PROVIDER HANDBOOK

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INTRODUCTION

My Choice Family Care, Inc. (MCFC) welcomes you to our network! As a contracted provider, please use our provider handbook as your primary resource for policies, procedures, claims processing, benefits, service authorizations as well as using our provider portal.

In addition to the provider handbook information, we recommend you and your staff review additional sources for Family Care information 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

Additional information can also be found by visiting these websites and/or calling Wisconsin's Department of Human Services (DHS) below:

WI Aging and Disability Resource Centers:	www.dhs.wisconsin.gov/adrc/consumer/index.htm
Wisconsin Medicaid website:	www.dhs.wisconsin.gov/medicaid
Long-Term Care website:	www.dhs.wisconsin.gov/LTCare
Wisconsin Medicaid's Provider Services:	Toll Free: 800-947-9627 or 608-221-9883

If you have questions or need help with this handbook, please call MCFC's Contracting Department at 414-287-7640.

WHO IS MY CHOICE FAMILY CARE?

In 2000, the State of Wisconsin launched Family Care as a pilot program in five Wisconsin counties. As part of this pilot program, My Choice Family Care (formerly Milwaukee County Department of Family Care) was selected as one of the original Managed Care Organizations (MCO) chosen to administer the Family Care benefit package. Over the past 17 years, MCFC has had the opportunity to serve over 27,300 members and looks forward to partnering with providers who stand beside us in our mission of honoring choice and providing quality, cost-effective supports and services.

My Choice Family Care contracts with the Wisconsin Department of Health Services to administer the Family Care benefit per the Health and Community Supports Contract and Administrative Code HFS 10.

A significant obligation within our DHS contract is to develop a provider network by contracting with community organizations able to provide the goods and services funded through our program. This is the role that you play – as a network provider!

The ***two*** major organizational components under the Family Care program:

1. Aging and Disability Resource Centers

Aging and Disability Resource Centers (ADRCs) are 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. A complete list of ADRCs can be found at:

https://www.dhs.wisconsin.gov/adrc/consumer/index.htm

2. Managed Care Organizations

The Wisconsin Department of Health Services (DHS) contracts with Managed Care Organizations (MCOs) to provide or arrange Family Care Benefit services.

OUR MISSION

We inspire people to experience life at its fullest by encouraging ownership of health, fostering independence, and service the whole person; and do so with an unwavering commitment as stewards of Medicaid funding.

OUR PHILOSOPHY

My Choice Family Care is committed to working together with Members, families, advocates, friends and others in a spirit that:

1. Promotes respect and dignity.
2. Supports choices of our Members.
3. Informs Members about the benefits of their choices.
4. Promotes Member participation.
5. Uses cost-effective methods.
6. Works within government policies and regulations.

WHO IS ELIGIBLE FOR MY CHOICE FAMILY CARE SERVICES?

My Choice Family Care provides services to individuals that meet the following criteria:

Age and Disability Requirements

- Frail elders
- At least 18 years of age for persons with physical, intellectual, or developmental disabilities

Financially Eligible

- Determined by Economic Support Division

Functionally Eligible

- Determined by screening with Aging and Disability Resource Center

The Aging and Disability Resource Center (ADRC) determines an individual's eligibility for My Choice Family Care services. Contact the ADRC in the individual's county of residence to initiate the enrollment process.

Individuals elect to become a Member of My Choice Family Care. Once enrolled with MCFC, we assign an Interdisciplinary Team (IDT) to the Member.

The Interdisciplinary Team consists of the individual Member, their families, a case manager, a nurse, and other professionals or consultants based upon the Member's needs. Upon completion of the eligibility and screen process, the IDT assesses the individual's needs.

FAMILY CARE BENEFIT PACKAGE

Family Care is a comprehensive and flexible long-term care program for seniors and adults with physical, intellectual, and developmental disabilities. By combining services otherwise covered separately through Medicaid and long-term care, Family Care improves the coordination of the services, is cost–effective, and most importantly, assists individuals in living more active and independent lives.

Family Care benefits are as follows:

- 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 Delivered Meals
- Home Health
- Home Modifications
- Mental Health Services
  (except those provided by a physician or on an inpatient basis)
- Nursing Facility
- Nursing Services
  (except for inpatient 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 both 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 Interdisciplinary Team (IDT) for **all** services to be rendered.

Covered and authorized services will be reimbursed by My Choice Family Care per the contracted rates in the Provider Contract. Reimbursement to contracted providers will be at current Medicaid fee-for-service rates or negotiated rates.

FAMILY CARE BENEFIT PACKAGE EXCLUSIONS

Medical Services, including acute and primary care services, physician visits, hospital stays, and medications are not included in the Family Care Benefit Package. For those residents who are Medicaid eligible, these services can be accessed with their Forward Card.

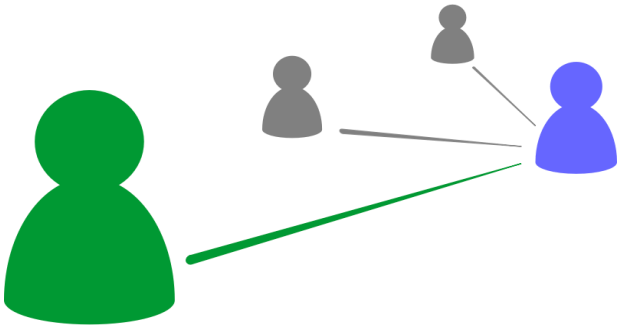
The following Medicaid fee-for-services are excluded from the “Family Care Benefit Package:”

- Alcohol and other Drug Abuse services provided by a physician in an office and/or 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, and speech therapy. Mental health and/or alcohol and other drug abuse services from a non-physician are covered in an outpatient setting)
- 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 therapy, mental health services from a non-physician, and alcohol and other drug abuse from a non-physician)
- Podiatry
- Prenatal Care Coordination
- Prosthetics

Providers should continue to bill the Member’s Medicaid or bill the primary commercial health insurance for services that are not included in the Family Care benefit package.

BECOMING A NETWORK PROVIDER

If a potential provider wishes to join the MCFC network, they should go to our website at www.mychoicefamilycare.org and complete a request for an application. As there are requirements and expectations for our network providers, please note that completing a "Request for Application" does not constitute a contract nor guarantee that a contract will be offered.



MCFC considers requests for contracting based on the following criteria:

- Proposed services are within the Family Care benefit package
- Provider meets applicable licensing and credentialing standards
- Provider has been in business a minimum of one year
- Provider type & services are needed to meet network adequacy
- Medicaid certified when applicable
- Is not on the excluded provider lists available at:

  http://wi-recordcheck.org and http://oig.hhs.gov/index.asp

PROVIDER NETWORK

The provider network consists of quality providers who have agreed to:

- My Choice Family Care rates.
- Follow contractual requirements.
- Maintain ongoing communications with My Choice Family Care.
- Meet or exceed quality assurance expectations of My Choice Family Care.

MCFC ensures the integrity of our network providers through credentialing, on-site quality visits, utilization review and ongoing quality initiatives.

As a contracted provider, your demographics are added to our Provider Directory and distributed to each Member. Members and their Interdisciplinary Team choose providers from the Provider

Directory based on services, availability and/or location(s). To view our latest Provider Directory, go to: http://www.mychoicefamilycare.org/provider-directories/

The Health and Community Supports Contract and HFS 10 require MCFC to continually monitor the Provider Network to ensure that service capacity and access are managed in accordance with current and anticipated Member service demands. My Choice Family Care is not required to contract with providers beyond the number necessary to meet the needs of Members. For current Provider Network availability, see website: www.mychoicefamilycare.org

OUT OF NETWORK PROVIDERS

My Choice Family Care is not required to add providers to our network simply because they are requested by Members. Non-contracted providers must meet a specific need outside the established Provider Network, meet our qualifying standards and accept the service rate(s) set by MCFC.

CONTRACTING DEPARTMENT

Should you have any questions and/or concerns relating to provider service need, your application, and/or contract, please contact My Choice Family Care, Inc. at:

Phone: 414-287-7640

Toll-free: 877-489-3814

Email: famccontractsf@mychoicefamilycare.org

You will be directed to your respective Contracting Representative.

CLAIM AND AUTHORIZATION INFORMATION

My Choice Family Care requires contracted providers to utilize our provider portal. Our provider portal, MIDAS (Member Information Documentation Authorization System), allows you to view your service authorizations, submit claims, and view claims status for our Members you serve.

SYSTEM REQUIREMENTS

Your computer will require the following specifications:

- Microsoft Windows 95 or later
- Internet Explorer 7.0 or above

*MIDAS will **not work** with the following:*

- Apple computers or applications
- Google Chrome or Firefox

ACCESS

Your Provider Relations and Network Representative will provide you with a MIDAS provider portal log-in and initial password. Keep this login information in a safe place as the records contained in the MIDAS database contain protected Member health information.

On the MIDAS home page (www.mcfc-midas.com) select "Provider Portal" from the system drop down menu and enter your login and password information.

PRE- AUTHORIZATION REQUEST

All Family Care Benefit services must be provided by a contracted provider and be pre-authorized by the Member's Interdisciplinary Team (IDT). Contact 1-800-223-6016 to obtain the IDT's contact information.

My Choice Family Care IDTs makes the final decision on Member eligibility for services and amount of services to be provided.

Providers will not be reimbursed for unauthorized services provided to Members or provided in amounts that exceed those authorized.

Providers should review that all information within the authorization is correct prior to rendering service. Verification can be completed via MIDAS.

Examples of areas/data to verify:

Date of Service Span:	Does the authorized service date span match or cover the expected service period?
Units of Service:	Do the total number of authorized units equal to the number of units needed for the current service period?
Service Codes:	Are all the applicable service codes, HCPCS and/or revenue codes authorized?

If a discrepancy is identified, immediately request a correction to the service authorization from the My Choice Family Care IDT. Untimely requests will result in claim denial and no reimbursement.

CLAIM SUBMISSION

1. Contracted providers are responsible to submit clean claims within the timely filing requirements. Claims for services must submitted to My Choice Family Care's third-party administrator, Wisconsin Physicians Service (WPS), Your clean claim must be received by WPS within **120 days** from the service start date **or** if a Clean Claim consists of multiple dates of service then the **120 day** period shall begin with the last date of service covered under the Clean Claim **or** within **90 days** from the date of Primary Insurer EOB / Medicare EOMB.

Claim Submission instructions and other useful claims documents are found in MIDAS at: https://www.mcfc-midas.com/UserDocuments.asp > "MCFC Provider Claims Training" folder > "MCFC Claims Submission User Guide.pdf

PROVIDER LIAISON SPECIALIST

My Choice Family Care has a Provider Liaison Specialist available to educate our contracted network Providers. Training is available for the Clean Claims submission process, interpreting the EOB/EOMBs, reconciling payments and our claims appeal process.

If you are interested in these trainings or if you are a new provider in need of assistance, please call 414-287-7424 or 414-287-7414.

PROVIDER APPEAL PROCESS

All claim payments and/or denials are accompanied by a PRA (Provider Remittance Advice) giving the specific explanation of the payment amount or the payment denial reason. If you have questions about your PRA, please contact the WPS / Family Care Contact Center at 1-800-223-6016. Most often disputes can be resolved with a telephone call.

Providers have the right to file an appeal for reconsideration of payment in the event the claim was incorrectly denied or partially paid in error.

If you wish to file an appeal, the following documentation must be included:

- Provider's Name and ID Number
- Member Name and Social Security Number
- Date of Service
- Procedure Code

- Units billed
- Copy of your Claim
- Copy of your WPS Provider Remittance Advice (PRA)
- Copy of your Primary Insurer EOB or Medicare (EOMB) (if applicable)
- Reason your claim merits reconsideration
- Any other documentation to support your appeal

The formal appeal must be in writing, include the above documentation and submitted within 60 calendar days from the original WPS denial date to the following address:

My Choice Family Care

Provider Claims Appeals

10201 W. Innovation Drive, Suite 100

Wauwatosa, Wi. 53226

My Choice Family Care will respond to your appeal in writing within 45 calendar days from the date of WPS receipt. Questions related to submitted appeals can be directed to the My Choice Family Care Provider Liaison Specialists at 414-287-7424 or 414-287-7414.

If My Choice Family Care fails to respond or if you are not satisfied with the final appeal decision, you have the right to appeal to the Department of Health and Family Services (DHFS) for payment reconsideration at:

Provider Appeals Investigator

Division of Medicaid Services

1 West Wilson Street, Room 518

P.O. Box 309

Madison, Wi 53707-0309

FRAUD, WASTE, AND ABUSE REPORTING

All Providers shall immediately investigate and contact MCFC in writing within five (5) 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 MCFC 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 MCFC, 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, MCFC may suspend claims payment pending investigation of a credible allegation of fraud.

MEMBER RIGHTS

My Choice Family Care must honor Member Rights and must ensure those rights when furnishing services. For additional information regarding Member Rights, please review the Member Handbook located at:

https://mychoicefamilycare.org/wp-content/uploads/2018/03/Web-version-of-Member-Handbook-2018.pdf

Or, go to the Provider Portal's User Documents. There you will find Member Handbooks in a variety of languages that describe Member Rights under the Family Care program.

MEMBER'S RIGHT TO FILE A COMPLAINT, GRIEVANCE OR APPEAL

We are committed to providing quality service to our Members.

If you or the Member has a concern that you are unable to resolve, contact the Member's IDT or call My Choice Family Care's Member Liaison at 414-287-7621. Further information regarding Member Grievance and Appeal processes can be found by accessing the Member's Handbook at

https://mychoicefamilycare.org/wp-content/uploads/2018/03/Web-version-of-Member-Handbook-2018.pdf

A grievance is when a Member is not satisfied with My Choice Family Care, one of our Providers, or has a concern about the quality of their care or services.

An appeal is a request for a review of a decision made by My Choice Family Care. For example, a Member can file an appeal if their Care 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 (NOA).

Members have the right to file a grievance or appeal a decision made by My Choice 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 will work with the Member throughout the entire grievance and appeal process to try to find a workable solution.

Providers recognize that the Member has the right to file appeals or grievances and assures that such actions will not adversely affect the way that the Provider treats the Member. 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, the Provider should inform the Member's Care Manager of such 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 8:00 am to 4:30 pm. Providers are permitted to assist Members in the filing of a grievance or appeal.