

Provider Manual for  
Wisconsin Southeast Region  
BadgerCare Plus Program

Effective July 1, 2011  
Version 1.0

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## Chapter 1: Introduction and Guide to Manual

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Our vision is simple – to significantly improve member health outcomes and efficiently manage costs with a next generation Medicaid health plan. CompCare Health Services Insurance Corporation, d.b.a. CommunityConnect<sup>SM</sup> HealthPlan, is hereafter referenced in this Manual as CommunityConnect HealthPlan, or CommunityConnect.

CommunityConnect HealthPlan provides coverage to BadgerCare Plus members in the state of Wisconsin. Service Area is Kenosha, Milwaukee, Ozaukee, Racine, Washington and Waukesha counties in the southeastern region of Wisconsin.

This Provider Manual (Manual) will present a general overview for network physicians, hospitals, facilities, ancillary providers, and other health care professionals under contract with CommunityConnect, and provides information regarding key administrative areas, including but not limited to: key contact information, quality improvement program, the utilization management and behavioral health programs, quality standards, reimbursement and administrations policies and provider appeals.

Please note that as you refer to this Manual, primary care provider (PCP) and primary care clinic (PCC) are used interchangeably to refer to the professional or professional group that provides the primary care to a CommunityConnect member.

This Manual, and any further updates, revisions and amendments, are part of your Participating Provider Agreement and related Addendums (Agreement). Should any language contained in this Manual conflict with language contained in the Agreement, the Agreement takes precedence.

### Using this Manual

CommunityConnect provides this Manual electronically at [www.CommunityConnectHealthPlan.com](http://www.CommunityConnectHealthPlan.com). You may link to any section of this Manual by clicking on the topic in the Table of Contents. Each section may also contain cross-links to other sections, a glossary, important phone numbers, or to our website or outside websites containing additional information. Icons, bold type, or boxes may draw attention to important information.

### How to Contact Us

CommunityConnect's business hours are Monday through Friday, 8 a.m. to 5 p.m., unless otherwise noted. **How to Contact Us** on our website is a listing of important telephone numbers, mailing and web addresses.

### Information Resources

The CommunityConnect website is our internet site available to CommunityConnect HealthPlan network providers at [www.CommunityConnectHealthPlan.com](http://www.CommunityConnectHealthPlan.com). The site provides information on:



## Chapter 1: Introduction and Guide to Manual

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- Quality management – the latest clinical practice guidelines and preventive health care guidelines approved for use by our medical staff
- Authorization – a comprehensive listing of services requiring prior authorization, custom forms, and Utilization Management Clinical Guidelines.
- Health education materials – information and resources from HealthCheck to interpreter services to brochures and flyers to give your members on our preventive and disease management programs.
- Provider communications – the current Provider Manual, operational updates and other important communications that we send to you by e-mail, fax or mail are posted on this site.
- Forms and tools – available forms, reference guides, member handbook, and provider directory for your use when serving our members enrolled in BadgerCare Plus.

CommunityConnect frequently provides training and education through Webinars, written materials, documents and resource information posted on our provider website, face-to-face meetings, planned collaborations and peer-to-peer consultations. For more information, contact your local provider network representative.

## Chapter 2: Legal and Administrative Requirements

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### Proprietary Information

The information contained in this Manual is proprietary. By accepting this Manual, the Provider agrees not to disclose such information, to protect and hold the information confidential, and to use this Manual solely for the purposes of referencing information regarding the provision of medical services to members enrolled in the BadgerCare Plus program who have chosen CommunityConnect as their health plan.



### Communications Between Provider and CommunityConnect

In the event we make a material change to the Provider Manual, we will use reasonable efforts to notify you in advance of such change.

CommunityConnect may give providers such notice through our periodic e-mail communications such as Rapid Updates, web-posted newsletters, fax communications, mailings or any other electronic or written method. Unless otherwise specified in your contract, the information contained in this Manual is not binding upon CommunityConnect and is subject to change.

CommunityConnect uses the Secure eMail encryption tool to ensure that your client's Protected Health Information (PHI) is kept private and secure. We're doing this because we know that many people are concerned about identify theft. Secure eMail encrypts e-mails and attachments identified as potentially having PHI. You can also use Secure eMail to send encrypted e-mail to CommunityConnect.

If you need technical assistance or have questions about Secure eMail, contact **Provider Services**. This service is available to you at no charge. We hope you understand the importance of taking these steps in protecting the personal information of your clients.

### Privacy and Security Statement

CommunityConnect's latest Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant privacy and security statements can be found on our website at **[www.CommunityConnectHealthPlan.com](http://www.CommunityConnectHealthPlan.com)**.

## Chapter 3: Access to Care Guidelines

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CommunityConnect has policies and procedures in place to promote the coordination and continuity of medical care for our BadgerCare Plus members. This includes the confidential exchange of information between primary care providers and specialists, as well as behavioral health providers.

All contracted providers must not exceed the specified intervals between the member's request for service and the date/time an appointment is scheduled for the enrollee to receive requested medical services.



### Appointment Access Standards

CommunityConnect's appointment access standards are as follows:

<b>General Appointment Standards</b>	
Emergency Examination	Immediate access 24/7
Urgent Examination	Within 24 hours of request
Routine Examination	Within 14 days of request
<b>Pregnancy Appointment Standards</b>	
Prenatal	Within 14 days of request
3rd Trimester	Within 5 days of request
High-Risk Pregnancy	Within 14 days of request
Postpartum exam	4 to 8 weeks after delivery
<b>Behavioral Health Appointment Standards</b>	
Life-threatening emergency	Immediately
Outpatient treatment post-psychiatric inpatient care	Within 7 days from the date of discharge
Routine behavioral health visits	Within 10 days of request
<b>Dental Appointment Standards</b>	
New Patient Exam	Within 90 days of request
Routine Exam after initial Diagnosis	Within 60 days of request

CommunityConnect follows state and federal accessibility standards for care and services. CommunityConnect conducts annual surveys not only on provider satisfaction, but also on appointment wait times and after-hours services provided.

### Wait Times

When a physician's office receives a call from a CommunityConnect member during regular business hours for assistance and possible triage, the physician or another health care professional must take the call, or call the member back within 30 minutes of their initial call.

### After-Hours Care

It is CommunityConnect's policy, and the state of Wisconsin's requirement, that BadgerCare Plus members have access to quality, comprehensive health care services 24 hours a day, 7 days a week. Primary care providers (PCPs) must have either an answering service or an answering machine for members after normal business hours for assistance and/or instructions, for both emergency and non-emergency calls.

## Chapter 3: Access to Care Guidelines

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- The answering service must properly instruct the caller to call 911 or go to the nearest emergency room for emergency situations. For non-emergency calls, the answering service must forward calls to the PCP or on-call physician, or instruct the members that the provider will contact them within 30 minutes.
- Instructing a member to leave a message on an answering machine is not compliant with the program standards.

We offer the following suggested text for answering machines:

“Hello, you have reached [insert physician office name]. If this is an emergency, hang up and dial 911 or go to the nearest hospital emergency room. If this is not an emergency and you have a medical concern or question, please call [insert contact phone or pager number]. You will receive a return call from the on-call physician within (timeframe).”

### **MedCall**

CommunityConnect members also may contact MedCall, our nurse advice line (telephone information available 24/7 daily and staffed by registered nurses) to ask questions about:

- Health concerns
- Transportation needs
- Authorization requests
- Medical conditions
- Prescription drugs
- Receiving information on where to go for appropriate health care services
- Local health care services

### **Non-Discrimination Statement**

You must post a statement in your office that provides hours of operation that do not discriminate against BadgerCare Plus members. This includes waiting times for appointments, and waiting times for care at facilities.

### **Interpreter Services/Languages Spoken in the Provider Office**

CommunityConnect will ensure that members requiring interpreter services shall have access to a telephone interpreter 24 hours a day, 7 days a week. Services include, but are not limited to, assistance during office visits and telephone assistance.

It is essential that providers verify eligibility prior to each date of service. BadgerCare Plus members are required to carry and present their ForwardHealth ID card (issued by the state of Wisconsin Department of Health Services) when seeking services.



State of Wisconsin Member Identification Card

CommunityConnect HealthPlan will issue a member identification card to our members. We instruct our members to show their card each time they receive services. The member identification number is the same as the identification number assigned by ForwardHealth; but the card is for member ID only and does not prove eligibility.



CommunityConnect Member Identification Card

## Options to Verify Member Eligibility

You may verify member eligibility through various resources:

### ForwardHealth website - [www.ForwardHealth.wi.gov/](http://www.ForwardHealth.wi.gov/)

- Secure area offers real-time member enrollment and eligibility verification for all ForwardHealth programs
- Used to determine the benefit plan(s) in which the member is enrolled, as well as state-contracted managed care programs (for BadgerCare Plus members)

- Available 24/7

ForwardHealth Enrollment Website

Home Search Managed Care **Enrollment** Account Contact Information Online Handbooks Site Map IC Functionality

You are logged in with ID: 69009026

Enrollment

**Enrollment Verification**  
Required fields are indicated with an asterisk (\*).

- One of the following is required:
  - Member ID
  - Social Security Number and Date of Birth
  - Member First/Last Name and Date of Birth

Member ID   
Last Name  First Name   
Social Security Number  Date of Birth   
From Date of Service\* 09/01/2010 To Date of Service\* 09/12/2010

Search

For your reference, the enrollment verification tracking number 1025500GV1 verifies the enrollment information below only for the following time frame of 09/01/2010 through 09/12/2010.

**Search Results**

Member Information

Member ID  Name   
Date of Birth  County Milwaukee  
Medicare ID  Address

Benefit Plan

Plan	Benefit Plan	Effective Date	End Date
MEDICAID	BC+ Standard Plan (HPSA Recipient)	09/01/2010	09/12/2010

Managed Care Enrollment

Provider Name	Telephone Number	Effective Date	End Date
COMMUNITYCONNECT HEALTHPLAN (Dental)	(866)647 6120	09/01/2010	09/12/2010

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Wisconsin Department of Health Services  
Production PROD\_WiPortal\_MZ39C\_5-5

ForwardHealth Enrollment Website

### ForwardHealth WiCall - 1-800-947-3544

- Enrollment verification
- Available 24/7

### CommunityConnect Provider Services - 1-877-350-6074

- Verify enrollment and benefits for CommunityConnect members
- Available 8:00 a.m. to 5:00 p.m. CST Monday - Friday

## Chapter 5: Products and Benefits

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CommunityConnect covers the following BadgerCare Plus eligible members when they choose us as their Medicaid HMO Plan:

- BadgerCare Plus Standard Plan covers families with income at or below 200 percent of the Federal Poverty Level (FPL).
- BadgerCare Plus Benchmark Plan covers families, self-employed parents, and caregivers with income above 200 percent of the FPL. The Benchmark plan provides fewer benefits and services than the Standard Plan.



### Providing Services during an Emergency

In emergency situations, you are required to treat the patient regardless of HMO affiliation. The provider should then bill the HMO that the patient is affiliated with. The state of Wisconsin requires that HMOs reimburse providers for medically necessary emergency services. You should instruct your patient to follow-up with their HMO.

### Benefits Comparison Chart

On our website at [www.CommunityConnectHealthPlan.com](http://www.CommunityConnectHealthPlan.com), you will find a chart that outlines BadgerCare Plus benefits by service for both the Standard Plan and the Benchmark Plan. Covered benefits periodically change. Verify coverage prior to providing services, and obtain authorization to services as required. You also may visit our website to view additional information about our programs.

### Copayments

CommunityConnect's does not require a copayment for members enrolled in the BadgerCare Plus program Standard Plan. However, copayment is required for some services related to the Benchmark Plan. Providers are required to request copayments from members. For more, information, see [\*\*covered benefits and services\*\*](#).

### Prescriptions and Over-the-Counter Medications

Prescriptions and certain over-the-counter medications are covered benefits of the BadgerCare Plus programs offered by the state of Wisconsin. Members may get their prescriptions from any pharmacy that will accept the ForwardHealth ID card. Members should show their card to the pharmacy. Contact ForwardHealth for information.

### Dental Services

CommunityConnect has contracted with [\*\*Southeast Dental Associates \(SEDA\)\*\*](#) to provide routine dental services. CommunityConnect covers the following services when performed by a SEDA contracted provider or with prior authorization from SEDA by an out-of-network provider:

## Chapter 5: Products and Benefits

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- Routine dental services
- Emergency services – immediately if trauma or dental conditions have turned to life threatening medical conditions.
- Urgent care – within 24 hours for uncontrollable swelling, pain and trismus.

### **Vision Services**

CommunityConnect has contracted with **MARCH Vision Care** to provide covered routine vision services. CommunityConnect covers the following services when performed by a MARCH contracted provider or with prior authorization from MARCH by an out-of-network provider:

- Routine vision services
- Emergency services – immediately if trauma or eye conditions have turned to life threatening medical conditions.

### **Non-Emergency Transportation Services**

CommunityConnect has contracted with **Medical Transportation Management (MTM)** to provide covered transportation services.

- Members should schedule nonemergency transportation services a minimum of 3 days in advance of the service
- Services are arranged by calling MTM

## Chapter 6: Claims and Billing

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### Claims Submittal for Payment

CommunityConnect HealthPlan utilizes payment rationale based upon extensive edits from the following sources:

- Current Procedural Terminology (CPT®),
- Healthcare Common Procedure Coding System (HCPCS),
- Internal Classification of Diseases, Ninth Edition (ICD-9),
- Centers for Medicare and Medicaid Services (CMS), and
- Correct Coding Initiative (CCI).



CommunityConnect encourages electronic claim submissions, for faster claims payment. We use a variety of clearinghouses for claims submission. When submitting directly to CommunityConnect, there is no charge to the provider. Our Payor ID Number is 95192. For questions regarding electronic billing, or to arrange a test-run, please contact **Provider Services**. If submitting claims by paper, please utilize the appropriate claims form and follow standard submission guidelines for your provider type and mail to CommunityConnect's claims department.

You may contact **Provider Services** with any questions regarding the processing of your claims. We do not issue providers a special identification number for billing purposes. However, each member has a unique member identification number.

To receive payment for services rendered to BadgerCare Plus, submit claims within the guidelines of your Participating Provider Agreement and related Addendums (Agreement). CommunityConnect is not obligated to pay claims received after the contractually agreed upon timeframe. Per your Agreement, you will not knowingly bill, collect or attempt to collect payment from our member for the services received after this contracted time period.

### Billing and Reimbursement of Professional Surgical Services

Note: We base the majority of the following information upon *ForwardHealth* Guidelines and are, therefore, subject to change. Please check the Wisconsin Department of Health Services (DHS) *ForwardHealth* website. Information not taken from *ForwardHealth* is noted with an asterisk (\*).

All surgical services must be BadgerCare Plus covered procedures in order for CommunityConnect to consider them for reimbursement. When submitting your CMS 1500 claim for surgical procedures, ensure timely payment by including the appropriate modifiers, when applicable. The procedure also may require prior authorization by CommunityConnect. See the **authorization requirements** on our website.

## Chapter 6: Claims and Billing

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### **Surgical Procedures\***

You must submit surgical procedures performed by the same physician, for the same member, on the same date of service (DOS) on the same claim form. CommunityConnect will deny surgeries that are billed on separate claim forms.

### **Co-Surgeons**

CommunityConnect reimburses each surgeon according to ForwardHealth guidelines. Attach supporting clinical documentation (such as an operative report) clearly marked “co-surgeon” to each surgeon's paper claim to demonstrate medical necessity. Refer to the Wisconsin Medicaid Provider Handbook located at [www.ForwardHealth.wi.gov/](http://www.ForwardHealth.wi.gov/) for appropriate modifiers.

### **Surgical Assistants**

CommunityConnect reimburses surgical assistants according to the ForwardHealth guidelines. To receive reimbursement for surgical assistants, indicate the surgery procedure code with modifier “80” (assistant surgeon) on the claim. Refer to the Wisconsin Medicaid Provider Handbook located at [www.ForwardHealth.wi.gov/](http://www.ForwardHealth.wi.gov/) for appropriate modifiers.

### **Bilateral Surgeries**

CommunityConnect reimburses bilateral surgical procedures according to the ForwardHealth Guidelines.

### **Multiple Surgeries**

Multiple surgical procedures are those procedures performed by the same physician for the same member during the same surgical session. CommunityConnect reimburses multiple surgeries according to the ForwardHealth Guidelines.

If bilateral surgical procedures and multiple procedures are done during the same operative session by the same physician the surgical procedure with the highest billed amount will be reimbursed as the primary procedure.\*

CommunityConnect permits full payments for surgeries that you perform on the same DOS but at *different* surgical sessions. For example, if a provider performs sterilization on the same DOS as a delivery, you may be reimbursed without reductions for both procedures if performed at different times (and if all of the billing requirements were met for the sterilization).

To obtain full reimbursement, submit a claim for all the surgeries performed on the same DOS that are being billed for the member. Then submit additional supporting documentation clarifying that you performed the surgeries in separate surgical sessions.

## Chapter 6: Claims and Billing

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*Note:* Most diagnostic and certain vascular injection and radiological procedures are not subject to the multiple surgery reimbursement limits. Call **Provider Services** for more information about whether a specific procedure code is subject to these reimbursement limits.

### Preoperative and Postoperative Care

Reimbursement for certain surgical procedures includes the preoperative and postoperative care days associated with that procedure. Preoperative and postoperative surgical care includes the preoperative evaluation or consultation, postsurgical E&M services (i.e., hospital visits, office visits), suture and cast removal.

Although evaluation and management (E&M) services pertaining to the surgery for DOS during the preoperative and postoperative care days are not covered, you may be reimbursed for an E&M service if it was provided in response to a different diagnosis.

*Note:* Separate reimbursement is allowed for postoperative management when it is performed by a provider other than the surgeon or shared with the surgeon following cataract surgery. Use the appropriate modifier.

All primary surgeons, surgical assistants, and co-surgeons are subject to the same preoperative and postoperative care limitations for each procedure. For surgical services in which a preoperative period applies, the preoperative period is typically three days. Claims for services which fall within the range of established pre-care and post-care days for the procedure(s) being performed are denied unless they indicate a circumstance or diagnosis code unrelated to the surgical procedure.

For the number of preoperative and postoperative care days applied to a specific procedure code, call **Provider Services**.

### CMS 1500/UB 04 Information

Whether you use electronic billing or a paper form, the standard health insurance claim forms (CMS 1500, or UB-04) should be used when billing CommunityConnect. For paper claims, we do require that you use a compliant red form. If the form is not red, we will return the form and request that you use a red form. Required information must be filled in completely, accurately and legibly. If the information is inaccurate or incomplete, your claim cannot be processed and will not be considered a “clean claim.” A clean claim has all the necessary data elements, such as timely filing on industry standard paper forms or by electronic format, with no defect or impropriety. A submission that does not include all the necessary information, or for which CommunityConnect must request additional information (for example, medical records, other coverage information, or subrogation information) is not a clean claim until the CommunityConnect receives the needed information.

You will find an example of a CMS 1500 form at:

<http://www.cms.gov/cmsforms/downloads/CMS1500805.pdf>.

You will find an example of a UB-04/CMS 1450 form at:

<http://www.cms.gov/Transmittals/downloads/R1104CP.pdf>.

## Chapter 6: Claims and Billing

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### Obstetrics Coding

Whether a clinic bills for individual obstetrics (OB) visits, delivery and/or postpartum care; or as a prenatal package or global billing for OB care, CommunityConnect will reimburse the clinic up to the maximum amount of the appropriate prenatal package or global billing. As a general guideline, CommunityConnect does not reimburse a global OB fee if the patient was a member less than 4 months prior to delivery.

To meet reporting requirements for this program, it is necessary to collect information regarding the frequency of ongoing prenatal care. To help achieve this, CommunityConnect requests when you are billing a prenatal package or global billing that you submit the dates of individual OB visits, including the CPT and ICD-9 codes.

### Multiple Births

Reimbursement for multiple births is dependent on the circumstances of the deliveries. CommunityConnect reimburses multiple births according to the ForwardHealth Guidelines.

### Coding First OB or Six-Week Postpartum Visits as a HealthCheck

If a BadgerCare Plus patient is under age 21 years, the first OB or six-week postpartum visit may be an ideal opportunity to complete a HealthCheck screen on a patient in this age group. Many of the required components of a HealthCheck screen are completed as part of these OB visits.

Note: Only one HealthCheck screen per year is allowed for this age group. The following guidelines address the billing of first OB or 6-week postpartum visits as HealthChecks:

- First OB visit:
  - 99384-99385 E&M code
  - V20.2 primary diagnosis (ICD-9) code and V22.2 secondary diagnosis (ICD-9) code
- For Initial Antepartum Care Visits, use appropriate E&M code(s):
  - 99204 Prenatal Visit – New Patient / First Visit
  - 99213 Detailed Prenatal Exam / Second Visit – zero charge
- For Subsequent Prenatal Office Visits until the patient delivers, use:
  - 99213 Prenatal Visit – Record zero charge
- Six-Week Postpartum Visit: If all of the OB care including prenatal care, delivery and postpartum care were provided, use global billing (59400 for vaginal delivery, 59510 for C-section delivery) and the date of delivery. Then using the date of the six-week postpartum visit, code the visit at the appropriate level (99384 or 99385). Otherwise, code for the appropriate services provided, using the CPT code for the 6-week postpartum visit.

### **Sterilization Consent Form Requirements and Coverage**

“Sterilization” means any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing. This does not cover medical procedures that, while they may have the effect of producing sterility, have an entirely different purpose, such as removal of a cancerous uterus or prostate gland. There must be 30 full days between the date of the consult and the date of the surgery. You must complete a state-mandated **Consent for Sterilization** form for all BadgerCare Plus members receiving this procedure.

Please Note: Payment cannot be made to providers of associated services (hospital, anesthesiologists, pathologists, radiologists) unless the consent form is completed in an accurate and timely manner. The state of Wisconsin DHS will make recoupment from CommunityConnect, which will subsequently be recouped from the provider.

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

- The patient has voluntarily given his/her consent to be sterilized.
- The patient was at least 21 years of age on the date consent was obtained.
- At least 30 days, but no more than 180 days, have passed between the date of the informed consent and the date of sterilization.
- The patient is not mentally incompetent.
- The patient is not an institutionalized person.
- The dates on the consent form cannot be altered.
- DHS provides a consent form and no other is to be used in substitution.

Note Exceptions: The 30-day waiting period may be waived as described below:

- In the case of emergency abdominal surgery where the patient signs an informed consent at least 72 hours prior to an emergency abdominal surgery, or
- In the case of premature labor where the patient has received informed consent at least 30 days prior to the expected date of confinement. The physician must indicate the expected date of confinement on the consent form.

### **Procedure for Sterilization**

The provider must follow these sterilization procedures for CommunityConnect to pay the claim:

## Chapter 6: Claims and Billing

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- At the time of the sterilization consult with a physician, the nurse verifies that the patient is a member of an HMO and then attaches the appropriate consent form to the front of the patient's chart.
- The patient is to complete the section “Consent for Sterilization.” The patient must sign and date this section.
- If an interpreter is necessary, the interpreter signs the consent form under “Interpreter’s Statement.”
- The physician completes the section “Statement of Person Obtaining Consent.” She/he signs and dates this section. (Be sure the name and address of the facility is completed)
- The scheduling nurse will then schedule surgery. If anything is not in order, the procedure is postponed until the issue is corrected.
- At the post-op visit, the physician signs and dates “Physician Statement” on the Consent for Sterilization forms.
- The signed consent form is then returned to Medical Records.
- A copy of the signed Consent for Sterilization form is forwarded to the facility where the procedure was done.
- The original signed Consent for Sterilization form is filed in the patient's chart.
- The provider sends a signed copy of the Consent for Sterilization form to CommunityConnect, Attn: Sterilization Consent

### Hysterectomy Consent Form Requirements and Coverage

The hysterectomy to be performed is not solely for the purpose of rendering the patient permanently incapable of reproduction, nor for medical purposes which by themselves do not mandate a hysterectomy (such as fibroid, fallen uterus and retroverted uterus).

Please note: Payment cannot be made to providers of associated services (hospital, anesthesiologist, pathologists, and radiologists) unless the “Acknowledgment of Receipt of Hysterectomy Information” form (*current form can be downloaded from the Department of Health Services website*) is filled out accurately and in a timely manner. DHS will make recoupment from CommunityConnect that will subsequently be recouped from the clinic.

### Procedure for Hysterectomies

The provider must follow these hysterectomy procedures for CommunityConnect to pay the claim:

## Chapter 6: Claims and Billing

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- At the time of the hysterectomy consult with a physician, the nurse verifies that the patient is a member of an HMO, and then attaches the **Acknowledgment of Receipt of Hysterectomy Information** form to the front of the patient's chart.
- The patient signs the form.
- If an interpreter is necessary, the interpreter signs the form in the appropriate field.
- The provider schedules the surgery. If everything is not in order, the procedure is postponed until the issue is corrected.
- The signed form is returned to Medical Records.
- The provider sends a signed copy of the form (*if previous sterilization was performed, also send copies of the progress notes*) to CommunityConnect, Attn: Hysterectomy Consent
- The provider sends a copy of the signed form to the facility where the procedure will be done.
- The provider files the original signed form in the patient's chart.

### **Abortion Certification Statement Requirements and Coverage**

The patient must meet the following requirements, for abortion procedures to be covered by the BadgerCare Plus program:

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

When an abortion meets criteria for coverage, all other medically necessary related services are also covered. Complications arising from an abortion, whether the abortion is covered or not, are a covered service.

Services incidental to a non-covered abortion are not covered. Such services include, but are not limited to any of the following services when directly related to the performance of a non-covered abortion:

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- Laboratory testing,
- Interpretation,
- Ultrasound services,
- Recovery room services,
- Routine follow-up visits, and
- Transportation (prenatal visits are covered).

The physician must fill out an **Abortion Certification Statement** attesting to one of the circumstances listed above. In the case of rape or incest, the physician must include evidence that the crime was reported to law enforcement authorities. The Abortion Certification Statements form must be faxed to CommunityConnect's claims department, along with progress notes and any law enforcement documentation. CommunityConnect will forward this information to the state of Wisconsin for final decision regarding coverage. Once the state has made their recommendations, CommunityConnect will notify the physicians' office of their decision.

Abortions must be scheduled and performed at a Wisconsin Medicaid-certified facility.

### **Coordination of Benefits**

If a member carries other insurance through more than one insurer, CommunityConnect will coordinate the benefits to ensure maximum coverage without duplication of payments. The provider must submit claims to the primary carrier before submitting to CommunityConnect. After the provider submits the claim to the primary carrier, a claim for the remaining balance should be submitted to CommunityConnect along with a copy of the primary carrier's remittance advice. The provider must submit the balance according to the terms of your Agreement.

On the UB-04 claim, box 50 is completed if there is any other insurance information. Remittance advices need to accompany each CMS 1500 claim and UB-04 claim where other insurance is indicated on the claim. For any questions regarding Coordination of Benefits, call **Provider Services**.

If the network provider fails to comply or is unaware of the primary insurance carrier, CommunityConnect will deny claims. This denial reason will print on the provider's remittance advice.

If a primary insurance is discovered after charges have been processed and the primary insurance makes payment, the provider might then have an overpayment. If you are overpaid due to primary insurance payment, you should return the balance to CommunityConnect.

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If CommunityConnect discovers a primary insurance after charges have been processed, we will reverse our original payment. You will see the adjustment reflected on the remittance advice. If the primary insurance denies a claim because of lack of information, CommunityConnect will also deny the claim.

If a CommunityConnect member has Medicare and other insurance, complete information must be on the CMS 1500 claim or UB-04 claim for us to process the claim efficiently. On the CMS 1500 claim, you should check box 11d “Yes” if there is any other insurance information. If you check box 11d “Yes,” you must complete boxes 9a-9d on the CMS 1500 claim, with the other insurance information.

### Corrected Claims

You may submit corrected claims on the appropriate claim form with “correction/resubmission” identified in box 19 on the UB-04, and written or stamped on CMS 1500. Go to the **How to Contact Us** page of our website to find the fax number to send corrected paper claims to our Claims department.

### Request for Additional Information to Process

At times, we may need additional information to process a claim. When this is necessary, we will request that you provide us with the following information:

- Patient’s name and date of birth
- ForwardHealth member ID number
- Where and when the patient was treated
- Requested information (such as ER notes, name of authorizing physician, etc.) Your cooperation and prompt response to assist with paying you timely is greatly appreciated. If you have a question or would prefer to provide requested information verbally, please contact **Provider Services**.

### Claim Appeal Process

If you have questions or if you are dissatisfied with the payment/denial reflected on your remittance advice, you may request an informal review of payment according to the terms of your Agreement.

To do this, please contact **Provider Services** by telephone. If your concern is not settled to your satisfaction during the telephone call, you also may appeal in writing by sending notice to **Attn: Provider Claims Appeals** at the address provided at **How to Contact Us**.

## Chapter 6: Claims and Billing

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The appeal must contain the member's name and ForwardHealth member ID number, the provider's name, date of service, date of billing, and date of rejection and reason for reconsideration. If your appeal is medical in nature (i.e., emergency, medical necessity and/or prior authorization related), you must submit medical records with your appeal.

All providers serving CommunityConnect's BadgerCare Plus members must appeal first to CommunityConnect and then to the state of Wisconsin's DHS if they disagree with our payment or nonpayment of a claim. If CommunityConnect fails to respond to your appeal within 45 days or if you are not satisfied with the response to your appeal, you may appeal to the DHS in writing within 60 days of the final decision or in the case of no response, within 60 days from the 45-day timeline allotted to CommunityConnect to respond. Providers must use the DHS's form **Managed Care Program Provider Appeal** when submitting a provider appeal for state review and all elements of the form must be completed at the time the form is submitted (i.e., medical records for appeal regarding medical necessity).

Forms must be sent to:

**BadgerCare Plus and Medicaid SSI Medicaid Managed Care Unit**  
**P.O. Box 6470**  
**Madison, WI 53716-0470**

### Member Billing

Providers cannot bill BadgerCare Plus members for a covered service, even if CommunityConnect HealthPlan becomes insolvent. See Section 1128B.(d)(1) of the (42U.S.C. 1320a-7b) of the Social Security Act and Wisconsin Statutes 49.49(3m) for more information. In addition, it is important that you not bill a BadgerCare Plus member for medically necessary covered services provided during the member's period of BadgerCare Plus enrollment. See the state of Wisconsin Division of Health Care Access and Accountability (DHCAA), for exceptions for allowable copayments and premiums during the member's period of enrollment in BadgerCare Plus.

If a member agrees in advance, in writing, to pay for a BadgerCare Plus *non-covered service*, then the provider may bill the member. The standard release form signed by the member at the time of services does not relieve the provider or CommunityConnect from the prohibition against billing a member in the absence of a knowing assumption of liability for a non-BadgerCare Plus covered service. The form or other type of acknowledgment relevant to a member's liability must specifically state the admissions, services or procedures that are not covered by BadgerCare Plus. We recommend that you use the **Waiver of Financial Responsibility** form when working with the member to provide them services not covered by the BadgerCare Plus program. Copy or paste onto your letterhead for use in your office. If you need this document in another language, please contact **Provider Services**.

## Chapter 6: Claims and Billing

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### Claims Overpayment

If you are notified by CommunityConnect of an overpayment, or discover that you have been overpaid, please mail a check for the overpayment along with a copy of the overpayment notification or other supporting documentation within 30 days to:

**Attn: Overpayment Recovery**  
**CommunityConnect HealthPlan**  
**P.O. Box 3157**  
**Eau Claire, WI 54702-3157**

## Chapter 7: Provider Roles and Responsibilities

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### Scope of Responsibilities Applicable to All Providers

The following responsibilities are expected of all providers serving CommunityConnect members enrolled in the BadgerCare Plus program:

- Verify eligibility before each service.
- Adhere to all prior authorization requirements.
- Notify members of the availability of CommunityConnect interpreter services and strongly discourage the use of minors, friends and family who may act as interpreters.
- Accommodate non-English proficient members by having multi-lingual messages on answering machines and training their answering services and on-call personnel on how to access CommunityConnect's interpreter services.
- Notify CommunityConnect of changes in the language capability of medical and administrative staff.



### Notification of Changes

Provide 30 calendar days notice prior to any change in information or status that would affect your participation in CommunityConnect's Medicaid network.

For example, CommunityConnect is responsible for creating and maintaining a provider directory on our website that can be used by members, providers and the Wisconsin Department of Health Services (DHS). The provider directory must include, at a minimum, the following information:

- Provider Name
- Address
- Specialty
- If the provider provides services to children
- Languages spoken
- If you are accepting new patients.

It is important that you keep us apprised of changes to your administrative structure, to serve our members and your patients enrolled in the BadgerCare Plus program in the best manner possible. You may complete and submit the **Provider Maintenance Form (PMF)** to update your organization's information.

## Chapter 7: Provider Roles and Responsibilities

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In addition to changes that affect the contracted network and serving our members, you are required to notify CommunityConnect of any:

- Change in professional business ownership.
- Change in federal 9-digit tax identification number (TIN).
- Change in business address or the location where services are provided.
- Legal or governmental action initiated against a health care professional, including but not limited to an action for professional negligence, for violation of the law, or against any license or accreditation, which, if successful, would impair the ability of the health care professional to carry out the duties and obligations under the Participating Provider Agreement and related Addendums (Agreement).
- Other problems or situation that impair the ability of the health care professional to carry out the duties and obligations under the Agreement care review and grievance resolution procedures.

When you add a new provider, change your office or remittance advice address or your tax identification number, complete the online PMF.

### Terminations

The participating provider or participating physician group is responsible for notifying CommunityConnect that they intend to terminate the Agreement. Please refer to your Agreement for notification timeframes for provider terminations.

In the event CommunityConnect determines that the quality of care or services provided by a health care professional is not satisfactory, as may be evidenced by or in member satisfaction surveys, member complaints or grievances, utilization management data, complaints or lawsuits alleging professional negligence or any other quality of care indicators, CommunityConnect may terminate the Agreement. Health care professionals agree to be bound by and comply with CommunityConnect's policies, procedures and rules.

A terminated physician or provider who is actively treating members must continue to treat members until their date of termination. Refer to your Agreement for termination notification requirements.

Once CommunityConnect receives a notice to terminate a contract, CommunityConnect notifies all members impacted by the termination. We send a letter to inform the affected members of:

- The impending termination of their physician or provider
- Their right to request continued access to care

## Chapter 7: Provider Roles and Responsibilities

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- The **Member Advocate** telephone number to make PCC changes and/or forward referrals to Care Management for continued access to care consideration

If the primary care clinic contract is ending, CommunityConnect will arrange for continuity of care provided by the terminating provider for its members who need continued access to care. The PCP or members can call the **Member Advocate Call Center** or the TTY line for members with hearing or speech loss.

Members under the care of specialists can also submit requests for continued access to care, including continued care after the transition period, by telephone to the **Member Advocate Call Center**. They should request **Continued Access to Care**.

### Collaboration

Each provider shares the responsibility of giving considerate and respectful care and working collaboratively with CommunityConnect affiliates, members and their families, specialist physicians, hospitals, ancillary providers, and others for the goal of providing timely, medically necessary, and quality health care services. All providers are required to permit members to participate actively in decisions regarding medical care, including, except as limited by law, their decision to refuse treatment.

### Collaboration for Optimizing Member Care

The PCP maintains frequent communication with the specialist physician, hospital and/or ancillary provider to ensure continuity of care. CommunityConnect encourages physicians, hospitals and providers to maintain open communication with their patients regarding appropriate treatment alternatives, regardless of their benefit coverage limitations. CommunityConnect does not penalize physicians, non-physician practitioners, or other health care providers for discussing medically necessary or appropriate patient care.

CommunityConnect established comprehensive and consistent mechanisms to ensure continued access to care for members when physicians terminate from CommunityConnect. Under specified circumstances, members may finish a course of treatment with the terminating physician. For more information, see **Continuity of Care Process**.

### Confidentiality

Providers are required to ensure that their members' medical, behavioral health and personal information are kept confidential as required by state and federal laws. They are required to prepare and maintain all appropriate records in a system that permits prompt retrieval of information on members receiving covered services from the Providers.

## Chapter 7: Provider Roles and Responsibilities

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### **Medical Records Documentation and Access to Medical Records and Information**

For information on medical records documentation, please refer to the **Quality Improvement Program** section of this Manual.

### **Mandatory Report of Abuse**

Providers ensure that office personnel have specific knowledge of local reporting requirements, agencies and procedures to make telephone and written reports of known or suspected cases of abuse or other conditions as required by state law. All health care professionals are required to report, immediately, actual or suspected child abuse, elder abuse or domestic violence to the local law enforcement agency by telephone. Providers are required to submit a follow-up written report to the local law enforcement agency within the timeframes as required by law.

### **Oversight of Non-Physician Practitioners**

All providers using non-physician providers are required to provide supervision and oversight of such non-physician providers consistent with state and federal laws. The supervising physician and the non-physician practitioner are required to have written guidelines for adequate supervision, and all supervising providers are required to follow state licensing and certification requirements.

Non-physician practitioners are licensed by the state and working under the supervision of a licensed physician as mandated by state and federal regulations.

### **Licenses and Certifications**

Providers are required to maintain all licenses, certification, permits, accreditations or other prerequisites as specified in their Agreement and as required by CommunityConnect, federal, state and local laws to provide medical services.

### **Prohibited Activities**

All providers are prohibited from:

- Billing eligible members for covered services,
- Segregating members in any way from other persons receiving similar services, supplies or equipment and
- Discriminating against CommunityConnect members or Medicaid participants.

## Chapter 7: Provider Roles and Responsibilities

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### Open Clinical Dialog/Affirmative Statement

Nothing within the Agreement or this Manual should be construed as encouraging providers to restrict medically necessary covered services or to limit clinical dialog between the providers and their patients. Providers can communicate freely with members regarding the treatment options available to them, including medication treatment options, regardless of benefit coverage and limitations.

### Provider Rights

Please review these guidelines as part of the provider's continuing assessment of the provider's office policies and procedures. CommunityConnect providers have the following rights:

- A health care professional, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a member who is his/her patient, for the following:
  - The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered
  - Any information the member needs in order to decide among all relevant treatment options
  - The risks, benefits and consequences of treatment or non-treatment
  - The member's right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions
  - To receive information on the Complaints, Grievances, Appeals and Fair Hearing procedures
  - To have access to policies and procedures covering authorization of services
  - To be notified of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope than is less than requested
  - To challenge, on behalf of the Medicaid members, the denial of coverage of, or payment for, medical assistance
  - To be free from discrimination for the participation, reimbursement or indemnification of any provider who is acting within the scope of his/her license or certification under applicable law solely based on that license or certification

CommunityConnect's provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

### Primary Care Providers Scope of Responsibilities

CommunityConnect members select a contracted primary care clinic (PCC) as their main provider of health care services within the established period of the effective date of enrollment. Within the PCC, your clinic may have direct primary care providers (PCP) assigned to a member.

## Chapter 7: Provider Roles and Responsibilities

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If, after the established period of the effective date of enrollment, the member has not selected a PCC, CommunityConnect assigns one to the member. PCCs are defined as clinics which have physicians in family practice, general practice, internal medicine, OB/GYN, Women's Health Specialists, and pediatric specialties, as well as nurse practitioners and physician assistants. PCCs agree to be responsible for coordinating the health care of the member, including necessary referrals to other providers.

PCCs serve as the member's initial and most important point of interaction with the rest of the contracted network and are the base of a medical home for each member.

### PCP Responsibilities

In addition to the requirements applicable to all providers, the responsibilities of the PCP include, but are not limited to:

- Maintaining continuity of each enrollee's health care by serving as the enrollee's primary care provider
- Providing 24-hour, 7-day-a-week access
- Providing or arranging for routine and preventive health care services within the established standards
- Making referrals for specialty care and other medically necessary services
- Maintaining a current medical record for the enrollee, including documentation of all services provided to the enrollee by the PCP, as well as any specialty or referral services
- Adhering to the **Wait Times**, as outlined within the contract and/or Provider Manual
- Facilitating interpreter services
- PCPs are required to ensure their CommunityConnect members' medical and personal information is kept confidential as required by state and federal laws

### Referrals

PCPs coordinate and make referrals to appropriate specialists, ancillary providers and community services. PCPs monitor and track all services and provide health education information, materials and referrals. Document referrals in the member's medical record.

### Transitioning Members between Facilities or to Home

PCPs initiate or help with the discharge or transfer of:

## Chapter 7: Provider Roles and Responsibilities

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- Members at an inpatient facility to the appropriate level of care of facility (skilled nursing facility, intermediate rehabilitation facility, etc.) when medically indicated, or home.
- Members who are hospitalized in an out-of-network facility to an in-network facility or to a home with home health care assistance (within benefit limits) when medically indicated. The coordination of member transfer from non-contracted out-of-network facilities to contracted in-network facilities is a priority that may require the immediate attention of the PCP. The PCP should contact a Utilization Management nurse to assist in this process.

### Office Hours

To maintain continuity of care, all PCPs are required to be available to provide services for a minimum of 24 hours each week. The PCPs are required to be available 24 hours a day by telephone or have an on-call physician take calls. Office hours are required to be conspicuously posted. PCPs hours of operation cannot discriminate against BadgerCare Plus members. The provider is required to inform members of the provider's availability at each site.

### Monitoring PCP Accessibility and Services

CommunityConnect monitors PCP accessibility by:

- Conducting the initial credentialing process and the triennial re-credentialing process
- Conducting annual member surveys
- Conducting annual After Hours and Appointment Access surveys

In addition, CommunityConnect monitors compliance of PCP services by tracking administrative complaints and grievances on a regular basis.

### Women's Health Specialists

A female member may have a women's health specialist as a PCP. Female members will have direct access to a women's health specialist within the network for covered women's routine and preventive health care services.

### Physician Care for Women

PCP responsibilities for the care of female members include:

- Inform and refer members for cervical and breast cancer screenings
- Educate members on the Preventive Care Guidelines for women
- Schedule screening exams for members

## Chapter 7: Provider Roles and Responsibilities

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Providers can access CommunityConnect's Preventive Health Care Guidelines on CommunityConnect's website at [www.CommunityConnectHealthPlan.com](http://www.CommunityConnectHealthPlan.com).

### Specialists' Scope of Responsibilities

Specialist physicians, licensed with additional training and expertise in a specific field of medicine, treat CommunityConnect members to supplement the care given by PCPs. Access to contracted network specialists is through the member's PCP. In limited cases, such as family planning and evaluation, diagnosis, treatment and follow-up of sexually transmitted infections (STIs) the member can self-refer.

PCPs refer members to contracted network specialist physicians for conditions beyond the PCP's scope of practice that are medically necessary. In addition to the requirements applicable to all physicians, Specialists diagnose and treat conditions specific to their area of expertise. Specialist care is limited to CommunityConnect **covered benefits and services**.

CommunityConnect members with special medical needs or chronic health conditions may select a specialist to act as a PCP when deemed appropriate. When a specialist serves as a PCP, the specialist is held accountable to the same medical standards as a PCP.

### Hospital Scope of Responsibilities

Professional providers refer members to contracted network hospitals for conditions beyond the professional provider's scope of practice that are medically necessary. Payment for hospital care is limited to CommunityConnect **covered benefits and services**. Hospital professionals diagnose and treat conditions specific to the area of expertise.

The hospital is required to notify CommunityConnect of an admission or service at the time the member is admitted or service is rendered. If the member is admitted or a service is rendered on a day other than a business day, the hospital is required to notify CommunityConnect of the admission or service during the morning of the next business day following the admission or service.

If the hospital has not received notice of **prior authorization** determination at the time of a scheduled admission or service, as required by the Utilization Management Guidelines and the Hospital Agreement, the hospital should request the status of the determination.

Any admission or service that requires prior authorization, as discussed in the Utilization Management Guidelines and the Hospital Agreement, and has not received the appropriate review, may be subject to post-service review denial. Generally, the physician is required to perform all prior authorization review functions; however, the hospital may ensure, before services are rendered that such has been performed, or risk post-service denial.

## Chapter 7: Provider Roles and Responsibilities

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### **Ancillary Scope of Responsibilities**

CommunityConnect has a network of various participating health care professionals and facilities. Health care professionals provide medically necessary services when a licensed physician or licensed health care professional orders the services and are in accordance with the applicable benefit agreement and Ancillary Agreement. All services provided by the health care professional, and for which the health care professional is responsible, are listed in the Ancillary Agreement. Health care professionals are required to agree that all medical services they provide or arrange for are included in the rates, as described in the Ancillary Agreement.

PCPs and specialists refer members to contracted network ancillary professionals for conditions beyond the PCP's scope of practice that are medically necessary. Ancillary professionals diagnose and treat conditions specific to their area of expertise. Ancillary care is limited to CommunityConnect **covered benefits and services**.

### **Urgent Care Centers and Walk-In Clinics**

CommunityConnect includes urgent care centers and walk-in clinics (UCC) as part of their network. UCCs must meet state-regulated criteria to be included in the provider directory. UCCs that provide services and that are not in the network will not be paid. A hospital emergency room may not serve as an urgent care or walk-in clinic. A physician's office may serve as an urgent care center or walk-in clinic as long as it meets the criteria.

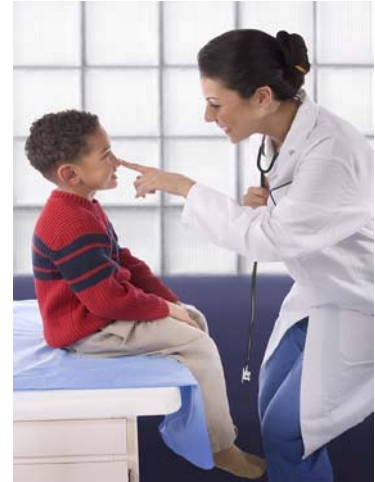
## Chapter 8: Medical Management

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### Emergency Medical Conditions and Services

CommunityConnect does not require authorization for treatment of emergency medical conditions. In the event of an emergency, members can access emergency services 24 hours a day, 7 days a week.

Members who call their PCP's office reporting a medical emergency (whether during or after office hours) are directed to dial 911 or told to go directly to the nearest hospital emergency room. All non-emergent conditions should be triaged by the PCP or treating physician with appropriate care instructions given to the member.



### Stabilization and Post-Stabilization

The emergency room's treating physician determines the services necessary to stabilize the member's emergency medical condition. After the member's medical condition is stabilized, the emergency room's treating physician must contact the member's PCC for authorization of further services. If the PCP does not respond within one hour, the needed services will be considered authorized.

The emergency room must send a copy of the emergency room record to the PCP's office within 24 hours. The PCP must then file the chart copy in the member's permanent medical record. The PCP reviews the emergency room chart, contacts the member, and schedules a follow-up office visit or a specialist referral, if appropriate.

All providers who are involved in the treatment of a member share responsibility in communicating clinical findings, treatment plans, prognosis and the psychosocial condition of the member with the member's PCP to ensure effective coordination of care.

### Utilization Management

CommunityConnect's Utilization Management (UM) program is in collaboration with providers to promote and document the appropriate use of health care resources. The program reflects our most current utilization management standards. The UM department takes a multidisciplinary approach to provide health care services in the setting best suited for the medical and psychosocial needs of the member based on benefit coverage, established criteria, and the community standards of care.

Authorization is based on medical necessity only and will be contingent upon eligibility and benefits. It is not a guarantee of payment. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing. You may call the UM department if the member has any additional medical or behavioral health needs.

The role of utilization management is to:

- Assist in providing the right care to the right member, at the right time, in the appropriate setting, and

## Chapter 8: Medical Management

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- Provide prior authorization, concurrent, and post-service reviews using clinical criteria based on sound clinical evidence. These criteria are available to members, physicians, and other health care providers upon request.

Staff is available at least eight hours a day on normal business days to answer UM-related calls and after normal business hours, an answering service is available to take UM-related messages. A UM staff member will return the call the next business day. In addition, MedCall is available for after-hours assistance. See **How to Contact Us**.

### Decision Making

CommunityConnect makes UM decisions affecting the health care of members in a fair, impartial, consistent, and timely manner. We do not reward practitioners and other individuals conducting utilization review for issuing denials of coverage or care. There are no financial incentives for UM decision makers that encourage decisions that result in under-utilization. If you disagree with a UM decision and would like to discuss the decision with the physician reviewer, please contact the UM Department.

The Utilization Management Committee (UMC) meets at least six times per year and supports the Physician's Quality Improvement Committee (PQIC) in appropriate provisions of medical services and provides recommendations for utilization management activities.

### Decision and Screening Criteria

Decision and notification timeframes for approval, modification, deferral, and denial are in alignment with state contracts and other applicable legislation. The UM department applies medical policies, Milliman Care Guidelines, and Clinical Guidelines for utilization management screening and decisions. UM does not rely solely on these guidelines, but also gives consideration to the clinical information that is provided, as well as the individual health care needs of the member. You will find our medical policies and clinical guidelines on our website.

Decision criteria incorporates nationally recognized standards of care and practice from sources such as the American College of Cardiology, American College of Obstetricians and Gynecologists, American Academy of Pediatrics, American Academy of Orthopedic Surgeons, current professional literature, and cumulative professional expertise and experience. The decision criteria used by the clinical reviewers are evidenced-based and consensus-driven. We periodically update criteria as standards of practice and technology change. We also involve actively practicing physicians in the development and adoption of the review criteria.

## Chapter 8: Medical Management

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### Prior Authorization

The services listed below require prior authorization review by CommunityConnect for BadgerCare Plus members. This list will be updated as needed. All providers are responsible for verifying eligibility and authorization for nonemergent services prior to rendering services to a CommunityConnect member. For benefits to be paid, the member must be eligible on the date of service and the service must be a covered benefit. Except in an emergency, failure to obtain prior authorization for the designated services below may result in a denial for reimbursement.

Services requiring prior authorization include the following:

- Air Ambulance
- Bariatric surgery
- Biofeedback
- Circumcision - CommunityConnect covers routine circumcision without authorization for up to 12 months of age. Medical necessity review is required after 12 months of age.
- Dental Services - Contact Southeast Dental Associates (SEDA) at **1-877-389-9870** regarding prior authorization of dental services.
- Some Durable Medical Equipment (DME) and Supplies (DMS)
- Genetic Testing - Routine amniocentesis and prenatal testing do not require prior authorization.
- HealthCheck - Other medically necessary services
- Home Health Care Services
- Hyperbaric Oxygen Therapy - Coverage is limited to E&M code 99183. No coverage for use of equipment.
- Infusion/Injection Therapy not covered under state-covered pharmacy benefit.
- Inpatient Services - Follow the procedures for inpatient services:
  - Notify CommunityConnect of emergent admissions within 24 hours or the next business day of inpatient admission.
  - Routine vaginal or Cesarean section deliveries do not require prior authorization or medical necessity review; however, both delivery types require notification.
  - Notify CommunityConnect of newborn deliveries. Use the **Newborn Enrollment Notification Report** following the fax and timeline instructions provided on the form. Failure to notify us of deliveries may result in claim denials.

## Chapter 8: Medical Management

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- Behavioral Health – All outpatient office visits and facility-based services require prior authorization, which include inpatient, partial hospital (PHP) and intensive outpatient services (IOP). Contact **1-877-471-6656** 24 hours a day, seven days a week, for specialty referrals and authorization.
- Pharmacy - Contact the state of Wisconsin ForwardHealth at **1-800-362-3002**.
- Physician Services – Referrals to out-of-network specialists require prior authorization.
- Radiology Services – Required for all PET/SPECT scans, CT, CTA, MRI and MRA.
- Inpatient and Outpatient Surgeries/Procedures
- Therapy Services - Physical therapy, occupational therapy and speech therapy require prior authorization from birth to three years of age.
- Transplant Services
- Vision Services - Contact MARCH Vision Care at **1-888-493-4070** for vision benefits and to determine authorization requirements.

### Required Information When Contacting Utilization Management

You may request prior authorization or report medical admission by telephone or fax.

To help the process go as quickly as possible, have the following information ready when calling:

- Member name and ID number
- Diagnosis with the International Classification of Diseases, 9th Revision, (ICD-9) code
- Procedure with the Current Procedural Terminology (CPT) code
- Date of injury/date of hospital admission and third-party liability information (if applicable)
- Facility name (if applicable)
- Primary care provider (PCP) name
- Specialist or attending physician name
- Clinical justification for the request
- Level of care
- Results of lab tests, radiology and pathology results
- Medications

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- Treatment plan with timeframes
- Prognosis
- Psychosocial status
- Exceptional or special needs issues
- Ability to perform activities of daily living
- Discharge plans

Physicians, hospitals and ancillary providers are required to provide information and documentation to UM. Physicians are also encouraged to review their utilization and referral patterns.

You will need to get a separate prior authorization for each service that requires approval. This prior authorization is necessary whether an in-network or out-of-network Wisconsin Medicaid-certified provider performs the service. Please refer to the document **Services Requiring Prior Authorization** for a full listing of services that require prior authorization. Always check our website for the latest information on Services Requiring Prior Authorization.

### **Prior Authorization Timeframe**

For routine non-urgent requests, the UM department will complete a preservice review within 14 calendar days from request. We will send requests that do not meet medical policy guidelines to our physician or medical director for review. We will notify providers by phone or fax within 14 calendar days from the receipt of the request of the UM decision, and will send the member and requesting provider a written notification by mail within 14 calendar days from the receipt of the request of any denial or deferral decision.

### **Requests with Insufficient Clinical Information**

For preservice requests with insufficient clinical information, CommunityConnect contacts the provider with a request for the clinical information reasonably necessary to determine medical necessity. We make one or two attempts to contact the requesting provider to obtain the additional necessary clinical information. If we do not obtain a response, we will send a Deferral—Lack of Medical Information letter to the member and provider.

This deferral letter includes specific information that we need to make a decision. If we do not receive the information, we send a denial letter to the member and provider within 14 calendar days from receipt of the request. We extend the deferral timeframe for another 14 calendar days if the member or the provider requests an extension.

For urgent requests, the UM department completes preservice review within 72 hours from receipt of the clinical information necessary to render a decision.

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Generally speaking, the provider is responsible for contacting CommunityConnect to request **prior authorization** for both professional and institutional services. However, the hospital or ancillary provider should always contact CommunityConnect to verify prior authorization status on all non-urgent services before rendering services.

### Referrals to Specialists

Referrals, whether to an in or out-of-network provider, must be to a provider that is Wisconsin Medicaid-certified. The UM department is available to assist providers in identifying a network specialist and/or arranging for specialist care. Here are some other items to keep in mind when referring members:

- Authorization from UM is not required if referring a member to an in-network specialist for consultation or a non-surgical course of treatment
- Authorization from UM is required when referring to an out-of-network specialist

Provider responsibilities include documenting referrals in the member's chart and requesting that the specialist provide updates as to the diagnosis and treatment plan.

### Prior Authorization for Out-of-Network Referrals and for Certain Services

Referrals, whether to an in- or out-of-network provider, must be to a provider that is Wisconsin Medicaid-certified. When you refer CommunityConnect members enrolled in the BadgerCare Plus program to another physician, specialist, hospital or facility, it is important to follow our prior authorization procedures. Certain services to in-network providers require prior authorization, and all out-of-network referrals for nonemergent services require prior authorization. Please remember to contact us before referring a member to an out-of-network provider. This includes, but is not limited to, laboratories and radiology service providers. To request prior authorization, contact UM by fax or phone.

Please obtain a prior authorization approval number before you refer our members to an out of network provider. For out-of-network providers, we require this prior authorization for the initial consultation and each subsequent service provided. In the vast majority of cases, failure to obtain prior authorization will result in a denial of the claim, including all related professional or hospital based claims.

### Inpatient Admission Notification

CommunityConnect identifies members admitted to the inpatient setting (acute care hospital, acute rehabilitation hospital, intermediate facility or skilled nursing facility) through:

- Facilities reporting admissions within 48 hours of admission or the first business day after a weekend

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- Providers reporting admissions
- Members or their representatives reporting admissions
- Preservice authorization requests for inpatient care for elective admissions

For medical admissions and mental health or substance abuse admissions, contact UM by phone.

Once CommunityConnect receives admission notification, a request is made for clinical information to support the medical necessity. Evidence-based criteria are used in determining medical necessity and appropriate level of care.

### Concurrent Review

#### Admission and Continued Stay Reviews

When continued stay is expected to exceed the number of days authorized during preservice review or when the inpatient stay did not have prior authorization, the hospital must contact CommunityConnect for concurrent review. In such cases, we require clinical reviews on all members admitted as inpatients in an acute care hospital, intermediate facility, or skilled nursing facility. We perform the reviews to assess that the medical care rendered is medically necessary, and that the facility and level of care are appropriate. CommunityConnect identifies members admitted to the inpatient setting through:

- Facilities reporting admissions
- Providers reporting admissions
- Members or their representatives reporting admissions
- Claims submissions for services rendered without authorization
- Preservice authorization requests for inpatient care

The UM department will complete concurrent inpatient reviews within 24 hours of receipt of clinical information, or sooner consistent with the member's medical condition. UM nurses will request clinical information from the hospital on the same day they are notified of the member's admission/continued stay. If the information provided meets medical necessity review criteria, we will approve the request within 24 hours from the time the information is received. We will send requests that do not meet medical policy guidelines to the physician advisor or medical director for review.

We will notify providers within 24 hours of the decision. We will send a written notification to the member and requesting provider within two business days of any denial decision.

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### **Clinical Information for Concurrent Review**

Facilities are required to provide clinical information within 24 hours of the admission notification in order to facilitate concurrent review, certify approved inpatient days, expedite discharge planning and authorizations and ensure proper claims payment. Decisions are made within 24 hours of the receipt of the clinical information needed to make a decision. The UM nurse or case manager performs ongoing, follow-up, concurrent reviews in collaboration with hospital UM staff and provides assistance with discharge planning, as needed, to facilitate and coordinate the timely transition of care when medically indicated.

### **Denial of Service**

Only a medical or behavioral health physician who possesses an active professional license or certification can deny a service (procedure, hospitalization or equipment) for lack of medical necessity. When a determination that a request is not medically necessary is made, the requesting provider will be notified in writing of the decision, the process for appealing the decision and how to reach the reviewing physician for a peer-to-peer discussion of the case. We inform the provider of the opportunity for an appeal should the final determination result in a denial.

The UM department has utilization management policies and procedures that address the availability of physician reviewers to discuss, by telephone, adverse determinations of any type, including those based on medical necessity. Providers may contact the physician clinical reviewers to discuss any UM decision by calling the UM department, 8 a.m. to 5 p.m., Monday to Friday, excluding holidays.

### **Post-Service/Retrospective Review**

Post-service review determines the medical necessity and/or level of care for services that were rendered without obtaining concurrent review, and therefore, no inpatient days certified. For inpatient admissions where no notification was received, facilities are required to submit a copy of the medical record with the claim.

### **Second Opinions**

There is no cost to members for second opinions. A second opinion must be given by an appropriately qualified health care professional. When the request is regarding care from a specialist, a provider of the same specialty must give the second opinion. This specialist must be within CommunityConnect's network and may be selected by the member. For cases in which there is no provider within the network who meets the specified qualification, CommunityConnect may authorize a second opinion by a qualified provider outside of the network, upon request by the member or provider.

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### Behavioral Health Services

CommunityConnect's Behavioral Health Program is an important resource to all providers when members experience mental health or substance abuse dependency problems. Our Behavioral Health department can be reached 24 hours a day, 7 days a week.

CommunityConnect is committed to providing a continuum of care management from initial contact to coordination of care and interventions. Our behavioral health care managers work closely with our medical case managers to support the services needed by the BadgerCare Plus members. CommunityConnect's tiered case management format is a key philosophy of our programs.

- **Tier I** is call center and outreach calls to members
- **Tier II** is an increased level of interaction with the member to assist with referral to provider or level of care and problem-solving with the member for any obstacles to receiving care or treatment
- **Tier III** intensive case management offers reactive interventions on an episodic basis or triggered by long length of stay, medical and behavioral health co-morbidity, and/or multiple admissions

CommunityConnect has implemented a Maternal Depression Program (MDP), a Behavioral Health Case Management Program and a Co-existing Depression and Anxiety Program (CODA). Please refer to [www.CommunityConnectHealthPlan.com](http://www.CommunityConnectHealthPlan.com) for additional information on these programs.

### Behavioral Health Prior Authorization

PCPs and behavioral health providers should contact CommunityConnect by telephone or fax to request a referral. Prior authorization is required for services, which include:

- Inpatient
- Partial hospital programs (PHP)
- Intensive outpatient services (IOP)
- Outpatient office visits

Please have the following information available when requesting a referral:

- Diagnosis with ICD-9 code
- Procedure with the CPT and/or HCPCS code
- First date of outpatient service or date of hospital admission
- Specialist or name of attending physician

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- Clinical information supporting the requests

CommunityConnect is committed to providing timely review and authorization for services. Non-urgent referrals will be reviewed within 14 calendar days; urgent referrals within 72 hours; and concurrent referrals within 24 hours. For emergencies, we request that you notify CommunityConnect within 24 hours or the next business day of any inpatient admissions. Please see **covered benefits and services** for additional behavioral health information.

### Care Management Program Overview

CommunityConnect's Care Management program for members affords both members and providers expert assistance in the coordination of complex health care. We encourage our providers to make use of this effective program.

Care management is a collaborative process that assesses, develops implements, coordinates, monitors and evaluates care plans designed to optimize members' health care benefits and promote quality outcomes. The case manager, through interaction with the member, member representative, and/or providers, collects and analyzes data and information about the actual and potential care needs for the purpose of developing a care plan. Cases may be identified by disease state or condition, dollars spent, or high utilization of services.

CommunityConnect makes the following information available to contracted providers:

- CommunityConnect's criteria for determining which members might benefit from care management
- The provider's responsibility in identifying members who may meet CommunityConnect's care management criteria
- The process for the provider to follow in notifying CommunityConnect when such members are identified
- A description of CommunityConnect's Care Coordination and Care Management programs - CommunityConnect has programs for the following conditions or needs:
  - Pregnancy, High Risk Obstetrics and Teen Pregnancy
  - Asthma
  - Diabetes
  - Cardiovascular Disease (including hypertension, coronary artery disease, and heart failure (CHF))
  - COPD (Chronic Obstructive Pulmonary Disease)
  - Chronic Kidney Disease (CKD) and End Stage Renal Disease (ESRD)
  - Oncology

## Chapter 8: Medical Management

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- Children with Special Health Care Needs
- Special Programs including Discharge Transitions

### Provider Responsibility

It is the provider's responsibility to be an ongoing source of primary care appropriate to the member's needs. The provider participates in the care management process through information sharing (such as medical records) and facilitation of the care management process by:

- Referring members who could benefit from care management
- Sharing information as soon as possible (for example, during the Initial Health Assessment the primary care provider [PCP] identifies care management needs)
- Collaborating with care management staff on an ongoing basis
- Recommending referrals to specialists as required
- Monitoring and updating the care plan to promote goal achievement
- Providing medical information
- Coordinating county or state-linked services such as public health, behavioral health, schools and waiver programs. The provider may call Care Management for additional assistance

### Referral Process to Care Management

Providers, nurses, social workers and members or their representatives may refer members to Care Management in one of two ways:

- By calling CommunityConnect's Care Management department at **1-877-471-6656**
- By faxing a completed Care Management Referral Form to **1-877-471-6658**; A case manager will respond to the person who submitted the faxed request within three business days

### Potential Referrals

CommunityConnect's care management services are provided at no cost to the member or provider. Examples of cases appropriate for referral include:

- Potential transplants
- Complex or multiple-care needs such as multiple trauma, cancer
- Chronic illness such as asthma, diabetes, heart failure

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- High-risk pregnancies (teen pregnancies)
- Preterm births
- HIV/AIDS
- Frequent hospitalizations or emergency room utilization
- Hemophilia, sickle cell anemia, cystic fibrosis, cerebral palsy
- Children or adults with special health care needs requiring coordination of care

### Role of the Case Manager

After identifying members who meet care management criteria, case managers develop a care plan and:

- Facilitate communication and coordination between all members of the health care team, involving the member and family in the decision-making process in order to minimize fragmentation in the health care delivery system.
- Educate the member and all providers of the health care delivery team about care management, community resources, benefits, cost factors, and all related topics so that informed decisions can be made.
- Encourage appropriate use of medical facilities and services, improving the quality of care and maintaining cost-effectiveness on a case-by-case basis.

The Care Management team includes licensed, experienced, registered nurses as well as social workers. The Care Management social workers, under the direction and supervision of registered nurse case managers, add valuable skills that address member's psychological, social and financial issues.

### Procedures

Upon identification of a potential member for care management, the case manager contacts the referring provider and member and completes an initial assessment. The case manager develops an individualized care plan based on information from the assessment and with the involvement of the member, the member's representative, and the referring provider. The provider and case manager coordinate services with public health, mental health, schools and other community resources.

The case manager periodically re-assesses the care plan to monitor progress toward goals, any necessary revisions, and any new issues to ensure that the member receives support and teaching to achieve care plan goals. Once goals are met or the case can no longer be impacted through care management, the case manager will close the member's case.

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### Disenrollees Transitions

It is the responsibility of the case manager to assist with transitioning a member, when a disenrolling member requests care management assistance, to another health plan. This must occur without disruption of a regimen of care that qualifies as a continuity of care condition. The case manager works with the member, involved physicians and the case manager at the new health plan to ensure an orderly transition.

### Continued Access to Care

If you have prior authorization for services and equipment from the previous health plan, we would appreciate your notifying us of these previously-approved authorizations so we can assist with the management of our member's care. Through February 2011, CommunityConnect will honor existing prior authorization for medically-necessary services and equipment.

After the transition period, CommunityConnect will follow our standard continuity of care guidelines. New members who choose CommunityConnect as their new health plan can receive services from out-of-network Wisconsin Medicaid-certified providers, if the providers contact us to discuss their scheduled health services in advance of the service date and one of the following qualifying conditions applies:

- The member has been approved and scheduled to receive a cornea and/or kidney transplant or tissue replacement,
- The member has been approved by the state of Wisconsin and scheduled to receive any other organ transplant or tissue replacement, CommunityConnect is responsible and will provide continuity of care for the preparation work for pre-surgery up until the member is transferred to fee-for-service Medicaid for the transplant or tissue replacement.
- The member is in her third trimester of pregnancy and has an established relationship with a Wisconsin Medicaid-certified out-of-network obstetrician and/or delivery hospital,
- The member has been scheduled for inpatient/outpatient surgery and has been approved prior to transitioning to CommunityConnect,
- The member has appointments within the initial month of CommunityConnect membership with Wisconsin Medicaid-certified out-of-network specialty physicians that were scheduled prior to the effective date of transition to CommunityConnect,
- The member is receiving ongoing chemotherapy or radiation treatment,
- Newborns are enrolled back to date of birth within the first 100 days of life, when born to a mother who was enrolled in the health plan at the time of the birth,
- The member is undergoing screening for long-term care placement,

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- The member is transitioning through behavioral health services, especially if the member received prior authorization from his or her previous health plan or through fee-for-service coverage

All new enrollees receive Evidence of Coverage (EOC) membership information in their enrollment packets. The EOC also provides information regarding members' rights to request continuity of care.

### Continuity of Care Process

CommunityConnect's care management nurses review member and provider requests for continuity of care and facilitate continuation with the current physician until short-term regimen of care is completed or the member transitions to a new practitioner.

Only a CommunityConnect physician can make adverse determination decisions which are sent in writing and mailed to the member and to the physician within two business days of the decision. Members and physicians can appeal the decision by following the procedures in the Complaints, Grievances and Appeals chapter.

Reasons for continuity of care denials include, but are not limited to:

- Not a qualifying condition
- Treating physician is currently contracted with CommunityConnect
- Request is for change of PCP only and not for continued access to care
- Member is ineligible for coverage
- Course of treatment is complete
- Services rendered are covered under a global fee
- Requested services are not a covered benefit

### Vision Care

Members access basic vision care services through MARCH Vision Care providers. For confirmation of vision services, contact **MARCH Vision Care**.

### Dental Care

Please contact **Southeast Dental Associates** regarding prior authorization of dental services. Medically necessary inpatient or outpatient services provided during the performance of a dental service may be covered.

## Chapter 9: Quality Improvement Program

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The BadgerCare Plus Managed Care Program requires that participating HMOs have effective quality improvement structures in place. As part of the state of Wisconsin and CommunityConnect relationship, we are required to provide the state with accurate encounter data within specified timeframes. This data is collated and reported annually by the state of Wisconsin. Indicator data is reported in the following areas: Women's Health Care; Child Health Care; Acute and Chronic Condition; Mental Health; Preventive Care and Other Health Care. Using this information, we are able to identify areas for improvement in serving the at-risk populations in the state of Wisconsin's Southeast Region. The health care provider's role in supplying this data is extremely important. With accurate information, we are able to provide better administrative support for our CommunityConnect network providers.



CommunityConnect's performance targets, aligned with the state of Wisconsin standards, include the following:

- Childhood immunization status
- Lead testing of 1 and 2-year-olds
- Use of appropriate medications for people with asthma
- Comprehensive Diabetes care: HbA1C testing and LDL-C screening
- Tobacco cessation
- Healthy birth outcomes
- COPD and CHF care

CommunityConnect's quality program is an integrated process throughout our organization. The Mission Statement for CommunityConnect's Quality Program is:

"CommunityConnect HealthPlan is committed to excellence in the quality of care and services provided to members and to the competence of its providers, practitioners and ancillary network. CommunityConnect HealthPlan is dedicated to improving customer satisfaction, improving the health status and quality of care for our members and the public, providing value added services, improving member safety, assuring member access to medical services and supporting the company's image as a highly respected and trusted national organization."

## Chapter 9: Quality Improvement Program

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This statement provides specific direction regarding the focus of quality for CommunityConnect. In order to satisfy the goals of this mission statement, we feel that all CommunityConnect providers – practitioners, facilities and ancillaries – must collaborate with and embrace the activities of quality. Such activities include satisfaction surveys, population and random sample based studies, and participation in multi-disciplinary teams for problem solving. These activities allow the organization to continuously improve upon processes of health care delivery in order to ensure that we are providing our members with highest quality of care in a cost-effective manner.

Information from quality improvement activities is actively shared with our providers and staff. We encourage constructive feedback and are available as a resource for quality improvement activities of CommunityConnect providers and facilities. Questions or requests for information should be directed to the attention of the Director, Quality Improvement, at our primary mailing address.

### **Quality Assessment and Performance Improvement Program Structure**

#### **Program Scope**

The Quality Assessment and Performance Improvement (QAPI) program includes the development and implementation of standards for clinical care and service, measuring conformity to those standards and taking action to improve performance. Refer to CommunityConnect's provider website under Quality Management for more information.

#### **QAPI Program Work Plan and Annual Evaluation**

CommunityConnect develops an annual work plan of activities based on the results of the previous year's QAPI program. CommunityConnect reviews and assesses the QAPI program's effectiveness annually in the QAPI program's evaluation. The evaluation is a written description of CommunityConnect's ability to implement the QAPI program, meet program objectives and develop and implement plans to improve the quality of care and service to members.

#### **Medical Records Documentation and Access to Medical Records and Information**

Providers are responsible for ensuring that member medical records are organized, and complete, and include documentation from specialists, hospitals, ancillary providers, services directly provided by the state, and community services when applicable. The PCP is required to record the use of any and all interpreter services. It is required that documentation be signed, dated, legible and completed in a timely manner. Medical records are required to be stored in a secured location.

Providers are required to provide CommunityConnect with prompt access, upon demand, to medical records or information for quality management or other purposes, including utilization review, audits, reviews of complaints or appeals, and other clinical quality studies. All physicians and providers are required to provide all medical records and information as requested within the timeframe established by CommunityConnect.

## Chapter 9: Quality Improvement Program

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Providers are required to provide CommunityConnect or its external quality review organization (EQRO) with access to office sites for facility or medical records reviews upon CommunityConnect's request. Mandated time limitations for the completion of reviews and studies require the cooperation of the provider to provide medical records expediently. Providers are required to have procedures in place to provide timely access to medical records in their absence.

For public health communicable disease reporting, providers are required to provide all medical records or information as requested and within the timeframe established by state and federal laws.

### Medical Office Site and Records Review

The general office review is conducted for all physician offices who have received a member complaint in one of the following categories: physical accessibility, physical appearance, and adequacy of waiting and examining room space. CommunityConnect has 60 days after a complaint to conduct an office review. Multiple complaints about the same provider within the same complaint category do not generate the need for additional office reviews. However, if a provider receives a complaint in a different category, CommunityConnect must conduct an additional office review whether or not a prior office review has been conducted. The purpose of this review is to verify that care is being provided in an appropriate environment that can adequately meet the needs of our members.

### Medical Record Review Criteria

The performance goal is an overall score of 80 percent. Offices who do not meet this are resurveyed every two years until the goal is met. *Each medical record is retrievable for review.* The medical record must be available for review to receive full credit. *Practices should maintain medical records in an organized, uniform manner.* Computerized medical records are acceptable. To receive full credit, each patient should have an individual and organized medical record. Family charts should maintain an organized and individual record for each member of the family to receive full credit. Unorganized records receive no credit. Partially organized records receive partial credit.

Each medical record contains a completed patient history, which consists of patient and family medical history, along with documentation of depression screening, tobacco, alcohol and *substance abuse history*. Each item counts 20 percent of the overall score. All items must be present to receive full credit (100 percent). Histories may appear in the progress notes, on a printed medical form, or in hospital dictations prepared by the physician. Transferred records with documentation that the current PCP has reviewed and noted the history are also acceptable. Histories from consultants are not acceptable in the absence of the PCP having made a note of the history. For pediatric patients, patient history consists of patient and family medical history only and each part counts 50 percent. Both items must be present to receive full credit (100 percent).

## Chapter 9: Quality Improvement Program

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The medical record has documentation of, and prominently displays, allergies or drug *reactions*. Documentation of allergy information, including the absence of known allergies (NKA or NKDA), should be documented in a consistent location for all charts (i.e., chart folder, progress note, diagnostic summary, history form, etc.) to receive full credit. Because consistency enables staff to readily identify allergies, medical records with a consistent location of allergy information are crucial to obtaining full credit.

*Each medical record has a diagnostic summary/problem list, including medical, surgical, and behavioral health conditions, medications, and preventive services/risk assessment in a consistent place in the chart.* Medical records with a current problem list in a consistent place that documents acute and chronic problems and medications receive full credit. Medical records that only include a medication list or only record medical-surgical conditions receive partial credit. If the problem list is not current or not in a consistent place within the chart then partial credit is given. Medical records with no diagnostic summary or problem list receive no credit. For pediatric patients, diagnostic summary/problem list is only scored if there is evidence of chronic illness in the patient's chart. Otherwise this is recorded as N/A and not included in the overall record review score.

Discussion of Advance Directives with the member must be documented in the member's permanent medical record. Whether or not an Advance Directive has been completed must also be documented by the provider in the member's medical record.

Progress notes are recorded for each patient encounter and include the following for full credit:

- Working diagnosis(es) consistent with findings. Each encounter should have documentation of an appropriate diagnosis(es) based on the findings for full credit.
- Treatment plan consistent with diagnosis(es). Encounters should include documentation of an appropriate treatment plan for the diagnosis(es) (which includes follow-up plans) and the care should be medically appropriate for full credit. Medical records with diagnosis-specific conditions and no treatment plan will receive no credit; an incomplete treatment plan will receive partial credit. CommunityConnect will also assess communications from facilities and specialists, including behavioral health providers, to the PCP. This does not calculate into the overall PCP's medical record review score.

In the event CommunityConnect determines that the quality of care or services provided by a health care professional is not satisfactory, as may be evidenced by or in member satisfaction surveys, member complaints or grievances, utilization management data, complaints or lawsuits alleging professional negligence, or any other quality of care indicators, CommunityConnect may terminate the Participating Provider Agreement and related Addendums. Health care professionals agree to be bound by and comply with CommunityConnect's policies, procedures and rules.

## Chapter 9: Quality Improvement Program

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### Oversight of Non-Physician Practitioners

All providers using non-physician providers are required to provide supervision and oversight of such non-physician providers consistent with state and federal laws. The supervising physician and the non-physician practitioner are required to have written guidelines for adequate supervision, and all supervising providers are required to follow state licensing and certification requirements.

Non-physician practitioners are advanced registered nurse practitioners (including certified nurse midwives) and physician assistants. These non-physician practitioners are licensed by the state and working under the supervision of a licensed physician as mandated by state and federal regulations.

### Advance Directives

Recognizing a person's right to dignity and privacy, CommunityConnect's members have the right to execute a living will to identify their wishes concerning health care services should they become incapacitated. Members may request physicians and/or providers to assist them in procuring and completing necessary forms. Refer to CommunityConnect's website at [www.CommunityConnectHealthPlan.com](http://www.CommunityConnectHealthPlan.com) for more information.

### Preventable Adverse Events

The breadth and complexity of today's health care system means there are inherent risks, many of which cannot be predicted or prevented. However, the occurrence of preventable adverse events should be tracked and reduced, with the ultimate goal being to eliminate them.

Physicians and health care systems, as patient providers and advocates, are responsible for the continuous monitoring, implementation, and enforcement of applicable standards. We will work with network physicians and hospitals to identify preventable adverse events that are measurable and preventable, as a means of improving the quality of patient care.

Preventable adverse events should not occur. We firmly support the concept that a health plan and patients should not pay for services that resulted from a preventable adverse event.

Through a focus on patient safety, we are committed to working collaboratively with network physicians and hospitals to ensure that physicians and hospitals are identifying preventable adverse events and implementing appropriate processes, technologies, and strategies to prevent adverse events and to enhance the quality of care received by not only our members but also all patients receiving care in these facilities.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations specify that Protected Health Information (PHI) can be disclosed for the purpose of health care operations in relation to quality assessment and improvement activities. Also, the information you share with us is legally protected through the peer review process; as such, it will be maintained in a strictly confidential manner. If you receive a request for medical records, please provide them within 10 days from the date of request.

## Chapter 9: Quality Improvement Program

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We will continue to monitor activities related to the list of adverse events from federal, state, and private payers.

### Credentialing Program

CommunityConnect HealthPlan (CommunityConnect) is proud of the professionals and facilities that comprise our panel of health care providers. We require that providers meet rigorous credentialing standards to be a part of our provider panel. Once credentialed, providers and facilities must be re-credentialed every three years to meet our credentialing standards.

### Summary of Credentialing Program

Providers and facilities are reviewed against many standards, including a current valid license, clinical privileges, valid DEA or CDS certification, educational background (including board certification), work history, malpractice history and professional liability claims history and accreditation. It is important that health care providers and facilities collaborate with CommunityConnect during this process. Diligence in the credentialing of health care providers is a necessary step in assuring that our members are receiving the highest quality of health care.

In some instances, credentialing is delegated. Please contact **CommunityConnect** for clarification.

You will find a summary description of CommunityConnect's **credentialing program** on our website.

Please direct questions or concerns about our credentialing program in writing, to **Attn: Director, Clinical Quality**, to our **primary mailing address**.

### Ownership Disclosure

As a part of the initial and subsequent recredentialing process, CommunityConnect follows the Centers for Medicare and Medicaid Services (CMS) regarding ownership disclosure. You may be periodically required to submit a Disclosure of Ownership Questionnaire.

### Non-Discrimination Statement

You must post a statement in your office that provider hours of operation do not discriminate against BadgerCare Plus members. This includes:

- Waiting times for appointments,
- Waiting times for care at facilities, and
- Whether or not provider(s) speak the member's language.

## Chapter 10: Programs and Services

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### Local and Community Services

CommunityConnect has agreements in place with Medicaid-certified providers - community-based health organizations (CBOs), local health departments, the Bureau of Milwaukee Child Welfare (BMCW), Prenatal Care Coordination Agencies, school-based services providers, targeted care management agencies, and county and other human service agencies for the Southeast Region service area.



We encourage our providers to work with these organizations and agencies to coordinate the care for our BadgerCare Plus members, to ensure continuity and culturally appropriate care and services. Our agreements with these service agencies indicate clear guidelines for sharing clinical data between CommunityConnect, the primary care provider, and other key agencies that can help the member benefit from the shared information.

Community-based organizations can provide HealthCheck outreach and screening, immunizations, family planning services, and other types of services. They also may provide WIC services as well.

### HealthCheck Information

HealthCheck is a preventive health check-up program for anyone under the age of 21 who is enrolled currently in BadgerCare Plus. HealthCheck is the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program in the state of Wisconsin.

HealthCheck meets the physical exam rules for programs such as Head Start; Child Care; Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and school physicals.

The HealthCheck program covers complete health checkups. These checkups are very important for those under 21. The HealthCheck checkup includes:

- Health and developmental history (including anticipatory guidance),
- Unclothed physical examination,
- Vision screening,
- Hearing screening,
- Dental screening and a referral to a dentist beginning at age one,
- Immunizations (shots) appropriate for age,
- Blood and urine lab tests, including blood lead level testing when appropriate for age, and tuberculosis screening,
- Health education, and
- Nutritional assessment.

## Chapter 10: Programs and Services

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### Target Levels

There are state and federal requirements that your clinic/organization must achieve. For HealthCheck, the target level is at least 80 percent of allowable screenings. A recipient is limited, based on their age, to the following number of comprehensive screenings for a consecutive 12-month period:

- Birth to first birthday, six screenings
- First birthday to second birthday, three screenings
- Second birthday to third birthday, three screenings
- Third birthday to 21st birthday, one screening per year

For more information, see the **Vaccines & Immunizations** page of the Centers for Disease Control and Prevention (CDC) website.

CommunityConnect will provide you with information regarding the percentage of allowable HealthCheck screenings your clinic has completed.

The following are the responsibilities of providers that help members receive HealthCheck services to maintain healthy lifestyles:

- Document all health care screenings, immunizations, procedures, health education and counseling on the member's medical record.
- Schedule preventive care appointments for all members under the age of 21 following the American Academy of Pediatrics (AAP) periodicity schedule.
- Provide immunizations as needed at all well child visits and according to the schedule established by the Advisory Committee on Immunization Practices (ACIP), American Academy of Family Physicians (AAFP) and AAP.
  - Childhood immunizations are to follow the current year's schedule as set by the AAP ([www.aap.org/healthtopics/immunizations.cfm](http://www.aap.org/healthtopics/immunizations.cfm)). An instant childhood immunization scheduler is available at the following CDC website at [www.cdc.gov/vaccines/recs/schedules/default.htm](http://www.cdc.gov/vaccines/recs/schedules/default.htm).
  - Should refer a member to the county health department and maintain a record of the child's immunization status if the provider does not routinely administer immunizations as part of his or her practice.

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- As a condition of certification as a BadgerCare Plus provider, CommunityConnect must share member immunization status with the local health departments and other non-profit HealthCheck providers upon their request without the necessity of member authorization. The Wisconsin Department of Health Services (DHS) also requires that the local health departments and other non-profit HealthCheck providers share the same information with CommunityConnect upon request. This provision ensures proper coordination of immunization services and prevents duplication of services. In addition, CommunityConnect requires that the majority of our providers have a signed user agreement with the Wisconsin Immunization Registry (WIR).
- Refer members, as appropriate, to dentists, optometrist/ophthalmologist or other specialists as needed; document referrals in the member's medical record.

Please note that “The HMO must provide a HealthCheck screen within 60 days (if a screen is due according to the periodicity schedule) for enrollees over one year of age for which a parent or guardian of an enrollee requests a Comprehensive HealthCheck screen. If the screen is not due within 30 days, then the HMO must schedule the appointment in accordance with the periodicity schedule. The HMO must provide a Comprehensive HealthCheck screen within 30 days (if a screen is due according to the periodicity schedule) for enrollees up to one year of age for which a parent or guardian of an enrollee requests a Comprehensive HealthCheck screen. If the screen is not due within 30 days, then the HMO must schedule the appointment in accordance with the periodicity schedule.”

### CommunityConnect's Responsibilities

CommunityConnect maintains intervention strategies to keep members current with the HealthCheck program and American Academy of Pediatrics (AAP) Periodicity schedules, including informing members of the following reminders:

- Immunization reminder calls at ages 3, 6, 9, 12, 15, and 18 months
- Preventive care calls to members ages 2-20 during their birth months

### Components of a Comprehensive HealthCheck Screening

The provider must assess and document all of the age-specific components in order for the state and CommunityConnect to recognize the visit and reimburse you as a complete HealthCheck screen/exam. Visit [www.cdc.gov/Vaccines](http://www.cdc.gov/Vaccines) for the current immunization periodicity chart.

CommunityConnect HealthPlan designs, implements and manages programs customized for the BadgerCare Plus program. We seek to assist providers improve the health and overall well being of CommunityConnect HealthPlan member by offering health education and disease management programs that educate, inform and encourage self-care.

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### Health Education Programs

To assist providers in helping members improve and manage their health, CommunityConnect developed several health education programs to address the member's health status and condition. Refer to [www.CommunityConnectHealthPlan.com](http://www.CommunityConnectHealthPlan.com) for more information.

### No-Cost Classes Available to Members

CommunityConnect offers health education classes that take place at hospitals and/or community-based organizations. Classes are available at no charge to the member and are accessible upon self-referral or referral by contracted providers. Classes vary from county to county. Some of the classes that CommunityConnect provides include:

- Asthma management
- Childbirth preparation
- Diabetes management
- Nutrition
- Weight management
- Parenting/well child
- Prenatal education
- Smoking cessation/tobacco prevention

### How to Schedule Health Education Classes

Members receive information about health education classes through enrollment materials, member newsletters, community resource coordinators (CRCs), and provider offices. Members should call [Health Management and Education](#) to schedule a health education class.

### Follow-Up

After attending the class, CommunityConnect sends an Attendance Confirmation letter to the member's PCP with the member's name, ID number and title of class attended. If a member does not show up for the registered class, CommunityConnect mails a "No Show" letter to the member's PCP. PCPs should document health education services in the member's medical record.

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### **How to Get Health Education Materials for Your Office**

CommunityConnect supplies providers with health education materials developed for CommunityConnect members' cultural and linguistic needs. To request health education materials, please call CommunityConnect's **Provider Services**.

### **Member Incentives**

Members who successfully complete prenatal classes, asthma education and/or diabetic education classes, and who demonstrate compliance with recommended care will be eligible for a gift card to purchase needed items for their newborn, recreational items or healthy grocery items.

Parents of minor children who access the emergency room for primary care treatable conditions will be provided with follow-up education packet that includes a free digital thermometer.

Pregnant members enrolled in the Healthy Habits Count "You and Your Baby" prenatal program who complete a prenatal visit with their obstetrician within 42 days of enrollment will receive a gift card to purchase needed items for their newborn; and those who complete a postpartum visit with their OB within 21-56 days of delivery will receive a gift card to purchase needed items for their newborn.

### **Preventive Care Programs**

CommunityConnect's preventive care programs were developed to help promote and maintain good health for members and to remind members about the importance of regular checkups. Providers are an integral part of these programs. Although the programs target different needs, they all share the same goal – helping members to live healthier lives.

### **Well Woman Program**

CommunityConnect's Well Woman Program encourages women to have regular cervical and breast cancer screenings. The program reminds and encourages women to call their PCP to make an appointment for schedule screenings.

### **Access to Women's Health Specialists**

If the primary care provider is not a women's health specialist, CommunityConnect will provide all female members with direct access to women's health specialists within the network for covered care necessary to provide their routine and preventive health care services.

Members have the right to receive family planning services, not including routine care, from any Medicaid provider. In addition, members also have the right to receive TB, STI and HIV/AIDS care from any public health agency.

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### Physician Care for Women

PCP responsibilities for the care of female members include:

- Inform and refer members for cervical and breast cancer screenings
- Educate members on the Preventive Care Guidelines for women
- Schedule screening exams for members

Providers can access CommunityConnect's Preventive Health Care Guidelines on CommunityConnect's website at [www.CommunityConnectHealthPlan.com](http://www.CommunityConnectHealthPlan.com).

### Medical Home Pilot

CommunityConnect has developed a Medical Home Pilot, specifically for providers who serve BadgerCare Plus members enrolled through CommunityConnect. Eligible providers are PCPs or PCCs that provide patients with accessible, continuous, coordinated, and comprehensive care through a patient-centered, physician-guided, cost-efficient, and longitudinal approach to care. If you are a PCP, talk to your network representative about provider incentives aligned with medical home principles related to:

- Preventive care,
- Expanded hours of operation for after-hours care availability,
- Prenatal care, especially for members at high risk,
- Childhood immunization rates,
- Blood lead testing,
- Asthma care,
- Diabetes care, and
- Tobacco cessation treatment.

### Prenatal Program

CommunityConnect executes two prenatal programs, which we describe in more detail below – the *Healthy Habits Count for You and Your Baby* prenatal program and the *High-Risk OB/Teen Pregnancy* programs. We also have strong relationships with community-based organizations and contracts with specialized vendors to reduce poor birth outcomes. Our programs include working with our health education and care management staff to assist members with issues related to smoking cessation, chronic health conditions, and to behavioral health issues during their pregnancy.

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But first, it's important to identify a pregnant member and notify CommunityConnect of that member's pregnancy. Please continue reading below.

### Notification of Pregnancy Form

We identify pregnancies through communication from PCPs and obstetric providers. When you identify a member as pregnant, please complete the **Notification of Pregnancy (NOP)** form, available from our website or from your local community resource coordinator. Complete and fax the NOP to the number on the form. More information regarding the form and process is below.

### Physician Assessment of Pregnancy Risk

The PCP or prenatal care physician is responsible for assessing all pregnant members for risk indicators during the initial prenatal care visit. For all pregnant members, the provider needs to:

- Complete and fax a **Notification of Pregnancy** to the number listed on the form.
- Refer members to prenatal education, childbirth education and breastfeeding classes; members and physicians can call our Health Education and Management department to register for prenatal education classes.
- Document all referrals in the member's medical record.
- Schedule the member for prenatal and postpartum visits.

### Healthy Habits Count for You and Your Baby

Once CommunityConnect receives notification that a member is pregnant, with her due date or estimated due date, we enroll her in the *Healthy Habits Count "You and Your Baby"* prenatal program. This program provides information and support from conception through 60 days postpartum.

The main objectives of the prenatal program are to help members achieve positive birth outcomes, encourage early and ongoing prenatal and post-partum care, and increase member's access to perinatal care. To refer a patient to this program, please complete the **Notification of Pregnancy** form, as indicated above in the section titled Identification of Pregnancies.

CommunityConnect's *Healthy Habits Count "You and Your Baby"* prenatal program consists of the following at no cost to the member:

- Prenatal educational booklet
- Prenatal health education classes
- Referral to care management for pregnancy risk screening to identify members eligible for additional prenatal interventions.
- Postpartum visit exam reminder card to members in their third trimester

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- Postpartum visit reminder live call to members in their third trimester
- Breastfeeding Support Line

If a member is screened as medium or high risk, they will be pursued for enrollment in the HROB (High-Risk Obstetrics)/Teen Pregnancy program. Upon member consent, the member will be assigned a personal nurse from the HROB/Teen Pregnancy Program to assist in the education and management of their pregnancy from the time of member identification through the post-partum period.

### High-Risk Obstetrics/Teen Pregnancy

If you determine a woman is at high-risk and has co-morbid conditions, enroll her into our care management program design for High-Risk Obstetrics/Teen Pregnancy (HROB), and when appropriate, our condition management program that includes disease management. To notify us of a member's high-risk pregnancy, complete the **Notification of Pregnancy** form as indicated above in the section titled *Identification of Pregnancies*. In addition, we use our data mining strategies to identify pregnant women at high risk to enroll these women in our care management programs.

Our HROB program consists of the following elements:

- Early identification of and periodic assessment for pregnancy risks
- Care management tailored to the needs of the member
- Assistance with referrals to specialists to ensure appropriate care during pregnancy
- Collaboration with and referrals to community resources, including behavioral health resources for education, training and social supports, including treatment of perinatal and postpartum depression disorders
- In-home health supports for members with identified needs, including 17-alpha-hydroxyprogesterone (17-P) injections to prevent recurrent preterm birth (available through the provider's office or in the member's home)
- Monitoring and evaluation to drive continuous quality improvement

### Breastfeeding Promotion

The Healthy People 2010 goal is to increase breastfeeding initiation at delivery to at least 75 percent of all mothers and achieve at least 50 percent continuation of breastfeeding for six months. The American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the American Public Health Association recognizes breastfeeding as the preferred method of infant feeding. Providers should encourage breastfeeding for all pregnant women unless it is not medically appropriate.

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### WIC Program

The Special Supplemental Nutrition Program for Women, Infants, and Children, better known as the WIC Program, serves to safeguard the health of low-income women, infants, and children up to age 5 who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to health care.

Providers are responsible for identifying if a member is eligible for WIC and for referring that member to the WIC program. The member or provider can call WIC to schedule an appointment for the member to apply for the program.

Providers are responsible for informing and educating eligible members of the availability of WIC services, including availability of food vouchers, nutrition, education classes and available community referrals. Written materials regarding WIC services (including education available, eligibility requirements, promotion of breast feeding and successful lactation) are to be made available in provider's office.

Members eligible for WIC must meet WIC's "Nutrition Risk Requirement" and be:

- A woman who is pregnant (during pregnancy and up to 6 weeks after the birth of an infant or the end of the pregnancy),
- A woman who is breastfeeding (up to the infant's first birthday),
- An infant (up to the infant's first birthday) or
- A child (up to the child's fifth birthday) who is at nutritional risk.

"Nutrition risk" means that an individual has medical-based or dietary-based conditions. Examples of medical-based conditions include anemia (low blood levels), underweight, or history of poor pregnancy outcome. A dietary-based condition includes failure to meet the dietary guidelines or inappropriate nutrition practices.

For more information about the WIC program, go to the WIC website at <http://www.fns.usda.gov/wic/aboutwic/>.

### Emergency Room Program

CommunityConnect employs a multi-faceted solution to address inappropriate emergency room use. Our Emergency Room (ER) Program is designed to increase members' knowledge and skills related to self-care management and decision-making about appropriate resources when a non-emergency event occurs. Ultimately, the goal of this program is to help members establish a medical home in a primary care setting.

To promote continuity of care and access to a PCP, this CommunityConnect initiative is comprised of targeted member and physician interventions based on the member's frequency of emergency room visits within a 12-month rolling period.

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Member interventions include:

- Dissemination of self-care books, letters and/or emergency room member education packets
- Outreach phone calls
- Care management (if appropriate)

Provider interventions include:

- Monthly member-specific ER-notification reports are sent to PCPs
- Providers are asked to place member-specific notifications in the medical record
- Providers are encouraged to follow-up with members regarding emergency room visits to help coordinate their care
- Providers also may request ER Program materials and/or provider office training on the ER Program by calling CommunityConnect's **Provider Services**

CommunityConnect's ER Program is based on three core principal components:

- Empowering members by providing education and a strong knowledge base to make informed decisions when seeking care for non-emergency events
- Collaborating with PCPs and encouraging them to actively provide access to care and treatment to their assigned members who are identified as high emergency room users
- Working in partnership with members and providers to identify and reduce barriers to access

### **Drug Lock-In Initiative**

In conjunction with our ER program to reduce inappropriate use of the ER, CommunityConnect utilizes a lock-in program to decrease inappropriate use of ERs for pain management and drug seeking behavior. Members receive information on what primary care, hospital and pharmacy they can receive services and medication from. Providers assigned to the member receive information on the members who are in the lock-in program.

### **Provider Assessment of Tobacco Use**

During office visits, providers can screen for tobacco use, and make several recommendations, including:

- Assess members' smoking status and offer quick advice about quitting.

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- Use Pregnancy Notification Reports as a way to notify us of women who smoke during pregnancy. Women are more likely to quit smoking during pregnancy. Encourage pregnant women to stop smoking, and continue this tobacco cessation after pregnancy.
- Offer members resources to stop smoking, including our TLC Program information.

### Tobacco Cessation Program

CommunityConnect provides smoking cessation information to all members and ensures that members in need of smoking cessation services receive necessary referrals and numerous resources and tools, including:

- Smoking cessation classes at no cost to members. Call **Provider Services** for more information.
- Smoking cessation clinical practice guidelines are posted online at: **[www.CommunityConnectHealthPlan.com](http://www.CommunityConnectHealthPlan.com)**.

In addition, we provide a special prenatal component of our program, *The Last Cigarette (TLC)*, to assist our pregnant members to stop smoking during pregnancy.

### Member Interventions

The TLC member component is based on educational materials and phone support, as well as advice from their physician to promote tobacco cessation. Interventions are as follows:

- On a monthly basis, members are identified for smoking cessation intervention from a variety of sources including the nurse advice line, care management nurses and social workers, state enrollment files, Notice of Pregnancy (NOP) report from providers and self-referrals from members who want to stop smoking. CommunityConnect recognizes that smoking during pregnancy creates additional risks; therefore, a special prenatal component for the *TLC* program was created. It is a multidisciplinary approach, targeting female smokers of childbearing age, along with high volume Obstetrics/Gynecologists (OB/GYN), family practitioners, and care managers who handle high-risk pregnancies. An “Ask and Inform” letter is sent to the identified smoker offering a quit kit, information on available classes at no cost and to talk to a coach option by calling **1-800-QUITNOW**. This comprehensive “Quit Kit” is designed to help make the journey to smoke-free life style a positive and successful one based on the extensive literature that making cessation resources available at the time the individual is ready to quit is most effective.

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- The TLC prenatal component addresses tobacco use and cessation during pregnancy. Identified pregnant members who are enrolled into the CommunityConnect Prenatal Program receive a packet of health information about the stages of pregnancy and which health behaviors can assist with a healthy pregnancy. As part of the prenatal packet, an extensive section is presented to increase knowledge about the importance of tobacco cessation during pregnancy, appropriate quit methods for pregnant women and remaining tobacco free after the baby is born.
- CommunityConnect offers a nurse advice line, which provides members with access to services 24 hours a day, seven days a week, through an 800 number. The service offers over 350 audio topics, which provide information on a variety of smoking health topics in English and Spanish.
- Awareness campaigns to encourage smoking cessation and inform member of available resources through the member newsletter, member handbook, health education fliers and member website.

### **Nurse Help Line**

MedCall, a telephone help line staffed by registered nurses, is available to all CommunityConnect members 24 hours a day, 7 days a week to help with health-related questions. The MedCall nurse help line gives general information only, not medical advice. If a CommunityConnect member needs emergency health care, he or she should call 911 right away.

### **How the Nurse Information Line Assists Members**

Your patients can contact MedCall for:

- Assistance with self-care information such as symptom triage, medications and side effects, and reliable self-care home treatments
- Information on hundreds of health topics through MedCall's audio tape library
- Information from nurses, trained to discuss pediatric, adolescent and teen issues

The nurses at MedCall have access to a telephone interpreter service for callers who do not speak English. All calls are confidential.

### **Member Outreach**

Community Advocates will outreach to members to provide in-home health education, health screening and live referral to care management and other programs.

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### Care Management Programs

CommunityConnect offers customized care management programs for the BadgerCare Plus population who live with chronic conditions and diseases. For more information, refer to our **Care Management Program Overview** or contact **Health Management and Education**.

### Disease Management Programs

CommunityConnect seeks to improve the health and overall well-being of members by offering disease management programs that educate, inform, and encourage self-care. The following programs were designed to assist members to learn and follow self-care regimens and treatment therapies for existing medical conditions, chronic diseases or health conditions. Refer to CommunityConnect's website at **www.communityconnecthealthplan.com** for more information.

### Asthma Program

CommunityConnect's Healthy Habits Count with Asthma Program is designed to increase identification of members with asthma, ensure that they receive appropriate treatment, and develop asthma action plans to improve their self-management skills. The program is based on the National Institute of Health (NIH) and National Heart, Lung, and Blood Institute (NHLBI) Guidelines for the Diagnosis and Management of Asthma (**www.nhlbi.nih.gov/guidelines/asthma**).

Identified members are automatically enrolled into the program and receive interventions according to risk stratification. A member may opt-out of the program at anytime by contacting CommunityConnect's **Health Management and Education** department. Providers can enroll a member into the HHCA program by calling the same number above.

### Diabetes Program

CommunityConnect designed its Healthy Habits Count with Diabetes Program for ages 21 and over and CommunityConnect's Healthy Habits Count for Your Child's Diabetes program for members under the age of 21 to augment the care of members with diabetes. CommunityConnect adopted the clinical practice guidelines from the American Diabetes Association, available on CommunityConnect's website, **www.communityconnecthealthplan.com**. Providers who do not have internet access can request a hard copy of these clinical practice guidelines by calling CommunityConnect's **Provider Services**.

Identified members are automatically enrolled into the program and receive interventions according to risk stratification. A member may opt-out of the program at anytime by contacting please call CommunityConnect's **Health Management and Education** department. Providers can enroll a member into the HHCD Program by calling the same number.

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### **Your Heart Program**

The Healthy Habits Count for your Heart (HHCH) program consists of a multidisciplinary approach that addresses members' medical and behavioral issues through education and care management. The program helps improve members' self-management skills and adherence to treatment plans for their cardiovascular conditions as well as to support treating physicians in the management of their patients' condition. The HHCH program encompasses the most up-to-date nationally-accepted clinical practice guidelines from recognized sources.

Identified members are automatically enrolled into the program and receive interventions according to risk stratification. A member may opt-out of the program at anytime by contacting please call CommunityConnect's **Health Management and Education** department. Providers can enroll a member into the HHCH Program by calling the same number.

### **Child Welfare Coordination**

CommunityConnect collaborates with county child-welfare agencies. In Milwaukee County, CommunityConnect provides coverage to BadgerCare Plus members with mental health and substance abuse services to individuals identified as clients of the Bureau of Milwaukee Child Welfare (BMCW). Outside of Milwaukee County, CommunityConnect coordinates with the appropriate county human services agency for the provision of services to members involved with the county.

### **Prenatal Care Coordination Agencies**

Prenatal Care Coordination (PNCC) agencies ensure coordination of care between CommunityConnect and the agency that provides outreach, risk assessment, care planning, care coordination and follow-up. CommunityConnect works with the PNCC agency to identify what covered services, in conjunction with other identified social services, you may provide to the member. CommunityConnect is not liable for medical services provided outside our provider network unless the provider receives prior authorization from CommunityConnect. In addition, we are not required to pay for services directly to the PNCC provider. The state of Wisconsin Department of Health Services pays such services on a fee-for-service (FFS) basis.

### **School-Based Services Providers**

CommunityConnect will make its best effort to help ensure continuity of care and to avoid duplication of services between network providers and SBS providers. CommunityConnect is only responsible for providing and paying for covered services in situations where a member's course of treatment is interrupted due to school breaks, after school hours or during the summer months.

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### **Targeted Care Management Agencies**

CommunityConnect interfaces with the case manager from the Targeted Care Management (TCM) agency to identify what covered services or social services are to be provided to a member. CommunityConnect is not required to pay for medical services directed outside our provider network by the case manager unless we have prior authorized to do so. Wisconsin DHS provides and periodically updates the list of certified TCM agencies.

## Chapter 11: Member Grievance and Appeals

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The following information identifies our member grievance and appeal process. For the provider claims appeal process, please see **Claims and Billing**.

### Member Grievance

It is the goal of CommunityConnect's Grievances and Appeals (G&A) department that we process and resolve verbal complaints and written grievances in a timely manner, and in accordance with state and federal regulations. We inform members about the existence of the complaint and grievance processes and how to use them through our member handbook and adverse determination communications.

CommunityConnect's Director, Grievance and Appeals, oversees the grievance process to ensure that tracking and resolving of all verbal complaints and written grievances, submitted by or on behalf of the enrollee are received and processed in a timely manner. The Director is responsible for submitting periodic grievance reports to regulating agencies as required.

CommunityConnect ensures that we will not take punitive action against anyone who either requests an expedited resolution or supports a member's grievance.

For those organizations in which we delegate any Customer Service or Grievance and Appeal Activities, or "gatekeepers," we will distribute the informational flyer on member grievance and appeal rights (the Ombuds Brochure). When a new brochure is available, CommunityConnect will distribute copies to these organizations within three weeks of receipt of the new brochure. In addition, CommunityConnect will ensure that all "gatekeepers" have written procedures for describing how we inform members of denied services, as applicable. CommunityConnect will make copies of the organizations grievance procedures available for review upon request by the Department.

### Verbal Complaint Process

Members are encouraged to discuss their concerns with the CommunityConnect staff involved as soon as possible. The staff person interacting with the member can resolve most verbal complaints. If the concern is not resolved to the member's satisfaction, the member or his/her advocate should bring it to the attention of the Grievance and Appeals Representative. CommunityConnect staff conducts the following:

- Interview the member and record the details in the Member Advocate tracking system. Members have the right to request interpreter services, if necessary, at no cost to the member. If the member needs interpreter services, we document the language requested, including interpreter services for the hearing impaired, and we make the appropriate accommodations.
- Investigate the complaint and seek resolution on behalf of the member before referring to the grievance process.



## Chapter 11: Member Grievance and Appeals

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- Act as a representative for the member including facilitation of the process and resolution of the complaint.

Once we determine that we cannot resolve the issue, we begin the grievance process by routing the grievance to the designated Grievance and Appeals Representative.

The member has the opportunity to meet with the Grievance Committee to discuss his/her concerns with the original decision/determination. CommunityConnect will provide an initial response to the member within ten (10) business days. If the matter remains unresolved after 10 business days, the Grievance Committee will make a determination within 30 calendar days of the initial contact.

If the member is dissatisfied with the proposed solution, we advise the member of his or her appeal options.

CommunityConnect documents all member information pertaining to a verbal complaint and the follow-up conducted within the Member Advocate tracking system.

### Grievance and Appeal Committee Process

Members may request a review of any decision by the company by filing a written (formal) grievance. The written grievance should include as much information pertinent to the grievance and appeal as possible. To facilitate processing, the member or his/her representative should **mail grievances and appeals** to the CommunityConnect Member Advocate department.

CommunityConnect's Board of Directors has delegated the authority to review member grievances and appeals to CommunityConnect's Grievance Committee. The Grievance Committee consists of the following individuals:

- Provider and Member Services Manager
- Director of Grievance and Appeals
- Compliance Manager
- Provider and Member Services Supervisor
- Compliance Coordinator
- Medical Management Manager
- BadgerCare Plus Advocate

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A member also may request to escalate a complaint to the Grievance Committee if he or she is not satisfied with the proposed resolution. If this request is verbal, we classify it as a verbal grievance. Upon receipt, we forward the grievance or appeal to the designated Grievance and Appeals Representative. At this point, CommunityConnect explains to the member that if he/she continues to receive the disputed service during the period while the grievance or appeal is being resolved, the member may be liable for the cost of care if the decision by the Grievance Committee is adverse to the member.

The Grievance and Appeals Representative documents the grievance or appeal in the Medical Management System. We create a file and we use the grievance tracking form to document critical transition dates. CommunityConnect will acknowledge receipt of a written (formal) grievance or appeal within five business days of receipt of the grievance or appeal by sending an acknowledgement letter to the member.

CommunityConnect will attempt to schedule a Grievance Committee Meeting with the member on a mutually agreeable date - not less than seven (7) days prior to the meeting, or less if the member agrees to an earlier date, we will notify the member of the date and time of the meeting. At that time, the member, or his/her representative, has the right to appear to present written and oral information to the members of the Grievance Committee before CommunityConnect makes a determination. All grievances will be resolved within 30 calendar days of receipt unless the Grievance Committee is unable to resolve the grievance.

If the original denial was due to either: 1) not medically necessary or 2) experimental treatment, and during the grievance process additional medical information is obtained, the complete grievance file will be sent to the Medical Director for a second review.

If the Grievance Committee is unable to resolve the grievance or appeal within the specified period, we will notify the member in writing that the Grievance Committee was unable to resolve the concern, the reason for the delay, and the period in which we expect to resolve the issue. This may extend the case up to an additional fourteen (14) calendar days for BadgerCare Plus members (not to exceed 45 calendar days from receipt).

Once we make a determination, we will send a resolution letter to the member. The letter will outline the following:

- CommunityConnect staff that were present during the meeting
- Documents reviewed to make the determination
- Appeal options available, if applicable

We document all case information, including the follow-up conducted, within the Medical Management system. In addition, we maintain all written member grievances and appeals in a file-based record keeping system that includes a copy of the original grievance, the response and the resolution. All members may freely choose to go outside of the CommunityConnect Grievance process at any time. Members may contact the Wisconsin Department of Health Services or the Wisconsin Office of the Commissioner of Insurance regarding their concern.

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We will provide the member and his or her representative an opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process.

Grievances or appeals handled on an urgent basis will be resolved within two business days of receiving the written request for an expedited review. CommunityConnect will make a reasonable effort to provide oral notice, in addition to written notice, of the resolution to the grievance or appeal. CommunityConnect's Medical Director will determine if the member's request for an urgent care review meets the criteria for an urgent care situation. An urgent care situation is one where treatment is required to prevent serious deterioration in an individual's health. We use these criteria to determine whether we should process a grievance or appeal on an urgent basis.

### Notifications to Members

When CommunityConnect discontinues, terminates, suspends, limits, or reduces a service, CommunityConnect will notify the affected member(s), and his/her provider when appropriate, in writing at least 10 days before the date of the action. If CommunityConnect denies coverage of a new service, we will notify the member of the denial in writing.

Notices for both ongoing services and new benefits must include all of the following:

- The nature of the intended action.
- The reasons for the intended action. We strive to state clearly the reason in sufficient detail to ensure the member understands the action being taken by CommunityConnect.
- The fact the member and/or his/her authorized representative have the right to appeal within 45 days of the date of the notice.
- The member has the right to examine the documentation CommunityConnect used to make its determination prior to CommunityConnect grievance committee hearing at the Division of Hearings and Appeals (DHA).
- The fact that interpreter services are available free of charge during the grievance and appeal process and how the member can access those services.
- A sentence in various languages that explains who to call for interpreter services or a copy of the letter in the appropriate language.
- The rights of the member to have a representative assist him/her at any point in the appeal process including reviews or hearings.
- The right of the member to present "new" information before or during the grievance and appeal process including reviews or hearings.
- The fact that we will not take punitive action against a member who appeals our decision.

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- The process for requesting an oral or written expedited grievance or appeals requires a medical provider to verify that delay can be a health risk.
- An explanation of the member's right to appeal our decision to the Department at any point in the process.
- The fact the member, if appealing our action, may file a request for a hearing with the DHA at any point in the process.
- The member can receive help in filing a grievance or appeal by calling the CommunityConnect Advocate or the Ombuds.
- The address and telephone number of the CommunityConnect Advocate and the Ombuds.
- Notifications to members of termination, suspension, or reduction of an ongoing benefit (including services authorized by the HMO the member was previously enrolled in or services received by the member on a fee-for-service basis), must, in addition to the bullets listed above, also include the following:
  - The fact a benefit will continue during the appeal or DHA fair hearing process if the member requests that it continue within 10 days of notification or before the effective date of the action, whichever is later.
  - The circumstances under which a benefit will continue during the grievance and appeal process.
  - The fact that if the member continues to receive the disputed service, the member may be liable for the cost of care if the decision is adverse to the member.

This notice requirement does not apply when CommunityConnect triages a member to a proper health care provider or when an individual health care provider determines that a service is medically unnecessary.

### Continuation of Benefits Requirements

If the member files a request for a hearing with the DHA on or before the later of the effective date or within 10 days of CommunityConnect mailing the notice of action to reduce, limit, terminate or suspend benefits, upon notification by the DHA CommunityConnect will notify the member they are eligible to continue receiving care but may be liable for care if DHA upholds our decision. If the member requests that we continue to cover the services in question pending the outcome of the fair hearing, the following conditions apply:

- If the DHA reverses our decision, we are responsible to cover services provided to the member during the administrative hearing process.

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- If the DHA upholds our decision, we may pursue reimbursement from the member for all services provided to the member, to the extent that we covered the services solely because of this requirement.

CommunityConnect will continue benefits until one of the following occurs:

- The member withdraws the appeal.
- A state fair hearing decision adverse to the member is made.
- The authorization expires or the authorization service is met.

### Office of the Commissioner of Insurance

The member may resolve their problem by taking the steps outlined in the above grievance process or they also may contact the Office of the Commission of Insurance (OCI), the state agency that enforces Wisconsin's insurance laws, and file a complaint.

The member can contact the OCI by writing to the following address:

**Attn: Information and Complaints Section  
Office of the Commissioner of Insurance  
P.O. Box 7873  
Madison, WI 53707-7873**

The member also may contact OCI by calling **1-800-236-8517** outside of the Madison, Wisconsin area or **1-608-266-0103** in the Madison, Wisconsin area to request a complaint form.

### Division of Hearings and Appeals Complaint Process

A BadgerCare Plus member may resolve their problem by taking the steps outlined in the above grievance process or they may contact the Division of Hearings and Appeals (DHA) and file a complaint or appeal to CommunityConnect's initial grievance decision. BadgerCare Plus members may call **1-800-760-0001** or write to:

**BadgerCare Plus and/or Medicaid SSI Fiscal Agent  
Managed Care Ombuds  
P.O. Box 6470  
Madison, WI 53716**

A member also may appeal our decision to the Division of Hearings and Appeals. The member or his/her representative must ask for a fair hearing within 45 days of the resolution letter. If the member or his/her representative asks 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**

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The state of Wisconsin holds the hearing within the county where the member lives. If the member needs special arrangements to attend the hearing due to a disability, or for English translation, please call **1-608-266-3096** (voice) or **1-608-264-9853** (hearing impaired).

If a member needs help in filing a grievance or wants to know more about their rights, they may call:

- BadgerCare Plus/Medicaid SSI Ombuds: **1-800-760-0001**
- HMO Enrollment Specialist: **1-800-291-2002**
- Employee Trust Funds website: **<http://etf.wi.gov/publications/et2405.pdf>**

Upon enrollment, our members receive a copy of their rights and responsibilities in their member handbook. We also provide annual updates to our providers about where they can find the latest copy of the members rights and responsibilities for your use, and to share with your patients if you so choose.

Community  Connect  
HEALTHPLAN