submitted in accordance with published policy.

## **BMI (Body Mass Index)**

Wisconsin Medicaid allows reimbursement to eligible providers and clinics for reporting BMI on professional claims for routine office visits and preventive services for members 2 to 18 years of age on the date of service. For the additional reimbursement, procedure code 3008F should be billed. An office visit procedure code may be billed in addition to the BMI code. Providers are required to maintain records that fully document the basis of charges upon all claims for additional reimbursement payments are made.

## **Chiropractic Services**

Chiropractic claims are only payable under Wisconsin Medicaid for the following diagnosis codes:

M99.01            M99.02            M99.03            M99.04            M99.05

## **EAPG Priced Claims**

Wisconsin Medicaid calculates payment on outpatient hospital claims using EAPG methodology. All charges billed for an outpatient encounter are considered in combination with each other using a formula that takes multiple factors into consideration and therefore each individual line may or may not generate a separate payment. In order to consider the encounter and pay the correct amount, all charges for the outpatient encounter must be submitted on a single claim form. By splitting up charges for a single event into multiple claims, there is the potential for both underpayment and overpayment of the claim. Splitting up charges for the purpose of obtaining a greater reimbursement may constitute fraud. If additional charges are required after the initial claim has been submitted, a single corrected claim which includes all charges for that encounter must be submitted. Portions of a single encounter will not be paid separately.

### **Laboratory Services - CLIA**

My Choice Wisconsin Health Plan complies with Federal CLIA requirements. All providers who perform lab tests in their office or facility are required to comply with Title 42 CFR Part 493, Laboratory Requirements “Any facility where testing is performed on specimens collected from human beings for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or assessment of health, comes under the Federal CLIA requirements.” There are four different CLIA certificates:

- Certificate of Waiver
- Provider Performed Microscopy
- Certificate of Compliance
- Certificate of Accreditation

CLIA regulations apply to *all* providers who perform CLIA-monitored laboratory services, including, but not limited to, the following:

- Clinics
- HealthCheck providers
- Independent clinical laboratories
- Nurse midwives
- Nurse practitioners
- Osteopaths
- Physician assistants
- Physicians
- Rural health clinics

### **Laboratory Services - Handling Fees and Venipuncture**

My Choice Wisconsin Health Plan will pay lab handling fees ONLY if a specimen was for a Covered Service and was sent out of the office to a contracted lab for processing. This must be indicated properly on the claim in box 20 of a CMS 1500 form or through use of a 90 modifier.

Venipuncture (36415) is not separately billable; fee is included in the lab procedure or handling fee reimbursement.

### **Newborn Claims**

Claims for newborns should NOT be billed under the mother. Newborns should be billed separately under the child’s own ID number and are not payable under the mother’s ID number. If the child’s ID number is not known at time of discharge, the claim will be held by My Choice Wisconsin Health Plan until the child has a number.

### **Non-Anatomical Pathology Charges**

Reimbursement for the professional component of non-anatomical pathology is included in the reimbursement for the lab code. Claims submitted for the professional component for non-anatomical pathology for codes that are not on the exemption list will be denied. This includes claims submitted by a pathologist.

### **Off Campus Provider Based Clinic Services**

In accordance with the Forward Health Update January 2016 No. 2016-02, For services provided in an off-campus provider-based outpatient clinic, the professional claim should be submitted with POS code 19. Per the new national code-set changes, hospital providers are required to include modifier PO on institutional claims to indicate the facility charge for services provided in off-campus provider-based outpatient clinics.

However, per ForwardHealth’s “4 walls policy,” Wisconsin Medicaid will not reimburse a facility charge for services provided in a provider-based outpatient clinic. Thus, ***institutional claims submitted with modifier PO for services provided in a provider-based outpatient clinic will be denied.*** Note: Providers may not omit modifier PO on an institutional claim submitted to ForwardHealth for services provided in an off-campus provider-based outpatient clinic as a mechanism to receive reimbursement for the facility charge.

### **Pharmacy and Disposable Medical Supply Claims**

Most pharmacy and disposable medical supplies (supplied by pharmacies) for Medicaid recipients are not administered through Wisconsin Managed Care Organizations. This is a carved-out service that is handled through FFS. Please bill these items directly to Wisconsin Medicaid. Forward Health publishes procedure codes that are and are not included in the carve out and publishes the table which can be found on the Forward Health Portal

[https://www.forwardhealth.wi.gov/WIPortal/content/Provider/mcicaid/physician/resources\\_31.htm.spage](https://www.forwardhealth.wi.gov/WIPortal/content/Provider/mcicaid/physician/resources_31.htm.spage)

### **Podiatry**

Routine foot care is defined as the cleaning, trimming, cutting, and debridement of toenails, corns, and callouses.

To receive routine foot care, the member must be under the active care of a physician and have one of the following diagnoses:

- Arteriosclerosis obliterans evidenced by claudication
- Blindness
- Cerebral palsy
- Cerebrovascular accident
- Diabetes mellitus
- Guillian-Barre syndrome
- Multiple sclerosis
- Parkinson's disease
- Peripheral neuropathies involving the feet, which are associated with one of the following:
  - Malnutrition or vitamin deficiency
  - Diabetes mellitus
  - Drugs and toxins
  - Multiple sclerosis
  - Urea
  - Polio
  - Scleroderma
  - Spinal cord injuries

### **Screening, Brief Intervention, and Referral to Treatment (SBIRT)**

BadgerCare Plus and Medicaid SSI covers substance abuse screening and intervention known as Screening, Brief Intervention, and Referral to Treatment (SBIRT). This benefit applies to My Choice Wisconsin Health Plan members who are 10 years or older on the Date of Service (DOS). SBIRT claims should be submitted with HCPCS procedure codes H0049 or H0050 and corresponding diagnosis codes Z13.9 and Z71.89.

### **Therapy (Physical, Occupational, Speech) Claims**

Therapy claims submitted by hospitals must only be billed on a CMS 1500 form or 837p electronic transaction with CPT codes. Respective modifiers must be billed with each service type. Physical Therapy = GP, Occupational Therapy = GO, Speech Therapy = GN.

### **Vaccines and the Vaccines for Children Program (VFC)**

Providers are required to indicate the procedure code of the actual vaccine administered, not the administration code, on claims for all immunizations. Reimbursement for both the vaccine, when appropriate, and the administration are included in the reimbursement for the vaccine procedure code, so providers should not separately bill the administration code.

Vaccines that are commonly combined, such as MMR or DTaP, are not separately reimbursable unless the medical necessity for separate administration of the vaccine is documented in the member's medical record.

Under the Vaccines for Children Program (VFC) all vaccines that are approved by the Advisory Council on Immunization Practices (ACIP) for children **less than 19 years of age** are available to providers enrolled in the VFC program. When a new vaccine is approved and the ACIP recommendations are published, the Wisconsin Immunization Program will have that vaccine available for providers to order as soon as it becomes available.

For vaccines that are not available through the VFC program, and vaccines provided to adults 19 years of age and older, providers may use a vaccine from a private stock. In these cases, the administration fee and vaccine fee will be payable however, only the vaccine code should be billed. The reimbursement for the vaccine code will include administration automatically. No modifier U1 is required to obtain reimbursement for both the vaccine and the administration. If the administration code is billed it will be denied because the reimbursement for administration is being paid under the vaccine code.

## **PROVIDER CLAIM APPEALS AND REQUESTS FOR RECONSIDERATION**

### **Definitions**

**Reconsideration of a Claim:** A request to review a claim or a portion of a claim that a provider feels was incorrectly paid or denied. A request for reconsideration of a claim is not a formal appeal. Contact Customer Service by phone: 855-530-6790 or fax 414-755-4410 to request reconsideration. In the event the reconsideration does not resolve the provider's dissatisfaction with the claim, Customer Service will provide information on filing a formal appeal (timely filing of appeals is still subject to the providers' contracted timeframe or 60 calendar days from the initial denial or payment notice).

**Resubmission of a Claim:** Submission of a previously submitted claim that that has been corrected, modified, or includes information that was missing on the first claim. Submit claim(s) via the normal claim submission process and within 60 days of the initial submission or within the providers' contracted timeframe. Paper claims or claims with attachments should be mailed to: My Choice Wisconsin Health Plan, P.O. Box 1171, Milwaukee, WI 53201. Code electronic claims with the appropriate Claim Frequency Code (7) that identifies a "corrected" claim to avoid a duplicate claim denial. DO NOT submit corrected claims to the Provider Claim Appeals Department.

**Appeal:** An application or proceeding for review when a provider does not agree with the claim reconsideration decision. Formal Appeals to My Choice Wisconsin Health Plan must be submitted in writing clearly marked "appeal." A written response will be provided. Appeals must be submitted within 60 days of initial payment/denial or the time frame specified in the providers' contract. The appeal must include:

- Provider's Name, Date of Service, member's name and BadgerCare Plus Medicaid ID number
- The reason(s) the claim merits adjustment and supporting documentation, submit medical records if the reason for the appeal is related to medical necessity
- A return address for the response is required. All communication will be sent in writing. If no return address is provided the response will be sent to the service location address on the claim(s) being appealed. My Choice Wisconsin Health Plan is not responsible if the entity filing the appeal does not receive the response in that situation.

### **Mail appeals to**

My Choice Wisconsin Health Plan Provider Claim Appeals Department, P.O. Box 70491 Milwaukee, WI 53207

**Fax appeals to 414-755-4410. For appeals with medical records or large volume, fax to 414-448-6710**

### **Provider Appeals Website**

Providers can review the appeals process on the ForwardHealth website by following the link [Provider Appeals \(wi.gov\)](https://www.forwardhealth.wi.gov/provider-appeals)

Additional information regarding the appeals process can be found in Topic #384 and Topic #385, found in the following link [Print \(wi.gov\)](#)

## **Procedure**

Upon receipt of the appeal, My Choice Wisconsin Health Plan will review the appeal and respond within 45 days unless your contract specifies a different timeframe. If the decision is in your favor, the claim will be paid within 30 days. After exhausting all appeal rights with the HMO, if a provider disagrees with the HMO's appeal response, they have the right to appeal to the Department of Health Services (DHS). Failure to follow the provider appeal process with the HMO will result in the appeal denial being upheld.

Providers may appeal the decision to the Department of Health Services through the Provider Appeals portal at <https://wi-appeals.entellitrak.com/> within 60 days of the final decision date or failure to respond from the MCO. Providers are required to submit appeals with legible copies of all supporting documentation as outlined in the Appeals to BadgerCare Plus HMOs and Medicaid SSI HMOs (#384) and Appeals to ForwardHealth (#385) topics of the ForwardHealth Online Handbook. The decision to overturn an HMO's/PIHP's denial must be clearly supported by the documentation the provider submits. Submitting incomplete or insufficient documentation may lead to ForwardHealth upholding the HMO's/PIHP's denial.

Providers should notify ForwardHealth if the HMO subsequently overturns their original denial and reprocesses and pays the claim for which an appeal has been submitted. Notification should be faxed to ForwardHealth at 608-224-6318. This documentation will be added to the original appeal documentation to complete the record and the appeal withdrawn. Providers can also call Managed Care Ombudsman Program Unit at 800-760-0001, option 1, to check on the status of a submitted appeal.

The Department has 45 days from the date of receipt of all written comments to inform the provider and the HMO of the final decision. If the Department's decision is in favor of the provider, the HMO will pay provider(s) within 45 days of receipt of the Department's final determination. The HMO and the provider must accept the Department's final decision regarding appeals of disputed claims. A reconsideration of a final decision will only be made if an error has been made or there was a misrepresentation of facts. The Department will review the appeal documents and make a Final Decision based on the contract (both the DHS-HMO contract and the HMO-provider contract, if submitted, will be used to make the decision). The Department does not adjudicate appeals for clinical level of care (e.g. observation vs. inpatient) provided to the member, nor does the Department review the results of contractually agreed upon HMO reviews of claims or medical records. As these actions are a contractual requirement, the HMO review decisions are not appealable to DHS.

### **Immunity from Punitive Action**

My Choice Wisconsin Health Plan does not take any punitive action against a member or provider for filing a complaint, appeal, or grievance on behalf of themselves or on behalf of someone else. This includes members or providers requesting expedited resolution.

**Please note:** Providers requesting an appeal on behalf of a member who has been denied services should not use the provider claim appeal process. Please see the Member Appeals and Grievances section of this document.

## **CARE MANAGEMENT**

Care Management is the umbrella term for My Choice Wisconsin Health Plan's overall program which encompasses Disease Management, and Medical Case Management. Both clinical and non-clinical staff is available and part of the program and work with DME providers, PCPs, specialists, discharge planners, social service and community agencies and others in a comprehensive program which address My Choice Wisconsin Health Plan's special needs members.

My Choice Wisconsin Health Plan identifies members who are appropriate for the care management program, but providers may also refer their patients for care management by calling 414-755-3619 or 855-530-6790 and selecting the prompt for "care management." A form for this purpose is also provided at the end of this manual and posted on the My Choice Wisconsin Health Plan website <https://mychoicewi.org/providers/resource-library/>. The form may be faxed to My Choice Wisconsin Health Plan at 414-771-1159 or emailed to [CareManagement@trilogyhealthinsurance.com](mailto:CareManagement@trilogyhealthinsurance.com).

Members who may be included in this category are those with conditions such as:

- Chronic conditions such as asthma, diabetes, renal disease or co-morbid conditions
- High risk pregnancy
- Premature babies
- Catastrophic conditions such as cancer
- Psychiatric and/or substance abuse

### **Prenatal Management**

My Choice Wisconsin Health Plan's care management program for high-risk pregnant women includes prenatal, inter-conception, and post-partum strategies and services. Women who fall into more than one category of care management such as those with chronic medical conditions and/or mental health or substance abuse issues are especially important to recognize early and get into a program.

All providers who see pregnant women as patients are asked to notify My Choice Wisconsin Health Plan as possible in the member's pregnancy so that we can initiate pre-natal Case Management services. My Choice Wisconsin Health Plan is committed to working with you and our members to ensure healthy birth outcomes.

Providers are asked to use the My Choice Wisconsin Health Plan ***Pregnancy Notification Form*** (at the end of this manual) for this purpose. Please complete and fax it to 414-771-1159.

### **Disease Management**

At the present time, My Choice Wisconsin Health Plan utilizes self-management/educational booklets which are placed in participating provider offices. Providers are encouraged to give the booklets to the My Choice Wisconsin Health Plan members they identify as appropriate. When the provider gives out a booklet they are asked to submit a referral form for case management. After a few days are allowed for the member to review the book, the member is called by a nurse who will go over the material in the book with them, answer questions and determine if medical case management is appropriate. Additional booklets are retained in the care management department and are sent to members who are identified as being appropriate.

The following booklets are available:

- Asthma Management
- Advanced Directives/End of Life
- Congestive Heart Failure Management
- Chronic Obstructive Pulmonary Disease Management
- Coronary Artery Disease Management
- Diabetes Management
- Hypertension Management
- Preventive Medicine Services

## **QUALITY IMPROVEMENT PROGRAM**

### **Overview**

The Quality Improvement Program incorporates both quality and processes as they relate to the delivery of health care as well as the quality of service to My Choice Wisconsin Health Plan's members. The program has processes in place to monitor and evaluate health care services including patient safety and access to medical care.

### **Goals/Objectives of the Program**

- Integrate quality improvement processes throughout My Choice Wisconsin Health Plan's health care delivery system and in the application of national, state and My Choice Wisconsin Health Plan goals and health care initiatives
- Promote preventive health care through provider and patient education and support
- Promote quality care through adherence to established clinical guidelines
- Ensure access to care
  - Number and location of providers of specific types
  - Length of time required to obtain appointments with PCPs and Specialists
  - Length of time waiting in a provider's office
  - Language and disability accommodations
- Assist the health plan in providing quality, cost effective and clinically sound care to its members
- Promote the utilization of technology to improve quality, efficiency and access to records and advanced medical care
- Promote preventive care
- Achieve Health Effectiveness Data and Information Set measures as defined in the contract between My Choice Wisconsin Health Plan and DHS
- Achieve member and provider satisfaction
- Monitor and adhere to Medicaid and DHS requirements as it relates to My Choice Wisconsin Health Plan's membership

### **Health Effectiveness Data and Information Set (HEDIS)**

Specific goals are set annually in both clinical and administrative areas. Clinical quality categories and results from My Choice Wisconsin Health Plan providers are dictated by the Department of Health Services to the HMOs who provide Medicaid services to Wisconsin recipients. The Department of Health Services utilizes HEDIS to define the quality areas that are monitored each year.

My Choice Wisconsin Health Plan will assist you in reaching quality goals in several ways including:

- Outreach to your patients for reminders to get certain services such as childhood immunizations or HbA1c testing for diabetics, lead screens for children, mammography screening for women, etc
- Feedback to you on your ratings and support from My Choice Wisconsin Health Plan's Medical Director
- We will provide members with educational mailings throughout the year

- Providing you with educational self-care booklets to use with your patients under the disease management program

Wisconsin Medicaid requires My Choice Wisconsin Health Plan to meet certain HEDIS quality indicators and to submit results. In order to fulfill that requirement, certain HEDIS quality indicators include collecting data from medical records through chart review. My Choice Wisconsin Health Plan will make every effort to accommodate provider office schedules and protocols and be as unobtrusive as possible when this becomes necessary.

My Choice Wisconsin Health Plan is required to report data to the state for the following HEDIS measures:

- Antidepressant medication management
- Controlling high blood pressure
- Breast cancer screenings
- Childhood immunizations prior to their second birthday
- Follow up after mental health hospitalizations
- Diabetes management with Hemoglobin A1C testing and control <8%
- Emergency department utilization
- Annual dental visits
- Prenatal and postpartum care
- Initiation and engagement of alcohol and other drug abuse treatment
- Tobacco cessation
- Lead screenings in children prior to their second birthday

For questions, please reference the following web site: <http://www.ncqa.org/hedis-quality-measurement/hedis-measures>

## **PROVIDER RESPONSIBILITIES**

### **Standards for Access to Care**

#### **General Information**

Providers may not create barriers to access to care by imposing requirements on members that are inconsistent with the provision of medically necessary and covered BadgerCare Plus benefits (e.g., COB recovery procedures that delay or prevent care).

Providers must comply with all non-discrimination requirements including but not limited to Title XIX of the Social Security Act and Title 42 of the CFR.

Providers must not discriminate in the provision of services or benefits on the basis of age, color, disability, national origin, race, religion, or sex/gender. This policy covers enrollment, access to services, facilities, and treatment for all programs and activities.

#### **After Hours and Substitute Coverage**

All practitioners must have back-up (on call) coverage after hours or during the practitioner's absence or unavailability. My Choice Wisconsin Health Plan requires practitioners to maintain a twenty-four (24) hour phone service, seven (7) days a week. This access may be through an answering service or a recorded message after office hours. Callers must be told how to reach the provider they are calling or be told who is covering for that provider. All covering providers must be credentialed providers.

#### **Office Wait Times**

My Choice Wisconsin Health Plan standards limit providers to waiting times for a scheduled appointment to an average of 10 – 15 minutes. In no case should the wait by My Choice Wisconsin Health Plan members exceed that of any other patients served by the provider's office.

### **Appointment Wait Times**

My Choice Wisconsin Health Plan has adopted the following as minimal standards for its contracted providers:

Preventive Care	Within 30 calendar days
Routine Primary Care (PCPs)	Within 14 calendar days
Urgent Care	Within 24 hours
High Risk Prenatal Care	Within 2 weeks of request or within 3 weeks for a specific practitioner
Routine referral visits (Specialists)	Within 60 calendar days
Emergency Providers	Immediately (24 hours a day, 7 days a week) and without prior authorization
Urgent Visit	Within 24 hours of request of appointment
Non-Urgent, symptomatic care	Within 7 calendar days of request of appointment
High Risk Prenatal Care	Within 2 weeks of a request of appointment or within 3 weeks if the request is for a specific provider
Physical or Sexual abuse assessment	Immediately upon request of appointment
Emergency visit	Immediately upon request of appointment
Routine Dental Care	Within 90 calendar days
Emergency Dental Care	Within 24 hours
Mental Health Initial Assessment	Within 10 calendar days
Mental Health appointment following inpatient psychiatric hospital stay	Within 3 calendar days

\*Emergency dental care is defined as an immediate service needed to relieve the patient from pain, an acute infection, swelling, trismus, fever, or trauma.

### **Billing Medicaid Members**

Balance billing BadgerCare Plus members by Wisconsin Medicaid providers is disallowed by regulation. Any provider who knowingly and willfully bills a BadgerCare Plus member for a Medicaid covered service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both as defined in Section 1128B.(d)(1) [42 U.S.C. 1320a-7b] of the Social Security Act and Wis. Stats. 49.49 (3m).

The standard release form signed by the member at the time of services does not relieve the HMO and its providers and subcontractors from the prohibition against billing a member in the absence of a knowing assumption of liability for a non-BadgerCare Plus covered service. If a member agrees in advance in writing to pay for a service not covered by BadgerCare Plus, then the HMO, HMO provider, or HMO subcontractor may bill the member. However, the form or other type of acknowledgment relevant to a member's liability must specifically state the admissions, services, or procedures that are not covered by BadgerCare Plus.

### **Billing Copays**

My Choice Wisconsin Health Plan does not charge copays for any services it provides. Provider is prohibited from trying to collect any copays.

### **Billing for Missed Appointments/No Shows**

Providers cannot bill My Choice Wisconsin Health Plan members for any missed appointments while the members are eligible under the BadgerCare Plus – Standard Plan Programs.

Providers should notify My Choice Wisconsin Health Plan's Member Advocate via email at if a member does not show up for a scheduled appointment and does not notify the provider in advance of the cancellation and provide the name of the patient and the date of the appointment(s). My Choice Wisconsin Health Plan's Member Advocate will contact the member and talk with him/her about the importance of keeping appointments.

If the patient exhibits a repeated pattern of missed appointment to the point where the provider intends to terminate care for a member, the provider must adhere to the following procedure.

Document the situation in the patient's chart

Send a certified letter to the patient with the following information:

- the reason for termination
- the effective date of the termination
- a directive to call My Choice Wisconsin Health Plan's Member Advocate for help selecting a new provider
- the phone number of the Member Advocate, which is 855-530-6790

Send a copy of the letter to My Choice Wisconsin Health Plan at the following address:

My Choice Wisconsin Health Plan  
Attention: Member Advocate  
10201 W Innovation Drive Suite 100  
Wauwatosa, WI 53226

A copy of the letter may alternately be faxed to 262-432-0396 or attached to email to [advocate@trilogyhealthinsurance.com](mailto:advocate@trilogyhealthinsurance.com). Retain a copy of the letter in the patient's chart. Providers must continue to see the patient for 30 days following the termination date for emergency services.

### **Confidentiality**

Providers are expected to comply with all applicable federal, state, and local laws, rules, regulations and Medicaid requirements including, but not limited to, the Health Insurance Portability and Accountability Act of 1996, and all rules and regulations promulgated hereunder. In addition, providers must abide by the confidentiality requirements established by My Choice Wisconsin Health Plan and by the Medicaid program to ensure that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas; to maintain the records and information in an accurate and timely manner; and to ensure timely access by members to the records and information that pertain to them.

### **Cultural Competency**

Providers are expected to incorporate cultural awareness and sensitivity in their interactions with Medicaid patients. In this context the term "cultural" incorporates language, ethnicity, gender, disability, economic status, and religious beliefs.

### **Medical Records**

My Choice Wisconsin Health Plan follows a minimum standard which conforms with Wis. Adm. Code, Chapter DHS 106.02, (9)(b) medical record content requirements and includes the following:

- Identifying information of the member including name, member identification number, date of birth, sex, and legal guardianship (if applicable)
- A summary of significant surgical procedures, past and current diagnoses or problems, allergies, social and family history, untoward reactions to drugs, and current medications (or notation that none are known)
- Periodic exam record
- Weight, height, and BMI information and, if indicated, growth chart
- Dated and signed entries by the appropriate party
- Relevant history of current illness/injury including chief complaint/purpose/reason for the visit, the objective, diagnoses, medical findings, or impression of the provider including behavioral health conditions
- Indicated referrals and diagnostic studies ordered (e.g., laboratory, x-ray, EKG) and referral reports
- Indicated therapies administered and prescribed including dosages and dates of initial or refill prescriptions
- Clinical observations and description of services provided including the results of treatment
- Name and profession of the provider rendering services (e.g., MD, DO, OD) including the signature or initials of the

provider

- Disposition/results, recommendations, instructions to the member, evidence of whether there was follow-up, and outcome of services
- A complete immunization history
- Obstetrical history and profile (if applicable)
- Risk assessment
- Anticipatory guidance and/or health education provided
- Family planning and/or counseling
- Information relating to the member's use of tobacco products and alcohol/substance abuse
- Summaries of all Emergency Services and Care and Hospital discharges with appropriate medically indicated follow up
- Reflection of the primary language spoken by the member and any translation needs of the member
- Identification of member's need for communication assistance in the delivery of health care services
- Documentation that the member was provided with written information concerning the member's rights regarding Advance Directives (end of life wishes, Do Not Resuscitate (DNR), written instructions for living will, or power of attorney) and whether or not the member has executed an Advance Directive. Neither My Choice Wisconsin Health Plan nor any of its providers shall, as a condition of treatment, require the member execute or waive an Advance Directive
- Indication of where the services were provided
- Any pertinent financial records
- All entries will be indelibly added to the member's record

Medical record retention will also comply with 160 and 45 C.F.R. part 164 subparts A and E and generally accepted medical practice. Records must be maintained for a period of ten (10) years from the final date of the contract period.

### **Restraint Policy**

My Choice Wisconsin Health Plan members have the right to be free from any form of restraint or seclusion used as a means of force, control, ease, or reprisal. My Choice Wisconsin Health Plan supports a physical, social, and cultural environment that limits restraint use to situations where it is clinically appropriate for the safety of the patient and in adequately justified situations. The goal is to protect the patient's health and safety, while preserving their dignity, rights, and well-being. It is My Choice Wisconsin Health Plan's policy that restraints should be used only where alternative methods are not sufficient to protect patients or others from injury and are not used as a substitute for less restrictive forms of protective restraint.

### **Notification of Changes**

My Choice Wisconsin Health Plan providers should notify us at least 10 business days in advance of the change, in writing, if any of the following situations should occur. Changes in:

- Address, phone, or email
- Billing service
- Tax ID
- Status of accepting or not accepting new patients
- Office hours
- Services provided in the office
- Medical licensure to practice
- In the case of the death of a provider, office staff should notify My Choice Wisconsin Health Plan as soon as possible

Changes can be sent to [dataservices@trilogyhealthinsurance.com](mailto:dataservices@trilogyhealthinsurance.com) or faxed to 414-755-4410.

### **Provider Termination**

Refer to your contract for specifics about all the various situations and notification requirements for those situations in which a provider or provider group wishes to terminate their participation in My Choice Wisconsin Health Plan. In general, My Choice Wisconsin Health Plan requires at least one hundred eighty (180) days prior written notice. In the event of such

termination, providers shall remain available at My Choice Wisconsin Health Plan's option as a provider, in accordance with Wis. Stat. § 609.24, relating to continuity of care, to provide services to members. Providers shall continue to provide health care services to members who are hospitalized as of the termination date until such member is discharged.

#### **Notification of Provider Termination**

Providers who notify their patients that they are terminating their relationship with My Choice Wisconsin Health Plan must include language to the member with instructions about how to obtain access to their medical records. Please refer member to the My Choice Wisconsin Health Plan Member Advocate at 855-530-6790 or through email at [advocate@trilogyhealthinsurance.com](mailto:advocate@trilogyhealthinsurance.com). The Advocate will help ensure the member is apprised of all their rights and understands how to obtain their records.

#### **Notification of Advance Directives**

Providers have a responsibility to inform patients about their right to have an advance directive. To provide patients with written information on state law about patients' rights to accept or refuse treatment, and the provider's own policies regarding advance directives. Providers must document in the patients' medical record any results of a discussion on advance directives. If a patient has or completes an advance directive their patient file should include a copy of the advance directive.

## **MEMBER RIGHTS AND RESPONSIBILITIES**

My Choice Wisconsin Health Plan respects the important role members play in their healthcare and informs them of their rights and responsibilities in filling that role. Members can expect certain things from My Choice Wisconsin Health Plan and from our providers, but they must understand there are certain things My Choice Wisconsin Health Plan and our providers expect from them. These members rights and member responsibilities are a key component in the development of a mutually respectful relationship between My Choice Wisconsin Health Plan, its providers, and its members.

#### **Member Rights**

To be provided with a listing of Primary Care Physicians (PCP) and be allowed to select a (and change) PCP from My Choice Wisconsin Health Plan's network of providers.

To obtain information about services that are covered, services that are not covered, and any costs that they may be responsible for paying.

To participate in their care by making decisions, discussing appropriate or medically necessary treatment options for their conditions regardless of cost or benefit coverage. Members have the right to obtain information about the risks and benefits of treatment. Members have the right to receive this information in terms they understand and to refuse medical care.

To obtain information about how to file a complaint, appeal, or grievance and to voice concerns about My Choice Wisconsin Health Plan, its providers, or the quality of care they receive. Members have the right to receive a prompt and fair review of their concerns without being discriminated against.

To have My Choice Wisconsin Health Plan's Member Advocate help them resolve problems and guide them through the grievance process if they do not agree with a decision My Choice Wisconsin Health Plan made. Members have the right to appear in person and present their case in a grievance hearing or to have My Choice Wisconsin Health Plan's Member Advocate represent their side at the hearing.

To ask for and receive information about Advance Directives.

To comment and make recommendations about My Choice Wisconsin Health Plan's service, quality improvement programs, and providers.

To have covered services provided to them in a respectful, dignified, and culturally sensitive manner regardless of

- Age
- Color
- Disability
- National origin
- Race
- Sex

To expect and to receive the right to privacy and confidentiality in communications and records about their care.

To receive medical treatment that is available when they need it. Members have the right to receive emergency medical treatment twenty-four hours a day/seven days a week.

To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in Federal regulations on the use of restraints and seclusion.

To have interpretation and translation services available to them free of charge.

### **Member Responsibilities**

To choose a Primary Care Physicians (PCP) from among My Choice Wisconsin Health Plan's network of PCPs and to establish a relationship with that provider. Members have a responsibility to call My Choice Wisconsin Health Plan if they want to change their PCP.

To read and understand their health insurance benefits and limitations and to follow required procedures. Members also have a responsibility to know how to use My Choice Wisconsin Health Plan's provider network and to ask questions when they do not understand.

To provide honest, accurate and complete information about their health history, their eligibility, and their enrollment.

To show their ForwardHealth card each time they receive services and to let their providers know if they have other insurance coverage.

To participate in their care by asking questions about their health. Members also have a responsibility to follow the plans and instructions for care that they have agreed upon with their providers and to make healthy lifestyle choices to maintain their health or manage their illness. Members have a responsibility to know the medicines they take and why and how to take those medicines.

To keep their appointments and be on time or to call their provider's office ahead of time if they are going to be late or miss an appointment. Members have a responsibility to understand that missing appointments without letting the provider know may cause the provider to refuse to see them.

To show the same consideration and respect to My Choice Wisconsin Health Plan staff and health care providers as they would like to receive.

To notify their local county/tribal/social or human service agency of any enrollment status changes such as family size or address. Members have a responsibility to notify My Choice Wisconsin Health Plan with any changes to their address or phone number.

To use My Choice Wisconsin Health Plan participating providers and health care facilities unless they have our approval to go somewhere else or it is a life-threatening emergency.

## DENTAL SERVICES

My Choice Wisconsin Health Plan subcontracts with DentaQuest to provide dental services. Please see the Contact Section at the beginning of this Guide for specific information.

## VISION SERVICES

My Choice Wisconsin Health Plan subcontracts with EyeQuest to provide routine vision services and hardware. Please see the Contact Section at the beginning of this Guide for specific information.

## WISCONSIN IMMUNIZATION REGISTRY

The Wisconsin Immunization Registry (WIR) is a computerized internet database application that was developed to record and track immunization dates of Wisconsin's children and adults. It provides assistance for keeping everyone on track for their recommended immunizations. Statewide release occurred in May 2000. All demographic information for births occurring in Wisconsin were back loaded to January 1995 and continues to be downloaded on a weekly basis. Immunization registries are seen as an integral tool for assuring that children and adults receive their immunizations according to recommended schedules and can prevent over-immunizing.

WIR is provided by the State of Wisconsin at no cost. Providers need only a PC with internet connectivity for access and to have a signed agreement with the Wisconsin Immunization Registry and to provide data on their patients.

As part of the Public Immunization Record Access feature, which allows look-up access to immunization records, parents and legal guardians have access to look up their child's immunization record in the WIR. Offering parents and guardians access to look-up their child's immunizations can decrease the number of requests to providers for immunization records from their patients. **We strongly urge providers to offer this service to their patients and join us in our efforts to eliminate vaccine preventable diseases in Wisconsin.**

Demonstrations and trainings are offered to providers and conducted throughout the state at no cost. The demonstrations will allow providers to see the many functions of the system that are designed to improve the immunization status of patients and the efficiency of their practices. To register to attend training, please contact WIR help desk at 608-266-9691 or email [dhswirhelp@dhs.wisconsin.gov](mailto:dhswirhelp@dhs.wisconsin.gov). For demonstrations, please contact WIR help desk at 608-266-9691 or email [dhswirhelp@dhs.wisconsin.gov](mailto:dhswirhelp@dhs.wisconsin.gov). The demonstrations will allow providers to see the many functions of the system that are designed to improve the immunization status of patients and the efficiency of their practices. Go to <https://www.dhs.wisconsin.gov/immunization/wir-healthcare-providers.htm> to learn more. Technical questions regarding WIR can be directed to the WIR helpdesk at 608-266-9691 or email [dhswirhelp@dhs.wisconsin.gov](mailto:dhswirhelp@dhs.wisconsin.gov).

If your organization has an existing electronic database, you have options to link with WIR. These options are as follows:

1. Data conversion of existing database via a flat file ASCII text file or HL7 specification to WIR. Even billing data can be converted and loaded into WIR. Then clinicians could use WIR to track clients and immunizations.
2. Continue to use your existing system and link with WIR via an ASCII text file or a HL7 compliant interface to download immunization data to WIR.
3. Have clinicians use WIR for data entry and then have WIR send data back to the organization via an ASCII text file or a HL7 compliant interface.
4. Use HL7 to do real-time queries or updates to WIR from Electronic Medical Record (EMR) System

# Notification of Pregnancy Form

## Fax completed form to (select one):

☐ Anthem 800-964-3627  
☐ Children's Community Plan 414-266-4726  
☐ Dean 608-252-0836  
☐ GHC of South Central Wisconsin  
☐ iCare 414-231-1090 Attn: Jill Denson  
☐ MHS Health WI 866-671-3668  
☐ MercyCare 608-752-3751

☐ Molina 877-708-2117  
☐ Physician's Plus 608-327-0322 Attn: Jack Donisch  
☐ My Choice Wisconsin Health Plan 414-771-1159  
☐ UnitedHealthcare Community Plan 877-353-6913  
☐ Unity 608-821-4207

### Member Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_ ID#: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Date of Initial Prenatal Visit: \_\_\_\_\_ Completion date of Pregnancy Form: \_\_\_\_\_

### Current Pregnancy

† In PNCC \_\_\_\_\_

Gravida \_\_\_\_\_ Para \_\_\_\_\_ LMP \_\_\_\_\_ EDC \_\_\_\_\_ Blood Type \_\_\_\_\_

† Multiple Gestation this pregnancy      † Maternal age  $\leq 16$  years      † Maternal age  $\geq 35$  years of age

### Previous Pregnancies

† Hx of Placenta Pre      † Multiple Gestations previous pregnancy  
† Hx of Post Partum Depression      † Preterm Labor/Delivery      † Hx of SAB/TAB/Fetal Demise  
† Previous C-Section      Week of delivery \_\_\_\_\_      Week of demise \_\_\_\_\_

### Medical History (Check all that apply)

† Cardiac Disease      † Clotting Disorders      † Hypertension or PIH (Current/Past)  
† Respiratory Conditions      † Behavioral Health Concerns      † Incompetent cervix (Current/Past)  
† HIV Status      † STD (Current/Past)      † Neurologic Disorders (Current/Past)  
† Sickle Cell Anemia      † Diabetes/Gestational Diabetes (Current/Past)

### Psycho/Social Issues (check all that apply)

† Drug Abuse (Current/Past)      † Alcohol Abuse (Current/Past)      † Smoker (Current/Past)  
† Domestic Abuse (Current/Past)      † Housing Issues      † Lack of Support System

### Prenatal Care and Nutrition (Check all that apply)

† Missed several medical appointments      † Currently Enrolled in WIC

Description of above or other unlisted conditions: \_\_\_\_\_

List of Medications: \_\_\_\_\_

### Provider Information

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Provider Printed Name

\_\_\_\_\_  
Provider Address

\_\_\_\_\_  
Provider Phone #

\_\_\_\_\_  
Delivery Hospital

\_\_\_\_\_  
Provider Fax #

