Provider Handbook

Dear providers,

Welcome to Lakeland Care. Inc.! As a new provider we are excited to welcome you, and for those providers already partnering with us, thank you for your commitment to serving our members. We take great pride in uniting with providers to form long-lasting partnerships to serve our members in a cost effective and high quality manner. Lakeland Care, Inc. administers the Family Care program in 22 counties: Brown, Calumet, Door, Florence, Fond du Lac, Forest, Kewaunee, Langlade, Lincoln, Manitowoc, Marathon, Marinette, Menominee, Oconto, Oneida, Outagamie, Portage, Shawano, Vilas, Waupaca, Winnebago, and Wood. One key to Lakeland Care, Inc.'s success hinges upon having a strong and diverse provider network. A network through which Lakeland Care, Inc. and providers work collaboratively to meet members' outcomes.

This handbook provides information and guidance for providers contracted with Lakeland Care, Inc., such as general information about our Network Relations Division, Provider Network, Managed Care Organizations (MCOs), the Family Care program and the Family Care Benefit Package. You will also find detailed information about the MIDAS Provider Portal, service authorizations, how to file claims, reasons claims are denied and how to file appeals for denied claims. This handbook is a good resource whenever you have questions, and can be a valuable tool for your new employees. Most importantly, please do not hesitate to contact your local Provider Specialist by phone or email. You'll find the contact information for our team located in the handbook as well.

Thank you again for making the decision to partner with us, we look forward to a productive working relationship.

Mike Kristmann
Network Relations Director
Lakeland Care, Inc.

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Chapter 1: Introduction

Welcome

We are excited to welcome you as a provider with the Lakeland Care, Inc.! We take great pride in uniting with providers to form long-lasting partnerships to serve our members in a cost effective and high quality manner. A key component to our success is the development of a strong and diverse provider network that supports members in meeting their long-term care outcomes.

This handbook serves as a resource for contracted providers regarding, general information about the provider network, the Family Care program and the Family Care Benefit Package. There is also detailed information about the MIDAS Provider Portal, service authorizations, how to file claims, reasons claims are denied and how to file appeals for denied claims. This handbook is a helpful resource whenever you have questions, and can be a valuable tool for your new employees.

This handbook should be used in conjunction with other resources, including:

- Lakeland Care, Inc. website, www.lakelandcareinc.com
- Lakeland Care, Inc. Contract and Addendums
- Wisconsin Physician Services (WPS) website, www.wpsic.com
- Family Care Guide for Wisconsin Medicaid-Certified Providers
    - Wisconsin Medicaid All-Provider Handbook
    - Wisconsin Medicaid service - specific handbooks
    - Wisconsin Medicaid and Badger Care Updates
    - Wisconsin Administrative Code, Chapters DHS 101-108

For more information, providers may also refer to:

- Aging Disability and Resource Centers(ADRC) operating within Lakeland Care, Inc.'s region:
    - Brown County: http://www.co.brown.wi.us/departments/?department=db50c2508c43&subdepartment=1dfd7417eea9
    - Calumet, Outagamie, Waupaca Counties: http://www.youradrcresource.org/
    - Door County: http://adrcdoorcounty.org/
    - Florence County: http://www.florencecountywi.com/departments/
    - Forest, Oneida, and Vilas Counties: http://www.adrcofthenorthwoods.org/index.php
    - Fond du Lac County: http://www.fdlco.wi.gov/departments/departments-n-z/social-services/aging-and-disability-resource-center-adrc-2486
    - Langlade, Lincoln, Marathon, and Wood Counites: http://www.adrc-cw.com/
    - Marinette: http://www.marinettecounty.com/adrc
    - Manitowoc/Kewaunee County: https://sites.google.com/site/adrcofthelakeshore/
    - Portage County: http://www.co.portage.wi.us/department/aging-disability-resource-center

    - Winnebago County: http://www.co.winnebago.wi.us/adrc
    - Wolf River Region: http://www.adrcwolfriver.org/
- Wisconsin Department of Health Services resources:
    - Medicaid's Web site: www.dhs.wisconsin.gov/medicaid
    - Long-term care Web site: www.dhs.wisconsin.gov/LTCare

Wisconsin Medicaid's Provider Services at (800) 947-9627 or (608) 221-9883

If you have questions, or need help in understanding anything throughout the handbook, please call one of the local Provider Specialists. (A chart can be found with the name and contact information of each Provider Specialist on page 16 of the handbook.)

The most current version of this LCI handbook can be found on the LCI website, www.lakelandcareinc.com

Chapter 2: Overview

What is Lakeland Care, Inc.

Lakeland Care, Inc. is a member-centered organization that coordinates members' long-term supports by:

-Delivering high quality, cost-effective options
-Expanding access and choices to members
-Enhancing partnerships and resources within our communities
-Improving the health and well-being of members and their families
-Maintaining a positive place to work and deliver services

Lakeland Care, Inc. Mission

Enriching individuals' lives by honoring their values through high quality, cost effective care and supports.

Lakeland Care, Inc. Guiding Principles

Guiding Principles are the actions and philosophies that guide LCI staff in all situations and decisions, define the desired culture of LCI, and help fulfil the LCI mission.

- Teamwork: Build and nurture collaborative relationships while valuing the contributions of all.

- Respect: Display a professional attitude that respects diverse opinions, values and expertise of all stakeholders.

- Accountability**:** Accept responsibility for actions and results.

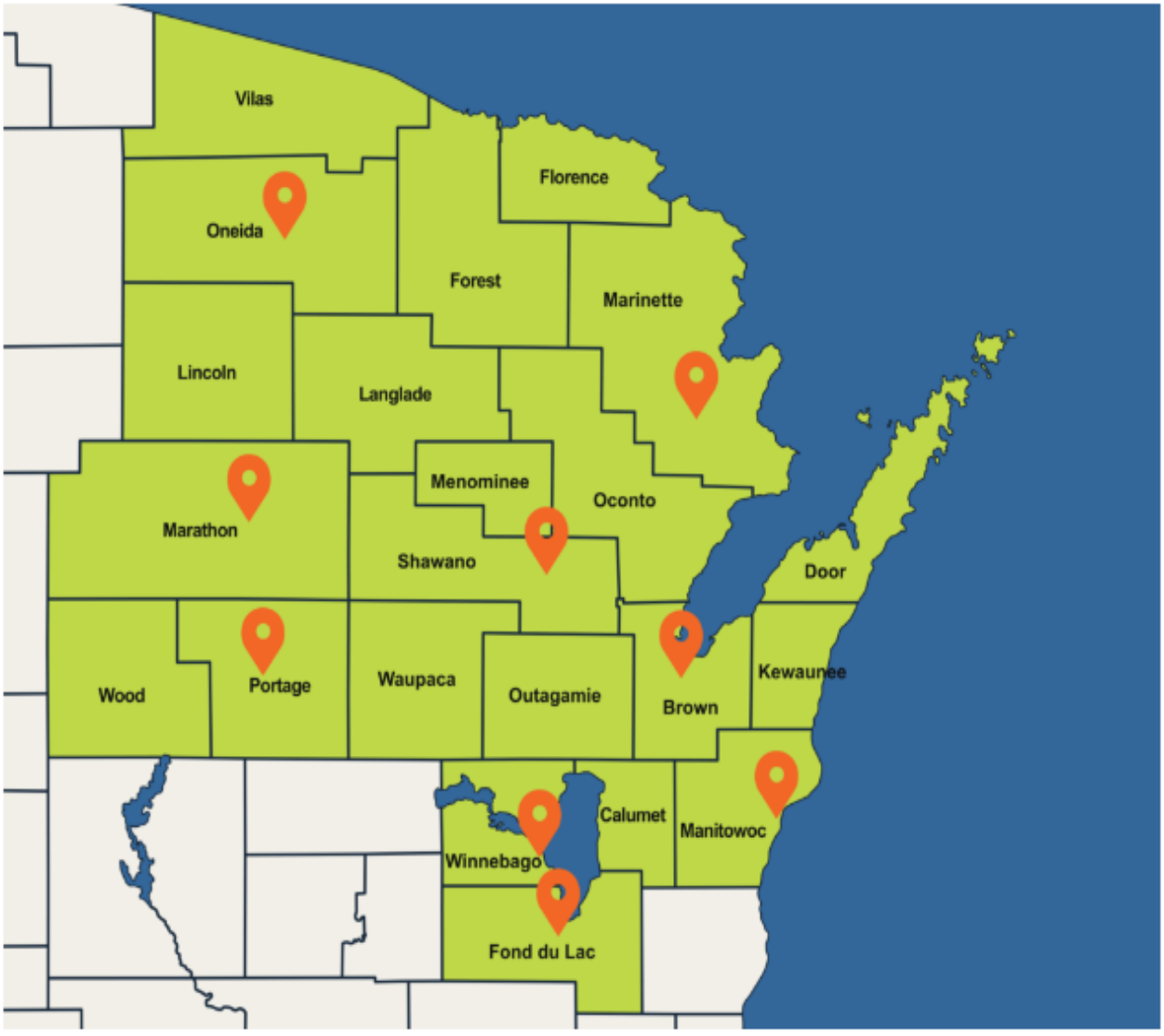
- Customer Service: Treat everyone as a customer and deliver high quality service through the dedicated effort of all.

- Communication: Utilize an open-minded and solution-focused approach with consistent and timely follow through.

Chapter 3: Contact information and Locations

Lakeland Care, Inc. Service Area

Lakeland Care, Inc. offers the Family Care Program in the following counties: Brown, Calumet, Door, Florence, Fond du Lac, Forest, Kewaunee, Langlade, Lincoln, Manitowoc, Marathon, Marinette, Menominee, Oconto, Oneida, Outagamie, Portage, Shawano, Vilas, Waupaca, Winnebago, and Wood.



We have offices located throughout our service region in **Ashwaubenon, Crivitz, Fond du Lac, Manitowoc, Oshkosh, Rhinelander, Shawano, Stevens Point and Wausau**.

All Lakeland Care, Inc. offices can be reached using the following contact information.

Lakeland Care, Inc.
8:00 a.m. – 4:30 p.m. Monday – Friday
Phone: 920-906-5100
Toll Free: 1-877-227-3335
TTY: 711
Fax: 920-906-5103
Website: www.lakelandcareinc.com

Lakeland Care, Inc. Office Locations

Crivitz
308 Henriette Avenue
(877) 227-3335

Fond du Lac
N6654 Rolling Meadows Drive
(920) 906-5100

Ashwaubenon
2985 Ridge Road(920) 425-3900

Manitowoc
3415 Custer Street
(920) 652-2440

Oshkosh
500 City Center
(920) 456-3200

Stevens Point*
5474 Highway 10 East
(715) 544-1650

Rhinelander*
232 S. Courtney Street
(715) 420-2450

Wausau*
501 S. 24th Avenue Suite 100
(715)298-6202

Shawano*
607 E. Elizabeth Street
(715)201-0407

***By Appointment**

Chapter 4: Program and Eligibility

Lakeland Care, Inc. Services

LCI's primary service is the efficient coordination of the Family Care program.

Family Care

Created in 1998, the Family Care program provides long-term care services and supports to people with physical disabilities, intellectual/developmental disabilities and frail elders. The specific goals of Family Care are:

- **Choice** - Give people better choices about the services and supports available to meet their needs.
- **Access** – Improve people's access to services.
- **Quality** – Improve the overall quality of the long-term care system by focusing on achieving people's health and social outcomes.

Family Care has two major organizational components:

1. **Aging and Disability Resource Centers (ADRCs)** are designed to be a single entry point where elderly people and people with disabilities and their families can get information and advice about a wide range of resources available to them in their local communities.
2. **Managed Care Organizations (MCOs)** manage and deliver the Family Care program. The Family Care program combines funding and services from a variety of programs into one flexible long-term care benefit through which care plans are tailored to each individual's needs, circumstances and preferences.

The Wisconsin Department of Health Services (DHS) contracts with multiple MCOs to coordinate services in the Family Care Benefit Package. Each MCO develops a provider network to deliver services to Family Care members who live in their own homes, in a skilled nursing facility, or in other group living situations. Each MCO coordinates and is responsible for contracting with an adequate number of providers throughout its designated service area to ensure that member's identified needs can be met. Services are delivered in a high-quality, member-centered, cost-effective manner and are outcome-based.

Eligibility

Lakeland Care, Inc. provides services to individuals that meet the following criteria:

- At least 18 years of age
- Persons with physical disabilities, intellectual/developmental disabilities or frail elders
- Are financially eligible as regularly determined by their local Income Maintenance (IM) Agency
- Are functionally eligible as determined through the Long Term Care Functional Screen conducted initially by the Aging and Disability Resource Center and then regularly by LCI
- A resident of one of the following counties: Brown, Calumet, Door, Florence, Fond du Lac, Forest, Kewaunee, Langlade, Lincoln, Manitowoc, Marathon, Marinette, Menominee, Oconto, Oneida, Outagamie, Portage, Shawano, Vilas, Waupaca, Winnebago, and Wood.

The ADRC determines an individual's initial eligibility for the Family Care program.

Enrollment into LCI is voluntary. However, members must maintain functional and financial eligibility to continue to be served through the Family Care program.

Once a member is enrolled with LCI, an Interdisciplinary Team (IDT) is formed. The team consists of the member, their legal representative (where applicable), a LCI Care Manager, a LCI RN Care Manager, and any other people the member wishes to include on their team such as family, friends, or other professionals or consultants. LCI IDT staff assesses the member's individual needs and works to develop a Member Centered Plan (MCP) which identifies all supports and interventions necessary to promote independence.

Disenrollment

Members may choose to end their membership with the Family Care program and LCI at any time. The member should notify their LCI care team as well as provider if they have made the decision for disenrollment.

Family Care Benefit Package

In general, long-term care services are included in the Family Care Benefit Package. Acute and primary care services, including physicians, hospital stays and medications, are not included in the Family Care Benefit Package. These medical services are funded by fee-for-service for those who are Medicaid eligible. The Family Care Benefit Package includes services covered by the Community Options Program (COP) and the home and community-based waivers program.

The following Medicaid Services are included in the Family Care Benefit Package

- Adaptive Aids (general and vehicle)
- Adult Day Care
- Alcohol and Other Drug Abuse Day Treatment Services (in all settings except hospital-based or physician provided)
- Alcohol and Other Drug Abuse Services (except those provided by a physician or on an inpatient basis)
- Care/Case Management (including assessment and care planning)
- Assistive Technology/Communication Aids
- Community Support Program (except physician provided)
- Consultative Clinical and Therapeutic Services for Caregivers
- Consumer Education and Training
- Counseling and Therapeutic Resources
- Daily Living Skills Training
- Day Services/Treatment
- Durable Medical Equipment and Medical Supplies (excludes hearing aids and prosthetics)
- Financial Management Services
- Home Delivered Meals
- Home Health
- Home Modifications
- Housing Counseling
- Mental Health Day Treatment Services (in all settings)
- Mental Health Services (except those provided by a physician or on an inpatient basis)

- Nursing Home including Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) and Institution for Mental Disease (IMD) (IMD coverage is for people under age 21, or 65 and older)
- Nursing Services (includes respiratory care, intermittent and private duty nursing)
- Occupational Therapy (in all settings except for inpatient hospital)
- Personal Care
- Personal Emergency Response System
- Physical Therapy (in all settings except for inpatient hospital)
- Prevocational Services
- Relocation Services
- Residential Services:
    - Adult Family Home (AFH)
    - Community-Based Residential Facility (CBRF)
    - Residential Care Apartment Complex (RCAC)
- Respite Care
- Self-Directed Personal Care
- Skilled Nursing Services RN/LPN
- Specialized Medical Equipment and Supplies
- Speech and Language Pathology Services (in all settings except for inpatient hospital)
- Supported Employment
- Supportive Home Care
- Training Services for Unpaid Caregivers
- Transportation (except ambulance)
- Vocational Futures Planning

Providers **must obtain prior service authorization** from LCI IDT staff for **all** services rendered or LCI will not cover the cost of the service.

Family Care Benefit Package Exclusions

- Alcohol and other Drug Abuse services provided by a physician or in an inpatient hospital setting
- Audiologist
- Chiropractic
- Crisis Intervention
- Dentistry
- Eyeglasses
- Family Planning Services
- Hearing Aids
- Hospice
- Hospital, Inpatient and Outpatient, including emergency room care (except for Outpatient Physical Therapy, Occupational Therapy, Speech, Mental Health services from a non-physician and Alcohol and other Drug Abuse from a non-physician)
- Independent Nurse Practitioner services
- Lab & X-Ray
- Medication
- Mental Health Services provided by a physician or in an inpatient hospital setting
- Optometry

- Physician and Clinic Services (except for Outpatient Physical Therapy, Occupational Therapy, Speech, Mental Health services from a non-physician and Alcohol and Drug Abuse for a non-physician)
- Podiatry
- Prenatal Care Coordination
- Prosthetics

Providers should continue to bill Medicaid fee-for-service for Medicaid card services that are not included in the Family Care Benefit Package when provided to Medicaid-eligible members

Chapter 5: Lakeland Care, Inc. and Family Care

Family Care Roles

Member**:**

A person voluntarily enrolled with LCI after having been found to be financially and functionally eligible for the Family Care Program. The Members or their legal representatives take an active role with the IDT in developing their care plans. Members are a central part of care planning and should be involved in every part of the process. LCI provides support and information to ensure members are making informed decisions about their needs and the services they receive. Members may also elect to self-direct some or all of their services on their care plan, allowing them to have increased control over their long-term care budgets and providers.

The Interdisciplinary Team (IDT):

Each member has support from an interdisciplinary team (IDT) that consists of, at a minimum, a Care Manager and a Registered Nurse. Other professionals, as appropriate, also participate as members of the IDT. The IDT conducts a comprehensive assessment of the member's needs, abilities, preferences, and values with the member and his or her representative, if any. The assessment evaluates areas such as activities of daily living, physical health, nutrition, autonomy and self-determination, communication, mental health, and cognition.

Care Manager**:**

The Care Manager helps members recognize and address their support needs as identified in their assessment. A few examples of areas members may evaluate with their Care Manager are employment, transportation, and supportive home care. All of the services the member receives through LCI are driven by the Member-Centered Plan and result in a Service Plan that is developed with the member. The Care Manager helps to arrange and monitor the services and supports included in the members' Individual Service Plan. The Care Manager is a required member of the IDT.

RN Care Manager (Nurse):

The Nurse Care Manager evaluates members' health care needs and coordinates health care services with members. The Nurse assists or works with others to make sure the member receives ongoing, individualized support for their member's long-term care and health care outcomes. The Nurse will provide prevention and wellness education to the member and other people in the member's life, including the use of influenza and pneumonia vaccines, if applicable and appropriate. The Nurse Care Manager is a required member of the IDT.

IDT staff**:**

A term used to reference LCI Care Manager and Nurse Care Manager.

Legal Representative**:**

Often times a member may have an appointed decision maker, such as a legal guardian or an activated power of attorney. If a legal representative has been appointed for a member, that individual person is always part of the IDT.

Others**:**

Members may wish to include other people as part of the IDT. Adult children or therapists are examples of others that members may choose to be part of their IDT.

Long-Term Care Functional Screen

The Wisconsin Long Term Care Functional Screen determines a person's eligibility for Family Care. The Functional Screen is conducted with a member and their supports and gathers information on an individual's health condition and their need for assistance in daily living activities such as bathing, getting dressed, using the bathroom, preparing meals, and managing medications. All LCI employees who conduct Functional Screens are certified by DHS.

Self-Directed Support

Self-Directed Support (SDS) is an option for all members in the Family Care Program. SDS allows members to manage some of their long-term care services, giving them more flexibility in how and from whom they receive services. SDS offers opportunities for members to direct one or some of the services available to them in the benefit package. If SDS is chosen, the member works with the team to determine a budget for services based on their care plan.

Resource Allocation Decision (RAD) Method

The Resource Allocation Decision (RAD) method is applied when requests are made for services in the Family Care benefit package. The RAD is a series of questions that helps members and IDT staff identify options that are available, to help support what is important to the member as it relates to their Long Term Care Outcomes (LTC Outcomes). LTC Outcomes are goals created to help the member be as healthy, safe, and independent as possible. The RAD method is utilized to help identify the most cost effective and efficient ways to meet the needs and achieve the member's goals. This includes both paid and unpaid support, including resources within members' community, friends, family or other volunteer organizations**.** The RAD method is a very useful tool to foster critical thinking as it relates to service authorization decision making in the Family Care program. It ensures that a consistent process is followed when decisions about authorization of services are made.

Chapter 6: Provider Network

Network Relations Team

The Network Relations team ensures that providers receive adequate support for the key aspects involved in providing direct services for LCI members. This support includes understanding and accurately delivering services as authorized, and the provision of high quality services that safeguard members' health and safety.

The Network Relations team provides training to service providers regarding use of the MIDAS Provider Portal. This training is available to all existing providers upon request and to all new providers upon acceptance to the provider network.

Each location has a local assigned Provider Specialist. The Provider Specialist is available to assist providers with Contract and Addendum questions, understanding Policies and Procedures, working collaboratively with LCI, or adding a service to their current contract
If you are a new or current provider and would like to schedule an appointment to address concerns, add services to your contract, or are in need of assistance in working with LCI, please call your local Provider Specialist. The chart below includes contact information for the entire Network Relations Division, including your local Provider Specialists.

Mike Kristmann **Network Relations Director** **mike.kristmann@lakelandcareinc.com**		
Jeremy Kral- 920.425.3869 **Network Relations Manager**	Lauren Lemberger- 920.906.5819 **Network Relations Manager**	Jane Brackett - 920.425.3882 **Network Quality Manager**
Megan Acheson-920.906.5181 **Employment Services** Coordinator	Courtnee Buttles- 920.456.3231 **Provider Specialist –Winnebago, and Waupaca Counties**	Jennifer Eiting- 920.456.3217 **Network Quality Specialist - Winnebago, Fond Du Lac, Calumet, Outagamie, Waupaca Counties**
Jill Wroblewski- 920.425.3883 **Provider Specialist –Brown, Oconto, and Marinette Counties**	Dan Zirbel- 920.906.5171 **Provider Specialist – Fond du Lac, Portage, and Wood Counties**	Debbie Verhyen- 920.425.3889 **Network Quality Specialist – Brown, Manitowoc, Door, Kewaunee Counties**
Wendy Jacobs- 920.425.3885 **Provider Specialist – Brown, Marinette, and Oconto Counties**	Nate Johnson- 920.425.3814 **Provider Specialist –Marathon, Menominee, Outagamie, and Shawano Counties**	Rachel Miller- 715.420.2446 **Network Quality Specialist – Oconto, Marinette, Shawano, Menominee, Florence, Forest, Langlade, Vilas, Oneida, Lincoln, Marathon, Wood, Portage Counties**
Melissa Lyon- 920.657.2181 **Provider Specialist – Door, Calumet, Manitowoc, and Kewaunee Counties**	Jordan Lefeber- 920.906.5865 **Network Relations ASA**	Raella Florea- 920.906.5106 **DME Coordinator**
Yvonne Brooks- 715.420.2465 **Provider Employment Specialist- Florence, Forest, Langlade, Lincoln, Oneida, and Vilas**	Loryn Strook- 920.906.5867 **Network Relations ASA**	

Joining the Provider Network

Providers interested in pursuing a contract with LCI can contact the Provider Specialists at their local branch, or email Network.Relations@lakelandcareinc.com. Application materials, a copy of the Service Provider contract, and the contract addenda can be found on the website at www.lakelandcareinc.com. Network Relations staff are available to assist providers throughout the application process.

Lakeland Care, Inc. will consider member requests for providers outside of our network, but is not required to approve all such requests. LCI may choose to add providers that meet the specific needs of a member whenever feasible.

Lakeland Care, Inc. will add providers to the network when all of the following standards are met:

- The requested service is in the Family Care benefit package;
- Network capacity indicates a need for additional providers within the applicable service code category (this standard is not applicable to Community Based Residential Facilities (CBRFs), Residential Care Apartment Complexes (RCACs), community rehabilitation programs, home health agencies, day service providers, personal care providers, or nursing facilities);
- The provider agrees to be reimbursed at LCI's contracted rate negotiated with similar providers for the same care, services, and/or supplies;
- The provider meets all applicable licensing/certification requirements as they apply to the services to be provided;
- The provider has demonstrated an ability to meet other applicable standards that are required by law or per their contract with LCI;
- The provider has positive references that demonstrate competency and quality services;
- The provider is willing to adhere to all components of LCI contract and addendums; and
- The provider is willing to submit other materials as requested by LCI to demonstrate rendering of quality service, and competency.

Ineligible Organizations

Lakeland Care, Inc. shall exclude organizations from participation in the provider network if any of the following categories are met (references to the Act in this section refer to the Social Security Act):

Entities which could be excluded under section 1128(b)(8) of the Social Security Act are entities in which a person who is an officer, director, agent or managing employee of the entity, or a person who has a direct or indirect ownership or control interest of 5% or more in the entity, or a person with beneficial ownership or control interest of 5% or more in the entity has:

a. Been convicted of any of the following crimes:
    i. Program related crimes, i.e., any criminal offense related to the delivery of an item or a service under Medicare or Medicaid. (See Section 1128(a) (1) of the Act);
    ii. Patient abuse, i.e., criminal offense relating to abuse or neglect of patients in connection with the delivery of health care (See Section 1128 (a) (2) of the Act;
    iii. Fraud, i.e., a State or Federal crime involving fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of health care or involving an act or omission in a program operated by or financed in whole or part by Federal, State or local government. (See Section1128 (b)(1) of the Act);
    iv. Obstruction of an investigation, i.e., conviction under State or Federal law of interference or obstruction of any investigation into any criminal offense described directly above (See Section 1128 (b) (2) of the Act;
    v. Offenses relating to controlled substance, i.e., conviction of a State or Federal crime relating to the manufacturing, distribution, prescription or dispensing of a controlled substance. (See Section 1128 (b) (3) of the Act;
b. Been excluded from participation in Medicare or a State Health Program. A State Health Care Program means a Medicaid program or any State program receiving funds under title V or title XX of the Act. (See Section 1128(b)(8)(iii) of the Act.)
c. Been assessed a Civil Monetary Penalty under Section 1128A of the Act. Civil monetary penalties can be imposed on individual providers, as well as on provider organizations, agencies, or other entities by the DHHS Office of Inspector General. Section 11238A authorizes their use in case of false or fraudulent submittal of claims for payment, and certain other violations of payment practice standards. (See Section 1128(b)(8)(B)(ii) of the Act.)

Provider Certification and Standards

Lakeland Care, Inc. shall only contract with providers that:

- Meet the provider standards in Wisconsin's approved s. 1915 (c) home and community-based waiver, meet all required licensure and/or certification standards applicable to the service provided, and are consistent with any applicable Department of Health Services, Division of Long Term Care policies and procedures;
- Meet the LCI's provider standards which have been approved by the Department of Health Services (DHS), Division of Long Term Care.

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Credentialing of Providers

Lakeland Care, Inc.'s credentialing standards are established to meet the requirements of LCI's contracts with Centers for Medicare & Medicaid Services (CMS) and the Wisconsin DHS.

The credentialing process ensures that providers are properly educated, trained, and accessible to LCI members. LCI always retains the right and the obligation to accept or reject the recommendations of credentialing delegates.

Information that is acquired through the credentialing and re-credentialing processes is considered confidential. LCI staff with access to the files are responsible for ensuring the information remains confidential, except as otherwise provided by law.

Lakeland Care, Inc. may not contract with or use any providers who are excluded from participation in any federal or state health care programs.

Room and Board in Residential Facilities

Lakeland Care, Inc. members are responsible to pay for room and board (rent and food) costs if they are living in a Certified or Licensed residential setting. Residential settings include Adult Family Homes (AFHs), Community-based Residential Facilities (CBRFs), or Residential Care Apartment complexes (RCACs). LCI will pay the residential provider for the Room and Board per the contracted rate, and will bill the member for reimbursement. LCI will pay for Room and Board for up to 14 days during the member's absence to maintain a member's placement at the facility

Care and Supervision in Residential Facilities

Lakeland Care, Inc. will pay for the care and supervision from the date of member's admission and all days of residence thereafter. LCI will not pay for Care and Supervision during a member's temporary absence from the facility due to the member requiring hospitalization or short term rehabilitation in a nursing home.

Service Authorizations

Providers are responsible for obtaining prior authorization before delivery of services. In some circumstances, initially, a verbal authorization will be given by the IDT staff which should be documented by the provider and the IDT staff. A verbal prior authorization from the IDT staff allows the provider to initiate the service immediately. A verbal authorization must be followed up as a written authorization within 48 hours. While LCI may not be the primary payer source, a prior authorization from LCI is required for payment of co-payments. LCI requests all contracted providers notify the IDT staff when a Medicare service is being administered, to ensure

coordination of care for LCI member. Additionally, if co-payment is necessary or if primary payer funding ends, the IDT staff need to complete the RAD process which explores all options available to meet the member's health and safety needs and determines the most effective way to address the member's LTC Outcome. This process requires collaboration between the member, family supports, and the provider involved.

The service authorization will include:

- the name of the member
- the type of service to be provided
- the number of units (amount of service) to be provided
- the rate per unit for the service or item
- the funding source
- the duration of the service to be provided

To obtain a Care Manager's or Nurse Care Manager's name and telephone number, contact your local LCI branch or call 1-877-227-3335.

When an LCI member is in need of a service within the benefit package after hours, contact the 24-hour authorization number at (920) 906-5177 or 866-359-9438. LCI afterhours authorization line has staff available 24 hours per day, 7 days per week who have the authority to authorize services in the Family Care benefit package and are familiar with the provider network.

Providers are not able to bill for payment from a member or the member's family for services that are covered in the Benefit Package that are needed to support the member's long term care outcomes.

MIDAS Provider Portal

An authorization for each service will be available to the provider via the MIDAS Provider Portal. Providers who are contracted with LCI can access the MIDAS Provider Portal through the LCI website. Once logged in the Provider is required to acknowledge all service authorizations before being able to navigate to any other screen within the portal. This is done by simply checking the box next to Select/Unselect All and selecting save at the bottom of the screen.

If the provider has a question about the Service Authorization or if there is a discrepancy, contact the IDT staff immediately. The IDT staff's name, phone number, and e-mail address is on the Service Authorization (See sample Service Authorization in attachment section).

Provider Specialists are available in each branch to assist providers and answer any questions about MIDAS. A MIDAS user guide is available to help learn the features of the Provider Portal this can be accessed on the LCI website.

Chapter 7: Provider Requirements and Expectations

Provider Responsibilities:

All providers have signed contracts with LCI and agree to adhere to all components of the contract including, but not limited to:

- Agreement of LCI contracted rate
- Follow contractual requirements related to authorizations and billing
- Maintain a collaborative working partnership with LCI staff
- Meet or exceed quality assurance expectations of LCI
- Maintain “in good standing” with any licensure or certification
- Provide compliance and fraud, waste, and abuse training for all staff
- Give written notice when there is any change in service type
- Compliance with all regulations related to Health Insurance Portability and Accountability Act (HIPAA)
- Notify Network Relations of any changes in address, telephone number, or contact information

The contract specifies the services that an agency is contracted to provide to LCI members. As a contracted provider in the provider network, the agency is included in the Provider Directory, which is available to members. Providers are chosen by the IDT, based on their ability to meet members’ LTC Outcomes.

The State of Wisconsin DHS and HFS 10 requires LCI to continually monitor the provider network to ensure that service capacity and access are managed in accordance with current and anticipated member service demands. Excess capacity in the provider network increases administrative costs and makes it more difficult to monitor provider quality. LCI is not required to contract with providers beyond the number necessary to meet the needs of the members.

Background Checks

Lakeland Care, Inc. complies with the Wisconsin Admin Code and DHS 13 which pertains to any provider’s staff who come in regular, direct contact with members.

Lakeland Care, Inc. requires providers to perform caregiver background checks on employees paid to provide services to LCI members. If requested through an audit, the caregiver background check shall be made available to LCI. LCI maintains the ability to withhold payment or decline to contract with any provider if LCI deems it is unsafe based on the findings of past criminal convictions stated in the caregiver background check.

Proof of Insurance

Lakeland Care, Inc. requires verification that all providers have current insurance policies. Providers must submit to LCI a copy of their current insurance certificate/liability certificate. The insurance listed on the policy must be appropriate and current. The Provider must submit an updated certificate to LCI each year.

Termination of Contract

The contract may be terminated by LCI for any reason or for no reason at all, following a sixty calendar day written notice to Provider. The contract may be immediately terminated if termination is essential to the safety and well-being of the members being served. Providers may terminate their contracts with LCI with a written sixty-day calendar notice.

Chapter 8: Claims Submission and Payment

Overview

Lakeland Care, Inc. regularly reviews service claims paid by its Third Party Administrator (TPA). A provider who makes an unintended error is typically advised of such and educated regarding the proper way to submit future claims. Repeat errors, or egregious errors, may be investigated for fraud or abuse. Claims submissions which may be investigated as potential fraud or abuse, particularly if repeated, include but are not limited to:

- a claim which indicates services were provided on a date or a time when the services were actually not provided (for example, on a day when the member was hospitalized);
- a claim which indicates more units than possible were provided within a date range (for example, 31 daily units for the month of February); and
- a claim which indicates more units than possible within a single day (for example, 2 units of snow removal on the same date, when this is a service contracted for only 1 unit per date regardless of the number of actual visits on that date).

Third Party Administrator (TPA)

Lakeland Care, Inc. contracts with a TPA to process provider claims for payment.

The Third Party Administrator is:

WPS INSURANCE CORP.
PO BOX 8631
MADISON, WI 53708-8631
Customer Service Phone #: (800) 223-6016

Claims Submission Options

There are two methods of submitting electronic claims to WPS:

- Providers may submit a claim via **Electronic Data Interchange (EDI)** either through a clearing house or by using WPS' claim entry software *PC-Ace Pro 32 and MoveIT* account (both are free). The EDI application is available on the LCI web site and on the WPS web site. For assistance, Providers may contact WPS' EDI Team's toll free number (800) 782-2680, option 2.

- The **WPS Excel spreadsheet** can be requested at www.wpsic.com/edi/index/shtml, by sending an email to FCWPS@wpsic.com, or calling the WPS' EDI Team's toll free number (800) 782-2680, option 2.

- CMS-1500 *(Please note the additional requirements below.)*
  - Authorization Numbers(s) in BOX 23
  - One authorization number per code

- Bill with service code from the Service Authorization Form

- UB-04 *(Please note the additional requirements below.)*
  - Authorization number(s) in BOX 63
  - One authorization number per code
  - Bill with service code from service Authorization Form

Exception- for Medicare Coinsurance claims, the original UB-04 submitted to Medicare may be used, however an authorization code for each LCI covered service must be entered in BOX 63.

Clean Claim Submission Process

1. All Family Care services must be performed by LCI contracted network provider.
2. All Family Care services must be pre-authorized by the member's IDT staff prior to performing services. **NO PAYMENTS WILL BE MADE WITHOUT PRIOR AUTHORIZATION.**
3. All information on the service authorization must be accurate before performing services, especially:

   - **Dates of Service:** Provider must verify that the service authorization covers the date span of the expected service period.
   - **Units of Service:** Provider must verify that the number of units authorized is equal to the number of units expected during the service period.
   - **Service Code/HCPCS/Revenue Code:** Provider must verify that the service code authorized is the same as the expected service to be provided.

   If the service provided does not correspond to LCI Service Authorization, contact the member's IDT staff immediately. Untimely requests will result in a denied claim and no reimbursement.

4. The provider is responsible for submitting a clean claim for each member served in order to receive payment. A clean claim is free from errors and contains all of the following:

   - Member Information:
     - Full name
     - Social Security Number (SSN)
     - Date of birth
   - Service Authorization Information:
     - Authorization number (each claim form must contain **only one** authorization number)
     - Date(s) of service (date range or individual days)
     - Service/HCPCS/Revenue Code/Modifier (if applicable)
     - Number of units (number of days in service period or units of provided service)

        - Unit rate/Billed amount
        - Attached Medicare EOMB/Primary Insurer EOB (if applicable)
    - Provider Information:
        - Provider Name
        - Provider address
        - Provider Number (TIN/EIN/SSN)
        - National Provider Identifier (NPI) (if applicable)

5. The clean claim **must** be received by WPS within **90 days** from the service end date or within **90 days** from the date of Primary Insurer EOB / Medicare EOMB.

6. Clean claims using paper filing must be mailed to:

    Lakeland Care, Inc.
    C/O WPS Insurance Corporation
    PO BOX 211595
    Eagan, MN 55121

7. If payment has not been received within 30 business days from the date submitted, please contact the Wisconsin Physicians Service Call Center at 1-800-223-6016.

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Provider Claims Appeal Process

A Provider may dispute LCI's payment, nonpayment, partial payment, late payment, or denial of claim by filing a written request with the Lakeland Care, Inc. Business Division within sixty days of LCI action. The Business Division will review claims for reconsideration when submitted by a provider.

Appeals from Providers must include the following elements:

1. Appeals must be clearly marked as "appeal" and addressed to the fiscal supervisor.
2. Appealed claims must be received within 60 days of the Explanation of Benefits (EOB), ERA, or denial letter.
3. Claims must have all the elements of a clean claim as outlined in the contract, including Provider's name, member's name, service description or code, date(s) of service, date of billing, date of rejection, and copy of EOB. Providers may request another copy of the letter of authorization from the Claims Customer Service Associate for the month of the claim if they do not have a copy of their original.
4. Claims must include a written statement indicating the reason for the appeal. If more than one claim is being appealed each must have a reason statement or contain a cover statement indicating the reason for the appeal is the same for all resubmitted claims.
5. Claims submitted as appeals will be reviewed by LCI one time only.
6. Providers can further dispute an unpaid claim with DHS.

Chapter 9: Members Rights and Responsibilities

The member's rights and responsibilities can be viewed in the Member Handbook located on LCI's website www.lakelandcareinc.com

Confidentiality

Protecting the privacy and security of our member's information is one of our highest priorities. As a LCI contracted provider, you are required to maintain strict confidentiality in all member information you generate or receive. It is an additional requirement that you must be in compliance with all Federal and State confidentiality laws and regulations.

You must also comply with the Federal regulations implemented in the Health Insurance Portability and Accountability Act of 1996, commonly known as HIPAA, to the extent those regulations apply to the services you provide or purchase with funds provided under contract with LCI.

As a provider, you must immediately report any and all allegations or violations of confidentiality or protected health information to the IDT staff, the Provider Specialist or to LCI Privacy Officer at:

Lakeland Care, Inc.
Privacy Officer
N6654 Rolling Meadows Dr.
Fond du Lac WI 54937
920-906-5100

Lakeland Care, Inc. will assist you in investigating any instances of alleged violation and will work with you to resolve substantiated violations.

Maintaining Confidentiality in Email Communications

Lakeland Care, Inc. is committed to maintaining confidentiality in all email communications and contracted providers must ensure they do not use personally identifiable information within the subject line or body of an email message.

Lakeland Care, Inc. has implemented an e-mail encryption system designed to protect e-mails sent to recipients outside of LCI's e-mail network.

This software will encrypt e-mails and e-mail attachments containing confidential data such as member names and social security numbers, and terms which may indicate the presence of sensitive information protected under HIPAA privacy rules.

When you receive an encrypted email from an LCI employee you will receive notification in your inbox that you have a "secure" message. You'll be required to log onto a website hosted by our vendor, Cisco, in order to retrieve the e-mail. The first time you receive an encrypted email from us, you will be required to set up an account at the website. Please follow the steps outlined

below in order to register and retrieve secure e-mails from LCI. If you already have an account established with Cisco, please skip to step five (5).

Instructions for opening a secure e-mail

1) Click *Download* and then *Open*.

2) Click *Register* in the box that comes up, fill out the registration form, and click *Register* at the bottom of the form.

3) The next screen will be notification of instructions sent to your e-mail account in order to activate the secure account. Go to your e-mail account to access these instructions.

4) When you open that e-mail, click on the link to activate the account (make sure you don't click on the link to *cancel* the account). You will get a message saying your e-mail address has been confirmed. You can now go back to the initial e-mail you received, which notified you that you have a secure e-mail.

5) Click the Download link, and open the file. (Note: do not try going into the Cisco envelope in the e-mail itself and putting in your password there).

6) Enter your log in information you just created, and you'll be taken to your message.

If you have questions about this process, please contact the sender of the e-mail.

*NOTE: If your e-mail system is using a secure format that is compatible to LCI's, you will receive secure e-mails from us in the same manner you receive all other e-mails, and you will not be required to go through the steps outlined above.

Members Grievance and Appeals

Lakeland Care, Inc. is committed to providing quality service to our members. There may be a time when a member has a concern. It is their right to file a grievance, or appeal a decision made by LCI, and to receive a prompt and fair review at any time.

When a member is unhappy with their services they should first talk with their care team. This is usually the easiest and fastest way to address concerns. If they do not wish to talk with their care team, they can contact the Member Rights Specialist. The Member Rights Specialist will inform them about their rights and attempt to informally resolve concerns. The Member Rights Specialist may also support the member to file a grievance and/or appeal and continue to mediate the situation throughout the process.

If a member does not feel as though their concern was resolved through working with their care team or Member Rights Specialist, Family Care offers several additional ways to address concerns. The member can:

- File a grievance or appeal with LCI

- Ask for a review by the Wisconsin Department of Health Services
- Ask for a State Fair Hearing with the Wisconsin Division of Hearings and Appeals

Each of the options listed above has different rules, procedures, and deadlines. The Member Rights Specialist will be able to assist with understanding these differences. Additionally, the rules and procedures are outlined in the LCI Member Handbook.

A provider may be involved in a member's appeal or grievance in several ways. The member may be concerned about the amount, type, or quality of service that is being provided. The member may also ask a provider to assist them with filing a grievance or appeal on their behalf and/or ask the provider to act as an advocate for them during a grievance or appeal.

If you, as a provider, are contacted about a complaint against you or your services, please direct the member to our Member Rights Specialist. Contact information:

Lakeland Care, Inc.
Member Rights Specialist
N6654 Rolling Meadows Drive
Fond du Lac, WI 54937
Toll-free: 1-877-227-3335
TTY: 1-800-947-3529

Should a member approach you for assistance regarding a grievance or appeal that is not about you as a provider, we recommend you review with them the instructions located in the LCI Member Handbook. You may also urge the member to contact the Member Rights Specialist.

Ombudsman Assistance

Any Lakeland Care, Inc. member can receive help from an Ombudsman. An ombudsman is an independent advocate who does not work for LCI, below are the contract

Age 60 or Older, contact: Wisconsin Board on Aging and Long Term Care
1402 Pankratz Street, Suite 111
Madison, WI 53704-4001
Toll-Free: 800-815-0015

Age 18 to 59, contact**:** Disability Rights Wisconsin
131 W. Wilson Street, Suite 700
Madison, WI 53703
General: 608-267-0214

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Chapter 10: Compliance

Fraud, Waste, and Abuse

Program Integrity – Fraud, Waste, and Abuse

All providers and provider's employees (as well as LCI employees, members, and SDS employees) are subject to LCI's Program Integrity Plan, Policies, and Procedures. Failure to comply with these policies and procedures may lead to civil and criminal liabilities/penalties and may also result in termination of provider contract(s). It is imperative that providers and their employees:

- Promote integrity and ethical behavior;
- Do not commit fraud or otherwise participate in fraudulent activities;
- Comply with LCI's Program Integrity Plan, Policy and Procedures;
- Assist in investigating any alleged violations, as requested; and
- Immediately report any suspicion of fraud, waste, or abuse – or any potential violations of LCI's Program Integrity Plan, Policy or Procedures, with as much detail as possible – to LCI's Program Integrity Compliance Officer by calling 920-906-5100, emailing Fraud@lakelandcareinc.com, or sending a letter to:

Lakeland Care, Inc.
Attn: Program Integrity Compliance Officer
N6654 Rolling Meadows Drive
Fond du Lac, WI 54937

Additionally, it is required that all providers:

- Perform background checks of employees and prospective employees;
- Certify that neither they nor any of their principals are debarred, declared ineligible, or voluntarily excluded from participating in federal assistance programs.
- Where applicable, monitor the status of employee's license and/or certification;
- Where applicable, monitor for employee debarment;
- Document and review business processes to ensure funds are processed and handled appropriately;
- Identify and correct situations where there is insufficient segregation of duties or where staff have the capability to override internal controls, and where necessary create cross-checks to serve as internal controls;
- Train staff to prevent and detect fraud, waste, and abuse and on relevant reporting responsibilities and procedures; and
- Create a safe environment for employees to report any suspicion of fraud, waste, or abuse.

Lakeland Care, Inc. complies with all Federal and State mandates to bar providers or suppliers from participation in the Medicaid program, or to suspend payments to a provider/supplier in

order to maintain program integrity. In compliance with the Patient Protection and Affordable Care Act, LCI may be required by the Wisconsin DHS, Office of the Inspector General (OIG), and/or the Wisconsin Department of Justice (DOJ) to immediately suspend claims payments pending investigation of a credible allegation of fraud.

Cultural Competency

Lakeland Care, Inc. agrees to deliver services in a culturally sensitive manner. LCI's approach to service delivery must honor the member's beliefs and customs and be sensitive to the cultural diversity and background of the member. This cultural sensitivity will be demonstrated in written and verbal communication with the member and their family, and in training of the Provider's staff who deliver the service. Providers must agree to provide services in a culturally competent manner; honoring members' beliefs, being sensitive to cultural diversity including members with limited English proficiency and diverse cultural and ethnic backgrounds, and interpersonal communication styles which respect members' cultural backgrounds.

Gifts

Lakeland Care, Inc. asks that providers do not offer gifts to LCI staff members as a means to uphold appropriate boundaries between member and paid providers.

Chapter 11: Quality Management Program

INCIDENT MANAGEMENT SYSTEM (IMS)

INCIDENT REPORTING

LCI would like to take this opportunity to thank you for partnering with us to serve LCI members in a cost-effective and high quality manner. Our goal is to develop a collaborative, mutually respectful relationship with you and to have open, ongoing communication between our organizations. As part of a contractual requirement, the Wisconsin Department of Health Services (DHS) requires Managed Care Organizations, like LCI, to investigate, document, and report on certain incidents to DHS. We are including information on the Incident Management System (IMS), what type of incidents/events providers should report to LCI, and the procedure to follow as outlined in LCI's Contract.

The Incident Management System (IMS) assists LCI in collaborating with all providers to maintain or improve the quality of services provided to LCI members. Through this system LCI is able to track and trend incidents and events affecting members, which in turn allows LCI to assist providers by offering insight regarding development and implementation of proactive and timely interventions to prevent the occurrence of incidents/events.

The IMS is a system that manages incidents/events, including Adverse Events and Quality Alerts occurring at the member and provider levels, in order to ensure member health and safety, reduce member incident risks, and enable development of strategies to prevent future incidents from occurring.

It is critical that LCI service providers ensure the immediate safety of members involved in incidents, emergencies, and/or events by taking steps necessary to assure that the member is protected from the risk of continued harm from the incident and/or event in which the member has been, or is, involved. Timely reporting of incidents/events by LCI service providers assists the organization in determining whether the root cause of the incident/event was preventable, or through proactive measures/practices, could be prevented in the future for the members. In order to remain in compliance on reporting incidents/events, LCI requires service providers to report incidents/events to the member's Interdisciplinary Team (IDT) staff **within one (1) business day of occurrence**.

If you as a LCI service provider report an incident/event, the IDT staff and you are responsible to follow up and work together with the member to set in place policies/procedures to prevent a similar situation from occurring. In addition, LCI's Network Quality Specialists and Quality Specialists are alerted of all incidents/events. It is their responsibility to identify, track, and trend incidents/events for our entire membership and to collaborate with providers in developing strategies to prevent future incidents/events from occurring.

At the close of the incident, LCI will provide the member/legal representative the outcomes of the investigation via written letter for certain incident types. Members/legal representatives are instructed to contact the IDT staff with any questions regarding the incident and outcomes.

IMS Reporting Evidence of Compliance

- Providers are responsible to report the incident to the member's IDT staff, within one (1) business day.
- Provider recognizes incidents in which harm has occurred.
- Provider responds to incident(s) in a way that, to the extent possible, ameliorates harm that has occurred and prevents future harm.
- Provider has adequate documentation of the incident/event.
- Provider cooperates with LCI in investigation of any alleged incidents/events through access to records, staff, and any other relevant sources of information.
- Provider agrees to furnish LCI with copies of their incident reports for incidents/events involving Members, if providers maintain such reports.

Reference the attached appendix 3 for Incidents/Events to report to LCI.

Statement of Deficiency (SOD)

Providers shall notify LCI of any visits by their licensing or other regulatory entities within three (3) days from visit. If a citation is issued, then the provider will supply LCI with a copy of applicable plan of correction submitted to the Divisional of Quality Assurance (DQA) concurrent with submitting to licensing.

The Plan of Correction must demonstrate a systematic change in practices that is reasonably expected to result in an ongoing correction of identified violations.

Lakeland Care, Inc. reserves the right to require additional plans of correction from providers. Providers must update LCI when they appeal the Statement of Deficiency from DQA.

GLOSSARY

Abuse:

For the purpose of Program Integrity, abuse is any practice that is inconsistent with sound fiscal, business or medical practices, and results in unnecessary program costs. It includes, but is not limited to, any act that constitutes abuse under applicable Federal or State law. Examples of abuse for Program Integrity purposes include but are not limited to:

  - Authorizing and/or submitting claims for services that are not necessary to support health and safety needs and/or a member's long term care outcomes (also known as 'overutilization'); and
  - Intentionally denying appropriate services (also known as 'underutilization').
- Physical Abuse: intentional or reckless infliction of physical pain or injury, illness, or any impairment of physical condition
- Emotional Abuse: language or behavior that serves no legitimate purpose and is intended to be intimidating, humiliating, threatening, frightening, or otherwise harassing, and that does or reasonably could intimidate, humiliate, threaten, frighten, or otherwise harass the individual to whom the conduct or language is directed.

Aging and Disability Resource Center:

A resource center that can enable older and/or disabled citizens to find and make use of the resources in their communities, helping them experience life with self-sufficiency, security, and dignity.

Caregiver Background Checks:

Background checks are to be completed by the regulated facility/entity on their employees and contractors. Employers must complete caregiver background checks on employees and contractors at the time of hire and at least every four years thereafter.

Care Manager:

Care managers conduct in-depth assessments, develop care plans and recommendations, coordinate services, act as liaisons to health care providers and insurers, and continuously monitor services to ensure that the individual's goals are met.

Clean Claim:

Must include the following information:

1. Member information: First and Last name, date of Birth and Member Number
2. Authorization Number
3. Provider Information: Billing or Pay to provider Name and Address, Servicing or Place of Business Name and Address and Billing Provider Tax ID. When applicable, Billing Provider NPI AND Rendering Provider Name and NPI.
4. Claim detail information: Date of Service, Service Code, Modifiers, Total Charges and Number of units.

If a Provider is unable to file claims electronically, the Provider must submit their claims on the LCI claim submission form, adhering to the same elements of a clean claim. Only (1) one member can be entered per form.

Current Procedural Terminology (CPT):

A code set that is used to report medical procedures and services to entities such as physicians, health insurance companies and accreditation organizations. CPT is used in conjunction with ICD-9-CM or ICD-10-CM numerical diagnostic coding during the electronic medical billing process.

Dates of Service:

Dates the services were provided.

Electronic Claims Submission:

A method of submitting claims via Electronic Data Interchange (EDI), through either the PC-ACE PRO 32 or a Move IT account (both are free). The EDI application is available on the LCI web site and on the WPS web site.

Explanation of Benefits (EOB):

Statement sent by a health Insurance company to covered individuals explaining what medical treatments and or services were paid for on their behalf.

Explanation of Medicare Benefits (EOMB):

A statement mailed to a Medicare participant explaining the payment of his or her claim.

Fraud

Any intentional deception or misrepresentation made by a person or entity with the knowledge that the deception or misrepresentation could result in some unauthorized benefit to him/herself/itself or to some other person or entity. This includes, but is not limited to, any act that constitutes fraud under applicable federal or state law. Examples of fraud include but are not limited to:

- Eligibility fraud, including falsification of financial and/or functional needs;
- Manipulation, falsification or alteration of accounting records or supporting documents to conceal theft or an entity's true financial condition;
- Falsifying timesheet records and/or payroll information;
- Submitting false claims for reimbursement;
- Billing for more expensive services or procedures than were actually provided;
- Use of LCI-purchased equipment or property for personal gain;
- Bid rigging;
- Double billing;
- Doctor shopping; and
- Falsification of provider credentials.

Healthcare Common Procedure Coding System (HCPCS):

(pronounced by its acronym as “hicks pics”) is a set of health care procedures codes based on the American Medical Association’s Current Procedural Terminology (CPT). Such coding is necessary for Medicare, Medicaid, and other health insurance programs to ensure that insurance claims are processed in an orderly and consistent manner.

Health Insurance Portability and Accountability Act (HIPAA):

A US law designed to provide privacy standards to protect patients ‘medical records and other health information provided to health plans, doctors, hospitals and other health care providers.

Interdisciplinary Team (IDT):

IDT is made up of the member and individuals identified by the MCO to provide care management services to members.

Medicare:

A government run and funded plan for paying hospital and other health care costs for those who qualify. These people are usually older than 65. Coverage is divided into Part A, which provides the compulsory hospital benefits, Part B, a voluntary program that covers medical expenses, Part C, which provides the option to choose from a package of health care plans, and Part D, which offers prescription drug coverage.

Member Centered Plan:

Member-centered planning is a record that documents a process by which the member and the interdisciplinary team staff further identify, define, and prioritize the member’s outcomes initially identified in the comprehensive assessment. It also identified the services and supports, paid or unpaid, provided or arranged by the MCO including the frequency and duration of each service, and the providers that will furnish each service.

MIDAS Provider Portal:

An internet based site, which stands for Member Information Documentation and Authorization System, and can be found by accessing the “MIDAS Login” link on the Lakeland Care, Inc. website: **www.lakelandcareinc.com**

Misuse

The incorrect, improper, needless, extravagant or careless use of something. Waste and errors fall under this category. Misuse does not necessarily involve private use or personal gain, but it almost always signifies poor decisions, practices, or controls. Examples of misuse include but are not limited to:

- Purchasing unneeded office supplies or equipment;
- Purchasing goods or services at inflated prices;
- Permitting serious abuse of paid time, such as significant unauthorized time away from work or significant use of paid time for personal business;
- Allowing abuse of employee expense reimbursement and/or travel reimbursement policies;

Failing to administer programs according to the Family Care Contract; and failing to administer programs according to state and/or federal laws and regulations.

Modifier:

Modifiers are codes that further describe the service provided. They allow payment of the fee specific to the procedure code/modifier combination. Once the appropriate procedure code/modifier rate is located; the maximum allowable fee pricing calculation is applied to determine the payable amount.

National Provider Identifier (NPI):

A unique ten-digit number required by HIPPA for all health care providers.

Patient Protection and Affordable Care Act (PPACA) or (ACA):

Also known as the Affordable Care Act. This Act is intended to extend coverage to millions of uninsured Americans, to implement measures that will lower health care costs and improve system efficiency, and to eliminate industry practices that include rescission and denial of coverage.

Resource Allocation Decision-making (RAD) process:

The process the IDT staff uses to help find the most effective and efficient ways to meet the member's needs through supporting member outcomes.

Restrictive Measures:

Any device, garment or physical hold that obstructs voluntary movement of a person's body or access to any part of the body and cannot be easily removed by the individual.

All members have the right to receive the least restrictive treatment that is appropriate to meet their needs. Restrictive measures that meet the definition above should only be used with written approval from LCI and DHS or in cases of emergency. Emergency is defined as an unanticipated dangerous and challenging situation that poses imminent risk.

Revenue Code:

A four digit set of numbers used to identify the rate of pay for the services provided.

RN Care Manager:

RN Care Managers conduct in-depth assessments, develop care plans and recommendations, coordinate services, act as liaisons to health care providers and insurers, and continuously monitor services to ensure that the individual's goals are met.

Service Codes:

The HCPCS, CPT or Revenue codes assigned to the authorized service.

Third Party Administrator (TPA):

A person or organization that processes claim and perform other administrative services in accordance with a service contract.

Unit Rate:

A fixed sum which is paid out per the provider's contract for each completed unit of service.

Units of Service:

A set time frame for which services are authorized (e.g.: minute, hour, daily, one time only)

Attachment 1: Service Authorization

SERVICE AUTHORIZATION

Authorization Number:100

Provider ID: 123456789
1(920) 555-1212
Phone:
Fax:
Provider Name and Address:
OUT OF THIS WORLD LLC
456 ANYWHERE ST
OSHKOSH, WI 54901

Payee Tax ID:
Phone: 1(920) 555-1212
Fax:
Checks will be made payable to:
OUT OF THIS WORLD LLC
456 ANYWHERE ST
OSHKOSH, WI 54901

Patient Name: DOE, JANE
Patient ID: 987654321
Date of Birth: 1/4/1933
Service Type: SHC - Supportive Home Care
Service Code: S5135 - SHC Assistance ADL'S 15M
Modifier Codes: N/A
Location: Home
Requested From: 7/1/2013 through: 7/31/2013
Services Requested: 12 (15 Minutes units)
Frequency: Weekly
Total Services Authorized: *Claims will be paid at T-19 or contracted rates*
Provider Notes:
Status: Approved by RN
CMU: West
Care Manager: Smith, Sally
Phone Number: 1(920) 456-3200 Fax: 1(920) 456-3201
Email: Sally.smith@lakelandcareinc.com

Please submit claims to: The Lakeland Care District's third party administrator, WPS

Claims Customer Service: 1 888-915-2499: 24/7 WPS / Lakeland Care, Inc. Customer Service Call Center

In order to maintain a proper balance between services authorized and services provided and paid, Lakeland Care, Inc. requires that clean claims be submitted for payment NO LATER THAN 60 DAYS AFTER SERVICES HAVE STARTED. Lakeland Care, Inc. will DENY clean claims (bills for service) that are received more than 60 days after service delivery.

Clean claims DO NOT include claims where there is no insurance as primary (i.e. Medicare or private insurance) where the provider needs to wait to get a response from the primary insurer before sending the claim to the TPA for processing and payment.

While authorization is a requirement to obtain services, it does not guarantee payment of services. Benefits are available only if the services are covered under the member's contract, and if the member is eligible at the time services are provided. Should you have any questions regarding this service authorization, please contact the Care Manager listed above or Lakeland Care, Inc. .

ATTACHMENT 2

WPS DENIAL CODE EXPLANATIONS

3/21/2013

Lakeland Care, Inc. PRA Explanation Codes

WPS Code	Explanation/Denial
AG	THIS SERVICE/SUPPLY WAS SUBMITTED WITHOUT A PRIOR AUTHORIZATION NUMBER. PLEASE RE-SUBMIT THE SERVICE/SUPPLY WITH THE AUTHORIZATION NUMBER AS ASSIGNED BY THE FAMILY CARE MANAGED CARE ORGANIZATION Please resubmit your claim to WPS with the authorization number within the timely filing limit.
A6	ASSIGNMENT WAS ACCEPTED AND THE PROVIDER HAS AGREED TO REDUCE THE CHARGE BY THIS AMOUNT. THE INSURED IS NOT RESPONSIBLE FOR THIS AMOUNT. Contractual Obligation write off.
BU	DURING THE PROCESSING OF THIS CLAIM, THIS LINE WAS BUNDLED INTO ANOTHER LINE FOR PROCESSING. No action needed, informational only.

CE THE EXPLANATION OF BENEFITS RECEIVED FROM THE PRIMARY INSURER DOES NOT REFLECT THE ORIGINAL PAID OR DENIED CHARGES. PLEASE SUBMIT A COPY OF THE ORIGINAL EXPLANATION.

The EOB/EOMB with claim submitted has either different dates of service or different billed amounts. The provider needs to resubmit the claim with the correct EOB/EOMB within the timely filing limit.

CN THE PROVIDER OF SERVICE WAS NOT AUTHORIZED TO PROVIDE THIS SERVICE. PLEASE CONTACT THE CUSTOMER'S CARE MANAGER WITH QUESTIONS.

Please resubmit your claim to WPS with the correct billing provider information.

CX THE PROCEDURE CODE, DIAGNOSIS CODE, AND/OR REVENUE CODE IS NOT VALID. PLEASE RESUBMIT WITH A VALID CODE.

Resubmit claim with valid procedure code, diagnosis code, and/or revenue code.
(94999, Z3450, Z3300, S1530)

DU THIS CLAIM IS A DUPLICATE TO A PREVIOUSLY RECEIVED CLAIM THAT IS CURRENTLY BEING REVIEWED FOR PROCESSING.

The charges received for processing are being considered. The denial informs the provider of the duplicate billing.

EM WE NEED THE MEDICARE EXPLANATION OF BENEFITS TO PROCESS THIS CHARGE.

Resubmit claim with the corresponding explanation of benefits for the services being billed.

ER MEDICARE ASSIGNMENT WAS ACCEPTED AND THE PROVIDER HAS AGREED TO REDUCE THE CHARGE BY THIS AMOUNT. THE INSURED IS NOT RESPONSIBLE FOR THIS AMOUNT.

Service was denied by Medicare as a Contractual Obligation. The Member is not responsible for service.

FC THIS PAYMENT CALCULATION WAS BASED ON THE FAMILY CARE OR MEDICAID FEE SCHEDULE.

Information only – the difference between the charge amount and the paid amount.

FW PERSONAL CARE AND HOME HEALTH CARE SERVICES MUST BE BILLED ON AN INSTITUTIONAL CLAIM FORMAT OR UB04 CLAIM FORM WITH THE APPROPRIATE REVENUE CODE AND THE AUTHORIZED CPT/HCPCS CODE. PLEASE RE-BILL USING THE INSTITUTIONAL CLAIM FORMAT OR UB04 CLAIM FORM.

Charges need to be billed on a UB04 claim form.

GK THE CLAIM WAS NOT SUBMITTED TO THE PATIENT'S PRIMARY CARRIER IN A TIMELY MANNER. REQUEST A REVIEW WITH THE DELAY REASON TO THE PRIMARY CARRIER. WHEN THE PRIMARY CARRIER HAS REACHED THEIR CONCLUSION, SEND THE EXPLATION OF BENEFITS WITH THE CLAIM TO US FOR PROCESSING.

The primary carrier did not make final determinations because your claim was not submitted to the carrier timely, please submit to the primary carrier for review and then submit the claim to WPS.

ID PLEASE RESUBMIT THIS CLAIM TO THE PRIMARY CARRIER WITH THE INFORMATION THEY REQUESTED. WHEN THE PRIMARY CARRIER HAS DETERMIND THEIR BENEFITS, SEND THE CLAIM AND THE EXPLANATION OF THE PRIMARY CARRIER BENEFITS TO US FOR PROCESSING.

The primary carrier did not make final determinations because of inadequate claim information, please submit to the primary carrier with the necessary information and then submit the claim to WPS.

MA PLEASE RESUBMIT THIS CLAIM TO MEDICARE WITH THE INFORMATION THEY REQUESTED. WHEN MEDICARE HAS DETERMINED THEIR BENEFITS, SEND THE EXPLANATION OF MEDICARE BENEFITS TO US FOR PROCESSING.

The primary carrier did not make final determinations because of inadequate claim information, please submit to the primary carrier with the necessary information and then submit the claim to WPS.

MT THE CLAIM WAS NOT SUBMITTED TO MEDICARE IN A TIMELY MANNER. REQUEST A REVIEW WITH THE DELAY REASON TO MEDICARE. WHEN MEDICARE HAS REACHED THEIR CONCLUSION, SEND THE EXPLANATION OF MEDICARE BENEFITS WITH THE CLAIM TO US FOR PROCESSING

The primary carrier did not make final determinations because your claim was not submitted to the carrier timely, please submit to the primary carrier for review and then submit the claim to WPS.

NM THE AUTHORATION NUMBER IS INVALIED WITH THE SERVICE/SUPPLY BILLED. PLEASE RE-BILL USING THE CORRECT AUTHORATION NUMBER WITHIN THE TIMELY FILING LIMIT.

The authorization number submitted on the claim is not valid in the WPS system; resubmit your claim with the correct number. Questions regarding authorizations should be directed to Lakeland Care, Inc..

NO THE CLAIM EXCEEDED THE NUMBER OF AUTHORIZED UNITS FOR THIS SERVICE.

Contact Lakeland Care, Inc. to determine if additional units can be authorized for this service.

NP THE SERVICE/SUPPLY BILLED DOES NOT MATCH WHAT WAS AUTHORIZED. PLEASE RE-BILL USING THE CORRECT SERVICE/SUPPLY CODE WITHIN THE TIMELY FILING LIMIT

The service code submitted on your claim does not match the service code on your authorization, please correct and resubmit your claim as a new claim with the correct service code

RP CORRECTION TO A PRIOR CLAIM. DURING A REVIEW OF YOUR FILE, WE DISCOVERED AN UNDERPAYMENT. THIS REPRESENTS REPAYMENT OF THAT AMOUNT.

Reconsideration of services already considered for benefits.

S8 THE NPI NUMBER PROVIDED FROM THE CLAIM IS INVALID. PLEASE RESUBMIT THE CLAIM WITH THE CORRECT NPI NUMBER WITHIN THE TIMELY FILING LIMIT.

	Please re-bill services/supplies with a valid NPI.
SG	THE NPI NUMBER IS MISSING FROM THE CLAIM. PLEASE RE-BILL WITH THE NPI NUMBER WITHIN THE TIMELY FILING LIMIT. Re-bill services/supplies including the provider's NPI number within timely filing.
SI	THE PROVIDER OF SERVICE WAS NOT AUTHORIZED TO PROVIDE THIS SERVICE The Billing Provider number submitted on your claim does not match the Billing provider number on your authorization, please correct and resubmit your claim as a new claim with the correct billing provider number
SU	IN ORDER TO PROCESS BENEFITS CORRECTLY, THIS LINE WAS SPLIT FOR PROCESSING. No action needed, informational only.
WS	THESE CHARGES WERE SUBMITTED UNDER AN INCORRECT CUSTOMER NUMBER. WE WILL PROCESS THESE CHARGES UNDER THE VALID NUMBER. TO AVOID DELAYS IN THE FUTURE, PLEASE USE THE CORRECT NUMBER AND VERIFY THAT THE PROVIDER HAS THE CORRECT NUMBER. No action needed, informational only.
18	WE'VE ALREADY PROCESSED THIS CHARGE. The charges received for processing have already been considered. The denial informs the provider of the duplicate billing.
22	OUR RECORDS SHOW THIS PATIENT HAS PRIMARY COVERAGE WITH ANOTHER INSURANCE COMPANY. PLEASE RESUBMIT WITH A COPY OF THE OTHER COMPANY'S EXPLANATION OF BENEFITS. The Explanation of Benefits (EOB) from the Primary Carrier was missing at the time the claim was submitted for benefit consideration. Please resubmit the claim with the corresponding explanation of benefits for the services being billed. The complete information must be received within the timely filing limit.

23 CLAIM DENIED/REDUCED BECAUSE CHARGES HAVE BEEN PAID BY ANOTHER PAYER AS PART OF COORDINATION OF BENEFITS, WHICH MAY INCLUDE MEDICARE PAYMENTS. COORDINATION OF BENEFITS WITH YOUR PRIMARY PLAN OF COVERAGE MAY RESULT IN EITHER A REDUCED PAYMENT OR NO PAYMENT.

The Patient's primary carrier, whether it is Medicare or a private health care insurance, has made payment on the claim. The primary carrier allowed a greater fee amount than Family Care's fee schedule. This would result in Waiver's making a reduced payment or no payment at all.

25 THE DATE OF SERVICE IS EITHER BEFORE OR AFTER THE DATE RANGE AUTHORIZED**.**

The date(s) of service submitted on your claim are not within the date(s) of service on your authorization, please correct and resubmit your claim as a new claim with the correct dates of service

27 EXPENSE(S) INCURRED AFTER COVERAGE TERMINATED. SERVICES PROVIDED AFTER THE TERMINATION DATE, ARE NOT COVERED.

If you feel services should be covered, please submit in writing to Lakeland Care, Inc. with an explanation and any documentation that supports your appeal in how the claim was processed.

28 EXPENSE(S) INCURRED PRIOR TO COVERAGE. SERVICES PROVIDED PRIOR TO THE EFFECTIVE DATE, ARE NOT COVERED.

If you feel services should be covered, please submit in writing to Lakeland Care, Inc. with an explanation and any documentation that supports your appeal in how the claim was processed

29 THE TIME LIMIT FOR FILING HAS EXPIRED. CHARGES MUST BE SUBMITTED ON A TIMELY BASIS IN ORDER TO BE CONSIDERED FOR PAYMENT.

If you feel services should be covered, please submit in writing to Lakeland Care, Inc. with an explanation and any documentation that supports your appeal in how the claim was processed.

4F THE CHARGE EXCEEDS THE AUTHORIZED CONTRACTED FEE FOR THIS SERVICE.

Attachment 3

IMS INCIDENTS/EVENTS TO REPORT TO LCI:

1. **Neglect** means an act, omission, or course of conduct by another that, because of the failure to provide or maintain adequate food, shelter, clothing, medical care or mental health care, creates a significant danger to the physical or mental health of a member.

2. **Self-neglect** means a significant danger to an individual's physical or mental health because the individual is responsible for his/her own care but fails to obtain adequate care, including food, shelter, clothing, or medical or dental care.

3. **Financial exploitation** (any of the following):
    a. Obtaining an individual's money or property by deceiving or enticing the individual, or by forcing, compelling, or coercing the individual to give, sell at less than fair market value, or in other ways convey money or property against his or her will without his or her informed consent
    b. Theft
    c. The substantial failure or neglect of a fiscal agent to fulfill his or her responsibilities
    d. Unauthorized use of an individual's personal identifying information or documents
    e. Unauthorized use of an entity's identifying information or documents, as prohibited
    f. Forgery
    g. Financial transaction card crimes

4. Abuse means any of the following:
    a. **Physical abuse**: Intentional or reckless infliction of physical pain or injury, illness, or any impairment of physical condition.

    b. **Sexual abuse**: A violation of criminal assault law, s. 940.225 (1), (2), (3), or (3m), Wis. Stats.

    c. **Emotional abuse**: Language or behavior that serves no legitimate purpose and is intended to be intimidating, humiliating, threatening, frightening, or otherwise harassing, and does or reasonably could intimidate, humiliate, threaten, frighten, or otherwise harass the individual to whom the conduct or language is directed.

    d. **Treatment without consent**: The administration of medication to or experimental research on an individual who has not provided informed consent.

    e. **Unreasonable confinement or restraint**: The intentional and unreasonable confinement of an individual in a locked room, involuntary separation of an individual from his/her living area, use on an individual of physical restraining devices, or the provision of unnecessary or excessive medication to an individual, but does not include the use of these methods or devices in entities regulated by the Department of Health Services if the methods or devices are

employed in conformance with state and federal standards governing confinement and restraint.

5. **Any unplanned (emergency) or unapproved use of restraints (or restrictive measure or intervention)** includes any physical, chemical, or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body
    a. Restraint types include: Mechanical supports, mechanical restraints, medical restraints, medical procedure restraint, restraints allowing healing, restraints for protection, and chemical restraints (use of as-needed (prn) medications for controlling acute or episodic behavior)

6. **Any unplanned (emergency) or unapproved use of isolation/seclusion (or restrictive measure or intervention)** includes the intentional and unreasonable confinement of an individual in a locked room, involuntary separation of an individual from his or her living area, use of physical restraining devices, or the provision of unnecessary or excessive medication to an individual

7. **Falls** occurring with or without injury is when a member is found on the ground/floor or a member reports a fall.
    a. The fall is unintentional (not a result of being pushed down)
    b. Falls can be unassisted or assisted
    c. Includes any member that rolls off a low bed onto a mat

8. **Deaths** should be reported to the LCD. While the LCD reports on deaths with unexplained, unusual, or suspicious circumstances to DHS, the LCD requires notification on <u>all</u> member deaths. This includes all deaths following accidents, whether the injury is or is not the primary cause of death.

9. **Missing Person** includes any instance when a member visually and physically wanders away or leaves a home or a community setting for any length of time without prior arrangement or permission.
    a. This does not include those instances when a member who is competent chooses not to disclose his or her whereabouts or location to the residential setting or other community setting.
    b. If a provider/support was able to maintain visual contact of the member, this does not classify as a missing person event.

10. **Any unplanned or unapproved involvement of law enforcement and/or the criminal justice system** includes any time law enforcement personnel are called to the residential or community setting as a result of an incident that jeopardizes the health, safety, or welfare of members, employees, or other persons…This reporting requirement does not apply to members under the jurisdiction of government correctional agencies.

11. **Medication errors** (to include but not limited to):
    a. Wrong medication – when a medication is given that is not prescribed or has been discontinued or the medication label is incorrect
    b. Wrong dose – when a member receives a medication in a dosage other than what was prescribed

c. Wrong time/omission – when a member does not receive medication at the time as prescribed
d. Wrong route – when a member receives a medication via a route other than what was prescribed
e. Wrong technique – when a medication is altered by crushing but should not be crushed, not given with or without food as prescribed, and/or incorrect timing between doses of eye drops, ear drops, nose drops, inhalers, etc.

Additional events, circumstances, or conditions to report to IDT staff as a means of effective care coordination include:

1. Accidents
2. Suicide attempts
3. Property Loss
4. Member rights violations
5. Adverse Events: any circumstance, event, or condition resulting from either action or inaction that:
    a. Was undesirable and unintended; and
    b. Did not result in any serious harm to a member's health, safety or well-being; and
    c. Indicates or may indicate a quality issue with the services provided by the service provider or any of its subcontractors