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INTRODUCTION

MISSION STATEMENT

The mission of Independent Care Health Plan (iCare) is to secure the wellness of persons with complex medical and behavioral conditions, respecting their dignity and the values of caring stakeholders.

COMPANY INFORMATION

Formed in 1994, Independent Care Health Plan receives funding from the State of Wisconsin Medicaid Program to coordinate healthcare services for individuals in the Southeastern Wisconsin Counties who receive Medicaid and Supplemental Security Income (SSI) benefits. A percentage of the membership has dual eligibility with Medicare as the primary insurer.

Independent Care also provides Medicare benefits and services to the dual eligible population in 22 Wisconsin counties.

Independent Care has 4 plans:
- The iCare SSI Medicaid Plan which is a Medicaid Health Maintenance Organization (HMO).
- The iCare Medicare Plan which is a Medicare Advantage Special Needs Plan (SNP).
- The iCare BagderCare Plan is in all Medicaid areas except Dane County
- The iCare Family Care Partnership Plan is in Milwaukee, Racine and Kenosha County.

The iCare population suffers from multiple medical co-morbidities further complicated by extensive social and behavioral needs. Through an integrated care management model, iCare works to identify and coordinate the home health, medical, dental, behavioral health, vision and prescription drug services its members need. The multidisciplinary care management team recognizes that social and behavioral factors impact the ability to provide successful medical treatment and improve quality of life. Independent Care members are treated with dignity and respect. We take pride in the diversity of our membership and consider cultural specific concerns when rendering services.

Independent Care contracts with providers interested and committed to serving individuals with special needs. We work hard to support our providers by sharing important information about iCare members and helping them follow through with intended treatment plans.
INTEGRATED CARE MANAGEMENT MODEL

Through the efforts of integrated care management, iCare’s Medicare and iCare Medicaid SSI BadgerCare and Partnership seek to:

- Improve healthcare access
- Improve health outcomes and quality of life
- Improve communication
- Manage healthcare costs

Independent Care acts as a partner to complement the efforts of its physicians, hospitals, and ancillary providers to achieve these goals.

Independent Care’s Management process consists of the following components:

- Assessment
- Care Planning
- Implementation of Care Plan
- Coordination of Services
- Collaboration with members and providers
- Education
- Monitoring of needs
- Evaluation of plan
- Documentation

Care Coordinators (CC), Care Managers (CM) and RN Case Managers (RNCM) assist iCare Medicare SNP, Medicaid SSI and Partnership members to meet their medical, behavioral health and social needs. They also work with hospital providers and physicians to assist in the discharge planning process to provide a smooth transition of care from one setting to the next.

When iCare is informed that your patient is experiencing a planned or unplanned transition in their care setting, we will contact you, and ask that you send a care plan consisting of any information that may assist in the members care in that setting. “Care Plan” is specifically defined by CMS as: a set of information about the patient that facilitates communication, collaboration and continuity of care across settings when a member experiences a transition. The care plan may contain, but is not limited to both medical and non-medical information, i.e. current problem list, medication regimen, allergies, advance directives, baseline physical and cognitive function, contact information for all professional care providers or practitioners and informal care providers. The care settings referred to include: home, inpatient hospital, home health care, acute care, skilled nursing facility, residential care and rehabilitation facility.

MEDICAL MANAGEMENT

Through iCare’s integrated process of Care Coordination and Case Management, iCare believes members receive quality, cost effective medical care. Through the Medical Management Department, iCare provides the following for the Badger Care members:

- Prior authorization
- Specialty referrals
- Discharge planning
- Disease management programs

Updated: 10/01/2014
Inpatient Admission Notification

Independent Care requires that all hospitals notify iCare by phone or fax within 24 hours of an admission (emergent or elective) or on the next business day. (See Exhibit 1 – Inpatient Admission Notification Form). This notification allows iCare to initiate early discharge planning.

iCare is also notified of Skilled Nursing Facility admissions. (See Exhibit 2 – Nursing Home/Facility Prior Authorization Form)

GENERAL INFORMATION
MAIN NUMBER
414-223-4847 or 800-777-4376

Please see individual department phone and fax numbers, below.

Behavioral Health and AODA Services
Phone: 1-855-893-0476
Fax: 414-231-1075

Claims/Appeals/Reconsiderations
Local: 414-231-1029
Fax: 414-231-1094
Out of Area: 877-333-6820

Eligibility and Provider Services
Local: 414-231-1029
Fax: 414-231-1094
Out of Area: 877-333-6820

Inpatient Admissions Notification
414-225-4760
Fax: 414-231-1075

Member Advocate
414-231-1076
Fax: 414-231-1090

Pharmacy
414-223-4847
Fax: 414-231-1092

Prior Authorization & Referrals
Fax: 414-231-1026

Provider Contracting
414-225-4741
Fax: 414-272-5618

Provider Services and Eligibility
Local: 414-231-1029
Fax: 414-231-1094
Out of Area: 877-333-6820
ELIGIBILITY

iCARE MEDICAID PLAN ELIGIBILITY CRITERIA

To enroll in the iCare Medicaid Program, SSI or Badger Care Standard the recipient must:

Be a resident of one of these Wisconsin counties

<table>
<thead>
<tr>
<th>Brown</th>
<th>Manitowoc</th>
<th>Shawno</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calumet</td>
<td>Marinette</td>
<td>Sheboygan</td>
</tr>
<tr>
<td>Dane*</td>
<td>Milwaukee</td>
<td>Walworth</td>
</tr>
<tr>
<td>Dodge</td>
<td>Onconto</td>
<td>Washington</td>
</tr>
<tr>
<td>Fond du Lac</td>
<td>Outagamie</td>
<td>Waukesha</td>
</tr>
<tr>
<td>Jefferson</td>
<td>Ozaukee</td>
<td>Waupaca</td>
</tr>
<tr>
<td>Kenosha</td>
<td>Racine</td>
<td>Winnebago</td>
</tr>
<tr>
<td>Kewaunee</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Meet the Supplemental Security Income (SSI) and SSI-related disability criteria as defined by the State of Wisconsin Medicaid program. Or
- Meet the Badger Care eligibility criteria established by the State of Wisconsin.
- Be living in the community
  - Not living in an institution
  - Not living in a nursing home
  - Not participating in a Home and Community Based (HCBW) Waiver program.

It is imperative the provider verifies eligibility each time services are provided. For various reasons, T-19/Medicaid eligibility can change at any time.

Eligibility is administered by the State of Wisconsin and requires the following:
- Only certified Wisconsin Member Assistance (MA) providers are allowed to provide services to iCare Medicaid and BadgerCare members.
- New Medicaid/Badger Care members are issued a ForwardHealth ID card (see below).
- The front of the cards display the recipient name, recipient Medicaid ID number and a unique 16-digit card number.
- The ForwardHealth cards offer providers an immediate and real-time eligibility Medicaid date and iCare designation when used with a point of service device or special computer software allowing access to the new eligibility verification system (EVS).
  - Providers may also verify a member’s Medicaid eligibility status by calling **800-947-9627**.
Medicaid ForwardHealth ID Card

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

To be eligible for the iCare Medicare Plan, the enrollee must meet the following criteria:

- Must live in iCare’s service area which includes the following counties:
  - Brown
  - Calumet
  - Dane
  - Kenosha
  - Kewaunee
  - Manitowoc
  - Menominee
  - Milwaukee
  - Oconto
  - Outagamie
  - Ozaukee
  - Racine
  - Shawano
  - Sheboygan
  - Walworth
  - Washington
  - Waukesha
  - Waupaca
  - Winnebago
- Must have Medicare Part A and B
- Cannot have End-Stage Renal Disease (some exceptions may apply).
- Must be dual eligible with Medicaid and Medicare coverage
  - The Medicaid coverage can be Fee for Service or any other Medicaid coverage including iCare.

iCare Medicare ID Card

1. Member Name
2. iCare Medicare Member Identification Number
3. RxBin: Number
4. RxPCN: Number
5. iCare Medicare Member Services Telephone Number
6. iCare’s claims address
iCARE MEDICAID/BADGERCARE BENEFITS

MEDICAL ASSISTANCE BENEFITS

- The iCare Program provides the same medically necessary services as the Wisconsin Medical Assistance Program (WMAP) other than chiropractic care which is covered under the Fee for Service (FFS) program.
- iCare may go beyond WMAP services if it is warranted by the member’s health condition.
- Refer to the Wisconsin Medical Assistance Program (WMAP) handbook for specific details of covered benefits.
  - The handbook is found on the Internet on the State of Wisconsin Medicaid website: http://dhs.wisconsin.gov/medicaid/INDEX.HTM

- Certified Wisconsin MA providers are required to provide services to all iCare members who present a valid Forward card issued by the State.

MEDICAID GENERAL SERVICES

iCare provides medically necessary Medicaid covered benefits through an approved provider when arranged through a Care Coordinator or Case Manager, with the exception of chiropractic services which are covered by the State of Wisconsin Medicaid Fee for Service Program. Some of the included Medicaid services are:

Physician
- Office and hospital visits
- Out-of-area routine care (referral required)
- Specialists (referral required only for Oral Surgery and Plastic Surgery)

General Hospital
- Inpatient
- Outpatient

Dental
- Emergency, preventive, restorative, endodontic, periodontics, removable prosthodontics, oral surgery

Vision
- Preventive (annual vision exam)
- Eyewear
  - Routine Physical and HealthCheck Exams
  - Yearly and periodic check-ups
  - HealthCheck exams and related services

Emergency/Urgent Care

Hearing Exams/Hearing Aids

Updated: 10/01/2014
Mental Health/Substance Abuse
- Inpatient/Outpatient

Nursing Home
- The first 90 days are covered

Vehicle Services
- Ambulance services for emergencies; (ambulance service for non-emergencies requires a Physician Certification Statement for Ambulance Transport)
- Specialized medical vehicles for medically necessary services
- Common carrier transport for medically necessary services Durable

Medical Equipment and Medical Supplies

Respiratory and Infusion Services

Home Health Services [Skilled Nursing and Personal Care Worker (PCW) services] Therapy
(Physical, Occupational, Speech, Cardiac and Pulmonary)

**LONG-TERM CARE**

When medically necessary, iCare Medicaid covers long-term care placement for up to 90 days. Nursing homes are responsible for notifying iCare of potential admissions to long-term care. (See Exhibit 2 – Nursing Home/Facility Prior Authorization Form) If an iCare member requires long-term care, he/she is automatically disenrolled from iCare after 90 days and continues Medicaid coverage with a Medicaid Fee for Service status. The facility is also obligated to notify the Social Security Administration (SSA) office that a member is in long-term care.

**ORGAN TRANSPLANTS**

iCare Medicaid covers kidney and cornea transplants only.

If an iCare member requires any other type of transplant the procedure must be preauthorized through the State of Wisconsin Medicaid Fee for Service (FFS) program. At the time of the transplant, the member is disenrolled from iCare Medicaid and reverts to the Medicaid FFS status effective the first of the month in which the transplant occurred.

**EMERGENCY SERVICES**

An emergency medical condition is defined by the State of Wisconsin as: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention could reasonably be expected to result in:

A. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy

B. Serious impairment of bodily functions; or

C. Serious dysfunction of any bodily organ or part; or
D. With respect to a pregnant woman who is in active labor:
   1. Where there is inadequate time to effect a safe transfer to another hospital before delivery; or
   2. When a transfer may pose a threat to the health or safety of the woman or the unborn child
E. A psychiatric emergency involving a significant risk of serious harm to oneself or others.
F. A substance abuse emergency because there is significant harm to the enrollee or others, or there is likelihood of return to drug abuse without immediate treatment.
G. An emergency dental care situation which is defined as immediate service needed to relieve the patient from pain, an acute infection, swelling, trismus, fever, or trauma. In all emergency situations, the provider must document in the recipient’s dental records the nature of the emergency.

URGENT CARE SERVICES

- An urgent medical situation is one that may require medical care but does not satisfy the emergency criteria.
- When in the area, members may contact their physician before requesting urgent care.
- If out-of-area urgent care services are required, the member notifies his or her Care Coordinator (CC) or Care Manager (CM) within 24 hours of receiving the services at: o 414-223-4847
  o 800-777-4376
  o TTY 800-947-3529/Voice 800-947-6444

OUT OF AREA SERVICES

If an emergency occurs outside the member’s service area, the following procedures should be followed:
- For emergency and urgent care, the member should go to the nearest hospital.
- iCare is to be notified within 24 hours of receiving the service.

For iCare Medicare and iCare Medicaid, routine services performed out of the service area are subject to the Independent Care Health Plan pre-authorization rules and guidelines. Authorization rules and guidelines may be obtained by calling 414-223-4847.
iCARE MEDICARE PLAN BENEFITS

Services covered by the iCare Medicare plan include: Inpatient Care
- Inpatient Hospital Care
- Inpatient Mental Health Care (up to 190 days in a Psychiatric Hospital in a lifetime)
- Skilled Nursing Facility (100 days are covered for each benefit period)
- Intermediate Care Facility
- Hospice (by a Medicare-certified Hospice)
- Home Health Care

Outpatient Care
- Annual Wellness Visit (for Medicare-covered benefits)
- Doctor Office Visits (for Medicare-covered benefits)
- Chiropractic Services (for Medicare-covered benefits)
- Podiatry Services (for Medicare-covered benefits)
- Outpatient Mental Health Care (for Medicare-covered benefits)
- Outpatient Substance Abuse Care (for Medicare-covered benefits)
- Outpatient Services/Surgery (for Medicare-covered benefits)
- Crisis Intervention Mental Health Services (for Medicare-covered benefits)
- Outpatient Rehabilitation Services (for Medicare-covered benefits)
- Respiratory Care for Ventilator Dependent
- Independent Nursing Services

Emergency and Urgent Care Services
- Emergency Care (for Medicare-covered Emergency Room visits)
- Urgently Needed Care (for Medicare-covered Urgently Needed Care visits)
- Ambulance Services (for Medicare-covered Ambulance services)

Outpatient Medical Services and Supplies
- Durable Medical Equipment (for Medicare-covered items)
- Prosthetic Devices (for Medicare-covered items)
- Diabetes Self-Monitoring Training and Supplies
- Diagnostic Tests, X-Rays, and Lab Services (for Medicare-covered services)

Preventive Services
- Bone Mass Measurement (for Medicare-covered Bone Mass Measurement)
- Colorectal Screening Exams (for Medicare-covered Colorectal Screenings)
- Immunizations
- Mammograms (for Medicare-covered screening Mammograms)
- Pap Smears and Pelvic Exams (for Medicare-covered Pap Smears and Pelvic Exams)
- Prostate Cancer Screening Exams (for Medicare-covered Prostate Cancer Screening)
- Family Planning Services

Outpatient Prescription Drugs
Additional Benefits

- Routine Physical Exams (for Medicare-covered benefits) Routine exams not covered
- Dental Services (for Medicare-covered Dental benefits) Preventive Dental not covered
- Hearing Services (routine hearing exams and aids not covered)
- Vision Services (for one pair of eyeglasses or contact lenses after cataract surgery)
HEALTH EDUCATION, PREVENTION AND WELLNESS PROGRAM

The purpose of iCare’s health education program is to improve the health and well-being of members through multi-faceted outreach and education strategies.

iCare has implemented preventive health and promotion programs to assist members to develop healthy lifestyles. These programs are developed to include members’ stages of change, when applicable, and reviewed on an annual basis.

Providers may refer patients into the health education programs. Providers should instruct their patients to contact their Care Coordinator (CC) or Care Manager (CM) at 414-223-4847.

Programs include:
- Tobacco Cessation Program for iCare Medicare, Medicaid, and BadgerCare members
- Flu Immune Program – Influenza and Pneumonia Vaccination Program for iCare Medicare and/or iCare Medicaid SSI and Badger Care members
- HealthCheck for iCare Medicaid members under age 21, includes SSI and Badger Care

TOBACCO CESSATION PROGRAM

- Tobacco use is the most common avoidable cause of illness and death in the U.S.
- Most tobacco users want to quit (70% to 80% in surveys).

iCare has developed a Tobacco Cessation Initiative for all iCare members that currently use tobacco products. Members are routinely screened by staff for tobacco use history and offered tobacco cessation resources. iCare members are referred to programs such as the Wisconsin Tobacco QuitLine, Striving to Quit, and First Breath, a program for pregnant women. The programs offer an array of resources to include smoking cessation counseling, medications, self-help materials and incentives. For those that are not quite ready, the staff will continue to address tobacco use history with subsequent member interactions.

FLU and Pneumococcal Vaccines

iCare has been working with providers to increase availability and accessibility of the influenza (flu) and pneumococcal (pneumonia) vaccines for iCare Medicare or iCare Medicaid members. Each year, eligible iCare members have the opportunity to receive a flu shot or pneumonia vaccine from their physician, or other healthcare professional. iCare encourages physicians and other healthcare professionals to provide these vaccinations to iCare members. Please encourage members to receive these vaccinations during a scheduled visit or encourage the member to call 211 or contact their iCare coordinator for another convenient location to receive these vaccines.

HEALTHCHECK PROGRAM

HealthCheck is a program that is mandated by federal Medicaid law to ensure that children in the State of Wisconsin are receiving periodic, comprehensive health screening exams. Nationally this program is known as the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. The program is intended to promote early detection and treatment of health conditions that could lead to chronic illness and disabilities in children.

Updated: 10/01/2014
The HealthCheck exam includes:
1. Comprehensive health and developmental history
   a. Health history
   b. Nutritional assessment
   c. Health education/anticipatory guidelines
   d. Developmental behavioral assessment
2. Physical assessment
   a. Unclad physical exam and personal growth assessment
   b. Growth assessment
   c. Sexual development
3. Age-appropriate vision screen
4. Age-appropriate hearing screen
5. Oral assessment and evaluation services plus direct referral to a dentist
6. Appropriate immunizations
7. Appropriate laboratory test

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

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Allowable procedure codes</th>
<th>Allowable providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>UA *</td>
<td>Comprehensive HealthCheck screen results in a referral or follow up visit for</td>
<td>99381-99385 and 99391-99395</td>
<td>All HealthCheck providers, including HealthCheck nursing agencies.</td>
</tr>
<tr>
<td></td>
<td>diagnostic or corrective treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EP</td>
<td>Service provided as part of [follow-up to] Medicaid early periodic screening</td>
<td>99211-99215, T1002, T1029, T1017,</td>
<td>HealthCheck nursing agencies only</td>
</tr>
<tr>
<td></td>
<td>diagnosis and treatment (EPSDT) program</td>
<td>and T1016</td>
<td></td>
</tr>
<tr>
<td>TS</td>
<td>Follow-up service [for lead inspection]</td>
<td>T1029</td>
<td>HealthCheck nursing agencies only</td>
</tr>
</tbody>
</table>

* Modifier “UA” is a national modifier that is state defined by Wisconsin Medicaid.
PREVENTIVE HEALTH GUIDELINES

iCare has adopted a set of preventive health guidelines that are recognized in the medical community to help prevent or delay serious health problems. The guidelines chosen are those adopted by the Agency for Healthcare Research Quality (AHRQ) from the U.S. Department of Health and Human Services (HHS). Unless another source is noted, they are evidence-based from the US Preventive Services Task Force (USPSTF) recommendations.

Access the Preventive Health Guidelines per AHRQ using the following link:

http://www.ahrq.gov/clinic/pocketgd/index.html

For immunizations iCare has chosen the Immunization Recommendations approved by the CDC, the American Academy of Family Practitioners (AAFP), the American College of Obstetricians and Gynecologists (ACOG), the American College of Physicians (ACP) and the American Academy of Pediatrics (AAP).

Included in the Recommendations are the following immunization schedules:

- Recommended Immunization Schedule for Persons Aged 0-6 Years
- Recommended Immunization Schedule for Persons Aged 7-18 Years
- Catch-up Immunization Schedule for Persons Aged 4 Months-18 Years who start late or who are more than 1 month behind
- Recommended Adult Immunization Schedule

PRENATAL CARE COORDINATION

Prenatal Care Coordination is available to assist high-risk recipients and their families to access medical, social, educational and other services related to pregnancy. The services are offered during the pregnancy and through the first 60 days following delivery.

Prenatal Care Coordination is available to iCare Medicaid and BadgerCare members directly from the Wisconsin Medicaid Fee for Service program. iCare assists in the coordination of transportation and needed services. All claims should be submitted to Wisconsin Medicaid and recipient eligibility should be verified prior to delivering any services.

Prenatal Care Coordination services include:

- Outreach
- Initial assessment
- Care plan development
- Ongoing care coordination and monitoring
- Health education and nutrition counseling services

Updated: 10/01/2014
How iCare Medicaid helps:

- iCare member services will provide the MTM phone number for transportation services to and from medical visits.
- The iCare member’s Care Coordinator (CC) or Care Manager (CM) works with the Prenatal Care Coordination staff to help coordinate needed services.
- For questions or assistance, contact the member’s Care Coordinator at (414) 223-4847.

**CUSTOMER SERVICE**

**TRANSPORTATION**

Transportation for Medicaid-covered services and iCare-sponsored programs is provided for iCare Medicaid and BadgerCare members. Transportation is covered for services deemed medically necessary as part of the care plan, supported by the prescribing physician and recommended by the iCare multidisciplinary team. Transportation can be in the form of bus, taxi or van service. When a member needs assistance in obtaining transportation to a medical appointment, they must call Medical Transportation Management, Inc. (MTM) before the transport takes place. Most Medicaid and BadgerCare members may receive non-emergency medical transportation services through MTM, Inc., if they have no other way to arrange a ride. The number is 1-866-907-1494.

MTM requires a Level of Need (LON) form from providers. The member will bring the form to the provider’s office for completion, or an iCare staff member might call the provider to make an “urgent” ride arrangement.

When a Family Care Partnership member needs transportation, they may call iCare at 414-223-4847 or 1-800-777-4376 for assistance.

**Specialized Motor Vehicle (SMV)**

- SMV requires a physician certification which identifies medical necessity. Certification is required for recipients who are legally blind or disabled to the extent that they cannot safely use private vehicles or mass transit services.
- The iCare Member Services Department verbally authorizes SMV transportation with the individual SMV provider.
- Members may not use SMV transportation to pick up prescription medication unless it’s on the way to or way home from an approved SMV appointment.
- Most SMV companies are unable to manage same day rides.
- All SMV procedure codes require the use of a trip modifier. Providers will find the modifiers and the descriptions of the modifiers in Topic #1815 on the ForwardHealth website for T-19.
AMBULANCE SERVICES

Ambulance services are used primarily in emergency situations. In cases of an emergency, it is recommended to call 911. Any other requests, other than emergencies, would require a Physician Certification Statement for Ambulance Transport. Submit the Physician Certification Statement with the claim for Medicaid and BadgerCare members. For additional information on Medicaid and BadgerCare members go to www.ForwardHealth.wi.gov under Handbooks select Ambulance. Chapter 3 includes covered and noncovered services.

Ambulance providers bill the Transportation HMO, which is MTM for Medicaid, and BadgerCare and the member cannot be billed. However, iCare does process the Medicaid Family Care Partnership non-emergency medical transport (NEMT) claims.

The Medicare program does not cover transportation services unless it is an inpatient stay and the patient requires an ambulance in order to move safely from one location to another. For example, a patient needs to go to another hospital that will provide a specific test. The cost of the ambulance transport is bundled into the service(s) the patient needed.

When an ambulance is medically necessary, Medicare will cover the service based criteria and on medical necessity. For details regarding ambulance services for Medicare members see the CMS IOM Claims Processing Manual, 100-04 Chapter 15 at https://www.cms.gov/manuals

TRANSLATION REQUEST

iCare will work with the provider and the Interpreter/Translator Agency to make sure the member’s rights are met during their appointment. When required, a provider makes their request for an interpreter to iCare. For an American Sign Language interpreter the agency needs 5-7 business days prior to the appointment to make arrangements. For other languages, the agency asks for at least 3 business days. Contact Customer Service at 414-223-4847 or toll free at 1-800-777-4376.

Healthcare Provider Role

After a provider determines that an interpreter is needed for an iCare member, the following steps are taken:

1. Send a request for assistance to the Customer Service Mailbox at callcen@icare-wi.org include the following:
   a. Name of member
   b. Medicaid ID number
   c. Date of appointment/Length of time
   d. Provider name and phone number
   e. Contact name of person at the provider. Once an interpreter is available for the appointment, the contact person will receive the information from customer service.

2. If an interpreter is not available the provider’s office will be notified via phone or e-mail.

3. If there is a cancellation of service, please provide more than a 24 hour notice to iCare.

Updated: 10/01/2014
Interpretation Agency Role

1. iCare contacts a contracted agency for an available interpreter.
2. The agency provides the name of the person that will be at the appointment.
3. iCare sends the Translator/Interpreter Payment Form to the agency.
   a. The interpreter takes the form to the appointment.
   b. The form must be completed and signed by the interpreter, hospital/clinic staff, and the hospital/clinic staff must print their name before a payment is made.
   c. The agency submits the invoice(s) and the payment form to iCare for payment. The address is:

   Independent Care Health Plan
   Attention: Accounts Payable
   1555 N. RiverCenter Dr. Suite 206
   Milwaukee, WI 53212
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

All Inpatient Mental Health and Alcohol or Other Drug Abuse (AODA) treatment services require prior authorization. Authorizations for most office based outpatient services are not required. However, we do require a form for notification of treatment and services for coordination of care and care management requirements for this level of service. See Exhibit 1 for Inpatient Admission Notification Form.

For Behavioral Health and AODA services, providers should call iCare at:

1-855-893-0476

Behavioral Health services that require prior notification or authorization include:

- Inpatient hospitalization
- Partial hospitalization
- Intensive outpatient program
- Psychological testing greater than 4 hours
- In-home treatment
- Community Day Treatment
- Crisis Stabilization

Prior authorization and outpatient notification forms are available on the iCare provider website at http://www.icare-wi.org/providers/forms.aspx and can be obtained from an iCare behavioral health staff member.

Outpatient Mental Health- Procedure Codes

CPT codes are required on all outpatient mental health claims submitted on the CMS 1500 Health Insurance Claim Form. Claims or adjustments received without a CPT code are rejected.

For procedure codes that do not indicate a time increment, providers are required to use the rounding guidelines per the Common Procedural Terminology (CPT) Manual.

The ForwardHealth website lists the applicable CPT codes and modifiers for mental health services. Go to https://www.forwardhealth.wi.gov/WIPortal/Default.aspx and login with an ID and password to view the material. Providers may create an ID and password at any time.

Substance Abuse Treatment-HCPCS and CPT Codes

HCPCS and CPT codes are required on all outpatient substance abuse treatment claims submitted on the CMS 1500 Health Insurance Claim Form. Claims or corrected claims received without an HCPCS or CPT code are denied.
For procedure codes that do not indicate a time increment, providers are required to use the rounding guidelines per the most current CPT manual. Providers may find codes and applicable modifiers at [https://www.forwardhealth.wi.gov/WIPortal/Default.aspx](https://www.forwardhealth.wi.gov/WIPortal/Default.aspx). For providers that submit claims on the CMS 1500 form below are procedures for psychiatric diagnostic or evaluative interview services.

Assessment services are limited to eight hours every rolling 12 months per member before PA is required under DHS 107.13(2)©4, Wisc. Admin. Code for the following services:

- Outpatient mental health benefits (procedure codes 90791 and 90792).
- Outpatient substance abuse treatment services (procedure codes 90791 and 90792).
- Adult mental health day treatment (procedure code H2012 with modifiers “HE” (mental health program) and “U6” (functional assessment)).
- Substance abuse day treatment (procedure code H2012 with modifiers “HF” (substance abuse program) and “U6” (assessment)).

### PHARMACY SERVICES

#### GENERAL PHARMACY BENEFITS FOR iCARE MEDICAID

WI Medicaid Fee-for-Service (FFS) administers the pharmacy benefit for members enrolled in iCare Medicaid SSI and Badger Care. Please contact WI Medicaid FFS for information regarding the coverage of medications for these members.

#### GENERAL PHARMACY BENEFITS FOR iCARE MEDICARE

1. Prescription drug claims are administered through MedImpact Healthcare Systems, Inc. Point of Service on-line prescription processing is preferred. Pharmacies are expected to process claims at the time of dispensing. Claims exceeding 90 days from the date of dispensing are rejected by the on-line processing system.

2. Most prescription claims exceeding $900 are reviewed for accurate submission. Compounded prescription claims exceeding $50 are also reviewed for accurate pricing and submission. Compounded prescriptions must contain at least one Part D covered drug to qualify for coverage. Pharmacies should call MedImpact at **1-800-910-4743** for assistance with claims exceeding these amounts.

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

4. Prior Authorizations for the iCare Medicare Pharmacy Benefit are processed by MedImpact. Providers may call MedImpact for additional information or to request a Medicare Part D Coverage Determination Request Form at **1-800-910-4743**.

5. For questions regarding eligibility and benefit coverage the iCare Pharmacy Services help-line is available:
   - **Monday through Friday from 8:30 am to 5:00 pm**
   - Call **414-223-4847** or **1-800-777-4376**

Updated: 10/01/2014
If calling outside normal business hours, the iCare Pharmacy Services help-line is automatically forwarded to MedImpact for assistance.

DRUGS COVERED BY iCARE MEDICARE

iCare Medicare utilizes a formulary approved by CMS which includes both brand and generic Part D medications. The formulary may change slightly during the year as new drugs become available or new information is released regarding a drug’s safety or efficacy.

Access the most current list of iCare Medicare covered drugs on the iCare website using the following link: http://www.icare-wi.org/providers/

In most cases, CMS requires that we notify all authorized prescribers and pharmacists 60 days prior to removing a covered Part D drug from our formulary or changing the preferred status of a covered Part D drug. You may access our 60 Day Notice of Formulary Changes on our website.

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

- **Prior Authorization (PA):** A prior authorization is required on certain drugs before they are covered. A Medicare Part D Coverage Determination Request Form (See Exhibit 10 – Medicare D Coverage Determination Request Form) can be faxed to MedImpact at 858-790-7100.

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

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

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

EXCEPTIONS TO iCARE MEDICARE COVERAGE LIMITS

When the medications on the iCare formulary used to treat a specific condition are not appropriate for a member, the provider may request coverage of a non-formulary Part D medication. This type of request is called a Formulary Exception. An exception may also be requested to the Step Therapy or Quantity Limit Restrictions. A Medicare Part D Coverage Determination Request Form (See Exhibit 10 – Medicare D Coverage Determination Request Form) can be faxed to MedImpact at 858-790-7100. Supporting medical information must be submitted with any exception request.

Standard Coverage Determinations are completed within 72 hours. If waiting the standard time frame may seriously harm the health of the member or their ability to function, request an Expedited Coverage Determination. Expedited Coverage Determinations are completed within 24 hours.

Updated: 10/01/2014
iCARE MEDICARE TRANSITION POLICY

New members to the iCare plan may be taking medications that are not on the iCare formulary or that are subject to certain restrictions such as Prior Authorization or Step Therapy. During the first 90 days of enrollment with iCare Medicare, we provide a temporary 30 day supply of a Part D medication to allow the member time to talk with the prescribing physician regarding the right course of action. You can either switch your patient to a different drug covered by our plan or ask us to make an exception and cover the current drug.

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

For current enrollees affected by formulary changes from one coverage year to the next, iCare provides a transition process consistent with the transition process required for new enrollees beginning in the new contract year. The transition process applies to both drugs that are removed from our formulary from one contract year to the next, as well as to formulary drugs that remain on formulary but to which a new prior authorization or step therapy restriction is added from one contract year to the next.

After covering the temporary supply, iCare generally does not cover these medications again without a Prior Authorization. For more detailed information, please see the iCare Transition Process at http://www.icare-wi.org/

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

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

iCARE MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM

The Centers for Medicaid and Medicare Services (CMS) requires each Medicare plan that offers prescription drug coverage to have a Medication Therapy Program (MTM). At the request of CMS, the program targets members who have multiple chronic diseases, are taking multiple Part D covered drugs, and have high drug costs. CMS hopes these programs will help ensure optimum therapeutic outcomes for the targeted members through improved medication use and reduction in adverse medication events. iCare Medicare partners with Outcomes Pharmaceutical Health Care (“Outcomes”), the national leader in MTM services, to administer our MTM program.

“Outcomes” has an established network of specially trained personal pharmacists to provide MTM services for all of our Medicare members. As part of the iCare MTM program, each MTM-eligible member is invited to participate in an annual face-to-face consultation with a personal pharmacist to review and organize the

Updated: 10/01/2014

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member’s medication usage and identify, resolve, and/or prevent medication-related problems. In addition, “Outcomes” also conducts retrospective analysis of prescription claims data to identify potential MTM interventions. Any possible interventions identified are sent to a network pharmacist with instructions and supporting documentation. “Outcomes” calls this the Targeted Intervention Program or “TIPs”. TIPs generally focus on issues such as formulary, use of potentially inappropriate meds in the elderly, therapeutic duplication, and compliance. Issues identified during the complete medication review, as well as many of the TIPs, might require the pharmacist to contact the prescriber for resolution.

The disease states and number of Part D medications targeted by the program may change from year to year. If there are questions regarding the iCare MTM Program, including whether or not a patient is involved with the iCare program, please call iCare Pharmacy Services at 414-223-4847.

Codes and Procedures Requiring Notification or Prior Authorization

Admission Notification

As part of our commitment to medical management, Independent Care requires that all hospitals notify iCare by fax within 24 hours of an admission (emergent or elective) or on the next business day. (See Exhibit 1 – Inpatient Admission Notification Form).

*Prior Authorization of Skilled Nursing Home Days; Prior authorization is required by iCare for approval of Skilled Nursing Facility days.*
(See Exhibit 2 – Nursing Home/Facility Prior Authorization Form)

Prior Authorization and Specialty Referrals Effective 11/1/2014

Prior authorization and specialty referral requirements have been revised to create efficiencies for both iCare and the providers. This list includes specific procedure codes to eliminate any confusion. The information regarding benefit coverage is for convenience only. iCare’s goal is to work with providers to provide quality care for members. Upon receipt of all required information, urgent prior authorization requests are processed within two (2) business days and fourteen (14) days for all other service and procedure authorizations. A home health agency has 7 days from start of services to submit a PA request for new services. A modification to a PA must be received before the end of the certification period, and continuation of services must be submitted before the end of the certification period. (14 days prior to end of certification period). An *MD signature is required* on every PA request for continuation of services. iCare is conducting 100% in home assessments of PCW services and authorizations will not be approved without a current assessment.

The following is iCare’s Prior Procedure Specific Listing:
- [iCare Prior List (Spreadsheet)](iCare Prior List (PDF))
- [iCare Prior List (PDF)](iCare Prior List (PDF))

Updated: 10/01/2014
Prior Authorization Requirements for Outpatient Therapy

The following iCare forms are used for the prior authorization and referral requests:

- General Prior Authorization Form – See Exhibit 3
- Home Health/PCW Prior Authorization Request Form – See Exhibit 4
- Physician Referral Form – See Exhibit 5
- Therapy Authorization Request Form – See Exhibit 6
- Hospice Prior Authorization Request Form – See Exhibit 7

The following information includes further instructions regarding authorization and/or documentation for specific situations:

ABORTION

When submitting an iCare Medicare or iCare Medicaid claim for reimbursement of an abortion, according to State Medicaid regulations a physician must attach a written certification statement, Form HCF 1161, attesting to one of the circumstances listed below.

In the case of rape or incest, the physician’s claim must include evidence that the crime was reported to law enforcement authorities.

- The abortion is directly and medically necessary to save the life of the woman, provided that prior to the abortion the physician attests, based on his or her best clinical judgment, that the abortion meets this condition by signing a certification.
- In a case of sexual assault or incest, provided that prior to the abortion the physician attests to his or her belief that sexual assault or incest has occurred, by signing a written certification and provided that the crime has been reported to the laws 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, based on his or her best clinical judgment, that the abortion meets this condition by signing a certification.

HYSTERECTOMY

Except in the situations noted below, an Acknowledgement of Receipt of Hysterectomy Information, Form HCF 1160, must be completed prior to the surgery and attached to a paper claim form. Use the following link to access the fillable and printable form:

http://dhs.wisconsin.gov/forms/F0/F01160.doc

Providers may develop their own form as long as it includes all of the same information as found on Wisconsin Medicaid’s form.

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

- The recipient was already sterile. This may include menopause. (The physician is required to state the cause of sterility in the recipient’s medical record.)
- The hysterectomy was required as the result of a life-threatening emergency situation, in which the physician determined that a prior acknowledgement of receipt of hysterectomy information was not possible. (The physician is required to describe the nature of the emergency.)

Updated: 10/01/2014
• The hysterectomy was performed during a period of retroactive recipient eligibility and one of the following circumstances applied:
  1) The recipient was informed before the surgery that the procedure would make her permanently incapable of reproducing.
  2) The recipient was already sterile.
  3) The recipient was in a life-threatening emergency situation which required a hysterectomy.

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

iCare Medicaid does not cover a hysterectomy for the following:
• Uncomplicated fibroids
• Fallen uterus
• Retroverted uterus
• Purpose of sterilization

STERILIZATION

iCare reimbursement for sterilizations is dependent on providers fulfilling all Federal and State requirements cited below and satisfactory completion of a Sterilization Informed Consent form, Form HCF 1164.

Use the following link to access instructions and the form:

http://dhs.wisconsin.gov/forms/F0/F01164A.pdf

Use the following link to access the fillable and printable form:

http://dhs.wisconsin.gov/forms/F0/F01164.doc

There are no exceptions. Federal and state regulations require the following:
• The recipient is not institutionalized.
• The recipient is at least 21-years-old on the date the informed written consent is obtained.
• The recipient gives voluntary informed written consent for sterilization.

• The recipient is not mentally incompetent. Wisconsin Medicaid defines a “mentally incompetent” individual as a person who is declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purposes, unless the individual has been declared competent for purposes that include the ability to consent to sterilization.
• At least 30 days, excluding the consent and surgery dates, but not more than 180 days, must pass between the date of written consent and the sterilization date, except in the case of premature delivery or emergency abdominal surgery if:
  o In the case of premature delivery, the sterilization is performed at the time of premature delivery and written informed consent was given at least 30 days before the expected end date of delivery and at least 72 hours before the premature delivery. The 30 days excludes the consent and surgery dates.
  o The sterilization is performed during emergency abdominal surgery and at least 72 hours have passed since the recipient gave written informed consent for sterilization.
**Sterilization Consent Form**

- The recipient must give voluntary written consent on the federally required Sterilization Informed Consent Form.
- Sterilization coverage requires accurate and thorough completion of the consent form.
- The physician is responsible for obtaining consent. Any corrections to the form, once completed, must be signed by the physician and/or recipient, as appropriate.
- Signatures and signature dates of the recipient, physician, and the person obtaining the consent are mandatory. Providers’ failure to comply with any of the sterilization requirements results in denial of the sterilization claims.
- To ensure reimbursement for sterilizations, providers are urged to use the Sterilization Informed Consent Form before all sterilizations (i.e., Medicaid and non-Medicaid recipients) in the event that the patient obtains Medicaid retroactive eligibility.
- Physicians must attach the completed consent form to a paper claim form to obtain reimbursement. Since an attachment is necessary, this claim cannot be submitted electronically.

**HIV**

As part of the Medicaid state reporting requirements, iCare requires physicians to supply written information regarding an iCare member’s HIV status and treatment. iCare sends a letter to the physician requesting initial HIV information on an iCare member. Information requested includes:

- Date of diagnosis (if known)
- Date treatment began
- Is the member still taking medication?

iCare needs a signature from the physician within two weeks of the letter. This information is required by the State of Wisconsin and iCare and the physician must comply with the request according to the Medicaid reporting regulations.

**CONCURRENT REVIEW**

iCare’s RN Case Managers (RNCMs) conduct concurrent review of inpatient stays on a regular basis either by telephone or onsite visits. iCare RNCMs work closely with the hospital discharge planners in transitioning member care, as appropriate.

Concurrent review is the process of obtaining information from providers and facilities to determine the level of care required to meet the member’s needs and to identify Case Management opportunities that focus on discharge planning. Inpatient utilization review is generally limited to nursing homes, questionable admissions and DRG outlier lengths of stay.

**DISCHARGE PLANNING**

Discharge planning is a multidisciplinary process to facilitate a member’s transition between healthcare settings. Discharge planning promotes the appropriate level of care and services needed to foster as much independence as possible. The medical RNCM performs discharge planning for all acute hospitalizations.

Updated: 10/01/2014
and follows members in nursing homes for discharge needs.

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

**DISEASE MANAGEMENT PROGRAM**

Disease management involves education to change patient behaviors related to a defined condition and coordinates care among all providers along the health care continuum. It involves identifying individuals who are at risk for chronic disease and assisting them to manage their care to avoid or delay onset of acute episodes.

**QUALITY IMPROVEMENT**

Independent Care Health Plan is committed to the Centers for Medicare and Medicaid standards through HEDIS (Healthcare Effectiveness Data and Information Set), CAPHS (Consumer Assessment of Health Providers and Systems), and HOS (Health Outcome Survey) and Department of Health Services (DHS) Pay for Performance (P4P) indicators. iCare strives to provide medically necessary health care that is efficient, effective, safe, accessible, accountable and fair. CAPHS and HOS ask members to report on and evaluate their experiences with their healthcare providers. It is important that iCare’s team of professionals along with the provider community, seek to improve the health of our members. It is also important to stay in communication with our members to make sure their needs are met.

Independent Care Health Plan’s Quality Improvement (QI) Program provides structure and processes that enable iCare to carry out its mission and commitment to ongoing improvements to the quality of care and services, availability and access to care, and health status of our members. It is through this commitment of continuous quality improvement that we are able to produce positive health outcomes for our members.

The QI program is integrated throughout iCare’s functional areas with each department accountable for reviewing procedures, systems, quality, cost and outcomes related to their areas of responsibility to ensure that they meet regulatory requirements, achieve business objectives and add value to our members and providers.

**GOALS OF THE QUALITY IMPROVEMENT PROGRAM:**

- Develop and maintain an integrated QI Program that provides structure for promoting and achieving excellence in all areas through continuous quality improvement.
- Use an ongoing, systematic approach to monitor, evaluate, and improve the quality, appropriateness, availability and accessibility of medical care and services to iCare members.
- Monitor the quality of care and services provided by participating providers, medical groups, organizational providers, and behavioral health providers and delegated entities to iCare members.
- Identify opportunities for improvement of the health status of our members through development and implementation of health promotion, preventive education programs and appropriate referrals.
- Allocate resources necessary to assist in quality improvement initiatives.
QUALITY IMPROVEMENT PROGRAM SCOPE

Includes:
- Member and Provider Satisfaction
- Network Adequacy and Access to Care
- Quality and Safety of Care and Services
- Utilization Management
- Credentialing and Re-credentialing
- Delegation Oversight
- Annual Quality Improvement Studies

CMS FIVE STAR PROGRAM

Background/History

In early 2008, the Centers for Medicare & Medicaid Services (CMS) contracted with the National Committee for Quality Assurance (NCQA) to develop a strategy to evaluate the quality of care provided by SNPs. This strategy relies on a phased approach, beginning with defining and assessing desirable structural characteristics and followed by assessing processes and, eventually, outcomes. The evaluation approach includes several types of assessment.

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

Focus of quality measures

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

iCare’s Commitment to Quality Improvement

iCare is committed to the delivery of quality health care services to its members as measured by HEDIS, CAPHs, HOS, and Pay for Performance. HEDIS measures include measures regarding the completion of prevention and early detection measures as well as chronic disease management measures. CAPHS and HOS ask members to report on and evaluate their experience with their healthcare providers.

iCare’s Quality Improvement Program works diligently with its network of providers to ensure the highest level of quality for our members. Our expectation is that through a collaborative effort outcomes will be continuously met.
ACCESS TO CARE

- Members are encouraged to select a primary care provider for BadgerCare.
- Currently iCare has an open network of medical physicians.
- iCare utilizes the following access standards:
  - Preventive appointments – within 30 days
  - Urgent care – within 24 hours
  - Emergent care – immediate availability
  - Office wait times – within 30 minutes of appointment time
  - After hours coverage/access – 24 hours a day/7 days a week
- iCare utilizes the following dental access guidelines:
  - New patient – within 90 days
  - Routine care – within 90 days
  - Emergent care – within 24-72 hours
- iCare provides interpretation services for members 24 hours a day, 7 days a week. Interpretation information can be found on page 21.
- iCare utilizes the following office wait time standards
  - Office wait times should not exceed 30 minutes after the schedules appointment time.
- Behavioral Health Access:
  - Wait times for routine office visit: 30 days or less
  - Follow up from an inpatient mental health stay: 30 days or less
  - The Behavioral Health line for UM is 1-855-893-0476.
- High Risk Prenatal Care - Wait time for appointments 2 weeks or less
- iCare has a Care Coordinator available for assistance 24 hours a day, 7 days a week. They can be reached at 414-223-4847 or 1-800-777-4376.
- Telephone access standards
  - iCare collects and performs analysis of performance against iCare’s telephone access standards and reports the findings to the QIC and in its annual Quality Improvement Program Evaluation.

CONFIDENTIALITY

iCare complies with State and Federal confidentiality and privacy laws and regulations, including HIPAA.

MEDICAL RECORDS

When iCare requests copies of a member’s medical records for purposes of determining whether benefits are payable (prior authorization requests, claims adjudication, utilization management, or grievances and appeals), iCare will not pay for medical records.

iCare’s Annual Diagnoses Collection and Confirmation Project

As part of iCare’s contract with The Centers for Medicare & Medicaid Services (CMS), it is required to compile and report diagnostic profiles annually. This information must be obtained via a medical record review of individual member diagnoses that were treated or impacted within a claim (calendar) year. iCare has partnered with Cognisight to perform the annual collection of data and confirmation project. Cognisight’s goal is to obtain a “complete diagnostic member profile”, while attempting to minimize

Updated: 10/01/2014
disruptions to your office workflow and staff. CMS will only accept submission of diagnoses when they are listed on an encounter note rather than on an active problem list, signed lab result or consult. This does not imply that a provider’s documentation for the purposes of patient care is not sufficient, only that CMS has specific requirements to recognize existing diagnoses for a patient.

This information is time sensitive and a response is needed as soon as possible.

If you have additional questions, please contact Paul Kesselring, Account Manager, at Cognisight at 877-271-1657 ext. 8087 or Provider Network Development at NetDev@icare-wi.org

GRIEVANCES/APPEALS

- Members may submit verbal and/or written grievances for review and investigation.
- Members are provided an opportunity to appear in person before the Grievance Committee for formal (written) grievances.
- Members can receive assistance from the iCare Member Advocate to file grievances.
- The Member Advocate can be contacted at: (414) 231-1076.

CLAIMS PROCESS OVERVIEW

One of iCare’s main goals is to facilitate the processing of provider claims in an efficient, accurate and timely manner. This section includes guidelines to ensure a payment system that is beneficial to both iCare and its providers.

CLAIM SUBMISSION

iCare claims are processed by The Trizetto Group. The Trizetto Group uses an automated claims processing system. All claims should be submitted on a paper CMS 1500, UB-04 or an electronic equivalent claims form. Each claim must accurately include the information on the tables on the following pages.
### iCare Requirements for Clean Claim (CMS 1500)

<table>
<thead>
<tr>
<th>Box</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Insured’s ID Number</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Patient Name</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Birth Date and Sex</td>
<td>Date of birth must be valid date and not future date</td>
</tr>
<tr>
<td>5</td>
<td>Patient Address</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Patient's or Authorized Person's Signature and Date Signed</td>
<td>Acceptable alternatives: Unable to sign, signature on file, SOF, Computer generated, signature marked with &quot;X&quot;, Authorization of File, Medicare/Medicaid Reclamation Claims, Transportation, Lodging</td>
</tr>
<tr>
<td>21</td>
<td>Diagnosis or Nature of Illness</td>
<td></td>
</tr>
<tr>
<td>24a</td>
<td>Dates of Service</td>
<td>Claim must include one detail line, must be a valid date, From date cannot include a future date, cannot have a date span into the future, cannot span a calendar year</td>
</tr>
<tr>
<td>24b</td>
<td>Place of Service</td>
<td>Must be 2 characters</td>
</tr>
<tr>
<td>24d</td>
<td>Procedures, Services or Supplies</td>
<td>Must be at least 5 characters</td>
</tr>
<tr>
<td>24f</td>
<td>Charges</td>
<td>A negative amount will be neglected</td>
</tr>
<tr>
<td>24g</td>
<td>Days or Units</td>
<td></td>
</tr>
<tr>
<td>24i/j</td>
<td>Taxonomy code and prefix</td>
<td>Must be present here or in Box 33b. Not required for SMV, personal care attendant, Blood bank or Community Care Organization. Prefix of PXC is required for all 5010 electronic submission, for paper submission either ZZ or blank is accepted.</td>
</tr>
<tr>
<td>24J (b)</td>
<td>NPI</td>
<td>Must be 10 numerical characters. Not required for SMV claims billed with POS 41,42,99</td>
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<td>25</td>
<td>Federal Tax ID Number</td>
<td>Must be 9 numerical characters</td>
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<td>28</td>
<td>Total Charge</td>
<td>Total charges must equal the sum of the line charges</td>
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<td>Signature of Physician or Supplier Physician</td>
<td>Not required for SMV claims billed with POS 41,42,99</td>
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<tr>
<td>33</td>
<td>Physician/Provider's Name, Billing Address, Zip Code</td>
<td></td>
</tr>
<tr>
<td>33a</td>
<td>Billing Physician/Provider NPI</td>
<td>Must be 10 numerical characters. Not required for SMV claims billed with POS 41,42,99</td>
</tr>
<tr>
<td>33b</td>
<td>Taxonomy code and prefix</td>
<td>Must be present here or in Box 24i/24j. Not required for SMV, personal care attendant, Blood bank or Community Care Organization. Prefix of PXC is required for all 5010 electronic submission, for paper submission either ZZ or blank is accepted. For electronic submission: Loop Number 2310A-BILLING PROVIDER NAME, Segment PRV, ElementPRV02 =PXC, ElementPRZ03=value populated by taxonomy code</td>
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<tr>
<td>Box</td>
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<td>Comments</td>
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<tr>
<td>-----</td>
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<tr>
<td>1</td>
<td>Provider Name and Address</td>
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<td>Bill Type</td>
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<td>Federal Tax ID</td>
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<td>6</td>
<td>Statement Covers Period</td>
<td>From and Through Dates of Claim</td>
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<td>8b</td>
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<td>9a-e</td>
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<td>Patient Sex</td>
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<td>Admission Date</td>
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<td>Admission Source</td>
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<tr>
<td>17</td>
<td>Discharge Status</td>
<td>Not required for rural health or federally qualified clinics.</td>
</tr>
<tr>
<td>42</td>
<td>Revenue Codes</td>
<td>If Revenue code of 0022, 0023, 0024 is listed in box 42 and there is no entry box on 44, reject claim for RUGS code missing</td>
</tr>
<tr>
<td>44</td>
<td>HCPCS/Rate</td>
<td>Required based on Type of Bill</td>
</tr>
<tr>
<td>45</td>
<td>Service Date</td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>Service Units</td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>Total/Line Item Charges</td>
<td>Negative Amount: Claim will reject for &quot;No Dollar Amount&quot;. Total Charges must equal the sum of the line item charges or claim will reject &quot;Total charge does not match line charge totals&quot;. Total charges with claim with Revenue Codes 0022, 0023, 0024 may be zero.</td>
</tr>
<tr>
<td>49</td>
<td>Unlabeled</td>
<td>Required for ESRD claims. Entry is Y or N</td>
</tr>
<tr>
<td>56</td>
<td>NPI</td>
<td></td>
</tr>
<tr>
<td>57a-57c</td>
<td>Other Provider ID</td>
<td>Required for ESRD claims</td>
</tr>
<tr>
<td>58a</td>
<td>Insured's Name</td>
<td></td>
</tr>
<tr>
<td>59a</td>
<td>Relationship to Uninsured</td>
<td></td>
</tr>
<tr>
<td>60a</td>
<td>Insured Identification Number</td>
<td></td>
</tr>
<tr>
<td>67</td>
<td>Primary Diagnosis Code</td>
<td>Box 67a-67Q other diagnosis code Present on Admission Indicator</td>
</tr>
<tr>
<td>69</td>
<td>Admitting Diagnosis Code</td>
<td>Inpatient claims only</td>
</tr>
<tr>
<td>81a-d</td>
<td>Taxonomy Code</td>
<td>For Electronic Submissions: Loop Number 2000A_BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL, Segment PRV, element PRV02 =PXC, PRV03=value populated</td>
</tr>
</tbody>
</table>

Updated 7/23/14 Date: 8/20/2012
ELECTRONIC CLAIMS SUBMISSION

Electronic Claims Submission offers an opportunity to save time and reduce costs. iCare partners with a leading claims submission provider, Claimsnet.com, to allow electronic claims submission.

- To register with Claimsnet.com for electronic claims submission via the internet, visit the following URL and click “Register:”
  http://www.claimsmatic.com/icare

- Use the special iCare section of the Claimsnet website and avoid paying set-up or submission fees when submitting claims through Claimsnet.com.

- Immediately take advantage of on-line claims submission, real-time error reporting and payer updates.

Submit electronic claims with the National Provider Identifier (NPI) and the tax identification number. To request an electronic remittance (835 file) please submit the request with the provider’s name, tax ID, NPI and the name of the contact person to NetDev@icare-wi.org.

MAILING ADDRESSES

Mail all iCare Medicare and iCare Medicaid paper claims to:

Independent Care Health Plan
P.O. Box 660346
Dallas, TX 75266-0346

For CORRECTED CLAIMS: A “Corrected” claim must include all the correct information, including all correct service lines, that were included in the original claim. Any missing line items are assumed to be deleted as part of the correction. Mark the claim as ‘Corrected Claim’ and include the initial claim number on the claim and mail to:

Independent Care Health Plan
P.O. Box 660346
Dallas, TX 75266-0346

CLAIMS FILING LIMITS

Providers have 60 days from the date of service to submit claims to iCare, unless otherwise stated in the provider’s agreement. Providers are to submit all claims for services rendered where iCare Medicare is primary or iCare Medicaid is primary according to the terms of the contract. Timely filing limits apply to initial claim submissions, resubmissions and corrected claims.

iCare Medicaid secondary claims for the Medicare coinsurance, copayment and deductible amounts from Medicare coverage other than iCare, must be received by whichever is later:

- Within 90 days of the Medicare EOMB date
- Within 365 days of the date of service

All other claims for which iCare Medicare is the secondary payer must be submitted with an EOB from the
primary payer within 365 days from date of service.

Medicare claims submitted beyond the timely filing limits are not eligible for payment and iCare members cannot be billed for the covered services. However, with the denied MEOB, iCare Medicaid can be billed and will cover within the payment limits, the deductible, coinsurance or copayment that would have been covered had the Medicare claim been submitted on time.

Medicare providers will have to submit the secondary claims by paper and include the Medicare MEOB from the other insurance carrier.

Medicaid claims submitted beyond the timely filing limits are not eligible for payment and iCare members cannot be billed for covered services.

**FEE SCHEDULES**

Each provider contract defines the fee schedule used to pay services provided by the contracted provider.

Direct questions regarding fee schedules to iCare Provider Services:
- Monday through Friday, 8:00-5:00
- Local: **414-231-1029**
- Out of Area: **1-877-333-6820**
- Email: providerservices@icare-wi.org

Direct questions regarding contracted rates to your iCare Network Development Representative:
- Monday through Friday 8:30-5:00 by phone or email

In most cases, iCare Medicare pays providers according to the CMS Medicare Fee for Service rates published by CMS at [www.wpsmedicare.com](http://www.wpsmedicare.com) and iCare Medicaid pays providers according to the State of Wisconsin Medicaid Fee for Service rates.

- Changes to the Medicare Fee for Service rates are effective as of the date National Government Services, LLC post the fee schedule changes at www.wpsmedicare.com.
- Changes to the State of Wisconsin Medicaid Fee For Service rates are recognized to be effective as of the date they posted to the State of Wisconsin Forward Health website or for provider specific rate changes, the business day after iCare is notified by the provider.

**CLAIMS EDITING**

iCare uses the McKesson ClaimCheck code auditing software solution. The ClaimCheck code auditing software solution is a clinically based software application used to insure consistent and accurate application of current coding guidelines, contractual requirements and medical policy. Edit rules are based on national guidelines and are widely accepted by the provider community. The categories of edits include:

- National Correct Coding Initiative
- Incidents
- Multiple Surgeons
- Global Surgery
- New Visit
- Age & Gender
• Multiple Evaluation & Management Services

CO-PAYMENTS

*iCare Medicare* members have co-payment requirements for facility emergency room services and medication.

- Medication copayments vary by coverage year.
- Certain *iCare* members may qualify for help from Medicare to pay for their medications (Low income subsidy or LIS).

*iCare Medicaid* SSI and Badger Care members may have co-payments anywhere from $.50 - $3.00, please check the Forward Health website for specific member information.

- Bill chiropractic services, prescription drugs and select OTC drugs directly to the State Medicaid program.
- Payments for these services are made using Medicaid Fee for Service rates.

CHECKING THE STATUS OF A CLAIM

*iCare* has a provider portal available to check on claim status. For access information, please email NetDev@icare-wi.org and request a PIN for the *iCare* portal. A portal user guide is at our website www.icare-wi.org/providers

Alternatively, you may direct calls regarding claim status to *iCare* Customer Services:

- Monday through Friday, 8:30-5:00
- Local: 414-231-1029
- Out of Area: 1-877-333-6820
- Email: providerservices@icare-wi.org

EXPLANATION OF PAYMENT/REMITTANCE

Providers receive an Explanation of Payment (EOP) including each claim submitted to *iCare*. Separate Medicare EOPs and Medicaid EOPs along with separate checks are mailed twice a week for processed Medicare and Medicaid claims.

Direct questions regarding the EOP to *iCare* Provider Services:

- Monday through Friday, 8:30-5:00
- Local: 414-231-1029
- Out of Area: 1-877-333-6820
- Email: providerservices@icare-wi.org

BILLING *iCARE* MEMBERS

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

Updated: 10/01/2014
Any provider who knowingly and willfully bills an enrollee for a Medicaid-covered service shall be guilty of a felony as defined in Section 1128B. (d)(1) [42 U.S.C.1320a-7b] of the Social Security Act.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) is necessary when a member is covered by more than one insurance carrier. With few exceptions, iCare Medicaid is the payer of last resort in most COB circumstances.

In order to process a claim when iCare is not the primary carrier, a complete Explanation of Benefits (EOB) from the primary insurer, including the Medicare EOB (MEOB), must accompany a copy of the original claim.

If the member has both iCare Medicare and iCare Medicaid submit the original claim with the iCare Medicare identification number then both the iCare Medicare and iCare Medicaid claims process. A Medicare EOB is not needed. Refer to the iCare Medicaid Coordination of Benefits with Medicare and Other Insurance processing guidelines below.

iCare Medicaid Coordination of Benefits with Medicare and With Other Insurance

This section contains coordination information about the following services:
1. Outpatient facility services
2. Professional services
3. Inpatient facility services and Skilled Nursing facility services

1. Outpatient Facility Services

Medicare and iCare Medicaid
The coinsurance/copayment amount for outpatient facility services are reimbursed at the lower of:
- The Medicare allowed Or
- The T-19 Published Medicaid Outpatient rate per visit or a specific iCare contracted rate (the Medicaid allowed) minus the Medicare payment amount

In addition the coinsurance/copayment payment amount, when added to the Medicare payment amount cannot exceed either
- The Medicaid allowed amount.
- The Medicare allowed amount.

Because of the above comparison and adjustments iCare Medicaid does not always pay the full Medicare coinsurance/copayment amount.

Then any Medicare deductible amount is added to the above calculated amount for the total iCare Medicaid coordinated payment.
Other Insurance and iCare Medicaid

Outpatient facility services for iCare Medicaid members having other primary insurance are reimbursed at the difference between:

- The T-19 Published Medicaid Outpatient rate per visit or a specific iCare contracted rate And
- The other primary insurance payment

No secondary iCare Medicaid payment is made when the primary insurance payment exceeds the Medicaid allowed.

2. Professional Services

Medicare and iCare Medicaid (SSI and Badger Care)

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

- The Medicare allowed Or
- The Medicaid FFS Fee Schedule or a specific iCare contracted rate (the Medicaid allowed) minus the Medicare payment amount

In addition the coinsurance/copayment amount, when added to the Medicare payment amount cannot exceed either:

- The Medicaid allowed amount
- The Medicare allowed amount

Because of the above comparison and adjustments iCare Medicaid does not always pay the full Medicare coinsurance/copayment amount.

Note the following examples that demonstrate the above calculation and results:

<table>
<thead>
<tr>
<th>iCare Medicaid Reimbursement for Coinsurance or Copayment of Medicare Part B Services</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider billed amount</td>
<td>$120</td>
<td>$120</td>
<td>$120</td>
</tr>
<tr>
<td>Medicare allowed amount</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Medicaid allowed amount</td>
<td>$90</td>
<td>$110</td>
<td>$75</td>
</tr>
<tr>
<td>Medicare payment with $20 coinsurance</td>
<td>$80</td>
<td>$80</td>
<td>$80</td>
</tr>
<tr>
<td>iCare Medicaid payment</td>
<td>$10</td>
<td>$20</td>
<td>$0</td>
</tr>
</tbody>
</table>


Then any Medicare deductible amount is added to the above calculated amount for the total iCare Medicaid coordinated payment.
Other Insurance and iCare Medicaid (SSI and Badger Care)
Professional services for iCare Medicaid members having other primary insurance are reimbursed at the difference between:

- The T-19 FFS Fee Schedule Rate or a specific iCare contracted rate
- The other primary insurance payment

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

3. Inpatient facility services

<table>
<thead>
<tr>
<th>iCare Medicaid Reimbursement for Medicare Part A Covered Inpatient Services Provided to Dual Eligible Members</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Provider’s billed amount</td>
<td>$1200</td>
</tr>
<tr>
<td>Medicare allowed amount</td>
<td>$1000</td>
</tr>
<tr>
<td>Medicaid allowed amount</td>
<td>$1200</td>
</tr>
<tr>
<td>Medicare payment</td>
<td>$1000</td>
</tr>
<tr>
<td><strong>Difference between Medicaid Allowed amount and Medicare-paid amount</strong></td>
<td><strong>$200</strong></td>
</tr>
<tr>
<td>Medicare coinsurance, copayment, and deductible</td>
<td>$0</td>
</tr>
<tr>
<td><strong>iCare Medicaid Payment</strong></td>
<td><strong>$0</strong></td>
</tr>
</tbody>
</table>

Medicare and iCare Medicaid SSI and Badger Care
Inpatient facility services for iCare Medicaid members having Medicare are reimbursed at the applicable years’ Medicare Deductible amount per benefit period.

The benefit period is the way Medicare measures the member’s use of hospital and skilled nursing facilities. A benefit period begins the day the member is admitted to a hospital as inpatient or admitted to a skilled nursing facility. The benefit period ends when the member has not received hospital or skilled nursing care for 60 days in a row. (See **Skilled Nursing Facility** services below.)

Hospital care within the first 60 days of the benefit period is not eligible for additional Medicaid reimbursement, i.e. the deductible paid for the initial benefit period satisfies the iCare Medicaid liability until the next benefit period begins. If the member is discharged from a hospital, and is readmitted within 60 days, no additional Medicare or Medicaid payment will be made.

If the member goes into the hospital after one benefit period has ended (60 days after discharge), a new benefit period begins. The inpatient hospital deductible is paid for each benefit period, subject to the State’s lesser of logic. There is no limit to the number of benefit periods the member can have.

For each benefit period, iCare Medicaid pays:

Updated: 10/01/2014
• For a hospital stay of 1-60 days – the applicable year’s Medicare inpatient deductible amount
• For days 61-90 of a hospital stay – the applicable year’s Medicare 61-90 day coinsurance rate times the number of days subject to the State’s lesser of logic.
• For days 91-150 of a hospital stay –
  Medicare only covers up to 90 days of an inpatient stay then the member decides whether or not to use Medicare Reserve Day coverage (See Reserve Days, below) if days are still available. The provider contacts the member and indicates the decision on the facility claim.
    o If Medicare Reserve days are used Medicaid pays the applicable year’s Medicare Reserve Day coinsurance rate times the number of days.
    o If Medicare Reserve days are NOT used Medicaid pays the Medicaid DRG for all remaining days over 90.
• When reserve days are used, for days beyond 150 days – the Medicaid DRG for all remaining days

To find the applicable year’s inpatient deductible and coinsurance amounts use the following link to access the CMS website:


Reserve Days are defined as “Sixty days that Medicare will pay for when the member is put in a hospital for more than 90 days”. These 60 Reserve Days can only be used once during the member’s lifetime. For each lifetime Reserve Day, Medicare pays all covered costs except for a daily (Reserve Day) coinsurance amount.

Other Insurance and iCare Medicaid, SSI and Badger Care
Inpatient facility services for iCare Medicaid members having other primary insurance are reimbursed at the difference between:
• The calculated T-19 Medicaid DRG/per diem amount or a specific iCare contracted rate And
• The other primary insurance payment

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

Skilled Nursing facility services
iCare Medicaid pays:
• For days 1-20 – $0; Medicare covers up to the Medicare allowed for each day and there is no coinsurance
• For days 21-100 – the applicable year’s Medicare SNF 21-100 day coinsurance rate times the number of days
• For days beyond 100, Medicaid is prime – either iCare Medicaid or Medicaid Fee for Service depending on the member’s enrollment in iCare Medicaid.

When the iCare member has SNF services for 90 days the member is disenrolled from iCare Medicaid at the end of that month. After the end of the month the Medicaid member continues coverage with Medicaid Fee for Service.
• For charges beyond the end of the month, submit the claim to Medicaid Fee for Service.

For the applicable year’s SNF day 21-100 coinsurance amount use the following link to access the CMS

Updated: 10/01/2014
CLAIM ERRORS

iCare strives to process submitted claims in a timely and accurate manner. Quality is a top priority. However, when claims processing and submission errors do occur, iCare’s goal is to accurately resolve the situation as quickly as possible.

Claim processing errors are identified by either the provider or iCare.

Preferably, when a provider identifies a processing error, whether an overpayment, underpayment or wrong provider payment follow the iCARE RECONSIDERATION procedure outlined below.

Please do not refund the money or return the check to iCare.

RECONSIDERATIONS

An iCare Reconsideration is a request to review a processed claim when the provider does not agree with the processing outcome. This includes situations where the provider feels there is a:

- Incorrect denial
- Underpayment
- Overpayment
- Incorrect adjustment
- Wrong provider payment

The provider has 60 days from the date of the EOP to contact iCare with an iCare Reconsideration request. The request may be made via the phone, in a letter format by mail or by fax.

To make an iCare Reconsideration request, contact iCare using one of the following methods:

1. By phone, call iCare Provider Services
   - Monday through Friday, 8:00-5:00
   - Local: 414-231-1029
   - Out of Area: 1-877-333-6820

2. By mail, use the following address:

   For Medicare and Medicaid Reconsiderations:

   - Independent Care Health Plan
   - P.O. Box 660346
   - Dallas, TX 75266-0346
   - ATTN: Operations Department


Updated: 10/01/2014
Regardless of the method used, all iCare Reconsideration requests must include:
- Member’s name
- Member’s identification number
  - For iCare Medicare the number assigned by iCare (C1111234567)
  - For iCare Medicaid the number assigned by the State Medicaid program +01 (12345678901)
- Provider’s name
- Date of service
- Service(s) to review
- Charge
- Payment
- Explanation why the claim decision should be reconsidered and what is expected
- Additional information to support the Review request

When complete request information is received, iCare Operations staff reviews the original claim submission, the request and all additional information provided. After research and benefit verification, a determination is made regarding whether or not the claim processed correctly. iCare has 60 days from the receipt of the reconsideration information to respond.

If the claim requires reprocessing or an adjustment (additional payment or recoupment), the claim is processed and the resulting Explanation of Payment (EOP) is iCare’s response to the Reconsideration request.

A recoupment is when an adjustment is made and the provider owes money to iCare. The amount owed is subtracted from the provider’s next check following the adjustment. When the provider owes more money than the payment, no check is issued with the EOP and a Negative Balance record is kept of the amount owed.

The balance owed is drawn down each week as iCare makes payments with subsequent EOPs until the amount owed is $0. Routinely review EOPs with a negative balance to be aware of the financial impacts of recoupments.

If the reviewed claim processed correctly, iCare contacts the provider with an explanation of why the reviewed claim is correct as processed.

**REFUNDS**

Before sending a refund, please refer to the **iCARE RECONSIDERATION** section above. If at some point it is necessary for the provider to send a refund to iCare, please make the checks payable to: iCare. Include the following information:
- A complete explanation of why the money is being refunded
- Member name
- Member identification number for the related claim
- DOS
- Service rendered
- Copy of the EOP containing the payment being refunded

Updated: 10/01/2014
Mail the information and check to:

INDEPENDENT CARE HEALTH PLAN ATTN:
FINANCE DIRECTOR
1555 N RIVERCENTER DRIVE, SUITE 206
MILWAUKEE WI 53212-3979

iCare then makes the necessary claim adjustments.

CLAIM APPEALS

iCare encourages the provider to request an iCare Medicare or Medicaid Reconsideration before going through the formal appeals process. See iCARE RECONSIDERATION in this section.

Appeal
A Provider’s appeal is a formal process for the provider to disagree with or question an iCare claim denial or a reduction in the level of benefits. The provider makes an appeal to iCare to change a claim decision.

A formal appeal must include all the following:
• A separate letter on the provider’s letterhead for each appealed claim
• Sent within 60 days of the EOP date
• Addressed to iCare as instructed below
  o A letter or fax is acceptable
  o An email with an attachment of the scanned letterhead letter
• Clearly mark ‘appeal’ in the body of the letter
• Provider’s name
• Date of service
• Date of payment or nonpayment/EOP date
• Member’s name
• Member’s identification number
  o Medicare claims, the iCare Medicare identification number (C1111234567)
  o Medicaid claims – identification number assigned by the State + 01 (12345678901)
  o BadgerCare claims, identification number assigned by the State (12345678901)
• The reason the claim merits a review

Send claim appeals to the following address:

INDEPENDENT CARE HEALTH PLAN
ATTN: OPERATIONS APPEALS
1555 N RIVERCENTER DRIVE, SUITE 206
MILWAUKEE WI 53212-3979

If the formal appeal is not sent within 60 days of the EOP date, the appeal is untimely and is denied and the claim decision is upheld.

If the appeal does not contain all the required parts of a formal appeal the document is considered an informal appeal and handled as an iCare Reconsideration request. See iCARE RECONSIDERATION in this section.

Updated: 10/01/2014
Tracers and resubmission claims do not meet the criteria of a formal appeal and are handled as an iCare Reconsideration request.

For proper processing, label claims submitted with corrected or additional information as a “Corrected Claim”. The Corrected Claim address is:

**For Medicare and Medicaid Reconsiderations:**
- Independent Care Health Plan
  P.O. Box 660346
  Dallas, TX 75266-0346
  ATTN: Operations Department

Within 10 days of receiving a formal appeal, iCare sends the provider a letter acknowledging the receipt of the appeal. iCare has 45 days to review the claim decision and respond in writing with a final decision. iCare’s decision is to either uphold or overturn the claim decision.

If the claim was processed correctly the claim decision is upheld and the appeal is denied. iCare contacts the provider with a written response that includes the reason the claim decision was upheld and instructions for submitting an appeal to DHS.

If the claim was not processed correctly the claim decision is overturned and the appeal is approved. iCare adjusts/reprocesses the claim and the resulting EOP is the provider’s response to the appeal.

If the provider is not satisfied with iCare’s response or if iCare fails to respond within 45 days of the receipt of the appeal, the provider may submit an appeal to DHS. This must be done within 60 days from the date of iCare’s written decision notification or within 60 days of when iCare should have provided the decision notification.

Before filing a DHS appeal with the State the provider must file a formal appeal or a written informal appeal (an iCare Reconsideration request) with iCare.

For further information refer to the **Medicare Managed Care Manual – Chapter 13** – Medicare Managed Care Beneficiary Grievances, Organization Determinations, and Appeals and refer to the section: Who May Request Reconsiderations.

For questions regarding processed claims refer to **CLAIM ERRORS** in this document.

**PROVIDER RIGHTS AND RESPONSIBILITIES**

**ACCESS TO CARE STANDARDS:**
In order to provide members access to quality health care services, iCare has adopted standards for member waiting times at the provider facility and waiting times for appointment scheduling to assure that the services available to iCare members.

- iCare utilizes the following access standards:
- Preventive appointments – within 30 days
- Urgent care – within 24 hours
- Emergent care – immediate availability
- Office wait times – within 30 minutes of appointment time
- After hours coverage/access – 24 hours a day/7 days a week
- iCare utilizes the following dental access guidelines:
  - New patient – within 90 days
  - Routine care – within 90 days
  - Emergent care – within 24-72 hours
- iCare provides translation services for members 24 hours a day, 7 days a week.
- iCare utilizes the following office wait time standards
  - Office wait times should not exceed 30 minutes after the schedules appointment time.
- Behavioral Health Access:
  - Wait times for routine office visit: 30 days or less
  - Follow up from an inpatient mental health stay: 30 days or less
- High Risk Prenatal Care - Wait time for appointments 2 weeks or less

**PROVIDER RIGHTS**

- Provider may bill iCare for Medicare or Medicaid covered services.

  **NOTE:** Provider must obtain a referral or prior authorization when applicable. Please see the Medical Management section for complete details.

- Provider may bill a member for non-covered services only if the provider informs the member prior to performing that service that he or she will be responsible for payment because Medicare or Medicaid does not cover the service.

  **NOTE:** Provider must obtain a written statement in advance verifying that the member has accepted liability for the service. The standard release form signed by the member at the time of the services or another type of acknowledgement relevant to iCare member liability must specifically state the admissions, services or procedures that are not covered by Medicare or Medicaid.

**PROVIDER RESPONSIBILITIES**

- Provider is required to obtain recipient eligibility information.

  **NOTE:** Possession of a Forward Card, ForwardHealth Card or Medicare Part A and/or Part B card does not guarantee eligibility.

- Provider accepts iCare reimbursement as payment in full except in cases where coordination of benefits applies.

- Provider is required to bill iCare for covered services provided to a recipient during periods of retroactive eligibility when notified that a recipient has received such eligibility.

- Provider and subcontractor shall not bill an iCare member for medically necessary services covered by Medicare or Medicaid and provided during the member’s period of iCare enrollment.
• Provider and subcontractor shall not bill an iCare member for co-payments and/or premiums for medically necessary services covered by Medicare or Medicaid and provided during the member’s period of iCare enrollment.

    NOTE: Any provider who knowingly and willfully bills a member for a Medicaid covered service shall be guilty of a felony, as defined in Section 1128B. (d)(1) [42 U.S.C.1320a-7b] of the Social Security Act. iCare shall report to the Department of Justice any violations of this act.

• Provider is prohibited from discriminating against iCare members. Provider’s hours of operation must not discriminate against iCare members.

• Provider will document in the member’s medical records whether or not the individual has executed an advance directive. Provider shall not discriminate in the provision of care or otherwise discriminate against a member based on whether or not the member has executed an advance directive.

• Provider shall ensure compliance with requirements of Wisconsin law (whether statutory or recognized by the courts of Wisconsin) respecting advance directives.

• With respect to the services provided to iCare members, provider is expected to observe and comply with all applicable Federal and State laws, rules or regulations in effect at the time services are provided, including health data and information privacy and security policies and any other standards and regulations as may be adopted or promulgated under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

• All appeals and reconsiderations should be dated and submitted to iCare within 60 days of receipt of the iCare Explanation of Payment.

    NOTE: For Medicaid appeals the provider may seek a final determination from the Department of Health Services (DHS). If iCare has not responded in writing within 45 days from the receipt of the request for the formal appeal, the provider will accept the DHS determination regarding appeals or disputed claims.

    Providers will notify iCare of new and changed information related to the provider’s practice. Including but not limited to:
    ○ Add provider to staff
    ○ Provider retires or terminates
    ○ New location or location moved
    ○ Terminate a location
    ○ NPI number
    ○ Tax Identification number and corresponding W9
    ○ Billing service change
    ○ Billing address change

    Send all changes to: NetDev@icare-wi.org
All Exhibits below can be found at www.icare-wi.org

Exhibit 1 – INDEPENDENT HEALTH CARE INPATIENT ADMISSION NOTIFICATION

This form is for providing notification for inpatient stays at time of admit; if you are inquiring if a CPT code or procedure needs authorization please utilize the general PA form which can be obtained from our website www.icare-wi.org

Independent Care Health Plan (iCare) needs to be notified of all inpatient stays within one (1) business day of the admission. Failure to adhere to iCare’s notification policy may result in delay or denial of payment of the related hospital claim.

Please complete all requested information on this form and fax to iCare at FAX# 414-231-1075.

If you have any questions about this form please contact iCare at 223-4847. Submission of the notification of an admission is not a guarantee of coverage or payment of the reported service.

**MEMBER INFORMATION:**

Name: ___________________________ DOB: ______

Medicare#: ___________________________ Medicaid#: ______

**ADMISSION INFORMATION:**

Admission Date: ______________ Time: ______________

Room #: ____________________________

Type of Admission: (Circle One) Emergency Elective

Admitting Hospital: ___________________________ Hospital Phone #: __________________

Facility NPI #: ___________________________ Facility Address: ___________________________

Admitting MD: ___________________________ Admitting MD’s Phone #: __________________

Admitting Dx: ___________________________ ICD9/ICD10 Code: __________________

Designated Contact Person: ___________________________ Title: ___________________________

Phone: (______) ___________________________ Fax: (______) ___________________________

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*********************************************************************************** DO NOT WRITE BELOW THIS LINE***********************************************************************************

March 2014
**Exhibit 2– Nursing Home/Facility Prior Authorization**

Independent Care Health Plan (iCare) reviews all admissions for medical necessity and appropriateness of level of care. In order to conduct these reviews on a timely basis, policy **REQUIRES** the facility to request authorization from iCare **at least one (1) day PRIOR** to tentative admission date. Prior authorization needs to be approved by iCare **BEFORE** admission to a facility. Failure to adhere to iCare’s authorization policy may result in delay or denial of payment of the related facility claim.

Please complete all requested information on this form and fax to iCare at FAX # 414-231-1075. If you have any questions about this form please contact iCare at 414-223-4847. Submission of the prior authorization request for an admission is not a guarantee of coverage or payment of the reported services.

<table>
<thead>
<tr>
<th><strong>MEMBER INFORMATION</strong></th>
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<tr>
<td>Name: __________________</td>
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<td>DOB: ____________________</td>
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<tr>
<th><strong>ADMISSION INFORMATION</strong></th>
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<tr>
<td>Admission Date: __________</td>
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<tr>
<td>Admitted From: ____________</td>
</tr>
<tr>
<td>Admitting Facility: ________</td>
</tr>
<tr>
<td>Facility Phone #: __________</td>
</tr>
<tr>
<td>Facility NPI#: ____________</td>
</tr>
<tr>
<td>Facility Address: __________</td>
</tr>
</tbody>
</table>

| Admitting DX: ____________ | ICD9/10 Code: ____________ |
| Phone: ( ) ________________ | Fax: ( ) ________________ |

Are you requesting a Medicare stay? YES____ NO ______
If so please provide dates of Medicare qualifying hospital stay ____________ to ____________

Please attach:
*Intake Assessment
*Therapy Notes
*Discharge Summary

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Authorization #: __________________

September 2014

Updated: 10/01/2014
Exhibit 3 – General Prior Authorization Request

Independent Care Health Plan

GENERAL PRIOR AUTHORIZATION REQUEST

PLEASE NOTE: Receipt of an approved prior authorization does not guarantee payment by iCare. Benefits are determined based on the dates that the services are rendered. Please fill out this form completely and fax to (414)231-1026. An incomplete form may delay processing and or claims payment.

Today’s date: __________

MEMBER INFORMATION:
Name: ___________________________ DOB: ______________________
Medicare: ___________________________ Medicaid: ___________________________
SSN: ___________________________ Phone #: ___________________________
ICD9/ICD10: ________ Diagnosis: ___________________________

Please check appropriate box:
☐ DME
☐ Elective Inpatient Procedure
☐ Outpatient Procedure
☐ Modification to authorization #: ___________________________

CPT Code: (1) ________ Procedure: ___________________________
(2) ________ Procedure: ___________________________
(3) ________ Procedure: ___________________________

Date Scheduled: ________ Performing MD/Provider: _____________ NPI #: _____________
PA Contact: __________________ Phone #: __________________ Fax #: __________________

FOR iCare USE ONLY:

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Fax 414-231-1026
www.icare-wi.org

September 2014
Exhibit 4 – Home Health/PCW Prior Authorization Request Form

Independent Health Care Plan

HOME HEALTH/PCW PRIOR AUTHORIZATION REQUEST

PLEASE NOTE: Receipt of an approved prior authorization does not guarantee payment by iCare. Benefits are determined based on the dates that the services are rendered. Please fill out this form completely and fax to (414)231-1026. An incomplete form may delay processing and/or claims payment. iCare conducts in home PCW assessments and authorizations will not be approved without a current assessment.

<table>
<thead>
<tr>
<th>MEMBER INFORMATION:</th>
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<tbody>
<tr>
<td>Name: ___________________________</td>
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<tr>
<td>Medicare: ___________________________</td>
</tr>
<tr>
<td>SSN: ___________________________</td>
</tr>
</tbody>
</table>

Today’s date: __________

NPI #: __________ Provider: ___________________________

ICD9/ICD10: _______ Diagnosis: ___________________________

PA Contact: __________ Phone #: __________ Fax #: __________

Please check appropriate box:

☐ New Services
☐ Modification of Authorization #: __________
☐ Social Worker/MSW
☐ Home Health/Aide Visit
☐ Home Health/Therapy (PT, OT, SLP)
☐ Home Health/Skilled Nurse Visit

Procedure Code: _______ Description: ___________________________ Quantity: _______
Procedure Code: _______ Description: ___________________________ Quantity: _______
Procedure Code: _______ Description: ___________________________ Quantity: _______
Procedure Code: _______ Description: ___________________________ Quantity: _______

PCW travel time # of units: _______ Is travel time included in above quantity? ☐ Yes ☐ No
PCW lives with member? ☐ Yes ☐ No
PCW Address_____________________________ Relationship to member_______________________

Comments: __________

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September 2014
Exhibit 5 - Physician Referral Form

Physician Referral Request Form

PLEASE NOTE: Receipt of an approved prior authorization does not guarantee payment by iCare. Benefits are determined based on the dates that the services are rendered. Please fill out this form completely and fax to (414) 231-1026. An incomplete form may delay processing and or claims payment.

**MEMBER INFORMATION:**

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<thead>
<tr>
<th>Name:</th>
<th>DOB:</th>
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<tr>
<th>Medicare:</th>
<th>Medicaid:</th>
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<table>
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<tr>
<th>SSN:</th>
<th>Phone #:</th>
</tr>
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</table>

Today’s date: ________

Check Specialty:

☐ Oral Surgery

☐ Plastic Surgery

Services Requested:

☐ One Time Consult

☐ Consult and Treat (please list dates) __________ # of visits ____

ICD9/ICD10: ________

Diagnosis: _______________________________

**Referring Physician**

<table>
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<tr>
<th>Name:</th>
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<th>Address:</th>
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<tr>
<th>City:</th>
<th>Zip Code:</th>
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<tr>
<th>Fax:</th>
<th>Fax:</th>
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</table>

PA Contact: ________________

Phone #: __________________ Fax #: __________________

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Updated: 10/01/2014
Exhibit 6- Therapy Authorization Request Form

THERAPY PRIOR AUTHORIZATION REQUEST FORM

PLEASE NOTE: Receipt of an approved prior authorization does not guarantee payment by iCare. Benefits are determined based on the dates that the services are rendered. Please fill out this form completely and fax to (414)231-1026. An incomplete form may delay processing or claims payment.

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<td>Name: ___________________________</td>
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<td>Medicare: ______________________</td>
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<tr>
<td>SSN: ___________________________</td>
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</tbody>
</table>

Today’s date: __________

Date of Evaluation: ________ ICD9/ICD10: ________ Diagnosis: __________________________

Facility/Provider: ___________________________ NPI #: __________________________

PA Contact: _______________ Phone #: __________________ Fax #: __________________

Please check appropriate box

☐ New Services  
(Must provide initial eval and signed MD order)

☐ Modification to Authorization # ________________  
(Must provide clinical documentation & revised treatment plan to support request)

PT # of visits ________  OT # of visits ________  SLP # of visits _______

If this service is being performed at a SNF

☐ Is the member ☐ Outpatient ☐ Inpatient

Are you trying to obtain a Medicare B authorization? ☐ Yes ☐ No  
(Medicare A does not require authorization)

☐ Cardiac Rehab  ☐ Pulmonary Rehab  ☐ Lymphedema Therapy

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Quantity</th>
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Updated: 10/01/2014
Exhibit 7- Hospice Prior Authorization Request Form

HOSPICE PRIOR AUTHORIZATION REQUEST FORM

PLEASE NOTE: Receipt of an approved prior authorization does not guarantee payment by iCare. Benefits are determined based on the dates that the services are rendered. Please fill out this form completely and fax to (414)231-1026. An incomplete form may delay processing and or claims payment.

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<th>MEMBER INFORMATION:</th>
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<td>Name: _______________________</td>
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<tr>
<td>Medicare: ___________________</td>
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<tr>
<td>SSN: _______________________</td>
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</table>

Today’s date: ________

NPI #: ______________ Provider: __________________________________________

ICD9/ICD10: ______________ Diagnosis: __________________________________________

PA Contact: ______________ Phone #: __________________ Fax #: ____________________

Please check appropriate box:

[ ] New Services
[ ] Continuation of Services

Certification/Recertification Dates: ______________________________

NOTE: Procedure Codes Required:

<table>
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<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Quantity</th>
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September 2014

Updated: 10/01/2014
Exhibit 8 – Outpatient Behavioral Health Prior Authorization Request Form

Behavorial Health Outpatient Notification of Treatment and Services

Date: ________________

Clinic Name: ________________________________________________________

Clinic Address: _______________________________________________________

___________________________________________________________

Treatment Provider: _________________________________________________

Member Name: _______________ DOB: ______________

Medicaid# _______________ Medicare # ________________

Assessment Date: ________________

Diagnosis: ____________________________________________________________

Additional Information: ________________________________________________

Discharge Date: (members out of treatment > 3 mo.) ________________

****Please return this form to iCare Fax 414-231-1090****

**Behavioral Health Outpatient treatment will only require a notification for admission and discharge to services. These services will no longer require an iCare authorization. iCare reserves the right to discuss treatment progress with providers. For this reason please obtain a release of information at the start of treatment.

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7/11 BH Services
Exhibit 9– Behavioral Health Services and Procedure Authorization Form

OUTPATIENT BEHAVIORAL HEALTH PRIOR AUTHORIZATION REQUEST

PLEASE NOTE: Receipt of an approved prior authorization does not guarantee payment by iCare. Benefits are determined based on the dates that the services are rendered. Please fill out this form completely and fax to (414)231-1075 within 1 business day of the initial treatment day. An incomplete form may delay processing and or claims payment. An initial clinical review is due within 24 hours of notification of initiation of services.

Today’s date: __________

MEMBER INFORMATION:

Name: ____________________________ DOB: ____________________________
Medicare: ____________________________ Medicaid: ____________________________
SSN: ____________________________ Phone #: ____________________________

ICD9/ICD10: __________  Diagnosis: __________________________________________

Planned Dates of Treatment: _________________________________________________

Facility or Performing Provider: ____________________________ NPI #: ____________________________
Facility Address: ___________________________________________________________________

PA Contact: ____________________________ Phone #: ____________________________ Fax #: ____________________________

Please check appropriate box:
☐ Partial hospitalization (PHP)
☐ Intensive Outpatient Therapy (IOP)
☐ Community Day Treatment Program
☐ Crisis Stabilization/Diversion
☐ In Home Psychotherapy
☐ Psychological Testing >5 hours
☐ Modification to authorization #: ____________________________

Please provide procedure codes & quantity of units (use visits for in home psychotherapy only)
Procedure Code: (1) __________ Quantity of Units/visits: __________
(2) __________ Quantity of Units/visits: __________
(3) __________ Quantity of Units/visits: __________

FOR iCare USE ONLY:

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Phone Number: (800)777-4376  Fax 414-231-1026 www.icare-wi.org Revision 10/2014

Updated: 10/01/2014
Exhibit 10– Behavioral Health Inpatient Authorization Request Form
BEHAVIOR HEALTH INPATIENT ADMISSION AUTHORIZATION REQUEST

This form is for providing notification for inpatient stays at time of admit; if you are inquiring if a CPT code or procedure needs authorization please utilize the general PA form which can be obtained from our website www.icare-wi.org

Independent Care Health Plan (iCare) needs to be notified of all inpatient stays within one (1) business day of the admission. Failure to adhere to iCare’s notification policy may result in delay or denial of payment of the related hospital claim.

Please complete all requested information on this form and fax to iCare at FAX# 414-231-1075.

If you have any questions about this form please contact iCare at 223-4847. Submission of the notification of an admission is not a guarantee of coverage or payment of the reported service.

MEMBER INFORMATION:

Name: _______________________________  DOB: __________________________
Medicare: ___________________________  Medicaid:______________________
SSN: ________________________________  Phone #:____________________

ADMISSION INFORMATION:

Admission Date: _________________  Time: _________________  Room #:  _______________________
Type of Inpatient Admission: ED _____  Voluntary _____
Admitting Facility: ______________________________  Facility Phone #:  _______________________
Facility NPI #:  ______________________  Facility Address:  ________________________________
Admitting Provider: _____________________  Admitting Dx:  ________________________________
ICD9/ICD10 Code: _______________________

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Authorization #: _______________________

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Phone Number: (800)777-4376 Fax 414-231-1026  www.icare-wi.org
Revision 10/2014

Updated: 10/01/2014
Exhibit 11 Medicare Part D Coverage Determination Request Form

Medicare Part D Coverage Determination Request Form

This form cannot be used to request:
Medicare non-covered drugs, including barbiturates, benzodiazepines, fertility drugs, drugs prescribed for weight loss, weight gain or hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).

Plan Name:

Patient Information

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Prescriber Name:</th>
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<tr>
<th>Member ID#</th>
<th>DEA#</th>
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</table>

City: State
City: State

Home Phone: Office Phone#
Office Fax: Zip:

Sex (circle): M F DOB: Contact Person:

Diagnosis and Medical Information

Medication: Strength and Route of Administration Frequency:

<table>
<thead>
<tr>
<th>□ New Prescription OR Date Therapy Initiated:</th>
<th>Expected Length of Therapy: Qty:</th>
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</table>

Height/Weight: Drug Allergies: Diagnosis:

Prescriber’s Signature: Date:

Rationale for Exception Request or Prior Authorization

FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION

D Alternate drug(s) contraindicated or previously tried, but with adverse outcome (i.e., toxicity, allergy, or therapeutic failure) Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s);

D Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change

Specify below: Anticipated significant adverse clinical outcome D Medical need for different dosage form and/or higher dosage

Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason

D Request for formulary tier exception

Specify below: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome

Other: D Explain below

REQUIRED EXPLANATION:

Request for Expedited Review

D REQUEST FOR EXPEDITED REVIEW [24 HOURS]

- BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION.

Information on this form is protected Health Information and subject to all privacy and security regulations under HIPAA.

Updated: 10/01/2014