Provider Manual

Family Care Provider Manual Supplement

Anthem

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1. Introduction

Welcome! Thank you for being part of the Anthem Family Care plan in Wisconsin. We are excited you have chosen to be part of our network and have committed to providing the best possible support for our Family Care Wisconsin members, who are at the center of everything we do.

The Wisconsin Family Care program is a Medicaid long-term care program that helps eligible older adults and adults with disabilities coordinate and receive cost-effective, member-centered services to support independence, health, and quality of life.

Anthem is committed to the goal of improving the health outcomes of the members we serve.

Accessing Information, Forms, and Tools on Our Website

A wide array of tools (including a scope of services guide), information, and forms are accessible via the provider website at **https://providers.anthem.com/wisconsin-provider/patient-care/family**. To access additional information on any topic, select from the list of quick links on the left-hand side of the screen.

If you have any questions about the content of this manual, contact Provider Services at **844-483-2704** during our hours of operation: Monday to Friday, 9 a.m. to 6 p.m. ET.

Websites

The Anthem website and this manual may contain links and references to internet sites owned and maintained by third-party sites. Neither Anthem nor its related affiliated companies operate or control, in any respect, any information, products, or services on third-party sites. Such information, products, services, and related materials are provided **as is** without warranties of any kind, either express or implied, to the fullest extent permitted under applicable laws. Anthem disclaims all warranties, express or implied, including but not limited to implied warranties of merchantability and fitness. Anthem does not warrant or make any representations regarding the use or results of the use of third-party materials in terms of correctness, accuracy, timeliness, reliability, or otherwise.

Anthem Contact Information

If you have questions about…	Contact Details
Provider Services	Anthem Family Care Provider Services Phone: 844-483-2704 TTY: **711** Hours: Monday to Friday, 8 a.m. to 5 p.m. CT Closure days Provider Services will be closed on the following days: • New Year's Day • Martin Luther King Jr. Day • Memorial Day • Juneteenth

	• Independence Day • Labor Day • Thanksgiving Day • Friday after Thanksgiving • Christmas Day
Availity Essentials	Availity Essentials: **Availity.com** • Eligibility and Benefits, including digital ID cards • Submit a prior authorization request • Check claim status • Check payment status • Electronic Remittance Advice (ERA) • Submit a claim dispute • View authorization status • Submit an authorization appeal on behalf of the member
Electronic funds transfer enrollment	https://enrollsafe.payeehub.org
Submitting claim disputes	Online: Disputes can be submitted through Availity Essentials Claim Status application. Locate your claim and select the dispute button to initiate, then select **Go To Request** to complete your dispute. (**Availity.com**) Mail: Anthem Blue Cross and Blue Shield Correspondence/ Claim Disputes P.O. Box 1599 Virginia Beach, VA 23466 By phone: Provider Services Phone: **844-483-2704** Hours: Monday to Friday, 8 a.m. to 5 p.m. CT
Fraud and Abuse Department	Calling Provider Services: **844-483-2704** (Hours of operation: Monday to Friday, 8 a.m. to 5 p.m. CT) Calling Member Services phone: **844-614-3182** (TTY: **711**) Contacting Special Investigations Unit (SIU): Phone: **866-847-8247** (**TTY: 866-494-8279**)

Provider Appeals/correspondence	For grievances and appeals: Contact: Anthem Provider Services Phone: **844-483-2704** Provider appeals can be submitted in the following ways: Electronically: Using Availity Essentials at Availity.com Fax: Directly to the Appeals Department at fax **888-458-1406** Mail: Submit the form to: Anthem Family Care: Correspondence/Appeals PO Box 61599 Virginia Beach, VA 23466-1599
Interpreter services	Anthem Provider Services Phone: **844-483-2704** Anthem Member Services **844-614-3182** **TTY: 711** Hours: Monday to Friday, 8 a.m. to 5 p.m. CT
24/7 NurseLine	Phone: 844-614-3182 TTY: **711** Hours: 24 hours a day, 7 days a week
LTSS UM Fax Number	Fax # **866-291-0838**
Member Services	Members can submit grievances and appeals via the member website or call Member Services to answer questions, make changes or file grievances and appeals, request interpreter services, or update personal information changes: Phone: **844-614-3182** TTY: **711** Interpreter Services can also be contacted through Member Services. Sign language, oral interpretation, oral translation, and auxiliary aids, and services must be available for the review of marketing materials at no cost to eligible individuals.
Non-emergent transportation services: Provided through MTM Health	Phone: **888-778-4479 TTY: 711** Hours: 24 hours a day, 7 days a week. Online: https://mtm.mtmlink.net

Purpose of the Supplement

This provider manual supplement for Wisconsin Family Care program providers offers additional, program-specific guidance and operational details that are not covered in the broader Anthem Medicaid provider manual. This supplement serves several important functions:

- Program-specific guidelines: Provides detailed information and clarification on the unique aspects of delivering services under the Wisconsin Family Care Program. This includes eligibility criteria, covered services, and specific policies related to the program.
- Operational procedures: Outlines specific operational procedures providers need to follow, such as care coordination, service authorization, and claims submission.
- Regulatory compliance: Information to ensure that providers are aware of and adhere to Federal and state regulations specific to Family Care.
- Billing and reimbursement: Offers detailed instructions on billing procedures and reimbursement policies specific to Family Care, including any unique codes required for claims processing.
- Quality assurance and improvement: Defines expectations related to quality standards and outlines quality oversight process, emphasizing the importance of delivering high-quality services and supports.
- Training and resources: Provides information about training opportunities and additional resources.
- Communication and contacts: Key contact and community protocols within the MCO, ensuring providers have the support they need for questions related to service delivery.

Overview of Wisconsin Family Care

The Wisconsin Family Care program is a Medicaid-managed Long-Term Services and Supports (LTSS) program designed to help individuals aged 65 and older and adults with physical or developmental disability receive comprehensive, person-centered care while remaining in their communities.

Anthem is responsible for coordinating and delivering services to eligible members. Anthem handles the administrative, financial, and coordination aspects of the program, leveraging a comprehensive service package. Examples of covered services may include personal care, home health services, respite care, adult day care, supportive home care, occupational and physical therapy, transportation, employment services, day services, residential services, and other essential supports services. Detailed information can be found within the scope of services guide.

This supplement acts as a specialized extension of the main Anthem Medicaid Provider Manual. Providers who participate with Anthem for non-Family Care services as well should also reference the Anthem Medicaid Provider Manual for additional information not specific to Family Care.

If you are looking for information related to Anthem BadgerCare and Medicaid Supplemental Security Income. This information is available in the **Wisconsin Medicaid Provider Manual**.

Definitions and key terms

Member: A member is an individual enrolled in a managed care organization (MCO) who receives long-term care services and supports, including people with disabilities and seniors, to help them live safely and independently in their home or community. The MCO coordinates the delivery of these services, developing a person-centered care plan based on the member's individual needs, strengths, and preferences.

Interdisciplinary team (IDT): A collaborative group that includes the Care Coordination team, the member, the member's family/caregiver, Provider(s), and all other participants who work together to create a comprehensive, person-centered care plan.

Level of Care: A categorization of the amount of care an individual needs and is used as eligibility criteria in each program

Functional Screen: A web-based application used to collect information about an individual's functional status, health, and need for assistance. The Functional Screen looks at a person's ability to complete both Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). It also looks at the person's cognition, behavior(s), diagnosis, medically oriented tasks and employment, indicators for mental health issues, substance use issues, and other conditions that put a person at risk of institutionalization in a nursing home or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID).

HCBS: Services that provide opportunities for Medicaid beneficiaries to receive services in their own homes or communities rather than institutional settings

LTSS: Services and supports used by individuals with functional limitations and chronic illnesses who need assistance with routine daily activities such as bathing, dressing, meal preparation, and management of medications. These services can be provided at home, in the community, in assisted living settings, or in nursing homes, and are important to enable individuals to maintain health and quality of life.

EVV: An electronic system required to be utilized by direct care workers who provide personal care and home health care services to report service delivery, ensuring individuals receive the services they need

1. Program Overview

The Family Care Program has several key objectives:

1. Promote Independence
    - Enable members to live as independently as possible in their own homes or community-based settings rather than in institutional care facilities.
2. Comprehensive Service Delivery
    - Provide a coordinated range of services tailored to the members' needs, promoting holistic care through effective service integration.
3. Cost-effective care
    - Deliver cost-effective solutions while maintaining quality care.

By focusing on person-centered care, Family Care aims to improve the quality of life for members, fostering greater independence and satisfaction. Through community integration, the program encourages integration and engagement within the community, supporting social connections and reducing isolation.

By offering a single point of coordination through Anthem for its members, we simplify access to services and streamlines the delivery of care.

Eligibility requirements and member populations

Residents of Wisconsin aged 65 or older and adults with physical or developmental disabilities may be eligible for participation based on Medicaid financial eligibility criteria, which considers income and asset limits, as well as functional eligibility criteria. Interested individuals can begin the process by contacting their local Aging and Disability Resource Center (ADRC). ADRCs provide information about eligibility, program options, and help facilitate the enrollment process into Family Care.

The Family Care program is managed through Geographic Service Regions (GSR). For additional GSR information, visit Family Care Geographic Service Regions (GSR) Family Care and IRIS Geographic Service Regions (GSR) Reconfiguration Timeline.

Provider responsibilities

As an Anthem contracted provider for Family Care, you play a key role in supporting members to live independently and with dignity. Below are your responsibilities as part of the Family Care Program.

1. Service Delivery
    - Provide only the services authorized in the member centered plan (MCP).
    - Deliver services and care that respects the member choices, preferences, culture, and goals.
    - Ensure staff are trained, competent, and available to provide reliable service coverage.
    - Support members in achieving the greatest level of independence possible.

- Required to meet state standards for timely access to care and services, with consideration for urgent services.

2. Health, Safety & Rights
    - Protect the health, safety, and welfare of members at all times.
    - Respect member rights: dignity, privacy, independence, and freedom from abuse or neglect.
    - Immediately report critical incidents (abuse, neglect, exploitation, injuries, hospitalizations, death, etc.) to Anthem and no later than 24 hours after incident.
3. Collaboration with Anthem
    - Communicate regularly with the care team about changes in member's condition or service needs.
    - Participate in the person-centered planning (MCP) process.
    - Cooperate with oversight, audits, site visits, and quality reviews as required.
4. Billing & Documentation
    - Submit accurate, timely claims using required codes and formats.
    - Keep clear service records (date, time, staff, services provided, member response) in alignment with Wisconsin Administrative Code DHS 106
    - Keep records as required by state and federal rules.
5. Compliance & Ethics
    - Meet all licensing, certification, and HCBS requirements for your service type.
    - Follow confidentiality laws (HIPAA, DHS privacy standards).
    - Prevent and report and suspected fraud, waste, or abuse.

Member Rights

Member Services: **855-690-7800 (TTY 711)**

Hours of Operation: Monday through Friday, 8 a.m. to 5 p.m. CT

Members should be clearly informed about their rights and responsibilities so they can make the best healthcare and support decisions. Members also have the right to ask questions about the way we conduct business, as well as the responsibility to learn about their healthcare plan coverage. Members have the right to choose from Anthem's network of providers.

The following member rights and responsibilities are defined by the state of Wisconsin and appear in the member handbook.

Member rights

Anthem honors civil rights and provides covered services to all eligible members regardless of:

- Age
- Color
- Disability
- Marital status
- National origin

- Race
- Religion
- Gender
- Gender identity
- Sexual orientation
- Military participation
- Arrest or conviction record

All necessary covered services are offered to all members. All services are given in the same way to all members. All persons or groups who work with Anthem, or who refer or suggest services to members, shall do so in the same way for all members. Translation or interpretation services are offered free of charge for those members who need assistance.

Members have the right to the following:

- **Choice:** Access to a Network provider based on cultural and identity preference to:
    - Obtain services from an out-of-network Indian healthcare providers with open availability to provide services.
    - Allow a non-network IHCP to refer an Indian member to an MCO network Provider.
    - Choose to receive primary care services from an Indian health care provider in the MCO's provider network, as long as that provider has the capacity to provide the services.
- **Non-Discrimination**: Freedom from unlawful discrimination when applying for or receiving benefits.
- **Information Security**: Assurance of the accuracy and confidentiality of member information.
- **Timely Decisions**: Prompt decisions regarding eligibility, entitlements, and cost-sharing, with available assistance.
- **Information Access**: Access to personal information, program details, and service system information.
- **Enrollment Choice**: The option to enroll in or disenroll from Anthem at any time, if eligible.
- **Service Information**: Servicing identified in the member's member-centered plan.
- **Member Support**: Assistance in understanding rights and responsibilities related to Family Care.

Support from Anthem includes:

- **Outcome Identification**: Help in self-identifying outcomes and long-term care needs.
- **Service Information**: Securing information on all potentially available services and supports through the benefit.
- **Service Planning**: Active participation in planning individualized services and making reasonable choices for services and providers to support identified outcomes.
- **Conflict Management**: Identifying, eliminating, or managing potential conflicts of interest.
- **Member-Centered Plan**: Access to services identified in the member's plan.

- **Rights Support**: Help in exercising rights and navigating grievance and appeal procedures.
- **Rights Protection**: Assurance that exercising rights does not negatively affect treatment by the MCO, providers, or state agencies.
- **Freedom from Restraint**: Protection from restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

Providers are responsible for protecting these rights and reporting any suspected violations immediately.

2. Provider Participation Requirements

Credentialing and re-credentialing process

All Family Care Wisconsin LTSS providers are required to enroll with Wisconsin Medicaid through the ForwardHealth Portal, and have a signed *Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation Standard Agreement/Acknowledgement for Home and Community-Based Waiver Service (Adult Long-Term Care) Providers*; F-00180C form as a completion requirement of their initial enrollment with the Department of Health Services (DHS). Providers must also complete Anthem's *Wisconsin LTSS Family Care Provider Application* and credentialing monitoring process prior to participating in the network. Credentialing verifies that providers meet applicable state and federal requirements, as well as the standards established by Anthem. The process includes, but is not limited to, verification of licensure, education, certifications, background checks, training requirements, and any other qualifications necessary for the provider's scope of service.

Recredentialing is required at least every **three (3) years**, and every four (4) years for Criminal Background Checks or more frequently if required by regulation or contract. Anthem and DHS will provide notice of upcoming recredentialing and instructions for submission of required documentation starting ninety (90) days in advance of the revalidation due date. Providers must respond timely to ensure continuity of network participation.

Providers are expected to maintain compliance with all credentialing standards at all times and are required to inform Anthem of any changes, including but not limited to licensure, Medicaid enrollment, certification and recertification status, changes in disclosure of ownership or controlled interest, and insurance coverage. Failure to complete, maintain, and notify Anthem of changes in status related to credentialing or recredentialing requirements may result in suspension or termination from the network.

Providers are required to keep provider enrollment documentation and all personnel files, including subcontracting arrangements, related to persons providing direct care to members for a minimum of ten (10) years from the end date of the Anthem Provider Agreement or from the date of completion of any provider audit with Anthem.

Training requirements

As a contracted provider with Anthem in the Wisconsin Family Care program, you are required to ensure that staff are properly trained to deliver safe, effective, and high-quality care. Anthem has additional responsibilities to oversee and support provider training in alignment with the Wisconsin Department of Health Services (DHS) requirements. Providers must ensure that staff maintain a level of training appropriate to the services they provide. This training must be documented and available for review if/when requested. Anthem may request training records to ensure compliance with these requirements. Providers who fail to meet training standards may be placed on a Remediation Plan until training requirements are met.

Anthem will assist in identifying training needs among providers are regularly share available resources and facilitate learning opportunities where appropriate. Anthem monitors training compliance through site visits, audits and credentialing/re-credentialing processes.

- Ensure compliance with DHS training and documentation standards, including:
    - Family Care Training and Documentation Standards for *Supportive Home Care (SHC)* and *In-Home Respite* (DHS Publication P-01602).
- Communicate training expectations clearly in contracts, provider updates, and routine monitoring activities.
- Support specialized training requirements related to 1-2 Bed Adult Family Homes (AFHs), HCBS Settings Rule Compliance

Compliance with federal and state regulations

All contracted providers must comply with applicable federal and state laws, rules, and regulations governing the provision of services under the Wisconsin Family Care program. This includes, but is not limited to:

- HIPAA (Health Insurance Portability and Accountability Act): Protecting the privacy and security of member health information.
- ADA (Americans with Disabilities Act): Ensuring equal access to services and reasonable accommodations for members with disabilities.
- CMS (Centers for Medicare & Medicaid Services) Regulations**:** Following federal rules applicable to Medicaid services.
- Wisconsin DHS Chapter 10 (Wis. Admin. Code): Governing managed care organizations.
- Wisconsin DHS Chapter 36 (Wis. Admin. Code): Standards for community mental health services.
- HCBS Settings Rule (42 C.F.R. § 441.301(c)(4) and § 441.710): Ensuring home and community-based services are delivered in settings that promote member choice, integration, and independence. The provider is responsible for ensuring each service location receives HCBS Settings Rule compliance.

Providers must also comply with any other applicable Wisconsin statutes, administrative codes, and federal requirements related to service delivery.

To the extent permitted by law, providers are required to fully cooperate with any member-related investigation conducted by Anthem, the Wisconsin Department of Health Services (DHS), the Federal Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), law enforcement, and/or any other legally authorized investigating entity.

Cooperation with investigations may include, but is not limited to, providing access to relevant records, documentation, or information, making staff available for interviews or inquiries, maintaining confidentiality, and responding promptly to requests for information or participation. Failure to cooperate with authorized investigations may result in corrective action, up to and including suspension or termination from the Anthem network.

Culturally and Linguistically Appropriate Services

Members are increasingly diverse, and needs are becoming more complex. It is important for providers to have the knowledge, resources, and tools to offer culturally competent and linguistically appropriate supports. Anthem wants to help, as we all work together to achieve health equity. The U.S. Department of Health and Human Services (HHS) defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. It is a dynamic, ongoing developmental process requiring long-term commitment. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains that healthcare is defined through a cultural lens for both patients and providers.

A member's cultural affiliations can influence:

- Where and how care is accessed, how symptoms are described,
- Expectations of care and treatment options,
- Adherence to care recommendations. Providers also bring their own cultural orientations, including the culture of medicine.

Offering culturally and linguistically appropriate care incorporates a variety of skills and knowledge, including, but not limited to, the ability to:

- Recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior.
- Develop understanding of others' needs, values, and preferred means of having those needs met
- Formulate culturally competent member-centered plans.
- Understand how and when to use language support services, including formally trained interpreters and auxiliary aids and services, to support effective communication.
- Avoid use of family members, especially minors, to act as interpreters for limited English proficient members.
- Understand and adhere to regulations to support the needs of diverse members, such as the Americans with Disabilities Act (ADA).
- Use culturally appropriate community resources as needed to support member needs and care. Anthem ensures providers have access to resources to help support delivery of culturally and linguistically appropriate services.

We encourage providers to access and use the following resources.

American Medical Association:

- https://www.ama-assn.org/delivering-care/health-equity/3-ways-mitigate-implicit-bias-exam-room
- https://www.ama-assn.org/delivering-care/health-equity/3-ways-battle-unconscious-bias

Cultural Competency Training (Cultural Competency and Patient Engagement)

A training resource to increase cultural and disability competency to help effectively support the health and healthcare needs of your diverse patients.

Caring for Diverse Populations Toolkit: A comprehensive resource to help providers and office staff increase effective communication by enhancing knowledge of the values, beliefs, and needs of diverse members. Anthem appreciates the shared commitment to ensuring Members receive culturally and linguistically appropriate services to support effective care and improved health outcomes.

Interpreter and accessibility services

For those instances when you cannot communicate with a member due to language barriers, interpreter services are available at no cost to you or the member. Anthem provides over-the-phone and face-to-face interpreters. Providers must notify members of the availability of interpreter services and strongly discourage the use of friends and family, particularly minors, to act as interpreters. Face-to-face interpreters for members needing language assistance, including American Sign Language, are available by placing a request at least 72 hours in advance. A 24-hour cancellation notice is required. Request telephone interpreter services by calling:

- Providers: **844-483-2704**
- Members: **844-614-3182**

For after-hours interpreter services, call the 24/7 NurseLine and take the following steps:

1. Give the member's identification (ID) number to Member Services.
2. Explain the need for an interpreter and state the language required.
3. Wait on the line while the connection is made.
4. Once connected to the interpreter, the associate or 24/7 NurseLine nurse introduces the Anthem member, explains the reason for the call, and begins the dialogue.

Request face-to-face interpreter services by calling:

- Providers: **844-483-2704**
- Members: **844-614-3182**

Services for members with hearing loss, visual and/or speech impairment

Members with hearing loss or speech impairment can call **711**. Members can also request face-to-face sign language interpreters at no cost. Members with visual impairments can request verbal assistance or alternative formats for assistance with printed materials at no cost.

Translation of materials

Members can request translation of materials into non-English languages at no cost by contacting Member Services: **844-614-3182**

Anthem appreciates the shared commitment to ensuring Members receive culturally and linguistically appropriate services to support effective care and improved health outcomes.

Reporting requirements

Providers play a critical role in protecting the health and safety of members. If an incident occurs, take immediate steps to prevent further harm and report the incident to Anthem within one (1) business day via the Incident Reporting form on the Anthem Provider website.

The following incidents must be reported:

Abuse

- Physical, sexual, emotional abuse
- Treatment without consent
- Unreasonable confinement or restraint

Neglect

- Failure to provide necessary care or services

Self-Neglect

- When a member is unable to care for themselves, putting health or safety at risk

Financial Exploitation

- Misuse of a member's funds, assets, or property

Exploitation

- Taking advantage of a member for personal gain through manipulation, threats, or coercion
- Includes: human trafficking, forced labor, forced criminality, child pornography, slavery, blackmail, sexual exploitation

Medication Errors (with moderate or severe impact)

- Wrong drug, dose, timing, route, technique, or omission
- Moderate injury/illness: requires medical evaluation beyond first aid
- Severe injury/illness: life-threatening, major impact on health, or requires hospital admission

Missing Person (when the member's whereabouts are unknown and at least one of the following applies):

- Member has a legal decision-maker
- Member is under protective placement
- Member lives in a residential facility

- Member is vulnerable/high-risk
- Weather creates danger
- Member injured or ill while missing

Falls

- Any fall resulting in moderate to severe injury or illness

Emergency Restraints/Restrictive Measures

- Used suddenly when behavior places the member or others at imminent risk of harm
- Unexpected behaviors or sudden escalation

Unapproved Restraints/Restrictive Measures

- Used before DHS approval is obtained, or after approval has expired

Deaths related to:

- Any of the above incidents
- Accident, suicide, psychotropic medication, or unusual/suspicious circumstances

Other Serious Events

- Any unexplained, unusual, or suspicious accident, illness, injury, death, or unplanned law enforcement involvement resulting in moderate or severe impact

Provider Responsibilities

- **Immediately:** Take steps to protect the member and others from further harm.
- **Within one (1) business day:** Report the incident to Anthem.

Document: Keep accurate records of the incident, actions taken, and outcome.

Reporting Other Events Related to Member Safety

Providers must report the following incidents to local law enforcement authorities:

- Incidents where the Member is a victim of a potential violation of the law are reported to local law enforcement authorities.
- Incidents where the Member is suspected of violating the law are reported to local law enforcement, to the extent required by law.

Appeal of Termination or Suspension Decision related to Network Participation

If a provider's participation is terminated or suspended, the provider has the right to appeal the decision. Written notice of termination or suspension will include the reason(s) for the action and instructions for filing an appeal. Appeals must be submitted in writing within fifteen (15) days of receiving the appeal notice. Written hearing request must be submitted to Anthem and the Wisconsin Department of Administration (DOA), Division of Hearing and Appeals (DHA), and

should include any supporting documentation the provider wishes to be considered, along with a copy of the termination letter. Appeals can be sent directly to Anthem at WI-LTSSNetwork@anthem.com and to DHA at DHAMail@wisconsin.gov.

For Anthem, appeals will be reviewed by individuals who were not involved in the original decision, and a written determination will be issued within **30 days** of receipt of the appeal and contingent upon DHA final decision. The provider will remain terminated or suspended with Anthem during the review process unless otherwise specified by applicable law or contract. For more information related to DHA's appeal process, visit the DOA Division of Hearings and Appeals page on the DOA website.

Service Authorization and Care Planning

Anthem uses a member-centered planning process to guide the authorization of Family Care LTSS services. This process ensures that services are individualized, align with the member's needs and preferences, and comply with benefit requirements.

Each new member is assigned a care management team (Service Coordinator and RN) within Anthem, and is encouraged to participate in the development of, and updating of, the member-centered plan (MCP).

Services will be authorized based on identification of the most cost-effective way to meet the members outcome determined through the Resource Allocation Decision Method process. The member, members family/friends/guardian, service provider, and Care Management team all collaborative to determine the best way to achieve the desired outcomes.

All requested services will be evaluated and either approved or denied with appropriate notice of adverse action within the 14-day timeline. If additional time is needed, a notice of a 14-day extension will be provided.

Role of the IDT in service authorization

In the Family Care program, the member-centered plan (MCP) is the foundation for all service authorizations. The MCP is developed collaboratively with the members, their care team, and others the members choose to involve. It identifies the members' goals, preferences, and assessed needs, and outlines the support and services necessary to achieve those outcomes.

All services delivered to a member must be authorized by Anthem in alignment with the MCP. Providers are expected to follow the authorized type, amount, frequency, and duration of services, and to communicate any changes in member needs to the care team so the MCP and service authorizations can be updated as appropriate.

Resource Allocation Decision (RAD) Method

The Resource Allocation Decision (RAD) Method is applied when requests are made for services in the Family Care benefit package. The RAD is a series of questions that helps members and IDT staff identify options that are available to help support services and supports needed related to their long-term care outcomes. Outcomes are goals created to help the member be as healthy, safe, and independent as possible. The RAD method is utilized to help identify the most cost-

effective and efficient ways to meet the needs and achieve the member's goals. This includes both paid and unpaid support, including resources within members' community, friends, family or other volunteer organizations. The RAD method is a very useful tool to foster critical thinking as it relates to service authorization decision-making in the Family Care program. It ensures that a consistent process is followed when decisions about authorization of services are made.

Member-Centered Planning and Comprehensive Assessment

At Anthem, our approach to care is **member-centered** — meaning every member's goals, preferences, and needs guide the services and supports they receive. The **Member-Centered Plan (MCP)** is a living document that reflects what is important **to** and **for** each member. It changes as the member's life and circumstances change.

Member-centered planning is a continuous, collaborative process between the **member**, their **Interdisciplinary Team (IDT)**, and, when appropriate, their **family, caregivers, and providers**. The goal is to ensure the services and supports authorized by Anthem help each member live safely and successfully in the most integrated community setting possible.

Comprehensive Assessment

Purpose

The comprehensive assessment is the foundation of the member's plan of care. It helps the IDT — which includes a social service coordinator and a registered nurse — understand the member's overall situation, including:

- Strengths and abilities
- Health and functional needs
- Risks and safety concerns
- Natural and community supports
- Personal outcomes and preferences

This information guides all service authorizations and care planning.

Assessment Process

- Anthem's IDT staff complete an **in-person assessment** with each member at least every **six months**.
- At least **once every twelve months**, the assessment takes place **in the member's home** (or every **six months** for members identified as high-risk or vulnerable).
- The assessment includes input from the member and anyone they choose to participate, such as family members, friends, guardians, or caregivers.
- The IDT reviews:
    - The Long-Term Care Functional Screen (LTCFS)
    - Medical and behavioral health records
    - Risks, strengths, and available supports

Anthem uses a **standardized assessment tool approved by DHS** to ensure consistency and thoroughness.

Assessment Areas

During the comprehensive assessment, the IDT gathers and documents information about the member's:

- Health conditions, medications, and self-management abilities
- Safety concerns (e.g., fall risk, nutrition, pain, skin integrity)
- Cognitive and mental health status
- Risk of abuse, neglect, or exploitation
- Housing stability and financial situation
- Education, employment, and community integration goals
- Preferences for living situation, caregivers, daily routines, and privacy
- Understanding of rights and self-directed supports
- Available natural supports and how to strengthen them

The IDT also reviews **medications every six months** or sooner if there are changes in the member's health or treatment. For members on complex or behavior-modifying medications, a nurse or licensed professional evaluates effectiveness, side effects, and member understanding of use and risks.

Member-Centered Planning

Purpose

Member-centered planning turns the information from the assessment into a **comprehensive plan of care** — the **Member-Centered Plan (MCP)**. The MCP:

- Identifies the member's long-term care outcomes and personal experience goals
- Lists all authorized **services and supports** — both paid and unpaid — that will help achieve those goals
- Ensures services are sufficient, appropriate, and satisfactory to the member

Planning Process

- The MCP is developed **with the member** and anyone they wish to include — family, caregivers, or providers.
- IDT staff help the member make informed choices about where and with whom they live, work, and receive services.
- The process includes identifying **potential risks** and strategies to reduce them.
- For members with communication or cognitive challenges, the IDT works closely with family and trusted supporters to ensure the member's voice is represented.
- Providers may be asked to participate in the MCP development and review when their services are part of the plan.

The MCP is written in **plain, accessible language** and translated or adapted as needed for members with limited English proficiency or communication barriers.

Documentation

The MCP includes:

- The member's **goals and outcomes** (both long-term care and personal experience outcomes)
- All **services and supports**, including those provided by natural supports or community resources
- The **frequency** of in-person and other contacts by IDT staff, with an explanation of how this frequency was determined
- Identified **risks** and mitigation strategies
- **Backup plans** for essential services
- The **provider(s)** responsible for each service
- The **time period** covered by the plan
- Documentation of the member's preferences and decisions regarding:
    - Living arrangements
    - Employment or educational goals
    - Integration into the community
    - Advance directives and rights

For members receiving residential services, the MCP also documents any **Home and Community-Based Settings (HCBS) Rule modifications**, including the reason for the modification, alternatives considered, and the member's informed consent.

Follow-Up and Review

- The MCP is updated whenever there are **significant changes** in the member's health, needs, or preferences.
- IDT staff review identified risks at least **every three months**, or more often if needed, to ensure the member's safety and satisfaction.
- Providers are expected to notify the IDT promptly if they observe changes in the member's condition, preferences, or service needs.

Provider Role

Providers play an essential role in member-centered planning by:

- Participating in assessments and planning discussions when requested
- Sharing accurate and timely information about the member's progress and needs
- Respecting the member's choices and preferences
- Supporting the member's independence and integration into the community
- Reporting significant changes or incidents promptly to Anthem

In Summary

Member-centered planning is not a one-time event — it's an **ongoing partnership** between Anthem, the member, and providers. By keeping the member's goals and voice at the center of all decisions, providers help ensure each member receives the right support at the right time to live their best possible life in the community.

Member-Centered Plans are available and accessible to providers through Anthem's secure provider application, Care Central, within Availity Essentials. Care Central is an application within Availity, designed specifically for home-and community-based Service (HCBS) providers to simplify and streamline processes related to member management.

- **Website:** https://Availity.com > *Payer Spaces* > Anthem Blue Cross and Blue Shield > *Applications* > *Care Central*
- Features:
  - Tailored for LTSS providers, reducing claim fields to essentials for the service type.
  - Provides real-time visibility into claim status.
  - View and attest to the MCP.
  - View Service Authorizations.
- For questions, contact Availity Client Services or your LTSS provider relations representative directly.

Anthem will promptly coordinate all Family Care services for members consistent with the member-centered plan (MCP).

Family Care Services include all of the following:

a. Home- and community-based waiver services
b. Long-term care Medicaid State Plan Services, and
c. Any cost-effective healthcare service Anthem identifies for a long-term care service in the Medicaid State Plan.

Prior authorization requirements and procedures

Anthem will issue service authorizations to providers before the start date of services. In situations where prior written authorization is not practical, providers may receive verbal authorization; written confirmation will follow. For services delivered on an emergency basis, Anthem will issue written confirmation of the authorization afterward, when appropriate.

Providers are required to deliver services only as authorized and should confirm that an authorization has been received prior to initiating services, except in emergency circumstances.

Standard Authorization	**Emergency Authorization**
• Written authorization is issued • Must be received prior to the start of services	• Service may begin immediately based on verbal authorization • Written confirmation issued afterward (when appropriate)

Service plan changes

There are instances in which a member-centered plan (MCP) may be updated or changed outside of the regularly scheduled review or reassessment. This may happen for a variety of reasons, including but not limited to:

1. Change in Member's condition
    - A sudden decline in health, functional status, or cognitive ability.
    - A hospital discharge requiring new supports at home.
2. Change in Member Preference of Goals
    - Member requests a different provider, service, or schedule.
    - Member wants to pursue a new outcome (e.g. employment, community activities).
3. Change in Natural Supports
    - Caregiver illness or unavailability
    - Loss of informal support such as family, friends, or community resources.
4. Change in Safety or Risk Factors
    - New risks of abuse, neglect, exploitation, or unsafe living conditions.
    - Provider reports concern that impact the member's well-being.
5. Authorization or Benefit Adjustments
    - Reduction, increase, or modification of service units.
    - Addition of emergency or short-term services (e.g. respite, equipment)

When this occurs, the care management team documents the change, consults with the member and/or legal decision maker, and updates the service plan. A revised service authorization is issued to provider to reflect the new plan in a timely manner to ensure providers can adjust services as needed, avoid delivering units beyond the revised authorization, and submit accurate and timely claims within the correct billing period.

Providers are responsible for reviewing revised authorizations upon receipt and delivering services consistent with the updated MCP.

3. Covered Long-Term Care Services

Long-Term Services and Supports Home- and Community-Based Services (HCBS) Covered Benefits

Family Care covered benefits include the long-term services and supports (LTSS) listed below:

Benefits	Family Care
Adult day care	Covered
Alcohol and other drug abuse (AODA) treatment	Covered
Assistive technology	Covered
Communication assistance	Covered
Community support program	Covered
Competitive integrated employment (CIE) exploration	Covered
Consultative clinical and therapeutic services	Covered
Consumer education and training	Covered
Counseling and therapeutic services	Covered
Daily living skills training	Covered
Day services	Covered
Durable medical equipment and supplies	Covered
Financial management services	Covered
Health and wellness	Covered
Home-delivered meals	Covered
Home health services	Covered
Home modifications	Covered
Housing counseling	Covered
Institutional care	Covered
Mental health treatment services	Covered
Nursing services	Covered
Occupational therapy	Covered
Personal care	Covered
Personal emergency response system (PERS)	Covered
Physical therapy	Covered
Prevocational services	Covered
Relocation services	Covered
Remote support monitoring	Covered
Residential services	Covered
Respite care	Covered
Specialized medical equipment and supplies	Covered
Speech and language therapy	Covered
Support broker	Covered
Supported employment (Individual employment services, small group and vocational futures planning and support)	Covered
Supportive home care	Covered
Training services for unpaid caregivers	Covered

Benefits	Family Care
Transportation services (Community transportation and non-emergency medical transportation services)	Covered

All covered services are contingent upon assessed need, authorization, and benefit coverage at the time of service. For additional details, see the Anthem Family Care: Scope of Services Refence Guide available on the Family Care page of the Anthem provider website.

Self-Directed Supports (SDS)

Self-Directed Supports (SDS) allow members to directly manage certain long-term care services to better meet their individual goals. Participation in SDS is voluntary, and members decide how much they want to self-direct.

- Members may self-direct many Home and Community-Based Waiver services (e.g., supportive home care, respite, transportation).
- SDS does not cover residential services or care/case management.
- Members who choose SDS will work with their interdisciplinary team (IDT) to set an individualized SDS budget.

Members may self-direct home and community-based waiver services, except for residential care and care management services.

Members may not self-direct the following services:

- Medicare primary care services and clinic and lab services
- Care management services provided by Anthem
- Bundled residential services (a bundled service includes any service that is part of the residential rate such as transportation or personal care)
- Medicaid state plan LTC services
- Medicaid state plan acute and primary care services

Member Rights in SDS

- Members have the right to choose whether to participate in SDS.
- Members may accept or decline SDS at any time.
- Members may file a grievance if SDS is denied or limited.
- Each year, members (or their legal decision makers) must sign a form stating whether they accept or decline SDS.

Responsibilities of the Interdisciplinary Team (IDT)

The IDT will:

- Educate members on the SDS philosophy, available choices, and supports.
- Assist members in developing an SDS budget and plan.
- Monitor spending, quality, and safety of SDS services.

- Reassess regularly to ensure the member's needs, goals, and risks are addressed.
- Implement additional safeguards for members identified as vulnerable or high-risk.

Financial Management Services (FMS) Entities

Members who hire their own workers will use an FMS entity to help with employer responsibilities.

- **Payroll & Taxes**: FMS ensures payroll taxes and legally required benefits are handled.
- **Worker's Compensation**:
  - If the member is the employer, the FMS purchases and manages worker's compensation on the member's behalf.
  - If a co-employment agency is used, that agency provides worker's compensation coverage.
- **Background Checks**: FMS or co-employment agencies must complete background checks that meet state requirements.

Provider Expectations in SDS

If you are providing services to a self-directing member:

- Follow the member-centered plan (MCP) — services must match the authorized SDS budget.
- Participate in monitoring by the IDT to ensure services are safe, effective, and consistent with member goals.
- Maintain required training and documentation standards, especially for supportive home care.
- Understand that members (or their legal representatives) are directing your work, with oversight from the MCO.

Members have the right to choose from Anthem's network of providers.

For detailed information related to the scope of covered services, descriptions, limits, and CPT/HCPCS codes, see https://providers.anthem.com/wisconsin-provider/patient-care/family to access the Family Care Scope of Services under the Family Care Covered Services.

4. Billing and Claims

General billing requirements (timely filing, HIPAA-compliant claims)

All Family Care services must be:

- Authorized in the member's member-centered plan (MCP).
- Delivered by a qualified and WI DHS ForwardHealth enrolled provider.
- Documented according to DHS and Anthem standards.

LTSS claims must reflect only the services which are delivered to the member. Providers are responsible for maintaining documentation for any audits or compliance reviews.

Claims filing limits

Claims must be submitted within the contracted filing limit to be considered for payment. Claims submitted after that time period will be denied. For Family Care, Anthem adheres to a timely filing limit of 365 days from the date of service.

Please note: Anthem is not responsible for a claim never received. If a claim is submitted inaccurately, prolonged periods before resubmission may cause you to miss the filing deadline. Claims must pass basic edits to be considered received. To avoid missing deadlines, submit clean claims as soon as possible after delivery of service.

Claim forms and filing limits

Form	Type to be billed	Time limit to file

CMS-1500 Claim Form	• Professional/community-based services, such as: Personal care, respite, therapy, in-home supports
	• Specific ancillary services, including:
	  ○ Durable medical equipment (DME)
	  ○ Mental health and substance abuse clinics
	  ○ Occupational therapy
	  ○ Speech therapy
	
	Some LTSS providers may use a CMS-1450 form if they are ancillary institutional providers. Ancillary charges by a hospital are considered facility charges.
		Submit within 365 days of date of service.

CMS-1450 Claim Form	• Facility-based billing, including Nursing Facilities, hospitals, skilled home health • Skilled nursing facility (SNF)	Submit within 365 days from date of service or date of discharge if the services are related to an inpatient stay.

Other filing limits

Action	Details	Time frame
Third-party liability or coordination of benefits (COB)	If the claim has third-party liability, COB, or requires submission to a third party before submitting to Anthem, timely filing is counted from the date of the explanation of payment of the other carrier.	Submit within 365 days from date of service or 90 days from the date of the explanation of payment of the other carrier.
Checking claim status	Check claims status by logging onto Availity.com. Select the **Claims & Payments** tab to access **Claims Status**. Refer to the Monitoring Submitted Claims section of this chapter for details.	
Claim correspondence or corrected claim	If we request additional information or a correction to a claim, a claim follow-up is needed, and you may need to submit a corrected claim.	Return the requested information within 365 days from the date of service
Reconsideration Claim appeal (First Level)	Claim Reconsideration (First level) appeals can be submitted digitally through Availity.com. From the **Claims & Payments** tab select **Claims Status**. Find your claim and use the Dispute button to file a dispute. Use your Appeals Dashboard to track your dispute. • Provider Services at **855-558-1443** (Monday to Friday, 8 a.m. to 5 p.m.). Anthem Blue Cross and Blue Shield Claim Appeals P.O. Box 61599 Virginia Beach, VA 23466-1599	Submit within 365 days from the date of service.
Formal Claim Dispute (Second Level)	Formal Claim dispute (Second level) can be submitted: In writing to: Anthem Blue Cross and Blue Shield Claim Appeals P.O. Box 61599 Virginia Beach, VA 23466-1599	Submit within 60 days of the date of the first-level reconsideration decision letter.

Action	Details	Time frame
Provider dispute	We may request additional information on the dispute filed.	Return the requested information within 60 days of the date of the request.

Claim Submission Process

Availity Essentials:

- **Website:** https://Availity.com
- EDI Payer ID:
  - Professional Claims: 00950
  - Institutional Claims: 00450
- Features:
  - Secure access to manage daily transactions with payers.
  - No special software is required.
  - Check eligibility, submit claims, and track claims status.
- If you have any questions, contact Availity Client Services at **800-282-4548** between 7 a.m. and 7 p.m. CT, Monday through Friday.

Care Central: This application is available through Availity Essentials and was designed specifically for HCBS providers to simply and streamline claims processes:

- **Website:** https://Availity.com > *Payer Space* > Anthem Blue Cross and Blue Shield > *Applications* > *Care Central*
- Features:
  - Tailored for HCBS providers, reducing claim fields to essentials for the service type.
  - Provides real-time visibility into claim status.
- If you have any questions, contact Availity Client Services or your LTSS provider relations representative directly.

Clearinghouse: Acts as an intermediary to electronically transmit claims data. This may involve fees charged to providers for submission services.

Family Care requires Electronic Visit Verification (EVV) for Personal Care and Supportive Home Care Services, as well as Home Health Services. For a detailed list of Family Care services that require EVV for Family Care, visit WI EVV Service Codes.

All claims for services that require Electronic Visit Verification (EVV) must be documented through either the DHS-provided EVV system, Sandata, or an approved alternate EVV system that aggregates with Sandata.

Residential Room and Board

Room and Board will be calculated on the following:

Residential Facility Type	Monthly Provider Rate
Owner Occupied Adult Family Home	County specific Efficiency HUD rate + monthly food allowance.
Corporate Adult Family Home	County specific Efficiency HUD rate + monthly food allowance.
Community Based Residential Facility	County specific one Bedroom HUD rate + monthly food allowance.
Residential Care Apartment Complexes	County specific Two Bedroom HUD rate + monthly food allowance.

Room and Board will be paid to the provider based on the above methodology. Anthem will be responsible for collection of Room and board from member.

For additional information on Medicaid Nursing Home Reimbursement rate setting, visit https://www.dhs.wisconsin.gov/nh-rates/index.htm.

Coordination of benefits (COB)

If a member carries insurance through multiple insurers, Anthem will coordinate the benefits to ensure maximum coverage without duplication of payments. Providers must submit COB claims to the primary carrier before submitting to Anthem. After submitting the claim to the primary carrier, submit a claim for the total billed charges to Anthem along with a copy of the primary carrier's remittance advice (RA). Indicate the other coverage information on the appropriate claim form. If you need to coordinate benefits, include at least one of the following items from the other healthcare program:

- Third-party RA
- Third-party letter explaining either the denial of coverage or reimbursement

COB claims received without at least one of these items will be mailed back to you with a request to submit to the other healthcare program first. Make sure the information you submit explains all coding listed on the other carrier's RA or letter. We cannot process the claim without this information. Timely filing is counted from the date of the explanation of payment of the other carrier.

Claims overpayment recovery and refund procedure

Anthem seeks recovery of all excess claims payments from the person or entity to whom the benefit check was made payable. When an overpayment is discovered, Anthem initiates the overpayment recovery process by sending written notification. If you are notified by Anthem of an overpayment or discover that you have been overpaid, mail the refund check, along with a copy of the notification or other supporting documentation, to the following address:

Anthem Blue Cross and Blue Shield in Wisconsin
P.O. Box 933657
Atlanta, GA 31193-3657

From our public website **https://providers.anthem.com/WI**, select the **Claims** tab. Under **Claims Submissions and Disputes** scroll down to the *Related Information* box. Find the *Recoupment Notification Form*. If you believe the overpayment notification was created in error, contact Provider Services: 844-483-2704.

For claims re-evaluation, send your correspondence to the address indicated on the overpayment notice. If Anthem does not hear from you or receive payment within 30 days, the overpayment amount is deducted from your future claims payments.

Third-party recovery

Providers may not interfere with or place any liens upon Wisconsin's or Anthem's right, acting as Wisconsin's agent, to recovery from third-party billing.

5. Quality, Compliance, and Program Integrity

Anthem HCBS provider oversight

Anthem is committed to ensuring that all providers deliver exceptional care and meet the highest standards of quality and compliance. To achieve this, we actively monitor the performance of both licensed and certified providers, as well as non-licensed and non-certified providers, to ensure continual adherence to required standards and expectations.

This includes several key areas:

- **Caregiver Background Checks**: We ensure that all caregivers have undergone thorough background checks to maintain the safety and well-being of our members.
- **Education and Training**: We verify that individuals who offer specific services possess the necessary education or skills training, ensuring they are well-equipped to meet our members' needs.
- **Incident Reporting**: We require all providers to diligently report any member incidents, ensuring Anthem can take necessary actions and continually improve care standards.

Should any deficiencies or areas needing improvement be identified, Anthem collaborates closely with providers to implement remediation actions swiftly and effectively.

Provider performance monitoring and audits

Anthem evaluates provider performance to ensure members receive high-quality, member-centered services that meet the standards and requirements of Wisconsin DHS, Anthem, and Family Care program expectations. Providers are expected to cooperate fully in Anthem's ongoing performance monitoring, reporting, and quality improvement activities.

Anthem uses a combination of sources to assess provider performance. These include, but are not limited to:

- Member satisfaction surveys
- Provider performance reports and self-audits
- Critical incident and grievance data
- Service authorization timeliness and accuracy
- Service initiation timeframes
- Referral acceptance rates
- Member outcome measures
- DHS or designated entity findings

These performance measures help Anthem identify trends, ensure contract compliance, and promote continuous quality improvement within the provider network.

Site Visits and Ongoing Monitoring

Anthem conducts annual and, when necessary, off-cycle provider site visits as a part of its ongoing monitoring and engagement process. During these visits, LTSS Provider Relations staff

use a Family Care Site Visit Tool to review and verify compliance with DHS and MCO requirements. Provider attestation is expected to ensure continued compliance.

Performance Deficiencies and Remediation

If Anthem identifies areas of noncompliance or substandard performance during routine monitoring, site visits, or data reviews, a **Corrective Action/Remediation Plan** will be required.

- Anthem notifies the provider in writing of the deficiency and the required corrective actions.
- Providers must submit a written remediation plan that outlines the actions, responsible parties, and completion timelines.
- Anthem LTSS Provider Relations monitors the provider's progress through follow-up reports, data reviews, and/or additional site visits.
- The corrective action/remediation plan is formally closed once Anthem determines that all required actions are complete and provider performance has stabilized.

Failure to comply with remediation requirements may result in additional oversight, temporary suspension of new referrals, or other contractual actions as permitted under the DHS Family Care contract.

Information on Fraud, Abuse, and Waste can be found in Chapter 20 of the BadgerCare Plus and Medicaid Supplement Security Provider Manual linked here: WI_CAID_Provider_Manual.pdf.

6. LTSS Provider Relations and Communication

LTSS Provider Relations Team

Anthem's Long-Term Services and Supports dedicated Provider Relations Team is responsible for fostering and maintaining strong partnerships with providers who deliver essential services participating in the Family Care programs. The team serves as a primary point of contact for providers, offering support and guidance to ensure they meet regulatory and contractual requirements.

LTSS providers are assigned a local and dedicated provider relations representative and will have access to other LTSS-dedicated resources, including a Provider Educator and LTSS Provider Network Contractor. This team works hand-in-hand with providers through onboarding, addressing provider concerns and inquiries, facilitating training sessions, disseminating important updates and best practices, and assisting with claims and billing processes.

To contact a member of the LTSS Provider Relations team, visit https://providers.anthem.com/wisconsin-provider/patient-care/family and select **LTSS Provider Relations Map** to identify your dedicated representative or email us directly at WI-LTSSProviderRelations@anthem.com.

A wide array of tools, information, and forms are accessible via the provider website at https://providers.anthem.com/wisconsin-provider/patient-care/family. To access additional information on any topic, select from the list of quick links and resources.

If you have any questions about the content of this manual, contact Provider Services: **855-558-1443**. Hours: Monday to Friday, 8 a.m. to 5 p.m.

Provider Advisory Council

Anthem will hold Provider Advisory Council (PAC) meetings in person, by phone, or by webinar on a semiannual basis. The PAC is a formal advisory group of diverse Family Care providers that will meet to share input, identify challenges, and collaborate with Anthem to address issues and recommend improvements to strengthen the care delivery system.

The Provider Advisory Council will be chaired by a representative from the Provider Advisory Council and supported by the Anthem LTSS Strategy and Development Director, with all meeting notices and agendas to be provided at least 30 calendar days in advance whenever possible.

PAC membership will include representation from a broad spectrum of provider types, including but not limited to:

- Home- and community-based service providers
- Residential care providers (AFHs, CBRFs)
- Behavioral health providers
- Primary and specialty medical care providers
- Tribal and culturally diverse providers

Anthem will maintain a membership roster and actively recruit to ensure balanced and representative participation.

7. Grievances, Appeals, and Dispute Resolution

Provider appeal process for denied claims or authorizations

Provider claim disputes are any provider inquiries, complaints, appeals, or requests for reconsiderations, ranging from general questions about a claim to a provider disagreeing with a claim denial. Claim disputes are required to be submitted within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later.

We have several options to file claim payment disputes:

- Disputes can be submitted through the **provider website**: https://www.anthem.com/wi/provider
- (Select **Login or Register** to access the secure site.). Through Availity Essentials, you can upload supporting documentation and receive immediate acknowledgement of your submission. Locate your claim using Claim Status and select the Dispute button to initiate, then select "Go To Request" to complete the dispute request. The dispute can be tracked on the Appeals dashboard.
- **Verbally** (for reconsiderations and claim payment appeals): Call Provider Services at **844-483-2704** (Monday to Friday, 8 a.m. to 5 p.m. CT). If you need to include supporting documentation (EOB, Consent Form, Medical Records, etc.), do not use this option.
- **Written** (for reconsiderations and claim payment appeals): Mail all required and supporting documentation to:

Anthem Blue Cross and Blue Shield
Payment Dispute Unit
P.O. Box 61599
Virginia Beach, VA 23466

Anthem requires the following information when submitting a claim payment dispute (reconsideration or claim payment appeal):

- Your name, address, phone number, email, and either your NPI number or TIN
- The member's name and their Anthem ID number
- A listing of disputed claims, including the Anthem claim number and the date(s) of service(s)
- All supporting statements and documentation

Member rights to file grievances and appeals and the provider's role in supporting

A grievance is any complaint about Anthem or any healthcare provider that is not related to a denial, limitation, reduction, or delay in your benefits. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights.

Grievances may be filed verbally or in writing at any time about any matter other than an adverse benefit determination by the member, provider on behalf of the member, or member representative.

Please call Anthem's Member Services at **844-614-3182** if you have a grievance or write to us at the following address if you have a grievance:

Anthem Blue Cross and Blue Shield
Central Appeals Processing
P.O. Box 62429
Virginia Beach, VA 23466-2429

Providers play an important role in supporting members who choose to file a grievance or appeal. Providers are expected to respect, support, and not obstruct a member's right to file a grievance or appeal, while cooperating with Anthem to ensure timely resolution and fair treatment. Providers must:

- Respect Member Rights
    - Respect the member's right to file a grievance or appeal without retaliation.
    - Ensure that filing a grievance or appeal does not affect how the member is treated. Retaliation of any kind is not allowed
- Cooperate Fully
    - Provide relevant documentation, service records, or information that may support the member's case promptly.
    - Cooperate with, and not interfere in, the member's grievance, appeal, or State Fair Hearing process.
- Support Access to the Process
    - Assist the member in understanding the process and, if requested, help them submit the grievance or appeal to Anthem.
- Continue delivering authorized services without during the grievance or appeal process, unless otherwise directed by Anthem.

The grievance and appeals team oversees and coordinates the member grievance process.

The grievance and appeals team coordinates the formal grievance process, initiates investigations of grievances and ensures that appropriate follow-up occurs.

For full details, including State Fair hearing rights, please refer to the Anthem Medicaid Provider Manual, starting on page 82.

State fair hearing rights

Under Wisconsin Administrative Code DHS 10, specifically § DHS 10.55, Family Care members (and enrollees) have the right to request a *State Fair Hearing* through the Division of Hearings and Appeals in certain situations.

Family Care members have the right to request a State Fair Hearing if they disagree with an MCO decision about their services. This includes decisions to deny, reduce, suspend, or end services, delays in acting on a request, or when the service plan does not meet their assessed needs.

Key points to understand:

- **Member Rights**: Members may request a State Fair Hearing after completing Anthem's appeal process. They can represent themselves or be represented by a family member, advocate, or attorney.
- **Timeframes**: Requests must be submitted within 45-90 days, depending on the type of decision. Anthem's notice of action will specify the deadline. The request can be submitted in writing to the state of Wisconsin:
    - Department of Hearing and Appeals, P.O. Box 7875, Madison, WI 53707-7875
- **Continuing Services**: If the member requests a hearing before a service reduction or termination takes effect, services will usually continue during the hearing process. If Anthem's decision is upheld, the member may be responsible for the cost of continued services.
- **Provider Role**: Providers must respect the member's right to a hearing, assist the member if asked, and continue authorized services during the process unless otherwise directed.

Members will receive written notice of their right to a hearing, instructions on how to file, and available assistance. Providers should direct members with questions to Anthem's grievance and appeal resources.

8. Emergency and Disaster Preparedness

Provider responsibilities during emergencies

In Wisconsin, Medicaid policies for disaster preparedness are guided by the CMS Emergency Preparedness Rule, which mandates health providers participating in Medicare and Medicaid to establish and maintain consistent emergency preparedness policies and procedures.

- Develop and maintain policies concerning fire evacuation and natural disasters, including ensuring staff are knowledgeable about evacuation procedures and any available safety equipment (for example, fire extinguishers).
- All policies should be reviewed and updated annually.
- Outline in the member-centered Plan a disaster preparedness plan specific to the member.

Reporting closures or service disruptions

Providers are responsible for notifying Anthem in writing of any location closure, temporary service disruption, or material operational change as soon as possible, but no later than within 24 hours for unplanned or emergency disruptions and at least 30 days in advance for planned closures of service terminations. Information included in the notification must include:

- Provider Name and NPI
- Service type(s) and impacted location(s)
- Description of the disruption or closure
- Anticipated duration and effective dates
- Number of affected members and the name of impacted Anthem members (if known)
- Plan for maintaining member services, including transition arrangements or alternative staffing
- Contact person for coordination

Providers are responsible for continuing to provide services to the extent possible until alternative arrangements are made, unless prevented by safety or regulatory issues, and to cooperate with Anthem in developing and implementing member transition plans.

9. Updates and Notifications

The provider manual and Family Care supplement, as part of your Provider Agreement and related addenda, are subject to change and may be updated at any time. In the event of an inconsistency between information in the manual and the Provider Agreement between you or your facility and Anthem, the Provider Agreement shall govern.

In the event of a material change to the provider manual, we will notify providers 30 days prior to such change through web-posted newsletters and bulletins, email notifications, fax communications, and other mailings. In such cases, the most recently published information should supersede all previous information and be considered the current directive. This manual is not intended to be a complete statement of all Anthem policies or procedures. Other policies and procedures not included in this manual may be posted on our website or published in specially targeted communications, as referenced above.

This manual does not contain legal, tax, or medical advice. Please consult your own advisors for such advice.

Provider Services: **844-483-2704**, TTY **711**
Operational hours: 8:00 am – 5:00 pm CT
https://providers.anthem.com/wisconsin-provider/patient-care/family