Family Care Guide

For Wisconsin Medicaid-Certified Providers

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FAMILY CARE
Options for Long-Term Care

wisconsin Medicaid and BadgerCare
Information for Providers
Department of Health and Family Services

Important Telephone Numbers

Wisconsin Medicaid's Eligibility Verification System (EVS) is available through the following resources to verify checkwrite information, claim status, prior authorization status, provider certification, and/or recipient eligibility.

Service	Information available	Telephone number	Hours
Automated Voice Response (AVR) System (Computerized voice response to provider inquiries.)	Checkwrite Info. Claim Status Prior Authorization Status Recipient Eligibility*	(800) 947-3544 (608) 221-4247 (Madison area)	24 hours a day/ 7 days a week
Personal Computer Software and Magnetic Stripe Card Readers	Recipient Eligibility*	Refer to Provider Resources section of All-Provider Handbook for a list of commercial eligibility verification vendors.	24 hours a day/ 7 days a week
Provider Services (Correspondents assist with questions.)	Checkwrite Info. Claim Status Prior Authorization Status Provider Certification Recipient Eligibility*	(800) 947-9627 (608) 221-9883	Policy/Billing and Eligibility: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T) Pharmacy: 8:30 a.m. - 6:00 p.m. (M, W-F) 9:30 a.m. - 6:00 p.m. (T)
Direct Information Access Line with Updates for Providers (Dial-Up) (Software communications package and modem.)	Checkwrite Info. Claim Status Prior Authorization Status Recipient Eligibility*	Call (608) 221-4746 for more information.	7:00 a.m. - 6:00 p.m. (M-F)
Recipient Services (Recipients or persons calling on behalf of recipients only.)	Recipient Eligibility Medicaid-Certified Providers General Medicaid Information	(800) 362-3002 (608) 221-5720	7:00 a.m. - 9:00 p.m. (M-F) 7:30 a.m. - 4:00 p.m. (Sat.)

*Please use the information exactly as it appears on the recipient's ID card or EVS to complete the patient information section on claims and other documentation. Recipient eligibility information available through EVS includes:

- Dates of eligibility.
- Medicaid managed care program name and telephone number.
- Privately purchased managed care or other commercial health insurance coverage.
- Medicare coverage.
- Lock-In Program status.
- Limited benefit information.

Refer to Appendix 1 of this handbook for a list of the Care Management Organizations' and Aging and Disability Resource Centers' telephone numbers.

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Preface

The Family Care Guide is issued by Wisconsin Medicaid and BadgerCare to all providers who are Wisconsin Medicaid certified. The Family Care Guide is intended to help both providers who are affiliated with Family Care — Care Management Organizations (CMOs) and providers who are not affiliated with CMOs make services available to Family Care members (individuals enrolled in Family Care CMOs). Care Management Organizations deliver the Family Care benefit (refer to the General Information chapter of this guide for more information on the role of CMOs).

Medicaid fee-for-service information in this guide refers to recipients of Wisconsin Medicaid, which includes the BadgerCare program. BadgerCare recipients receive the same health benefits as Wisconsin Medicaid recipients and their health care is administered through the same delivery system. Individuals who are eligible for BadgerCare may also be eligible for Family Care if they meet the Family Care eligibility requirements outlined in this guide.

Providers should use the Family Care Guide in conjunction with other Wisconsin Medicaid resources, including:

- Wisconsin Medicaid All-Provider Handbook.
- Wisconsin Medicaid service-specific handbooks.
- *Wisconsin Medicaid and BadgerCare Updates*.
- Wisconsin Administrative Code, Chapters HFS 101-108.

Refer to the Provider Resources section of the All-Provider Handbook for more information on ordering the above publications.

For more information, providers may also refer to:

- Wisconsin Medicaid's Web site at *www.dhfs.state.wi.us/medicaid/*.
- Long term care Web site at *www.dhfs.state.wi.us/LTCare/*.
- Wisconsin Medicaid's Provider Services at (800) 947-9627 or (608) 221-9883.
- Wisconsin Medicaid's Professional Relations representatives (refer to the Provider Resources section of the All-Provider Handbook for a list of Professional Relations representatives).

General Information

What is Family Care?

Family Care incorporates both Medicaid and non-Medicaid services to meet the long term care needs of CMO members.

Family Care is a voluntary long term care managed care program. The Department of Health and Family Services (DHFS) contracts with Care Management Organizations (CMOs) that provide or arrange for services in the Family Care benefit package. Each CMO develops a provider network to provide services to Family Care — CMO enrollees who live in their own homes, nursing facilities, or other group living situations. Family Care fosters enrollees' independence and quality of life, while recognizing the need for support to remain independent.

Family Care covers certain Medicaid-covered services as well as services provided by the Wisconsin Medicaid Community Options Program (COP) and the Wisconsin Medicaid home and community-based waiver (HCBW) programs. (For the purposes of this guide, "Medicaid-covered" means services that are covered by Medicaid, but not including services covered by the Medicaid HCBW programs or by COP.)

Currently in a pilot phase, Family Care has been implemented in several counties. (Refer to the map at the end of this chapter for locations of current and proposed Family Care pilots.) Refer to Appendix 4 of this guide for a list of services that are included and not included in the Family Care benefit package.

Designed to improve the quality of life for elderly people and people with physical or developmental disabilities, Family Care offers members:

- A flexible health and long term care benefit package.
- Improved access to services.
- Consumer-centered care.
- Understandable and responsive services and options.

Family Care incorporates both Medicaid and non-Medicaid services to meet the long term care needs of CMO members.

Local Aging and Disability Resource Centers and CMOs are the two primary components of Family Care. During the pilot phase, both CMOs and Resource Centers are operated by county agencies.

The Role of Aging and Disability Resource Centers

Local Aging and Disability Resource Centers help individuals to "one-stop shop" for long term care information. Resource Center services are not limited to Medicaid-eligible individuals; anyone may receive services from a Resource Center.

The primary functions of the Resource Centers are to:

- Provide prevention and early intervention activities and community outreach services to help people maintain their independence.
- Offer counseling about options for obtaining long term care services.
- Help people apply for government program benefits, including Medicaid.
- Offer Pre-Admission Consultation (PAC) to provide individuals with information and counseling about available long term care options before they make choices regarding their care. As part of the PAC process, nursing homes, community-based residential facilities, adult family homes, residential care apartment complexes, and hospitals are required to refer individuals with long term care needs to Resource Centers.

- Determine functional eligibility for Family Care. (The county economic support unit determines financial eligibility. Refer to the Member Information chapter of this guide for more information on eligibility.)
- Offer assistance to individuals who want to enroll in a CMO.

Refer to Appendix 2 of this guide for a list of the names, addresses, and contact numbers of current Resource Centers.

The Role of Care Management Organizations

Family Care provides services through CMOs.

The primary functions of the CMOs are to:

- Deliver health and long term care services, either by contracting for services or directly providing them.
- Coordinate services that they are not responsible for providing.
- Ensure and continually improve the quality of services.
- Involve the member (and the member's family or representative) in decision making.

Care management organizations differ from HMOs in the range of services provided. Typically, an HMO provides a comprehensive range of primary and acute health care services covered under the Medicaid State Plan. The CMO provides some, but not all, of the services covered under the Medicaid State Plan. Most notably, the CMO does not cover physician services or hospital inpatient services. The CMO also provides long term care services not covered by HMOs.

The Role of County Economic Support Units

After the Resource Center has administered a Long Term Care Functional Screen to determine functional eligibility, the county economic support unit determines over-all eligibility for Family Care. The county economic support unit also calculates the amount of the cost-share.

The Role of the State

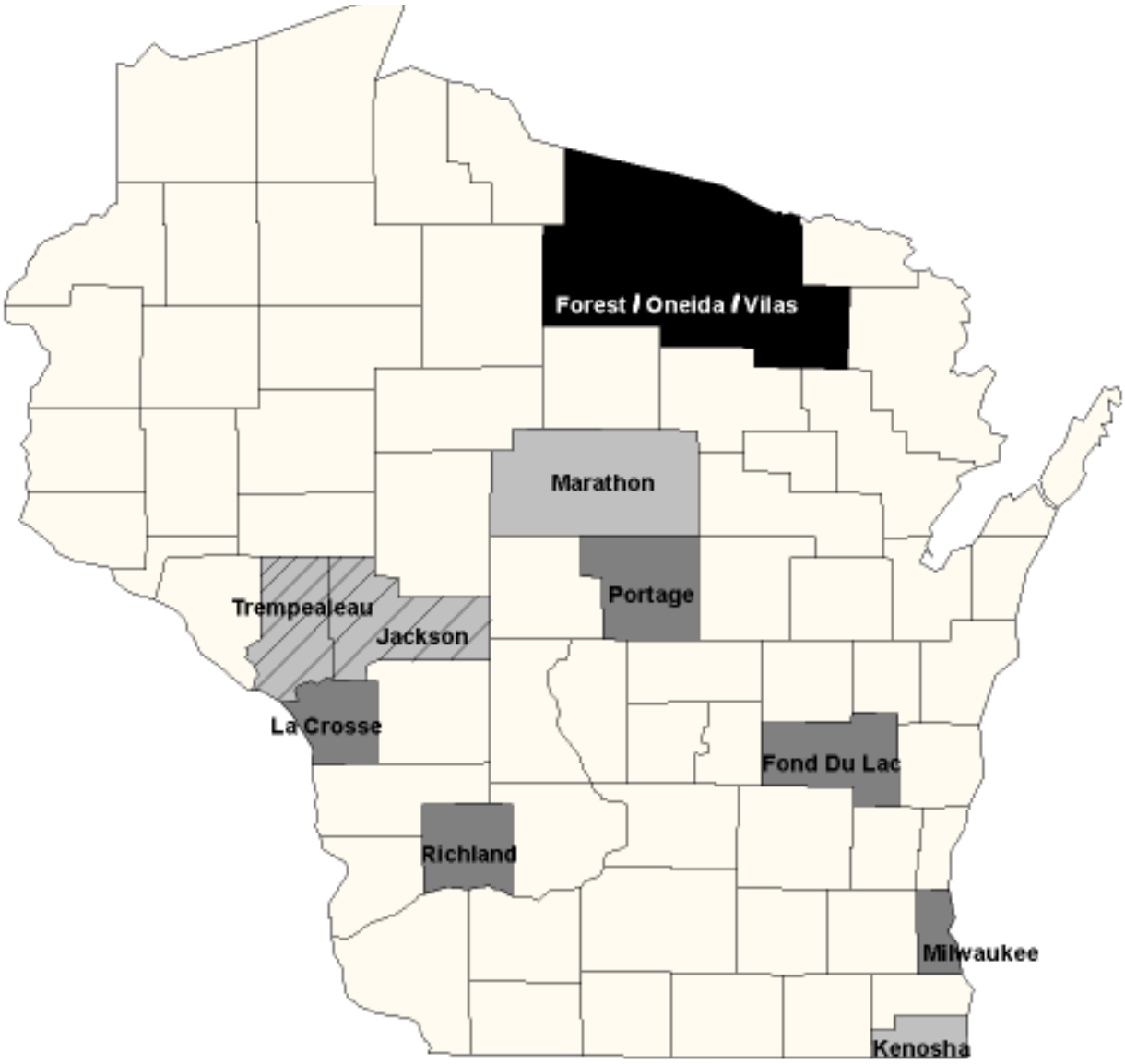
The DHFS oversees the implementation of Family Care pilots and is responsible for ensuring that members receive quality care.

The DHFS' primary role is to:

- Certify CMOs as health care entities.
- Provide oversight to ensure Resource Centers and CMOs meet performance requirements.
- Provide the CMOs with a monthly capitation payment for each member.
- Monitor to ensure the Resource Centers and CMOs meet consumers' needs.
- Help resolve members' and providers' formal complaints, grievances, and appeals regarding Resource Centers or CMOs.

The CMO also provides long term care services not covered by HMOs.

Family Care Pilots



Resource Center and CMO operational
Resource Center operational, CMO dependent upon future funding
Resource Center operational, no CMO currently planned
Resource Center and CMO dependent upon future funding

Member Information

Eligibility for Family Care

Individuals are required to meet both functional and financial eligibility criteria to qualify for Family Care.

Family Care covers adults 18 years and older who have long term care needs, specifically:

- Elderly persons.
- Persons with physical disabilities.
- Persons with developmental disabilities.

Specific target groups served vary among the pilot projects.

Individuals are required to meet both functional and financial eligibility criteria to qualify for Family Care. Individuals who meet the Family Care eligibility criteria are not necessarily eligible for Medicaid (refer to Members Who Are Not Eligible for Medicaid in this chapter for more information).

Providers should refer individuals who may benefit from information on long term care to their local Resource Center, whether or not the individuals are eligible for Medicaid.

Functional Eligibility Criteria

Functional eligibility is based on the degree to which an individual can independently manage the activities of daily living, such as mobility and eating, and/or instrumental activities of daily living, such as money management or arranging transportation. The Long Term Care Functional Screen, administered by Resource Center staff, determines functional eligibility.

Financial Eligibility Criteria

Besides functional eligibility criteria, individuals must also meet certain financial thresholds to be eligible for Family Care. Medicaid-eligible individuals automatically meet the financial criteria for Family Care. Individuals who are not financially eligible for Medicaid may still qualify for Family Care based on their cost of care.

Individuals receiving the Family Care benefit may be required to pay a cost share to the care management organization (CMO). Except for the functional eligibility determination made at the Resource Center, all other eligibility determinations, and cost-share, are determined at the county Economic Support Unit. (Refer to the Billing for Medicaid-Eligible Members chapter in this guide for more information on cost-share.)

How Are Individuals Enrolled in Care Management Organizations?

Resource Center staff offer counseling on available long term care options, including the Family Care benefit. If the individual is eligible for Family Care and chooses to participate in Family Care, he or she enrolls in a CMO. Resource Center staff and/or Family Care enrollment brokers will help the individual complete the necessary paperwork for enrolling in a CMO. Individuals enrolled in CMOs are referred to as *members*.

Note: The Family Care benefit is only available through the CMO. Members may disenroll from a CMO at any time during the month, but they no longer receive the Family Care benefit once they disenroll.

Identification and Verification of Members Who Are Eligible for Medicaid

Identification

Medicaid-eligible Family Care members receive Wisconsin Medicaid Forward cards. Since members can enroll in, or disenroll from, a CMO ***at any time*** during the month, providers should ***always*** verify member

eligibility before providing services. Providers may access eligibility information through the Automated Voice Response (AVR) system or through an eligibility verification vendor.

Refer to the Provider Resources section of the All-Provider Handbook for detailed information on the methods of verifying eligibility.

Verification Through the Automated Voice Response System

The AVR system will state:

1. That the member is enrolled in Family Care.
2. The CMO's telephone number.

The AVR will respond, "For this period, recipient is enrolled in the Family Care program, this is not an HMO. The phone number is <phone number>. For additional assistance in determining Family Care benefits, press 0."

Verification Through Eligibility Verification Vendors

Eligibility verification vendors (e.g., magnetic stripe card readers or computer software) will provide:

1. The CMO's name and telephone number.
2. The message "Family Care Program."

Members Who Are Not Eligible for Medicaid

Individuals who do not meet the eligibility criteria for Medicaid may still meet the functional and financial criteria to enroll in a CMO. As with Medicaid-eligible individuals, individuals who do not qualify for Medicaid are required to enroll in a CMO to receive the Family Care benefit.

These members:

- Receive CMO services included in the Family Care benefit package (refer to the Service Information chapter of this guide

Enrollment in a Care Management Organization

An **individual** contacts, or is referred to (through the Pre-Admission Consultation process), the local county **Aging and Disability Resource Center** for information on long term care options.

The **Resource Center** staff discuss available long term care options and determine **functional eligibility**. The county economic support unit determines **financial eligibility** and potential **cost-share** for Family Care.

If the **individual** is eligible for and wants to receive the Family Care benefit, he or she enrolls in a CMO and becomes a **member.** The Family Care benefit is only available through CMOs.

for information on services included in the Family Care benefit package).
- May receive services that are not included in the Family Care benefit package. Wisconsin Medicaid will not reimburse services provided to CMO members who are not eligible for Medicaid. The member, the member's commercial health insurance, or Medicare (if the member has Medicare coverage) is responsible for reimbursing the provider for services that are not included in the Family Care benefit package.

Care Management Organization members who are not eligible for Medicaid will be assigned an identification number but will *not* receive Forward cards.

Providers should bill non-Medicaid-eligible members or their commercial health insurance for any services that are not included in the Family Care benefit package. Medicaid does not reimburse for Medicaid services provided to CMO members who are not eligible for Medicaid.

Providers with questions about CMO members who are not eligible for Medicaid should contact the appropriate CMO at the number listed in Appendix 1 of this guide.

Refer to Appendix 5 of this guide for an illustration of how eligibility and covered services differ between members who are eligible for Medicaid fee-for-service and members who are not eligible for Medicaid fee-for-service.

Identification

Care Management Organization members who are not eligible for Medicaid will be assigned an identification number but will *not* receive Forward cards. However, any members who were previously eligible for Medicaid may still have Forward cards.

For members who do not have Forward cards, providers may verify Family Care eligibility through the AVR or an eligibility verification vendor method by entering the members' identification number into the system.

To obtain the identification number of members who do not have existing Forward cards, providers may:

- Contact Wisconsin Medicaid's Provider Services (telephone correspondents) at (800) 947-9627 or (608) 221-9883.
- Contact the member's CMO (refer to Appendix 1 of this guide for a list of CMO contact numbers).

Verification Through the Automated Voice Response System

When verifying Family Care eligibility for members who are not eligible for Medicaid, the AVR system will state:

1. That the member is enrolled in Family Care.
2. The CMO's telephone number.

The AVR system will state "For this period, recipient is eligible only for services provided by the Family Care program. No Medicaid card services are available."

As with Medicaid-eligible members, the AVR system also responds "For this period, recipient is enrolled in the Family Care program, this is not an HMO. The phone number is <phone number>. For additional assistance in determining Family Care benefits, press 0."

Verification Through Eligibility Verification Vendors

Eligibility verification vendors will provide:

1. The CMO's name and telephone number.
2. The message, "Family Care Program."

Eligibility verification vendors will also indicate "Services through Family Care prog. Not eligible for Medicaid card services."

Estate Recovery

Members and Estate Recovery

As with other long term care programs, Family Care benefits are subject to estate recovery. Amounts recovered are returned to the State and used for the benefit of other participants.

Recovery can be made for the following services when they were received on or after February 1, 2000:

- For CMO members age 55 or older who reside in the community, the cost of the following benefits received by the members while enrolled in a CMO:
  - √ All services provided through the CMO.
  - √ All inpatient hospital services.
  - √ All prescription/legend drugs.
- For CMO members of any age who live in inpatient hospitals and contribute to their cost of care, and members who live in nursing facilities, the cost of all services that were received during such stays may be recovered.

The recoverable amount is the actual cost of the service as reported to the Department of Health and Family Services (DHFS) by the CMO.

Services that are recoverable for both Medicaid-eligible members and those members who are not eligible for Medicaid is the same as for other home and community-based waiver programs or Medicaid waiver services. Recovery may be made through the member's estate and also through a lien on the home of a member who lives in a hospital and is required to contribute to the cost of care, or who lives in a nursing facility and is not reasonably expected to return home to live. **Liens are not placed on homes of members living in the community.**

Providers and Estate Recovery

Providers are not required to take any action concerning estate recovery. Refer members to their local Aging and Disability Resource Center or local county or tribal social or human services department for more information.

Member Complaints and Grievances

Members have the right to voice their dissatisfaction about services arranged or provided by a CMO and to grieve CMO decisions to deny, reduce, or terminate any services.

Members have three options for filing complaints or grievances:

- Members may submit a complaint or grievance to the CMO (all CMOs must have written policies and procedures in place to handle member complaints and grievances).
- Members may submit a written complaint or grievance directly to the DHFS before, during, or after using the CMO complaint or grievance process.
- Members may file a grievance through the state fair hearing process before, during, or after using the CMO and/or DHFS complaint or grievance process.

Members have the right to voice their dissatisfaction about services arranged or provided by a CMO and to grieve CMO decisions to deny, reduce, or terminate any services.

Provider Assistance for Member Complaints and Grievances

Care Management Organization members may ask professional advocates or other persons, including providers, to assist or represent them in these situations. Providers can file a complaint or grievance on behalf of a CMO member.

Refer to Appendix 3 of this guide for a list of complaints and grievance contacts at the DHFS and the Division of Hearings and Appeals (for the state fair hearings process).

Service Information

Provider Networks

To provide and manage care for its members, each Care Management Organization (CMO) develops a network of providers under contract with or employed by the CMO. As the sole payment source for Family Care services, CMOs provide their own service authorizations.

Before providing services included in the Family Care benefit package to Family Care members, providers should contact the CMO to make arrangements. Refer to Appendix 1 of this guide for a list of CMO telephone numbers.

Providers should continue to bill Medicaid fee-for-service for Medicaid services that are not included in the Family Care benefit package when provided to Medicaid-eligible CMO members.

Member Requests for Providers Not Affiliated With a Care Management Organization

Providers who have not contracted with a CMO may, under certain circumstances, obtain CMO authorization to provide services to CMO members. For instance, a member may request a specific provider for services, or the CMO may not have a specialist in its network to meet a member's specific needs.

Care Management Organizations are required to consider member requests for providers outside the network, but the requested provider must meet the quality standards and accept the rate of pay set by the CMOs. Care Management Organizations are not required to add providers requested by members to their networks.

Care Management Organizations may not reimburse providers at rates higher than the Medicaid rate for Medicaid services included in the Family Care benefit package.

Covered Services

Medicaid Services Included in the Family Care Benefit Package

Refer to Appendix 4 of this guide for a list of Medicaid-covered services included in the Family Care benefit package.

In general, long term care services (for example, home health services) are included in the Family Care benefit package. Acute and primary care services, including physician and hospital, and medications, are not included in the Family Care benefit package and will remain fee-for-service for those who are Medicaid eligible.

Home and Community-Based Waiver Services Included in the Family Care Benefit Package

The Family Care benefit package also includes services covered by the Community Options Program and the home and community-based waivers program.

Services Not Included in the Family Care Benefit Package

Refer to Appendix 4 of this guide for a list of Medicaid services that are not included in the Family Care benefit package.

Providers should continue to bill Medicaid fee-for-service for Medicaid services that are not included in the Family Care benefit package when provided to Medicaid-eligible CMO members.

For members who are not eligible for Medicaid, providers should bill members or the members' commercial health insurance for any services that are not included in the Family Care benefit package.

Provision of Noncovered Services

The CMO is responsible for authorizing the Medicaid-covered services included in the Family Care benefit package that the member requires to meet his or her long term care needs. These services are listed in the member's Individual Service Plan. However, the CMO is not restricted to providing only the services listed in the benefit package and may determine that alternative or non-traditional services can cost-effectively meet a member's needs. Therefore, providers should always contact the CMO before assuming the member will need to pay for a service that is not included in the Family Care benefit package, not covered by Medicaid, and not covered by the member's commercial health insurance.

A member may file a complaint or grievance if the CMO refuses to provide a service included in the Family Care benefit package that the member believes would help meet his or her long term care needs.

Members may receive and pay for services that are not covered by either Family Care or Medicaid, but:

- Providers should contact the CMO to determine if the CMO would authorize the service as part of the member's Individual Service Plan.
- Providers should contact the CMO to determine if the CMO has refused to provide the service and if the member is grieving the refusal. If the outcome of the grievance is favorable to the member, the CMO is required to pay for the service.
- If the CMO does not authorize the service, and the member does not grieve the CMO's decision to not authorize the service, the provider:
  1. Should contact the CMO to verify all policies and procedures for accepting payment from Family Care members for services.
  2. Is required to inform the member prior to providing the service that the CMO will not reimburse the service.
  3. Is required to tell the member prior to providing the service that he or she will be billed for the service.
  4. Is encouraged to obtain a written statement in advance verifying that the recipient has accepted liability for the service.

Note: Refer to the Covered and Noncovered Services section of the All-Provider Handbook for information on providing noncovered Medicaid services to Medicaid-eligible members.

Emergency and Urgent Care Services

Emergency Care

Emergency medical services may be needed in situations such as:

- Trouble breathing.
- Broken bones.
- Suspected poisoning.
- Suspected heart attack.
- Choking.

Members are instructed to dial 911 in the event of a medical emergency.

Emergency medical services are typically provided by physicians, emergency rooms, or emergency medical technicians/ambulances and are not included in the Family Care benefit package. Therefore, providers of emergency medical services need not be in the CMO provider network.

However, providers should consult the appropriate CMO prior to providing any follow-up services that are included in the Family Care benefit package.

Providers should always contact the CMO before assuming the member will need to pay for a service that is not included in the Family Care benefit package, not covered by Medicaid, and not covered by the member's commercial health insurance.

Urgent Care

In an urgent care situation, the member requires care sooner than a routine care appointment allows.

Urgent care situations involving Family Care services may occur in such situations as:

- A member is discharged from the emergency room and requires transportation to return home.
- A member visits the emergency room and is not admitted, but requires a home health aide immediately.
- A member's home health aide is sick and the member requires an immediate replacement.

Providers are required to seek authorization for any urgent care services included in the Family Care benefit package (such as home health or durable medical equipment) from the CMO prior to providing the services.

For urgent care services that are *not* included in the Family Care benefit package, Medicaid-eligible members are instructed to go to the Medicaid-certified clinic of their choice; members who are not eligible for Medicaid may go to any clinic of their choice.

24-Hour Access to the Care Management Organization

Each CMO has a telephone number available 24 hours a day, seven days a week. Providers and members may use the number for urgent situations and to request authorization for services included in the Family Care benefit package. The CMO is required to respond to calls within 30 minutes.

Refer to Appendix 1 of this guide for a list of the CMOs' 24-hour telephone numbers.

Each CMO has a telephone number available 24 hours a day, seven days a week.

Out-of-Area Care

Members traveling outside of their CMO service area sometimes require routine care. As with providers located in the service area, providers outside of the service area are required to have CMO authorization prior to providing services in the Family Care benefit package.

Prior to providing services, providers should contact the appropriate CMO at the number indicated by the Eligibility Verification System or listed in Appendix 1 of this guide.

The CMO may refuse to reimburse for services if the provider does not obtain CMO authorization prior to providing the services.

Prior Authorization

Existing Medicaid Fee-for-Service Prior Authorization

Existing Medicaid fee-for-service prior authorization (PA) for services included in the Family Care benefit package will not be applicable when a member enrolls in Family Care. Providers are required to obtain a new service authorization from the CMO to provide services included in the Family Care benefit package.

However, providers should not discard a member's Medicaid PA once that member enrolls in a CMO because:

- If a member disenrolls from a CMO, but remains eligible for Medicaid under fee-for-service, the services provided that are within the grant and expiration dates would still be allowable under the original PA.
- The PA may apply to several procedures, including Medicaid services that are not included in the Family Care benefit package. In this instance, providers can still use the authorized PA to bill their approved fee-for-service services to Medicaid.

Care Management Organization Authorization

For services included in the Family Care benefit package, service authorization decisions are made at the local level by the CMO and

not through the Medicaid PA process. The CMO is responsible for authorizing the services included in the Family Care benefit package.

All providers, including providers who are not affiliated with a CMO, should contact the CMO prior to providing any of the services included in the Family Care benefit package since the CMO:

- Is the sole payment source for Family Care services received by its members.
- May refuse payment for services it did not authorize.

The CMO is responsible for authorizing the services included in the Family Care benefit package.

Billing for Medicaid-Eligible Members

The CMO will determine the reimbursement rate for the services included in the Family Care benefit package, if the CMO authorizes payment for the services.

Billing for Services Included in the Family Care Benefit Package

Providers should bill the Care Management Organization (CMO) for services included in the Family Care benefit package. Each CMO will determine the policies and procedures for billing services, including:

- Claim form and coding requirements.
- Billing deadlines.
- Coordination of benefits (commercial health insurance and Medicare).

Contact the appropriate CMO for more information on the required billing procedures. Refer to Appendix 1 of this guide for a list of CMO contacts.

The CMO will determine the reimbursement rate for the services included in the Family Care benefit package, if the CMO authorizes payment for the services. Care Management Organizations may not reimburse providers at rates higher than the Medicaid rate for Medicaid services included in the Family Care benefit package.

Wisconsin Medicaid fee-for-service will not reimburse providers for services included in the Family Care benefit package. An explanation of benefits code will appear on the provider's Remittance and Status Report, indicating Wisconsin Medicaid has denied the service because the member is enrolled in a Medicaid managed care program.

Medicare Crossover Claims

When a provider first bills Medicare for services included in the Family Care benefit package:

1. The provider sends the claim to Medicare, using existing Medicare billing guidelines.
2. If a member has both Medicare and Medicaid coverage, the claim will process through the Medicare claims system, then may cross over to Medicaid fee-for-service.
3. Medicaid fee-for-service will deny all charges for services included in the Family Care benefit package.
4. The provider is responsible for following the appropriate CMO's billing instructions for consideration of Medicare's coinsurance and deductible.

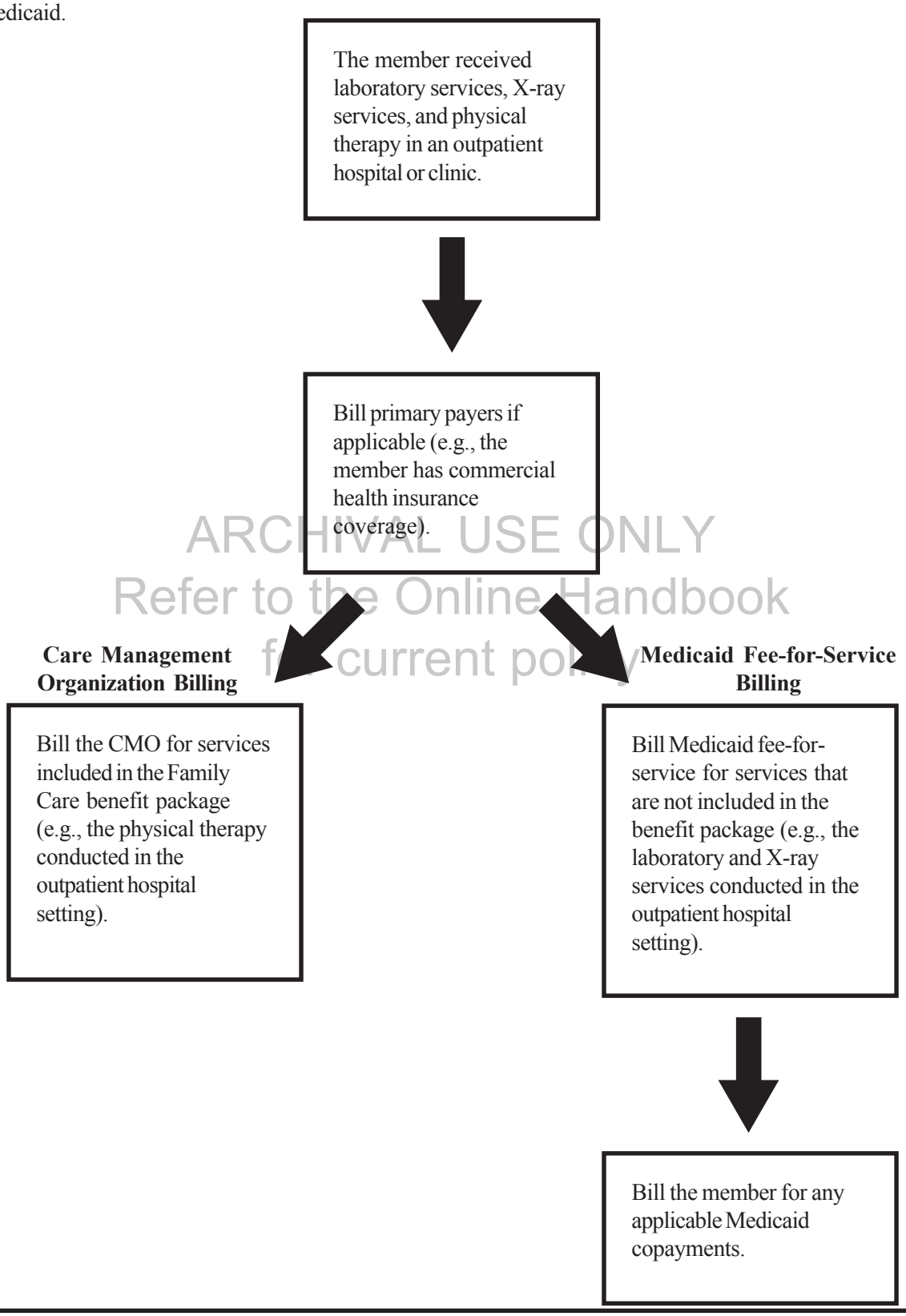
Providers should bill Medicare prior to billing the CMO to obtain the necessary payment or denial information from Medicare. However, providers do not need to wait for Medicaid fee-for-service to deny a claim before billing the CMO for services included in the Family Care benefit package.

Billing for Medicaid Services Not Included in the Family Care Benefit Package

Providers should bill Wisconsin Medicaid fee-for-service for Medicaid-covered services that are not included in the Family Care benefit package when provided to Medicaid-eligible members. Providers are required to follow all Medicaid fee-for-service policies, including policies for prior authorization and for billing primary payers (e.g., Medicare or other insurance) prior to billing Medicaid.

Split Billing Example for Medicaid-Eligible Members

The following chart illustrates a split billing situation, which occurs when the provider is required to bill both the CMO and Medicaid fee-for-service for services provided to a member. The example assumes the member is eligible for both Family Care and Medicaid.



Refer to the All-Provider Handbook and your service-specific handbook for more information on billing services to Wisconsin Medicaid.

Split Billing

Services included in the Family Care benefit package **do not** require a recipient copayment.

Providers may need to produce two separate bills for services provided to a Medicaid-eligible CMO member. This occurs when one service is included in the Family Care benefit package and another service is not included in the Family Care benefit package, but is covered by Medicaid fee-for-service.

When this occurs:

- Bill Medicaid fee-for-service for services that are not included in the Family Care benefit package (e.g., outpatient hospital lab and X-ray services).
- Bill the appropriate CMO for services included in the Family Care benefit package (e.g., outpatient hospital physical therapy, the nursing home daily rate for room and board agreed to in the CMO contract).

Refer to the chart on the previous page for an illustration of a split-billing situation.

Member Payment for Services

Copayment

Services included in the Family Care benefit package **do not** require a recipient copayment. However, Medicaid services that are *not* included in the Family Care benefit package require the applicable Medicaid recipient copayment. Refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook for more information on Medicaid fee-for-service copayment.

Member Cost-Share

As outlined in the Member Information chapter of this guide, the financial eligibility assessment determines if a CMO member is required to pay a monthly cost-share. The monthly cost-share is based on the member's income and assets and his or her monthly cost of care. The CMO may collect the cost-share amount or direct a specific provider to collect the amount.

Family Care cost-share ***is not*** the same as Medicaid spenddown.

Medicaid Nursing Home Resident Liability

If a Medicaid-eligible member is residing in a nursing home and enrolls in Family Care, the individual will no longer be responsible for a Medicaid nursing home liability amount. Instead, when the individual is enrolled in a CMO, the individual:

- Will only pay the Medicaid nursing home resident liability for the current month.
- Will pay his or her cost-share beginning the next month.

The same policy applies when an individual enrolls in a CMO mid-month.

Provider Appeals

Both providers who are affiliated and providers who are not affiliated with a CMO may file an appeal when they disagree with the CMO's payment/denial determination.

When a CMO denies a provider's claim, the CMO is required to send the provider a notice describing the appeal process, including specific deadlines which must be met at various points in the process. The CMO is also responsible for supplying the provider with instructions on filing an appeal with that CMO. Providers are required to file their first appeal to the CMO within 60 days of the initial payment/denial notice. The CMO has 45 days from the date of receipt of the appeal request to respond in writing to the provider.

If the CMO fails to respond within the 45-day time frame, or if the provider is not satisfied with the CMO's response, the provider may

seek a final determination from the Department of Health and Family Services (DHFS). If the CMO does respond within the 45-day time frame, the provider has 60 days from receipt of the CMO's response to file the appeal to the DHFS.

The DHFS has 45 days from the date of receipt of written appeals to make a decision. The DHFS' decision is final. The CMO is required to pay the provider within 45 days of the DHFS' decision, if applicable.

Refer to Appendix 3 of this guide for a list of CMO and DHFS provider appeal contacts.

Billing for Non-Medicaid-Eligible Members

Providers should bill members or the members' commercial health insurance for any services that are not included in the Family Care benefit package.

Billing for Services Included in the Family Care Benefit Package

Providers should bill the Care Management Organization (CMO) for services included in the Family Care benefit package. Each CMO will determine the policies and procedures for billing services, including:

- Claim form and coding requirements.
- Billing deadlines.
- Coordination of benefits (commercial health insurance and Medicare).

Contact the appropriate CMO for more information on the required billing procedures. Refer to Appendix 1 of this guide for a list of CMO contacts.

Medicare Crossover Claims

Providers should bill Medicare prior to billing the CMO to obtain the necessary payment or denial information from Medicare. The crossover claim will go through the same steps as described under Medicare Crossover Claims in the Billing for Medicaid-Eligible Members chapter of this guide. All charges for non-Medicaid-eligible members that are automatically forwarded to Medicaid fee-for-service by Medicare are denied by Medicaid.

Providers do not need to wait for Medicaid fee-for-service to deny a claim before billing the CMO for services included in the Family Care benefit package.

Billing for Services Not Included in the Family Care Benefit Package

Medicaid fee-for-service *will not* reimburse services provided to CMO members who are not eligible for Medicaid. Providers should bill members or the members' commercial health insurance for any services that are not included in the Family Care benefit package. Refer to "Provisions of Non-Covered Services" in the "Service Information"chapter of this section for more information on non-covered services.

Member Payment for Services

No Copayment

Services included in the Family Care benefit package **do not** require a member copayment.

Member Cost-Share

As outlined in the Member Information chapter of this guide, the financial eligibility assessment determines if a CMO member is required to pay a monthly cost-share. The monthly cost-share is based on the member's income and assets and his or her monthly cost of care. The CMO may collect the cost-share amount or direct a specific provider to collect the amount.

Provider Appeals

Both providers who are affiliated and providers who are not affiliated with a CMO may file an appeal when they disagree with the CMO's payment/denial determination.

When a CMO denies a provider's claim, the CMO is required to send the provider a notice describing the appeal process, including specific deadlines which must be met at various points in the process. The CMO is also responsible for supplying the provider with instructions on filing an appeal with that CMO. Providers are required to file their first appeal to the CMO within 60 days of the initial payment/denial notice. The CMO has 45 days from the date of receipt of the appeal request to respond in writing to the provider.

If the CMO fails to respond within the 45-day time frame, or if the provider is not satisfied with the CMO's response, the provider may seek a final determination from the Department of Health and Family Services (DHFS). The provider has 60 days to file the appeal to the DHFS.

The DHFS has 45 days from the date of receipt of written appeals to make a decision. The DHFS' decision is final. The CMO is required to pay the provider within 45 days of the DHFS' decision, if applicable.

Refer to Appendix 3 of this guide for a list of CMO and DHFS provider appeal contacts.

Refer to Appendix 3 of this guide for a list of CMO and DHFS provider appeal contacts.

Appendix

ARCHIVAL USE ONLY
Refer to the Online Handbook
for current policy

Appendix 1

Care Management Organization Contact Numbers

The table below lists the county served, county code, and contact number for current Care Management Organizations (CMOs).

Care Management Organization	County Served County Code*	Provider Contact Number	Recipient Contact Number
Creative Care Options of Fond du Lac County	Fond du Lac 20	(920) 906-5100	(920) 906-5100
La Crosse County Care Management Organization	La Crosse 32	(608) 785-6054	(608) 785-6054
Supportive Options for Seniors	Milwaukee 40	(414) 289-6874	(414) 289-6874
Community Care of Portage County	Portage 49	(715) 345-5968	(715) 345-5968
Aging and Disability Services of Richland County	Richland 52	(608) 647-8821	(608) 647-8821

*When providers verify eligibility, the Eligibility Verification System will indicate the county code of the CMO.

Appendix 2
Aging and Disability Resource Centers

The names, addresses, and contact numbers for Wisconsin's current Aging and Disability Resource Centers are listed below.

Fond du Lac County
Aging and Disability Resource Center of Fond du Lac County
Address: Department of Social Services
87 Vincent Street
Fond du Lac, WI 54935
Telephone: (920) 929-3466
Fax: (920) 929-3447

La Crosse County
La Crosse County Aging and Disability Resource Center
Address: Human Services Department
300 North 4th Street
P.O. Box 4002
La Crosse, WI 54601
Telephone: (608) 785-5700
Fax: (608) 785-5790

Milwaukee County
Elderlink Aging Resource Center of Milwaukee County
Address: Department on Aging
235 West Galena Street
Suite 180
Milwaukee, WI 53212-3948
Telephone: (414) 289-6874
Fax: (414) 289-8568

Portage County
Aging and Disability Resource Center of Portage County
Address: Department on Aging
1519 Water Street
Stevens Point, WI 54481
Telephone: (715) 346-1401
Fax: (715) 346-1418

Richland County
Richland County Health, Aging and Disability Resource Center
Address: 181 West Seminary Street
(1st. Floor Courthouse)
Richland Center, WI 53581
Telephone: (877) 641-4616 or (608) 647-4616
Fax: (608) 647-8962
E-mail: resctr@co.richland.wi.us

Kenosha County
Aging and Disability Resource Center of Kenosha County
Address: Division on Aging
5407 8th Avenue
Kenosha, WI 53140
Telephone: (262) 605-6646
Fax: (262) 605-6649

Marathon County
Aging and Disability Resource Center of Marathon County
Address: Commission on Aging
Lake View Center
1000 Lake View Drive
Wausau, WI 54403
Telephone: (715) 261-6070
Fax: (715) 261-6090

Jackson County
Help Link Aging and Disability Resource Center
Address: Jackson County Department of Health and Human Services
P.O. Box 457
Black River Falls, WI 54615
Telephone: (715) 284-5898
Fax: (715) 284-7713

Trempealeau County
Aging and Disability Resource Center of Trempealeau County
Address: Department of Social Services
36245 Main Street
P.O. Box 67
Whitehall, WI 54773
Telephone: (715) 538-2311
Fax: (715) 538-4210

Appendix 3

Complaints, Grievances, and Appeals Contacts

Member Complaints and Grievances Contacts

The following is contact information for registering consumer complaints and grievances with the Department of Health and Family Services and the Division of Hearings and Appeals.

Family Care Complaints and Grievances

Address: c/o Office of Strategic Finance
Area Administration Section
P.O. Box 7850
Madison, WI 53707-7850
Toll-free: (888) 203-8338
Fax: (608) 266-8278
E-mail: famcare@dhfs.state.wi.us

State Fair Hearings

Address: Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875
Telephone: (608) 266-3096
Fax: (608) 264-9885

Provider Appeals Contacts

The following is contact information for registering provider appeals with the Care Management Organization (CMO) and the Department of Health and Family Services:

Care Management Organizations

Fond du Lac Care Management Organization

Address: Creative Care Options of Fond du Lac County
Attn: Maggie McCullough
50 North Portland Street
Fond du Lac, WI 54935
Telephone: (920) 906-5100

La Crosse Care Management Organization

Address: Human Services Department
Attn: Nancy Schmidt
300 North Fourth Street
La Crosse, WI 54601
Telephone: (608) 785-6059

(continued next page)

Appendix 3

(Continued)

Milwaukee Care Management Organization

Address: Department on Aging
Attn: Mark Lucoff
Contract Administrator
235 West Galena Street
Suite 160
Milwaukee, WI 53212
Telephone: (414) 289-6586

Portage Care Management Organization

Address: Community Care Options of Portage County
Business Manager
817 Whiting Avenue
Stevens Point, WI 54481
Telephone: (715) 345-5968

Richland County Care Management Organization

Address: Aging and Disability Services of Richland County
Attn: Betty Broadbent, Provider Network Developer
221 West Seminary
Richland, WI 53581
Telephone: (608) 647-8821 extension 272

Department of Health and Family Services

Address: Family Care Contracts Supervisor
Center for Delivery Systems Development/Office of Strategic Financing
1 South Pinckney Street
Suite 340
Madison, WI 53701-1379
Telephone: (608) 261-7807

Appendix 4

Medicaid Services Included and Not Included in the Family Care Benefit Package

Medicaid Services Included in the Family Care Benefit Package

The Family Care benefit package includes the following Medicaid-covered services:

- ***Case Management*** — provided by case management agencies.

- ***Home Care Services*** — provided by home health agencies, personal care agencies, independent nurses, and respiratory therapists.
  - √ Home health aide services.
  - √ Personal care.
  - √ Skilled nursing (including independent nursing services).
    - — Intermittent (less than eight hours per day).
    - — Private duty nursing (eight or more hours per day).
    - — Respiratory care.
  - √ Occupational and physical therapy, and speech and language pathology services *(Refer to Therapy Services*).

- ***Mental Health/Substance Abuse and Related Services*** — provided by mental health providers, substance abuse (alcohol and other drug abuse) treatment providers, day treatment programs, community support programs.
  - √ Mental health and substance abuse services.
    - — Except those services provided by a physician.
    - — Except those services provided in an inpatient hospital setting.
  - √ Day treatment (mental health and substance abuse) in all settings.
  - √ Child/adolescent mental health day treatment.
  - √ Community Support Program services.
    - — Except when provided by a physician.
    - — Except non-psychiatric medication and treatment services.
  - √ In-home intensive psychotherapy.
  - √ In-home autism treatment.

- ***Nursing Facilities*** — all nursing facility stays (including Intermediate Care Facility for People with Mental Retardation and Institution for Mental Disease).
  - — Except lab and radiology ancillary services.

- ***Supplies and Equipment*** — provided by any provider.
  - √ Disposable medical supplies.
    - — Except supplies used in a hospital or physician clinic, including enteral nutritional products.
  - √ Durable medical equipment (DME) purchased or rented in all settings.
    - — Except for hearing aids, hearing aid accessories, hearing aid batteries, and assistive listening devices.
    - — Except for prosthetics.
  - √ Repair and maintenance of DME.
    - — Except for repair and maintenance of hearing aids and assistive listening devices.
    - — Except for repair and maintenance of prosthetics.
  - √ Orthotics (purchase and repair).

- ***Therapy Services*** — provided by therapy and speech and language providers.
  - √ Occupational therapy.
    - — Except those services provided by physicians in clinic settings.
    - — Except those services provided in an inpatient hospital setting.
  - √ Physical therapy.
    - — Except those services provided by physicians in clinic settings.
    - — Except those services provided in an inpatient hospital setting.
  - √ Speech and language pathology services.
    - — Except those services provided by physicians in clinic settings.
    - — Except those services provided in an inpatient hospital setting.

- ***Transportation*** — provided by specialized medical vehicle providers.

Medicaid Services Not Included in the Family Care Benefit Package

The Family Care benefit package does not include the following services:

- Ambulance transportation.
- Audiology.
- Chiropractic.
- Crisis intervention services.
- Dentistry.
- End-Stage Renal Disease services.
- Eyeglasses.
- Family planning services.
- Hearing aids (including batteries, accessories, and assistive listening devices; and repair and maintenance of hearing aids and assistive listening devices).
- Hospice.
- Hospital: Inpatient (except DME).
- Hospital: Outpatient (except physical therapy, occupational therapy, speech and language pathology, mental health services, and substance abuse treatment).
- Independent nurse practitioner services.
- Lab and X-ray.
- Mental health services provided by a physician or provided in an inpatient hospital setting.
- Nurse midwife services.
- Optometry.
- Pharmaceuticals.
- Physician services.
- Podiatry.
- Prenatal care coordination.
- Prosthetics (including repair and maintenance).
- School-based services.
- Substance abuse services provided by a physician or provided in an inpatient hospital setting.
- Transportation by common carrier (the billing method for this service remains unchanged).

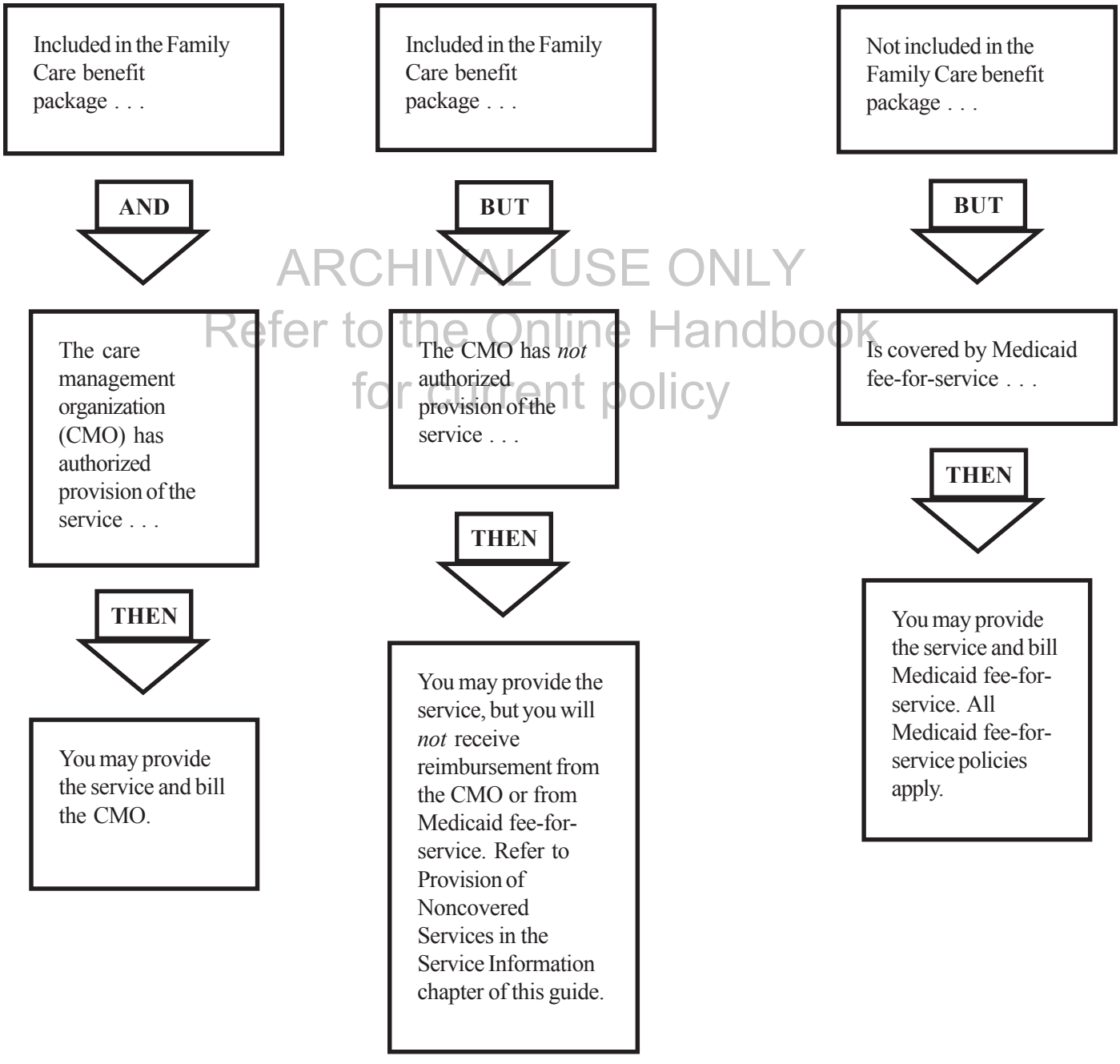
Appendix 5

Eligibility and Covered Services Illustrations

The following two charts highlight the difference in service provision between Family Care members who are eligible for Medicaid fee-for-service and Family Care members who are not eligible for Medicaid fee-for-service. As the chart on this page shows, members who are Medicaid eligible may receive services included in the Family Care benefit package as well as Medicaid services that are not included in the Family Care benefit package. As shown in the chart on the next page, members who are not eligible for Medicaid may also receive Medicaid services that are not included in the benefit package. However, these services are not reimbursable by Medicaid.

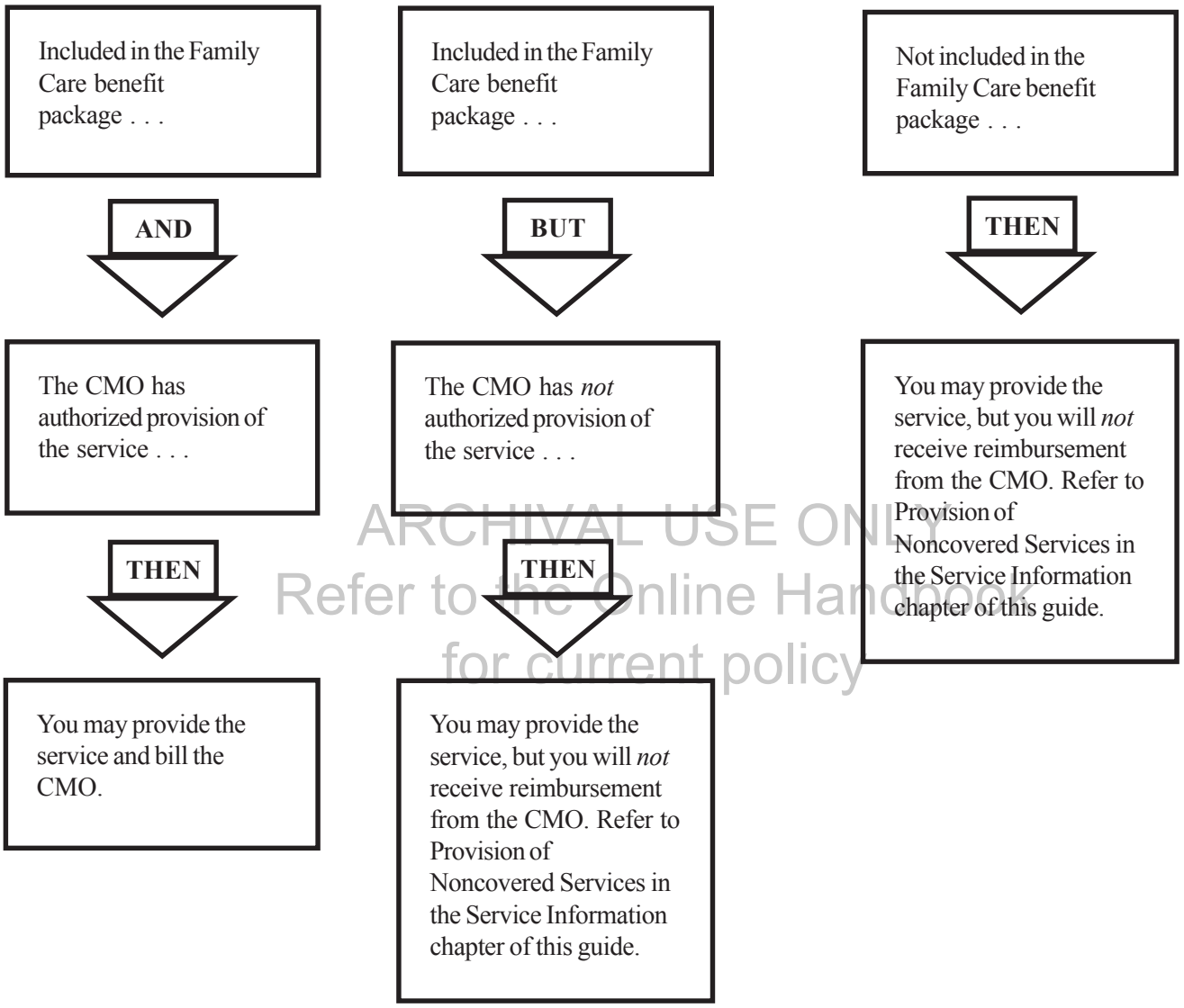
For Members Who Are Eligible for Both Family Care and Medicaid Fee-for-Service

If the service you intend to provide is . . .



For Members Who Are Eligible for Family Care and Not Eligible for Medicaid Fee-For-Service

If the service you intend to provide is . . .



Glossary of Common Terms

ADL

Activities of Daily Living. The functions or activities performed in the course of a normal day in an individual's life, including bathing, dressing, eating, mobility, transferring from one surface to another (such as from the bed to a chair), and using the toilet.

Aging and Disability Resource Centers

Aging and Disability Resource Centers provide older people, people with disabilities, and their families with information and advice about a wide range of resources available to them in their local communities.

CMO

Care Management Organization. Care Management Organizations provide long term care and health care services, coordinate the provision of other services, and promote preventive services for enrolled members.

COP

Community Options Program. A long-term support program that helps people who are elderly or disabled to live at home or in community-integrated settings typical of residential arrangements in which non-disabled persons reside. The goal of the COP is similar to the home and community-based waiver (HCBW) programs, but the COP relies only on state funds and not on Medicaid. Community Options Program funds can be used somewhat more flexibly than HCBW waiver funds to support people in the community and it emphasizes the use of informal supports to help people remain independent.

Cost-share

The maximum amount that some members are required to pay to the Care Management Organization each month to contribute to the cost of their long term care. Income, assets, and the cost of care plan services are among several factors considered in determining whether the member will be required to contribute and, if so, the maximum amount of the contribution.

Crossover claim

A Medicare-allowed claim for a dual entitlee sent to Wisconsin Medicaid for possible additional payment of the Medicare coinsurance and deductible.

DHCF

Division of Health Care Financing. *Please see the definition under DHFS.*

DHFS

Wisconsin Department of Health and Family Services. The DHFS administers the Wisconsin Medicaid program. Its primary mission is to foster healthy, self-reliant individuals and families by promoting independence and community responsibility; strengthening families; encouraging healthy behaviors; protecting vulnerable children, adults, and families; preventing individual and social problems; and providing services of value to taxpayers.

DHCF

Division of Health Care Financing. The DHCF administers Wisconsin Medicaid for the Department of Health and Family Services (DHFS) under statutory provisions, administrative rules, and the state's Medicaid plan. The state's Medicaid plan is a comprehensive description of the state's Medicaid program that provides the Health Care Financing Administration (HCFA) and the U.S. Department of Health and Human Services (DHHS), assurances that the program is administered in conformity with federal law and HCFA policy.

OSF

Office of Strategic Finance. In the Department of Health and Family Services (DHFS), the OSF, which includes the Center for Delivery Systems Development, is responsible for implementing Family Care pilots.

EVS

Eligibility Verification System. The EVS allows providers to verify recipient eligibility prior to providing services. Providers may access recipient eligibility information through the following methods:

- Wisconsin Medicaid's Automated Voice Response (AVR) system.
- Commercial magnetic stripe card readers.
- Commercial personal computer software and Internet access.
- Wisconsin Medicaid's Provider Services (telephone correspondents).
- Wisconsin Medicaid's Direct Information Access Line with Updates for Providers (Dial-Up).

Family Care target groups

Family Care covers adults 18 years and older with long term care needs who are any of the following:

- Elderly.
- Physically disabled.
- Developmentally disabled.

Specific target groups served vary among the pilot projects.

Fee-for-service

The traditional health care payment system under which physicians and other providers receive a payment for each unit of service provided rather than a capitation payment for each recipient.

Financial eligibility

Financial eligibility for Family Care means either the individual is financially eligible for Medicaid or the projected cost of the individual's care plan is more than the amount the individual is required to pay each month toward the cost of the services, based on available income and assets.

Functional eligibility

Functional eligibility for Family Care is based on the degree to which an individual can independently manage the activities of daily living (ADL) and instrumental activities of daily living (IADL).

HCBW

Home and community-based waivers. Home and community-based waivers provide Medicaid funds to help people who would be eligible for nursing home care to remain in their own homes or other community-based settings. Home and community-based waiver programs include:

- Community Integration Programs (CIP) 1A and 1B for individuals with developmental disabilities.
- CIP-II and Community Options Program — Waiver (COP-W) for elderly individuals and individuals with physical disabilities.
- Community Supported Living Arrangements (CSLA).
- Brain Injury Waiver (BIW).

HCFA

Health Care Financing Administration. An agency housed within the U.S. Department of Health and Human Services (DHHS), HCFA administers Medicare, Medicaid, related quality assurance programs, and other programs.

IADLs

Instrumental Activities of Daily Living. A range of self-maintaining activities more complex than those needed for personal care, including meal preparation and nutrition, management of medications and treatments, money management, using the telephone, arranging and using transportation, and the ability to function at the job site.

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for people with disabilities, people 65 years and older, children and their caretakers, and pregnant women who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Medicaid is also known as the Medical Assistance Program, Title XIX, or T19.

Medicaid-covered

For the purposes of this guide, "Medicaid-covered" means services that are covered by Medicaid, but not including services covered by the Medicaid home and community-based waivers (HCBW) program.

Medicaid nursing home resident liability

Any income in excess of a recipient's personal needs allowance that is used to cover the recipient's cost of care in his or her nursing facility.

Medicare

A federal health insurance program for people 65 years of age or older, certain younger people with disabilities, or people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD). Medicare coverage is made up of two parts:

- Medicare Hospital Insurance (Part A) that pays for inpatient hospital stays, care in a skilled nursing facility, home health care, and hospice care.

- Medicare Medical Insurance (Part B) that helps pay for doctors' services, outpatient hospital care, and other medical services that are not covered by Part A.

OSF

Office of Strategic Finance. *Please see the definition under DHFS.*

R/S Report

Remittance and Status Report. A statement generated by the Medicaid fiscal agent to inform providers regarding the processing of their Medicaid fee-for-service claims.

Spenddown

Similar to an insurance deductible, the spenddown amount is a set amount of medical charges that a recipient must pay out-of-pocket. The certifying agency establishes the amount for individuals who meet all Medicaid eligibility requirements except those that pertain to financial status.

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