WISCONSIN MEDICAL ASSISTANCE PROGRAM

HEALTHCHECK OUTREACH AND CASE MANAGEMENT HANDBOOK

PART D, DIVISION II

PART D, DIVISION II
HEALTHCHECK SCREENING SERVICES PROVIDER HANDBOOK
TRANSMITTAL LOG

This log is designed as a convenient record sheet for recording receipt of handbook updates. Each update to Part D, Division I, of the handbook will be numbered sequentially. This sequential numbering system will alert the provider to any updates not received. Providers must delete old pages and insert new pages as instructed. Use of this log will help eliminate errors and ensure an up-to-date handbook.

If you are missing a transmittal, please request it by transmittal number. For example, if the last transmittal number on your log is 2D-3 and you receive 2D-5, you are missing 2D-4. If the provider is missing a transmittal, copies of complete provider handbooks may be obtained by completing the order form in Appendix 36 of the WMAP Part A Provider Handbook.

Transmittal Number	Initials	Issue Date
2D-1		03/92
2D-2		02/95

Transmittal Number	Initials	Issue Date

HEALTHCHECK OUTREACH AND CASE MANAGEMENT PROVIDER HANDBOOK
TABLE OF CONTENTS

INTRODUCTION

The Wisconsin Medical Assistance Program (WMAP) is governed by a set of regulations known as the Wisconsin Administrative Code, Chapters HSS 101-108 and by state and federal law. These regulations are interpreted for provider use in two WMAP provider handbooks. The two handbooks are designed to be used in conjunction with each other and with the Wisconsin Administrative Code.

Part A of the WMAP handbook includes general policy guidelines, regulations and billing information applicable to all types of providers certified in the WMAP. The service specific handbook includes information applicable to a specific provider type and includes information on provider eligibility criteria, covered services, reimbursement methodology and billing instructions. Each provider is sent a copy of the Part A and appropriate service specific handbook at the time of certification.

Additional copies of provider handbooks may be obtained by writing to Document Sales at the address listed in Appendix 3 of Part A of the WMAP Provider Handbook.

When requesting a handbook, be sure to indicate the type(s) of service provided (i.e., physician, chiropractic, dental, etc.) and the document number. The document number of Part D, Division II of the handbook is POH-1050-D-II.

It is important that both the provider of service and the provider's billing personnel read this material prior to initiating services to ensure a thorough understanding of WMAP policy and billing procedures.

NOTE: For a complete source of WMAP regulations and policies, the provider is referred to Wisconsin Administrative Code, Chapters HSS 101-108, also referred to as the Super Rule. In the event of any conflict in meaning between HSS 101-108 and the handbook, the meaning of the Wisconsin Administrative Code will hold. Providers may purchase HSS 101-108 from Document Sales.

Providers should also be aware of other documents including state and federal laws and regulations, relating to the WMAP.

1. Chapter 49.43 - 49.497, Wisconsin Statutes

2. Title XIX of the Social Security Act and its enabling regulations, Title 42 - Public Health, Parts 430-456.

A list of common terms and the abbreviations appear in the WMAP Part A handbook and also in the Wisconsin Administrative Code, Chapter HSS 101.

A. TYPE OF HANDBOOK

HealthCheck Outreach and Case Management is Part D, Division II, a supplement to Part D, Division I, HealthCheck Screening Services Handbook. It contains information applicable to HealthCheck Outreach and Case Management providers. The intent of this supplement is to provide information regarding provider eligibility criteria, covered services, terms of reimbursement, and billing instructions specific to the HealthCheck Outreach and Case Management function. It is to be used with both Part D, Division I, HealthCheck Screening Services Handbook, and Part A of the Wisconsin Medical Assistance Provider Handbook which includes general policy guidelines, regulations, and billing information applicable to all types of providers certified in the Wisconsin Medical Assistance Program (WMAP).

B. PROVIDER INFORMATION

Provider Eligibility and Certification Requirements

The requirements for outreach and case management providers under HealthCheck are detailed in HSS 105.37(2) of the Wisconsin Administrative Code as follows:

1. The provider must be certified under HSS 105.37(1) as a provider of HealthCheck assessment and evaluation services (i.e., HealthCheck screening).

2. The provider must submit to the Department of Health and Social Services (DHSS) a plan of outreach and case management which includes the following:

   a. Description of the geographical area the provider serves (county, municipality, etc.).

   b. Characteristics of the target population (number of eligible recipients under age 21, ethnic/language affiliation, access barriers such as rural distance, lack of providers, etc.).

   c. Coordination with support activities conducted by the DHSS and other health-related services. The plan must also include a description of the methods and procedures for coordinating and integrating HealthCheck case management activities. At a minimum, the provider must identify the name, location and phone number of the following resources:

      - Women, Infants and Children (WIC) Program
      - Maternal and Child Health Services
      - Head Start Program
      - Family Planning Services (including teen or school based clinics)
      - School health and pupil services
      - Medical Assistance certified physicians and dentists for ongoing HealthCheck care
      - Job Opportunities and Basic Skills Training (JOBS) and Job Training Partnership Act (JTPA)
      - Child day care services
      - Mental Health and Alcohol/Drug Abuse agency

B. PROVIDER INFORMATION (continued)

- County human or social service agencies
- Domestic Abuse agency
- Translator and interpreter services, if not on staff
- Vocational rehabilitation programs
- Specialized services such as perinatal programs, genetic counseling, and sickle cell anemia programs
- Developmentally Disabled Child Service programs

d. Description of methods used to ensure that recipients receive the necessary diagnosis and treatment services for conditions detected during HealthCheck screenings.

e. Description of how scheduling and transportation assistance will be provided.

f. Description of how case management will be documented and where records will be maintained.

g. Procedures for ensuring HealthCheck services do not duplicate care by another local health care or case management provider.

h. The procedures to be used for educating recipients about the health care system; how to responsibly use Medical Assistance services and utilize various local community services (e.g., WIC, Head Start). What kinds of health education will be offered.

i. Description of how other local health and social service providers are to be made aware of HealthCheck services.

The DHSS will review all proposed plans, and approve or deny the provider's request for certification. The decision to approve or deny will be based on demonstration that all the requirements of the HealthCheck outreach/case management program are being met. All screening providers requesting certification for case management will receive written notice of the DHSS decision.

Case management providers must comply with all Medical Assistance provider requirements and the signed case management agreement with the DHSS for case management activities.

Billed Amount

Providers are required to bill at a uniform rate when rendering an identical service to Wisconsin Medical Assistance recipients and to private pay patients. Providers shall not discriminate against recipients by charging a higher fee for a service than that charged to a private pay patient.

B. PROVIDER INFORMATION (continued)

Terms of Reimbursement

1. Targeted Outreach - Certified HealthCheck Outreach and Case Management providers will be reimbursed the lesser of the provider's usual and customary charge or the maximum allowable fee for targeted outreach and case management services. Reimbursement for recipients from the provider's targeted list, who receive a HealthCheck screening, may be claimed for outreach and case management service.

2. Non-targeted Outreach - Reimbursement for recipients who are not on a provider's targeted list and receive a screening may also be claimed for outreach and case management but at a lower rate than that for the targeted group.

Provider Responsibilities

Specific responsibilities as a provider under the WMAP are stated in Part A of the WMAP Provider Handbook. The WMAP Part A Provider Handbook should be referenced for detailed information regarding fair treatment of the recipient, maintenance of records, recipient requests for noncovered services, services rendered to a recipient during periods of retroactive eligibility, grounds for provider sanctions and additional state and federal requirements.

Providers of HealthCheck Outreach and Case Management services are required to:

1. Focus outreach and case management efforts upon the targeted list of HealthCheck eligibles that EDS sends to providers on a monthly basis.

2. Inform eligible recipients about the availability and benefits of a HealthCheck screening, remove barriers to program participation and provide all necessary follow-up.

3. Have resources for informing disabled, illiterate and non-English speaking recipients, including access to persons who speak the language of the non-English speaking population in the local service area.

4. Develop the following records and documentation:

   a. All written outreach materials must be available for review as part of the provider's records.

   b. All records must be maintained by the provider for five years from the date of payment following the screening as required by HSS 105.02(4), Wis. Adm. Code.

   c. A file for each recipient for whom reimbursement was claimed for outreach and case management must be maintained. The file must include the following information:

      - Copy of the HealthCheck screening services claim form which documents the screening;

      - Record of the targeted list priority number the recipient was assigned on the targeted listing, if available;

      - Date that the initial, annual, or periodic outreach contact or notification was made;

B. PROVIDER INFORMATION (continued)

- Record of linkage (where possible) of recipient to an ongoing primary health care provider;
- Record of all case management referrals, dates of appointments, whether appointments were met, and any other follow-up documentation notes to referrals;
- Date of the recipient's next scheduled HealthCheck periodic screening;
- Record of dental referrals and follow-up for recipients beginning at age 3 years; and
- Documentation of the health history completed for the recipient at the time of the screening.

Confidentiality

Federal and state regulations define the limitations for the use of Medical Assistance recipient information. Disclosure of recipient information is limited to the following persons or agencies:

1. Representatives of federally assisted programs which provide assistance, in cash or in kind, or services (e.g., Head Start Program, WIC Supplemental Food Program), directly to the individual on the basis of need (45 CFR 205.50).

2. Under HSS 108.01, Wis. Adm. Code, legally qualified representative or agen representatives outside the Wisconsin DHSS (e.g., courts, law enforcement officers, governmental authorities) for the purpose of direct program administration, including:

   a. Determining initial eligibility of the applicant and continuing eligibility of the recipient;

   b. Determining appropriate services to be covered;

   c. Providing services for recipients;

   d. Processing provider claims for reimbursement;

   e. Auditing provider claims for reimbursement; or

   f. Seeking third-party payment for services provided to a recipient.

3. For purposes of outreach and case management and screenings, information obtained on the claim form may be shared with referred providers. Information may also be disclosed in summary, statistical, or other form which does not identify specific recipients.

   Persons or agencies receiving such information are bound by law to observe confidentiality standards comparable to those of the DHSS. Please refer to Section IV Part A of the WMAP Provider Handbook for detailed information.

   All questions about recipient information should be directed to:

   Bureau of Health Care Financing
   Attn: HealthCheck Coordinator
   Post Office Box 309
   Madison, WI 53701-0309

C. RECIPIENT INFORMATION

Eligibility for Medical Assistance

Outreach and case management workers may find persons unable to pay for health care services who may be eligible for the WMAP. Providers should advise these persons, or a representative, to contact the local county department of social services to make application for the WMAP. Low income pregnant women should be encouraged to make application for the WMAP.

Brochures describing eligibility requirements and HealthCheck may be obtained from county departments of social services or by writing to:

Department of Health and Social Services
Division of Economic Support
Attn: Public Information
1 West Wilson Street
Madison, WI 53701

Recipients meeting eligibility requirements for Medical Assistance are issued Medical Assistance identification cards. These cards include the recipient's name, date of birth, 10-digit Medical Assistance identification number, medical status and an indicator of private health insurance coverage, HMO coverage and/or Medicare coverage.

Medical Assistance identification cards are sent to recipients on a monthly basis. All Medical Assistance identification cards are valid only through the end of the month for which they are issued. It is important that providers or the designated staff check a recipient's Medical Assistance identification card prior to each time service is provided to determine if the recipient is currently eligible and if there are any limitations to coverage.

All recipients under age 21 are eligible for HealthCheck screening and case management services. In addition, the HealthCheck screening referral provides access to other health services such as dental or mental health services.

Part A of the WMAP Provider Handbook provides detailed information regarding eligibility for Medical Assistance, Medical Assistance identification cards and how to verify eligibility. This section should be reviewed carefully by the provider before services are rendered. A sample Medical Assistance identification card can be found in Appendix 7 of Part A of the WMAP Provider Handbook.

A. INTRODUCTION

What is HealthCheck Outreach & Case Management?

The purpose of outreach is to inform recipients about the benefits and availability of HealthCheck prevention services, how to obtain those services, and the availability of transportation and scheduling assistance.

Providers are encouraged to seek out for HealthCheck screening Medical Assistance-eligible recipients under age 21 years and their families who have been targeted as "at risk". Refer to Appendix 2 of this handbook for information on HealthCheck outreach/case management need determination.

Each month providers are sent a listing by county and in priority order of recipients who are targeted as "at risk" for HealthCheck Outreach and Case Management services. These recipients are "at risk" because they have not received preventive health, dental or other care for a significant period of time, which places them at risk of poor health and vulnerable to illness or disease. Providers also receive a monthly listing of all Medical Assistance recipients who are eligible for HealthCheck outreach and case management services but who are not targeted as "at risk".

Once all recipients who are targeted as "at risk" have been contacted, the case manager may contact all other Medical Assistance recipients who are eligible for HealthCheck case management services.

Case management is a tool for linking targeted and non-targeted recipients with HealthCheck screening services and health care providers for follow-up and ongoing primary care services. Case management services include the following:

- Linking of non-users of health care with HealthCheck screening;
- Comprehensive health and social service needs assessment;
- Assistance with referrals to all appropriate resources beyond the HealthCheck screening process;
- Education for the proper utilization of health and Medical Assistance services;
- Removal of barriers to services and resources (both HealthCheck primary care and non-Medical Assistance related); and
- Linkage of the recipient to a primary health care provider and dentist for all future health care.

This handbook describes the required components of outreach and case management services. All case management providers are responsible for assuring that an initial HealthCheck screening is conducted on each recipient and that all appropriate referrals, resource linkages and follow-ups occur.

B. OUTREACH/ CASE MANAGEMENT STEPS

The goal of outreach/case management is to ensure that a targeted "at risk" recipient receives a HealthCheck screening and other associated services, including screening referrals and follow-up.

A schematic diagram of the steps involved in the HealthCheck case management process is found in Appendix 1 of this supplement. The following enumerates and describes those steps:

B. OUTREACH/ CASE MANAGEMENT STEPS (continued)

1. On a monthly basis, HealthCheck outreach/case management providers receive a listing from EDS of Medical Assistance recipients who are targeted for HealthCheck outreach screening services. Providers also receive a second list of all Medical Assistance recipients who are eligible for HealthCheck services.

2. The outreach case management provider is responsible for contacting all recipients who are on the targeted list in priority order. After all recipients who are on the targeted list are contacted, the provider may contact eligible HealthCheck recipients who are not on the targeted list, but are in need of case management. Refer to Appendix 2 of this handbook for information on HealthCheck outreach/case management need determination.

   Recipients may be contacted by telephone, home visit, mail or any other method the outreach case management provider finds effective. In performing outreach, the case manager discusses the HealthCheck program with the recipient, determines when the recipient last received health care, the purpose of that health care, and whether the recipient has ongoing primary care. (Appendix 2 of this handbook may be used as a questionnaire for determining need.) The purpose of these questions is to confirm that the recipient is appropriately targeted and to identify barriers which may impede the recipient's access to care and other needed services.

3. If the recipient received a preventive health checkup within the past six to twelve months (depending upon the recipient's age), then a HealthCheck screening may not be appropriate and should not be provided. If the recipient has not had a screening, but reports having a primary care provider, the case manager should contact the provider to determine if they will provide the HealthCheck screenings.

   NOTE: If the child is age 3 or greater, and has not seen a dentist, a dental referral must be part of the screening. The physician screener should be reminded about the dental referral requirement.

4. In addition to explaining HealthCheck benefits, the outreach case management provider must also explain to the recipient the appropriate use of the health care delivery system and how to effectively use Medical Assistance services and other health and social service resources. (Refer to Section II-C of this handbook for examples of non-Medical Assistance resources.)

5. If the recipient is in need of a HealthCheck screening, the outreach/case management provider must schedule a time and date for the screening, and ensure that the recipient has transportation resources to reach the appointment. The provider must also ensure that transportation is available for any other referral appointments which may develop as a result of the initial needs assessment.

6. If the recipient decides not to use HealthCheck, or fails to keep a scheduled appointment, the outreach/case management provider should attempt to investigate the problem and reschedule a second screening time. Only two attempts are necessary for scheduling a screening during a 12-month period.

7. If the recipient has a primary care physician or dentist, then the outreach/case management provider must coordinate and share HealthCheck related information with the recipient's primary care provider. If the recipient does not have a primary care physician or dentist, then the outreach case management provider should assist the recipient in locating an appropriate provider.

B. OUTREACH/ CASE MANAGEMENT STEPS (continued)

NOTE: The Department of Health and Social Services will provide upon request to certified outreach and case management providers a current listing of WMAP providers for their respective counties.

8. Following the screening, any positive findings will require the screener to make referrals for diagnosis and treatment. This includes a referral for all recipients beginning at age 3 years to a dentist for an exam and cleaning as part of the routine HealthCheck screening, unless the recipient has received dental care during the six months prior to the screening date. The outreach/case management provider must know of all referral appointments and ensure that the recipient has the ability to reach these appointments. Appointments with providers on referral (generally diagnosis and treatment) are confirmed as having been kept through case manager verification with the provider.

9. Follow-up of all referrals is completed when the recipient has kept the appointment or at least two case management attempts to get the recipient to keep the appointments have been made.

   NOTE: Diagnosis and treatment appointments are required by federal regulation to be scheduled <u>within 60 days of the date of screening</u>. Good professional judgment will dictate timely action for diagnosis and treatment.

10. If, in the judgement of the outreach/case management provider, additional referrals are needed, then the provider should assist with referral and follow-up, including the assurance of all recipient transportation.

11. Upon completion of the screening process, the recipient's name is removed from the targeted list.

C. REFERRAL AND FOLLOW-UP

HealthCheck Referral Requirements

Following HealthCheck screening, the case management provider is responsible for ensuring that all necessary referral appointments are kept. A critical responsibility of the case manager is the removal of all barriers a recipient may encounter for accessing various services on referral. Screenings are valuable only if problems found during the HealthCheck exam are diagnosed and treated. Prompt scheduling of all appointments and referrals will enable the case manager to complete timely recipient follow-up.

There are several types of referrals:

1. <u>Treatment Referral</u> - as a result of the HealthCheck physical examination, findings indicate the need for further evaluation, diagnosis, or treatment.

2. <u>Mandatory Dental Referral</u> - <u>all children age 3 years or greater</u> must be referred to a dentist for an oral assessment. Case managers should be sure this legally required referral occurs as part of the HealthCheck assessment process. In some cases, a dental referral for children under 3 years old may also be necessary.

3. <u>Recipient</u> - self-referrals may occur when the recipient expresses a particular need to the case manager (e.g., Day Care, Head Start) or chooses to receive services from a provider other than the screening provider or the screener's referral. Case managers must be sensitive to these requests and assist the recipient with identification of other sources of treatment and services.

C. REFERRAL AND FOLLOW-UP (continued)

4. Other Providers - as a result of a previous screening referral, the referral provider may make additional referrals for recipient care. Case managers must be prepared to assist and follow-up these referrals.

5. Support Referral (Non-Medical Assistance Covered Services) - these may include other maternal and child health services in the community, employment development programs, food assistance, the WIC program, nutrition counseling, food stamps, special educational services, housing, and other needs. Case managers must develop a thorough knowledge of local community resources and the client's needs to facilitate these referrals.

The referral process must also include a discussion and resolution of potential barriers to recipient follow through, such as:

1. Transportation difficulties;

2. Cost concerns;

3. Lack of knowledge of providers;

4. Language and cultural barriers; and

5. Failure to understand the need for care.

6. Confidentiality concerns (adolescents).

The recipient should also know the periodicity schedule and date of the next periodic exam. A reminder notice should be mailed by the case manager one week prior to the next periodic screening date.

Follow-Up
In all referral cases the case manager will:

1. Assist the recipient in scheduling and meeting appointments;

2. Offer and arrange for transportation for all referral visits; and

3. Contact the recipient or referral provider to determine the results of referral appointments.

An optional "follow-up notes" form is offered for use in Appendix 3 of this handbook.

Open communication between screeners and case managers is important for effective delivery of services and benefits to all recipients.

Transportation
Recipients may request transportation assistance as needed for any HealthCheck related screening or other referral appointment. Transportation should also be offered by case managers during outreach and screening follow-up. While the Bureau of Health Care Financing does not require transportation to be provided to every eligible recipient who receives a HealthCheck screening, diagnosis, or treatment appointment, transportation assistance is a need for those recipients who clearly cannot meet appointments without case management assistance for accessing services.

C. REFERRAL AND FOLLOW-UP (continued)

Transportation resources may vary by county. In general, county social services departments either provide volunteer drivers, vouchers, or direct reimbursement for related transportation expenses. Counties are obligated by state social and economic assistance program contracts to provide some form of HealthCheck related transportation assistance on recipient request.

HealthCheck case managers need not rely strictly on their own resources for helping recipients with transportation assistance and should assist recipients with accessing county transportation or other voluntary community resource assistance.

D. NONCOVERED SERVICES

HealthCheck outreach and case management is not a reimbursable service under the following circumstances:

1. Case management services do not result in a screening.

2. The recipient was not eligible on the date the HealthCheck outreach/case management or HealthCheck screening services were provided. The outreach/case management provider should inform the recipient that any services obtained during a period in which the recipient is not eligible will not be covered by the WMAP.

3. Outreach and case management services are billed more than once per recipient during a periodicity interval. Outreach provided in connection with an interperiodic screening is not a covered benefit.

A. CLAIM FORM INSTRUCTION

General billing procedures and reimbursement policy are in the WMAP Part A Provider Handbook. Sample HealthCheck case management claims are in Appendix 4 of this handbook.

B. CLAIM SUBMISSION

In order to claim reimbursement for outreach, case management providers must have on file verification that the HealthCheck screening occurred. This verification may be received in written form or through a conversation with either the provider or the recipient.

Paperless Claim Submission

As an alternative to submission of paper claims, the fiscal agent is able to process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted through these systems have the same legal requirements as claims submitted on paper and will be subjected to the same processing requirements as paper claims. Software for electronic submissions may be obtained free of charge. Electronic submissions have substantial advantages in reducing clerical effort and errors, reducing mailing costs and delays, and improving processing time. Additional information on paperless claim submission is available by contacting the Electronic Media Claims (EMC) Department at::

EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

Paper Claim Submission

HealthCheck services must be submitted using the National HCFA 1500 claim form. Sample claim forms can be found in Appendix 4 of this handbook. Claim form completion instructions can be found in Appendix 3 of the WMAP Part D, Division I HealthCheck Handbook. When billing with claim sort indicator "H," physician services must be submitted on a separate claim form from HealthCheck services using the appropriate claim sort indicator for each type of claim.

HealthCheck services submitted on any paper form other than the National HCFA 1500 claim form are denied.

The National HCFA 11500 claim form is not provided by the WMAP or the fiscal agent. It may be obtained from a number of sources, including:

State Medical Society Services
Post Office Box 1109
Madison, WI 53701
(608) 257-6781 (Madison area)
1-800-362-9080 (toll-free)

B. CLAIM SUBMISSION (continued

Completed claims submitted for payment must be mailed to the following address:

EDS
6406 Bridge Road
Madison, WI 53784

Submission of Claims
All claims for services rendered to eligible WMAP recipients must be received by EDS within 365 days from the date the service was rendered. This policy applies to all initial claim submission, resubmissions, and adjustment requests.

Exceptions to the claim submission deadline and requirements for submission to Late Billing Appeals can be found in Section IX of Part A of the WMAP Provider Handbook

C. PROCEDURE CODES

Outreach/case management providers may claim reimbursement when either targeted or non-targeted outreach has been provided that results in a comprehensive HealthCheck screening by either the same agency or an outside screener, such as a physician clinic. Case management for assisting the recipient in scheduling follow-up appointments to the screening is part of the total service.

Two outreach/case management billing codes are available:

W0712 Targeted outreach/case management
W7014 Non-targeted outreach/case management

D. MODIFIERS

When billing for outreach, one of the currently allowable modifiers is required if claim sort indicator "H" is used on the claim. Claim sort indicator "H" is allowable for claims received by the fiscal agent not later than 6/30/95.

If claim sort indicator "P" is used, no modifier is required. Claim sort indicator "P" is allowable for claims received by the fiscal agent beginning 2/15/95. Refer to Appendix 5 for a summary of the billing options available.

E. DATE OF SERVICE

Outreach case management is a service that spans over a time period. If possible, for billing purposes, use the screening date as the date of service recorded on the claim.

F. FOLLOW-UP TO CLAIM SUBMISSION

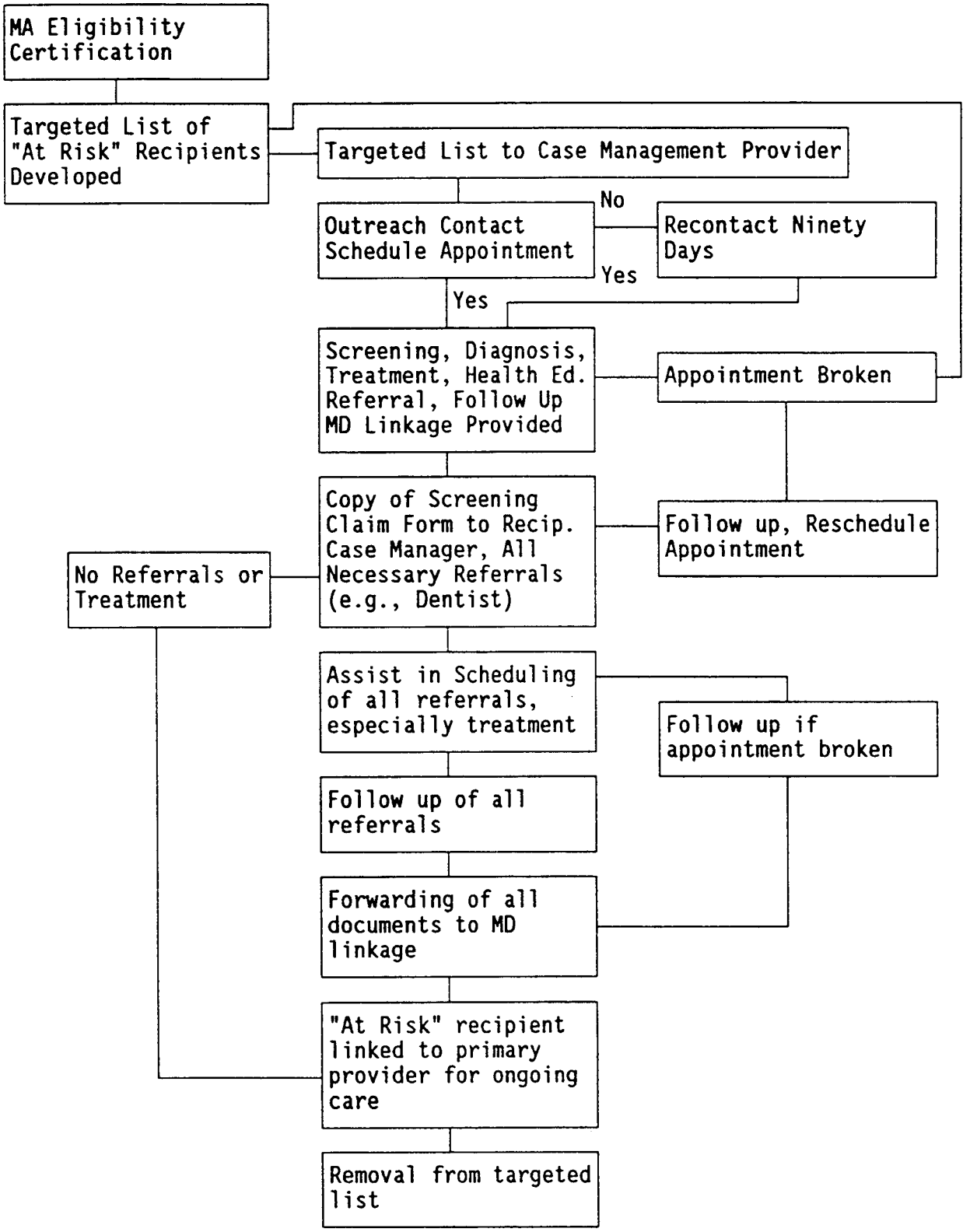
It is the responsibility of the provider to initiate follow-up procedures on claims submitted to the fiscal agent. Processed claims will appear on the Remittance and Status Report either as paid, pending or denied. Providers should be advised that the fiscal agent will take no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for filing an adjustment request form to the fiscal agent. Section X of the WMAP Part A Provider Handbook includes detailed information regarding:

- the Remittance and Status Report;
- adjustments to paid claims;
- return of overpayments;
- duplicate payments;
- denied claims; and
- Good Faith claims filing procedures.

HEALTHCHECK OUTREACH AND CASE MANAGEMENT
APPENDICES

APPENDIX I

HEALTHCHECK OUTREACH AND CASE MANAGEMENT FLOWCHART OF ACTIVITY



APPENDIX 2
HEALTHCHECK OUTREACH/CASE MANAGEMENT NEED DETERMINATION

Purpose:
The targeted list the provider agency receives prioritizes eligible Medical Assistance recipients who may be in need of outreach and case management. Some recipients may in fact have received a screening or other health care since this list was generated. Therefore, it is critical that the provider determine if the recipient has received health care. Begin with the first prioritized listed recipient. To determine if the recipient is in need of case management, ask the following questions:

1. When was the date the recipient was last screened, or had an extensive physical exam?

   a. If the recipient is under age 2, and was not screened within the past six months, then the recipient is in need of case management.

   b. If the recipient is at least 2 years of age but under 5 years of age, and not screened within the past twelve months, then the recipient is in need of case management.

   c. If the recipient is at least age 5 but under age 21, and not screened within the past 24 months, then the recipient is in need of case management, or if the recipient is pregnant and is not currently receiving prenatal care.

2. Does the recipient have a primary health care provider from whom regular health care is obtained?

   a. If yes, the provider should attempt to link the recipient with the physician for a HealthCheck screening. If this is not possible, or the recipient requests screening services from the outreach and case management provider, then screen the recipient. In either screening situation, case management should be provided.

   b. If no, recipient does not have a primary physician, you may screen and case manage the recipient. The recipient should be linked with a medical assistance certified physician for future care. Screening results should be shared with the physician. If the recipient is age 3 or older, referral should be made to a dentist for examination and ongoing care. The recipient's physician should also know the dentist's name for future screening referral.

3. Conduct inventory needs assessment of the recipient and family as guided by the case management plan.

NOTE: The HealthCheck screening schedule is outlined by the Periodicity Schedule as listed in Appendix 5 of the HealthCheck Screening Services Provider Handbook, Part D, Division I.

Case management claims for reimbursement must document that a screening did occur. This is done via a screening claim or a physician screening provider referral/modifier code on the outreach and case management claim form.

Outreach and case management may also be provided to eligible recipients who are not on a targeted list, but are eligible for Medical Assistance and "in-need" of a screening based on questions 1 and 2 above. The provider may also claim case management reimbursement if screening services are provided to this recipient. Refer to Section II-C of this handbook for information on non-targeted outreach.

APPENDIX 3

HEALTHCHECK FOLLOW-UP NOTES

Recipient Name	MA ID Number	Date Screened

Problem and/or Referral Destination	Date	Notes

PROBLEM #1

PROBLEM #2

PROBLEM #3

PROBLEM #4

APPENDIX 4a
BILLING EXAMPLE
NON-TARGETED OUTREACH /COMPREHENSIVE SCREEN WITH IMMUNIZATIONS
CLAIM SORT INDICATOR "H"
RECEIVED BY EDS NO LATER THAN 6/30/95

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER			1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
[ ] (Medicare #) [H] (Medicaid #) [ ] (Sponsor's SSN) [ ] (VA File #) [ ] (SSN or ID) [ ] (SSN) [ ] (ID)			1234567890
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Recipient, Im A	MM DD YY M [ ] F [X]		
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)
609 Willow St.	Self [ ] Spouse [ ] Child [ ] Other [ ]		
CITY / STATE	8. PATIENT STATUS		CITY / STATE
Anytown / WI	Single [ ] Married [ ] Other [ ]		
ZIP CODE / TELEPHONE (Include Area Code)	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]		ZIP CODE / TELEPHONE (INCLUDE AREA CODE)
55555 / (XXX) XXX-XXXX			( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER
OI-Y			
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [ ] NO		a. INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]	b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)		b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? [ ] YES [ ] NO		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes*, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / MM DD YY TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / MM DD YY TO
19. RESERVED FOR LOCAL USE			20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V70 0 2. 3. 4.			22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 29 95		3	1	W7014	01	1	XX XX	1				
2 01 29 95		3	1	W7000	04	1	XX XX	1				
3 01 29 95		3	1	90701		1	XX XX	1				
4 01 29 95		3	1	W7020		1	XX XX	1				
5 01 29 95		3	1	90712		1	XX XX	1				
6 01 29 95		3	5	85018		1	XX XX	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
[ ] [ ]	1234JD	[ ] YES [ ] NO	$ XXX XX	$	$ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
I. M. Authorized		I. M. Billing 1 W. Williams Anytown, WI 55555
SIGNED MM/DD/YY DATE		PIN# GRP# 87654321

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

APPENDIX 4b
BILLING EXAMPLE

TARGETED OUTREACH / COMPREHENSIVE SCREEN WITH IMMUNIZATION
CLAIM SORT INDICATOR "P"
RECEIVED BY THE FISCAL AGENT ON OR AFTER 2/15/95
HEALTHCHECK NURSING AGENCY PROVIDER

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [P] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow St.

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-Y

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. V70 0
2.
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 01 95	3	1	W7012		1	XX XX	1				
2 02 01 95	3	1	99392	HC	1	XX XX	1				
3 02 01 95	3	1	W7018		1	XX XX	1				
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 1234JD

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ XXXX XX

29. AMOUNT PAID $

30. BALANCE DUE $ XXXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
I.M. Authorized
SIGNED MM/DD/YY DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
I. M. Billing
1 W. Williams
Anytown, WI 55555
PIN# GRP# 87654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

APPENDIX 4c
HEALTHCHECK SERVICE CODES
TARGETED OUTREACH
SCREENING PROVIDED BY ANOTHER PROVIDER
CLAIM SORT INDICATOR 'P'
RECEIVED BY THE FISCAL AGENT ON OR AFTER 2/15/95

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

1 MEDICARE [ ] (Medicare #) MEDICAID [P] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow St.

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX) XXX-XXXX

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [ ] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V70.0
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 03 25 95		3	1	W7012		1	XX XX	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 1234JD

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO

28. TOTAL CHARGE $ XX XX

29. AMOUNT PAID $

30. BALANCE DUE $ XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Authorized MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I. M. Billing
1 W. Williams
Anytown, WI 55555

PIN# GRP# 87654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

APPENDIX 5
OUTREACH/CASE MANAGEMENT PROCEDURE CODES WITH ALLOWABLE CLAIM SORT INDICATOR AND MODIFIERS

"H" Claim Sort Indicator
Effective for Claims Received by the Fiscal Agent
by June 30, 1995

Procedure Code	Description	POS	TOS	Claim Sort	Modifiers
W7012	Targeted Outreach/Case Management	0,2,3,4	1	H	01-07, 09-12, 14-20
W7014	Non-targeted Outreach/ Case Management	0,2,3,4	1	H	01-07, 09-12, 14-20

OR

"P" Claim Sort Indicator
Effective for Claims Received by the Fiscal Agent
on and after 2 /15 /95

Procedure Code	Description	POS	TOS	Claim Sort	Modifiers
W7012	Targeted Outreach/Case Management	0,2,3,4	1	P	None
W7014	Non-targeted Outreach/ Case Management	0,2,3,4	1	P	None

APPENDIX 6
HEALTHCHECK SERVICES CODES

ALLOWABLE PLACE OF SERVICE

Code	Description
0	Other
2	Outpatient Hospital
3	Office
4	Home

ALLOWABLE TYPE OF SERVICE

Code	Description
1	Medical
5	Lab
9	Other

NOTE: Refer to Appendix 18, 18a and 18b of Part D, Division I, of the HealthCheck Handbook to identify allowable place of service and type of service codes for specific HealthCheck procedure codes.