



ForwardHealth has developed this FAQs document to capture submitted questions about the COVID-19 public health emergency and to share answers. This document will be revised with new information as it is available. Additionally, more information will be communicated in future ForwardHealth Updates and Alerts.

## Topic Category Guide

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## BadgerCare Reform

**Date:** 06/18/2020

**Question:** The BadgerCare Reform Treatment Needs Question Policy & Procedure Deadline was originally April 3, 2020. Can this deadline be extended?

**Answer:** HMOs were asked to submit a policy and procedure for this process by **April 3, 2020**. Due to the COVID-19 outbreak, we extended this deadline two weeks to **April 17, 2020**.

**Date:** 06/18/2020

**Question:** What data is currently being shared with HMOs?

**Answer:** As previously described, HMOs are continuing to receive the Health Information Report. More information about this report can be found at the bottom of the ForwardHealth [webpage](#).

**Date:** 06/18/2020

**Question:** What should HMOs be doing with these data?

**Answer:** HMOs should continue taking in Health Information Report to utilize for case management. This includes reaching out to members who have already answered 'yes' to the treatment needs question.

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Created: 06/18/2020

Revised:

**Date:** 06/18/2020

**Question:** At this time, is the treatment needs question required for childless adult members?

**Answer:** At this time, the treatment needs question is **not** required as a part of eligibility (during application or renewal). In addition to this, the Department of Health Services (DHS) is looking back at all childless adults who were denied eligibility for not answering the question to give them benefits.

**Date:** 06/18/2020

**Question:** At this time, are the premium payments required for childless adult members?

**Answer:** At this time, premiums for childless adults **have been suspended**. In addition to this, DHS is looking back at all childless adults who have paid premiums since the February 1, 2020, implementation and is reimbursing them.

**Date:** 06/18/2020

**Question:** What impacts has COVID-19 had on ER copay for non-emergent services for childless adults?

**Answer:** DHS is proceeding with implementation. DHS is communicating updates regarding childless adults ER copay via ForwardHealth Updates.

HMOs and providers should [subscribe to ForwardHealth Updates](#) for the latest information.

**Date:** 06/18/2020

**Question:** What impacts has COVID-19 had on the residential facility substance use disorder treatment benefit?

**Answer:** DHS is proceeding with implementation. DHS had previously communicated that in 2020 HMO members needing residential facility substance use disorder treatment would receive it on a fee-for-service basis, not as a benefit provided by HMOs.

**Date:** 06/18/2020

**Question:** What impacts has COVID-19 had on community engagement?

**Answer:** The community engagement piece of BadgerCare Reform is delayed at this time. More updates will come in the future.

### Care Management

**Date:** 06/18/2020

**Question:** Will DHS approve SSI HMOs to deliver care management services via telehealth instead of requiring home visits?

**Answer:** SSI HMOs currently receive reimbursement outside the monthly capitation payment for certain HCPCS procedures for care management, which are detailed in the SSI billing guide. From March 1, 2020, through the end of the federal public health emergency, DHS will allow HMOs to offer these same services via telehealth for the same reimbursement, with the exception of the home visit code. HMOs

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should note the member's consent to receive telehealth care management as well as indicate any telehealth-delivered services in the member's care plan and notes.

DHS and MetaStar will conduct annual chart reviews later in 2020.

Care Management Procedure Code	Description	Notes
G9001	initial assessment, needs stratification, and care plan development	The screening and care plan development is already allowed via telephone or telehealth.
G9002	monthly care plan maintenance	This can be delivered via telehealth. Use place of service code 2, request 95 modifier.
G9006	care plan maintenance in a home visit	This is the same as G9002, only reimbursed higher in the home. DHS would expect SSI HMOs to use G9002 during the health emergency, as home visits are not expected during the emergency.
G9007	team conference for care plan	This could continue, noting any providers absent from team conferences due to COVID-19 priorities, and how any care plan updates were communicated with the absent provider(s).
G9012	transition care planning (e.g. post discharge)	This is already allowed via telephone or telehealth

**Date:** 06/18/2020

**Question:** Now that the majority of work is completed through telehealth, is there any room for DHS to allow more than one G9002 code per month for SSI HMO care management?

**Answer:** No, G9002 is a monthly reimbursement for all care plan maintenance activities and has been allowed already via telehealth prior to the public health emergency.

**Date:** 06/18/2020

**Question:** Are SSI HMOs allowed to bill G9006 if a virtual face-to-face visit for care management is conducted?

**Answer:** No, the higher reimbursement for G9006 is to reflect travel to the member's home for monthly care management activities. If there is no home visit, HMOs would submit G9002.

## Eligibility and Enrollment

**Date:** 06/18/2020

**Question:** How are HMO members impacted regarding Medicaid eligibility and renewals?

**Answer:** DHS is extending the current eligibility periods for all members in response to COVID-19 by three months (in line with eligibility and enrollment flexibilities documented in the [COVID-19 FAQ document](#) published by CMS). This means:

- March renewals that were postponed to June are now extended for an additional three months
- April renewals are due in July
- May renewals are due in August
- June renewals are due in September

DHS will continue to adjust the schedule as warranted by the federal COVID-19 public health emergency and will be providing updates on any changes to timelines as they occur. One additional change that DHS is implementing is that for any cases that are able to go through the administrative renewal process (i.e., renew without any action by the member), we will be renewing those cases starting in June 2020. This generally amounts to around 20% of overall renewals.

**Date:** 06/18/2020

**Question:** If a member has eligibility ending in April 2020, but eligibility is extended by three months until July 2020, will their 2021 renewal date be April or July 2021?

**Answer:** It will be 12 months from the new renewal date. A renewal due July 31, 2020, will result in a 12-month certification period ending July 31, 2021.

**Date:** 06/18/2020

**Question:** If a member has eligibility ending April 2020, but eligibility is extended by three months until July 2020, and they decide to renew early anyway, when is their 2021 renewal date?

**Answer:** The renewal date will always be 12 months from when they actually complete an early renewal. If someone completes an early renewal in June, it will set a 12-month certification period starting July 1.

**Date:** 06/18/2020

**Question:** Do HMOs need to continue outreach to childless adults who are up for renewal and need to answer the treatment needs question by the end of the month to renew their benefits?

**Answer:** No, HMOs should stop all member eligibility renewal outreach at this time.

**Date:** 06/18/2020

**Question:** Can members proactively complete eligibility renewal early?

**Answer:** Members can proactively renew their eligibility for benefits. However, some members have had their eligibility extended for three months. This means they would have more time to complete their renewal, and it may not be in their best interest to renew early.

## HMO FAQs About COVID-19

Created: 06/18/2020

Revised:

**Date:** 06/18/2020

**Question:** Has DHS modeled out the enrollment impacts (such as increases, peaks, and declines) due to COVID-19?

**Answer:** Currently, DHS has not modeled out the membership impact and timing. DHS is monitoring the enrollment numbers through daily reports to gauge potential increases in ForwardHealth program enrollments.

**Date:** 06/18/2020

**Question:** What is the current enrollment backlog and how long will it take to process new members?

**Answer:** At this time, there is no backlog for members applying for health care eligibility.

**Date:** 06/18/2020

**Question:** What populations does DHS anticipate an increase in enrollment (such as childless adults/temporary assistance to needy families/expansion or aged/blind/and disabled)?

**Answer:** Because the aged, blind and disabled population typically has more stable income sources than the BadgerCare Plus population, we anticipate that while there will be increases in new applicants for both populations, the majority will be for BadgerCare Plus.

**Date:** 06/18/2020

**Question:** How can HMOs help with this potential increase in membership?

**Answer:** DHS plans to utilize our regular COVID and contract administrators meetings to give HMOs ideas and actions they can do to help our members.

### Encounters & Reimbursement

**Date:** 06/18/2020

**Question:** If the HMO claims system accepts the 02 modifier, will that cause an issue with the encounter data? Is the expectation that HMOs accept only the 02 code or is there flexibility?

**Answer:** If the services are currently allowed as listed in the [Telehealth](#) topic (#510) of the Online Handbook, then the 02 claims of services will be processed. The 95 modifier only applies to the temporary telehealth services.

**Date:** 06/18/2020

**Question:** In the draft 1135 waiver, DHS included a request to waive actuarial soundness. Multiple HMOs had concerns; can this be clarified?

**Answer:** The actuarial soundness provision was removed from the list of 1135 waiver requests and was not part of AB 1038.

### Member Communications

**Date:** 06/18/2020

**Question:** Will DHS be flexible on the draft member handbook submission date due to the COVID-19 pandemic?

## HMO FAQs About COVID-19

Created: 06/18/2020

Revised:

**Answer:** Yes, DHS will be flexible on the draft member handbook submission date due to the COVID-19 pandemic. HMOs can contact their DHS contract monitor if an extension is needed.

**Date:** 06/18/2020

**Question:** Do HMOs' COVID-19-specific outreach scripts, talking points, or written materials need to be submitted to DHS for approval?

**Answer:** HMOs will not need to submit COVID-specific health education or member outreach materials for review and approval through the federal COVID-19 public health emergency, provided the information is drawn from the CDC or DHS websites.

**Date:** 06/18/2020

**Question:** Are HMOs allowed to contact members using email addresses provided in the supplemental demographics file?

**Answer:** Yes, phone calls and emails are currently permitted.

**Date:** 06/18/2020

**Question:** Can HMOs text message their members without consent about COVID-19?

**Answer:** HMOs should maintain current process when reaching out to members via text messaging. This includes gathering consent and giving members a way to opt-in and out of text messaging at any time.

**Date:** 06/18/2020

**Question:** During the federal public health emergency, DHS is allowing HMOs to offer the same service via telehealth for the same reimbursement. How should the HMOs document consent?

**Answer:** The HMO should note the members consent to receive telehealth care management, as well as indicate any telehealth-delivered service in the member's care plan and notes.

## Nursing Home Admission Guidance During COVID-19 Public Health Emergency

### ***Fee-for-Service Medicaid Level of Care Approval Process***

Fee-for-service Medicaid approves nursing home levels of care for 120 days at a time. Levels of care are granted to all members for whom placement in a nursing facility is medically necessary and appropriate. Reviews are conducted based on minimum data set (MDS) submissions that indicate member's levels of assistance required with activities of daily living, as well as other diagnoses such as dementia that may warrant a nursing facility stay being appropriate.

Notably, fee-for-service Medicaid does not require that nursing facility stays be rehabilitative or that a member's condition is expected to improve. Medically necessary custodial care is covered. No prequalifying hospital stay is required, and the member does not have to be receiving therapies in order for a level of care to be granted. Nursing facility stays are covered services whenever medically necessary.

### ***During COVID-19***

During the public health emergency, the Centers for Medicare & Medicaid Services has waived timely MDS submission requirements. As a result, ForwardHealth is not reviewing MDS assessments for approving nursing facility levels of care submitted on a fee-for-service basis.

## HMO FAQs About COVID-19

Created: 06/18/2020

Revised:

All submitted level of care determination requests are approved for an initial period of 120 days. Any levels of care that would ordinarily end during the public health emergency (for lack of a qualifying MDS) will be extended for an additional 120 days. This recognizes that members may have changing medical and social needs during the public health emergency (such as unavailability of natural/family supports) that may warrant placement in a nursing facility.

See ForwardHealth Update [2020-16](#), titled “Approval of Nursing Home Levels of Care During COVID-19,” for further information.

### **Medicaid HMO Nursing Facility Coverage**

In order to ensure that Medicaid HMOs provide at least the same benefits as fee-for-service Medicaid, HMOs shall adopt a policy of coverage of nursing facility stays during the duration of the public health emergency consistent with the purpose and intent of the fee-for-service change. Any member for whom a nursing facility stay is medically necessary shall be approved for such placement until the member’s length of stay meets the guidelines for disenrollment as outlined in the 2020–2021 HMO contract in Article II, B, 3, b.

### **FAQs**

**Date:** 04/29/2020

**Question:** What is the ForwardHealth change for Nursing Home authorizations during the public health emergency?

**Answer:** Before the public health emergency, ForwardHealth applied clinical medical necessity criteria to approve nursing home stays for an initial period of 120 days, and received ongoing MDS assessments that extended approvals for additional 120 day segments. During the public health emergency, no clinical review criteria are being applied. Any initial requests are approved for 120 days, and any renewals are extended for an additional 120 days.

**Date:** 04/29/2020

**Question:** Does ForwardHealth pay nursing home claim at the billed rate without any review for the level of care in the nursing home?

**Answer:** Fee-for-services Medicaid establishes per diem rates for nursing homes, based on acuity level. During the public health emergency, ForwardHealth will accept the level of care request form without applying any clinical review criteria.

**Date:** 04/29/2020

**Question:** Would ForwardHealth be open to the HMO doing a post-pay review of medical necessity?

**Answer:** If a member’s long-term stay results in institutional Medicaid and the member was disenrolled from the HMO, the nursing home stay would be deemed medically necessary.

HMOs may continue to have nursing homes follow a prior authorization or notification process to allow HMOs to do care management, but not as a cost avoidance tool during the public health emergency. HMOs should not apply a medical necessity criteria for admission decision. The expectation is that HMOs are relying on providers for admission decisions. The intent is not for HMOs to recoup payments to nursing homes after the emergency ends through a post-pay review process.

## HMO FAQs About COVID-19

Created: 06/18/2020

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**Date:** 04/29/2020

**Question:** Can HMOs deny a nursing home prior authorization that is obviously a custodial admission?

**Answer:** No, this would be more restrictive coverage than ForwardHealth policy. ForwardHealth covers non-rehab, long-term stays as long as medically necessary. Outside the public health emergency, fee-for-service members typically qualify for nursing home level of care based on activities of daily living, based on MDS algorithm, or certain diagnoses or behavioral comorbidities.

**Date:** 04/29/2020

**Question:** Is the Wisconsin DHS' MDS algorithm publicly available? Could DHS and HMOs work together to improve alignment in policies after the public health emergency?

**Answer:** DHS will consider this as an item for discussion after the public health emergency.

**Date:** 04/29/2020

**Question:** For Medicaid SSI HMO member, would HMO need to cover 120 days?

**Answer:** DHS is not changing any disenrollment process or policy. HMOs are expected to request disenrollment if a member is admitted beyond 90 days and the member's stay is expected to continue, and the disenrollment would be processed at the end of the next calendar month.

**Date:** 04/29/2020

**Question:** Do we still notify ForwardHealth of the date as we do now?

**Answer:** Yes, HMOs would provide notification of members that need ongoing nursing home stays so that disenrollment can be processed, consistent with current process.

**Date:** 04/29/2020

**Question:** For a member in a nursing home, is the nursing home still required to communicate the discharge date to the HMO? For example, if a member is expected to be in a nursing home for 4 weeks?

**Answer:** DHS is not making any changes to requirements on how nursing homes and HMOs collaborate on discharge planning.

**Date:** 04/29/2020

**Question:** Does ForwardHealth expect HMOs to retro this back to 3/12/20?

**Answer:** If HMOs have members that were denied for nursing home authorization during this time period, HMOs should re-review denials to be consistent with fee-for-service policy change.

**Date:** 04/29/2020

**Question:** How will ForwardHealth monitor for overuse?

**Answer:** DHS is not anticipating a significant increase in use as nursing homes are limiting admissions to minimize COVID-19 exposure within their facilities, but DHS is providing flexibility for members needing nursing home level of care due to COVID-19.

**Date:** 04/29/2020

**Question:** What is the policy for dual-eligible members?

**Answer:** Medicare has relaxed their guidelines for nursing home stays by removing the three-day hospitalization requirement prior to nursing home admission. ForwardHealth anticipates a large percentage of dually eligible members will have their stays covered by Medicare, thus easing costs for Wisconsin Medicaid.

**Date:** 04/29/2020

**Question:** How will this impact Skilled Bed availability for those who need it?

**Answer:** DHS does not anticipate this change detrimentally affecting member access to nursing facilities.

**Date:** 04/29/2020

**Question:** Can HMOs still do interventions to do wraparound care coordination?

**Answer:** Yes, DHS supports HMOs doing care management in working with nursing home providers or working to keep members in the community when possible and appropriate. The goal is to increase flexibility if the nursing home is a better care setting for individual members.

**Date:** 04/29/2020

**Question:** Does this policy apply to Long-Term Acute Care Hospitals and Inpatient Rehab Facilities?

**Answer:** No, this policy only applies to nursing facilities.

## **Other Contract Questions & Flexibilities**

**Date:** 06/18/2020

**Question:** Can counties share COVID-19 positive results with HMOs?

**Answer:** DHS and DPH will not share this information at this time.

**Date:** 06/18/2020

**Question:** What should HMOs do with deadlines of contract-specified reports to DHS (such as the Grievance and Appeals Report, the Court Ordered Birth Cost Report, the Attestation Report, and the Encounter Data Quarterly Report)?

**Answer:** HMOs should reach out to their DHS Contract Monitor if they are having issues meeting reporting deadlines. All reports should be submitted electronically, not mailed to DHS.

**Date:** 06/18/2020

**Question:** How has COVID-19 impacted OB medical homes (OBMH)?

**Answer:** See the following guidance:

- DHS will suspend home visit contract requirements for the duration of the federal public health emergency.
- Members participating in OBMH should still be referred to community resources and services, including WIC, prenatal care coordination, and home visiting programs.
- OBMHs that offer group prenatal classes should document in each participant's notes when the class was cancelled or if the class was continued via telehealth.

## HMO FAQs About COVID-19

Created: 06/18/2020

Revised:

- HMOs should notify DHS of any difficulty in submitting chart reviews for External Quality Review Organization Review and request extensions as needed.
- OBMH services delivered via telehealth according to ForwardHealth Updates and Alerts will count toward the 10-visit requirement for prenatal and post-partum visits and should be documented in the registry and charts.

**Date:** 06/18/2020

**Question:** Will the timeline for implementing the new grievance and appeals process be delayed due to the COVID-19 pandemic?

**Answer:** DHS is committed to implementing the new grievance and appeals policy in third quarter of 2020, but some interim milestones have been revised. The implementation date for the updated member notices and HMO call scripts have been delayed from April 1, 2020, to July 1, 2020. The new grievance and appeal reports will not begin until after the July 1, 2020, implementation. Continue to track and report using the same quarterly format used for first quarter and second quarter 2020.

**Date:** 06/18/2020

**Question:** Is there any flexibility in the current non-emergency medical transportation (NEMT) policy?

**Answer:** Policies regarding ride limitations and exceptions have been updated. Refer to ForwardHealth Alert 003, titled "[Non-Emergency Medical Transportation \(NEMT\) Services](#)," for more information.

**Date:** 06/18/2020

**Question:** Can HMOs implement food vouchers, gift cards, or meal delivery programs for enrolled members?

**Answer:** Yes. HMOs should submit their program plans to their respective DHS analyst for documentation.

**Date:** 06/18/2020

**Question:** Can contract guidance regarding utilization of offshore subcontractors be lifted during the federal public health emergency?

**Answer:** DHS will not be modifying this contractual requirement. HMOs should continue to follow their current policies related to subcontractors.

### Prior Authorization

**Date:** 06/18/2020

**Question:** Are HMOs being asked to extend hospice authorizations 90 days?

**Answer:** ForwardHealth does not require prior authorizations for hospice services. If the HMO has prior authorization requirements for hospice, DHS expects the HMO to extend currently approved authorizations for 90 days.

**Date:** 06/18/2020

**Question:** Do prior authorization extensions apply to all services or just personal care services?

**Answer:** Prior authorizations will be extended by 90 days for prior authorizations set to expire on or before June 30, 2020. This extension applies to many services. Refer to the ForwardHealth Update

(2020-13), titled "[Temporary Changes to Clinical Policy and Prior Authorization](#)," for additional information.

## **Provider Enrollment**

The following FAQs have been developed in response to BadgerCare Plus and Medicaid SSI HMOs inquiries about provider enrollment processes during the COVID-19 public health emergency.

**Date:** 05/01/2020

**Question:** Does Update (2020-14), titled "[Temporary Changes to the Provider Enrollment Process](#)," about expedited enrollment apply to only Medicare-enrolled providers?

**Answer:** Yes, the flexibility outlined in the Update applies to providers currently enrolled in Medicare.

**Date:** 05/01/2020

**Question:** When the expedited enrollment process takes place for Medicare-enrolled providers, will the Wisconsin DHS have a way of notifying the HMOs of the providers that are temporarily enrolled?

**Answer:** All providers who are enrolled during the COVID-19 emergency will be documented in the weekly certified provider listing to HMOs. These providers will not be specifically identified as telehealth or temporary enrollment providers.

**Date:** 05/01/2020

**Question:** How will HMOs know of the provider's end date if their enrollment stops at 90 days?

**Answer:** DHS anticipates that most providers will not drop off from this temporary enrollment and would become permanent if they meet Medicaid enrollment criteria. The weekly certified provider listing sent to HMOs includes provider effective and end dates and will be updated in the event a provider is no longer enrolled.

**Date:** 05/01/2020

**Question:** If member needs service tomorrow and an HMO has a vendor relationship already, is it accurate that the provider cannot start providing services until an application is submitted?

**Answer:** The provider enrollment process is being expedited and allowing backdating from March 12, 2020, when the executive order was declared. Refer to Update [2020-14](#) for additional information. HMOs can review the provider directory at any time for real-time enrollment information in addition to reviewing the weekly certified provider listing report.

**Date:** 05/01/2020

**Question:** Some HMO members are in quarantine in other states and are unable to travel back to Wisconsin. HMOs have tried to get providers to apply for Wisconsin Medicaid enrollment, but providers are often unwilling. Could DHS provide any flexibility or information for these situations?

**Answer:** The Division of Medicaid Services' fiscal agent maintains a Provider Services Call Center that is available to support providers with their enrollment application. Representatives are available to expedite all application requests. Providers must be enrolled in Wisconsin Medicaid in order to receive payment for covered services.

**Date:** 05/01/2020

**Question:** Is ForwardHealth requiring providers to submit demographic updates due to COVID-19? For example, providers have closed, changed locations, and/or changed their hours of service.

**Answer:** Providers are required to maintain up-to-date information with ForwardHealth regarding their mailing and servicing address. This is to ensure that ForwardHealth communication can be accurately delivered. DHS is not collecting temporary changes in hours or availability from providers, nor is DHS issuing any member communication regarding these type of changes at this time.

## **Service Delivery & Access**

**Date:** 06/18/2020

**Question:** The March 16, 2020, bulletin states: “**Network Adequacy and Access to Out-of-Network Services.** HMOs should verify their provider networks are adequate to handle a potential increase in the need for health care services in the event more COVID-19 cases are diagnosed in Wisconsin. The Department determined that COVID-19 testing and treatment meets the definition of emergency medical services under Article IV(A)(9)(b). HMOs must provide out-of-network services related to the testing and/or treatment of COVID-19 as if they are in-network.” Could the DHS please clarify when this provision ends?

**Answer:** This provision is in effect as long as the DHS determines that COVID-19 testing and treatment meets the definition of emergency medical services under Article IV(A)(9)(b). HMOs will be notified if the time comes in which these are no longer defined as such.

**Date:** 06/18/2020

**Question:** Will a member’s home be allowed as an allowable originating site for services delivered by telehealth?

**Answer:** Yes, an originating site can be anywhere. Refer to ForwardHealth Update (2020-09), titled “[Changes to ForwardHealth Telehealth Policies for Covered Services, Originating Sites, and Federally Qualified Health Centers](#),” for more information regarding telehealth.

**Date:** 06/18/2020

**Question:** What are the waivers and extensions for provider enrollment, re/credentialing, claims submissions, etc.?

**Answer:** Please refer to the ForwardHealth Update (2020-14), titled “[Temporary Changes to the Provider Enrollment Process](#),” which explains enrollment waivers allowed during COVID-19. Refer to the [COVID-19: ForwardHealth Provider News and Resources page](#) on the ForwardHealth Portal for additional resources and information.

## **Telehealth**

**Note:** Telehealth services are considered a method of service delivery for Wisconsin Medicaid, not a separate provider type or specialty. In response to COVID-19, ForwardHealth published a variety of updates and guidance to allow enrolled providers to utilize this new service delivery method for covered services. While DHS is actively researching the appropriateness of expanding telehealth services, including provider types, for Wisconsin, those changes are not in scope for COVID-19 provider enrollment flexibilities.

## HMO FAQs About COVID-19

Created: 06/18/2020

Revised:

**Date:** 05/01/2020

**Question:** For larger organizations that are providing telehealth, will they need to wait for temporary certification before providing services?

**Answer:** Per Update [2020-14](#), eligible new providers will need to complete the application, then they will be temporarily enrolled once the application is complete. Wisconsin Medicaid will allow backdating of these temporary enrollment applications to allow providers to immediately deliver services in response to COVID-19. Wisconsin Medicaid will allow up to 90 days backdating, with an effective start date no earlier than March 12, 2020.

**Date:** 05/01/2020

**Question:** We have reviewed Emergency Order #16 Related to Certain Health Care Providers and the Department of Safety and Professional Services Credentialing. Will DHS be providing updated guidance/direction for telehealth and the use of out-of-state providers from a licensing, Medicaid certification, and credentialing perspective?

**Answer:** Emergency Order #16 provides ForwardHealth the flexibility to enroll providers when they are not currently licensed in the State of Wisconsin, as long as they maintain a current license in another state and are asking to practice within the scope of that license. This does not create a licensure specialty for telehealth. Update (2020-15), titled "[Additional Services to Be Provided via Telehealth](#)," provides instructions on how providers can deliver telehealth services.

**Date:** 05/01/2020

**Question:** Will there be any indicator that this provider does telehealth services? Could DHS create a TH identifier for Medicare-enrolled providers?

**Answer:** The provider's enrollment will not specify whether or not the provider is able to provide telehealth services, as ForwardHealth does not require that indicator. Update [2020-15](#) includes instructions to providers on how to submit claims for telehealth services. Providers are requested to include modifier 95 as an informational modifier to indicate that they are submitting claims in accordance with ForwardHealth public health emergency guidance.

**Date:** 05/01/2020

**Question:** Would a telehealth vendor also need to get enrolled in Wisconsin Medicaid, or is it only the providers who must enroll?

**Answer:** All providers who will be billing and/or rendering services must enroll in Wisconsin Medicaid. The electronic platform vendors do not need to be enrolled if they are not billing or rendering services. DHS encourages HMOs to require providers to document in their individual contracts what telehealth platform the provider is utilizing in the event of Health Insurance Portability and Accountability Act of 1996 (HIPAA) concerns.

**Date:** 05/01/2020

**Question:** If the telehealth vendor does enroll, would they be a billing or rendering provider? How would these visits be coded?

**Answer:** Refer to Update [2020-15](#) for billing guidance.

## HMO FAQs About COVID-19

Created: 06/18/2020

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**Date:** 05/01/2020

**Question:** Can DHS enroll an entire group of telehealth clinicians instead of each one individually? For example, WellDoc only has five Medicare-certified providers. Is there a way for the entire group to become Medicaid enrolled if they are Medicare certified instead of submitting individual applications?

**Answer:** At this time, ForwardHealth policies require each individual provider to be enrolled to deliver services.

**Date:** 05/01/2020

**Question:** Can an out-of-state provider who is not enrolled in Wisconsin Medicaid bill for services without becoming enrolled?

**Answer:** Providers must be enrolled in Wisconsin Medicaid in order to bill Wisconsin Medicaid.