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WISCONSIN
Health Plan



My Choice Wisconsin Provider Handbook
Family Care, Partnership, Medicaid SSI, Dual Advantage

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Caring Starts Here

All references to Medicaid BadgerCare Plus or Supplemental Security Income (SSI) plans in this manual are applicable for dates of service prior to June 30, 2024 only.

For information regarding Medicaid BadgerCare Plus and SSI activities, operations, and support for dates of service July 1, 2024 and after, please reference the Molina Healthcare of Wisconsin, Inc. Provider Manual
<https://www.molinahealthcare.com/providers/wi/medicaid/manual/provman.aspx>

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SECTION 1: INTRODUCTION

My Choice Wisconsin (MCW) welcomes you to our provider network! As a contracted provider, please use our provider handbook as your primary resource for policies, procedures, claims processing guidelines, benefits information, service authorizations requirements as well as using our MIDAS Provider Portal and Claims Web Portal, as applicable.

In addition to the provider handbook information, we recommend you and your staff review additional sources for Family Care information including:

- Family Care Guide for Wisconsin Medicaid-Certified Providers
- Wisconsin Medicaid All-Provider Handbook
- Wisconsin Medicaid service-specific handbooks
- Wisconsin Medicaid and BadgerCare Updates
- Wisconsin Administrative Code, Chapters DHS 101-108

Additional information can also be found by visiting these websites and/or calling Wisconsin's Department of Human Services (DHS) below:

WI Aging and Disability Resource Centers: www.dhs.wisconsin.gov/adrc/consumer/index.htm

Wisconsin Medicaid website: www.dhs.wisconsin.gov/medicaid

Long-Term Care website: www.dhs.wisconsin.gov/LTCare

Wisconsin Medicaid's Provider Services: Toll Free: 800-947-9627 or 608-221-9883

If you have questions or need help with this handbook, please call Customer Service at 800-963-0035.

About My Choice Wisconsin

My Choice Wisconsin is a Managed Care Organization (MCO) and Health Maintenance Organization (HMO) with a passion for putting our members first. With five programs across Wisconsin, members receive long-term care and health services to help them live their best lives independently in their own communities. We offer [Family Care](#), [Family Care Partnership](#), [Medicare Dual Advantage](#), [Medicaid SSI](#), and [BadgerCare Plus](#).

My Choice Wisconsin works collaboratively with local agencies and health care providers to ensure our members have ample choices and high-quality support and services from a diverse network. We provide seamless care for each member based on their own needs, goals, and abilities. With offices in 14 cities throughout Wisconsin, we strive to be a valued partner within all the communities we serve.

My Choice Wisconsin is proud of its long history and is excited to continue serving people throughout Wisconsin for many years to come.

Our Mission

We are committed to the improved health of our members and the betterment of our communities. As trusted stewards of public funds, we care for the whole person and well-being of all by offering services that promote independence, value diversity, and inspire self-advocacy.

Our 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.

Our Programs

Family Care

- The Family Care program helps frail elders and adults with disabilities coordinate their home and community-based long-term care needs.

Family Care Partnership “Partnership”

- The Partnership program helps frail elders and adults with disabilities with higher care needs coordinate their medical, health, and long-term care services.

Medicaid SSI

- The Medicaid SSI program helps adults who qualify for Supplemental Security Income (SSI) coordinate their healthcare needs.

Medicare Dual Advantage

Medicare Dual Advantage (HMO SNP) is a Medicare Advantage plan for people who qualify for both Medicaid and Medicare. This plan helps coordinate your healthcare needs with no monthly premiums or deductibles. Your plan includes prescription medications, and you will have access to unique program benefits like dental and vision coverage and a monthly allowance to spend through our over-the-counter catalog.

Our Special Needs Plans

Medicare Special Needs Plans (SNPs) are specially designated Medicare Advantage plans, with custom designated benefits to meet the needs of a specific population. Enrollment in a SNP is limited to Medicare beneficiaries within the target SNP population. Qualified enrollees for the My Choice Wisconsin Medicare Dual Advantage and Partnership Programs are members of My Choice Wisconsin’s Special Needs Plans.

Our SNP goals are to improve and assure the member’s receipt of:

- Access to affordable care and medical, mental health, social and preventive health services
- Coordinated care through an identified point of contact
- Transition of care across health care settings and practitioners
- Appropriate utilization of services
- Cost-effective services
- Overall improved member health outcomes

Our Model of Care (MOC)

My Choice Wisconsin is committed to offering a Model of Care (MOC) that meets the unique needs of our SNP members. SNP members face chronic and often co-occurring physical and behavioral health conditions. These members also face complex psychosocial issues (poverty, homelessness, addiction, and lack of resources) that impact their ability to effectively manage their care. Through the integration of physical, behavioral, social, medical, and community resources, the SNP MOC aims to address barriers that impact the members' ability to self-managed care and coordinate needs.

By developing and implementing a SNP MOC, members can experience improved health outcomes, access to essential services, coordination and seamless transitions of care, appropriate utilization of services, and satisfaction.

The My Choice Wisconsin SNP Model of Care is a service delivery mechanism that contains the following elements:

- Description of the SNP-specific target population
- Measurable goals
- Staff structure and care management roles
- Interdisciplinary care team
- A network having special expertise and use of clinical practice guidelines
- Model of care training for personnel and provider network
- Health risk assessment (HRA)
- Individualized care plan
- Communication network
- Care Management for the most vulnerable subpopulations
- Performance and health outcome measurements

Our Provider Network

Giving our members access to an extensive network of high-quality providers is “mission critical” for My Choice Wisconsin (MCW). MCW is proud to work with the dedicated Primary Care Physicians (PCPs), specialists, behavioral health providers, residential services, nursing home, hospitals, home care and hospice facilities, home health care agencies, durable medical equipment providers and more which comprise our network.

We contract with more than 500 healthcare clinics throughout Wisconsin, covering more than 1,700 primary care providers. In addition, we connect members with a range of services depending on program, including pharmacy, transportation, employment, day care, residential facilities, and more.

Our provider network consists of quality providers who have agreed to:

- MCW rates.
- Follow contractual requirements.
- Maintain ongoing communications with MCW.
- Meet or exceed quality assurance expectations of MCW.

The Health and Community Supports Contract and HFS 10 require MCW to continually monitor the Provider Network to ensure that service capacity and access are managed in accordance with current and anticipated Member service demands. MCW is not required to contract with providers beyond the number necessary to meet the needs of Members. For current Provider Network availability, see website: www.mychoicewi.org

As we fulfill our commitment to our members, we also commit to being an exceptional partner to our providers. Join us.

Thank you for being part of our provider network and helping us to improve the health outcomes of our members.

Out of Network Providers

MCW is not required to add providers to our network simply because Members request them. Non-contracted providers must meet a specific need outside the established Provider Network, meet our qualifying standards and accept the service rate(s) set by MCW.

SECTION 2: PROVIDER RESPONSIBILITIES

Introduction

This section of the Provider Manual addresses the responsibilities of providers participating in our provider network. “Providers” are individuals or organizations that are contracted to participate in My Choice Wisconsin’s provider network and offer health, medical, and long-term care services to My Choice Wisconsin members.

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

My Choice Wisconsin may not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his/her patient, including any of the following:

- For the member’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
- For any information the member needs in order to decide among all relevant treatment options.
- For the risks, benefits, and consequences of treatment or non-treatment.
- For the member’s right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Becoming a Network Provider

If you are interested in participating in the MCW Provider Network, please click the following link - [Joining Our Network](#) and click “fill out an application here” to complete a request for an application. As there are requirements and expectations for our network providers, please note that completing a “Request for Application” does not constitute a contract nor guarantee that a contract will be offered.

Our contracting team will review your information and reach out with confirmation of acceptance or denial of your request. We perform a rigorous quality review of all organizations to ensure that we not only meet, but exceed, the regulatory requirements of our funding agencies, Medicaid and Medicare. Safety, quality, and member happiness are our priorities.

MCW considers requests for contracting based on the following criteria:

- Proposed services are within our Program benefit package(s)
- Provider meets applicable licensing and credentialing standards
- Provider has been in business a minimum of one year
- Provider type & services are needed to meet network adequacy
- Medicaid and Medicare certified when applicable
- Is not on the excluded provider lists available at: [Exclusions Database](#)

Credentialing of Providers

My Choice Wisconsin (MCW) credentialing standards are established to meet the requirements of MCW's contract with CMS and DHS. Although MCW delegates some credentialing activities to recognized credentialing programs, MCW always retains the right and the obligation to accept or reject the recommendations of our credentialing delegates.

When a provider contracts with MCW, the provider will be advised whether the credentialing application must be completed. It is possible credentialing may be handled by one of MCW's credentialing delegates. Failure to provide credentialing information to MCW will delay the credentialing, or re-credentialing, process and may affect your status as a plan provider.

Information acquired through the credentialing and re-credentialing processes is considered confidential. MCW staff and credentialing delegates with access to the files are responsible for ensuring the information remains confidential, except as otherwise provided by law. The release of any information acquired through these processes is prohibited without a provider's written consent. If a law enforcement agency or other government agency seeks provider information, a legal opinion is sought prior to the release of such information.

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

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

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

My Choice Wisconsin will adopt any change in legal, regulatory, or accreditation requirements automatically as of the requirement's effective date and such changes will be effective for all new and existing providers upon that date.

Department of Health Services Provider Enrollment Agreement

My Choice Wisconsin verifies that all potential providers who must be enrolled with the WI Department of Health Services have the appropriate enrollment agreement.

Compliance with the Home and Community-Based Setting Requirements

Providers must maintain compliance with the Home and Community-Based Setting Requirements under 42 C.F.R. § 441.301(c)(4) as outlined in Article VIII.G.1.a. iv. of the DHS-MCO contract.

Insurance Coverage

My Choice Wisconsin verifies that all potential providers have appropriate insurance, depending on provider type. Providers are required to provide MCW with a Certificate of Insurance. Insurance Coverage Minimums are noted below.

Provider Type	Automobile Liability	General Liability	Umbrella Liability	Professional Liability	Workers Compensation
Adult Day Care- Less than 25 Employees	\$500,000	\$500,000	Not required	\$500,000	Required
Adult Day Care- More than 25 Employees	\$1,000,000	\$1,000,000	\$1,000,000	\$1,000,000	Required
AFH- 1-4 Bed- Non-Owner Occupied	\$1,000,000	\$1,000,000	Not required	\$500,000	If workers are contracted WC may be required
AFH- 1-4 Bed- Owner Occupied	\$100,000 (Leased) \$300,000 Owned	\$500,000	Not required	\$500,000	Not required
CBRF- Less than 100 beds	\$1,000,000	\$1,000,000	\$1,000,000	\$1,000,000	Required
CBRF- More than 100 beds	\$1,000,000	\$1,000,000	\$2,000,000	\$1,000,000	Required
DMS/DME/Pharmacy- Less than 25 employees	\$500,000	\$500,000	Not required	\$500,000	Required
DMS/DME/Pharmacy- More than 25 employees	\$1,000,000	\$1,000,000	Not required	\$1,000,000	Required
Home Health- Less than 25 employees	\$500,000	\$500,000	Not required	\$500,000	Required
Home Health- More than 25 employees	\$1,000,000	\$1,000,000	\$1,000,000	\$1,000,000	Required
Lawn and Snow	\$1,000,000	\$1,000,000	Not required	Not required	If Applicable
Personal care- Less than 25 employees	\$500,000	\$500,000	Not required	\$500,000	Required
Personal care- More than 25 employees	\$1,000,000	\$1,000,000	\$1,000,000	\$1,000,000	Required
Prevocational - Less than 25 employees	\$500,000	\$500,000	Not required	\$500,000	If workers are contracted and not full employee's WC may not be required

Prevocational - More than 25 employees	\$1,000,000	\$1,000,000	\$1,000,000	\$1,000,000	Required
RCAC- Less than 100 Beds	\$1,000,000	\$1,000,000	\$1,000,000	Not required	Required
RCAC- More than 100 Beds	\$1,000,000	\$1,000,000	\$2,000,000	Not required	Required
Skilled Nursing Facility- Less than 25 employees	\$500,000	\$500,000	Not required	\$500,000	Required
Skilled Nursing Facility- More than 25 employees	\$1,000,000	\$1,000,000	\$1,000,000	\$1,000,000	Required
Supportive Home Care- Less than 25 employees	\$1,000,000	\$1,000,000	Not required	\$1,000,000	If workers are contracted and not full employee's WC may not be required

Insurance Coverage Minimums are continued below.

Provider Type	Automobile Liability	General Liability	Umbrella Liability	Professional Liability	Workers Compensation
Supportive Home Care- More than 25 employees	\$1,000,000	\$1,000,000	Not required	\$1,000,000	If workers are contracted and not full employee's WC may not be required
Transportation- Less than 25 employees	\$1,000,000	\$1,000,000	Not required	Not required	If workers are contracted and not full employee's WC may not be required
Transportation- More than 25 employees	\$1,000,000	\$1,000,000	Not required	Not required	If workers are contracted and not full employee's WC may not be required
Health Care – Facility Level		\$1,000,000 (Occurrence)/ \$3,000,000 (Aggregate)		\$1,000,000 (Occurrence)/ \$3,000,000 (Aggregate)	Required
Health Care Practitioner Level				\$1,000,000 (Occurrence)/ \$3,000,000 (Aggregate)	
Financial Management/ Rep Payee /	\$500,000	\$500,000	Not required	\$500,000	Required

Financial Management/ Rep Payee / Guardianship – More than 25 employees	\$1,000,000	\$1,000,000	Not required	\$1,000,000	Required
Other- Counseling and Therapeutic Resources – Less than 25 employees	\$500,000	\$500,000	Not required	\$500,000	Required
Other- Counseling and Therapeutic Resources – More than 25 employees	\$1,000,000	\$1,000,000	Not required	\$1,000,000	Required

Reporting Changes to My Choice Wisconsin

Providers are required to notify MCW of changes in tax identification numbers, addresses, loss of liability insurance and any other change which would impact their status with My Choice Wisconsin.

Report changes to Provider Services:

- Complete forms available online at: [My Choice Wisconsin Resource Library](#)
Mail or Email to the address that is listed on the form

Change in Ownership

Providers Have 35 Days to Report a Change in Ownership.

Medicaid-enrolled providers are required to notify Forward Health of a change in ownership within 35 calendar days after the effective date of the change, in accordance with the Centers for Medicare & Medicaid Services Final Rule 42 C.F.R. 455.104(c)(1)(iv).

Failure to report a change in ownership within 35 calendar days may result in denial of payment, per 42 C.F.R. 455.104(e).

Written Notification and a New Enrollment Application Are Required

Any time a change in ownership occurs, providers are required to do **one** of the following:

- Mail a change in ownership notification to Forward Health. After mailing the notification, providers are required to complete a new [Medicaid provider enrollment application](#) on the Portal.
- Upload a change in ownership notification as an attachment when completing a new [Medicaid provider enrollment application](#) on the Portal.

Forward Health must receive the change in ownership notification, which must include the affected provider number (National Provider Identifier [NPI] or provider ID), within 35 calendar days **after** the effective date of the change in ownership.

Providers will receive written notification of their new Medicaid enrollment effective date in the mail once their provider file is updated with the change in ownership.

Written Notification and a New Enrollment Application are required any time a change in ownership occurs, providers are required to do **one** of the following:

- Mail a change in ownership notification to Forward Health. After mailing the notification, providers are required to complete a new [Medicaid provider enrollment application](#) on the Portal.
- Upload a change in ownership notification as an attachment when completing a new [Medicaid provider enrollment application](#) on the Portal.

Forward Health must receive the change in ownership notification, which must include the affected provider number (National Provider Identifier [NPI] or provider ID), within 35 calendar days **after** the effective date of the change in ownership. Providers will receive written notification of their new Medicaid enrollment effective date in the mail once their provider file is updated with the change in ownership.

Special Requirements for Specific Provider Types

The following provider types require Medicare enrollment and/or [Wisconsin Division of Quality Assurance](#) certification with current provider information before submitting a Medicaid enrollment change in ownership:

- Ambulatory surgery centers
- Community health centers
- End-stage renal disease services providers
- Home health agencies
- Hospice providers
- Hospitals (inpatient and outpatient)
- Nursing homes
- Outpatient rehabilitation facilities
- Rehabilitation agencies
- Rural health clinics
- Tribal federally qualified health centers

Events That Forward Health Considers a Change in Ownership

Forward Health defines a change in ownership as an event where a different party purchases (buys out) or otherwise obtains ownership or effective control over a practice or facility.

The following events are considered a change in ownership and require the completion of a new provider enrollment application:

- Change from one type of business structure to another type of business structure. Business structures include the following:
 - Sole proprietorships
 - Corporations
 - Partnerships
 - Limited Liability Companies
- Change of name and tax identification number associated with the provider's submitted enrollment application (for example, Employer Identification Number).
- Change (addition or removal) of names identified as owners of the provider.

Examples of a Change in Ownership

Examples of a change in ownership include the following:

- A sole proprietorship transfers title and property to another party.
- Two or more corporate clinics or centers consolidate, and a new corporate entity is created.
- There is an addition, removal, or substitution of a partner in a partnership.
- An incorporated entity merges with another incorporated entity.
- An unincorporated entity (sole proprietorship or partnership) becomes incorporated.

Repayment Following a Change in Ownership

Medicaid-enrolled providers who sell or otherwise transfer their business or business assets are required to repay Forward Health for any erroneous payments or overpayments made to them. If necessary, Forward Health will hold responsible for repayment to the provider to whom a transfer of ownership is made prior to the final transfer of ownership. The provider acquiring the business is responsible for contacting Forward Health to ascertain if they are liable under this provision. The provider acquiring the business is responsible for full repayment within 30 days after receiving such a notice from Forward Health.

Providers may send inquiries about the determination of any pending liability to the following address:

Office of the Inspector General
PO Box 309
Madison WI 53701-0309

Forward Health has the authority to enforce these provisions within four years following the transfer of a business or business assets. Refer to Wis. Stat. § [49.45\(21\)](#) for complete information.

New Prior Authorization Requests Must Be Submitted After a Change in Ownership

Medicaid-enrolled providers are required to submit new prior authorization (PA) requests when there is a change in billing providers. New PA requests must be submitted with the new billing provider's name and billing provider number. The expiration date of the new PA request will remain the same as the original PA request. The provider is required to send the following to Forward Health with the new PA request:

- A copy of the original PA request, if possible
- The new PA request, including the required attachments and supporting documentation indicating the new billing provider's name, address, and billing provider number
- A letter requesting to end date the original PA request (may be a photocopy), which should include the following information:
 - The previous billing provider's name and billing provider number, if known
 - The reason for the change of billing provider (The new billing provider may want to verify with the member that the services from the previous billing provider have ended. The new billing provider may include this verification in the letter.) new billing provider's name and billing provider numberThe requested effective date of the change

How to Bill for a Hospital Stay That Spans a Change in Ownership

When a change in hospital ownership occurs, use the NPI that is current on the date of discharge. For example: A change in ownership occurs on July 1. A patient stay has dates of service from June 26 to July 2. The hospital submits the claim using the NPI effective July 1.

Providers with further questions about changes in ownership may call Forward Health Provider Services.

Reporting of Primary Care Provider Status Change

Primary Care Providers must notify My Choice Wisconsin of status changes by calling the My Choice Wisconsin Customer Service Department at 1-800-963-0035, so that My Choice Wisconsin can fulfill its obligations under its contract with CMS. Status changes include changing from an open to closed practice, retirement, transfer, resignation, termination, or leave of absence, relocation, and the like.

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

My Choice Wisconsin will assist members in transferring care and will notify members of material provider status changes.

Provider Directory

The My Choice Wisconsin Provider Directory contains a listing of our network providers for all Programs. You may use the searchable online [Provider Directory on our website](#).

Please note that a listing in the Provider Directory does not necessarily mean that all of a provider's services are covered under a member's benefit plan. My Choice Wisconsin cannot guarantee continued affiliation with any provider. If a member requires services that a provider is unable to render, the member should be referred only to another My Choice Wisconsin network provider. It is important to always contact My Choice Wisconsin before coordinating services for a member with another provider in order to assure the services are a covered benefit.

Cultural Competency

The U.S. Department of Health and Human Services defines cultural and linguistic competence as a set of congruent behaviors, attitudes and policies that come together in a system or agency or among professionals and enable effective work in cross-cultural situations. Delivering quality, sensitive care to a diverse cross-cultural population promotes respectful and responsive healthcare without cultural communication differences hindering the relationship. Cultural competency occurs in both clinical and non-clinical areas of My Choice Wisconsin. In the clinical area, it is based on the patient-provider relationship. In the non-clinical arena, it involves organizational policies and interactions that impact healthcare services.

My Choice Wisconsin has a strong commitment to diversity in its members, providers, employees and the communities it serves. My Choice Wisconsin and participating network providers shall honor and support member beliefs and be sensitive to cultural diversity. This includes members with limited English proficiency and diverse cultural and ethnic backgrounds. Contracted providers shall collaborate with My Choice Wisconsin in fostering staff/provider attitudes, equity and inclusion and interpersonal communication styles to respect member cultural backgrounds.

Contact Info for the Contracting Department

Should you have any questions and/or concerns relating to provider service need, your application, and/or contract, please contact My Choice Wisconsin at:

Phone: 414-287-7640

Toll-free: 877-489-3814

Email: shfamcontracts@mychoicewi.org

You will be directed to your respective Contracting Representative.

Contact Info for Providers in the My Choice Wisconsin Network

My Choice Wisconsin's Provider Services team develops and maintains relationships with thousands of Wisconsin providers; from acute and primary care providers at major health systems to small, community-based organizations.

If you're a contracted provider and have general questions or are requesting authorizations, please reach out to our Customer Service team at 800-963-0035, Monday - Friday, 8:00 a.m. to 4:30 p.m.

If you have a specific billing and/claims inquiry, please reach out directly to the claims center. A dedicated claims representative will assist you.

My Choice Wisconsin Provider Help Desk: TriZetto members
Toll-Free at 855-878-6699
Monday - Friday, 8:00 a.m. to 4:00 p.m.

WPS Customer Service Toll – Free at 800-223-6016

For additional contact information, such as email addresses or program locations, please check out the contact information on the My Choice Wisconsin website. Go to [MCW Contact Us Page](#) for a complete list of contact information as well as access to our quick reference guide.

Other Important Contacts

Forward Health Portal: www.forwardhealth.wi.gov/WIPortal/

- Providers should use the Forward Health Portal for any eligibility or enrollment questions.

Forward Health Portal Help Desk: 866-908-1363

- Providers and trading partners may call the Forward Health Portal Help Desk with technical questions on Portal functions.

WiCall Automated Voice Response (AVR) System: 800-947-3544

- Available 24 hours a day, seven days a week. WiCall is an AVR system that allows providers direct access to enrollment verification.

Member Incidents

My Choice Wisconsin encourages open communication. If you have a member-related concern or incident, including Member Incidents, call My Choice Wisconsin's Customer Service team at 800-963- 0035 to be directed to the member's Interdisciplinary Care Team or other designated Care Management Staff. For after-hours inquiries, please call the toll-free number above. Our on-call staff will be glad to assist you.

Providers receive training on their contractual obligations related to member incidents and incident reporting during provider onboarding.

Providers are required to report a member incident within one (1) business day after the incident is discovered and to provide all information related to the incident to the care team, so that a thorough investigation can be completed. The priority is always to assure the safety of the members. The provider must identify, respond to, document, and report member incidents to MCO as outlined in Article V.J.5 of the DHS-MCO contract.

Provider Quality Committee

My Choice Wisconsin operates a Provider Quality Committee (PQC) that monitors quality concerns that arise from statements of deficiency, internal quality alerts, or patterns seen in the My Choice Wisconsin incident report management system. The goal of the PQC is to foster collaboration, communication, and improvement as it relates to quality of care for MCW members. The meeting times and dates are provided in MCW's Newsletter that is distributed quarterly for providers who would like to participate.

Authorizations

Our programs require prior authorization for certain services and claims for some services will not be paid in the absence of correct prior authorization. Providers must verify member eligibility and benefits prior to rendering non-emergency services. For the full list of prior authorization requirements, forms, and instructions for submission, see our Claims & Authorizations information on our website. Go to www.mychoicewi.org/providers/authorizations/ or a complete list of prior authorization requirements, as well as forms and instructions for submission.

Partnership, Medicare Dual Advantage, and Medicaid SSI Authorizations

To submit a request for prior authorization for Partnership, Medicare Dual Advantage, and Medicaid SSI members, use the My Choice Wisconsin form appropriate to the service and fax it to 608-210-4050. Go to www.mychoicewi.org/providers/authorizations/ and search the document library.

Family Care Authorizations

All Family Care Benefit services must be provided by a contracted provider and be pre-authorized by the Member's Interdisciplinary Team (IDT). Contact 800-963-0035 to obtain the IDT's contact information. My Choice Wisconsin IDTs make the final decision on Member eligibility for services and number of services to be provided.

Care teams will enter all authorizations and providers will be able to see and/or print the authorization from the MIDAS portal for these members. Go to www.mcfc-midas.com for the MIDAS portal. This excludes Partnership, Medicare Dual Advantage, and Medicaid SSI members.

Please see the Prior Authorization Reference Document for authorization requirements for these programs. Go to www.mychoicewi.org/providers/authorizations/ for a complete list of prior authorization requirements, as well as forms and instructions for submission.

Providers will not be reimbursed for unauthorized services provided to Members or provided in amounts that exceed those authorized.

Providers should review that all information within the authorization is correct prior to rendering service. Verification can be completed via MIDAS.

Examples of areas/data to verify:

Date of Service Span:	Does the authorized service date span match or cover the expected service period?
Units of Service:	Do the total number of authorized units equal to the number of units needed for the current service period?
Service Codes:	Are all the applicable service codes, HCPCS and/or revenue codes authorized?

If a discrepancy is identified, immediately request a correction to the service authorization from the My Choice Wisconsin IDT. Untimely requests will result in claim denial and no reimbursement.

Drug Coverage Requests or Authorizations

For drug coverage requests or authorizations, you can use appropriate form or use our online system at [PromptPA](#).

Inpatient Admissions Notification

- My Choice Wisconsin requires notification of all inpatient admissions. Providers should email notification to carewisconsinadmissions@carewisc.org
- If providers need to contact My Choice Wisconsin care management staff directly regarding an inpatient admission for an SSI member, please call **855-463-0026**.

Medical Record Standards

My Choice Wisconsin providers shall ensure medical records are accurately maintained for each member. It shall include the quality, quantity, appropriateness, and timeliness of services performed under the provider’s Agreement for Services.

Medical records shall be maintained for a period of no less than ten (10) years, including after termination of the Agreement and retained further if records are under inspection, evaluation, or audit, until such is completed.

Upon request, My Choice Wisconsin, or any federal or state regulatory agency, as permitted by law, may obtain copies and have access to any medical, administrative, or financial record of physician related and medically necessary covered services to any member. The provider further agrees to release copies of medical records of members discharged from the provider to My Choice Wisconsin for retrospective review.

A medical record documents a member's medical treatment, current and past health status, and current treatment plans. A member's medical record is an essential component in the delivery of quality health care.

Primary Care Provider Responsibilities

The following are some of the responsibilities of participating Primary Care Providers of My Choice Wisconsin's provider networks:

- Establish and maintain a strong provider/patient relationship; assume responsibility for the healthcare of members who select you as their primary care provider.
- Review and monitor member's compliance with medication and prescribed treatments.
- Assist members with Advance Directives, if necessary.
- Avoid duplication of services.
- Evaluate and treat acute and chronic illness.
- Provide preventive care, screening services and routine maintenance checks as appropriate and indicated.
- Communicate with specialists involved in a members' care.
- Ensure that the exchange of member healthcare information among treating providers is handled in a confidential manner.
- Use respectful communication in all interactions with My Choice Wisconsin members and Care Management staff.
- Recognize that conflict may occasionally arise between My Choice Wisconsin and providers, or My Choice Wisconsin and members, and that conflict should be resolved within the parameters of the grievance or appeals processes outlined in the applicable My Choice Wisconsin document.
- Ensure that My Choice Wisconsin members with limited English proficiency or reading skills, diverse cultural or ethnic backgrounds, or physical or mental disabilities understand any treatment plans.
- Refrain from comments or advice on payment or insurance coverage issues. Refer members with coverage questions or concerns to the My Choice Wisconsin Customer Service Department.
- Ensure that My Choice Wisconsin members receive information needed to participate fully in their own care (e.g., medication management, use of medical equipment, potential complications, and symptoms that should be communicated to provider, patient education, etc.).

Specialist Provider Responsibilities

The following describes some of the responsibilities of participating specialty providers of My Choice Wisconsin's provider networks:

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

Hospital Responsibilities-Medicare Outpatient Observation Notice (MOON)

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

<https://www.federalregister.gov/articles/2016/08/22/2016-18476/medicare-programs-hospital-inpatientprospective-payment-systems-for-acute-care-hospitals-etc>

Requests for Testimonials and Letters of Support

It is My Choice Wisconsin's policy to refrain from providing testimonials and other kinds of letters of support requested by contracted and non-contracted providers. My Choice Wisconsin (MCW) values the providers in its provider networks, in addition to any out of network providers that may provide services to its members.

Some exclusions may apply as there may be times when MCW is interested in promoting the efforts of a group of provider types because those efforts may lead to improved outcomes for members. For example, My Choice Wisconsin might choose to support employment providers' grant applications for expanded services to the target group served. In these cases, MCW may choose to respond to a provider's request for a testimonial or letter of support so long as it supports MCW's mission and is in compliance with all regulatory and contractual requirements.

SECTION 3: MEMBER ELIGIBILITY & BENEFITS

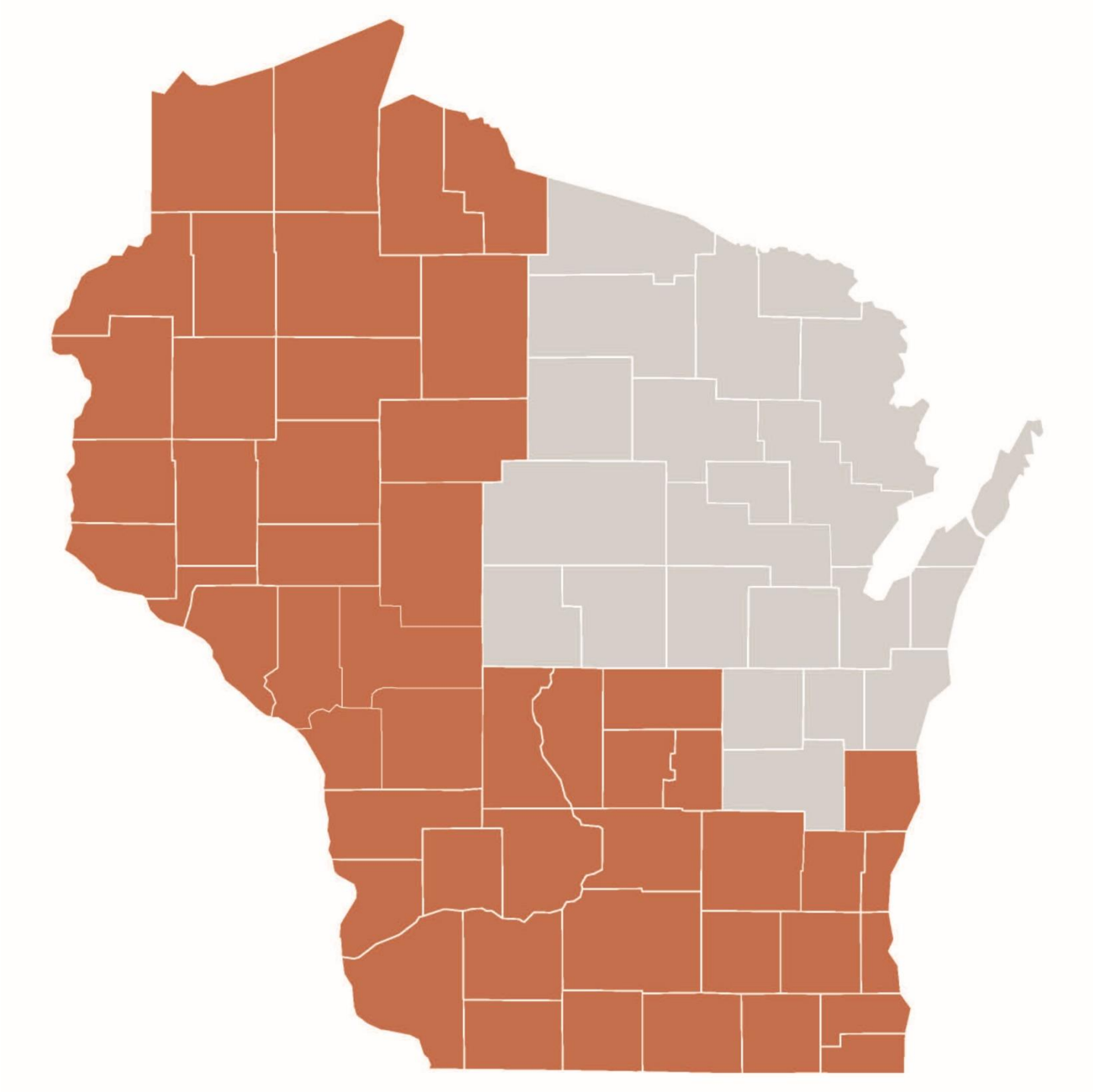
Member Eligibility

The following table illustrates the eligibility requirements for each My Choice Wisconsin program. Eligibility commonalities and differences are noted below.

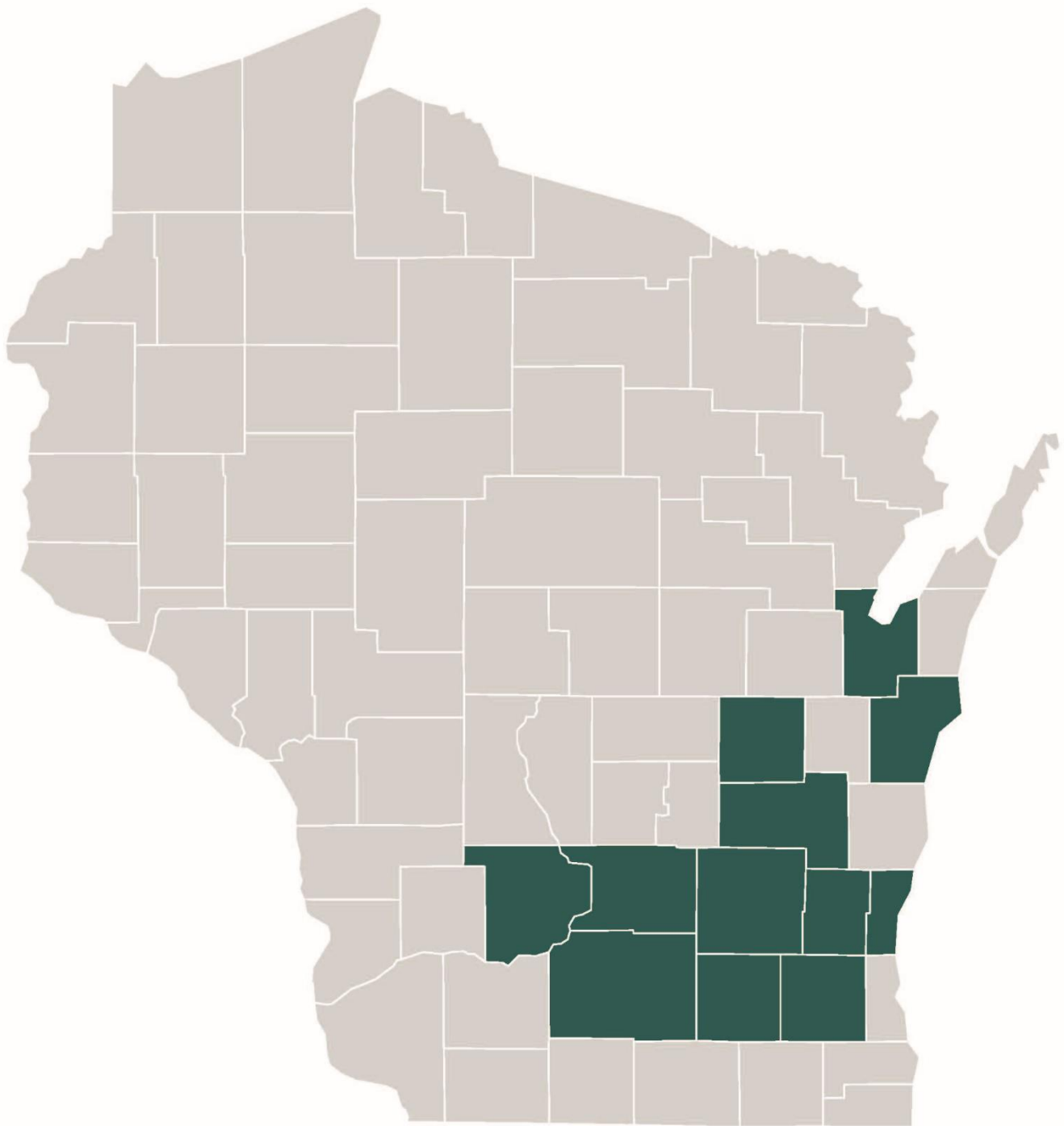
Family Care	Partnership	Medicaid SSI	Medicare Dual Advantage
Eligible for Medicaid	Eligible for Medicaid and <u>may</u> also be eligible for Medicare	Eligible for Medicaid SSI due to a disability determined by the Disability	Eligible for both Medicaid and Medicare
Be a frail adult, age 65 or older, or 18 or older with physical, intellectual or developmental disabilities*		Determination Bureau	Family Care and Medicaid SSI Members Eligible for Medicare Can Also Join Medicare Dual Advantage
Meet functional requirements which mean that a person needs help performing other activities such as bathing, dressing, or eating			

Our Service Areas

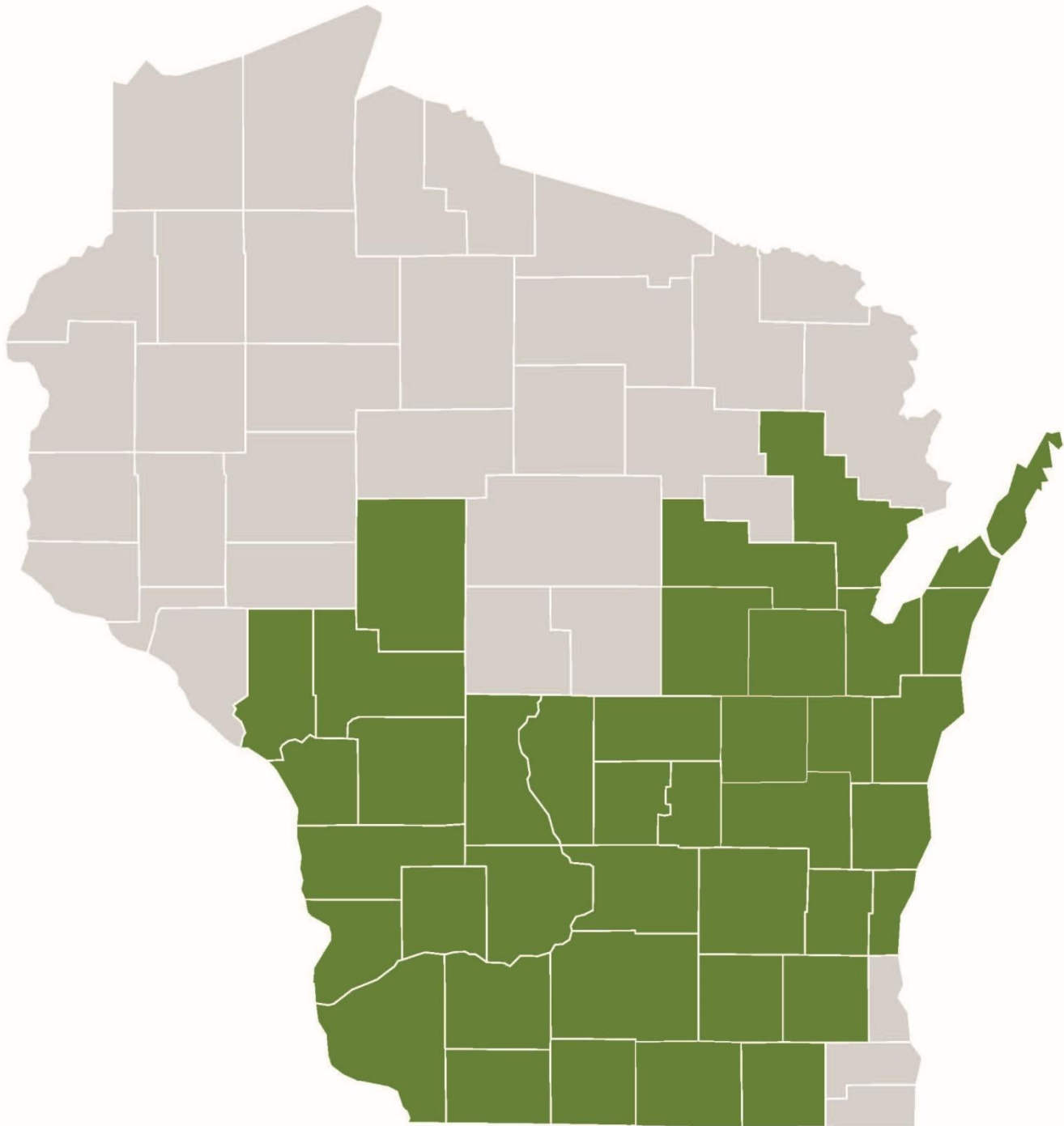
Family Care - My Choice Wisconsin's Family Care service area includes 50 counties across the state of Wisconsin.



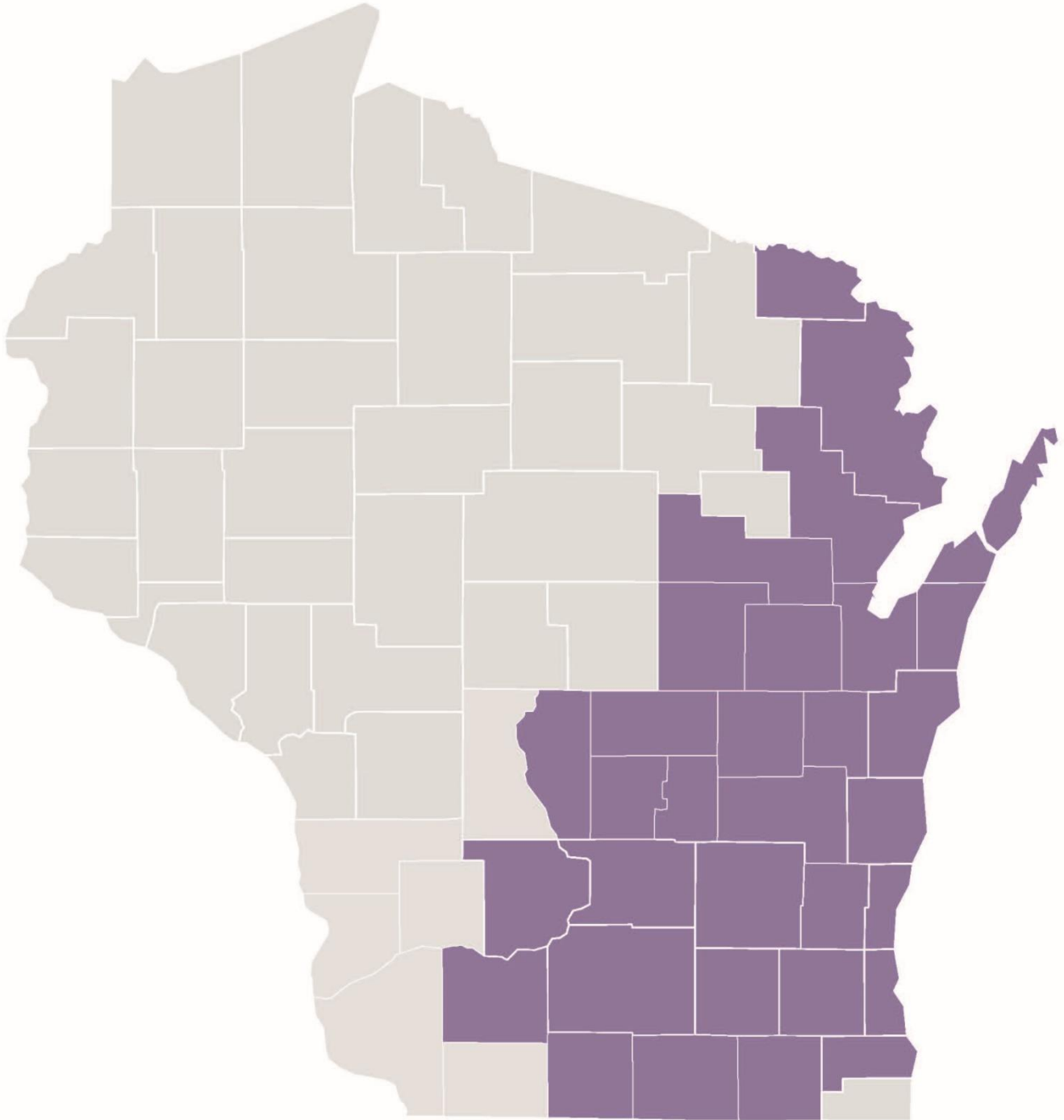
Family Care Partnership “Partnership”- My Choice Wisconsin’s Partnership service area includes 12 counties across the state of Wisconsin.



Medicaid SSI - My Choice Wisconsin's Medicaid SSI service area includes 39 counties across the state of Wisconsin.



Medicare Dual Advantage - My Choice Wisconsin's Medicare Dual Advantage service area includes 32 counties across the state of Wisconsin.

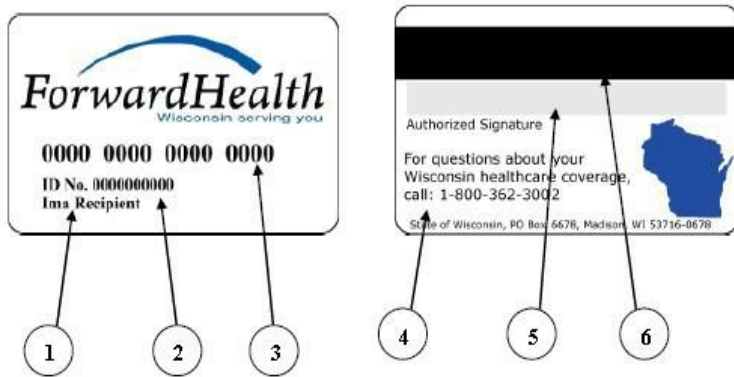


Member Identification

Family Care

My Choice Wisconsin does issue an identification card for our Family Care members. The Family Care ID Cards are sent to each member in their New Member Welcome Kit. The Welcome Kits are sent within three days of enrollment. Members are encouraged to keep their My Choice Wisconsin Family Care ID Card with their Forward Health ID Card. Members are issued a Forward Health ID card by the Wisconsin Medical Assistance Program, which is used for non-Family Care items and services, specifically acute and primary services such as medical appointments, hospitalizations, eyeglasses, podiatry, and dentistry. See example of Forward ID card below. Verify member eligibility at each member encounter via the Forward Health Portal and Medicare's MARx User Interface for members eligible for Medicare. Please note, members of the My Choice Wisconsin Family Care program that are Medicare eligible may enroll in the My Choice Wisconsin Medicare Dual Advantage program. Please see Medicare Dual Advantage for eligibility and member identification information.

DHS Forward Health ID Card Example



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

My Choice Wisconsin Family Care ID Card



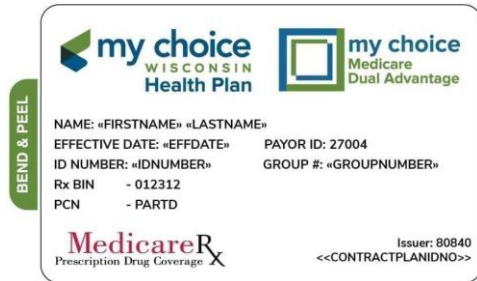
Family Care Partnership “Partnership”

Verify member eligibility at every member encounter via the Forward Health Portal. My Choice Wisconsin issues members of the Partnership program a My Choice Wisconsin identification card, see below. Partnership members are not issued a Forward Health ID Card by the Wisconsin Medical Assistance Program, as the My Choice Wisconsin identification card replaces that.



Medicare Dual Advantage

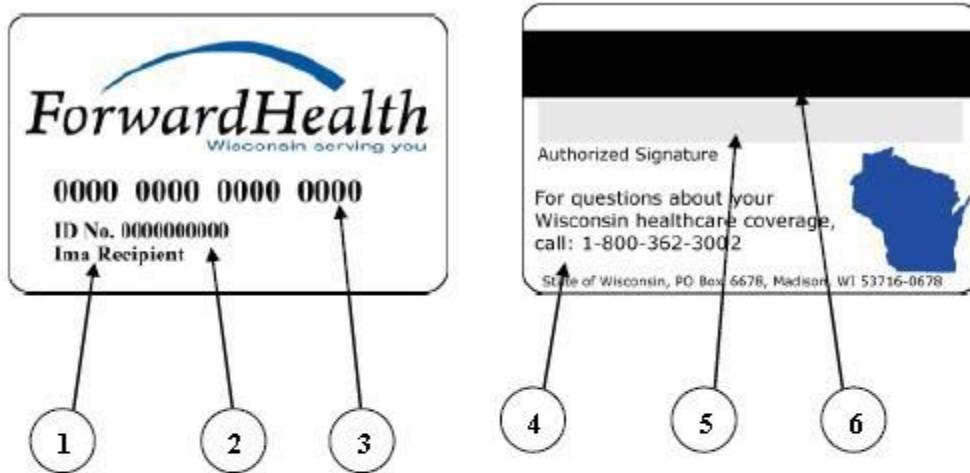
Members are issued a My Choice Wisconsin identification card, see below. Verify member eligibility via Medicare’s MARx User Interface. Members of Medicare Dual Advantage may receive Medicaid benefits with other insurers. Verify member eligibility in Forward Health at each encounter.



Medicaid SSI

Medicaid SSI members do not receive Insurance Identification cards from My Choice Wisconsin. Medicaid SSI members are required to carry and present their Forward Health card (issued by the Department of Health Services) when seeking services. Verify member eligibility at each member encounter via the Forward Health Portal and Medicare's MARx User Interface for member's eligible for Medicare. Please note, members of My Choice Wisconsin's Medicaid SSI program who are Medicare eligible may enroll in the My Choice Wisconsin Medicare Dual Advantage program. Please see Medicare Dual Advantage for eligibility and member identification information.

DHS Forward Health Card Example



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

Member Benefits

Family Care Benefits

My Choice Wisconsin's Family Care Program provides long-term care services covered by Wisconsin Medicaid, as well as services covered by Wisconsin's Home and Community-Based Waiver (HBCW) and other waiver services. Family Care is a comprehensive and flexible long-term care program for seniors and adults with physical, intellectual, and developmental disabilities.

By combining services otherwise covered separately through Medicaid and long-term care, Family Care improves the coordination of the services, is cost-effective, and most importantly, assists individuals in living more active and independent lives.

Family Care Partnership Benefits

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

Family Care and Family Care Partnership Member Benefits Chart

The Family Care and Family Care Partnership member benefit chart can be found at: [Comparison of services in IRIS, Family Care, Partnership, and PACE, P-00570](#). For complete definitions of the services listed in the member benefit chart, see the Benefit Package Service Definitions addendum of the MCO Contract at: <https://www.dhs.wisconsin.gov/familycare/mcos/contract.htm>

Home & Community Based Waiver Covered Services under the Partnership and Family Care program are subject to prior authorization through the Member's Care Team. Contact the Member's Care Team for prior authorization. If you require assistance in connecting with the Member's Care Team, contact the My Choice Wisconsin Customer Service Center at 800-963-0035.

All health care services must be medically necessary and provided in accordance with professionally recognized standards of care.

Medicaid SSI Benefits

The My Choice Wisconsin Medicaid SSI program covers Medicaid covered services. Some services not covered by My Choice Wisconsin that may be covered through the member's Forward Health card or other Forward Health contracted provider, such as, legend drugs, chiropractic care, and transportation to obtain medical care. My Choice Wisconsin Medicaid SSI covered services may include:

- Home health services
- Hospice care
- Inpatient hospital services other than services in an institution for mental disease
- Laboratory and radiology services
- Medical supplies and equipment
- Outpatient physical, speech, and occupational therapy services
- Mental health services
- Physician services
- Short-term skilled nursing facility services
- Substance abuse (alcohol and other abuse services)

Contact Customer Service to verify member-specific benefits.

My Choice Wisconsin Medicaid SSI Members who request non-emergency medical transportation services should be directed to the transportation manager per the Forward Health Update at: [Non-Emergency Medical Transportation - WI DHS](#). The member may also contact Medical Transportation Management Inc. (MTM Inc.) at 866-907-1493 (TTY: 800-855-2880).

My Choice Wisconsin covers emergency ambulance transportation for life-threatening emergencies. For all non-emergent ambulance transportation, please direct the member to contact Medical Transportation Management Inc. (MTM Inc.) at 866-907-1493 (TTY: 800-855-2880).

Medicaid SSI Sterilization Consent Form Requirements

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

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

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

The Forward Health "Consent for Sterilization" state mandated consent form and instructions for completion are available on the Department of Health Services website at www.dhs.wisconsin.gov/forms/index.htm. This form must be completed for all Wisconsin Medicaid SSI members.

The following requirements are necessary before the sterilization can be performed:

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

Medicaid SSI Hysterectomy Consent Form Requirements

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

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

A hysterectomy may be covered without a valid acknowledgment form if one (1) of the following circumstances applies:

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

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

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

The Forward Health "Acknowledgment of Receipt of Hysterectomy Information" state mandated form and instructions for completion are available on the Department of Health Services website at www.dhs.wisconsin.gov/forms/index.htm. This form must be completed for all Wisconsin Medicaid SSI members.

Medicaid SSI Abortion Certification Statement Requirements

When an abortion meets the following criteria for coverage, all other medically necessary related services are also covered. Complications arising from an abortion, whether the abortion was covered or not, are also a covered service. Services incidental to a non-covered abortion are not covered.

Such services include but are not limited to any of the following services when directly related to the performance of a non-covered abortion: laboratory testing and interpretation, ultrasound services, recovery room services, routine follow-up visits, and transportation (transportation to prenatal visits is covered).

Criteria for coverage:

1. The abortion is directly and medically necessary to save the life of the woman, provided that prior to the abortion the physician attests in a signed, written statement, based on their best clinical judgment, that the abortion meets this condition.
2. In a case of sexual assault or incest, provided that prior to the abortion the physician attests in a signed, written statement, to their belief that sexual assault or incest has occurred, and provided that the crime has been reported to the law enforcement authorities.
3. Due to a medical condition existing prior to the abortion, the physician determines that the abortion is directly and medically necessary to prevent grave, long-lasting physical health damage to the woman, provided that prior to the abortion, the physician attests in a signed, written statement, based on their best clinical judgment, that the abortion meets this condition.

The Forward Health “Abortion Information Provision Certification” state mandated form is available on the Department of Health Services website at www.dhs.wisconsin.gov/forms/index.htm. This form must be completed for all Wisconsin Medicaid SSI members. In the case of rape or incest, the physician must include evidence that the crime was reported to law enforcement authorities.

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

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

Medicare Dual Advantage Benefits

The My Choice Wisconsin Medicare Dual Advantage Program member is eligible for all Medicare covered services under Medicare Parts A, B, and D, as appropriate. To learn more about an individual member’s covered benefits, please use one of these three (3) resources:

1. Reference the members’ Summary of Benefits and Evidence of Coverage at <https://mychoicewi.org/medicare-dual-advantage/member-resources/>
2. Contact Customer Service to verify member-specific benefits.
3. Medicare: Search the CMS Medicare Coverage Database available online at: <http://www.cms.hhs.gov/mcd/overview.asp>. Below is a summary of covered services by Medicare.

Summary of Medicare Part A Covered Services

Inpatient Care (see restrictions in Medicare coverage database)

- Anesthesia
- Chemotherapy
- Room and board
- All meals and special diets
- General nursing
- Medical social services
- Physical, occupational, and speech-language therapy
- Drugs except for some self-administered drugs
- Blood transfusions
- Other diagnostic and therapeutic items and services
- Medical supplies and use of equipment
- Inpatient alcohol or substance abuse treatment
- Part A blood (see the restrictions under non-covered services)
- Clinical trials (Inpatient)
- Kidney Dialysis (Inpatient)

Summary of Medicare Part B Covered Services

Medically Necessary Outpatient Services (see restrictions in Medicare coverage database)

- Durable Medical Equipment (DME)
- Home health services
- Outpatient physical, speech, and occupational therapy services
- Chiropractic care
- Outpatient mental health services
- Part B blood
- Physician services
- Prescription drugs
- Preventive care services
- Radiology and laboratory services

Summary of Medicare Part D Covered Services

For a complete plan formulary (list of Part D prescription drugs) and any restrictions, go to our website at [My Choice Wisconsin Medicare Dual Advantage Formulary Search](#)

Benefit Exclusions

Some services are excluded from coverage under My Choice Wisconsin's programs. For information and questions on service exclusions, please contact the members of My Choice Wisconsin care team or Customer Service. In addition to specific excluded services, My Choice Wisconsin may deny coverage if:

- The service is not medically necessary;
- The service is not a covered benefit; or
- The member is not enrolled in a My Choice Wisconsin program at the time the services are provided.

Family Care Benefit Package Exclusions

Medical Services, including acute and primary care services, physician visits, hospital stays, and medications are not included in the Family Care Benefit Package. For those members who are Medicaid eligible, these services can be accessed with their Forward Card.

Emergency Services

When included as a benefit under a member's program, medically necessary emergency services are covered within and outside of My Choice Wisconsin's service area. In the event of an emergency, the member should seek immediate care or call 911. Prior authorization is not required.

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

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

Post-Stabilization Care Services

When included as a benefit under the member's program, My Choice Wisconsin covers post-stabilization care services. Post-stabilization care services are services related to an emergency medical condition that are either provided after a member is stabilized in order to maintain the stabilized condition or provided to improve or resolve the member's condition. All health care services must be medically necessary and provided in accordance with professionally recognized standards of care.

Urgently Needed Care

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

Notification of Emergency Services and Urgently Needed Care

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

Renal Dialysis Services

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

Use of Network Providers

Members must use My Choice Wisconsin network providers to get covered services, except in limited cases. Examples of when it is permissible to use out-of-network provider include:

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

Member Rights and Responsibilities

My Choice Wisconsin must honor Member Rights and must ensure those rights when furnishing services. My Choice Wisconsin members receive a list of their rights and responsibilities upon enrollment and in the Member's program Member Handbook.

Family Care Member Rights

Go to the MIDAS Provider Portal's User Documents. There you will find Member Handbooks in a variety of languages that describe Member Rights under the Family Care program.

Direct Access to Preventive Care

My Choice Wisconsin members have direct access to preventive health care services when coverage is provided by My Choice Wisconsin. Members have access to the following services from a Network Provider without the need for a referral:

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

Member Rights

- 1.) **We must provide information in a way that works for the member, including information provided in the member handbook or any provider handouts or documentation (in languages other than English, in Braille, in large print, or other alternate formats, etc.).** A member can call My Choice Wisconsin Customer Service to get information on what works for them at 800-963-0035 (TTY users should call Wisconsin Relay System 711).

Members also have the right to ask for an interpreter and have one provided to them during any covered service. Our plan has free interpreter services available to answer questions from non-English-speaking members. We can also give members information in Braille, in large print, or other alternative formats if needed.

If a member is eligible for Medicare because of a disability, My Choice Wisconsin is required to give the member information about the plan's benefits that is accessible and appropriate for the member. To get appropriate information about what works for the members, please contact Customer Service at 800-963-0035.

If a member has any trouble getting information from our plan because of problems related to language or a disability, and the member has Medicare, the member can call Medicare and ask to file a complaint at 800-MEDICARE (800-633-4227), 24 hours a day, 7 days a week. TTY users can call 877-486-2048.

- 2.) **We must treat a My Choice Wisconsin member with fairness, dignity, and respect with the need for privacy always.** Members have the right:

- To get compassionate, considerate care from My Choice Wisconsin staff and providers.
- To get care in a safe, clean environment.
- To not have to do work or perform services for My Choice Wisconsin.
- To be encouraged and helped in talking to My Choice Wisconsin staff about changes in policy that the member thinks should be made or services that the member thinks should be provided.
- To be encouraged to exercise rights as a member of My Choice Wisconsin.
- To be free from discrimination. My Choice Wisconsin and providers must obey laws to protect members from discrimination or unfair treatment. We do not discriminate based on a person's race, mental or physical disability, religion, gender, sexual orientation, health, ethnicity, creed (beliefs), age, national origin, or source of payment.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. This means a member has the right to be free from being restrained or forced to be alone in order to make the member behave in a certain way or to punish because someone finds it useful.
- To be free from abuse, neglect, and financial exploitation.
 - **Abuse** can be physical, emotional, financial, or sexual. Abuse can also be if someone gives the member a treatment such as medication, or experimental research without their informed consent.
 - **Neglect** is when a caregiver fails to provide care, services, or supervision which creates significant risk of danger to the individual. Self-neglect is when an individual who is responsible for his or her own care fails to obtain adequate care, including food, shelter, clothing, or medical or dental care.

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

What can a member do if they are experiencing abuse, neglect, or financial exploitation?

The member's care team, or other care management staff, is available to talk with a member about issues that members may feel may constitute abuse, neglect, or financial exploitation. They can help members with reporting or securing services for safety. Members should always call 911 in an emergency.

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

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

- If there is a life-threatening emergency, call 911.
- Call the Care Team at 800-963-0035, 8:00 a.m. to 4:30 p.m., Monday-Friday.
 - For assistance after-hours, on weekends and holidays, call the same number.

- 3.) **We must ensure members receive assistance in a prompt, courteous, appropriate, and culturally competent manner.**
- 4.) **We must ensure that My Choice Wisconsin members get timely access to covered services and drugs as provided for in Federal and State law. When medically appropriate, services must be available 24 hours a day, 7 days a week.** As a member of our plan, a member has the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for covered services. Members can call Customer Service to learn which doctors are accepting new patients. Members also have the right to go to a women's health specialist, such as an Obstetrician and Gynecologist (OB/GYN), nurse midwife, or licensed midwife, without a referral in addition to choosing from their primary care physician.

My Choice Wisconsin members have the right to get appointments and covered services from the plan's network providers *within a reasonable amount of time*. This includes the right for members with prescription benefits to get prescriptions filled or refilled at any of our network pharmacies without long delays.

If a member thinks they are not getting medical care or prescription drugs within a reasonable amount of time, they can refer to their Evidence of Coverage to learn what to do or contact Customer Service. (If My Choice Wisconsin has denied coverage for a member's medical care or drugs, and a member does not agree with our decision, a member can refer to their Evidence of Coverage, or contact Customer Service to learn what to do.)

- 5.) **We must protect the privacy of a member's personal health information.** Federal and state laws protect the privacy of our members' medical records and personal health information. We protect members' personal health information as required by these laws.
- A member's "personal health information" includes the personal information they gave the health plan upon enrollment, as well as their medical records and other medical and health information.
 - The laws that protect a member's privacy give the member rights related to getting information and controlling how the information is used. My Choice Wisconsin gives members a written notice, called a "Notice of Privacy Practice," that tells the member these rights and explains how we protect the privacy of the member's health information.

A member can contact My Choice Wisconsin Customer Service at 800-963-0035 (TTY users should call Wisconsin Relay System 711) for questions or concerns about the privacy of their personal health information.

Rights included in the My Choice Wisconsin "Notice of Privacy Practice" include the right for a member to:

- Get a copy of their health and claims records
- Correct their health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared their information
- Get a copy of our privacy notice
- Choose someone to act for them
- File a complaint if they believe their privacy rights have been violated

The above is not a complete description of My Choice Wisconsin's Privacy Practices. Contact the Privacy Officer at (608) 245-3073 or dlfamcprivacyofficer@mychoicefamilycare.org, or send USPS mail Attn: Privacy Officer to 10201 W Innovation Drive Ste 100 Wauwatosa, WI 53226.

- 6.) **A member has the right to receive their records and information that pertains to them within a timely manner.**
- 7.) **We must give members information about the plan, its network of providers, and their covered services.** A member of My Choice Wisconsin has the right to get several kinds of information from us such as:
- Information about our plan
 - Information about our network providers, including our network pharmacies
 - Information about their coverage and the rules members must follow when using their coverage
 - Information about why something is not covered and what they can do about it

- 8.) **We must support a member's right to make decisions about their care.** A member has the right to know their treatment options and participate in decisions about their health care.

A member has the right to get full information from their doctors and other health care providers when they go for medical care. Providers must explain a member's medical condition and their treatment choices *in a way that they can understand*.

Members also have the right to participate fully in decisions about their health care. To help them make decisions with their doctors about what treatment is best for them; their rights include the following:

- **To know all about all their choices.** This means that members have the right to be told about all the treatment options that are recommended for their condition, no matter what they cost or whether they are covered by our plan, including the right to request a second opinion. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **Consent to treatment.** A member has the right to have their medical provider request their consent for all treatment, except in the case of an emergency where the member's life is in serious danger and the member is unable to sign a consent form.
- **To know about the risks.** Members have the right to be told about any risks involved in their care. Members must be told in advance if any proposed medical care or treatment is part of a research experiment. Members always have the choice to refuse any experimental treatments.
- **The right to say "no."** Member has the right to refuse any recommended treatment and to be advised of the probable consequences of the refusal. This includes the right to leave a hospital or other medical facility, even if their doctor advises them not to leave. Member also has the right to stop taking their medication. Of course, if they refuse treatment, or stop taking medication, members accept full responsibility for what happens to their body as a result.
- **Advance Directive.** A member has the right to choose an Advance Directive to designate the kind of care the member prefers to receive if the member becomes unable to express their wishes.
- **To receive an explanation if a member is denied coverage for care.** Members have the right to receive an explanation from us if a provider has denied care that they believe they should receive. To receive this explanation, members will need to ask My Choice Wisconsin for a coverage decision. The member's Evidence of Coverage provides an explanation of how to do this, or member can contact Customer Service for assistance.

A member has the right to give instructions about what is to be done if they are not able to make decisions for themselves. A member can refer to the Evidence of Coverage for additional help or contact Customer Service on how to do this.

9.) **A member has the right to make complaints, file a grievance or appeal and to ask us to reconsider decisions we have made without fear of retaliation, and to receive a response in a timely manner.** A member can refer to the Evidence of Coverage for information about what to do if they have any problems or concerns about their covered services or care. It gives the details about how to deal with all types of problems and complaints. Members may also contact Customer Services for assistance.

10.) **What can a member do if they believe they are being treated unfairly, or their rights are not being respected?**

If it is about discrimination, call the Office for Civil Rights.

If the member believes they have been treated unfairly, or their rights have not been respected due to their race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, they should call the Department of Health and Human Services' Office for Civil Rights at 800368-1019 or TTY 800-537-7697 or call their local Office for Civil Rights.

Is it about something else?

If member believes they have been treated unfairly, or their rights have not been respected, *and* it's *not* about discrimination, they can get help dealing with the problem they are having:

- Members can **call My Choice Wisconsin Customer Service** at 800-963-0035 (TTY users should call Wisconsin Relay System 711).
- Members can **call the State Health Insurance Assistance Program**. Members can find details about this organization and how to contact it in their Evidence of Coverage.
- Or, members **can call Medicare** at 1-800-MEDICARE (800-633-4227), 24 hours a day, 7 days a week. TTY users should call 877-486-2048.

11.) **We must provide an option of referral to another provider if a provider objects to providing treatment to a member based on religious or moral grounds.**

12.) **How can members get more information about their rights?** There are several places where a member can go to get more information about their rights:

- Members can **call My Choice Wisconsin Customer Service** at 800-963-0035 (TTY users should call Wisconsin Relay System 711).
- Members can **call the State Health Insurance Assistance Program**. Members can find details about this organization and how to contact it in their Evidence of Coverage.
- Members can contact **Medicare**.
 - Member can visit the Medicare website to read or download the publication "Your Medicare Rights and Protections." (The publication is available at: <https://www.medicare.gov/pubs/pdf/11534-medicare-rights-and-protections.pdf>.)
 - Or, members can call 800-MEDICARE (800-633-4227), 24 hours a day, 7 days a week. TTY users should call 877-486-2048.

Member Responsibilities

Please reference the member's Evidence of Coverage on My Choice Wisconsin's website: [Medicare Dual Advantage 2024 Evidence of Coverage](#).

Members Rights for Appeal and Grievance

We are committed to providing quality service to our members. If you or the Member has a concern that you are unable to resolve, contact the Member's IDT or call My Choice Wisconsin's Member Rights Specialist at 800-963-0035 ext. 3448.

Members have the right to file a grievance or appeal against a decision made by My Choice Wisconsin and to receive a prompt and fair review. The Member Rights Specialist can tell the Member about their rights, attempt to informally resolve their concerns, and help them file a grievance or appeal. The Member Rights Specialist will work with the Member throughout the entire grievance and appeal process to try to find a workable solution.

Providers recognize that the Member has the right to file appeals or grievances and assure them that such actions will not adversely affect the way that the Provider treats the Member. If a Provider becomes aware of concerns or dissatisfaction expressed by a member, or on behalf of a member related to the Member's care or needs, the Provider should inform the Member's Care Manager of such concerns. The Care Manager's name, phone number, and email address is printed on every Provider Service Authorization. Care Managers are available Monday through Friday from 8:00 am to 4:30 pm. Providers are permitted to assist Members in the filing of a grievance or appeal.

My Choice Wisconsin members have the right to appeal MCO adverse benefit determinations and to grieve any action or inaction that the member perceives as having a negative impact on them. Members, their legal representative, or, with member's written permission, anyone, (including provider involved in the member's care) has the right to assist the member or file a grievance or appeal for the member. An "Adverse Benefit Determination" is any of the following:

- The denial of functional eligibility under Wis. Stat. § 46.286(1)(a) as a result of the MCO's administration of the long-term care functional screen, including a change from nursing home level of care to non-nursing home level of care.
- The denial or limited authorization of a requested service that falls within the benefit package specified in Addendum VII, including the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service, unless the service was only authorized for a limited amount of time or duration and that amount or duration has been completed.
- The denial, in whole or in part, of payment for a service that falls within the benefit package specified in Addendum VII.
- The denial of a member's request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.
- The denial of a member's request to obtain services outside the MCO's network when the member is a resident of a rural area with only one managed care entity.

- The failure to provide services and support items included in the member’s MCP in a timely manner, as defined by the Department.
- The development of a member-centered plan that is unacceptable to the member because any of the following apply.
 - a) The plan is contrary to a member’s wishes insofar as it requires the member to live in a place that is unacceptable to the member.
 - b) The plan does not provide sufficient care, treatment, or support to meet the member’s needs and support the member’s identified outcomes.
 - c) The plan requires the member to accept care, treatment, or support items that are unnecessarily restrictive or unwanted by the member.
- The involuntary disenrollment of the member from the MCO at the MCO’s request.
- The failure of the MCO to act within the timeframes for resolution of grievances or appeals.

An “action” is not:

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

What are Appeals and Grievances?

An **appeal** is a request for My Choice Wisconsin to review an “adverse benefit determination.” If a member is dissatisfied with the My Choice Wisconsin appeal decision, he/she may request a State Fair Hearing.

An appeal of an adverse benefit determination must be filed within sixty (60) calendar days of receipt of the NOA. If the member wants a service to continue during the appeal process, the appeal must be filed on or before the effective date on the NOA. However, if My Choice Wisconsin’s proposed action is upheld in the appeal process, the member may be liable for the cost of any continued benefits.

A **grievance** is an expression of dissatisfaction about any matter other than an adverse benefit determination. (i.e., poor quality of service, does not feel respected by staff, etc.). If a member wants to file a grievance it can be either oral or written and should begin by contacting their Care Team Staff or the My Choice Wisconsin Member Rights Specialist. A grievance can be submitted at any time with no time limits.

How can Members File an Appeal or Grievance

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

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

Members can also send a grievance or appeal letter to:

My Choice Wisconsin
Member Rights Specialist
10201 West Innovation Drive
Suite 100
Wauwatosa WI 53226-4822

Additional information on appeals and grievances can be found on the My Choice Wisconsin website for all programs: www.mychoicewi.org/contact/grievances-appeals/

Medicaid SSI Member Appeal or Grievance

Medicaid SSI members have access to the grievance and appeal process in My Choice Wisconsin's Medicaid SSI Member Handbook and Evidence of Coverage manual. The Wisconsin Badger Care Plus or Medicaid SSI-HMO Ombuds Brochure is available at:

<http://www.dhs.wisconsin.gov/publications/p1/p12002.pdf>

Interdisciplinary Care Team Responsibilities

The Interdisciplinary Care Team of My Choice Wisconsin's Family Care Partnership ("Partnership") program has many roles, including playing an integral role with the My Choice Wisconsin provider network. The Interdisciplinary Care Team will:

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

SECTION 4: PRACTICE GUIDELINES, UTILIZATION MANAGEMENT & PRIOR AUTHORIZATION

Utilization Management Criteria

Physicians and nurses at My Choice Wisconsin use clinical criteria, based on medical necessity, to make coverage decisions. It is the policy of My Choice Wisconsin to use clinical practice guidelines that are evidence-based and/or expert consensus-driven. All clinical practice guidelines are based on scientific evidence, review of the medical literature, or appropriately established authority, as cited. All recommendations are based on published consensus guidelines and do not favor any particular treatment based solely on cost consideration. My Choice Wisconsin's clinical decision-making process may include the use of McKesson InterQual® criteria.

The recommendations for care are suggested as guides for making Medical Necessity clinical decisions. Clinicians and their patients must work together to develop individual treatment plans that are tailored to the specific needs and circumstances of each patient.

My Choice Wisconsin makes available practice guideline references through the My Choice Wisconsin website where they are available to providers, members, and potential members. Go to the Provider Resource Library: www.mychoicewi.org/providers/resource-library/. Scroll down where you will find a section titled "Resource Downloads for Providers." Type "Guideline" in the search bar where you will find various practice guidelines based on provider type.

Resource Allocation Decision (RAD) Method

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

If you have questions regarding any of the criteria or decision methods used by My Choice Wisconsin, you may call My Choice Wisconsin to request information regarding the criteria at 800-963-0035.

Guide to Pre-certification, Notification, and Concurrent Review Hospital Responsibilities:

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

Skilled Nursing Facility Responsibilities:

- Pre-certify all admissions.
- Cooperate with concurrent review activities, both by telephone and on-site.

Home Health Agency Responsibilities:

- Pre-certify all services.

Pre-certification of Hospital Admissions

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

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

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

Second Opinions

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

Prior Approval

Coverage for My Choice Wisconsin members is provided in accordance with Medicaid and Medicare criteria and guidelines, including the use of Utilization Management Criteria. Procedures that do not meet applicable coverage criteria and guidelines are not covered by My Choice Wisconsin. To ensure coverage, services must be:

- Obtained from a Network Provider, unless prior approval is obtained through My Choice Wisconsin to utilize an Out-of-Network Provider, as outlined below.
- Approved in advance by the member's My Choice Wisconsin Interdisciplinary Team or other care management staff, except in a medical emergency. For additional information on My Choice Wisconsin's prior authorization requirements, go to www.mychoicewi.org/providers/authorizations/

Prior Authorization for Out-of-Network Providers

My Choice Wisconsin's Medical Advisor will consider approval of prior authorization requests for Out-of-Network Providers only if **all** of the following requirements are met:

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

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

New Technology

My Choice Wisconsin will follow Medicare's coverage determinations for new technology.

Remote Waiver Services and Interactive Telehealth

Remote waiver services mean waiver services delivered using audiovisual communication technology that permits 2-way, real-time, interactive communications between a provider and a member. Remote waiver services do not include communications delivered solely by audio-only telephone, facsimile machine, or electronic mail.

To authorize a waiver service for remote delivery the following, but not limited to, requirements must be met:

- The service can be delivered remotely with functional equivalence to face to face. Functional equivalence exists when there is no reduction in quality, safety, or effectiveness of the face-to-face service because it is delivered by using audiovisual telecommunication technology.
- Member consent to receive the service remotely.
- The member has the proper equipment and connectivity to participate in the service remotely. The MCO is not required to provide the proper equipment and connectivity to enable the member to access the service remotely.
- The provider must have the service in their contract with the 95 modifier prior to services being rendered and providers must bill using the 95 modifier if Remote Services is approved and authorized.
- The following services may not be authorized for remote delivery:
 - Adult Day Care Services
 - Home-delivered meals
 - Residential Care
 - Transportation – Community and Other
 - Relocation Services
 - Self – Directed Personal Care
 - Skilled Nursing Services RN/LPN
 - Specialized Medical Equipment and Supplies
 - State Plan services via interactive telehealth

Interactive telehealth means telehealth delivered using multimedia communication technology that permits 2-way, real-time, interactive communications between a certified provider of Medical Assistance at a distant site and the Medical Assistance recipient or the recipient's provider.

For Telehealth or Remote Service Delivery the provider may not require the member to receive a service via interactive telehealth or remotely if in person service is available.

SECTION 5: RESIDENTIAL PROVIDERS

Introduction

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

Residential Placement Process

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

Member placement occurs at the provider's contracted rate. The Interdisciplinary Team will enter a Service Authorization at the appropriate contracted tier rate and a move can be completed.

Excessive Damage to a Residential Facility Caused by a Member

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

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

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

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

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

Room and Board

My Choice Wisconsin collects the Room and Board payment from the member. The residential provider submits a claim for one rate that is inclusive of both Support Services and Room and Board and My Choice Wisconsin pays the provider.

Respite for Residents of an AFH

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

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

SECTION 6: BILLING AND CLAIMS

Contracted providers are responsible for submitting clean claims within the timely filing requirements outlined in their contract. If you have any questions related to billing, claims, reimbursement, denials, adjustments, or refunds, please contact:

My Choice Wisconsin Provider Help Desk (TriZetto Members)
Toll-Free at 855-878-6699
Monday - Friday, 8:00 a.m. to 4:00 p.m.

WPS Customer Service Toll-Free at 800-223-6016

Family Care Claim and Authorization Information

MCW requires prior authorization for all Family Care Services. Failure to obtain an authorization prior to the delivery of services could result in denial of claim payment. MCW requires contracted providers to utilize our provider portal. Our provider portal, MIDAS (Member Information Documentation Authorization System), allows you to view your service authorizations, submit claims, and view claims status for our Members you serve.

MIDAS System Requirements

Your computer will require the following specifications:

- Microsoft Windows 95 or later
- Internet Explorer 7.0 or above

MIDAS will **not** work with the following:

- Apple computers or applications
- Google Chrome or Firefox

MIDAS Access

Your Provider Relations and Network Representative will provide you with a MIDAS provider portal login and initial password. Keep this login information in a safe place as the records contained in the MIDAS database contain protected Member health information.

On the MIDAS home page at www.mcfc-midas.com select "Provider Portal" from the system drop down menu and enter your login and password information

My Choice Wisconsin Claims Web Portal

Long-Term Care providers who currently bill on the My Choice Wisconsin General or Residential claim forms have access to My Choice Wisconsin's Claims Web Portal (Legacy Care Wisconsin Members only).

If you are one of these providers, you have the option to bill electronically using the Claims Web Portal. You can view electronic remittance, verify eligibility, and check claim status through the Claims Web Portal. Providers may sign up and obtain instructions for the Claims Web Portal at:

www.mychoicewi.org/providers/claims/.

Providers serving Family Care Partnership members:

- Please do not submit claims for covered services to Medicare or Medicaid. Doing so will delay your payment.

Providers serving Family Care and Medicaid SSI members:

- When providing services to members who have both Medicare and Medicaid, claims for Medicare-covered services must first be submitted to Medicare, unless the member is enrolled in My Choice Wisconsin's Medicare Dual Advantage Plan.

General Claims Information:

Physicians/providers are required to use the standard CMS codes for ICD-10, CPT and HCPCS services, regardless of the type of submission. Claims processing is subject to change based upon newly promulgated guidelines and rules from the Department of Health Services Wisconsin Medicaid Program (WMP) or Centers of Medicare and Medicaid Services (CMS). See Long-Term Care Claims Information for more information on submitting Long-Term Care claims.

General Payment Guidelines:

For payment of claims, My Choice Wisconsin has adopted all guidelines and rules established by Medicaid and Medicare. This includes Mandatory Payment Reductions in the Medicare Program – "Sequestration." In general, Medicare claims with dates-of-service or dates-of-discharge on or after April 1, 2013, incur a 2 percent reduction in Medicare payment.

Claims should be submitted in one of three formats:

- Electronic claims submission;
- CMS 1500 form; or
- UB04 form

Claims by Mail:

This correct mailing address can be found on the Service Authorization

Mail Claims to:

My Choice Wisconsin (TriZetto Members)
PO Box 226897
Dallas, TX 75222-6897

My Choice Wisconsin (WPS Members)
C/O WPS Insurance Corporation
PO Box 211595
Eagan, MN 55121

WPS ONLY – New and Corrected Claims Submitted by Fax:

Providers can now submit paper claims and the Corrected Claim Form to WPS via fax to 608-327-6332 instead of mailing.

- For new and corrected claims, please **do NOT include a FAX coversheet**. You may fax just the claim form or just the Corrected Claim Form and normal supporting documents (PRA).

Electronic Claims Submission:

My Choice Wisconsin (Legacy Care Wisconsin Members) accepts standard electronic billing for Professional and Institutional claims (837P or 837I as appropriate) using Payer ID 27004. Please contact our vendor Change Healthcare at 800-845-6592 for additional information on this billing option.

Pharmacy Claims Submission:

All My Choice Wisconsin (Legacy Care Wisconsin Members) pharmacy claims should be submitted to EnvisionRX electronically.

Long-Term Care Claims Submission:

My Choice Wisconsin (Care Wisconsin Legacy Members) has created a Residential Claim Form for its residential providers to utilize in the submission of room and board/care and supervision. For My Choice Family Care Legacy Members, a standard claim form must be used.

A General Claim Form has been created for Care Wisconsin Legacy members the submission of certain Long-Term Care services that include, but are not limited to:

- Supportive Home Care
- Adult Day Care
- Meals
- Personal Emergency Response System
- Transportation

Providers who submit on the Residential or General claim forms for Care Wisconsin Legacy members also have the option of submitting claims via spreadsheet. For more information, contact the **Provider Help Desk at 855-878-6699.**

Standard claim forms should be utilized for the submission of skilled nursing facility services, therapies, mental health, DME/DMS, home health, personal care, etc.

Non-Covered Services

My Choice Wisconsin administers Wisconsin Medicaid healthcare benefits through our SSI Medicaid,

Family Care, and Partnership programs and complies with Wisconsin Administrative code outlined in DHS 107.03. Care Wisconsin provides Medicare benefits to members in our Dual Advantage program, as well as dual eligible members in our Partnership program. Please see [Items and Services Not Covered Under Medicare](#) for more information. The Family Care and Partnership programs include Home and Community-based Waiver benefits in addition to traditional Medicaid coverage.

Coordination of Benefits

General Information

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

Provider must submit claims to the primary insurance before submitting to My Choice WI. Following the primary insurance determination, a copy of the original claim form and a copy of the primary insurance Remittance Advice (RA) must be submitted to My Choice WI for secondary benefit determination (regardless of balance due). Providers must submit the documents within one hundred and twenty (120) days from the date on the primary RA.

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

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

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

If the primary insurance denies a claim because of lack of information, My Choice Wisconsin will also deny. In the event the denial was due to the member's lack of compliance in responding to the primary insurance request for additional information, My Choice Wisconsin may reconsider the denial based on the following process: the provider must make, and document, three attempts (verbal or written) to the member indicating they must become compliant in providing the missing information in order for the primary insurance to process. There must be at least one (1) week between contacts attempts. The provider must submit documentation of these outreach efforts and if the member is not following through, documentation of the outreach attempts can be resubmitted with the claim, documenting in box 19 of the CMS-1500 "non-compliant". In the case where the claim is submitted on a UB, notation of "non-compliant" can be documented anywhere on the claim form.

- If a member has Medicare and/or other insurance, complete information must be on the CMS1500 claim or UB-04 claim for the claim to be processed efficiently.
- On the CMS-1500 claim, box 11d should be checked "Yes" if there is any other insurance information. If box 11d is checked "Yes", boxes 9a – 9d on the CMS-1500 claim must be completed with the other insurance information.
- On the UB-04 claim, box 50 is completed if there is any other insurance information.
- Other insurance remittance advice needs to accompany each CMS-1500 claim and UB-04 claim where other insurance is indicated on the claim.

Coordination of Benefit Rules for My Choice Wisconsin Partnership and Medicare Dual Advantage Members

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

Corrected Claims

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

My Choice Wisconsin
PO Box 226897
Dallas, TX 75222-6897

Corrected claims for My Choice Family Care Legacy members must be submitted on the WPS Corrected Claim form. Submission of the Corrected Claim Forms to WPS are subject to the timely filing time frame identified in the provider's contract. Corrected Claim forms should be sent to the normal WPS claims address at:

My Choice Wisconsin
C/O WPS Insurance Corporation
PO Box 211595
Eagan, MN 55121

Subrogation

My Choice Wisconsin does not pay for services to the extent that there is a third party that is required to be the primary payer.

For services for Partnership and Medicare Dual Advantage enrolled members, My Choice Wisconsin follows Medicare's guidelines for reimbursement any time there is a third-party entity involved. Providers may reference the following:

Medicare Managed Care Manual for Medicare Secondary Payer (MSP) procedures, go to <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf>

Medicare Claims Processing Manual for Medicare claims processing procedures, go to <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals>

For services for Medicaid SSI and Family Care enrollment member, My Choice Wisconsin follows Medicaid's guidelines for reimbursement any time there is a third-party entity involved. Providers may reference the online, searchable Provider handbooks, go to <https://www.forwardhealth.wi.gov/WIPortal/Default.aspx>

General Subrogation Information

- All liability insurer medical or dental coverage benefits are considered primary to My Choice Wisconsin payment of Medicaid claims as per Wisconsin Statutes, Medicaid is payer of last resort. My Choice Wisconsin reserves the legal right to process claims accordingly.
- Wisconsin Statutes Chapter 49 and Administrative Code DHS §106 govern how providers should submit liability claims and how My Choice Wisconsin reviews these claims for processing. Wisconsin law also protects My Choice Wisconsin's right of subrogation.
- My Choice Wisconsin reserves all legal, statutory, and contractual subrogation and recoupment rights related to paid claims and will enforce its right in all cases, unless waived in writing by My Choice Wisconsin.

Balance Billing Information

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

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

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

- The member accepts responsibility for payment.
- The provider and member make payment arrangements for the service.

Providers must obtain a written statement in advance, documenting that the member has accepted responsibility for the payment of the service. Furthermore, the service must be separate or distinct from a related, covered service.

Payer of Last Resort

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

Provider Liaison Specialist

My Choice Wisconsin has a Provider Liaison Specialist available to educate our contracted Family Care network Providers. Training is available for the Clean Claims submission process, interpreting the EOB/EOMBs, reconciling payments and our claims appeal process.

If you are interested in these trainings or if you are a new Family Care provider in need of assistance, please call 414-287-7450.

SECTION 7: PROVIDER APPEALS

This process is to be used to appeal My Choice Wisconsin determinations relative to claim denials, payments, medical necessity, and prior authorization for Covered Services. My Choice Wisconsin providers must appeal within sixty (60) days after receiving an initial denial or partial payment of a claim.

The provider may call the My Choice Wisconsin (Care Wisconsin Legacy Members) Provider Help Desk at 855-878-6699. The Provider Help Desk will help answer provider questions, and/or will route the call to the appropriate department. For My Choice Wisconsin (My Choice Family Care Legacy Members) the provider may call a Provider Liaison representative at 414-287-7450 for assistance with the appeal process.

All appeals related to denials based on medical necessity will be reviewed by My Choice Wisconsin's health care professionals possessing the appropriate clinical expertise. Requests for review of prior authorization or denials based on medical necessity should be put in writing and mailed to:

My Choice Wisconsin
ATTN: Appeals
1617 Sherman Ave.
Madison, WI 53704

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

(Partnership, SSI, and Dual Advantage Members)
My Choice Wisconsin
Claims Appeals
1617 Sherman Ave.
Madison, WI 53704

(Family Care Members)
My Choice Wisconsin
Provider Claims Appeals
10201 W. Innovation Drive, Suite 100
Wauwatosa, WI 53226

If you wish to file an appeal, the following documentation must be included:

- Provider's Name and ID Number
- Member Name and Member ID number
- Date of Service
- Procedure Code
- Units billed
- Copy of your Claim
- Copy of your My Choice Wisconsin Remittance Advice
- Copy of your Primary Insurer EOB or Medicare (EOMB), if applicable
- Reason your Claim Merits Reconsideration
- Any other documentation to support your appeal

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

Family Care and/or Family Care Partnership Providers Only

All Family Care and Family Care Partnership providers must appeal first to My Choice Wisconsin and then to the Department if they disagree with My Choice Wisconsin's payment or nonpayment of a claim. Appeals must be submitted to DHS within sixty (60) days of the date of written notification of My Choice Wisconsin's final decision resulting from a request for reconsideration, or, if My Choice Wisconsin fails to respond, within sixty (60) days from the forty-five (45) day timeline allotted to My Choice Wisconsin to respond. DHS appeals may be emailed, faxed, or mailed.

Email: DHSLTCProviderAppeals@dhs.wisconsin.gov

Fax: (608) 266-5629

Mail: Provider Appeals Investigator
Division of Medicaid Services
1 West Wilson Street, Room 518
P.O. Box 309
Madison, WI 53701-0309

Medicaid SSI Providers Only

All Medicaid SSI providers must appeal first to the HMO and then to the Department if they disagree with the HMO's payment or nonpayment of a claim. If the health plan fails to respond to the appeal within forty-five (45) days, or if you are not satisfied with the response to your appeal, you may appeal to the Department in writing within sixty (60) days of the final decision; or in the case of no response, within sixty (60) days from the forty-five (45) day timeline allotted to the HMO to respond.

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.

SECTION 8: FRAUD, WASTE AND ABUSE REPORTING

Fraud, Waste and Abuse Program

Under the direction of the Centers for Medicare and Medicaid Services (CMS) and the Wisconsin Department of Health Services, My Choice Wisconsin is required to have an effective fraud, waste, and abuse (FWA) program in place.

Provider Requirements

- All providers and their employees must complete training within ninety (90) calendar days of new hire and annually thereafter.
- Please maintain records of all training—this is to include dates, methods of training, materials used for training, identification of trained employees via sign-in sheets or other method, etc.
 - My Choice Wisconsin may request such records to verify that training occurred.

- If the organization has contracted with other entities to provide health and/or administrative services on behalf of My Choice Wisconsin members, you must provide this training material to your subcontractor for training and ensure the subcontractor and any other entity they may have contracted with to provide the service, also maintain records of training.
- All contracted entities should have policies and procedures to address fraud, waste, and abuse—including effective training, reporting mechanism and methods to respond to detected offenses.

Definitions

First Tier Entity – Any party that enters into a written agreement with the health plan to provide administrative or healthcare services for the health plan’s enrollees.

- Examples include, but are not limited to, pharmacy benefit manager (PBM), contracted hospitals, or providers.

Downstream Entity – Any entity that enters into a written agreement below the level of the arrangement between a sponsor and a first-tier entity for the provision of administrative or healthcare services for the provision of administrative or healthcare services for a Medicare eligible individual under Medicare Advantage or Part D programs.

- Examples include, but are not limited to, pharmacies, claims processing firms, billing agencies.

Related Entity – Any entity that is related to the health plan by common ownership or control and,

1. Performs some of the sponsor’s management of functions under contract of delegation;
2. Furnishes to Medicare enrollees under an oral or written agreement; or
3. Leases real property or sells materials to the sponsor at a cost of more than \$2,500 during a contract period.

Fraud – Means an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to her or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.

- Examples include Billing for services not furnished;
- Soliciting, offering, or receiving a kickback, bribe or rebate; or
- Violations of the physician self-referral (“Stark”) prohibition.

Waste – Generally, means over-use of services, or other practices that result in unnecessary costs. In most cases, waste is not considered caused by reckless actions but rather the misuse of resources.

Abuse – Means provider practices that are inconsistent with generally accepted business or medical practices, and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary, or that fail to meet professionally recognized standards for health care.

Some examples of abuse:

- Charging in excess for services or supplies;
- Providing medically unnecessary services; or
- Providing services that do not meet professionally recognized standards.

Pertinent Statutes, Laws and Regulations

False Claims Act

The Federal False Claims Act 1985 permits a person with knowledge of fraud against the United States Government, referred to as the “qui tam plaintiff,” to file a lawsuit on behalf of the government against the person or business that committed the fraud (the defendant). If the action is successful, the qui tam plaintiff is rewarded with a percentage of the recovery.

Violations of Medicare laws and the Medicare Fraud and Abuse Statute also constitute violations of the False Claims Act. Since the Federal Government indirectly funds Medicaid, violations of Medicaid laws will also be covered under the False Claims Act.

The Federal False Claims Act creates liability for the submission of a claim for payment to the government that is known to be false – in whole or in part. Several states have also enacted false claims laws modeled after the Federal False Claims Act.

A “claim” is broadly defined to include any submissions that results, or could result, in payment. Claims “submitted to the government” includes claims submitted to intermediaries such as state agencies, managed care organizations, and other subcontractors under contract with the government to administer health care benefits.

Liability can also be created by the improper retention of an overpayment. Examples include:

- A physician who submits a bill for medical services not provided.
- A government contractor who submits records that they know (or should know) are false and that indicates compliance with certain contractual or regulatory requirements.
- An agent who submits a forged or falsified enrollment application to receive compensation from a Medicare health plan sponsor.

Whistleblower and Whistleblower Protections

The False Claims Act and some state false claims laws permit private citizens with knowledge of fraud against the U.S. Government or state government to file suit on behalf of the government against the person or business that committed the fraud. Individuals who file such suits are known as “whistleblowers.” The Federal False Claims Act and some state false claims acts prohibit retaliation against individuals for investigating, filing, or participating in a whistleblower action.

Anti-Kickback Statute

The Anti-Kickback law makes it a crime for individuals or entities to knowingly and willfully offer, pay, solicit, or receive something of value to induce or reward referrals of business under federal health care programs.

The Anti-Kickback law is intended to ensure that referrals for health care services are based on medical need and not based on financial or other types of incentives to individuals or groups.

Examples include:

- A frequent flier campaign in which a physician may be given credit toward airline frequent flier mileage for each questionnaire completed for a new patient placed on a drug company’s product.
- Free laboratory testing is offered to health care providers, their families, and their employees to induce referrals.

In addition to criminal penalties, violation of the Federal Anti-Kickback Statute could result in civil monetary penalties and exclusion from federal health care programs, including Medicare and Medicaid programs.

Potential FWA committed by: Skilled Nursing Facility (“SNF”)

- SNFs improperly up-coding resident RUGs assignments to gain higher reimbursement;
- SNF improperly utilizing therapy services to inflate the severity of the RUG classification to obtain additional reimbursement; and
- DME or supplies offered by DME provider that are covered by the Medicare Part A benefit in the SNP’s payment.

Potential FWA committed by: Hospital

- Failure to follow the same day rule;
- Abuse of partial hospitalization payments;
- Same day discharges and readmissions;
- Improper billing for observation services;
- Improper reporting of pass-through costs;
- Billing on an outpatient basis for “inpatient only” procedures;
- Submitting claims for medically unnecessary services by failing to follow local policies; and
- Improper claims for cardiac rehabilitation services.

Potential FWA committed by: Physician and Others

- Chiropractor intentionally billing Medicare for physical therapy and chiropractic treatments that were never actually rendered for the purpose of fraudulently obtaining Medicare payments;
- A psychiatrist billing Medicare, Medicaid, the health plan and private insurance for psychiatric services that were provided by the practices’ nurses rather than by them;
- Physician certifies on a claim form that they performed laser surgery on a Medicare beneficiary when they knew that the surgery was not actually performed on the patient;
- Physician instructs their employees to tell the OIG investigators that the physician personally performs all treatments when, in fact, medical technicians do the majority of the treatment, and the physician is rarely present in the office;
- Physician, who is under investigation by the FBI and the health plan, alters records to cover up improprieties;
- Neurologist knowingly submits electronic claims to Medicare carrier for tests that were not reasonable and necessary and intentionally up-coded office visits and electromyograms to Medicare;
- Podiatrist knowingly submits claims to the Medicare and Medicaid programs for non-routine surgical procedures when they performed routine, non-covered services such as the cutting and trimming of toenails and the removal of corns and calluses; and
- Performing tests on a beneficiary to establish medical necessity.

Potential FWA committed by: Pharmaceutical Manufacturer

- **Illegal Off-label Promotion** – Illegal promotion of off-label drug usage through marketing, financial incentives, or other promotion campaigns;
- **Illegal Usage of Free Samples** – Providing free samples to physicians knowing and expecting those physicians to bill the federal health care programs for the sample;
- Billing for items or services not rendered or not provided as claimed;
- Submitting claims for equipment or supplies and services that are not reasonable and necessary;
- Double billing resulting in duplicate payment;
- Billing for non-covered services as if covered;
- Knowing misuse of provider identification numbers, which results in improper billing;
- Unbundling (billing for each component of the service instead of billing or using all-inclusive code);
- Failure to properly code using coding modifiers;
- Improper telemarketing practices;
- Compensation programs that offer incentives for items or services ordered and revenue generated;
- Inappropriate use of place of service codes;
- Routine waivers of deductibles/coinsurance;
- Clustering; and
- Up coding the level of service provided.

Potential FWA committed by: Durable Medical Equipment, Prosthetics, Orthotics and Suppliers (DMEPOS)

- DME provider billed for items or services not provided to the beneficiary;
- Continued billing for rental items after they are no longer medically necessary;
- Resubmission of denied claims with different information in an attempt to be improperly reimbursed;
- Providing and/or billing for substantially excessive amounts of DME items or supplies;
- Up coding a DME item by selecting a code that is not the most appropriate;
- Providing a wheelchair and billing for the individual parts (unbundling);
- Delivering or billing for certain items or supplies prior to receiving a physician's order and/or appropriate certificate of necessity;
- Completing portions of the certificate of necessity that is reserved for completion by the treating physician only;
- Cover letters to encourage physicians to order medically unnecessary items or services;
- Improper use of KX modifier;
- Providing false information on the DMEPOS supplier enrollment form;

- Knowing misuse of a supplier number, this results in improper billing;
- Furnishing more visits than as medically necessary;
- Duplicate billing for the same service;
- Submission of claims for home health aide services to beneficiaries that did not require any skilled qualifying service;
- Provision of personal care services by aides in assisted living facilities when such is required by the assisted living's state licensure;
- Providing services at no charge to an assisted living center.

Reporting Obligation

If you identify, or are made aware of, potential misconduct or a suspected fraud, waste, or abuse situation, it is your right and responsibility to report it. Providers, vendors, and delegates can report compliance concerns to any of the following:

- The compliance officer/hotline of the applicable Medicaid or Medicare plan with whom you contract
- My Choice Wisconsin's Compliance Hotline at 608-245-3576
- 1-800-Medicare if Medicare funds are involved
- Your county public assistance fraud agency

All Providers shall immediately investigate and contact MCW in writing within five (5) business days of: any payment, claim, action, inaction, error, and/or omission by Provider's staff, contractors, and/or subcontractors which may constitute Medicare and/or Wisconsin Medicaid fraud, waste, and/or abuse. In accordance with applicable Law, Providers shall assist MCW with any reporting, investigation, and/or actions necessary for both parties' continued compliance with Medicare and/or Wisconsin Medicaid regulations, including, but not limited to, providing MCW, CMS and/or DHS with access to all records and personnel necessary to fully investigate the alleged or actual fraud, waste, and/or abuse. Providers understand and agree that in conjunction with the requirements of the Accountable Care Act, 42 C.F.R. § 455.2 and .23, MCW may suspend claims payment pending investigation of a credible allegation of fraud.

Retaliation is prohibited when a report is made in good faith.

Fraud, Waste and Abuse Training

- My Choice Wisconsin's providers, including first-tier, downstream and related entities, must complete fraud, waste, and abuse training within ninety (90) calendar days of new hire and annually thereafter.
- Providers are required to maintain records of all training, to include dates of training, methods of training, training curriculum, identification of trained employees via sign in sheets or other method. My Choice Wisconsin may request such records to ensure training has occurred.

- Providers should have policies and procedures to address fraud, waste, and abuse, including effective training, reporting mechanisms and methods to respond to detected offenses.
- My Choice Wisconsin offers fraud, waste, and abuse training curriculum to its providers. Training is available on the My Choice Wisconsin website at: www.mychoicewi.org/providers/providercompliance-privacy/.
- Medicare participating providers may complete the CMS training available through the CMS Medicare Learning Network (MLN) at: <https://www.cms.gov/Outreach-and-Education/MedicareLearning-Network-MLN/MLNGenInfo/index.html>

Fraud, Waste, and Abuse Resources

- CMS Prescription Drug Benefit Manual – Chapter 9: <https://www.cms.gov/medicare/prescription-drugcoverage/prescriptiondrugcovcontra/partdmanuals.html>
- Code of Federal Register (see 42 CFR 422.503 and 42 CFR 422.504): <http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms4124fc.pdf>
- Office of Inspector General: <https://oig.hhs.gov/fraud/index.asp>
- Medicare Learning Network (MLN) Fraud & Abuse Resources: <http://www.cms.gov/Outreachand-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html>

Marketing Prohibitions

Providers shall comply with all Medicare Marketing Guidelines as set forth by the Centers for Medicare and Medicaid Services (CMS). At minimum, participating physicians and providers should observe the following:

1. Providers or provider groups are prohibited from distributing printed information comparing benefits of different health plans, unless the materials have consent from all the health plans listed, and received prior approval from the Centers for Medicare and Medicaid Services (CMS);
2. Providers shall not accept enrollment applications or offer inducement to persuade beneficiaries to join plans;
3. Providers may not offer anything of value to induce plan enrollees to select them as a provider; and
4. Provider offices or other places where health care is delivered shall not accept applications for health plans, except in the case where such activities are conducted in common areas in the healthcare setting.

SECTION 9: PROVIDER COMPLIANCE & MEMBER PRIVACY

Federal and state laws require My Choice Wisconsin and all of our providers to protect the privacy of our members. We are committed to only sharing information with others who have the legal right and the need to know. If the federal and state laws do not typically apply to you, My Choice Wisconsin will require you to sign a Business Associate Agreement. This agreement explains how you are allowed to use and disclose our members' information, as well as your responsibilities to protect that information and report any improper use or disclosure to My Choice Wisconsin.

- When you must discuss member information, services, or care, remember to do so in a private place
- *Unless it is an emergency*, avoid discussing members in public areas, like hallways, elevators, cafeterias, or other common areas
- Do not use a member's name or other identifying information, like date of birth or home address, in an email unless the information is encrypted

Personal concern or curiosity about an "interesting case" are not sufficient reasons to access or share member information. Information that you hear, see, and learn regarding our members is confidential and not to be shared with friends or family unless they have the legal right and need to know.

Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains provisions and rules related to protecting the privacy and security of protected health information (PHI).

- HIPAA Privacy – The Privacy Rule outlines specific protections for the use and disclosure of PHI. It also grants rights specific to members.
- HIPAA Security – The Security Rule outlines specific protections and safeguards for electronic PHI.

If you become aware of a potential breach of protected information, you must comply with the security breach and disclosure provisions under HIPAA and, if applicable, with any business associate agreement.

Protected Health Information (PHI)

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

In working with My Choice Wisconsin, providers and their employees and subcontractors may have access to confidential and/or proprietary information. Such information may include, but not be limited to, medical records, staff compensation, and certain proprietary and management information concerning both organizations. Any providers or employees or subcontractors assigned to perform services or who otherwise have access to such information will be made aware of the confidential nature of such information and will receive training and education on protecting confidentiality.

SECTION 10: QUALITY MANAGEMENT PROGRAM

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

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

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

Our Quality Improvement Steering Committee:

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

HealthCheck

HealthCheck is Wisconsin's name for the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program which was put into place to assure that all Medicaid-enrolled children receive periodic, comprehensive health screening exams resulting in the identification and provision of needed health care services. HealthCheck services consist of a comprehensive health screening of all members younger than 21 years of age that includes all of the following:

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

A HealthCheck screening examination may be distinguished from other preventive health care under Wisconsin Medicaid because HealthCheck includes a strong anticipatory guidance and health education component and a schedule for periodic examinations (based on recommendations by organizations that are recognized as authorities in the field of child and adolescent health). Members under age 21 should receive annual HealthCheck examinations.

Wisconsin Medicaid has developed and makes available free of charge forms that meet the documentation requirements of the program. Use of these forms is optional. Many clinics/agencies have developed documentation systems which work well for them, and they are encouraged to continue to do this. It is required that documentation shows that all seven areas listed above have been assessed and is located in the member's medical record. Additional information and resources for HealthCheck providers can be found through the Forward Health Portal for Providers in the Online Handbook at: www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/tabid/152/Default.aspx

Medicaid SSI Quality Improvement

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

Pay for Performance

My Choice Wisconsin works with the Department of Health Services of Wisconsin (DHS) on performance initiatives. The Department of Health Services has developed Pay for Performance initiatives for health plans managing SSI populations. The initiatives are chosen based on clinical need,

high risk, high cost and measures that require increased performance. Providers are expected to support compliance with the expectations of Pay for Performance measures.

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

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

Medicaid SSI OB Medical Home Program (OBMH)

My Choice Wisconsin works with the Department of Health Services of Wisconsin (DHS) to provide enhanced care coordination for high-risk pregnant women. The OBMH Program is a care delivery model that is patient-centered, comprehensive, team-based, coordinated, accessible and focused on quality. The goal of the OBMH program is to improve birth outcomes and reduce birth disparities among pregnant women by providing enhanced care coordination early in the prenatal period through the postpartum period. The HMO, in partnership with the medical home site shall be guided by four (4) core principles:

1. Having a designated obstetric (OB) care provider who serves as the team leader and a point of entry for new problems. The OB care provider is defined as a physician, nurse midwife, nurse practitioner or physician assistant with specialty in obstetrics, who provides prenatal care and performs deliveries;
2. Providing ongoing care over the duration of the pregnancy and postpartum period;
3. Providing comprehensive care (e.g., care that meets the member's range of health and psychosocial needs); and
4. Coordination of care across a person's conditions providers and settings

Additional information regarding the OB Medical Home Initiative may be found on the Forward Health Portal (click the link to be directed to the website): [OB Medical Home](#)

Requirements to participate and be eligible for any performance reimbursement with My Choice Wisconsin:

- The OBMH initiative is available in the following counties only: Dane, Kenosha, Milwaukee, Ozaukee, Racine, Rock, Washington, and Waukesha
- Target Population - Pregnant Medicaid SSI members who are at high-risk for a poor birth outcome. A poor birth outcome is defined as:
 - Preterm birth – gestational age less than 37 weeks
 - Low birth weight – birth weight less than 2,500 grams (5 lbs. 8 oz.)
 - Neonatal/early neonatal death – death of a live-born infant within the first 28 days of life
 - Stillbirth – fetal demise after 20 weeks gestation

OB Medical Home Eligible Members

Documentation must indicate that the member is within the first 16 weeks of pregnancy to be enrolled in the medical home and must meet one or more of the following criteria:

- Listed on the Department's Birth Outcome Registry Network (BORN) of high-risk women
- Less than 18 years of age
- African American
- Homeless
- Have a chronic medical or behavioral health condition which the obstetric care provider determines would negatively impact the outcome of the pregnancy

OB Medical Home Payment Structure

Enhanced payments are available for clinics for pregnant women that meet the defined eligibility criteria above and the criteria for delivery of services articulated below. The Department issues payments to the HMOs and the HMOs subsequently issue the enhanced payment on to the OB medical home site.

Medical record reviews by the Department's External Quality Review Organization (EQRO) will be used to verify eligibility. If the EQRO is unable to verify any of the criteria as required by the OB Medical Home Initiative, the clinic is ineligible for the enhanced payment for those women. To receive the initial \$1,000, at minimum, the clinic must clearly document that all the following criteria are met. The member:

- Has had a pregnancy-related appointment with a health care provider within the first 16 weeks of her pregnancy. She must be enrolled in the OB Medical Home within 20 weeks of her pregnancy (the clinic is responsible for obtaining all medical records for documentation),
- Has attended a minimum of 10 medical prenatal care appointments with the OB care provider,
- Has a member centric, comprehensive care plan that has been reviewed by the member and, at minimum, the OB provider,
- Has been continuously enrolled in the OB medical home and receiving services during her pregnancy, and
- Has continued enrollment through 60 days postpartum, including the date of the scheduled 60-day medical postpartum visit, and any documentation of no shows or appointment refusals.

The Department will issue an additional \$1,000 (for a total of \$2,000) if the mother has a healthy birth outcome as defined by the Department.

Pregnancy loss prior to 20 weeks will not be eligible for the OBMH incentive, as limited care coordination and delivery of other services has occurred. Providers will still receive payment for the medical prenatal care through the usual claim submission process.

OB Medical Home Sites

The OB Medical Home must be a single clinic or network of clinics that is accountable for the total care of the member and must:

- Include an OB care provider that serves as the care team leader and a point of entry for new problems during the member's pregnancy. The OB care provider, the care coordinator, and the member's primary care physician (who may or may not be the OB care provider) will work together to identify the prenatal and psychosocial needs of the member to ensure that she will have a healthy birth outcome

Adopt written standards for patient access and communication to the member as determined by the HMO and approved by the Department. These written standards must, at a minimum,

meet appointment and wait times according to Article V of the contract. In addition, treatment and/or medical advice must be available 24 hours a day, 7 days a week.

- Use an electronic health record system to manage patient data to:
 - Document medical home enrollment date,
 - Organize clinical information,
 - Identify diagnoses and conditions among the provider's patients that have a chronic condition that will impact the pregnancy,
 - Track patient test results,
 - Identify abnormal patient test results,
 - Systematically track referrals and follow up, and
 - Document birth outcomes.
- Provide appropriate best practice medical care for high-risk pregnant women, which may include:
 - Consultation from a maternal fetal specialist and close monitoring and surveillance;
 - To the extent it is covered by Forward Health (such as through face-to-face consultation per Forward Health Topic 510), HMOs may encourage OBMH providers to use telehealth services to identify problems early in the pregnancy and provide treatment to avoid further complications and preterm labor. HMOs have the flexibility to use administrative funding to support more enhanced telehealth services like store and forward (asynchronous) and remote patient monitoring;
 - Progesterone therapy, as appropriate;
 - Plan for interconception care, including educating members on options for long- of acting reversible contraception post-delivery as part of "LARC First practice." This is the practice a prescriber who promotes awareness and use of long-acting reversible contraception as the first-line contraceptive option for women, including teens.

- Adopt and implement evidence-based guidelines that are based on, but not limited to, screening, treatment, and management of the following chronic medical conditions:
 - Asthma
 - HIV/AIDS
 - Cardiac disease
 - Diabetes mellitus
 - Hypertension
 - Pulmonary disease
 - Behavioral health, including:
 - Depression
 - Smoking
 - Substance Abuse
 - Morbid Obesity

The HMO and medical home sites must have clear procedures for addressing the complex needs of women with these conditions, including, but not limited to, referrals to appropriate specialists and community resources.

Develop guidelines to ensure that screening for social factors (that could have a negative impact on pregnancy outcome and newborn health) is a routine part of care to the pregnant and postpartum member. The guidelines should address the following:

- Integrating initial and periodic screening into information gathering
- Incorporating identified social needs (and strengths) into the comprehensive care plan
- Effective strategies for addressing social factors, including the following,
 - Identifying pertinent community resources, including personal supports;
 - Referral to community health worker services;
 - Developing effective working/referral relationships with these resources;
 - Communication and information sharing (e.g., obtaining written authorization from the member where necessary);
 - Obtaining periodic feedback from members and community resources to ensure identified resources continue to be relevant and appropriate.
- Systematic electronic tracking and follow-up on community and social determinants of health referrals to ensure referral completion.
- Actively support and promote patient self-management.
- Demonstrate cultural competency among provider and office staff.

OB Medical Home Documentation Requirements

The medical home should retain electronic documentation to support the provision of the medical home services outlined in this section of the contract.

OB Medical Home Care Coordination – General Requirements

A key component of the OB Medical Home Initiative is the coordination of care for the members. Each medical home site must have a designated care coordinator on-site (located where the member's OB care provider is located) to do the following:

- Establish a relationship with the member and maintain regular face-to-face contact throughout the pregnancy;
- Communicate with the member and other care providers to identify needs and assist in developing a member-centric care plan and keeping the plan up to date;
- Make referrals to appropriate services (e.g., physical, dental, behavioral health and psychosocial) and provide follow-up.

All care coordinators must be easily accessible on a regularly established schedule for members participating in the OB medical home. To ensure continuity of care, the care coordinator shall work with the member to obtain the appropriate release forms and contact the office(s) of any PCP, with whom the participating member had/has an ongoing relationship, to gather information about the member's medical history, current health conditions and any concerns that the PCP may have regarding the member.

HMOs and medical home sites must use the OB Medical Home Registry, provided by the Department and hosted by the Department's External Quality Review Organization, to track enrollment in the OB Medical Home.

OB Medical Home Information Gathering and Comprehensive Assessment of Need

Prior to the development of a comprehensive care management plan, the OB care provider must communicate with pertinent healthcare providers, the member and others as appropriate, to identify the member's strengths and care coordination needs. Information gathering activities include:

- Obtaining pertinent information from the initial prenatal clinic visit, the OB care provider, the member's PCP, HMO, or other source;
- Taking the member's history to identify social factors that could have a negative impact on the health and well-being of the mother and baby;
- Identifying the member's strengths and social support.

OB Medical Home Comprehensive Care Plan

The care coordinator must ensure that each medical home member has a comprehensive care plan. The OB care provider must be central to the development of the care plan. To the maximum extent possible, the member and the member's PCP (if different from the OB care provider) must also be included in the development of the care plan.

The care plan must address the medical and non-medical needs identified during the information gathering process and must include:

- A listing of key health and community resources specific to the member's needs;
- A prioritized plan of action that reflects the member's preferences and goals;
- Timeframes for addressing (and following-up) on each identified need;
- Strategies to encourage patient self-care and adherence to treatment recommendations (e.g., assisting the member in identifying self-management goals and in communicating with her obstetric care provider, offering home visits, checking in with the member between visits, referring members to group classes, and sharing culturally sensitive and appropriate materials).

The care coordinator should offer home visits. Best practice suggests that the home visit occur within 30 days of enrollment in the medical home. Members who decline the initial offer should be asked again throughout the pregnancy. The offer attempts and refusals must be documented in the medical record.

The care coordinator must establish regular communication with the member, OB care provider and PCP, if any, and any home visiting agency/provider the member may be working with, to track progress on the care plan and ensure coordinated care.

The care plan must be developed by the OB care provider, the care coordinator, and the member. The provider must attest to the agreement and understanding of the care plan by the respective parties and document, including the date, within the EHR. The plan must be reviewed and updated as the member's health and circumstances change.

OB Medical Home Ongoing Monitoring and Follow-up

Ongoing monitoring and follow-up include activities and contacts that are necessary to implement and maintain the care plan. These activities include:

- Ensuring services are being furnished in accordance with the member's care plan;
- Making referrals, which includes related activities such as assisting with scheduling follow-up appointments;
- Tracking and following up on all referrals, including referrals to community resources;
- Flagging critical referrals to ensure immediate follow-up on overdue reports (e.g., following up on laboratory and imaging results to determine the need for additional services).
 - Referrals are not complete without timely follow up with the member and/or with the service provider to track the results of the referral
- Communicating with the member, the OB care provider and other individuals instrumental to the member's care and support, to assess the usefulness of key community resources and to ensure the care plan is meeting the member's needs.
- Reviewing and updating the care plan, as necessary, following each health care encounter or home visit.
- Assisting in removing barriers to care, (e.g., offering flexible scheduling and assessing and addressing communication gap between the health care provider and the member.)

OB Medical Home Transition Plan (Transfer of Care)

All members shall remain enrolled and receive services as needed within the OB medical home for sixty (60) days postpartum. Regardless of birth outcome, the medical home provider should do the following to minimize disruption during the transfer of care:

- Engage the member in the transfer of care, to the maximum extent possible.
- Collaborate with the HMO to ensure continuity of care for the mother and newborn following medical home discharge. For example, the medical home could summarize, and share issues related to the need for ongoing support, outstanding test results, community referrals, upcoming appointments, and any unmet needs or concerns from the member's care plan.
- Ensure that each member has a transition plan, as described below.
 - Healthy Birth Outcome - If the member has a healthy birth outcome, the following activities shall take place within the member's sixty (60) day postpartum period:
 - The member shall have at least one (1) postpartum follow-up appointment with the OB care provider that meets all American Congress of Obstetricians and Gynecologists (ACOG) or other applicable postpartum guidelines.
 - Ensure that the member is connected to a PCP and has an appointment as appropriate with a PCP.
 - Ensure that the member has identified a PCP for the newborn and has made an initial appointment.
- The care coordinator shall contact the member's PCP to inform her/him of the birth outcome and any concerns that the OB care provider has regarding the member's and/or child's health postpartum.
- The care coordinator shall educate the member on interconnection care specific to her needs.
 - Poor Birth Outcome - In addition to items listed under healthy birth outcome above, for members who have a poor birth outcome, as defined by the Department, the HMO is responsible for the following:
- Working with the OB medical home site to develop a care plan for the infant and the mother that incorporates input from the mother, the OB care provider, and the PCP and/or pediatrician. The plan shall include the coordination of care with other providers (which may be within the medical home) who are appropriate to provide ongoing services for the mother's and infant's specific needs.
- Conduct follow-up with the mother to ensure that the initial referral appointments with other providers are kept.
- To the extent feasible, maintain ongoing contact with the mother following the birth to ensure the mother and child are receiving appropriate care. HMO responsibility for follow-up ends when the member is no longer enrolled in the HMO.

OB Medical Home Learning Collaborative

In addition to providing comprehensive, quality care, a second goal of the OB Medical Home Initiative is to provide care that meets the unique needs of each member. Prior experience in implementing the Initiative demonstrates the efficacy of OB medical home sites learning from each other. To facilitate this process, the HMOs and clinic sites must identify and/or develop and participate in at least one (1) collaborative learning opportunity per year. Such opportunities must address identified needs of the clinics serving as OB medical homes and the members they serve.

SECTION 11: APPENDIX A - GLOSSARY

Abuse – Provider practices that are inconsistent with generally accepted business or medical practices, and that result in an unnecessary cost to the Medicaid program, or in reimbursement for goods or services that are not medically necessary, or that fail to meet professionally recognized standards for health care.

Advance Directive – A legal document that describes, in writing, a person’s choices about the treatments they want, or do not want, or about how healthcare decisions should be made for when they become incapacitated and cannot express their wishes.

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

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

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

Care Team – See “Interdisciplinary Team.”

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

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

Coordination of Benefits – The process used to determine whether My Choice Wisconsin is the primary or secondary payer on claims submitted on behalf of My Choice Wisconsin members.

Member Incident – A circumstance, event, or condition resulting from action or inaction that is either:

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

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

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

Downstream Entity – Any entity that enters into a written agreement below the level of the arrangement between a sponsor and a first-tier entity for the provision of administrative or health care services for the provision of administrative or healthcare services for a Medicare eligible individual under Medicare Advantage or Part D programs.

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

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

First Tier Entity – Any party that enters into a written agreement with the health plan to provide administrative or healthcare services for the health plan’s enrollees.

Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to her or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.

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

Inpatient Status – A hospital stay longer than 24 hours.

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

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

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

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

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

- Consistent with the symptom(s) or diagnosis and treatment of the illness or injury.
- Furnished for an appropriate duration and frequency and in accordance with accepted medical practice and My Choice Wisconsin Health Plan protocols to treat that illness or injury.
- Not solely for the member's convenience or the convenience of the physician, hospital, or other health care provider.
- The most appropriate service or location for providing such a service that can be safely provided to the member and accomplishes the desired end result in the most economical manner.
- Supported by information contained in the member's medical record and from other relevant sources.
- Services or supplies that meet the following: (1) they are appropriate and necessary for symptoms, diagnosis, or treatment of the medical condition; (2) they are provided for the diagnosis or direct care and treatment of medical conditions; (3) they meet the standards of good medical practice within the medical community in the service area; (4) they are NOT primarily for the convenience of the patient or provider; (5) they are the most appropriate level or supply of service that can safely be provided.

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

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

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

Network Physician – A licensed Doctor of Medicine or osteopathy with which My Choice Wisconsin has an Agreement for Services for the provision of medical services to members.

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

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

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

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

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

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

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

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

Related Entity – Any entity that is related to the health plan by common ownership or control and:

1. Performs some of the sponsor’s management of functions under contract of delegation;
2. Furnishes to Medicare enrollees under an oral or written agreement; or

Leases real property or sells materials to the sponsor at a cost of more than \$2,500 during a contract period.

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

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

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

Waste – Generally, the overuse of services, or other practices that result in unnecessary costs. In most cases, waste is not considered to be caused by reckless actions but rather the misuse of resources.



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