About Trilogy

Trilogy Health Insurance, Inc., a Wisconsin insurance company ("Trilogy") is contracted with the Wisconsin Department of Health Services (DHS) to provide healthcare coverage for BadgerCare Plus populations in Wisconsin. For the most up-to-date listing of our service area counties, please refer to our website at TrilogyHealthInsurance.com.

At Trilogy, we believe that our providers should be spending their time practicing medicine, not managing through unnecessary insurance company "red tape". We strive to make our administrative requirements simple and clear, and we are firm in our commitment to consistently "do the right thing" on behalf of all those that we serve.

With Trilogy, you'll get personalized service from someone you know, in your community, who is focused entirely on the needs of small businesses and Medicaid program administration.

Our company only serves Wisconsin, and our office and administrative services are handled **locally.** You will work with people right here in southeast Wisconsin for all your needs, including:

- Provider Relations and Contracting
- Medical Management, Case Management and Disease Management
- Customer Service
- Claims Administration

We encourage your comments and suggestions about our program, and appreciate your partnership.

Our Trilogy of Values:

Respect *for our Members*
Responsiveness *to their Needs*
Responsibility *for our Actions*

About the Policies in This Provider Manual

The policies in this manual may be revised from time to time. The latest version will be published on the Trilogy website TrilogyHealthInsurance.com

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CONTACT LIST

Customer Service

All departments may be accessed through customer service. Service hours: Monday - Friday, 8:00 am to 5:00 pm.

Phone: 414-755-3619 or 855-530-6790
Fax: 414-755-4410
Email:customerservice@trilogyhealthinsurance.com

Providers needing Trilogy's BIN & PCN numbers to file pharmacy claims may call ForwardHealth at 800-947-9627

Provider Relations and Contracting

Phone: 414-755-3619 or 855-530-6790
Fax: 414-755-4410
Email:providerrelations@trilogyhealthinsurance.com

Claim Submission

Medical and Behavioral Health Claims

Mail: Trilogy Health Networks
P.O. Box 1171
Milwaukee, WI 53201
EDI Payer ID: 62777

Vision Claims (Herslof)

Herslof Opticians
12000 W. Carmen Ave
Milwaukee, WI 53225

Phone: 414- 462-5800
Fax: 414-462-9821

Dental Claims (DentaQuest of Wisconsin)

DentaQuest of WI
11100 W. Liberty Drive
Milwaukee, WI 53224

Phone: 855-453-5287
Electronic: via DentaQuest's website (www.dentaquest.com).

Medicaid Member Advocate

Phone: 855-530-6790
Fax: 414-755-4410
Email: advocate@trilogyhealthinsurance.com

24 hour Emergency Line: 855-530-6790

Medical and Behavioral Health Claim Appeals

My Choice Wisconsin Health Plan Health Insurance
Provider Appeals Department
P.O. Box 70491
Milwaukee, WI 53207
Fax: 414-755-4410

Dental Appeals

DentaQuest
11100 W. Liberty Drive
Milwaukee, WI 53224
Attention: Appeals Department

Fax: 262.834.3452

Prior Authorization and Referrals

Medical

Phone: 414-755-3619 or 855-530-6790
Fax: 414-771-1159
Email:medicalmanagement@trilogyhealthinsurance.com
Forms: www.TrilogyHealthInsurance.com

Behavior Health

Phone: (855) 530-6790
Fax: 608-245-3097
Forms for Prior Authorization of Behavioral Health services are available on the Trilogy website at www.TrilogyHealthInsurance.com/provider/

Dental (DentaQuest)

Phone: 855-453-5287
Fax: 262-834-3450

ELIGIBILITY

Medicaid recipients may lose eligibility to participate in a Medicaid program and/or may change their HMO affiliation. Providers should always verify eligibility status and health insurance enrollment prior to delivering service to ensure that the patient is eligible for benefits and is a member of Trilogy. Trilogy enrolls Members who are in BadgerCare Plus.

Trilogy does not issue its own identification cards to its members. Providers should utilize the ForwardHealth Card issued to BadgerCare Plus recipients when they become eligible for benefits. Each individual family member receives his or her own individual ID number and card.

The ForwardHealth card includes the member's name, 10-digit Medicaid ID number, magnetic stripe, signature panel, and the EDS Recipient Services telephone number. The card also has a unique, 16-digit card number on the front. This number is for internal use only and is not used for billing. The card does not need to be signed to be valid, although adult members are encouraged to sign their cards. Providers may use the signature as another means of identification.

ForwardHealth cards contain no eligibility dates. Recipients are instructed to keep their ID card if they lose eligibility in case they become eligible for BadgerCare Plus again. It is possible a member will present a card when he or she is not eligible; therefore, it is essential providers confirm eligibility before providing services.

Members who lose their card or have it stolen or damaged may get a free replacement by calling EDS Recipient Services at 1-800-362-3002 and asking for a replacement card.

Providers may see a patient who has a temporary or presumptive eligibility card. These are issued on green and beige paper respectively. Patients who present with these cards are not Trilogy members but are covered under Medicaid Fee for Service. Providers are encouraged to make a copy of Members' ID cards and retain them in the patient file.

Checking Eligibility under the State System

Providers may check eligibility through the State's systems in the following manner:

- Through the ForwardHealth Portal www.forwardhealth.wi.gov/ if you have a provider account.
- Calling WiCall, the state's automated voice response system by calling 1-800-947-3544.
- Calling the State Provider Services line at 1-800-947-9627 from 7 a.m. to 6 p.m. Monday-Friday.

Using the state system is the most accurate, up to date information on eligibility.

Wisconsin Medicaid, from time to time, will retroactively terminate an individual's eligibility for services. When that happens, Trilogy will recoup money paid for these members. The provider should then re-bill Medicaid or the HMO the member was retroactively assigned to at the time of service.

Checking Eligibility through Trilogy

Call Customer Service at: 414-755-3619 or 855-530-6790 from 8:00 AM to 5:00 PM Monday through Friday.

PCP ASSIGNMENT

In addition to eligibility for Medicaid and enrollment in Trilogy, PCPs should check to make sure they are the assigned PCP prior to rendering services.

Trilogy believes that the patient-PCP relationship is vital to quality of care and requires all members to have a PCP. Knowing who the PCP is can be important when trying to coordinate care between health care providers, or performing case or disease management and getting information back to the current PCP. All Trilogy members are required to have a PCP on record.

PCP Selection

All Medicaid recipients are given the option to select a Primary Care Physician (PCP) at the time of enrollment with Trilogy. They are sent a selection form with their member welcome material along with a self-addressed stamped envelope. They may either return the form or call Customer Service to make their selection.

PCP Auto-Assignment

If a member does not select a PCP within 30 days of receiving that form, they are auto-assigned a PCP. PCPs are selected based on the zip code of the member and zip code of the PCP. The member is then notified by mail of the PCP assignment and informed of their ability, and the process, to change to a different PCP.

PCP Changes

Trilogy members are allowed to change their PCP as desired by contacting Customer Service. If a PCP office calls to verify they are the PCP and it is found that they are not, the PCP cannot be changed without speaking directly to the Case Head. However, Trilogy makes a form available to its PCP offices that may be completed by the member and faxed in at the time of the visit. In either case the change is effective immediately and the PCP may see the member.

The PCP Change form should be faxed to: 414-755-4410.

For transportation, Members should be directed to call the State transportation agent Medical Transportation Management Inc. (MTM, Inc.) at 1-866-907-1493 (or TTY 1-866-288-3133). MTM is open between 7:00AM and 6:00PM Monday through Friday. Trilogy does not arrange transportation.

PRIOR AUTHORIZATION AND REFERRAL GUIDELINES (Medical)

NOTE: Specific behavioral health authorization guidelines are included in this section under appropriate headings.

REFERRALS

It is Trilogy's philosophy that the patient-PCP relationship is vital to quality of care. All Trilogy members are required to have a PCP. Requiring members to go through their PCP in order to seek care from specialists accomplishes several goals in providing quality health care:

- Less chance of duplication in diagnostic testing
- Less chance of prescribing medications that may have dangerous interactions or when prescribed together may have a different outcome in the patient's response
- Greater understanding of the 'whole person' through knowledge of the other treating providers
- Greater opportunity for the patient to receive coordinated services between a PCP and specialist or specialists
- Greater opportunity for effective treatment if the PCP is helping the patient to select the type of specialist that is most appropriate for their suspected condition

All referrals to specialists must be initiated by the member's primary care provider (PCP) or a covering provider, regardless of whether or not the specialist being referred to is within or outside of the PCP's office except in the following instances:

- OB-GYNs may refer for genetics or perinatology services.
- OB-GYNs operating in a PCP capacity may refer to other specialists.

Referrals are initiated by fax. Letters of approval or denial will be sent to the specialist and the number and type of service approved will be indicated on the approved referral. Additional visits may be approved if requested prior to the

expiration of a current approved referral. All other changes require the PCP to generate a new referral. Post-dated referrals or referrals requested after service has been provided are not allowed.

Services to be delivered in a home setting require a face-to-face assessment as part of the authorization request. These services include home health; durable medical equipment/durable medical supplies; physical, speech and occupational therapies and personal care worker services. Refer to the appropriate referral request form for more information.

Services Requiring Referrals

Services provided by any in-plan Specialist or out of plan Provider unless on the exception list below.

Exceptions – Services by In-Network Providers Which Do Not Require a Referral

- Provider is an OB/GYN functioning as a PCP
- Provider is seeing the member on an emergency or urgent care basis for the first visit. All subsequent visits require a referral
- The member is a 1 or 2-year-old getting lead screening at any WIC office
- Primary care services performed in a WIC office or health department
- The Provider is seeing the member while inpatient or observation status in the hospital
- The member has other insurance and Trilogy is paying secondary
- Provider is performing Screening, Brief Intervention, and Referral to Treatment (SBIRT) services
- Specialist is an in-network Chiropractor
- Dental services unless oral surgery is being performed
- Specialists performing only the professional component of a service (modifier 26) do not require a referral
- Specialists performing only diagnostic testing (with exceptions – see the prior authorization section)
- There is a referral to a different Specialist but the rendering Specialist is in the same office or Tax ID as the Specialist being seen
- Routine vision care
- Any exceptions in the provider's individual contract with Trilogy
-

Women's Access to Reproductive Care

- Trilogy female members may self-refer to an in-network OB/GYN provider for routine annual gynecological exams, pregnancy and any other OB/GYN medical related issues or may select an OB/GYN as a Primary Care Provider.
- Trilogy female members may self-refer to any Medicaid Family Planning provider.

Pregnancy Notification

While no actual referral is *required* for pregnancy we ask that you call and notify us as soon as possible in the member's pregnancy so that we can initiate pre-natal Case Management services. This will also allow us to put in a tentative authorization for the estimated date of delivery. Trilogy is committed to working with you and our members to ensure healthy birth outcomes. Providers are asked to use the Trilogy ***Pregnancy Notification Form*** on page 29 for this purpose. Please complete and fax it to 414-771-1159.

Referrals to Physicians within Contracted Networks

- Most referrals will be approved for a maximum of six visits, not to exceed six months.
- Genetics or Perinatology referrals will be approved for a maximum of three visits with a six-month maximum. If more visits are requested, a treatment plan must be submitted for review by Trilogy's Medical Director.
- The diagnosis must be consistent with the type of specialist to whom the referral is written.
- Dietary consultations will be approved with a PCP's written order for five visits for a maximum of six months. If more visits are requested, a treatment plan must be submitted for review by Trilogy's Medical Director.

Out of Network Referrals

Trilogy believes in preserving continuity of care for our members and providing them with the most appropriate specialty services. Referrals to non-network physicians are normally considered for approval in the following instances:

- The out of network physician performed prior invasive medical care, which necessitates that the same physician provide the follow-up care, **or**
- There are no in-network member physicians that can provide the necessary service(s).

Call us if you have any concerns or you would like us to consider an out of network referral based on your patient's special needs at 414-755-3619 or 855-530-6790 and select the Medical Management option.

PRIOR AUTHORIZATION (PA) REQUIREMENTS (MEDICAL)

Services requiring prior authorization:

Inpatient Authorizations
Acute Hospital-Medical or Surgical – within 48 hours or the next business day
Any Elective Admission – 5 days in advance
Any Emergency Admission – within 48 hours or the next business day
Long Term Acute Care (LTAC)
Newborn stay **beyond** the Mother's stay
OB related medical stays due to OB complications
Rehabilitation Facility – free standing or hospital floor
Skilled Nursing Facility (SNF)

Procedures/Services
Transplants (including evaluation) (facility obtains the authorization)
Hospice Care – in any Setting
Abortions – must meet State criteria and include consent
Advanced Imaging Services – CT, MRI, MR, PET
Audiological Testing for hearing instrumentation
Bariatric Evaluation and Surgery
Blepharoplasty
Botox Injections
Capsule Endoscopy
Cardiac Imaging
Cochlear Implant
Cosmetic, Plastic or Reconstructive Surgery or procedure except for cancer diagnosis
Court – Ordered Services
Dermabrasion
Dental Procedures under General Anesthesia < 5 years of age
Potentially Experimental or Investigational Services or Procedures
Gynecomastia Surgery
HealthCheck other services
Hearing Aid: must use State required vendor
Hysterectomy requires the acknowledgement of consent form
Implantable devices including contraceptives

Ancillary Services
Air Ambulance or Ambulance for Non-Emergency Transportation
DME or DMS > $500 per line item: including Prosthetics and Orthotics
Home Care Service(s): • Skilled Nursing Visits • Hospice • Personal Care Worker • Wound Care, including Wound Vacs
Outpatient Therapy Services or Rehabilitation (**after evaluation**) (up to 3 modalities of treatment are allowed at the time of an evaluation): • Birth to Three Program • Occupational Rehabilitation • Physical Therapy • Speech Therapy
Infertility and impotence services
Injectable medications or Specialty Drugs not covered under the State's Pharmacy benefit (including but not limited to 17P)
Mammaplasty – reduction or augmentation unless a cancer diagnosis
OB Ultrasound – 2 are allowed in 9 months. Any additional require authorization with the exception of those ordered by a Perinatologist
Pain Management Evaluations and Procedures
Pectus excarvatum/carinatum Services
Penile Prosthesis
Rhinoplasty
Screening for CT Colonoscopy
Sclerotherapy or surgery for varicose veins
Septoplasty
Sleep Studies – with the exception of those ordered by a Pulmonologist
Sterilization – Male or Female – also requires informed consent
TMJ Evaluation and Surgery
Ultraviolet (UV) Therapy
Vagal Nerve Stimulator Implant Surgery
Vaginal Construction
Wearable Cardioverter Defibrillator
Weight Management Services > 5 visits in a year

PRIOR AUTHORIZATION (PA) REQUIREMENTS (BEHAVIORAL HEALTH)

Services Not Requiring Prior Authorization:

Narcotic Treatment Services. Prior authorization is not required for Narcotic Treatment Services that are considered a covered benefit. This automatic authorization is only given to providers with active credentialing and provider participation status who are seeing Trilogy members.

Initial Outpatient Mental Health and AODA Visits. Network providers may see new patients for Outpatient Mental Health and AODA services without an authorization when the service is considered a covered benefit. This automatic authorization is only given to providers with active credentialing and provider participation status who are seeing Trilogy members.

Services Requiring Prior Authorization:

Intensive In Home Mental Health Therapy. Authorization must be obtained prior to receiving services.

Day Treatment/Partial Hospitalization and Transitional Care. All authorization requests for Day Treatment/Partial Hospitalization and Transitional Care must be obtained prior to receiving the service.

Outpatient Neuropsychological and Psychological Testing. All authorization requests for outpatient neuro/psychological testing must be obtained prior to members receiving the service. Neuro/psychological testing done on an inpatient basis does not require prior authorization. Brief testing measures such as rating scales, checklists, and inventories are not reimbursed as testing and should be included as part of the initial intake.

Medication Management. Authorization is not required when medication management is provided by a contracted provider (MD, PA, NP), including Suboxone treatment.

Inpatient Care. In the event of an emergency admission, notification including clinical information supporting the need for admission is required on the next business day. A target length of stay will be determined and communicated to the provider. Additional clinical information (concurrent review) may be needed to assess length of stays that are longer than the initial authorization. Clinician-to-clinician reviews may be conducted during concurrent review. Review and planning of further care should occur prior to expiration of any current authorization. Concurrent reviews generally occur during normal business hours. Notification of discharge date and discharge plan is required at the time of discharge.

Emergency Detention Admissions

For admissions that result from an Emergency Detention, the member's healthcare coverage should be verified and the HMO informed of the admission within the first 72 hours (three business days plus any intervening weekend days and/or holidays). The County should contact the HMO to discuss authorization and treatment plan options, as soon as they become aware of the admission.

The HMO is responsible for the cost of Emergency Detention and court-related mental health/substance abuse treatment, including involuntary commitment provided out-of-network. Treatment provided by out-of-network providers will be covered only if the time need to obtain treatment in-network would have risked permanent damage to the enrollee's health or safety, or the health or safety of others.

Other Admissions (other than Emergency Detentions)

Notify the HMO prior to the member's admission to discuss authorization and treatment plan options. As part of the case management responsibilities, the HMO may suggest alternate care options.

Services that require prior authorization should not be started prior to the determination of coverage (approval or denial of the prior authorization) for non-emergency services. Non-emergency treatment started prior to the

determination of coverage will be performed at the financial risk of the provider office. If coverage is denied, the treating Provider may be financially responsible.

Exceptions to the Prior Authorization Requirement

No prior authorization is needed for professional charges during an inpatient stay. This includes the doctors, lab services, radiologists, pathologists, anesthesiologists, etc. Only the hospital needs the prior authorization.
No prior authorization is required if Trilogy is paying secondary to other insurance coverage.
No prior authorization is required for a newborn unless the baby is in the hospital longer than the mother.

Emergency or Urgent Authorizations

In an **emergency** situation, the need to prior authorize services is waived. These services will be reviewed retrospectively for **medical necessity**. Trilogy defines Emergency and Medical Necessity as defined in the DHS Contract between Trilogy and the Department of Health Services.

> ***"Emergency"*** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge on health and medicine, could reasonably expect the absence of immediate medical attention to result in:
>
> - Placing the health of the individual (or, with respect to a pregnant woman, the health of the women or her unborn child) in serious jeopardy;
> - Serious impairment of bodily functions;
> - Serious dysfunction of any bodily organ or part;
> - With respect to a pregnant woman who is in active labor—that there is adequate time to affect a safe transfer to another hospital before delivery or that transfer may pose a threat to the health or safety of the woman or the unborn child;
> - A psychiatric emergency involving a significant risk or serious harm to oneself or others;
> - A substance abuse emergency exists if there is significant risk of serious harm to a Member or others, or there is likelihood of return to substance abuse without immediate treatment
>
> "***Medically necessary***" means a medical assistance service, item or supply defined in HFS 101.03 (96m) as a medical assistance service under Ch. HFS 107 that meets the following standards:
>
> - Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
> - Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;
> - Is appropriate with regard to generally accepted standards of medical practice;
> - Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
> - Is of proven medical value or usefulness and, consistent with s. DHS 107.035, is not experimental in nature;
> - Is not duplicative with respect to other services being provided to the recipient;
> - Is not solely for the convenience of the recipient, the recipient's family or a provider;
> - With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost−effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
> - Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

Emergency Admissions

Emergency admissions, defined as those situations in which the patient requires immediate medical intervention, do not require prior authorization. However, Trilogy should be notified by the admitting facility within 24 hours following admission or by the next business day if on a weekend or holiday.

Trilogy should be notified within 24 hours of an emergency admission or by next business day by the admitting facility. Information required includes:

- Patient's name and member number
- Admitting diagnosis
- Treatment plan
- Date of Admission

Emergency review will be done retrospectively at the time the admission review is done by the Utilization Management staff. Determination will be made regarding compliance with established criteria. In cases where the criteria are met, the admission may be authorized and the facility notified of the approval.

In cases where criteria compliance is questionable or not met, the admitting physician will be contacted for further information. If, after speaking with the admitting physician, criteria are still not met, the case is referred to the Trilogy Medical Director who will discuss the case with the physician personally.

Final determination is made by the Trilogy Medical Director.

Prior Day Admissions

Day prior admissions for procedures are **not** a covered benefit unless the physician can document an expected **improved outcome** from the day prior admission. Requests for day prior admission are evaluated on a case-by-case basis by Trilogy. The admitting physician must provide supporting documentation. If the extra day meets designated criteria for inpatient stay, the day prior to admission will be approved. If the extra day does not meet the designated criteria, the Trilogy Medical Director will review the request and make a final decision.

Delivery and Length of Stay

Postpartum length of stay is based on the type of delivery and other services provided. Postpartum discharge will be routinely assumed to occur at two days for vaginal delivery, and at four days for cesarean delivery. Postpartum tubal ligations should be done within 24 hours of delivery. Total length of stay for delivery with postpartum tubal ligations should not exceed 48 hours.

Anesthesiology

Anesthesiologists providing surgical anesthesia do not need a separate authorization. They will be covered under the inpatient authorization obtained by the facility and claims will not be denied for lack of prior authorization.

Anesthesiologists providing pain management outside of a surgical setting do require prior authorization.

Home Health Care

Home health agencies should initiate the authorization request. Submit signed physician orders and the home health agency's assessment (including an in-person assessment) with the completed authorization form. Trilogy will review the request and make a determination based on medical necessity. Please note that custodial care is not covered.

PT/OT/ST

After an initial evaluation, a signed physician request and a copy of the initial evaluation (including an in-person assessment) with a plan of care should be submitted with the appropriate form requesting authorization. An initial evaluation and any modality performed on the same day do not require a referral. Any future services do require a referral and should not be performed until an approved referral is received.

REFERRAL AND PRIOR AUTHORIZATION SUBMISSION

If a referral is required for the services desired, it must be made to specialists within the same network as the Primary Care Provider. If the desired specialty is not located within that network, or for other out-of-network referrals, contact Trilogy Medical Management for assistance. Call 414-755-3619 or 855-530-6790 and press the prompt for Medical Management. Please note that ***backdated referrals are not permitted.*** Primary Care Providers must submit referral information in a timely fashion to allow for processing time. Unless a referral is not required in a specific situation, specialists may not see members without an approved referral.

All Referrals and Authorizations will be reviewed by the Medical Management staff using criteria established by the State of Wisconsin Medicaid guidelines and Milliman Care Guidelines. If documentation is incomplete, the request for authorization will be denied administratively. ***You must receive confirmation of approval prior to performing a service.***

The referral or authorization will be approved as a covered benefit if the requested service and submitted documentation is consistent with clinical guidelines. If the requested service requires the determination of medical necessity or the appropriateness of care, the request will be referred to one of Trilogy's Medical Directors for review and determination. All decisions to deny, or reduce the duration, amount or scope of a requested authorization must be reviewed and signed off by a Medical Director. The Medical Director who makes the decision on a denial or reduction in services will have the appropriate clinical expertise in an area relevant to the member's condition or disease.

NO REFERRAL OR PRIOR AUTHORIZATION from Trilogy is needed when other insurance is primary.

Time Frames

Referral requests should be made 2 to 3 working days prior to a scheduled appointment.

Authorization requests should be made 7 to 10 working days prior to an elective admission or outpatient procedure, and within 24 to 48 hours after emergency admissions.

If expedited service is required for either a referral or authorization, please call Trilogy and let us know.
Call 414-755-3619 or 855-530-6790.

Determination will be made within 2 working days unless the nature of the admission or procedure requires review of medical records. The Medical Management staff will make every effort to expedite the review process and many times determination will be made the same day as the request.

Urgent prior authorization requests will be determined and the provider notified within one working day.

Urgent or ***Emergent*** Prior Authorizations, unless defined otherwise by a state are defined as those requests for services to treat situations which involve the resolution of acute pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury that a prudent layperson, possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person, or
- Serious disfigurement of such person.

Notification

The notification of the determination of a request for authorization is communicated in writing to the treating Provider as expeditiously as the member's condition requires:

1) Within 14 days of the receipt of the request (with one 14-day extension if it is determined that additional information is required to make a decision), or
2) Within 3 working days if the physician indicates or Trilogy determines that following the ordinary time frame could jeopardize the member's health or ability to regain maximum function.

In the case of denial of an authorization request or failure of the Utilization Management staff to make a determination within required timeframes, a letter is sent to both the member and provider indicating the service that is being denied, the criteria used to make the determination, appeal rights and procedures to both Trilogy and the Department of Health Services.

Trilogy shall provide to the Provider and the member, upon request, a copy of the review criteria utilized in benefit determination and the qualifications of the medical professional that made the determination to deny it.

No requests for referral or prior authorization are approved immediately. All requests are reviewed prior to determination of approval. You may be required to submit medical records.

Retrospective Review or Post Service

All urgent or emergent prior authorization will be reviewed retrospectively.

The Provider must send in the appropriate documentation marked "Retrospective Review" along with all necessary documents to be reviewed after treatment has been provided. The retrospective review is completed by the nurse to determine coverage and to certify that the services were urgent or emergent in nature. The clinical criteria utilized in the retrospective review are the same criteria utilized in the prior authorization process to determine medical necessity and appropriateness of care. All decisions to deny, or reduce the duration, amount or scope of a requested authorization must be reviewed and signed off by a Medical Director. The Medical Director who makes the decision on a denial or reduction in services will have the appropriate clinical expertise in an area relevant to the member's condition or disease.

Time Frames for Retrospective Review or Post Service

All retrospective reviews shall be determined within thirty (30) working days from the initiation of the UM process unless a more stringent standard applies per regulation. Provider notification of denied or reduced determinations will be made within two (2) working days of the decision by Trilogy.

Checking the Status of a Referral or Authorization

Prior to receiving notification, the PCP or person requesting Authorization may call Trilogy at 414-755-3619 or 855-530-6790 and speak with the Medical Management Staff.

SERVICES WITH SPECIAL REGULATIONS, PRIOR AUTHORIZATION OR CONSENT REQUIREMENTS

Abortion

No prior authorization is required; however, documentation of the following must accompany claim submission. The abortion must be directly and medically necessary to save the life of the mother. The physician must attest that based on his or her best clinical judgment that the abortion meets this condition. There should be a statement to that effect when a claim for an abortion is submitted.

Abortions are covered in a case of sexual assault or incest, provided that prior to the abortion the physician attests to his or her belief that sexual assault or incest has occurred by signing a certification, and provided that the crime has been reported to the law enforcement authorities.

Abortions are covered if, due to a medical condition existing prior to the abortion, the physician determines that the abortion is directly and medically necessary to prevent grave, long-lasting physical health damage to the mother, provided that prior to the abortion, the physician attests, based on his or her best clinical judgment that the abortion meets this condition.

Services performed in connection with the abortion such as lab work, ultrasound, etc. are not covered unless the abortion is performed under the guidelines and restrictions above. However, treatment for complications arising due to an abortion is covered regardless of whether the abortion itself is covered or not.

Trilogy complies with Wisconsin Statute 20.927 which stipulates that physicians must affix to their claims for reimbursement written certification attesting to the direct medical necessity of the abortion or his or her belief that sexual assault or incest has occurred and has been reported to law enforcement authorities.

Abortion services are also subject to prior consent as defined below.

Mifeprex

No prior authorization is required; however, documentation of the following must accompany claim submission. Administration of Mifeprex (morning after pill) follows the same rules as for Abortions. Wisconsin Medicaid Reimburses for Mifeprex (known as RU-486 in Europe) under the same coverage policy that it reimburses other surgical or medical abortion. Only physicians may obtain and dispense Mifeprex.

Provider must attach to each claim a completed Abortion Certification Statement that includes information showing the situation is one in which Wisconsin Medicaid covers abortion.

Consent for Abortion or Mifeprex

A woman's consent to an abortion (including administration of Mifeprex) is not considered informed consent unless at least 24 hours prior to an abortion a physician has, in person, orally provided the woman with certain information specified in the statute. That information includes, among other things, all of the following:

- Medical risks associated with the woman's pregnancy.
- Details of the abortion method that would be used.
- Medical risks associated with a specific abortion procedure.
- "Any other information that a reasonable patient would consider material and relevant to a decision of whether or not to carry a child to birth or to undergo an abortion."

Claims submitted with no Consent Form or Abortion Certification Statement on file will be denied.

Sterilization

Prior authorization is needed for sterilization procedures for both males and females. Sterilization (rendering an individual incapable of reproducing) is covered under Medicaid when it is the primary purpose of a surgical procedure under strict federal and state requirements.

A completed informed consent form must be submitted with the claim in addition to obtaining prior authorization in order for the claim to be paid. To consent to sterilization, the following conditions must apply:

Individual must be 21 years old at the time consent is given.

Individual must not have been declared mentally incompetent by federal, state or local court for any purposes unless that individual has been declared competent for the purpose of consenting to sterilization.

Individual is not institutionalized.

Individual has voluntarily given informed consent as follows:

- At least 30 days, but not more than 180 days have passed between the date of informed consent and surgery (except in the case of premature delivery or emergency abdominal surgery)
- An individual may be sterilized at the time of premature delivery if informed consent was given at least 30 days before the expected date of delivery and at least 72 hours have passed since informed consent for sterilization was given
- In the case of emergency abdominal surgery informed consent was given at least 72 hours prior to the surgery.

Sterilization by Hysterectomy or Hysteroscopy

Patient Consent Form is needed for hysterectomies or hysteroscopies.

Hysterectomy performed ONLY to produce sterility is covered if:

- The individual providing the information for the hysterectomy has informed the individual orally and in writing that the procedure will render her permanently incapable of reproducing
- The individual has signed and dated a written acknowledgement of receipt of that information prior to the hysterectomy being performed.

Hysterectomy may be performed on an individual who was already sterile and whose physician has provided written documentation, including a statement of the reason for sterility, with the claim form or requiring a hysterectomy due to a life-threatening situation in which the physician determines that prior acknowledgement is not possible (the physician performing the operation shall provide written documentation including a description of the nature of the emergency with the claim form).

Before reimbursement for either Sterilization or Hysterectomy is made Trilogy must have:

- Completed consent form https://www.dhs.wisconsin.gov/forms/F0/F01164.docx

- Acknowledgement of receipt of hysterectomy information or a physician's certification form for hysterectomy performed without prior acknowledgement of receipt of hysterectomy information.

CLAIM SUBMISSION

General Information

Checking Claim Status

The status of submitted claims may be obtained by calling 414-755-3619 or 855-530-6790 and speaking with the Customer Service Staff. When speaking with a Customer Service Representative we ask that you limit the number of claims you are calling on to 5 at one time. We need to do this in order to ensure that other callers receive prompt attention. Claims will be paid or denied within 30 days of receipt. For larger projects related to claims please contact provider relations at 855-530-6790 or providerrelations@trilogyhealthinsurance.com.

Coding

Trilogy requires claims to be billed in compliance with required Wisconsin Medicaid instructions for your specific services as described in the online provider handbooks and published provider updates which may be accessed through the Forward Health Portal https://www.forwardhealth.wi.gov/WIPortal/ Online handbooks specify allowable provider types, procedure and/or diagnosis codes, modifiers, unit limits and related information to be used when billing specific services.

In addition, claims will be processed in compliance with the provider type/specialty, place of service, modifiers and procedure codes specified in the Medicaid fee schedule which also may be accessed through the Forward Health Portal

Referrals and Prior Authorization requirements listed on the Forward Health Portal refer to Medicaid Fee for Service claims. Trilogy's requirements may be different. Please refer to the Referral and Prior Authorization section of this manual for Trilogy's requirements.

Coordination of Benefits

Trilogy will deny claims if it is determined that the member has other insurance as their primary carrier. Trilogy requires a copy of the EOB (Explanation of Benefits) or electronic submission of other insurance payments showing a denial or payment from the primary insurance carrier before payment will be considered or coordinated.

1. Only services covered by Medicaid are payable regardless of other insurance coverage.

2. Trilogy will consider the Medicaid allowable for the entire claim and the entire amount paid by the primary insurance when calculating secondary payment. If the primary insurance paid more than Medicaid allowable for the entire claim no additional money will be paid.

Electronic Claim Submission

HIPAA X12 standards, version **5010** regulates the electronic transmission of specific health care transactions and became effective in 2012. Covered entities, such as health plans (including Trilogy), health care clearinghouses, and health care providers, are required to conform to **HIPAA 5010** standards. Therefore, all electronic claims submitted to Trilogy must be submitted in compliance with HIPAA 5010 standards. Claims must be submitted within 120 days of the date of service or the timeframe specified within the providers' contract.

Claims may be submitted electronically. Use payer ID 62777.

Overpayments

Pursuant to 42 CFR s. 438.608 Trilogy must recover all overpayments made to network providers, and further require providers to return overpayments within 60 days of identification by the provider or notice of overpayment by Trilogy. Overpayments may occur due to changes in primary insurance coverage, member eligibility, provider billing errors, health plan payment error, post payment audits, or similar reasons. Trilogy may request refunds in writing but reserves the right to offset overpayments against, or deduct or recoup overpayments from, any other payments Trilogy owes to Provider. Failure of the provider to refund overpayments either when requested by Trilogy or identified by the provider will result in recoupment of funds or further collection activities.

Paper Claim Submission

Paper claims submitted to Trilogy must be complete and contain all information required to process the claim and comply with Wisconsin Medicaid standards. Claims must be submitted within 120 days of the date of service or the timeframe specified within the providers' contract.

Claims with attachments and paper claims must be submitted to:

Trilogy Health Networks
P.O. Box 1171
Milwaukee, WI 53201

Resubmission of Corrected Claims: Providers may resubmit a claim that has been corrected or modified from the original submission via the normal claim submission process within 60 days of original payment/denial or the timeframe specified within the providers' contract. Resubmitted claims should not be sent to the provider appeals address.

Electronic submission: payer ID 62777. Paper claims or claims with attachments should be mailed to: Trilogy Health Networks, P.O. Box 1171, Milwaukee, WI 53201

ELECTRONIC REPLACEMENT/CORRECTED CLAIM SUBMISSIONS. The Trilogy Health Insurance claim system recognizes claim submission types on electronic claims by the frequency code submitted. The ANSI X12 837 claim format allows you to submit changes to claims that were not included on the original adjudication. Please refer to the 837 Implementation Guides for explanation and usage of claim frequency codes.

Supportive Documentation

Providers must submit additional information and/or documents when billing the following services.

Abortion: Trilogy complies with Wisconsin Statute 20.927 which stipulates that physicians must submit written certification attesting to the direct medical necessity of the abortion or his or her belief that sexual assault or incest has occurred and has been reported to law enforcement when submitting claim. Abortion claims must also be submitted with a completed informed consent form.

Hospice Services: HMOs are required to have hospice providers submit form F-01008 Notification of Hospice Benefit Election with the first claim.

Hysterectomies: Hysterectomy may be performed on an individual who was already sterile and whose physician has provided written documentation, including a statement of the reason for sterility, with the claim form or requiring a hysterectomy due to a life-threatening situation in which the physician determines that prior acknowledgement is not possible (the physician performing the operation shall provide written documentation including a description of the nature of the emergency with the claim form)
Before reimbursement for either Sterilization or Hysterectomy is made Trilogy must have:

- A signed informed consent form
- Acknowledgement of receipt of hysterectomy information or a physician's certification form for hysterectomy performed without prior acknowledgement of receipt of hysterectomy information

Sterilization: A completed informed consent form must be submitted with the claim for sterilization in addition to obtaining prior authorization in order for the claim to be paid.

Timely Filing

Claims should be submitted to Trilogy within 120 days of the date of service or of discharge or the timeframe specified within the providers' contract. Timely filing limits will vary by contractual agreement with Trilogy.

Timely Filing When Trilogy is Secondary Payer

When Trilogy is the secondary payer due to other insurance coverage, the provider must submit the claim along with the EOB or explanation that payment from the primary carrier was sought first. Trilogy will allow 120 days from the date of the primary carrier's EOB, or the providers' contracted limits.

SPECIFIC CLAIM TYPES

Specific billing requirements included in this section of the manual are not all inclusive and are presented for quick reference and reminders for commonly billed services.

Anesthesiologists

Anesthesiologists providing surgical anesthesia do not need a separate authorization. They will be covered under the inpatient authorization and claims will not be denied for lack of prior authorization. Anesthesiologists providing pain management outside of a surgical setting, do require prior authorization (see the Referral and Authorization section of this manual)

Behavioral Health

Trilogy requires providers to bill mental health and substance abuse services in accordance with published service specific provider online handbooks available on the Forward Health Web Portal. Such handbooks specify billable provider types/specialties, modifiers, allowable places of service and other informative coding specifications.

ForwardHealth Clarification of Coverage of IOP and PHP for Hospital Providers

Wisconsin Medicaid covers a continuum of non-inpatient behavioral health services, including intensive outpatient programs (IOP) and partial hospitalization programs (PHP). WI Medicaid covers these programs, when medically necessary, for all full-benefit Medicaid members and requires all contracted BadgerCare Plus and Medicaid SSI health plans (HMOs) to cover these services. Relevant coverage policies and requirements for these services are described in Wis. Admin Code chs. DHS 105 and 107 and the ForwardHealth Online Handbook. In most cases, the services provided in an IOP are covered in accordance with published policy for outpatient mental health services or outpatient substance abuse services. For more intensive services, the IOP provider would be certified as a day treatment program and provide services under the day treatment policy. The services provided in a PHP are always covered in accordance with published policy for mental health or substance abuse day treatment.

Wisconsin Medicaid covers medically necessary IOPs and PHPs provided by certified hospitals when delivered in accordance with all program requirements.

IOP Services

When providing "outpatient mental health" or "outpatient substance abuse treatment", including most IOPs, hospitals may submit claims for the service using the UB-04 claim form and the appropriate revenue and procedure codes. The services must be provided within the licensed hospital. The WI Medicaid Claims and Encounter systems are configured to accept revenue codes 0905 and 0906 submitted with the appropriate HCPCS procedure codes.

PHP/Day Treatment Services

When providing day treatment services, including PHPs, hospitals must adhere to published policy requirements for "adult mental health day treatment" and "substance abuse day treatment". These requirements include provider certification as a day treatment program by the Wisconsin Division of Quality Assurance and submission of health care claims on a 1500 Health Insurance Claim form using HCPCS code H2012. Institutional claims on the UB-04 claim form using revenue codes 0912 and 0913 are not reimbursable by WI Medicaid, but the day treatment services themselves remain covered and reimbursable when claims are submitted in accordance with published policy.

BMI (Body Mass Index)

Wisconsin Medicaid allows reimbursement to eligible providers and clinics for reporting BMI on professional claims for routine office visits and preventive services for members 2 to 18 years of age on the date of service. For the additional reimbursement, procedure code 3008F should be billed. An office visit procedure code may be billed in addition to the BMI code. Providers are required to maintain records that fully document the basis of charges upon all claims for additional reimbursement payments are made.

Chiropractic Services

Chiropractic claims are only payable under Wisconsin Medicaid for the following diagnosis codes:
M99.01 M99.02 M99.03 M99.04 M99.05

EAPG Priced Claims

Wisconsin Medicaid calculates payment on outpatient hospital claims using EAPG methodology. All charges billed for an outpatient encounter are considered in combination with each other using a formula that takes multiple factors into consideration and therefore each individual line may or may not generate a separate payment. In order to consider the encounter and pay the correct amount, all charges for the outpatient encounter must be submitted on a single claim form. By splitting up charges for a single event into multiple claims, there is the potential for both underpayment or overpayment of the claim. Splitting up charges for the purpose of obtaining a greater reimbursement may constitute fraud. If additional charges are required after the initial claim has been submitted, a single corrected claim which includes all charges for that encounter must be submitted. Portions of a single encounter will not be paid separately.

Laboratory Services - CLIA

Trilogy complies with Federal CLIA requirements. All providers who perform lab tests in their office or facility are required to comply with Title 42 CFR Part 493, Laboratory Requirements "Any facility where testing is performed on specimens collected from human beings for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or assessment of health, comes under the Federal CLIA requirements". There are four different CLIA certificates:

- Certificate of Waiver
- Provider Performed Microscopy
- Certificate of Compliance
- Certificate of Accreditation

CLIA regulations apply to *all* providers who perform CLIA-monitored laboratory services, including, but not limited to, the following:

- Clinics.
- HealthCheck providers.
- Independent clinical laboratories.
- Nurse midwives.
- Nurse practitioners.
- Osteopaths.
- Physician assistants.
- Physicians.
- Rural health clinics.

Laboratory Services - Handling Fees and Venipuncture

Trilogy will pay lab handling fees ONLY if a specimen was for a Covered Service and was sent out of the office to a contracted lab for processing. This must be indicated properly on the claim in box 20 of a CMS 1500 form or through the use of a 90 modifier.

Venipuncture (36415) is not separately billable; fee in included in the lab procedure or handling fee reimbursement.

Newborn Claims

Claims for newborns should NOT be billed under the mother. Newborns should be billed separately under the child's own ID number and are not payable under the mother's ID number. If the child's ID number is not known at time of discharge, the claim will be held by Trilogy until the child has a number.

Non-Anatomical Pathology Charges

Reimbursement for the professional component of non-anatomical pathology is included in the reimbursement for the lab code. Claims submitted for the professional component for non-anatomical pathology for codes that are not on the exemption list will be denied. This includes claims submitted by a pathologist.

Off Campus Provider Based Clinic Services

In accordance with the Forward Health Update January 2016 No. 2016-02, For services provided in an off-campus provider-based outpatient clinic, the professional claim should be submitted with POS code 19. Per the new national code-set changes, hospital providers are required to include modifier PO on institutional claims to indicate the facility charge for services provided in off-campus provider-based outpatient clinics.

However, per ForwardHealth's "4 walls policy," Wisconsin Medicaid will not reimburse a facility charge for services provided in a provider-based outpatient clinic. Thus, ***institutional claims submitted with modifier PO for services provided in a provider-based outpatient clinic will be denied***. Note: Providers may not omit modifier PO on an institutional claim submitted to ForwardHealth for services provided in an off-campus provider-based outpatient clinic as a mechanism to receive reimbursement for the facility charge.

Pharmacy and Disposable Medical Supply Claims

Most pharmacy and disposable medical supplies (supplied by pharmacies) for Medicaid recipients are not administered through Wisconsin Managed Care Organizations. This is a carved-out service that is handled through FFS. Please bill these items directly to Wisconsin Medicaid. Forward Health publishes procedure codes that are and are not included in the carve out and publishes the table which can be found on the Forward Health Portal https://www.forwardhealth.wi.gov/WIPortal/content/Provider/medicaid/physician/resources_31.htm.spage

Podiatry

Routine foot care is defined as the cleaning, trimming, cutting, and debridement of toenails, corns, and callouses.
To receive routine foot care, the member must be under the active care of a physician and have one of the following diagnoses:

- Arteriosclerosis obliterans evidenced by claudication.
- Blindness.
- Cerebral palsy.
- Cerebrovascular accident.
- Diabetes mellitus.
- Guillian-Barre syndrome.
- Multiple sclerosis.
- Parkinson's disease.
- Peripheral neuropathies involving the feet, which are associated with one of the following:
  - Malnutrition or vitamin deficiency.
  - Diabetes mellitus.
  - Drugs and toxins.
  - Multiple sclerosis.

Uremia.
Polio.
Scleroderma.
Spinal cord injuries.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

BadgerCare Plus and Medicaid SSI covers substance abuse screening and intervention known as Screening, Brief Intervention, and Referral to Treatment (SBIRT). This benefit applies to Trilogy members who are 10 years or older on the date of service (DOS). SBIRT claims should be submitted with HCPCS procedure codes H0049 or H0050 and corresponding diagnosis codes Z13.9 and Z71.89

Therapy (Physical, Occupational, Speech) Claims

Therapy claims submitted by hospitals must only be billed on a CMS 1500 form or 837p electronic transaction with CPT codes. Respective modifiers must be billed with each service type. Physical Therapy = GP, Occupational Therapy = GO, Speech Therapy = GN.

Vaccines and the Vaccines for Children Program (VFC)

Providers are required to indicate the procedure code of the actual vaccine administered, not the administration code, on claims for all immunizations. Reimbursement for both the vaccine, when appropriate, and the administration are included in the reimbursement for the vaccine procedure code, so providers should not separately bill the administration code.

Vaccines that are commonly combined, such as MMR or DTaP, are not separately reimbursable unless the medical necessity for separate administration of the vaccine is documented in the member's medical record.

Under the Vaccines for Children Program (VFC) all vaccines that are approved by the Advisory Council on Immunization Practices (ACIP) for children **less than 19 years of age** are available to providers enrolled in the VFC program. When a new vaccine is approved and the ACIP recommendations are published, the Wisconsin Immunization Program will have that vaccine available for providers to order as soon as it becomes available.

For vaccines that are not available through the VFC program, and vaccines provided to adults 19 years of age and older, providers may use a vaccine from a private stock. In these cases, the administration fee and vaccine fee will be payable however, only the vaccine code should be billed. The reimbursement for the vaccine code will include administration automatically. No modifier U1 is required to obtain reimbursement for both the vaccine and the administration. If the administration code is billed it will be denied because the reimbursement for administration is being paid under the vaccine code.

PROVIDER CLAIM APPEALS AND REQUESTS FOR RECONSIDERATION

Definitions

Reconsideration of a Claim: A request to review a claim or a portion of a claim that a provider feels was incorrectly paid or denied. A request for reconsideration of a claim is not a formal appeal. Contact Customer Service by phone: 855-530-6790, or fax: 414-755-4410 to request reconsideration. In the event the reconsideration does not resolve the provider's dissatisfaction with the claim, Customer Service will provide information on filing a formal appeal. (timely filing of appeals is still subject to the providers' contracted timeframe or 60 calendar days from the initial denial or payment notice.)

Resubmission of a Claim: Submission of a previously submitted claim that that has been corrected, modified, or includes information that was missing on the first claim. Submit claim(s) via the normal claim submission process and within 60 days of the initial submission or within the providers' contracted timeframe. Electronically: Paper claims or claims with attachments should be mailed to: Trilogy Health Networks, P.O. Box 1171, Milwaukee, WI 53201. Code electronic claims with the appropriate Claim Frequency Code (7) that identifies a "corrected" claim to avoid a duplicate claim denial. DO NOT submit corrected claims to the Provider Claim Appeals Department.

Appeal: An application or proceeding for review when a provider does not agree with the claim reconsideration decision. Formal Appeals to Trilogy must be submitted in writing clearly marked "appeal". A written response will be provided. Appeals must be submitted within 60 days of initial payment/denial or the time frame specified in the providers' contract. The appeal must include:

- Provider's Name, Date of Service, Member's name and BadgerCare Plus Medicaid ID number
- The reason(s) the claim merits adjustment and supporting documentation, submit medical records if the reason for the appeal is related to medical necessity
- A return address for the response is required. All communication will be sent in writing. If no return address is provided the response will be sent to the service location address on the claim(s) being appealed. Trilogy is not responsible if the entity filing the appeal does not receive the response in that situation.

  Mail appeals to: Trilogy Provider Claim Appeals Department, P.O. Box 70491 Milwaukee, WI 53207
  Fax appeals to 414-755-4410. **For appeals with medical records or large volume, Fax to** 414-448-6710

Procedure

Upon receipt of the appeal, Trilogy will review the appeal and respond within 45 days unless your contract specifies a different time period. If the decision is in your favor, the claim will be paid within 30 days. After exhausting all appeal rights with the HMO, if a provider disagrees with the HMO's appeal response, they have the right to appeal to the Department of Health Services (DHS). Failure to follow the provider appeal process with the HMO will result in the appeal denial being upheld.

Appeals to the Department must be submitted in writing within 60 calendar days of the date on the HMO's final decision notice or, in the case of no response, within 60 calendar days from the 45-calendar day timeline allotted the HMO to respond. If, based on the preliminary information provided by the provider, the Department determines that there is insufficient evidence to overturn the original denial, the Department will not pursue additional contact with the HMO or the provider and uphold the denial. If, however, the Department determines that the provider's appeal necessitates further review, it will seek rebuttal from the HMO. The Department may send an official Request for Additional Information notice, as appropriate, either via US mail or secure email to the HMO or the provider. The Additional Information notice and requested documents must be returned to the Department, within 14 (or 21) calendar days (unless 21 calendar days is granted by DHS due to volume of appeals), via US mail, fax or electronically if sent over a secure network. If the HMO fails to submit the requested information by the date required by the Department, the Department will overturn the original denial and compel the HMO to pay the claim. The Department will uphold the original denial if the provider fails to provide the requested information as outlined in the BadgerCare Plus Handbook.

A decision to uphold the HMO's original payment denial or to overturn the denial will be made based on the documentation submitted for Departmental review. Failure to submit the required documentation or submitting incomplete/insufficient/illegible documentation will lead to an upholding of the original denial. The decision to overturn an HMO's denial must be clearly supported by the documentation submitted for review.

Providers may use the Department's form when submitting an appeal for State review. All elements of the form must be completed or listed in a letter if the form is not used. The form with instructions is available at the following website: https://www.dhs.wisconsin.gov/library/F-12022.htm. Providers are required to submit legible copies of all of the following documentation. Incomplete appeals will not receive Departmental review and the denial will be upheld. The appeal packet must contain:

- A copy of the original claim submitted to the HMO. If applicable, include a copy of all corrected claims submitted to the HMO.
- A copy of all the HMO's payment denial remittance(s) showing the date(s) of denial and reason code with a description of the exact reason(s) for the claim denial.
- A copy of the provider's written appeal to the HMO
- A copy of the HMO response to the appeal.
- A copy of the medical record for appeals regarding coding issues, or emergency determination. Providers should only send relevant medical documentation that supports the appeal. Large records submitted with no indication of where supporting information is found, will not be reviewed. Large documents should be submitted on a CD.
- A copy of any contract language that supports the appeal. If contract language is submitted, indicate the exact language that supports overturning the payment denial. Contract language submitted with no indication will not be reviewed and the appeal denial upheld. Contract language will be used to determine compliance.
- Any other documentation that supports the appeal (e.g., commercial insurance Explanation of Benefits/Explanation of Payment to support Wisconsin Medicaid as the payer of last resort).

Appeals to the Department can be faxed or mailed to: BadgerCare Plus and Medicaid SSI Managed Care Unit – Provider Appeal P.O. Box 6470 Madison, WI 53716-0470 Fax Number: 608-224-6318

Providers should notify ForwardHealth if the HMO subsequently overturns their original denial and reprocesses and pays the claim for which an appeal has been submitted. Notification should be faxed to ForwardHealth at 608-224-6318. This documentation will be added to the original appeal documentation to complete the record and the appeal withdrawn. Providers can also call Managed Care Ombudsman Program Unit at (800) 760-0001, option 1, to check on the status of a submitted appeal.

The Department has 45 days from the date of receipt of all written comments to inform the provider and the HMO of the final decision. If the Department's decision is in favor of the provider, the HMO will pay provider(s) within 45 days of receipt of the Department's final determination. The HMO and the provider must accept the Department's final decision regarding appeals of disputed claims. A reconsideration of a final decision will only be made if an error has been made or there was a misrepresentation of facts. The Department will review the appeal documents and make a Final Decision based on the contract (both the DHS-HMO contract and the HMO-provider contract, if submitted, will be used to make the decision). The Department does not adjudicate appeals for clinical level of care (e.g. observation vs. inpatient) provided to the member, nor does the Department review the results of contractually agreed upon HMO reviews of claims or medical records. As these actions are a contractual requirement, the HMO review decisions are not appealable to DHS.

Immunity from Punitive Action

Trilogy does not take any punitive action against a member or Provider for filing a complaint, appeal or grievance on behalf of themselves or on behalf of someone else. This includes members or providers requesting expedited resolution.

Please note: Providers requesting an appeal on behalf of a member who has been denied services should not use the provider claim appeal process. Please see the Member Appeals and Grievances section of this document.

CARE MANAGEMENT

Care Management is the umbrella term for Trilogy's overall program which encompasses Disease Management, and Medical Case Management. Both clinical and non-clinical staff is available and part of the program and work with DME providers, PCPs, specialists, discharge planners, social service and community agencies and others in a comprehensive program which address Trilogy's special needs members.

Trilogy identifies members who are appropriate for the care management program but Providers may also refer their patients for care management by calling 414-755-3619 or 855-530-6790 and selecting the prompt for "care management". A form for this purpose is also provided at the end of this manual and posted on the Trilogy website http://www.TrilogyHealthInsurance.com. The form may be faxed to Trilogy at: 414-771-1159 or emailed to CareManagement@trilogyhealthinsurance.com.

Members who may be included in this category are those with conditions such as:

(1) Chronic conditions such as asthma, diabetes, renal disease or co-morbid conditions
(2) High risk pregnancy
(3) Premature babies
(4) Catastrophic conditions such as cancer
(5) Psychiatric and/or substance abuse

Prenatal Management

Trilogy's care management program for high risk pregnant women includes prenatal, interconception and post-partum strategies and services. Women who fall into more than one category of care management such as those with chronic medical conditions and/or mental health or substance abuse issues are especially important to recognize early and get into a program.

All providers who see pregnant women as patients are asked to notify Trilogy as possible in the member's pregnancy so that we can initiate pre-natal Case Management services. Trilogy is committed to working with you and our members to ensure healthy birth outcomes.

Providers are asked to use the Trilogy ***Pregnancy Notification Form*** (at the end of this manual) for this purpose. Please complete and fax it to 414-771-1159.

Disease Management

At the present time, Trilogy utilizes self-management/educational booklets which are placed in participating provider offices. Providers are encouraged to give the booklets to the Trilogy members they identify as appropriate. When the provider gives out a booklet they are asked to submit a referral form for case management. After a few days are allowed for the member to review the book, the member is called by a nurse who will go over the material in the book with them, answer questions and determine if medical case management is appropriate. Additional booklets are retained in the care management department and are sent to members who are identified as being appropriate. The following booklets are available:

- Asthma Management
- Advanced Directives/End of Life
- Congestive Heart Failure Management
- Chronic Obstructive Pulmonary Disease Management
- Coronary Artery Disease Management
- Diabetes Management
- Hypertension Management
- Preventive Medicine Services

QUALITY IMPROVEMENT PROGRAM

Overview

The Quality Improvement Program incorporates both quality and processes as they relate to the delivery of health care as well as the quality of service to Trilogy's members. The program has processes in place to monitor and evaluate health care services including patient safety and access to medical care.

Goals/Objectives of the Program

- Integrate quality improvement processes throughout Trilogy's health care delivery system and in the application of national, state and Trilogy goals and health care initiatives
- Promote preventive health care through provider and patient education and support
- Promote quality care through adherence to established clinical guidelines
- Ensure access to care
    - Number and Location of providers of specific types
    - Length of time required to obtain appointments with PCPs and Specialists
    - Length of time waiting in a provider's office
    - Language and disability accommodations
- Assist the health plan in providing quality, cost effective and clinically sound care to its members
- Promote the utilization of technology to improve quality, efficiency and access to records and advanced medical care
- Promote preventive care
- Achieve HEDIS measures as defined in the contract between Trilogy and DHS.
- Achieve member and provider satisfaction
- Monitor and adhere to Medicaid and DHS requirements as it relates to Trilogy's membership

HEDIS

Specific goals are set annually in both clinical and administrative areas. Clinical quality categories and results from Trilogy providers are dictated by the Department of Health Services to the HMOs who provide Medicaid services to Wisconsin recipients. The Department of Health Services utilizes the Health Effectiveness Data and Information Set (HEDIS) to define the quality areas that are monitored each year.

Trilogy will assist you in reaching quality goals in a number of ways including:

- Outreach to your patients for reminders to get certain services such as childhood immunizations or HbA1c testing for diabetics, lead screens for children, mammography screening for women, etc.
- Feedback to you on your ratings and support from Trilogy's medical director.
- We will provide members with educational mailings throughout the year
- Providing you with educational self-care booklets to use with your patients under the disease management program.

Wisconsin Medicaid requires Trilogy to meet certain HEDIS quality indicators and to submit results. In order to fulfill that requirement, certain HEDIS quality indicators include collecting data from medical records through chart review. Trilogy will make every effort to accommodate provider office schedules and protocols and be as unobtrusive as possible when this becomes necessary.

Trilogy is required to report data to the state for the following HEDIS measures:

1. Antidepressant medication management
2. Controlling high blood pressure
3. Breast cancer screenings
4. Childhood immunizations prior to their second birthday
5. Follow up after mental health hospitalizations

6. Diabetes management with Hemoglobin A1C testing and control <8%
7. Emergency department utilization
8. Annual dental visits
9. Prenatal and postpartum care
10. Initiation and engagement of alcohol and other drug abuse treatment
11. Tobacco cessation
12. Lead screenings in children prior to their second birthday

For questions please reference the following web site: http://www.ncqa.org/hedis-quality-measurement/hedis-measures

PROVIDER RESPONSIBILITIES

Standards for Access to Care

General Information

Providers may not create barriers to access to care by imposing requirements on Members that are inconsistent with the provision of medically necessary and covered BadgerCare Plus benefits (e.g., COB recovery procedures that delay or prevent care).

Providers must comply with all non-discrimination requirements including but not limited to Title XIX of the Social Security Act and Title 42 of the CFR.

Providers must not discriminate in the provision of services or benefits on the basis of age, color, disability, national origin, race, religion or sex/gender. This policy covers enrollment, access to services, facilities, and treatment for all programs and activities.

After Hours and Substitute Coverage

All practitioners must have back-up (on call) coverage after hours or during the practitioner's absence or unavailability. Trilogy requires practitioners to maintain a twenty-four (24) hour phone service, seven (7) days a week. This access may be through an answering service or a recorded message after office hours. Callers must be told how to reach the provider they are calling or be told who is covering for that provider. All covering providers must be credentialed providers.

Office Wait Times

Trilogy standards limit providers to waiting times for a scheduled appointment to an average of 10 – 15 minutes. In no case should the wait by Trilogy members exceed that of any other patients served by the provider's office.

Appointment Wait Times

Trilogy has adopted the following as minimal standards for its contracted providers:

Preventive Care	Within 30 calendar days
Routine Primary Care (PCPs)	Within 14 calendar days
Urgent Care	Within 24 hours
High Risk Prenatal Care	Within 2 weeks of request, or within 3 weeks for a specific practitioner
Routine referral visits (Specialists)	Within 60 calendar days
Emergency Providers	Immediately (24 hours a day, 7 days a week) and without prior authorization
Urgent Visit	Within 24 hours of request of appointment
Non-Urgent, symptomatic care	Within 7 calendar days of request of appointment
High Risk Prenatal Care	Within 2 weeks of a request of appointment Within 3 weeks if the request is for a specific provider
Physical or Sexual abuse assessment	Immediately upon request of appointment

Emergency visit	Immediately upon request of appointment
Routine Dental Care	Within 90 calendar days
Emergency Dental Care	Within 24 hours
Mental Health Initial Assessment	Within 10 calendar days
Mental Health appointment following inpatient psychiatric hospital stay	Within 3 calendar days

*Emergency dental care is defined as an immediate service needed to relieve the patient from pain, an acute infection, swelling, trismus, fever or trauma.

Billing Medicaid Members

Balance billing BadgerCare Plus members by Wisconsin Medicaid providers is disallowed by regulation. Any provider who knowingly and willfully bills a BadgerCare Plus member for a Medicaid covered service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B.(d)(1) [42 U.S.C. 1320a-7b] of the Social Security Act and Wis. Stats. 49.49 (3m).

The standard release form signed by the member at the time of services does not relieve the HMO and its providers and subcontractors from the prohibition against billing a member in the absence of a knowing assumption of liability for a non-BadgerCare Plus covered service. If a member agrees in advance in writing to pay for a service not covered by BadgerCare Plus, then the HMO, HMO provider, or HMO subcontractor may bill the member. However, the form or other type of acknowledgment relevant to a member's liability must specifically state the admissions, services, or procedures that are not covered by BadgerCare Plus.

Billing Copays

Trilogy does not charge copays for any services it provides. Provider is prohibited from trying to collect any copays.

Billing for Missed Appointments/No Shows

Providers cannot bill Trilogy members for any missed appointments while the members are eligible under the BadgerCare Plus – Standard Plan Programs.

Providers should notify Trilogy's Member Advocate via e-mail at advocate@trilogyhealthinsurance.com if a member does not show up for a scheduled appointment and does not notify the provider in advance of the cancellation and provide the name of the patient and the date of the appointment(s). Trilogy's Member Advocate will contact the member and talk with him/her about the importance of keeping appointments.

If the patient exhibits a repeated pattern of missed appointment to the point where the provider intends to terminate care for a member, the provider must adhere to the following procedure.

Document the situation in the patient's chart

Send a certified letter to the patient with the following information:

- the reason for termination
- the effective date of the termination
- a directive to call Trilogy's Member Advocate for help selecting a new provider
- the phone number of the Member Advocate is 855-530-6790

Send a copy of the letter to Trilogy at the following address:

Trilogy Health Insurance
Attention: Member Advocate
18000 West Sarah Lane, Suite 310
Brookfield, WI 53045

A copy of the letter may alternately be faxed to 262-432-0396 or attached to email to: advocate@trilogyhealthinsurance.com. Retain a copy of the letter in the patient's chart
Providers must continue to see the patient for 30 days following the termination date for emergency services.

Confidentiality

Providers are expected to comply with all applicable federal, state, and local laws, rules, regulations and Medicaid requirements including, but not limited to the Health Insurance Portability and Accountability Act of 1996, and all rules and regulations promulgated hereunder. In addition, Providers must abide by the confidentiality requirements established by Trilogy and by the Medicaid program to ensure that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas; to maintain the records and information in an accurate and timely manner; and to ensure timely access by members to the records and information that pertain to them.

Cultural Competency

Providers are expected to incorporate cultural awareness and sensitivity in their interactions with Medicaid patients. In this context the term "cultural" incorporates language, ethnicity, gender, disability, economic status and religious beliefs.

Medical Records

Trilogy follows a minimum standard which conforms with Wis. Adm. Code, Chapter DHS 106.02, (9)(b) medical record content requirements and includes the following:

- Identifying information of the Member including name, Member identification number, date of birth, sex and legal guardianship (if applicable);
- A summary of significant surgical procedures, past and current diagnoses or problems, allergies, social and family history, untoward reactions to drugs and current medications (or notation that none are known);
- Periodic exam record
- Weight, height and BMI information and, if indicated-growth chart
- Dated and signed entries by the appropriate party;
- Relevant history of current illness/injury including: chief complaint/purpose/reason for the visit, the objective, diagnoses, medical findings or impression of the provider including behavioral health conditions;
- Indicated referrals and diagnostic studies ordered (e.g., laboratory, x-ray, EKG) and referral reports;
- Indicated therapies administered and prescribed including dosages and dates of initial or refill prescriptions;
- Clinical observations and description of services provided including the results of treatment
- Name and profession of the provider rendering services (e.g., MD, DO, OD), including the signature or initials of the provider;
- Disposition/results, recommendations, instructions to the Member, evidence of whether there was follow-up and outcome of services;
- A complete immunization history;
- Obstetrical history and profile (if applicable)
- Risk Assessment
- Anticipatory guidance and/or health education provided
- Family planning and/or counseling
- Information relating to the Member's use of tobacco products and alcohol/substance abuse;
- Summaries of all Emergency Services and Care and Hospital discharges with appropriate medically indicated follow up;
- Reflection of the primary language spoken by the Member and any translation needs of the Member;
- Identification of Member's need for communication assistance in the delivery of health care services;
- Documentation that the Member was provided with written information concerning the Member's rights regarding Advance Directives (end of life wishes DNR (do not resuscitate), written instructions for living will or power of attorney) and whether or not the Member has executed an Advance Directive. Neither Trilogy, nor any of its Providers shall, as a condition of treatment, require the member execute or waive an Advance Directive;
- Indication of where the services were provided;

- Any pertinent financial records;
- All entries will be indelibly added to the Member's record.

Medical record retention will also comply with 160 and 45 C.F.R. part 164 subparts A and E and generally accepted medical practice. Records must be maintained for a period of ten (10) years from the final date of the contract period.

Restraint Policy

Trilogy members have the right to be free from any form of restraint or seclusion used as a means of force, control, ease or reprisal. Trilogy supports a physical, social and cultural environment that limits restraint use to situations where it is clinically appropriate for the safety of the patient and in adequately justified situations. The goal is to protect the patient's health and safety, while preserving their dignity, rights, and well-being. It is Trilogy's policy that restraints should be used only where alternative methods are not sufficient to protect patients or others from injury and are not used as a substitute for less restrictive forms of protective restraint.

Notification of Changes

Trilogy providers should notify us at least 10 business days in advance of the change, in writing, if any of the following situations should occur. Changes in:

- Address, Phone or Email
- Billing service
- Tax id
- Status of accepting or not accepting new patients
- Office hours
- Services provided in the office
- Medical licensure to practice
- In the case of the death of a provider, office staff should notify Trilogy as soon as possible

Changes can be sent to dataservices@trilogyhealthinsurance.com or faxed to 414-755-4410

Provider Termination

Refer to your contract for specifics about all the various situations and notification requirements for those situations in which a provider or provider group wishes to terminate their participation in Trilogy. In general Trilogy requires at least one hundred eighty (180) days prior written notice. In the event of such termination, Providers shall remain available at Trilogy's option as a provider, in accordance with Wis. Stat. § 609.24, relating to continuity of care, to provide services to Members. Providers shall continue to provide health care services to Members who are hospitalized as of the termination date until such Member is discharged.

Notification of Provider Termination

Providers who notify their patients that they are terminating their relationship with Trilogy must include language to the member with instructions about how to obtain access to their medical records. Please refer member to the Trilogy Member Advocate at 855-530-6790 or through email at advocate@trilogyhealthinsurance.com. The Advocate will help ensure the member is apprised of all their rights and understands how to obtain their records.

Notification of Advance Directives:

Providers have a responsibility to inform patients about their right to have an advance directive. To provide patients with written information on state law about patients' rights to accept or refuse treatment, and the provider's own policies regarding advance directives. Providers must document in the patients' medical record any results of a discussion on advance directives. If a patient has, or completes an advance directive their patient file should include a copy of the advance directive.

MEMBER RIGHTS AND RESPONSIBILITIES

Trilogy respects the important role members play in their healthcare and informs them of their rights and responsibilities in filling that role. Members can expect certain things from Trilogy and from our Providers but they must understand there are certain things Trilogy and our Providers expect from them. These Members Rights and Member

Responsibilities are a key component in the development of a mutually respectful relationship between Trilogy, its Providers and its Members.

MEMBER RIGHTS

To be provided with a listing of Primary Care Providers (PCP) and be allowed to select a (and change) PCP from Trilogy's network of providers

To obtain information about services that are covered, services that are not covered and any costs that they may be responsible for paying

To participate in their care by making decisions, discussing appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage. Members have the right to obtain information about the risks and benefits of treatment. Members have the right to receive this information in terms they understand and to refuse medical care.

To obtain information about how to file a complaint, appeal, or grievance and to voice concerns about Trilogy, its providers or the quality of care they receive. Members have the right to receive a prompt and fair review of their concerns without being discriminated against.

To have Trilogy's Member Advocate help them resolve problems and guide them through the grievance process if they do not agree with a decision Trilogy made. Members have the right to appear in person and present their case in a grievance hearing or to have Trilogy's member Advocate represent their side at the hearing.

To ask for and receive information about Advance Directives

To comment and make recommendations about Trilogy's service, quality improvement programs and providers

To have covered services provided to them in a respectful, dignified, and culturally sensitive manner regardless of:

- Age
- Color
- Disability
- National Origin
- Race
- Sex

To expect and to receive the right to privacy and confidentiality in communications and records about their care

To receive medical treatment that is available when they need it. Members have the right to receive emergency medical treatment twenty-four hours a day/seven days a week

To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in Federal regulations on the use of restraints and seclusion

To have interpretation and translation services available to them free of charge

MEMBER RESPONSIBILITIES

To choose a personal provider (PCP) from among Trilogy's network of PCPs and to establish a relationship with that provider. Members have a responsibility to call Trilogy if they want to change their PCP

To read and understand their health insurance benefits and limitations, and to follow required procedures. Members also have a responsibility to know how to use Trilogy's provider network and to ask questions when they do not understand

To provide honest, accurate and complete information about their health history, their eligibility, and their enrollment

To show their ForwardHealth card each time they receive services and to let their providers know if they have other insurance coverage

To participate in their care by asking questions about their health. Members also have a responsibility to follow the plans and instructions for care that they have agreed upon with their Providers and to make healthy lifestyle choices to maintain their health or manage their illness. Members have a responsibility to know the medicines they take and why and how to take those medicines.

To keep their appointments and be on time or to call their provider's office ahead of time if they are going to be late or miss an appointment. Members have a responsibility to understand that missing appointments without letting the provider know may cause the provider to refuse to see them.

To show the same consideration and respect to Trilogy staff and health care providers as they would like to receive

To notify their local county/tribal social or human service agency of any enrollment status changes such as family size or address. Members have a responsibility to notify Trilogy with any changes to their address or phone number.

To use Trilogy participating providers and health care facilities unless they have our approval to go somewhere else or it is a life-threatening emergency.

DENTAL SERVICES

Trilogy subcontracts with DentaQuest to provide dental services. Please see the Contact Section at the beginning of this Guide for specific information.

VISION SERVICES

Trilogy subcontracts with Herslof to provide routine vision services and hardware. Please see the Contact Section at the beginning of this Guide for specific information.

WISCONSIN IMMUNIZATION REGISTRY

The Wisconsin Immunization Registry (WIR) is a computerized Internet database application that was developed to record and track immunization dates of Wisconsin's children and adults. It provides assistance for keeping everyone on track for their recommended immunizations. Statewide release occurred in May 2000. All demographic information for births occurring in Wisconsin were back loaded to January 1995 and continues to be downloaded on a weekly basis. Immunization registries are seen as an integral tool for assuring that children and adults receive their immunizations according to recommended schedules and can prevent over-immunizing.

WIR is provided by the State of Wisconsin at no cost. Providers need only a PC with Internet connectivity for access and to have a signed agreement with the Wisconsin Immunization Registry and to provide data on their patients.

As part of the Public Immunization Record Access feature, which allows look-up access to immunization records, parents and legal guardians have access to look up their child's immunization record in the WIR. Offering parents and guardians access to look-up their child's immunizations can decrease the number of requests to providers for immunization records from their patients. **We strongly urge providers to offer this service to their patients and join us in our efforts to eliminate vaccine preventable diseases in Wisconsin.**

Demonstrations and trainings are offered to providers and conducted throughout the state at no cost. The demonstrations will allow providers to see the many functions of the system that are designed to improve the immunization status of patients and the efficiency of their practices. To register to attend training, please contact WIR help desk at 608-266-9691 or email. For demonstrations, please contact WIR help desk at 608-266-9691 or email. The demonstrations will allow providers to see the many functions of the system that are designed to improve the immunization status of patients and the efficiency of their practices. Click here (PDF, 17.4 KB) for a list of provider specifications. Technical questions regarding WIR can be directed to the WIR helpdesk at: (608) 266-9691 DHSWIRHelp@wi.gov.

If your organization has an existing electronic database, you have options to link with WIR. These options are as follows:

1. Data conversion of existing database via a flat file ASCII text file or HL7 specification to WIR. Even billing data can be converted and loaded into WIR. Then clinicians could use WIR to track clients and immunizations.
2. Continue to use your existing system and link with WIR via an ASCII text file or a HL7 compliant interface to download immunization data to WIR.
3. Have clinicians use WIR for data entry and then have WIR send data back to the organization via an ASCII text file or a HL7 compliant interface.
4. Use HL7 to do real-time queries or updates to WIR from Electronic Medical Record (EMR) System

Notification of Pregnancy Form

Fax completed form to (select one):

[ ] Anthem 800-964-3627
[ ] Children's Community Plan 414-266-4726
[ ] Dean 608-252-0836
[ ] GHC of South Central Wisconsin
[ ] iCare 414-231-1090 Attn: Jill Denson
[ ] MHS Health WI 866-671-3668
[ ] MercyCare 608-752-3751
[ ] Molina 877-708-2117
[ ] Physician's Plus 608-327-0322 Attn: Jack Donisch
[ ] Trilogy 414-771-1159
[ ] UnitedHealthcare Community Plan 877-353-6913
[ ] Unity 608-821-4207

Member Information

Last Name:_____ First Name: _____ DOB: _____ ID#: _____

Address:_____ City: _____ Zip: _____ Phone #: _____

Date of Initial Prenatal Visit:_____ Completion date of Pregnancy Form:_____

Current Pregnancy †**In PNCC** _____

Gravida _____ Para_____ LMP_____ EDC_____ Blood Type _____

†Multiple Gestation this pregnancy †**Maternal age < 16 years** †Maternal age ≥ 35 years of age

Previous Pregnancies

†Hx of Placenta Pre †Multiple Gestations previous pregnancy

†Hx of Post Partum Depression †**Preterm Labor/Delivery** †**Hx of SAB/TAB/Fetal Demise**

†Previous C-Section **Week of delivery _____** Week of demise _____

Medical History (Check all that apply)

†**Cardiac Disease** †Clotting Disorders †Hypertension or PIH (Current/Past)

†**Respiratory Conditions** †**Behavioral Health Concerns** †Incompetent cervix (Current/Past)

†HIV Status †STD (Current/Past) †Neurologic Disorders (Current/Past)

†Sickle Cell Anemia †**Diabetes/Gestational Diabetes (Current/Past)**

Psycho/Social Issues (check all that apply)

†Drug Abuse(Current/Past) †Alcohol Abuse (Current/Past) †Smoker (Current/Past)

†Domestic Abuse (Current/Past) †Housing Issues †Lack of Support System

Prenatal Care and Nutrition (Check all that apply)

†Missed several medical appointments †Currently Enrolled in WIC

Description of above or other unlisted conditions: _____

_____

List of Medications: _____

_____

Provider Information

_____ _____
Provider Signature Provider Printed Name

_____ _____
Provider Address Provider Phone #

_____ _____
Delivery Hospital Provider Fax #