Department of
Family Care
Milwaukee County

Provider Handbook

MILWAUKEE COUNTY
INCORPORATED 1835

TABLE OF CONTENTS

PREFACE

This handbook is issued by the Milwaukee County Department of Family Care. It provides information and guidance for providers who are affiliated with the Milwaukee County Department of Family Care. This handbook contains general information about the Managed Care Organization (MCO), our provider network, Family Care and the Family Care Benefit Package. You will also find detailed information about the MIDAS Provider Portal, service authorizations, how to file claims, reasons claims are denied and how to file appeals. The handbook is a good place to begin when you have questions. It can also be very valuable for new provider employees.

Providers should use this handbook in conjunction with other resources, including:

- Family Care Guide For Wisconsin Medicaid-Certified Providers
- Wisconsin Medicaid All-Provider Handbook
- Wisconsin Medicaid service-specific handbooks
- *Wisconsin Medicaid and BadgerCare Updates*
- Wisconsin Administrative Code, Chapters DHS 101-108

For more information, providers may also refer to:

- Milwaukee County Department on Aging **www.milwaukee.gov/county/aging**
- Wisconsin Medicaid's Web site at **www.dhs.wisconsin.gov/medicaid**
- Long-term care Web site at **www.dhs.wisconsin.gov/LTCare**
- Wisconsin Medicaid's Provider Services at (800) 947-9627 or (608) 221-9883

If you have questions or you need help in understanding anything in this handbook, please call your Contract Services Coordinator. (Refer to Appendix 1 of this handbook for Contract Services Coordinator assignments.)

WHAT IS FAMILY CARE?

Family Care, authorized by the Governor and Legislature in 1998, serves people with physical disabilities, people with developmental disabilities and frail elders, with the specific goals of:

- Giving people better choices about where they live and what kinds of services and supports they get to meet their needs.
- Improving access to services.
- Improving quality through a focus on health and social outcomes.
- Creating a cost-effective system for the future.

Family Care has two major organizational components:

1. **Aging and Disability Resource Centers** (ADRCs), designed to be a single entry point where older 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) who manage and deliver the Family Care benefit. The Family Care benefit combines funding and services from a variety of existing programs into one flexible long-term care benefit, tailored to each individual's needs, circumstances and preferences.

The Wisconsin Department of Health Services (DHS) contracts with Managed Care Organizations (MCOs) to provide or arrange for services in the Family Care Benefit Package. Each MCO develops a provider network to provide services to Family Care Members who live in their own homes, nursing facilities, or other group living situations.

THE MILWAUKEE COUNTY DEPARTMENT OF FAMILY CARE MANAGED CARE ORGANIZATION

The Milwaukee County Managed Care Organization (MCO) is a department of Milwaukee County contracted with the Wisconsin Department of Health Services to administer the Family Care benefit in Milwaukee County per the Health and Community Supports Contract and Administrative Rule HFS 10.

A significant part of our responsibility is to partner with community organizations able to provide the goods and services funded through our program. This is the role that our providers play in Family Care.

The Milwaukee County MCO is located in the Milwaukee County Courthouse, Courthouse Room 307A - 901 N. 9th Street, Milwaukee, WI 53233.

OUR MISSION STATEMENT

The Milwaukee County MCO respects the dignity and personal autonomy of each Member by honoring choice and promoting the Member's continued participation in the life of their community, by providing a continuum of quality cost-effective long-term care to its Members, and by supporting the families and caregivers of its Members.

OUR CORE VALUES

The core values serve as the foundation to guide both the development of the organization's mission and the identification of appropriate behavior and activities in the fulfillment of the mission.

1. **Member-centered** - We acknowledge that our Members are the purpose for our existence. We will always put the best interest of our Members at the center of decision-making.

2. **Care that embraces the whole person** - We are committed to providing quality care that encompasses the body, mind, spirit and social relationships and that preserves the quality of life for our Members.

3. **Dignity** - We will respect the dignity and personal autonomy of each Member.

4. **Collaboration** - We believe in being inclusive and fostering teamwork and collaborative efforts with our Members, their families/support systems, and other organizations.

5. **Justice** - We believe that it is critical for all Members to receive fair equitable treatment that is free from discrimination.

6. **Stewardship** - As a public agency, we have a concern for careful use of our resources and a responsibility to be responsive to the public's input.

7. **Beneficence** - We will strive to provide the best care for our Members.

8. **Cultural Competence** - We are committed to care delivery that is responsive to the cultural values of our Members.

WHO IS ELIGIBLE FOR MILWAUKEE COUNTY MCO SERVICES?

The Milwaukee County MCO provides services to individuals that meet the following criteria:

- Age and Disability Requirements
    * At least 18 years of age
    * Persons with physical disabilities, developmental disabilities or frail elders

- Financially Eligible - Determined by Economic Support Division

- Functionally Eligible - Determined by screening with Aging and Disability Resource Center

- A resident or responsibility of Milwaukee County

The Aging and Disability Resource Center (ADRC) determines an individual's eligibility for Milwaukee County MCO services. You can contact the ADRC at 414-289-6874.

Enrollment in the Milwaukee County MCO is voluntary. Members choose whether or not they want to be a Member of the program. Once enrolled, an Interdisciplinary Team is assigned to the Member.

This Team consists of the individual Member, their families, a case manager, a nurse, and other professionals or consultants as determined necessary by the Member's needs. Upon completion of the eligibility and screen process, this Team assesses the individual needs of the Member and works to develop a Member Centered Plan.

Specific providers are chosen based on their ability to meet the outcomes of the Member.

PROVIDER NETWORK

The network of providers have signed contracts with the Milwaukee County MCO and agreed to adhere to all components of the contract including, but not limited to:

- Agree to Milwaukee County MCO rate.
- Follow contractual requirements related to authorizations and billing.
- Maintain ongoing communications with Milwaukee County MCO staff.
- Meet or exceed quality assurance expectations of Milwaukee County MCO.
- Submit an annual audit as applicable.

The contract specifies the services that an agency is authorized to provide to Milwaukee County MCO Members. As a contracted provider in the Milwaukee County MCO Provider Network, the agency is added to the Provider Directory, which is given to Members. Members and their Interdisciplinary Team choose the Member's service providers from the Provider Directory. All providers are required to be HIPAA compliant.

The Health and Community Supports Contract and HFS 10 requires Milwaukee County MCO to continually monitor the Provider Network to ensure that service capacity and access are managed in accordance with current and anticipated Member service demands. Excess capacity in the Provider Network increases our administrative costs and makes it more difficult to monitor provider quality. Milwaukee County MCO is not required to contract with providers beyond the number necessary to meet the needs of Members.

INELIGIBLE ORGANIZATIONS

The Milwaukee County MCO shall exclude all organizations from participation in the provider network, which can be included in any of the following categories (references to the Act in this section refer to the Social Security Act):

1. *Ineligibility*
   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 the following crimes:

      i. Program related crimes, i.e., any criminal offense related to the delivery of an item or service under Medicare or Medicaid. (See Section 1128(a)(1) of the Act);
      ii. Patient abuse, i.e., criminal offense relating to abuse or neglect of patients in connection with the delivery of health care. (See Section 1128(a)(2) of the Act);
      iii. Fraud, i.e., a State or Federal crime involving fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of health care or

involving an act or omission in a program operated by or financed in whole or part by Federal, State or local government. (See Section 1128(b)(1) of the Act);

iv. Obstruction of an investigation, i.e., conviction under State or Federal law of interference or obstruction of any investigation into any criminal offense described directly above. (See Section 1128(b)(2) of the Act); or,

v. Offenses relating to controlled substances, i.e., conviction of a State or Federal crime relating to the manufacture, distribution, prescription or dispensing of a controlled substance. (See Section 1128(b)(3) of the Act).

b. Been excluded from participation in Medicare or a State Health Care Program.
A State Health Care Program means a Medicaid program or any State program receiving funds under title V or title XX of the Act. (See Section 1128(b)(8)(iii) of the Act.)

c. Been assessed a Civil Monetary Penalty under Section 1128A of the Act.
Civil monetary penalties can be imposed on individual providers, as well as on provider organizations, agencies, or other entities by the DHHS Office of Inspector General. Section 11238A authorizes their use in case of false or fraudulent submittal of claims for payment, and certain other violations of payment practice standards. (See Section 1128(b)(8)(B)(ii) of the Act.)

CAREGIVER BACKGROUND CHECKS

The Milwaukee County MCO shall comply with Wisconsin Admin Code DHS 12 and DHS 13 which pertains to any providers or MCO staff who come in direct contact with Members.

The MCO requires providers to perform caregiver background checks on people paid to provide services to Members. The MCO maintains the ability to not pay or contract with any provider if the MCO deems it is unsafe based on the findings of past criminal convictions stated in the caregiver background check. If requested, the caregiver background check shall be made available to the MCO, the Member or entity that is the employer.

OUT OF NETWORK PROVIDERS

The Milwaukee County MCO will consider Member requests for providers outside of our network, but the Milwaukee County MCO is not required to add providers to our network simply because they are requested by Members. The requested provider must meet the quality standards set by the Milwaukee County MCO and accept the service rate set by the Milwaukee County MCO. The Milwaukee County MCO will add providers that meet the specific needs of a Member whenever feasible.

FAMILY CARE BENEFIT PACKAGE

In general, long-term care services (for example, health services in a Member's home) 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 will remain fee-for-service for those who are Medicaid eligible. The Family Care Benefit Package also includes services covered by the Community Options Program and the home and community-based waivers program. The following Medicaid Services **are** included in the "Family Care Benefit Package."

- Adaptive Aids (general and vehicle)
- Adult Day Care
- Alcohol and other Drug Abuse Services, except those provided by a physician or on an inpatient basis
- Assessment and Case Planning
- Case Management
- Communication Aids/Interpreter Services
- Community Support
- Counseling and Therapeutic Resources
- Daily Living Skills Training
- Day Services and Treatment
- Durable Medical Equipment and Medical Supplies (except for hearing aids and prosthetics)
- Home Health
- Home Modifications
- Meals delivered to Member's home
- Mental Health Services (except those provided by a physician or on an inpatient basis)
- Nursing Facility
- Nursing Services (except for in-patient hospital stays)
- Occupational Therapy (in all settings except for inpatient hospital)
- Personal Care
- Personal Emergency Response System Services
- Physical Therapy (in all settings except for inpatient hospital)
- Prevocational Services
- Residential Services: Intermediate Care Facility for People with Mental Retardation (ICF/MR), Residential Care Apartment complex (RCAC), Community Based Residential Facility (CBRF) and Adult Family Home (AFH)
- Respite Care (provided in non-institutional and institutional settings for caregivers of Members)
- Specialized Medical Supplies
- Speech and Language Pathology Services (in all settings except for inpatient hospital)
- Supported Employment
- Supportive Home Care
- Transportation: all Medicaid covered transportation services (except ambulance)

Providers **must obtain prior authorization** from the Member's Care Manager for **all** services to be rendered or the Milwaukee County MCO may not cover the cost of the service.

The Milwaukee County MCO will not reimburse providers at rates higher than the Medicaid rate for Medicaid services included in the Family Care Benefit Package.

FAMILY CARE BENEFIT PACKAGE EXCLUSIONS

The following Medicaid Services are **not** included in the "Family Care Benefit Package". Medicaid eligible Members can access these services with their Forward Card.

- 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 and 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 other Drug Abuse for a non-physician)
- Podiatry
- Prenatal Care Coordination
- Prosthetics

The Milwaukee County MCO may consider paying for the services listed above on an individual basis even though they are not a Family Care benefit. Providers **must obtain prior authorization** from the Care Manager before rendering the service if they want the Milwaukee County MCO to cover the cost of the service.

Providers should continue to bill Medicaid fee-for-service for Medicaid services that are not included in the Family Care Benefit Package when provided to Medicaid-eligible Milwaukee County MCO Members.

For Members who are not eligible for Medicaid, providers should bill Members or the Members' commercial health insurance for any services that are not included in the Family Care Benefit Package.

SERVICE AUTHORIZATION

As the sole payment source for Family Care services, the MCO provides our own service authorizations. Prior to delivery of service to a Family Care Member, the provider must obtain a Service Authorization from the Member's Care Manager. To obtain a Care Manager's name and telephone number, contact Family Care Customer Service at (800) 223-6016.

The Care Manager needs the following information in order to consider creating a Service Authorization:

a. Member name
b. Service to be provided including HCPC or procedure code
c. Units and frequency of service
d. Dates of service
e. Service location

Providers who have a contract with Milwaukee MCO may access the MIDAS Provider Portal website at **https://www.FamilyCareMilwaukeeCounty.com** to view and print their Service Authorizations. (If necessary, it is possible for the MCO to arrange for printing Service Authorizations nightly and mailing them to a provider on a daily basis.) If a provider has a question about the Service Authorization or if there is a discrepancy, contact the Care Manager immediately. The Care Manager name, phone number, and e-mail address is on the Service Authorization. (See sample Service Authorization in the Appendix.)

A Service Authorization does not guarantee payment of your services. Benefits are available as long as the Member is eligible at the time service is provided.

Contact your Contract Services Coordinator to obtain your Provider Portal access code. Please see the Appendix of this handbook for a guide to the features available on the Provider Portal.

THIRD PARTY ADMINISTRATOR

The Milwaukee County MCO contracts with a Third Party Administrator (TPA) to process provider claims for payment.

The Third Party Administrator is:

Milwaukee County Care Management Organization
c/o **WPS INSURANCE CORP.**
PO Box 7460
Madison, WI 53707-7460
Customer Service Phone #: (800) 223-6016

PROVIDER TRAINING SPECIALIST

The Milwaukee County MCO has a Provider Training Specialist to ensure that our providers receive adequate education in all aspects of Family Care billing in order to facilitate timely and accurate payments to their organizations.

The Provider Training Specialist provides training to Milwaukee County MCO service providers regarding use of the Provider Portal, understanding the clean claim and appeal process, electronic submission of claims, and the appropriate use of explanation of benefits (EOB) reports to verify and reconcile payments. This training is available to all existing providers upon request and to all new providers upon acceptance to the network and is performed at your location.

If you would like to set up an appointment with our Provider Training Specialist to discuss any current or ongoing issues, or if you are a new provider in need of assistance, please call: **(414) 287-7423.**

MILWAUKEE COUNTY DEPARTMENT OF FAMILY CARE
MANAGED CARE ORGANIZATION

CLEAN CLAIM SUBMISSION PROCESS

1. All Family Care services must be performed by a Milwaukee County Department of Family Care contracted network provider.

2. All Family Care services must be pre-authorized by the member's care manager prior to performing services. **No payments will be made without prior authorization.**

3. All information on the service authorization must be accurate before performing services, especially:
   - **Dates of Service:** Provider must verify that the service authorization covers the date span of the expected service period.
   - **Units of Service:** Provider must verify that the number of units authorized is equal to the number of units expected during the service period.
   - **Service Code/HCPCS/Revenue Code:** Provider must verify that the service code authorized is the same as the expected service to be provided.

If the service you are going to provide does not correspond to the Family Care service authorization, you must contact the member's care manager immediately. Untimely requests will result in a denied claim and no reimbursement.

4. 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:
     - Member full name
     - Social Security Number (SSN) and/or Master Client Index (MCI) number
     - Date of birth

   - Service Authorization Information:
     - Authorization number (each claim form must contain ONLY ONE authorization number)
     - Date(s) of service (date range or individual days)
     - Service/HCPCS/Revenue code/Modifier (if applicable)
     - Number of units (number of days in service period or units of provided service)
     - Unit rate/Billed amount
     - Attached Medicare EOMB/Primary Insurer EOB (if applicable)

   - **Provider Information:**
     - Provider name
     - Provider address
     - Provider number (TIN/EIN/SSN)
     - National Provider Identifier (NPI)

5. Your clean claim must be received by WPS within **120 days** from the service start date or within **90 days** from the date of Primary Insurer EOB / Medicare EOMB.

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

Milwaukee County Family Care
C/O WPS Insurance Corporation
P.O. Box 7460
Madison, WI 53707-7460

7. If payment has not been received within 30 business days from the date submitted, please contact Family Care customer service at 1-800-223-6016.

FRAUD, WASTE, AND ABUSE REPORTING

All Providers shall immediately investigate, and contact the MCO in writing within two (2) business days of, any payment, claim, action, inaction, error, and/or omission by Provider's staff, contractors, and/or subcontractors which may constitute Medicare and/or Wisconsin Medicaid fraud, waste, and/or abuse. In accordance with applicable Law, Providers shall assist the MCO with any reporting, investigation, and/or actions necessary for both parties' continued compliance with Medicare and/or Wisconsin Medicaid regulations, including, but not limited to, providing the MCO, CMS and/or DHS with access to all records and personnel necessary to fully investigate the alleged or actual fraud, waste, and/or abuse. Providers understand and agree that in conjunction with the requirements of the Accountable Care Act, 42 C.F.R. § 455.2 and .23, the MCO may suspend claims payment pending investigation of a credible allegation of fraud.

CLAIM SUBMISSION OPTIONS

1. **Electronic Filing**

   - WPS accepts electronic claims in the HIPPA standard format
   - (ASC X 12 837 v5010) for both professional and institutional services
   - Claims may be submitted direct from a provider's office using vendor-developed or WPS-supplied software, or through an approved clearinghouse or billing service.

   To enroll with WPS for electronic claim submission or to discuss electronic submission options, contact our Electronic Data Services consultant at (608) 223-5858. To obtain access to our WPS plus patient eligibility/claim status application, contact WPS Electronic Data Services at (608) 223-5858.
   - Bill only **one** procedure code with the corresponding authorization per claim

2. **CMS-1500** ***(Please note the additional requirements below.)***

   - Authorization Number(s) in BOX 23
   - One authorization number per code
   - Bill with service code from the Service Authorization Form

3. **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 -04submitted to Medicare may be used, however an authorization code for each Family Care covered service must be entered in Box 63.

4. **Milwaukee County Department of Family Care billing form** ***(Please note the additional requirements below.)***

   - **One Member** per claim
   - **One authorization number** per claim
   - Dates of service (Date span or individual days)
   - Bill with service code from service Authorization Form

   (Refer to the Appendix for an example of a blank CMS 1500 claim form and a blank UB-4 form.)

5. **If you generate invoices and wish to continue using them, WPS will accept them in lieu of the standard claim form. However, the following information must be included on the invoice bill to avoid delay or denial of payments:**

   - Pre-Service Authorization Number
   - Member Name and Member Number

- Provider Name, Provider Address, and Provider Number (NPI, TIN, EIN, SSN)
- Date(s) of Service
- Bill with service code from service authorization form
- Charge/Billed Amount
- Number of Units/Days of service provided

EX Code Explanation Listing for MCDFC

WPS	ANSI	Reason
4F	**--**	THE CHARGE EXCEEDS THE AUTHORIZED CONTRACTED FEE FOR THIS SERVICE. The amount billed is greater than the allowable fee as determined by MCDFC.
18	**18**	WE'VE ALREADY PROCESSED THIS CHARGE. The charges received for processing have already been considered. The denial informs the provider of the duplicate billing.
22	**22**	CLAIM DENIED BECAUSE THIS CARE MAY BE COVERED BY ANOTHER PAYER PER COORDINATION OF BENEFITS. PLEASE SEND THE OTHER CARRIER'S NOTICE OF PAYMENT OR DENIAL TO WPS PO BOX 8190. IF WE ARE IN ERROR, PLEASE CALL THE WPS CUSTOMER SERVICE DEPARTMENT AT (800) 221-5313. 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 90 days from the date listed on the EOB.
23	**23**	CLAIM DENIED/REDUCED BECAUSE CHARGES HAVE BEEN PAID BY ANOTHER PAYER AS PART OF COORDINATION OF BENEFITS, WHICH MAY INCLUDE MEDICARE PAYMENTS. COORDINATION OF BENEFITS WITH YOUR PRIMARY PLAN OF COVERAGE MAY RESULT IN EITHER A REDUCED PAYMENT OR NO PAYMENT. The Patient’s primary carrier, whether it be Medicare or a private health care insurance, has made payment on the claim. The primary carrier allowed a greater fee amount than MCDFC’s fee schedule. This would result in MCDFC making a reduced payment or no payment at all.
25	**62**	THE DATE OF SERVICE IS EITHER BEFORE OR AFTER THE DATE RANGE AUTHORIZED BY FAMILY CARE. AUTHORIZATIONS ARE OBTAINED THROUGH THE CUSTOMER'S CMU CARE MANAGER. The dates of service billed are not within the AUTH number submitted. Check the dates to make sure they are correct. If the dates are not correct, resubmit a new claim within 90 days from the date of service or 90 days from the date of the EOB. If the dates are correct, contact the patient’s CMU to obtain a new authorization and resubmit claim with new authorization.
27	**27**	EXPENSE(S) INCURRED AFTER COVERAGE TERMINATED. SERVICES PROVIDED AFTER THE TERMINATION DATE, ARE NOT COVERED.

		If you feel services should be covered, please submit in writing to MCDFC an explanation and any documentation that supports your appeal in how the claim was processed.
28	**26**	EXPENSE(S) INCURRED PRIOR TO COVERAGE. SERVICES PROVIDED PRIOR TO THE EFFECTIVE DATE, ARE NOT COVERED. If you feel services should be covered, please submit in writing to MCDFC an explanation and any documentation that supports your appeal in how the claim was processed.
29	**29**	THE TIME LIMIT FOR FILING HAS EXPIRED. CHARGES MUST BE SUBMITTED ON A TIMELY BASIS IN ORDER TO BE CONSIDERED FOR PAYMENT. If you feel services should be covered, please submit in writing to MCDFC an explanation and any documentation that supports your appeal in how the claim was processed.
46	**96**	THIS SERVICE IS NOT COVERED. If you feel services should be covered, please submit in writing to MCDFC an explanation and any documentation that supports your appeal in how the claim was processed.
AG	**62**	THIS SERVICE/SUPPLY WAS SUBMITTED WITHOUT A PRIOR AUTHORIZATION NUMBER. PLEASE RE-SUBMIT THE SERVICE/SUPPLY WITH THE PRIOR AUTHORIZATION NUMBER AS ASSIGNED BY THE FAMILY CARE MANAGED CARE ORGANIZATION.
.		Re submit the claim with the correct AUTH number or contact CMU to obtain an authorization and resubmit claim with new authorization. All must be within the time limit.
B6	**171**	THIS SERVICE/PROCEDURE IS DENIED/REDUCED WHEN PERFORMED/BILLED BY THIS TYPE OF PROVIDER, BY THIS TYPE OF PROVIDER IN THIS TYPE OF FACILITY, OR BY A PROVIDER IN THIS SPECIALITY. THIS POLICY DOESN'T COVER SERVICES BY THIS PROVIDER. If you feel services should be covered, please submit in writing to MCDFC an explanation and any documentation that supports your appeal in how the claim was processed.
B7	**B7**	THIS PROVIDER WAS NOT CERTIFIED FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE; OR THIS PROVIDER WAS NOT AUTHORIZED TO PERFORM THIS SERVICE.

		If you feel services should be covered, please submit in writing to MCDFC an explanation and any documentation that supports your appeal in how the claim was processed.
BU	**97**	DURING THE PROCESSING OF THIS CLAIM, THIS LINE WAS BUNDLED INTO ANOTHER LINE FOR PROCESSING. If you feel services should be covered, please submit in writing to MCDFC an explanation and any documentation that supports your appeal in how the claim was processed.
CE	**CE**	THE EXPLANATION OF BENEFITS RECEIVED FROM THE PRIMARY INSURER DOES NOT REFLECT THE ORIGINAL PAID OR DENIED CHARGES. PLEASE SUBMIT A COPY OF THE ORIGINAL EXPLANATION. The EOB/EOMB with claim submitted has either different dates of service or different billed amounts. The provider needs to resubmit the claim with the correct EOB/EOMB.
CX	**OA**	THE PROCEDURE CODE, DIAGNOSIS CODE, AND/OR REVENUE CODE IS NOT VALID. PLEASE RESUBMIT WITH A VALID CODE. Resubmit claim with valid procedure code, diagnosis code, and/or revenue code.
DU	**18**	THIS CLAIM IS A DUPLICATE TO A PREVIOUSLY RECEIVED CLAIM THAT IS CURRENTLY BEING REVIEWED FOR PROCESSING. The charges received for processing are being considered. The denial informs the provider of the duplicate billing.
EM	**22**	WE NEED THE MEDICARE EXPLANATION OF BENEFITS TO PROCESS THIS CHARGE. Resubmit claim with the corresponding explanation of benefits for the services being billed.
I3	**125**	THESE CHARGES ARE NOT COVERED AS THEY WERE BILLED IN ERROR BY THE PROVIDER OF SERVICE. If you feel services should be covered, please submit in writing to MCDFC an explanation and any documentation that supports your appeal in how the claim was processed.
NM	**15**	THE AUTHORIZATION NUMBER IS INVALID WITH THE SERVICE/SUPPLY BILLED. PLEASE RE-BILL USING THE CORRECT FAMILY CARE AUTHORIZATION NUMBER WITHIN 90 DAYS FROM THE DATE OF SERVICE OR 90 DAYS FROM MEDICARE'S OR THE PRIMARY CARRIER'S DETERMINATION. CONTACT THE CUSTOMER'S CMU CARE MANAGER WITH QUESTIONS.

		Re-bill using the correct AUTH code that was authorized by MCDFC with in timely filing.
NO	**119**	THE CLAIM EXCEEDED THE NUMBER OF AUTHORIZED UNITS FOR THIS SERVICE. Contact CMU to obtain an authorization and resubmit claim with new authorization.
NP	**B18**	THE PROCEDURE CODE IS MISSING OR DOES NOT MATCH THOSE AUTHORIZED BY FAMILY CARE. PLEASE RE-BILL WITH THE CORRECT CODE WITHIN 90 DAYS FROM THE DATE OF SERVICE OR 90 DAYS FROM MEDICARE'S OR THE PRIMARY CARRIER'S DETERMINATION. CONTACT THE CUSTOMER'S CMU CARE MANAGER WITH QUESTIONS. Re-bill using the correct procedure code that was authorized by MCDFC with in timely filing.
S8	**16**	THE NPI NUMBER PROVIDED FROM THE CLAIM IS NOT VALID. PLEASE RESUBMIT THE CLAIM WITH THE CORRECT NPI NUMBER WITHIN THE TIMELY FILING LIMIT FROM THE DATE OF SERVICE OR FROM THE DATE OF MEDICARE'S OR THE PRIMARY CARRIER'S DETERMINATION. Re-billing using the correct NPI Number.
SG	**----**	THE NPI NUMBER IS MISSING FROM THE CLAIM. PLEASE RESUBMIT CLAIM WITH THE NPI NUMBER WITHIN 120 DAYS FROM THE DATE OF SERVICE, OR 120 DAYS FROM MEDICARE'S OR THE PRIMARY CARRIER'S DETERMINATION. Re-bill including the provider’s NPI number within timely filing.
SU	**97**	IN ORDER TO PROCESS BENEFITS CORRECTLY, THIS LINE WAS SPLIT FOR PROCESSING. No action needed, informational only.
WS	**125**	THESE CHARGES WERE SUBMITTED UNDER AN INCORRECT CUSTOMER NUMBER. WE WILL PROCESS THESE CHARGES UNDER THE VALID NUMBER. TO AVOID DELAYS IN THE FUTURE, PLEASE USE THE CORRECT NUMBER AND VERIFY THAT THE PROVIDER HAS THE CORRECT NUMBER. No action needed, informational only.

PROVIDER APPEAL PROCESS

(Printed on the back of every EOB)

A provider has the right to appeal a "Clean Claim" denial or partial claims payment to Milwaukee County Family Care c/o WPS Insurance Corp.

To determine if the formal Appeal Process is required for your claim denial or partial claims payment, contact WPS Customer Service at (800) 223-6016. Representatives are available between 8:00 a.m. and 4:30 p.m. (CST) Monday through Friday.

A Customer Service Representative will review and advise you on the necessary steps to take in order to resolve your case. Sometimes all that is necessary is a telephone call to WPS Insurance Corporation.

1. Written Appeal to the MCO

If you wish to file an appeal you must submit a separate letter or form that is clearly marked "**Appeal**" and include the following:

- **a. Provider's Name and ID Number**
- **b. Member Name and Social Security Number**
- **c. Date of Service, Procedure Code, Units billed, and Dollar Amount Billed**
- **d. Copy of the Family Care Service Authorization**
- **e. Copy of WPS Explanation of Benefit (EOB) Rejection,**
- **f. Copy of Explanation of Medicare Benefit (EOMB) or Other Insurance EOB**
- **g. Reason(s) your claim merits reconsideration**

Your appeal must be submitted within **60** calendar days of **the initial** denial or partial payment to:

Milwaukee County-MCO c/o WPS Insurance Corp.
PO Box 7460
Madison, WI 53707-7460
Phone: 800-223-6016

2. Written Appeal to Department of Health Services

A provider has the right to appeal to the Department of Health Services (DHS) if the MCO fails to respond to the appeal within 45 calendar days, or if the provider is not satisfied with the MCO's response to the request for reconsideration.

a. All appeals to DHS must be submitted in writing within **60** calendar days from the **MCO's Final Decision** as follows:

Provider Appeals Investigator
Division of Long-Term Care
1 West Wilson Street, Room 518
PO Box 7851
Madison, WI 53707-7851

b. DHS will accept written comments from all parties to the dispute prior to making the decision.

c. DHS has 45 calendar days from the date of receipt of all written comments to respond to these appeals.

d. The Milwaukee County-MCO shall pay the provider within 45 calendar days of receipt of a DHS final determination found in favor of the provider.

PROVIDER CONCERNS/COMPLAINTS

Provider Complaints

Providers should direct their concerns, complaints, and questions to the Contract Services Coordinator assigned to work with them. See Appendix 1 for the service areas managed by each Contract Services Coordinator.

MEMBERS' RIGHT TO FILE A COMPLAINT

If a Provider becomes aware of concerns or dissatisfaction expressed by a Member, or on behalf of a Member, related to the Member's care or needs, then the Provider should inform the Member's Care Manager of the concerns. The Care Manager's name, phone number, and email address is printed on every Provider Service Authorization. Care Managers are available Monday through Friday from 8:00am to 4:30pm.

We are committed to providing quality service to our Members. Our goal is to improve the care and services our Members receive. If a Member is unhappy with their care or services they can call their Team or our Member Liaison. Members also have the right to file a grievance or appeal a decision made by the Milwaukee County Department of Family Care and to receive a prompt and fair review.

The Member Liaison can tell the Member about their rights, attempt to informally resolve their concerns, and help them file a grievance or appeal. The Member Liaison can work with the Member throughout the entire grievance and appeal process to try to find a workable solution.

If the Member is unable to resolve their concerns by working directly with the Team or our Member Liaison, Family Care provides several ways to address concerns. The methods are:

- File a **grievance** or **appeal** with the Milwaukee County Department of Family Care.
- Ask for a **review** by the **Wisconsin Department of Health Services** (DHS).
- Ask for a **State Fair Hearing** with the Wisconsin Division of Hearings and Appeals (DHA).

Any or all of these methods can be used together or at different times. **Each method has different rules, procedures and deadlines**.

If you or the Member has a particular type of concern that you do not know how to resolve, you can ask the Team or the Milwaukee County Department of Family Care's Member Liaison.

GRIEVANCES

A grievance is when a Member is not satisfied with the Milwaukee County Department of Family Care, one of our providers, or has a concern about the quality of their care or services.

There is no deadline to file a grievance – Grievances can be filed at any time.

If a Member wants to file a grievance, they have two options. They can:

1.) Start by filing a grievance with the Milwaukee County Department of Family Care.
   ➔ See Option 1, listed below.

2.) Start by asking for a review by the Wisconsin Department of Health Services (DHS).
   ➔ See Option 2 listed below.

GRIEVANCE OPTION 1: File A Grievance With The Milwaukee County Department Of Family Care

Members can file a grievance with the Milwaukee County Department of Family Care by calling or writing to us at:

The Milwaukee County Department of Family Care
Quality Improvement Coordinators
901 N. 9th Street, Courthouse Room 307C
Phone: (414) 287-7616 or (414) 287-7623
Toll-free: 1- (877) 489 – 3814
TTY: (414) 287-7601

GRIEVANCE OPTION 2: Ask For A DHS Review

Members can also ask the State of Wisconsin Department of Health Services (DHS) to review the grievance instead of or before filing a grievance with the Milwaukee County Department of Family Care. DHS is the agency that is in charge of the Family Care Program. The purpose of a DHS review is to see if they can work out an informal solution. Members can ask for a DHS review by calling or writing to DHS at:

DHS Family Care Grievances
Toll-free: 1 (888) 203-8338
E-mail: dhsfamcare@wisconsin.gov

APPEALS

An appeal is a review of a decision made by the Milwaukee County Department of Family Care. For example, a Member can file an appeal if their Team denies a service or support they requested. **The Member must file their appeal no later than 45 days after they receive the Notice of Action**.

If a Member wants to file an appeal, they have three options. They can:

- ➔ File an appeal with the Milwaukee County Department of Family Care. See Appeals Option 1.
- ➔ Ask the Wisconsin Department of Health Services (DHS) to review our decision. See Appeals Option 2.
- ➔ File an appeal with the State Division of Hearings and Appeals (DHA). See Appeals Option 3.

Members can use any or all of these methods together or at different times. However, **each way has different rules, procedures and deadlines**.

An appeal with the State Division of Hearings and Appeals is the final level of appeal. If the Member chooses that appeal first and doesn't like the decision, they can't go back and file the same appeal with the Milwaukee County Department of Family Care or DHS.

APPEAL OPTION 1: Filing An Appeal With The Milwaukee County Department Of Family Care

To file an appeal with the Milwaukee County Department of Family Care Members can:

- **Call** the Milwaukee County Department of Family Care.
- **Send in a request form available online at:** http://www.dhs.wisconsin.gov/LTCare/Memberinfo/MCOrequest.htm.
- **Mail a request in a letter**.
- **Write down your request on a piece of paper**.

To file an appeal with the Milwaukee County Department of Family Care**, call:**

The Milwaukee County Department of Family Care
Quality Improvement Coordinators
Phone: (414) 287-7616 or (414) 287-7623
Toll-free: 1- (877) 489 – 3814
TTY: (414) 287-7601

Or, mail a completed request form, letter, or written note to:

The Milwaukee County Department of Family Care
Quality Improvement Coordinators
901 N. 9th Street, Courthouse Room 307C
Fax: (414) 287-7705
Email: familycare@milwaukeecounty.com

APPEAL OPTION 2: Ask The Department Of Health Services (DHS) To Review The Milwaukee County Department Of Family Care's Decision

The Wisconsin Department of Health Services (DHS) is the agency that is in charge of the Family Care Program. DHS works with an outside organization to review decisions made by the Milwaukee County Department of Family Care. Staff from this external review organization will try to resolve the concerns informally.

The external review organization won't issue a decision. Instead, they will review the concerns and try to come up with an informal solution that is acceptable to you and the Milwaukee County Department of Family Care.

A DHS review will not typically result in DHS ordering the Milwaukee County Department of Family Care to do what the Member wants. Nor will DHS order the Member to accept what the Milwaukee County Department of Family Care is planning to do. However, if the review organization tells DHS that we didn't follow certain requirements, DHS may order the Milwaukee County Department of Family Care to take steps to correct the problem.

Members may request a DHS review by calling or e-mailing:

DHS Family Care Appeals
Toll-free: 1 (888) 203-8338
E-mail: dhsfamcare@wisconsin.gov

Members must ask for a DHS review within 45 days after you receive a Notice of Action from the Milwaukee County Department of Family Care.

APPEAL OPTION 3: File An Appeal With The Wisconsin Division Of Hearings And Appeals (DHA)

If a Member files an appeal with the Wisconsin Division of Hearings and Appeals (DHA), they will have a State Fair Hearing with an independent judge. Judges at DHA do not have any connection to the Milwaukee County Department of Family Care. You can find more information about State Fair Hearings online at http://dha.state.wi.us/home/HrgInfo.htm.

An appeal with DHA is the final level of appeal. If the Member goes to DHA first and doesn't agree with the decision, they can't go back and file an appeal with the Milwaukee County Department of Family Care or ask for a Department of Health Services review about the same issue. However, if the Member requests a State Fair Hearing, the Department of Health Services will automatically review the appeal.

To ask for a State Fair Hearing, a Member can either:

- **Send a request form**. A copy of the form can be found online at: http://dhs.wisconsin.gov/forms/f0/f00236.doc.

- **Mail a letter** and **explain** what is being appealed.

To request a State Fair Hearing

Send the completed request form or a letter asking for a hearing to:

Family Care Request for Fair Hearing
c/o Wisconsin Division of Hearings and Appeals
5005 University Ave., #201
P.O. Box 7875
Madison, WI 53707-7875
(Or fax your request to (608) 264-9885)

An appeal must be filed within 45 days after the Member receives a Notice of Action.

If the Member disagrees with the Administrative Law Judge's decision, they have two options.

1.) Ask for a re-hearing. If the Member wants DHA to reconsider its decision, they must ask within 20 days from the date of the Judge's decision. The Administrative Law Judge will only grant a re-hearing if:
   - The Member can show that a serious mistake in the facts or the law happened, or
   - The Member has new evidence that they were unable to obtain and present at the first hearing.

2.) Take their case to circuit court. If the Member wants to take their case to court, they must file their petition within 30 days from the date of the Judge's decision.

For assistance with the grievance and appeals process contact the Milwaukee County Department of Family Care's **Member Liaison, at**:

The Milwaukee County Department of Family Care
Member Liaison
901 N. 9th Street, Courthouse Room 307C
Phone: (414) 287-7621
Toll-free: 1- (877) 489 - 3814
TTY: (414) 287-7601

Ombudsman Programs
Regional Ombudsmen programs are available to help all Family Care Members with grievances and appeals. They can respond to your concerns in a timely fashion. Both Ombudsmen programs will typically use informal negotiations to resolve your issues without a hearing.

Wisconsin Board on Aging and Long Term Care
Ombudsmen from this agency provide advocacy to Family Care Members age 60 and older.

Board on Aging and Long Term Care
1402 Pankratz Street, Suite 111
Madison, WI 53704-4001
Toll-free: 1-800-815-0015
Fax: (608) 246-7001
http://longtermcare.state.wi.us

Disability Rights Wisconsin (DRW)
Ombudsmen from this agency provide advocacy to Family Care Members under age 60.

Disability Rights Wisconsin
131 W. Wilson St., Suite 700
Madison, WI 53703
608-267-0214
TTY: 1 (888) 758-6049
Fax: (608) 267-0368

Madison Toll-free: 1 (800) 928-8778
Milwaukee Toll-free: 1 (800) 708-3034
Rice Lake Toll-free: 1 (877) 338-3724
http://www.disabilityrightswi.org

SPEEDING UP AN APPEAL

The Milwaukee County Department of Family Care has 20 business days to make a decision on an appeal. If waiting that long could seriously harm the Member's health or ability to perform daily activities, the Member can ask us to speed up the appeal. We call this an "expedited appeal." We will let the Member know as soon as possible if we can expedite their appeal. In an expedited appeal, the Member will get a decision on the appeal within 72 hours of their request. However, the Milwaukee County Department of Family Care may extend this to a total of 14 days if additional information is necessary and if the delay is in the Member's best interest.

To request an expedited appeal, contact:

The Milwaukee County Department of Family Care
Quality Improvement Coordinators
Phone: (414) 287-7616 or (414) 287-7623
Toll-free: 1- (877) 489 – 3814
TTY: (414) 287-7601
Email: familycare@milwaukeecounty.com

CONTINUING SERVICES DURING AN APPEAL

If the Milwaukee County Department of Family Care decides to stop or reduce a service that a Member is currently receiving, the Member has the right to ask the Milwaukee County Department of Family Care, DHS, or DHA to continue their services during the appeal. Once services stop, they cannot be continued.

If a Member wants their services to continue, they must:

- Postmark or fax their appeal ***on or before*** the date the Milwaukee County Department of Family Care plans to stop or reduce the services; **AND**
- Ask that the services continue throughout the course of the appeal.

If services are continued during an appeal with the Milwaukee County Department of Family Care and the Member loses the appeal, the Member can continue their services at the next level of appeal if they, once again, request that the services be continued.

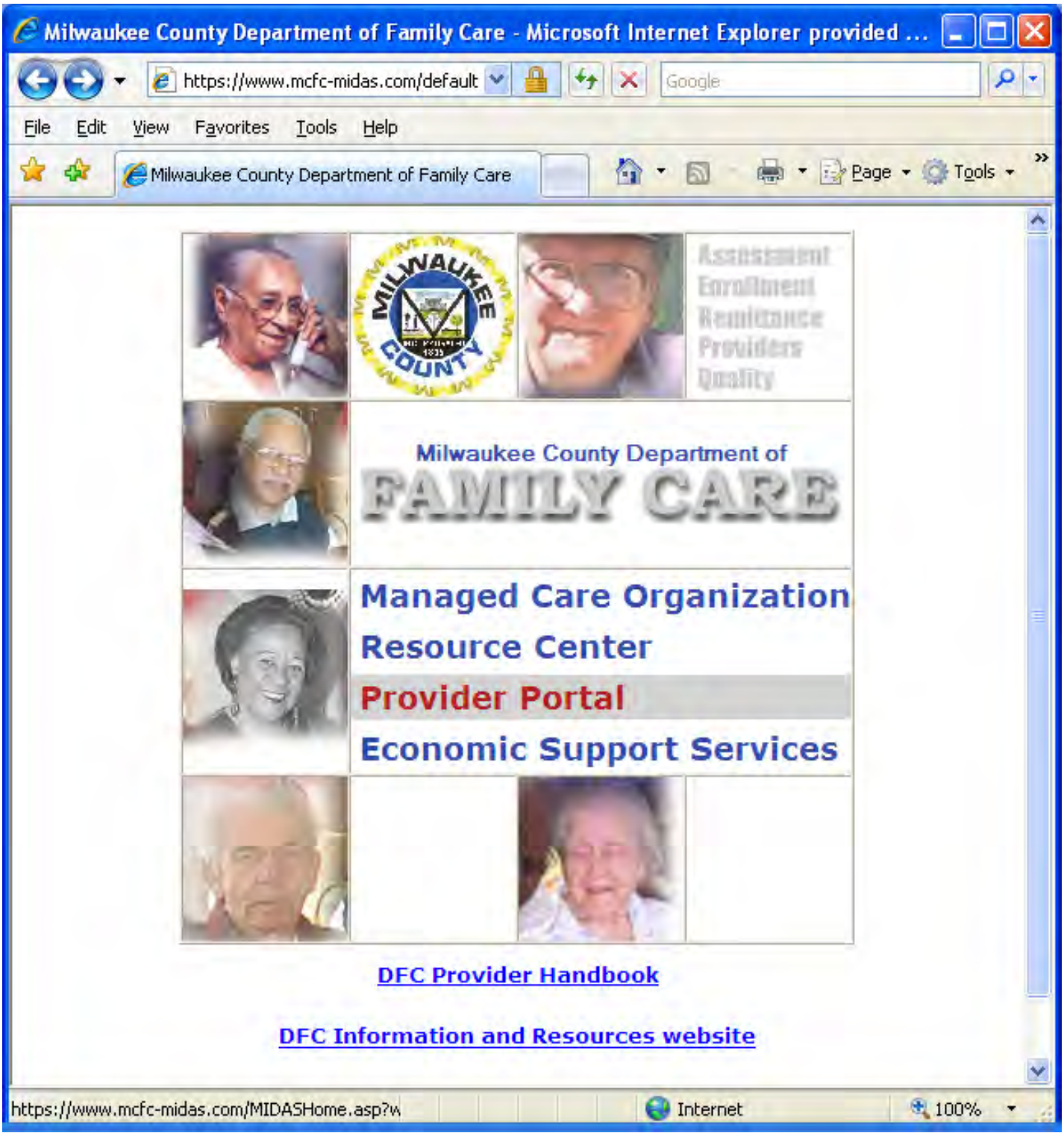
The final decision of the appeal may not be in the Member's favor. If that happens, **the Member might have to pay the Milwaukee County Department of Family Care back for the service they got during the appeal process**. If they can show that this would be a substantial financial burden, they may not have to pay us back.

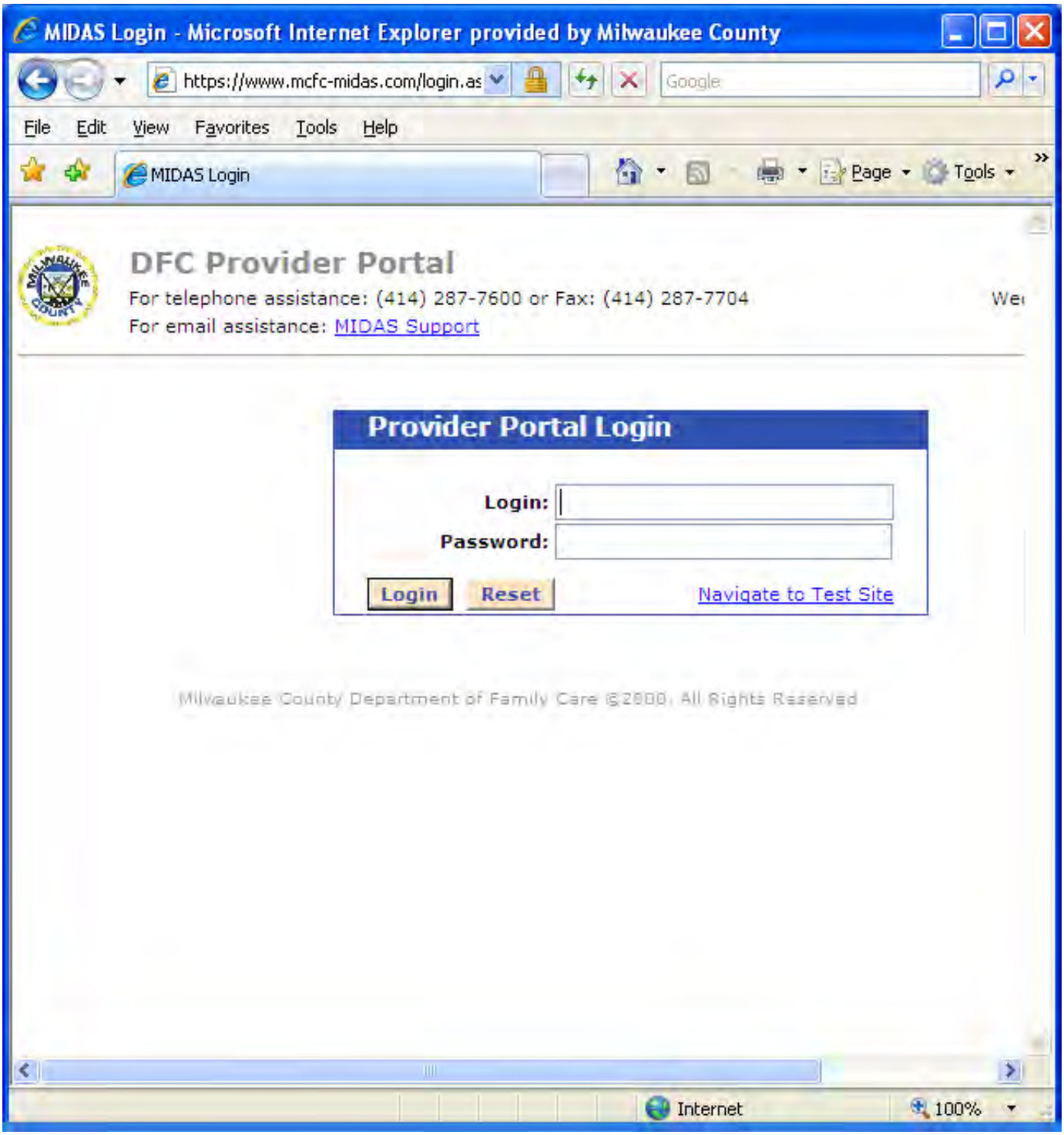
Appendix

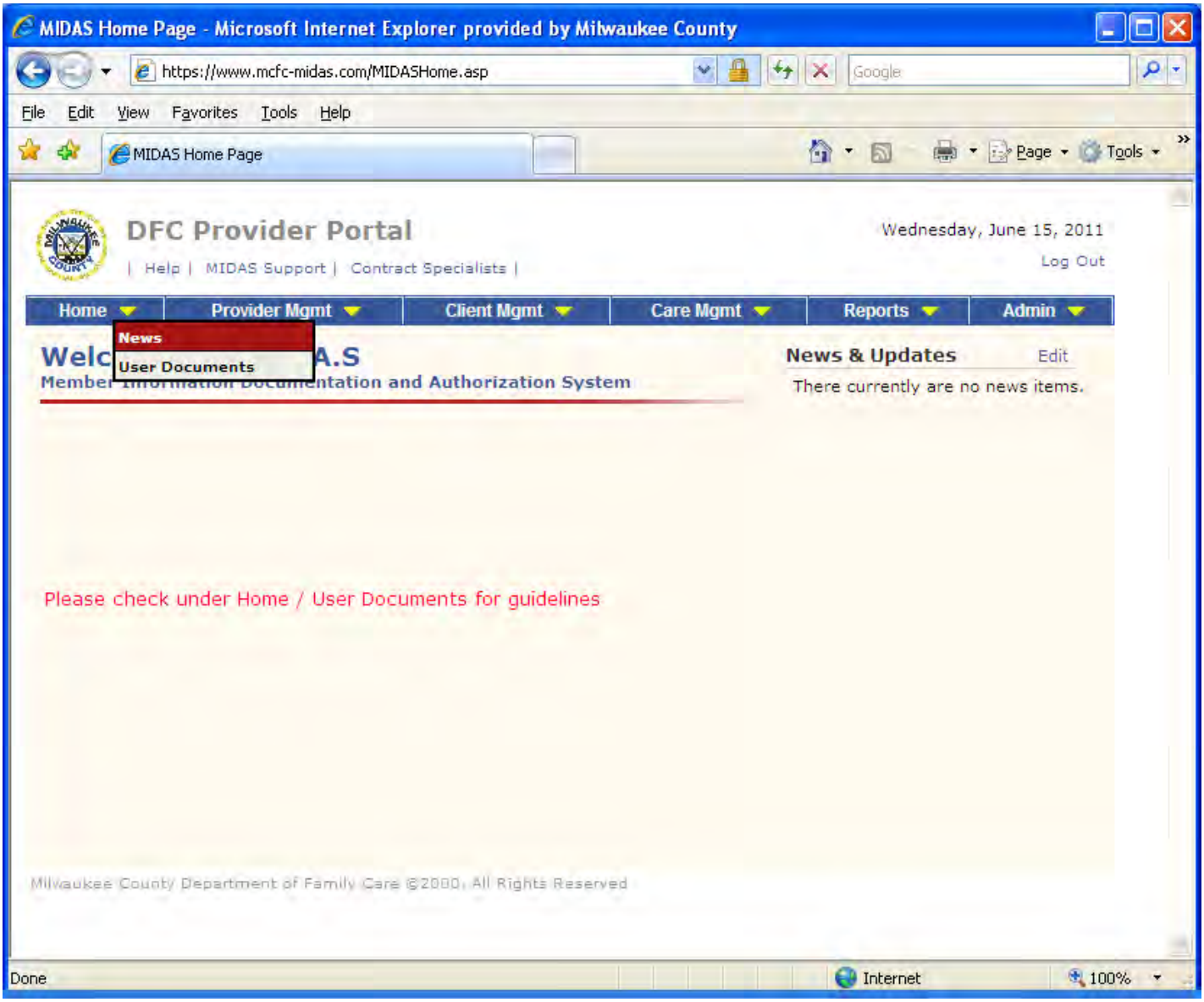
Department of Family Care
Milwaukee County

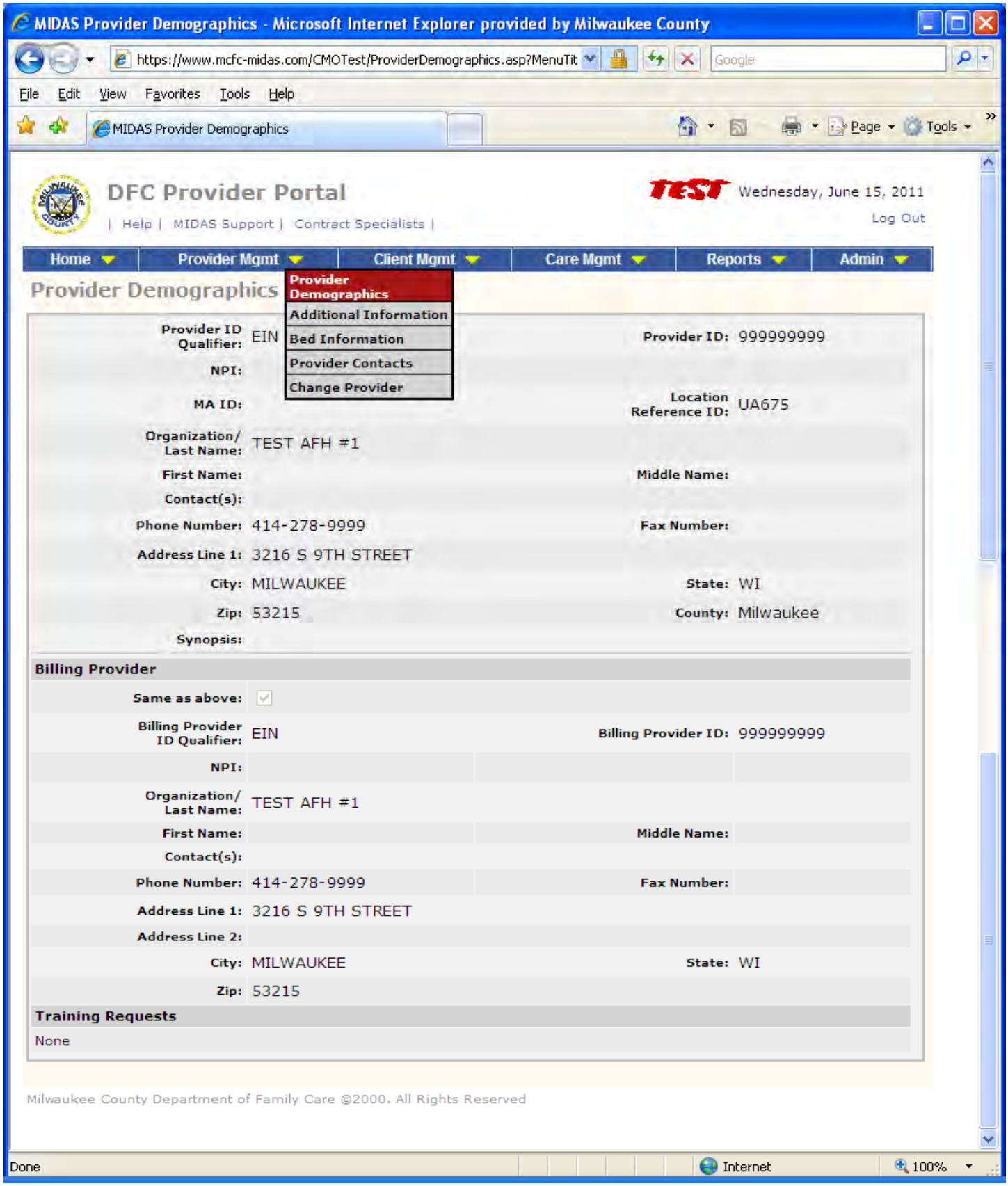
Contract Administration Staff Assignments

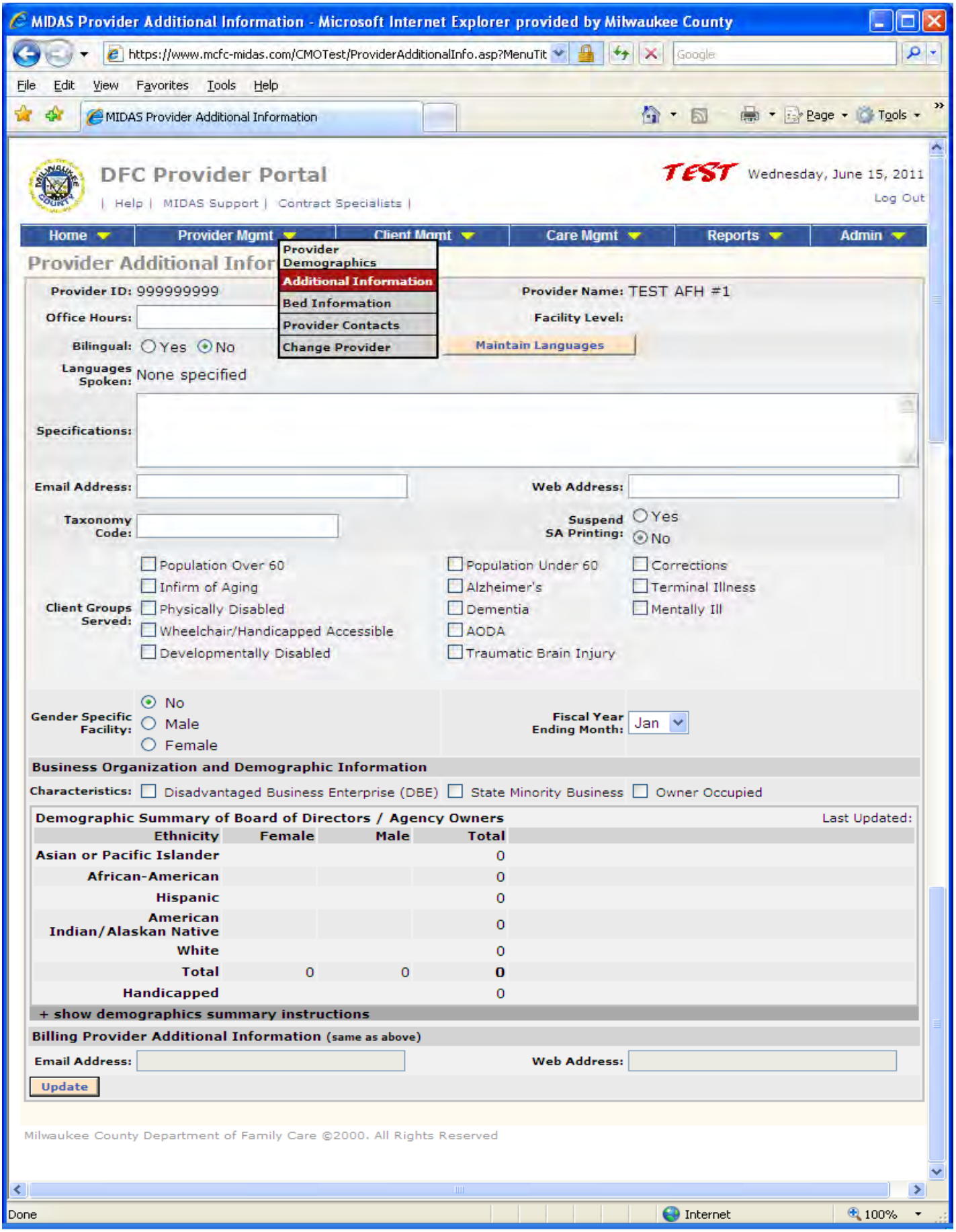
Staff Member	Service Type	Email Address	Telephone Number
Diane Baumbach	5 to 8 bed Community-Based Residential Facility (CBRF) 3 & 4 bed Adult Family Home (AFH)	Diane.Baumbach@milwaukeecounty.com	(414) 287-7652
Kelly Burt	Care Management Units (CMU) Home delivered meals SHC/PC Chore and miscellaneous services Personal emergency response system Transportation	Kelly.Burt@milwcnty.com	(414) 287-7653
Jefferlyn Harper-Harris	Quality Surveyor/Improvement	Jefferlyn.Harper-Harris@milwcnty.com	(414) 287-7654
Sharon Murphy	Home Health Day Care/Day Services DME/DMS Therapies - PT/OT/Speech Daily Living Skills (DLS) Supported Independent Living (SIL) Self Directed Supports (SDS) Fiscal Agent (FA) Medicare consultant Independent Living Arrangements (ILA) Employment Services	Sharon.Murphy@milwaukeecounty.com	(414) 287-7655
Sara Topczewski	9+ beds Community-Based Residential Facility (CBRF) 1 & 2 bed Adult Family Home (AFH) Residential Care Apartment Complex (RCAC)	Sara.Topczewski@milwcnty.com	(414) 287-7657
Sheri Wojtowicz	Adult Family Home Certifications Financial Services Nursing Home Alcohol and Other Drug Abuse (AODA) Mental Health (MH)	sheri.wojtowicz@milwcnty.com	(414) 287-7656


Milwaukee County Department of Family Care - Microsoft Internet Explorer provided ...
https://www.mcfc-midas.com/default
Google
File Edit View Favorites Tools Help
Milwaukee County Department of Family Care
Page Tools
Assessment
Enrollment
Remittance
Providers
Quality
Milwaukee County Department of
FAMILY CARE
Managed Care Organization
Resource Center
Provider Portal
Economic Support Services
DFC Provider Handbook
DFC Information and Resources website
https://www.mcfc-midas.com/MIDASHome.asp?w
Internet
100%


MIDAS Login - Microsoft Internet Explorer provided by Milwaukee County
https://www.mcfc-midas.com/login.as
Google
File Edit View Favorites Tools Help
MIDAS Login
Page Tools
DFC Provider Portal
For telephone assistance: (414) 287-7600 or Fax: (414) 287-7704
For email assistance: MIDAS Support
Provider Portal Login
Login:
Password:
Login
Reset
Navigate to Test Site
Milwaukee County Department of Family Care ©2008. All Rights Reserved
Internet
100%


MIDAS Home Page - Microsoft Internet Explorer provided by Milwaukee County
https://www.mcfc-midas.com/MIDASHome.asp
Google
File Edit View Favorites Tools Help
MIDAS Home Page
Page Tools
DFC Provider Portal
Wednesday, June 15, 2011
| Help | MIDAS Support | Contract Specialists |
Log Out
Home
Provider Mgmt
Client Mgmt
Care Mgmt
Reports
Admin
News
User Documents
Welc A.S
Member Information Documentation and Authorization System
News & Updates
Edit
There currently are no news items.
Please check under Home / User Documents for guidelines
Milwaukee County Department of Family Care ©2000. All Rights Reserved
Done
Internet
100%


MIDAS Provider Demographics - Microsoft Internet Explorer provided by Milwaukee County
https://www.mcfc-midas.com/CMOTest/ProviderDemographics.asp?MenuTit
File Edit View Favorites Tools Help
MIDAS Provider Demographics
DFC Provider Portal
Help | MIDAS Support | Contract Specialists |
TEST
Wednesday, June 15, 2011
Log Out
Home
Provider Mgmt
Client Mgmt
Care Mgmt
Reports
Admin
Provider Demographics
Additional Information
Bed Information
Provider Contacts
Change Provider
Provider Demographics
Provider ID Qualifier: EIN
Provider ID: 999999999
NPI:
MA ID:
Location Reference ID: UA675
Organization/ Last Name: TEST AFH #1
First Name:
Middle Name:
Contact(s):
Phone Number: 414-278-9999
Fax Number:
Address Line 1: 3216 S 9TH STREET
City: MILWAUKEE
State: WI
Zip: 53215
County: Milwaukee
Synopsis:
Billing Provider
Same as above:
Billing Provider ID Qualifier: EIN
Billing Provider ID: 999999999
NPI:
Organization/ Last Name: TEST AFH #1
First Name:
Middle Name:
Contact(s):
Phone Number: 414-278-9999
Fax Number:
Address Line 1: 3216 S 9TH STREET
Address Line 2:
City: MILWAUKEE
State: WI
Zip: 53215
Training Requests
None
Milwaukee County Department of Family Care ©2000. All Rights Reserved
Done
Internet
100%


MIDAS Provider Additional Information - Microsoft Internet Explorer provided by Milwaukee County
https://www.mcfc-midas.com/CMOTest/ProviderAdditionalInfo.asp?MenuTit
File Edit View Favorites Tools Help
MIDAS Provider Additional Information
DFC Provider Portal
TEST
Wednesday, June 15, 2011
Log Out
Help | MIDAS Support | Contract Specialists |
Home
Provider Mgmt
Client Mgmt
Care Mgmt
Reports
Admin
Provider Demographics
Additional Information
Bed Information
Provider Contacts
Change Provider
Provider Additional Infor
Provider ID: 999999999
Provider Name: TEST AFH #1
Office Hours:
Facility Level:
Bilingual: Yes No
Maintain Languages
Languages Spoken: None specified
Specifications:
Email Address:
Web Address:
Taxonomy Code:
Suspend SA Printing: Yes No
Client Groups Served:
Population Over 60
Population Under 60
Corrections
Infirm of Aging
Alzheimer's
Terminal Illness
Physically Disabled
Dementia
Mentally Ill
Wheelchair/Handicapped Accessible
AODA
Developmentally Disabled
Traumatic Brain Injury
Gender Specific Facility: No Male Female
Fiscal Year Ending Month: Jan
Business Organization and Demographic Information
Characteristics: Disadvantaged Business Enterprise (DBE) State Minority Business Owner Occupied
Demographic Summary of Board of Directors / Agency Owners
Last Updated:
Ethnicity Female Male Total
Asian or Pacific Islander 0
African-American 0
Hispanic 0
American Indian/Alaskan Native 0
White 0
Total 0 0 0
Handicapped 0
+ show demographics summary instructions
Billing Provider Additional Information (same as above)
Email Address:
Web Address:
Update
Milwaukee County Department of Family Care ©2000. All Rights Reserved
Done
Internet
100%

EXAMPLE

SERVICE AUTHORIZATION

Authorization Number: 9999999

Provider ID: 123456789
Phone: 414-444-4444
Fax: 414-999-9999

Payee Tax ID:
Phone: 414-444-4444
Fax: 414-333-3333

Provider Name and Address:
YOUR COMPANY NAME HERE
123 E. UPTOWN AVENUE
MILWAUKEE, WI 53203

Checks will be made payable to:
YOUR COMPANY NAME HERE
P. O. BOX 123456
MILWAUKEE, WI 53221

Patient Name: DOE, JANE
Patient ID: 123456789
Date of Birth: 12/12/1932
Service Type: DME - Durable Medical Equipment
Service Code: K0004 - WHEELCHAIR HIGH STRENGTH, LHTWEIGHT (Rent)
Modifier Codes: N/A
Location: Home
Requested From: 01/01/2011 Through: 12/31/2011
Services Requested: 1 (1 day units)
Frequency: Daily
Total Services Authorized: *Claims will be paid at T-19 or contracted rates*
Status: Approved by Care Manager
CMU: Aurora
Care Manager: Last Name, First Name
Phone Number: 444-4444 Fax: 333-3333
Email: caremanater@aurora.org

Please submit PAPER CLAIMS to: Milwaukee County Department of Family Care
C/O WPS Insurance Corporation
PO BOx 7460
Madison, WI 53707 -7460

Claims Customer Service: 1 800 223 6016

In order to maintain a proper balance between services authorized and services provided and paid, the CMO requires that clean claims be submitted for payment NO LATER THAN 120 DAYS AFTER SERVICES HAVE BEEN PROVIDED. The CMO will DENY clean claims (bills for service) that are received more than 90 days after service delivery. Clean claims DO NOT include claims where there is no insurance as primary (i.e. Medicare or private insurance) where the provider needs to wait to get a response from the primary insurer before sending the claim to the TPA for processing and payment.

While authorization is a requirement to obtain services, it does not guarantee payment of services. Benefits are available only if the services are covered under the member's contract, and if the member is eligible at the time services are provided. Should you have any questions regarding this service authorization, please contact the care manager listed above or Sheri Wojtowicz at (414) 287-7422, (by email at swojtowicz@milwaukeecounty.com). Please contact the care manager listed above or the following MCDFC staff.

Providers with names starting with A-J contact Sheri Wojtowicz at 414-287-7422 or swojtowicz@milwaukeecounty.com

Providers with names starting with K-Z contact Richard Rolbiecki at 414-287-7424 or rrolbiecki@milwaukeecounty.com

---

Please include the Authorization Number listed at the top right on your claim forms for services provided to this member for services listed above.

Printed: 02/18/2011

MILWAUKEE COUNTY DEPARTMENT OF FAMILY CARE

MEMBER INFORMATION		**PROVIDER INFORMATION**	
1. **Member Identification #:**		4. **Provider NPI #:**	
2. **Member Name:**		5. **Provider Telephone or Fax #:**	
3. **Member Date of Birth:**		6. **Patient Account (invoice) #:**	
PROVIDER SERVICING ADDERSS *(SERVICING PROVIDER BUSINESS ADDRESS)*		**PROVIDER BILLING ADDRESS** *(PHYSICIAN'S OR SUPPLIER'S BILLING ADDRESS)*	
7. **Provider TAX/EIN/SSN:**		11. **Rendering Provider Name:**	
8. **Business Name:**		12. **Billing Provider Name:**	
9. **Business Address:**		13. **Billing Address:**	
10. **City/State/Zip Code:**		14. **City/State/Zip Code:**	

15. **Date of Service (MM/DD/YY)** (*Date Span or Individual Days*)		16. **Service Code**	17. **Mod 1**	18. **Mod 2**	19. **Authorization Number**	20. **Units Billed**	21. **($) Unit Cost**	22. **($) Total Units Cost**
From Date	**To Date**							

I certify that all services indicated above have been provided. (Claims for services must reflect actual services provided.)

23. **($) Total Charges:**

24. **Authorized Signature:**_____ **Print Name:**_____ **Date:**_____

Claim Reminders:
*One Member Per Claim Form
*One Authorization Number per Claim Line
*Use same Service Code that is listed on the Milwaukee County of Family Care Service Authorization form.

Claim Status Questions:
WPS Call Center: (800) 223-6016

Please Mail this Claim Form to:
Milwaukee County Family Care
c/o WPS Insurance Corporation
PO BOX 7460
Madison, WI 53707-7460

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH
			7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28	29 ACDT STATE	30

	31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37
a							a
b							b

38		39 VALUE CODES CODE AMOUNT	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE AMOUNT
	a			
	b			
	c			
	d			

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		***PAGE ____ OF ____***	***CREATION DATE***		***TOTALS***				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI		
A							57		A
B							OTHER		B
C							PRV ID		C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE	

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

76 ATTENDING	NPI		QUAL	
LAST		FIRST		
77 OPERATING	NPI		QUAL	
LAST		FIRST		
78 OTHER	NPI		QUAL	
LAST		FIRST		
79 OTHER	NPI		QUAL	
LAST		FIRST		

UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARTY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
   (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
   (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
   (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
   (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
   (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
   (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
   (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
   (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

SEE http://www.nubc.org/ FOR MORE INFORMATION ON UB-04 DATA ELEMENT AND PRINTING SPECIFICATIONS

Reset Form | Print Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Medicaid #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

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

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

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

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

b. AUTO ACCIDENT? YES | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

PATIENT AND INSURED INFORMATION

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

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

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17 b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

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

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. Place of Service	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

NUCC Instruction Manual available at: www.nucc.org

OMB No. 1215-0055
Expires: 11/30/2012