

Southeast Wisconsin Medicaid Managed Care Organizations RFP 1684 DHCAA-SM

Appendix C

BadgerCare Plus HMO Certification Packet and Encounter Data Certification Requirements

As a condition of the State issuing contracts as a result of this RFP process, HMOs must meet all of the State's HMO certification and encounter data certification requirements. Selected contractors will have approximately two months to complete these requirements after the notifications of intent to award are issued by the State. The State will provide to selected contractors the final requirements and the timeline for completing them upon award of the contracts.

NOTE: Completion of these requirements is not required as part of the RFP response. The requirements are provided for informational purposes only. Those HMOs which are awarded contracts will be required to complete these requirements to the satisfaction of the Department in order to be issued a contract with the State.

- A. HMO Certification Application: displayed below is a representation of the document the State will require as part of the process described above.
- B. Encounter data certification requirements: Information on encounter data certification requirements can be found in the following documents:
- [Encounter Data Training Memo](#), September 2009 (PDF, 51 KB)
 - [Fiscal Agent Requirement Checklist](#) (PDF, 28 KB)
 - [Department Certification Checklist](#) (PDF, 21 KB)
 - [Encounter Data Training Manual](#) (PDF, 605 KB)

These documents can also be found under Provider Contracts >> BadgerCare Plus and Medicaid SSI Certification >> Encounter Data Certification at the following website:
<https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/managed%20care%20organization/referenceAndTools.htm.spage>

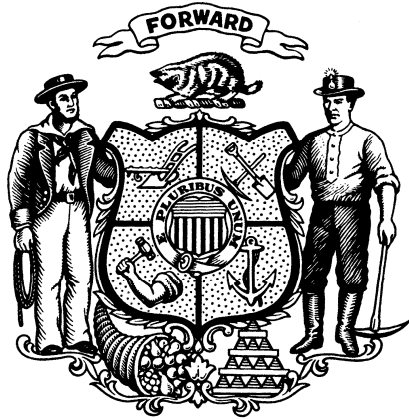
HMO Certification Application

for

**The Wisconsin Department of
Health Services**

BadgerCare Plus Program

2010



**CHECKLIST FOR HMOs COMPLETING THE
CERTIFICATION APPLICATION PACKET**

Application Item	Is it included? (check off)
A. General Information	
B. Ownership and Controlling Interest	
C. HMO Data Sheet	
D. Reports and Resources (Technical Data Sheet)	
E. Optional Service Coverage	
F. Subcontracts	
G. MOUs	
H. Quality Improvement	
I. Member Grievance policy and procedures	
J. Provider Appeals System	
K. HMO Advocate	
L. Member Handbook and Informing Materials	
M. Reporting and Data Administration	
N. Encounter Data from Third Party Vendors	
O. Computer and Data Processing System	
P. Fraud and Abuse	
Q. Language Access Policies and Procedures	
R. Signature	

HMO APPLICATION FOR CERTIFICATION

Enclosed are the materials, formats, and additional instructions necessary to apply for certification to provide services to BadgerCare Plus members Milwaukee, Washington, Ozaukee, Waukesha, Racine and Kenosha counties under the HMO program. Every item is required. Improperly completed forms, outdated or incomplete information may result in denial or delay of certification. The application may be typed or printed and submitted by email to the Director of Bureau of Benefits Management. A hard copy of the documentation must be mailed to the Department.

The signature page must be signed and dated in ink by the HMO's authorized agent responsible for applying for certification, and mailed to the Department.

A. General Information

Applicant HMO Name:

Applicant HMO Name – The name indicated on the above line must be the name used on all other documents for the Wisconsin BadgerCare Plus Program. BadgerCare Plus requires a Wisconsin HMO license for HMO certification so the applicant name must match the name on the license.

Contract Administrator: _____

Physical Address: (Street): _____

(City): _____ **(State):** _____

(Zip): _____

(Contact Person): _____

(Telephone Number): _____

*Physical address - Indicate the address where the HMO's primary office is located. **Do not use a billing service address.** This address is used for mailing BadgerCare Plus correspondence. Please indicate the complete nine digit zip code.*

Payee's Name: _____

Payee Name – Enter the name to whom checks are payable. HMOs reporting income to the IRS under an employer identification number (EIN) must indicate the name associated with the EIN and enter the name exactly as it is recorded with the IRS.

Group Name or Attention to (Optional): _____

Group Name or Attention To – Enter an additional name (e.g., business, group, and agency) that should be printed on checks and Remittance and Status Reports (payment/denial report).

Payee's Address (Street): _____

(City): _____ **(State):** _____ **(Zip):** _____

Payee's Address – Indicate where Remittance and Status Reports (payment/denial report), and other financial information should be mailed.

Taxpayer Identification Number: _____

Taxpayer Identification Number (TIN) – Enter the TIN that should be used to report income to the IRS. The number must be the TIN of the payee name and match what is recorded with the IRS.

Contact name for questions on this application:

Contact Name: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____

E-Mail Address: _____

The “Contact Name” should be the person most knowledgeable about the certification. The address and phone number will be used if there are any questions about the application.

B. Ownership and Controlling Interest Information

The Department requires the Ownership and Controlling interest information by Federal law and for administrative purposes. The information must be supplied in the given format. Additional pages should be attached if needed, with the same information in the same format.

Has the HMO (including any employee, vendors, or providers) in whom the HMO has a controlling interest, or any person having a controlling interest in the HMO, since the inception of the Medicare, Medicaid, or Title XX services program, been convicted of a crime related to, or been terminated from, a federal-assisted or state-assisted medical program?

Yes No

As defined by CMS, "Controlling Interest" includes, but is not limited to, all owners, creditors, controlling officers, administrators, mortgage interest holders, employees or stockholders with holdings of 5 percent or greater of outstanding stock, or holders with such position or relationship who may have a bearing on the operation or administration of a medical service-related business.

Specifically: "Controlling interest or ownership" means that a person:

1. Possesses a direct or indirect interest in 5 percent or more of the issued shares of stock in a corporate entity;
2. Is the owner of an interest of 5 percent or more in any mortgage, deed of trust, note, or other secured obligation;
3. Is an officer or director of the corporation; or
4. Is a partner in the partnership?

List the names and addresses of all persons (individual and/or corporate) who have a controlling interest in the HMO.

Name: _____

Address (Street): _____

City: _____ State: _____ Zip: _____

County: _____ Business Telephone: _____

Home Telephone: _____

Type and percent of controlling interest:

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List the names and addresses of all vendors of drugs or medical supplies, laboratories, pharmacies, transportation providers, or other providers in which the HMO has a controlling interest or ownership.

Name: _____

Medicaid Provider #: _____

Social Security Number or Federal Tax ID Number (FEIN): _____

Address (Street): _____

City: _____ State: _____ Zip: _____

County: _____ Business Telephone: _____

Home Telephone: _____

Type and percent of controlling interest:

C. HMO Data Sheets

HMOs are required to completely and accurately fill out the HMO Data Sheet. A name and telephone number is needed for each item. Incomplete forms will be returned. This form is used for administrative purposes. If, during the contract period, any changes are made, the Bureau of Benefits Management Contract Monitor must be notified in writing of the changes and the effective dates. Changes may be submitted via e-mail.

HMO Data Sheet

HMO Name: _____
 Mailing Address: _____
 Physical Address (Street): _____
 (City) _____ (State) _____ (Zip) _____

Telephone Numbers:

Corporate: _____
 General Information: _____
 Member Services: _____
 24 Hour Nurse Line/Member Services: _____
 24 Hour Provider Number: _____
 Mental Health: _____
 TDD: _____
 FAX: _____

Contact People	Name	Phone Number	E- Mail Address
Chief Executive Officer:			
Medical Director:			
Contract Administrator:			
Enrollment:			
Finance:			
Electronic Funds Transfer:			
Hospital/ASC Assessment:			
Coordination of Benefits:			
Fraud and Abuse Compliance Officer:			
Quality Improvement:			
Reporting (utilization/survey):			
Grievance:			
MetaStar:			
Systems:			
Claims Processing:			
Provider Relations:			
Member Outreach/Marketing:			
HealthCheck:			
BadgerCare Plus HMO Advocate Primary: Back up:			
Targeted Case Management:			
Birth to Three Contact:			
Encounter Data Reporting: Primary: Back up:			
Privacy Officer:			

D. Reports and Resources (Technical Data Sheet)

The Department of Health Services (DHS) electronically produces multiple reports and resources for use by BadgerCare Plus HMOs, which are listed at the following website:

https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage.

The below reports are distributed to HMOs in paper format. Please indicate the person and address where the report should be mailed.

DHS Report/Resource for HMOs	HMO Person and Address to Send Report/Resource
<p>REMITTANCE ADVICE - SUMMARY (Weekly)</p>	<p>_____</p> <p>(Attention to: i.e., Department or individual)</p> <p>_____</p> <p>(Street)</p> <p>_____</p> <p>(City)</p> <p>_____</p> <p>(State) (Zip)</p> <p>_____</p> <p>(Phone Number)</p> <p>_____</p> <p>(E-mail Address)</p>

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DHS Report/Resource for HMOs	HMO Person and Address to Send Report/Resource
REMITTANCE ADVICE – FINANCIAL TRANSACTIONS (Weekly)	<hr/> (Attention to: i.e., Department or individual) <hr/> (Street) <hr/> (City) <hr/> (State) (Zip) <hr/> (Phone Number) <hr/> (E-mail Address)

E. Optional Service Coverage

Chiropractic Coverage (please check one):

- HMO elects to cover chiropractic services.
- HMO elects not to cover chiropractic services.

F. Subcontracts

Provider Contracts

The HMO must submit copies of all provider contracts. HMOs are reminded to submit any changes in subcontract language to the Department for approval prior to obtaining signatures.

1. Group Contracts [Independent Practice Association (IPA) Contracts]:

An IPA is an intermediate entity with which the HMO contracts. The HMO subcontracts with the IPA and the IPA, in turn, subcontracts with individual providers. Providers continue in their existing individual or group practices. The following entities with which the HMO subcontracts are considered to be IPAs: chiropractic networks, physician services, group physician practices, and mental health benefits managers.

For each contracted group (IPA), please submit the following information:

- Name of IPA
- Complete address of IPA
- Type of services provided (chiropractic, mental health, physician, etc.)

2. Administrative Services Agreements (ASA):

ASAs are entities with which HMOs contract to provide administrative support.

Following is a list of types of ASAs (however this list is not meant to be all-inclusive):

- a. Claims processing
- b. Utilization reporting
- c. Quality improvement
- d. Computer support
- e. HealthCheck screening and/or outreach
- f. Third party liability

For each contracted ASA, please submit the following:

- Name of subcontractor
- Complete address of subcontractor
- Type of services provided.

3. Delegation:

Please submit policy and procedure governing delegation, including sample written agreement. Include polices on:

1. Pre-delegation evaluation of prospective subcontractor's ability to perform
2. Monitoring activities and reporting requirements
3. Corrective actions when problems are identified
4. Provisions for termination of delegation
5. Provisions for retention by the HMO of the right to make final selection decisions about practitioners and providers credentialed or recertified by a delegate

G. Memoranda of Understanding (MOUs)

HMO must provide a listing of all organizations with which there are MOUs, including but not limited to:

- Community-Based Health Organizations
- PNCC agencies
- School Based Services Providers
- Targeted Case Management agencies
- County Child Welfare Agencies, including Bureau of Milwaukee Child Welfare in Milwaukee County
- Local Health Departments
- WIC projects contracted with the Department of Public Health
- County or other human service agencies for the provision of services ordered by courts and for the provision of mental health and/or substance abuse services

HMO's must submit copies of all signed MOU's. HMOs who are not successful in negotiating a MOU with an agency must submit documentation of their good faith attempts to negotiate the MOU.

H. Quality Improvement

All HMOs must submit the following:

1. Most recent annual Quality Assessment/Performance Improvement (QAPI) work plan.
2. Most recent QAPI program annual report.
3. QAPI program description, including description of program monitoring and oversight, committees, position descriptions and FTE staffing data.
4. Quality program and/or overall HMO organizational chart.
5. Policy on clinical practice guidelines, including development, adoption, dissemination, and monitoring. Copies of clinical practice guidelines need not be submitted, though a sample of one that has been circulated to providers would be helpful.
6. Sample documentation of a performance improvement project.
7. Standards and policies on access to care, availability of providers and monitoring procedures. Include the HMO's access standards for in-office wait time, appointment wait time, emergency, routine sick care and preventive or non-illness appointment wait times. Include policy on monitoring clinical site conformance with the HMO's access standards, if it is not described in the standards policy.
8. Documentation on policy and strategy for preventive health services.
9. Policies and procedures on continuity and coordination of care, particularly for pregnant and post-partum women (i.e. interconception care), those with chronic conditions, and high-cost members.
10. Policies and procedures for identification of enrollees with special health care needs, assessment and linkage to appropriate services.
11. Documentation of policy and procedure for practitioner and institutional provider (hospital, nursing home, home health agency, hospices and free-standing ambulatory surgical centers) credentialing and recredentialing. Must include:
 - a. initial credentialing policy and procedure;
 - b. recredentialing policy and procedure; and
 - c. policy and procedure governing practitioner and institutional provider termination for quality issues, appeal procedures and reporting to entities as required by law (DHS, NPDB, DRL).
12. Policies governing confidentiality, including HIPAA compliance, security, transfer, organization, disclosure, completeness and monitoring of medical records.
13. Policies governing utilization management (UM), notification of adverse actions, timeliness of decisions, persons authorized to make denial decisions based on medical necessity, UM criteria conformity with applicable HMO clinical proactive guidelines, and inter-rater reliability. Also, clinical information requirements, consultation guidelines, policies for processing expedited and urgent authorization requests. **Do not submit UM criteria, but identify which criteria are used, ie: InterQual, Milliman, HMO-developed, etc.**
14. Policy and procedure governing telephone triage, clinical protocols in use, clinical credentials required for staff (not credentials documentation—only a description of the minimum credentials required, for example, “RN with three years of acute experience” etc., and copy of annual evaluation of the clinical appropriateness of decisions made through the system). **(Applies only to HMOs using “nurse lines” or other telephone triage demand management systems where clinical advice is provided by telephone. If no such system is in operation, please provide written indication of that).**

I. Member Complaint and Grievance System

Please submit written documentation detailing the BadgerCare Plus member complaint and grievance process outlined in the BadgerCare Plus contract. The documentation must include and will be evaluated based on the following criteria:

1. A definition of a grievance.
2. A definition of an appeal.
3. A definition of an emergency grievance.
4. A description of the formal grievance process including a timeline for handling formal grievances and emergency grievances.
5. A description of the process for handling HIPAA privacy complaints.
6. The name and phone number of the person(s) responsible for receiving, routing, and processing grievances.
7. A description of the process and format used for logging informal grievances.
8. A description of the recordkeeping system for formal grievances.
9. A description of how members are informed about the grievance process.
10. IPA policies and procedures for enrollee grievances and a description of how IPAs notify HMO enrollees of the complaint/grievance process.
11. A sample of informal grievance logs.
12. A description of how the HMO assures compliance with the time frames for adjudicating grievances as required in the HMO Contract.
13. A description of how the HMO assures that grievances filed by BadgerCare Plus and members are adjudicated based on Medicaid rules.
14. A description of how the HMO assures that individuals with authority to require the HMO to implement a corrective action are involved in the grievance process.
- 15.** Sample copies of **all** types of template letters utilized by the HMO during the grievance process for BadgerCare Plus members, including but not limited to: the initial response, all denial reasons, and all termination, and reduction of an ongoing benefit letters to enrollees.
16. A description of how members are informed about access to interpreter services during the grievance process.

J. Provider Appeals System

HMOs are required to submit written documentation of the BadgerCare Plus provider appeals process as outlined in the BadgerCare Plus contract, consisting of:

1. Samples of remittance advice notices with provider appeal language included.
2. Documentation of how providers are advised of their right to appeal to the Department if the HMO fails to respond to their appeal within 45 days.
3. Samples of **all** template notification letters sent to providers as a result of the appeal process.
4. Policies and procedures for adjudicating provider appeals, showing time lines for adjudication.
5. A description of how the HMO assures that provider appeals pertaining to BadgerCare plus services are adjudicated using Medicaid (not commercial) policies and procedures.

K. BadgerCare Plus HMO Advocate

The HMO must submit to the Department:

1. Job description(s) of the HMO Advocate position(s).
2. Number of FTE's allocated to the advocate position(s).
3. Other duties or responsibilities of the advocate position(s) other than those required in the HMO Contract.
4. Organizational chart showing reporting relationship of the advocate position(s) to the Contract Administrator.
5. The work plan of the Advocate(s) covering the next three years.
6. Policies and procedures for evaluating the advocate position to determine when additional FTE's may be necessary.

L. Member Handbook and Informing Materials

The HMO must submit to the Department:

1. BadgerCare Plus member handbook
2. BadgerCare Plus member communication and outreach materials
3. HMO's (or subcontractor's) BadgerCare Plus member communication plan and outreach plan for the proceeding year. This plan must include the HMO's outreach and education plan for newly enrolled BadgerCare Plus members.

M. Reporting and Data Administration

1. Provider ID Numbers

The Department must ensure that HMOs are using Wisconsin Medicaid certified providers when providing services to BadgerCare Plus members. The contract between the Department and HMOs requires that HMOs use only providers certified by the Medicaid program when rendering services to members, except in emergency situations.

The data submitted by the HMOs will be used to assist in monitoring this requirement. This means that data submitted by the HMO will be edited and reviewed to ensure that a valid Medicaid provider ID or Medicaid-certified NPI is present, except when the service is identified as an emergency service and the provider of emergency services does not have a Medicaid-certified NPI.

The HMO must submit:

- a. Description of how the HMO currently updates its provider file with Wisconsin Medicaid provider IDs and NPI numbers.
- b. Description of the circumstances in which the HMO would submit encounter data without a valid BadgerCare Plus assigned non-NPI provider ID or NPI.
- c. Description of the steps the HMO takes to ensure that when new providers are added to the network, they are appropriately certified in the Wisconsin BadgerCare Plus program and have a valid NPI or Medicaid assigned non-NPI.

2. Claim Adjustment Reason (ANSI) Codes

The HMO must:

- a. Address how it will correct 98 percent of all encounter errors that are over 120 days old.
- b. Complete the following chart of all claim adjustment (ANSI) reason codes the HMO uses to show a provider that the claim or service is denied, partially paid, or paid in full.

ANSI CODE	ANSI CODE DESCRIPTION	Claim Denied. No HMO Disbursement of Funds	Claim Partially Paid	Claim Paid in Full
1	Deductible amount			
2	Coinsurance amount			
3	Co-payment amount			
4	The procedure code is inconsistent with the modifier used or a required modifier is missing			
5	The procedure code/bill type is inconsistent with the place of service			
6	The procedure code is inconsistent with the patient's age			

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ANSI CODE	ANSI CODE DESCRIPTION	Claim Denied. No HMO Disbursement of Funds	Claim Partially Paid	Claim Paid in Full
7	The procedure code is inconsistent with the patient's gender			
8	The procedure code is inconsistent with the provider type			
9	The diagnosis is inconsistent with the patient's age			
10	The diagnosis is inconsistent with the patient's gender			
11	The diagnosis is inconsistent with the procedure			
12	The diagnosis is inconsistent with the provider type			
13	The date of death precedes the date of service			
14	The date of birth follows the date of service			
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services			
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using the remittance advice remarks codes whenever appropriate. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or the NCPDP Reject Reason Code).			
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or the NCPDP Reject Reason Code).			
18	Duplicate claim/service			
19	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier			
20	Claim denied because this injury/illness is covered by the liability carrier			
21	Claim denied because this injury/illness is the liability of the no-fault carrier			
22	Payment adjusted because this care may be covered by another payer per coordination of benefits			
23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments			
24	Payment for charges adjusted. Charges are covered under a capitation agreement			
25	Payment denied Your stop loss deductible has not been met			
26	Expenses incurred prior to coverage			
27	Expenses incurred after coverage terminated			
28	Coverage not in effect at the time the service was provided			
29	The time limit for filing has expired			
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements			
31	Claim denied as patient cannot be identified as our insured			
32	Our records indicate that this dependent is not an eligible dependent as defined			

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ANSI CODE	ANSI CODE DESCRIPTION	Claim Denied. No HMO Disbursement of Funds	Claim Partially Paid	Claim Paid in Full
33	Claim denied Insured has no dependent coverage			
34	Claim denied Insured has no coverage for newborns			
35	Benefit maximum has been reached			
36	Balance does not exceed co-payment amount			
37	Balance does not exceed deductible			
38	Services not provided or authorized by designated (network) providers			
39	Services denied at the time authorization/pre-certification was requested			
40	Charges do not meet qualifications for emergent/urgent care			
41	Discount agreed to in Preferred Provider contract			
42	Charges exceed our fee schedule or maximum allowable amount			
43	Gramm-Rudman reduction			
44	Prompt-pay discount			
45	Charges exceed your contracted/ legislated fee arrangement			
46	This (these) service(s) is (are) not covered			
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.			
48	This (these) procedure(s) is (are) not covered			
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam			
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer			
51	These are non-covered services because this is a pre-existing condition			
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed			
53	Services by an immediate relative or a member of the same household are not covered			
54	Multiple physicians/assistants are not covered in this case			
55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer			
56	Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by the payer			
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage			
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service			
59	Charges are adjusted based on multiple surgery rules, assistant surgery rules, or concurrent anesthesia rules			
60	Charges for outpatient services with this proximity to inpatient services are not covered			
61	Charges adjusted as penalty for failure to obtain second surgical opinion			

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ANSI CODE	ANSI CODE DESCRIPTION	Claim Denied. No HMO Disbursement of Funds	Claim Partially Paid	Claim Paid in Full
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization			
63	Correction to a prior claim			
64	Denial reversed per Medical Review			
65	Procedure code was incorrect This payment reflects the correct code			
66	Blood Deductible			
67	Lifetime reserve days			
68	DRG weight			
69	Day outlier amount			
70	Cost outlier - Adjustment to compensate for additional costs.			
71	Primary payer amount			
72	Coinsurance day			
73	Administrative days			
74	Indirect medical education adjustment			
75	Direct medical education adjustment			
76	Disproportionate share adjustment			
77	Covered days			
78	Non-covered days/room charge adjustment			
79	Cost report days			
80	Outlier days			
81	Discharges			
82	PIP days			
83	Total visits			
84	Capital adjustment			
85	Interest amount			
86	Statutory adjustment			
87	Transfer amount			
88	Adjustment amount represents collection against receivable created in prior overpayment			
89	Professional fees removed from charges			
90	Ingredient cost adjustment			
91	Dispensing fee adjustment			

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ANSI CODE	ANSI CODE DESCRIPTION	Claim Denied. No HMO Disbursement of Funds	Claim Partially Paid	Claim Paid in Full
92	Claim paid in full			
93	No Claim level adjustments			
94	Processed in excess of charges			
95	Benefits adjusted. Plan procedures not followed.			
96	Non-covered change(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).			
97	Payment is included in the allowance for another service/procedure.			
98	The hospital must file the Medicare claim for this inpatient non-physician service			
99	Medicare secondary payer adjustment amount			
100	Payment made to patient/insured/responsible party			
101	Predetermination, anticipated payment upon completion of services or claim adjudication			
102	Major Medical adjustment			
103	Provider promotional discount (ie senior citizen discount)			
104	Managed care withholding			
105	Tax withholding			
106	Patient payment option/election not in effect			
107	Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim			
108	Payment reduced because rent/purchase guidelines were not met			
109	Claim not covered by this payer/contractor You must send the claim to the correct payer/contractor			
110	Billing date predates service date			
111	Not covered unless the provider accepts assignment			
112	Payment adjusted as not furnished directly to the patient and/or not documented			
113	Payment denied because service/procedure was provided outside the United States or as a result of war			
114	Procedure/product not approved by the Food and Drug Administration			
115	Payment adjusted as procedure postponed or canceled			
116	Payment denied The advance indemnification notice signed by the patient did not comply with requirements			
117	Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care			
118	Charges reduced for ESRD network support			
119	Benefit maximum for this time period has been reached			
120	Patient is covered by a managed care plan			

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ANSI CODE	ANSI CODE DESCRIPTION	Claim Denied. No HMO Disbursement of Funds	Claim Partially Paid	Claim Paid in Full
121	Indemnification adjustment			
122	Psychiatric reduction			
123	Payer refund due to overpayment			
124	Payer refund amount - not our patient			
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks code whenever appropriate. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).			
126	Deductible - Major Medical			
127	Coinsurance - Major Medical			
128	Newborn's services are covered in the mother's allowance			
129	Claim denied - prior processing information appears incorrect			
130	Claim submission fee			
131	Claim specific negotiated discount			
132	Prearranged demonstration project adjustment			
133	The disposition of this claim/service is suspended pending further review			
134	Technical fees removed from charges			
135	Claim denied. Interim bills cannot be processed			
136	Claim denied/reduced Plan procedures of a prior payer were not followed			
137	Payment/Reduction for regulatory surcharges, Assessments, Allowances or Health Related Taxes			
138	Claim/service denied. Appeal procedures not followed or time limits not met			
139	Contracted funding agreement - Subscriber is employed by the provider of services			
140	Patient/Insured health identification number and name do not match			
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage			
142	Claim adjusted by the monthly Medicaid patient liability amount.			
143	Portion of payment deferred.			
144	Incentive adjustment, e.g. preferred product/service.			
145	Premium payment withholding			
146	Payment denied because the diagnosis was invalid for the date(s) of service reported			
147	Provider contracted/negotiated rate expired or not on file.			
148	Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete			
149	Lifetime benefit maximum has been reached for this service/benefit category			

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ANSI CODE	ANSI CODE DESCRIPTION	Claim Denied. No HMO Disbursement of Funds	Claim Partially Paid	Claim Paid in Full
150	Payment adjusted because the payer deems the information submitted does not support this level of service			
151	Payment adjusted because the payer deems the information submitted does not support this many services			
152	Payment adjusted because the payer deems the information submitted does not support this length of service			
153	Payment adjusted because the payer deems the information submitted does not support this dosage			
154	Payment adjusted because the payer deems the information submitted does not support this day's supply			
155	This claim is denied because the patient refused the service/procedure.			
156	Flexible spending accounts payments			
157	Payment denied/reduced because service/procedure was provided as a result of an act of war			
158	Payment denied/reduced because the service/procedure was provided outside of the United States as a result of terrorism			
160	Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion			
161	Provider performance bonus			
162	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for the specific explanation			
163	Claim/Service adjusted because the attachment referenced on the claim was not received			
164	Claim Service adjusted because the attachment referenced on the claim was not received in a timely fashion			
165	Payment denied /reduced for absence of, or exceeded referral			
166	These services were submitted after this payer's responsibility for processing claims under this plan ended			
167	This (these) diagnosis(es) is (are) not covered			
168	Payment denied as Service(s) have been considered under the patients medical plan. Benefits are not available under this dental plan			
169	Payment adjusted because an alternate benefit has been provided			
170	Payment is denied when performed/billed by this type of provider			
171	Payment is denied when performed/billed by this type of provider in this type of facility			
172	Payment is adjusted when performed/billed by a provider of this specialty			
173	Payment adjusted because this service was not prescribed by a physician			
174	Payment denied because this service was not prescribed prior to delivery			
175	Payment denied because the prescription is incomplete			
176	Payment denied because the prescription is not current			
177	Payment denied because the patient has not met the required eligibility requirements			
178	Payment adjusted because the patient has not met the required spend down requirements			
179	Payment adjusted because the patient has not met the required waiting requirements			
180	Payment adjusted because the patient has not met the required residency requirements			

HMO BadgerCare Plus Certification Application for RFP region

ANSI CODE	ANSI CODE DESCRIPTION	Claim Denied. No HMO Disbursement of Funds	Claim Partially Paid	Claim Paid in Full
181	Payment adjusted because this procedure code was invalid on the date of service			
182	Payment adjusted because the procedure modifier was invalid on the date of service			
183	The referring provider is not eligible to refer the service billed.			
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed			
185	The rendering provider is not eligible to perform the service billed			
186	Payment adjusted since the level of care changed			
187	Health Savings account payments			
188	This product/procedure is only covered when used according to FDA recommendation			
189	"Not otherwise classified" or "unlisted" procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service			
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay			
191	Claim denied because this is not a work related injury/illness and thus not the liability of the workers' compensation carrier			
192	Non standard adjustment code from paper remittance advice			
193	Original payment decision is being maintained. This claim was processed properly the first time			
194	Payment adjusted when anesthesia is performed by the operating physician, the assistant surgeon or the attending physician			
195	Payment denied/reduced due to a refund issued to an erroneous priority payer for this claim/service			
196	Claim/service denied based on prior payer's coverage determination.			
197	Payment adjusted for absence of precertification/authorization. This change effective 1/1/2008: Payment adjusted for absence of precertification/authorization/notification			
198	Payment Adjusted for exceeding precertification/ authorization.			
199	Revenue code and Procedure code do not match.			
200	Expenses incurred during lapse in coverage			
201	Workers Compensation case settled. Patient is responsible for amount of this claim/service through WC "Medicare set aside arrangement" or other agreement. (Use group code PR).			
202	Payment adjusted due to non-covered personal comfort or convenience services			
203	Payment adjusted for discontinued or reduced service.			
204	This service/equipment/drug is not covered under the patient's current benefit plan			
205	Pharmacy discount card processing fee			
206	NPI denial - missing			
207	NPI denial - Invalid format			
208	NPI denial - not matched			

HMO BadgerCare Plus Certification Application for RFP region

ANSI CODE	ANSI CODE DESCRIPTION	Claim Denied. No HMO Disbursement of Funds	Claim Partially Paid	Claim Paid in Full
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use Group Code OA)			
210	Payment adjusted because pre-certification/authorization not received in a timely fashion			
211	National Drug Codes (NDC) not eligible for rebate, are not covered.			
212	Administrative surcharges are not covered			
A0	Patient refund amount			
A1	Claim denied charges			
A2	Contractual adjustment			
A3	Medicare secondary payer liability met			
A4	Medicare claim PPS capital day outlier amount			
A5	Medicare claim PPS capital cost outlier amount			
A6	Prior hospitalization or 30 day transfer requirement not met			
A7	Presumptive Payment Adjustment			
A8	Claim denied; ungroupable DRG			
B1	Non-covered visits			
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test			
B11	The claim/service has been transferred to the proper payer/processor for processing claim/service not covered by this payer/processor			
B12	Services not documented in patients' medical records			
B13	Previously paid Payment for this claim/service may have been provided in a previous payment			
B14	Payment denied because only one visit or consultation per physician per day is covered			
B15	Payment adjusted because this procedure/service is not paid separately			
B16	Payment adjusted because 'New Patient' qualifications were not met			
B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current			
B18	Payment adjusted because this procedure code and modifier were invalid on the date of service			
B19	Claim/service denied/reduced because of the finding of a review organization			
B2	Covered visits			
B20	Payment adjusted because procedure/service was partially or fully furnished by another provider			
B21	The charges were reduced because the service/care was partially furnished by another physician			
B22	This payment is adjusted based on the diagnosis.			

HMO BadgerCare Plus Certification Application for RFP region

ANSI CODE	ANSI CODE DESCRIPTION	Claim Denied. No HMO Disbursement of Funds	Claim Partially Paid	Claim Paid in Full
B23	Claim/ service denied because this provider has failed an aspect of a proficiency testing program			
B3	Covered charges			
B4	Late filing penalty			
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded			
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty			
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service			
B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized			
B9	Services not covered because the patient is enrolled in a hospice			
D1	Claim/service denied Level of subluxation is missing or inadequate			
D10	Claim/service denied Completed physician financial relationship form not on file			
D11	Claim lacks completed pacemaker registration form			
D12	Claim/service denied Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test			
D13	Claim/service denied Performed by a facility/supplier in which the ordering/referring physician has a financial interest			
D14	Claim lacks indication that plan of treatment is on file			
D15	Claim lacks indication that service was supervised or evaluated by a physician			
D16	Claim lacks prior payer payment information.			
D17	Claim/Service has invalid non-covered days.			
D18	Claim/Service has missing diagnosis information.			
D19	Claim/Service lacks Physician/Operative or other supporting documentation			
D2	Claim lacks the name, strength, or dosage of the drug furnished			
D20	Claim/Service missing service/product information.			
D21	This (these) diagnosis(es) is (are) missing or are invalid			
D3	Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing			
D4	Claim/service does not indicate the period of time for which this will be needed			
D5	Claim/service denied Claim lacks individual lab codes included in the test			
D6	Claim/service denied Claim did not include patient's medical record for the service			
D7	Claim/service denied Claim lacks date of patient's most recent physician visit			
D8	Claim/service denied Claim lacks indicator that `x-ray is available for review'			
D9	Claim/service denied Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used			
W1	Workers Compensation State Fee Schedule Adjustment			

N. Encounter Data from Third Party Vendors

Some of the encounter data the HMO submits to the Department may come from third party vendors who pay and process claims on the HMO's behalf (e.g., behavioral health benefits manager). The HMO must:

1. Identify any third party vendors used, the service provided, and the type of encounters (e.g., inpatient, behavioral health, etc.).
2. Describe how the HMO will obtain the required data from the third party vendor, how often the HMO will obtain the data (e.g., monthly), and the timeliness of transmitting the data (i.e., how soon after the date of service will the data be transmitted to the HMO, and subsequently to the Department).
3. Please describe how the HMO will ensure accuracy of data (through audit or other means).

O. Computer and Data Processing System

1. The HMO must prepare a written description that addresses the system hardware and software, the technical resources that will be used and the name of the agency or organization (e.g., HMO, outside vendor, etc.) responsible for the following:
 - Claims Processing
 - Monitoring Enrollment and Disenrollment
 - Non-Encounter Data Reporting (e.g., Neonatal ICU patient care data)
 - Encounter Data Reporting
2. The HMO must describe how it will comply with Wisconsin Medicaid standards for HIPAA compliant transactions as specified in the 820 Payroll Deducted and Other Group Premium Payment for Insurance Products and the 834 Benefit Enrollment and Maintenance Implementation Guides.
3. The HMO must address the following questions on quality control of the HMO's information system:
 - a. How and how often (daily, etc.) is system performance monitored?
 - b. What processes are in place to identify and inform staff of any system performance problems?
 - c. Please, briefly describe the HMO's systems disaster recovery program.
4. The HMO must describe the HMO's system's ability to provide data necessary to monitor program performance relative to the Department's Quality Performance Benchmarks.

P. Fraud and Abuse Policies and Procedures

The Federal Medicaid Managed Care Rule requires HMOs to have administrative and management procedures to guard against fraud and abuse. Therefore, HMOs must submit the following documentation to the Department:

1. Submit a compliance plan that includes written procedures, a description and designation of a compliance officer and compliance committee.
2. Describe the training requirements for the compliance officer and employees.
3. Describe the enforcement standards and disciplinary guidelines developed by the HMO.
4. Describe the HMO's internal monitoring and auditing procedures.
5. Describe how the HMO will provide a prompt response to detected problems.
6. Provide the name and contact information of the HMO's Compliance Officer.

Q. Language Access Policies and Procedures

HMOs are required to provide oral and written language access to non-English speaking or limited English proficiency members. HMOs must submit the following documentation to the Department:

1. Provide a description or policy statement regarding the provision of language access services including the effective date of the policy, next review date of the policy, and who the policy affects.
2. Describe the criteria for selection of interpreters including evaluation of competency in both English and other languages; and include information about sign language interpreter services for members with hearing impairments.
3. Describe how emergency interpretation services will be provided.
4. Describe the HMO's monitoring mechanism for member satisfaction, and provider compliance.
5. Provide a list of all materials produced by the HMO that must be translated.
6. Describe how the HMO will identify LEP or hearing impaired members.
7. Describe how the hearing-impaired members' preference for the type of auxiliary aid(s) is addressed.
8. Provide a list of all interpreters, including sign language interpreters, used by the HMO and the procedures for updating the list and evaluating the need for additional interpreters.
9. Describe how members are notified of the availability of free interpretation services including the frequency of the notification, and the manner in which members are notified.

R. Signature

Our HMO wishes to provide services in Milwaukee, Washington, Ozaukee, Waukesha, Racine and Kenosha counties and agrees to abide by rules and regulations governing Wisconsin's BadgerCare Plus Program. I hereby certify that the information contained herein is accurate and complete.

I further understand and acknowledge that, should information provided to the Department or its fiscal agent as a part of the certification process prove to be false or incomplete, any certification granted as a result of that information could be subject to sanctions indicated in HFS 106, Wis. Adm. Code.

Signature of Applicant – Applications must have the signature of an authorized representative for the organization. ALL signatures and signature dates must be in pen. Photocopied or stamped signatures and dates are not acceptable.

Signature of HMO's Authorized Agent

Date of Signature

Typed / Printed Name of HMO's Authorized Agent