LAKELAND CARE

Together, we build better lives.

Provider Handbook

Dear Providers,

Welcome to Lakeland Care, Inc.! We are excited to have you join us as a new provider, and for those already partnering with us—thank you for your continued commitment to serving our members. We deeply value the strong, collaborative relationships we build with our provider network, ensuring high-quality, cost-effective care for those who depend on us.

Lakeland Care, Inc. (LCI) proudly administers the Family Care program across 31 counties: Adams, Brown, Calumet, Columbia, Dane, Dodge, Door, Florence, Fond du Lac, Forest, Green Lake, Jefferson, Kewaunee, Langlade, Lincoln, Manitowoc, Marathon, Marinette, Marquette, Menominee, Oconto, Oneida, Outagamie, Portage, Rock, Shawano, Vilas, Waupaca, Waushara, Winnebago, and Wood. Our success is built on a diverse and dedicated provider network, working together to support meaningful outcomes for our members.

This handbook is designed to be a valuable resource, offering important 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'll also find detailed guidance on the DataClarity Provider Portal, service authorizations, claims filing, common reasons for claim denials, and the appeals process. We encourage you to use this handbook as a reference and a training tool for new team members.

Most importantly, please don’t hesitate to reach out to your Provider Specialist by phone or email—we’re here to support you.

Thank you for your partnership. We look forward to working together and making a positive impact in the lives of those we serve.

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Chapter 1: Introduction

Purpose of Provider Handbook

Lakeland Care, Inc.'s (LCI) handbook is a comprehensive resource for contracted providers, offering valuable information to support you and your employees. It is designed to be used alongside other key 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. Contact information for each ADRC can be found:
    - https://www.dhs.wisconsin.gov/adrc/contacts.htm.
- 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 any questions or need assistance with any part of this handbook, please contact a Provider Specialist. Contact information is available on the Lakeland Care, Inc. (LCI) website.

The most up-to-date version of this handbook can also be accessed on the LCI website.

Chapter 2: Overview

What is Lakeland Care, Inc.?

Lakeland Care was formed through Creative Care Options, one of the first Managed Care Organizations (MCOs) to pilot the Family Care program in Wisconsin. For over 24 years, we have remained dedicated to providing tailored solutions and support, ensuring we meet the needs of the individuals and organizations we serve effectively and compassionately. Our dedication to delivering high-quality, sustainable support is at the heart of everything we do, as we strive to make a meaningful and positive impact on the communities and individuals we serve.

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.

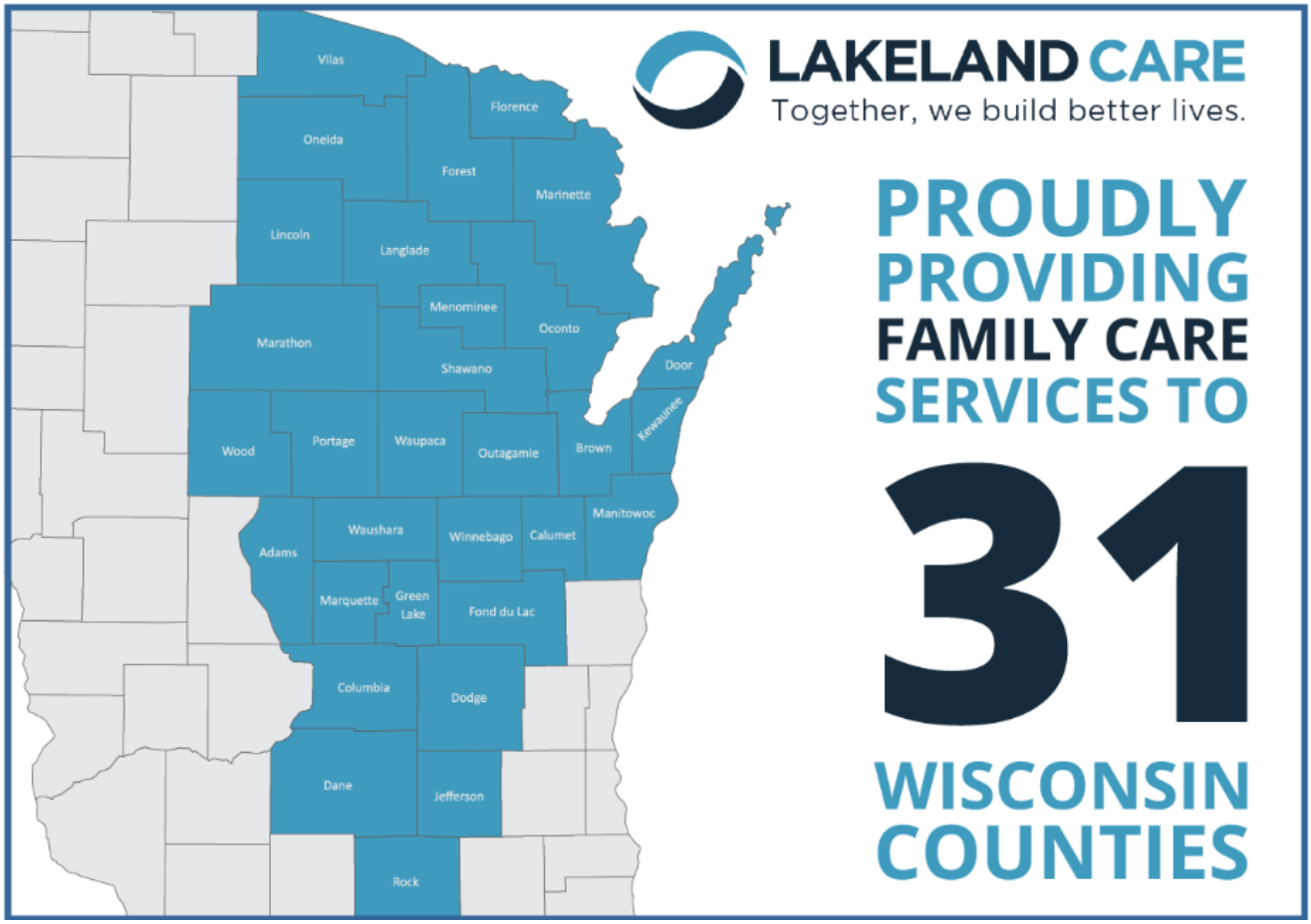
Lakeland Care, Inc. Vision:

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: Adams, Brown, Calumet, Columbia, Dane, Dodge, Door, Florence, Fond du Lac, Forest, Green Lake, Jefferson, Kewaunee, Langlade, Lincoln, Manitowoc, Marathon, Marinette, Marquette, Menominee, Oconto, Oneida, Outagamie, Portage, Rock, Shawano, Vilas, Waupaca, Waushara, Winnebago, and Wood



We have offices located throughout our service region in **Appleton, Crivitz, Fond du Lac, Green Bay, Madison, Manitowoc, Marinette, Oshkosh, Rhinelander, Shawano, Waupaca, and Wausau.**

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

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

Lakeland Care, Inc. Office Locations

Office	Street Address	City, State, Zip Code
Appleton*	4545 West College Ave	Appleton, WI 54914
Crivitz*	308 Henriette Ave	Crivitz, WI 54114
Fond du Lac*	N6654 Rolling Meadows Drive	Fond du Lac, WI 54937
Green Bay*	2985 S. Ridge Road	Green Bay, WI 54304
Madison*	4602 Biltmore Lane #104	Madison, WI 53718
Manitowoc*	1 E. Waldo Blvd	Manitowoc, WI 54220
Marinette*	2003 Marinette Avenue	Marinette, WI 54143
Oshkosh*	1922 S. Washburn St.	Oshkosh, WI 54904
Rhinelander*	232 S. Courtney St.	Rhinelander, WI 54501
Shawano*	1233 E. Green Bay St.	Shawano, WI 54166
Waupaca*	815 W. Fulton St. #1	Waupaca, WI 54981
Wausau*	501 S. 24th Avenue, Suite 100	Wausau, WI 54401

**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: Adams, Brown, Calumet, Columbia, Dane, Dodge, Door, Florence, Fond du Lac, Forest, Green Lake, Jefferson, Kewaunee, Langlade, Lincoln, Manitowoc, Marathon, Marinette, Marquette,

Menominee, Oconto, Oneida, Outagamie, Portage, Rock, Shawano, Vilas, Waupaca, Waushara, 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:

Adult day care

Adult day care services are provided to a group of adults in a setting outside the home for part of the day. It's for adults who need social interaction. It's also for those who need supervision, help with daily activities, and support to be healthy and safe. Services may include personal care, light meals, medical care, and transportation to and from the day care site.

Alcohol and other drug abuse (AODA) treatment

Individual and group outpatient and day AODA treatment services provided by non-physician providers, such as therapists, psychologists, and other professionals.

Assistive technology

Assistive technology includes items that help people with daily activities at home, work, and in the community. They may include technology like tablets, mobile devices, or software, items called adaptive aids, and a fully trained service dog from a reputable provider. The service may also include an assessment of a person's assistive technology needs and repair or maintenance of devices or items.

Communication assistance

Communication assistance includes items and services needed to help with hearing, speaking, reading, or other forms of communication. Items may include alternative or augmentative communication systems, speech amplification devices, electronic technology, mobile applications, and software. Services may include sign language interpretation or facilitation, assessment of communication needs, repair and maintenance of communication devices, and training to be able to use communication devices.

Community Support Program

Coordinated professional care and treatment for adults who live with severe mental illness. Clients receive a range of services in the community. Services aim to meet a member's unique needs, reduce symptoms, and lead to recovery.

Competitive integrated employment (CIE) exploration

CIE exploration services help members explore career pathways. They also help members decide if they want to work in the community alongside people who do not have disabilities. Services include business tours, job shadowing, informational interviews, or employment planning. Members can also get education about employment services for people with disabilities and help with identifying interests, knowledge, and skills that may be useful for finding a job.

Consultative clinical and therapeutic services for caregivers

Consultative clinical and therapeutic services help unpaid caregivers and paid support staff carry out a treatment or support plan. Services include assessments, development of home treatment plans, support plans, intervention plans, and training and assistance to carry out the plans. Services also include training for caregivers and staff who serve members with complex needs (beyond routine care).

Consumer education and training

Consumer education and training services help people with disabilities develop self-advocacy skills, support self-determination, exercise civil rights, and get the skills needed for control and responsibility over other support services. These services include education and training for members and their caregivers or legal decision makers. It may pay for enrollment fees, books and other educational materials, and transportation to training courses, conferences, and other similar events.

Counseling and therapeutic services

Counseling and therapeutic services treat personal, social, physical, medical, behavioral, emotional, cognitive, mental health, or alcohol or other drug abuse disorders. It may include help adjusting to aging and disability, help with relationships, and recreational, art, or music therapy. It may also include nutrition, medical, weight, or grief counseling.

Daily living skills training

Daily living skills training helps members do everyday tasks. This includes skills that help the member be independent and take part in community life. Examples include teaching money management, home care maintenance, food preparation, mobility training, self-care skills, and the skills necessary for accessing and using community resources.

Day services

Day services are regularly scheduled activities provided outside the home to a group of adults. Day services help members participate in the community, learn social skills, and develop the skills needed for activities of daily living and community living.

Durable medical equipment and supplies

Durable medical equipment and supplies are medically necessary devices and supplies that can help treat an illness, injury, or improve functioning.

Financial management services

Financial management services help with managing service dollars or personal finances. If a member chooses to self-direct one or more services, this service includes a person or agency paying service providers after the member authorizes payment. These services also help members budget to ensure money is available for housing and other needs.

Health and wellness

Health and wellness services help members maintain or improve their health, well-being, social skills, and inclusion in the community. They include activities that focus on developing healthy habits; classes, lessons, and events related to physical activity and nutrition; wellness services like yoga and mindfulness classes; and sexuality education and training.

Home-delivered meals

Home-delivered meals (sometimes called "meals on wheels") include the preparation and delivery of one or two meals a day if a member is unable to make or get healthy meals without help. Home delivered meals can also help members if they are unable to manage a special diet recommended by a health care provider for a medical condition.

Home health services

Home health services are a variety of services that are delivered in a member's home through a home health agency. They can include nursing services, home health aide services, personal care services, and physical, occupational or speech therapy.

Home modifications

Home modifications include items and services that make a member's home safer and easier to get around in. This may include ramps, stair lifts, wheelchair lifts, kitchen or bathroom modifications, specialized accessibility or safety adaptations, and voice-, light-, or motion-activated electronic devices that increase the member's self-reliance and ability to live independently.

Housing counseling

Housing counseling helps members find accessible, affordable, and safe housing in the community. Housing counseling includes exploring home ownership and rental options, identifying financial resources, identifying preferences of location and type of housing, identifying accessibility and modification needs, and locating available housing. Housing counseling does not include payment for rent or mortgage.

Institutional care

Care and treatment in an institutional setting, such as a nursing home, psychiatric hospital (also called institutes for mental disease (IMDs)), or intermediate care facilities for individuals with intellectual disabilities (ICF or IIDs).

Mental health treatment services

Individual and group mental health outpatient and day treatment services provided by non-physician providers, such as therapists, psychologists, and other professionals.

Nursing services

Nursing services include care that can only be provided by an advanced practice nurse, a registered nurse (RN), or a licensed practical nurse (LPN) supervised by an RN. It could involve keeping an eye on and recording symptoms and reactions, general nursing procedures and techniques, and may include assessment and ongoing monitoring of a medical condition.

Occupational therapy

A type of therapy that helps with learning or relearning to do everyday tasks and activities.

Personal care

Personal care services help members with daily activities and housekeeping needed to live in the community. This includes help with bathing, eating, dressing, managing medications, oral, hair, and skin care, meal preparation, bill paying, mobility, toileting, transferring, and using transportation. A physician must write an order for a member to get this service. If a member chooses to self-direct this service, they can choose the person or agency they want to provide the service and can act as their employer or co-employer.

Personal emergency response system (PERS)

PERS directly connects a member with health professionals in case of an emergency. It is a phone or other electronic system.

Physical therapy

A type of therapy that uses exercises to treat pain and help members maintain or improve strength and flexibility.

Prevocational services

Prevocational services are learning and work experiences that help members develop general strengths and skills to get jobs in community settings. Members can learn how to work with supervisors, coworkers, and customers. They can also learn about how to dress, follow directions, do tasks, solve problems, stay safe, and get around. These services help members get jobs in the community that pay them the usual wage and benefits paid to employees who do not have disabilities.

Relocation services

Relocation services include one-time expenses that help members move from an institution or residential care setting to their own home or apartment in the community. They can help pay for moving expenses, cleaning and organization, a security deposit, and utility connection costs. They can also help with furniture, cooking utensils, cleaning and household supplies, and basic furnishings and appliances.

Remote monitoring and support

Remote monitoring and support services help members get live support from a remote caregiver. The remote caregiver can make sure the member is safe and provide support in case of an emergency. This service provides technology like sensors, monitors, and other two-way communication devices. It also includes the support provided by remote caregivers and the repair and maintenance of devices. The member has to say in writing that they want this service.

Residential services

Residential services are provided in a homelike community-based residential setting. They include 1-2 bed adult family homes and settings for three or more adults (like 3-4 bed adult family homes or residential care apartment complexes). Services usually include personal care, help with daily activities, home care, treatment, and general support and supervision. Services may also include transportation and recreational or social activities, behavior and social support, and daily living skills training.

Respite care

Respite services provide short-term breaks for family or other primary caregivers. This helps relieve daily stress and care demands. Respite care may be provided in the member's home, a residential facility, a licensed camp, a hospital, or a nursing home.

Specialized medical equipment and supplies

Specialized medical equipment and supplies are items that maintain the member's health, manage a medical or physical condition, and improve functioning or independence. Items may include over-the-counter medications, medically necessary prescribed skin lotions, prescribed Vitamin D, multi-vitamins or calcium supplements, and books or therapy aids.

Speech and language therapy

A type of therapy that helps with communication and language skills. It can also include treatment for swallowing disorders.

Support broker

A support broker is a person or agency the member chooses to help plan, get, and direct self-directed supports. A support broker knows about local services and can help recruit, hire, train, manage, and schedule workers.

Supported employment services

Supported employment services help members get and keep jobs. The goal is to keep a job in the community at or above minimum wage, working alongside people who do not have disabilities. The job should also meet their personal and career goals.

- **Individual employment services** help members get a job, grow skills for that job, and get interviews. It could also include job coaching and training, rides to work, workplace personal assistance, benefits counseling, career advancement services, or self-employment support.
- **Small group employment services** are services and training provided in a business, industry, or community setting for groups of two to six workers with disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in community workplaces. Services may include small group

career exploration and education, skill development, employment planning, job placement, meeting with employers, job coaching and training, rides to work, and work experiences matched to the member's interests and skills.

- **Vocational futures planning and support** helps members get, keep, or advance in a job in the community. This may include assistive technology assessment, creating an employment plan, career exploration, job seeking support, job coaching and training, and ongoing personal assistance at their job. Members can also learn more about work incentives and how employment may impact their benefits.

Supportive home care

Supportive home care helps with daily living activities and personal needs at home or in the community. Services help with staying safe in the home and community, routine housekeeping tasks like cleaning, cooking, and laundry, and major household tasks like yard care and snow removal. Services may also help with dressing, bathing, managing medications, eating, going to the bathroom, grooming, getting around, paying bills, using transportation, and household chores.

Training services for unpaid caregivers

Training services for unpaid caregivers help those who provide unpaid care, training, companionship, supervision, or other support to a member. It trains unpaid caregivers how to do treatments and use equipment in treatments and other services included in the member's care plan and gives guidance on how to keep the member safe in the community.

Transportation services

- **Community transportation services** help members access community services, activities, and resources included in their care plan. This may include tickets or fare cards, reimbursement for mileage, as well as transportation of members and their attendants to destinations. It excludes emergency (ambulance) transportation.
- **Non-emergency medical transportation services** help members get non-emergency, Medicaid-covered medical services. Services may include tickets or fare cards, reimbursement for mileage, as well as transportation of members and their attendants to destinations. It excludes non-medical transportation, which is provided under community transportation—see above. It also excludes emergency (ambulance) transportation.

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 identify 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 risk. 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** is dedicated to ensuring that providers have the support they need to deliver high-quality, authorized services to LCI members. We are here to help providers navigate service requirements while maintaining the highest standards of care, ensuring the health and safety of the members we serve.

The **Provider Relations and Contracting Team** works closely with providers throughout the contracting process. Once contracted, each provider is assigned a **Provider Specialist**, who serves as a dedicated resource for:

- Answering questions about contracts and addendums
- Clarifying policies and procedures
- Collaborating effectively with LCI
- Adding services to an existing contract

If you are a new or current provider and would like to schedule an appointment to discuss concerns, expand your services, or need guidance in working with LCI, please reach out to your local **Provider Specialist**—we're here to help!

Joining the Provider Network

Providers interested in pursuing a contract with LCI can contact the Provider Development 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 reviews member requests for providers outside of our network as part of the **IDT RAD process**. While we strive to accommodate member needs, LCI is not obligated to approve all such requests. Whenever feasible, we may consider adding providers who meet specific member needs.

LCI will add providers to our network when all of the following criteria are met:

- The requested service is included in the **Family Care benefit package**.
- **Network capacity** indicates a need for additional providers within the applicable service code category. *(This standard does not apply to Community-Based Residential Facilities (CBRFs), Certified Residential Care Apartment Complexes (RCACs), community rehabilitation programs, home health agencies, day service providers, personal care providers, or nursing facilities.)*
- The provider agrees to **LCI's contracted rate**, which is negotiated with similar providers offering the same care, services, and/or supplies.
- The provider meets all **licensing and certification requirements** relevant to the services they will provide.
- The provider has demonstrated the ability to meet **all other applicable legal and contractual standards** required by LCI.
- The provider has **positive references** that reflect competency and a commitment to quality services.

- The provider agrees to **adhere to all components of LCI's contract and addendums**.
- The provider is willing to submit any **additional materials requested by LCI** to demonstrate service quality and competency.

Our goal is to ensure a high-quality provider network that meets the diverse needs of our members. If you have any questions regarding this process, please reach out to your Provider Specialist for further assistance.

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.) This includes Registered RCACs.
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.
- Meet requirements and have been issued a notice of compliance or have an HCBS Compliance / Public Funding Status of Compliant on the provider's profile on: https://www.forwardhealth.wi.gov/WIPortal/subsystem/public/DQAProviderSearch.aspx by the overseeing entity regarding the qualities of setting that are eligible for reimbursement for Medicaid HCBS under 42 C.F.R. § 441.301(c)(4) and 42 C.F.R. § 441.710.
- Meet 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. has established credentialing standards to comply with the requirements of our contracts with the Centers for Medicare & Medicaid Services (CMS) and the Wisconsin Department of Health Services (DHS).

The credentialing process ensures that our providers are properly educated, trained, and accessible to LCI members. LCI reserves the right and obligation to accept or reject the recommendations made by credentialing delegates.

Please note that any information acquired during the credentialing and re-credentialing processes is treated as confidential. LCI staff members with access to these files are responsible for maintaining the confidentiality of this information, except as required by law.

Additionally, Lakeland Care, Inc. is prohibited from contracting with or utilizing 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 for paying room and board (rent and food) costs while residing in a certified or licensed residential setting. These settings include Adult Family Homes (AFHs), Community-Based Residential Facilities (CBRFs), and Residential Care Apartment Complexes (RCACs). LCI will cover the room and board costs included in the single residential support rate and will bill the member for reimbursement.

As part of LCI's established practice, room and board reimbursement is determined using the previous year's U.S. Department of Housing and Urban Development (HUD) Fair Market Rent (FMR) data. Specifically:

- Room Portion: Calculated based on HUD FMR data for the county where the facility is located, regardless of the member's county of legal residence or responsibility.
- Board Portion: A standardized value established by the Department of Health Services, which applies uniformly across all facility types and counties. This value is derived from FoodShare figures and costs associated with facility maintenance.

Care and Supervision in Residential Facilities

Lakeland Care, Inc. will cover the costs for care and supervision from the date of the member's admission and for all subsequent days of residence. However, LCI will not pay for care and supervision during a member's temporary absence from the facility, such as when the member is hospitalized, undergoing short-term rehabilitation in a nursing home, or staying overnight with family or friends.

Residential Bed Holds

Lakeland Care, Inc.'s Provider Service Contract allows residential providers to request bed hold reimbursement during a member's medically related temporary absence from their original or primary residential facility. This policy aims to support the member's return to their primary residence.

For medically related temporary absences, bed hold payments, when deemed appropriate, will cover a period not exceeding **14 days** from the initial full day of absence or until the member returns to their original facility, whichever comes first. Please note that extensions are not permitted.

Due to federal regulations prohibiting duplication of services such as care and supervision, the bed hold rate may vary based on the member's temporary location and whether Medicaid funds are being utilized to cover that location.

In cases of temporary absence due to personal or community integration reasons, the current full authorization will remain active at the full daily rate for up to **14 days**, with no extensions allowed. During this temporary absence, the original facility will continue to receive full funding to ensure availability for the member's support if needed.

Nursing Home Bed Holds:

Nursing Homes are contractually obligated to adhere to Medicaid regulations when billing Lakeland Care, Inc. (LCI) for bed holds. They must bill LCI when they are at an eligible census according to Medicaid regulations.

Providers are required to contact the member's Interdisciplinary Team (IDT) staff when a member leaves the nursing home, and the facility meets the requirements for a bed hold. To ensure timely payment of bed hold claims, LCI nursing home providers must submit verification to the LCI Network Relations Division.

If a provider bills and receives the bed hold payment without submitting the necessary verification, LCI will request the return of those funds, as the provider did not adhere to the Medicaid Nursing Home Bed Hold Criteria. Furthermore, LCI will withhold all future payments until the funds are returned.

Bed hold charges will be paid per the LCI Service Provider Contract only when there is mutual agreement between LCI and the provider that the member is expected to return to their current room. Bed hold days will commence on the first day following the member's last overnight stay in the original facility.

Service Authorizations:

Providers are responsible for obtaining prior authorization before delivering services. In some cases, a verbal authorization may be granted by the Interdisciplinary Team (IDT) staff. It is essential that both the provider and the IDT staff document this verbal authorization. This allows the provider to initiate the service immediately. However, a verbal authorization must be followed up with a written authorization within 48 hours.

Although LCI may not be the primary payer source, prior authorization is required for the payment of co-payments. We ask all contracted providers to notify the IDT staff when a Medicare service is being administered to ensure coordinated care for LCI members. Additionally, if a co-payment is necessary or if the primary payer funding ends, the IDT staff will complete the RAD process. This process explores all options available to meet the member's health and safety needs and determines the most effective way to achieve the member's long-term care outcomes. Collaboration between the member, family supports, and the involved provider is crucial during this process.

The service authorization will include the following information:

- 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, please contact your local LCI branch or call 1-877-227-3335.

If an LCI member requires a service within the benefit package after hours, please contact the after-hours authorization number at (920) 906-5177 or 866-359-9438. The LCI after-hours authorization line has staff available outside of LCI's standard business hours of operation (Monday - Friday, 8:00 AM – 4:30 PM). This line is available 7 days per week outside of business hours and has the authority to authorize services in the Family Care benefit package. The staff is also familiar with the provider network.

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

DataClarity Provider Portal

Each service authorization will be available to providers through the **DataClarity Provider Portal**. Contracted providers can easily access the DataClarity Provider Portal via the LCI website.

If you have any questions about the service authorization or notice a discrepancy, please contact the IDT staff immediately. The name, phone number, and email address of the IDT staff will be included on the service authorization (see the sample service authorization in the attachment section).

Our **Provider Relations Staff** are available to assist you with any questions regarding DataClarity. Additionally, a DataClarity user guide and supporting videos are available on the LCI website to help you learn about the features of the Provider Portal.

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 outlines the services an agency is contracted to provide to LCI members. As part of the provider network, the agency is included in the Provider Directory, which is accessible to members. Providers are selected by the IDT based on their ability to meet members’ LTC Outcomes.

In accordance with Wisconsin DHS and HFS 10 regulations, LCI is required to continuously monitor the provider network to ensure service capacity and access align with current and anticipated member needs. Excess network capacity increases administrative costs and complicates provider quality oversight. Therefore, LCI is not obligated to contract with providers beyond what is necessary to meet member needs.

Background Checks

LCI complies with the Wisconsin Admin Code chapters DHS 12 and DHS 13 which pertain to any caregiving staff who is any of the following:

- Has regular, direct contact with the entity’s clients or the personal property of the clients;
- The owner or administrator of an entity, whether or not they have regular, direct contact with clients; or
- A board member or corporate officer who has regular, direct contact with the clients served.

Reference: Wisconsin Background Check and Misconduct Investigation Program Manual: https://www.dhs.wisconsin.gov/publications/p0/p00038.pdf.

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 LCI 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. If 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

LCI 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.
    - **Services Requiring EVV:** Provider must submit claims by date as they will not process with a date span.

    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 the 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. Appeals 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. Appealed claims 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. This 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. Reference: Appeals and Grievance Policy on LCI Website: https://www.lakelandcareinc.com/wp-content/uploads/2024/11/LCI-Website-Appeals-and-Grievance-Policy.docx

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. Program Integrity Abuse is defined as practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Family Care program and LCI in reimbursement for services that are not medically necessary, or services that fail to meet professionally recognized standards for health. Program integrity abuse also includes member practices that result in unnecessary costs to the Family Care program. This definition of program integrity abuse includes Home and Community Based Services provided in the Family Care program.

LCI holds Program Integrity in elevated regard, and considers prevention, detection, and correction of Program Integrity abuse a key goal at all levels throughout the organization. LCI's program integrity practices are maintained in our detailed program integrity policy and procedure. If a contracted provider is found to have committed Program Integrity abuse, or any other unethical conduct related to the appropriate use of public resources, it may lead to civil and criminal liabilities and penalties and may also result in termination of provider contract(s).

It is imperative that contracted providers and their employees:

- Promote integrity and ethical conduct;
- Do not commit Program Integrity abuse, fraud or otherwise participate in fraudulent, wasteful, or abusive financial activities;
- Immediately report any suspected fraud, waste, financial abuse, or unethical conduct to LCI's 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
  Fond du Lac, WI 54937

You may remain anonymous!

Additionally, it is required that all contracted 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, and/or exclusion;
- Promptly refund identified overpayments, specifically including but not limited to, recoveries of overpayments due to fraud, waste, or abuse
- 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 terminate a provider or supplier from participation in the Medicaid program, or to suspend payments to a provider or supplier to maintain Program Integrity. LCI may also 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 Provider Quality Department collaborates with providers to proactively enhance the quality of services for LCI members through education and process improvement recommendations. The Provider Quality Specialists partner with providers to assist in problem resolution following incidents, provider licensure surveys and provider surveys.

Adult Incident Reporting System (AIRS)

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 Adult Incident Reporting System (AIRS), what type of incidents/events providers should report to LCI, and the procedure to follow as outlined in LCI's Contract.

The Adult Incident Reporting System (AIRS) 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.

AIRS 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. 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 Provider 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. The Provider Quality Specialists (PQS) 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.

AIRS 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 AIRS Types and Definitions below SOD.

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.

AIRS Types and Definitions Level 1 and Level 2 Incidents:

Abuse:

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

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

- **Sexual Abuse: Sexual contact without consent in the first through fourth degrees as defined in Wis.Stats. 940.225.**

- **Treatment without consent:** 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 fr the administration or performance.

- **Unreasonable confinement or restraint:** The intentional and unreasonable confinement of an individual in a locked room involuntary separation of an individual from their 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 congormance with state and federal standards governing confinement and restraint
- **Neglect:** 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.
- **Self-Neglect:** A significant danger to an individual's physical or mental health because the individual is responsible for their own care but fails to obtain adequate care, including food, shelter, clothing, or medical or dental care. See, Wis. Stats. 46.90(1)(g). This includes suicide, suicide attempt, not taking medication as prescribed, self-inflicted harm, and accidental overdose.
- **Exploitation**: Taking advantage of someone for personal gain with manipulation, intimidation, threats, or coercion.
- **Financial Exploitation:** Includes any of the following acts: Fraud, enticement, or coercion, theft, misconduct by a fiscal agent, identity theft, unauthorized use of the identity of a company or agency, misconduct by a fiscal agent, identity theft, forgery, unauthorized use of financial transaction cards including credit, debit ATM, and similar cards.
- **Medication Error:** Any time a member does not receive their medication as prescribed that resulted in moderate or severe injury/illness.
- **Missing Person:** When a member's whereabouts are or were unknown for any amount of time.
- **Fall:** An action where a member inadvertently descended to a lower level by losing control, losing balance, or collapsing from a standing, sitting or lying down position.
- **Emergency Use of Restrictive Measures:** Restrictive measures include any type of manual restraint, isolation, seclusion, protective equipment, medical procedure restraint, or restraint to allow healing.
- **Unapproved Use of Restrictive Measures:** Restrictive measures include any type of manual restraint, isolation, seclusion, protective equipment, medical procedure restraint, or restraint to allow healing.
- **Other incident type:** An accident, injury, illness, death, or unplanned law enforcement involvement that cannot be captured in any other incident type.

Level 3 Incidents:

- IMD admission, ITP admission, Media event, Other AIRS Level 3

Level 4 Incidents:

- Adverse Events: include behavioral events or member rights violations
- Quality Alerts: Concerns regarding a contracted provider's delivery of services

Glossary

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 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 website.

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.

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.
	Action: 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.
	Action: Contractual Obligation write off.
BU	During the processing of this claim, this line was bundled into another line for processing.
	Action: 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.
	Action: 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.
	Action: 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.
	Action: 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.
	Action: 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.
	Action: 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.
	Action: 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.
	Action: 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.
	Action: 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 explanation of benefits with the claim to us for processing.
	Action: 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 determined their benefits, send the claim and the explanation of the primary carrier benefits to us for processing.
	Action: 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.
	Action: 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
	Action: 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 authorization number is invalid with the service/supply billed. Please re-bill using the correct authorization number within the timely filing limit.
	Action: 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.
	Action: 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
	Action: 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.
	Action: 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.
	Action: 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.
	Action: 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
	Action: 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.
	Action: 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.
	Action: No action needed, informational only.

18	We have already processed this charge.
	Action: 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.
	Action: 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.
	Action: 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.
	Action: 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.
	Action: 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.
	Action: 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.
	Action: 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

AIRS 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