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 Provider Relations and Contracting Departments, Provider Network, Managed Care Organizations (MCOs), the Family Care program and the Family Care Benefit Package. You will also find detailed information about the DataClarity 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 Provider Specialist by phone or email.

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

Table of Contents

Chapter 1: Introduction

Purpose of Provider Handbook

Lakeland Care, Inc.'s handbook serves as a resource for contracted providers. It is full of helpful information and can be a valuable tool for you and your 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) within Lakeland Care, Inc.'s region:
    - Brown County: Brown County ADRC Website
    - Calumet, Outagamie, Waupaca Counties: Calumet, Outagamie and Waupaca Counties ADRC Website
    - Door County: Door County ADRC Website
    - Florence County: Florence County ADRC Website
    - Forest, Oneida, and Vilas Counties: ADRC of the Northwoods Website
    - Fond du Lac County: Fond du Lac County ADRC Website
    - Langlade, Lincoln, Marathon, and Wood Counites: Central Wisconsin ADRC Website
    - Marinette: Marinette County ADRC Website
    - Manitowoc/Kewaunee County: Lakeshore ADRC Website
    - Portage County: Portage County ADRC Website
    - Winnebago County: Winnebago County ADRC Website
    - Shawano, Oconto, and Menominee Counties: Wolf River Region ADRC Website
- Wisconsin Department of Health Services resources:
    - Medicaid Website: www.dhs.wisconsin.gov/medicaid
    - Long-term Care Website: 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 Provider Specialists (contact information can be found on LCI website)

The most current version of this handbook can be found on the LCI website

Chapter 2: Overview

What is Lakeland Care, Inc.?

Lakeland Care, Inc. is a managed care organization (MCO) 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:

Empowering Individuals. Strengthening Communities, Inspiring Futures.

Lakeland Care, Inc. Core Values:

- Kindness: We believe kindness is always possible and that no compassionate act is ever wasted.

- Inclusion: We believe that open hearts and open minds are the only path to a brighter future.

- Trust: We believe that honesty is still in style and that promises still have power.

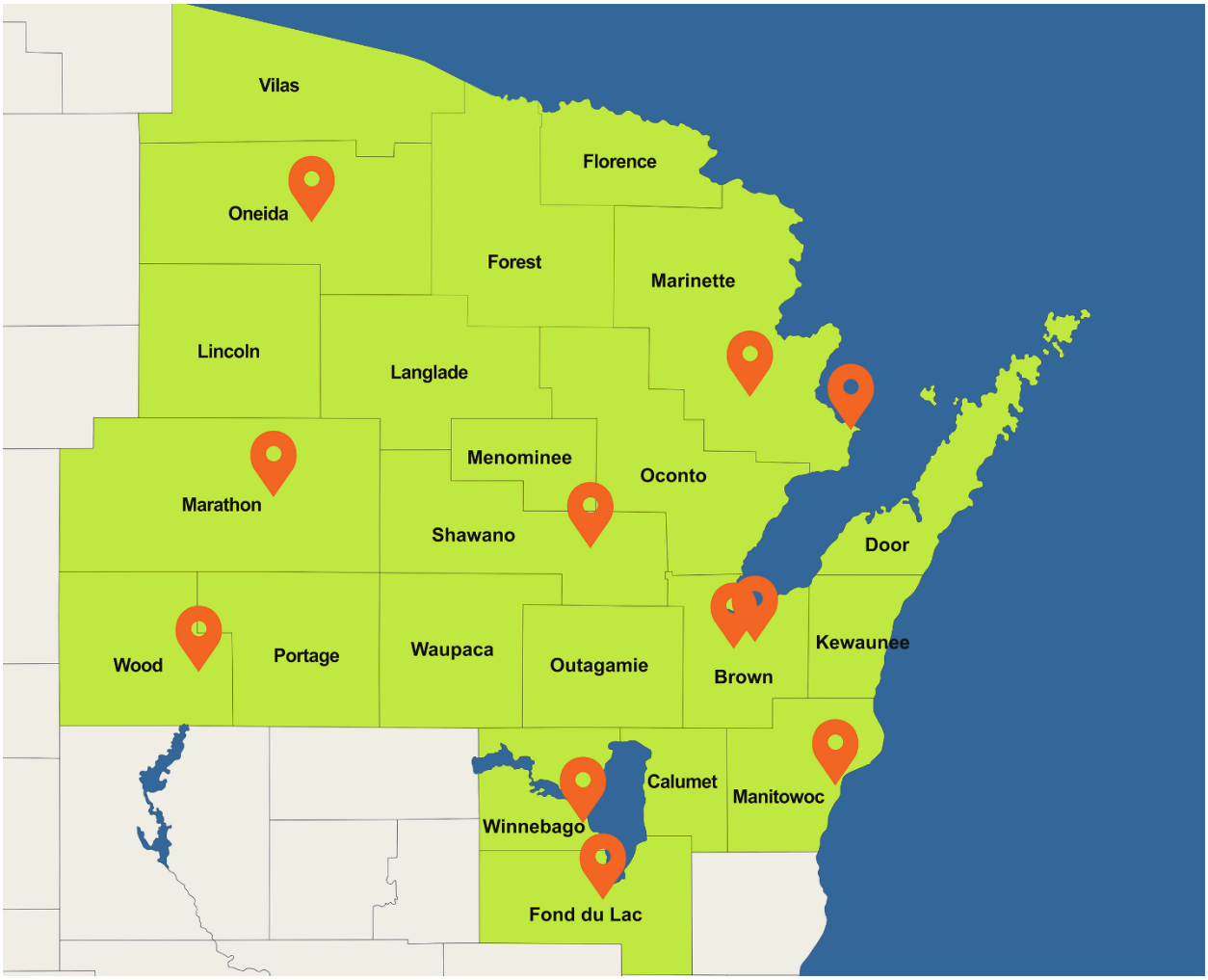
Lakeland Care, Inc. Vision:

To create a world we all want to live in.

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 **Crivitz, Fond du Lac, Green Bay, Manitowoc, Marinette, Oshkosh, Rhinelander, Shawano, , Wausau and Wisconsin Rapids**.

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

Office	Street Address	City, State, Zip Code	Phone Number
Crivitz*	308 Henriette Avenue	Crivitz, WI 54114	715-854-3333
Fond du Lac*	N6654 Rolling Meadows Drive	Fond du Lac, WI 54937	920-906-5100
Green Bay*	2985 S. Ridge Road	Green Bay, WI 54304	920-425-3900
Green Bay*	2050 Riverside Drive	Green Bay, WI 54301	920-425-3900
Manitowoc*	3415 Custer Street	Manitowoc, WI 54220	920-652-2440
Marinette*	2003 Marinette Avenue	Marinette, WI 54143	715-330-6400
Oshkosh*	520 N. Koeller Street	Oshkosh, WI 54901	920-456-3200
Rhinelander*	232 S. Courtney Street	Rhinelander, WI 54501	715-420-2450
Shawano*	607 E. Elizabeth Street	Shawano, WI 54166	715-201-0407
Wausau*	501 S. 24th Avenue, Suite 100	Wausau, WI 54401	715-298-6202
Wisconsin Rapids	1335 8th Street South	Wisconsin Rapids, WI 54494	715-423-5100

**All offices are open by appointment only.*

Please mail correspondence to Lakeland Care's Fond du Lac office.

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. The LCI care team will refer the member to the Aging and Disability Resource Center (ADRC) for Options Counseling and potential disenrollment. In accordance with the Division of Long-Term Care memo, *Influencing the Exercise of Participants Freedom of Choice,* at no time should a provider or the LCI care team encourage or counsel a member to disenroll from the family care program.

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 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**:**

Once a person is enrolled with LCI they are considered a member. Prior to enrollment in a long-term care program, such as Family Care, a person must be financially and functionally eligible. 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 their services on their care plan (excluding Care Management), allowing them to have increased control over their long-term care budgets and providers.

The Interdisciplinary Team (IDT):

The member, the RN Care Management and the Care Manager make up the full interdisciplinary team (IDT). Other professionals or informal supports identified by the member may also participate as members of the IDT.

IDT staff**:**

A term used to reference LCI Care Manager and Nurse Care Manager. The IDT staff 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.

Legal Decision Maker**:**

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 functional 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 or all their long-term care services, giving them more flexibility in how and from whom they receive services. SDS offers opportunities for members to direct some or all the services available to them in the benefit package. If SDS is chosen, the member works with the IDT 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 services and supports needed related to their long-term care 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 Relations and Contracting

Provider Relations and Contracting Team

The Provider 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 Provider Relations and Contracting Team collaborates with providers through all aspects of contracting, once contracted each provider has an 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 need assistance in working with LCI, please call your local Provider Specialist.

Joining the Provider Network

Providers interested in pursuing a contract with LCI can contact the Provider Credentialing Specialist , 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.

LCI 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.

LCI 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 title XVIII or under any State health care program. (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 or audit, i.e., conviction under State or Federal law of interference or obstruction of any investigation or audit related to any criminal offense described directly above (See Section 1128 (b) (2) of the Act); or,
    v. Offenses relating to controlled substance, i.e., conviction of a State or Federal crime relating to the manufacture, 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 Care 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 or 1129 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 1128A 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.

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 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 included as part of the single residential support rate and will bill the member for reimbursement. LCI may pay for bed holds 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, short term rehabilitation in a nursing home or staying overnight with family/friends. As noted above LCI may pay for a bed hold for up to 14 days during the member's absence to maintain a member's placement at the facility.

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 needs a service within the benefit package after hours, contact the afterhours authorization number at (920) 906-5177 or 866-359-9438. LCI after hours authorization line has staff available outside of LCI standard business hours of operation Monday- Friday, 8:00am – 4:30pm. The afterhours line is available 7 days per week outside of business hours, 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.

DataClarity Provider Portal

An authorization for each service will be available to the provider via the DataClarity Provider Portal. Providers who are contracted with LCI can access the DataClarity Provider Portal through the LCI website.

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 Relations Staff are available in each branch to assist providers and answer any questions about DataClarity. A DataClarity 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 program integrity training on fraud, waste, and financial abuse 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); and
- Notify Provider Relations of any changes in address, telephone number, or contact information at networkrelationssupport@lakelandcareinc.com

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

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

LCI. 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

LCI 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.

Access and Timeliness of Services Standard

Provider shall not create barriers to access to care by imposing requirements on members that are inconsistent with the services authorized by Purchaser or the member's care and treatment plan. Provider agrees that services will be made available to members at any time that provider is open for business or otherwise serving customers, members, or patients funded by any other revenue source. Providers shall make all reasonable efforts to initiate service provision at the date and time requested by the LCI IDT on behalf of the member. In the event that initiation of the service at the member's preferred time is not possible, the provider will express such to the LCI IDT, who will arrange an alternative start date of services, or, if necessary, arrange to meet the member's needs by other means.

Member Communications by Licensed Providers

Purchaser will not prohibit, or otherwise restrict, a licensed provider acting within the lawful scope of practice from advising or advocating on behalf of a member who is a patient of the licensed provider, including any of the following:

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

Termination of Contract

The contract may be terminated by LCI for any reason or for no reason at all, following a sixty (60) 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 (60) calendar day 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 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. An authorization is not required for services on which Medicare is the primary payer, and LCI is secondary. Claims for which LCI is primary require an authorization number, in most cases.

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,** when LCI is the primary payer. On Medicare primary claims, LCI will make payment up to the T19/Medicaid rate when combined with the Medicare payment.
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
     - Member ID assigned by WPS available on the authorization
     - 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 billing 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.

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 https://www.lakelandcareinc.com/

Confidentiality

Protecting the privacy and security of members' information is one of LCI's highest priorities. LCI contracted providers are required to maintain strict confidentiality in all member information generated or received. Providers must comply with all Federal and State confidentiality laws and regulations.

Providers must comply with the Federal regulations implemented in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to the extent those regulations apply to the services provided or purchased with funds provided under contract with LCI.

Providers must immediately report (in no less than 10 calendar days) any and all allegations or violations of confidentiality or protected health information to the IDT staff, the Provider Specialist, and LCI's Compliance Division at:

Lakeland Care, Inc.
Attn: Compliance Division
N6654 Rolling Meadows Dr.
Fond du Lac, WI 54937
920-906-5100
Compliance@lakelandcareinc.com

LCI will assist providers in investigating any instances of an alleged privacy and security violation and will work with providers to resolve substantiated violations.

Maintaining Confidentiality in Email Communications

LCI is committed to maintaining confidentiality in all email communications. All contracted providers must ensure that personally identifiable information is not used within the subject line of an email message. All emails that contain personally identifiable information in the body of an email message must be encrypted.

LCI utilizes an e-mail encryption system designed to protect e-mails sent to recipients outside of LCI's e-mail network. The system encrypts all e-mails and e-mail attachments containing personally identifiable information such as member names, social security numbers, and terms which may indicate the presence of sensitive information protected under HIPAA privacy rules.

When providers receive an encrypted email from an LCI employee, there will be an email notification that a "secure" message has been received. Providers will be required to log onto a website hosted by Cisco to retrieve the e-mail. The first time an encrypted email is received from LCI, the provider will be required to set up an account at the website. Providers must follow the steps outlined below to register and retrieve secure e-mails from LCI. If you an account is already 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 the e-mail account to activate the secure account. Go to the e-mail account to access these instructions.

4) When opening the e-mail, click on the link to activate the account (don't click on the link to *cancel* the account). A message will be received saying the e-mail address has been confirmed. Go back to the initial secure e-mail received.

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

6) Enter the log in information just created, and the message will be available to view.

Please contact the sender of the e-mail with any questions.

*NOTE: If an e-mail system uses a secure format that is compatible to LCI's, secure e-mails will be received from LCI in the same manner all other e-mails are received, and the above steps will not be required.

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. Members have the right to grieve an action or inaction of LCI that the member perceives as negatively impacting them at any time. They also have the right to file an appeal regarding adverse benefit determinations made by LCI. They will receive prompt and fair review of grievances and appeals.

IDT staff are the first level of support when a member has a concern or is dissatisfied. Tyis is usually the most prompt and efficient way to address concerns. Unless the member states otherwise, the IDT staff will attempt to resolve the member's concern. If IDT staff are unable to resolve the concern, the Member Rights Specialist is available to assist. If the member does 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.

Family Care offers several additional ways to address concerns. The member can:

- File a grievance or appeal with LCI
- After filing a grievance and receiving a decision by LCI, the member can ask for a review by the Wisconsin Department of Health Services

- After filing an appeal and receiving a decision by LCI, the member can 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. Anyone acting on the member's behalf, with written permission from the member/legal decision maker, including the provider, may file an appeal or grievance with LCI.

If you, as a provider, are contacted about a complaint against you or your services, you can 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 encourage 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 contacts

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

Chapter 10: Compliance

Program Integrity – Fraud, Waste, and Financial Abuse

The appropriate use of public resources is critical to maintaining public confidence and trust in the Family Care program and LCI. LCI is committed to preventing, detecting, and prompt correction of fraud, waste, and financial abuse. All contracted providers and provider's employees (as well as LCI employees, interns, volunteers, members, Board Members, SDS employees, and other stakeholders) are subject to LCI's Program Integrity Annual Work Plan and Program Integrity 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 Annual Work Plan and Program Integrity Policy and Procedures;
- Immediately report any potential fraud, waste, or financial abuse to the Compliance Division,
- Immediately report any potential violations of LCI's Program Integrity Annual Work Plan and/or Program Integrity Policy or Procedures to the Compliance Division; and
- Assist in investigating any alleged violations, as requested.

Reporting Methods:

- Online form submission – Click *How to Report Fraud or Privacy Concerns* link
- Phone: 920-906-5100
- Email: Fraud@lakelandcareinc.com
- Mail to:

  Lakeland Care, Inc.
  Attn: Compliance Division
  N6654 Rolling Meadows Drive

You may remain anonymous!

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 on fraud, waste, and financial abuse prevention and detection, and reporting responsibilities and procedures; and
- Create a safe environment for employees to report any suspicion of fraud, waste, or financial abuse.

LCI 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 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

LCI delivers 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. 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, disabilities, and regardless of gender, sexual orientation or gender identity, and interpersonal communication styles which respect members' cultural backgrounds.

Gifts

LCI asks that providers do not offer gifts to LCI staff members to uphold appropriate boundaries between members and paid providers.

Civil Rights

Federal civil rights laws prohibit discrimination of members, applicants, enrollees, and beneficiaries in any programs or activities that receive Federal financial assistance. Those laws include Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, Title IX of the Educational Amendments of 1972, the Age Discrimination Act of 1976, Section 1557 of the Patient Protection and Affordable Care Act of 2010, and their respective implementing regulations, and prohibits LCI from discriminating on the basis of race, color, national origin, sex, age, disability, and, in some programs, religious creed or political affiliation or beliefs, in their programs or activities, and in retaliating or engaging in reprisals against individuals for opposing discrimination protected under these laws.

All LCI employees, LCI Board of Directors, members, and providers/suppliers, including those employed by members via the Self-Directed Supports (SDS) program, must comply with all applicable civil rights compliance laws and regulations, and all civil rights laws that may be created or amended during the time of the compliance period.

Interpreter Services

LCI and contracted providers must provide interpreter services for LCI members. LCI and contracted providers shall utilize independent interpreters or interpreter agencies to ensure adequate quality of service when a language barrier or special communication need(s) exists. Interpreter services may include, but are not limited to, oral interpretation and/or written translation of vital documents. LCI and contracted providers shall provide qualified interpreters that honor LCI members' beliefs and are sensitive to cultural diversity, including members with Limited English Proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. LCI and contracted providers foster attitudes and interpersonal communication styles which represent all members' cultural backgrounds.

Interpreters may assist with obtaining sensitive and/or confidential member information. LCI shall comply with Title VI of the Civil Rights Act of 1964; maintain an adequate network of interpreter providers; and follow LCI's Civil Rights Compliance Plan. Contracted providers shall also comply with Title VI of the Civil Rights Act of 1964; provide interpreters when needed; and following the provider's Civil Rights Compliance Plan (if applicable).

LCI and contracted providers must offer a qualified interpreter, such as a foreign language interpreter or sign language interpreter or a transcriber, in all situations requiring language assistance as soon as it is determined that the individual is of Limited English Proficiency or has other special communication needs.

LCI will provide 24/7 access to interpreters conversant in languages spoken by the members of LCI. LCI will make all reasonable efforts to acquire an interpreter timely to assist adequately with all necessary care.

Qualified interpreters will be used when needed where technical, medical, or treatment information is to be discussed. Family members, especially children, may not be used as interpreters for discussion of technical, medical, or treatment information or in assessments, therapy, and other situations when impartiality is critical.

Payment for Interpreter Services: LCI is responsible to pay for interpreter services when the services are required for LCI related matters. Contracted providers are responsible to pay for interpreter services when the services are required for provider related matters.

Member Records

Requests for member records can be routed to the Compliance Division by email at Compliance@lakelandcareinc.com. LCI will determine if a release of information (ROI) is necessary or if the request is a core health activity of treatment, payment or health care operations as defined in the HIPAA Privacy Rule at 45 C.F.R. 164.501.

Chapter 11: Quality Management Program

The Network Quality Department collaborates with providers to proactively enhance the quality of services for LCI members through education and process improvement recommendations. The Network Quality Specialists partner with providers to assist in problem resolution following incidents, provider licensure surveys and provider surveys.

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 an 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:

- **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.
- **Physical Abuse**: intentional or reckless infliction of physical pain or injury, illness, or any impairment of physical condition.

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.

Financial Abuse:

For the purpose of Program Integrity, financial abuse is any practice that is inconsistent with sound fiscal, business, or medical practices, and results in unnecessary program costs or any act that constitutes financial abuse under applicable federal or state law. Financial abuse includes actions that may, directly or indirectly, result in:

- Unnecessary costs to LCI;
- Improper payments;
- Payment for services that fail to meet professionally recognized standards of care;
- Services that are medically unnecessary;
- Payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment;
- 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').

Fraud:

Any intentional deception or misrepresentation made by a person or entity with the knowledge that the deception or misrepresentation could result in personal gain or damage to another individual, group, or entity. Fraud includes, but is not limited to, any act that constitutes fraud under applicable federal or state law. Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means or false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the control of, any health care benefit program (U.S.C. 1347). 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 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 of 1996 (HIPAA):

A set of laws, rules, and regulations that provide data privacy and security provisions for safeguarding medical information.

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.

DataClarity Provider Portal:

An internet-based site, where provider service authorizations are accessed and can be found by accessing the "DataClarityLogin" link on the Lakeland Care, Inc. website: **https://www.lakelandcareinc.com**

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 HIPAA 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.

Restraint:

Defined in the DHS Restrictive Measures Guidelines and Standards (RMGS*)* as: Any device, garment, or physical hold that restricts the voluntary movement of, or access to, any part of an individual's body and the individual cannot easily remove it.

Restrictive Measure:

The term used to encompass any type of manual restraint, isolation, seclusion, protective equipment, medical procedure restraint, or restraint to allow healing as defined in the DHS RMGS.

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).

Waste:

The incorrect, improper, needless, extravagant, or careless use of something; waste does not necessarily involve private use or personal gain, but it almost always signifies poor decisions, practices, or controls. Examples of waste 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 the 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 the state and/or federal laws and regulations.

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

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

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 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, as prohibited in s. 943.20.
    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, as prohibited in s. 943.201.
    e. Unauthorized use of an entity's identifying information or documents, as prohibited in s.943.203.

f. Forgery, as prohibited in s. 943.38.
g. Financial transaction card crimes, as prohibited in s. 943.41

4. Abuse means any of the following:
    a. **Physical abuse**: defined in s. 46.90(1)(fg), Wis. Stats., as intentional or reckless infliction of bodily harm. Bodily harm means physical pain or injury, illness, or any impairment of physical condition.

    b. **Emotional abuse**: defined in s. 46.90(1)(cm), Wis. Stats., includes 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.

    c. **Sexual abuse**: Sexual conduct in the first through fourth degrees as defined in Wis. Stat. § 940.225 (1), (2), (3), or (3m).

    d. **Treatment without consent**: defined in s. 46.90(1)(h), Wis. Stats., as the administration of medication to an individual who has not provided informed consent, or the performance of psychosurgery, electroconvulsive therapy, or experimental research on an individual who has not provided informed consent, with the knowledge that no lawful authority exists for the administration or performance.

    e. **Unreasonable confinement or restraint**: defined in s. 46.90(1)(i), Wis. Stats., as 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 an individual or 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: Manual restraint, protective equipment, medical procedure restraint, or restraint to allow healing as defined in the DHS RMGS; 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)** The intentional and unreasonable confinement of an individual in a locked room, involuntary separation of an individual from his or 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 if the methods or

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

a. Isolation as defined in DHSRMGS : “Isolation is the involuntary physical or social separation of an individual from others by the actions or direction of staff, contingent upon behavior.”
    i. Isolation by staff withdrawal as defined in the DHS RMGS*:* “Isolation by staff withdrawal occurs in situations where, for safety reasons, the support team determines staff should withdraw from the individual due to the presence of behaviors that present imminent risk of harm to staff.”
b. Seclusion as defined in DHS RMGS : “A restrictive measure in which staff physically set the individual apart from others inside a room using locked doors equipped with a pressure-locking mechanism.”

7. **Falls** Unless there is evidence to indicate otherwise, a fall, with or without injury, has occurred when a member is found on the ground/floor or a member reports a fall. The fall is unintentional (not a result of being pushed down) and may be an assisted or unassisted fall; may include rolling off a low bed onto a mat. An unintentional change in position due to a sudden medical condition is not a fall (because treatment for a medical condition is different than treatment for a fall). Member falls are reportable when the result/outcome includes a moderate or major injury requiring medical evaluation and treatment or further monitoring.

8. **Deaths** should be reported to LCI. All member deaths are reportable in which the death is under any of the following circumstances:
    a. Involving unexplained, unusual or suspicious circumstances;
    b. Involving apparent abuse or neglect;
    c. Apparent homicide;
    d. Apparent suicide;
    e. Apparent poisoning;
    f. Apparent accident, whether the resulting injury is or is not the primary cause of death; or
    g. When a physician refuses to sign the death certificate.

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** a preventable event resulting in the incorrect administration of a medication, or harm or potential harm to a member. The practitioner's written order identifies the prescribed medication, does, time and route of administration for the member. Includes:
    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