

Table of Contents

Introduction	3
• Physicians Plus Contact Information	
• Physicians Plus Website	
• Provider Updates/Changes	
BadgerCare Plus Managed Care	5
• Overview	
• Benefit Packages	
• BadgerCare Plus Service Area	
• Provider Eligibility	
• Mandatory or Voluntary Enrollment	
• Enrollment Contractor	
• Enrollment Process	
• BadgerCare Plus Member Education Materials	
• Exemptions	
• Federal Regulations	
• Covered/Non Covered Services	
• Short Term Exemptions	
• Long Term Exemptions	
• Miscellaneous Exemptions	
BadgerCare Plus Enrollment Process	12
• Length of Enrollment	
• Assignment of Primary Care Physician (PCP)	
• Enrollment Data	
• BadgerCare Plus Identification (ID) Card	
• Temporary & Presumptive Eligibility Cards	
• Physicians Plus Eligibility Verification	
• Eligibility Verification Vendors	
BadgerCare Plus Claims Submission	16
• Claim Completion	
• Coordination of Benefits (COB)	
• Hold Harmless	
BadgerCare Plus Coding Requirements	17
• Modifiers	
• HealthCheck Modifiers	
Population Health	19
BadgerCare Plus HealthCheck Program	20
• HealthCheck Program Description	
• HealthCheck Other Services	
• Outreach Report	
• HealthCheck Codes	

- HealthCheck Modifiers
- HealthCheck Components
- Vaccines for Children Program (VFC)
- HealthCheck Questions & Answers
- BadgerCare Plus Prior Authorization Requirements.....31**
 - Services Requiring Prior Authorization
 - Completing the Prior Authorization Form
 - Dispensing the Prior Authorization Form
 - Obtaining Additional Prior Authorization Forms
 - Elective Inpatient Procedure Prior Authorization Form
 - Durable Medicine Equipment (DME)
 - Provider Responsibility
 - ASH Reporting – Abortions
 - ASH Reporting – Sterilizations
 - ASH Reporting – Hysterectomies
- BadgerCare Plus Mental Health/AODA.....39**
 - Mental Health Center of Dane County
 - Methods
 - Forms and Requirements
 - Urgent Care
 - Emergent Care
 - Inpatient Care
 - Transitional/Partial Hospitalization
 - Insufficient Information
 - Concurrent Review
 - Denial of Service and Appeal Process
 - Mental Health Benefits
- BadgerCare Plus Member Rights & Responsibilities.....48**
 - Member Rights
 - Member Responsibilities
 - No Show Policy
- BadgerCare Plus Member Complaint, Appeal & Grievance Procedure.....50**
- BadgerCare Plus Provider Appeal Process.....52**
- Member Notice of Physicians Plus Privacy & Confidentiality Practices.....53**
- Compliance with Equal Opportunity Laws, Regulations & Rules.....59**

Welcome to BadgerCare Plus Managed Care

Additional information can be found in [Physicians Plus Provider Manual](#).

The purpose of the BadgerCare Plus Provider Manual is to serve as a resource for policies and procedures that affect BadgerCare Plus Managed Care. If you have questions relating to this information, or are unable to find information that you are looking for, contact the Physicians Plus Provider Service Department.

CUSTOMER SERVICE (608) 282-8900
(800) 545-5015
Fax: (608) 327-0321
Email: ppicinfo@pplusic.com

Hours 7:00 a.m. to 5:00 p.m. Monday –Friday

MEMBER ADVOCATE

Kristin Gasser-Casucci (608) 417-4515
Email: kristin.gasser-casuci@pplusic.com

MENTAL HEALTH CENTER OF DANE COUNTY (608) 280-2702
(877) 745-6700

PROVIDER NETWORK MANAGEMENT

Traci Schaefer, Provider Liaison II (608) 417-4680
Email: traci.schaefer@pplusic.com

Mark Bennehoff, Provider Liaison I (608) 417-4679
Email: mark.bennehoff@pplusic.com

Jean Hooverson, Provider Liaison II (608) 417-4677
Email: jean.hooverson@pplusic.com

Mary D. Strasser, Senior Director of PNM (608) 417-4675
Email: maryd.strasser@pplusic.com

Physicians Plus Insurance Corporation Website

www.pplusic.com

Physicians Plus Insurance Corporation offers a wealth of information through its website at: www.pplusic.com. A sample of the information you will find, specific to Physicians Plus, is listed below:

Members

- Member Materials
- Benefit Information
- Member Newsletters

Provider GO-TO

- Authorization Status
- Member Eligibility
- Claims Status
- Provider Forms
- Secure Messages

Providers

- Care Guidelines
- Provider Manual & Forms
- Regulatory Updates
- Population Health Management
- Provider Newsletters

Find a Provider

- Primary Care
- Specialty Care
- Other Facilities

Physicians Plus strives to give you the most up to date information as quickly as possible. We hope that you access the Website often and find it useful. If you have additional questions, please contact our Provider Service Department.

Provider Updates/Changes

To ensure Physicians Plus has the most current demographic information for our network providers, please contact your Provider Network Liaison for: additions, changes or terminations.

In order to treat a BadgerCare Plus patient, you must be certified as a BadgerCare Plus Provider. Contact Electronic Data Systems (EDS) at 608-221-4746 for information on how to apply for certification.

BadgerCare Plus Managed Care

www.DHS.wisconsin.gov/medicaid

Overview

BadgerCare Plus is a state sponsored program that provides healthcare coverage to qualified members. BadgerCare Plus combined Family Medicaid, BadgerCare, and Healthy Start into a single program. To qualify for BadgerCare Plus members must meet income requirements and fall into one of the following groups:

- Uninsured Children
- Pregnant Women
- Parents and Caretaker Relatives
- Parents with children in foster care who are working to reunify their families
- Young adults exiting out-of-home care, such as foster care, because they have turned 18 years of age.
- Certain farmers and other self-employed parents and caretaker relatives.

Not all BadgerCare Plus members will be enrolled in HMOs. Some members will remain straight Medicaid or Fee-for-Service (FFS), where they have access to any BadgerCare Plus Certified Provider.

Benefit Packages

BadgerCare Plus has two benefit packages, the Standard Plan and the Benchmark Plan. The Standard plan has the same benefits as the past Medicaid Program but incorporates copays. The Benchmark Plan was designed to resemble a commercial policy and includes both copays and benefit limitations. Qualified members are placed into the two plans based on their income level.

The following members are exempt from co-payment requirements under the Standard Plan:

- Nursing Home Residents
- Pregnant women
- Members under 18 years of age who are members of a federally recognized tribe
- Members under 18 years of age with incomes at or below 100% of the FPL

The following members are exempt from co-payment requirements under the Benchmark Plan:

- Pregnant women
- Members under 18 years of age who are members of a federally recognized tribe

For more detailed information on BadgerCare Plus, reference the Website at: www.DHS.wisconsin.gov/medicaid.

BadgerCare Plus Service Area

Dane County is the only county included in the Physicians Plus BadgerCare Plus service area.

Provider Eligibility

Certification from the State is needed in order to be a BadgerCare Plus Provider. A clinic or individual provider can receive certification by contacting Electronic Data Systems (EDS) at (608) 221-4746 for information on how to apply for certification.

If a provider does not have BadgerCare Plus certification they can **not** see a Physicians Plus BadgerCare Plus member. **Without certification, the provider's claims will be denied for payment.**

Mandatory or Voluntary Enrollment

Enrollment in an HMO will be mandatory in areas where there are two or more HMOs currently accepting BadgerCare Plus enrollees. If only one HMO is in a service area, members will have the choice of HMO or FFS. If you are interested in other HMOs providing services in your area, contact EDS at (608) 221-4746.

You will need to check either the patient's ForwardHealth or Forward Card for current eligibility and HMO enrollment status.

Enrollment Contractor

Wisconsin does not allow HMOs to market or enroll BadgerCare Plus members in their HMOs. The Department of Health and Family Services has contracted with Automated Health Systems (AHS) to act as the enrollment broker for

members. AHS is located in Milwaukee and has offices throughout the state. AHS performs enrollment, education, outreach, and advocacy for members. Their primary role is to help members select the best HMO for the member's needs. The enrollment contractor's telephone number is (800) 291-2002.

Enrollment Process

Members will receive one mailing from AHS, requesting they choose an HMO. If members do not choose an HMO, they will be automatically assigned to an HMO. Assignment will be to all HMOs serving in the member's ZIP code and will be distributed equally among the qualified HMOs.

Members may change HMOs during the first three months of enrollment but will be locked into the HMO beginning the fourth month of enrollment. Lock-in will continue through the twelfth month of enrollment. Members can only change HMOs if they meet exemption criteria discussed later in this section.

BadgerCare Plus Member Educational Materials

The State of Wisconsin DHS contracts with AHS as the enrollment broker for the Wisconsin BadgerCare Plus Managed Care Program.

The role of the Enrollment Specialist is to perform member outreach, enrollment, and education for Wisconsin BadgerCare Plus Managed Care Programs. This is accomplished through telephone, in-person contact, and the distribution of written materials, called Member Informing Materials, to managed care eligible members. These Informing Materials give the member information on HMOs available to them through the BadgerCare Plus Managed Care Program. The materials educate members about a managed care system, such as: accessing services, the role of the primary care practitioner, and preventive health services.

Exemptions

Some members that are assigned to HMOs may qualify for an HMO exemption. A chart begins on page 9 which lists the reasons for exemption from HMO enrollment. Providers who have questions regarding exemptions should call EDS at (608) 221-4746 and ask for an HMO contract monitor or call the BCP Member Advocate at Physicians Plus.

Federal Regulations

To operate an HMO program, Wisconsin obtained a waiver of certain Federal regulations. Some regulations that **cannot be waived** are:

- Access to services must be the same or better than in FFS.
- HMOs must provide all medically necessary services required by the contract HMOs sign with DHS.

Covered/Non-Covered Services

Physicians Plus will **NOT cover** the following services. **HOWEVER**, these are covered benefits and will be paid FFS by billing directly to **EDS**:

- Dental
- Chiropractic
- Pharmacy
- Prenatal Care Coordination (PNCC)
- School Based Services (SBS)
- Family planning services provided by Medicaid certified family planning clinics
- Targeted case management
- Crisis Intervention Services

These services should be billed to EDS following the current billing procedures.

The Benchmark plan has additional benefits that either have limitations, higher copays, or are not covered. Please refer to the Wisconsin Medicaid web site at: **DHS.wisconsin.gov/Medicaid** for specific information regarding the Benchmark Plan benefits. All other services provided to Physicians Plus BadgerCare Plus members should be billed to Physicians Plus. In addition, it is important to note that BadgerCare Plus HMOs must provide all medically necessary or covered services as FFS. In the Standard Plan there are no caps or limits on BadgerCare Plus services like you see in commercial plans. The Benchmark Plan does incorporate copays and benefit limitations.

BadgerCare Plus HMOs reference the Wisconsin Medical Assistance Program (WMAP) prior authorization guidelines and handbooks to determine medical necessity. The HMOs may develop their own policies and procedures to determine who will provide services and when services will be authorized. Physicians Plus has developed policies and procedures which may be similar to FFS in some areas. **See the Prior Authorization Section within this manual for Physicians Plus referral and prior authorization policies and procedures.**

Short Term Exemptions

Type of exemption	Length of exemption	Who may request this exemption	Criteria
Third trimester pregnancy exemption	Two full months past the Expected Date of Confinement (EDC)	Enrollee	<p>The enrollee did not voluntarily choose her HMO</p> <p>-AND-</p> <p>The enrollee must be seeking care from a provider who is not affiliated with the HMO to which they were assigned.</p>
Ninth month pregnancy exemption	Two full months past the EDC	Enrollee, HMO Provider	<p>The first month in the HMO the enrollee delivers or is expected to deliver</p> <p>-AND-</p> <p>The provider (i.e., doctor or hospital) the enrollee is seeing is not affiliated with the HMO the enrollee was assigned to.</p>
High risk Pregnancy Exemption	Two full months past the EDC	Enrollee	<p>The enrollee has a medical condition that has a direct risk on the enrollee's or the unborn child's health</p> <p>-AND-</p> <p>The provider the enrollee is seeing is not affiliated with an HMO or the HMO is closed to enrollment</p>
Continuity of Care	May be up to six months	Enrollee	<p>The enrollee is receiving short term care which began prior to enrollment in an HMO and needs to complete a specific treatment plan or course</p> <p>-AND-</p> <p>A switch in healthcare providers would cause a major disruption to the enrollee's care (i.e., Post-operative follow up after gall bladder surgery).</p>

Long Term Exemptions

Type of exemption	Length of exemption	Who may request this exemption	Criteria
Birth to 3	To the child's third birthday	Casehead	A child between the age of 0 and three who is developmentally delayed -AND- is enrolled in a county's birth to three program.
Methadone treatment	Through the course of the treatment	Casehead	Must be actively participating in a methadone program.
Severely emotionally disturbed	Through the course of treatment	Casehead	The enrollee must be receiving mental health treatment for a severe mental health disability (i.e., psychosis) -AND- Receiving intensive in-home therapy.
HIV Positive/AIDS	Permanent	Casehead	The enrollee must have AIDS or be HIV positive -AND- Receiving an FDA approved antiretroviral medication.

Miscellaneous Exemptions

Exemption	Length of exemption	Who may request this exemption	Criteria
Transplants (Liver, Lung, Heart, Pancreas, Heart-Lung, Pancreas-Kidney, or Bone Marrow)	Permanent	HMO Provider	Enrollee has had one of the listed transplants.
Supplemental Security Income (SSI)	Length of SSI eligibility	Enrollee	A member of a AFDC/Healthy Start household is SSI and Medicaid eligible -AND- the SSI enrollee is using providers who are not affiliated with any Medicaid HMO(s).
Other commercial insurance	Length of time the other HMO type of insurance is in effect	Enrollee	The enrollee has an HMO insurance which locks the enrollee into providers who are not affiliated with <i>any</i> HMO that is participating in the managed care program, or is not participating in a region.
Federal Qualified Health Center (FQHC), Certified Nurse, Midwife or Nurse Practitioner	Indefinitely	Enrollee	The enrollee is utilizing services of an FQHC, Nurse Midwife, or Nurse Practitioner -AND- The FQHC, Nurse Midwife or Nurse Practitioner is not affiliated with any HMO in the service area -AND- <i>For Nurse Midwives and Nurse Practitioners only:</i> The Nurse Midwife or Nurse Practitioner is not independently certified as a provider of any HMO within the service area.
Just cause	Permanent (Some cases are reviewed after two years.)	HMO	The HMO is unable to provide medically necessary care to an enrollee for reasons beyond the HMO's control -OR- Continued enrollment in the HMO would be harmful to the best interest of the member.
Medicare	Permanent	Enrollee, Provider, or HMO	Enrollees who become eligible for Medicare will be disenrolled the first of the month of notification.

BadgerCare Plus Enrollment Process

Length of Enrollment

All BadgerCare eligibility is reviewed monthly by DHS. All eligible enrollees, residing in HMO mandatory service areas, must serve an initial 12 month lock-in period. The first three months of this lock-in period will be open enrollment in which the enrollee may change his/her HMO. The enrollee will be locked-in to the HMO they have chosen or been assigned to after the first three months.

Assignment of Primary Care Physician (PCP)

Physicians Plus requires all members to select a primary care physician (PCP). The PCP must be part of the BadgerCare Plus network of providers and be available at the time of enrollment.

If the member does not choose a PCP, Physicians Plus will assign a physician in the following manner:

1. If Physicians Plus receives a claim for a primary care service, the rendering physician is assigned as the member's PCP.
2. If claims have not been received, a PCP will be chosen for the member according to the member's geographic location.
3. If a former member is rejoining Physicians Plus within one year of disenrollment, Physicians Plus will assign the former PCP; as long as the physician is still accepting new BadgerCare Plus patients.

Members may change their PCP at any time by contacting the Physicians Plus Member Services Department.

Enrollment Data

Because DHS does not allow HMOs to enroll their own members, Physicians Plus must receive enrollment information from DHS each month.

Physicians Plus receives the initial enrollment information from DHS for a coverage month on or around the 21st of the month prior to the month of coverage. This information will be automatically downloaded into our system.

Physicians Plus will receive final enrollment information from DHS on or around the 1st of the current coverage month. The information includes either a disenrollment or continuation for all members on a “pending” status from the initial report and any newborns added since the 21st of the previous month.

All new enrollees will have a temporary NO PCP designation until we are able to receive their choice for a PCP or Physicians Plus assigns one.

BadgerCare Plus Identification (ID) Card

Wisconsin BadgerCare Plus members receive a “ForwardHealth” ID card upon initial enrollment into Wisconsin BadgerCare Plus. Each individual in a BadgerCare Plus family is enrolled with their own individual ID number and card.

BadgerCare Plus ID cards may be in any of the following formats:

- White Forward Health cards (standard).
- Blue plastic Forward cards (previous design).
- Green Temporary paper cards.
- Beige Presumptive Eligibility (maternity) paper cards.

It is important that providers or their designated agents determine the member’s eligibility and HMO enrollment status **prior** to each visit. Providers should verify eligibility for each date of service and cannot charge a member for doing so. This is important because members can move between the Standard and Benchmark Plans, thus copays and benefits may change between appointments.

The ForwardHealth card is designed to be kept indefinitely by members, who are encouraged to always keep their cards even though they may have periods of ineligibility. 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.

If a card is lost, stolen or damaged, Wisconsin BadgerCare Plus will replace the card at no cost to the member. Members should contact EDS Recipient Services at (800) 362-3002, as instructed on the back of the card, for replacement cards.

Physicians Plus will not issue members a separate ID card; the ForwardHealth card will serve as their Physicians Plus insurance card.

Forward Card Features

Medicaid ID Card (Resembles an automated teller 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. However, adult members are encouraged to sign their cards. Providers may use the signature as another means of identification.

Temporary and Presumptive Eligibility Cards

Temporary cards are issued on green colored paper and Presumptive Eligibility cards are issued on beige colored paper. These cards are accepted by Wisconsin BadgerCare Plus. These members will be covered by they Fee-for-Service Plan, not the managed care programs. Providers should make a copy of the member's temporary card in the event a claim denies.

Physicians Plus Eligibility Verification

Coverage for BadgerCare Plus members may be confirmed through the [Provider GO-TO Web Portal](#). Eligibility information is provided by DHS monthly.

Eligibility Verification Vendors

The following vendors offer eligibility verification services for purchase:

<p>HDX</p> <p>Contact Name: Dan Birch 467 Creamery Way Exton, PA 19341 Daniel.Birch@siemens.com www.hdx.com Provides: Browser-based and integrated eligibility</p>	<p>United Wisconsin Proservices</p> <p>Contact name: Kathy Cataldo-Elm, Technical Systems Analyst 401 W Michigan St. Milwaukee, WI 53203 (800) 822-8050 x6541 or (414) 226-6541 email: kcataldo@uws.com www.uwproservices.com Provides: Internet Services</p>
<p>Medifax-EDISM, Inc.</p> <p>Contact Name: Dan Stone, District Sales Manager 1283 Murfreesboro Rd. Nashville, TN 37217-2421 (800) 444-4336 x2903 Fax: (615) 565-2903 Email: dan.stone@medifax.com www.medifax.com Provides: Internet solution, software, magnetic strip card readers, point of service terminals, networkable solution, full integration</p>	<p>Web MD/Envoy</p> <p>Contact name: John Kost 8919 Pawnee Ln Leawood, KS 66206 (913) 649-3529 Fax: (913) 649-3586 Email: jkost@webmd.net Provides: Internet, non-internet/dialup windows software, credit card readers</p>
<p>Passport Health Communications</p> <p>Contact name: Lloyd Baker 720 Cool Springs Blvd, Suite 450 Franklin, TN 37067 (651) 261-2675 (888) 661-5657 x2675 email: Lloyd.Baker@passporthealth.com www.passporthealth.com Provides: Internet, Interface systems, File-batch eligibility systems</p>	<p>Wisconsin Health Information Network (WHIN)</p> <p>Contact name: Carole Gray Unis 5900 South Lake Dr., Second Floor Cudahy, WI 53110-3171 (800) 331-9446 email: carole.unis@whin.net www.whin.net Provides: Browser-based internet</p>

BadgerCare Plus Claims Submission

To help minimize claim rejection or claim payment errors, Physicians Plus asks for your cooperation with the following:

Claim Completion

Member Identification

When submitting claims, Physicians Plus requires the use of the ID number listed on the Forward Health Card. Using the correct member number on the claims submitted to Physicians Plus will help us ensure correct claim payment.

Provider Identification

All claims should be submitted with the provider NPI number.

Timely Filing

Refer to your Physicians Plus Provider Agreement for timely filing requirements.

Coordination of Benefits (COB)

BadgerCare Plus is always payor of last resort. If Physicians Plus has record of other health insurance coverage for the member during the same time-frame, the claim will be denied as other insurance primary. After the primary insurance has processed the claim, the claim along with the EOB can be submitted to Physicians Plus for consideration of supplemental payment. Please contact our Provider Service Department with updates to a member's health insurance coverage.

Hold Harmless

When a physician or clinic becomes a "Plan Provider" they agree to accept payment made by Physicians Plus as payment in full. **Contractual discounts can not be billed to the member or the supplemental insurance company.**

Please see the [Claims Procedure Section](#) of the Physicians Plus Provider Manual for more claims submission information.

BadgerCare Plus Coding Requirements

The Wisconsin BadgerCare Plus program follows the Health Insurance Portability and Accountability Act (HIPPA) standards by using the medical code set requirements for claims submission. Some non-medical code sets, such as type of service codes, will also be eliminated. All providers will be expected to make these same coding changes when billing Physicians Plus for BadgerCare Plus members. Please continue to check the BadgerCare Plus web site at www.DHS.wisconsin.gov/medicaid for specific updates.

For providers submitting claims to Physicians Plus for BadgerCare Plus members, the corresponding modifier(s) must be indicated on the claim to ensure appropriate reimbursement and reduce delays in payment. The cross references are as follows:

Modifier	Description	Guideline
22	Unusual Services	Not recognized for MA/Badger Care
25	<u>Significant, separately identifiable</u> evaluation and management service by the same physician on the same day	PHYSICIANS PLUS will follow MA guidelines
26	Professional Component only	Provider should reduce the charged amount
50	Bilateral Procedure	Charged amount should be 150% of what the procedure would cost if done unilaterally
51	Multiple Procedures	PHYSICIANS PLUS will follow MA guidelines (100%-50%-25%, 13%)
52	Reduced Services	PHYSICIANS PLUS will reduce by 25%
80	Surgical Assist	PHYSICIANS PLUS will pay at 20% of fee schedule amount for the surgery
81	Minimum Assistant Surgeon / PA	PHYSICIANS PLUS will pay at 16% of the fee schedule amount for the surgery
82	Assistant Surgeon (when qualified resident surgeon not available) / NP	PHYSICIANS PLUS will pay at 16% of the fee schedule amount for the surgery

AS	Surgical Assist by a PA	PHYSICIANS PLUS will pay at 20% of fee schedule amount for the surgery
NU	Durable Medical Equipment (DME) purchase	Informational
RP	Replacement & repair of DME	Informational
RR	Rental of DME	Informational

TC	Technical Component only	Provider should reduce the charged amount based on what a total component would be
AA QX QZ QY QK	Anesthesia (bill units by minutes)	AA-M.D. personally performed QX- CRNA or AA, M.D. medically directing one or more QZ- CRNA only, non-medically directed more than one QY- M.D. medically directing one CRNA QK- M.D. medically directing two, three, four CRNAs/AAs

HEALTH CHECK MODIFIERS

Provider Type	Modifier	Modifier Description
Physicians, Physician Assistants, Nurse Practitioners	UA	Medical Referral
Health Check Nursing Agencies (Local Public Health Agencies)	EP TS	Indicates that interperiodic screen, outreach and case management, and lead inspection services were provided as part of EPSDT Indicates follow-up services to an environmental lead inspection

The following diagnosis codes are required for HealthCheck billing:

- V20.2- Routine infant or child HealthCheck
- V70.0- Adult over 18 years of age

All claims will be subject to code auditing review.

Population Health Management

Physicians Plus chronic illness management programs, designed for members who meet specific criteria, help participants improve their health.

Disease Prevention

In order to prevent chronic illnesses and their complications, Physicians Plus promotes preventive screenings. Reminders are sent to members who are at-risk for diseases such as breast cancer, cervical cancer and colon cancer. Members are encouraged to get timely screenings.

Diabetes, High Blood Pressure, High Cholesterol

Members that have elevated blood glucose, blood pressure or cholesterol, work with a nurse case manager to learn self-management skills. Case managers work with the member, primary care provider and specialists to ensure proactive care.

Heart Failure

Physicians Plus uses Cardiocom™, a program that helps members manage their heart failure (HF). Members use an in-home scale to monitor daily weight and symptoms. Information is sent via phone line to a nurse case manager. The nurse reviews these reports and contacts the member and/or physician to identify needed changes to the member's treatment plan.

WeighToGo

A home-based program for members committed to weight loss, WeighToGo provides support, tips, meal plan information and more to help members achieve weight loss goals through healthy eating and active living. A remote monitoring system provides daily support between health care professionals and patients. Participants are charged a monthly fee and are eligible for Good Health Bonus reimbursement.

Depression

Depression can impact optimal management of other chronic illnesses. Members with a chronic illness are also more likely to develop depression. For these reasons, Physicians Plus conducts an annual depression screening for members with a chronic illness. This screening helps to identify members with depression and ensures that they receive the most appropriate treatment.

HealthCheck Program

HealthCheck is Wisconsin BadgerCare Plus's Federally mandated program known nationally as Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Refer to 42 CFR Part 441. Physicians Plus' contract with the State of Wisconsin requires that at least 80 percent of BadgerCare Plus children enrolled in our HMO receive age appropriate HealthCheck screenings. HealthCheck screenings are designed to ensure that BadgerCare Plus enrollees under the age of 21 receive regular, comprehensive, preventive healthcare. Through the HealthCheck program, Wisconsin BadgerCare Plus pays for necessary healthcare, diagnostic services, treatment and other needed services that are described in the Medical Assistance section of the Social Security Act, which are necessary to correct or improve defects, physical and mental illnesses and conditions discovered during the screening services.

The screening includes, but is not limited to, the following:

- A review of the recipient's health history; and
- An assessment of growth and development; and
- Identification of potential physical or developmental problems; and
- Preventive health education; and
- Referral assistance to providers.

HealthCheck Other Services

Standard Plan recipients who receive a HealthCheck are also eligible for HealthCheck "Other Services" for a year following the visit, unless a BadgerCare Plus-covered service will reasonably meet the identified medical need. To be covered under HealthCheck "Other Services," the services must be:

- Identified in a HealthCheck screening; and
- Medically necessary; and
- Allowed services under the Social Security Act; and
- Identified in 1905 (r) of the Social Security Act as covered under BadgerCare Plus; and
- Provided to a recipient under age 21; and
- Provided by a qualified provider; and
- Prior authorized by DHS.

With the completion of a healthcheck, some normally non-covered over-the-counter drugs are covered without prior authorization. Pharmacy benefits are covered by the FFS Plan and covered prescriptions can be found through the states preferred drug list.

-
- The member must be covered under the Standard Plan; the benchmark policy does not cover HealthCheck Other Services
 - The provider must either complete the pink HealthCheck card with the date of the HealthCheck ' or
 - Provide the prescription on the date of the HealthCheck.

A prior authorization is **NOT** required for the following OTC drugs with a prescription that specifies the date of the HealthCheck and "HealthCheck Other Services":

- Anti-diarrheals
- Iron Supplements
- Lactase products
- Laxatives
- Multivitamins
- Topical Protectants

Why should I provide HealthCheck services?

- HealthCheck visits are designed to ensure regular, comprehensive preventive healthcare for BadgerCare Plus members under the age of 21.
- Under the Standard Plan, with a HealthCheck referral, medically necessary services that are otherwise non-covered by BadgerCare Plus may be reimbursed.
- Screening exam intervals are consistent with the American Academy of Pediatrics' recommendations.
- HealthCheck screening requirements follow State and Federal regulations and represent what most pediatric BadgerCare Plus providers see as "best practice".
- Screening as many BadgerCare Plus members as possible helps PHYSICIANS PLUS get maximum premium from the state which will help your reimbursement rate.

How often should a child obtain a HealthCheck screening?

Age range	Number of screenings	Recommended ages for screening
Birth to first birthday	6	Birth 3-4 weeks 6-8 weeks 4 months 6 months 9 months
First birthday to second birthday	3	12 months 15 months 18 months
Second birthday to third birthday	2	2 years 2 ½ years
Third birthday to 21 st birthday	1	Every other year, not to exceed once per year

Each provider is asked to designate an individual in their office as a Clinic HealthCheck contact. **You can contact your Provider Liaison for assistance with billing questions, training requests and questions on the HealthCheck program at (608) 282-8900.**

Performing complete HealthChecks for ALL BadgerCare Plus children keeps them healthy and provides higher reimbursement to you. It is important to have correct HealthCheck billing information at the time of the visit.

- Physicians Plus will not know about a HealthCheck if another health insurance is primary.
- BadgerCare Plus eligibility changes frequently.

If a comprehensive HealthCheck screen does not result in a referral, use the appropriate procedure code without any modifier. All other visits should be billed using office visit procedure codes.

HealthCheck Codes

Procedure Code	Description
99381	Initial preventive medicine, new patient; infant (age under 1 year).
99382	99382* Initial preventive medicine, new patient; early childhood (age 1 through 4 years).
99383	Initial preventive medicine, new patient; late childhood (age 5 through 11 years).
99384	Initial preventive medicine, new patient; adolescent (age 12 through 17 years).
99385	Initial preventive medicine, new patient, (age 18 through 39 years).
99391	Established patient, periodic preventive medicine; (age under 1 year).
99392	Established patient, periodic preventive medicine; early childhood (age 1 through 4 years).
99393	Established patient, periodic preventive medicine; late childhood (age 5 through 11 years).
99394	Established patient, periodic preventive medicine; adolescent (age 12 through 17 years).
99395	Established patient, periodic preventive medicine, (age 18 through 39 years).

These codes do not need a modifier

Do not apply any modifiers to the HealthCheck codes other than the ones listed below.

HealthCheck Modifiers

Provider type	Modifier	Modifier description
Physicians, Physicians Assistants, Independent Nurse Practitioners	UA	Medical referral

Provider type	Modifier	Modifier description
HealthCheck Nursing Agencies (Local Public Health Agencies)	EP	Indicates that interperiodic screens, outreach and cast management, and lead inspection services were provided as part of EPSDT
	TS	Indicates follow-up services to an environmental lead inspection

The following diagnosis codes are required for HealthCheck billing:

- V20.2 – Routine Infant or Child HealthCheck
- V70.0 – Adult over 18 years of age

Health Check Components

Including documentation notes from State Audits

Health History

- Including special risk factors, or prior conditions/treatments/medications.
- If there are no recent changes, indicate in chart discussion took place.
- Document recent services done elsewhere.

Nutritional Assessment

- Assessment with review of eating patterns, habits, appetite, vitamins, snacks, pickiness.
- Still necessary for older children and teens..

Health Education/Anticipatory Guidance

- Discussion of age-appropriate preventive health education topics including parenting, lead poisoning, use of car seats, proper nutrition, alcohol/drug abuse, mental health concerns, injury prevention.
- Handouts are sufficient, but documentation must be found in the chart of age specific handouts given.

Developmental Behavioral Assessment

- Observed behavior and attainment of age-appropriate developmental milestones including response to tools, concerns, relationships.
- Important for school-age children and teens.

Vision Assessment

- Vision chart results.
- If an exam is done at school, documentation is sufficient and best practice would be to:
 - Document results.
 - If child wears glasses, note of last exam with ophthalmologist or optometrist. Refer or complete exam if more than one year.
 - Plan for vision assessed at 20/40, whether referred or follow-up deemed appropriate.
 - Document incomplete exams and reason (lack of cooperation)
 - To avoid problems in school, closer screening for children starting kindergarten or first grade.

Hearing Assessment

- Puretone audiometric results.
- If exam done at school, documentation is sufficient and best practice would be to:
 - Document results
 - If child wears hearing aid, note of last exam with specialist. Refer or complete exam if more than one year.
 - Follow-up concerns
 - Look for audiogram if indications of speech difficulties during the visit
 - Document incomplete exams and reason (lack of cooperation)
 - To avoid problems in school, closer screening for children starting kindergarten or first grade

Lab Tests

- Blood lead required at age 1 & 2 regardless of verbal assessment.
- Verbal assessment for lead recommended age 6-72 months.
- Document parental refusal.
- Follow-up if elevated.
- If test done elsewhere, document with results for best practice. (Parents don't always follow-up, opportunity for reinforcement or education of elevated levels).

Physical Examination

- On forms it is, important to mark off each body system. If a line is drawn through it, it is determined deferred.
- Explanation of any body system deferred.

Sexual Development

- Reference to Tanner Sex Maturity Rating is sufficient.
- Note sexual development in patients who have reached puberty.
- If deferred, reason should be documented.
- Pelvic exam for girls. Document referral to OB/GYN, or note exam by OB/GYN in the past year.
- Adolescent males receive testicular exam.

Oral Assessment

- Children under age 3: Determination if early dental care is necessary. “No early oral concerns” is adequate documentation. Note teething progress or behaviors linked to future dental concerns.
- Children over age 3: Note whether patient is receiving regular dental care, or referral to a dentist.
- HEENT does not provide enough documentation for an oral assessment.

Immunizations

- Parents declining immunizations documented at each visit
- If had chickenpox disease, document month and year
- Insufficient records. Document reminders to parents and attempts to locate.

Visit the Department of Health and Family Resources website for HealthCheck Visit [forms](#).

Vaccines for Children Program (VFC)

In August 1993, Congress passed the Omnibus Budget Reconciliation Act creating the Vaccines For Children program (VFC). This Federal VFC program is intended to help raise childhood immunization levels in the U.S. The VFC supplies free vaccine to private and public healthcare providers who administer vaccines to eligible children. Eligible children under the VFC program include, among other groups, all BadgerCare Plus-eligible children.

The Department of Health & Social Services (DHSS), Bureau of Public Health, ships the vaccines. Vaccines are shipped on a request basis to providers from the State distribution center.

Participation in Vaccines for Children Program:

- Enrollment
 - Complete two Center for Disease Control forms (one set of forms per shipping site, not per provider):
 - The “Provider Enrollment” form indicates agreement with the components of the VFC program. This form is completed only once and must be signed by a physician.
 - The “Provider Profile” form estimates the number of children vaccinated in your practice annually and the proportion likely to qualify for VFC. This profile is used to establish maximum order levels per shipping site. The form is updated annually and can be updated more frequently if your needs change.

Send the enrollment profile forms to the State Immunization Program:

Wisconsin Immunization Program
1 W. Wilson Street
P.O. Box 309
Madison, WI 53701

- Ordering and Shipping
 - Order forms #DOH 1099 should be sent to the WI Immunization Program. Order forms may be obtained from the WI Immunization Program
 - Vaccinations must be ordered. There will be no automatic shipments.
 - Vaccines will be provided to you within two weeks.

- Accounting and Storage
 - Vaccine for Children Program vaccines must **NOT** be kept with other vaccines. Use the oldest unexpired vaccine first.
 - Establish an in-clinic tracking system to determine when to reorder VFC vaccine.
 - Usage of vaccines is subject to review by the State of Wisconsin.

HealthCheck Questions & Answers

Q: Why should I provide HealthCheck services?

A: Here are several reasons for providing HealthChecks:

- HealthCheck visits are designed to ensure regular, comprehensive preventive healthcare for BadgerCare Plus members under the age of 21.
- Under the Standard Plan, with a HealthCheck referral, medically necessary services that are otherwise non-covered by BadgerCare Plus may be reimbursed.
- Screening exam intervals are consistent with the American Academy of Pediatrics' recommendations.
- HealthCheck screening requirements follow State and Federal regulations and represent what most pediatric BadgerCare Plus providers see as "best practice".

Q: Does HealthCheck billing require different forms than other Medicaid billing?

A: Billing for HealthCheck is done on the CMS-1500 claim form. This is the same claim form used for other BadgerCare Plus billing. Comprehensive screens are billed using CPT codes to indicate that a comprehensive HealthCheck screen was performed.

In addition, it is not the intent of the program to make you change your documentation system. Documentation of the listed components should be incorporated into your normal process.

Q: Will patients receive extra benefits from having a HealthCheck exam?

A: Healthcheck Other Services are only covered under the Standard Plan. With a healthcheck exam medical services that are medically necessary may be paid for, even though they are not normally covered by BadgerCare Plus. One example is noncovered over-the-counter medications. The Benchmark Plan does not cover Healthcheck Other Services.

Q: What is the difference between a HealthCheck and a well-baby exam?

A: These two exams are very similar and may be the same. The difference is the HealthCheck requires an assessment and documentation of all seven components, whereas a well-baby exam may not.

Q: What if a patient refuses to let the provider do an unclothed physical exam?

A: Federal law requires an unclothed physical exam to assure clinicians are evaluating for potential physical abuse. This requirement does not mean the child must be totally unclothed for the entire exam.

Q: Is color blindness screening required as part of a vision screening?

A: Screening for potential problems is the requirement. If there is a reason to believe colorblindness is a problem, of course you would check further, but a routine exam is not required.

Q: If vision and/or hearing screening is done at the school and reported by the parent, does the provider need to have a copy of those reports before billing for a HealthCheck exam?

A: HealthCheck providers are required to access and document vision and hearing screening. If that assessment is that the member has just had a vision and/or hearing screening somewhere else, the provider should document that fact and it would meet the requirements.

Q: Can a dietician provide nutrition therapy through an interperiodic visit?

A: Nutrition therapy can be billed as an interperiodic visit if the comprehensive screen identified a problem (not a potential problem) and if the dietician works for the HealthCheck agency. The billing is done by the HealthCheck agency. This is for fee-for-service. Check with the HMO if the member is in a BadgerCare Plus HMO.

Q: Do you need to wait a full 365 days between a member's annual HealthCheck screenings?

A: In BadgerCare Plus fee-for-service, the provider can bill up to 20 days before the year is up. If the member is enrolled in Physicians Plus' Managed Care Program, there are no restrictions on the frequency of HealthCheck screenings.

Q: What specific incentives can be used to get parents to have their children examined?

A: At least two specific incentives can help promote HealthCheck to members' parents:

Transportation For Standard Plan:

Offering reliable transportation to get children covered under the Standard Plan to their HealthCheck appointments can increase participation in HealthCheck. Access to transportation is a key issue for many members in rural and central city areas in particular. Members should call LogistiCare Solutions, LLC at 866-907-1493 or 866-288-3133 (TTY) between 7:00a.m – 6:00p.m. to arrange for transportation at least 48 hours in advance of their scheduled appointment.

The Benchmark Plan does not cover transportation to medical appointments.

Access to over-the-counter drugs:

The Standard Plan also pays for medically necessary over-the-counter drugs prescribed by physicians, as long as a HealthCheck screen was done. Some prescriptions are subject to prior authorization. Over-the-counter drugs can be an important benefit, and a key incentive to raise intervals in HealthChecks. The Benchmark Plan does not cover Healthcheck "Other Services".

Q: How can I get more information on HealthCheck in Wisconsin?

A: The Wisconsin BadgerCare Plus program Website contains the handbook information on HealthCheck. The Website address for the BadgerCare Plus handbook section on HealthCheck is:

http://www.DHS.wisconsin.gov/Medicaid2/handbooks/partd_d1/chapters.htm.

The entire HealthCheck Services handbook may be printed from this site.

BadgerCare Plus Prior Authorization Definition

Prior authorization is the process of obtaining Physicians Plus authorization for services by reviewing related documentation, verifying benefits and medical necessity and ensuring the appropriate provider will be delivering the services. Prior authorization is defined as: approval from Physicians Plus Health Services Department **prior** to the patient receiving services. Verbal or written requests do not constitute prior authorization without approval. Approval is subject to all other policy limits and provisions.

Services Requiring Prior Authorization

The following services require prior authorization from Physicians Plus before rendering services:

- Durable Medical Equipment (DME) and Supplies

The following Prior Authorization requirement for DME and supplies will be in effect until December 31, 2011

- Durable Medical Equipment/prosthetics/supplies: All purchases over \$5,000.00 require prior authorization.

The following Prior Authorization requirement for DME and supplies will be in effect January 1, 2012

- Durable Medical Equipment and Supplies:
 - All purchases over \$750
 - All rentals over \$750 per month
 - All CPAP machine purchases and rentals

Please refer to section F6 of the Provider Manual for additional information regarding coverage of DME.

- Electroconvulsive therapy (ECT)
- Genetic testing
- Home care services, supplies and therapies
- Hospice care

- Inpatient services at:
 - Acute care facility
 - Hospice facility
 - Long term acute care facility
 - Rehabilitation facility
 - Skilled nursing facility (including therapy)
 - Subacute facility

- Non-emergent ambulance transportation

- Non-participating providers: ALL services

- Outpatient procedures/surgery/services that may be considered cosmetic, including but not limited to:
 - Blepharoplasty
 - Botox injections
 - Canthoplasty
 - Reduction mammoplasty
 - Septo-rhinoplasty
 - Skin Tag removal

- Prosthetics, Limb: All purchases

- Rehabilitation:
 - Day / Neurotrauma

- Transplants

PRIOR AUTHORIZATION FORM

Completing the Prior Authorization Form

When the physician determines the patient is in need of medical or specialty care that requires prior authorization, the physician will complete and sign a prior authorization form. The Prior Authorization Form has five sections that the physician must complete in its entirety. Prior Authorization requests may be forwarded to Physicians Plus.

Patient Information

Please complete this section as thoroughly as possible, including the patient's name, address, phone number, member number, and insurance status.

Primary Care Provider

Please supply the provider name, address, and phone number. Signature of the referring provider and date signed is required.

Referral Information

On the form, please supply the provider name, address, phone number and specialty.

Appointment Information

Describe the services being requested including duration dates and total number of visits. The duration of the Prior Authorization must not exceed 12 months.

Reason for Request

Check **Prior Authorization** for services referred to a nonparticipating provider and/or for services requiring prior authorization.

Thoroughly complete the Diagnosis Code, narrative description, and the reason for Prior Authorization in the narrative section. Check the appropriate box to include or exclude other services. Medical records are helpful if the request is unusual or complex. Having the necessary information significantly reduces processing time. If the request is for a non-participating provider, the following must be listed on the Prior Authorization form:

- **the specific services being requested; and**
- **the specific physician to whom the patient is being referred; and**
- **the reason why the requested service cannot be provided by a participating provider.**

Dispensing the Prior Authorization Form

1. The Prior Authorization form should be forwarded to the Health Services Department at Physicians Plus.
2. Our Health Services Department will review the request and either approve or deny the requested services.
3. Health Services will forward a determination to all appropriate parties.
4. Physicians Plus' Medical Director/Physician Reviewer is available to discuss any denial decisions.
5. If the treating physician would like to discuss the case with a Physician Reviewer, please call Health Services at (608) 282-8900 or (800) 545-5015.

Mail the Prior Authorization form to:

Health Services Department
Physicians Plus Insurance Corporation
2650 Novation Parkway
Suite 400
Madison, WI 53713

If services that require Prior Authorization need to be provided in less than seven days, Prior Authorization may be obtained via telephone or fax by contacting our Health Services Department:

Phone: (608) 282-8000 or (800) 545-5015

Fax: (608) 327-0322

Obtaining Additional Prior Authorization Forms

Visit the Department of Health and Family Resources website for the proper [forms](#).

If you have questions regarding the prior authorization process, please call the Physicians Plus Provider Services staff at (608) 282-8900 or (800) 545-5015.

Elective Inpatient Procedure Prior Authorization Form

The Physicians Plus [Elective Inpatient Procedure Prior Authorization Form](#) must be completed in its entirety when an inpatient surgery is being performed on a Physicians Plus member. For a scheduled procedure, the completed form should be faxed to our Health Services Department at (608) 327-0322. All unscheduled procedures can be mailed to:

Health Services Department
Physicians Plus Insurance Corporation
2650 Novation Parkway
Suite 400
Madison, WI 53713

Please contact your Provider Network Management Liaison if you have any questions regarding this information.

Provider Responsibility

Providers are responsible for completing the prior authorization requirements. Members are held harmless and cannot be billed for covered benefits denied if the provider fails to complete prior authorization requirements. **Medical services obtained without the appropriate prior authorization requirements will not be granted backdated approval.**

Abortion, Sterilization and Hysterectomy (ASH) Reporting

Abortions

All abortions require prior authorization. It is the provider's responsibility to notify Physicians Plus that the abortion will be performed and that the required documentation has been completed. Physicians Plus needs medical documentation and the physician's statement verifying that the abortion is being performed due to either long-lasting health damage or it is medically necessary to save a woman's life. Please direct requests for abortions to the **Health Services Department at Physicians Plus or fax to (608) 327-0322.**

Physicians Plus is required to report abortions, along with sterilization's and hysterectomies, to the State of Wisconsin on a quarterly basis.

Complications arising from an abortion, regardless of whether the abortion itself is a covered service, are payable. This is because the complications represent new conditions, and thus the services are not directly related to the performance of an abortion.

If a BadgerCare Plus provider performs a non-Medicaid covered abortion on a BadgerCare Plus member and claims Medicaid reimbursement for other services that were provided to the same member **between nine months prior to and six weeks after the non-covered abortion**, the claim(s) must be submitted on paper, and documentation must accompany the claim.

Visit the DHF website for the proper [forms](#).

Common Abortion Reporting Problems:

- The physician must attach medical documentation as well as a physician's statement when the abortion is performed due to either the long-lasting health damage or the medical necessity to save the woman's life.

Sterilizations

All types of sterilization require prior authorization. The sterilization consent form must be signed and a copy of this will need to be provided to Physicians Plus for reporting purposes. At least 30 days, but not more than 180 days, must have passed between the date of informed consent and the date of sterilization. **Do not count date signed or date of surgery in that 30 day criteria.**

Other important information about the Sterilization Consent Form

- The use of opaque correction fluid, ribbons, or tape to cover errors or make changes makes the sterilization form invalid.
- If changes are made to the Consent form, the following steps must be taken:
 - line-out the error;
 - correct the error; and
 - initial the error.

Visit the DHF website for the proper [forms](#).

The patient must initial any changes on the form if it directly relates to them.

- Informed consent may not be obtained while the individual to be sterilized is:
 - In labor or childbirth;
 - Seeking to obtain or obtaining an abortion; or
 - Under the influence of alcohol or other substance that affects the individual's state of awareness.
- The person who obtains the informed consent must orally provide all of the requirements for informed consent as set forth on the consent form. They must offer to answer any questions and must provide a copy of the consent form to the individual to be sterilized for his or her consideration during the waiting period. (The person obtaining the consent may, but is not required to be, the physician performing the procedure).
 - An interpreter must be provided to assist the member if he or she does not understand the language used on the consent form or the language used by the person obtaining the consent.

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- Suitable arrangements must be made to ensure that the required information is effectively communicated to members to be sterilized who are blind, deaf or otherwise disabled.
 - A witness chosen by the member may be present when the consent is obtained. The witness may not be the person obtaining consent.
 - Common Sterilization Reporting Problems:
 - The sterilization occurs less than 30 days after the date of informed consent:
 - *Neither the date of the informed consent nor the date of the sterilization count in the thirty days.*
 - *The physician forgets to indicate either a premature delivery or an emergency abdominal surgery.*
 - The sterilization occurs less than 30 days after the date of informed consent and the physician has indicated a premature delivery:
 - *Physician must indicate the "EDC" for a premature delivery.*
 - *Admission history and discharge summary must be included with the sterilization consent form if the sterilization was performed with an emergency abdominal surgery*
 - On the physician's statement portion of the consent form, the signature date must be either the day of the surgery or after the surgery date. **It may not be prior to the date of the sterilization.**
 - **Member must be at least 21 years of age on the date he or she signs the consent form.**
 - The procedure being performed must be completely spelled out in one of the appropriate places. Abbreviations are fine for the other areas.
 - **Send completed consent forms for sterilizations to the Health Services Department at Physicians Plus or fax to (608) 327-0322.**

Hysterectomies

Inpatient hysterectomies require prior authorization. Outpatient hysterectomies do not require prior authorization. All hysterectomies require that an acknowledgment of information form be completed. This form must be on the patient's record at the time of hospitalization.

A hysterectomy is **not covered** if:

- It was performed solely for the purpose of rendering an individual permanently incapable of reproducing; or
- There was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

Common Hysterectomy Reporting Problems:

- The date the **member** signs the form must be **on or before the date of service on the claim.**
- The date the **provider** signs the form must be **on or before the date of service on the claim.**

May be performed without the "Acknowledgment of Receipt of Hysterectomy Information" if:

- The individual was already sterile prior to the hysterectomy and appropriate documentation is attached such as a prior sterilization consent form.
- The individual requires a hysterectomy because of a life threatening emergency in which the physician determines that a prior acknowledgment is not possible. The physician must attach the admission history and discharge summary in this case.

Visit the **DHF website** for the proper [forms](#).

Prior authorization requests and/or the acknowledgement form for hysterectomies can be forwarded to the Health Services Department at Physicians Plus or faxed to (608) 327-0322.

BadgerCare Plus Mental Health/AODA Prior Authorization Requirements

Journey Mental Health Center

The Journey Mental Health Center (JMHC) Utilization Management Program (UMP) must authorize all requests for behavioral health services for Physicians Plus BadgerCare Plus members.

**Phone: (608) 280-2702
(877) 745-6700**

Fax: (608) 280-2707

The purpose of service authorization is to monitor all requests for behavioral health services to assure that members are approved for care that meets their level of need and is sufficient in duration to meet recovery goals.

Methods

A licensed and certified clinician, working in collaboration with the JMHC Medical Director or his/her designee, will authorize all requests for Behavioral Health Services for HMO members.

Requests for behavioral health services should be directed to the Utilization Management Program at the JMHC. Requests for service authorization may come from a variety of sources. These include, but are not limited to:

- Case Managers at the HMO;
- Primary Care Physicians;
- The HMO member or a family member;
- Agencies/organizations providing services to the member.

Members may seek services under a variety of circumstances:

- 1. A new member is already engaged in behavioral health services and wants to continue with current provider.**

The member and/or provider must contact the JMHC and make a request for service authorization. This request can be made telephonically, in writing.

- 2. A member is not currently receiving behavioral health services and needs access to services.**

The member can contact the JMHC directly by calling the contact number provided in member materials. The UMP Care Facilitator will conduct an intake screen to help determine the member's level of need. The member will be given the contact information for behavioral health providers. The member can choose to contact the provider directly, or request assistance from the UMP Care Facilitator.

2. A member would like to change behavioral health providers.

In the event that a member receiving behavioral health services would like to change providers, the member can contact the UMP directly using the contact information found in the member materials. The member will be given the contact information for behavioral health providers. The member can choose to contact the provider directly, or request assistance from the UMP Care Facilitator.

Forms and Requirements

The UMP will forward a Service Initiation Form and a Service Authorization Request to the provider. The Service Initiation form must be completed and returned within 7 calendar days of the initial visit following the member's enrollment. The Service Authorization Form must be returned within 30 calendar days of the initial visit following the member's enrollment.

In non-urgent situations, the UMP will respond to the Service Authorization Request within 15 Calendar days.

Thereafter, service authorization will occur when the authorized number of visits has been used up or the time allotted for service has expired. The UMP will contact the Provider when reauthorization is due, however it is the responsibility of the provider to comply with Service Authorization procedures.

The UMP will further facilitate the transition to a new provider by conducting a discharge Planning review with the initial behavioral health provider.

For BadgerCare Plus Behavioral Health Forms, visit the [Provider Manual & Forms Section](#) of the Physicians Plus Website.

Urgent Care

Urgent care is any request for service to which the application of the timeframes used above could contribute to increased symptomology or increased post-traumatic stress. Urgent care requests for outpatient services will be reviewed and approved or denied within 24 hours following an assessment by the Care Facilitator or in consultation with a behavioral health care provider. Notification will be given both telephonically and in writing. Care Facilitators will consult with the Medical Director or his/her designee on all urgent requests.

Urgent requests can be made telephonically, in writing, or by email. Requests can be made by the service provider or by the member. Approved Urgent requests could lead to a variety of services to include, but not limited to:

- An increase in the frequency and number of approved outpatient visits;
- Use of hospital diversion services such as Crisis Home care or Recovery House;
- Use of Crisis Stabilization services such as intensive case management.
- Hospitalization.

Emergent Care

For emergencies please contact the member's therapist. If the member does not currently have a therapist or cannot reach the therapist, call the Emergency Services Unit with JMHC at 608-827-2600 located at 625 West Washington Avenue, Madison, WI 53703.

Inpatient Care

If a patient is admitted to any facility, including Meriter Hospital, JMHC must be notified by phone as soon as the admission occurs for authorization, concurrent review and discharge planning. JMHC can be reached at 608-280-2702, if no one is available please leave a message.

Transitional/Partial Hospitalization

Prior to admission into any transitional program the psychiatrist or attending clinician must contact JMHC for authorization, concurrent review and discharge planning. This can be done by telephone at 608-280-2702.

Insufficient Information

When a service authorization lacks required elements or sufficient clinical information to make an authorization decision, the request is determined to be “insufficient”. The Care Facilitator will:

- Notify the network provider and the member that the authorization cannot be made because of insufficient information.
- Provide details of additional information being requested.
- The notification will be made telephonically and in writing within 24 hours for urgent service requests and within 15 calendar days for non-urgent service requests.

The network provider has 5 business days to respond to the request. Once the Care Facilitator has received a response to the request for additional information, they must notify the network provider and the member. Notification will be made within two business days.

CONCURRENT REVIEW

The JMHC conducts periodic Concurrent Reviews on active cases for HMO members currently engaged in treatment.

The purpose of the Concurrent Review process is to assess the need for continued stay in treatment; assure that the current course of treatment is appropriate and effective in resolving symptoms; to ensure collaboration between all involved parties in the development of a comprehensive aftercare and discharge plan; and to ensure that services are delivered in a culturally competent and recovery oriented manner.

Methods

Reviews can be conducted telephonically, on site, or in writing between the JMHC Care Facilitator and the network provider. All reviews will be documented in the confidential JMHC clinical database. Reviews are to be conducted based on the plan of care and at intervals not to exceed six months.

Documentation of the Concurrent review must include, but is not limited to:

- Current presenting symptoms;
- Current medication regimen;
- Response to current course of treatment, including response to medications, changes in level of functioning related to mental status, substance use/abuse, medical issues, social skills;

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- Indications of members involvement in treatment planning;
 - Outcome of family meetings, interagency meetings, including description of all natural supports;
 - Progress on personal recovery goals identified by the client;
 - Assessment of clients strengths as well as areas of need;
 - Current DSM-IV diagnosis;
 - Evidence that cultural considerations are a part of treatment planning;
 - Aftercare and discharge plan, including any crisis plan.

It is the responsibility of the Care Facilitator to conduct the review. The JMHC Care Facilitators are licensed and certified social workers, counselors, nurses or otherwise clinically trained staff.

Timelines

1. Decisions regarding treatment continuation resulting from a Concurrent Review conducted in the course of non-urgent service must be made and transmitted to the provider and member within 30 days.
2. Decisions regarding treatment continuation resulting from a Concurrent Review conducted as the result of an urgent/emergency situation must be made and transmitted to the provider and member within 24 hours.
3. Decisions regarding the denial of services resulting from a Concurrent Review conducted in the course of non-urgent service must be made and transmitted to the provider and member within 15 days.
4. Decisions regarding the denial of services resulting from a Concurrent Review conducted in the course of an urgent/emergency situation must be made and transmitted within 24 hours.

Notification of service approval or service denial will include contact information for the JMHC Care Facilitator, including name, phone number, email address and hours of availability.

DENIAL OF SERVICE AND APPEAL PROCESS

The Journey Mental Health Center (JMHC), Utilization Management Program (UMP) may determine that behavioral health services requested by a member or behavioral health network provider are not appropriate to the level of need. In some cases this may result in the denial of services either in full or in part.

The purpose of the policy for the denial of service is to describe the process used to make denial decisions and describe the process used to appeal that decision.

Methods

Services may be denied based on the results of the service authorization process, the concurrent review process, a post-service review request, and/or a clinical assessment conducted by the behavioral health Care Facilitator.

If the Care Facilitator determines that a requested service does not establish medical necessity, or is clinically inappropriate, the Medical Director or his/her designee must review the request. Only a qualified psychiatrist can make a denial decision.

There are five (5) possible responses to a request for service. The requested service can be approved exactly as requested, or:

- Denied in its entirety.
- Approved at a lesser frequency (i.e. 3 hours a week of psychotherapy are requested but only one hour a week is approved).
- Approved for a shorter duration (i.e. six months of treatment is requested but three months are approved).
- Denied while approving a different service that is determined to be more appropriate.

The member and the network provider will be notified telephonically and in writing when a denial decision is made. For urgent service requests, the decision will be made and notification sent within 24 hours. For non-urgent service requests, the decision will be made and notification sent within 15 calendar days. This procedure applies to pre-service, concurrent and post-service denials.

The notification will include:

- The reason for the denial,
- A reference to the benefit provision, guideline, protocol, or other criteria upon which the denial was based, And where the criteria can be found,
- Information on the appeals process.

Members and network providers are encouraged to contact the Utilization Management program to discuss any service denial. To discuss denial decisions members and network providers can contact the Utilization Management Program at (608) 280-2700.

Appeals

Appeals to service authorization denials must be made to:

**Journey Mental Health Center
Utilization Management Program
Appeals Unit
625 West Washington Ave
Madison, Wisconsin 53703
(608) 280-2700
FAX: (608) 280-2707**

Members and/or the member's authorized representative are informed of the appeals process through various mechanisms that include member handbook, denial letters, and network provider materials.

The UMP strives to make the Appeals process expeditious and user friendly. The UMP encourages members and/or the member's authorized representative to contact the UMP telephonically as the first step in an appeals process. A telephonic review of the decision process may lead to an immediate resolution.

If a telephone discussion does not lead to a satisfactory resolution, a written appeal can be mailed or faxed to the address above. Member's and/or the member's authorized representative have the right to submit written comments, documents, or other information relevant to the appeal.

All pre-service, concurrent, or post-service non-urgent appeals will be reviewed and notification sent to the member and/or the member's authorized representative within 15 calendar days.

All pre-service, concurrent, or post-service urgent appeals will be reviewed and notification sent to the member and/or the member's authorized representative within 24 hours.

All expedited appeals will be reviewed and notification sent to the member and/or the member's authorized representative within 24 hours.

The UMP will willingly and efficiently cooperate with any request for an external appeal.

Notification of service approval or service denial will include contact information for the JMHC Care Facilitator, including name, phone number, email address and hours of availability.

BadgerCare Plus Member Rights & Responsibilities

Our members and patients deserve the best health care and services possible. Physicians Plus is committed to maintaining a mutually respectful relationship with its members. To promote effective health care, Physicians Plus makes clear its expectations for the rights and responsibilities of its members, to foster cooperation among members, providers and Physicians Plus.

MEMBER RIGHTS

- You have the right to be treated with dignity and respect.
- You have the right to make decisions about your health care.
- You have the right to ask for an interpreter and have one provided to you during any BadgerCare Plus-covered service.
- You have the right to receive the information provided in another language or another format.
- You have the right to receive health care services as provided for in federal and state law. All covered services must be available and accessible to you. When medically appropriate, services must be available 24 hours a day, seven days a week.
- You have the right to receive information about treatment options, including the right to request a second opinion.

MEMBER RESPONSIBILITIES

- Read and understand materials made available by Physicians Plus about your health Plan benefits and coverage.
- Build a relationship with your primary care physician and keep your appointments or provide proper notice if you must cancel with any Provider.
- Provide information that Physicians Plus and Providers need in order to care for you.
- Provide ID card in order to identify the correct health insurance carrier information.
- Follow the plans and instructions for care that you and your physician agree on.
- Treat health Plan and health care Providers, employees and other patients with respect and show proper behavior in the health care setting.

No Show Policy

A provider cannot bill Physicians Plus or a BadgerCare Plus member for no show appointments.

- If the provider has a policy in place for termination of care due to **no show** appointments, the policy must be implemented for both commercial patients and BadgerCare Plus patients.
- If a BadgerCare Plus member does not show up for a scheduled appointment and does not notify the provider in advance of the cancellation, the provider may contact the Physicians Plus Member Advocate for assistance.
- The Member Advocate will counsel BadgerCare Plus members regarding the importance of keeping appointments.
- The Physicians Plus Member Advocate **must** be contacted if: A pattern has begun to develop for missed appointments by a BadgerCare Plus member; **AND** you plan on terminating a patient's care.
- Letters regarding termination of care must be sent to the Member Advocate **prior** to member notification. The Member Advocate will ensure all standards set by Department of Health and Family Services (DHS) are met.

BadgerCare Plus Member Complaint, Appeal & Grievance Procedure

Interpreter services are available, free of charge, during the grievance and appeal process by contacting our Member Service department at (800) 545-5015 or (608) 282-8900.

A member may have a question or concern about benefits, claims or some other parts of our service. Member Service is available to answer questions and try to resolve concerns immediately.

Request for Hearing

At any point during the process of a Grievance or Appeal, a member can file a request for a hearing with the Department of Hearings and Appeals (DHA) at P.O. Box 7875, Madison, WI 53707-7875. The request must be made in writing and should include their name, mailing address, a brief report of the problem, which county or state agency took the action or denied the service, their social security number and their signature.

Emergency Appeal

When life or health may be at risk, if your appeal, at any level, is not immediately taken care of, an emergency review may be allowed.

Complaint

If the member is not happy with our services or claims practices, he or she may file a complaint with Physicians Plus. A complaint is taken over the phone by Member Service. All complaints are looked into and answered by our member advocate.

Grievance

If the member is not happy with our services or claims practices, he or she may file a grievance with Physicians Plus. All Grievances must be sent to us in writing to:

Grievance
Physicians Plus Insurance Corporation
2650 Novation Parkway
Suite 400
Madison, WI 53713

Our Grievance Committee will review member grievances and respond in an appropriate amount of time. Members have the following rights during the appeal process:

- You, or your personal representative, have the right appeal a decision made within 45 days of the date of the notice of denial.
- You, and or a personal representative, have the right to take part in the Grievance Committee meeting in person or on the telephone.
- The right to review the documents we used to make our decision prior to your meeting to review your appeal with Physicians Plus or the Department of Hearing and Appeals.
- Have a representative assist you at any point during the appeal process including reviews and hearings.

NOTE: No retaliation or action will be taken against any member that appeals an HMO decision. If any member continues to receive disputed services, he or she may be responsible for the cost of that care, if the decision is not in his or her favor.

If you would like additional information on Member Appeal Rights, please call Member Service at (608) 282-8900 or (800) 545-5015.

BadgerCare Plus Provider Appeal Process

If you wish to appeal a decision that results in payment denial to the provider of care an appeal must be submitted to PHYSICIANS PLUS within six (6) months unless specifically stated otherwise in the provider agreement.

A written request must include the following information:

- Clearly marked **PROVIDER APPEAL**.
- Contain the Providers Name, Date of Service(s), original billing date, date of denial.
- Reason for reconsideration.

Appeals should be directed via mail or fax to the Appeal Administrator.

Appeal Administrator
Physicians Plus Insurance Corporation
2650 Novation Parkway
Suite 400
Madison, WI 53713
Appeals Fax: (608) 327-0328

PHYSICIANS PLUS will respond to your appeal within 45 days of receipt. If PHYSICIANS PLUS does not respond in 45 days or if the provider of care is not satisfied with our response to the request; the provider may appeal to the Wisconsin Department of Health and Family Services (DHS) for a final determination. Appeals to DHS must be submitted in writing within 60 days of PHYSICIANS PLUS response.

BadgerCare Plus
Managed Care Unit
PO Box 6470
Madison, WI 53716-0470

The appeal will be reviewed to make sure that it is a provider appeal and not a grievance on the member's behalf. You will be contacted via phone or in writing to inform you that the appeal has been received, and you will be notified within 45 days when a decision has been made.

Member Notice of Physicians Plus Insurance Corporation Privacy and Confidentiality Practices

You do not have to act on this Notice. It is for informational purposes only. This Notice lets you know how medical information about you and your family may be used and how you can find this information. Please review this notice with care. If you have any questions about this notice, please contact the Physicians Plus Privacy Officer at (800) 545-5015 or (608) 282-8900.

PHYSICIANS PLUS' PLEDGE REGARDING MEDICAL INFORMATION:

Physicians Plus knows and respects the privacy of your medical information. Physicians Plus is required by law to maintain the privacy of "Protected Health Information (PHI)." PHI is information that may identify you and that relates to your past, present or future medical condition including care and payment for care. Physicians Plus keeps your PHI private and safe by following and going beyond state and federal law to make sure of the protection of your PHI.

Physicians Plus is required to:

- Keep PHI safe and provide you with certain rights to obey state and federal law;
- Give you this notice of our legal duties and privacy practices with respect to your PHI; and
- Abide by the terms of this notice that is currently in effect.

This notice will inform you about the ways Physicians Plus may use and release PHI about you and your dependents. It also tells you of your rights and certain rules we have about the use and disclosure of your PHI.

HOW PHYSICIANS PLUS MAY USE AND RELEASE PROTECTED HEALTH INFORMATION (PHI)

Under law, Physicians Plus may use and give out PHI without your permission in certain cases in order to provide you with health-related services. The following examples show how PHI is used and given out by Physicians Plus for this purpose (this is not a complete list and not every type of use or reason to give out PHI is listed):

Payment - Physicians Plus may use and give out PHI for payment of your health and pharmacy claims. We may use and give out PHI for purposes of billing, claims payment, to determine eligibility and coverage for health benefits. For example, in order to pay for your health care services or treatment, Physicians Plus will receive and review claims for services sent to us by your doctors. We may also use and give out PHI to see if medical treatments are necessary. For

example, we may review your PHI to determine whether a specific medical procedure is needed and consistent with your health condition.

Health Care Operations - Physicians Plus may use and give out PHI for health care operations, which include long term illness management activities, quality assessment activities, legal services and review of physicians who provide care for our members. We may also use and give out your PHI for certain internal marketing activities. For example, your name, address or e-mail address may be used to send you a newsletter (you may contact our Privacy Officer to ask that these materials not be sent to you). Physicians Plus may also use PHI to contact you to promote healthy living and disease prevention. For example, we might send out various reminders involving: follow-up appointments; examinations; pre-natal and post-natal screenings; counseling on nutrition and exercise; immunization; recommendations regarding heart health; cancer prevention; diabetes health management; and other specific health and long term illness management programs. We may also use and give out PHI received at the time of enrollment for underwriting and finding out premiums, as well as answering questions about our insurance products.

Business Associates - Physicians Plus may contract with others known as Business Associates to provide certain services on our behalf. To provide these services, Business Associates may receive, create, maintain, use and/or give out PHI, but only after they agree in writing to apply safety measures regarding PHI. For example, we may give out PHI to a Business Associate to do claims administration services, legal services or pharmacy management services, but they must agree in writing to apply safety measures to our PHI.

OTHER PERMITTED OR REQUIRED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

The following describe other ways in which Physicians Plus may use and give out PHI without authorization:

As Required By Law - We may use or give out PHI as required by law so long as the use or release complies with related law(s).

Legal Proceedings - We may use or give out PHI in the course of any legal proceedings. Physicians Plus may give out PHI in response to a court or administrative order. We may also give out PHI in response to a subpoena, discovery request or other lawful process, so long as such disclosure complies with applicable law.

Law Enforcement - We may give out PHI for law enforcement purposes as required by law. Physicians Plus may also give out PHI in regard to the following situations: identifying or locating suspects, fugitives, material witnesses or

missing persons; in regard to suspected victims of crimes; in regard to a death that may have resulted from criminal conduct; or in regard to possible crimes at our location(s). release

Worker's Compensation - We may use or give out PHI to obey worker's compensation laws or similar programs.

Disclosures to Benefit Plan Sponsors/Employers - Physicians Plus may give out PHI to employers who sponsor group health plans for a variety of purposes. For example, we may give out summary PHI to employers in regard to getting premium bids or changing or ending a group health plan. We may also give out enrollment and termination information to employers, including information relating to deductibles, premiums, Medicare and COBRA status. We may give out PHI to employers for group health plan administrative functions, such as administering a wellness or other employer-sponsored plan or program. For example, when an employer-sponsored wellness plan provides a benefit to employees who have a checkup each year, we may verify the completion and date of this checkup. In all such instances of giving out PHI to employers, we will give out only as much as is needed to complete the request.

Health Oversight Activities - We may give out your PHI to a health oversight agency for activities authorized by law, including audits, investigations, inspections and licensure. These activities are needed for the government to check the health care system, government programs, and compliance with civil rights laws.

Research - We may give out your PHI to researchers when:

- (1) the individual identifiers have been removed; or
- (2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established measures to ensure the privacy of the requested information, and approves the research.

DISCLOSURES WITH YOUR AGREEMENT OR OPPORTUNITY TO OBJECT

Individuals Involved in Your Care - Physicians Plus may give out your PHI to a family member, relative, close friend or someone else you have personally identified, if that person is involved in your health care or payment for your health care. For example, we may get in touch with your spouse in regard to payment of a bill, as long as you have not requested that this PHI remain confidential. In this type of situation, we will give out only as much PHI as is needed to complete the task. If you are not able to agree or disagree to our contacting your family or friends, we will decide if giving out PHI is in your best interest, using our best professional judgment.

OTHER USES OF MEDICAL INFORMATION

Other uses and giving out of PHI not covered by applicable laws or this notice will be made only with your written consent. If you authorize the use or giving out of your PHI, you may cancel it, in writing, at any time. If you cancel it, we will not use or give out your PHI for the reasons covered by your written consent from the time of your request and forward. However, cancelling it will not apply to uses or the giving out of PHI made prior to when you cancelled it in accordance with the authorization.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI)

The following are your rights regarding your PHI. As you review these rights, please keep in mind that Physicians Plus does not keep your medical records. To make requests or ask questions about any of these rights, please write Physicians Plus at:

Privacy Officer
Physicians Plus Insurance Corporation
2650 Novation Parkway
Suite 400
Madison, WI 53713
ppicinfo@pplusic.com

Right to Inspect and Copy Protected Health Information (PHI) - You have the right to inspect and get a copy of PHI that may be used to make decisions about your health care benefits. To inspect or copy your PHI, you must submit a written request to the address listed above. Under law, certain types of PHI are not available to inspect or copy, including psychotherapy notes, PHI put together in preparation of, or use in, any civil, criminal or administrative claim or legal proceeding, or other PHI subject to laws that deny access. If we deny access to certain PHI, you may ask for a review of the decision by writing to the address listed above.

Right to Amend - If you believe that any of your PHI is incorrect or incomplete, you may ask to have that PHI changed. You have the right to ask for an amendment to PHI for as long as the PHI is kept. To ask for an amendment, you must submit your written request, including the reasons that support your requested amendment(s), to the address listed above. Physicians Plus will answer your request in writing within 30 days of receiving it and will give you more information about your rights in the event we allow or deny your request to amend.

Right to an Accounting of Disclosures - You have the right to receive a written report of certain disclosures we make of your PHI. The report would not include disclosures made for payment or health care operations as explained in this notice. The report would also exclude disclosures made to you or family members or friends involved in your care or those made according to your signed approval. The report would include a list of those to whom PHI was released, a short description of the PHI released, and the purpose for the release. To learn more about asking for a report of disclosures, please write to the address listed above.

Right to Request Restrictions and Confidential Communications - You have the right to ask for certain limits on the use of PHI for treatment, payment or health care operations. You also can ask for limits on the release of PHI to someone who may be involved in your care or payment for your care, like a family member or friend. To learn more about your rights on asking for these types of limits, please contact us at the address listed above. Please note that we do not have to agree to the restrictions you ask. You also have the right to ask that we contact you about PHI by certain means or at a certain location. We will handle such requests to the best of our ability. To ask for confidential communication changes, you must submit your request in writing to the address listed above. We may refuse your request if you have not provided information as to how payment, if that applies, will be handled or do not tell us how or where you wish to be contacted.

Right to Paper Copy of This Notice - You have the right to a paper copy of this notice. You may ask for a copy at any time. If you want to get this notice through e-mail, you may still ask for a paper copy of the notice. To receive a paper copy of this notice, contact us at (800) 545-5015 or (608) 282-8900 or write us at the address listed above. You can also print it from our website at www.pplusic.com.

CHANGES TO THIS NOTICE

We reserve the right to make changes to this notice. If we make a lot of changes to the notice, we will send it to you within 60 days of the changes. The notice will contain the new effective date in the upper right-hand corner of page 1.

COMPLAINTS

If you believe your privacy rights have been violated; you may file a privacy complaint with Physicians Plus or with the Secretary of the Department of Health and Human Services. To file a privacy complaint with Physicians Plus, contact the Privacy Officer at the address listed above. Please note that all other complaints not related to privacy must follow the rules outlined in your Policy or Medical Certificate of Coverage. We will not treat you different in any way for filing a complaint.

Compliance with Equal Opportunity Laws, Regulations & Rules

Physicians Plus is in compliance with the equal opportunity policy and standards of the Department of Workforce Development, the Department of Family Services and all applicable State and Federal statutes and regulations relating to nondiscrimination in employment and service delivery.

It is the policy of Physicians Plus to implement Affirmative Action measures designed to eliminate discrimination and to ensure equal opportunity for women, racial or ethnic minorities and persons with disabilities. Physicians Plus recognizes the need to identify job groups and classification with under represented groups and to develop an Affirmative Action plan for implementing goals through outreach, recruitment and training.

No otherwise qualified person shall be excluded from employment, be denied benefits of employment or otherwise be subject to discrimination for employment in any manner on the basis of age, race, religion, color, sex, national origin or ancestry, disability or association with a person with a disability, arrest or conviction record, sexual orientation, marital status, pregnancy, political belief or affiliation, military participation, or use or non use of lawful products and programming activities relating to nondiscrimination in employment.

No otherwise qualified application for service or service participation shall be excluded from participation, be denied benefits, or otherwise be subject to discrimination in any manner on the basis of race, color, national origin or ancestry, disability or association with a person with a disability. This policy covers eligibility for the access to service delivery and treatment in all of the programs and activities.