INDEPENDENT CARE HEALTH PLAN

*i*Care is a wholly-owned subsidiary of Humana

Provider Reference Manual

Revised 6/2025

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I. INTRODUCTION

Welcome to the Independent Care Health Plan (Independent Care or *i*Care) Provider Network. The information in this manual and the *i*Care Provider Website (https://www.icarehealthplan.org/Provider.htm) offers information you need for transactions related to *i*Care Medicare and Medicaid members. This information applies to any individual practitioner or entity rendering services to *i*Care Medicare and Medicaid members. For services provided to *i*Care Family Care Partnership members, please also refer to the *i*Care Family Care Partnership Reference Manual located here: https://www.icarehealthplan.org/Provider.htm.

A. COMPANY INFORMATION

*i*Care was formed in 1994 as a joint venture between Humana and Centers for Independence, Inc. (CFI) In 2021, Humana acquired CFI's shares, making *i*Care a wholly owned subsidiary of Humana.

Our plans include:

- SSI Medicaid Plan
- Medicare Advantage Special Needs Plans (SNP)
- BadgerCare Plus Plan (a Medicaid Plan for low-income Wisconsin residents)
- Family Care Partnership Plan (an integrated health and long-term care program for frail elderly and people with disabilities)
- Family Care (a long-term care program for frail elderly and people with disabilities). This programs currently operates under the brand name "Inclusa." For information on this program, please visit: www.Inclusa.org.

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

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

B. CULTURAL COMPETENCY and NON-DISCRIMINATION

Providers are prohibited from discriminating against any *i*Care member on the basis of race, color, national origin, age, disability status, gender identity, or sex. Providers serving *i*Care members are required to be sensitive to cultural diversity including members with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. Providers are required to foster in their staff attitudes and interpersonal communication styles which respect members' individual needs related to their diversity. Provider agrees to comply with all non-discrimination requirements and all applicable affirmative action and civil rights compliance laws and regulations as applicable, including providing *i*Care with a Letter of Assurance, and if the provider has more than 50 employees and receives more than $50,000 in Federal funds, completing and keeping on file a Civil Rights Compliance Plan. For more information, please see https://www.dhs.wisconsin.gov/civilrights/index.htm.

C. INTEGRATED CARE MANAGEMENT MODEL

Through the efforts of integrated Care Management in all of its plans, *i*Care seeks to achieve the following goals:

- Improve healthcare access
- Improve health outcomes and member satisfaction
- Improve communication
- Manage healthcare costs

Independent Care acts as a partner to complement the efforts of its physicians, hospitals and ancillary providers to achieve these goals. The Care Management process at *i*Care consists of the following components:

- Assessment
- Care planning
- Implementation and ongoing evaluation of a care plan
- Coordination of services
- Collaboration with members and providers
- Education

The inter-disciplinary team can consist of Care Coordinators, Care Managers, Community Health Workers, Nurses, and Behavioral Health Specialists depending upon the complexity of the medical, behavioral, and social needs of the members. *i*Care also considers the health care provider as part of the inter-disciplinary care management team and integral to the success of the care plan. The team will contact providers to coordinate care and collaborate on concerns. Likewise, providers are encouraged to contact the team for the same purposes by calling our Customer Service line and requesting to speak to Care Management. If the provider has access to WISHIN, the care management teams' names and phone numbers along with the member's care plan are accessible in the Care Summaries section of the member's record. *i*Care's teams also work with hospital providers and physicians to assist in the discharge planning process to provide a smooth transition of care from one setting to the next.

D. MODEL OF CARE

*i*Care stratifies the entire membership into risk tiers based on utilization, health outcomes, cost and social determinants of health. Members stratified to the emerging risk and high-risk tiers are offered care management services. Regardless of risk, members are encouraged to complete a yearly health risk assessment and certain health measures, contacted after most hospitalization, and educated on how to contact iCare for health system navigation needs or benefit questions.

Care Management services for members stratified as emerging or high risk and who agree to work with the team, include the following:

- Conducting a comprehensive assessment to identify members' medical, behavioral and social determinants of health needs
- Creating a dynamic care plan with the member that addresses and prioritizes their needs and goals
- Monitoring member progress toward goals
- Identifying resources to meet member needs
- Coordinating service provision with providers and members
- Assisting members with accessing services
- Working with members to promote behavioral change and self-empowerment to achieve improved quality of life
- Monitoring hospital experiences for treatment progress and appropriate discharge planning
- Coordinating provision of appropriate care following acute care episodes
- Facilitating provision of services along the continuum of care needs
- Engaging members in health promotion through education about resource utilization, disease management and self-care
- Monitoring service provision for quality of care

Implementing Quality Improvement Initiatives Ultimately, the *i*Care Care Management process supports patient adherence with treatment plans, which can be a challenge when working with special needs populations. *i*Care serves as a resource for both members and providers by addressing those factors, in addition to clinical care, that impact health such as social concerns and lifestyle change.

With *i*Care, providers have extra tools and support to ensure something as simple as members consistently attending appointments or as complex as providing multi-disciplinary support in a comprehensive treatment plan.

A further description of the Model of Care for each *i*Care plan is available as a webinar on the *i*Care Provider Website (https://www.icarehealthplan.org/Education/Care-Management.htm). Please use the educational webinars annually for any new staff and refresh your knowledge of the Model of Care for your practice.

E. GENERAL CONTACT INFORMATION

Main Number / Customer Service	**Local: 414-223-4847** **Toll-free: 800-777-4376**
Claims, Appeals and Reconsiderations	**Local: 414-231-1029** **Fax: 414-231-1094** **Out of Area: 877-333-6820**
Eligibility and Provider Services	**Local: 414-231-1029** **Fax: 414-231-1094** **Out of Area: 877-333-6820**
Inpatient Admissions Notification	**Local: 414-225-4760** **Fax: 414-231-1075**
Member Advocate/Member Rights Specialist	**Local: 414-231-1076** **Fax: 414-231-1090**
Medicare Pharmacy Benefits Management (MedImpact)	**Toll-free: 1-800-910-4743** **Fax: 414-231-1092**
Prior Authorization and Referrals	**Fax: 414-231-1026** **Local: 414-299-5539** **Toll-free: 1-855-839-1032**
Provider Services and Eligibility	**Local: 414-231-1029** **Fax: 414-231-1094** **Out of Area: 877-333-6820**

II. MEMBER ELIGIBILITY

A. MEDICAID PLAN ELIGIBILITY CRITERIA

To enroll in the *i*Care Medicaid Program, SSI or BadgerCare Plus, recipients must:

- Be a resident of a county in the *i*Care Medicaid service area. Note that in any particular county, *i*Care may be certified for BadgerCare Plus, Medicaid SSI, or both
- Medicaid SSI: Meet the Supplemental Security Income (SSI) and SSI-related disability criteria as defined by the State of Wisconsin Medicaid program. More information about Medicaid SSI eligibility can be found here: http://www.emhandbooks.wisconsin.gov/meh-ebd/meh.htm
- BadgerCare Plus: Meet the BadgerCare Plus eligibility criteria established by the

State of Wisconsin. More information about BadgerCare Plus eligibility can be found here: http://www.emhandbooks.wisconsin.gov/bcplus/bcplus.htm

- Be living in the community
- Not living in an institution
- Not living in a nursing home
- Not participating in a Home and Community Based (HCBW) Waiver program

Only certified Wisconsin Medical Assistance (MA) providers are allowed to provide services to *i*Care Medicaid and BadgerCare Plus members. Providers are expected to verify member eligibility each time services are provided. For various reasons, Medicaid eligibility can change at any time.

Eligibility is administered by the State of Wisconsin and Medicaid/BadgerCare Plus members are issued a ForwardHealth ID card (see below) for member eligibility verification:

ForwardHealth ID CARD

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

The front of the card displays the member name, member Medicaid ID number and a unique sixteen (16) digit card number. To determine enrollment for the current date (since a member's enrollment status may change) and to discover any limitations to the member's coverage, providers are expected to verify member eligibility at every visit. Enrollment verification provided by ForwardHealth allows providers to:

- Verify member's enrollment in a ForwardHealth program(s)
- Verify the MCO enrollment
- Identify other coverage such as Medicare or commercial health insurance coverage
- Identify any exemption from copayment for BadgerCare Plus members

Providers can access the Wisconsin Enrollment Verification System (EVS) through the ForwardHealth Portal, WiCall, commercial enrollment verification vendors or by calling ForwardHealth Provider Services at 800-947-9627

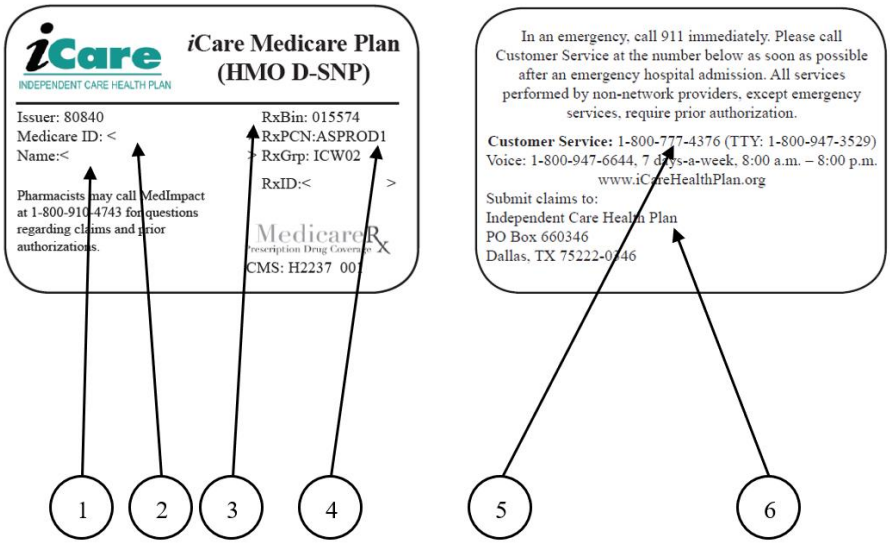
B. MEDICARE PLAN ELIGIBILITY CRITERIA

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

- Must live in *i*Care's service area
- Must have Medicare Part A and B
- Must NOT have End-Stage Renal Disease (some exceptions may apply)
- Must be dual eligible with Medicaid and Medicare coverage

*i*Care Medicare members may have Medicaid coverage from *i*Care, any other Medicaid MCO, or Fee for Service Medicaid. Information regarding tools for verification of Medicare eligibility can be found at: https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/Eligibility.html

*i*CARE MEDICARE ID CARD



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

III. INDEPENDENT CARE HEALTH PLAN BENEFITS

A. MEDICAID/BADGERCARE PLUS PLAN BENEFITS

The *i*Care Program provides the same medically necessary services as the Wisconsin Medical Assistance Program (WMAP) except for chiropractic care (which is covered under the Fee for Service (FFS) program). Refer to the Wisconsin Medical Assistance Program (WMAP) handbook for specific details of covered benefits. The handbook is

available on the Wisconsin Department of Health Services website: http://www.dhs.wisconsin.gov/medicaid/INDEX.HTM

Members are required to obtain most services from *i*Care's contracted in-network providers. These services include, but are not limited to, the following:

- Durable medical equipment and supplies
- Home nursing services (skilled nursing and personal care)
- Outpatient therapy services (PT, OT and speech therapy)
- Vision hardware
- Dental
- Second opinions

The Wisconsin Department of Health Services has contracted with Veyo to provide non-emergency medical transportation (NEMT) services to Medicaid and Badger Care members. Veyo works closely with healthcare providers to ensure members receive the most appropriate and cost-effective mode of transportation to Medicaid and Badger Care appointments. Healthcare providers can contact Veyo to help facilitate NEMT services for members. The MTM reservation phone number is 1-866-907-1493 (or TYY 71). More information about NEMT is available at https://www.dhs.wisconsin.gov/nemt/index.htm

A Summary of *i*Care Medicaid SSI Benefits is also available on *i*Care's web page: http://www.icarehealthplan.org/Plans/Medicaid/SSIBenefits.aspx

A summary of *i*Care BadgerCare Plus Benefits is also available on iCare's web page: https://www.icarehealthplan.org/Members/Plans-Benefits/BCPLUS.htm

Certified Wisconsin Medicaid providers who are contracted with *i*Care for its Medicaid Plans are required to provide services to all *i*Care members who present a valid Forward Card issued by the state.

B. MEDICARE PLAN BENEFITS

*i*Care Medicare Plan (HMO D-SNP) is a Medicare Advantage program that offers healthcare benefits for all eligible Medicare beneficiaries with special needs. This plan is available to anyone who has both Medical Assistance from the state and Medicare.

Members are required to obtain most services from *i*Care contracted in-network providers. These services include, but are not limited to, the following:

- Durable medical equipment and supplies
- Home nursing services (skilled nursing and personal care)
- Outpatient therapy services (PT, OT and speech therapy)
- Second opinions

A Summary of *i*Care Medicare Benefits, including plan documents, is available on our website.

C. SUPPLEMENTAL MEDICARE BENEFITS

*i*Care offers additional benefits called Medicare Supplemental Benefits (MSB). MSBs are added benefits above what Original Medicare covers. MSBs may change from year to year. iCare Medicare Plan (icarehealthplan.org)

D. OUT OF AREA SERVICES: URGENT AND EMERGENCY

If an emergency occurs outside the member's service area, the member should go to the nearest facility.

An urgent medical situation is one that may require medical care but does not satisfy the emergency criteria. When in the area, members may contact their physician before requesting urgent care.

If out-of-area urgent care services or emergency services are required, members may notify their Care Coordinator or Care Manager within twenty-four (24) hours of receiving the services at:

- 414-223-4847
- 800-777-4376
- TTY 800-947-3529/Voice 800-947-6444

IV. HEALTH EDUCATION, PREVENTION AND DISEASE MANAGEMENT PROGRAMS

The purpose of *i*Care's health education program is to improve the health and well-being of members through multifaceted outreach and education strategies. Independent Care supports health promotion programs to assist members in developing healthy lifestyles.
Providers may refer patients to any of the following programs by contacting the Customer Service Department (**1-800-777-4376)** and requesting a referral to care management programs.

Programs include:

- Vaccinations – Flu, pneumonia, COVID and childhood immunization programs

Well Child Visits *i*Care Medicaid members under age twenty-one (21) (includes SSI and BadgerCare)

- Behavioral Health Programs
- Complex Chronic Conditions Program
- Mom/Baby Program

A. FLU, COVID AND PNEUMOCOCCAL VACCINES

Each year, eligible *i*Care members can receive a flu, COVID, or pneumonia vaccine from their physician or another healthcare professional. *i*Care encourages physicians and other healthcare professionals to provide these vaccinations to *i*Care members. Providers may encourage members to receive these vaccinations during a scheduled visit, encourage members to call 211 or contact *i*Care for another convenient location to receive vaccines. To support providers in this effort and to close the gap on vaccine coverage, *i*Care will provide providers a list of attributed patients who have not yet received their flu vaccinations, upon request.

B. Well Child Visits / HEALTHCHECK PROGRAM

The purpose of Health Check or Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is to ensure that children receive early detection and care, so that health problems are prevented or diagnosed and treated as early as possible. HealthCheck is the term used for EPSDT in Wisconsin for children up to 21 years of age.

The HealthCheck exam includes:

- Comprehensive health history
- Nutritional assessment
- Health education/anticipatory guidelines
- Developmental behavioral assessment
- Physical exam and physical growth assessment
- Sexual development
- Age-appropriate vision screen
- Age-appropriate hearing screen
- Oral assessment and evaluation services plus direct referral to a dentist
- Appropriate immunizations
- Appropriate laboratory test

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

HealthCheck CPT Modifiers

Modifier	Description	Allowable procedure codes	Allowable providers
UA *	Comprehensive HealthCheck screen results in a referral or follow up visit for diagnostic or corrective treatment	99381-99385 and 99391-99395	All HealthCheck providers, including HealthCheck nursing agencies.

EP	Service provided as part of [follow-up to] Medicaid early periodic screening diagnosis and treatment (EPSDT)	99211-99215, T1002, T1029, T1017, and T1016	HealthCheck nursing agencies only
TS	Follow-up service [for lead inspection]	T1029	HealthCheck nursing agencies only

*Modifier "UA" is a national modifier that is defined by Wisconsin Medicaid.

C. BEHAVIORAL HEALTH PROGRAM

Quality and timely follow up with a mental health provider after hospitalization supports the member's success in managing their mental illness and lowers the risk of a readmission. Each member who has a hospital admission with a primary diagnosis of a mental illness or intentional self-harm will receive a follow up call from our trained care coordination staff. The member is offered supportive case management services and assisted with obtaining the appropriate follow up care. If the member agrees to the program, the team outreaches to their established providers to coordinate care as needed. If the member has no established providers, the team will assist in the appropriate referrals.

D. COMPLEX CHRONIC CONDITIONS

Members with co-occurring behavioral health and medical conditions are at increased risk for poor health outcomes and premature death. Proper management and good quality of life requires management of a complex set of symptoms, self-management techniques, provider networks and medications. The complexity can be overwhelming. We offer case management services to those members with the highest needs and would like support. Our interdisciplinary case management team is made up of social workers, nurses, and community health work collaboratively with the member to assess their needs, establish their priorities, set goals and work to overcome barriers. The team outreaches to the member's providers and formal supports to ensure a unified plan of care.

The Wisconsin Interdisciplinary Care Team (WICT) provides intensive case management services for Medicaid members who have complex medical, behavioral and social needs which are exacerbated by gaps in care, support and services, The interdisciplinary team includes case managers, nurses, and Community Health Workers who are supported by staff with expertise in trauma, mental illness and substance use disorders. The team works to engage the member and the member's support system to create a mutual plan to stabilize the member's health and create a course for improved health outcomes.

E. MOM/BABY PROGRAM

Maternal health is crucial for the well-being of the member and their new baby. As early

in pregnancy as possible, outreach is attempted to pregnant members in our Medicaid population by our Mom/Baby team to assess for medical, social, behavioral, and educational concerns. If needs are identified, members are offered enrollment into our Mom/Baby Program where they will receive case management services to address those needs. Case Management extends through the post-partum period. Case management includes referrals to OB/GYNs, pediatricians, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), baby supplies, parenting supports. The program also refers and coordinates with the Prenatal Care Coordination Program, a Medicaid Fee for Service program for pregnant persons, without duplicating services. If the member agrees to the program, the team will outreach to their established providers to coordinate care or make referrals where needed.

V. CUSTOMER SERVICE

The *i*Care Customer Service Department is available to assist members in contacting their Care coordinator, answer questions about claim submissions or payment and respond to language interpretation requests. Please call Customer Service (414-231-1029 or toll free: 1-877-333-6820) and have the member's ID number available.

VI. LANGUAGE INTERPRETATION SERVICES FOR LIMITED ENGLISH PROFICIENCY (LEP) MEMBERS

Under Title VI of the U.S. Civil Rights Law, all healthcare programs and activities that receive federal financial assistance from the U.S. Department of Health and Human Services (e.g., hospitals, healthcare clinics, physician's practices, community health centers, nursing homes, and rehabilitation centers) are required to take reasonable steps to provide meaningful access to each individual with limited English proficiency served or likely to be encountered in its health programs and activities. Reasonable steps may include the provision of language assistance services such as oral language assistance or written translations. Facilities must offer a qualified interpreter when oral interpretation is a reasonable step to provide an individual with meaningful access. Where language services are required, the service must be provided free of charge and in a timely manner. Entities may not require an individual to provide his or her own interpreter.

Independent Care also provides Interpreter/Translator Agency services and coordinates with providers to assure services are available to meet member needs and protect member rights.

If a healthcare provider determines an interpreter is needed, please call 414-231-1029 (or toll free: 1-877-333-6820) and include the following information:

- Name of member
- *i*Care member ID number
- Date of appointment including length of visit
- Language being requested
- Healthcare provider contact (name, address, suite number and phone number)
- Contact name and phone number of person at the healthcare provider

Once an interpreter is identified for the appointment, the interpreter/translator agency will provide the name of the interpreter to *i*Care Provider Services. *i*Care will in turn provide confirmation to the healthcare provider including the name and contact information for the agency and interpreter. If an interpreter is not available, notice is provided by phone or e-mail to the requester.

The Translator/Interpreter Payment form is sent to the agency by *i*Care Provider Service. The interpreter takes this form to the appointment and requests the form be completed by the healthcare provider. Essential information must include the date, time of the service and name (printed and signed) of staff and interpreter/translator agency completing the form. The interpreter/translator agency submits the invoice(s) and signed payment form to *i*Care:

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

If an America Sign Language interpreter is needed, please send the request five (5) to seven (7) business days prior to the appointment. For other languages, please make requests at least three (3) business days prior to the appointment. Please notify *i*Care Customer Service of any cancellation twenty-four (24) hours prior to the appointment or as soon as possible.

VII. PHARMACY SERVICES

A. GENERAL PHARMACY BENEFITS FOR *i*CARE MEDICAID

Wisconsin Medicaid Fee-for-Service (FFS) administers the pharmacy benefit for members enrolled in *i*Care Medicaid SSI, Family Care Partnership SSI and BadgerCare Plus. Please contact Wisconsin Medicaid FFS (DHS Member Services: 1-800-362-3002) for information regarding the coverage of medications for these members.

B. GENERAL PHARMACY BENEFITS FOR *i*CARE MEDICARE

Prescription drug claims are administered through MedImpact HealthCare Systems, Inc. Point of Service online prescription processing is preferred. Pharmacies are expected to process claims at the time of dispensing. Claims exceeding ninety (90) days from the date of dispensing are rejected by the online processing system.

Compounded prescription claims exceeding $25 in non-covered Part D ingredients are rejected at point of sale. Compounded prescriptions must contain at least one Part D covered drug to qualify for coverage. Pharmacies should call MedImpact (1-800-910-4743) for assistance with claims exceeding these amounts.

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

Prior Authorizations for the *i*Care Medicare Pharmacy Benefit are processed by MedImpact. Providers may call MedImpact for additional information or to request a Medicare Part D Coverage Determination Request Form (1-800-910-4743). Online submission of prior authorizations can be found at https://www.icarehealthplan.org/Education/Providers/Drug-Coverage-Info.htm

For questions regarding eligibility and benefit coverage, *i*Care's Customer Services is available:

Monday-Friday: 8:30 am- 5:00 pm
414-223-4847 or 1-800-777-4376

If calling outside normal business hours, *i*Care's Pharmacy Services is automatically forwarded to MedImpact for assistance.

C. DRUGS COVERED BY *i*CARE MEDICARE

Independent Care's Medicare plans utilize a formulary approved by the Centers for Medicare and Medicaid Services (CMS), which includes both brand and generic Part D medications. The formulary may change slightly during the year as new drugs become available or new information is released regarding drug safety or efficacy.

In most cases, CMS requires that *i*Care notify all authorized prescribers and pharmacists sixty (60) days prior to removing a covered Part D drug from the formulary or changing the preferred status of a covered Part D drug. You may access the most current list of *i*Care Medicare covered drugs (including the sixty (60) Day Notice of Formulary Changes) on the *i*Care website (http://www.icarehealthplan.org/Providers/DrugCoverage.aspx).

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

Prior Authorization (PA): A prior authorization is required on certain drugs before they are covered. A Medicare Part D Coverage Determination Request Form (http://www.icarehealthplan.org/Providers/DrugCoverage.aspx) can be faxed to MedImpact at 858- 790-7100 or online submission of prior authorizations can be found at https://www.icarehealthplan.org/Education/Providers/Drug-Coverage-Info.htm

Step Therapy (ST): In some cases, a member is required to try one drug to treat a medical condition before another drug for that condition is covered.

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

encourage cost effective utilization and safety.

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

D. EXCEPTIONS TO *i*CARE MEDICARE COVERAGE LIMITS

When the medications on the *i*Care formulary used to treat specific conditions are not appropriate for a member, a provider may request coverage of a non-formulary Part D medication. This type of request is called a Formulary Exception. An exception may also be requested to the Step Therapy or Quantity Limit Restrictions. A Medicare Part D Coverage Determination Request Form ((http://www.icarehealthplan.org/Providers/DrugCoverage.aspx) can be faxed to MedImpact: 858-790-7100 or online submission of prior authorizations can be found at https://www.icarehealthplan.org/Education/Providers/Drug-Coverage-Info.htm.

Supporting medical information must be submitted with any exception request. Standard Coverage Determinations are completed within seventy-two (72) hours. If waiting for the standard time frame may seriously harm the health of the member or their ability to function, request an Expedited Coverage Determination. Expedited Coverage Determinations are completed within twenty-four (24) hours.

E. TRANSITION POLICY FOR *i*CARE MEDICARE

New members to the *i*Care plan may be taking medications that are not on the *i*Care formulary or that are subject to certain restrictions such as Prior Authorization or Step Therapy. During the first ninety (90) days of enrollment with *i*Care Medicare, *i*Care provides a temporary thirty (30) day supply of a Part D medication to allow the member time to talk with the prescribing physician regarding the right course of action. The prescribing provider can either switch the patient to a different covered drug covered by *i*Care or ask *i*Care for a prior authorization or an exception to cover the current drug.

For members residing in a long-term care facility, *i*Care provides up to a thirty-one (31) day supply of medication during the first ninety (90) days of enrollment with *i*Care Medicare. For residents of a long-term care facility, *i*Care allows a one-time emergency thirty-one (31) day supply of a medication when the member is past the first ninety (90) days of enrollment with *i*Care Medicare.

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

therapy restriction is added from one contract year to the next.

After covering the temporary supply, *i*Care generally does not cover these medications again without Prior Authorization. For more detailed information, please see the *i*Care Transition Process: http://www.icarehealthplan.org/Providers/DrugCoverage.aspx.

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

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

G. MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM

CMS requires each Medicare plan that offers prescription drug coverage to have a Medication Therapy Program (MTMP). At the request of CMS, the program targets members who have multiple chronic diseases, are taking multiple Part D covered drugs and have high drug costs. CMS hopes these programs help ensure optimum therapeutic outcomes for the targeted members through improved medication use and reduction in adverse medication events. myMTMcare is the partner selected by to administer our MTMP program.

Through myMTMcare, specially trained personal pharmacists are trained to deliver services telephonically.

These pharmacists are qualified to help members get the best results from their medication while keeping out-of-pocket costs down. All *i*Care members in one of our Medicare plans are eligible for MTM services at no additional cost. Members may be contacted by phone to receive MTM services. MTM services include an annual comprehensive medication review and quarterly targeted medication reviews. Any issues identified during these telephonic interactions may require the pharmacy to contact the prescriber for a resolution.

The criteria for eligibility changes from year to year. Please call *i*Care Customer Service with any questions regarding the program.

H. PROFESSIONALLY ADMINISTERED MEDICATIONS

Some Part B “buy and bill” and specialty medications billed to iCare as an institutional or facility claim require prior authorization through iCare’s Prior Authorization Department. See VIII. MEDICAL MANAGEMENT below.

VIII. MEDICAL MANAGEMENT

A. PRIOR AUTHORIZATION (PA) REQUIREMENTS

In an increasingly complex healthcare environment, *i*Care is committed to offering solutions that help healthcare professionals save time and serve their patients. The prior authorization process is in place to ensure *i*Care members receive the appropriate level of care and to mitigate potential fraud, waste, and abuse. All Prior Authorization and Notification forms can be found at the *i*Care Provider Website: https://www.icarehealthplan.org/Prior-Authorization.htm.

Please note that prior authorization does not guarantee payment.

Services requiring a prior authorization include, but are not limited to:

- Admission to an inpatient medical or behavioral health hospital
- Admission to a subacute facility (e.g., Inpatient Rehab Facility, Long Term Acute Care Hospital and Skilled Nursing Facility)
- Behavioral Health Day Treatment programs, such as Partial Hospitalization and Intensive Outpatient Programs.
- Select professionally-administered specialty medications billed to *i*Care on an institutional claim, and not included on ForwardHealth's Physician Administered Drugs Carve Out Procedure Codes. For an list of all specialty medication HCPCS codes requiring prior authorization, refer to *i*Care's Prior Authorization List (PAL).
- Durable Medical Equipment: refer to *i*Care's Prior Authorization List (PAL) for an inclusive list of CPT/HCPCS codes requiring prior authorization https://www.icarehealthplan.org/Prior-Authorization.htm
- Home healthcare services, including skilled nursing, therapy, and Personal Care Worker (PCW) services.
- Hospice
- Non-Medicaid certified Providers (all services other than emergency services)
- Referrals for second or additional opinions
- Select procedures: refer to *i*Care's Prior Authorization List (PAL) for an inclusive list of CPT/HCPCS codes requiring prior authorization https://www.icarehealthplan.org/Prior-Authorization.htm
- All non-emergent out of state service including referrals
- Outpatient physical, occupational, and speech therapy
- Transplants
- Urine drug screen (presumptive and definitive)

Please note that supporting clinical documentation is required for all prior authorization requests in order to determine medical necessity. Incomplete prior authorization requests may delay processing. *i*Care does not authorize services rendered prior to the

determination of a prior authorization. For detailed procedure code specific information regarding services, procedures, and devices that require prior authorization, please reference *i*Care's Prior Authorization List (PAL) : https://www.icarehealthplan.org/Prior-Authorization.htm

1. PRIOR AUTHORIZATION (PA) FORMS

Upon receipt, urgent prior authorization requests are processed within seventy-two (72) hours, or twenty-four (24) hours for a medication request. "Urgent" is defined as situations when the treatment requested is required to prevent imminent, serious deterioration in the member's health, and delaying treatment would jeopardize the member's ability to regain maximum function. *i*Care reserves the right to deny the request for urgent review outside of this definition. Standard requests are processed within fourteen (14) calendar days, or seventy-two (72) hours for a medication request. Requests for court-ordered services are processed within five (5) calendar days.

To request services that require prior authorization, please complete and fax the appropriate form along with clinical documentation supporting medical necessity to 414-231-1026. All Prior Authorization Forms can be found at the *i*Care Prior Authorization Website: https://www.icarehealthplan.org/Prior-Authorization.htm

For all outpatient requests, please provide the name and information for the ordering practitioner, as well as the information for the servicing provider.
*i*Care reviews requests for admissions, services, and procedures for medical necessity, based on federal and state statues, current standards of medical practice, and *i*Care medical policies. Providers may contact the Prior Authorization Department at 414-299-5536 or 855-839-1032 to request a copy of the clinical criteria used to review a particular service or procedure.

2. PEER TO PEER CONSULTATIONS

The ordering physician or practitioner has the opportunity to discuss an authorization determination with an *i*Care Medical Director within 5 business days from the date of the determination letter. Instructions on how to schedule a peer-to-peer consultation are included on every partial approval or denial letter.

3. HOSPITAL ADMISSION AUTHORIZATION

As part of our commitment to medical management, *i*Care requires that all hospitals notify *i*Care within twenty-four (24) hours (next business day) following an inpatient admission (emergent or elective) or observation admission. *i*Care will review all medical admissions concurrently with the hospital stay. The Inpatient Admission Form can be found here: https://www.icarehealthplan.org/Prior-Authorization.htm

4. BEHAVIORAL HEALTH AUTHORIZATION

Inpatient Mental Health and Alcohol and Other Drug Abuse (AODA) treatment services and day treatment services (Partial Hospitalization and Intensive Outpatient programs) require prior authorization. *i*Care will review all inpatient behavioral health, AODA, and day treatment program admissions concurrently with the admission or program duration. Refer to the Prior Authorization List (PAL) for an inclusive list of CPT/HCPCS codes requiring prior authorization and please use the provided authorization forms provided on our website: https://www.icarehealthplan.org/Prior-Authorization.htm.

For any questions regarding Behavioral Health Authorization/notification, please call 855-839-1032

5. SUB-ACUTE FACILITIES PRIOR AUTHORIZATION

All sub-acute facility (e.g., skilled nursing facility, inpatient rehab facility, and long-term acute care hospital) admissions require prior authorization. *i*Care completes concurrent reviews on all sub-acute prior authorization requests for admissions and therapies not included in a Medicare Part A stay. All prior authorization requests and clinical documentation supporting medical necessity must be faxed to *i*Care at 414-231-1026 and approved prior to the member's admission to the facility (see Prior Authorization Subacute Request Form https://www.icarehealthplan.org/Provider-Documents.htm).

6. HOME HEALTH AND PERSONAL CARE WORKER SERVICE PRIOR AUTHORIZATION

- PA requests for home health and personal care services are only approved for *i*Care contracted in-network providers (an exception may be granted by the Medical Director).
- In order to ensure that *i*Care members are receiving the appropriate level of care, personal care worker (PCW) prior authorization requests may not be determined until a new or updated independent assessment is completed. *i*Care reserves the right to not authorize any services rendered prior to the date of the independent assessment.
- All PA requests for home health services must include a signed physician order, plan of care and the initial in-home evaluation.
- All PA requests for home health services must be submitted to *i*Care within fourteen (14) calendar days from the start of care. *i*Care will not authorize services submitted after the fourteenth (14) day.
- All PA requests for ongoing services are required to be submitted within seven (7) days after the expiration date of previous authorization. *i*Care will not authorize services submitted after the seventh (7) day.
- All late PA requests for home health services are reviewed for medical necessity starting from the date requests are received by *i*Care.
- Personal Care agencies and Home Health Care Services are required to meet

all Electronic Visit Verification (EVV) requirements as outlined in the ForwardHealth Policy published on the ForwardHealth website in accordance with Section 12006(a) of the federal 21st Century Cures Act.

- *i*Care does not require EVV for live-in caregivers, however:
    - The agency must indicate PCW's residence status on the PCW Prior Authorization Request Form.
    - Provider must supply a completed Electronic Visit Verification Live-In Worker Identification form, F-02717 at the time of authorization for all live-in workers. Failure to submit required documentation will result in a denial of authorization for a live-in worker.
    - Personal Care agencies must verify live-in workers' permanent residency based on the ForwardHealth criteria for live-in workers at least annually. The agency is required to retain all documentation supporting the determination of live-in worker status. Supporting documentation must be submitted to *i*Care upon request.
    - Once a PA for a live-in worker is approved, claims for services provided by a live-in worker must include the modifier KX. Using the modifier KX will prevent the claim from denying due to lack of EVV data.
- Requests for Home Health services should be submitted on *i*Care's standard prior authorization form (https://www.icarehealthplan.org/Prior-Authorization.htm), while PCW requests should be submitted using the Personal Care Screening Tool and Personal Care Worker Fillable Form (https://www.icarehealthplan.org/Prior-Authorization.htm).

7. OUTPATIENT THERAPY (PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH LANGUAGE THERAPY)

- PA requests for outpatient therapy are only approved for *i*Care contracted in-network providers (exception may be granted by the Medical Director).
- Prior Authorization is required for all outpatient therapy services including physical therapy (PT), occupational therapy (OT) and speech and language therapy (SLP). Comprehensive information about members helps establish the functional potential of the member and helps determine if members will benefit from the requested services. Please submit the Prior Authorization Request Form (https://www.icarehealthplan.org/Prior-Authorization.htm) along with the billed CPT codes, complete therapy evaluation, plan of care and signed physician prescription to determine if the service is medically necessary.
- Outpatient therapy is authorized based on medical necessity. Services that are medically necessary are defined under Wis. Admin. Code § DHS 101.03(96m). The provider is responsible to assure the services provided are covered under the Medicare or Medicaid benefit.
- An approved PA request is backdated to the initial date of the evaluation (if the PA request is received within fourteen (14) calendar days of the initial therapy evaluation). Requests submitted beyond the fourteen (14) calendar

days of the initial evaluation are not authorized by *i*Care.

- Continuing therapy may be requested when a member's need for therapy services is expected to exceed the maximum allowable treatment days authorized.
- Prior authorization must be obtained for continuing therapy. PA requests for ongoing therapy are not backdated. To request additional visits, please submit the completed Prior Authorization Request Form (https://www.icarehealthplan.org/Prior-Authorization.htm) attached with clinical documentation supporting medical necessity for ongoing therapy services.
- PA requests are approved for varying periods of time based on the clinical justification submitted. Providers will receive a copy of the PA decision notice when a PA request for a service is approved. Providers may then begin providing the approved service on the start date given. Approved request means that the requested service, not necessarily by code was approved. Providers are encouraged to review approved PA requests confirming the services authorized and assigned start and end dates.

8. URINE DRUG SCREENS (PRESUMPTIVE AND DEFINITIVE)

Testing for presumptive and definitive Drugs of Abuse requires a prior authorization request. The following supporting clinical documentation is required:

- Limited to relevant medical history, physical examination, risk assessment and results of pertinent diagnostic procedures.
- A signed and dated member-specific order for each drug test. This order must provide sufficient information to substantiate each testing panel component performed. Standing orders, custom profiles and orders to conduct additional testing (as needed) are insufficient and cannot be used to verify medical necessity.
- Rationale for ordering a definitive drug test for each drug class tested
- If a direct-to-definitive drug test is ordered, documentation supporting the inadequacy of presumptive drug testing is necessary.

Independent Care authorizes testing for Drugs of Abuse using the PA-Testing for Drugs of Abuse guidelines found at https://www.icarehealthplan.org/Provider-Documents.htm

9. OUT OF AREA SERVICES

If an emergency occurs outside the member’s service area, members should go to the nearest facility. Members must notify *i*Care within twenty-four (24) hours of the service. Routine services performed out-of-network are subject to *i*Care prior authorization rules and guidelines. Prior Authorization is required for non-urgent services provided by out of area providers. To request Prior Authorization for an out of area referral, submit the Prior Authorization Request Form (

https://www.icarehealthplan.org/Prior-Authorization.htm) as well as clinical documentation supporting the medical necessity for the performed services.

10. SECOND OPINION

Upon member request, second opinions are available from qualified in-network providers subject to prior authorization review and approval. If a qualified in-network provider is not available, *i*Care may authorize a second opinion out-of-network at no charge to the allowable copayment. Please submit the Prior Authorization Request Form (https://www.icarehealthplan.org/Prior-Authorization.htm) as well as clinical documentation supporting the medical necessity for the requested service.

B. OTHER REQUIRED DOCUMENTATION

1. ABORTION

When submitting a claim to ForwardHealth, physicians are required to attach or upload via the ForwardHealth Portal a completed and signed certification statement attesting to one of the previous circumstances. The optional Abortion Certification Statements form is available to use in this situation. Providers may develop a form of their own, as long as it includes the same information.

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

2. HYSTERECTOMY

Except in the situations noted below, an Acknowledgement of Receipt of Hysterectomy Information must be completed prior to the surgery and attached to a paper claim form.) Providers may develop their own form as long as it includes all of the same information as found on Wisconsin Medicaid's form.

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

- The recipient was already sterile
  - May include menopause (physicians are required to state the cause of sterility in the recipient's medical record)

- The hysterectomy was required as the result of a life-threatening emergency situation, in which the physician may determine that a prior acknowledgement of receipt of hysterectomy information was not possible (physicians are required to describe the nature of the emergency).

- The hysterectomy was performed during a period of retroactive recipient eligibility and one of the following circumstances applied:

  - The recipient was informed before the surgery that the procedure would make her permanently incapable of reproducing.
  - The recipient was already sterile.
  - The recipient was in a life-threatening emergency situation which required a hysterectomy.

For all of the exceptions above, physicians must identify in writing the applicable circumstance and attach the signed and dated documentation to the paper claim. A copy of the preoperative history, physical exam and operative report is usually sufficient.

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

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

3. STERILIZATION

Independent Care reimbursement for sterilizations is dependent on providers fulfilling all federal and state requirements (cited below) and satisfactory completion of a Sterilization Informed Consent Form HCF 1164.

Use the following link to access instructions and fillable form:
http://dhs.wisconsin.gov/forms/F0/F01164A.pdf.
There are no exceptions. Federal and state regulations require the following:

- The recipient is not institutionalized.
- The recipient is at least twenty-one (21) years old on the date the informed written consent is obtained.
- The recipient gives voluntary informed written consent for sterilization.
- The recipient is not mentally incompetent (Wisconsin Medicaid defines a

"mentally incompetent" individual as a person who is declared mentally incompetent by a federal, state or local court of competent jurisdiction for any purposes, unless the individual has been declared competent for purposes that include the ability to consent to sterilization).

At least thirty (30) days, excluding the consent and surgery dates, but not more than one-hundred and eighty (180) days, must pass between the date of written consent and the sterilization date, except in the case of premature delivery or emergency abdominal surgery if:

- Sterilization is performed at the time of premature delivery.
- Written informed consent was given at least thirty (30) days before the expected end date of delivery and at least seventy-two (72) hours before the premature delivery.
- The thirty (30) days exclude the consent and surgery dates.
- Sterilization is performed during emergency abdominal surgery and at least seventy-two (72) hours have passed since the member gave written informed consent for sterilization.
- The member must give voluntary provide written consent on the federally required Sterilization Informed Consent Form: http://dhs.wisconsin.gov/forms/F0/F01164A.pdf.
- Sterilization coverage requires accurate and thorough completion of the consent form.
- Physicians are responsible for obtaining consent. Any corrections to the form must be signed by the physician and/or recipient.
- Signatures and signature dates of the recipient, physician and the person obtaining the consent are mandatory.
- Provider failure to comply with any of the sterilization requirements results in denial of the sterilization claims.
- To ensure reimbursement for sterilizations, providers are urged to use the Sterilization Informed Consent Form before all sterilizations (e.g., Medicaid and non-Medicaid recipients) in the event that the patient obtains Medicaid retroactive eligibility.
- Physicians must attach the completed consent form to a paper claim form to obtain reimbursement.

C. DISCHARGE PLANNING

Discharge planning is a multidisciplinary process to facilitate a member's transition between healthcare settings. Discharge planning promotes the appropriate level of care and services needed to foster as much independence as possible.

The Prior Authorization Department, in conjunction with the medical or behavioral health nurse care managers (RNCM), performs discharge planning for all acute hospitalizations and assists in the prior authorization process for transitions to subacute facilities, inpatient rehab and long-term acute care facilities. Proactive discharge planning

beginning before the hospital admission or during the initial review facilitates continuity of care and timely development of a discharge plan to coordinate services. RNCM's revise and update the care plan to reflect the member's transition of care.

D. PREVENTIVE HEALTH GUIDELINE

All Clinical Practice Guidelines recommended by iCare are based on national medical association and health organization recommendations. The information provided in this policy applies to all providers of care to iCare members and is reviewed annually and updated no less than every two years, or as national guidelines change.
A Clinical Practice Guideline (CPG) is created by national medical associations and/or health organizations for the explicit purpose of disseminating peer-reviewed, evidence-based practice recommendations to enhance the quality and consistency of care delivered to all patients, regardless of payor source. The CPGs guide decisions and provide criteria regarding diagnosis, management, and treatment in specific areas of healthcare based on published evidenced-based medical literature. The CPGs reflect current evidence in the literature for large groups of individuals with specific health diagnoses; The licensed and boarded practitioner is encouraged to practice patient-centered care, developing care plans with each individual patient's needs and conditions in mind, utilizing medical justifications for exceptions when deviating from the CPGs, based on the provider's expertise and clinical judgment.

*i*Care publishes medical guidelines from several well-respected national sources. These guidelines may have some differences in recommendations. Information contained in the guidelines is not a substitute for a physician's or other healthcare professional's clinical judgment and is not always applicable to an individual. Therefore, the physician or healthcare professional and patient should work in partnership in the decision-making process regarding the patient's treatment. Furthermore, using this information will not guarantee a specific outcome for each patient. None of the information in the guidelines is intended to interfere with or prohibit clinical decisions made by a treating physician or other healthcare professional regarding medically available treatment options for patients. Utilization review determinations are based on medical necessity, appropriateness of care and service and existence of coverage. *i*Care does not reward providers or staff for denying coverage or services. There are no financial incentives for *i*Care staff to encourage decisions that result in underutilization. *i*Care does not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or condition.
Publication of these guidelines is not a promise or guarantee of coverage. Individuals should review their coverage to determine benefits.

*i*Care aligns with the CPG of Humana, our parent corporation. These guidelines can be found at Humana for Healthcare Providers – medical resources /clinical practice guidelines: https://www.humana.com/provider/medical-resources/clinical/guidelines.

Please note that Health Programs, and Transplant Services information at that site location are not applicable to Wisconsin *i*Care members.

Additional references and guidance on falls in the elderly, beyond the Humana posted CPG are included below:

Falls in Elderly Prevention

a. 2021- NCOA – FP 6 Steps Infographic English, and Spanish
b. 2021 Falls Prevention Awareness Week – 6 Steps to Keep Your Loved One from Falling
c. CDC STEADI algorithm for Fall Risk Screening, Assessment, and Intervention for Community -Dwelling Adults 65 years and older 2019
d. USPSTF Recommendation Interventions to Prevent Falls in Community - Dwelling Older Adults 2018

IX. QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT (QAPI)

The purpose of *i*Care's Quality Assurance and Performance Improvement (QAPI) Program is to collect data, and use this data to assess, monitor, evaluate, and facilitate improvement in the quality of health care services provided to *i*Care's members. The QAPI Program focuses on health outcomes, health improvement and health-related social needs. Provider cooperation with all QAPI activities and use of provider performance data as requested is required.

The QAPI Program is integrated throughout *i*Care's functional areas with each department being accountable for reviewing procedures, systems, quality, cost and outcomes related to their areas of responsibility. The QAPI Program ensures each department meets regulatory requirements, achieves business objectives and adds value to the services for our members and providers.

A. QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT (QAPI) PROGRAM SCOPE

- Population Health Management Program
- Health Equity Program
- Annual Performance Improvement and Chronic Care Improvement Projects
- Credentialing and Re-credentialing
- Cultural Competency
- Delegation Oversight
- Assessment of Member and Provider Satisfaction
- Network Adequacy and Access to care
- Provider Quality Management
- Quality and Safety of Care and Services
- Monitoring of Performance Metrics
- Pay-4-Performance
- CMS 5 Star Program
- Utilization Management
- Grievances and Appeals

- Care Management Services
- Customer Service

B. GOALS AND OBJECTIVES OF THE QAPI PROGRAM

Independent Care strives to empower individuals to improve their health, engage in their healthcare and to drastically improve quality of care and healthcare outcomes, and to reduce or eliminate health disparities. In order to support these goals, *i*Care will implement innovative and strategic solutions to Quality Management and Improvement and collaborate with the State of Wisconsin Department of Health Services and other organizations as appropriate, to develop data-driven, outcomes based continuous quality improvement process. Independent Care's QAPI goals and objectives include but are not limited to:

- Cooperating with the Wisconsin Department for Medicaid Services (DMS) and the External Quality Review Organization (EQRO) to align with priorities, goals and objectives.
- Developing clinical strategies and providing clinical programs that look at the whole person, while integrating behavioral and physical health care
- Identifying and resolving issues related to member access and availability to health care services.
- Providing a mechanism where members, member representatives, practitioners, and providers can express concerns to *i*Care regarding care and service.
- Providing effective customer service to address member and provider needs and requests.
- Monitoring coordination and integration of member care across the continuum of care.
- Monitoring, evaluating and improving the quality and appropriateness of care and service delivery to members through performance improvement projects (PIP), file reviews, performance measures, surveys, and related activities.
- Providing mechanisms where members with complex needs and multiple chronic conditions can achieve optimal health outcomes.
- Guiding members to achieve optimal health by providing tools that help them understand their health care options and take control of their health needs.
- Monitoring and promoting the safety of clinical care and service.

C. HEDIS

Independent Care is committed to CMS standards through HEDIS (Healthcare Effectiveness Data and Information Set), the CMS 5 Star Program, Consumer Assessment of Health Providers and Systems (CAHPS), Health Outcome Survey (HOS), the Department of Health Services (DHS) and Pay-for-Performance (P4P) measures. Independent Care strives to provide medically necessary healthcare that is efficient,

effective, safe, accessible, and accountable. Both the CAHPS and HOS ask members to report and evaluate their experiences with their healthcare providers. It is important that *i*Care's team of professionals, along with the provider community, seek to improve the health outcomes of our members. It is also important to stay in communication with our members ensuring their needs are met.

CMS contracted with the National Committee for Quality Assurance (NCQA) to develop a strategy to evaluate the quality of care provided by Special Needs Plans. This strategy relies on a phased approach, beginning with defining and assessing desirable structural characteristics, followed by assessing processes and, eventually, outcomes. The evaluation approach includes several types of assessments:

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

D. FOCUS OF QUALITY MEASURES

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

E. STANDARDS FOR ACCESS TO CARE

Independent Care adopts access standards from DHS, CMS and NCQA and applies whichever standard is the most restrictive. Appointment access standards adopted by *i*Care are as follows:

Primary Care Access Standards:

- Routine appointments: within fifteen (15) days
- Urgent care: within forty-eight (48) hours
- Emergent care: immediate availability
- After hours coverage/access: twenty-four (24) hours a day/seven (7) days a week

Behavioral Healthcare Access Standards:

- Care for a non-life-threatening emergency: within six (6) hours
- Urgent Care: within forty-eight (48) hours
- Initial visit for routine care: within ten (10) business days
- Follow-up routine care: ten(10) days
- Medication- Assisted Treatment (MAT) Services: no more than seventy-two (72) hours

Speciality Care (Non-Urgent)

- Routine appointments: within thirty (30) days

Dental Access Standards:

- Routine care: within ninety (90) days
- Emergent care: within twenty-four (24) hours

OB/GYN Access Standards:

- Routine appointments: within fifteen(15) days

High Risk Prenatal Care Standards:

- Appointments: within two (2) weeks of member request

Office Wait Time Standards:

- Office wait times should not exceed thirty (30) minutes after the scheduled appointment time

F. CONFIDENTIALITY

Independent Care is a covered entity under the Health Insurance Portability and Accountability Act of 1996 as amended (HIPAA) and complies with all applicable state and federal confidentiality and privacy laws and regulations (See 45 CFR § 160.103). Under HIPAA, a covered entity may disclose protected health information to another covered entity without informed consent if the disclosure is for the purposes of the healthcare operations activities of the entity that receives the information, and if each entity has or had a relationship with the individual who is the subject of the information being requested. (See 45 CFR § 164.506(c) (4)). Care management, Care Coordination and conducting quality assessment and improvement activities, including outcomes evaluation are healthcare operations activities under HIPAA (See 45 CFR § 164.501). Wisconsin law also permits access to patient healthcare records without informed consent of the patient if the releases are for the purposes of healthcare operations as defined by HIPAA (see Wis. Stats. § 146.82).

G. MEDICAL RECORDS

Due to the reporting that *i*Care is required to submit to CMS and DHS in support of the quality programs outlined above, providers of covered services are required to provide medical records and documentation validating members received certain healthcare services. Independent Care's contracted providers should reference their contract with *i*Care for more information.

When *i*Care requests copies of a member's medical records for purposes of determining whether benefits are payable (e.g., prior authorization requests, claims adjudication, utilization management, or Grievances and Appeals), *i*Care does not pay for medical records. Following state guidelines, payment is not required under the law.

H. ANNUAL DIAGNOSES COLLECTION AND CONFIRMATION PROJECT

Independent Care is required by CMS to compile and report diagnostic profiles annually. This information must be obtained via a medical record review of individual member diagnoses that were treated or impacted within a claim (calendar) year. Independent Care has partnered with Cognisight to perform the annual collection of data and confirmation project. Cognisight's goal is to obtain a complete diagnostic member profile, while attempting to minimize disruptions to your office workflow and staff. CMS only accepts submission of diagnoses when it is listed on an encounter note rather than on an active problem list, signed lab result or consult. This does not imply that a provider's documentation for the purposes of patient care is not sufficient, only that CMS has specific requirements to recognize existing diagnoses for a patient.

This reporting requirement is time sensitive, and a response is needed as soon as possible.

If you have additional questions, please contact Provider Network Development at netdev@icarehealthplan.org.

X. MEMBER GRIEVANCES AND APPEALS

Please refer to detailed member Grievance and Appeal information, including required timeframes, which can be found on the *i*Care website, by member plan type.

An ***Adverse benefit determination*** means any of the following:

- The denial or limited authorization of a requested service, including determinations based on 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 or duration and that amount or duration has been completed.
- The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" under 42 CFR § 447.45(b) is not an adverse benefit determination.
- The failure to provide services in a timely manner.
- The failure of *i*Care to act within the required timeframes regarding the resolution of grievances and appeals.
- For a resident of a rural area with only one health plan, the denial of a member's request to exercise his or her right, under 42 CFR § 438.52(b)(2)(ii), to obtain services outside the network.

- The denial of a member's request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

An ***Appeal*** means a review by *i*Care of an adverse benefit determination. Members can request a Fair Hearing with the Wisconsin Division of Hearings and Appeals if they are dissatisfied with the outcome of an appeal to *i*Care.

An ***Authorized Representative*** is an individual appointed by the member, including a provider or estate representative, who may serve as an authorized representative with documented consent of the member. Authorized representatives may file an appeal or grievance on behalf of the member.

A ***Grievance*** is an expression of dissatisfaction about any matter other than an adverse benefit determination. A grievance is any complaint about *i*Care or an *i*Care provider that is not related to a denial, change, or delay to member's benefits. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by *i*Care to make an authorization decision. The member or authorized representative may file a grievance either orally or in writing.

All Wisconsin BadgerCare Plus and Medicaid health plans are required to implement and enforce all requirements regarding member grievance and appeal processes, including those outlined in the DHS BadgerCare Plus and Medicaid contract The DHS contract provides requirements for member grievances and appeals, including notice timing and content requirements, as well as resolution timeframes. Providers should refer to their *i*Care provider contract for pertinent information.

Members can receive assistance in filing a grievance or appeal from the *i*Care Member Advocate. The *i*Care Member Advocate can be reached at: (414) 231-1076.

Other assistance is available to *i*Care members to voice complaints: Please refer to the Wisconsin BadgerCare Plus or Medicaid SSI HMO Ombuds brochure at the *i*Care website (BadgerCare Plus or Medicaid SSI HMO Ombuds) and attached as Exhibit 1.

Medicare members may also submit feedback or a complaint about their health plan or prescription drug plan directly to Medicare using the form found at this link: Medicare Complaint Form.

XI. CLAIMS PROCESS OVERVIEW

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

*i*Care follows CMS and ForwardHealth claim processing guidelines.

When submitting claims for dual eligible *i*Care members, be sure to submit the appropriate coding and modifiers used by both CMS and ForwardHealth to ensure the secondary claim will process correctly.

A. CLAIM SUBMISSION

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

Updated 11/08/2016

Box	Description	Comment
1a.	Insured's ID number	
2.	Patient name	
3.	Date of birth and gender	Date of birth must be valid and not future date
5.	Patient Address	
12.	Patient's or authorized person's signature and date signed	Acceptable alternatives: unable to sign, signature on file (SOF), computer generated, signature marked with "X," authorization on file, Medicare/Medicaid Reclamation claims, transportation, or lodging
21.	Diagnosis or nature of illness	
24a.	Dates of service	Claim must include one detail line, not future dates and cannot span a calendar year
24b.	Place of service	Must be 2 characters
24d.	Procedures, services or supplies	Must be at least 5 characters
24f.	Charges	A negative amount will be rejected
24g.	Days or units	
24i/j.	Taxonomy code and prefix	Must be present here or in Box 33b. Not required for SMV, personal care attendant, Blood bank or Community Care Organization. Prefix of PXC is required for all 5010 electronic submission, for paper submission either ZZ or blank is accepted.
24J (b)	National Provider Identifier (NPI)	Must be 10 numerical characters. Not required for SMV claims billed with POS 41, 42, 99
25	Federal Tax ID Number (TIN)	Must be 9 numerical characters

28	Total charge	Total charges must equal the sum of the line charges
31	Signature of physician or supplier physician	Not required for SMV claims billed with POS 41, 42, 99
33	Physician or provider's name, billing address, zip code	
33a	Billing physician	Provider NPI: must be 10 numerical characters. Not required for SMV claims billed with POS 41, 42, 99. The Medicaid provider must be certified as a billing provider.
33b	Taxonomy code and prefix	Must be present here or in Box 24i/24j. Not required for SMV, personal care attendant, blood bank or community care organization. Prefix of PXC is required for all 5010 electronic submission, for paper submission either ZZ or blank is accepted. For electronic submission: Loop Number 2310A-BILLING PROVIDER NAME, Segment PRV, ElementPRV02 = PXC, ElementPRZ03 = value populated taxonomy code

Box	**Description**	**Comment**
1.	Provider name	
4.	Bill Type	
5.	Federal Tax ID (TIN)	
6.	Statement covers period	From and through dates of claim
8b	Patient name	
9a-e.	Patient address	
10.	Date of birth	
11.	Patient gender	
12.	Admission date	Required inpatient, home health and SNF
14.	Admission type	Inpatient claim only
15.	Admission source	
17.	Discharge status	Not required for rural health or federally qualified clinics
18.	Condition codes	
29.	Accident state	
42.	Revenue codes	If Revenue Code of 0022, 0023, or 0024 is listed in box 42 and there is no entry box on 44, reject claim for RUGS code missing
44.	HCPCS/rate	Required based on type of bill

45.	Service date	
46.	Service units	
47.	Total/line item charges	Negative amount: claim will reject for "No Dollar Amount." Total charges must equal the sum of the line item charges or the claim will reject. Total charges with claim with Revenue Codes 0022, 0023, or 0024 may be zero.
49.	Unlabeled	
56.	National Provider Identifier (NPI)	
57a-57c.	Other provider ID	Required for ESRD claims
58a.	Insured's name	
59.	Relationship to uninsured	
60a.	Insured Identification number	

B. ELECTRONIC CLAIMS SUBMISSION

- Electronic Claims Submission offers an opportunity to save time and reduce costs. Independent Care partners with SSI Claimsnet, a leading claims submission provider, for electronic claims submission. To register with SSI Claimsnet, visit the following URL and click "Register:" https://products3.ssigroup.com/ProviderRegistration/register.
- Select *i*Care in the payer drop down box on the registration form to avoid paying any set-up or submission fees for your *i*Care claims through SSI Claimsnet. Providers who do not have an NPI, please enter 9999999999 in the *required field. *i*Care's EDI payer ID code is 11695
- Providers are strongly encouraged to take advantage of electronic claims submission, real-time error reporting and payer updates.
- Providers are encouraged to review Claims Processing information posted on the *i*Care website: https://www.icarehealthplan.org/Claims/Claims-Processing.htm including Claim Specific Guides: https://www.icarehealthplan.org/Education/Resources.htm.
- Electronic claims should be submitted with the National Provider Identifier (NPI) and the Tax Identification Number (TIN).
    - To request an electronic remittance (835 file) please submit the request with the provider's name, TAX ID, NPI, ClearingHouse and the name of the contact person: department-providerservices@icarehealthplan.org.

C. MAILING ADDRESSES

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

Independent Health Care Plan (ICHP)
PO Box 280
Glen Burnie MD 21061 - 0280

D. CORRECTED CLAIMS

Providers have 60 days from the original *i*Care explanation of payment (EOP) date to submit a corrected claim (unless otherwise specified in the provider contract).
Note: If the original *i*Care claim denies for the Primary EOB, the provider must submit a hardcopy corrected claim with the itemized Primary EOB within 60 days of the original *i*Care EOP date.

- Corrected claims must be marked as "corrected claim" and include ALL the line items from the original claim submitted.
- If ALL original line items are not included in the corrected claim, it is assumed that deletion of the line item is part of the correction.

Corrected Claims can be submitted as follows:

- Paper claim submission with "Corrected Claim" stamped/written on the claim or include:
    - CMS 1500 claim form
        - Box 22 – Resubmission Code, 7 (replacement of prior claim) and Original Ref No. (*i*Care Claim number)
    - UB04 claim form
        - last digit of bill type indicating 7 (117, 137, etc.)
        - Include Document Control Number in Box 64 (*i*Care claim number)
        - Changing a claim from Inpatient to Outpatient would be a "Corrected Claim" not a New Claim
    - Mail corrected claims to:

Independent Health Care Plan (ICHP)
ATTN: Operations Department
PO Box 280
Glen Burnie MD 21061 – 0280

- Electronic Professional and Facility corrected claims can also be submitted by following the 5010 standards for electronic claims submission – the provider's clearinghouse will be aware of these requirements.

E. CLAIMS FILING LIMITS

Providers have one hundred and twenty (120) days from the date of service to submit claims to *i*Care, unless otherwise stated in the provider's agreement. Timely filing limits also apply to resubmissions and corrected claims. Claims which contain multiple dates of service on one Claim will be treated as follows dependent upon the type of Claim/service being billed: i) for home and community-based waiver services and facility inpatient services, the latest date of service represented on the Claim will be the date used to determine timely filing for the entire Claim; ii) for professional Claims and facility outpatient Claims, each date of service represented on the Claim (Claim line) will be

assessed individually for timeliness.

Medicaid secondary *i*Care claims for the Medicare coinsurance, copayment and deductible amounts from Medicare coverage other than *i*Care must be received within ninety (90) days of the Medicare Remittance Advice (RA) date provided that the claim was submitted to Medicare within three hundred and sixty-five (365) days of the date of service.

All other claims for which *i*Care is the secondary payer must be submitted with a RA from the primary payer within three hundred and sixty-five (365) days from date of service unless otherwise stated in the provider's agreement.

Claims for Medicaid secondary payment after primary payment must be submitted to *i*Care on paper and include the Medicare RA from the primary insurance carrier.

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

F. FEE SCHEDULES

Unless stated otherwise in the provider's agreement, *i*Care Medicare pays providers according to the CMS Medicare Fee for Service rates (published by CMS: http://www.ngsmedicare.com) and *i*Care Medicaid pays providers according to the State of Wisconsin Medicaid Fee for Service rates (http://www.forwardhealth.wi.gov). All payments are without application of any Medicare or Medicaid quality bonuses or penalties.

Changes to these rates are effective prospectively as of the date the agency (CMS or DHS) provides as the effective date of the change in its notice. If a claim has already been processed and paid by *i*Care prior to the date, *i*Care receives the notice of the rate change; *i*Care does not retroactively adjust that claim to apply the new pricing, regardless of whether the new pricing is an increase or decrease over the former rate.

Each provider contract defines the rates and fee schedule used to pay services. Questions regarding contracted rates should be directed to *i*Care Network Development (netdev@icarehealthplan.org). For other questions regarding fee schedules, please contact *i*Care Provider Relations: providerrelationsspecialist@icarehealthplan.org.

Monday-Friday, 8:00 am-5:00 pm
Local: 414-231-1029
Out of Area: 1-877-333-6820

G. CLAIMS EDITING

*i*Care uses the ClaimsXten code auditing software solution. The ClaimsXten code auditing software solution is a clinically based software application used to insure

consistent and accurate application of current coding guidelines, contractual requirements and medical policy. Edit rules are based on national guidelines and are widely accepted by the provider community. The categories of edits include:

- Age and gender
- Global surgery
- Incidentals
- Multiple evaluation and management services
- Multiple surgeons
- National Correct Coding Initiative
- Mutual Exclusive Edits

H. CO-PAYMENTS

*i*Care Medicare members have co-payment requirements for medication. Medication copayments vary by coverage year. Certain *i*Care members may qualify for help from Medicare to pay for their medications (low income subsidy or LIS). Please reference the Summary of Benefits for more information on copayments for *i*Care Medicare members: http://www.icarehealthplan.org/Plans/iCareMedicare/Benefits.aspx

Independent Care Medicaid SSI and BadgerCare Plus members may have co-payments of anywhere from $.50 -$3. Providers can access information regarding the member's copayment obligation through the Wisconsin Enrollment Verification System (EVS) through the ForwardHealth Portal, WiCall, commercial enrollment verification vendors or by calling ForwardHealth Provider Services at 800-947-9627.

I. CHECKING THE STATUS OF A CLAIM

The provider portal is available to check on claim statuses. For access information, please email providerrelationsspecialist@icarehealthplan.org or mailto:providerservices@icarehealthplan.org to request a PIN for the *i*Care Provider Portal. A Provider Portal user guide is available on our *i*Care's website: https://www.icarehealthplan.org/Provider/Provider_Portal.htm

Alternatively, calls to check on claim status can be directed to *i*Care Customer Service:

Local: 414-231-1029
Out of Area: 1-877-333-6820

J. EXPLANATION OF PAYMENT/REMITTANCE

Providers receive an Explanation of Payment (EOP) for each claim submitted to *i*Care. Separate Medicare EOPs and Medicaid EOPs, along with separate checks, are mailed twice a week for processed Medicare and Medicaid claims. Duplicate copies of the provider EOPs are available upon request to *i*Care Provider Services (department-

providerservices@icarehealthplan.org).

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

Local: 414-231-1029
Out of Area: 1-877-333-6820

K. BILLING MEMBERS

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

As a Medicaid certified provider, you cannot charge a Medicaid member for services covered by Medicaid. Providers are responsible for checking ForwardHealth to review eligibility prior to providing services. Wisconsin law prohibits providers who are Medicaid certified from billing or collecting payment from a Medicaid eligible individual for services that are covered by Medicaid in lieu of properly billing the patient's Medicaid coverage for the service (Wis. Admin. Code. §DHS 106.04(3)). Providers can have their Medicaid certification terminated or suspended by the state for billing or collecting payment from a Medicaid covered individual in violation with Wis. Admin. Code § DHS 106.06 (21).

The Social Security Act, Section 1128B. (d)(1), [42 U.S.C. 1320a-7b], also provides that Medicaid certified providers may not bill Medicaid eligible members for medically necessary covered services. Any provider who knowingly and willfully bills a member for a Medicaid covered service may be guilty of a felony as defined in Section 1128B. (d)(1) [42 U.S.C.1320a-7b] of the Social Security Act.

Federal law prohibits providers from collecting Medicare Part A and Part B coinsurance, copayments, and deductibles from Qualified Medicare Beneficiaries (QMBs), including those enrolled in Medicare Advantage and other Part C plans. Furthermore, providers may not discriminate against QMBs by refusing service because they are protected from paying cost sharing. For additional information, you may refer to the CMS Medicare Learning Matters article that notifies Medicare providers of the prohibition on billing QMBs for Medicare A/B deductibles and cost sharing, available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1128.pdf.

L. COORDINATION OF BENEFITS

Coordination of Benefits (COB) is necessary when a member is covered by more than

one insurance carrier. With few exceptions, *i*Care Medicaid is the payer of last resort in most COB circumstances.

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

If the member has both *i*Care Medicare and *i*Care Medicaid, submit the original claim with the *i*Care Medicare identification number. Both *i*Care Medicare and *i*Care Medicaid benefits are adjudicated in this process. A Medicare EOP is not required.

This section contains coordination information about the following services:

- Outpatient facility services
- Professional services
- Inpatient facility services and skilled nursing facility services

1. OUTPATIENT FACILITY SERVICES

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

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

- The Medicare allowed amount
- The Published Medicaid Outpatient rate per visit
- Specific *i*Care contracted rate (the Medicaid allowed) minus the Medicare payment amount

When adding the coinsurance/copayment payment amount to the Medicare payment amount, the billed amount cannot exceed the Medicaid or Medicare allowed amount.
*i*Care Medicaid does not always pay the full Medicare coinsurance/copayment amount.

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

b. Other insurance and *i*Care Medicaid

Outpatient facility services for *i*Care Medicaid members having other primary insurance are reimbursed at the difference between the published Medicaid Outpatient rate per visit or the specific *i*Care contracted rate and other primary insurance payment.

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

payment exceeds the Medicaid allowed.

2. PROFESSIONAL MEDICARE PART B SERVICES

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

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

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

The Medicare payment amount (including the coinsurance/copayment) cannot exceed the Medicaid or Medicare allowed amount.

*i*Care Medicaid does not always pay the full Medicare coinsurance/copayment amount. Note the following:

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

(Please see the ForwardHealth: *All Provider Coordination of Benefits:* http://www.forwardhealth.wi.gov/kw/pdf/all_coord.pdf).

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

b. Other Insurance and *i*Care Medicaid (SSI and BadgerCare Plus)

- Professional services for *i*Care Medicaid members having other primary insurance are reimbursed at the difference between:
  - The Medicaid Fee Schedule Rate or a specific *i*Care contracted rate
  - The other primary insurance payment

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

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

3. INPATIENT FACILITY SERVICES

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

Inpatient facility services for *i*Care Medicaid members having Medicare are reimbursed at the applicable years Medicare Deductible amount per benefit period

The benefit period is the way Medicare measures the member's use of hospital and skilled nursing facilities. A benefit period begins the day the member is admitted to a hospital as inpatient or admitted to a skilled nursing facility. The benefit period ends when the member has not received hospital or skilled nursing care for sixty (60) days in a row (see Skilled Nursing Facility services below). Hospital care within the first sixty (60) days of the benefit period is not eligible for additional Medicaid reimbursement; e.g., the deductible paid for the initial benefit period satisfies the *i*Care Medicaid liability until the next benefit period begins. If the member is discharged from a hospital and is readmitted within sixty (60) days, no additional Medicare or Medicaid payment is made.
If the member goes into the hospital after one benefit period has ended (sixty (60) days after discharge), a new benefit period begins. The inpatient hospital deductible is paid for each benefit period and is subject to the state's lesser of logic. There is no limit to the number of benefit periods the member can have.

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

- Hospital stay one (1) to sixty (60) days: the applicable year's Medicare inpatient deductible amount.
- Hospital stay sixty-one (61) to ninety (90) days: the applicable year's Medicare sixty-one (61) - ninety (90) days coinsurance rate times the number of days' subject to the state's lesser of logic.
- Hospital stay ninety-one (91) to one hundred and fifty (150) days: Medicare only covers up to ninety (90) days of an inpatient stay then the member decides whether or not to use Medicare Reserve Day coverage

(see Reserve Days below) if days are still available. The provider contacts the member and indicates the decision on the facility claim.

- If Medicare Reserve days are used, Medicaid pays the applicable year's Medicare Reserve Day coinsurance rate times the number of days.
- If Medicare Reserve days are not used, Medicaid pays the Medicaid Diagnostic Related Group (DRG) for all remaining days over ninety (90).
- When reserve days are used for days beyond one hundred and fifty (150) days, the Medicaid DRG for all remaining days.

To find the applicable year's inpatient deductible and coinsurance amounts, use the following link to access the CMS website:
http://www.cms.hhs.gov/transmittals/downloads/R49GI.pdf

Reserve Days are the sixty days Medicare will pay when the members inpatient stay is more than ninety (90) days. These sixty (60) Reserve Days can only be used once during the member's lifetime. For each lifetime Reserve Day, Medicare pays all covered costs except for a daily (Reserve Day) coinsurance amount.

b. Other Insurance and *i*Care Medicaid (SSI and BadgerCare Plus)

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

- The calculated Medicaid DRG/per diem amount
- Specific *i*Care contracted rate and
- Other primary insurance payment

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

Skilled Nursing Facility Services *i*Care Medicaid pays:

- Days one (1) to twenty (20): $0
- Medicare covers up to the Medicare allowed for each day and there is no coinsurance
- Days twenty-one (21) to one hundred (100): the applicable year's Medicare SNF twenty-one (21) to one hundred (100) day coinsurance rate times the number of days

- Days one hundred (100) and beyond: Medicaid is prime; either *i*Care Medicaid or Medicaid Fee for Service depending on the member's enrollment in *i*Care Medicaid

When an *i*Care member has SNF services for ninety (90) days, the member is

disenrolled from *i*Care Medicaid at the end of that month. After the end of the month, the Medicaid member continues coverage with Medicaid Fee for Service.

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

For the applicable year's SNF day twenty-one (21) to one hundred (100) coinsurance amount, use the following link to access the CMS website: http://www.cms.hhs.gov/transmittals/downloads/R49GI.pdf.

M. CLAIM ERRORS, REVIEW/REOPENING AND RECONSIDERATION/APPEAL

Quality is a top priority and *i*Care strives to process submitted claims in a timely and accurate manner. Claims processing and submission errors do occur and *i*Care's goal is to accurately resolve the situation as quickly as possible. Providers of Family Care Partnership covered services should refer to the Family Care Partnership Provider Reference Manual.

1. Medicaid SSI and BadgerCare Plus Covered Services

Reconsideration/Appeal: formal request for review of an Action (e.g., the denial, in whole or in part of payment for a service). For provider Appeals, an application or proceeding for review when a provider does not agree with the claim reconsideration decision. For example: a claim is denied by *i*Care for untimely claim filing. The provider must appeal the denial Action to *i*Care; an internal review by *i*Care is required.

Review/Reopen of a Claim: a request to review a claim or a portion of a claim that a provider feels was incorrectly paid or denied because of processing errors.

Resubmission of a Corrected Claim: See Section D

Providers contracted within *i*Care's network, as well as non-contracted providers may request reconsideration from *i*Care if the payment or denial determination on a claim is questionable. Providers must submit the reconsideration request in writing within sixty (60) calendar days of the initial claim payment or denial notice. Independent Care has forty-five (45) calendar days from the date of receipt of the request to respond in writing to the provider.

If a provider does not agree with the results of the reconsideration, or if *i*Care fails to respond to the provider's request for reconsideration within forty-five (45) days, both contracted and non-contracted providers may file a formal appeal with *i*Care. Requests for an appeal must be submitted in writing within sixty (60) calendar days

of the date the provider is notified of the initial claim payment or denial notice, the decision on the reconsideration, or the end of the forty-five (45) day period for a reconsideration response (if no response was received) as applicable. Independent Care has forty-five (45) calendar days from the date of receipt of the request for an appeal to respond in writing to the provider. Requests for a Review/Reopen or Reconsideration /Appeal must be sent to *i*Care as follows:

Review/Reopen:
Independent Health Care Plan (ICHP)
PO Box 280
Glen Burnie MD 21061 - 0280

Reconsideration/Appeal:
Independent Care Health Plan
Appeal Department
1555 N. RiverCenter Dr., Suite 206
Milwaukee, WI 53212

If a provider is not satisfied with *i*Care's response to an appeal, or if *i*Care does not respond to the provider within the required timeframe as set forth above, the provider may appeal to DHS. Providers are required to first exhaust all appeal rights with *i*Care before appealing to DHS. All Appeals to DHS must be submitted in writing to DHS within sixty (60) calendar days of *i*Care's final decision or failure to respond to the provider.

Providers are required to submit appeals to DHS through the Provider Appeals portal.

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.

Required Documentation:

When submitting an appeal to ForwardHealth through the Provider Appeals portal, the following documentation must be submitted/attached in required fields:

- The original claim submitted to the HMO/PIHP and all corrected claims submitted to the HMO/PIHP
- All of the HMO's/PIHP's payment denial remittances showing the dates of denial and reason codes with descriptions of the exact reasons for the claim

denial

- The provider's written appeal to the HMO/PIHP
- The HMO's/PIHP's response to the appeal
- Relevant medical documentation for appeals regarding coding issues or emergency determination that supports the appeal (Providers should only submit relevant documentation that supports the appeal. Large medical records submitted with no indication of where supporting information is found will not be reviewed.)
- Any contract language that supports the provider's appeal with the exact language that supports overturning the payment denial indicated (Contract language submitted with no indication of where supporting information is found will not be reviewed, and the denial will be upheld.)
- Any other documentation that supports the appeal (for example, commercial insurance Explanation of Benefits/Explanation of Payment to support Wisconsin Medicaid as the payer of last resort)

To check the status of an appeal submitted to ForwardHealth, providers can:

- Access the Provider Appeals portal
- Call the ForwardHealth Managed Care Unit at 800-760-0001, option 1

2. Medicare Covered Services

A provider who is contracted within *i*Care's network may request a reopening from *i*Care if the provider disagrees with *i*Care's payment or denial determination on a claim. A provider must submit the reopening request in writing within sixty (60) calendar days of the initial Claim payment or denial notice. Independent Care has sixty (60) calendar days from the date of receipt of the request to respond in writing to provider. Requests for a reopening must be sent to *i*Care as follows:

Reopenings:
Independent Health Care Plan (ICHP)
PO Box 280
Glen Burnie MD 21061 – 0280

Providers who are not contracted within *i*Care's network may request a reopening as set forth above. In addition, providers may file an appeal with *i*Care if the reopening process does not resolve their concerns. Non-contracted provider requests for an appeal must be submitted in writing within sixty-five (65) calendar days of the date the provider is notified of the initial claim payment or denial notice, the decision on the reopening, or the end of the sixty (60) day period for a reopening response (if no response was received) as applicable. Providers should complete the Reconsideration/Formal Appeal form and attach supporting documentation, including the required Waiver of Liability (WOL) form. The forms can be found or our website: https://www.icarehealthplan.org/Claims/Claims-Processing.htm Request cannot be handled telephonically and should be mailed. Independent Care has sixty (60) calendar days from

the date of receipt of the request for an appeal to respond in writing to the provider. Requests for an appeal must be sent to *i*Care as follows:

Appeals:
Independent Care Health Plan
Appeal Department
1555 N. RiverCenter Dr., Suite 206
Milwaukee, WI 53212

If a non-contracted provider is not satisfied with *i*Care's response to an appeal, or if *i*Care does not respond to the provider within the required timeframe as set forth above, iCare will automatically submit the appeal within sixty (60) days to a CMS Independent Review Entity (IRE). Providers are required to first exhaust all appeal rights with *i*Care before appealing to the IRE.

Further information on all of the above processes, and the required forms can be found on the provider-claims processing tab of the *i*Care website: http://www.icarehealthplan.org.

3. Overpayments

In accordance with the requirements of 42 U.S.C. § 1320a-7k(d) and its implementing regulations, Providers must report any overpayments to *i*Care when identified, return any overpayments to *i*Care within sixty (60) days of the date that the overpayment was identified and notify *i*Care in writing of the reason for the overpayment (explanation of why the payment is being refunded). If *i*Care identifies the overpayment, it will seek to recover the overpayment within 60 days the overpayment was identified.

If the DHS Office of the Inspector General (OIG), or one of OIG's contracted program integrity (PI) vendors, identifies an overpayment through provider audits or other means and recovers overpayment from *i*Care, *i*Care may elect to recover these overpayments from the responsible Provider.

Providers must collaborate with OIG and OIG's contracted PI vendors with regard to all records requests and respond to any request in a timely manner as specified in the request.

If a Provider would like to submit rebuttal to initial findings for consideration by OIG or OIG's contracted PI vendors, the Provider must submit the rebuttal documentation to the OIG or OIG's contracted PI vendors by the date specified in the preliminary findings letter or amended preliminary findings letter.

If a Provider would like to appeal OIG or OIG's contracted PI vendors' findings in the Notice of Intent to Recover (NIR) letter, the Provider must submit notification to the Division of Hearings and Appeals, as specified in the NIR letter.

XII. PROVIDER RIGHTS AND RESPONSIBILITIES

A. PROVIDER RIGHTS

Practitioners have the right to review information obtained to evaluate their credentialing application, attestation or CV and the right to correct erroneous information. *i*Care notifies practitioners when credentialing information obtained from other sources varies substantially from information provided by the practitioner. The practitioner should be notified within seven days of the discrepancy. The notification indicates which part of the application is discrepant, the format for submitting corrections and the person to whom corrections should be submitted. If the application, attestation and/or CV must be updated, only the practitioner may attest to the update, a staff member may not. The practitioner has 14 business days to respond in order to resolve the discrepancy. The receipt of any corrections should be documented in the credentialing file. A practitioner has the right, upon request, to be informed of the status of his/her application. *i*Care should respond to these requests in a timely manner. Once a practitioner application for initial credentialing has been approved or denied, the practitioner should be notified within 60 days. Credentialing denials will be communicated to the practitioner by the Credentialing Manager in writing, will include the reason(s) for the denial and should be provided within 60 days of denial. *i*Care will make available all application and verification policies and procedures upon written request from the applying healthcare professional.

Providers may bill *i*Care for Medicare or Medicaid covered services. Provider must obtain a referral or prior authorization when applicable. Please see the Prior Authorization section of this manual for complete details.

Providers may bill a member for non-covered services only if the provider informs the member prior to performing the service that the member is responsible for payment because Medicare or Medicaid does not cover the service. Providers must obtain a written statement in advance verifying that the member has accepted liability for the specific service. The standard release form signed by the member at the time of the services is not sufficient. A written and signed acknowledgment from the member must specifically state the admissions, services or procedures that are not covered by Medicare or Medicaid and that the member is accepting liability for payment.

Providers acting within the lawful scope of practice may advise or advocate for patients. Independent Care may not prohibit, or otherwise restrict, a healthcare professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient, for the following:

- The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
- Any information the member needs in order to decide among all relevant

treatment options, regardless of benefit coverage limitations.
- The risks, benefits, and consequences of treatment or non-treatment.
- The member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.

Providers may file an appeal or grievance on behalf of the member, provided the member's written consent. Independent Care informs providers and subcontractors, in writing at the time the contract is finalized, of the toll-free number for members to file oral Grievances and appeals and their right to appeal a denied/reduced payment or payment recoupment after audit or Utilization Management review (42 CFR s. 438.414). The toll-free number is 800-777-4376. For additional information, please also reference the Wisconsin BadgerCare Plus or Medicaid SSI HMO Ombuds brochure at the *i*Care website: https://www.icarehealthplan.org/Provider.htm or http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html and attached.

Providers are not prohibited from contracting with HMOs other than *i*Care.

B. PROVIDER RESPONSIBILITIES

Send all provider demographic changes to netdev@icarehealthplan.org. A form for submission of this information is available at the *i*Care Provider website: https://www.icarehealthplan.org/Provider.htm.

Providers are required to obtain member eligibility information. Possession of a ForwardHealth ID Card or Medicare Part A and/or Part B card does not guarantee eligibility. To determine enrollment for the current date (since a member's enrollment status may change) and to discover any limitations to the member's coverage, providers are expected to verify member eligibility at every visit. Enrollment verification provided by ForwardHealth allows the provider to verify member's enrollment in a ForwardHealth program(s), the MCO enrollment, Medicare or other commercial health insurance coverage and any exemption from copayment for BadgerCare members. Providers can access the Wisconsin Enrollment Verification System (EVS) through the ForwardHealth Portal, WiCall, and commercial enrollment verification vendors or by calling ForwardHealth Provider Services: 800-947-9627.

Providers must accept *i*Care reimbursement as payment in full except in cases where coordination of benefits applies.

Providers are required to bill *i*Care for covered services provided to a member during periods of retroactive eligibility when notified that a member has obtained such eligibility.

Providers shall not bill an *i*Care member for medically necessary services covered by Medicare or Medicaid and provided during the member's period of *i*Care enrollment.

Providers shall not bill an *i*Care member for co-payments and/or premiums for medically necessary services covered by Medicare or Medicaid and provided during the member's period of *i*Care enrollment.

As a Medicaid certified provider, state and federal law prohibits providers from charging a Medicaid member for services covered by Medicaid. Providers are responsible for checking ForwardHealth to review eligibility prior to providing services. Any provider who knowingly and willfully bills a member for a Medicaid covered service may also be guilty of a felony, as defined in Section 1128B. (d)(1) [42 U.S.C.1320a-7b] of the Social Security Act. *i*Care is required to report violations of this act.

Providers are prohibited from discriminating against *i*Care members. Provider's hours of operation must not discriminate against *i*Care members.

Providers should document in the member's medical records whether or not the member has executed an advance directive. Provider shall not discriminate in the provision of care or otherwise discriminate against a member based on whether or not the member has executed an advance directive. Provider shall ensure compliance with requirements of Wisconsin law (whether statutory or recognized by the courts of Wisconsin) respecting advance directives.

With respect to the services provided to *i*Care members, providers expected to observe and comply with all applicable federal and state laws, rules or regulations in effect at the time services are provided, including health data and information privacy and security requirements and any other standards and regulations as may be adopted or promulgated under Health Insurance Portability and Accountability Act of 1996 as amended (HIPAA) or state laws.

Providers shall notify *i*Care of changes in information related to the provider's practice

Notification is required for:

- Addition of a provider
- Provider retirement or termination
- New location
- Closing of a location
- Any change in NPI number
- Any change in Tax Identification number (TIN) (submit with revised and corresponding W9)
- Any billing service change
- Any billing address change

Providers shall comply with appointment access standards adopted by *i*Care as follows:

- Preventive and routine care appointments: within thirty (30) days

- Urgent care: within twenty-four (24) hours
- Emergent care or services urgently needed: immediate availability
- Services that are not emergency or urgently needed, but the enrollee requires medical attention: within 7 business days
- After hours coverage/access: twenty-four (24) hours a day/ seven (7) days week
- Dental access guidelines:
    - New patient: within ninety (90) days
    - Routine Care: within ninety (90) days
    - Emergent Care: within twenty-four (24) to seventy-two (72) hours office wait time standards
- Office wait times should not exceed thirty (30) minutes after the scheduled appointment time
- Behavioral Health access:
    - Routine office visit: thirty (30) days or less
    - Follow up from an inpatient mental health stay: thirty (30) days or less
- Urgent behavioral health care: within twenty-four (24) hours
- Emergent behavioral health care or services urgently needed: immediate availability
- Behavioral health services that are not emergency or urgently needed, but the enrollee requires medical attention: within 7 business days

- High risk prenatal care:
    - Appointments: two (2) weeks or less

Under Title VI of the U.S. Civil Rights Law, all healthcare programs and activities that receive federal financial assistance from the U.S. Department of Health & Human Services (e.g., hospitals, healthcare clinics, physician's practices, community health centers, nursing homes, rehabilitation centers) are required to take reasonable steps to provide meaningful access to each individual with limited English proficiency served or likely to be encountered in its health programs and activities. Reasonable steps may include the provision of language assistance services, such as oral language assistance or written transactions. Facilities must offer a qualified interpreter when oral interpretation is a reasonable step to provide an individual with meaningful access. Where language services are required, the service must be provided free of charge and in a timely manner. Entities may not require an individual to provide his or her own interpreter.

Provider Preventable Conditions: providers must report to *i*Care all provider preventable conditions (as defined below) with claims for payment or member treatments for which payment would otherwise be made:

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and trauma; including fractures, dislocations, intracranial injuries,

crushing injuries, burns, or other injuries
- Catheter-associated urinary tract infection (UTI)
- Vascular catheter associated infection
- Manifestations of poor glycemic control including diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, or secondary diabetes with hyperosmolarity
- Surgical site infection following coronary artery bypass graft (CABG)-Mediastinitis
- Surgical site infection following bariatric surgery for obesity, including laparoscopic gastric bypass, gastroenterostomy, or laparoscopic gastric restrictive surgery
- Surgical site infection following certain orthopedic procedures including spine, neck shoulder and elbow
- Surgical site infection following cardiac implantable electronic device (CIED)
- Deep vein thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement with pediatric and obstetric exceptions
- Iatrogenic pneumothorax with venous catheterization.

Other Provider-Preventable Conditions are conditions occurring in any healthcare setting that meets the following criteria:

- Identified in the State plan
- Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence based guidelines
- Has a negative consequence for the beneficiary
- Is auditable
- At a minimum includes:

    - Wrong surgical or other invasive procedure performed on a patient
    - Surgical or other invasive procedure performed on the wrong body part
    - Surgical or other invasive procedure performed on the wrong patient

Providers who are required by law to report suspected child abuse and neglect must know and understand the laws, identification requirements, and reporting procedures under Wisconsin Statutes s. 48.981. For further training on reporting suspected child abuse, refer to the following link: WI Child Welfare Professional Development Mandated Reporter.

Electronic Visit Verification: Provider shall comply with Electronic Visit Verification (EVV) requirements established by DHS for personal care services funded by Medicaid.

Providers shall cooperate with *i*Care's quality improvement activities to improve the quality care and services and member experience, including allowing *i*Care to use Provider's performance data for quality improvement activities.

Fraud, Waste, and Abuse:

Providers must educate their employees about:

- The requirement to report suspected or detected fraud, waste, or abuse (FWA);
- How to make a report of actual or suspected FWA;
- The False Claims Act's prohibition on submitting false or fraudulent claims for payment, penalties for false claims and statements, whistleblower protections and each person's responsibility to prevent and detect FWA.

*i*Care should be notified immediately if a physician/provider or their office staff:

- Is aware of any physician/provider that may be billing inappropriately, e.g., falsifying diagnosis codes and/or procedure codes, or billing for services not rendered;
- Is aware of a member intentionally permitting others to use his/her member ID card to obtain services or supplies from the plan or any network provider;
- Is suspicious that someone is using another member's ID card;
- Has evidence that a member knowingly provided fraudulent information on his/her enrollment form that materially affects the member's eligibility.

Providers may provide the above information via an anonymous phone call to Humana's fraud hotline at 800-614-4126. All information will be kept confidential. Entities are protected from retaliation under 31 U.S.C. 3730 (h) for False Claims Act complaints.

Humana ensures no retaliation against callers as Humana has a zero-tolerance policy for retaliation or retribution against any person who reports suspected misconduct. Providers also may contact Humana at 800-4HUMANA (800-448-6262).

In addition, providers may use the following contacts:

Telephonic:

- SIU Hotline: 800-614-4126 (24/7 access)
- Ethics Help Line: 877-5-THE-KEY (877-584-3539)

Email:

- SIUReferrals@humana.com; or
- ethics@humana.com

Web:

- Ethicshelpline.com; or
- Humana.com

C. CAREGIVER BACKGROUND CHECKS

All *i*Care contracted providers are required to comply with all applicable requirements of Wis. Admin. Code §§ DHS 12 and 13 relating to caregiver background checks. Providers are required to provide documentation of compliance with these requirements

to *i*Care at the point of applying for network provider status and periodically thereafter to validate continuing compliance.

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

D. ACCESS AND AUDIT

Pursuant to the requirements of 42 CFR §§ 438.3(h) and 438.230 and the provisions of *i*Care's DHS and CMS Contracts, *i*Care, the State of Wisconsin, CMS, the Secretary of United States Department of Health and Human Services (DHHS), the DHHS Inspector General, and/or the Comptroller General of the United States, or any of their duly authorized representatives, have the right to audit, evaluate and inspect any books, records, contracts, computer or other electronic systems, premises, physical facilities and equipment of Providers that pertain to any aspect of the services and activities performed, or determination of amounts payable. Providers must make such items available for audit, evaluation and inspection. The right to audit exists through ten (10) years from the final date of the DHS or CMS contract period or from the date of completion of any audit, whichever is later. If the State, CMS or the DHHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, they may inspect, evaluate and audit a Provider at any time.

XIII. MEMBER RIGHTS

A. MEMBER RIGHTS

The following section contains the rights of all *i*Care members as set forth by DHS. Independent Care goes to great lengths to ensure that members' rights are protected. Please be familiar with the following:

As an *i*Care Medicaid member, you have the right to make recommendations regarding the member rights and responsibilities policy. You, your provider or your designated representative also have the right to receive a copy of *i*Care's Member Rights and Responsibilities statement.

If you would like to make recommendations or receive a copy of this statement separate from this handbook, please visit the *i*Care web site at www.iCareHealthPlan.org. You may also contact *i*Care Customer Service at 1-800-777-4376 (TTY: 711).

*i*Care provides free aids and services to people with disabilities to communicate effectively with us. We also provide free language services to people whose primary language is not English. If you need these services to communicate with us, contact

Customer Service at 1-800-777-4376 (TY: 711) 24 hours a day, 7 days a week. Our office hours are Monday – Friday, 8:30 a.m. – 5:00 p.m.

- Knowing Provider Credentials: members have the right to information about our providers including the provider's education, board certification, and recertification. To get this information, members may call our Customer Service Department at 1-800-777-4376.
- Completing an Advance Directive, Living Will, or Power of Attorney for HealthCare: members have the right to make decisions about their medical care. Members have the right to accept or refuse medical or surgical treatment. Members have the right to plan and direct the types of healthcare received if unable to express the requests through the use of an advance directive, living will or power of attorney for healthcare. Members have the right to file a grievance with the DHS Division of Quality Assurance if their advance directive, living will, or power of attorney wishes are not followed. Members may request help in filing a grievance.
- Transition of Care: If a member has moved from ForwardHealth or a BadgerCare Plus HMO to a new BadgerCare Plus HMO, then they have the right to:
  - Continue to see their current providers and access their current services for up to 90 days. They should call their HMO upon enrollment to let them know who their provider is. If this provider is still not in the HMO network after ninety (90) calendar days, they will be given a choice of participating providers to make a new choice.
  - Receive services that would pose a serious health risk or hospitalization if you did not receive them.
- Member Rights to Medical Records: members have the right to ask for copies of their medical records from their provider(s). Members may receive assistance from *i*Care in obtaining copies of their medical records. Members may request that their medical record be amended, as specified in 45 CFR 164.525 and 164.526.
- HMO Moral or Religious Objection: The HMO will inform members of any covered Medicaid benefits which are not available through the HMO because of an objection on moral or religious grounds. *i*Care will inform members about how to access those services through the State.
- Members have the right to have an interpreter during any covered service.
- Members have the right to get the information provided in this member handbook in another language or format.
- Members have the right to get healthcare services as provided for in federal and state law. All covered services must be available and accessible. When medically appropriate, services must be available twenty four (24) hours a day, seven (7) days a week.
- Members have a right to get information about treatment options including the right to request a second opinion.
- Members have the right to make decisions about your health care. They also have the right to participate with your providers in making decisions about your health care.
- Members have the right to have an open and honest talk with *i*Care and their providers. During this talk they can address what is the best care for their health no matter the cost or benefit coverage.

- Members have the right to be treated with respect and dignity. They also have a right to their privacy.
- Members have the right to be free from any form of restraint or seclusion used as a means of force, control, ease, or reprisal.
- Members have a right to voice grievances or appeals about *i*Care or the care it provides.
- Members have the right to be free to exercise your rights without adverse treatment by the HMO and its network providers.
- Members may switch HMOs without cause during the first 90 days of *i*Care enrollment.
- Members have the right to switch HMOs, without cause, if the State imposes sanctions or temporary management on *i*Care.
- Members have the right to receive information from *i*Care about the organization and its services. Members have the right to receive information from *i*Care regarding any significant changes with *i*Care at least 30 days before the effective date of the change

- Members have the right to disenroll from the HMO Program if: They move out of the HMO's service area; HMO does not, for moral or religious objections, cover a service they want; they need a related service performed at the same time, not all related services are available within the provider network, and their PCP or another provider determines that receiving the services separately could put them at unnecessary risk; other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with their care needs.

B. MEMBER CIVIL RIGHTS

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

- Age
- Color
- Disability
- National Origin
- Race
- Gender
- Gender Identity
- Sex
- Ancestry
- Ethnicity
- Sexual Orientation
- Marital Status
- Religion
- Language

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

members.

Member Responsibilities

Responsibilities means the things members are supposed to do. It also means accepting the positive or negative results of their actions. These are their responsibilities as an *i*Care member:

- A responsibility to give *i*Care and our providers the information we need to provide your health care and services.
- A responsibility to follow their care plan and follow the instructions for care that they agreed to with their providers,
- A responsibility to understand their health problems.
- A responsibility to participate in creating mutually agreed-upon treatment goals to the extend they can.

XIV. PROHIBITED MARKETING/OUTREACH PRACTICES

Provider agrees that they will follow the marketing guidance, including prohibited and allowed activities, as set forth in the DHS HMO and PIHP Communication, Outreach and Marketing guide. *i*Care may, in its sole discretion and without Provider's approval, prepare, distribute materials and furnish information generally describing Providers or its Participating Providers and will furnish information on Provider's qualifications.

APPENDIX

Exhibit 1:

Ombuds for BadgerCare Plus and SSI Medicaid HMO Members

What is an ombud?

An ombud is a person who responds to grievances from BadgerCare Plusand Supplemental Security Income (SSI) Medicaid HMO members. A grievance can be submitted if you have a complaint or problem with your health care from your HMO. HMO stands for health maintenance organization. Your HMO is also called your health plan. An HMO is a group of doctors, clinics, and hospitals that you can get health care services from. If you have questions or concerns about your HMO, an ombud may be able to help you.

What does an ombud do?

An ombud:

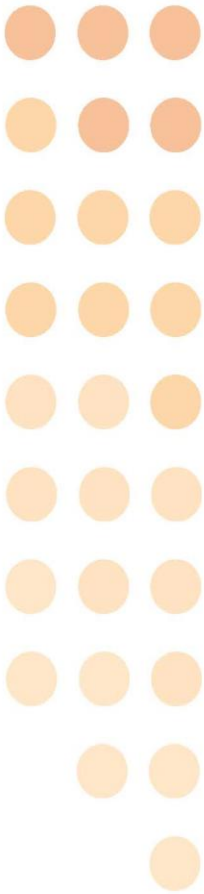
- Helps solve problems members have with the care or services they get from a BadgerCare Plus or SSI Medicaid HMO.
- Helps members submit grievances.
- Helps members understand their rights and responsibilities.
- Represents members' rights with BadgerCare Plus or SSI Medicaid HMOs.
- Communicates with both the HMO and member to help solve conflicts.

How do you submit a grievance?

You can submit a grievance by contacting an ombud and telling them your problem with your HMO. You can either call or write a letter. Your health care benefits will not be affected because you file a grievance. All information will be kept confidential.

When can you contact an ombud?

As a member of a BadgerCare Plus or SSI Medicaid HMO, you may call an ombud anytime during your HMO enrollment.



Why would you call an ombud?

You would call an ombud if you have questions or concerns with your HMO. The following are examples of when to call an ombud for help:

- You are unsure of your rights as a member.
- You are unable to get a covered service from your HMO.
- Your HMO has denied, reduced, or stopped providing covered services.
- You feel you were treated unfairly or disrespectfully by your HMO.
- You get a bill for services.

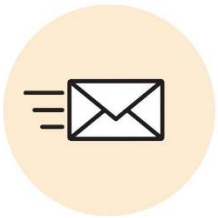
You Have Rights

You have the right to:

- Voice complaints and file grievances.
- Be treated with respect.
- Be treated fairly.
- Get interpreter services during the grievance process.

Contact an Ombud

By phone:
Monday through Friday
8 a.m. to 4:30 p.m.
800-760-0001 (TTY and translation services available)



By mail:
BadgerCare Plus or Medicaid
HMO Ombuds
PO Box 6470
Madison, WI 53716-1470

Wisconsin Department
of Health Services
P-12002 (11/2021)