

Dean Health Plan's BadgerCare Plus Manual

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Welcome to BadgerCare Plus

Managed Care

The purpose of this manual is to serve as a resource for policies and procedures that affect BadgerCare Plus Managed Care. If you have questions relating to this information, or are unable to find information that you are looking for, contact the Dean Health Plan Customer Care Center.

Customer Care Center

(608) 828-1301

(800) 279-1301

FAX (608) 827-4212

HOURS

7:30 a.m. to 5:00 p.m. Monday –Thursday

8:00 a.m to 4:30 p.m. Friday

Corporate Compliance Department

(608) 827-4386

**Mike Fox –
SENIOR DIRECTOR OF
GOVERNMENT PROGRAMS**

(608) 827-4131

(800) 356-7344, EXT. 4131

**Babette Casey –
PROGRAM COORDINATOR/
MEMBER ADVOCATE**

(608) 827-4221

(800) 356-7344, EXT. 4221

**Jaime Prickett-
EDUCATION/OUTREACH
COORDINATOR**

(608) 827-4168

(800) 356-7344, EXT. 4168

**Provider Services Assistant –
PROVIDER SERVICES DEPARTMENT**

(608) 836-1400, EXT. 4538

(800) 356-7344, EXT. 4538

**DEAN MEDICAL CENTER
PSYCHIATRY DEPARTMENT**

(608) 252-8226

(800) 57-NURSE

Please refer to the Practitioner Manual in the *Health Plan Overview* section for other phone numbers for reference purposes.



Dean Health Systems Website

www.deancare.com

Dean Health Plan offers a wealth of information through the Dean Health Systems Website. Dean Health Systems' affiliates can access information by clicking on:

<http://www.deancare.com/providers/index.aspx>



Provider Updates/Changes

To ensure that DHP has the most current demographic information for our network provider, contact your Provider Services Representative for any of the following situations:

New Physicians:

- When multi-specialty or independent clinic physicians add to their staff; requests to consider this physician for plan provider status should be directed, in writing, to Provider Services. Approval by DHI/DHP Senior Administration is required before an application will be sent for completion.

All applications must be the original, a photocopy, or faxed copy. Furthermore, DHP does not allow practitioners to see DHP members until they have completed the credentialing process. No retroactive effective dates are granted.

Physician Extenders & Locum Tenens:

- Dean Health Plan welcomes physician extenders (Physician Assistants or Nurse Practitioners) to participate in the plan provider network.

Physician Assistants/Nurse Practitioners are required to complete the credentialing process when a supervising physician is not physically on-site at the clinic location.

- **Dean Health Plan requires our plan providers notify us IN ADVANCE of the need for a locum tenens.** The plan provider utilizing a locum tenens should inform their Provider Services Representative with the name of the locum tenens and the expected coverage time involved.

A physician extender form should be completed and returned to your designated Provider Services Representative to assure proper claim payments before any services are rendered to DHI/DHP members.

http://www.deancare.com/healthplan/documents/Dean_Physician_Extender_Form.pdf

Dean Health Plan Termination of Patient/Doctor Relationship Policy & Procedure

A practitioner may terminate the care of a member only for good cause, as determined by Dean Health Plan (DHP). Examples of good cause include such instances as a member:

- Physically injured or threatened a practitioner or other member of the clinic staff;
- Repeatedly and materially refused to pay coinsurance, copayments, or deductibles associated with DHP/Premier claims after all reasonable collection efforts have been exhausted;



- Displayed verbally abusive behavior or harassment towards a practitioner or other member of the clinic staff;
- Repeatedly refuses to cooperate with the practitioner.
- Fails to attend or late cancel 3 or more scheduled appointments after having received a written warning.

Practitioner requests to terminate a patient/doctor relationship must be sent in writing to the Provider Services Department stating the reasons for the request. Dean Health Plan will review the request and notify the provider of the determination. To avoid concerns of abandonment, the provider is requested to continue seeing the patient for 30 days from the termination notice if the patient presents for urgent or emergent care. This will give the member time to choose a new practitioner. The termination letter sent to the member should include the DHP Customer Care Center phone number (800)-279-1301 as a resource. DHP will assist the member in choosing a new provider and setting up transportation to appointment if necessary. The member will also be sent correspondence explaining their options and providing a Medical Record Release Form.

The following process applies to Members with commercial policies, including State of Wisconsin and federal employees. If the member is a recipient of Medicaid or BadgerCare, please contact Babette Casey member advocate at (608)827-4221.

Practitioner-Member Communication

- Dean Health Plan shall ensure that DHI/DHP allows open Practitioner-Member communication regarding appropriate treatment alternatives and shall not penalize Practitioners for discussing medically necessary or appropriate care with Members.

Other Situations

All of the above requests need to be submitted in writing to the attention of your Provider Services Representative. Please provide as much **ADVANCE NOTICE** and information regarding the new practitioner and/or change to the practitioner's status, as soon as possible, to avoid any disruption to your patients or claim payments.

- **Provider Demographic Information:**
 - *Name
 - *Gender
 - *Specialty
 - *Hospital Affiliations
 - *Office locations
- **Medical Group Affiliations**
- **Relocation/Retirement of a provider** (DHP provides member notification to ensure continuity of care).



- **Request to expand or add new clinics and/or office locations.** These requests to expand are required to have prior approval through the Provider Services Department.
- **Request to add additional services and/or programs.** These requests are required to have prior approval through the Provider Services Department.
- When a physician finds it necessary to discontinue accepting new patients or limit his/her practice (following this page is a *Patient Acceptance Form* that is required to be completed to communicate this information). This does not apply to practitioners who are with a Dean Medical Center/St. Marys Dean Venture Clinic site.
- When a physician will be out of the office, vacationing or on extended leave and another facility or location will be covering his/her practice. DHI/DHP requires **written notification** to include name, location, and duration of the covering physician or facility. **The covering physician must be a plan provider and have completed the credentialing process.**

DHP BadgerCare Plus Policies

Closed Panel Policy

All providers initially have an **open panel** for BadgerCare Plus Members. If after a **period of six months** a provider needs to close their panel for Badgercare Plus members:

- The provider must complete a Patient Acceptance Form (refer to last page of this section) in its entirety.
- Forward the completed form to the designated DHP Provider Services Representative for review.
- The provider will be notified by DHP when a decision has been made regarding the request to close the provider's panel.

No Show Policy

A provider cannot bill the BadgerCare Plus program (Dean Health Plan) or 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 DHP Member Advocate.
- The Member Advocate will counsel BadgerCare Plus members regarding the importance of keeping appointments.
- The DHP Member Advocate **must** be contacted if:
- A pattern has begun to develop for missed appointments by a BadgerCare Plus member;
AND
- You plan on terminating a patient's care. Letters regarding termination of care must be sent to the Member Advocate **prior** to member notification. The Member Advocate will ensure all standards set by Department of Health Services (DHS) are met.

Government Programs Department

The Government Programs Department is responsible for overseeing the development, implementation, and ongoing operation of the Dean Health Plan (DHP) BadgerCare Plus Managed Care Program. The Department serves as a liaison between DHP, providers, and the Department of Health Services (DHS). Staff is available to assist providers and members in understanding BadgerCare Plus policies and procedures, DHS requirements, exemptions and appeals.

The Department serves on DHS regional forums, task forces and a variety of provider committees. They also work 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 Member Advocate is actively involved in the development of the infrastructure of the DHP BadgerCare Plus Managed Care Program and provides assistance to members who need conflict resolution. Members receive assistance in resolving problems and understanding their rights and responsibilities in the appeal and grievance process.

The Education and Outreach Coordinator oversees the federal Early Periodic Screening Diagnosis and Treatment (EPSDT) HealthCheck Program, working with providers, local health departments, and members to assure compliance with federal screening levels and appropriate healthcare for children in the plan.

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.



PATIENT ACCEPTANCE FORM

DATE: _____

NAME OF PROVIDER: _____

CLINIC NAME: _____

ADDRESS: _____

PRACTICE
RESTRICTIONS: _____

NOT ACCEPTING NEW PATIENTS,
EFFECTIVE DATE: _____

NOT ACCEPTING NEW PATIENTS,
EXPIRATION DATE: _____

REASON FOR CLOSING PANEL/PROBLEMS
EXPERIENCED: _____

This form can be completed and returned to Dean Health Plan, Inc. if you are no longer accepting new patients. In the event you expect to discontinue taking new patients for an extended period of time, our member materials will be updated to reflect your status.

Please forward form to:

Dean Health Plan
Provider Services Department
P.O. Box 56099
Madison, WI 53705



Member Rights & Responsibilities

Dean Health Plan, Inc. (DHP) members deserve the best service and healthcare possible. DHP is committed to maintaining a mutually respectful relationship with its members. To promote effective health care, DHP makes clear its expectations for the rights and responsibilities of its members, to foster cooperation among members, practitioners and DHP. These **Member Rights and Responsibilities**, outlined below, also appear annually in the DHP provider and member newsletters.

Dean Health Plan members have the right to:

- Be treated with respect and recognition of their dignity and right to privacy.
- Receive a listing of DHP participating practitioners in order to choose a Primary Care Physician.
- Present a question or complaint or grievance to DHP, about the organization or the care it provides, without fear of discrimination.
- Receive information on procedures and policies regarding their healthcare benefits.
- Timely responses to requests regarding their healthcare plan.
- Request information regarding Advance Directives.
- Participate with practitioners in making decisions about their healthcare.
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Receive information about the organization, its services, its practitioners and providers, and members' rights and responsibilities.
- Make recommendations regarding the organization's members' rights and responsibilities policies.

Dean Health Plan members have the responsibility to:

- Read and understand the materials provided by DHP concerning their healthcare benefits. DHP encourages members to contact the Plan if they have any questions.
- Present their ID Card in order to identify themselves as DHP members before receiving healthcare services



- Notify DHP of any enrollment status changes such as family size or address.
- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- Follow plans and instructions for care that they have agreed on with their practitioners.
- Understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Fulfill financial obligations as it relates to any co-pays, deductibles and/or premiums as outlined in your policy.

These rights and responsibilities are available for you to access on our Website at http://www.deancare.com/healthplan/members/rights_responsibilities.asp

Dean Health Plan's Member Privacy Policy

Protecting the Privacy of Personal Health Information

The privacy of your nonpublic personal information is very important to us at Dean. This Notice describes how we protect the confidentiality of the nonpublic personal information we receive on all members, including former members. The following is a brief explanation of the manner in which we obtain, use, and protect your nonpublic personal information.

What types of nonpublic personal information does Dean collect about you?

We collect a variety of nonpublic personal information needed to administer health insurance coverage and benefits. We collect nonpublic personal information about you from some of the following sources:

- ◆ Information we receive directly or indirectly from you or your employer or benefits plan sponsor through applications, surveys or other forms. The information may be received in writing, in person, by telephone, or electronically. Examples include name, address, social security number, date of birth, marital status, and medical history.
- ◆ Information about your transactions with us, our affiliates, our providers, our agents, and others. This includes information from health care claims, medical history, eligibility information, payment information, service request, and appeal and grievance information.
- ◆ Information you authorize us to collect from others.

How does Dean protect this information?

We limit the collection of nonpublic personal information to that which is necessary to administer our business, provide quality service, and meet regulatory requirements. We maintain physical, electronic, and procedural safeguards that comply with federal and state regulations to protect your



nonpublic personal information. We limit the internal use of oral, written, and electronic nonpublic personal information about you and ensure that only authorized staff with the need to know have access to it. We maintain safeguards for your nonpublic personal information and review them regularly to protect your privacy.

When Dean May Not Use or Disclose Your Health Information

We will not disclose your nonpublic personal information unless we are allowed or required by law to do so. If required by law, we will obtain your authorization prior to using or disclosing your health information. You may revoke this authorization in writing at any time. The following categories describe the ways that Dean may use and disclose your nonpublic personal information. In carrying out the functions listed below, Dean may transmit your nonpublic personal information to people or organizations outside of Dean as allowed under the law. When Dean transmits or releases nonpublic personal information to another organization, Dean requires the other organization to protect your information from unauthorized and inappropriate use or disclosure. Not every use or disclosure we might make will be listed.

Payment Functions: We may use or disclose your health information to make or collect payment for treatment or services you receive. For example, we may use or disclose your health information to determine your eligibility for plan benefits, obtain premiums, and collect payment from third parties such as other health plans or providers for the care you receive.

Health Care Operations: We may use and disclose your health information to carry out necessary insurance-related activities and to provide coverage and services to you. Health care operations include such activities as: underwriting, premium rating, case management and care coordination, fraud and abuse detection programs, medical reviews, business planning and development, and general administrative activities such as customer service efforts and resolution of internal grievances.

Treatment Alternatives: We may contact you or your health care providers with information about treatment alternatives and other related functions that may be of interest to you.

Distributing Health-Related Benefits and Services: We may use or disclose your health information to provide information on health-related benefits and services that may be of interest to you.

Disclosure to Plan Sponsors: If applicable, we may disclose certain health information to the sponsor of your group health plan for purposes of administering benefits under the plan or to determine whether you are participating in the health plan.

Summary Statement of Your Health Information Rights

All requests to exercise the rights listed below must be submitted in writing to the Privacy Officer, or you can call Dean Health Plan Customer Care Center to request the appropriate form to complete. You have the right to:

- ◆ Request restrictions on certain uses and disclosures of your health information.



- ◆ Receive your health information through a reasonable alternative means or at an alternative location.
- ◆ Inspect and copy certain health information about you.
- ◆ Request that Dean amend health information held by Dean that you believe is incorrect or incomplete.
- ◆ Receive a list of certain disclosures of your health information.

Questions?

If you would like a paper copy of this Notice, want more information about our privacy practices, have questions about any part of this Notice, or you have a complaint regarding our privacy practices, please contact the Privacy Officer at the following address, or call the Dean Customer Care Center at (800) 279-1301: Privacy Officer, 1277 Deming Way, Madison, Wisconsin 53717.

Dean Health Plan's Affirmative Action Statement

Compliance with Equal Opportunity Laws, Regulations and Rules and Other Laws. It is the policy of Dean Health Insurance (DHI)/Dean Health Plan (DHP) to implement Affirmative Action (AA) measures designed to eliminate present effects of past discrimination and to ensure equal opportunity for women, racial or ethnic minorities, and persons with disabilities. DHI/DHP recognizes the need to identify job groups and classifications with under-representation, and to set goals and timetables for increasing the employment of under-represented groups; and to develop an AA Plan for implementing those reasonable goals through outreach, recruitment, training and other activities and commitments.

DHI/DHP is in compliance with the equal opportunity policy and standards of the Department of Workforce Development, Department of Health and Family Services, and all applicable State and Federal statutes and regulations relating to nondiscrimination in employment and service delivery.

No otherwise qualified person shall be excluded from employment, be denied by the benefits of employment or otherwise be subject to discrimination in employment in any manner on the basis of age, race, religion, color, sex, national origin or ancestry, disability or association with a person with a disability, arrest or conviction record, sexual orientation, marital status or pregnancy, political belief or affiliation, military participation, or use or non use of lawful products off the employers premises during working hours. All employees are expected to support goals and programmatic activities relating to nondiscrimination in employment.

No otherwise qualified applicant for service or service participant shall be excluded from participation, be denied benefits, or otherwise be subject to discrimination in any manner on the basis of race, color, national origin or ancestry, sex, religion, age, political belief or affiliation, disability or association with a person with a disability. This policy covers eligibility for the access to service delivery, and treatment in all of the programs and activities.



BadgerCare Plus Managed Care Overview

www.dhfs.wisconsin.gov/medicaid

BadgerCare Plus is a state sponsored program that provides healthcare coverage to qualified members. BadgerCare Plus combined Family Medicaid, BadgerCare, and Healthy Start into a single program. To qualify for BadgerCare Plus members must meet income requirements and fall into one of the following groups:

- Uninsured Children
- Pregnant Women
- Parents and Caretaker Relatives
- Parents with children in foster care who are working to reunify their families
- You adults exiting out-of-home care, such as foster care, because they have turned 18 years of age.
- Certain Farmers and other self-employed parents and caretaker relatives.

Not all BadgerCare Plus members will be enrolled in HMOs. Some members will remain straight Medicaid or Fee-for-Service (FFS), where they have access to any BadgerCare Plus Certified Provider.

BadgerCare Plus Core Plan

The Core Plan provides access to basic health care services including primary care, preventive care, certain generic and over-the-counter drugs and a limited number of brand name drugs to adults who were previously not eligible to enroll in state health programs. The Core Plan benefits will be less comprehensive than the BadgerCare Plus Standard and Benchmark Plans, with different benefit/copay structure for most services. Please be sure to check the Forward Health Portal for the most up to date benefits. Besides benefits and copays there are other key differences in the Core Plan package.

Members enrolled in the Core Plan are required to obtain a comprehensive physical examination within the first twelve months of enrollment. If a physical examination is not completed the member will lose his or her coverage for six months. Another notable difference is that providers are required to report three health indicators (height, weight, and blood pressure) for every member who receives a physical.

Physical Exam and Health Indicators (PEHI)

Dean Health Plan (DHP) providers have two options for reporting this information:

1. The health indicators can be manually entered into the ForwardHealth Portal at www.forwardhealth.wi.gov . Once signed into your account on the portal, there will be a link in the lower right corner of the screen.



-
2. The second way to report the health indicators is to send an electronic file directly to DHP. If you choose this option, contact your Provider Services Representative.

The PEHI is a data collection tool supplied by the Department of Health Services used by providers to report the data needed for members enrolled in the BadgerCare Plus Core Plan. The following link can be used for training on the PEHI data collection tool:

<http://media1.wi.gov/DHFS/Viewer/?peid=4bb36171-6a37-4062-8534-36fb40a1b926>

Benefit Packages

BadgerCare Plus has two benefit packages, the Standard Plan and the Benchmark Plan. The Standard plan has the same benefits as the past Medicaid Program but incorporates copays. The Benchmark Plan was designed to resemble a commercial policy and includes both copays and benefit limitations. Qualified members are placed into the two plans due to income level.

The following members are exempt from co-payment requirements under the Standard Plan:

- Nursing Home Residents
- Pregnant women
- Members under 18 years of age who are members of a federally recognized tribe
- Members under 18 years of age with incomes at or below 100% of the FPL

The following members are exempt from co-payment requirements under the Benchmark Plan:

- Pregnant women
- Members under 18 years of age who are members of a federally recognized tribe

For more detailed information on BadgerCare Plus, reference the Website at www.dhfs.wisconsin.gov/medicaid.

BadgerCare Plus Service Area

The following counties are included in the DHP BadgerCare Plus service area:

- Dane
- Dodge
- Grant
- Columbia
- Rock
- Green
- Jefferson
- Sauk
- Iowa

All ZIP codes are included for each county listed above.

Providers who sign a BadgerCare Plus contract and are not located within the above listed counties can still see DHP BadgerCare Plus members.

If you have any questions about the service area, please feel free to contact DHP's Member Advocate at (608) 827-4221.



Provider Eligibility

Certification from the State is needed in order to be a BadgerCare Plus Provider. A clinic or individual provider can receive certification. Contact EDS at (608) 221-4746 for information on how to apply for certification.

If a provider does not have BadgerCare Plus certification they may **not** see a DHP BadgerCare Plus member. **Without certification, the provider's claims will be denied for payment.**

Mandatory or Voluntary Enrollment

Enrollment in an HMO will be mandatory in areas where there are two or more HMOs currently accepting BadgerCare Plus enrollees. If only one HMO is in a service area, members will have the choice of HMO or FFS. If you are interested in other HMOs providing services in your area, contact Electronic Data Systems (EDS) at (608) 221-4746.

You will need to check either the patient's ForwardHealth or Forward Card for current eligibility and HMO enrollment status.

Enrollment Contractor

Wisconsin does not allow HMOs to market or enroll BadgerCare Plus members in their HMOs. The Department of Health and Family Services has contracted with Automated Health Systems, Inc. (AHSI) to act as enrollment broker for members. Automated Health Systems, Inc. is stationed in Milwaukee and has offices throughout the state. Automated Health Systems, Inc. performs enrollment, education, outreach, and advocacy for members. Their primary role is to help members select the best HMO for the member's needs. The enrollment contractor's telephone number is (800) 291-2002.

Enrollment Process

Members will receive one mailing from Automated Health Services, Inc., requesting they choose an HMO. If members do not choose an HMO, they will be automatically assigned to an HMO. Assignment will be to all HMOs serving in the member's ZIP code and will be random.

Members may change HMOs during the first three months of enrollment but will be locked into the HMO beginning the fourth month of enrollment. Lock-in will continue through the twelfth month of enrollment. Members can only change HMOs if they meet exemption criteria discussed later in this section.



BadgerCare Plus Member Educational Materials

The State of Wisconsin Department of Health and Family Services contracts with Automated Health Systems, Inc. as the enrollment broker for the Wisconsin BadgerCare Plus Managed Care Program.

The role of the Enrollment Specialist is to perform member outreach, enrollment, and education for Wisconsin BadgerCare Plus Managed Care Programs. This is accomplished through telephone, in-person contact, and the distribution of written materials, called Member Informing Materials, to managed care eligible members. These Informing Materials give the member information on HMOs available to them through the BadgerCare Plus Managed Care Program. The materials educate members about a managed care system, such as: accessing services, the role of the primary care practitioner, and preventive health services.

Exemptions

Some members that are assigned to HMOs may qualify for an HMO exemption. A chart begins on page 6. The charts list the reasons for exemption from HMO enrollment. Providers who have questions regarding exemptions should call EDS at (608) 221-4746 and ask for an HMO contract monitor or call the Government Programs Department at DHP.

Federal Regulations

To operate an HMO program, Wisconsin obtained a waiver of certain Federal regulations. Some regulations that **cannot be waived** are:

- Access to services must be the same or better than in FFS.
- Health Maintenance Organizations must provide all medically necessary services required by the contract HMOs sign with DHFS.

Covered/Non-Covered Services

Dean Health Plan will **NOT cover** the following services. **HOWEVER**, these are covered benefits and will be paid FFS by billing directly to **EDS**:

- Dental
- Chiropractic
- Pharmacy
- Prenatal Care Coordination (PNCC)
- School Based Services (SBS)
- Family planning services provided by Medicaid certified family planning clinics
- Targeted case management
- Crisis Intervention Services

These services should be billed to EDS following the current billing procedures.



The Benchmark plan has additional benefits that either have limitations, higher copays, or are non-covered. Please refer to the Wisconsin Medicaid web site at dhfs.wisconsin.gov/Medicaid for specific information regarding the Benchmark Plan benefits. All other services provided to DHP BadgerCare Plus members should be billed to DHP. In addition, it is important to note that BadgerCare Plus HMOs must provide all medically necessary or covered services as FFS. In the Standard Plan there are no caps or limits on BadgerCare Plus services like you see in commercial plans. The Benchmark Plan does incorporate copays and benefit limitations.

BadgerCare Plus HMOs reference the Wisconsin Medical Assistance Program (WMAP) prior authorization guidelines and handbooks to determine medical necessity. The HMOs may develop their own policies and procedures to determine who will provide services and when services will be authorized. DHP has developed policies and procedures which may be similar to FFS in some areas. **See the Referral Section within this manual for DHP referral and prior authorization policies and procedures.**

Dean Health Plan New Member Materials

The Customer Service (Enrollment) and Government Program Departments send new members the following within the first month of enrollment:

- Translation request card
- Welcome letter
- DHP member handbook (see detail below)
- PCP directory
- PCP selection form (additional reminders sent)
- Postage paid return envelope
- Notice of Privacy Practices
- List of Eyeglass Providers
- HealthCheck brochure
- Women, Infants & Children brochure
- Lead poisoning prevention brochure

Members who are enrolled in DHP 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
 - ✓ Dean Medical Center Psychiatry Department
- Choosing a Doctor/PCP
- Using the ForwardHealth Card
- Obtaining Referrals
- HealthCheck
- Accessing care for urgent or emergency situations
- Obtaining Mental Health and AODA Treatment
- Complaints and Appeals



- TDD number
- Enrollment Specialist

The handbook is available in the following languages:

- English
- Russian
- Hmong
- Spanish

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 her HMO -AND- The enrollee must be seeking care from a provider who is not affiliated with the HMO to which they were assigned.
Ninth month pregnancy exemption	Two full months past the EDC	Enrollee, HMO Provider	The first month in the HMO the enrollee delivers or is expected to deliver -AND- The provider (i.e., doctor or hospital) the enrollee is seeing is not affiliated with the HMO the enrollee was assigned to.
High risk Pregnancy Exemption	Two full months past the EDC	Enrollee	The enrollee has a <u>medical</u> condition that has a direct risk on the enrollee's or the unborn child's health -AND- The provider the enrollee is seeing is not affiliated with an HMO or the HMO is closed to enrollment.
Continuity of Care	<i>May be up to six months</i>	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 -AND- A switch in healthcare providers would cause a <u>major</u> 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 3	To the child's third birthday	Casehead	A child between the age of 0 and three who is developmentally delayed -AND- is enrolled in a county's birth to three program.
Methadone treatment	Through the course of the treatment	Casehead	Must be actively participating in a methadone program.
Severely emotionally disturbed	Through the course of the treatment	Casehead	The enrollee must be receiving mental health treatment for a severe mental health disability (i.e., psychosis) -AND- Receiving intensive in-home therapy.
HIV Positive/AIDS	Permanent	Casehead	The enrollee must have AIDS or be HIV positive - AND- Receiving an FDA approved antiretroviral medication.



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.
Supplemental Security Income (SSI)	Length of SSI eligibility	Enrollee	A member of a AFDC/Healthy Start household is SSI and Medicaid eligible -AND- The SSI enrollee is using providers who are not affiliated with any Medicaid HMO(s).
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 <i>any</i> HMO that is participating in the managed care program, or is not participating in a region.
Federal Qualified Health Center (FQHC), Certified Nurse, Midwife or Nurse Practitioner	Indefinitely	Enrollee	The enrollee is utilizing services of an FQHC, Nurse Midwife, or Nurse Practitioner -AND- The FQHC, Nurse Midwife or Nurse Practitioner is not affiliated with any HMO in the service area -AND- <i>For Nurse Midwives and Nurse Practitioners only:</i> The Nurse Midwife or Nurse Practitioner is not independently certified as a provider of any HMO within the service area.
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 -OR- 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 the first of the month of notification.



BadgerCare Plus Enrollment Process

Length of Enrollment

All enrollees residing in HMO mandatory service areas must serve an initial 12 month lock-in period. The first three months of this lock-in period will be open enrollment in which the enrollee may change his/her HMO. The enrollee will be locked-in to the HMO they have chosen or been assigned to after the first three months.

Assignment of Primary Care Practitioner (PCP)

Initially, all PCP assignments will be handled manually by the Customer Service (Enrollment) Department. If a member goes three (3) months with no PCP assignment, DHP will assign a PCP as described below. However, members may change their PCP at any time by contacting our Customer Service Department.

All new enrollees will receive an initial packet which contains:

- A list of eligible PCPs
- PCP selection form
- A letter requesting the member choose a PCP as soon as possible by calling our Customer Service Department or returning the form.

***Refer to BadgerCare Plus Managed Care section under *DHP New Member Materials* for complete listing.**

If the member notifies Dean Health Plan (DHP) of their PCP choice we will assign that provider if he/she meets the qualifications of a BadgerCare Plus PCP.

DHP will assign a PCP in the following manner:

1. If DHP receives a claim for a BadgerCare Plus member for a primary care service, that provider is chosen as the PCP. A report is generated and sent to Policy Holder Services and the claim is processed.
2. If no claims have been received, a PCP will be chosen for the member according to their zip code.
3. If former member is rejoining DHP within a year of disenrollment:

DHP receive an Enrollment tape from EDS which says the member is an "Add Reinstated." DHP will assign the former PCP if that provider is still accepting new BadgerCare Plus patients. We will notify the member of the PCP assignment if it has been over six months since disenrollment.



Enrollment Data

Because the Department of Health Services (DHS) does not allow HMOs to enroll their own members, DHP must receive enrollment information from DHS each month.

DHP receive the initial enrollment information from the State for a coverage month on or around the 19th of the month prior to coverage. This information will be automatically downloaded to the system.

DHP will receive final enrollment information from the State on or around the 5th of the current coverage month. The information includes either a disenrollment or continuation for all members on a pending status from the initial report and any newborns added since the 19th of the previous month.

All new enrollees will have a dummy NO PCP designation until we are able to receive their choice for a PCP or DHP assigns one.

BadgerCare Plus Identification (ID) Cards

Wisconsin BadgerCare Plus members receive a "ForwardHealth" Medicaid ID card upon initial enrollment into Wisconsin BadgerCare Plus. Each individual in a BadgerCare Plus family is enrolled with their own individual ID number and card.

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 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 EDS Recipient Services at (800) 362-3002, on the back of the card, for replacement cards.

Dean Health Plan will not issue members a separate ID card; the ForwardHealth card will serve as their insurance card.



Forward Card Features

Medicaid ID Card (Resembles an automated teller card)



ForwardHealth Core Plan Card



The ForwardHealth cards includes the member's name, 10-digit Medicaid ID number, magnetic stripe, signature panel, and the EDS Recipient Services telephone number.

The card also has a unique, 16-digit card number on the front. This number is for internal use only and is not used for billing. The card does not need to be signed to be valid. However, adult members are encouraged to sign their cards. Providers may use the signature as another means of identification.



Temporary and Presumptive Eligibility Cards

Temporary cards are issued on green colored paper and Presumptive Eligibility cards are issued on beige colored paper. These cards are accepted by Wisconsin BadgerCare Plus. These members will be covered by Fee-for-Service, not the managed care programs. Providers should make a copy of the member's temporary card in the event a claim denies.

Weekly Listing

All Primary Care Providers/Sites will receive a weekly listing of all eligible DHP BadgerCare Plus Members. This listing will include up-to-date information on BadgerCare Plus members' PCP designation and eligibility. A cover letter specifies that the report is for BadgerCare Plus members. The listing is printed on white paper and is clearly labeled to show that it is the BadgerCare Plus list, rather than DHP's commercial enrollment list.

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. This is important because members can move between the Standard and Benchmark Plans, thus copays and benefits may change between appointments.

Providers may verify member's eligibility in the following ways:

- ForwardHealth Portal
- WiCall
- Commercial Enrollment Vendors
- 270/271 Health Care Enrollment/Benefit Inquiry and Information Response transactions

More information regarding the methods for verifying member eligibility can be found in the ForwardHealth August 2008 Update, No. 2008-151 at www.dhs.wisconsin.gov/forwardhealth/.



Eligibility Verification Vendors

The following vendors offer eligibility verification services for purchase:

HDX

Contact Name: Dan Birch
467 Creamery Way
Exton, PA 19341
Daniel.Birch@siemens.com
www.hdx.com
Provides: Browser-based and integrated eligibility

Medifax-EDISM, Inc.

Contact Name: Dan Stone,
District Sales Manager
1283 Murfreesboro Rd.
Nashville, TN 37217-2421
(800) 444-4336 x2903
Fax: (615) 565-2903
Email: dan.stone@medifax.com
www.medifax.com
Provides: Internet solution, software, magnetic strip card readers, point of service terminals, networkable solution, full integration

Passport Health Communications

Contact name: Lloyd Baker
720 Cool Springs Blvd, Suite 450
Franklin, TN 37067
(651) 261-2675
(888) 661-5657 x2675
email: Lloyd.Baker@passporthealth.com
www.passporthealth.com
Provides: Internet, Interface systems, File-batch eligibility systems

United Wisconsin Proservices

Contact name: Kathy Cataldo-Elm,
Technical Systems Analyst
401 W Michigan St.
Milwaukee, WI 53203
(800) 822-8050 x6541
or
(414) 226-6541
email: kcataldo@uws.com
www.uwproservices.com
Provides: Internet Services

Web MD/Envoy

Contact name: John Kost
8919 Pawnee Ln
Leawood, KS 66206
(913) 649-3529
Fax: (913) 649-3586
Email: jkost@webmd.net
Provides: Internet, non-internet/dialup windows software, credit card readers

Wisconsin Health Information Network (WHIN)

Contact name: Carole Gray Unis
5900 South Lake Dr., Second Floor
Cudahy, WI 53110-3171
(800) 331-9446
email: carole.unis@whin.net
www.whin.net
Provides: Browser-based internet



Here's Help

A Quick Access Guide to BadgerCare Plus Information

Billing, Eligibility, and Policy Questions

EDS Provider Services – (608) 221-9883 or (800) 947-9627

Recipient eligibility information and all other provider service inquired (except pharmacy):

8:30 a.m. to 4:30 p.m. Monday, Wednesday – Friday.

9:30 a.m. to 4:30 p.m. on Tuesdays.

Not available on holidays.

Recipient eligibility information and policy/billing information relating to pharmacy services:

8:30 a.m. to 6:00 p.m. Monday, Wednesday – Friday.

9:30 a.m. to 6:00 p.m. on Tuesdays.

Not available on holidays.

Eligibility Questions

Automated Voice Response – (608) 221-4247 or (800) 947-3544

Available 24 hours a day, seven days a week.

Electronic Data Interchange

Electronic Data Interchange (EDI) Help Desk – (608) 221-9036

8:30 a.m. to 4:30 p.m. Monday – Friday.

www.wisconsinedi.org

EDI Help Desk e-mail: [wiedi@dhfs.state.wi.us/](mailto:wiedi@dhfs.state.wi.us)

Medicaid Managed Care Contract Monitors

For Providers or Recipients – (800) 760-0001

7:45 a.m. to 4:30 p.m. Monday – Friday.

Member Services (for members only)

(800) 362-3002 or (608) 221-5720

7:30 a.m. to 5:00 p.m., Monday through Friday.

SeniorCare Customer Services (for members only)

(800) 657-2038

7:30 a.m. to 5:00 p.m., Monday through Friday.

Not available on holidays.

www.dhfs.wisconsin.gov/seniorcare/index.htm

BadgerCare Plus Web Sites

www.dhfs.wisconsin.gov/medicaid/

www.dhfs.wisconsin.gov/badgercare/



BadgerCare Plus Claims Submission

To help minimize claim rejection or claim payment errors, Dean Health Plan (DHP) ask for your cooperation with the following:

Claim Completion

- When submitting claims, DHP require you use the correct and complete BadgerCare Plus ID number. Using the correct member number on the claims submitted to DHP will help us ensure correct claim payment.
- Due to the revised CMS billing form and increasing need and requirements to provide medical data, it is imperative for services to be coded accurately with valid ICD-9, CPT-4 and HCPCS codes. **Services will reimbursed based on ICD-9, CPT-4, or HCPCS codes only.** If you do not have current coding manuals, DHP encourage you to obtain them. The following is a list of potential suppliers:

American Medical Association
515 North State Street
Chicago, IL 60610

Practice Management Information Corp.
727 Wilshire Boulevard
Los Angeles, CA 90010

St. Anthony Publishing, Inc.
PO Box 14212
Washington, DC 20044

University Bookstore
711 State Street
Madison, WI 53703
(608) 257-3784

- DHP will accept the two digit place of service code only. Contact our Customer Care Center if you would like a listing of these codes.
- DHP no longer identifies a specific service which is being billed when code 99070 is used. If the correct HCPCS code is not used, services billed with 99070 will be denied and an explanation of the services must be resubmitted for review.



The following is a list of data elements which are required on each claim submission. The table below indicates the appropriate box number from the CMS-1500 and UB04 claim forms for each required element. The newly required elements are identified by bold print.

Required Information	CMS 1500 (08-05) Claim Form	Note
Member Name	Box 2	
Date of Birth	Box 3	
Member Number	Box 1.A	11 digits/10 for MA
Diagnosis Code	Box 21	
Date of Service	Box 24.A	
Place of Service	Box 24.B	2 digit
Type of Bill	N/A	
Service Code	Box 24.D	
Billed Amounts	Box 24.E	
Units	Box 24.G	
Doctor Indicator	G2 in Box 24.I	
Individual Doctor Number	Top of Box 24.J	
NPI Type 1	Bottom of Box 24.J	
Provider Name	Box 31	
Service Facility Location	Box 32	
Provider Billing Address	Box 33	
NPI (Type 2)	Box 33.A	
Individual Vendor ID	Box 33.B	
Vendor Indicator	BQ Box 33.B (just before DHP vendor ID)	

No space, hyphen, or separator is to be used between the qualifier and the number. Dean Health Plan is not requiring the two digit qualifier.

DHP requires that all claim submissions for DHP Products include DHP Legacy number and Vendor ID. When available include your NPI Type 1 and Type 2 along with the DHP Legacy Number.

Required Information	UB04 Claim Form	Note
Member Name	Box 8	
Date of Birth	Box 10	
Member Number	Box 60	11 digits/10 for MA
Diagnosis Codes	Box 66	
Date of Service	Box 6	
HCPCS Code	Box 44	
Type of Bill	Box 4	
Revenue Code	Box 42	4-digit required
Billed Amounts	Box 47	
Units	Box 46	
NPI (Type 2)	Box 56	
DHP Vendor ID	Box 57	

DHP is requiring that all claim submissions for DHP Products include the DHP Vendor ID number. When available include your NPI Type 2 in Box 56.



Claim Resubmission & ECT Confirmation Guidelines

Refer to the DHP Practitioner Manual in the *Claims, Timely Filing, EOPs* for an overview of the DHP guidelines.

Claims Processing

Claims will be entered into our claims processing system via paper claims or electronic claim transmissions (ECT). These claims are reviewed if necessary to ensure proper payment. **Claims will then be adjudicated and the payment cycle will run weekly. Payment for BadgerCare Plus members is generated separately from commercial business.**

Automated Voice Response (IVR)

Please refer to the DHP Practitioner Manual in the *Claims, Timely Filing, EOPs* for an overview of the IVR system and its use.

Coordination of Benefits (COB)

BadgerCare Plus is always payor of last resort. If DHP has record of other health insurance coverage for the member during the same time-frame, the claim will be denied as other insurance primary. After the primary insurance has processed the claim, the claim along with the EOB can be submitted to DHP for consideration of supplemental payment. Please contact our Customer Care Center with updates to a member's health insurance coverage.

Subrogation/Worker's Compensation Guidelines

Refer to the DHP Practitioner Manual in the *Claims, Timely Filing, EOPs* for an overview of the DHP guidelines.

Member Billing

When a physician or clinic becomes a "Plan Provider" they agree to accept payment made by DHP as payment in full. **Discounts and withholds are not to be billed to the member or the supplemental insurance company.**



Claim Submission for:

- **Mom/Baby**

A newborn's temporary 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 deny 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 DHP 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 from your original EOP.

- **Eyeglasses – NOT COVERED UNDER BENCHMARK PLAN**

Eyeglasses must be ordered from North (Central) Ophthalmics in St. Cloud, MN. Any questions regarding the process involved can be answered by contacting North (Central) Ophthalmics. at (800) 328-3829. **Dispensing fees should be submitted to DHP.**

- **Outside Laboratories**

The outside lab should submit lab charges directly to DHP and will be reimbursed at BadgerCare Plus FFS rates. The provider also needs to submit the collection and handling fees to DHP. If the provider submits the charge for all services combined to DHP reimbursement will be subject to 92 percent of BadgerCare Plus FFS rates.

- **Diabetic Supplies**

All diabetic supplies; including supplies related to insulin pumps, the pump is covered under the medical benefits and paid by DHP.



BadgerCare Plus Coding Requirements

The Wisconsin BadgerCare Plus program follows the Health Insurance Portability and Accountability Act (HIPAA) standards by using the medical code set requirements for claims submission. Some non-medical code sets, such as type of service codes, will also be eliminated. All providers will be expected to make these same coding changes when billing Dean Health Plan (DHP) for BadgerCare Plus members. Please continue to check the BadgerCare Plus web site at www.dhfs.wisconsin.gov/medicaid for specific updates.

For providers submitting claims to DHP for BadgerCare Plus members, the corresponding modifier(s) must be indicated on the claim to ensure appropriate reimbursement and reduce delays in payment. The cross references are as follows:

Type of Service (TOS)/Description	Modifier/Description
8 - Surgical Assistant	80 - Assistant Surgeon AS - Physicians Assistant
7 - Anesthesia (bill units by minutes)	AA - M.D. personally performed QX - CRNA or AA, M.D. medically directing one QX - CRNA or AA, M.D. medically directing more than one QZ - CRNA only, non-medically directed more than one QY - M.D. medically directing one CRNA QK - M.D. medically directing two, three, four CRNAs/AAs
P - Purchase new Durable Medical Equipment (DME)	
Q - Diagnostic Radiology, professional component (interpretation)	26 - Professional component
R - DME rental (per day)	RR - Rental
S - Radiation Therapy, professional component only	26 - Professional component
T - Nuclear Medicine, professional component only	26- Professional component
U - Diagnostic Radiology, technical component only	TC - Technical component
W - Diagnostic Medical, professional component only (interpretation)	26 - Professional component
X - Diagnostic Lab, professional component	26 - Professional component



Bilateral Modifier

Bilateral procedures are reimbursed the same as DHP's regular and Senior lines of business. Bill on one line, using one unit, adding the -50 modifier. The charged amount should indicate 150 percent of what the procedure would cost if it was done unilaterally.

Multiple Surgeries

Multiple surgeries are reimbursed at 100 percent for the primary procedure, 50 percent for the second procedure, 25 percent for the third procedure, and 13 percent for the fourth through fifth procedure performed on the same day, by the same surgeon, in the same surgical setting. (The percentages are based on the BadgerCare Plus FFS maximum allowable amount). To ensure correct payment and reduce delays in payment or claims returned to clarify appropriate reimbursement, please use the -51 modifier on any procedure that is billed beyond the primary procedure. A post-payment audit will be done periodically to verify correct reimbursement.

Enhanced Reimbursements

Pediatric Services

Wisconsin BadgerCare Plus provides an enhanced reimbursement rate for office and other outpatient services (CPT codes 99201-99215) and emergency department services (CPT codes 99281-99285) for members 18 years of age and under.

To obtain enhanced reimbursement for members under 18 years old, indicate one of the applicable procedure codes and the modifier "TJ" in element 24D of the CMS 1500 claim form.

Health Personnel Shortage Area

Wisconsin BadgerCare Plus provides enhanced reimbursement to primary care and emergency medicine providers who provide care in or to members from areas designated by Wisconsin BadgerCare Plus as a Health Professional Shortage Area (HPSA).

The incentive payment for HPSA-eligible primary care and emergency medicine procedures is an additional 20 percent of the FFS physician maximum allowable fee. HPSA-eligible **obstetrical** procedures receive an additional 25 percent.

Primary care and emergency medicine providers are eligible for HPSA-enhanced reimbursement for HPSA-eligible procedure codes if the following statement applies:



- The member has a residential address (according to BadgerCare Plus eligibility records) with a HPSA-eligible zip code.
OR:
- The practitioner has a zip code designated as HPSA by BadgerCare Plus

To obtain the HPSA-enhanced reimbursement, indicate in element 24D of the CMS 1500 claim form “AQ” for physicians providing services in a Rural and/or Urban HPSA area.

Reimbursement for eligible procedure codes billed with the “AQ” modifier includes the pediatric incentive payment. Do not bill “AQ” and “TJ” modifiers for the same procedure code. The “TJ” modifier can be billed for eligible services in situations that do not qualify for HPSA-enhanced reimbursement.

The enhanced HPSA reimbursement does not apply to HealthCheck claims because HealthCheck has the higher rate. **Please refer to the *HealthCheck* section of this manual for further explanation of HealthCheck reimbursement.**

Health Professional Shortage Area

In order to receive the enhanced reimbursement for the Health Professional Shortage Areas (HPSA), either the patient or the physician must have a ZIP code that has been designated as a HPSA area by BadgerCare Plus. The ZIP codes can be found at <http://dhfs.wisconsin.gov/medicaid/updates/2006/2006pdfs/2006-89.pdf> and are as follows:

County	HPSA Name	ZIP Codes
Adams (entire county)	Adams	53910, 53920, 53927, 53934, 53936, 53952, 53964, 53965, 54457, 54613, 54921, 54930, 54943,
Columbia	Portage/Pardeeville	53901, 53911, 53923, 53928, 53932, 53935, 53954, 53955, 53956, 53960, 53969
Crawford	Boscobel	53805, 53826, 53831, 54657
Dodge	Portage/Pardeeville	53956, 53916
Grant	Lancaster/Fennimore	53802, 53804, 53806, 53809, 53810, 53813, 53820, 53825, 53569
Grant	Platteville/Cuba City	53554, 53818, 53807, 53811, 53820
Grant	Boscobel	53518, 53573, 53801, 53804, 53805, 53809, 53816, 53821, 53927
Green	Darlington/Shullsburg	53504, 53516
Green Lake	Markesan/Kingston	53949, 53946, 53926, 53923, 53939, 53947
Iowa	Platteville/Cuba City	53554, 53580
Juneau	Hillsboro	54634, 53968, 53929
Kenosha	Kenosha	53140, 53142, 53143, 53144



Lafayette	Platteville/Cuba City	53510, 53818, 53803, 53807, 53811
Lafayette	Darlington/Shullsburg	53565, 53530, 53504, 53516, 53587, 53541, 53586
Marquette (entire county)	Marquette	54930, 54982, 54960, 53964, 53952, 53920, 53926, 53949, 53953, 53954
Richland	Boscobel	53518, 53573
Richland	Hillsboro	53924, 53941, 54634
Richland	Spring Green/Plain	53556
Rock	Beloit	53511, 53512
Sauk	Hillsboro	53968
Sauk	Spring Green/Plain	53556, 53577, 53578, 53583, 53588, 53937, 53943, 53951,
Vernon	Hillsboro	53929, 53968, 54634, 54638, 54639, 54651

The correct modifier must be used to generate the additional reimbursement.

- **AQ**-Rural and Urban
- **TJ**-Pediatric rate
- **TH**-Obstetrical treatment/services; prenatal*

*Providers are required to use the "TH" with procedure codes 99204 and 99213 only when those codes are used to indicate the first three antepartum care visits.



BadgerCare Plus Prior Authorization

Planned Inpatient Hospital Admissions

Pre-certification for planned hospital admissions to plan hospitals is not required. All inpatient admissions will be reviewed for medical necessity. Plan hospitals are required to continue to report admissions to Dean Health Plan (DHP) on the next business day.

Planned admissions to non-plan hospitals require prior authorization and must be approved by a DHP Medical Director.

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 DHP 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 for prior authorization of emergency room services and will be able to provide information about alternative care available in and outside 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 DHP 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 effect 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; and;
 - 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 | • severe airway restrictions |
| • serious broken bones | • unconsciousness |
| • severe burns | • severe pain |
| • suspected poisoning | • severe bleeding |
| • convulsions | • suspected heart attack or stroke |
| • prolonged or repeated seizures | |

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 DHP 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 | • lacerations requiring stitches |
| • minor burns | • sprains |
| • most drug reactions | |

Routine Care:

Routine care services are services that are non-emergent/urgent.



Prior Authorization Process

The following outlines DHP'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 non-plan facilities must notify DHP of an inpatient emergency admission the next business day.
 - ✓ Urgent/Non-Emergent/Routine
 - If the member is instructed to be seen at the ER by their physician, authorization by Dean on Call is not needed. Dean Health Plan considers authorization by the physician acceptable. The ER record should indicate that the physician authorized care.
 - If the member self refers to the ER, ER staff should have the member contact Dean on Call for prior authorization of ER treatment. Prior authorization is available 24 hours per day, 7 days a week by calling (800) 57-NURSE (1-800-576-8773) or (608) 250-1393.
 - After the patient has undergone initial evaluation screening by Dean on Call, an authorization number will be issued to the member if services are approved. If needed, the provider may verify the authorization number by contacting Dean on Call directly.

Dean on Call may respond with one of the following answers:

- Authorization of ER treatment is approved; and an authorization number is provided to member. Provider may verify authorization by contacting Dean on Call directly, if desired.
- Authorization of ER treatment is denied and patient is directed to appropriate level of care (i.e., MD office, self care instructions).

Dean Health Plan will enter the authorization into our computer system, including ER treatment approval/denial and/or authorization of alternative services, as appropriate.

If the member refuses to call Dean on Call for authorization, this must be documented in the chart, and the member should be treated.

If the member refuses to follow the direction of Dean on Call and wants to be treated in the ER, the member should be treated and documentation made on the ER record.



-
- ✓ Urgent Care Facility Use
 - Plan Facilities: No prior authorization.
 - Non-Plan: Require prior authorization.

Reimbursement of Services

Hospital services will be reimbursed at the BadgerCare Plus Fee-for Service (FFS) hospital rate/day for all outpatient services; plus laboratory test reimbursement (billed amount or FFS's laboratory fee schedule allowable, whichever is lower).

DHP must be billed within the timely filing limit outlined your contract. If a provider utilizes the UB-92 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.

DHP 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 by 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.

Appeals

If a provider wishes to appeal an initial HMO determination, they should contact our Customer Service Department 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. DHP will respond to appeals within 45 days.

If DHP fails to respond within the 45 day time frame, or if the provider is not satisfied with DHP's response, the provider may seek a final determination from the DHFS. All appeals to DHFS must be submitted in writing within 60 days of DHP's final decision, to the following address:

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



Member Education

The provider, in addition to DHP, will provide education to members on how to use the BadgerCare Plus program.

Prior Authorization of Specific Services

Please refer to the DHP Practitioner Manual in the “Referral/Prior Authorization” section for details on the DHP’s Health Maintenance Organization (HMO) prior authorization guidelines.

These guidelines also apply to BadgerCare Plus members.

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 based on medical necessity
- **Vision**
 - ✓ The following services require prior authorization and are based on medical necessity:
 - Vision training and therapy, including orthoptics and pleoptics
 - Contact lens and contact lens therapy, **except** when the diagnosis is aphakia (379.3) or keratoconus (371.6), or if the contacts are being used as a therapeutic or bandage lens (92070)
 - 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 a plan provider. A second opinion from a non-plan provider requires prior authorization and will be reviewed by a Medical Director.

Transferring Patients

(Refer to Practitioner Manual)

Referral Services

Dean Health Plan's BadgerCare Plus contract states that it is the provider's responsibility to obtain a referral when required. A member must be referred to a BadgerCare Plus certified provider.

The referral process is the same for BadgerCare Plus members as it is for commercial DHP members. Case Management services will be utilized for more extensive long-term cases.

The ID number can be obtained from the BadgerCare Plus ID card and should be put on the referral form in the subscriber number space. Providers should access the EDS online system to verify eligibility and HMO enrollment.

In most cases, a BadgerCare Plus member seeks specialty care outside of their PCP site, a referral must be completed.

Dean Health Plan no longer requires referral requests to the following locations and physicians:

- **Dean Medical Centers**
- **Clinics in association with Dean Medical Center (SMDV-St. Marys Dean Ventures)**
- **Dean Medical Center physicians performing services at outreach locations**
- **Plan mental health clinics and plan physical, occupational and speech therapy facilities**
- **Plan Alcohol and Other Drug Abuse (AODA) clinics and/or facilities**

Prior authorization may be still be required due to a medical policy for a specific service or due to fee schedule limitation.

www.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp

Some additional exceptions include:

- A female member seeks care from an OB/GYN specialist for covered OB/GYN benefits and services.
- Emergency Care
- Family Planning Services
- Member seeking care at a plan mental health clinic



ASH Reporting

Abortions

- All abortions require prior authorization. It is the provider's responsibility to notify DHP that the abortion will be performed and that the required documentation has been completed. Dean Health Plan need medical documentation (refer to Attachment #1 found on page 7) and the physician's statement verifying that the abortion is being performed due to either long-lasting health damage or it is medically necessary to save a woman's life. DHP currently follows similar guidelines to BadgerCare Plus when determining coverage for an abortion. Please direct requests for abortions **to Medical Affairs Division at DHP or Fax to (608) 836-6516.**

Dean Health Plan is required to report abortions, along with sterilization's and hysterectomies, to the State of Wisconsin on a quarterly basis.

Complications arising from an abortion, regardless of whether the abortion itself is a covered service, are payable. This is because the complications represent new conditions, and thus the services are not directly related to the performance of an abortion.

- 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, and documentation (refer to Attachment #2 found on page 9) 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 we would need to see documentation about the start of antiretroviral medication, T-cell counts, and other appropriate medical documentation. **All medical documentation provided must be submitted *prior* to the abortion.**



In examples 1 and 3 on the previous page, the statement by the physician must also include a statement of the woman's pre-existing physical condition (i.e., diagnosis, to clarify the specific physical health danger).

All claims for abortions will be rejected unless one of the above physician certification statements and the recipient statement are attached to the claim form.

This policy is in accordance with the U.S. Supreme Court's decision of Harris vs. McRae on June 30, 1980.

Payment for the medical necessity of preserving the mother's mental health will not be made.



Attachment #2

Required Documentation for BadgerCare Plus Reimbursement

“No service billed to Wisconsin BadgerCare Plus on the attached claim form was directly related to the performance of a non-Medicaid-covered abortion procedure. I understand that this statement is a representation of a material fact made in a claim for payment under Wisconsin BadgerCare Plus within the meaning of s.49.49, Wis. Stats., and HFS 106.06 (17), Wis. Admin. Code. Accordingly, if this statement is false, I understand that I am subject to criminal prosecution for BadgerCare Plus fraud or termination as a BadgerCare Plus provider, or both.”

Signed

Date

Provider Number



Sterilizations

Sterilizations do not require prior authorization. The sterilization consent form must be signed and a copy of this will need to be provided to DHP for reporting purposes (refer to Attachment #3 found on page 12). 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 that 30 day criteria.**

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" (**DEFINE**) 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 to the Medical Affairs Division at DHP or fax to (608) 836-6516.**



Attachment #3 Sample Sterilization Consent Form

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT OF STERILIZATION ■

I have asked for and received information about sterilization from 1 (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, Such as AFDC or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT AND NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a/an 2. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on 3 Month Day Year. I, 4, hereby consent of my own free will to be sterilized by 5 (Doctor)

by a method called 6. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health, Education, and Welfare or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

7 Signature--Recipient Date 8 Month Day Year

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- American Indian or Alaska Native
- Black (not Hispanic origin)
- Asian or Pacific Islander
- Hispanic
- White (not Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form 10 language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

11 Signature--Interpreter Date Signed 12

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before 13 signed the consent form, I explained to him/her the nature of the sterilization operation 14, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that the sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

15 Signature-- Person Obtaining Consent Date Signed 16
17 Facility
18 Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon 19 on 20, Name of individual to be sterilized Date of sterilization operation I explained to him/her the nature of the sterilization operation 21, the fact that it is intended to

specify type of operation be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years of and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) The sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable boxes and fill in information requested):

- Premature delivery
 - Individual's expected date of delivery: _____
 - Emergency abdominal surgery: _____
- (describe circumstances): _____

23 Signature--Physician Date Signed 24



How to Complete the Sterilization Consent Form

Consent to Sterilization Section

- **Element 1--*Doctor or clinic (required)***
The physician named in Element 1 is not required to match elements Elements 5 or 23. A recipient may receive information from one doctor/clinic and be sterilized by another. Corrections to this field must be initialed by the person obtaining consent or the physician.
- **Element 2-- *Procedure (required)***
The information given in Element 2 must be comparable, but not necessarily identical, to Elements 6, 14, or 21. If the full name of the operation is provided in one of Elements 2, 6, 14, or 21, it is permissible to use an abbreviation for the other elements. Corrections to this field must be initialed by the recipient.
- **Element 3--*Date of Birth (required)***
Recipient's date of birth. The month, day, and year must be clearly indicated. Corrections to this field must be lined through and initialed by the recipient. (This does **not** require a new 30-day waiting period.)
- **Element 4--*Name of Recipient (required)***
The recipient's name must be legible. **Initials are acceptable for the first and/or middle only.** The name may be typed. If this element does not match the signature in Element 7, check the Eligibility Verification System (EVS) to verify that this is the same person. Consider the name in Element 4 to be the valid name. Corrections to this field must be initialed by the recipient. (This correction does **not** require a new 30-day waiting period.)
- **Element 5--*Doctor (required)***
The name of the doctor, affiliates, or associates is acceptable. The physician in Element 5 is not required to match Element 1 or 23. Corrections to this element must be initialed by the person obtaining consent or the physician. (A consent form *is* transferable and does **not** necessitate a new 30-day waiting period.)
- **Element 6--*Procedure (required)***
The information given in Element 6 must be comparable, but not necessarily identical to Elements 2, 14, or 21. If the full name of the operation is provided in one of Elements 2, 6, 14, or 21 it is permissible to use an abbreviation for the other elements. Corrections to this field must be initialed by the recipient.
- **Element 7--*Signature (required)***
The recipient's signature does not need to **exactly** match the name in Element 4. It is unacceptable for the recipient's signature to be **completely** different from the name in Element 4. Initials are acceptable for the first and/or middle name. An "X" is acceptable as a



signature *if* a witness of the recipient's choice has signed the form. The individual obtaining consent may not act as a witness. There is no field on the form for a witness' signature; it should appear directly below the recipient signature element and be followed by the date of witness, which must match the recipient's signature date in Element 8. Corrections to Element 7 must be initialed by the recipient. (A correction does **not** require a new 30-day waiting period).

- Element 8--*Date (required)*

The recipient must be at least 21 years old on this date. If the signature date is the recipient's 21st birthday, the claim is acceptable. At least 30 days, but not more than 180 days, excluding the consent and surgery dates, must have passed between the date of the written informed consent and the date of sterilization, except in the case of premature delivery. Corrections to this field must be initialed by the recipient. (A correction does **not** require a new 30-day waiting period.)

- Element 9--*Race and Ethnicity Designation (not required)*

Interpreter's Statement (required if applicable)

- Elements 10 to 12--*Language, Interpreter, Date*

If applicable, the date the interpreter signs can be on or prior to the recipient's signature date in Element 8.

Statement of Person Obtaining Consent

- Element 13--*Name of Recipient (required)*

The recipient's name does not need to **exactly** match the name in Element 4. Corrections to this field must be initialed by the recipient. (This correction does **not** require a new 30-day waiting period.)

- Element 14--*Procedure (required)*

The information given in Element 14 must be comparable, but not necessarily identical to Elements 2, 6, or 21. If the full name of the operation is provided in one of Elements 2, 6, 14, or 21, it is permissible to use an abbreviation for the other elements. Corrections to this field must be initialed by the recipient.

- Elements 15 to 18—*Signature of Person Obtaining Consent, Date, Facility, Address (required)*

The person obtaining the consent may, but is not required to be, the physician performing the procedure. A facility and/or facility address must be indicated, but only one (of the providers' choice) is required. Additionally, the signature date (Element 16) can be prior to, on, or after the date the recipient signs (Element 8). Corrections to this field must be initialed by the person obtaining consent.



Physicians Statement

- **Element 19--Name of Recipient (required)**
The recipient's name does not need to **exactly** match the name in Element 4. Corrections to this field must be initialed by the recipient. (This does **not** require a new 30-day waiting period.)
- **Element 20--Date of Sterilization (required)**
Date must match the date of service (DOS) on the claim. Reimbursement is not allowed unless at least 30 days, but no more than 180 days, have passed between the date of informed consent and the date of the sterilization. This means the DOS must be at least the 31st day after the recipient signature date and no later than the 181st day after that date. Neither the date of informed consent nor the date of surgery will be counted as part of the 30-day requirement. In cases of premature delivery, the consent form must have been signed at least 30 days prior to the expected date of delivery as identified in Element 22 and at least 72 hours must have passed before premature delivery. In cases of emergency abdominal surgery, at least 72 hours must have passed from the date the recipient gave informed consent to be sterilized. Element 22 must be completed in the case of premature delivery or emergency abdominal surgery. Corrections to this field must be initialed by the physician.
- **Element 21—Specify type of operation (required)**
Must be comparable to Elements 2, 6, and 14 or state "same". If the full name of the operation is provided in one of Elements 2, 6, 14, or 21, it is permissible to use an abbreviation for the other elements. Corrections to this field must be initialed by the recipient. (This correction does **not** require a new 30-day waiting period.)
- **Element 22--Exception to 30-Day Requirement (required if less than 31 days have passed between date of signed consent and sterilization date)**
The individual's expected date of delivery must be stated in the case of premature delivery. In the case of emergency abdominal surgery, the circumstances must be described. Corrections to this field must be initialed by the physician.
- **Element 23 & 24--Physician Signature and date (required)**
 - ✓ Alterations to this field must initialed by the physician.
 - ✓ Initials may be used in the signature for the first and/or middle name only.
 - ✓ A signature stamp or computer-generated signature is not acceptable.
 - ✓ The physician's signature on the consent form does not need to exactly match the **performing** physician's name on the claim form. It is unacceptable for the physician's signature to be completely different from the name on the claim.
 - ✓ Physician's signature date must be on or after the date the sterilization was performed.
 - ✓ A nurse or other individual's signature is not acceptable.



Hysterectomies

Hysterectomies do not require prior authorization. Hysterectomies do require that an acknowledgment of information form be completed (see Attachment #4 found on page 18). 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 **before the date of service on t.**

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 acknowledgement form for hysterectomies can be forwarded to DHP Medical Affairs Division or fax to (608) 836-6516.



Attachment #4

Acknowledgment of Receipt of Hysterectomy Information

Name—Recipient		Address—Recipient	
Recipient's BadgerCare Plus ID No.	Name—Physician	Physician's BadgerCare Plus Provider No.	

It has been explained to _____ that the hysterectomy to be
 (Name—Recipient)
 performed on her (me) will render her (me) permanently incapable or reproducing.

SIGNATURES—Recipient, Representative, and Interpreter

 Recipient

 Representative

 Interpreter

 Date Signed



Instructions for Completion of Form

- *Name – Recipient*
Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the BadgerCare Plus identification card and the EVS do not match, use the spelling from the EVS. The name in this element must match the name on the claim.
- *Address – Recipient*
Enter the recipient's address. Use the EVS to obtain the address.
- *Recipient's BadgerCare Plus ID No.*
Enter the recipient's 10-digit BadgerCare Plus identification number. Do not enter any other numbers or letters. This identification number must match the identification number on the claim.
- *Name – Physician*
Enter the performing provider's name.
- *Physician's BadgerCare Plus Provider No.*
Enter the performing provider's eight-digit provider number. This performing provider number must match the performing provider number indicated on the claim.
- *Name – Recipient*
Enter the recipient's name. The name in this element must match the recipient's name entered at the top of the form.
- *Signatures – Recipient, Representative, and Interpreter*
 - ✓ *Recipient* – The recipient must sign and date this element. (Signing this form does not require the recipient to undergo the hysterectomy surgery.)
 - ✓ *Representative* – The representative must sign and date this element if a representative was required for the recipient.
 - ✓ *Interpreter* – An interpreter must sign and date this element if the recipient does not understand the language used on the form and if an interpreter was used to translate this information.
- *Date Signed*
Enter the date the recipient signs the Acknowledgment of Receipt of Hysterectomy Information form in this element. This date must be **on or before** the date of service on the claim.



Outpatient Mental Health

Dean Health Plan (DHP) in compliance with the State of Wisconsin Managed Care Quality Improvement Initiative, strongly encourages our BadgerCare Plus members to follow-up with an outpatient behavioral health provider within 30 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.

To demonstrate our compliance with this initiative, we will send mental health practitioners a letter indicating the date of the follow-up appointment, and ask that DHP is notified if the appointment changes or is canceled. This process will alert us to special needs that a patient may have, which may qualify the patient for case management through the Health Plan.

We thank you in advance for your support of this initiative and for your ongoing clinical expertise in the sound clinical management of DHP members.

If you have any questions regarding this initiative, please contact our Behavioral Health Coordinators at (608) 836-1400 extension 4054 or 4102.

Authorizing Outpatient Mental Health Care

The Primary Care Practitioner (PCP) acts as the “gatekeeper” of the member’s care. DHP would like the member’s PCP to be an integral part in the authorizing of behavioral health services to assure appropriate utilization. Because a referral is no longer required for plan mental health services; if the PCP determines mental health services are medically necessary and knows the plan mental health provider they want to refer the member to, they may do so without completing a Referral Request Form. If the PCP is not certain which mental health practitioner is most clinically appropriate, the PCP may contact Dean Medical Center (DMC) Psychiatry Department at (608) 252-8226 during normal business hours for assistance in determining the practitioner or office site that will best meet their patient’s needs.

If the PCP feels the patient needs to be seen urgently, DMC Psychiatry Department is available to assess the urgency of the need and facilitate an appointment for mental health services or to provide consultation about the options for treatment for the member, when necessary.

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

The PCP will issue a written referral only when the patient requires behavioral health services at a non-plan DHP mental health clinic site.

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



All referrals to non-plan behavioral health providers need to be approved by DHP. DHP may ask the DMC Psychiatry Department to assist in determining if out of network services are appropriate, or if services are available within the DHPnetwork of providers. If you determine that your patient needs specialty outpatient mental health services not available at your clinic/practice, you need to consult with DMC Psychiatry Department about your assessment and recommendations.

The DMC Psychiatry staff at (608) 252-8226 is available after hours to members and providers for situations where an urgent or emergency situation may exist. Dean On Call at (800) 57-NURSE is also available 24 hours a day, 7 days a week to direct members to the nearest provider in their area.

Terminating patients from your clinic/practice:

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

When you are considering termination of care, **the DHP Member Advocate must be informed.** In certain cases, enrollees may be disenrolled from DHP's BadgerCare Plus HMO for just cause. Furthermore, DMC Psychiatry Department should be notified in writing if a patient is being formally terminated from care at your clinic/practice. The DMC Psychiatry Department will consider a DHP BadgerCare Plus patient to be assigned to you. Dean Medical Center Psychiatry Department will not consider "closing" a patient chart due to the end of an episode of care or a patient "dropping out" of treatment as necessarily constituting a termination.

Dean Health Plan and DMC Psychiatry Department 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 DHP 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 DHP, with a carbon copy to DMC Psychiatry Department. Dean Health Plan will stand by your recommendation or, in special circumstances, seek a second opinion. In all cases such as these, DHP assumes that you communicate your recommendations directly to the member.

Concerns about coordination with County Social Services:

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

Communicate your concerns/questions to a staff member at DMC Psychiatry Department at (608) 252-8226.



Inpatient Mental Health

Hospital admissions follow the same guidelines as found on page 1 of this section.

Alcohol and Other Drug Abuse (AODA) Services

The AODA process is the same for BadgerCare Plus members as it is for DHP commercial members. Dean Health Plan BadgerCare Plus members can self refer to a plan AODA provider for an initial assessment.

Please refer to the DHP Practitioner Manual in the “*Overview of Coverage*” section for details on the DHP policies for court-ordered care and full-time students. These guidelines apply to BadgerCare Plus members.



Medicaid Pharmacy Benefit

The essence of the program is that we are layering the over-the-counter drugs that are covered under Fee-For-Service (FFS) Medicaid on top of the traditional drug benefit administered by Dean Health Plan. The following are specifics:

- No copayments are required.
- A maximum 30-day supply can be dispensed. The only exception is oral contraceptives, which can be dispensed 3 cycles at a time.
- Fertility drugs are not covered.
- Covered Over the Counter (OTCs):

✓ Acetaminophen	✓ Insulin
✓ Antacids	✓ Iron Supplements if Pregnant
✓ Antibiotic Ointments	✓ Lice Control Products
✓ Aspirin	✓ Meclizine
✓ Contraceptives	✓ Ophthalmic Lubricants
✓ Cough Syrup with Codeine	✓ Plain Expectorant Cough Syrups
✓ Diphenhydramine	✓ Pseudoephedrine
✓ Hydrocortison Creams	✓ Topical Antifungals
✓ Ibuprofen	✓ Vaginal Antifungals.
- **With the completion of a HealthCheck**, some normally non-covered OTC drugs are covered without prior authorization.
 - ✓ The provider must either complete the pink HealthCheck card with the date of the HealthCheck or;
 - ✓ Provide the prescription with date of the HealthCheck.

Please contact our HealthCheck Coordinator at (608) 827-4168, with any additional questions
- All diabetic supplies; including supplies related to insulin pumps, the pump is covered under the medical benefits and paid by Dean Health Plan (DHP).
- Generics will be dispensed if available.
- The DHP Formulary represents the covered legend (i.e. prescription) drugs. Also, DHP's prior authorization policies and criteria apply as opposed to those used under FFS Medicaid.
- If a new MA/BadgerCare member is currently taking a drug that is not on the DHP Formulary, please contact our Customer Care Center at (800) 279-1301 for further assistance



BadgerCare Plus

Member Complaint, Appeal, and Grievance Procedure

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

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

The procedure for filing a complaint, appeal, or grievance is defined below. This information is located in the Member Handbook.

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

Complaint:

Dean Health Plan takes all member complaints seriously and is committed to responding to them in an appropriate and timely manner.

If a member has a complaint regarding any aspect of care or decision made by you, please contact the Customer Care Center at **(608) 828-1301** or **(800) 279-1301**. We will document and investigate the member complaint and notify the member of the outcome of the complaint. If the complaint is not resolved to their satisfaction they can file a grievance.

Any written expression of dissatisfaction will automatically be addressed as a grievance (see Grievance subsection).

Grievance:

To file a grievance, a member can submit it to us in writing or contact the Customer Care Center at:

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

Upon receipt of the grievance, the Grievance Committee will acknowledge it within 5 business days. Our acknowledgment letter will advise the member of their right to submit written



comments, documents or other information regarding their grievance, to be assisted or represented by another person of their choice, to appear before the Grievance Committee, and the date and time of the next scheduled meeting, which will not be less than seven calendar days from the date of their acknowledgment and within 30 calendar days of receiving the grievance. If the member chooses to appear before the Committee, they must notify us. If they are unable to appear before the Committee, they do have the option of scheduling a conference call.

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

The member can speak to someone outside of the DHP by calling the HMO Enrollment Specialist at 1-800-291-2002. The Enrollment Specialist may be able to help resolve the problem or help write a formal grievance to either DHP or to the BadgerCare Plus Program.

The address to complain to the Wisconsin BadgerCare Plus Program is:

BadgerCare Plus and Medicaid SSI
Managed Care Ombuds
P.O. Box 6470
Madison, WI 53716-0470
(800) 760-0001

The member has the right to appeal to the State of Wisconsin Division of Hearings and Appeals (DHA) for a fair hearing if they believe that their benefits are wrongly denied, limited, reduced, delayed, or stopped by DHP. An appeal must be made no later than 45 days after the date of the action being appealed. If they appeal the action to DHA before the effective date, the service may continue. The member may need to pay for the cost of services if the hearing decision is not in their favor.

For a fair hearing, send a written request to:

Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

The fair hearing will be held in the county where the member resides. The member is able to be accompanied or be represented at the hearing. Special arrangements for a disability or for English language translation can be requested at (608)266-3096 (voice) or (608) 264-9853 (hearing impaired).

The member can seek help writing the request for a Fair Hearing, by call the BadgerCare Plus Ombudsman at 1-800-760-0001 or the HMO Enrollment Specialist at 1-800-291-2002.



BadgerCare Plus Provider Appeals Process

If DHP denies a claim or benefit that results in payment denial to the provider of care 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 DHP or of the denial or payment determination.

A written request must be submitted or utilize the BadgerCare Plus Provider Appeal form and:

- clearly marked "appeal"
- contain the provider of care's name, date of service, date of billing, date of rejection, and reason(s) claim merits reconsideration
- be submitted to: Provider Appeals, PO Box 56099, Madison, WI 53705

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 DHP does not respond within 45 days or if the provider of care is not satisfied with DHP's response to the request, DHP will notify the provider they may appeal to the Wisconsin Department of Health and Family Services (DHFS) for a final determination. Appeals to the Wisconsin DHFS must be submitted in writing within 60 days of DHP's response.

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



HealthCheck Program

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. DHP'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 recipient's health history.
- An assessment of growth and development.
- Identification of potential physical or developmental problems.
- Preventive health education.
- Referral assistance to providers.

HealthCheck Other Services

Standard Plan recipients who receive a HealthCheck 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.

- Member must be covered under the Standard Plan. The benchmark policy does not cover Healthcheck Other Services
- The provider must either complete the pink HealthCheck card with the date of the HealthCheck or:
- Provider 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-diarrheals
- 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 DHP get maximum premium from the state which will help your reimbursement rate.

How often should a child obtain a HealthCheck screening?

- The 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 3-4 weeks 6-8 weeks 4 months 6 months 9 months
First birthday to second birthday	3	12 months 15 months 18 months
Second birthday to third birthday	2	2 years 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 HealthChecks and our plan providers help us strengthen that commitment.

Each provider is asked to designate an individual in their office as a Clinic HealthCheck contact. **You can reach the HealthCheck Coordinator for assistance with your billing questions, training requests and questions on the HealthCheck program at (608) 827-4168.**

Outreach Report

- Your office will receive a listing every other month of HealthCheck eligible children assigned to your clinic for primary care. According to our records, they are due for their next HealthCheck. We invite you to contact these patients to receive their health checks. Please report discrepancies to the HealthCheck Coordinator.

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

HealthCheck Billing

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

- Dean Health Plan (DHP) 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
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).
99431*	History and examination of normal newborn infant, initiation of diagnostic and treatment programs and preparation of hospital records.
99432*	Normal newborn care in other than hospital or birthing room setting, including physical examination or baby and conference(s) with parent(s).
99435*	History and examination of normal newborn infant, including the preparation of medical records.

* *These codes do not need a modifier*

Do not apply any modifiers to the HealthCheck codes other than the ones listed below.

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 case management, and lead inspection services were provided as part of EPSDT
	TS	Indicates follow-up services to an environmental lead inspection

The following diagnosis codes are required for HealthCheck billing:

- V20.2 – Routine Infant or Child HealthCheck
- V70.0 – Adult over 18 years of age



DHP Outreach Initiatives

- **Madison Metropolitan School District** - School nurses outreach to families to encourage children to see their physician for a HealthCheck, hold weekly HealthCheck clinics, and three Teen Clinics each school year at school sites.
- **County Agencies** - Various county agencies receive a report of DHP 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.
- **Dane County Coalition for Neighborhood Child Health** - Community group that coordinates free HealthCheck clinics for all children regardless of insurance status.
- **Dane County Advocates** - Group of HMO and Contract Administrator members that meet monthly to share problem-solving solutions to issues facing the BadgerCare Plus demographic, including barriers to obtaining healthcare. Members also participate in several community service activities per year and host speakers to keep abreast of issues affecting Medicaid recipients.
- **Provider Education/Awareness** - The HealthCheck Coordinator organizes and provides training and educational materials for DHP staff and providers to enhance understanding of the HealthCheck program and to communicate requirements. She monitors HealthCheck screening levels, including provider performance and appropriate claim coding and develops processes to provide regular feedback to providers and DHP staff on outcomes.

***** If you have any questions regarding HealthChecks or suggestions for additional outreach initiatives or ways to improve current ones, please contact DHP's HealthCheck Coordinator, at (608) 827-4168, as your ideas could really make a difference.**



Health Check Components

Including documentation notes from State Audits

Health History

- Including special risk factors, or prior conditions/treatments/medications
- If there are no recent changes, indicate in chart 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, injury prevention
- Handouts are sufficient, but documentation must be found in the chart of age specific handouts given

Developmental Behavioral Assessment

- Observed behavior and attainment of age-appropriate developmental milestones including response to tools, concerns, 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 kindergarten or first grade

Hearing Assessment

- Puretone audiometric results
- If exam 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 kindergarten or first grade

Lab Tests

- Blood lead required at age 1 & 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 referral 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.



HealthCheck Visit 3-4 Weeks

Date:		Medicaid ID #:		Date of Birth:	
Patient Name: (affix label if available)			Immunizations up to date? Y N		
			DTP/DT/DTAP _____	Hep B _____	IPV _____
Address:			Referral to: _____		
Phone #:			Physician: _____		
Age:		Weight:		Chest Circ: _____	
Sex:		Height:		Head Circ: _____	
			Hearing: Gross _____		Fam History Done: Y
			Audiogram _____		N
Physical Examination:					
Characteristic		N	Abn	Comments (describe abnormal findings)	
General Appearance					
Skin					
Nodes					
HEENT					
Neck					
Lungs					
Heart					
Fem Pulses					
Abdomen					
Genitourinary					
Back					
Extremities/Hips					
Neuromuscular					
Umbilicus					
Nutrition: Breast/formula, vits/fluoride, water source, avoid bottle in crib					
Dental Concerns:					
Bowel/Bladder: Stools/voids					
Sleep:					
Development/Behavior/Discipline: Regards face, alert to noise, lifts head, crying					
Safety/Anticipatory Guidance: Car seat, Smoke alarms, siblings/pets					
Other Observations:					
Concerns/Plan/Follow-up: Immunization information, newborn screen					
Next Appt:		Handouts given? Y N		Physician Signature:	



HealthCheck Visit 6–8 Weeks

Date:		Medicaid ID #:		Date of Birth:	
Patient Name: (affix label if available)			Immunizations up to date? Y N		
Address:			DTP/DT/DTAP _____ HIB _____		
			IPV _____ Hep B _____		
Phone #:			OPV _____ Other _____		
			Referral to: _____		
Age:			Weight:		Hearing: Gross _____
Sex:			Height:		Audiogram _____
					Head Circ: _____
					Fam History Done: Y N
Physical Examination:					
Characteristic	N	Abn	Comments (describe abnormal findings)		
General Appearance					
Skin					
Nodes					
HEENT					
Neck					
Lungs					
Heart					
Fem Pulses					
Abdomen					
Genitourinary					
Back					
Extremities/Hips					
Neuromuscular					
Nutrition: Breast/formula, introduction to solids, water source, avoid bottle in crib					
Dental Concerns					
Bowel/Bladder: Stools/voids					
Sleep:					
Development/Behavior/Discipline: Sit w/ support, grasps, reaches, enjoys people, laughs, drools					
Safety/Anticipatory Guidance: Car seat, smoke alarms, sun protection, falls, small objects, teething, dangling toys					
Other Observations:					
Concerns/Plan/Follow-up: Immunization review					
Next Appt:		Handouts given? Y N		Physician Signature:	



HealthCheck Visit 3-4 Months

Date:		Medicaid ID #:		Date of Birth:	
Patient Name: (affix label if available)		Immunizations up to date? Y N DTP/DT/DTAP _____ HIB _____ IPV _____ Hep B _____ OPV _____ Other _____			
Address:		Referral to: _____ Medications: _____ Allergies: _____			
Phone #:		Physician:			
Age:	Weight:	Hearing: Gross _____	Head Circ: _____		
Sex:	Height:	Audiogram _____	Fam History Done: Y N		
Physical Examination:					
Characteristic	N	Abn	Comments (describe abnormal findings)		
General Appearance					
Skin					
Nodes					
HEENT					
Neck					
Lungs					
Heart					
Fem Pulses					
Abdomen					
Genitourinary					
Back					
Extremities/Hips					
Neuromuscular					
Nutrition: Breast/formula, introduction to solids, water source, avoid bottle in crib					
Dental Concerns:					
Bowel/Bladder: Stools/voids					
Sleep:					
Development/Behavior/Discipline: Sit w/ support, grasps, reaches, enjoys people, laughs, drools					
Safety/Anticipatory Guidance: Car seat, smoke alarms, sun protection, falls, small objects, teething, dangling toys					
Other Observations:					
Concerns/Plan/Follow-up: Immunization review					
Next Appt:	Handouts given? Y N		Physician Signature:		



HealthCheck Visit 5-6 Months

Date:		Medicaid ID #:		Date of Birth:	
Patient Name: (affix label if available)			Immunizations up to date? Y N DTP/DT/DTAP _____ Hep B _____ IPV _____ Varicella _____ OPV _____ Referral to: _____		
Address:			Medications: _____ Allergies: _____		
Phone #:			Physician:		
Age:		Weight:	Blood Lead:		Head Circ:
Sex:		Height:	Hearing: Gross _____ Audiogram _____		Fam History Done: Y N
Physical Examination:					
Characteristic	N	Abn	Comments (describe abnormal findings)		
General Appearance					
Skin					
Nodes					
HEENT					
Neck					
Lungs					
Heart					
Fem Pulses					
Abdomen					
Genitourinary					
Back					
Extremities/Hips					
Neuromuscular					
Nutrition: Breast/formula, solids, cup, water source, AVOID: honey, citrus, egg whites, avoid bottle in crib, avoid juice in bottle					
Dental Concerns:					
Bowel/Bladder:					
Sleep: Through the night/naps					
Development/Behavior/Discipline: Sitting, transfers hand to hand, enjoys people, babbles, bears weight, resists pull toy, separation anxiety					
Safety/Anticipatory Guidance: Child proof, ipecac, walker, car seat, smoke alarms, sun protection					
Other Observations:					
Concerns/Plan/Follow-up: Immunization review					
Next Appt:		Handouts given? Y N		Physician Signature:	



HealthCheck Visit 9 Months

Date:		Medicaid ID #:		Date of Birth:	
Patient Name: (affix label if available)			Immunizations up to date? Y N DTP/DT/DTAP _____ Hep B _____ IPV _____ HIB _____ OPV _____ Other _____ Referral to: _____ Medications: _____ Allergies: _____		
Address:			Physician:		
Phone #:			Weight:		
Age:	Height:	Blood Lead:		Head Circ:	
Sex:	Height:	Hearing: Gross _____ Audiogram _____		Fam History Done: Y N	
Physical Examination:					
Characteristic	N	Abn	Comments (describe abnormal findings)		
General Appearance					
Skin					
Nodes					
HEENT					
Neck					
Lungs					
Heart					
Fem Pulses					
Abdomen					
Genitourinary					
Back					
Extremities/Hips					
Neuromuscular					
Nutrition: Milk (breast/formula/2%whole) cup, advancing diet, table foods, finger foods, water source. AVOID: honey, nuts, popcorn, chips, candy					
Dental Concerns:					
Bowel/Bladder:					
Sleep: Through the night/naps					
Development/Behavior/Discipline: Pulls self to stand, cruises crawls, imitates sounds, throws/pushes toys off tray, stranger/separation anxiety					
Safety/Anticipatory Guidance: Walker, water temp, shoes, car seat, smoke alarms, sun protection, ipecac, child proofing					
Other Observations:					
Concerns/Plan/Follow-up: Immunization review				Handouts given? Y N	
Next Appt:	Handouts given? Y N		Physician Signature:		



HealthCheck Visit 12 Months

Date:	Medicaid ID #:	Date of Birth:	
Patient Name: (affix label if available)		Immunizations up to date? Y N	
		DTP/DT/DTAP _____	Hep B _____
		IPV _____	HIB _____
		OPV _____	Other _____
Referral to: _____		Medications: _____	
Allergies: _____		Physician: _____	
Address:		Weight: _____	
Phone #:		Blood Lead: _____	
Age: _____	Height: _____	Head Circ: _____	
Sex: _____	Height: _____	Hearing: Gross _____	Fam History Done: Y N
Audiogram _____			
Physical Examination:			
Characteristic	N	Abn	Comments (describe abnormal findings)
General Appearance			
Skin			
Nodes			
HEENT			
Neck			
Lungs			
Heart			
Fem Pulses			
Abdomen			
Genitourinary			
Back			
Extremities/Hips			
Neuromuscular			
Nutrition: Milk, table foods, cup/weaning, spoon, water source. AVOID: nuts, popcorn, candy			
Dental Concerns:			
Bowel/Bladder:			
Sleep: Through the night/naps			
Development/Behavior/Discipline: Walking, climbing, throws overhand, plays ball/pat-a-cake, mama/dada, single words			
Safety/Anticipatory Guidance: Falls, stairs, ipecac, car seat, smoke alarms, child proofing			
Other Observations:			
Concerns/Plan/Follow-up: Immunization review			
Next Appt:		Handouts given? Y N	Physician Signature:



HealthCheck Visit 15 Months

Date:		Medicaid ID #:		Date of Birth:	
Patient Name: (affix label if available)			Immunizations up to date? Y N		
Address:			DTP/DT/DTAP _____ MMR _____		
			IPV _____ Hep B _____		
Phone #:			OPV _____ HIB _____		
			Varicella _____		
Physician:			Referral to: _____		
Medications: _____			Allergies: _____		
Age:		Weight:		Blood Lead:	
Sex:		Height:		Head Circ:	
T.B.(opt.)		Hgb/HCT:		Family History Done: Y N	
				Hearing: Gross _____ Audiogram _____	
Physical Examination:					
Characteristic	N	Abn	Comments (describe abnormal findings)		
General Appearance					
Skin					
Nodes					
HEENT					
Neck					
Lungs					
Heart					
Fem Pulses					
Abdomen					
Genitourinary					
Back					
Extremities/Hips					
Neuromuscular					
Nutrition: Diet-table food, milk (1pt-1qt), 3 meals/day with snacks, vits/fluoride, weaned from bottle					
Dental Concerns:					
Bowel/Bladder: Toilet training					
Sleep: Through the night/naps					
Development/Behavior/Discipline: Walks alone, walks backwards, scribbles with pencil, 2+ single words, uses spoon with spilling					
Safety/Anticipatory Guidance: Climbing, stove, water, poisons, obedience, temper tantrums, sibling rivalry					
Other Observations:					
Concerns/Plan/Follow-up: Immunization review					
Next Appt:		Handouts given? Y N		Physician Signature:	



HealthCheck Visit 18 Months

Date:		Medicaid ID #:		Date of Birth:	
Patient Name: (affix label if available)			Immunizations up to date? Y N		
Address:			DTP/DT/DTAP _____ MMR _____		
			IPV _____ Hep B _____		
			OPV _____ HIB _____		
			Varicella _____		
			Referral to: _____		
			Medications: _____		
			Allergies: _____		
Phone #:			Physician:		
Age:		Weight:		Blood Lead:	
Sex:		Height:		Head Circ:	
T.B.(opt.)		Hgb/HCT:		Fam History Done: Y N	
				Hearing: Gross _____ Audiogram _____	
Physical Examination:					
Characteristic	N	Abn	Comments (describe abnormal findings)		
General Appearance					
Skin					
Nodes					
HEENT					
Neck					
Lungs					
Heart					
Fem Pulses					
Abdomen					
Genitourinary					
Back					
Extremities/Hips					
Neuromuscular					
Nutrition: Diet-table food, milk (1pt-1qt), 3 meals/day with snacks, vits/fluoride, weaned from bottle					
Dental Concerns:					
Bowel/Bladder: Toilet training					
Sleep: Through the night/naps					
Development/Behavior/Discipline: Kicks ball forward, makes tower of 2 or 4 cubes, says 10+ single words, removes own clothing					
Safety/Anticipatory Guidance: Climbing, stove, poisons, street, need for supervision, peer activities, discipline, limit setting					
Other Observations:					
Concerns/Plan/Follow-up: Immunization review					
Next Appt:		Handouts given? Y N		Physician Signature:	



HealthCheck Visit 2 years & 2 ½ years

Date:		Medicaid ID #:		Date of Birth:	
Patient Name: (affix label if available)			Immunizations up to date? Y N		
Address:			DTP/DT/DTAP _____ MMR _____		
			IPV _____ Hep B _____		
			OPV _____ HIB _____		
			Varicella _____		
			Referral to: _____		
			Medications: _____		
			Allergies: _____		
Phone #:			Physician:		
Age:		Weight:		Blood Lead:	
Sex:		Height:		Head Circ:	
				Hearing: _____	
				Gross _____	
				Audiogram _____	
T.B.(opt.)		Hgb/HCT:		Urinalysis:	
				Dentist: Y N	
Physical Examination:					
Characteristic	N	Abn	Comments (describe abnormal findings)		
General Appearance					
Skin					
Nodes					
HEENT					
Neck					
Lungs					
Heart					
Fem Pulses					
Abdomen					
Genitourinary					
Back					
Extremities/Hips					
Neuromuscular					
Nutrition: Three meals/day with snacks, lowfat milk					
Dental Concerns:					
Bowel/Bladder: Toilet training					
Sleep: Naps					
Development/Behavior/Discipline: Runs well, up & down stairs, 2-3 word sentence, hide & seek, body parts, rough & tumble play					
Safety/Anticipatory Guidance: Street, knives, falls, T.V., bedtime, discipline, intellectual development, praise, smoke alarms					
Other Observations:					
Concerns/Plan/Follow-up: Immunization review					
Next Appt:		Handouts given? Y N		Physician Signature:	



HealthCheck Visit Pre-school (3 years – 5 years)

Date:		Medicaid ID #:		Date of Birth:	
Patient Name: (affix label if available)			Immunizations up to date? Y N DTP/DT/DTAP _____ MMR _____ IPV _____ Hep B _____ OPV _____ Varicella _____ HIB _____ Referral to: _____ _____ Medications: _____ Allergies: _____		
Address:					
Phone #:			Physician:		
Age:		Weight:		Blood Lead: _____	
				Blood Pressure: _____ / _____	
Sex:		Height:		Family History Done: Y N	
T.B.(opt.) _____		Hgb/HCT: _____		Urinalysis: _____	
				Dentist: Y N	
Vision: R _____ / _____ L _____ / _____			Hearing: Gross _____ Audiogram _____		
Physical Examination:					
Characteristic	N	Abn	Comments (describe abnormal findings)		
General Appearance					
Skin					
Nodes					
HEENT					
Neck					
Lungs					
Heart					
Fem Pulses					
Abdomen					
Genitourinary					
Back					
Extremities/Hips					
Neuromuscular					
Nutrition: Regular meals, snacks					
Bowel/Bladder: Toilet training: day, night					
Sleep: Behavior at bedtime, naps, nightmares, facilities					
Development/Behavior/Discipline: Temperament, general mood, reaction to new situations, intensity of reactions, attention span, peers					
Safety/Anticipatory Guidance: Independence, biting, kicking, accidents, dental & personal care, T.V., sexual awareness					
Other Observations:					
Concerns/Plan/Follow-up: Immunization review					
Next Appt:		Handouts given? Y N		Physician Signature:	



HealthCheck Visit Elementary School (6–12 years)

Date:		Medicaid ID #:		Date of Birth:	
Patient Name: (affix label if available)			Immunizations up to date? Y N		
Address:			DTP/DT/DTAP _____ MMR _____		
			IPV _____ Hep B _____		
			OPV _____ HIB _____		
			Varicella _____		
			Referral to: _____		
			Medications: _____		
			Allergies: _____		
Phone #:		Physician:			
Age:	Weight:	Blood Lead:		Blood Pressure: /	
Sex:	Height:	Family History Done: Y N			
T.B.(opt.):	Hgb/HCT (2yrs):	Urinalysis (2yrs):		Dentist: Y N	
Vision: R _____ / _____ L _____ / _____			Hearing: Gross _____ Audiogram _____ (4yrs>8)		
Physical Examination:					
Characteristic	N	Abn	Comments (describe abnormal findings)		
General Appearance					
Skin					
Nodes					
HEENT					
Neck					
Lungs					
Heart					
Fem Pulses					
Abdomen					
Genitourinary					
Back					
Extremities/Hips					
Neuromuscular					
Nutrition: Variety, balance, weight/diet concerns					
Bowel/Bladder:					
Sleep:					
Development/Behavior/Discipline: Achievement, attendance, peers, family, body/sexual awareness, limit setting, praise pos. behavior					
Safety/Anticipatory Guidance: Puberty, sex education, smoking/drugs/alcohol, seat belt, bike safety, after-school supervision					
Other Observations:					
Concerns/Plan/Follow-up: Immunization review					
Next Appt:		Handouts given? Y N		Physician Signature:	



HealthCheck Visit 13 years – 21 years

Date:		Medicaid ID #:		Date of Birth:	
Patient Name: (affix label if available)			Immunizations up to date? Y N DTP/DT/DTAP _____ MMR _____ IPV _____ Hep B _____ OPV _____ HIB _____ Varicella _____ Referral to: _____ Medications: _____ Allergies: _____		
Address:					
Phone #:			Physician:		
Age:		Weight:		LMP:	
				Blood Pressure: /	
Sex:		Height:		Family History Done: Y N	
T.B.(opt.)		Hgb/HCT (2 yrs):		Urinalysis (2yrs):	
				Dentist: Y N	
Vision: R _____ / _____ L _____ / _____			Hearing: Gross _____ Audiogram _____ (4yrs)		
Physical Examination:					
Characteristic	N	Abn	Comments (describe abnormal findings)		
General Appearance					
Skin					
Nodes					
HEENT					
Neck					
Lungs					
Heart					
Fem Pulses					
Abdomen					
Genitourinary					
Back					
Extremities/Hips					
Neuromuscular					
Nutrition: Weight/diet concerns, breakfast					
Bowel/Bladder:					
Sleep:					
Development/Behavior/Discipline: Achievement, attendance, peers, family, body/sexual awareness, independence, rebellion					
Safety/Anticipatory Guidance: Puberty, sex education, contraceptives, smoking/drugs/alcohol, seat belt, breast/testicular self-exams					
Other Observations:					
Concerns/Plan/Follow-up:					
Next Appt:		Handouts given? Y N		Physician Signature:	



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 vaccine 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 Department of Health & Social Services, 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. With a 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 noncovered over-the-counter medications. The Benchmark Plan does not cover Healthcheck Other Services.

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 DHP'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. Counties are responsible for assisting members with transportation. The Benchmark Plan does not cover transportation to medical appointments.

- **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. The Benchmark Plan does not cover Healthcheck "Other Services".



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

A: The Wisconsin BadgerCare Plus program Website contains the handbook information on HealthCheck. The Website address for the BadgerCare Plus handbook section on HealthCheck is:

http://www.dhfs.wisconsin.gov/Medicaid2/handbooks/partd_d1/chapters.htm.

The entire HealthCheck Services handbook may be printed from this site.

We welcome any questions and any suggestions you may have on how we can improve our processes. You can reach DHP's HealthCheck Coordinator for assistance with your billing questions, training requests and questions on the HealthCheck program at (608) 827-4168.