

SECTION 3 - COVERED SERVICES

Medicare and Medicaid Coverage

“Covered services” includes the medical care, services, supplies and equipment covered by the Program. This section contains a Benefits Chart that identifies covered services and what Members may pay for each covered service.

Some general requirements apply to *all* covered services. The covered services listed in the Benefits Chart are covered only when *all* requirements listed below are met:

- Services must be provided according to the coverage guidelines established by Wisconsin Medicaid and when applicable, the Medicare program.
- The medical care, services, supplies and equipment identified as covered services must be medically necessary. Certain preventive care and screening tests are also covered.
- Services must be approved in advance, provided by Plan Providers or authorized by PHP. Exceptions include care for a medical emergency, urgently needed care and Medicare covered renal (kidney) dialysis received when outside the plan’s service area.

In the event eligibility for Wisconsin Medicaid is lost but eligibility for Medicare remains, Members will remain enrolled in Program until the end of the month of eligibility. Under such eligibility circumstances the benefits will be limited to those covered by Medicare.

Medicare Advantage plans cover all Medicare Part A, Part B and Part D covered services, as well as additional benefits. All services must be medically necessary and provided in accordance with professionally recognized standards of health care. PHP’s covered services include CMS’s national coverage decisions and published coverage decisions of local carriers and intermediaries.

Cost Sharing

Except for limited instances, (i.e., prescription drug coverage) PHP Members do not have a Medicare cost share for covered services. All other deductibles, coinsurance and co-pays are covered through PHP Medicaid coverage.

Emergency Care Services

Medically necessary emergency health services are covered within and outside of PHP’s service area. In the event of an emergency medical condition, the Member should seek immediate care or call 911. Prior authorization is not required for emergency services and PHP will not deny payment if a Plan or Non-Plan Provider instructs a Member to seek emergency care.

Please reference the glossary at the end of this manual to obtain PHP’s definition of an emergency medical condition.

Post-Stabilization Care Services

Post-stabilization care is included in PHP's coverage. The attending practitioner determines when the condition is no longer an emergency and the Member is considered stable for discharge or transfer. Care after the condition is no longer an emergency requires coordination of care with PHP. Post-stabilization care is covered if it is prior-authorized by PHP, or it is automatically approved if PHP could not be reached for prior authorization via reasonable efforts. The automatic approval of post-stabilization care continues until:

- The Member's PCP assumes responsibility for their care
- The Member's PCP assumes responsibility for their care through transfer
- PHP and the treating physician reach an agreement concerning the Member's care
- The Member is discharged

Urgent Care

Urgent care health services are covered if a Member receives them from a Plan Provider within PHP's service area or a Member is temporarily outside of the PHP service area and needs to seek care. Non-Plan Provider urgent care services will be authorized when PHP Plan Providers are unavailable or inaccessible due to an unusual event.

Notification of Services

Members are encouraged to notify PHP as soon as possible after receiving urgent care, emergency or post-stabilization health services. If urgent care is received without contacting PHP (within 24 hours) the cost of follow-up care may not be covered. PHP Hospitals who are Plan Providers are required to notify PHP when a Member is admitted to the hospital.

Benefits Chart	What must be paid by Member with these covered services
Inpatient Services	
<p>Inpatient hospital care Covered services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Semiprivate room (private room only if medically necessary) • Meals including special diets • Regular nursing services • Special care units such as intensive or coronary care units • Drugs and medications • Lab tests • X-rays and other radiology services. • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room services • Rehabilitation services, such as physical therapy, occupational therapy and speech therapy • Blood • Physician services <p><i>Under certain conditions, corneal and kidney transplants are covered.</i></p>	<p>Member is not responsible for payment when receiving these covered services from Plan Providers.</p>
<p>Inpatient mental health care Includes mental health care services that require a hospital stay</p>	<p>Member is not responsible for payment when receiving these covered services from Plan Providers.</p>
<p>Skilled nursing facility care Covered services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Semiprivate room (private room only if medically necessary) • Meals, including special diets • Regular nursing services • Physical therapy, occupational therapy and speech therapy • Wisconsin Medicaid and Medicare Part A covered drugs (this includes substances that are naturally present in the body, such as blood clotting factors) • Blood • Medical and surgical supplies • Laboratory tests • X-rays and other radiology services • Use of appliances such as wheelchairs • Physician services 	<p>Member is not responsible for payment when receiving these covered services from Plan Providers.</p>

Benefits Chart	What must be paid by Member with these covered services
Home health care Covered services include: <ul style="list-style-type: none">• Home health agency care• Skilled nursing and home health aide services• Physical therapy, occupational therapy and speech therapy• Medical social services• Medical equipment and supplies	Member is not responsible for payment when receiving these covered services from Plan Providers.
Hospice care – Medicare Covered services include: <ul style="list-style-type: none">• Drugs for symptom control and pain relief, short-term respite care and other services not otherwise covered by Medicare• Home care• Hospice consultation services (one time only) for a terminally ill individual who has not yet elected the hospice benefit	If the Member is eligible for Medicare and is enrolled in a Medicare certified Hospice, the hospice services are paid by Medicare.
Hospice care – Medicaid (WMAP) Covered services include: <ul style="list-style-type: none">• Hospice care services• Medical equipment and supplies• Skilled nursing and home health aide services• Physical therapy, occupational therapy, and speech therapy• Medical social services	If the Member is eligible only for WMAP and the Member is enrolled in a WMAP certified Hospice, the Hospice services are paid by PHP.

Benefits Chart	What must be paid by Member with these covered services
Outpatient Services	
<p>Physician services Covered services include:</p> <ul style="list-style-type: none"> • Office visits, including medical and surgical care in a physician’s office or certified ambulatory surgical center • Consultation, diagnosis and treatment by a specialist • Second opinion by another practitioner prior to surgery • Outpatient hospital services • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease or services that would be covered when provided by a doctor) 	<p>Member is not responsible for payment when receiving these covered services from Plan Providers.</p>
<p>Chiropractic services Manual manipulation of the spine to correct subluxation.</p>	<p>Member is not responsible for payment when receiving these covered services from Plan Providers.</p>
<p>Podiatry services Covered services include:</p> <ul style="list-style-type: none"> • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for Members with certain medical conditions affecting the lower limbs 	<p>Member is not responsible for payment when receiving these covered services from Plan Providers.</p>
<p>Outpatient mental health care (including partial hospitalization services) Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant or other mental health care professional as allowed under applicable state laws.</p>	<p>Member is not responsible for payment when receiving these covered services from Plan Providers.</p>
<p>Outpatient substance abuse services Services when Member is not hospitalized overnight but visits a hospital, clinic or associated facility for excessive use of a drug (such as alcohol, narcotics or cocaine) without medical justification.</p>	<p>Member is not responsible for payment when receiving these covered services from Plan Providers.</p>
<p>Outpatient surgery Services when Member is not hospitalized overnight but visits a hospital, clinic or associated facility for an operative or manual procedure.</p>	<p>Member is not responsible for payment when receiving these covered services from Plan Providers.</p>

Benefits Chart	What must be paid by Member with these covered services
<p>Outpatient services Services when Member is not hospitalized overnight but visits a hospital, clinic or associated facility for diagnosis or treatment.</p>	<p>Member is not responsible for payment when receiving these covered services from Plan Providers.</p>
<p>Ambulance services Services dispatched through 911 and where other means of transportation could endanger the health or as meets medical necessity criteria. Includes, but not limited to, ambulance services to and from one institution (such as a hospital or Skilled Nursing Facility) to another.</p>	<p>Member is not responsible for payment when receiving these covered services from Plan Providers.</p>
<p>Emergency care Coverage is for care provided within the U.S.</p>	<p>Member is not responsible for payment when receiving these covered services from Plan Providers.</p>
<p>Urgent care Coverage is for care provided within the U.S.</p>	<p>Member is not responsible for payment when receiving these covered services from Plan Providers.</p>
<p>Outpatient rehabilitation services (physical therapy, occupational therapy, cardiac rehabilitation, speech and language therapy) Cardiac rehabilitation therapy covered for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery and/or have stable angina pectoris.</p>	<p>Member is not responsible for payment when receiving these covered services from Plan Providers.</p>
<p>Durable medical equipment and related supplies (wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer and walker)</p>	<p>Member is not responsible for payment when receiving these covered services from Plan Providers.</p>
<p>Prosthetic devices and related supplies (other than dental) Replaces a body part or function. These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” below for more detail.</p>	<p>Member is not responsible for payment when receiving these covered services from Plan Providers.</p>

Benefits Chart	What must be paid by Member with these covered services
<p>Diabetes self-monitoring, training and supplies For Members who have diabetes (insulin and non-insulin users)</p> <ul style="list-style-type: none">• Blood glucose monitor, blood glucose test strips, lancet devices, lancets and glucose control solutions for checking the accuracy of test strips and monitors• Therapeutic shoes for severe diabetic foot disease, including fitting of shoes or inserts (one pair per calendar year)• Self-management training for Members at risk of diabetes• Fasting plasma glucose tests	<p>Member is not responsible for payment when receiving these covered services from Plan Providers.</p>
<p>Medical nutrition therapy Provided for Members with diabetes, renal (kidney) disease (but not on dialysis) and after a transplant when referred by the doctor.</p>	<p>Member is not responsible for payment when receiving these covered services from Plan Providers.</p>
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <ul style="list-style-type: none">• X-ray• Outpatient radiation therapy• Surgical supplies, such as dressings• Supplies, such as splints and casts• Laboratory tests• Blood	<p>Member is not responsible for payment when receiving these covered services from Plan Providers.</p>

Benefits Chart	What must be paid by Member with these covered services
Preventive Care and Screening Tests	
<p>Bone mass measurements For qualified Members at risk of losing bone mass or at risk of osteoporosis, the following services are covered every 2 years or more frequently if medically necessary:</p> <ul style="list-style-type: none"> Procedures to identify bone mass, detect bone loss, determine bone quality, include a physician's interpretation of the results 	Member is not responsible for payment when receiving these covered services from Plan Providers.
<p>Colorectal screening For Members 50 and older:</p> <ul style="list-style-type: none"> Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months Fecal occult blood test, every 12 months <p>For Members at high risk of colorectal cancer:</p> <ul style="list-style-type: none"> Screening colonoscopy (or screening barium enema as an alternative) every 24 months <p>For Members not at high risk of colorectal cancer:</p> <ul style="list-style-type: none"> Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy 	Member is not responsible for payment when receiving these covered services from Plan Providers.
<p>Immunizations</p> <ul style="list-style-type: none"> Pneumonia vaccine Flu shots, once a year in the fall or winter Hepatitis B vaccine Other vaccines if the Member is at risk 	Member is not responsible for payment when receiving these covered services from Plan Providers.
<p>Mammography screening</p> <ul style="list-style-type: none"> One baseline exam between the ages of 35 and 39 One screening every 12 months for women age 40 and older 	Member is not responsible for payment when receiving these covered services from Plan Providers.
<p>Pap smears, pelvic exams, and clinical breast exam</p> <ul style="list-style-type: none"> For all women, Pap tests, pelvic exams and clinical breast exams are covered once every 12 months 	Member is not responsible for payment when receiving these covered services from Plan Providers.
<p>Prostate cancer screening exams For men over age 50, the following are covered once every 12 months:</p> <ul style="list-style-type: none"> Digital rectal exam Prostate Specific Antigen (PSA) test 	Member is not responsible for payment when receiving these covered services from Plan Providers.

Benefits Chart	What must be paid by Member with these covered services
<p>Cardiovascular disease testing Blood tests for the early detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease).</p>	<p>Member is not responsible for payment when receiving these covered services from Plan Providers.</p>
<p>Physical exams An examination of the bodily functions and condition of an individual.</p>	<p>Member is not responsible for payment when receiving these covered services from Plan Providers.</p>
Other Services	
<p>Renal Dialysis (Kidney)</p> <ul style="list-style-type: none"> • Outpatient dialysis treatments (including Medicare covered dialysis treatments when temporarily out of the service area) • Inpatient dialysis treatments (if the Member is admitted to a hospital for special care) • Self-dialysis training (includes training for the Member and for the person helping with the home dialysis treatments) • Home dialysis equipment and supplies <p>Certain home support services (such as, visits by trained dialysis workers to check on home dialysis, to help in emergencies or to check the dialysis equipment and water supply when necessary).</p>	<p>Member is not responsible for payment when receiving these covered services from Plan Providers.</p>
<p>Complementary therapies</p> <ul style="list-style-type: none"> • Massage Therapy • Reflexology • Acupuncture • Healing Touch Therapy 	<p>Member is not responsible for payment when receiving these covered services from Plan Providers. However, prior authorization rules may apply, contact Plan for details.</p>
<p>Athletic club membership Focus for rehabilitation and diet exercise programs. Required to attend Athletic Club minimum 8 times per month unless medical excuse applies.</p>	<p>Member may pay a monthly co-pay.</p>

Benefits Chart	What must be paid by Member with these covered services
<p>Prescription drugs “Drugs” include substances that are naturally present in the body, such as blood clotting factors.</p> <ul style="list-style-type: none">• Drugs that usually are not self-administered by the patient and are injected while receiving physician services. The Program also covers some drugs that are “usually not self-administered” even if the Member injects them at home• Drugs the Member takes using durable medical equipment (such as nebulizers) authorized by PHP• Clotting factors the Member gives to themselves by injection if the Member has hemophilia• Immunosuppressive drugs, if there was an organ transplant that was covered by Medicare• Injectable osteoporosis drugs, if Member is homebound, has a bone fracture that a doctor certifies was related to post-menopausal osteoporosis and cannot self-administer the drug• Antigens• Certain oral anti-cancer drugs and anti-nausea drugs• Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, Erythropoietin (Epogen®) or Epoetin Alfa, and Darboetin Alfa (Aranesp®)• Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in the home• Other outpatient prescription drugs• All other Medicare covered prescription drugs	<p>If Member is eligible for Medicare, there is no benefit limit on drugs covered under Medicare.</p> <p>Co-pays will include, depending upon Member’s income:</p> <p>\$1 for generic prescription drugs \$3 for brand name prescription drugs OR \$2 for generic prescription drugs \$5 for brand name prescription drugs</p> <p>There are no co-payments for prescription drugs during certain stays in a medical institution or nursing facility.</p> <p>If Member is not eligible for Medicare, the Member will not have to pay anything for the prescription drugs.</p>

For formulary questions please reference our PHP website at www.communityhealthpartnership.com

Benefits Chart	What must be paid by Member with these covered services
Additional Benefits	
<p>Dental services</p> <ul style="list-style-type: none"> • Routine dental care • Surgery of the jaw or related structures • Setting fractures of the jaw or facial bones • Extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease • Services that would be covered when provided by a doctor • Dental services covered by Wisconsin Medicaid 	<p>Member is not responsible for payment when receiving these covered services from Plan Providers.</p>
<p>Hearing services</p> <ul style="list-style-type: none"> • Diagnostic hearing exams • Routine hearing exams • Hearing aids and repair 	<p>Member is not responsible for payment when receiving these covered services from Plan Providers.</p>
<p>Vision care</p> <ul style="list-style-type: none"> • Yearly routine vision exams • Dispensing fee prescription eye glasses • Outpatient physician services for eye care • For Members who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes and African-Americans who are age 50 or older, one glaucoma screening per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens • Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant • Tinted lenses for appropriate diagnosis (ordered by MD/OD, not an optician) • Additional exams for documented medical necessity • One pair of eyeglass frames and lenses due to prescription change from the same provider in a 12-month period • One replacement pair of eyeglasses, due to loss or breakage, from the same prescription per 12-month period 	<p>Member is not responsible for payment when receiving these covered services from Plan Providers.</p>
<p>Health and wellness education programs</p> <p>Includes programs focused on clinical health conditions such as hypertension, cholesterol, asthma and special diets. Programs designed to enrich the health and lifestyles of Members include weight management, smoking cessation, fitness and stress management.</p>	<p>Member is not responsible for payment when receiving these covered services from Plan Providers.</p>

Benefits Chart	What must be paid by Member with these covered services
<p>Other health related and community based services</p> <ul style="list-style-type: none">• Case management• Assisted living facility services• Personal care assistance and chore services• Respite care• Adult day care• Home modifications• Medical and non-medical transportation• Specialized medical equipment and supplies• Home delivered meals• Personal Emergency Response Systems• End of Life services	<p>There are no co-payments for these Medicaid covered services and supplies. However, patient liability and prior authorization rules may apply, contact Plan for details.</p>
