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I. INTRODUCTION

This manual is intended to serve as a reference for provider information and guidelines applicable to the Independent Care Health Plan (iCare or Independent Care) Family Care Partnership (FCP) plan, especially information and guidelines for iCare’s network of Long Term Care (LTC) service providers (also known as Home and Community Based Services (HCBS) or long-term services and supports (LTSS) providers. Throughout this document the term LTC will be used.) For Medicare and Medicaid covered services to FCP members and for information applicable to iCare’s Medicare SNP, Medicaid SSI, and BadgerCare Plus health plans please reference the Provider Reference Manual found on the iCare provider website: https://www.icarehealthplan.org/Provider.htm. The iCare website offers additional information regarding iCare’s Family Care Partnership Plan, Medicare SNP, Medicaid, SSI, and BadgerCare Plus Plans.

A. MISSION STATEMENT

The mission of iCare is to improve the quality of life for individuals with unique and complex medical, behavioral, and human service needs while providing value to our customers and stakeholders, embracing the dignity and diversity of those we serve.

B. COMPANY INFORMATION

iCare has a unique history, originating from a non-profit human service provider supported by a major for-profit national health insurer. This unusual blend of competencies supports member confidence in iCare’s mission to respond to complex health needs of persons who otherwise go unserved. iCare also has unique members, many with complex health care needs and who are disabled and poor.

iCare began as a research and demonstration project sponsored by the Health Care Financing Administration (now Centers for Medicare and Medicaid Services or CMS) that integrated managed health care and social services for adults with disabilities. Formed in 1994, iCare was jointly created by Center for Independence (CFI) and a local health insurer, Wisconsin Health Organization (which was later acquired by Humana). In 2021, Humana acquired CFI’s shares making iCare a wholly-owned subsidiary of Humana.

In 2003, iCare was reincorporated as a Wisconsin-licensed HMO insurance corporation, creating an insurer that is operationally and financially independent from its owners. Since its beginning in 1994, iCare has grown from a small federal demonstration project with a new care model into one of Wisconsin’s largest health insurers for adults with disabilities and into one of the nation’s best working examples of how integrated care can occur and benefit members with complex care needs. In 2021, Humana acquired CFI’s shares making iCare a wholly-owned subsidiary of Humana.
C. WHAT IS FAMILY CARE PARTNERSHIP?

The Family Care Partnership (FCP) Program is a comprehensive program of services for frail elders and adults with developmental or physical disabilities in Wisconsin. The program integrates health and long-term support services, and includes home and community-based services, physician services and medical care. Services are delivered in the participant's home or a setting of his or her choice. Member choice is a cornerstone of the FCP Program. Independent Care and its providers make every effort to honor member preferences of how, when, and where services are delivered. Another key component of the FCP Program is team-based care management. Under this arrangement, an Interdisciplinary Care Team (IDT) develops a care plan to coordinate all service delivery.

The goals of the FCP Program are to:

- Increase the ability of people to live in the community and participate in decisions regarding their own health care.
- Improve quality and coordination of health care and service delivery while containing costs.

The FCP program integrates primary and acute services with LTC services. All FCP members have a nursing home level of need. Most FCP services are provided in the member’s own home in the community. Sixty-one percent of FCP members are dually eligible for both Medicare and Medicaid coverage. LTC services are accessed through contracted arrangements with services reimbursed by iCare. The goal of the program is to help members remain as independent as possible. Independent Care’s FCP program offers a member-centered care model, where the member or the member’s guardian is part of an interdisciplinary team (IDT) that includes a Nurse Practitioner (NP), a Registered Nurse (RNCM), a Social Services Care Coach (CC) and other professionals as appropriate. The IDT develops a care plan to coordinate all service delivery.

iCare’s care management model provides members with a person-centric approach to healthcare. This “whole-person” model recognizes that in serving individuals with complex needs, iCare must also address social and behavioral issues while also addressing health care needs.

Independent Care treats its members with dignity and respect. We take pride in the diversity of our membership and consider cultural specific concerns when coordinating services. iCare values its providers who share the iCare mission and commitment to serving individuals with special needs.

D. MODEL OF CARE/INTERDISCIPLINARY CARE TEAM (IDT)

In our member-centric model of care management, the member is at the center of each IDT. Every iCare FCP member is assigned an IDT and provided with the name and
The IDT completes a comprehensive assessment of members’ needs, abilities, preferences, and values. Guided by the assessment, the IDT develops and implements an evidence based, individualized member-centered plan (MCP) based upon member defined outcomes. This helps members take ownership of their health and guides what the IDT staff and members work on together. A key component of the MCP is for the IDT staff to work with the member in determining if the member’s goals/outcomes are met or not met. If the goal/outcome are not met the IDT will reassess the current MCP and determine alternative actions. The outcomes of these alternative actions will also be assessed, and the cycle will repeat at minimum every 6 months or with a significant change of condition, as needed. The MCP provides staff with a focused approach to member education and future follow-up contacts. The member-centered care management system is updated at least every six months and with changes in condition, utilization, or risk level.

The IDT will discuss a variety of strategies to address the clinical, functional, and personal outcomes that are listed in the MCP for the member. Some of these may include paid services that are covered under the iCare FCP plan. The IDT will utilize the Resource Allocation Decision-making (RAD) process developed by the State of Wisconsin to determine cost-effective strategies to make use of available resources and services to meet a particular outcome.

The IDT assures that members receive coordinated services to help them maintain their independence and remain active in the community. Members participate in team decision making, including working in collaboration with the member’s primary care provider for all medical and LTC services. FCP services support the member’s best possible functioning in the least restrictive setting. The member-centric approach emphasizes services provided in the location desired by the member by the providers desired by the member and embodies the member’s choice, autonomy, and independence.

iCare’s care management model is rooted in the premise that coordination of services relative to the entire spectrum of medical, behavioral, and social needs is necessary to optimize the well-being of the FCP member. This model of care management is supported by an advanced care management electronic record with referenceable standards of care. iCare’s care management solution has predictive and claims tracking capability, enabling the IDT staff to review the past 24 months of encounter information. IDT staff can see clearly where the member touches the healthcare system, the frequency of use, and the regularity of that contact. One of the principle aims of the model of care management is for the member to establish a reliable and steady relationship with a primary care resource. Another aim of the care management models is for the members to grow in the ability to care for their own health needs as an active agent. A further description of the Model of Care for each iCare plan is available on the iCare Provider Website (https://www.icarehealthplan.org/Education/Providers.htm). Please use the educational
resources annually, for any new staff, and to refresh your knowledge of the Model of Care for your practice.

II. GENERAL PROVIDER NETWORK INFORMATION

A. ACCESS AND CAPACITY STANDARDS

It is iCare’s goal to offer members a provider network with adequate geographic coverage, adequate capacity for timely provision all services in the benefit package and to provide members a choice of providers. Capacity of the provider network and adequacy of the provider network is routinely monitored by iCare to assure that this goal is met.

Providers must offer hours of operation that are not less than the hours of operation offered to other MCO members or Medicaid FFS members.

Providers are prohibited from creating barriers to access care by imposing requirements that are inconsistent with the provision of services necessary to achieve MCP outcomes. Access standards for acute and primary services can be found in the Provider Reference Manual at https://www.icarehealthplan.org/Files/Resources/PROVIDER-DOCS/Provider_Reference_Manual

B. CONFIDENTIALITY

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

C. EQUITY and INCLUSION

Providers are prohibited from discriminating against any iCare member on the basis of race, color, national origin, age, disability status, gender identity, or sex. Providers serving iCare members are required to be respectful of member and staff culture, heritage and other identity facets including members with limited English proficiency and diverse cultural and backgrounds and ethnicity, disabilities, and regardless of gender, sexual orientation or gender identity. Providers are required to foster in their staff attitudes and interpersonal communication styles which respect members’
individual needs related to their diversity. Providers must agree to comply with all non-discrimination requirements and all applicable affirmative action and civil rights compliance laws and regulations as applicable. For more information, please see https://www.dhs.wisconsin.gov/civilrights/index.htm.

D. NOTICE OF CHANGE

Providers shall notify iCare of changes in information related to the provider’s practice. Send all provider demographic changes to netdev@icarehealthplan.org. A form for submission of this information is available at the iCare Provider website: https://www.icarehealthplan.org/Provider.htm.

Notification is required for:

- Addition of a provider
- Provider retirement or termination
- New location
- Closing of a location
- Any change in NPI number
- Any change in Tax Identification number (TIN) (submit with revised and corresponding W9)
- Any billing service change
- Any billing address change
- Change in licensure or certification
- Any sanctions imposed by a governmental agency
- Any Criminal investigations

E. CONTACT INFORMATION

**MAIN NUMBER:** 414-223-4847 or 1-800-777-4376
Please see individual department phone and fax numbers and email addresses below.

**Customer Service**
Monday through Friday- 8:30 a.m. to 5:00 p.m.
**Member Local:** 414-223-4847
**Out of area:** 1-800-777-4376

**Provider Services**
**Local:** 414-231-1029
**Out of Area:** 1-877-333-6820
**Email:** providerservices@icarehealthplan.org

**Interdisciplinary Team**
414-223-4847
Provide the member’s name and DOB to be connected to the IDT CC
III. MEMBER ELIGIBILITY

To participate in the iCare FCP Program, the member must be eligible for Medicaid and be certified at the Medicaid nursing home level of care. The program also serves people who are eligible for both Medicaid and Medicare. Participation in the program is voluntary. Individuals interested in learning more about their options for long-term care, including applying for Family Care Partnership, should contact their local Aging and Disability Resource Center (ADRC). ADRC services are available to everyone, whether or not they are eligible for Family Care or other Medicaid programs.

A. iCARE FCP PLAN ELIGIBILITY CRITERIA

To enroll in the iCare Family Care Partnership Plan the recipient must contact their local ADRC. General eligibility requirements are listed below.

- Be a resident of Dane, Kenosha, Milwaukee, Racine, or Sauk County.
- Be a person with physical or developmental disabilities (18 years of age or older) OR a frail elderly adult over 60 years of age.
- Be eligible for full Wisconsin Medicaid.
- Have long term care services needs as determined by the State of Wisconsin Long- Term Care Functional Screen.

To be eligible for the iCare Medicare plan under Family Care Partnership, the member must have active coverage in Part A and Part B.

It is imperative the provider verify eligibility each time services are provided. For various reasons, Medicaid eligibility can change at any time.

- Eligibility is administered by the State of Wisconsin.
- The State of Wisconsin issues all Medicaid members a Forward Health ID card. The front of the ForwardHealth card displays the recipient’s name, Medicaid ID number, and a unique 16-digit card number.
- iCare issues the FCP member an iCare ID card includes both Medicare and
Medicaid ID numbers (if member is eligible for both) and pharmacy information.

Providers can access immediate and real-time eligibility, Medicaid date and iCare designation using a point of service device or special computer software allowing access to the Eligibility Verification System (EVS).

Providers may also verify a member’s Medicaid eligibility status by calling 1-800-947-9627.

B. iCARE FAMILY CARE PARTNERSHIP ID CARD

iCare issues the member an ID Card with both Medicare and Medicaid identification numbers and pharmacy information.
In an emergency, call 911 immediately. Please call Customer Service at the number below as soon as possible after an emergency hospital admission. All services performed by non-network providers, except emergency services, require prior authorization.

Voice: 1-800-947-6644, 7 days-a-week, 8:00 a.m. - 8:00 p.m.
www.iCareHealthPlan.org
Submit claims to:
Independent Care Health Plan
PO Box 224255
Dallas, TX 75222-4255
IV. MEMBER BENEFITS

The attached chart (Exhibit 1) lists LTC services along with the Medicaid and Medicare services available to members in the iCare FCP plan. This document is also available at https://www.dhs.wisconsin.gov/publications/p0/p00570.pdf. More information regarding benefits is available at Forward Health https://www.forwardhealth.wi.gov/WIPortal/Default.aspx or by calling iCare Customer Service (414-223-4847).

For a complete listing of benefits of the FCP program, please reference the Summary of Benefits and Evidence of Coverage at https://www.icarehealthplan.org/Members/Plans-Benefits/iCare-Family-Care-Partnership-Plan/2023-Family-Care-Partnership.htm

A. ACUTE/PRIMARY SERVICES

Please reference the iCare Provider Reference Manual for information regarding acute and primary Medicaid services and Medicare services, including the process to follow for services that require authorization. The iCare Provider Reference Manual is found on the iCare provider website: https://www.icarehealthplan.org/Providers/

B. LONG TERM CARE SERVICES

All LTC services must be reviewed and authorized by the IDT. To receive authorization for LTC services, please contact the member’s CC. Service authorizations are provided by the IDT to the provider prior to the start date of designated services by the provider. When prior written authorization is not practicable, verbal authorization is provided for the service and written authorization issued later.

LTC services will be provided to iCare FCP members through our network of providers. All LTC services must be authorized through the IDT. Prior to delivery of a service to an iCare FCP member, the provider must obtain a Service Authorization from the member’s IDT staff at iCare outlining the specific services and rates of reimbursement.

Members, guardians, or providers can request new services or extensions of existing services from the member’s IDT staff. The IDT will consider all requests for service and will approve or deny the request using the RAD method. A written Service Authorization for each service will be sent to the provider.

C. SERVICE AUTHORIZATION

The IDT needs the following information to consider a Service Authorization request:
• Member name
• Description of services to be provided and HCPCS code (5-digit code)
• Units and frequency of service
• Dates of service
• Service location

Providers are requested to notify the IDT as soon as possible in an emergency situation. The IDT will work to authorize necessary services. For emergencies after-hours, please contact iCare at 414-223-4847 to reach the Care Coach on call.

Questions regarding authorizations should be addressed to the member’s CC. Contact information for the CC and other IDT staff is on the Service Authorization Letter. To obtain the name and telephone number of a member’s CC, contact iCare Customer Service at 414-223-4847.

D. SUPPORTIVE HOME CARE

Providers of supportive home care or in-home respite care services shall comply with the Managed Care Organization Training and Documentation Standards for Supportive Home Care and in-Home Respite at the following link:

Supportive home care providers requesting a Service Authorization for S5125 or S5126 must meet Electronic Visit Verification (EVV) requirements as outlined in ForwardHealth Policy published on the ForwardHealth website in accordance with Section 12006(a) of the federal 21st Century Cures Act.

iCare does not require EVV for live-in workers, however:

• The Supportive home care agency must supply a completed Electronic Visit Verification Live-In Worker Identification form, F-02717 at the time of the service request submission for all live-in workers.
• Supportive home care agencies must verify live-in workers’ permanent residency based on the ForwardHealth criteria for live-in workers at least annually.
• The agency is required to retain all documentation supporting the determination of live-in worker status according to the record retention requirements as set forth in the Long Term Care Services Agreement. Supporting documentation must be submitted to iCare upon request.

Once a service authorization request for a live-in worker is approved, claims for services provided by a live-in worker must include the modifier KX. Using the modifier KX will prevent the claim from denying due to lack of EVV data.
E. RESIDENTIAL CARE SERVICES

A registry of FCP contracted residential providers for room availability is maintained by iCare. For new availability, complete the iCare Residential Availability Form (http://www.icarehealthplan.org/forms/ProviderForms.aspx) and e-mail it to the attention of: Community Resource Specialist-Family Care Partnership at icareresidentialopenings@icarehealthplan.org

Residential care services providers are prohibited from distributing marketing/outreach activities or materials to general public that claim Family Care, Partnership or PACE programs will pay for an individual to continue to receive services from the provider after the member’s private financial resources have been exhausted.

Residential care providers must report to iCare that a member has been or will be involuntarily discharged.

F. TRANSPORTATION

Transportation is a covered benefit under the iCare FCP program. This includes transportation as specified in the member’s plan for waiver and community activities and resources to support the member’s long-term outcomes, medical appointments, and iCare sponsored programs. As with all LTC services in the FCP program, all transportation must be authorized by the IDT team before the transportation takes place. Transportation can be in the form of bus, taxi, van, or specialized medical vehicle service (SMV).

Transportation, when authorized by the IDT staff, will be for the member and may include a person that accompanies the member, if necessary, for their health and safety.

G. LANGUAGE ACCESS

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

If a healthcare provider determines an interpreter is needed, please send a request for interpreter services to the Provider Service Mailbox at callcenters@icarehealthplan.org or call 414-231-1029 (or toll free: 1-877-333-6820) and include the following information:

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

Once an interpreter is identified for the appointment, the interpreter/translator agency will provide the name of the interpreter to iCare Provider Services (callcenters@icarehealthplan.org). iCare will in turn provide a confirmation to the healthcare provider including the name and contact information for the agency and interpreter. If an interpreter is not available, notice is provided by phone or e-mail to the requester.

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

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

V. QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT (QAPI)

The purpose of iCare’s Quality Assurance and Performance Improvement (QAPI) Program is to collect data, and use this data to assess, monitor, evaluate, and facilitate improvement in the quality of health care services provided to iCare’s members. The QAPI Program focuses on health outcomes, health improvement and health-related social needs. Provider cooperation with all QAPI activities and use of provider performance data as requested is required.
The QAPI Program is integrated throughout iCare’s functional areas with each department being accountable for reviewing procedures, systems, quality, cost and outcomes related to their areas of responsibility. The QAPI Program ensures each department meets regulatory requirements, achieves business objectives and adds value to the services for our members and providers.

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

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

B. GOALS AND OBJECTIVES OF THE QAPI PROGRAM

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

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

C. CMS 5 STAR PROGRAM

Independent Care is committed to CMS standards through HEDIS (Healthcare Effectiveness Data and Information Set), Consumer Assessment of Health Providers and Systems (CAHPS), Health Outcome Survey (HOS), the Department of Health Services (DHS) and Pay-for-Performance (P4P) indicators. iCare strives to provide medically necessary healthcare that is efficient, effective, safe, accessible, and accountable. Both the CAHPS and HOS ask Medicare members to report 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 outcomes of our members. It is also important to stay in communication with our members ensuring their needs are met.

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

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

D. FOCUS OF QUALITY MEASURES

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

E. CAREGIVER BACKGROUND CHECKS

All iCare contracted providers are required to comply with all applicable requirements of Wis. Stat. § 50.065 and Wis. Admin. Code §§ DHS 12 and 13 relating to caregiver background checks. Providers are required to provide documentation of compliance with these requirements to iCare at the point of applying for network provider status and periodically thereafter to validate continuing compliance.

iCare reserves the right to decline to contract with, or to terminate the contract of any provider who cannot document that it is in compliance with the requirements of Wis. Stat. § 50.065 and Wis. Admin. Code §§ DHS 12 and 13. The results of caregiver background checks shall be made available by the provider to iCare members consistent with the requirement of Wis. Admin. Code §§ 12 and 13.

F. PREVENTIVE HEALTH AND CLINICAL PRACTICE GUIDELINES

Independent Care Health Plan (iCare) contracts with individual and group providers of health care products and services for Medicare and Medicaid recipients. Each line of business functions under its own contract guidelines for which benefit, and reimbursement requirements vary. Specific contract benefits, guidelines, and/or policies supersede information outlined in this policy.

Independent Care is dedicated to enriching the quality of clinical care provided to our members by our staff and contracted providers. Clinical Practice Guidelines support providers in treating chronic disease, providing preventative care, and facilitating provider-member interactions.

All Clinical Practice Guidelines recommended by iCare are based on national medical association and health organization recommendations. The information provided in
this policy applies to all providers of care to iCare members and is reviewed annually and updated no less than every two years, or as national guidelines change.

A Clinical Practice Guideline (CPG) is created by national medical associations and/or health organizations for the explicit purpose of disseminating peer-reviewed, evidence-based practice recommendations to enhance the quality and consistency of care delivered to all patients, regardless of payor source. The CPGs guide decisions and provide criteria regarding diagnosis, management, and treatment in specific areas of healthcare based on published evidenced-based medical literature. The CPGs reflect current evidence in the literature for large groups of individuals with specific health diagnoses; The licensed and boarded practitioner is encouraged to practice patient-centered care, developing care plans with each individual patient’s needs and conditions in mind, utilizing medical justifications for exceptions when deviating from the CPGs, based on the provider’s expertise and clinical judgment.

iCare publishes medical guidelines from several well-respected national sources. These guidelines may have some differences in recommendations. Information contained in the guidelines is not a substitute for a physician’s or other healthcare professional’s clinical judgment and is not always applicable to an individual. Therefore, the physician or healthcare professional and patient should work in partnership in the decision-making process regarding the patient’s treatment. Furthermore, using this information will not guarantee a specific outcome for each patient. None of the information in the guidelines is intended to interfere with or prohibit clinical decisions made by a treating physician or other healthcare professional regarding medically available treatment options for patients.

Publication of these guidelines is not a promise or guarantee of coverage. Individuals should review their coverage to determine benefits.

iCare aligns with the CPG of Humana, our parent corporation. These guidelines can be found at Humana for Healthcare Providers – medical resources /clinical practice guidelines.

Please note that Health Programs, and Transplant Services at that site location are not applicable to WI iCare members.

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

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

iCare expects all clinical providers to access the Clinical Practice Guidelines to enrich the quality of clinical care provided to our members by contracted clinical providers.

G. REPORTABLE INCIDENTS CATEGORIES

Contracted providers must report member incidents to IDT Staff no later than one (1) business day after the incident was discovered.

Reportable Member Incidents includes the following suffered by or caused by a Member:

- **Neglect:** As defined in §46.90(1)(f), Wis. Stats., to mean the failure of a caregiver, as evidenced by an act, omission, or course of conduct, to endeavor to secure or maintain adequate care, services, or supervision for an individual, including food, clothing, shelter, or physical or mental health care, and creating significant risk or danger to the individual’s physical or mental health. “Neglect” does not include a decision that is made to not seek medical care for an individual, if that decision is consistent with the individual’s previously executed declaration or do-not-resuscitate order under Ch. 154, Wis. Stats., a power of attorney for health care under Ch. 155, Wis. Stats., or as otherwise authorized by law.

- **Self-Neglect:** As defined in § 46.90(1)(g), Wis. Stats., means a significant danger to an individual’s physical or mental health because the individual is responsible for his/her own care but fails to obtain adequate care, including food, shelter, clothing, or medical or dental care.

- **Financial Exploitation:** As defined in Wis. Stats. § 46.90 (1) (ed) includes any of the following acts:
  - Fraud, enticement or coercion;
  - Theft;
  - Misconduct by a fiscal agent;
  - Identity theft;
  - Unauthorized use of the identity of a company or agency;
  - Forgery; or
  - Unauthorized use of financial transaction cards including credit, debit, ATM, and similar cards.
• **Abuse, Physical:** As defined in Wis. Stats. § 46.90 (1) (fg) intentional or reckless infliction of physical pain or injury, illness, or any impairment of physical condition.

• **Abuse, Sexual:** Wis. Stats. §46.90 (1)(gd) a violation of criminal assault law, Wis. Stats. §§ 940.225 (1), (2), (3), or (3m).

• **Abuse, Emotional:** As defined in Wis. Stats. §46.90 (1)(cm) language or behavior that serves no legitimate purpose and is intended to be intimidating, humiliating, threatening, frightening, or otherwise harassing, and that does or reasonably could intimidate, humiliate, threaten, frighten, or otherwise harass the individual to whom the conduct or language is directed.

• **Abuse, Treatment Without Consent:** Administration of medication to an individual who has not provided informed consent or the performance of psychosurgery, electroconvulsive therapy, or experimental research on an individual who has not provided informed consent, with the knowledge that no lawful authority exists for the administration or performance.

• **Abuse, Unreasonable Confinement or Restraint:** The intentional and unreasonable confinement of an individual from his or her living area, use on an individual of physically restraining devices, or the provision of unnecessary or excessive medication to an individual, but does not include the use of these methods or devices in entities regulated by the department if the methods or devices are employed in conformance with state and federal standards governing confinement or restraint.

• **Any Unplanned or Unapproved Use of Restraints (or restrictive measures):** restraint types include: mechanical supports, mechanical restraints, medical restraints, medical procedure restraint, restraints allowing healing, restraints for protection. Also – chemical restraints (use of as-needed (prn) medications for controlling acute or episodic behavior.

• **Any Unplanned or Unapproved Use of Isolation/seclusion:** The intentional and unreasonable confinement of an individual from his or her living area, use on an individual of physically restraining devices, or the provision of unnecessary or excessive medication to an individual, but does not include the use of these methods or devices in entities regulated by the department if the methods or devices are employed in conformance with state and federal standards governing confinement or restraint.

• **Falls:** Unless there is evidence to indicate otherwise, a fall, with or without injury, has occurred when a member is found on the ground/floor or a member reports a fall. A fall is an unintentional occurrence (not as a result of being pushed down) and may be an assisted or unassisted fall; may include rolling off
a low bed onto a mat. An unintentional change in condition due to a sudden medical condition is not a fall (because treatment for a medical condition is different than treatment for a fall).

- **Death:** Deaths under the following categories are considered a reportable incident:
  - Neglect
  - Self-neglect
  - Financial exploitation
  - Abuse
  - Accident
  - Restraint
  - Isolation/seclusion
  - Suicide
  - Psychotropic medication
  - Medication error
  - Fall(s)
  - Unexplained, unusual, or suspicious circumstances
  - Missing person
  - Other
  - Deaths from a known diagnosed disease, health condition, or similar situation are not considered an incident but still need to be reported to the Client.

- **Missing Person:** Any instance when a member visually and physically wanders away or leaves a home or a community setting for any length of time without prior arrangement or permission.

- **Any Unplanned or Unapproved Involvement of Law Enforcement and/or Criminal Justice System:** Any time law enforcement personnel are called to the CBRF, AFH, RCAC, or other community setting as a result of an incident that jeopardizes the health, safety, or welfare of residents/member) or employees/other persons.

- **Medication Errors:**
  - errors in medication time;
  - omission;
  - wrong medication;
  - wrong dose;
  - wrong person;
  - wrong route of administration; or
  - wrong technique
H. RESTRICTIVE MEASURES

Provider agrees to submit a request for restrictive measures involving any one or more members prior to submission to iCare. Independent Care will contact the State once iCare and the provider agree to the measures. The use of isolation, seclusion, and restrictive measures in licensed facilities in WI is regulated by the DHS. Providers may find information on restrictive measures at: https://www.dhs.wisconsin.gov/library/p-02572.htm

In emergency situations, the provider must contact the iCare IDT team as soon as possible after the incident; the day of the incident if possible, or within 24 hours of the incident.

Provider must adhere to regulatory requirements and iCare standards relative to restrictive measures including any type of restraint, isolation, seclusion, protective equipment, or medical restraint as required Wis. Stat. 51.61(1)(i) and Wis. Admin Code DHS 94.10.

I. MEDICAL RECORDS

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

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

Medical records and other documentation may be requested and reviewed as part of the quality concern and grievance processes. The provider agrees to make records available to members and individuals the member has authorized in writing to receive records within ten (10) business days of the records request if the records are maintained on site and sixty (60) calendar days if maintained off site. Provider further agrees to forward records to iCare pursuant to grievance and appeals within 15 business day of iCare’s request or immediately, if the appeal is expedited. If requested, copies of medical records are reimbursed as specified in your iCare Provider Agreement.
J. ACCESS AND AUDIT

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

K. MEMBER GRIEVANCES AND APPEALS

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

An Adverse Benefit Determination includes any of the following:

- The denial or limited authorization of a requested service that falls within the Family Care Partnership benefit package, including the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service, unless the service was only authorized for a limited amount of time or duration and that amount or duration has been completed.
- The denial, in whole or in part, of payment for a service that falls within the Family Care Partnership benefit package. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a “clean claim under 42 CFR § 447.45(b) is not an adverse benefit determination
- The failure to provide services and support items included in the member’s member centered plan in a timely manner.
- The failure of iCare to act within the required timeframes for resolution of grievances or appeals.
- The development of a member-centered plan that is unacceptable to the member because any of the following apply:
  - The plan is contrary to a member’s wishes insofar as it requires the member to live in a place that is unacceptable to the member.
• The plan does not provide sufficient care, treatment or support to meet the member’s needs and support the member’s identified outcomes.

• The plan requires the member to accept care, treatment or support items that are unnecessarily restrictive or unwanted by the member.

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

• The involuntary disenrollment of the member from iCare at iCare’s request.

• The failure of iCare to act within the timeframes for resolution of grievances or appeals.

• The denial of functional eligibility under Wis. Stat. § 46.286(I)(a) as a result of iCare’s administration of the LTCFS, including a change from nursing home level of care to non-nursing home level of care.

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

A **Grievance** is an expression of dissatisfaction about any matter other than an adverse benefit determination. If a member is dissatisfied with iCare’s grievance decision, they can request DHS Review of the decision.

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

Members can receive assistance in filing a grievance or appeal from the iCare Member Rights Specialist. The iCare Member Rights Specialist can be reached at: (414) 231-1076.

Family Care Partnership members can also get free help from an independent ombudsman. The following agencies advocate for Family Care Partnership members:

**For members age 18 to 59:**

Disability Rights Wisconsin  
Toll Free: 800-928-8778  
TTY: 711

**For members age 60 and older:**

Wisconsin Board on Aging and Long Term Care
VI. CLAIMS PROCESSING 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.

iCare claims are processed by the TriZetto Group, a Cognizant company, at its Dallas, Texas location. The TriZetto Group uses an automated claims processing system called QNXT.

All claims for LTC services should be submitted on either the iCare LTC Residential Services Claim Form or the iCare LTC Professional Services Claim Form. The documents, as fillable forms, are found at the iCare Website (http://www.icarehealthplan.org/Providers/ClaimsProcessing.aspx)

Claim completion requirements can be found on page 2 of both forms.

A. PROVIDER PORTAL

https://www.icarehealthplan.org/Provider/Provider_Portal.htm

The iCare Provider Portal provides information about service authorizations and claims information for the iCare's members you serve. To request a PIN for access to the Portal, email providerrelationsspecialist@icarehealthplan.org.

The iCare Portal User Guide provides step by step instructions for registration and outlines portal functions and is found at https://www.icarehealthplan.org/Provider/Provider_Portal.htm. If you have any questions, please contact ProviderOutreach@icarehealthplan.org.

B. CLAIM SUBMISSION

The iCare LTC claims forms are mailed to:

iCare Family Care Partnership Long Term Care Services
Independent Care Health Plan
PO Box 224255
Dallas, Texas 75222-4255


If you are providing services that fall under the scope of iCare’s primary and acute
care network submit the services for payment using the CMS 1500 or UB-04 claim forms. Please refer to the Provider Reference Manual and the iCare website for more information. [http://www.icarehealthplan.org/Providers/](http://www.icarehealthplan.org/Providers/).

C. CORRECTED CLAIMS

Mark the claim as “Corrected Claim”. Corrected claims will not be accepted via fax. For proper processing label claims submitted with corrected or additional information as a “Corrected Claim”. The corrected claim address is:

**Long Term Care Claims:**
Independent Care Health
Plan PO Box 224255
Dallas, Texas 75222-4255

D. CLAIMS FILING LIMITS

The contracts between providers and iCare have specific claims filing limit information. All claims for LTC services rendered for iCare Family Care Partnership, must be submitted according to the terms of the contract. Timely filing limits of 120 days from the date of service apply to initial claims submissions, resubmissions and corrected claims, and unless specified in your agreement. Claims which contain multiple dates of service on one Claim will be treated as follows dependent upon the type of Claim/service being billed: i) for Home and Community-Based Waiver Services and facility inpatient services, the latest date of service represented on the Claim will be the date used to determine timely filing for the entire Claim; ii) for professional Claims and facility outpatient Claims, each date of service represented on the Claim (Claim line) will be assessed individually for timeliness.

E. CHECKING CLAIM STATUS

Claim status can be found at the iCare Provider Portal [https://www.icarehealthplan.org/Provider/Provider_Portal.htm](https://www.icarehealthplan.org/Provider/Provider_Portal.htm)

Providers may also direct calls to Customer Service regarding status of a claim or email Provider Services at [providerservices@icarehealthplan.org](mailto:providerservices@icarehealthplan.org)

F. EXPLANATION OF PAYMENT/REMITTANCE

Providers receive an Explanation of Payment (EOP) including each claim submitted to iCare. The Remittance Education Package explains the EOP and can be located at [http://www.icarehealthplan.org/Providers/ClaimsProcessing.aspx](http://www.icarehealthplan.org/Providers/ClaimsProcessing.aspx)
The EOPs can also be found in the Provider Portal. Please note there is a charge of $25.00 for duplicate copies of the EOPs. Direct questions to Customer Service.

G. BILLING MEMBERS

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

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

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

H. REFUNDS

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
- Date of Service
- Service rendered
- Copy of the EOP containing the payment being refunded

I. CLAIM ERRORS, REVIEW/REOPENING AND RECONSIDERATION/APPEALS

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

**Medicaid and Medicare Covered Services**

Appeal: formal request for review of an adverse benefit determination (e.g., the denial, in whole or in part of payment for a service). For example: a claim is denied or paid at a rate that the provider believes is incorrect. The provider must appeal the denial action to iCare; an internal review by iCare is required.

Providers may file a formal appeal with iCare if the provider disagrees with iCare’s payment or denial determination on a claim. Requests for an appeal must be submitted in writing within sixty (60) calendar days of the date the provider is notified of the initial claim payment or denial notice. Independent Care has forty-five (45) calendar days from the date of receipt of the request for an appeal to respond in writing to the provider. Requests for an appeal must be sent to iCare as follows:

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

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

 Fax: (608) 266-5629

 Or

 Mail: Provider Appeals Investigator
 Division of Medicaid Services
 1 West Wilson Street, Room 518
 P.O. Box 309
 Madison, WI 53701-0309

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

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

**Overpayments**

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

**VII. MEMBER RIGHTS**

Independent Care recognizes each member as an individual and emphasizes each member’s capabilities. Independent Care staff and affiliated providers shall demonstrate dignity and respect in all of their interactions with members and take members’ rights into account when furnishing services to members, including but not limited to:

We must honor your rights as a member of iCare Family Care Partnership.

- **You have the right to be included in the care management process of an assessment of your understanding of your rights**, such as control of money, freedom of speech, freedom of religion, right to vote, right to privacy, freedom of association, right to possessions, right to employment, right to education, access to healthcare, and right to choose leisure and rest. You also have the right to an assessment on your understanding of executing advance directives and whether you are aware and understand you can choose a guardian, durable power of attorney or activated power of attorney for health care.

- **We must provide information in a way that works for you.** To get information from us in a way that works for you, please contact your Care Team.

- **We must treat you with dignity, respect, and fairness always.** You have the right:
  - To get compassionate, considerate care from iCare Family Care Partnership staff and providers.
  - To get your care in a safe, clean environment.
  - **To not have to do work or perform services for iCare Family Care Partnership.**
  - To be encouraged and helped in talking to iCare Family Care Partnership staff about changes in policy that you think should be made or services that you think should be provided.
To be encouraged to exercise your rights as a member of iCare Family Care Partnership.

To be free from discrimination. iCare Family Care Partnership must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person’s race, mental or physical disability, religion, gender, gender identity, sexual orientation, health, ethnicity, creed (beliefs), age, national origin, or source of payment.

To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. This means you have the right to be free from being restrained or forced to be alone to make you behave in a certain way or to punish you or because someone finds it useful.

To be free from abuse, neglect, and financial exploitation.

- Abuse can be physical, emotional, financial, or sexual. Abuse can also be if someone gives you a treatment such as medication, or experimental research without your informed consent.

- Neglect is when a caregiver fails to provide care, services, or supervision which creates significant risk of danger to the individual. Self-neglect is when an individual who is responsible for his or her own care fails to obtain adequate care, including food, shelter, clothing, or medical or dental care.

- Financial exploitation can be fraud, enticement or coercion, theft, misconduct by a fiscal agent, identity theft, forgery, or unauthorized use of financial transaction cards including credit, debit, ATM, and similar cards.

What can you do if you are experiencing abuse, neglect, or financial exploitation? Your Care Team is available to talk with you about issues that you feel may be abuse, neglect, or financial exploitation. They can help you with reporting or securing services for safety. You should always call 911 in an emergency.

If you feel that you or someone you know is a victim of abuse, neglect, or financial exploitation, you can contact Adult Protective Services. Adult Protective Services help protect the safety of seniors and adults-at-risk who have experienced abuse, neglect, or exploitation. They also help when a person is unable to look after his or her own safety due to a health condition or disability.

You may call the following numbers to report incidents of witnessed or suspected abuse:

Call your Team at 1-800-777-4376 (TTY: 1-800-947-3529) to consult with you regarding issues that you feel may constitute abuse, neglect, or financial exploitation. They will assist you with coordination of reporting or securing services for safety.
You should always call 911 in an emergency for immediate assistance. The County Health and Human Services Department offers Adult Protective Services which are provided to people with developmental disabilities, degenerative brain disorder, serious and persistent mental illness, or other similar incapacity to keep the individual safe from abuse, neglect, financial exploitation, or misappropriation of property or prevent the individual from experiencing deterioration or from inflicting harm on himself or herself or another person.

ADRC of Dane County  
2865 N. Sherman Avenue  
Northside Town Center  
Madison WI 53704  
Toll-Free Phone: 855-417-6892  
Local Phone: 608-240-7400  
TTY/TDD/Relay: 608-240-7404  
Email: adrc@countyofdane.com

ADRC of Kenosha County  
8600 Sheridan Road, Suite 500  
Kenosha, WI 53143  
Phone: 800-472-8008  
TTY/TDD/Relay: WI Relay 711  
Email: adrc@kenoshacounty.org

ADRC of Milwaukee County  
1220 W. Vliet Street, Suite 300  
Milwaukee, Wisconsin 53205  
Phone: 414-289-6874  
Email: ADRC@milwaukeecountywi.gov

ADRC of Racine County  
14200 Washington Ave  
Sturtevant, Wisconsin 53177  
Phone: 1-866-219-1043  
TTY: Wisconsin Relay 711  
Email: adrc@racinecounty.com

ADRC of Eagle Country – Sauk County Office  
(serving Crawford, Juneau, Richland and Sauk counties)  
Phone: 877-794-2372  
TTY/TDD/Relay: WI Relay 711
• **We must ensure that you get timely access to your covered services.** As a member of iCare Family Care Partnership, you have a right to receive services listed in your care plan when you need them. Your Care Team will arrange for your covered services. Your team will also coordinate with your health care providers. Examples of these are doctors, dentists, and podiatrists. Contact your team for assistance in choosing your providers.
  
o As a member of iCare Family Care Partnership, you have the right to choose a primary care provider (PCP) in the provider network and receive the services listed in your care plan when you need them. Call iCare Family Care Partnership to learn which doctors are accepting new patients. If you think that you are not getting your medical care or drugs within a reasonable amount of time, talk to your Care Team. You may also refer to Chapter 8 which explains what you can do.

• **We must protect the privacy of your personal health information.** If you have questions or concerns about the privacy of your personal health information, please call your team. See Appendix 6 for iCare Family Care Partnership’s Notice of Privacy Practices.

• **We must give you access to your medical records.** Ask your Care Team if you want a copy of your records. You have the right to ask iCare Family Care Partnership to change or correct your records.

• **We must give you information about iCare Family Care Partnership, our network of providers, and available services.** Please contact your Team if you want this information or go to our website (www.icare-wi.org).

• **We must support your right to make decisions about your care.**
  
o You have a right to know about all your choices. This means you have the right to be told about all the options that are available, what they cost and whether they are covered by Partnership. You can also suggest other services or supports that you think would meet your needs.

  o You have the right to be told about any risks involved in your care.

  o You have the right to say “no” to any recommended care or services.

  o You have the right to get second medical opinions.

  o You have the right to give instructions about what you want done if you are not able to make decisions for yourself. Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means if you want, you can develop an **advance directive.** There are different types of advance directives and different names for them. Documents called **living will** and **power of attorney for**
**health care** are examples of advance directives. Contact your Care Team if you want to know more about advance directives.

- **You have the right to receive your Partnership services in places that let you be a true part of the community in which you live.** This is your right under the federal home and community-based services settings rule. The rule applies to the setting where you live and the settings outside of your home where you receive services during the day. iCare has to make sure you receive your Partnership services in places that connect you to your community and support your independence. This means places that support your ability to:
  - Live where you want to live.
  - Participate in community life.
  - Find and participate in work in the same way as other people in your community.
  - Control your schedule.
  - Access and control your money.
  - Decide who to see and when to see them.
  - Maintain your privacy.

- **You have the right to file a grievance or appeal if you are dissatisfied with your care or services.** Chapter 8 includes information about what you can do if you want to file a grievance or appeal.

**Your Responsibilities**

Things you need to do as a member of iCare Family Care Partnership are listed below. If you have any questions, please contact your Care Team. We are here to help.

- Become familiar with the services in the Partnership benefit package. This includes understanding what you need to do to get your services. See Chapters 3 and 4 for more information.
- Participate in the initial and ongoing development of your care plan.
- Participate in the Resource Allocation Decision (RAD) process to find the most cost-effective ways to meet your needs and support your outcomes. Members, families, and friends share responsibility for the most cost-effective use of public tax dollars.
- Talk with your Care Team about ways your friends, family or other community and volunteer organizations may help support you or ways in which you can do more for yourself.
- Follow the care plan that you and your Care Team agreed to.-.
• Tell your doctors and other providers that you are in Partnership so they can work with you and your Care Team to be a part of your care plan.

• Be responsible for your actions if you refuse treatment or do not follow the instructions from your Care Team or providers.

• Use the providers that are part of iCare Family Care Partnership unless you and your Care Team decide otherwise.

• Show your Partnership membership card whenever you get medical care or prescription drugs. It is important to show your membership card so that providers know to bill Partnership not you.

• Follow iCare Family Care Partnership’s procedures for getting care after hours.

• Notify us if you move to a new address or change your phone number.

• Notify us of any planned temporary stay or move out of the service area.

• Provide iCare Family Care Partnership with correct information about your health care needs, finances, and preferences and tell us as soon as possible about any changes in your status. This includes signing a “release of information” form when we need other information you do not have easily available.

• Treat your Team, home care staff, and providers with dignity and respect.

• Accept services without regard to the provider’s race, color, religion, age, gender, sexual orientation, health, ethnicity, creed (beliefs), or national origin.

• Pay any monthly costs on time, including any cost share or room and board charges you may have. Let your Care Team know as soon as possible if you have problems with your payment.

• Complete an “Annual Renewal” for Medicaid eligibility. The Income Maintenance agency uses the annual renewal to determine your financial eligibility. The renewal is to make sure you still meet all the program requirements. You will be notified by mail the month before your renewal is due. This letter will tell you how to do your renewal.

If you do not complete your renewal timely, you will lose your Medicaid and Partnership coverage and there will be a gap or delay in your benefits. Contact your team if you need assistance or have questions about the annual renewal.

• Use your private insurance benefits, when appropriate. If you have any other health insurance coverage, tell iCare Family Care Partnership and the Income Maintenance agency. Let your Care Team know right away if you enroll in Medicare or think you may be eligible for Medicare.

• Take care of any durable medical equipment (DME), such as wheelchairs, and hospital beds provided to you by iCare Family Care Partnership.
• Report fraud or abuse on the part of providers or iCare Family Care Partnership employees.

If you suspect anyone of misuse of public assistance funds, including Partnership, you can call the fraud hotline or file a report online at:

**Report Public Assistance Fraud**

1-877-865-3432 (toll-free) or visit

www.reportfraud.wisconsin.gov

Do not engage in any fraudulent activity or abuse benefits. This may include:

- Misrepresenting your level of disability
- Misrepresenting income and asset level
- Misrepresenting residency
- Selling medical equipment supplied by iCare Family Care Partnership

Any fraudulent activity may result in disenrollment from Partnership or possible criminal prosecution.

• Help your Team, doctors and other providers help you by giving them information, asking questions, sharing concerns, and following through on your care.

• Call your Care Team for help if you have questions or concerns.

• Tell us how we are doing. From time to time, we may ask if you are willing to participate in member interviews, satisfactions surveys, or other quality review activities. Your responses and comments will help us identify our strengths as well as the areas we need to improve. Please let us know if you would like to know the results of any surveys. We would be happy to share that information with you.

VIII. PROVIDER RIGHTS AND RESPONSIBILITIES

A. PROVIDER RIGHTS

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

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

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

- The member’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
- Any information the member needs in order to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment.
- The member’s right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.

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

B. PROVIDER RESPONSIBILITIES

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

Provider must accept iCare reimbursement as payment in full except in cases where coordination of benefits applies. Providers are required to bill iCare for covered services provided to a member during periods of retroactive eligibility when notified that a member has obtained such eligibility.

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

Provider shall not bill an iCare member for medically necessary services covered by Family Care, Medicare, or Medicaid that are provided during the member’s period of iCare enrollment.

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

Provider agrees not to create barriers to access to care by imposing requirements on members that are inconsistent with the provision of services in the benefit package that are necessary to achieve outcomes.

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

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

Providers are prohibited from discriminating against iCare members. Provider’s hours of operation must not discriminate against iCare members. Provider agrees to comply with all non-discrimination requirements and all applicable affirmative action and civil rights compliance laws and regulations, including providing iCare with a Letter of Assurance, and if the provider has more than 50 employees and receives more than $50,000 in Federal funds, completing and keeping on file a Civil Rights Compliance Plan. Reference https://www.dhs.wisconsin.gov/civil-rights/index.htm.

Providers and subcontractors to providers are required to cooperate with any member-related investigation conducted by iCare, DHS, DHHS, CMS, law enforcement, or any other legally authorized investigative entity. This includes submitting information when requested that is related to the member incident.

All LTC services must be prior-authorized through the IDT. Prior to delivery of a service to an iCare FCP member, the provider must obtain a Service Authorization from the IDT staff at iCare outlining the specific services and rates of reimbursement.

All appeals and reconsiderations should be dated and submitted to iCare within sixty (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 and Human Services (DHS) if iCare has not responded in writing within 45 days from receipt of the request for reconsideration. The provider will accept the DHFS determination regarding appeals of disputed claim(s).

Providers shall comply with Electronic Visit Verification (EVV) requirements established by DHS for supportive home care (Section IV. D.) and personal care services funded by Medicaid. Prior authorization and EVV requirements for personal care services are outlined in the iCare Provider Reference Manual, found on the iCare provider website: https://www.icarehealthplan.org/Providers/.

Provider may not require a member to receive a service via interactive telehealth or remotely if in person service is available.
Providers are prohibited from influencing a member’s choice of long term care programs or of MCOs or ICAs...

C. PROVIDER MINIMUM INSURANCE COVERAGE REQUIREMENTS

Providers are required to have in effect and maintain, at a minimum, the insurance coverage as set forth in the chart below.

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>General Liability</th>
<th>Auto Liability</th>
<th>Worker’s Compensation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supportive Home Care</td>
<td>General Liability Per Occurrence $1,000,000 Aggregate $3,000,000</td>
<td>Combined Single Limit $1,000,000</td>
<td>Per Occurrence $100,000 Aggregate $500,000</td>
</tr>
<tr>
<td>AFH 1-2 Bed</td>
<td>General Liability Per Occurrence $1,000,000 Aggregate $2,000,000</td>
<td>Combined Single Limit $1,000,000</td>
<td>Per Occurrence $100,000 Aggregate $500,000</td>
</tr>
<tr>
<td>AFH 3-4 Bed</td>
<td>General Liability Per Occurrence $1,000,000 Aggregate $2,000,000</td>
<td>Combined Single Limit $1,000,000</td>
<td>Per Occurrence $100,000 Aggregate $500,000</td>
</tr>
<tr>
<td>CBRF &gt;8 Bed</td>
<td>General Liability Per Occurrence $1,000,000 Aggregate $2,000,000</td>
<td>Combined Single Limit $1,000,000</td>
<td>Per Occurrence $100,000 Aggregate $500,000</td>
</tr>
<tr>
<td>CBRF &lt;8 Bed</td>
<td>General Liability Per Occurrence $1,000,000 Aggregate $2,000,000</td>
<td>Combined Single Limit $1,000,000</td>
<td>Per Occurrence $100,000 Aggregate $500,000</td>
</tr>
<tr>
<td>Fiscal Agency</td>
<td>General Liability Per Occurrence $1,000,000 Aggregate $2,000,000</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Day Program</td>
<td>General Liability Per Occurrence $1,000,000 Aggregate $2,000,000</td>
<td>Combined Single Limit $1,000,000</td>
<td>Per Occurrence $100,000 Aggregate $500,000</td>
</tr>
<tr>
<td>Employment Programs</td>
<td>General Liability Per Occurrence $1,000,000 Aggregate $2,000,000</td>
<td>Combined Single Limit $1,000,000</td>
<td>Per Occurrence $100,000 Aggregate $500,000</td>
</tr>
<tr>
<td>Other providers including home and community-based</td>
<td>General Liability Per Occurrence $1,000,000</td>
<td>Combined Single Limit $1,000,000</td>
<td>Per Occurrence $100,000 Aggregate $500,000</td>
</tr>
</tbody>
</table>
service providers not otherwise noted above.  Aggregate $2,000,000

Primary and acute care providers must meet Wisconsin Statutory requirements for professional liability coverage.

Please contact your insurance agent to obtain a Certificate of Insurance with iCare Health Plan (1555 River Center Drive, Suite 206, Milwaukee, WI 53212) as the certificate holder.

**Proof of Insurance**

iCare requires all Network Providers to procure and maintain comprehensive policies of property and casualty insurance including general and professional liability insurance, and workers compensation, if the Provider is acting as an employer as defined in Wis. Stat. § 102.04. Provider will provide certificates of insurance within thirty (30) calendar days of a renewal of any property or casualty policy annually. Provider will list iCare Health Plan as a certificate holder on the Certificate of Insurance.

**IX. PROHIBITED MARKETING/OUTREACH PRACTICES**

Provider agrees that iCare may, in its sole discretion and without Provider’s approval, prepare, distribute materials and furnish information generally describing Providers or its Participating Providers and may furnish information on Provider’s qualifications. The following marketing/outreach practices are prohibited:

1. Practices that are discriminatory.
2. Practices that seek to influence enrollment in conjunction with the sale or offering of any other insurance product.
3. Direct and indirect cold calls, either door-to-door, email, telephone, text or other cold call marketing activity.
4. Offer of material or financial gain to potential members as an inducement to enroll.
5. Activities and materials that could mislead, confuse or defraud members or potential members or otherwise misrepresent iCare, its marketing representatives, DHS, or CMS. Statements that would be considered inaccurate, false, or misleading include, but are not limited to any assertion or statement (whether written or oral) that:
   a. The recipient must enroll in iCare in order to obtain benefits or in order to not lose benefits.
   b. iCare is endorsed by CMS, the federal or state government, or other similar entity.
6. Practices that are reasonably expected to have the effect of denying or discouraging enrollment.
7. Practices to influence the recipient to either not enroll in or to disenroll from another insurance plan.
8. Marketing/outreach/communication activities that have not received written approval from DHS.
EXHIBIT

Exhibit 1: Services Included in IRIS, Family Care, Partnership and PACE
## EXHIBIT 1

Services Included in IRIS, Family Care, Partnership, and PACE

<table>
<thead>
<tr>
<th>Family Care Partnership</th>
<th>Medicare Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>PACE (Program of All-Inclusive Care for the Elderly)</td>
<td>Medicare Part A (Hospital), Part B (Medical), and Part D (Prescription Drugs)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IRIS</th>
<th>Medicaid Card Services Long-Term Care</th>
<th>Acute and Primary Medicaid Services</th>
<th>Medicare Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home and Community-Based Waiver Services</td>
<td>Alcohol and other drug abuse day treatment services (in all settings except hospital-based)</td>
<td>Physician services</td>
<td>Durable Medical Equipment, Prosthetics, Orthotics and Supplies</td>
</tr>
<tr>
<td>- Adaptive aids (general and vehicle)**</td>
<td>- Community support program</td>
<td>- Laboratory and x-ray services</td>
<td>- Ambulance services</td>
</tr>
<tr>
<td>- Adult day care</td>
<td>- Durable medical equipment, except for hearing aids and prosthetics</td>
<td>- Inpatient hospital</td>
<td>- Ambulatory surgical centers</td>
</tr>
<tr>
<td>- Assistive technology</td>
<td>- Home health</td>
<td>- Outpatient hospital services</td>
<td>- Blood</td>
</tr>
<tr>
<td>- Care/case management**</td>
<td>- Medical supplies</td>
<td>- Early and Periodic Screening, Diagnostic, and Treatment (under 21)</td>
<td>- Durable Medical Equipment, Prosthetics, Orthotics and Supplies</td>
</tr>
<tr>
<td>- Consultative clinical and therapeutic services for caregivers</td>
<td>- Mental health day treatment services (in all settings)</td>
<td>- Family planning services and supplies</td>
<td>- Cardiac rehab</td>
</tr>
<tr>
<td>- Consumer education and training</td>
<td>- Mental health services, except those provided by a physician or on an inpatient basis</td>
<td>- Federally-qualified health center services</td>
<td>- Chiropractic services — extremely limited (only manipulation of the spine to correct a minor dislocation, called &quot;subluxation&quot;)</td>
</tr>
<tr>
<td>- Counseling and therapeutic resources</td>
<td></td>
<td>- Rural health clinic services</td>
<td>- Diabetes supplies</td>
</tr>
<tr>
<td>- Individual directed goods and services***</td>
<td></td>
<td>- Nurse midwife services</td>
<td>- Diagnostic tests, x-rays and lab services</td>
</tr>
<tr>
<td>- Interpreter services</td>
<td></td>
<td>- Certified nurse practitioner services</td>
<td>- Physician services</td>
</tr>
<tr>
<td>- Daily living skills training</td>
<td></td>
<td>- Prescribed drugs (very limited if Medicare eligible. Medicare Part D would cover most outpatient drugs)</td>
<td>- Emergency and urgent care services</td>
</tr>
<tr>
<td>- Day services/treatment</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- Financial management services**</td>
<td></td>
<td></td>
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<tr>
<td>- Fiscal employer agent services ***</td>
<td></td>
<td></td>
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<tr>
<td>- Home modifications</td>
<td></td>
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</tr>
</tbody>
</table>
## PACE (Program of All-Inclusive Care for the Elderly)

### Family Care Partnership

### IRIS

<table>
<thead>
<tr>
<th>Home and Community-Based Waiver Services</th>
<th>Medicaid Card Services Long-Term Care</th>
<th>Acute and Primary Medicaid Services</th>
<th>Medicare Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Housing counseling</td>
<td>• Nursing facility (all stays including Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) and Institution for Mental Disease (IMD) IMD not covered between ages 21-64)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• IRIS consultant services***</td>
<td>• Nursing services (including respiratory care, intermittent and private duty nursing)</td>
<td></td>
<td></td>
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<tr>
<td>• Live-in caregiver ***</td>
<td>• Occupational therapy (in all settings except for inpatient hospital)</td>
<td></td>
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<tr>
<td>• Home delivered meals</td>
<td>• Personal care</td>
<td></td>
<td></td>
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<tr>
<td>• Personal emergency response system services</td>
<td>• Self-directed personal care</td>
<td></td>
<td></td>
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<tr>
<td>• Prevocational services</td>
<td>• Physical therapy (in all settings except for inpatient hospital)</td>
<td></td>
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<tr>
<td>• Relocation services</td>
<td>• Speech and language pathology services (in all settings except for inpatient hospital)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Residential services (adult family home, community-based residential facility, certified residential care apartment complex)</td>
<td>• Diagnostic, screening, preventive, and rehabilitation services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Respite care</td>
<td>• Clinic services</td>
<td></td>
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<tr>
<td>• Self-directed personal care</td>
<td>• Primary care case management services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Skilled nursing (amounts above Medicaid card coverage)</td>
<td>• Dental services, dentures</td>
<td></td>
<td></td>
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<tr>
<td>• Specialized medical equipment and supplies</td>
<td>• Dialysis service</td>
<td></td>
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<tr>
<td>• Specialized/community transportation</td>
<td>• Hospice care</td>
<td></td>
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<tr>
<td>• Support broker services</td>
<td>• Prosthetic devices, eyeglasses</td>
<td></td>
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<td></td>
<td>• TB–related services</td>
<td></td>
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<tr>
<td></td>
<td>• Other specific medical and remedial care</td>
<td></td>
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<tr>
<td></td>
<td>• Inpatient mental health</td>
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<tr>
<td></td>
<td>• Chiropractic services</td>
<td></td>
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<td></td>
<td>• Podiatry services</td>
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<td></td>
<td>• Outpatient mental health provided by a physician</td>
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<td></td>
<td>• Outpatient substance abuse provided by a physician</td>
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<tr>
<td></td>
<td>• Home health care if homebound and need skilled nursing or therapy services</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>• Hospice care</td>
<td></td>
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<td></td>
<td>• Inpatient hospital care</td>
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<tr>
<td></td>
<td>• Inpatient mental health care</td>
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<tr>
<td></td>
<td>• Outpatient mental health care</td>
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<td></td>
<td>• Outpatient hospital services, including outpatient surgery</td>
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<td></td>
<td>• Limited post-hospital skilled nursing facility if daily skilled nursing and/or rehabilitation services needed</td>
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<td></td>
<td>• Physical/speech/occupational therapy</td>
<td></td>
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<td></td>
<td>• Podiatry services (only treatment of injuries or diseases of the foot, no routine care)</td>
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<tr>
<td></td>
<td>• Prescription drugs, including drugs covered under Medicare Part A, Part B, and Part D</td>
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</tr>
</tbody>
</table>
### PACE (Program of All-Inclusive Care for the Elderly)

#### Family Care Partnership

**IRIS**

<table>
<thead>
<tr>
<th>Home and Community-Based Waiver Services</th>
<th>Medicaid Card Services Long-Term Care</th>
<th>Acute and Primary Medicaid Services</th>
<th>Medicare Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Supported employment services</td>
<td>- Transportation to receive</td>
<td>- Outpatient surgery</td>
<td>- Very limited</td>
</tr>
<tr>
<td>- Supportive home care</td>
<td>- non-emergency medical care (except</td>
<td>- Ambulance services</td>
<td>dental, hearing</td>
</tr>
<tr>
<td>- Training services for unpaid</td>
<td>- Emergency care</td>
<td>- Urgent care</td>
<td>and vision services,</td>
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<tr>
<td>caregivers</td>
<td>- Urgent care</td>
<td>- Diagnostic services</td>
<td>excluding all</td>
</tr>
<tr>
<td>- Vehicle modifications***</td>
<td>- Hearing services</td>
<td>- Vision services</td>
<td>dental services ex</td>
</tr>
<tr>
<td>- Vocational futures planning</td>
<td>- Transportation to medical</td>
<td>- Various preventive</td>
<td>cept where</td>
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<td></td>
<td>- care</td>
<td>services, screenings, vaccinations,</td>
<td>necessary to the</td>
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<td></td>
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<td>and yearly wellness visit.</td>
<td>provision of other,</td>
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<td>covered medical</td>
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<td>services, also</td>
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<td>eye care and</td>
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<td>hearing exams and</td>
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<td>hearing aids.</td>
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<td>Eyeglasses and</td>
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<td>contacts limited</td>
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<td>to one pair after</td>
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<td>cataract surgery.</td>
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<td>Substance abuse</td>
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<td></td>
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<td></td>
<td>treatment (outpatient)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Various preventive</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>services, screenings, vaccinations, and</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>yearly wellness visit.</td>
</tr>
</tbody>
</table>

* Partnership members who are enrolled in Medicare  ** Not an IRIS waiver service  *** IRIS only

IRIS participants access Medicaid LTC card services and acute/primary services with their Medicaid card. Family Care members access acute/primary services with their Medicare card. Individuals enrolled in IRIS or Family Care may also be eligible for Medicare and access acute/primary services with their Medicare card.

Contact a Local Aging and Disability Resource Center to learn if you are eligible for a publicly funded long-term care program and to find out which programs are available in your area.

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**Wisconsin Department of Health Services**

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