# BADGERCARE PLUS MANUAL

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# REVISION LOG

*Please note that some sections in this updated provider manual have been reorganized and reformatted from the previous version.*

Updates are made regularly to the information in this manual. The grid below highlights recent changes. For future updates, refer to the Historical Revision Log as a reference to past revisions.

| Description of Change | Link | Page |
|---|---|---|
| **Updated:** Branding changes made to reflect Dean Health Plan by Medica throughout | | All |
| **Updated**: BadgerCare Plus and ForwardHealth phone numbers, resources, and web pages listed in the Directory. | Directory | 4 |
| **Updated:** Dean Health Plan BadgerCare Plus Service Areas to include Fond Du Lac and Green counties. | BadgerCare Plus Service Areas | 6 |
| **Updated:** Pay-for-Performance (P4P) program information. | Pay-for-Performance | 8 |
| **Updated:** HMO enrollment exemption table. | HMO Enrollment Exemptions | 11 |
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# INTRODUCTION

BadgerCare Plus is a healthcare coverage program under Wisconsin ForwardHealth. Dean Health Plan BadgerCare Plus is available to eligible residents residing in counties included in the Dean Health Plan BadgerCare Plus service area. This Dean Health Plan BadgerCare Plus Provider Manual contains specific BadgerCare Plus rules, processes, and resources to support in-network providers serving members enrolled in Dean Health Plan BadgerCare Plus. It is intended to be used as an addendum to the Dean Health Plan Provider Manual available from the Document Library on the Dean Health Plan website. Dean Health Plan is based in Madison, WI and has a strategic partnership with Medica, a non-profit Minnesota-based health plan.

If you have questions about information in this manual or can't find the information that you are seeking, please refer to the directory below to contact the appropriate department or to access the applicable resource. When in doubt, please don't hesitate to contact our Customer Care Center at 800-279-1301.

# DIRECTORY

| CONTACT INFORMATION & WEB PAGES | |
|---|---|
| Dean Health Plan Customer Care Center<br>Monday – Thursday 7:30 am to 5:00 pm<br>Friday 8:00 am to 4:30 pm | (608) 828-1301 \| (800) 279-1301 |
| ForwardHealth Member Services<br>Monday – Friday 7:30 am to 5:00 pm | 800-362--3002 |
| Ryan Haack, Medicaid Program Specialist – Member Advocate | (608) 828-2863 \| (800) 356-7344, ext. 2863 |
| Daniel Ryan, Product Manager - Medicaid | (608) 827-4170 \| (800) 356-7344 ext. 4170 |
| Stefanie Schulz, Education and Outreach Coordinator | (608) 828-2907 \| (800) 356-7344 ext. 2907 |
| Corporate Compliance Department | (608) 827-4386 \| (800) 356-7344 ext. 4386 |
| Medicaid Managed Care Contract Monitors (for providers and members)<br>Monday – Friday 7:45 am to 4:30 pm | (800) 760-0001 |
| HealthCheck Coordinator | (608) 828-1956 |
| Dean Health Plan Provider Web Page | www.deancare.com/providers |
| Dean BadgerCare Plus Web Page | deancare.com/members/badgercare-plus-member |
| ForwardHealth Home Web Page | forwardhealth.wi.gov |
| BadgerCare Plus Web Pages | dhs.wisconsin.gov/medicaid/ and dhs.wisconsin.gov/badgercareplus/ |

# BADGERCARE PLUS MANAGED CARE OVERVIEW

The Department of Health Services (DHS) is a state agency in Wisconsin that oversees state health services and programs under ForwardHealth. BadgerCare Plus is a state-sponsored health care program under ForwardHealth that provides coverage to qualified state residents who meet income requirements and fall into one of the following groups:

- Children age 17 and younger
- Pregnant women
- Parents and caretakers
- Childless adults
- Transitional medical assistance individuals, also known as member on extensions.

Dean Health Plan offers BadgerCare Plus to eligible residents residing in counties included in the Dean Health Plan BadgerCare Plus service area. Dean Health BadgerCare Plus HMO members have full access to the Dean Health Plan network of providers who are enrolled as Medicaid providers. Not all BadgerCare Plus members are enrolled in HMOs. Some members remain in straight Medicaid or as fee-for-service members where they have access to any Medicaid-enrolled provider. Members enrolled in BadgerCare Plus receive a ForwardHealth-branded member ID card.

## GOVERNMENT PROGRAMS DEPARTMENT

The Government Programs Department is responsible for overseeing the development, implementation, and ongoing operation of the Dean Health Plan BadgerCare Plus Managed Care Program. This includes oversite of DHS-required performance improvement projects each year. The success of these projects relies on provider participation and collaboration. The Government Programs Department serves as a liaison between Dean Health Plan, providers, and the DHS. Government Programs Department staff is available to assist providers and members in understanding BadgerCare Plus policies and procedures, DHS requirements, exemptions, and appeals.

Additionally, the Government Programs Department works with the enrollment contractor, community-based organizations, local public health departments, county or tribal human service departments, and enrollee advocacy groups to provide education and outreach on issues specific to BadgerCare Plus members.

The Education and Outreach Coordinator, listed in this manual's Directory, oversees the federal Early Periodic Screening Diagnosis and Treatment (EPSDT) HealthCheck Program, as well as quality improvement initiatives and works with providers, local health departments, and members to assure compliance with the pay for performance goals.

Government Programs Department staff works with schools, human service departments, public health agencies, prenatal care coordination providers, and targeted case management agencies to assure coordination of social and healthcare issues.

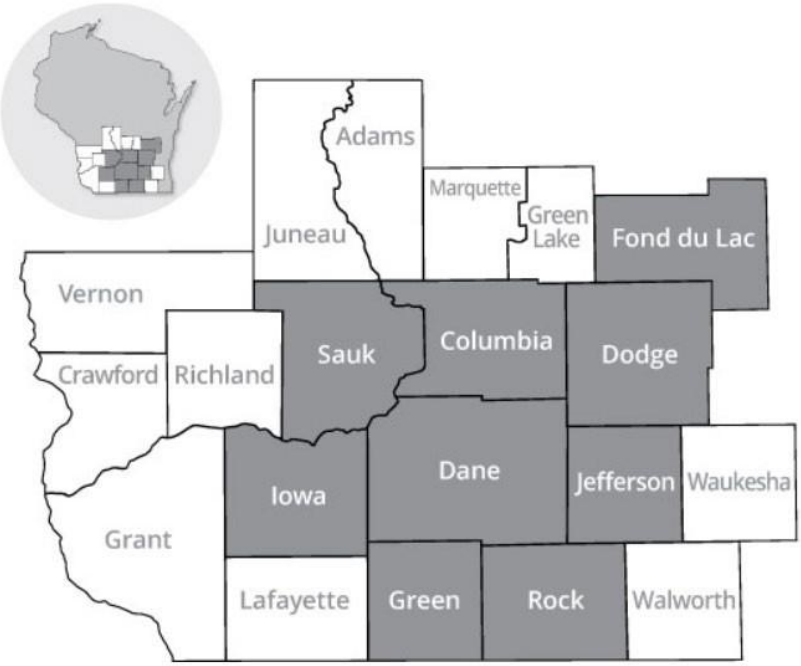
## MEMBER ADVOCATE

The Member Advocate is actively involved in the development of the infrastructure of the Dean Health Plan BadgerCare Plus Managed Care Program and helps members with conflict resolution, if needed. Members receive assistance in resolving problems and understanding their rights and responsibilities in the appeal and grievance process.

# BADGERCARE PLUS SERVICE AREAS

The following counties are included in the Dean Health Plan BadgerCare Plus service area (all ZIP codes are included for each of these counties).

- Columbia
- Dane
- Dodge
- Fond du Lac
- Green
- Iowa
- Jefferson
- Rock
- Sauk

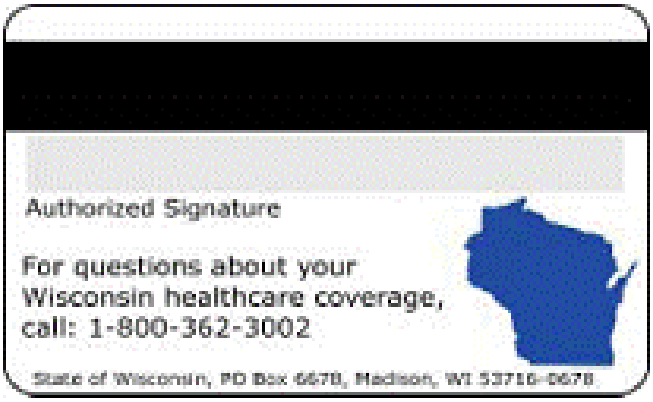



**Providers with a signed BadgerCare Plus contract who are not located within the Dean Health Plan BadgerCare Plus service area can still see Dean Health Plan BadgerCare Plus members.** Please contact Dean Health Plan's Member Advocate, listed in this manual's Directory, with any questions.

# MEMBER ID CARDS

Wisconsin BadgerCare Plus members receive a "ForwardHealth" ID card upon initial enrollment. Each individual in a BadgerCare Plus family receives their own individual ID number and card. **Dean Health Plan will not issue members a separate ID card, unless the member has been assigned or has chosen Access Community Health Centers as their primary care provider site.**


**FRONT**




**BACK**

The front of the ForwardHealth member ID card includes the member's name, 10-digit Medicaid ID number, and unique 16-digit number. This number is for internal use only and is not used for billing.

The back of the ForwardHealth member ID card includes a magnetic stripe, signature panel, and the ForwardHealth Member Services telephone number. The card does not need to be signed to be valid. However, adult members are encouraged to sign their cards. Providers may use the signature as another means of identification.

The ForwardHealth cards are designed to be kept indefinitely by members, who are encouraged to always keep their cards even though they may have periods of ineligibility. It is possible a member will present a card when he or she is not eligible, therefore it is essential that providers confirm eligibility before providing services.

If a card is lost, stolen, or damaged, Wisconsin BadgerCare Plus will replace the card at no cost to the member. Members should contact ForwardHealth's Member Services at 800-362-3002 to request replacement cards.

## ELIGIBILITY VERIFICATION

It is important that providers or their designated agents determine the member's eligibility and HMO enrollment status **prior** to each visit. Providers should verify eligibility for each date of service and cannot charge a member for doing so.

Providers may verify BadgerCare Plus member eligibility through Dean Health Plan as they do for members enrolled in Commercial products using any one of the following:

- The 270/271 Eligibility and Benefit Inquiry and Response transaction.
- The Eligibility application in the Dean Health Plan Provider Portal accessible from the Account Login page.
- Access online member health plan benefit information, including certificate of coverage, member policy, or certificate at memberbenefits.deancare.com by entering the full member ID or group number.
- The Customer Care Center at 800-279-1301.

Or through ForwardHealth using any one of the following:

- ForwardHealth Portal account at forwardhealth.wi.gov.
- WiCall, Wisconsin's automated voice response system, by calling 800-947-3544.
- 270/271 Health Care Enrollment/Benefit Inquiry and Information Response transaction.

# PROVIDER REQUIREMENTS

## MEDICAID ENROLLMENT

Dean Health Plan providers must be actively enrolled as a Wisconsin Medicaid provider in order to see Dean Health Plan BadgerCare Plus members. For information on how to become a Medicaid-enrolled provider, click the 'Become a Provider link' from the ForwardHealth home page at forwardhealth.wi.gov.

If a provider is not a Dean Health Plan contracted provider and is also enrolled with the Wisconsin Medicaid Program, they may **not** see a Dean Health Plan BadgerCare Plus member**. Without an active Wisconsin Medicaid provider enrollment, claims will be denied for payment.**

If at any time a Dean Health Plan provider's Medicaid enrollment changes, it is the provider's responsibility to report the change to the Health Plan. This includes if a provider becomes newly enrolled as a Medicaid provider, their Medicaid enrollment expires, or if their Medicaid enrollment is reinstated. Keeping the Health Plan informed of provider enrollment status will facilitate timely and accurate claim payment. If the provider fails to notify Dean Health Plan of changes, claims may be denied because updated information is not on file with the Health Plan, and the member cannot be billed for these services.

Refer to the Dean Health Plan Provider Manual for Health Plan contracting and credentialling requirements for providers.

# BADGERCARE PLUS PROGRAMS

## LOCK-IN PROGRAM

The purpose of the Lock-In Program is to coordinate the provision of healthcare services for members who abuse or misuse BadgerCare Plus benefits by seeking duplicate or medically unnecessary services, particularly for controlled substances. The Lock-In Program focuses on the abuse or misuse of prescription benefits for controlled substances. Abuse or misuse is defined under Recipient Duties in Wis. Admin. Code § DHS 104.02.

All Dean Health Plan providers are expected to participate in the Lock-In Program for our BadgerCare Plus members. Dean Health Plan works in collaboration with the Department of Health Services (DHS) by assigning members to a prescriber where restricted medication must be filled for at least a two-year time period. Providers should contact the Health Plan if they suspect member abuse or misuse of prescription benefits for controlled substances so that the member may be enrolled in a Lock-In Program, if appropriate.

Providers with a previous history of prescribing for a BadgerCare Plus member may be assigned as a Lock-In Prescriber. The Health Plan notifies providers via letter and also asks for an alternate prescriber, if necessary. Please note that nothing additional is required of assigned prescribers except for continuing to monitor and prescribe medications.

## WISCONSIN DEPARTMENT OF HEALTH SERVICES' (DHS) HMO QUALITY PROGRAM

Wisconsin Medicaid establishes a three-year managed care quality roadmap to ensure access to effective health care services for enrollees. As part of this plan, the DHS reserves a portion of health plan revenue and makes that revenue available to the health plan if the health plan meets certain performance targets. This performance-based payment system is the Pay-for-Performance (P4P) program. Refer to the Resources for Hospital Providers web page for Wisconsin Medicaid Hospital Quality Program Pay-for-Performance Guides.

Through the P4P program, HMOs and the DHS track key health care measures with the goal of improving the quality of health care delivery. The P4P program is a partnership between Dean Health Plan and our clinics to act as a resource to share ideas and suggest process changes that can better support our members. Please contact the Medicaid Program Specialist with any questions, concerns, or to discuss strategies for improvement.

The measures set by DHS may change every year, but typically focus on preventive care and screenings, comprehensive diabetes care, mental/behavioral health, pregnancy/healthy birth, and, more recently, cultural awareness in the provision of health care services.

**Why is the HMO P4P Program Important?**

- **Quality:** Improve quality of care for BadgerCare Plus members.
  - DHS sets annual goals for each measure. Dean Health Plan monitors rates and works with members, clinics, and outside organizations to meet the defined targets.
- **Performance**: Dean Health Plan's ranking among area health plans.
  - DHS creates an annual BadgerCare Plus Report Card to show performance in relation to other HMOs, along with the state and national averages. This information is made available to members to help them choose an HMO to suit their healthcare needs.

The DHS collects HEDIS (Healthcare Effectiveness Data and Information Set) from the contracted health plans for its P4P initiative and to report to CMS as part of the State Medicaid quality report card. *Please see HEDIS Technical Specifications for additional details*. The DHS utilizes National Committee for Quality Assurance's (NCQA) Quality Compass data for Medicaid as one of the key inputs for setting targets for the P4P measures.

**Wisconsin Department of Health Services- P4P Measures**

- Blood Lead Screening: The percent of children who receive a blood lead screen by their second birthday.
- EPSDT/HealthCheck: Prevention screens performed on children as a percentage of the total required EPSDT screens for members under 21 years of age.
- Childhood Immunization Status (CIS): The percent of children who had all of their combination three immunizations by their second birthday.
- Timeliness of Prenatal and Postpartum Care (PPC): Percent of deliveries of live births who receive prenatal and postpartum care within the designated timeframes. For prenatal care, the percentage of deliveries that received a prenatal care visit in the first trimester, or within 42 days of enrollment in the HMO. For postpartum care, the percentage of deliveries that had a postpartum visit on or between 21-56 days after delivery or 3-8 weeks.

| *Measures* | *Target Rate** |
|---|---|
| Childhood Immunization Status | 75.2% |
| Timeliness of Prenatal Care | 92.0% |
| Timeliness of Postpartum Care | 80.9% |
| | * 2021 data |

# MEMBER ENROLLMENT

## DEAN HEALTH PLAN NEW MEMBER MATERIALS

New members receive the following within their first month of enrollment:

- Welcome letter
- Provider Directory
- Dean Health Plan Member Handbook
- Health Needs Assessment Survey
- Primary Care Provider (PCP) selection form to be sent back in the enclosed postage paid return envelope
- Request to receive documents in another language
- Notice of Privacy Practices

Members who are enrolled in Dean Health Plan will receive a handbook which gives them important information, such as:

- Important phone numbers
  - Dean Health Plan Customer Care Center
  - Dean on Call - 24-hour emergency number
- How to choose a Doctor/Primary care provider
- How to use the ForwardHealth Card
- How to obtain referrals
- HealthCheck information
- How to access urgent and emergent care
- How to obtain mental health and alcohol and other drug abuse (AODA) treatment
- Complaints and grievances information
- TDD number
- Enrollment Specialist information

The handbook is available in the following languages:

- English
- Hmong
- Chinese
- Spanish

## MANDATORY OR VOLUNTARY ENROLLMENT

Member enrollment in an HMO is mandatory in areas where there are two or more HMOs accepting BadgerCare Plus enrollees. If only one HMO is in a service area, members will have the choice of an HMO or fee-for-service. Also, BadgerCare enrollees who are members of a First Nation do not need to enroll in an HMO.

## ENROLLMENT CONTRACTOR

Wisconsin does not allow HMOs to market or enroll BadgerCare Plus members in their HMOs. The DHS has contracted with Maximus to act as an enrollment broker for members. Maximus performs enrollment, education, outreach, and advocacy for members. Their primary role is to help members select the best HMO for their needs. The enrollment contractor's telephone number is (800) 291-2002. Questions about a member's enrollment status may be directed to Maximus at 800- 291-2002.

## ENROLLMENT PROCESS

Enrollment in HMOs for BadgerCare members is handled by the State of Wisconsin and Maximus. Members can choose an HMO when applying for Medicaid, or can choose an HMO after they are determined eligible for benefit coverage. If a member does not choose an HMO, one will be assigned randomly. Random assignment will be distributed to all HMOs serving in that area. Members may change HMOs during the first three months of enrollment but will be locked into the HMO beginning in the fourth month of enrollment. The HMO lock-in will continue through the twelfth month of enrollment.

## ASSIGNMENT OF PRIMARY CARE PRACTITIONER

When Dean Health Plan is notified of a new BadgerCare+ enrollee, DHP checks member history and retains the PCP assignment that is on record for the member. If a member does not have a PCP history, and they do not complete the Primary Care Provider (PCP) selection form included in the Welcome Packet, Dean Health Plan will send reminders. If a member does not select their primary care provider within three months, Dean Health Plan will assign one to the member. However, members may change their primary care provider at any time by contacting our Customer Care Center at 800-279-1301.

If the member notifies Dean Health Plan of their primary care provider choice, the Health Plan will assign that provider as long as they meet the qualifications of a BadgerCare Plus primary care provider.

## EXEMPTION FROM HMO ENROLLMENT

### SHORT TERM EXEMPTIONS

| Type of exemption | Length of exemption | Who may request this exemption | Criteria |
|---|---|---|---|
| Third trimester pregnancy exemption | Two full months past the Expected Date of Confinement (EDC) | Enrollee | The enrollee did not voluntarily choose their HMO<br>**-AND-**<br>the enrollee must be seeking care from a provider who is not affiliated with the HMO to which they were assigned. |
| High risk Pregnancy Exemption | Two full months past the EDC | Enrollee | The enrollee has a medical condition that has a direct risk on the enrollee's or the unborn child's health<br>**-AND-**<br>the provider the enrollee is seeing is not affiliated with an HMO or the HMO is closed to enrollment. |
| Continuity of Care | ***May** be up to three months* | Enrollee | The enrollee is receiving short term care which began prior to enrollment in an HMO and needs to complete a specific treatment plan or course<br>-**AND-**<br>a switch in healthcare providers would cause a major disruption to the enrollee's care (i.e., post-operative follow up after gall bladder surgery). |

### LONG TERM EXEMPTIONS

| Type of exemption | Length of exemption | Who may request this exemption | Criteria |
|---|---|---|---|
| Birth to three | To the child's third birthday | Casehead | A child between the age of 0 and three who is developmentally delayed<br>-**AND-**<br>is enrolled in a county's birth to three program. |
| Enrollment in another Medicaid managed care program | Through the course of the treatment | Casehead | If member is enrolled in Wraparound Milwaukee or Children Come First. |

### MISCELLANEOUS EXEMPTIONS

| Exemption | Length of exemption | Who may request this exemption | Criteria |
|---|---|---|---|
| Transplants (Liver, Lung, Heart, Pancreas, Heart-Lung, Pancreas-Kidney, or Bone Marrow) | Permanent | HMO Provider | Enrollee has had one of the listed transplants. |
| Other commercial insurance | Length of time the other HMO type of insurance is in effect | Enrollee | The enrollee has an HMO insurance which locks the enrollee into providers who are not affiliated with *any* HMO that is participating in the managed care program, or is not participating in a region. |
| Just cause | Permanent (Some cases are reviewed after two years.) | HMO | The HMO is unable to provide medically necessary care to an enrollee for reasons beyond the HMO's control<br>**-OR-**<br>continued enrollment in the HMO would be harmful to the best interest of the member. |
| Medicare | Permanent | Enrollee, Provider, or HMO | Enrollees who become eligible for Medicare will be disenrolled in the first of the month of notification. |

# MEMBER RIGHTS AND RESPONSIBILITIES

Members have the right:

- To receive the information in another language or format.
- To receive health care services as provided for in federal and state laws. All covered services must be available and accessible to members when medically appropriate, 24 hours a day, 7 days a week.
- Be treated with dignity and respect.
- Receive information about treatment options, including the right to request a second opinion.
- To make decisions about their health care.
- To ask for an interpreter and have one provided during any covered service.
- To be free from any form of restraint or seclusion used as a means of force, control, or reprisal.

# BADGERCARE PLUS POLICIES

Dean Health Plan adheres to ForwardHealth's policies for the Dean Health Plan BadgerCare Plus Managed Care Program.

## COLLECTING COPAYMENTS

Per DHS 104.01(12), Wis. Admin. Code, providers are prohibited from collecting copayment from certain members that are enrolled in BadgerCare Plus.

## NO SHOW POLICY

A provider cannot bill the BadgerCare Plus program, Dean Health Plan, or a BadgerCare Plus member for no show appointments.

- If the provider has a policy in place for termination of care due to **no show** appointments, the policy must be implemented for both commercial patients and BadgerCare Plus patients.
- If a BadgerCare Plus member does not show up for a scheduled appointment and does not notify the provider in advance of the cancellation, the provider should contact the Dean Health Plan Member Advocate at 608-828-2863.
- The Member Advocate will counsel BadgerCare Plus members regarding the importance of keeping appointments.
- The Dean Health Plan Member Advocate must be contacted if a pattern has begun to develop for missed appointments by a BadgerCare Plus member.

## COVERAGE OF SERVICES

Dean Health Plan does not cover the services listed below because they are covered and reimbursable as fee-for-service and should be billed directly to ForwardHealth:

- Dental
- Non-emergency Medical Transportation
- Chiropractic
- Childcare Coordination
- Tuberculosis related services
- Community support program services
- Medication Therapy management
- Pharmacy and over-the-counter drugs and diabetic supplies dispensed by a pharmacy
- Provider administered drugs and their administration, as detailed in the ForwardHealth Online Handbook topics titled "Provider Administered Drugs" (topic #4382) and "Synagis" (topic #1951) at forwardhealth.wi.gov
- Prenatal Care Coordination (PNCC)
- School Based Services (SBS)
- Family planning services provided by Medicaid certified family planning clinics
- Targeted case management
- Crisis Intervention Services

Refer to ForwardHealth's Online Handbook for Medicaid claim instructions. All other services provided to Dean Health Plan BadgerCare Plus members should be billed to Dean Health Plan.

## BENEFIT PACKAGES

A BadgerCare member has the same benefits as a Medicaid enrollee. If questions on coverage arise, please check the ForwardHealth Online Handbook.

# BADGERCARE PLUS CLAIMS SUBMISSION

All claims submitted to Dean Health Plan for a BadgerCare Plus member must be submitted with the same information as if billing Wisconsin Medicaid directly for a Medicaid fee-for-service member. This includes the correct and complete BadgerCare Plus member ID number, billing and rendering NPIs, taxonomy code, and 9-digit zip code.

Information in this section of the manual contains Dean Health Plan-related claim guidelines with specific callouts for BadgerCare Plus claims that may be different than information for commercial claims. Refer to the Dean Health Plan Provider Manuals for more details on claim submissions, corrections, and timely filing. Refer to ForwardHealth's Online Handbook for Medicaid claim instructions.

## CLAIM SUBMISSION AND GUIDELINES

While Dean Health Plan will accept paper or electronically submitted claims, it's recommended to submit electronically to expedite processing and reduce claim rejections. All claims submitted, regardless of submission method, must comply with the applicable national billing rules as well as the published Companion Guides.

- Do not submit decimals on claims. Fractional quantities on claims must be rounded up or down, accordingly.
- It is imperative for services to be coded accurately with valid ICD-10, CPT-4, and HCPCS codes to avoid claim denials.
- Indicate the applicable two-digit place of the service code on claims.

## CLAIMS PROCESSING

Claims are reviewed, if necessary, to ensure proper payment. Claims will then be adjudicated, and the payment cycle will run weekly.

## REIMBURSEMENT OF SERVICES

Dean Health Plan must be billed within the timely filing limit outlined in your contract. If a provider utilizes the UB-04 form, the provider must submit the revenue and related HCPCS codes to ensure appropriate reimbursement. Itemized billings for each service, including admission and discharge diagnoses, and documentation that authorization was obtained, is required.

Dean Health Plan shall make every attempt to reimburse a claim with all required information within 30 days of receipt. Payments for qualifying emergencies (including services at a hospital or urgent care facility) are based on the medical signs and symptoms of the condition upon initial presentation. The retrospective findings of a medical workup may provide a legitimate basis to determine how much additional care may be authorized, but will not influence payment for the initial emergency services.

**A member may not be billed for a service, other than a set copay, unless the member is told prior to receiving the service that it is a non-covered benefit under BadgerCare Plus. If the member elects to have the service, the provider must explain the member's responsibility for payment and the member must sign a waiver form.**

Payment for BadgerCare Plus members is generated separately from commercial lines of business.

Dean Health Plan will always use the most recent maximum fee schedule file provided by Forward Health when processing claims. In the event that the maximum fee schedule file retroactively adds or deletes services from the file, Dean Health Plan does not reprocess impacted claims, but each situation is reviewed independently, and claims may be reprocessed at the Health Plan's discretion.

## OVERPAYMENTS

Once identified, providers need to return overpayments made for BadgerCare members within 60 days of identification of the overpayment, in accordance with CMS rules.

## COORDINATION OF BENEFITS (COB)

**BadgerCare Plus is always payor of last resort.** If Dean Health Plan has record of other health insurance coverage for the member during the same timeframe, the claim will be denied as "other insurance primary." After the primary insurance has processed the claim, the claim along with the Explanation of Benefit (EOB) can be submitted to Dean Health Plan for consideration of supplemental payment. Providers are asked to contact our Customer Care Center at 800-279-1301 or ForwardHealth to share any updates to a member's health insurance coverage.

Dean Health Plan will coordinate benefits with another insurance company as long as the balance is **below** our allowed amount and the member has followed their primary insurance. If the member does not follow their primary's rules, Dean Health Plan will deny the Medicaid claim. This is different from the process for Commercial members.

## SUBROGATION/WORKER'S COMPENSATION

Refer to the Dean Health Plan Provider Manual for information on subrogation and worker's compensation.

## MEMBER BILLING

Dean Health Plan in-network providers agree to accept payment made by Dean Health Plan as payment in full. **Discounts and withholds are not to be billed to the member or the supplemental insurance company.**

## SPECIFIC BILLING INSTRUCTIONS FOR SERVICES RENDERED TO BADGERCARE PLUS MEMBERS

- **Mom/Baby**
  A newborn's ID number, assigned by the State of Wisconsin, should be used instead of the mother's ID number for the initial submission of a newborn's claim. If a claim is submitted for a newborn under the mother's ID number within the time limit outlined in your provider agreement, the claim will be reflected on your Rejected Claims Report or denied on an Explanation of Payment (EOP) for invalid member number. When the newborn is enrolled in BadgerCare Plus, send in the Rejected Claims Report to Dean Health Plan with some type of notation next to the claim indicating that the baby is now enrolled, or resubmit the claim clearly marking "resubmission" and list the claim number or ICN from your original EOP/rejection report.

- **Eyeglasses**
  Classic Optical (Classic Optical Laboratories, Inc.) is the vendor for the SPEC (State Purchase Eyeglass Contract). Eyeglasses must be ordered from Classic Optical Laboratories. Any questions regarding the process involved can be answered by contacting Classic Optical at 888-522-2020. **Dispensing fees should be submitted to Dean Health Plan.**

- **Diabetic Supplies**
  All diabetic supplies, including supplies related to insulin pumps, are covered under the medical benefit and paid by Dean Health Plan.

# BADGERCARE PLUS PRIOR AUTHORIZATION

## AUTHORIZATION SERVICES

Dean Health Plan's BadgerCare Plus contract states that it is the provider's responsibility to obtain an authorization when required. A member must be referred to a Medicaid enrolled provider. Primary care practitioners (and sometimes in-network specialists) should complete and submit an authorization request for an out-of-network provider when they believe that the request is medically necessary. Dean Health Plan in-network providers are responsible for submitting authorization requests and ensuring that an approved prior authorization is in place prior to rendering services.

The prior authorization process is the same for Dean BadgerCare Plus members as it is for Dean Health Plan Commercial members. Case Management services will be utilized for more extensive long-term cases.

The member ID number can be obtained from the BadgerCare Plus ForwardHealth ID card and should be put on the authorization form in the subscriber number space. Providers should always verify Dean Health Plan Badger Care Plus eligibility and HMO enrollment through the ForwardHealth Portal or by contacting the Dean Health Plan Customer Care Center at 800-279-1301.

Dean Health Plan Medical Policies are published in the Dean Health Plan Document Library that is linked from the Dean Health Plan Medical Management page.

## PLANNED INPATIENT HOSPITAL ADMISSIONS

Prior authorization is required for any elective (planned) inpatient hospital admission at least seven days prior to the scheduled admission date. **All inpatient admissions will be reviewed for medical necessity. Plan hospitals are required to report inpatient and observation admissions to Dean Health Plan no later than the following business day.**

Elective (planned) inpatient admissions to non-plan hospitals require prior authorization and must be approved by a Dean Health Plan Medical Director prior to admission.

## EMERGENCY CARE SERVICES

If care meets the definition of emergency defined below, prior authorization is not required to treat or admit. However, emergency inpatient admissions to **both plan and non-plan hospitals must be reported to Dean Health Plan on the next business day and will be reviewed for medical necessity.**

Prior authorization is not required for emergency services provided at an urgent care center. Prior authorization is required for all emergency services that do not meet the BadgerCare Plus definition of an emergency.

Dean on Call, the nurse line, is available 24 hours per day to discuss your urgent medical care issues and will be able to provide information on the appropriate care for your medical needs both in and out of the DHP provider network. The number to contact is (800) 576-8773 or (608) 250-1393.

### Definitions

The following are the definitions of emergency, non-emergent, urgent, and routine care services as defined in the Dean Health Plan BadgerCare Plus Contract:

- **Emergency Care:**
  An emergency medical condition means one of the following:
  - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:
    - Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
    - Serious impairment of bodily function; or

- Serious dysfunction of any bodily organ or part;

- With respect to a pregnant woman who is in active labor:
  - That there is inadequate time to affect a safe transfer to a plan hospital before delivery;

    or
  - The transfer to a plan facility may pose a threat to the health or safety of the woman or the unborn child;

- A psychiatric emergency involving a significant risk of serious harm to oneself or others;

- An AODA emergency exists if there is significant risk of serious harm to a member or others, or there is likelihood of return to substance abuse without immediate treatment;

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

Some examples of emergency medical conditions may include, but are not limited to:

- choking
- serious broken bones
- severe burns
- suspected poisoning
- convulsions
- prolonged or repeated seizures
- severe airway restrictions
- unconsciousness
- severe pain
- severe bleeding
- suspected heart attack or stroke

- **Urgent/Non-Emergent Care:**
  Non-emergent/urgent care services are services that are needed in order to treat an unforeseen medical problem that is not life-threatening, but requires prompt diagnosis and/or treatment in order to preserve the member's health. Members with non-emergent conditions may be directed to a Dean Health Plan contracted facility without risk to the member's health. Examples of services which may require non-emergent care services include, but are not limited to:
  - most broken bone cases
  - minor burns
  - most drug reactions
  - lacerations requiring stitches
  - sprains

- **Routine Care:**
  Routine care services are services that are non-emergent/urgent.

### Prior Authorization Process

The following outlines Dean Health Plan's prior authorization process for emergency services.

Patient arrives at emergency department seeking care. Patient undergoes initial evaluation and care is determined to be:

- Emergency
  - Patient is treated by emergency room (ER) physician and staff.
    - No prior authorization is needed.
    - Plan and out-of-network facilities must notify Dean Health Plan of an emergency inpatient or observation admission no later than the next business day.

- Urgent/Non-Emergent

- If the member is instructed to be seen at the ER or Urgent Care by their physician, authorization by Dean Health Plan is not needed. Dean Health Plan considers authorization by the physician acceptable. The ER record should indicate that the physician authorized care.
- No prior authorization

## PRIOR AUTHORIZATION OF SPECIFIC SERVICES

Dean BadgerCare Plus policies use Forward Health authorization policies for guidelines specific to coverage of services requested by Dean BadgerCare Plus providers and members. If the ForwardHealth Portal authorization process does not address or provide medical necessity or coverage criteria for services requiring prior authorization, Utilization Management staff will then refer to Dean Health Plan Medical Policies and/or have the request reviewed by a Dean Health Plan Medical Director.

The items below **differ** from our HMO prior authorization guidelines.

- **Home Health Services**
  - Home Health services for private duty nursing, home health aides, and personal care workers require prior authorization and are based on medical necessity of the requested services.

- **Vision**
  - The following services require prior authorization and are based on medical necessity. All prior authorizations must be submitted to Dean Health Plan:
    - Vision training and therapy, including orthoptics and pleoptics
    - Contact lenses and contact lens therapy, **except** when the diagnosis is aphakia or keratoconus, or if the contacts are being used as a therapeutic or bandage lens
    - Low vision services and aids for all diagnostic conditions
    - Aniseikonic services
    - Eyeglass frames and lenses beyond the original and one unchanged prescription replacement pair (either a complete appliance, lens replacement, or a frame replacement dispensed on a different date of service) from the same provider in a 12-month period
    - Ptosis crutch services and materials
    - Contracted occupational safety frames and lenses
    - Tinted eyeglass lenses (contacted tints and coatings including rose #1 and rose #2, ultraviolet coating, and photochromic lens)
      Special lens designs and components (contracted high index glass and plastic, polycarbonate lenses for members age 21 and over, large eye size 59mm or over)

## SECOND OPINION

Dean Health Plan will allow a second opinion from an in-network provider. A second opinion from an out-of-network-plan provider requires prior authorization and will be reviewed by a Medical Director.

## TRANSFERRING PATIENTS

Transplants are life changing and complex, not only affecting the member but involving their family as well. Dean Health Plan's Care Management team offers support before and after the procedure, providing education and coordination of services to ensure members receive the care they need. The case manager collaborates with the transplanting facility, especially with the member's nurse coordinator.

A transplant case manager and program outreach specialist can help members:

- Understand and manage the complex disease that is leading toward transplantation.
- Coordinate care with providers, clinics, and programs through the transplant process.
- Navigate and understand health coverage and benefits before, during, and after transplant.
- Understand whether appropriate prior authorizations for transplant services are in place.
- Connect with an advance care planning social worker, if desired.

For more information, go to the Dean Health Plan Transplant Case Management web page at deancare.com/wellness/care-management/transplant-case-management.

## OUTPATIENT MENTAL HEALTH

Dean Health Plan recommends that providers encourage BadgerCare Plus members to follow-up with an outpatient behavioral health provider within 7 days of being discharged from an inpatient mental health or AODA facility. There is no question that rapid outpatient follow-up is consistent with standard practice guidelines and leads to better patient care.

**Authorizing Behavioral Health**

The primary care provider acts as the "gatekeeper" for member care to ensure members receive appropriate, high-quality care in a cost-effective manner. The primary care provider is an integral part in the authorization of behavioral health services to ensure appropriate utilization. Because an authorization is not required for in-network mental health services, if the primary care provider determines mental health services are medically necessary and knows the in-network mental health provider they want to refer the member to, they may do so without completing an Authorization Request Form. If the primary care provider needs to find an in-network provider, they may do so at deancare.com and select the "Find a Doctor" link located at the top of the web page to search our online directory. They may search by provider name, specialty, or location.

When a Dean Health Plan BadgerCare Plus patient is referred for behavioral health services, they should be treated no differently than commercial Dean Health Plan patients in terms of timely access to care, either at intake or for follow-up services.

**Patients requiring outpatient services not offered at a plan clinic/practice:**

All authorizations to out-of-network behavioral health providers need to be approved by Dean Health Plan.

**Terminating patients from your clinic/practice:**

Dean Health Plan BadgerCare Plus members should not be treated any differently than commercial Dean Health Plan members who receive services at your clinic/practice. As long as you apply your policies consistently, there is nothing prohibiting you from terminating a Dean Health Plan BadgerCare Plus patient from your clinic/practice.

When you are considering termination of care, **the Provider Network Consultant must be informed.** In certain cases, enrollees may be disenrolled from Dean Health Plan's BadgerCare Plus HMO for just cause.

Dean Health Plan will assist the member in arranging care with another provider.

**Patient does not require or would not benefit from services:**

If on the basis of a thorough bio-psych-social evaluation your clinic determines either that a Dean Health Plan BadgerCare Plus member does not require or would not benefit from specific behavioral health services, your staff needs to document this conclusion in writing to Dean Health Plan. Dean Health Plan will stand by your recommendation, or, in special circumstances, seek a second opinion. In all cases such as these, Dean Health Plan assumes that you communicate your recommendations directly to the member.

**Concerns about coordination with County Social Services:**

The DHS requires Dean Health Plan to enter into a "Memorandum of Understanding" (MOU) between County Human Service Agencies and Dean Health Plan. The purpose is to develop a working relationship with community agencies involved in the provision of non-medical services to BadgerCare Plus members.

## INPATIENT MENTAL HEALTH

Hospital admissions follow the same guidelines as planned inpatient hospital admissions.

## BEHAVORIAL HEALTH AND SUBSTANCE ABUSE

The mental health/substance abuse services process is the same for BadgerCare Plus members as it is for Dean Health Plan commercial members. Dean Health Plan BadgerCare Plus members can self-refer to an in-network provider for an initial assessment. Please refer to the Dean Health Plan Provider Manual for details on the Dean Health Plan policies for court-ordered care. These guidelines also apply to BadgerCare Plus members.

## PROVIDER APPEALS

If a provider wishes to appeal an initial HMO determination, they should contact our Customer Care Center for more information. **Please refer to the *Inquiry/Complaint Process* Section in this manual for a description of the procedure.**

The appeal must be submitted within 60 business days of receipt of Dean Health Plan's original determination. Dean Health Plan will respond to appeals within 45 days. If Dean Health Plan fails to respond within the 45-day time frame, or if the provider is not satisfied with Dean Health Plan's response, the provider may seek a final determination from the DHS (Department of Health Services). All appeals to DHS must be submitted in writing within 60 days of Dean Health Plan's final decision, to the following address:

HMO Contract Monitors
P.O. Box 6470
Madison, WI 53791-9823

# FORWARDHEALTH FORMS

ForwardHealth requires voluntary or mandatory forms for certain services, as outlined in this section of the provider manual. "Mandatory" means that a specific form must be used. "Voluntary" means that a provider may develop and use their own form for the service, however, it must contain all of the information included in the ForwardHealth-provided form. ForwardHealth forms are available from the ForwardHealth Forms web page. Users may search the page by Form Type, Keyword, or Form Number. Forms are generally available in English, Hmong, and Spanish languages in Word and PDF formats. When necessary, instructions are available in an accompanying document.

## ABORTIONS

Dean Health Plan follows all State and Federal requirements for abortions. Abortions do not require prior authorization if provided by an in-network provider. Out-of-network providers are required to fax a PA request to Dean Health Plan's Utilization Management Department at (608) 836-6516 as well as the Abortion Certification Statement Form 1161 on the ForwardHealth Forms web page.

Please note the following important information about abortion coverage:

- Complications arising from an abortion, regardless of whether the abortion itself is a covered service, are payable. This is because complications represent a new condition.
- If a BadgerCare Plus provider performs a non-Medicaid covered abortion on a BadgerCare Plus member and claims Medicaid reimbursement for other services that were provided to the same member **between nine months prior to and six weeks after the non-covered abortion**, the claim(s) must be submitted on paper with documentation, as outlined in the Abortion Certification Statements form must accompany the claim.

Common Abortion Reporting Problems:

- The physician must attach medical documentation as well as a physician's statement when the abortion is performed due to either the long-lasting health damage or the medical necessity to save the woman's life. Example: For a member with AIDS, documentation about the start of antiretroviral medication, T-cell counts, and other appropriate medical documentation would be required. **All medical documentation provided must be submitted *prior* to the abortion.**

## STERILIZATIONS

Sterilizations do not require prior authorization if provided by an in-network provider. The Consent for Sterilization form must be signed, and a copy submitted with the sterilization claim. At least 30 days, but not more than 180 days, must have passed between the date of informed consent and the date of sterilization. **Do not count date signed or date of surgery in the 30-day criteria.** Refer to the ForwardHealth Online Handbook topic titled "Sterilizations" (topic #1584) for more information.

**Other important information about the Sterilization Consent Form**

- The use of opaque correction fluid, ribbons, or tape to cover errors or make changes makes the sterilization form invalid.
- If changes are made to the Consent form, the following steps must be taken:
  - line-out the error;
  - correct the error; and
  - initial the error

**The patient must initial any changes on the form if it directly relates to them.**

- Informed consent may not be obtained while the individual to be sterilized is:
  - In labor or childbirth;
  - Seeking to obtain or obtaining an abortion; or
  - Under the influence of alcohol or other substance that affects the individual's state of awareness.
- The person who obtains the informed consent must orally provide all of the requirements for informed consent as set forth on the consent form. They must offer to answer any questions and must provide a copy of the

consent form to the individual to be sterilized for his or her consideration during the waiting period. (The person obtaining the consent may, but is not required to be, the physician performing the procedure).
    - An interpreter must be provided to assist the member if he or she does not understand the language used on the consent form or the language used by the person obtaining the consent.
    - Suitable arrangements must be made to ensure that the required information is effectively communicated to members to be sterilized who are blind, deaf, or otherwise disabled.
- A witness chosen by the member may be present when the consent is obtained. The witness may not be the person obtaining consent.
- Common Sterilization Reporting Problems:
    - The sterilization occurs less than 30 days after the date of informed consent:
        - Neither the date of the informed consent nor the date of the sterilization count in the thirty days.
        - The physician forgets to indicate either a premature delivery or an emergency abdominal surgery.
    - The sterilization occurs less than 30 days after the date of informed consent and the physician has indicated a premature delivery:
        - *Physician must indicate the "EDC" (estimated date of confinement) for a premature delivery.*
        - *Admission history and discharge summary must be included with the sterilization consent form if the sterilization was performed with an emergency abdominal surgery*
    - On the physician's statement portion of the consent form, the signature date must be either the day of the surgery or after the surgery date**. It may not be prior to the date of the sterilization.**
        - **Member must be at least 21 years of age on the date he/she signs the consent form.**
        - The procedure being performed must be completely spelled out in one of the appropriate places. Abbreviations (i.e., PPTL) are fine for the other areas.
        - **Send completed consent forms for sterilizations with the claim to Dean Health Plan.**
        - The form can be found at: dhs.wisconsin.gov/forms/F0/F01164.pdf
        - The instructions can be found at : dhs.wisconsin.gov/forms/F0/F01164A.pdf

## HYSTERECTOMIES

Hysterectomies do not require prior authorization if provided by an in-network provider as an outpatient procedure. Hysterectomies do require that an acknowledgment of information form be completed. This form must be on the patient's record at the time of hospitalization.

A hysterectomy is **not covered** if:

- It was performed solely for the purpose of rendering an individual permanently incapable of reproducing; or
- There was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

Common Hysterectomy Reporting Problems:

- The date the **member** signs the form must **be prior to or coincide with the date of the surgery.**
- The date the **provider** signs the form must be **before the date of service.**

May be performed without the "Acknowledgment of Receipt of Hysterectomy Information" if:

- The individual was already sterile prior to the hysterectomy and appropriate documentation is attached such as a prior sterilization consent form.
- The individual requires a hysterectomy because of a life-threatening emergency in which the physician determines that a prior acknowledgment is not possible. The physician must attach the admission history and discharge summary in this case.

The form and instructions can be found at: dhs.wisconsin.gov/forms/f0/f01160.pdf.

**Instructions for Completion of Form**

The Acknowledgement of Receipt of Hysterectomy Information form, F-01160, is to be completed by a physician before performing the surgery and either uploaded via the ForwardHealth Portal for electronically submitted claims or attached to a paper 1500 Health Insurance Claim Form or UB-04 Claim Form. **The Acknowledgement of Receipt of Hysterectomy Information form, F-01160, is mandatory; use an exact copy. Alternate versions (i.e., retyped or otherwise reformatted) of the Acknowledgement of Receipt of Hysterectomy Information form, F-01160, will not be accepted.**

ForwardHealth reimbursement for a hysterectomy requires the completion of the Acknowledgement of Receipt of Hysterectomy Information form, F-01160. The Acknowledgement of Receipt of Hysterectomy Information form, F-01160, is not to be used for purposes of consent of sterilization. A member must give voluntary written consent on the federally required Consent for Sterilization form, F-01164, which can be located on the Forms page of the ForwardHealth Portal at forwardhealth.wi.gov/WIPortal/content/provider/forms/index.htm.spage#.

# BADGERCARE PLUS MEMBER APPEAL AND GRIEVANCE PROCEDURES

The Appeal and Grievance Procedure is used to resolve member issues. We ask that our providers familiarize themselves with this process, and refer all grievances to Dean Health Plan. With consent from their patients, this process may also be used by providers to file appeals or grievances on behalf of their patients.

When an appeal or grievance has been submitted, Dean Health Plan may contact a provider for more information related to the issue. We require that our practitioners respond promptly to any requests for information from Dean Health Plan. This will assist us in providing a timely response and resolution to appeals or grievances filed with our office. To ensure a fair decision, Dean Health Plan gives our practitioners the opportunity to discuss decisions that are based on medical necessity with a Dean Health Plan Medical Director. The treating physician will be informed at the time of the denial by the Medical Affairs Division on how to initiate this process should he/she want to discuss the decision.

The procedure for filing an appeal or grievance is defined below. This information is located in the BadgerCare Member Handbook.

Your understanding of this process will assist us in resolving member issues in a timely manner.

### GRIEVANCE

Any written expression of dissatisfaction will automatically be addressed as a grievance. We will document and investigate the member complaint and notify the member of the outcome of the grievance. A member or their authorized representative can file a grievance in writing to the following address or fax number:

**Dean Health Plan**
**P.O. Box 56099**
**Madison, WI 53705**
**(608) 828-1301/(800) 279-1301**
**Fax 608-252-0812**

Expedited grievances, or situations that may seriously jeopardize the member's life, health, or the ability to regain maximum functionality, may also be submitted by telephone at the phone number below. Standard grievances will be researched and responded to within 30 calendar days, while expedited grievances will be resolved and responded to within 72 hours.

Upon receipt of the grievance, Dean Health Plan's Grievance and Appeal Department will acknowledge it within 5 business days. The acknowledgment letter will advise the member of their right to:

- Submit additional written comments, documents, or other information regarding their grievance
- Be assisted or represented by another person of their choice
- Appear before the Grievance and Appeal Committee, if they wish to do so. The date and time will not be less than seven calendar days from the date of their acknowledgment and within a 30 calendar day timeframe of receiving the grievance

If a member chooses to appear before the Committee, they must notify the Health Plan. If they are unable to appear in-person before the Committee, they have the option of scheduling a conference call.

The member or the member's authorized representative have the right to request a copy of documents, free of charge, relevant to the outcome of the grievance by sending a written request to the address listed above.

Their grievance will be documented and investigated. All grievances will be resolved within 30 calendar days of receipt.

## INDEPENDENT EXTERNAL REVIEW

A member may be entitled to an independent external review (IER) of a final adverse determination involving care which has been determined not to meet the Health Plan's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of care, or where the requested services have been found to be experimental treatment. Determinations involving pre-existing conditions and Policy Rescissions are also eligible for IER. A member must exhaust all appeal/grievance options before requesting an independent external review.

However, if we agree with the member that the matter should proceed directly to independent review, or if they need immediate medical treatment and believe that the time period for resolving an internal grievance will cause a delay that could jeopardize their life or health, they may ask to bypass our internal grievance process. In these situations, the request will be processed on an expedited basis.

If the member or the member's authorized representative wish to file a request for an independent review, the request must be submitted in writing to the address listed above in the "Grievance" subsection and received within four months of the decision date of the grievance.

Upon receipt of the request, a Utilization Review Accreditation Commission (URAC) accredited IER will be assigned to the case through an unbiased random selection process. The assigned IER will also deliver a notice of the final external review decision in writing to the member or the member's authorized representative and Dean Health Plan within 45 calendar days of their receipt of the request.

A decision made by an IER is binding for both Dean Health Plan and the member with the exception of pre-existing condition exclusions and the rescission of the Medicaid coverage. The member is not responsible for the costs associated to the IER. The decision is binding for both the insurer (the Plan) and the insured. Requests for benefits beyond those defined in the benefit package are not eligible for independent external review. Please contact our Customer Care Center for information regarding availability, and the process for initiating the review.

## EXPEDITED GRIEVANCE

If the initial grievance involves the need for urgent care, we will resolve those within 72 hours of receiving the grievance according to Dean Health Plan's criteria which is based upon the urgent care grievance provisions of state law. If the grievance meets criteria for an expedited grievance, meaning the situation is deemed urgent in nature or the member is receiving ongoing treatment, they are also eligible for an expedited external review concurrent with the internal expedited review of their grievance. The request may be oral or written.

## BADGERCARE PLUS APPEALS PROCESS

If Dean Health Plan denies a claim or benefit that results in payment denial to the provider or makes a payment determination that is unsatisfactory to the provider, the provider is entitled to appeal the denial. The appeal must be received in writing 60 days from the date that the provider received notice from Dean Health Plan of the denial or payment determination.

The appeal can be submitted online through the Dean Health Plan Provider Portal or via paper submission. Electronic submission is always encouraged. In-network providers are encouraged to submit claim appeals online through the Claim Appeal application of the Dean Health Plan Provider Portal at providerauth.deancare.com. Refer to the Dean Health Plan Provider Portal User Guide, available to users through their secure portal account, for instructions on how to submit a claim appeal.

Dean Health Plan will respond in writing to the request within 45 days of receipt. We require that practitioners respond promptly to any requests for information regarding their appeal. If Dean Health Plan does not respond within 45 days or if the provider of care is not satisfied with Dean Health Plan's response to the request, Dean Health Plan will notify the provider that they may appeal to the Department of Health Services (DHS) for a final determination. Appeals to the DHS must be submitted in writing within 60 days of Dean Health Plan's response.

The DHS will accept comments from both parties. The DHS has 45 days from the date of receipt of all written comments to respond to the appeal. If the DHS finds in favor of the provider of care, Dean Health Plan must pay the provider of care within 45 days of receipt of this appeal determination.

# BadgerCare Plus Provider Appeal Form

***Please complete in full***

Provider Name and Address:

_____

_____

_____

_____

Claim No:_____

Subscriber No:_____

Date of Service:_____

Date of Billing:_____

Date of Rejection:_____

Reason Claim Merits Reconsideration:

_____

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Provider Signature_____ Date_____

Please return this completed form to:

Attn: Provider Appeals
Dean Health Plan
P.O. Box 56099
Madison, WI 53705

**Please include all appropriate documentation to review your appeal.**

# HEALTHCHECK PROGRAM

## HEATHCHECK PROGRAM DESCRIPTION

HealthCheck is Wisconsin BadgerCare Plus's federally mandated program known nationally as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); refer to 42 CFR Part 441. Dean Health Plan's contract with the State of Wisconsin requires that at least 80 percent of BadgerCare Plus children enrolled in our HMO receive age-appropriate HealthCheck screenings. HealthCheck screenings are designed to ensure that BadgerCare Plus enrollees under the age of 21 receive regular, comprehensive, preventive healthcare. Through the HealthCheck program, Wisconsin BadgerCare Plus pays for necessary healthcare, diagnostic services, treatment, and other needed services that are described in the Medical Assistance section of the Social Security Act, which are necessary to correct or ameliorate defects, physical and mental illnesses, and conditions discovered during the screening services.

The screening includes, but is not limited to, the following:

- A review of the member's health history.
- An assessment of growth and development.
- Identification of potential physical or developmental problems.
- Preventive health education.
- Referral assistance to providers.
- Lead testing.

## HEALTHCHECK "OTHER SERVICES"

Members who receive a HealthCheck screening are also eligible for HealthCheck "Other Services" for a year following the visit, unless a BadgerCare Plus-covered service will reasonably meet the identified medical need. To be covered under HealthCheck "Other Services," the services must be:

- Identified in a HealthCheck screening
- Medically necessary
- Allowed services under the Social Security Act
- Identified in 1905 (r) of the Social Security Act as covered under BadgerCare Plus
- Provided to a recipient under age 21
- Provided by a qualified provider
- Prior authorized by the Department of Health and Family Services (DHFS)

With the completion of a HealthCheck, some normally non-covered OTC drugs are covered without prior authorization. Pharmacy benefits are covered by FFS and covered prescriptions can be found though the states preferred drug list.

- The provider must submit requests for services with documentation of the date the last HealthCheck was provided and a physician signature.
- Provide the prescription with the date of the HealthCheck.

A prior authorization is **NOT** required for the following OTC drugs with a prescription that specifies the date of the HealthCheck and "HealthCheck Other Services:"

- Anti-diarrheal products
- Iron supplements
- Lactase products
- Laxatives
- Multivitamins
- Topical protectants

**Why should I provide HealthCheck services?**

- HealthCheck visits are designed to ensure regular, comprehensive preventive healthcare for BadgerCare Plus members under the age of 21.
- Under the Standard Plan, with a HealthCheck referral, medically necessary services that are otherwise non-covered by BadgerCare Plus may be reimbursed.
- Screening exam intervals are consistent with the American Academy of Pediatrics' recommendations.
- HealthCheck screening requirements follow State and Federal regulations and represent what most pediatric BadgerCare Plus providers see as "best practice."
- Screening as many BadgerCare Plus members as possible helps Dean Health Plan get the maximum premium from the state which will help your reimbursement rate.

**How often should a child obtain a HealthCheck screening?**

The Wisconsin Medical Assistance Program (WMAP) has established a periodicity schedule for screening services that is based on Federal EPSDT:

| Age range | Number of screenings | Recommended ages for screening |
|---|---|---|
| Birth to first birthday | 6 | birth<br>3-4 weeks<br>6-8 weeks<br>4 months<br>6 months<br>9 months |
| First birthday to second birthday | 3 | 12 months<br>15 months<br>18 months |
| Second birthday to third birthday | 2 | 2 years<br>2 ½ years |
| Third birthday to 21st birthday | 1 | Every other year, not to exceed once per year |

Dean Health Plan has a commitment to HealthCheck screenings and our in-network providers help to strengthen that commitment.

Each provider is asked to designate an individual in their office as a Clinic HealthCheck contact. **Contact the HealthCheck Coordinator for assistance with your billing questions, training requests, and questions on the HealthCheck program at (608) 828-1956.**

**Outreach Report**

- Clinics that provide HealthCheck screenings will receive a listing every other month of HealthCheck eligible children who are assigned to them for primary care and are due for their next HealthCheck. We invite providers to contact these members to receive their HealthCheck screening. Please report any discrepancies in the provided listing to the HealthCheck Coordinator.

**Performing complete HealthChecks for ALL BadgerCare Plus children keeps them healthy and provides higher reimbursement to providers.**

## HEALTHCHECK BILLING

Correct insurance information at the time of the visit is very important.

- Dean Health Plan BadgerCare Plus will not know about a HealthCheck if another health insurance is primary
- BadgerCare Plus eligibility changes frequently

If a comprehensive HealthCheck screen does not result in a referral, use the appropriate procedure code without any modifier. All other visits should be billed using office visit procedure codes.

## HEALTHCHECK REFERENCE SHEET

**HealthCheck Codes**

| Procedure Code | Description |
|---|---|
| -99202-99205** | New patient |
| -99213-99215** | Established patient |
| 99381^ | Initial preventive medicine, new patient; infant (age under 1 year). |
| 99382^ | Initial preventive medicine, new patient; early childhood (age 1 through 4 years). |
| 99383^ | Initial preventive medicine, new patient; late childhood (age 5 through 11 years). |
| 99384^ | Initial preventive medicine, new patient; adolescent (age 12 through 17 years). |
| 99385^ | Initial preventive medicine, new patient, (age 18 through 39 years). |
| 99391^ | Established patient, periodic preventive medicine; (age under 1 year). |
| 99392^ | Established patient, periodic preventive medicine; early childhood (age 1 through 4 years). |
| 99393^ | Established patient, periodic preventive medicine; late childhood (age 5 through 11 years). |
| 99394^ | Established patient, periodic preventive medicine; adolescent (age 12 through 17 years). |
| 99395^ | Established patient, periodic preventive medicine, (age 18 through 39 years). |
| 99460^ | Initial hospital or birthing center care for normal newborn infant. |
| 99461^ | Initial care in other than a hospital or birthing center for normal newborn infant. |
| 99463^ | Initial hospital or birthing center care of normal newborn infant (admitted/discharged same date). |

**^ These codes do not need an ICD-10-CM "Z" code.**

******* **These CPT-4 codes must be used in conjunction withICD-10-CM codes:**

- Z76.2 – Encounter for health supervision and care of other healthy infant and child,
- Z00.121 – Encounter for routine child health examination with abnormal findings,
- Z00.129 – Encounter for routine child health examination without abnormal findings.
- Z00.110 – Health examination for newborn under 8 days old and
- Z00.111 – Health examination for newborn 8 to 28 days old and/or
- Z00.00-01 – Encounter for general adult medical examination without/with abnormal findings and/or
- Z02.0 – Encounter for examination for admission to educational institution,
- Z02.1 – Encounter or pre-employment examination,
- Z02.2 – Encounter for examination for admission to residential institution,
- Z02.3 – Encounter for examination for recruitment to armed forces,
- Z02.4 – Encounter for examination for driving license,
- Z02.5 – Encounter for examination for participation in sport,
- Z02.6 – Encounter for insurance purposes,
- Z02.81 – Encounter for paternity testing,

- Z02.82 – Encounter for adoption services,
- Z02.83 – Encounter for blood-alcohol and blood-drug test,
- Z02.89 – Encounter for other administrative examinations,
- Z00.8 – Encounter for other general examination,
- Z00.6 – Encounter for examination for normal comparison and control in clinical research program,
- Z00.5 – Encounter for examination of potential donor of organ and tissue,
- Z00.70 – Encounter for examination for period of delayed growth in childhood without abnormal findings,
- Z00.71 - Encounter for examination for period of delayed growth in childhood with abnormal findings.

**For the procedure codes that do require a modifier, do not apply any other modifiers to the HealthCheck codes other than those listed in the following table.**

## HEALTHCHECK MODIFIERS

| Provider type | Modifier | Modifier description |
|---|---|---|
| Physicians, Physicians Assistants, Independent Nurse Practitioners | UA | Medical referral |

| Provider type | Modifier | Modifier description |
|---|---|---|
| HealthCheck Nursing Agencies (Local Public Health Agencies) | EP | Indicates that interperiodic screens, outreach and cast management, and lead inspection services were provided as part of EPSDT |
| | TS | Indicates follow-up services to an environmental lead inspection |

## DEAN HEALTH PLAN OUTREACH INITIATIVE

- **County Agencies -** Various county agencies receive a report of Dean Health Plan members in their area that are due for HealthChecks. Members are contacted to schedule a HealthCheck. The HealthCheck Coordinator also serves as the primary contact for Local Health Departments and other community organizations in relation to HealthCheck services.
- **Reminder Cards –** Children from one month to two years receive a reminder card for each HealthCheck that is required during the first two years. Children two years to age eight receive birthday cards indicating a HealthCheck is needed.
- **Provider Education/Awareness** - The HealthCheck Coordinator organizes and provides training and educational materials for Dean Health Plan staff and providers to enhance understanding of the HealthCheck program and to communicate requirements. They monitor HealthCheck screening levels, including provider performance and appropriate claim coding, and develops processes to provide regular feedback to providers and Dean Health Plan staff on outcomes.

**If you have any questions regarding HealthChecks or suggestions for additional outreach initiatives or ways to improve current ones, please contact Dean Health Plan's Education and Outreach Coordinator , as your ideas could really make a difference.**

## HEALTH CHECK COMPONENTS

Including documentation notes from State Audits.

**Health History**

- Include special risk factors, or prior conditions/treatments/medications.
- If there are no recent changes, document in the chart that discussion took place.
- Document recent services done elsewhere.

**Nutritional Assessment**

- Could include eating patterns, habits, appetite, vitamins, snacks, pickiness.
- Still necessary for older children and teens.

**Health Education/Anticipatory Guidance**

- Discussion of age-appropriate preventive health education topics including parenting, lead poisoning, use of car seats, proper nutrition, alcohol/drug abuse, mental health concerns, and injury prevention.
- Handouts are sufficient, but document in the chart what specific handouts were provided.

**Developmental Behavioral Assessment**

- Observed behavior and attainment of age-appropriate developmental milestones including response to tools, concerns, and relationships.
- Denver Prescreening, State Confidential Health Survey for Teens.
- Important for school-age children and teens.

**Vision Assessment**

- Vision chart results.
- If exam done at school, documentation is sufficient and best practice would be to document results.
- If child wears glasses, note of last exam with ophthalmologist or optometrist. Refer or complete exam if more than one year.
- Plan for vision assessed at 20/40, whether referred or follow-up deemed appropriate.
- Document incomplete exams and reason (lack of cooperation).
- To avoid problems in school, closer screening for children starting in kindergarten or first grade.

**Hearing Assessment**

- Puretone audiometric results.
- If exam is done at school, documentation is sufficient and best practice would be to document results.
- If child wears hearing aid, note of last exam with specialist. Refer or complete exam if more than one year.
- Follow-up concerns.
- Look for audiogram if indications of speech difficulties during the visit.
- Document incomplete exams and reason (lack of cooperation).
- To avoid problems in school, closer screening for children starting in kindergarten or first grade.

**Lab Tests**

- Blood lead required at age 1 and 2, regardless of verbal assessment
- Verbal assessment for lead recommended age 6-72 months.
- Document parental refusal.
- Follow-up if elevated.
- If test done elsewhere, document with results for best practice. (Parents don't always follow-up; opportunity for reinforcement or education of elevated levels.)

**Physical Examination**

- On forms it is important to mark off each body system. If a line is drawn through it, it is determined deferred.
- Explanation of any body system deferred.

**Sexual Development**

- Reference to Tanner Sex Maturity Rating is sufficient.
- Note sexual development in patients who have reached puberty.
- If deferred, reason should be documented.
- Pelvic exam for girls; document referral to OB/GYN, or note exam by OB/GYN in the past year.
- Adolescent males receive testicular exam.

**Oral Assessment**

- Children under age 3: Determination if early dental care is necessary. "No early oral concerns" is adequate documentation. Note teething progress or behaviors linked to future dental concerns.
- Children over age 3: Note whether patient is receiving regular dental care, or refer to a dentist.
- HEENT does not provide enough documentation for an oral assessment.

**Immunizations**

- Parents declining immunizations documented at each visit.
- If had chickenpox disease, document month and year.
- Insufficient records: Document reminders to parents and attempts to locate.

Refer to ForwardHealth Forms web page for HealthCheck Visit forms.

## VACCINES FOR CHILDREN PROGRAM (VFC)

In August 1993, Congress passed the Omnibus Budget Reconciliation Act creating the Vaccines for Children Program (VFC). This Federal VFC program is intended to help raise childhood immunization levels in the U.S. The VFC supplies free vaccines to private and public healthcare providers who administer vaccines to eligible children. Eligible children under the VFC program include, among other groups, all BadgerCare Plus-eligible children.

The DHS Bureau of Public Health ships the vaccines. Vaccines are shipped on a request basis to providers from the State distribution center.

Participation in Vaccines for Children Program:

- Enrollment
  - Complete two Center for Disease Control forms (one set of forms per shipping site, not per provider):
    - The "Provider Enrollment" form indicates agreement with the components of the VFC program. This form is completed only once and must be signed by a physician.
    - The "Provider Profile" form estimates the number of children vaccinated in your practice annually and the proportion likely to qualify for VFC. This profile is used to establish maximum order levels per shipping site. The form is updated annually and can be updated more frequently if your needs change.

  - Send the enrollment profile forms to the State Immunization Program:
    Wisconsin Immunization Program
    1 W. Wilson Street
    P.O. Box 309
    Madison, WI 53701

- Ordering and Shipping
  - Order forms #DOH 1099 should be sent to the WI Immunization Program. Order forms may be obtained from the WI Immunization Program.
  - Vaccinations must be ordered. There will be no automatic shipments.
  - Vaccines will be provided to you within two weeks.

- Accounting and Storage

- Vaccine for Children Program vaccines must **NOT** be kept with other vaccines. Use the oldest unexpired vaccine first.
- Establish an in-clinic tracking system to determine when to reorder VFC vaccine.
- Usage of vaccines is subject to review by the State of Wisconsin.

For more information on the VFC Program, please refer to your WMAP Provider Handbook, Part D, Division I, page 1D2-010.

## HEALTHCHECK QUESTIONS & ANSWERS

**Q: Why should I provide HealthCheck services?**

A: Here are several reasons for providing HealthChecks:

- HealthCheck visits are designed to ensure regular, comprehensive preventive healthcare for BadgerCare Plus members under the age of 21.
- Under the Standard Plan, with a HealthCheck referral, medically necessary services that are otherwise non-covered by BadgerCare Plus may be reimbursed.
- Screening exam intervals are consistent with the American Academy of Pediatrics' recommendations.
- HealthCheck screening requirements follow State and Federal regulations and represent what most pediatric BadgerCare Plus providers see as "best practice."

**Q: Does HealthCheck billing require different forms than other Medicaid billing?**

A: Billing for HealthCheck is done on the CMS-1500 claim form. This is the same claim form used for other BadgerCare Plus billing. Comprehensive screens are billed using CPT codes to indicate that a comprehensive HealthCheck screen was performed.
In addition, it is not the intent of the program to make you change your documentation system. Documentation of the listed components should be incorporated into your normal process.

**Q: Will patients receive extra benefits from having a HealthCheck exam?**

A: HealthCheck Other Services are only covered under the Standard Plan. HealthCheck exam medical services that are medically necessary may be paid for, even though they are not normally covered by BadgerCare Plus. One example is non-covered over-the-counter medications.

**Q: What is the difference between a HealthCheck and a well-baby exam?**

A: These two exams are very similar and may be the same. The difference is the HealthCheck requires an assessment and documentation of all seven components, whereas a well-baby exam may not.

**Q: What if a patient refuses to let the provider do an unclothed physical exam?**

A: Federal law requires an unclothed physical exam to assure clinicians are evaluating for potential physical abuse. This requirement does not mean the child must be totally unclothed for the entire exam.

**Q: Is color blindness screening required as part of a vision screening?**

A: Screening for potential problems is the requirement. If there is a reason to believe color blindness is a problem, of course you would check further, but a routine exam is not required.

**Q: If vision and/or hearing screening is done at the school and reported by the parent, does the provider need to have a copy of those reports before billing for a HealthCheck exam?**

A: HealthCheck providers are required to access and document vision and hearing screening. If that assessment is that the member has just had a vision and/or hearing screening somewhere else, the provider should document that fact and it would meet the requirements.

**Q: Can a dietician provide nutrition therapy through an interperiodic visit?**

A: Nutrition therapy can be billed as an interperiodic visit if the comprehensive screen identified a problem (not a potential problem) and if the dietician works for the HealthCheck agency. The billing is done by the HealthCheck agency. This is for fee-for-service. Check with the HMO if the member is in a BadgerCare Plus HMO.

**Q: Do you need to wait a full 365 days between a member's annual HealthCheck screenings?**

A: In BadgerCare Plus fee-for-service, the provider can bill up to 20 days before the year is up. If the member is enrolled in Dean Health Plan's Managed Care Program, there are no restrictions on the frequency of HealthCheck screenings.

**Q: What specific incentives can be used to get parents to have their children examined?**

A: At least two specific incentives can help promote HealthCheck to members' parents:

- **Transportation For Standard Plan:**
  Offering reliable transportation to get children covered under the Standard Plan to their HealthCheck appointments can increase interest in HealthCheck. Access to transportation is a key issue for many members in rural and city areas in particular.
- **Access to over-the-counter drugs:**
  The Standard Plan also pays for medically necessary over-the-counter drugs prescribed by physicians, as long as a HealthCheck screen was done. Some prescriptions are subject to prior authorization. Over-the-counter drugs can be an important benefit, and a key incentive to raise intervals in HealthChecks.

**Q: How can I get more information on HealthCheck in Wisconsin?**

A: Refer to the Wisconsin Department of Health Service BadgerCare Plus web page for more information. The ForwardHealth Online Handbook also contains a HealthCheck (EPSDT) section. Access the Online Handbook link from the ForwardHealth home page at forwardhealth.wi.gov/WIPortal.

# HISTORICAL REVISION LOG

With the next revision of this manual, the grid below will list past revisions to the manual for historical reference.

| Description of Change | Revision Date |
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