

Children's Community Health Plan

Provider Manual



Table of Contents

Welcome	2
Integrated Voice Response	3
Enrollment.....	4
Provider Responsibilities.....	5
Prior Authorizations	11
Medicaid Coding Requirements.....	12
Enhanced Reimbursements.....	14
Claim Submission.....	15
Medicaid Provider Appeals Process.....	24
HealthCheck/Early and Periodic Screening, diagnosis and Treatment (EPSDT)	25
HealthCheck Frequently Asked Questions	28
Ash Reporting	31
Required Documentation for Medicaid reimbursement	31
Wisconsin DHS Regulations for Sterilization and Hysterectomy Procedures.....	32
Sample Sterilization Consent Form	33
Hysterectomies	34
Acknowledgement of Receipt of Information	35

Welcome

Children's Community Health Plan (CCHP) is an HMO for BadgerCare Plus eligible children and adults living in Milwaukee, Ozaukee, Walworth, Washington, Waukesha, Racine and Kenosha Counties. We are affiliated with Children's Hospital of Wisconsin. We welcome you as a provider in our network and thank you for serving our members.

The following pages will give you important information regarding our BadgerCare Plus plan. We are committed to providing the best possible service to our members and providers and welcome any suggestions you may have.

Important Telephone Numbers	
Provider Services	1-800-482-8010
Claim Submissions	P.O. Box 56099, Madison, WI 53705
Claim Payment Appeals	P.O. Box 56099, Madison, WI 53705
Inpatient & Emergency Admissions	1-800-482-8010
Out of Network Referrals	1-800-482-8010
Pre-certification Department	1-800-482-8010
Provider Changes	Submit requests in writing to: CCHP Provider Relations MS 6280, PO Box 1997 Milwaukee, WI 53201-1997
CCHP Nurse Line	1-877-257-5861
Email CCHP	TBD
CCHP's Web site	www.childrenschnp.com
Department of Health & Family Services Web site	www.forwardhealth.wi.gov
EDS Recipient Services to replace Forward cards	1-800-362-3002

Integrated Voice Response

Children's Community Health Plan (CCHP) has an integrated voice response (IVR) system, 1-800-356-7344 ext. 4420, to answer provider calls 24 hours a day, seven days a week. Providers can obtain the following information through IVR:

Member Eligibility - To check member eligibility, enter the 10 digit member number for BadgerCare Plus members off their Forward card. Once the member number is entered, and the member's date of birth is verified, it will give you information pertaining to eligibility:

- Effective & expiration dates of the member's policy
- The Primary Care Practitioner/Clinic

Claims Status - To check claims status, you will be prompted to give the member number and verify the member's date of birth, your CCHP provider number, and the date of service in question. This option will give you the following information:

- The receipt date of the claim
- If the claim is currently in review and the approximate processing time
- Reason for an error on a claim
- If the claim has been denied
- If full or partial payment has been made
- The process date of the claim
- Whom the claim was paid to
- If CCHP does not have record of a claim

Enrollment

Length of Enrollment

All enrollees residing in a mandatory HMO service area must serve an initial twelve month lock-in period. The first three months of this lock-in period is an open enrollment period. During this open enrollment period enrollees can change their HMO. After the open enrollment period, enrollees are locked-into their selected HMO.

Assignment of Primary Care Clinic (PCC)

Members are encouraged to select a Primary Care Clinic (PCC). If a member goes three (3) months without selecting a PCC, CCHP will automatically assign a PCC to the member in the following ways:

1. If CCHP receives a claim for primary care services for a member, CCHP will select that clinic as the member's PCC.
2. If CCHP does not have any claims on file, a PCC is chosen for the member according to their zip code.
3. If a former member is rejoining CCHP within a year of disenrollment, CCHP is notified from EDS that the member is an "Add Reinstate." CCHP will assign the former PCC to the member if that provider is still accepting new Medicaid patients.

Members can change PCC's at any time by contacting the Customer Service Department. PCC changes will become effective the same day the member notifies CCHP of the change.

Medicaid Identification (ID) Card

Beginning February 1, 2008, ID Cards for Wisconsin Medicaid and BadgerCare Plus have a new look. The Forward card will be continued to be used but people who are new to Wisconsin Medicaid and BadgerCare Plus will receive a Forward Health card. The current Forward card and the new Forward Health card are both valid and providers should accept either.

BadgerCare Plus members receive a "Forward Health" Medicaid ID card upon initial enrollment into the Wisconsin BadgerCare Plus Programs. Each individual family member receives his or her own individual ID number and card. BadgerCare Plus ID cards are in any of the following formats:

- Blue plastic Forward cards (standard).
- Green Temporary paper cards.
- Beige Presumptive Eligibility (maternity) paper cards.

Members are encouraged to always keep their cards even though they may have periods of ineligibility. It is possible a member will present a card when he or she is not eligible; therefore, it is essential providers confirm eligibility before providing services.

If a card is lost, stolen or damaged, Wisconsin BadgerCare Plus will replace the card at no cost to the member. Members should contact EDS Recipient Services at 1-800-362-3002, for replacement cards.

Children's Community Health Plan will not issue members a separate ID card; the Forward card and Forward Health card will serve as their insurance card.



The Forward card and Forward Health card includes the member's name, 10-digit Medicaid ID number, magnetic stripe, signature panel, and the EDS Recipient Services telephone number.

The card also has a unique, 16-digit card number on the front. This number is for internal use only and is not used for billing. The card does not need to be signed to be valid, although adult members are encouraged to sign their cards. Providers may use the signature as another means of identification.

Temporary and Presumptive Eligibility Cards

Temporary cards are issued on green colored paper and Presumptive Eligibility cards are issued on beige colored paper. These members are covered by Fee-for-Service, not CCHP. Providers should make a copy of the member's temporary card in the event a claim denies.

Provider Responsibilities

Provide Official Written Notice

Providers must notify Children's Community Health Plan, in writing of the following events. Notification can be sent to Provider Relations, MS 6280, PO Box 1997, Milwaukee, WI 53201-1997.

1. Any changes in practice ownership, name, address, phone or federal tax id numbers;
2. Adding a new physician - in order to treat a BadgerCare Plus patient you must be a certified Medicaid provider;
3. Loss or suspension of your license to practice;
4. Bankruptcy or insolvency
5. Any suspension, exclusion, debarment or other sanction from a State or Federally funded healthcare program;
6. Any indictment, arrest or conviction for a felon or any criminal charge related to your practice;
7. Material changes in cancellation or termination of liability insurance;
8. When a provider is no longer available to provide care to CCHP members;
9. When locum tenens are providing services, locum tenens must be credentialed by CCHP.

Cultural Awareness

At Children's Community Health Plan (CCHP) we respect and value everyone and the richness their diversity brings. This includes both our members and providers. As a result, we see the importance of providing resources to help others understand the differences that exist among cultures and how those differences impact decisions regarding individual healthcare needs.

CCHP is committed to creating and sustaining an environment that welcomes everyone. The CCHP web site, Information for Providers page, has helpful tools that promote cultural awareness. Please visit it for more information at childrenschp.com.

Access Standards

- Children's Community Health Plan establishes standards for appointment access and after-hours care in order to ensure timely access to care for members.
- The providers in the CCHP network have hours of operation that do not discriminate against BadgerCare Plus Standard or Benchmark members.
- Translation services are available if a provider does not speak the member's language

Primary Care Provider Appointments

No longer than 14 days for an appointment with a primary care provider

Urgent Care Appointments - within two (2) calendar days

After-Hours Care - 24 hours/7 days a week

Office wait times - within 30 minutes

Mileage Access Standard for Primary Care

Milwaukee County access standard - 2 primary care physicians within 3 miles

All other Counties access standard - 1 primary care physician within 10 miles

Prenatal Care Appointments

High Risk - within 2 weeks of request for an appointment or within 3 weeks if the request is for a specific practitioner.

Emergency Care - Immediate

Members are instructed to present directly to the nearest emergency room or to call 9-1-1 if they are experiencing a life-threatening situation. Members do not need prior authorization to seek emergency services.

Dental Care

Routine - within 90 days

Emergency - immediately. A dental emergency is defined as uncontrollable pain, swelling or bleeding.

Behavioral Health

No longer than 10 days for an appointment with a Mental Health provider to receive an initial assessment; when at all possible, this wait time shall be no longer than 5 days

In calendar year 2010 and calendar 2010, no longer than 7 days for an appointment with a Mental Health provider for members discharged from an inpatient psychiatric hospital stay; this timeframe will be reduced to 5 days in 2012 and 3 days in 2013

Physician Assistants

CCHP welcomes Physician Assistants (PAs) to participate in the provider network. If the PA's supervising physician is credentialed with CCHP, the PA is not required to complete the credentialing process. The physician assistant will receive a provider number that needs to be used when billing for the PA services.

Locum Tenens

CCHP requires providers to notify us in advance when locum tenens will be providing services. Providers working as locum tenens must first be credentialed by CCHP in order to assist the provider on a locum tenens basis. A provider who utilizes a CCHP credentialed locum tenens must notify CCHP of the expected coverage time involved. This must be done prior to the locum tenens providing services to CCHP members.

Referrals

Written referrals to in-network specialists are not required for CCHP members. If a physician requests an out-of-network referral, a referral form must be fully completed and faxed to (608) 836-6516. CCHP will notify the provider of the approval or denial. Providers can also call 1-800-482-8010 to check the status of a referral.

Prior Authorizations

Prior authorizations are required for some CCHP covered services. Please refer to the prior authorization section of this manual.

Requests to Terminate Patient/Doctor Relationships

If a provider wants to request the termination of a patient/doctor relationship, it must be sent in writing to Provider Relations stating the reasons for the request. Children's Community Health Plan will review the request and notify the provider of the determination to approve or deny the request. To avoid concerns of abandonment, the provider is requested to continue seeing the patient for 30 days from the termination notice if the patient seeks urgent or emergent care. This will give the member time to choose a new primary care practitioner.

Not Accepting New Patients

Providers closing their panel to new patients must submit the request in writing to CCHP that they are not accepting new patients.

No Show Policy

A provider cannot bill a CCHP member for a no show appointment. If a member does not show up for a scheduled appointment and does not notify the provider in advance of the cancellation, the provider should contact the CCHP Medicaid Advocate. The Medicaid Advocate will counsel BadgerCare Plus members regarding the importance of keeping appointments. The CCHP Medicaid Advocate **must** be contacted if: a pattern has developed for missed appointments by a member; or a provider plans on terminating a patient's care. Letters regarding termination of patient care must be sent to the Medicaid Advocate prior to notifying the member. The Medicaid Advocate will ensure standards set by Department of Health Services (DHS) are met. Your letter may be addressed to:

Medicaid Advocate
Children's Community Health Plan
MS 6280
P.O. Box 1997
Milwaukee, WI 53201-1997

Arranging Substitute Coverage

When a physician is out of the office and another facility or location covers his/her practice, CCHP requests notification to include the duration of coverage, name, and location of the covering facility or practitioner. The covering practitioner must be a CCHP provider and have completed the credentialing process.

Member Notification of Physician Departure from CCHP Provider Network

When providers leave the CCHP network, the provider is required to notify CCHP as outlined in the provider agreement. At least 30 days prior to the effective date of termination, CCHP will send members a letter notifying them of the change, provided CCHP was notified timely of the change.

Transition of Patient Care Following Termination of Provider Participation

For any reason, if a CCHP provider terminates, providers must participate in the transition of the patient to ensure timely and effective care. As a result, this may include providing service(s) for a reasonable time, at the contracted rate.

Advance Directives

The federal Patient Self-Determination Act (PSDA) gives individuals the legal right to make decisions about their medical care in advance of an incapacitating illness or injury through an advance directive. Physicians and providers, including home health agencies, skilled nursing facilities and hospices must provide patients with written information on state law about patients' right to accept or refuse treatment, and the provider's own policies regarding advance directives. As a provider, you must inform patients about their right to have an advance directive. Providers must document in the patient's medical record any results of a discussion on advance directives. If a patient has, or completes an advance directive their patient file should include a copy of the advance directive.

If you are unable to implement the member's advance directive due to an objection of conscience you must inform the member. The member should contact Customer Service to select a new primary care physician. As a primary care physician you should contact customer service and tell them you will be unable to be the member's provider care physician because of a conscionable objection to an advance directive.

Medical Records

As a contracted provider with CCHP, we expect that you have policies to address the following:

1. Maintain a single, permanent medical record for each patient that is available at each visit.
2. Protect patient records from destruction, tampering, loss or unauthorized use.
3. Maintain medical records in accordance with state and federal regulations.
4. Maintain patient signature of consent for Treatment/Screening.

General Documentation Guidelines

CCHP expects you to follow these commonly accepted guidelines for medical record information and documentation:

- Date all entries, and identify the author.
- Make entries legible.
- On a problem list site significant illnesses and medical condition. Include dates of onset and resolution.
- Make notes on medication allergies and adverse reactions. Also note if the patient has no know allergies or adverse reactions.
- Make it easy to identify the medical history, and include serious illnesses, injuries and operations for patients seen three or more times.

Document these items:

- Alcohol use, tobacco habits and substance abuse for patients age 11 and older.
- Immunization record
- Family and social history
- Preventive screenings and services
- Blood pressure, height, and weight.

Demographic Information

The medical record for each patient should include:

- Patient name and/or member ID number on every page
- Gender
- Age or date of birth
- Address
- Marital status
- Occupational history
- Home and work phone numbers
- Name and phone number of emergency contact
- Name of spouse or relative
- Insurance information

Patient Encounters

When you see a patient, document the visit by noting:

- Patient's complaint or reason for the visit
- Physical assessment
- Unresolved problems from previous visit(s)
- Diagnosis and treatment plans consistent with your findings
- Growth chart for pediatric patients
- Development assessment for pediatric patients
- Patient education, counseling or coordination of care with other providers
- Date of return visit or other follow-up care
- Review by the primary physician (initialed) on consultation, lab, imaging, special studies, outpatient and inpatient records
- Consultation and abnormal studies including follow-up plans
- Discharge note for any procedure performed in the physician's office
- Reasons for referrals documented

Patient Hospitalization

When a patient is hospitalized, your records should include:

- History and physical
- Consultation notes
- Operative notes
- Discharge summary
- Other appropriate clinical information

Member Rights & Responsibilities

CCHP is committed to maintaining a mutually respectful relationship with its members. To promote effective health care, CCHP makes clear its expectations for the rights and responsibilities of its members, to foster cooperation among members, practitioners and CCHP.

Children's Community Health Plan members have the right to:

1. Be treated with respect and recognition of their dignity and right to privacy.
2. Receive a listing of CCHP participating practitioners in order to choose a Primary Care Practitioner/Clinic.
3. Present a question, complaint or grievance to CCHP, about the organization or the care it provides, without fear of discrimination.
4. Receive information on procedures and policies regarding their health care benefits.
5. Timely responses to requests regarding their care plan.
6. Request information regarding Advance Directives.
7. Participate with practitioners in making decisions about their health care.
8. A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
9. Receive information about the organization, its services, its practitioners and providers, and members' rights and responsibilities.
10. Make recommendations regarding the organization's members' rights and responsibilities policies.

Children's Community Health Plan members have the responsibility to:

1. Read and understand the materials provided by CCHP concerning their health care benefits. CCHP encourages members to contact the Plan if they have any questions.
2. Notify their local county/tribal social or human service agency of any enrollment status changes such as family size or address.
3. Present their ID Card in order to identify themselves as CCHP members before receiving health care services.
4. Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
5. Follow plans and instructions for care that they have agreed on with their practitioners.
6. Understand their health problems and participate in developing mutually agreed upon treatment goals to the highest degree possible.

These rights and responsibilities are available for you to access on our website at www.childschp.com.

Prior Authorizations

Planned Inpatient Hospital Admissions

Children's Community Health Plan (CCHP) requires pre-certification for planned hospital admission by calling 1-800-482-8010. All inpatient admissions are reviewed for medical necessity. If there is an admission on a weekend or after hours, hospitals must report the admission to CCHP on the next business day. Planned admissions to non-CCHP hospitals also require prior authorization.

Emergency Care Services

Emergency inpatient admissions must be reported to CCHP within 24 hours of admission or the next business day. Inpatient admission notifications to CCHP can be made via fax at 608-836-6516 or calling 1-800-482-8010. For any transfers to non-plan facilities call 1-800-482-8010 for prior authorization.

CCHP's nurse line is available 24 hours a day, 7 days a week and can provide information about alternative care available in and outside of the CCHP provider network. The number to contact is 1-877-257-5861.

Urgent/Non-Emergent Care

Non-emergent/urgent care services are needed in order to treat an unforeseen medical problem that is not life threatening, but requires prompt diagnosis and/or treatment in order to preserve the member's health. Members with non-emergent conditions should be directed to CCHP contracted facilities.

In all cases of emergency or urgent care situations, providers should instruct members to contact their primary care physician for follow-up services that may be needed.

Chiropractic Services - not covered by CCHP. Members may use any Medicaid-certified chiropractor on a fee for service (FFS) basis.

Routine Vision - no referral required; must use Herslof Opticians. Routine vision services are covered annually. Referral for medical conditions must be to in-plan ophthalmologists. See listing in the CCHP Provider Services Directory.

Medicaid Coding Requirements

Providers are expected to bill Children’s Community Health Plan (CCHP) the same way they would bill Medicaid Fee for Service. Please continue to check the Medicaid web site at www.forwardhealth.wi.gov for specific updates.

Providers submitting claims to CCHP must include the corresponding modifier(s) to ensure appropriate reimbursement and reduce delays in payment. The cross references are as follows:

Type of Service (TOS)/Description	Modifier/Description
8 - Surgical Assistant	80 - Assistant Surgeon AS - Physicians Assistant
7 - Anesthesia (bill units by minutes)	AA - M.D. personally performed QX - CRNA or AA, M.D. medically directing one QX - CRNA or AA, M.D. medically directing more than one QZ - CRNA only, non-medically directed more than one QY - M.D. medically directing one CRNA QK - M.D. medically directing two, three, four CRNAs/AAs
P - Purchase new Durable Medical Equipment (DME)	
Q - Diagnostic Radiology, professional component (interpretation)	26 - Professional component
R - DME rental (per day)	RR - Rental
S - Radiation Therapy, professional component only	26 - Professional component
T - Nuclear Medicine, professional component only	26- Professional component
U - Diagnostic Radiology, technical component only	TC - Technical component
W - Diagnostic Medical, professional component only (interpretation)	26 - Professional component
X - Diagnostic Lab, professional component	26 - Professional component

Bilateral modifier

Bilateral procedures are reimbursed by billing on one line, using one unit, and adding the -50 modifier. The charged amount should indicate 150% of what the procedure would cost if it were done unilaterally.

Multiple surgeries

Multiple surgeries are reimbursed at 100% for the primary procedure, 50% for the second procedure, 25% for the third procedure, and 13% for the fourth through fifth procedure performed on the same day, by the same surgeon, in the same surgical setting. The percentages are based on the Medicaid FFS maximum allowable amount. To ensure correct payment and reduce delays use the 51 modifier on any procedure that is billed beyond the primary procedure. A post-payment audit will be done periodically to verify correct reimbursement.

Enhanced Reimbursements

Pediatric Services

Wisconsin BadgerCare Plus provides an enhanced reimbursement rate for office and other outpatient services (CPT codes 99201-99215) and emergency department services (CPT codes 99281-99285) for members 18 years old and younger.

To obtain enhanced reimbursement for members 18 years old and under, indicate one of the applicable procedure codes and the modifier “TJ” in element 24D of the CMS 1500 claim form.

Health Personnel Shortage Area

Wisconsin Medicaid provides enhanced reimbursement to primary care and emergency medicine providers that provide care in or to members from areas designated as a Health Professional Shortage Area (HPSA). The following zip codes are considered HPSA areas:

County	HPSA Name	Zip Codes
Milwaukee	Milwaukee	53203, 53204, 53205, 53206, 53208, 53209, 53210, 53212, 53215, 53216, 53218, 53233
Kenosha	Kenosha	53140, 53142, 53143, 53144
Racine		
Waukesha		

The incentive payment for HPSA-eligible primary care and emergency medicine procedures is an additional 20% of the FFS physician maximum allowable fee. HPSA-eligible **obstetrical** procedures receive an additional 50%. Providers performing HealthCheck screenings in the HPSA areas should bill the HealthCheck modifier first since it has a higher reimbursement.

To obtain the HPSA-enhanced reimbursement, indicate in element 24D of the CMS 1500 claim form one of the following modifiers:

- “AQ” for physicians providing services in a Rural HPSA area
- “AQ” for physicians providing services in an Urban HPSA area

To receive additional reimbursement providers must use the correct modifier. Reimbursement for eligible procedure codes billed with the “AQ” modifier includes the pediatric incentive payment. Do not bill “AQ” and “TJ” modifiers for the same procedure code. The modifier “TJ” can be billed for eligible services in situations that do not qualify for HPSA-enhanced reimbursement.

AQ-Rural/Urban

TJ-Pediatric rate

TH-Obstetrical treatment/services; prenatal*

*Providers are required to use the “TH” with procedure codes 99204 and 99213 only when those codes are used to indicate the first three antepartum care visits.

Claim Submission

Submit CCHP claims to: CCHP
P.O. Box 56099
Madison, WI 53705

Completing Claims

Children's Community Health Plan (CCHP) understands providers want to receive prompt and accurate payments for services. Here are some helpful hints on how to minimize claim rejection and/or claim payment errors.

1. When submitting claims, CCHP requires the correct and complete Medicaid ID number. This will help CCHP ensure correct claim payment.
2. Include correct provider identification when submitting claims. The individual provider name and provider number goes in Field 31 of the CMS-1500 claim form. Field 32 should be filled out with the name and address of the facility where services were rendered (if other than office). Field 33 should be used for the name and billing address of your office. Field 33 is also used for your vendor number and individual CCHP provider number. Failure to use the correct provider identification could result in unnecessary delays in claim processing. It is also possible that claims will be returned to your office if they lack the above requested information.
3. It is important for services to be coded accurately with valid Medicaid codes. Services are reimbursed according to Medicaid guidelines.
4. CCHP will accept the two-digit place of service codes only. Contact our Customer Service Department if you would like a listing of these codes.
5. CCHP does not identify the code 99070 as a specific service. If the correct HCPCS code is not used, services billed with 99070 will be denied and an explanation of the services must be resubmitted for review.

Initial Claims Submission

To allow for more efficient processing of your claims, we ask for your cooperation with the following:

- When submitting claims use the correct and complete member number. Using the correct member number on the claim helps ensure correct and timely claim payment.
- CCHP requires providers file claims in a timely manner. Claims must be submitted in accordance with the claim-filing limit outlined in your Network Agreement.
- Claims related to work related injuries or illness should be submitted to the Worker's Compensation carrier. Claims denied by the Worker's Compensation carrier, should be submitted to CCHP along with the denial for consideration. Members are required to follow CCHP's referral and prior authorization guidelines. Claims must be submitted within the timely filing guidelines along with the denial.
- Subrogation claims should be sent to CCHP for processing. CCHP will pursue recovery of those expenses from the at-fault party and/or their liability insurer. Members are required to follow CCHP's referral and prior authorization guidelines. Claims must be submitted within the timely filing guidelines along with the denial.

The table below indicates the list of data elements that are required on each claim submission. Listed are the appropriate box number from the CMS-1500 and UB 92 claim forms for each required element.

Required Information	CMS 1500 Claim Form	UB92 Claim Form	Note
Member Name	Box 2	Box 12	
Date of Birth	Box 3	Box 14	
Member Number	Box 1.a	Box 60	10 for MA
Diagnosis Code	Box 21	Box 67	
Date of Service	Box 24.A	Box 6	
Place of Service	Box 24.B	N/A	2 digit
Type of Bill	N/A	Box 4	
Service Code	Box 24.D	Box 42	4 digit revenue code on UB-92
Billed Amounts	Box 24.E	Box 47	
Units	Box 24.G	Box 46	
Provider Name	Box 31	Box 1	
Provider Billing Address	Box 33	Box 1	
Provider Number	Top Box 24.J	Box 51	
Vendor Number	Box 33b	Box 51	

Individual provider numbers are required under the Pin # field in Box 33. Vendor number must be entered under the GRP # field in Box 33 of the CMS form. If you bill on a UB92, the vendor should be listed under Box 51. Failure to use the correct provider identification could result in claim payment denials or reduction in payments. Claims will be returned to providers if they lack the above requested information. Please contact the Provider Service Department at 1-800-482-8010 with any questions regarding the required claim form fields.

Timely Filing Guidelines for Initial Submission

The initial submission of a claim is subject to CCHP timely filing guidelines. CCHP will give providers proof of receipt and confirmation of claims via the Electronic Claims Confirmation Report, Paper Confirmation Report, and Rejected Claims Reports. The date CCHP received the claim is on the reports.

During claims processing, claims goes through an initial editing phase that checks for valid patient information, correct identification numbers, provider information, etc. If the claim fails initial editing, it is rejected. The provider is notified of the rejection via the Rejected Claims Report. Rejected claims can be resubmitted to CCHP or the correction can be made on the Rejected Claims Report within the filing limit for improper submission and sent back to CCHP at PO Box 56099, Madison, WI 53705.

When you receive your confirmation reports back from CCHP, retain them for your records in case you need to file an untimely filing waiver request. If a provider fails to submit a claim timely, rights to payment from CCHP are forfeited and the provider may not seek payment from the members for these covered services.

Exceptions to Initial Claim Submission Timely Filing Guidelines

- A Provider can request, in writing, a temporary extension of the claim-filing limit for just cause as determined CCHP. This includes computer system conversions or other short-term circumstances. These requests should be made to the CCHP Manager of Operations.
- Coordination of Benefit (COB) claims must be received within the timely filing limit outlined in your agreement with CCHP; beginning with the date noted on the primary payor's explanation of benefits.
- Provider experiences complications obtaining patient insurance information from the member, claims must be received within the timely filing limit beginning with the date the CCHP coverage is identified, but not longer than 180 days from the date of service. Provider shall submit supporting documentation that demonstrates measures taken to obtain this information. Upon receipt of such information, provider must submit claims and supporting documentation within the timely filing limit outlined in their agreement.
- When members change physicians during their pregnancy, claims for prenatal visits, which would have been normally billed as part of a global obstetrics (OB) charge, must be billed separately since the member changed physicians. The claims must be submitted within timely filing limit, beginning with the date of delivery. CCHP will not accept a global obstetrical charge from a provider in this situation.

Timely Filing Guidelines for Claim Resubmissions/Corrections

All resubmitted/corrected claims need to be received by CCHP within the filing limit. The first day of the filing limit for resubmissions/corrections begins with the date upon which CCHP notifies the provider a claim has failed processing. You will find this date on the Explanation of Payment (EOP) or Rejected Claims Reports.

The provider can make resubmissions and/or corrections in the following ways:

1. Directly on the Rejected Claims Reports
2. On the Explanation of Payment received, or
3. Use the “yellow resubmission stickers.” Indicate it is a “Corrected Claim” and circle the correction (indicating the claim number) or a “Tracer Claim.”

Exceptions to Timely Filing Guidelines on Claim Resubmissions:

- When a claim is rejected or denied as a result of CCHP’s error, the submitted/corrected claim must be reviewed within one year of the Rejected Claims Reports or the EOP date.
- If the provider is a hospital-based providers (radiology, anesthesiology, etc.) or is submitting claims for a hospital-based provider who must wait for the inpatient discharge of member to file a claim, claims must be confirmed as having been received within sixty (60) calendar days from the discharge date of the member’s inpatient confinement.
- When the provider discovers new or additional information and requests additional payment on a processed and paid claim, such information must be received within sixty (60) calendar days of provider’s receipt of information.
- HealthCheck claims are exempt from the claim filing limit.
- Newborn claims will be accepted up to 14 months from the date of birth.

Claim Submission Reports

CCHP provides 100% confirmation on all new claim submissions. Confirmation of receipts are generated and sent to providers for all claims received by CCHP, whether it is filed on paper or through Electronic Claims Transmission (ECT).

There are three reports generated daily based on claims received:

- ECT Confirmation Report,
- Paper Confirmation Report,
- Rejected ECT

Electronic Claims Transmission (ECT) Confirmation Report

Providers that submit claims electronically will receive a Confirmation Report showing all of their claims that were loaded into the claims system. All claims that CCHP receives from a provider’s transmission will be on this report. The ECT Report is used as a confirmation tool of the number of claims received and the total dollar amount associated with those claims. Claims submitted on a CMS-1500 form will be listed alphabetically and totaled. Claims submitted on a UB92 will be listed together alphabetically and totaled. If the totals on the report do not match the provider’s totals, this may indicate that there was a problem with the transmission.

If you have questions on how to get set up to submit electronically or are experiencing problems with transmitting, **please contact CCHP at (800) 482-8010.**

The following is an example of our ECT Confirmation Report:

ECT CONFIRMATION REPORT		RUN DATE		06/07/2005		PAGE 2	
ABC Clinic 123 Main Street Anywhere, WI 55555							
VENDOR #: 12345							
MEMBER NAME	MEMBER #	PAT ACCT#	FIRST DATE OF SERVICE	TOTAL SERVICE LINES	TOTAL BILLED	CLAIM NUMBER	
Bessy Dressy	12345678901	B123	02/17/2005	1	\$250.15	060705 007 52	
Jones Sally	98765432101	J456	01/15/2005	2	\$213.25	067005 007 51	
Smith Johnny	45632178901	S789	02/01/2005	5	\$456.21	060705 007 50	
TOTAL CMS TRANSACTIONS: 3				TOTAL DOLLARS TRANSMITTED:		\$919.61	
MEMBER NAME	MEMBER #	PAT ACCT #	FIRST DATE OF SERVICE	TOTAL SERVICE LINES	TOTAL BILLED	CLAIM NUMBER	
Cosmo Killian	12544789201	C458	01/01/2005	1	\$2,504.00	060705 010 15	
Know Cooper	78521469801	K759	01/15/2005	1	\$3,567.33	060705 010 16	
Sullivan Sammy	23658471901	S478	01/31/2005	6	\$23,467.99	060705 010 14	
TOTAL CMS TRANSACTIONS: 3				TOTAL DOLLARS TRANSMITTED:		\$29,539.32	

Paper Claims Confirmation Report

Providers that submit paper claims receive a Paper Confirmation Report from CCHP. This report is similar to the ECT Confirmation Report, except the Paper Confirmation Report indicates the "received date" of each claim. Providers should review the Paper Confirmation Report, to confirm all claims were received by CCHP and entered into claims processing system. Also, retain confirmation reports incase a timely filing waiver is requested. CCHP will only honor this report in disputes relating to the timely filing receipt of claims.

PAPER CONFIRMATION REPORT		RUN DATE		06/07/2005		PAGE 2	
ABC Clinic 123 Main Street Anywhere, WI 55555							
VENDOR #: 12345							
MEMBER NAME	MEMBER #	PAT ACCT #	FIRST DATE OF SERVICE	TOTAL SERVICE LINES	TOTAL BILLED	CLAIM NUMBER	RCVD DATE
Bessy Dressy	12345678901	B 123	02/17/2005	1	\$250.15	060705 600 52	5/15/2005
Jones Sally	98765432101	J456	01/15/2005	2	\$213.25	067005 607 51	4/30/2005
Smith Johnny	45632178901	S789	02/01/2005	5	\$456.21	060705 640 50	6/1/2005
TOTAL HCFA TRANSACTIONS: 3				TOTAL DOLLARS TRANSMITTED:		\$919.61	
MEMBER NAME	MEMBER #	PAT ACCT #	FIRST DATE OF SERVICE	TOTAL SERVICE LINES	TOTAL BILLED	CLAIM NUMBER	RCVD DATE
Cosmo Killian	12544789201	C458	01/01/2005	1	\$2,504.00	060705 610 15	5/15/2005
Know Cooper	78521469801	K759	01/15/2005	1	\$3,567.33	060705 600 16	4/30/2005
Sullivan Sammy	23658471901	S478	01/31/2005	6	\$23,467.99	060705 620 14	6/1/2005
TOTAL HCFA TRANSACTIONS: 3				TOTAL DOLLARS TRANSMITTED:		\$29,539.32	

Rejected Claims Reports

The Rejected Claims Reports shows paper and electronic claims that were not entered into the claims processing system. Error codes are used to explain why claims did not pass the initial editing process. Provider can make corrections directly on the report and return it to CCHP. Corrections submitted more than 60 days from the initial date of the report must include an Untimely Filing Waiver Request Form.

The following is an example of the ECT & Paper Rejected Claims Reports and a key of our edit codes:

REJECTED CLAIMS REPORT: ELECTRONIC AND PAPER SUBMISSION													RUN DATE 06/07/05		PAGE 2	
VENDOR #	PROV #	CLAIM #	GROUP #	MEMBER #	PAT ACC #	MEMBER NAME	DATE OF BIRTH									
SVCDAT	POS	SVCCOD	UNITS	CHARGES												
PRCCODE1	PRCDATE1	PRCCODE2	PRCDATE2	PRCCODE3	PRCDATE3	PRCCODE4	PRCDATE4	PRCCODE5	PRCDATE5	PRCCODE6	PRCDATE6	ADMTDG				
DIAGN1	DIAGN2	DIAGN3	DIAGD1	DIAGD2	DIAGD3	DIAGD4	DIAGD5	DIAGD6	DIAGD7	DIAGD8	DIAGD9					
12345	123	100105	001 01		125	12345678901	15410000901M	JONES	JENNY	111722						
09/01/2005	11	88309	1	\$45.65				ERROR CODES: 03								
OOOOO				OOOOO		OOOOO		OOOOO		OOOOO		OOOOO				
239.0																
08/01/2005	11	88331	2	\$34.56				ERROR CODES: 09								
OOOOO				OOOOO		OOOOO		OOOOO		OOOOO		OOOOO				
162.9																
				TOTAL BILLED:	\$80.21											
12345	256	100105	002 56		356	98765432101	S546 S546	SMITH	JOHNNY	120347						
10/01/2005	11	250	1	\$46.78				ERROR CODES: 06								
93.54		110900		OOOOO		OOOOO		OOOOO		OOOOO		OOOOO				
239.0																
10/01/2005	11	356	2	\$15.78				ERROR CODES: 05								
81.54		110900		OOOOO		OOOOO		OOOOO		OOOOO		OOOOO				
162.9																
				TOTAL BILLED:	\$62.56											
PLEASE INDICATE CORRECTIONS IN THE RIGHT HAND COLUMN OR BELOW THE CLAIM AND RETURN THIS REPORT TO: THE ECT DEPARTMENT AT DEAN HEALTH PLAN"																

Problem Claim Request Form/Claim Resubmission

Below is an example of CCHP Problem Claim Request Form. The purpose of this form is to make claim payment adjustments more efficient. When a claim has been paid incorrectly (zero payment, underpayment, or overpayment) this form can be completed in lieu of resubmitting the claim or sending a refund check. When this form is used, adjustments are made on future remittances.

If possible, please indicate the claim number of the denied claim. This prevents resubmitted claims from being denied as a duplicate or for untimely filing. This form must be resubmitted within 60 days of the date of the denial.

*Children’s Community Health Plan
Problem Claim Request Form*

If confirmation of receipt for this submission is desired, please indicate how you wish to receive confirmation: Mail Fax

Provider/vendor name _____ Vendor# _____

Provider address

Fax number _____

Date sent _____

Who should CCHP contact with questions regarding the information provided on this form?
_____, at (____) _____, extension _____

This form must be filled out in its entirety for the reversal(s) to be completed.

Claim Number	Date of Service	Patient Name	Member Number	Amount to Reverse	Description of Problem

Reversals of overpayments will result in an automatic offset against future payments

Explanation of Payment

Children's Community Health Plan produces Explanation of Payments (EOP) on a weekly basis. If your office would like to check the status of a claim or questions an item on the EOP, please contact our Provider Service Department at 1-800-482-8010 or call our Integrated Voice Response (IVR) system. Examples of the EOP's for paid services, denied services, claim reversal/adjustments and claim overpayment, refund and adjustments can be found under Forms and Reports.

Claim Adjustments

If a provider believes they were underpaid, they can contact Customer Service and request an adjustment. Providers that identify they were overpaid should promptly return the overpayment to CCHP. In cases when CCHP discovers an overpayment, CCHP may offset the overpayment against other amounts due to the provider. (Please refer to your Network Agreement for the handling of overpayments.) These adjustments will appear on the provider's EOP following the processing of future provider's claims.

Medicaid Provider Appeals Process

Providers are entitled to make a claim appeal if they believe a denial or payment determination is unsatisfactory. The appeal must be in writing and submitted to CCHP within 60 days from the date the provider receives the denial or payment determination.

Providers can submit a written request or utilize the Medicaid Provider Appeal form and provide the following:

1. Include the provider's name, date of service, date of billing, date of rejection and reason(s) for reconsideration
2. Submit to Provider Appeals, PO Box 56099, Madison, WI 53705
3. Remember to clearly mark it "Appeal"

CCHP will respond to the request in writing within 45 days of receipt. If CCHP does not respond within 45 days or if the provider is not satisfied with CCHP's response, the provider may appeal to the Wisconsin Department of Health Services (DHS) for a final determination, to Wisconsin Managed Care, Ombudsman, PO Box 6470, Madison, WI 53716-0470. Appeals to the DHS must be submitted in writing within 60 days of CCHP's response. DHS will accept comments from both parties and has 45 days from the date of receipt of all written comments to respond to the appeal. If DHS finds in favor of the provider, CCHP must pay the Provider within 45 days of receipt of the determination.

HealthCheck/Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

HealthCheck, which is Wisconsin's Early and Periodic Screening, Diagnosis and Treatment (EPSDT), is mandated under federal Medicaid law. HealthCheck screenings are designed to promote that Medicaid enrollees under the age of 21 receive regular, comprehensive, preventive health care. The State of Wisconsin requires that a least an 80% compliance rate be attained for HealthCheck exams. Children's Community Health Plan is required to report compliance with HealthCheck standards to the State, and will do so based upon claims data. Primary Care Physicians are expected to follow the HealthCheck periodicity schedule for all members including women under 20 years old that are pregnant. HealthCheck screenings include the seven components listed below.

HEALTHCHECK COMPONENTS

There are seven components to a HealthCheck exam. Each of the following components should be documented in the patient's medical record when a HealthCheck exam is billed.

Health and Development History

The health and development history identifies any special risk factors, or prior conditions/treatments pertinent to future care of the patient. This history should include; a nutritional assessment, health education/anticipatory guidance including age appropriate preventive health education and an explanation of screening findings and developmental behavior assessment which includes observed behavior and attainment of developmental milestones compare to age-specific norms.

Unclothed Physical Exam and Growth Assessment

This assessment reviews body systems, indicating normal or abnormal findings. Blood pressure must be taken on all patients beginning at age 3 years; growth assessment: height, weight and head circumference are plotted on growth charts, head circumference must be completed up to age 2 and sexual development, especially on patients who have reached puberty.

Vision Assessment

Use of vision assessments must be attempted starting at age 4 years and done annually. If attempted but unable to complete due to age, this must be documented. The general guideline is: start on the 20/25 line (if unable to read, go up one level). If the child misses one letter on a line = pass. If the child misses two or more in one row = fail, and record vision at the previous level. If the child wears glasses, a vision assessment is not necessary. Document the child wears glasses, and when the child was last seen by an optometrist/ophthalmologist for an eye exam.

Hearing Assessment

Infancy and childhood should include otoscopic exam and /or tympanometric measurement for detection of chronic/recurrent otitis media.

Lab Tests

The blood lead test is the only required lab. Other lab is at provider discretion.

Oral Assessment

This assessment is to identify children in need of early examination by dentist. Children 3 years and older (and younger if medically necessary) must be instructed to seek dental care.

Immunizations

Childhood immunizations should be provided according to the Wisconsin Department of Health Immunization Guidelines. Parents declining immunizations should be documented at each visit.

How often should a child obtain a HealthCheck screening?

The State of Wisconsin established a periodicity schedule for screening services based on the Federal EPSDT:

Age Range	Number Of Screenings	Recommended Ages For Screening
Birth to first birthday	6	Birth 3-4 weeks 6-8 weeks 4 months 6 months 9 months
First birthday to second birthday	3	12 months 15 months 18 months
Second birthday to third birthday	2	2 years 2 ½ years
Third birthday to 21 st birthday	1	Every other year, not to exceed once per year

HealthCheck Reporting and Member Outreach

To make sure members comply with the recommended preventive visits and preventive screenings, tracking and reporting is necessary. Every other month, your clinic will receive a listing of eligible children assigned to your clinic for primary care. We ask that you contact these patients to schedule their HealthChecks. Performing complete HealthChecks for ALL Medicaid children keeps them healthy and provides higher reimbursement to you.

HealthCheck Billing

Preventive Care

Bill HealthCheck exams using any of the following CPT codes:

New Patient

- 99381* Initial preventive medicine visit, age under 1 year
- 99382* Initial preventive medicine visit, age 1 through 4 years
- 99383* Initial preventive medicine visit, age 5 through 11 years
- 99384* Initial preventive medicine visit, age 12 through 17 years
- 99385* Initial preventive medicine visit, age 18 to 21 years

Established Patient

99391*	Periodic preventive medicine, age under 1 year
99392*	Periodic preventive medicine, age 1 through 4 years
99393*	Periodic preventive medicine, age 5 through 11 years
99394*	Periodic preventive medicine, age 12 through 17 years
99395*	Periodic preventive medicine, age 18 to 21 years
99431*	History and examination of normal newborn infant, initiation of diagnostic and treatment programs and preparation of hospital records.
99432*	Normal newborn care in other than hospital or birthing room setting, including physical examination or baby and conference(s) with parent(s).
99435*	History and examination of normal newborn infant, including preparation of medical records.

* These codes do not need a modifier.

Do not apply any modifiers to the HealthCheck codes other than the ones listed below.

Provider type	Modifier	Modifier description
Physicians, Physicians Assistants, Independent Nurse Practitioners	UA	Medical referral

Provider type	Modifier	Modifier description
HealthCheck Nursing Agencies (Local Public Health Agencies)	EP	Indicates that interperiodic screens, outreach and cast management, and lead inspection services were provided as part of EPSDT
	TS	Indicates follow-up services to an environmental lead inspection

The following diagnosis codes should be used when billing for HealthChecks:

1. V20.2 - Routine Infant or Child HealthCheck
2. V70.0 - Adult over 18 years of age

Vaccine for Children Program (VFC)

VFC is a Federal Program intended to help raise childhood immunization levels in the U.S. The VFC supplies free vaccine to private and public health care providers who administer vaccines to eligible children, which includes all Medicaid eligible children. For more information on the VFC Program, refer to your Wisconsin Medicaid Provider Handbook.

Lead Screening/Treatment

Children with a lead blood level that exceeds 20-mg/dl must be referred to the Local Health Department.

HealthCheck Frequently Asked Questions

What is a HealthCheck?

HealthCheck, which is Wisconsin's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, is mandated under federal Medicaid law. HealthCheck promotes early detection and treatment of health conditions that could lead to chronic illness and disabilities in children. This health-screening exam for children includes growth and developmental screenings, hearing and vision screenings and immunizations, as well as a complete physical exam.

Why should I provide HealthCheck services?

There are several reasons for providing HealthChecks:

- HealthCheck visits are designed to ensure regular, comprehensive preventive health care for Medicaid members under the age of 21.
- HealthCheck reimburses at a higher rate than well-baby, well-child visit, or HPSA bonus payments.
- Through a HealthCheck referral, medically necessary services that are otherwise non-covered by Medicaid may be reimbursed.
- Screening exam intervals are consistent with the American Academy of Pediatrics' recommendations.
- HealthCheck screening requirements follow state and federal regulations and represent what most pediatric Medicaid providers see as "best practice".

Does HealthCheck billing require different forms than other Medicaid billing?

Billing for HealthCheck is done on the CMS-1500 claim form. This is the same claim form used for other Medicaid billing. Comprehensive screens are billed using CPT codes to indicate that a comprehensive HealthCheck screen was performed.

In addition, it is not the intent of the program to make you change your documentation system. Documentation of the listed components should be incorporated into your normal process.

Will patients receive extra benefits from having a HealthCheck exam?

With a HealthCheck exam, medical services that are medically necessary may be paid for, even though they're not normally covered by Medicaid. One example is noncovered over-the-counter medications.

What is the difference between a HealthCheck and a well-baby exam?

These two exams are very similar and may be the same. The difference is the HealthCheck requires an assessment and documentation of all 7 components, whereas a well-baby exam may not.

What if a patient refuses to let the provider do an unclothed physical exam?

Federal law requires an unclothed physical exam to assure clinicians are evaluating for potential physical abuse. This requirement does not mean the child must be totally unclothed for the entire exam.

Is color blindness screening required as part of a vision screening?

Screening for potential problems is the requirement. If there is a reason to believe color blindness is a problem, of course you would check further, but a routine exam is not required.

If vision and/or hearing screening is done at the school and reported by the parent, does the provider need to have a copy of those reports before billing for a HealthCheck exam?

HealthCheck providers are required to access and document vision and hearing screening. If that assessment is that the member has just had a vision and/or hearing screening somewhere else, the provider should document that fact and it would meet the requirements.

Can a dietician provide nutrition therapy through an interperiodic visit?

Nutrition therapy can be billed as an interperiodic visit if the comprehensive screen identified a problem (not a potential problem) and if the dietician works for the HealthCheck agency. The billing is done by the HealthCheck agency. This is for fee-for-service. Check with the HMO if the member is in a Medicaid HMO.

Do you need to wait a full 365 days between a member's annual HealthCheck screenings?

In Medicaid fee-for-service, the provider can bill up to 20 days before the year is up. If the member is enrolled in CCHP's Managed Care Program, there are no restrictions on the frequency of HealthCheck screenings.

What specific incentives can be used to get parents to have their children examined?

At least two specific incentives can help promote HealthCheck to members' parents:

1. Transportation: offering reliable transportation to get Medicaid children to their HealthCheck appointments can increase interest in HealthCheck. According to the Medicaid Handbook, "Wisconsin Medicaid pays for member transportation if it is required by members to access necessary medical care." Access to transportation is a key issue for many members in rural and central city areas in particular. Counties are responsible for assisting members with transportation.
2. Access to over-the-counter drugs: Medicaid also pays for medically necessary over-the-counter drugs prescribed by physicians, as long as a HealthCheck screen was done. Some prescriptions are subject to prior authorization. Over-the-counter drugs can be an important benefit, and a key incentive to raise intervals in HealthChecks. *Please reference the Pharmacy section of this manual for a list of over-the-counter medications.*

How can I get more information on HealthCheck in Wisconsin?

The Wisconsin Medicaid program website contains the handbook information on HealthCheck. The website address for the Medicaid handbook section on HealthCheck is:

<https://www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/tabid/151/Default.aspx>.

The entire HealthCheck Services handbook may be printed from this site.

ASH REPORTING

Abortions

Abortion is not a covered benefit, except in cases to preserve the life of the woman or in cases of rape or incest. It is the provider's responsibility to complete the required documentation and submit that information with the claim. Physicians are required to follow the Medicaid Policy and Consent Procedures for abortions.

Abortion Documentation

Wis. Stats. 20.927 stipulates that physicians must affix to their claims for reimbursement written certification attesting to the direct medical necessity of the abortion or his or her belief that sexual assault or incest has occurred and has been reported to law enforcement authorities. The following are examples of the types of documentation that will satisfy the above requirements:

Example 1

Life of the mother

I, _____, certify that on the basis of my best clinical judgment, abortion
Provider Name
is directly and medically necessary to save the life of _____ of

_____, for the following reason (s):
Recipient Name
Recipient Address

Specific physical condition/diagnosis

Signature Date Signed

Example 2

Victim of rape or incest

I, _____, certify that it is my belief that _____ of
Provider Name Recipient Name
_____, was the victim of rape (or incest).

Recipient Address

Signature Date Signed

Example 3

Grave and Long-lasting Damage to Physical Health

I, _____, certify that on the basis of my best clinical judgment, due to an
Provider Name
existing medical condition, grave, long-lasting physical health damage to _____

of _____, would result if the pregnancy were carried to term. The
Recipient Name

Recipient Address
following medical condition necessitates the abortion: _____
(Specific medical condition/diagnosis)

Signature Date Signed

When using either example 1 or 3, the statement by the physician must also include a statement of the women's pre-existing physical condition, (i.e., diagnosis, to clarify the specific physical health danger).

All claims for abortions will be rejected unless one of the above physician certification statements and the recipient statement are attached to the claim form.

This policy is in accordance with the U.S. Supreme Court's decision of Harris vs. McRae on June 30, 1980.

Payment for the medical necessity of preserving the mother's mental health will not be made.



Attachment #2

Required Documentation for Medicaid Reimbursement

“No service billed to Wisconsin Medicaid on the attached claim form was directly related to the performance of a non-Medicaid-covered abortion procedure. I understand that this statement is a representation of a material fact made in a claim for payment under Wisconsin Medicaid within the meaning of s.49.49, Wis. Stats., and HFS 106.06 (17), Wis. Admin. Code. Accordingly, if this statement is false, I understand that I am subject to criminal prosecution for Medicaid fraud or termination as a Medicaid provider, or both.”

Signed

Date

Provider Number

Wisconsin DHS Regulations for Sterilization and Hysterectomy Procedures

Children's Community Health Plan is required to report all sterilizations and hysterectomies to the State of Wisconsin on a quarterly basis.

The sterilization consent form, (*see Attachment #3*) must be signed and a copy of this will need to be provided to CCHP for reporting purposes. At least 30 days, but not more than 180 days, must have passed between the date of informed consent and the date of sterilization. **Do not count date signed or date of surgery in that 30 day criteria.**

The person who obtains the informed consent must orally provide all of the requirements for informed consent as set forth on the consent form. They must offer to answer any questions and must provide a copy of the consent form to the individual to be sterilized for his or her consideration during the waiting period. An interpreter must be provided to assist the member if he or she does not understand the language used on the consent form or the language used by the person obtaining the consent. And suitable arrangements must be made to ensure that the required information is effectively communicated to members to be sterilized who are blind, deaf or otherwise disabled. A witness chosen by the member may be present when the consent is obtained. The witness may not be the person obtaining consent.

Common Sterilization Reporting Problems:

1. The sterilization occurs less than thirty days after the date of informed consent
2. The sterilization occurs less than thirty days after the date of informed consent and the physician has indicated a premature delivery. The Physician must indicate the "EDC" (DEFINE) for a premature delivery. Admission history and discharge summary must be included with the sterilization consent form if the sterilization was performed with an emergency abdominal surgery.
3. On the physician's statement portion of the consent form, the signature date must be either the day of the surgery or after the surgery date. It may not be prior to the date of the sterilization.
4. Member must be at least twenty-one years of age on the date he/she signs the consent form.

Sample Sterilization Consent Form

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS. ¶ CONSENT OF STERILIZATION ¶

I have asked for and received information about sterilization from _____ 1 _____ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, Such as AFDC or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a/an _____ 2 _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____ 3 _____ Month Day Year. I, _____ 4 _____, hereby consent of my own free will to be sterilized by _____ 5 _____ (Doctor)

by a method called _____ 6 _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health, Education, and Welfare or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

____ 7 _____ Date _____ 8 _____
Signature-Recipient Month Day Year

You are requested to supply the following information, but it is not required: Race and ethnicity designation (please check)

- American Indian or Black (not Hispanic origin)
 Alaska Native Hispanic
 Asian or Pacific Islander White (not Hispanic origin)

¶ INTERPRETER'S STATEMENT ¶

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form _____ 10 _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation. _____ 11 _____ 12 _____

____ Signature-Interpreter Date Signed

¶ STATEMENT OF PERSON OBTAINING CONSENT ¶

Before _____ 13 _____ signed the (name of individual) consent form, I explained to him/her the nature of the sterilization operation _____ 14 _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that the sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

____ 15 _____ 16 _____
Signature- Person Obtaining Consent Date Signed

____ 17 _____

____ Facility

____ 18 _____

____ Address

¶ PHYSICIAN'S STATEMENT ¶

Shortly before I performed a sterilization operation upon _____ 19 _____ on _____ 20 _____, Name of individual to be sterilized Date of sterilization operation I explained to him/her the nature of the sterilization operation

_____ 21 _____, the fact that it is intended to specify type of operation

be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years of age and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) The sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable boxes and fill in information requested):

Premature delivery
 22 Individual's expected date of delivery: _____

Emergency abdominal surgery:
 (describe circumstances): _____

____ 23 _____ 24 _____
Signature-Physician Date Signed

Hysterectomies

Children's Community Health Plan is required to report all hysterectomies, along with abortions and sterilization to the State of Wisconsin on a quarterly basis.

Hysterectomies do not require prior authorization. Hysterectomies do require that an Acknowledgment of Receipt of Hysterectomy Information form be completed. This form must be on the patient's record at the time of hospitalization. (See Attachment #4)

A hysterectomy is **not covered** if:

1. It was performed solely for the purpose of rendering an individual permanently incapable of reproducing; or
2. There was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

Common Hysterectomy Reporting Problems:

1. The date the member signs the form must be prior to or coincide with the date of the surgery.
2. The date the provider signs the form must be before the date of service on the claim.

Hysterectomies may be performed without the "Acknowledgment of Receipt of Hysterectomy Information" in the following circumstances:

1. The individual was already sterile prior to the hysterectomy and appropriate documentation is attached such as a prior sterilization consent form.
2. The individual requires a hysterectomy because of a life threatening emergency in which the physician determines that a prior acknowledgment is not possible. The physician must attach the admission history and discharge summary in this case.

The acknowledgement form for hysterectomies can be forwarded to CCHP with the claim.

Acknowledgment of Receipt of Hysterectomy Information

Name—Recipient		Address—Recipient	
Recipient's Medicaid ID No.	Name—Physician		Physician's Medicaid Provider No.

It has been explained to _____ that the hysterectomy to be
(Name—Recipient)
performed on her (me) will render her (me) permanently incapable or reproducing.

SIGNATURES—Recipient, Representative, and Interpreter

Recipient

Representative

Interpreter

Date Signed
