Certification and Ongoing Responsibilities

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Certification and Ongoing Responsibilities:Certification

Categories of Certification

Wisconsin Medicaid certifies providers in four billing categories. Each billing category has specific designated uses and restrictions. These categories include the following:

- Billing/rendering provider.
- Rendering provider.
- Group billing that requires a rendering provider.
- Group billing that does not require a rendering provider.

Providers should refer to their certification materials or to service-specific information in the Online Handbook to identify what types of certification categories they may apply for or be assigned.

Billing/Rendering Provider

Certification as billing/rendering provider allows providers to identify themselves on claims (and other forms) as either the provider billing for the services or the provider rendering the services.

Rendering Provider

Certification as a rendering provider is given to those providers who practice under the professional supervision of another provider (e.g., physician assistants). Providers with a rendering provider certification cannot submit claims to ForwardHealth directly, but have reimbursement rates established for their provider type. Claims for services provided by a rendering provider must include the supervising provider or group provider as the billing provider.

Group Billing

Certification as a group billing provider is issued primarily as an accounting convenience. This allows a group billing provider to receive one reimbursement, one RA, and the 835 transaction for covered services rendered by individual providers within the group.

Group Billing That Requires a Rendering Provider

Individual providers within certain groups are required to be Medicaid certified because these groups are required to identify the provider who rendered the service on claims. Claims indicating these group billing providers that are submitted without a rendering provider are denied.

Group Billing That Does Not Require a Rendering Provider

Other groups (e.g., physician pathology, radiology groups, and rehabilitation agencies) are not required to indicate a rendering provider on claims.

Group billing providers should refer to their certification materials or to service-specific information in the Online Handbook to determine whether or not a rendering provider is required on claims.

Certification Application

To participate in Wisconsin Medicaid, providers are required to be certified by Wisconsin Medicaid as described in [DHS 105](#), Wis. Admin. Code. Providers certified by Wisconsin Medicaid may render services to members enrolled in Wisconsin Medicaid, BadgerCare Plus, and SeniorCare.

Providers interested in becoming certified by Wisconsin Medicaid are required to complete a provider application that consists of the following forms and information:

- General certification information.
- Certification requirements.
- TOR.
- Provider application.
- Provider Agreement and Acknowledgement of Terms of Participation.
- Other forms related to certification.

Providers may submit [certification applications](#) by mail or through the ForwardHealth Portal.

General Certification Information

This section of the provider application contains information on contacting ForwardHealth, certification effective dates, notification of certification decisions, provider agreements, and terms of reimbursement.

Certification Requirements

Wisconsin Administrative Code contains requirements that providers must meet in order to be certified with Wisconsin Medicaid; applicable Administrative Code requirements and any special certification materials for the applicant's provider type are included in the certification requirements document.

To become Medicaid certified, providers are required to do the following:

- Meet all certification requirements for their provider type.
- Submit a properly completed provider application, provider agreement, and other forms, as applicable, that are included in the certification packet.

Providers should carefully complete the certification materials and send all applicable documents demonstrating that they meet the stated Medicaid certification criteria. Providers may call [Provider Services](#) for assistance with completing these materials.

Terms of Reimbursement

Wisconsin Medicaid certification materials include Wisconsin Medicaid's TOR, which describes the methodology by which providers are reimbursed for services provided to BadgerCare Plus, Medicaid, and SeniorCare members. Providers should retain a copy of the TOR in their files. TOR are subject to change during a certification period.

Provider Application

A key part of the certification process is the completion of the Wisconsin Medicaid Provider Application. On the provider application, the applicant furnishes contact, address, provider type and specialty, license, and other information needed by Wisconsin Medicaid to make a certification determination.

Provider Agreement and Acknowledgement of Terms of Participation

As part of the application for certification, providers are required to sign a provider agreement with the DHS. Providers applying for certification through the Portal will be required to print, sign and date, and send the provider agreement to Wisconsin Medicaid.

Providers who complete a paper provider application will need to sign and date the provider agreement and submit it with the other certification materials.

By signing a provider agreement, the provider certifies that the provider and each person employed by the provider, for the purpose of providing services, holds all licenses or similar entitlements and meets other requirements specified in DHS 101 through DHS 109, Wis. Admin. Code, and required by federal or state statute, regulation, or rule for the provision of the service.

The provider's certification to participate in Wisconsin Medicaid may be terminated by the provider as provided at DHS 106.05, Wis. Admin. Code, or by the DHS upon grounds set forth in DHS 106.06, Wis. Admin. Code.

This provider agreement remains in effect as long as the provider is certified to participate in Wisconsin Medicaid.

Completing Certification Applications

Health care providers are required to include their NPI on the certification application.

Note: Obtaining an NPI does not replace the Wisconsin Medicaid certification process.

Portal Submission

Providers may apply for Medicaid certification directly through the ForwardHealth Portal. Though the provider certification application is available via the public Portal, the data are entered and transmitted through a secure connection to protect personal data. Applying for certification through the Portal offers the following benefits:

- Fewer returned applications. Providers who apply through the Portal are taken through a series of screens that are designed to guide them through the application process. This ensures that required information is captured and therefore reduces the instances of applications returned for missing or incomplete information.
- Instant submission. At the end of the online application process, applicants instantly submit their application to ForwardHealth and are given an ATN to use in tracking the status of their application.
- Indicates documentation requirements. At the end of the online process, applicants are also given detailed instructions about what actions are needed to complete the application process. For example, the applicant will be instructed to print the provider agreement and any additional forms that Wisconsin Medicaid must receive on paper and indicates whether supplemental information (e.g., transcripts, copy of license) is required. Applicants are also able to save a copy of the application for their records.

Paper Submission

Providers may also submit provider applications on paper. To request a paper provider application, providers should do one of the following:

- Contact Provider Services.
- Click the "Contact Us" link on the Portal and send the request via e-mail.
- Send a request in writing to the following address:

  ForwardHealth
  Provider Maintenance
  6406 Bridge Rd
  Madison WI 53784-0006

Written requests for certification materials must include the following:

- The number of provider applications requested and each applicant's/provider's name, address, and telephone number (a

provider application must be completed for each applicant/provider).
- The provider's NPI (for health care providers) that corresponds to the type of application being requested.
- The program for which certification is requested (Wisconsin Medicaid).
- The type of provider (e.g., physician, physician clinic or group, speech-language pathologist, hospital) or the type of services the provider intends to provide.

Paper provider applications are assigned an ATN at the time the materials are requested. As a result, examples of the provider application are available on the Portal for reference purposes only. These examples should not be downloaded and submitted to Wisconsin Medicaid. For the same reason, providers are not able to make copies of a single paper provider application and submit them for multiple applicants. These policies allow Wisconsin Medicaid to efficiently process and track certifications and assign effective dates.

Once completed, providers should mail certification materials to the address indicated on the application cover letter. Sending certification materials to any other Wisconsin Medicaid address may cause a delay.

Effective Date of Medicaid Certification

When assigning an initial effective date, ForwardHealth follows these regulations:

1. The date the provider submits his or her online provider application to ForwardHealth or contacts ForwardHealth for a paper application is the earliest effective date possible and will be the initial effective date if the following are true:
    ❍ The provider meets all applicable licensure, certification, authorization, or other credential requirements as a prerequisite for Wisconsin Medicaid on the date of notification. Providers should not hold their application for pending licensure, Medicare, or other required certification but submit it to ForwardHealth. ForwardHealth will keep the provider's application on file and providers should send ForwardHealth proof of eligibility documents immediately, once available, for continued processing.
    ❍ ForwardHealth received the provider agreement and any supplemental documentation within 30 days of submission of the online provider application.
    ❍ ForwardHealth received the paper application within 30 days of the date the paper application was mailed.
2. If ForwardHealth receives the provider agreement and any applicable supplemental documents more than 30 days after the provider submitted the online application or receives the paper application more than 30 days after the date the paper application was mailed, the provider's effective date will be the date the complete application was received at ForwardHealth.
3. If ForwardHealth receives the provider's application within the 30-day deadline described above and it is incomplete or unclear, the provider will be granted one 30-day extension to respond to ForwardHealth's request for additional information. ForwardHealth must receive a response to the request for additional information within 30 days from the date on the letter requesting the missing information or item(s). This extension allows the provider additional time to obtain proof of eligibility (such as license verification, transcripts, or other certification).
4. If the provider does not send complete information within the original 30-day deadline or 30-day extension, the initial effective date will be based on the date ForwardHealth receives the complete and accurate application materials.

Group Certification Effective Dates

Group billing certifications are given as a billing convenience. Groups (except providers of mental health services) may submit a written request to obtain group billing certification with a certification effective date back 365 days from the effective date assigned. Providers should mail requests to backdate group billing certification to the following address:

ForwardHealth
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

Request for Change of Effective Date

If providers believe their initial certification effective date is incorrect, they may request a review of the effective date. The request should include documentation that indicates the certification criteria that were incorrectly considered. Requests for changes in certification effective dates should be sent to Provider Maintenance.

Medicare Enrollment

ForwardHealth requires certain types of providers to be enrolled in Medicare as a condition for Medicaid certification. This requirement is specified in the certification materials for these provider groups.

The enrollment process for Medicare is separate from Wisconsin Medicaid's certification process. Providers applying for Medicare enrollment *and* Medicaid certification are encouraged to apply for Wisconsin Medicaid certification at the same time they apply for Medicare enrollment, even though Medicare enrollment must be finalized first. By applying for Medicare enrollment and Medicaid certification simultaneously, it may be possible for ForwardHealth to assign a Medicaid certification effective date that is the same as the Medicare enrollment date.

Materials for New Providers

On an ongoing basis, providers should refer to the Online Handbook for the most current BadgerCare Plus and Medicaid information. Future changes to policies and procedures are published in *Updates*.

Certain providers may opt not to receive these materials by completing the Deletion from Publications Mailing List form in the certification materials. Providers who opt out of receiving publications are still bound by ForwardHealth's rules, policies, and regulations even if they choose not to receive *Updates* on an ongoing basis. *Updates* are available for viewing and downloading on the ForwardHealth Portal.

Multiple Locations

The number of Medicaid certifications allowed or required per location is based on licensure, registration, certification by a state or federal agency, or an accreditation association identified in the Wisconsin Administrative Code. Providers with multiple locations should inquire if multiple applications must be completed when requesting a Medicaid certification application.

Multiple Services

Providers who offer a variety of services may be required to complete a separate Medicaid certification packet for each specified service/provider type.

Health care providers who are federally required to have an NPI are responsible for obtaining the appropriate certification for their NPI.

If a Medicaid-certified provider begins offering a new service *after* he or she has become initially certified, it is recommended that he or she call Provider Services to inquire if another application must be completed.

Notice of Certification Decision

Wisconsin Medicaid will notify the provider of the status of the certification usually within 10 business days, but no longer than 60 days, after receipt of the complete application for certification. Wisconsin Medicaid will either approve the application and issue the certification or deny the application. If the application for certification is denied, Wisconsin Medicaid will give the applicant reasons, in writing, for the denial.

Providers who meet the certification requirements will be sent a welcome letter and a copy of the signed provider agreement. Included with the letter is an attachment with important information such as effective dates, assigned provider type and specialty, and taxonomy code. This information will be used when conducting business with BadgerCare Plus, Medicaid, or SeniorCare (for example, health care providers will need to include their taxonomy code, designated by Wisconsin Medicaid, on claim submissions and requests for PA).

The welcome letter will also notify non-healthcare providers (e.g., SMV providers, personal care agencies, blood banks) of their Medicaid provider number. This number will be used on claim submissions, PA requests, and other communications with ForwardHealth programs.

Provider Addresses

ForwardHealth interChange has the capability of storing the following types of addresses and related information, such as contact information and telephone numbers:

- *Practice location address and related information (formally known as physical address).* This address is where the provider's office is physically located and where records are normally kept. Additional information for the practice location includes the provider's office telephone number and telephone number for member's use. With limited exceptions, the practice location and telephone number for member's use are published in a provider directory made available to the public.
- *Mailing address.* This address is where ForwardHealth will mail general information and correspondence. Providers should indicate concise address information to aid in proper mail delivery.
- *PA address.* This address is where ForwardHealth will mail PA information.
- *Financial addresses (formally known as payee address).* Two separate financial addresses are stored in ForwardHealth interChange. The checks and RA address is where Wisconsin Medicaid will mail checks and RAs. The 1099 mailing address is where Wisconsin Medicaid will mail IRS Form 1099.

Providers may submit additional address information or modify their current information through the ForwardHealth Portal or by using the Provider Change of Address or Status form.

Note: Providers are cautioned that any changes to their practice location on file with ForwardHealth may alter their ZIP+4 code information required on transactions. Providers may verify the ZIP+4 code for their address on the U.S. Postal Service Web site.

Provider addresses are stored separately for each program (i.e., Medicaid, WCDP, and WWWP) for which the provider is certified. Providers should consider this when supplying additional address information and keeping address information current. Providers who are certified for multiple programs and have an address change that applies to more than one program should provide this information for each program. Providers who submit these changes on paper need to submit *one* Provider Change of Address or Status form if changes are applicable for multiple programs.

Provider Certification

All Medicaid-certified PNCC providers in Milwaukee County and the city of Racine are automatically certified to provide CCC services.

Beginning January 1, 2010, Medicaid-certified PNCC providers within the city of Racine will have the option of providing CCC services in partnership with the city of Racine Health Department's Healthy Births, Healthy Families program. The goal of both of these efforts is to reduce fetal and infant mortality and morbidity in the city of Racine.

To qualify to provide CCC services within the city of Racine, a provider must meet the following criteria:

- Be a Medicaid-certified PNCC provider within the city of Racine (defined as a provider whose physical address falls within ZIP codes 53401 to 53408 and 53490).
- Have a DHS-approved MOU with the city of Racine's Health Department. Submit the MOU to the ForwardHealth Provider

Enrollment Department at 6406 Bridge Rd, Madison, WI 53784-0006. At a minimum, the MOU must identify a contact person at both the PNCC provider's office and the Racine Health Department and address communication and coordination, including frequency of contacts and referrals between programs.

- Establish an MOU with state-contracted HMOs providing services within the city of Racine. At a minimum, the MOU must identify a contact person at both the HMO and PNCC provider's office and address communication and coordination, including frequency of contacts and referrals between programs.

Medicaid-certified PNCC providers within the city of Racine may begin to provide CCC services to applicable members on January 1, 2010, but claims may not be submitted to ForwardHealth for these services until March 1, 2010.

Subcontracting for Child Care Coordination Services

Medicaid-certified PNCC providers may subcontract with agencies not certified by Medicaid for CCC services. However, the Medicaid-certified provider retains all legal and fiscal responsibility for the services provided by subcontractors.

It is the certified provider's responsibility to ensure that the subcontractor provides services and maintains records in accordance with the Medicaid requirements for the provision of CCC services. According to DHS 105.02(6)(a), Wis. Admin. Code, the following records must be maintained:

"Contracts or agreements with persons or organizations for the furnishing of items or services, payment for which may be made in whole or in part, directly or indirectly, by Wisconsin Medicaid."

Although the subcontracted agency may submit claims to Wisconsin Medicaid using the certified provider's Medicaid number, Wisconsin Medicaid only reimburses the certified provider.

Provider Type and Specialty Changes

Providers who want to add a certification type or make a change to their certification type should call Provider Services

Health care providers who are federally required to have an NPI are cautioned that any changes to their provider type and/or specialty information on file with ForwardHealth may alter the applicable taxonomy code for a provider's certification.

Recertification

Periodically, ForwardHealth conducts provider recertifications that require providers to update their information. Providers will be notified when they need to be recertified and will be provided with instructions on how to complete the recertification process.

Reinstating Certification

Providers whose Medicaid certification has ended for any reason other than sanctions or failure to be recertified may have their certification reinstated as long as all licensure and certification requirements are met. The criteria for reinstating certification vary, depending upon the reason for the cancellation and when the provider's certification ended.

If it has been less than 365 days since a provider's certification has ended, the provider is required to submit a letter or the Provider Change of Address or Status form, stating that he or she wishes to have his or her Medicaid certification reinstated.

If it has been more than 365 days since a provider's certification has ended, the provider is required to submit new certification materials. This can be done by completing them through the ForwardHealth Portal or submitting a paper provider application.

Tracking Certification Materials

Wisconsin Medicaid allows providers to track the status of their certification application either through the ForwardHealth Portal or by calling Provider Services. Providers who submitted their application through the Portal will receive the ATN upon submission, while providers who request certification materials from Wisconsin Medicaid will receive an ATN on the application cover letter sent with their provider application. Regardless of how certification materials are submitted, providers may use one of the methods listed to track the status of their certification application.

Note: Providers are required to wait for the Notice of Certification Decision as official notification that certification has been approved. This notice will contain information the provider needs to conduct business with BadgerCare Plus, Medicaid, or SeniorCare; therefore, an approved or enrolled status alone does not mean the provider may begin providing or billing for services.

Tracking Through the Portal

Providers are able to track the status of a certification application through the Portal. By clicking on the "Certification Tracking Search" quick link in the Provider area of the Portal and entering their ATN, providers will receive current information on their application, such as whether it's being processed or has been returned for more information.

Tracking Through Provider Services

Providers may also check on the status of their submitted application by contacting Provider Services and giving their ATN.

Documentation

1099 Miscellaneous Forms

ForwardHealth generates the 1099 Miscellaneous form in January of each year for earnings greater than $600.00, per Internal Revenue Service regulations. One 1099 Miscellaneous form per financial payer and per tax identification number is generated, regardless of how many provider IDs or NPIs share the same tax identification number. For example, a provider who conducts business with both Medicaid and WCDP will receive separate 1099 Miscellaneous forms for each program.

The 1099 Miscellaneous forms are sent to the address designated as the "1099 mailing address." The address formerly known as the "payee address" is used as the 1099 mailing address unless a provider has reported a separate address for the 1099 mailing address to ForwardHealth.

Assessment Updates

Providers may update the Child Care Coordination Family Questionnaire as frequently as needed. Providers may also administer other assessment instruments periodically, if appropriate, to determine the child's (or mother's) progress toward meeting basic developmental milestones or program goals. For example, the assessment tools may include Denver Developmental, Wisconsin Child Protective Services Risk Management System, or the HOME Screening tool.

Providers should indicate the ongoing care coordination and monitoring procedure code and modifier when submitting claims for updates to the Family Questionnaire and/or administration of other assessments.

Availability of Records to Authorized Personnel

The DHCAA has the right to inspect, review, audit, and reproduce provider records pursuant to DHS 106.02(9)(e), Wis. Admin. Code. The DHCAA periodically requests provider records for compliance audits to match information against ForwardHealth's information on paid claims, PA requests, and enrollment. These records include, but are not limited to, medical/clinical and financial documents. Providers are obligated to ensure that the records are released to an authorized DHCAA staff member(s).

Wisconsin Medicaid reimburses providers $0.06 per page for the cost of reproducing records requested by the DHCAA to conduct a compliance audit. A letter of request for records from the DHCAA will be sent to a provider when records are required.

Reimbursement is not made for other reproduction costs included in the provider agreement between the DHCAA and a provider, such as reproduction costs for submitting PA requests and claims.

Also, state-contracted MCOs, including HMOs and SSI HMOs, are not reimbursed for the reproduction costs covered in their contract with the DHS.

The reproduction of records requested by the PRO under contract with the DHCAA is reimbursed at a rate established by the PRO.

Care Plan Development

Care planning will be reimbursed as a CCC service when provided by qualified staff. Care planning includes developing and implementing a care plan.

The development of a care plan will be reimburced for members who score 70 or more points on the Child Care Coordination

Family Questionnaire. A completed Family Questionnaire must predate the care plan.

Wisconsin Medicaid has provided a blank model of a care plan; however, providers are not required to use this sample.

Providers will be reimbursed for the development of one care plan per member, per 365 days. (Updates to the care plan will be reimbursed under the ongoing care coordination and monitoring procedure code.)

The care coordinator is required to develop an individualized care plan for each eligible member. Wisconsin Medicaid does not require a specific care plan format, but the care plan must be:

- Developed (or reviewed) and signed or initialed by a qualified professional.
- In writing.
- Based on the results of the Family Questionnaire.

To ensure the member's needs are met, the care plan must:

- Identify needs, problems, necessary services, necessary referrals, and frequency of monitoring.
- Include an array of services regardless of funding sources.

To the maximum extent possible, include the member in the development and any subsequent revisions of the care plan. Include family members and other supportive persons as appropriate. The member and care coordinator who developed the care plan are required to sign and date the plan.

Note: Providers should note in the care plan if the member does not want to address issues identified in the Family Questionnaire.

Care Plan Updates

Providers are required to review and update the care plan at least every 60 days, or earlier if the member's needs change, during the first year of the child's life. Thereafter, providers should review and update the care plan at least every 180 days. If necessary, providers should update the member's care plan during each visit.

The provider and the member are required to sign and date all updates to the care plan. The provider may initial updates to the care plan if a signature page is included in the recipient's file. Providers are required to keep signed copies of the updates in the member's file.

Providers should indicate the ongoing care coordination and monitoring procedure code and modifier when submitting claims for updates to the care plan.

Confidentiality

ForwardHealth supports member rights regarding the confidentiality of health care and other related records, including an applicant or member's billing information or medical claim records. An applicant or member has a right to have this information safeguarded, and the provider is obligated to protect that right. Therefore, use or disclosure of any information concerning applicants and members for any purpose not connected with program administration, including contacts with third-party payers that are necessary for pursuing third-party payment and the release of information as ordered by the court, is prohibited unless authorized by the applicant or member.

To comply with the standards, providers are required to follow the procedures outlined in the Online Handbook to ensure the proper release of this information. ForwardHealth providers, like other health care providers, are also subject to other laws protecting confidentiality of health care information including, but not limited to, the following:

- s. 146.81-146.84, Wis. Stats., Wisconsin health care confidentiality of health care information regulations.

- 42 USC s. 1320d - 1320d-8 (federal HIPAA) and accompanying regulations.

Any person violating this regulation may be fined an amount from $25 up to $500 or imprisoned in the county jail from 10 days up to one year, or both, for each violation.

A provider is not subject to civil or criminal sanctions when releasing records and information regarding applicants or members if such release is for purposes directly related to administration or if authorized in writing by the applicant or member.

Electronic

Records kept electronically are subject to the same requirements as those maintained on paper. In addition, the following requirements apply to electronic documentation:

- Providers are required to have a paper or electronic back-up system for electronic documentation. This could include having files saved on disk or CD in case of computer failure.
- For audits conducted by the DHCF, providers are required to produce paper copies of electronic records upon request.
- Providers are required to have safeguards to prevent unauthorized access to the records.

Providers are required to have the signature of the individual performing each service and maintain each signature in their records. This individual is referred to as the "performer."

Electronic Signature Standards

Wisconsin Medicaid accepts electronic signatures as long as the provider has established policies and procedures regarding the use of electronic signatures. Providers are required to meet the following guidelines when using electronic signatures:

- The electronic signature of the performing provider must be under the sole control of that individual. Only the performer has the authority to use his or her electronic signature.
- Documentation must show the electronic signature that belongs to each performer. For example, if a performer uses a number, the provider is required to maintain a confidential list that contains the performer's name and corresponding electronic signature number.

The following are examples of electronic signatures:

- Typed name — Performer may type his or her complete name.
- Number — Performer may type a number unique to him or her.
- Initials — Performer may type initials unique to him or her.

No one may sign on behalf of the performer. Also, the performer is required to review, sign, and date each entry in a member's record when information is entered on the performer's behalf.

Financial Records

According to **DHS 106.02(9)(c)**, Wis. Admin. Code, a provider is required to maintain certain financial records in written or electronic form.

Medical Records

A dated clinician's signature must be included in all medical notes. According to **DHS 106.02(9)(b)**, Wis. Admin. Code, a provider is required to include certain written documentation in a member's medical record.

Additional Documentation Requirements for Core Plan Home Health Services Following an Inpatient Hospital Stay

In addition to the documentation requirements specified by the Wisconsin Administrative Code and other documentation requirements, providers are required to maintain a copy of the member?s hospital discharge plan when billing for home health services provided to Core Plan members. The hospital discharge plan must include the following detail:

- A clear statement declaring that discharge from the hospital is contingent on the member obtaining medically necessary prescribed home health services.
- The name of the home health agency that has agreed to provide the prescribed home health services and to accept the patient for care immediately after discharge from the hospital.
- The specific prescribed medically necessary services the home health agency is to provide to the member.

Member Access to Records

Providers are required to allow members access to their health care records, including those related to ForwardHealth services, maintained by a provider in accordance with Wisconsin Statutes, excluding billing statements.

Preparation and Maintenance of Records

All providers who receive payment from Wisconsin Medicaid, including state-contracted MCOs, are required to maintain records that fully document the basis of charges upon which all claims for payment are made, according to DHS 106.02(9)(a), Wis. Admin. Code. This required maintenance of records is typically required by any third-party insurance company and is not unique to ForwardHealth.

Record Retention

Providers are required to retain documentation, including medical and financial records, for a period of not less than five years from the date of payment, except RHCs, who are required to retain records for a minimum of six years from the date of payment.

According to DHS 106.02(9)(d), Wis. Admin. Code, providers are required to retain all evidence of billing information.

Ending participation as a provider does not end a provider's responsibility to retain and provide access to fully maintained records unless an alternative arrangement of record retention and maintenance has been established.

Reviews and Audits

The DHS periodically reviews provider records. The DHS has the right to inspect, review, audit, and photocopy the records. Providers are required to permit access to any requested record(s), whether in written, electronic, or micrographic form.

Records Requests

Requests for billing or medical claim information regarding services reimbursed by BadgerCare Plus may come from a variety of individuals including attorneys, insurance adjusters, and members. Providers are required to notify ForwardHealth by contacting Provider Services when releasing billing information or medical claim records relating to charges for covered services except the following:

- When the member is a dual eligible (i.e., member is eligible for both Medicare and Wisconsin Medicaid or BadgerCare Plus) and is requesting materials pursuant to *Medicare* regulations.

- When the provider is attempting to exhaust all existing health insurance sources prior to submitting claims to BadgerCare Plus.

Request from a Member or Authorized Person

If the request for a member's billing information or medical claim records is from a member or authorized person acting on behalf of the member, the provider should send a copy of the requested billing information or medical claim records, along with the name and address of the requester, to the following address:

> Department of Health Services
> Casualty/Subrogation Program
> PO Box 6243
> Madison WI 53791

ForwardHealth will process and forward the requested information to the requester.

Request from an Attorney, Insurance Company, or Power of Attorney

If the request for a member's billing information or medical claim records is from an attorney, insurance company, or power of attorney, the provider should do the following:

1. Obtain a release signed by the member or authorized representative.
2. Furnish the requested material to the requester, marked "BILLED TO FORWARDHEALTH" or "TO BE BILLED TO FORWARDHEALTH," with a copy of the release signed by the member or authorized representative. Approval from ForwardHealth is not necessary.
3. Send a notice of the material furnished to the requester to Coordination of Benefits at the previously listed address with a copy of the signed release.

Request for Information About a Member Enrolled in a State-Contracted Managed Care Organization

If the request for a member's billing information or medical claim records is for a member enrolled in a state-contracted MCO, the provider is required to do the following:

1. Obtain a release signed by the member or authorized representative.
2. Send a copy of the letter requesting the information, along with the release signed by the member or authorized representative, directly to the MCO.

The MCO makes most benefit payments and is entitled to any recovery that may be available.

Request for a Statement from a Dual Eligible

If the request is for an itemized statement from a dual eligible, pursuant to HR 2015 (Balanced Budget Act of 1997) s. 4311, a dual eligible has the right to request and receive an itemized statement from his or her Medicare-certified health care provider. The Act requires the provider to furnish the requested information to the member. The Act does *not* require the provider to notify ForwardHealth.

For More Information

For additional information about requests for billing information or medical claim records, providers should call Provider Services. Providers may also write to the following address:

Division of Health Services
Estate and Casualty Recovery Section
PO Box 309
Madison WI 53701-0309

Release of Billing Information to Government Agencies

Providers are permitted to release member information without informed consent when a written request is made by the DHS or the federal HHS to perform any function related to program administration, such as auditing, program monitoring, and evaluation.

Providers are authorized under BadgerCare Plus confidentiality regulations to report suspected misuse or abuse of program benefits to the DHS, as well as to provide copies of the corresponding patient health care records.

Requirements

According to DHS 106.02(9), Wis. Admin. Code, all providers are required to prepare and maintain truthful, accurate, complete, legible, and concise documentation and records. Providers may keep records in written or electronic formats. If providers keep electronic records, they are required to have hard copies available for review and audit.

As defined in DHS 105.52(5), Wis. Admin. Code, a member's file must include the following documents, as appropriate:

- The member's completed Child Care Coordination Family Questionnaire. The Family Questionnaire must be scored, signed, and dated.
- The member's care plan, signed and dated as required. The provider may initial the care plan if a signature page is included in the member's record.
- A log that clearly and concisely documents all care coordination activities. All entries must be signed and dated.
- Completed consent document(s) for release of information.
- A written record of all member-specific care coordination and monitoring activities. The record must include documentation of the following information:
  1. The member's name.
  2. The date of the contact.
  3. The full name and title of the person who made the contact.
  4. A clear description of the reason for and nature of the contact.
  5. The results of the contact.
  6. The length of time of the contact (the number of minutes or the exact time (e.g., 9:15-10:05 a.m.).
  7. Where or how the contact was made.
- Referrals and follow up.
- All pertinent correspondence relating to coordination of the member's care.

Providers should use the following as general guidelines for documentation of activities:

- Maintain accurate and legible documentation.
- Correct errors with caution. Do not erase or obliterate errors in established records. Instead, draw a line through the error so the words remain legible. Sign or initial and date the correction.
- Arrange the file in logical order if possible, so that documents can easily be reviewed and audited.
- Ensure that all entries are signed and dated and in chronological order. Initials are acceptable if the member's file includes a page bearing the provider's full name and signature.
- Keep documentation concise, but descriptive and pertinent. The notation for each entry should be reasonably reflective of the length of time documented for the activity. For example, an entry stating, "Called Member X to remind her of baby's HealthCheck appointment" should not have a length of time of one hour.

  A more reasonable notation would state the following: "Called Member X to remind her of baby's upcoming HealthCheck

appointment. Made sure that she knew the name and location of the clinic and the name of the pediatrician. Answered Member X's questions regarding the appointment, transportation arrangement, and child care for her other children. Provided her with the name and telephone numbers of several transportation and day care providers in the area. Made plans with the member for a follow-up home visit."

- If unusual abbreviations and symbols are used routinely (e.g., abbreviations pertaining to internal policy or personal shorthand codes), maintain a key describing each one.

Wisconsin Medicaid provides a sample time log form for providers to document activities performed.

Ongoing Responsibilities

Accommodating Members with Disabilities

All providers, including ForwardHealth providers, operating an existing public accommodation have requirements under Title III of the Americans with Disabilities Act of 1990 (nondiscrimination).

Change in Ownership

New certification materials, including a provider agreement, must be completed whenever a change in ownership occurs. ForwardHealth defines a "change in ownership" as when a different party purchases (buys out) or otherwise obtains ownership or effective control over a practice or facility. Examples of a change in ownership include the following:

- A sole proprietorship transfers title and property to another party.
- Two or more corporate clinics or centers consolidate and a new corporate entity is created.
- There is an addition, removal, or substitution of a partner in a partnership.
- An incorporated entity merges with another incorporated entity.
- An unincorporated entity (sole proprietorship or partnership) becomes incorporated.

The following provider types require Medicare enrollment and/or DQA certification for Wisconsin Medicaid certification change in ownerships:

- Ambulatory surgery centers.
- ESRD services providers.
- Federally qualified health centers.
- Home health agencies.
- Hospice providers.
- Hospitals (inpatient and outpatient).
- Nursing homes.
- Outpatient rehabilitation facilities.
- Rehabilitation agencies.
- RHCs.

All changes in ownership must be reported in writing to ForwardHealth and new certification materials must be completed *before* the effective date of the change. The affected provider numbers should be noted in the letter. When the change in ownership is complete, the provider(s) will receive written notification of his or her provider number and the new Medicaid certification effective date in the mail.

Providers with questions about change in ownership should call Provider Services.

Repayment Following Change in Ownership

Medicaid-certified providers who sell or otherwise transfer their business or business assets are required to repay ForwardHealth for any erroneous payments or overpayments made to them by Wisconsin Medicaid. If necessary, the provider to whom a transfer of ownership is made will also be held liable by ForwardHealth for repayment. Therefore, prior to final transfer of ownership, the provider acquiring the business is responsible for contacting ForwardHealth to ascertain if he or she is liable under this provision.

The provider acquiring the business is responsible for making payments within 30 days after receiving notice from the DHS that the amount shall be repaid in full.

Providers may send inquiries about the determination of any pending liability on the part of the owner to the following address:

> Division of Health Care Access and Accountability
> Bureau of Program Integrity
> PO Box 309
> Madison WI 53701-0309

ForwardHealth has the authority to enforce these provisions within four years following the transfer of a business or business assets. Refer to s. 49.45(21), Wis. Stats., for complete information.

Civil Rights Compliance (Nondiscrimination)

Providers are required to comply with all federal laws relating to Title XIX of the Social Security Act and state laws pertinent to ForwardHealth, including the following:

- Title VI and VII of the Civil Rights Act of 1964.
- The Age Discrimination Act of 1975.
- Section 504 of the Rehabilitation Act of 1973.
- The ADA of 1990.

The previously listed laws require that all health care benefits under ForwardHealth be provided on a nondiscriminatory basis. No applicant or member can be denied participation in ForwardHealth or be denied benefits or otherwise subjected to discrimination in any manner under ForwardHealth on the basis of race, color, national origin or ancestry, sex, religion, age, disability, or association with a person with a disability.

Any of the following actions may be considered discriminatory treatment when based on race, color, national origin, disability, or association with a person with a disability:

- Denial of aid, care, services, or other benefits.
- Segregation or separate treatment.
- Restriction in any way of any advantage or privilege received by others. (There are some program restrictions based on eligibility classifications.)
- Treatment different from that given to others in the determination of eligibility.
- Refusing to provide an oral language interpreter to persons who are considered LEP at no cost to the LEP individual in order to provide meaning access.
- Not providing translation of vital documents to the LEP groups who represent five percent or 1,000, whichever is smaller, in the provider's area of service delivery.

Note: Limiting practice by age is not age discrimination and specializing in certain conditions is not disability discrimination. For further information, see 45 CFR Part 91.

Providers are required to be in compliance with the previously mentioned laws as they are currently in effect or amended. Providers who employ 25 or more employees and receive $25,000 or more annually in Medicaid reimbursement are also required to comply with the DHS Affirmative Action and Civil Rights Compliance Plan requirements. Providers that employ less than 25 employees and receive less than $25,000 annually in Medicaid reimbursement are required to comply by submitting a Letter of Assurance and other appropriate forms.

Providers without Internet access may obtain copies of the DHS Affirmative Action and Civil Rights Compliance Plan (including the Letter of Assurance and other forms) and instructions by calling the Affirmative Action and Civil Rights Compliance Officer at (608) 266-9372. Providers may also write to the following address:

> AA/CRC Office

1 W Wilson St Rm 561
PO Box 7850
Madison WI 53707-7850

For more information on the acts protecting members from discrimination, refer to the civil rights compliance information in the Enrollment and Benefits booklet. The booklet is given to new ForwardHealth members by local county or tribal agencies. Potential ForwardHealth members can request the booklet by calling Member Services.

Title VI of the Civil Rights Act of 1964

This act requires that all benefits be provided on a nondiscriminatory basis and that decisions regarding the provision of services be made without regard to race, color, or national origin. Under this act, the following actions are prohibited, if made on the basis of race, color, or national origin:

- Denying services, financial aid, or other benefits that are provided as a part of a provider's program.
- Providing services in a manner different from those provided to others under the program.
- Aggregating or separately treating clients.
- Treating individuals differently in eligibility determination or application for services.
- Selecting a site that has the effect of excluding individuals.
- Denying an individual's participation as a member of a planning or advisory board.
- Any other method or criteria of administering a program that has the effect of treating or affecting individuals in a discriminatory manner.

Title VII of the Civil Rights Act of 1964

This act prohibits differential treatment, based solely on a person's race, color, sex, national origin, or religion, in the terms and conditions of employment. These conditions or terms of employment are failure or refusal to hire or discharge compensation and benefits, privileges of employment, segregation, classification, and the establishment of artificial or arbitrary barriers to employment.

Federal Rehabilitation Act of 1973, Section 504

This act prohibits discrimination in both employment and service delivery based solely on a person's disability.

This act requires the provision of reasonable accommodations where the employer or service provider cannot show that the accommodation would impose an undue hardship in the delivery of the services. A reasonable accommodation is a device or service modification that will allow the disabled person to receive a provider's benefits. An undue hardship is a burden on the program that is not equal to the benefits of allowing that handicapped person's participation.

A handicapped person means any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

In addition, Section 504 requires "program accessibility," which may mean building accessibility, outreach, or other measures that allow for full participation of the handicapped individual. In determining program accessibility, the program or activity will be viewed in its entirety. In choosing a method of meeting accessibility requirements, the provider shall give priority to those methods that offer a person who is disabled services that are provided in the most integrated setting appropriate.

Americans with Disabilities Act of 1990

Under Title III of the ADA of 1990, any provider that operates an existing public accommodation has four specific requirements:

1. Remove barriers to make his or her goods and services available to and usable by people with disabilities to the extent that it is readily achievable to do so (i.e., to the extent that needed changes can be accomplished without much difficulty or expense).

2. Provide auxiliary aids and services so that people with sensory or cognitive disabilities have access to effective means of communication, unless doing so would fundamentally alter the operation or result in undue burdens.
3. Modify any policies, practices, or procedures that may be discriminatory or have a discriminatory effect, unless doing so would fundamentally alter the nature of the goods, services, facilities, or accommodations.
4. Ensure that there are no unnecessary eligibility criteria that tend to screen out or segregate individuals with disabilities or limit their full and equal enjoyment of the place of public accommodation.

Age Discrimination Act of 1975

The Age Discrimination Act of 1975 prohibits discrimination on the basis of age in programs and activities receiving federal financial assistance. The Act, which applies to all ages, permits the use of certain age distinctions and factors other than age that meet the Act's requirements.

Contracted Staff

Under a few circumstances (e.g., personal care, case management services), providers may contract with non-Medicaid certified agencies for services. Providers are legally, programmatically, and fiscally responsible for the services provided by their contractors and their contractor's services.

When contracting services, providers are required to monitor the contracted agency to ensure that the agency is meeting member needs and adhering to ForwardHealth requirements.

Providers are also responsible for informing a contracted agency of ForwardHealth requirements. Providers should refer those with whom they contract for services to ForwardHealth publications for program policies and procedures. ForwardHealth references and publications include, but are not limited to, the following:

- Wisconsin Administrative Code.
- *ForwardHealth Updates*.
- The Online Handbook.

Providers should encourage contracted agencies to visit the ForwardHealth Portal regularly for the most current information.

Examples of Ongoing Responsibilities

Responsibilities for which providers are held accountable are described throughout the Online Handbook. Medicaid-certified providers have responsibilities that include, but are not limited to, the following:

- Providing the same level and quality of care to ForwardHealth members as private-pay patients.
- Complying with all state and federal laws related to ForwardHealth.
- Obtaining PA for services, when required.
- Notifying members in advance if a service is not covered by ForwardHealth and the provider intends to collect payment from the member for the service.
- Maintaining accurate medical and billing records.
- Retaining preparation, maintenance, medical, financial records, along with other documentation, for a period of not less than five years from the date of payment, except rural health clinic providers who are required to retain records for a minimum of six years from the date of payment.
- Billing only for services that were actually provided.
- Allowing a member access to his or her records.
- Monitoring contracted staff.
- Accepting Medicaid reimbursement as payment in full for covered services.
- Keeping provider information (i.e., address, business name) current.

- Notifying ForwardHealth of changes in ownership.
- Responding to Medicaid recertification notifications.
- Safeguarding member confidentiality.
- Verifying member enrollment.
- Keeping up-to-date with changes in program requirements as announced in ForwardHealth publications.

Keeping Information Current

Types of Changes

Providers are required to notify ForwardHealth of changes, including the following:

- Address(s) — practice location and related information, mailing, PA, and/or financial.
- Telephone number, including area code.
- Business name.
- Contact name.
- Federal Tax ID number (IRS number).
- Group affiliation.
- Licensure.
- Medicare NPI for health care providers or Medicare provider number for providers of *non-healthcare* services.
- Ownership.
- Professional certification.
- Provider specialty.
- Supervisor of nonbilling providers.

Failure to notify ForwardHealth of changes may result in the following:

- Incorrect reimbursement.
- Misdirected payment.
- Claim denial.
- Suspension of payments in the event that provider mail is returned to ForwardHealth for lack of a current address.

Entering new information on a claim form or PA request is *not* adequate notification of change.

Address Changes

Healthcare providers who are federally reuired to have an NPI are cautioned that changes to their practice location address on file with ForwardHealth may alter their ZIP+4 code information that is required on transactions.

Submitting Changes in Address or Status

Once certified, providers are required to submit changes in address or status as they occur, either through the Portal or on paper.

ForwardHealth Portal Submission

After establishing a provider account on the ForwardHealth Portal, providers may make changes to their demographic information online. Changes made through the Portal instantly update the provider's information in ForwardHealth interChange. In addition, since the provider is allowed to make changes directly to his or her information, the process does not require re-entry by ForwardHealth.

Providers should note, however, that the demographic update function of the Portal limits certain providers from modifying some types of information. Providers who are not able to modify certain information through the Portal may make these changes using the Provider Change of Address or Status form.

Paper Submission

Providers must use the Provider Change of Address or Status form. Copies of old versions of this form will not be accepted and will be returned to the provider so that he or she may complete the current version of the form or submit changes through the Portal.

Change Notification Letter

When a change is made to certain provider information, either through the use of the Provider Change of Address or Status form or through the Portal, ForwardHealth will send a letter notifying the provider of the change(s) made. Providers should carefully review the Provider File Information Change Summary included with the letter. If any information on this summary is incorrect, providers may do one of the following:

- If the provider made an error while submitting information on the Portal, he or she should correct the information through the Portal.
- If the provider submitted incorrect information using the Provider Change of Address or Status form, he or she should either submit a corrected form or correct the information through the Portal.
- If the provider submitted correct information on the Provider Change of Address or Status form and believes an error was made in processing, he or she can contact Provider Services to have the error corrected or submit the correct information via the Portal.

Notify Division of Quality Assurance of Changes

Providers licensed or certified by the DQA are required to notify the DQA of changes to physical address, changes of ownership, and facility closures by calling (608) 266-8481.

Providers licensed or certified by the DQA are required to notify the DQA of these changes *before* notifying ForwardHealth. The DQA will then forward the information to ForwardHealth.

Legal Framework

The following laws and regulations provide the legal framework for BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid:

- Federal Law and Regulation:
    - Law — United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
    - Regulation — Title 42 CFR Parts 430-498 and Parts 1000-1008 (Public Health).
- Wisconsin Law and Regulation:
    - Law — Wisconsin Statutes: 49.43-49.499, 49.665, and 49.473.
    - Regulation — Wisconsin Administrative Code, Chapters DHS 101, 102, 103, 104, 105, 106, 107, and 108.

Laws and regulations may be amended or added at any time. Program requirements may not be construed to supersede the provisions of these laws and regulations.

The information included in the ForwardHealth Portal applies to BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid. BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid are administered by the DHS. Within the DHS, the DHCAA is directly responsible for managing these programs.

Section 49.46(2)(b)12m, Wis. Stats. provides the legal framework for CCC services.

Wisconsin Medicaid added the CCC benefit under the authority of 1995 Wisconsin Act 303. The benefit extends Medicaid PNCC services to include CCC services for recipients in Milwaukee County.

Provider Numbers

National Provider Identifier

Health care providers are required to indicate an NPI on electronic and paper transactions submitted to ForwardHealth.

The NPI is a 10-digit number obtained through NPPES.

Providers should ensure that they have obtained an appropriate NPI to correspond to their certification.

There are two kinds of NPIs:

- Entity Type 1 NPIs are for individuals who provide health care, such as physicians, dentists, and chiropractors.
- Entity Type 2 NPIs are for organizations that provide health care such as hospitals, group practices, pharmacies, and home health agencies.

It is possible for a provider to qualify for both Entity Type 1 and Entity Type 2 NPIs. For example, an individual physical therapist may also be the owner of a therapy group that is a corporation and have two Wisconsin Medicaid certifications — one certification as an individual physical therapist and the other certification as the physical therapy group. A Type 1 NPI for the individual certification and a Type 2 NPI for the group certification are required.

NPIs and classifications may be viewed on the NPPES Web site. The Centers for Medicare and Medicaid Services Web site includes more Type 1 and Type 2 NPI information.

Some providers hold multiple certifications with ForwardHealth. For example, a health care organization may be certified according to the type of services their organization provides (e.g., physician group, therapy group, home health agency) or the organization may have separate certification for each practice location. ForwardHealth maintains a separate provider file for each certification that stores information used for processing electronic and paper transactions (e.g., provider type and specialty, certification begin and end dates). When a single NPI is reported for multiple certifications, ForwardHealth requires additional data to identify the provider and to determine the correct provider file to use when processing transactions.

Either or both of the following additional data is required with NPI when a single NPI corresponds to multiple certifications:

- The ForwardHealth-designated taxonomy code.
- ZIP+4 code (complete, nine digits) that corresponds to the practice location address on file with ForwardHealth.

Omission of the additional required data will cause claims and other transactions to be denied or delayed in processing.

Taxonomy Codes

Taxonomy codes are standard code sets used to provide information about provider type and specialty for the provider's certification. Providers are required to use the taxonomy code designated by ForwardHealth when the NPI reported to ForwardHealth corresponds to multiple certifications and the provider's practice location ZIP+4 code does not uniquely identify the provider.

ForwardHealth designates a taxonomy code as additional data to be used to correctly match NPI to the correct provider file. The designated taxonomy code may be different than the taxonomy code providers originally submitted to NPPES when obtaining their NPI as not all national taxonomy code options are recognized by ForwardHealth. For example, some taxonomy codes may correspond to provider types not certifiable with ForwardHealth, or they may represent services not covered by ForwardHealth.

Omission of a taxonomy code when it is required as additional data to identify the provider or indicating a taxonomy code that is not designated by ForwardHealth will cause claims and other transactions to be denied or delayed in processing.

Refer to the ForwardHealth-designated taxonomy codes for the appropriate taxonomy code for your certification.

Note: The ForwardHealth-designated taxonomy code does not change provider certification or affect reimbursement terms.

ZIP Code

The ZIP+4 code is the ZIP code of a provider's practice location address on file with ForwardHealth. Providers are required to use the ZIP+4 code when the NPI reported to ForwardHealth corresponds to multiple certifications and the designated taxonomy code does not uniquely identify the provider.

Omission of the ZIP+4 code of the provider's practice location address when it is required as additional data to identify the provider will cause claims and other transactions to be denied or delayed in processing.

Providers may verify the ZIP+4 code for their address on the U.S. Postal Service Web site.

Provider Rights

A Comprehensive Overview of Provider Rights

Medicaid-certified providers have certain rights including, but not limited to, the following:

- Limiting the number of members they serve in a nondiscriminatory way.
- Ending participation in Wisconsin Medicaid.
- Applying for a discretionary waiver or variance of certain rules identified in Wisconsin Administrative Code.
- Collecting payment from a member under limited circumstances.
- Refusing services to a member if the member refuses or fails to present a ForwardHealth identification card. However, possession of a ForwardHealth card does not guarantee enrollment (e.g., the member may not be enrolled, may be enrolled only for limited benefits, or the ForwardHealth card may be invalid). Providers may confirm the current enrollment of the member by using one of the EVS methods, including calling Provider Services.

Ending Participation

Providers other than home health agencies and nursing facilities may terminate participation in ForwardHealth according to DHS 106.05, Wis. Admin. Code.

Providers choosing to withdraw should promptly notify their members to give them ample time to find another provider.

When withdrawing, the provider is required to do the following:

- Provide a written notice of the decision at least 30 days in advance of the termination.
- Indicate the effective date of termination.

Providers will not receive reimbursement for nonemergency services provided on and after the effective date of termination. Voluntary termination notices can be sent to the following address:

> ForwardHealth
> Provider Maintenance
> 6406 Bridge Rd
> Madison WI 53784-0006

If the provider fails to specify an effective date in the notice of termination, ForwardHealth may terminate the provider on the date the notice is received.

Hearing Requests

A provider who wishes to contest a DHS action or inaction for which due process is required under s. 227, Wis. Stats., may request a hearing by writing to the DHA.

A provider who wishes to contest the DHCAA's notice of intent to recover payment (e.g., to recoup for overpayments discovered in an audit by DHCAA) is required to request a hearing on the matter within the time period specified in the notice. The request, which must be in writing, should briefly summarize the provider's basis for contesting the DHS decision to withhold payment.

Refer to DHS 106, Wis. Admin. Code, for detailed instructions on how to file an appeal.

If a timely request for a hearing is not received, the DHS may recover those amounts specified in its original notice from future amounts owed to the provider.

Note: Providers are not entitled to administrative hearings for billing disputes.

Limiting the Number of Members

If providers choose to limit the number of members they see, they cannot accept a member as a private-pay patient. Providers should instead refer the member to another ForwardHealth provider.

Persons applying for or receiving benefits are protected against discrimination based on race, color, national origin, sex, religion, age, disability, or association with a person with a disability.

Requesting Discretionary Waivers and Variances

In rare instances, a provider or member may apply for, and the DHCAA will consider applications for, a discretionary waiver or variance of certain rules in DHS 102, 103, 104, 105, 107, and 108, Wis. Admin. Code. Rules that are not considered for a discretionary waiver or variance are included in DHS 106.13, Wis. Admin. Code.

Waivers and variances are not available to permit coverage of services that are either expressly identified as noncovered or are not expressly mentioned in HFS 107, Wis. Admin. Code.

Requirements

A request for a waiver or variance may be made at any time; however, all applications must be made in writing to the DHCAA. All applications are required to specify the following:

- The rule from which the waiver or variance is requested.
- The time period for which the waiver or variance is requested.
- If the request is for a variance, the specific alternative action proposed by the provider.
- The reasons for the request.
- Justification that all requirements for a discretionary waiver or variance would be satisfied.

The DHCAA may also require additional information from the provider or the member prior to acting on the request.

Application

The DHCAA may grant a discretionary waiver or variance if it finds that all of the following requirements are met:

- The waiver or variance will not adversely affect the health, safety, or welfare of any member.
- Either the strict enforcement of a requirement would result in unreasonable hardship on the provider or on a member, or an alternative to a rule is in the interests of better care or management. An alternative to a rule would include a new concept, method, procedure or technique, new equipment, new personnel qualifications, or the implementation of a pilot project.
- The waiver or variance is consistent with all applicable state and federal statutes and federal regulations.
- Federal financial participation is available for all services under the waiver or variance, consistent with the Medicaid state plan, the federal CMS, and other applicable federal program requirements.
- Services relating to the waiver or variance are medically necessary.

To apply for a discretionary waiver or variance, providers are required to send their application to the following address:

Division of Health Care Access and Accountability

Waivers and Variances
PO Box 309
Madison WI 53701-0309

Sanctions

Intermediate Sanctions

According to DHS 106.08(3), Wis. Admin. Code, the DHS may impose intermediate sanctions on providers who violate certain requirements. Common examples of sanctions that the DHS may apply include the following:

- Review of the provider's claims before payment.
- Referral to the appropriate peer review organization, licensing authority, or accreditation organization.
- Restricting the provider's participation in BadgerCare Plus.
- Requiring the provider to correct deficiencies identified in a DHS audit.

Prior to imposing any alternative sanction under this section, the DHS will issue a written notice to the provider in accordance with DHS 106.12, Wis. Admin. Code.

Any sanction imposed by the DHS may be appealed by the provider under DHS 106.12, Wis. Admin. Code. Providers may appeal a sanction by writing to the DHA.

Involuntary Termination

The DHS may suspend or terminate the Medicaid certification of any provider according to DHS 106.06, Wis. Admin. Code.

The suspension or termination may occur if both of the following apply:

- The DHS finds that any of the grounds for provider termination are applicable.
- The suspension or termination will not deny members access to services.

Reasonable notice and an opportunity for a hearing within 15 days will be given to each provider whose certification is terminated by the DHS. Refer to DHS 106.07, Wis. Admin. Code, for detailed information regarding possible sanctions.

In cases where Medicare enrollment is required as a condition of certification with Wisconsin Medicaid, termination from Medicare results in automatic termination from Wisconsin Medicaid.

Sanctions for Collecting Payment from Members

Under state and federal laws, if a provider inappropriately collects payment from an enrolled member, or authorized person acting on behalf of the member, that provider may be subject to program sanctions including termination of Medicaid certification. In addition, the provider may also be fined not more than $25,000, or imprisoned not more than five years, or both, pursuant to 42 USC s. 1320a-7b(d) or 49.49(3m), Wis. Stats.

There may be narrow exceptions on when providers may collect payment from members.

Withholding Payments

The DHS may withhold full or partial Medicaid provider payments without prior notification if, as the result of any review or audit, the DHS finds reliable evidence of fraud or willful misrepresentation.

"Reliable evidence" of fraud or willful misrepresentation includes, but is not limited to, the filing of criminal charges by a prosecuting attorney against the provider or one of the provider's agents or employees.

The DHS is required to send the provider a written notice within five days of taking this action. The notice will generally set forth the allegations without necessarily disclosing specific information about the investigation.

Claims

2

Archive Date:03/01/2010
Claims:Adjustment Requests

Allowed Claim

An allowed claim (or adjustment request) contains at least one service that is reimbursable. Allowed claims display on the Paid Claims Section of the RA with a dollar amount greater than "0" in the allowed amount fields. Only an allowed claim, which is also referred to as a claim in an allowed status, may be adjusted.

Denied Claim

A claim that was completely denied is considered to be in a denied status. To receive reimbursement for a claim that was completely denied, it must be corrected and submitted as a new claim.

Electronic

Even if the original claim was submitted on paper, providers may submit electronic adjustment requests using an 837 transaction.

Provider Electronic Solutions Software

The DHCAA offers electronic billing software at no cost to providers. The PES software allows providers to submit electronic adjustment requests using an 837 transaction. To obtain PES software, providers may download it or contact the EDI Helpdesk.

Follow-Up

Providers who believe an error has occurred or their issues have not been satisfactorily resolved have the following options:

- Submit a new adjustment request if the previous adjustment request is in an allowed status.
- Submit a new claim for the services if the adjustment request is in a denied status.
- Contact Provider Services for assistance with paper adjustment requests.
- Contact the EDI Helpdesk for assistance with electronic adjustment requests.

Paper

Paper adjustment requests must be submitted using the Adjustment/Reconsideration Request form.

Portal Claim Adjustments

Providers can submit claim adjustments via the Portal. Providers may use the search function to find the specific claim they would like to adjust. Once found, the provider can alter the claim to reflect the desired change and resubmit it to ForwardHealth. Any claim (excluding dental and pharmacy) ForwardHealth has paid can be modified on the Portal and resubmitted, regardless of how the claim was originally submitted.

Processing

Within 30 days of receipt, ForwardHealth generally reprocesses the original claim with the changes indicated on the adjustment

request and responds on ForwardHealth remittance information.

Purpose

After reviewing both the claim and ForwardHealth remittance information, a provider may determine that an allowed claim needs to be adjusted. Providers may file adjustment requests for reasons including the following:

- To correct billing or processing errors.
- To correct inappropriate payments (overpayments and underpayments).
- To add and delete services.
- To supply additional information that may affect the amount of reimbursement.
- To request professional consultant review (e.g., medical, dental).

Providers may initiate reconsideration of an allowed claim by submitting an adjustment request to ForwardHealth.

Submitting Paper Attachments with Electronic Claim Adjustments

Providers may submit paper attachments to accompany electronic claim adjustments. Providers should refer to their companion documents for directions on indicating that a paper attachment will be submitted by mail.

Good Faith Claims

Definition

A good faith claim may be submitted when a claim is denied due to a discrepancy between the member's enrollment information in the claims processing system and the member's actual enrollment. If a member presents a temporary card or an EE card, BadgerCare Plus encourages providers to check the member's enrollment and, if the enrollment is not on file yet, make a photocopy of the member's temporary card or EE card. If Wisconsin's EVS indicates that the member is not enrolled in BadgerCare Plus, providers should check enrollment again in two days or wait one week to submit a claim to ForwardHealth. If the EVS indicates that the member still is not enrolled after two days, or if the claim is denied with an enrollment-related EOB code, providers should contact Provider Services for assistance.

Overpayments

Adjustment Request vs. Cash Refund

Except for nursing home and hospital providers, cash refunds may be submitted to ForwardHealth in lieu of an adjustment request. However, whenever possible, providers should submit an adjustment request for returning overpayments since both of the following are true:

- A cash refund does not provide documentation for provider records as an adjustment request does. (Providers may be required to submit proof of the refund at a later time.)
- Providers are not able to further adjust the claim after a cash refund is done if an additional reason for adjustment is determined.

Adjustment Requests

When correcting an overpayment through an adjustment request, providers may submit the adjustment request electronically or on paper. Providers should not submit provider-based billing claims through adjustment processing channels.

ForwardHealth processes an adjustment request if the provider is all of the following:

- Medicaid certified on the DOS.
- Not currently under investigation for Medicaid fraud or abuse.
- Not subject to any intermediate sanctions under DHS 106.08, Wis. Admin. Code.
- Claiming and receiving ForwardHealth reimbursement in sufficient amounts to allow the recovery of the overpayment within a very limited period of time. The period of time is usually no more than 60 days.

Electronic Adjustment Requests

ForwardHealth will deduct the overpayment when the electronic adjustment request is processed. Providers should use the companion document for the appropriate 837 transaction when submitting adjustment requests.

Paper Adjustment Requests

For paper adjustment requests, providers are required to do the following:

- Submit an Adjustment/Reconsideration Request form through normal processing channels (not Timely Filing), regardless of the DOS.
- Indicate the reason for the overpayment, such as a duplicate reimbursement or an error in the quantity indicated on the claim.

After the paper adjustment request is processed, ForwardHealth will deduct the overpayment from future reimbursement amounts.

Cash Refunds

When submitting a personal check to ForwardHealth for an overpayment, providers should include a copy of the RA for the claim to be adjusted and highlight the affected claim on the RA. If a copy of the RA is not available, providers should indicate the ICN, the NPI (if applicable), and the payee ID from the RA for the claim to be adjusted. The check should be sent to the following address:

ForwardHealth

Financial Services Cash Unit
6406 Bridge Rd
Madison WI 53784-0004

ForwardHealth-Initiated Adjustments

ForwardHealth may initiate an adjustment when a retroactive rate increase occurs or when an improper or excess payment has been made. ForwardHealth has the right to pursue overpayments resulting from computer or clerical errors that occurred during claims processing.

If ForwardHealth initiates an adjustment to recover overpayments, ForwardHealth remittance information will include details of the adjustment in the Claims Adjusted Section of the paper RA.

Requirements

As stated in DHS 106.04(5), Wis. Admin. Code, the provider is required to refund the overpayment within 30 days of the date of the overpayment if a provider receives overpayment for a claim because of duplicate reimbursement from ForwardHealth or other health insurance sources.

In the case of all other overpayments (e.g., incorrect claims processing, incorrect maximum allowable fee paid), providers are required to return the overpayment within 30 days of the date of discovery.

The return of overpayments may occur through one of the following methods:

- Return of overpayment through the adjustment request process.
- Return of overpayment with a cash refund.
- Return of overpayment with a voided claim.
- ForwardHealth-initiated adjustments.

Note: Nursing home and hospital providers may not return an overpayment with a cash refund. These providers routinely receive retroactive rate adjustments, requiring ForwardHealth to reprocess previously paid claims to reflect a new rate. This is not possible after a cash refund is done.

Voiding Claims

Providers may void claims on the ForwardHealth Portal to return overpayments. This way of returning overpayments may be a more efficient and timely way for providers as a voided claim is a complete recoupment of the payment for the entire claim. Once a claim is voided, the claim can no longer be adjusted; however, the services indicated on the voided claim may be resubmitted on a new claim.

Responses

An Overview of the Remittance Advice

The RA provides important information about the processing of claims and adjustment requests as well as additional financial transactions such as refunds or recoupment amounts withheld. Providers will receive an RA from the appropriate ForwardHealth program when they have at least one claim, adjustment request, or financial transaction processed. An RA is generated regardless of how a claim or adjustment is submitted (electronically or on paper).

National Provider Identifier on the Remittance Advice

Providers who have a single NPI that is used for multiple certifications will receive an RA for each certification with the same NPI reported on each of the RAs. For instance, if a hospital has obtained a single NPI and the hospital has a clinic, a lab, and a pharmacy that are all certified by Medicaid, the clinic, the lab, and the pharmacy will submit separate claims that indicate the same NPI as the hospital. Separate RAs will be generated for the hospital, the clinic, the lab, and the pharmacy.

Calculating Totals on the Remittance Advice for Adjusted and Paid Claims

The total amounts for all adjusted or paid claims reported on the RA appear at the end of the adjusted claims and paid claims sections. ForwardHealth calculates the total by adding the amounts for all of the claims; cutback amounts are subtracted from the allowed amount to reach the total reimbursement for the claims.

Note: Some cutbacks that are reported in detail lines will appear as EOB codes and will not display an exact dollar amount.

Claim Number

Each claim or adjustment request received by ForwardHealth is assigned a unique claim number (also known as the ICN). However, denied claims submitted using the NCPDP 5.1 transaction are not assigned an ICN.

Interpreting Claim Numbers

The ICN consists of 13 digits that identify valuable information (e.g., the date the claim was received by ForwardHealth, how the claim was submitted) about the claim or adjustment request.

Claim Status

ForwardHealth generally processes claims and adjustment requests within 30 days of receipt. Providers may check the status of a claim or adjustment request using the AVR system or the 276/277 transaction.

If a claim or adjustment request does not appear in claim status within 45 days of the date of submission, a copy of the original claim or adjustment request should be resubmitted through normal processing channels.

Cutback Fields on the Remittance Advice for Adjusted

and Paid Claims

Cutback fields indicate amounts that reduce the allowed amount of the claim. Examples of cutbacks include other insurance, member copayment, spenddown amounts, deductibles, or patient liability amounts. Amounts indicated in a cutback field are subtracted from the total allowed reimbursement.

Providers should note that cutback amounts indicated in the header of an adjusted or paid claim section apply only to the header. Not all cutback fields that apply to a detail line (such as copayments or spenddowns) will be indicated on the RA; the detail line EOB codes inform providers that an amount was deducted from the total reimbursement but may not indicate the exact amount.

Note: Providers who receive 835 transactions will be able to see all deducted amounts on paid and adjusted claims.

Electronic Remittance Information

Electronic remittance information may be obtained using the 835 transaction. It provides useful information regarding the processing of claims and adjustment requests, which includes the status or action taken on a claim, claim detail, adjustment, or adjustment detail for all claims and adjustments processed that week, regardless of whether they are reimbursed or denied. However, a claim submitted by a pharmacy using the NCPDP 5.1 transaction will not appear on remittance information if the claim is denied by ForwardHealth.

Provider Electronic Solutions Software

The DHCAA offers electronic billing software at no cost to the provider. The PES software allows providers to download the 835 transaction. To obtain PES software, providers may request the software through the ForwardHealth Portal. Providers may also obtain the software by contacting the EDI Helpdesk.

Explanation of Benefit Codes in the Claim Header and in the Detail Lines

EOB codes are four-digit numeric codes specific to ForwardHealth that correspond to a printed message about the status or action taken on a claim, claim detail, adjustment, or adjustment detail.

The claim processing sections of the RA report EOBs for the claim header information and for the detail lines, as appropriate. Header information is a summary of the information from the claim, such as the DOS that the claim covers or the total amount paid for the claim. Detail lines report information from the claim details, such as specific procedure codes or revenue codes, the amount billed for each code, and the amount paid for a detail line item.

Header EOBs are listed below the claim header information and pertain only to the header information. Detail line EOBs are listed after each detail line and pertain only to the detail line.

Identifying the Claims Reported on the Remittance Advice

The RA reports the first 12 characters of the MRN and/or a PCN, also referred to as Patient Account Number, submitted on the original claims. The MRN and PCN fields are located beneath the member's name on any section of the RA that reports claims processing information.

Providers are strongly encouraged to enter these numbers on claims. Entering the MRN and/or the PCN on claims may assist

providers in identifying the claims reported on the RA.

Note: Claims processing sections for dental and drug claims do not include the MRN or the PCN.

Obtaining the Remittance Advice

One paper copy of each RA is mailed to the provider.

Providers who receive the paper RA may also access RAs through their secure ForwardHealth Portal accounts. The main page of the secure Portal account lists the last 10 RAs issued to the provider.

Providers may choose to opt out of receiving a paper RA by sending a written request to the following address:

ForwardHealth
Provider Maintenance
Madison WI 53784-0006

Note: Providers who do not receive a paper RA can not view the RA on the Portal. Providers who opt out of receiving the paper RA should make sure they receive the electronic 835 transaction.

Providers may obtain additional paper copies of the RA by sending a written request to the following address:

ForwardHealth
Written Correspondence
6406 Bridge Rd
Madison WI 53784-0005

Providers may call Provider Services to request additional paper copies of the RA.

Overview of Claims Processing Information on the Remittance Advice

The claims processing sections of the RA includes information submitted on claims and the status of the claims. The claim status designations are paid, adjusted, or denied. The RA also supplies information about why the claim was adjusted or denied or how the reimbursement was calculated for the payment.

The claims processing information in the RA is grouped by the type of claim and the status of the claim. Providers receive claims processing sections that correspond to the types of claims that have been finalized during the current financial cycle.

The claims processing sections reflect the types of claims submitted, such as the following:

- Compound drug claims.
- Dental claims.
- Drug claims.
- Inpatient claims.
- Long term care claims.
- Medicare crossover institutional claims.
- Medicare crossover professional claims.
- Outpatient claims.
- Professional claims.

The claims processing sections are divided into the following status designations:

- Adjusted claims.
- Denied claims.
- Paid claims.

Reading Non-Claims Processing Sections of the Remittance Advice

Address Page

The Address page displays the provider name and "Pay to" address of the provider for purposes of mailing the paper RA.

Banner Messages

The Banner Messages section of the RA contains important, time-sensitive messages for providers. For example, banner messages might inform providers of claim adjustments initiated by ForwardHealth, claim submission deadlines, and dates of upcoming training sessions. It is possible for each RA to include different messages, so providers who receive multiple RAs should read all of their banner messages.

Explanation of Benefits Code Descriptions

The EOB Code Descriptions section lists all EOB codes reported on the RA with corresponding descriptions.

Financial Transactions Page

The Financial Transactions section details the provider's weekly financial activity. Financial transactions reported on the RA include payouts, refunds, accounts receivable, and payments for claims.

Payouts are payments made to the provider by ForwardHealth that do not correspond to a specific claim (i.e., nursing home assessment reimbursement).

Refunds are payments made to providers for overpayments.

The Accounts Receivable section displays the accounts receivable for amounts owed by providers. The accounts receivable is set to automatically recover any outstanding balance so that money owed is automatically recouped from the provider. If the full amount cannot be recouped during the current financial cycle, an outstanding balance will appear under "Accounts Receivable." The "Total Recoupment" field lists the cumulative amount recovered for the accounts receivable.

Every financial transaction that results in the creation of an accounts receivable is assigned an identification number called the "adjustment ICN." The adjustment ICN for an adjusted claim matches the original ICN assigned to the adjusted claim. For other financial transactions, the adjustment ICN is determined by the following formula.

Type of Character and Description	Applicable Characters and Description
Transaction — The first character indicates the type of financial transaction that created the accounts receivable.	V — Capitation adjustment 1 — OBRA Level 1 screening void request

	2 — OBRA Nurse Aide Training/Testing void request
Identifier — 10 additional numbers are assigned to complete the Adjustment ICN.	The identifier is used internally by ForwardHealth.

Service Code Descriptions

The Service Code Descriptions section lists all the service codes (i.e., procedure codes or revenue codes) reported on the RA with their corresponding descriptions.

Summary

The Summary section reviews the provider's claim activity and financial transactions with the payer (Medicaid, WCDP, or WWWP) for the current financial cycle, the month-to-date, and the year-to-date, if applicable.

Under the "Claims Data" heading, providers can review the total number of claims that have been paid, adjusted, or denied along with the total amount reimbursed for all paid and adjusted claims. Only WWWP providers will see amounts reported for "Claims in Process." Other providers will always see zeroes in these fields.

Under the "Earnings Data" heading, providers will see total reimbursement amounts for other financial transactions, such as reimbursement for OBRA Level 1 screening, reimbursement for OBRA Nurse Aid Training/Testing, and capitation payments.

Note: HMOs should note that capitation payments are only reported in the Summary section of the RA. HMOs receive supplemental reports of their financial transactions from ForwardHealth.

The "Earnings Data" portion also summarizes refunds and voids and reports the net payment for the current financial cycle, the month-to-date, and the year-to-date, if applicable.

Providers should note that the Summary section will include outstanding checks 90 days after issuance and/or payments made to lien holders, if applicable.

Reading the Claim Adjustments Section of the Remittance Advice

Providers receive a Claim Adjustments section in the RA if any of their claims were adjusted during the current financial cycle. A claim may be adjusted because one of the following occurred:

- An adjustment request was submitted by the provider.
- ForwardHealth initiated an adjustment.
- A cash refund was submitted to ForwardHealth.

In a claim adjustments section, the original claim information in the claim header is surrounded by parentheses. Information about the adjusted claim appears directly below the original claim header information. Providers should check the Adjustment EOB code(s) for a summary of why the claim was adjusted; other header EOBs will provide additional information.

The claim adjustments section lists detail lines only for the adjusted claim with detail line EOBs. Details from the original claim will not be reported on the adjusted claims sections of the RA.

Note: For adjusted drug claims, only the compound drug sections include detail lines.

Below the claim header and the detail information will be located one of three possible responses with a corresponding dollar amount: "additional payment," "overpayment to be withheld," or "refund amount applied."

An amount appears for "additional payment" if ForwardHealth owes additional monies to the provider after the claim has been adjusted. This amount will be added to the provider's total reimbursable amount for the RA.

An amount appears for "overpayment to be withheld" if ForwardHealth determines, as the result of an adjustment to the original claim, that the provider owes ForwardHealth monies. ForwardHealth automatically withholds this amount from payments made to the provider during the same financial cycle or during subsequent financial cycles, if necessary. This amount also appears in the Financial Transactions section as an outstanding balance under "Accounts Receivable."

An amount appears for "refund amount applied" if ForwardHealth makes a payment to refund a cash receipt to a provider.

Reading the Claims Denied Section of the Remittance Advice

Providers receive a [Claims Denied](#) section in the RA if any of their claims were denied during the current financial cycle.

In the denied claims section, providers will see the original claim header information reported along with EOB codes for the claim header and the detail lines, as applicable. Providers should refer to the EOB Code Description section of the RA to determine why the claim was denied.

Reading the Claims Paid Section of the Remittance Advice

Providers receive a [Claims Paid](#) section in the RA if any of their claims were determined payable during the current financial cycle.

In a paid claims section, providers will see the original claim information reported along with EOB codes for both the header and the detail lines, if applicable. Providers should refer to the EOB Code Description section of the RA for more information about how the reimbursement amount was determined.

Remittance Advice Financial Cycles

Each financial payer (Medicaid, WCDP, and WWWP) has separate financial cycles that occur on different days of the week. RAs are produced and mailed to providers after each financial cycle is completed. Therefore, providers might receive RAs from different payers on different days of the week.

Certain financial transactions may run on a daily basis, including non-claim related payouts and stop payment reissues. Providers may receive the RAs generated by these financial transactions at any time during the week.

Remittance Advice Generated by Payer and by Provider Certification

Providers may receive an RA from one or more of the following ForwardHealth financial payers:

- Wisconsin Medicaid (Wisconsin Medicaid is the financial payer for the Medicaid, BadgerCare Plus, and SeniorCare programs).

- WCDP.
- WWWP.

Note: Each of the three payers generate separate RAs for the claims, adjustment requests, or other financial transactions submitted to the payer. A provider who submits claims, adjustment requests, or other financial transactions to more than one of these payers may receive several RAs.

The RA is generated per provider certification. Providers who have a single NPI that is used for multiple certifications should be aware that an RA will be generated for each certification, but the same NPI will be reported on each of the RAs.

For instance, a hospital has obtained a single NPI. The hospital has a clinic, a lab, and a pharmacy that are all certified with ForwardHealth. The clinic, the lab, and the pharmacy submit separate claims that indicate the same NPI as the hospital. Separate RAs will be generated for the hospital, the clinic, the lab, and the pharmacy.

Reporting a Lost Check

To report a lost check to ForwardHealth, providers are required to mail or fax a letter to ForwardHealth Financial Services. Providers are required to include the following information in the letter:

- Provider's name and address, including the ZIP+4 code.
- Provider's identification number.
    - For healthcare providers, include the NPI and ForwardHealth-issued taxonomy code.
    - For non-healthcare providers, include the provider identification number.
- Check number, check date, and check amount. (This should be recorded on the RA.)
- A written request to stop payment and reissue the check.
- The signature of an authorized financial representative. (An individual provider is considered his or her own authorized financial representative.)

Fax the letter to ForwardHealth at (608) 221-4567 or mail it to the following address:

ForwardHealth
Financial Services
6406 Bridge Rd
Madison WI 53784-0005

Searching for and Viewing All Claims on the Portal

All claims, including pharmacy and dental, will be available for viewing on the Portal.

To search and view claims on the Portal, providers may do the following:

- Go to the ForwardHealth Portal.
- Log in to the secure Provider area of the Portal.
- The most recent claims processed by ForwardHealth will be viewable on the provider's home page or the provider may select "claim search" and enter the applicable information to search for additional claims.
- Select the claim the provider wants to view.

Sections of the Remittance Advice

The RA includes the following sections:

- Address page.
- Banner messages.
- Paper check, if applicable.
- Claims processing information.
- EOB code descriptions.
- Financial transactions.
- Service code descriptions.
- Summary.

Remittance Advice Header Information

The first page of each section of the RA (except the address page) displays the same RA header information.

The following fields are on the left-hand side of the header:

- The technical name of the RA section (e.g., CRA-TRAN-R), which is an internal ForwardHealth designation.
- The RA number, which is a unique number assigned to each RA that is generated.
- The name of the payer (Medicaid, WCDP, or WWWP).
- The "Pay to" address of the provider. The "Pay to" address is used for mailing purposes.

The following information is in the middle of the header:

- A description of the financial cycle.
- The name of the RA section (e.g., "Financial Transactions" or "Professional Services Claims Paid").

The right-hand side of the header reports the following information:

- The date of the financial cycle during which the RA was generated.
- The page number.
- The "Payee ID" of the provider. A payee ID is defined as the identification number of a unique entity receiving payment for goods and/or services from ForwardHealth. The payee ID is up to 15 characters long and may be based on a pre-existing identification number, such as the Medicaid provider number. The payee ID is an internal ForwardHealth designation. The Medicaid provider number will display in this field for providers who do not have an NPI.
- The NPI of the provider, if applicable. This field will be blank for those providers who do not have an NPI.
- The number of the check issued for the RA, if applicable. The date of payment on the check, if applicable.

Verifying Accuracy of Claims Processing

After obtaining ForwardHealth remittance information, providers should compare it to the claims or adjustment requests to verify that ForwardHealth processed elements of the claims or adjustment requests as submitted. To ensure correct reimbursement, providers should do the following:

- Identify and correct any discrepancy that affected the way a claim processed.
- Correct and resubmit claims that are denied.
- Submit an adjustment request for allowed claims that require a change or correction.

When posting a payment or denial to a member's account, providers should note the date on the ForwardHealth remittance information that indicates that the claim or adjustment has finalized. Providers are required to supply this information if further follow-up actions are necessary.

Responsibilities

Accuracy of Claims

The provider is responsible for the accuracy, truthfulness, and completeness of all claims submitted whether prepared or submitted by the provider or by an outside billing service or clearinghouse.

Providers may submit claims only *after* the service is provided.

A provider may not seek reimbursement from ForwardHealth for a noncovered service by charging ForwardHealth for a covered service that was not actually provided to the member and then applying the reimbursement toward the noncovered service. In addition, a provider may not seek reimbursement for two separate covered services to receive additional reimbursement over the maximum allowed amount for the one service that was provided. Such actions are considered fraudulent.

Exceptions to the Submission Deadline

State and federal laws provide eight exceptions to the submission deadline. According to federal regulations and DHS 106.03, Wis. Admin. Code, ForwardHealth may consider exceptions to the submission deadline only in the following circumstances:

- Change in a nursing home resident's level of care or liability amount.
- Decision made by a court order, fair hearing, or the DHS.
- Denial due to discrepancy between the member's enrollment information in ForwardHealth interChange and the member's actual enrollment.
- Reconsideration or recoupment.
- Retroactive enrollment for persons on GR.
- Medicare denial occurs after ForwardHealth's submission deadline.
- Refund request from an other health insurance source.
- Retroactive member enrollment.

ForwardHealth has no authority to approve any other exceptions to the submission deadline.

Claims or adjustment requests that meet one of the exceptions to the submission deadline may be submitted to Timely Filing.

Submission Deadline

ForwardHealth recommends that providers submit claims at least on a monthly basis. Billing on a monthly basis allows the maximum time available for filing and refiling before the mandatory submission deadline.

With few exceptions, state and federal laws require that providers submit correctly completed claims before the submission deadline.

Providers are responsible for resolving claims. Members are not responsible for resolving claims. To resolve claims before the submission deadline, ForwardHealth encourages providers to use all available resources.

Claims

To receive reimbursement, claims and adjustment requests must be received within 365 days of the DOS. This deadline applies to claims, corrected claims, and adjustments to claims.

Crossover Claims

To receive reimbursement for services that are allowed by Medicare, claims and adjustment requests for coinsurance, copayment, and deductible must be received within 365 days of the DOS or within 90 days of the Medicare processing date, whichever is later. This deadline applies to all claims, corrected claims, and adjustments to claims. Providers should submit these claims through normal processing channels (not timely filing).

Usual and Customary Charges

For most services, providers are required to indicate their usual and customary charge when submitting claims. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to the program's benefits. For providers using a sliding fee scale, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-program patients. For providers who have not established usual and customary charges, the charge should be reasonably related to the provider's cost for providing the service.

Providers may not discriminate against BadgerCare Plus or Medicaid members by charging a higher fee for the same service than that charged to a private-pay patient.

For services requiring a member copayment, providers should still indicate their usual and customary charge. The copayment amount collected from the member should not be deducted from the charge submitted. When applicable, BadgerCare Plus automatically deducts the copayment amount.

For most services, BadgerCare Plus reimburses the lesser of the provider's usual and customary charge or the maximum allowable fee established.

Submission

1500 Health Insurance Claim Form Completion Instructions for Child Care Coordination Services

A [sample 1500 Health Insurance Claim Form](#) is available for CCC services.

Use the following claim form completion instructions, not the claim form's printed descriptions, to avoid denial or inaccurate claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so.

Members enrolled in BadgerCare Plus and Medicaid receive a ForwardHealth identification card. Always verify a member's enrollment before providing nonemergency services to determine if there are any limitations on covered services and to obtain the correct spelling of the member's name.

When submitting a claim with multiple pages, providers are required to indicate page numbers using the format "Page X of X" in the upper right corner of the claim form.

Submit completed paper claims to the following address:

ForwardHealth
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

Element 1 — Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Blk Lung, Other
Enter "X" in the Medicaid check box.

Element 1a — Insured's ID Number
Enter the member identification number. Do not enter any other numbers or letters. Use the ForwardHealth card or Wisconsin's EVS to obtain the correct member ID.

Element 2 — Patient's Name
Enter the member's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

Element 3 — Patient's Birth Date, Sex
Enter the member's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/CCYY format (e.g., February 3, 1955, would be 02/03/1955). Specify whether the member is male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name
Data are required in this element for OCR processing. Any information populated by a provider's computer software is acceptable data for this element (e.g., "Same"). If computer software does not automatically complete this element, enter information such as the member's last name, first name, and middle initial.

Element 5 — Patient's Address
Enter the complete address of the member's place of residence, if known.

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name (not required)

Element 9a — Other Insured's Policy or Group Number (not required)

Element 9b — Other Insured's Date of Birth, Sex (not required)

Element 9c — Employer's Name or School Name (not required)

Element 9d — Insurance Plan Name or Program Name (not required)

Element 10a-10c — Is Patient's Condition Related to: (not required)

Element 10d — Reserved for Local Use (not required)

Element 11 — Insured's Policy Group or FECA Number (not required)

Element 11a — Insured's Date of Birth, Sex (not required)

Element 11b — Employer's Name or School Name (not required)

Element 11c — Insurance Plan Name or Program Name (not required)

Element 11d — Is there another Health Benefit Plan? (not required)

Element 12 — Patient's or Authorized Person's Signature (not required)

Element 13 — Insured's or Authorized Person's Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Element 17 — Name of Referring Provider or Other Source (not required)

Element 17a (not required)

Element 17b — NPI (not required)

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use (not required)

Element 20 — Outside Lab? $Charges (not required)

Element 21 — Diagnosis or Nature of Illness or Injury
Enter the appropriate ICD-9-CM diagnosis code as follows:

- Enter V61.8 (other specified family circumstances) if the [Child Care Coordination Family Questionnaire](#) indicates the member to be high risk (a score of 70 or more points on the Child Care Coordination Family Questionnaire). HCPCS procedure code T1016 with modifiers "U2" or "U3" are only allowable if V61.8 is indicated.
- Enter V61.9 (unspecified family circumstances) if the Child Care Coordination Family Questionnaire indicates the member is not high risk (a score of fewer than 70 points on the Child Care Coordination Family Questionnaire).

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number (not required)

Element 24
The six service lines in Element 24 have been divided horizontally. Enter service information in the bottom, unshaded area of the six service lines. The horizontal division of each service line is not intended to allow the billing of 12 lines of service.

Element 24A — Date(s) of Service
For services performed on more than one DOS within the month, indicate the last date the service was performed. If billing for more than one month of activities, or more than one procedure code, use one detail line for each month's activities with the DOS determined as described below.

Enter to and from DOS in MM/DD/YY or MM/DD/CCYY format. If the service was provided on only one DOS, enter the date under "From." Leave "To" blank or re-enter the "From" date.

If the service was provided on consecutive days, those dates may be indicated as a range of dates by entering the first date as the "From" DOS and the last date as the "To" DOS in MM/DD/YY or MM/DD/CCYY format.

A range of dates may be indicated only if the POS, the procedure code (and modifiers, if applicable), the charge, the units, and the rendering provider were identical for each DOS within the range.

Element 24B — Place of Service
Enter the appropriate two-digit POS code for each item used or service performed.

Element 24C — EMG (not required)

Element 24D — Procedures, Services, or Supplies
Enter the single most appropriate five-character procedure code. ForwardHealth denies claims received without an appropriate procedure code.

Modifiers
Enter the appropriate (up to four per procedure code) modifier(s) in the "Modifier" column of Element 24D.

Element 24E — Diagnosis Pointer
Enter the number(s) that corresponds to the appropriate ICD-9-CM diagnosis code(s) listed in Element 21. Up to four diagnosis pointers per detail may be indicated. Valid diagnosis pointers, digits 1 through 8, should *not* be separated by commas or spaces.

Element 24F — $ Charges
Enter the total charge for each line item.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

Providers are to bill ForwardHealth their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to ForwardHealth benefits.

Element 24G — Days or Units

Enter the number of days or units. Only include a decimal when billing fractions (e.g., 1.50).

Element 24H — EPSDT/Family Plan (not required)

Element 24I — ID Qual (not required)

Element 24J — Rendering Provider ID. # (not required)

Element 25 — Federal Tax ID Number (not required)

Element 26 — Patient's Account No. (not required)
Optional — Providers may enter up to 14 characters of the patient's internal office account number. This number will appear on the RA and/or the 835 transaction.

Element 27 — Accept Assignment? (not required)

Element 28 — Total Charge
Enter the total charges for this claim. If submitting a multiple-page claim, enter the total charge for the claim (i.e., the sum of all details from all pages of the claim) only *on the last page of the claim*.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

Element 29 — Amount Paid (not required)

Element 30 — Balance Due
Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28. If submitting a multiple-page claim, enter the balance due for the claim (i.e., the sum of all details from all pages of the claim minus the amount paid by commercial insurance) *only on the last page of the claim*.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

Element 31 — Signature of Physician or Supplier, Including Degrees or Credentials
The provider or authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/CCYY format.

Note: The signature may be a computer-printed or typed name and date or a signature stamp with the date.

Element 32 — Service Facility Location Information (not required)

Element 32a — NPI (not required)

Element 32b (not required)

Element 33 — Billing Provider Info & Ph #
Enter the name of the provider submitting the claim and the practice location address. The minimum requirement is the provider's name, street, city, state, and ZIP+4 code.

Element 33a — NPI
Enter the NPI of the billing provider.

Element 33b

If an NPI was entered in Element 33a, enter qualifier "ZZ" followed by the 10-digit provider taxonomy code.

Do not include a space between the qualifier "ZZ" and the provider taxonomy code.

Attached Documentation

Providers should not submit additional documentation with a claim *unless* specifically requested.

Copy Claims on the ForwardHealth Portal

Providers can copy both institutional and professional paid claims on the ForwardHealth Portal. Providers can open any paid claim, click the "Copy" button, and all of the information on the claim will be copied over to a new claim form. Providers can then make any desired changes to the claim form and click "Submit" to submit as a new claim. After submission, ForwardHealth will issue a response with a new ICN along with the claim status.

Correct Errors on Claims and Resubmit to ForwardHealth on the Portal

Providers can view EOB codes and descriptions for any claim submitted to ForwardHealth on the Portal. The EOBs will be useful for providers to determine why a claim did not process successfully, so the provider may correct the error online and resubmit the claim. The EOB will appear on the bottom of the screen and will reference the applicable claim header or detail.

Direct Data Entry of Professional and Institutional Claims on the Portal

Providers can submit professional and institutional claims to ForwardHealth via DDE on the Portal. DDE is an online application that allows providers to submit claims directly to ForwardHealth. DDE is not available for dental or pharmacy claims at this time.

When submitting claims via DDE, required fields are indicated with an asterisk next to the field. If a required field is left blank, the claim will not be submitted and a message will appear prompting the provider to complete the specific required field(s). Portal help is available for each online application screen. In addition, search functions accompany certain fields so providers do not need to look up the following information in secondary resources.

On professional claim forms, providers may search for and select the following:

- Procedure codes.
- Modifiers.
- Diagnosis codes.
- Place of service codes.

On institutional claim forms, providers may search for and select the following:

- Type of bill.
- Patient status.
- Admission source.
- Admission type.
- Diagnosis codes.
- Revenue codes.

- Procedure codes.
- Modifiers.

Fields within the claim form will automatically calculate totals for providers, eliminating potential clerical errors.

Electronic Claims Submission

Providers are encouraged to submit claims electronically. Electronic claims submission does the following:

- Adapts to existing systems.
- Allows flexible submission methods.
- Improves cash flow.
- Offers efficient and timely payments.
- Reduces billing and processing errors.
- Reduces clerical effort.

Electronic claims for CCC services must be submitted using the 837P transaction. Electronic claims for CCC services submitted using any transaction other than the 837P will be denied.

Providers should use the companion document for the 837P transaction when submitting these claims.

Provider Electronic Solutions Software

The DHCAA offers electronic billing software at no cost to providers. The PES software allows providers to submit electronic claims using an 837 transaction. To obtain PES software, providers may download it or contact the EDI Helpdesk.

HIPAA-Compliant Data Requirements

Procedure Codes

All fields submitted on paper and electronic claims are edited to ensure HIPAA compliance before being processed. Compliant code sets include CPT and HCPCS procedure codes entered into all fields, including those fields that are "Not Required" or "Optional."

If the information in all fields are not valid and recognized by ForwardHealth, the claim will be denied.

Provider Numbers

For health care providers, NPIs are required in all provider number fields on paper claims and 837 transactions, including rendering, billing, referring, prescribing, attending, and "Other" provider fields.

Non-healthcare providers, including personal care providers, SMV providers, blood banks, and CCOs should enter valid provider numbers into fields that require a provider number.

Ongoing Care Coordination

To be reimbursed for additional ongoing care coordination time which may have been omitted from the original claim, providers are required to submit an Adjustment/Reconsideration Request.

Paper Claim Form Preparation and Data Alignment

Requirements

Optical Character Recognition

Paper claims submitted to ForwardHealth on the 1500 Health Insurance Claim Form and UB-04 Claim Form are processed using OCR software that recognizes printed, alphanumeric text. OCR software increases efficiency by alleviating the need for keying in data from paper claims.

The data alignment requirements do not apply to the Compound Drug Claim and the Noncompound Drug Claim.

Speed and Accuracy of Claims Processing

OCR software processes claim forms by reading text within fields on claim forms. After a paper claim form is received by ForwardHealth, the claim form is scanned so that an image can be displayed electronically. The OCR software reads the electronic image on file and populates the information into the ForwardHealth interChange system. This technology increases accuracy by removing the possibility of errors being made during manual keying.

OCR software speeds paper claim processing, but only if providers prepare their claim forms correctly. In order for OCR software to read the claim form accurately, the quality of copy and the alignment of text within individual fields on the claim form need to be precise. If data are misaligned, the claim could be processed incorrectly. If data cannot be read by the OCR software, the process will stop and the electronic image of the claim form will need to be reviewed and keyed manually. This will cause an increase in processing time.

Handwritten Claims

Submitting handwritten claims should be avoided whenever possible. ForwardHealth accepts handwritten claims; however, it is very difficult for OCR software to read a handwritten claim. If a handwritten claim cannot be read by the OCR software, it will need to be keyed manually from the electronic image of the claim form. Providers should avoid submitting claims with handwritten corrections as this can also cause OCR software processing delays.

Use Original Claim Forms

Only original 1500 Health Insurance Claim Forms and UB-04 Claim Forms should be submitted. Original claim forms are printed in red ink and may be obtained from a federal forms supplier. ForwardHealth does not provide these claim forms. Claims that are submitted as photocopies cannot be read by OCR software and will need to be keyed manually from an electronic image of the claim form. This could result in processing delays.

Use Laser or Ink Jet Printers

It is recommended that claims are printed using laser or ink jet printers rather than printers that use DOT matrix. DOT matrix printers have breaks in the letters and numbers, which may cause the OCR software to misread the claim form. Use of old or worn ink cartridges should also be avoided. If the claim form is read incorrectly by the OCR software, the claim may be denied or reimbursed incorrectly. The process may also be stopped if it is unable to read the claim form, which will cause a delay while it is manually reviewed.

Alignment

Alignment within each field on the claim form needs to be accurate. If text within a field is aligned incorrectly, the OCR software may not recognize that data are present within the field or may not read the data correctly. For example, if a reimbursement amount of $300.00 is entered into a field on the claim form, but the last "0" is not aligned within the field, the OCR software may read the number as $30.00, and the claim will be reimbursed incorrectly.

To get the best alignment on the claim form, providers should center information vertically within each field, and align all information on the same horizontal plane. Avoid squeezing two lines of text into one of the six line items on the 1500 Health Insurance Claim Form.

The following sample claim forms demonstrate correct and incorrect alignment:

- Correct alignment for the 1500 Health Insurance Claim Form.
- Incorrect alignment for the 1500 Health Insurance Claim Form.
- Correct alignment for the UB-04 Claim Form.
- Incorrect alignment for the UB-04 Claim Form.

Clarity

Clarity is very important. If information on the claim form is not clear enough to be read by the OCR software, the process may stop, prompting manual review.

The following guidelines will produce the clearest image and optimize processing time:

- Use 10-point or 12-point Times New Roman or Courier New font.
- Type all claim data in uppercase letters.
- Use only black ink to complete the claim form.
- Avoid using italics, bold, or script.
- Make sure characters do not touch.
- Make sure there are no lines from the printer cartridge anywhere on the claim form.
- Avoid using special characters such as dollar signs, decimals, dashes, asterisks, or backslashes, unless it is specified that these characters should be used.
- Use Xs in check boxes. Avoid using letters such as "Y" for "Yes," "N" for "No," "M" for "Male," or "F" for "Female."
- Do not highlight any information on the claim form. Highlighted information blackens when it is imaged, and the OCR software will be unable to read it.

Note: The above guidelines will also produce the clearest image for claims that need to be keyed manually from an electronic image.

Staples, Correction Liquid, and Correction Tape

The use of staples, correction liquid, correction tape, labels, or stickers on claim forms should be avoided. Staples need to be removed from claim forms before they can be imaged, which can damage the claim and cause a delay in processing time. Correction liquid, correction tape, labels, and stickers can cause data to be read incorrectly or cause the OCR process to stop, prompting manual review. If the form cannot be read by the OCR software, it will need to be keyed manually from an electronic image.

Additional Diagnosis Codes

ForwardHealth will accept up to eight diagnosis codes in Element 21 of the 1500 Health Insurance Claim Form. To correctly add additional diagnosis codes in this element so that it can be read properly by the OCR software, providers should indicate the fifth diagnosis code between the first and third diagnosis code blanks, the sixth diagnosis code between the second and fourth diagnosis code blanks, the seventh diagnosis code to the right of the third diagnosis code blank, and the eighth diagnosis code to the right of the fourth diagnosis code blank. Providers should not number any additional diagnosis codes.

Anchor Fields

Anchor fields are areas on the 1500 Health Insurance Claim Form and the UB-04 Claim Form that the OCR software uses to identify what type of form is being processed. The following fields on the 1500 Health Insurance Claim Form are anchor fields:

- Element 2 (Patient's Name).

- Element 4 (Insured's Name).
- Element 24 (Detail 1).

The following fields on the UB-04 Claim Form are anchor fields:

- Form Locator 4 (Type of Bill).
- Form Locator 5 (Fed. Tax No.).
- Form Locator 9 (Patient Address).
- Form Locator 58A (Insured's Name).

Since ForwardHealth uses these fields to identify the form as a 1500 Health Insurance Claim Form or a UB-04 Claim Form, it is required that these fields are completed for processing.

Paper Claim Submission

Paper claims for CCC services must be submitted using the 1500 Health Insurance Claim Form (dated 08/05). Wisconsin Medicaid denies claims for CCC services submitted on any other claim form.

Providers should use the appropriate claim form instructions for CCC services when submitting these claims.

Obtaining the Claim Forms

Wisconsin Medicaid does not provide the 1500 Health Insurance Claim Form. The forms may be obtained from any federal forms supplier.

Submitting Claims with a Different Identification Number

If the mother becomes ineligible for Wisconsin Medicaid while receiving CCC services, a provider may submit a claim to Medicaid for those services using the eligible child's Medicaid identification number. Providers are required to document in the member's file the reason for using the child's Medicaid identification number when submitting claims for CCC services.

Submitting Paper Attachments with Electronic Claims

Providers may submit paper attachments to accompany electronic claims and electronic claim adjustments. Providers should refer to their companion documents for directions on indicating that a paper attachment will be submitted by mail.

Paper attachments that go with electronic claim transactions must be submitted with the Claim Form Attachment Cover Page. Providers are required to indicate an ACN for paper attachment(s) submitted with electronic claims. (The ACN is an alphanumeric entry between 2 and 80 digits assigned by the provider to identify the attachment.) The ACN must be indicated on the cover page so that ForwardHealth can match the paper attachment(s) to the correct electronic claim.

ForwardHealth will hold an electronic claim transaction or a paper attachment(s) for up to 30 calendar days to find a match. If a match cannot be made within 30 days, the claim will be processed without the attachment and will be denied if an attachment is required. When such a claim is denied, both the paper attachment(s) and the electronic claim will need to be resubmitted.

Providers are required to send paper attachments relating to electronic claim transactions to the following address:

ForwardHealth
Claims and Adjustments

6406 Bridge Rd
Madison WI 53784-0002

Timely Filing Appeals Requests

Requirements

When a claim or adjustment request meets one of the exceptions to the submission deadline, the provider is required to submit a Timely Filing Appeals Request form with a paper claim or an Adjustment/Reconsideration Request form to override the submission deadline.

DOS that are beyond the submission deadline should be submitted separately from DOS that are within the deadline. Claims or adjustment requests received that contain both current and late DOS are processed through normal channels without review by Timely Filing and late DOS will be denied.

Resubmission

Decisions on Timely Filing Appeals Requests cannot be appealed. Providers may resubmit the claim to Timely Filing if both of the following occur:

- The provider submits additional documentation as requested.
- ForwardHealth receives the documentation before the specified deadline for the exception to the submission deadline.

Submission

To receive consideration for an exception to the submission deadline, providers are required to submit the following:

- A properly completed Timely Filing Appeals Request form.
- A legible claim or adjustment request.
- All required documentation as specified for the exception to the submission deadline.

To receive consideration, a Timely Filing Appeals Request must be received before the deadline specified for the exception to the submission deadline.

When completing the claim or adjustment request, providers are required to indicate the procedure code, diagnosis code, POS code, etc., as effective for the DOS. However, providers should use the current claim form and instructions or adjustment request form and instructions. Reimbursement for Timely Filing Appeals Requests is contingent upon the claim or adjustment request meeting program requirements for the DOS.

The following table lists the filing deadlines and documentation requirements as they correspond to each of the eight allowable exceptions.

Change in Nursing Home Resident's Level of Care or Liability Amount		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a nursing home claim is initially received within the submission deadline and reimbursed incorrectly due to a change in the member's authorized level of care or liability amount.	To receive consideration, the request must be submitted within 455 days from the DOS and the correct liability amount or level of care must be indicated on the Adjustment/Reconsideration Request form. The most recent claim number (also known as the ICN)	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

	must be indicated on the Adjustment/Reconsideration Request form. This number may be the result of a ForwardHealth-initiated adjustment.	

Decision Made by a Court, Fair Hearing, or the Department of Health Services		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a decision is made by a court, fair hearing, or the DHS.	To receive consideration, the request must be submitted within 90 days from the date of the decision of the hearing. A complete copy of the notice received from the court, fair hearing, or DHS must be submitted with the request.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Denial Due to Discrepancy Between the Member's Enrollment Information in ForwardHealth interChange and the Member's Actual Enrollment		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a claim is initially received by the deadline but is denied due to a discrepancy between the member's enrollment information in ForwardHealth interChange and the member's actual enrollment.	To receive consideration, the following documentation must be submitted within 455 days from the DOS: ● A copy of remittance information showing the claim was submitted in a timely manner and denied with a qualifying enrollment-related explanation. ● A photocopy of one of the following indicating enrollment on the DOS: ○ White paper BadgerCare Plus EE for pregnant women or children identification card. ○ Green paper temporary identification card. ○ White paper PE for the FPW identification card. ○ The response received through the EVS from a commercial eligibility vendor. ○ The transaction log number received through WiCall.	ForwardHealth Good Faith/Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

ForwardHealth Reconsideration or Recoupment		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when ForwardHealth reconsiders a previously processed claim. ForwardHealth will initiate an adjustment on a previously paid claim.	If a subsequent provider submission is required, the request must be submitted within 90 days from the date of the RA message. A copy of the RA message that shows the ForwardHealth-initiated adjustment must be submitted with the request.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Retroactive Enrollment for Persons on General Relief		
Description of the Exception	**Documentation Requirements**	**Submission Address**

| This exception occurs when the local county or tribal agency requests a return of a GR payment from the provider because a member has become retroactively enrolled for Wisconsin Medicaid or BadgerCare Plus. | To receive consideration, the request must be submitted within 180 days from the date the backdated enrollment was added to the member's enrollment information. The request must be submitted with one of the following:

• "GR retroactive enrollment" indicated on the claim.
• A copy of the letter received from the local county or tribal agency. | ForwardHealth
GR Retro Eligibility
Ste 50
6406 Bridge Rd
Madison WI 53784-0050 |

Medicare Denial Occurs After the Submission Deadline		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when claims submitted to Medicare (within 365 days of the DOS) are denied by Medicare after the 365-day submission deadline. A waiver of the submission deadline will not be granted when Medicare denies a claim for one of the following reasons: • The charges were previously submitted to Medicare. • The member name and identification number do not match. • The services were previously denied by Medicare. • The provider retroactively applied for Medicare enrollment and did not become enrolled.	To receive consideration, the following must be submitted within 90 days of the Medicare processing date: • A copy of the Medicare remittance information. • The appropriate Medicare disclaimer code must be indicated on the claim.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Refund Request from an Other Health Insurance Source		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when an other health insurance source reviews a previously paid claim and determines that reimbursement was inappropriate.	To receive consideration, the following documentation must be submitted within 90 days from the date of recoupment notification: • A copy of the commercial health insurance remittance information. • A copy of the remittance information showing recoupment for crossover claims when Medicare is recouping payment.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Retroactive Member Enrollment		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a claim cannot be submitted within the submission deadline due to a delay in the determination of a member's retroactive	To receive consideration, the request must be submitted within 180 days from the date the backdated enrollment was added to the member's enrollment information. In addition, "retroactive enrollment" must be indicated on the	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd

enrollment.	claim.	Madison WI 53784-0050

Covered and Noncovered Services

3

Archive Date:03/01/2010
Covered and Noncovered Services:Codes

Diagnosis Codes

All diagnosis codes indicated on claims (and PA requests when applicable) must be the most specific ICD-9-CM diagnosis code. Providers are responsible for keeping current with diagnosis code changes. Etiology and manifestation codes may not be used as a primary diagnosis.

The required use of valid diagnosis codes includes the use of the most specific diagnosis code. Valid, most specific diagnosis codes may have up to five digits. Claims submitted with three- or four-digit codes where four- and five-digit codes are available may be denied.

Claims submitted for CCC services must include either diagnosis code V61.8 (other specified family circumstances) or V61.9 (unspecified family circumstances).

Use these diagnosis codes under the following circumstances:

- V61.8: Use when submitting a claim on behalf of a member who scores 70 points or more on the Child Care Coordination Family Questionnaire (i.e., those who are determined eligible to receive services).
- V61.9: Use when submitting a claim on behalf of a member who scores fewer than 70 points on the Family Questionnaire (i.e., those who are assessed but determined ineligible to receive services).

Wisconsin Medicaid will deny claims if providers use other diagnosis codes when submitting claims for CCC services.

Modifiers

Wisconsin Medicaid recognizes three locally defined HCPCS modifiers ("U1," "U2," and "U3") for CCC services. Modifier descriptions for CCC services are as follows:

- Modifier "U1" — Assessment. Indicate this modifier when submitting a claim for the initial, comprehensive assessment.
- Modifier "U2" — Initial care plan development. Indicate this modifier when submitting a claim for the initial care plan development.
- Modifier "U3" — Ongoing child care coordination and monitoring. Indicate this modifier when submitting a claim for ongoing activities, including updates to the assessment and care plan.

Claims for risk assessments that do not include the appropriate modifier indicating the recipient's total risk assessment score will be denied.

Place of Service Codes

Services that are reimbursable through the CCC must be provided in an allowable POS.

Place of Service Code	Description
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility

07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room — Hospital
31	Skilled Nursing Facility
32	Nursing Facility
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
54	Intermediate Care Facility/Mentally Retarded
71	State or Local Public Health Clinic
72	Rural Health Clinic
99	Other Place of Service

Procedure Codes

All claims submitted to Wisconsin Medicaid must include allowable HCPCS codes for CCC services. Claims or adjustment requests received without the appropriate HCPCS codes will be denied.

Procedure Code	Description	Required Modifier and Description
T1016	Case management, each 15 minutes	**U1** Assessment
T1016	Case management, each 15 minutes	**U2** Initial care plan development
T1016	Case management, each 15 minutes	**U3** Ongoing child care coordination and monitoring

Rounding Guidelines

For all services provided, one unit of service is equal to 15 minutes. Providers should follow the rounding guidelines for CCC services to determine the total number of time units.

When submitting claims for risk assessment and initial care plan development, always indicate one unit. Round time unit to the nearest tenth of an hour when submitting claims for ongoing care coordination and monitoring.

Rounding Guidelines	
Accumulated time	Unit(s) billed
1-5 minutes	.3
6-10 minutes	.7
11-15 minutes	1.0
16-20 minutes	1.3
21-25 minutes	1.7

26-30 minutes	2.0

Covered Services and Requirements

A Comprehensive Overview

CCC services help a member and, when appropriate, the member's family gain access to and coordinate a full array of services, including necessary medical, social, educational, vocational, and other services. Wisconsin Medicaid CCC services are available to Medicaid and BadgerCare Plus Standard Plan members in Milwaukee County and the city of Racine who either:

- Receive a DHS-approved initial risk assessment using the [Child Care Coordination Family Questionnaire](#) assessment tool within eight weeks following the birth of a child.
- Received Medicaid PNCC services, if they receive the initial risk assessment using the Child Care Coordination Family Questionnaire assessment tool within six months following delivery.

Members in Milwaukee County qualify for CCC services until the child's seventh birthday. Members in the city of Racine qualify for CCC services until the child's second birthday.

CCC services include all of the following:

- Initial assessment.
- Care plan development.
- Ongoing care coordination and monitoring.

Wisconsin Medicaid does not cover direct service provision, including health and nutrition education, as part of the CCC benefit.

Child Care Coordination Goal

The CCC benefit extends the Medicaid PNCC benefit in Milwaukee County and the city of Racine. The goals of the CCC benefit are to promote positive parenting, improve child health outcomes, and prevent child abuse and neglect.

The main objectives for obtaining these goals include the following:

- Improving family functioning.
- Improving parenting skills and positive parenting outcomes.
- Increasing members' understanding of infant and child development.
- Increasing members' access to and appropriate use of the health care delivery system.
- Improving employment outcomes.
- Encouraging planned pregnancies.
- Improving future birth outcomes.

CCC services do not end with the completion of the initial assessment, unless the assessment determines the member does not need further assistance. To obtain the program's goals, it is critical that providers have the ability to offer all three components of the CCC benefit, not just the assessment, to eligible members.

The following terms are used to describe child care coordination providers and staff:

- Care Coordination Provider — the entity that meets the requirements as a certified provider, is assigned the Medicaid billing provider number, and has legal liability for the provision of CCC services.
- Care Coordinator — the individual who is providing CCC services to members.

Child Care Coordination and Child Welfare

CCC services provided to families who are undergoing a child protective services investigation or initial assessment are covered. These families are not yet receiving ongoing child welfare case management services.

If a family is involved in the child welfare system, the CCC provider may not submit claims to Wisconsin Medicaid for ongoing care coordination services. However, two concurrent visits between the CCC provider and the Safety Services or ongoing case management provider are covered if the family is receiving either:

- Services from a Safety Services provider under contract with the Bureau of Milwaukee Child Welfare.
- Ongoing case management services through the child welfare system.

Providers are required to consult with the family and the Safety Services or ongoing case management provider regarding the necessity and timing of concurrent visits. Providers are required to document the reason for the joint visits.

Providers are encouraged to develop referral protocols and maintain working relationships with the Safety Services and child protective services providers in their service areas.

Referrals From the Child Welfare System

In some cases, families will be identified by the child welfare system, including Safety Services, prior to receiving CCC services. The CCC provider may accept these referrals in the following situations:

- The family meets the eligibility criteria for the benefit.
- The family became involved with the child welfare system, including Safety Services, within eight weeks following the birth of the baby, regardless of the age of the child at the time of the referral.

Child Care Coordinators

A member should not require CCC services from more than one provider. Although Wisconsin Medicaid does not deny claims for concurrent services, both providers are notified of the overlap. It is the providers' responsibility to eliminate the overlap by communicating with the family and with each other to determine which provider will continue to provide CCC services.

Coordinating Prenatal Care Coordination Services and Child Care Coordination Services

The PNCC benefit covers the period of pregnancy through the 60th day (the postpartum period) following delivery. During the postpartum period, CCC providers may be reimbursed through the CCC benefit for administering the Child Care Coordination Family Questionnaire and developing a care plan for members enrolled in the BadgerCare Plus Standard Plan or Medicaid. (CCC services are not covered for members enrolled in the Benchmark Plan.) However, providers may not submit claims for ongoing CCC services provided to members receiving PNCC services, except as outlined below.

Ongoing CCC services provided to a member receiving PNCC services are covered if the following information is documented in the member's record:

- The member's care plan specifically addresses the need for both services at the same time, as demonstrated in the following two examples:
  - *Example 1:* A member receiving PNCC services has just given birth to healthy twins. However, the member is a 19-year-old, first-time mother who moves frequently and is sometimes homeless. At present, she lives with an abusive partner who is often absent for days at a time. She receives little or no emotional support from family members and is

not sure she is happy with twins. In this example, the prenatal care coordinator may decide (with the member) to include the child care coordinator during the postpartum period because of the member's immediate and significant needs.

○ *Example 2:* A member receiving CCC services becomes pregnant. The member has a child who is at high risk for child abuse and/or neglect, has a history of gestational diabetes, poor nutrition, and other significant medical problems. The member also has a history of poor compliance with prenatal medical appointments and advice. In this situation, the child care coordinator may decide (in consultation with the member) that the expertise of a prenatal care coordinator is also appropriate.

- The member's care plan includes a clear delineation of the role of each care coordinator (regardless of whether the care coordinators are employed by the same or different agencies). The care coordinators should decide, along with the member, which care coordinator will provide or follow up on which services.
- The services provided by the care coordinators are not duplicative.
- The member's care plan addresses the frequency of contacts between the care coordinators. The care coordinators must have a face-to-face or telephone contact to discuss the member's progress every 60 days, at a minimum. The need for ongoing joint care coordination should be reassessed during that time.

Definition of Covered Services

A covered service is a service, item, or supply for which reimbursement is available when *all* program requirements are met. DHS 101.03(35) and 107, Wis. Admin. Code, contain more information about covered services.

Guidelines and Performance Measurements

The Guidelines and Performance Measurements for CCC services provide detailed information about the benefit's operational standards and performance measurements. Wisconsin Medicaid uses the performance measurements to determine if providers are complying with the benefit guidelines. If a guideline is not met, providers are required to have written documentation that there is a reasonable alternative in place.

Providers are encouraged to use the guidelines to help ensure that quality services are provided and activities are directed toward the program's objectives and goals. Wisconsin Medicaid also uses the guidelines to monitor the administration of the benefit.

Child Care Coordination Administration

Providers should use the following guidelines while providing CCC services:

Child Care Coordination Administration	
Guideline	**Performance Measurement**
The provider must complete the following:	
I.A. Develop a plan which addresses the hiring and ongoing support and training of staff who can provide quality services that are family-centered and culturally appropriate.	**I.A.** The provider's plan to hire, support, and train staff to provide services that are family-centered and culturally appropriate must be documented and available for review. Documentation of staff training includes the name of the employee, date of training, and the employee's signature.
I.B. Develop and implement an outreach plan to inform potentially eligible pregnant women and families with newborns (eight weeks or younger) about the availability of CCC services. At a minimum, the plan must: • Identify the provider's target population (for example, teens only, all eligible families in the county, families in specific ZIP codes).	**I.B.** The provider is required to have an outreach plan available for review. The plan also must be specific to the target population and address strategies to inform eligible pregnant women about CCC services.

- Outline the strategies that will be used to inform eligible members, the local community, social service providers, schools, local health care providers, and other appropriate agencies and organizations about the availability of CCC services.

Outreach efforts could also include community presentations, informational brochures, posters, billboards, television ads, or newspaper articles.

I.C. Establish written procedures to ensure that care coordinators include members, to the full extent of their ability, in all decisions regarding appropriate services and providers.	**I.C.** Written procedures that meet the stated guidelines are available for review.
I.D. Develop and implement internal policies and procedures for ensuring that quality services are provided in accordance with Medicaid rules. At a minimum, these policies and procedures address: - Patient confidentiality. These policies must include clear statements regarding the type of information that can be released, the time period for which the authorization is valid, and the agencies or individuals to whom the information can be released. - Accuracy, legibility, and completeness of records (e.g., the accurate scoring of Child Care Coordination Family Questionnaires, the legibility of care plans and other written information, and documentation of all contacts with, or on behalf of, a member). - Procedures to ensure that priorities established in individual care plans are addressed in a timely manner. - Procedures to ensure that members are offered services that are sufficient in intensity. The procedures must include well-defined criteria for increasing or decreasing the intensity of services. - Procedures to ensure that timely and appropriate referrals are made and there is follow up on all referrals. Unless otherwise stated, follow up on referrals must be made within two weeks of the referral. - Ongoing staff training and support, including adequate supervision and support of paraprofessionals. Provide face-to-face supervision of paraprofessionals every 90 days, at a minimum. - Appropriate staff-to-client ratio. Ensure that care coordinators have an adequate amount of time to spend with each family. The number of clients per care coordinator will vary depending on the needs of the families on their caseload. - The provision of services by culturally competent staff. - The provision of services that are family-centered. - Procedures to ensure that staff are following the provider's policies and procedures for the provision of services. The policies and procedures must clearly identify: - The staff responsible for oversight of the policies and procedures. - Steps for prioritizing, monitoring, and correcting problem areas.	**I.D.** Written policies and procedures that meet the stated guidelines are available for review. Documentation of all activities that meet the stated guidelines is also available for review. Provider records indicate paraprofessional supervision every 90 days, at a minimum.
I.E. Develop written procedures and policies for determining when cases are to be closed (for example, the member no longer lives in the county, or the member has accomplished all identified goals).	**I.E.** The provider has written procedures and policies for determining when cases are to be closed.
I.F. Establish written procedures to ensure that a qualified professional reviews and signs all assessments completed by paraprofessional staff.	**I.F.** The provider has written procedures requiring the review by and signature of qualified professionals for all Family

	Questionnaires completed by paraprofessionals.
I.G. Develop a written plan for providing timely, non-disruptive, translator services for members who are hearing impaired and for members who do not speak or understand English. If the provider does not have an interpreter on staff, the provider must maintain a current list of interpreters who are "on call" to provide interpreter services. Do not use family members as interpreters when administering Family Questionnaires or for the initial care plan development. Do not use children as interpreters.	**I.G.** The provider has a written plan that meets the stated guidelines available for review. If the interpreter is not a staff member, the agency has a current list of "on call" interpreters available for review.
I.H. Develop written procedures for scheduling members for the initial assessment, initial care plan development, and for ongoing care coordination and monitoring services. The schedule should allow adequate time with each individual to address her problems, develop a plan of action, and provide information, if necessary. If possible, schedule the initial assessment within 10 working days after the request for a service or after receiving a referral. The procedures must also include guidelines for staff regarding the time frame within which the initial contact must be scheduled after the Family Questionnaire and care plan are completed.	**I.H.** Written procedures that clearly outline the provider's plans for scheduling the initial assessment, the initial care plan development, and ongoing care coordination and monitoring services must be available for review.
I.I. Develop written procedures for following up with members who fail to keep appointments (care coordination, social service, medical or other appointments). Include time frames within which the member must be contacted and the steps designed to help the member keep future appointments.	**I.I.** Written procedures that meet the stated guidelines are available for review.
I.J. Maintain a current list of appropriate community resources (for referral purposes). The list includes, but is not limited to, the following services and agencies: ● Adoption. ● AIDS/HIV. ● Adult protective services. ● Alcohol, tobacco, and other drug abuse. ● Child welfare services. ● Children with special health care needs program. ● Day care centers. ● Domestic/family violence. ● Early childhood intervention programs (e.g., Head Start, B - 3). ● Education. ● Employment/job training. ● Family planning. ● Food pantries/other food services. ● Special Supplemental Food Program for WIC programs. ● Housing and shelters for the homeless. ● Legal assistance. ● Social services (e.g., family/marriage counseling, family support services, clothing for newborns). ● Parenting education (including fathers). ● Perinatal loss/grief counseling. ● Respite/family resource centers. ● Transportation. The list(s) must include the description of services offered, name of agency, address, telephone number, contact person, and any costs associated with the services.	**I.J.** A current list of appropriate community resources - including, but not limited to, the services and agencies stated in the guidelines - and addresses, telephone numbers, and any associated costs is on file.
I.K. Establish working relationships (for the purpose of referrals) with key community agencies, social services providers, HMOs, and Medicaid primary care providers. If possible, develop written agreements that address the specific procedures to be followed for making referrals and for obtaining information on the outcome of the	**I.K.** The provider's file includes written agreements or documentation that show that the provider has made good faith efforts to develop effective working

referrals from these agencies and providers. Ensure that staff is aware of these agreements. Medicaid HMOs are required to sign a MOU with all prenatal care coordination providers in their service area. The MOUs address the provision of services to pregnant women. As appropriate, work with the HMOs to expand the cooperative agreement beyond the postpartum period.	relationships with key health and social services providers.
I.L. Establish written procedures regarding the release of member-specific information. Members may sign a general release of information. However, providers must obtain specific approval to release sensitive information about the member.	**I.L.** The provider has written policies regarding the release of member-specific information. The policies specifically address the release of sensitive information.

Family Questionnaire Administration

The provider must administer the Medicaid-approved assessment tool (the Child Care Coordination Family Questionnaire) to determine eligibility for the benefit. The assessment tool is designed to identify the member's strengths and needs. In addition to the Family Questionnaire, the provider may use any commercial or self-designed form to conduct a more detailed assessment.

All members must have a completed copy of the Family Questionnaire in their file.

Note: The Family Questionnaire includes several questions to which the member may object. Prior to administering the Family Questionnaire, explain the assessment and care planning process, acknowledge the intrusiveness of some of the questions and explain why you need to ask the questions. If necessary, share your agency's confidentiality policies with the member, including who will have access to the information provided.

Family Questionnaire Administration	
Guideline	**Performance Measurement**
The provider must complete the following:	
II.A. Administer and score the Family Questionnaire in its entirety unless the member objects to a particular question or section, or the information is unavailable.	**II.A.** The member's file includes a completed and scored Family Questionnaire. If the questionnaire is not completed in its entirety, there is documentation that explains why.
II.B. Review and finalize the Family Questionnaire in a face-to-face meeting with the member. The staff completing the Family Questionnaire must sign and date it. A qualified professional must review and sign all Family Questionnaires completed by paraprofessional staff.	**II.B.** The member's file includes documentation that the Family Questionnaire was reviewed and finalized in a face-to-face visit. The Family Questionnaire is signed and dated. The member's file also includes documentation that a qualified professional reviewed and signed all Family Questionnaires completed by paraprofessional staff.
II.C. Inform members who score 70 or more points on the Family Questionnaire that they are eligible to receive CCC services. If the member is not interested in receiving services, try to determine the reason. Give the member a written copy of the agency's address and telephone number and ask the member to call or stop by if she changes her mind.	**II.C.** The member's file documents that the member was offered CCC services. If the member is not interested in receiving services, the reason is documented. The file includes documentation that the member received a written copy of the provider's address and telephone number and was asked to call if she changes her mind about receiving services.
II.D. Inform members who score less than 70 points on the Family Questionnaire that they are not eligible to receive CCC services. Based on the member's identified needs, refer her to other community resources as appropriate. Give the member a written copy of the agency's telephone number and ask her to call or stop by if she has a significant negative change in her family, medical, social, or economic	**II.D.** The member's file includes documentation that the member was referred to other community resources as appropriate. The file also documents that the member was asked to contact the provider if she has a significant negative change in her family, medical, social, or economic status within six months. Changes to the Family

status within six months after the initial assessment. Also, the provider may reassess the member if someone, such as a health care professional, a school, or a social worker, refers her back to the provider within six months of the initial assessment. The provider may use the same Family Questionnaire if the reassessment or update is within 12 months of the initial assessment. Changes to the Family Questionnaire must be clearly identified (for example, use of different color ink, cross out old response). Do not erase or totally obliterate the original response. Re-sign and date the Family Questionnaire.	Questionnaire are legible and clearly identified. The Family Questionnaire is signed and dated.
II.E. Use a new Family Questionnaire for assessments administered after 12 months of the initial assessment.	**II.E.** The member's file includes a new Family Questionnaire if more than 12 months have elapsed since the initial assessment.

Care Plan Development

The Family Questionnaire must be completed prior to the development of the care plan. The provider is not required to use a specific care plan format. However, the care plan must be based on the results of the Family Questionnaire.

As appropriate, the activities outlined in the care plan must be aimed at the following:

- Improving family functioning.
- Improving parenting skills and positive parenting outcomes.
- Increasing members' understanding of infant and child development.
- Increasing members' access to and appropriate use of the health care delivery system.
- Improving employment outcomes.
- Encouraging planned pregnancies.
- Improving future birth outcomes.

Care Plan Development	
Guideline	**Performance Measurement**
The provider must complete the following:	
III.A. Develop a written individualized care plan for each member scoring 70 or more points on the Family Questionnaire. Develop only one care plan for each member.	**III.A.** The member's file includes an individualized care plan if the member scored 70 or more points on the Family Questionnaire.
III.B. Include the member in the development and any subsequent revisions of the care plan. Include family members and other supportive persons as appropriate. The member and provider who developed the care plan must sign and date the plan.	**III.B.** The member's file includes documentation that the member and, when appropriate, the member's family and other supportive persons actively participated in the development of the care plan. The member and provider have signed the care plan.
III.C. Inform the member that the care plan can be changed at any time, and as often as necessary. Provide the member with information on how to request changes to the care plan, including the name and telephone number of the person to contact to initiate the change.	**III.C.** The member's file includes documentation of the stated guideline.
III.D. Ensure that the care plan includes the following: • Identification and prioritization of strengths and problems identified during the initial assessment.	**III.D.** The member's file includes a care plan that meets the stated guidelines. If necessary, the care plan identifies all of the care coordinators involved with the family, addresses the role of each care coordinator, and addresses

- Identification and prioritization of all services to be arranged with the member, including the names of the service providers (including health care providers).
- A description of the member's informal support system, including collaterals, and activities planned to strengthen it if necessary.
- Appropriate referrals and planned follow up.
- Expected outcome of each referral.
- Progress or resolution of identified priorities.
- Documentation of unmet needs and gaps in service.
- Planned frequency, time, and place of contacts with the member.
- Identification of individuals who participated in the care plan development.
- The member's responsibility in the plan's implementation.

If there are other care coordinators involved with the family, the care plan must:

- Identify the role of each care coordinator.
- Address any needed collaboration or coordination.
- Address, at least every 60 days, the frequency of contacts between the care coordinators.

This requirement applies whether or not Medicaid covers the other care coordinator's services. The family's preferences concerning which care coordinator should provide services must be considered when the care coordinators' roles overlap. The need for more than one care coordinator in the family must be reassessed every 12 months.

the frequency of contacts between the care coordinators.	

III.E. At a minimum, review and update the member's care plan every 60 days for the first year of the child's life. Thereafter, review and update the care plan at least every 180 days. If necessary, update the member's care plan during each visit. All updates to the care plan must be dated and signed or initialed by the provider and the member.	**III.E.** The member's file includes documentation that the care plan was updated at least every 60 days for the first year of the child's life and reviewed and updated a minimum of every 180 days thereafter. All updates to the care plan are dated and signed or initialed by the provider and the member.
III.F. Provide the member with the written name and telephone number of: - The person who will provide the ongoing care coordination services. If necessary, introduce the member to the care coordinator if he or she is different from the person who administered the assessment and developed the care plan. - The person to contact in urgent situations or as backup when the care coordinator is unavailable.	**III.F.** The member's file includes a copy of, or documentation stating that the provider gave to the member, written information identifying the name and telephone number of the care coordinator and of the person to contact as backup.

Ongoing Child Care Coordination and Monitoring

All members must have a care plan in their file that predates the delivery of ongoing CCC services, except for in urgent situations. In such cases, the provider is required to document the urgent situation. The provider is required to document all member and collateral contacts. The documentation must include the following:

- The member's name.
- The date of the contact.
- The full name and title of the person who made the contact.
- A clear description of the reason for and nature of the contact.
- The length of time of the contact (the number of minutes or the exact time; e.g., 9:15-10:05 a.m.).
- Where or how the contact was made.

Ongoing CCC services must be based on the care plan.

For activities aimed at improving parenting skills and positive parenting outcomes, the provider must complete the following requirements:

- Establish written protocols for assessing potential/actual child abuse.
- Meet legal reporting requirements.
- Identify the frequency and intensity of monitoring those families identified as at risk for abuse.

The member's file includes documentation relative to assisting the member in obtaining services to learn about and improve life skills and all referrals and follow-up.

Ongoing Child Care Coordination and Monitoring	
Guideline	**Performance Measurement**
IV.A. On an ongoing basis, the provider must: - Determine which services identified in the care plan have been or are being delivered. - Determine if the services are adequate for the member's needs. - Provide supportive contact to ensure that the member is able to access services, is actually receiving services, or is engaging in activities specified in the care plan. - Monitor the member and the family's satisfaction with the service. - Ask the member to evaluate the quality, relevance, and desirability of the services to which she or her family have been referred. - Identify changes in the family's circumstances that would require an adjustment in the care plan.	**IV.A.** The member's file includes documentation that indicates the provider offered ongoing services as stated.
IV.C. When referring the member for services, the care coordinator must: - Ensure that the member understands the reason and need for the referral. - Inform the member of all available options for obtaining the needed service. - Explain any costs involved or limitation in the service. - Assist the member in learning how to access the service for which the referral was made, including the appropriate use of contact name, telephone number, and address. - Follow up with the service agency, including appropriate advocacy on behalf of the member to ensure that services are provided.	**IV.C.** The member's file includes copies of referrals, consent for release of information, and documentation of the coordinator's follow-up on all referrals with the member and the service provider.

Follow up on referrals within two weeks unless otherwise dictated by the urgency of the circumstance.	
IV.D. Ensure that the intensity and frequency of contacts with the member corresponds to the level of need and/or risk identified by the Family Questionnaire. For example, schedule frequent face-to-face visits if the family is in crisis, if there is violence in the home, or if the mother is a first-time parent with no support system. If necessary, call or visit the member daily or weekly. At a minimum: • Contact (face-to-face or telephone) the member every 30 days in the first 6 months. • Make face-to-face contact with the member every 60 days during the first year. • Contact (face-to-face or telephone) the member every 90 days in subsequent years. Document the reason for less frequent contacts in the member's file.	**IV.D.** The member's file includes documentation that contacts with the member correspond to the level of need/risk and includes the date, time, location, and length of member contact, progress and/or resolution of identified problems and signature of a professional reviewer. The member's file includes documentation supporting contacts with the member that are less frequent than the stated guidelines.
ACTIVITIES AIMED AT IMPROVING FAMILY FUNCTIONING	
The care coordinator must complete the following:	
IV.E. Assist the member in identifying neighborhood activities and support groups that will enhance family functioning. Follow up with the member to determine if participation occurred.	**IV.E.** The member's file includes documentation of activities and the groups identified for participation by the member and the care coordinator. The file includes documentation of participation.
IV.F. Encourage the member to establish safe behaviors. Activities to encourage safe behaviors include, but are not limited to, the following: • Assisting the member in obtaining a home safety checklist. • Assisting the member in evaluating the risk for injuries in the home and other settings where her children spend a significant amount of time. • Helping the member plan changes in the home to establish a safe environment for infants and young children. • Encouraging the member to conduct a home safety checklist at each new residence and at least annually. • Assisting the member as needed to access safety projects, including properly installed smoke detectors. In the case of rental property, assist the member in contacting and following up with the landlord if necessary.	**IV.F.** The member's file documents all safety-related assistance, including deficiencies found and plans for corrective action. The file also includes documentation of referrals and related follow-up, including any contact with the member's landlord.
IV.G. Assist the member in obtaining services to learn about and improve life skills, such as: • Consumer skills, including self-advocacy. • Home and money management, including resources for food, food budgeting, preparation, and storage. • Arranging appropriate and inexpensive family leisure activities.	**IV.G.** The member's file includes documentation relative to assisting the member in obtaining services to learn about and improve life skills, and all referrals and follow-up.
ACTIVITIES AIMED AT IMPROVING PARENTING SKILLS AND POSITIVE PARENTING OUTCOMES	
The provider must complete the following:	
IV.H. Assess the member's interpersonal relationships with the infant/child, her partner, and other family members living in the home.	**IV.H.** The member's file includes documentation of assessment, problems noted, and referrals made. The file

The assessment should include, but is not limited to, the member's strengths, weaknesses, support system, social environment, stresses, attitude toward the infant/other children, and past experiences with parenting. Refer the member for psychosocial services as appropriate. Ensure timely follow-up.	also includes documentation that the care coordinator followed up with the member to confirm that the referrals resulted in appointments.
IV.I. Immediately refer the member to a qualified professional if the member exhibits behavior that may be dangerous to herself or others. Situations requiring immediate referral must be documented in the member's file. Specifically document all known referrals to the child welfare system. Within 24 hours of making the referral, confirm that the member has made the appointment(s).	**IV.I.** The member's file includes documentation of the specific concern or behavior noted, a copy of referrals made (including specific documentation of known referrals to the child welfare system), and outcome of the referrals. The file also includes documentation that, within 24 hours of making the referral, the care coordinator followed up with the member to confirm that the referrals resulted in appointments.
IV.J. As appropriate, provide referrals for parenting education that will: • Educate the member about normal developmental milestones. • Help the member identify the early signs associated with potential developmental delays and/or emotional problems. • Help the member develop positive parenting skills. • Help the member provide a nurturing environment for her children. • Help the member develop the necessary skills to become a self-advocate and to advocate on her children's behalf. Monitor type and frequency of parenting support and training. Follow up with the member to determine if she is receiving services.	**IV.J.** The member's file includes documentation of referral for parenting education and all contacts with parenting support services. Changes in parenting behavior are documented in the member's file.
ACTIVITIES AIMED AT INCREASING MEMBERS' UNDERSTANDING OF INFANT/CHILD DEVELOPMENT	
The care coordinator must complete the following:	
IV.K. Assess the member's knowledge and understanding about nutrition and infant/child feeding practices and how these factors affect growth and development. This screening is required to begin with the first visit and is required to be followed up with periodic assessments. Refer the member to a qualified professional if knowledge deficiencies are found in any of the following topics: • Infant's hunger/fullness cues. • Infant nutrition and appropriate feeding practices. • Successful breastfeeding. • Food and/or formula preparation and storage. • Meal pattern and feeding practices for infants, toddlers, and preschool children. • Dangers of eating non-food substances (pica) and of folk remedies. • Nutrition to reduce the effects of lead poisoning (e.g., calcium-rich and iron-rich foods). Ensure timely follow-up on referrals.	**IV.K.** The member's file includes documentation of the assessment, information provided to the member, and any follow-up done by the care coordinator relative to the member's increased understanding of infant/child development.
IV.L. Assess the member's knowledge regarding basic child health and development. Refer the member to a qualified professional if deficiencies are found in any of the following areas:	**IV.L.** The member's file includes documentation of identified health education needs, the information provided, referrals given, and follow-up.

- Bathing, skin care, diaper rash.
- Normal growth and development, including developmental milestones (e.g., toilet training), and vision, hearing, speech, and motor development.
- Child nurturing and stimulation.
- Effects of secondhand smoke on infant/child health.
- Taking temperature, treatment of nausea, vomiting, fever, or dehydration.
- Injury prevention and safety, including use of car seats, falls, choking, sleep positions, and poisoning.

Ensure timely follow-up on referrals.

IV.M. Assess the member's knowledge of the steps involved in obtaining appropriate and reliable child care. Provide information or refer the member for assistance if deficiencies are found in the following areas: - Knowledge regarding available resources for checking provider references. - Evaluating child care settings for safety. - Obtaining financial assistance for child care. - Appropriate monitoring of the child care provider. - Reporting suspected child abuse or neglect by the child care provider.	**IV.M.** The member's file includes documentation of the assessment, information provided, referrals given, and follow-up.
ACTIVITIES AIMED AT INCREASING ACCESS TO AND USE OF PRIMARY HEALTH CARE SERVICES	
The care coordinator must complete the following:	
IV.N. Assist the member in accessing and appropriately using the health care delivery system. For example, ensure that the member: - Can identify the family's primary care physician(s) or clinic and HMO if appropriate. - Has health care providers' telephone numbers and addresses and knows where to find them. - Knows the proper procedures for obtaining medical information or health care after hours. - Understands how to obtain specialty care, for example, mental health/substance abuse (alcohol and other drug abuse) treatment or speech therapy. - Knows when to use the hospital emergency room. - Knows how to schedule, reschedule, and cancel appointments. Assist the member in obtaining information as appropriate.	**IV.N.** The member's file includes documentation of member's knowledge, deficiencies, and information provided as stated in the guidelines.
IV.O. Assess the member's awareness of the importance of timely immunizations and regular dental and well-child checkups (HealthCheck). Determine the member's compliance with the visit schedules for these services. Assist the member in obtaining services as appropriate. Reassess the member's compliance with the recommended schedules on an ongoing basis.	**IV.O.** The member's file includes documentation of the child's immunization, dental, and HealthCheck compliance status. If deficiencies are found, file includes documentation of referrals, appointments made, and follow up to bring family into compliance.
IV.P. Assess the member's awareness of the effects of lead poisoning. Assist the member as needed to receive recommended blood lead tests and necessary follow up services.	**IV.P.** The member's file includes dates and results of lead tests and follow up for any elevated lead test results.

IV.Q. Refer the member for additional support, assistance, and specific training to learn how to care for her child if the child is identified as having a birth defect or a special health care need.	**IV.Q.** The member's file includes documentation of the identified problem, referrals given, and follow up.
ACTIVITIES AIMED AT IMPROVING EMPLOYMENT OUTCOMES	
The care coordinator must complete the following:	
IV.R. Help the member identify employment goals and barriers to obtaining or maintaining employment. Address the following areas with the member: • Transportation problems. • Medical problems of family members. • Child day care and/or health care needs. • Appropriate conflict/grievance procedures. • Job preparation and interview skills. • Appropriate attire. • Job training or retraining needs. • Educational needs. Assist the member in obtaining services as appropriate.	**IV.R.** Member's file includes documentation of employment status and/or barriers to employment and, as appropriate, indicates referral to the appropriate agency for assistance in obtaining necessary services to support employment.
ACTIVITIES AIMED AT ENCOURAGING PLANNED PREGNANCIES	
IV.S. Assess the member's self-esteem, assertiveness, and empowerment regarding family planning decisions. Help the member determine what referrals or other actions are needed.	**IV.S.** The member's file includes documentation of referral, information provided, and any follow-up.
IV.T. Assess the member's knowledge of the following: • Family planning practices/methods. • Prevention of sexually transmitted diseases. • Continuity of basic primary and reproductive health care, including the need for mammograms and routine pap smears. Provide the member with necessary referrals, and ensure timely and appropriate follow-up on all referrals.	**IV.T.** The member's file includes written documentation of assessment and referrals related to family planning and basic health issues of the mother.
ACTIVITIES AIMED AT IMPROVING FUTURE BIRTH OUTCOMES	
IV.U. Refer the member to the WIC program, if appropriate. Ensure timely follow up.	**IV.U.** The member's file includes documentation of a WIC referral and appropriate follow-up.
IV.V. Assess the member's knowledge of the need for early and ongoing prenatal care, the importance of not smoking during pregnancy, and the importance of planned pregnancies. Provide the member with necessary referrals, and ensure timely and appropriate follow-up on all referrals.	**IV.V.** The member's file includes documentation of the assessment and any referrals made.

Initial Assessment

Providers are required to administer an initial, comprehensive risk assessment to all members, including members who received PNCC services. The purpose of the initial assessment is to determine the needs and strengths of the members. The DHS-approved tool is the Child Care Coordination Family Questionnaire.

Wisconsin Medicaid will reimburse only one comprehensive assessment per 365 days.

Medical Necessity

Wisconsin Medicaid reimburses only for services that are medically necessary as defined under DHS 101.03(96m), Wis. Admin. Code. Wisconsin Medicaid may deny or recoup payment if a service fails to meet Medicaid medical necessity requirements.

Member Payment for Covered Services

Under state and federal laws, a Medicaid-certified provider may not collect payment from a member, or authorized person acting on behalf of the member, for covered services even if the services are covered but do not meet program requirements. Denial of a claim by ForwardHealth does not necessarily render a member liable. However, a covered service for which PA was denied is treated as a noncovered service. (If a member chooses to receive an originally requested service instead of the service approved on a modified PA request, it is also treated as a noncovered service.) If a member requests a covered service for which PA was denied (or modified), the provider may collect payment from the member if certain conditions are met.

If a provider collects payment from a member, or an authorized person acting on behalf of the member, for a covered service, the provider may be subject to program sanctions including termination of Medicaid certification.

Ongoing Care Coordination and Monitoring

Ongoing care coordination and monitoring activities must be based on the member's written care plan. Ongoing care coordination and monitoring services that are not based on the member's care plan will not be covered.

Ongoing care coordination and monitoring is a covered CCC service for members who score 70 or more points on the Child Care Coordination Family Questionnaire. Except for urgent care situations, providers are required to complete the Family Questionnaire and a care plan for each member prior to providing ongoing care coordination and monitoring services. Providers may offer ongoing care coordination services on the same date they complete the Family Questionnaire and care plan.

Activities for Ongoing Care Coordination and Monitoring

Covered activities include the following:

- Member contacts.
- Collateral contacts.
- Information and referral.
- Assessment and care plan updates.
- Recordkeeping.

Member Contacts

Member contacts may be face-to-face, by telephone, or in writing, as appropriate. Member contacts for the direct provision of services are not covered. Wisconsin Medicaid reimburses for the provision of many medical services under other Medicaid benefits.

Wisconsin Medicaid does not limit the number of contacts providers may have with a member.

Care coordination services provided to Medicaid-eligible family members. Services to non-Medicaid-eligible family members (including mothers who become ineligible for Medicaid) are covered only as outlined below. The need for care coordination services provided to family members must be identified in the member's care plan and must be directly related to meeting the goals and objectives of the benefit.

Providers may assist a non-Medicaid-eligible family member in locating and accessing services only if the service is directly related to addressing the needs of the eligible member. For example, the provider is providing services to a family of four. The mother, the baby and the grandmother are all eligible for Medicaid. The baby's father is not. The baby has special health care needs. Wisconsin Medicaid will cover CCC services related to assisting the father in locating and accessing educational resources necessary to help him better meet the baby's needs. However, Wisconsin Medicaid would not cover care coordination activities related to assisting the father in accessing needed substance abuse treatment services for himself.

Collateral Contacts

A collateral is anyone who has direct supportive contact with the member, such as a family member, friend, service provider, guardian, housemate, or school official. Since the purpose of contacts with a collateral is to mobilize services and support on behalf of the member, the provider is required to identify the role of the collateral in the member's care plan.

Collateral contacts also include time spent on client-specific meetings and formal case consultations with other professionals or supervisors. Do not include time spent discussing or meeting on non-client-specific or general program issues.

Collateral contacts will be reimbursed even if there is no member contact during the month for which the provider is billing.

Information and Referral

Information and referral means providing members with current information about available resources and programs to help them gain access to needed services. Providers may complete a Referral Form, which contains reasons for the referral and an authorizatithe member. Providers are required to ensure follow up on all referrals within two weeks, unless otherwise stated. Wisconsin Medicaid reimburses information and referral under ongoing care coordination and monitoring.

Refer to the HealthCheck (EPSDT) periodicity schedule for a HealthCheck visit schedule.

Assessment and Care Plan Updates

Providers may update the Family Questionnaire and care plan, and administer other assessment tools when necessary. Wisconsin Medicaid reimburses these activities as ongoing care coordination and monitoring services.

Recordkeeping

Wisconsin Medicaid considers recordkeeping a reimbursable ongoing care coordination and monitoring activity. Reimbursable recordkeeping activities include time spent on the following:

- Updating care plans.
- Documenting member and collateral contacts.
- Preparing and responding to correspondence to and for members and collaterals.
- Documenting the member's activities in relation to the care plan.

Recordkeeping is reimbursed only if a member or collateral contact occurred during the month for which the provider is billing.

If a member or collateral contact occurs on the last day of the month, the provider may bill Medicaid for the documentation of the contact in the following month (e.g., if the contact occurred on June 30, the provider may bill for the contact with the July contacts). Wisconsin Medicaid will only allow this exception if the provider documents the contact no later than the next business day.

Provision of Services in Urgent Situations

When ongoing care coordination services are provided in an urgent situation (e.g., the family is homeless or lacks food), the provider is required to:

- Document the nature of the urgent situation.
- Complete the Family Questionnaire and care plan as soon as possible but no later than 30 days following the actions taken to alleviate the urgent situation.

Note: Providers may offer ongoing care coordination services to members in urgent situations, but Wisconsin Medicaid will not reimburse for these services when they are provided to members who score fewer than 70 points on the Family Questionnaire.

Frequency of Ongoing Monitoring

As part of the care planning process, the provider is required to discuss and document the frequency of ongoing contacts and monitoring with the member (and the member's collaterals, if appropriate). The care coordinator is required to note the rationale for contacts that are less frequent than the following:

- A contact (face-to-face or telephone) with the member every 30 days, if the member has a child aged 6 months or less.
- A face-to-face contact with the member every 60 days, if the member has a child aged 12 months or less.
- A face-to-face or telephone contact with the member every 90 days after the first year of the child's life.

When the member is a child under age 18 who is living with the parent(s) or guardian, the provider satisfies the member contact requirements if the face-to-face contact is with either the member or with the custodial parent(s) or guardian.

Reduction or Termination of Ongoing Care Coordination Services

If a provider needs to reduce or terminate ongoing care coordination services for any reason, the provider should notify the member in advance and document this in the member's record. A decision that services can be reduced or terminated should be mutually agreed upon by the provider and member. The member's file must include a statement, signed and dated by the member, indicating agreement with the decision to terminate services. Changes in the care plan should always be discussed with the member/guardian/parent.

In circumstances when the provider is unable to obtain a signature from the member for the termination of services (for example, the member consistently misses meetings with the provider and does not follow through on referrals, but indicates she wants to continue receiving CCC services), the member's file must include documentation of all attempts to contact the member through telephone logs and returned or certified mail. The provider is encouraged to provide the member with the names and addresses of other CCC providers.

If a provider terminates ongoing CCC services for any reason, the member's case is closed. However, there is no limit to the number of times a provider may reopen a member's case. The provider is required to document in the member's record why the case has been closed and reopened.

Other Care Coordinators

When multiple family members have care coordinators (case managers), the care plan must identify the role of each care coordinator. Coordinators may not duplicate services. This requirement applies whether or not Medicaid covers the other care coordinator's services. The need for more than one service coordinator in the family must be reassessed after 12 months. The family's preferences concerning which care coordinator should provide services must be considered when the care coordinators' roles overlap.

Program Requirements

For a covered service to meet program requirements, the service must be provided by a qualified Medicaid-certified provider to an enrolled member. In addition, the service must meet all applicable program requirements, including, but not limited to, medical necessity, PA, claims submission, prescription, and documentation requirements.

The following related limitations apply to PNCC and CCC services:

- Wisconsin Medicaid will only reimburse ongoing care coordination and monitoring services *once* per member, per month of service. The units billed are the sum of the time for the month.
- PNCC and CCC services are available to members who are inpatients in hospital or nursing facilities if:
  - The services do not duplicate discharge planning services that the hospital or nursing facility is required to provide.
  - The service is provided during the 30 days prior to discharge.

Resetting Service Limitations

Service limitations used by a member enrolled in the BadgerCare Plus Benchmark Plan and the BadgerCare Plus Core Plan within their continuous 12-month enrollment year will reset in the following situations:
- A fee-for-service member is enrolled in an HMO.
- A member switches from one HMO to another HMO (only allowable within the first 90 days of Core Plan enrollment).
- A member is disenrolled from an HMO and moves to fee-for-service.

Note: When a member goes from fee-for-service into an HMO and subsequently moves back to fee-for-service, service limitations will not be reset for the services that were received under the initial fee-for-service enrollment period.

PA requests for services beyond the covered service limitations will be denied.

Resetting service limitations does not change a member's Benchmark Plan enrollment year or a member's Core Plan enrollment year.

Services That Do Not Meet Program Requirements

As stated in DHS 107.02(2), Wis. Admin. Code, BadgerCare Plus may deny or recoup payment for covered services that fail to meet program requirements.

Examples of covered services that do not meet program requirements include the following:

- Services for which records or other documentation were not prepared or maintained.
- Services for which the provider fails to meet any or all of the requirements of DHS 106.03, Wis.Admin. Code, including, but not limited to, the requirements regarding timely submission of claims.
- Services that fail to comply with requirements or state and federal statutes, rules, and regulations.
- Services that the DHS, the PRO review process, or BadgerCare Plus determines to be inappropriate, in excess of accepted standards of reasonableness or less costly alternative services, or of excessive frequency or duration.
- Services provided by a provider who fails or refuses to meet and maintain any of the certification requirements under DHS 105, Wis. Admin. Code.
- Services provided by a provider who fails or refuses to provide access to records.
- Services provided inconsistent with an intermediate sanction or sanctions imposed by the DHS.

Wisconsin Medicaid Managed Care

CCC services are not covered by state-contracted Medicaid HMOs or special managed care programs (such as programs for people with disabilities). Therefore, providers should submit claims for CCC services directly to Wisconsin Medicaid for members enrolled in these programs.

Noncovered Services

Benchmark Plan Noncovered Services

The following services are not covered under the BadgerCare Plus Benchmark Plan:

- Case management.
- CCC.
- Enteral nutrition products.
- PDN, including PDN for ventilator-dependent members.
- Personal care.
- SMV and common carrier transportation.

Core Plan Noncovered Services

The following services are not covered under the BadgerCare Plus Core Plan:

- Case management.
- Enteral nutrition products.
- Hearing services, including hearing instruments, cochlear implants, bone-anchored hearing devices, hearing aid batteries, and repairs.
- Home care services (home health, personal care, PDN).
- Inpatient mental health and substance abuse treatment services.
- Non-emergency transportation (i.e., common carrier, SMV).
- Nursing home.
- PNCC.
- Routine vision services (CPT codes 92002-92015); vision materials such as glasses, contact lenses, and ocular prosthetics; repairs to vision materials; and services related to the fitting of contact lenses and spectacles.
- SBS.

Services that exceed a service limitation established under the BadgerCare Plus Core Plan are considered noncovered. Providers are required to follow certain procedures for billing members who receive these services.

Billing Members for Noncovered Services

Services rendered during a noncovered home health visit will not be reimbursed by ForwardHealth. Providers are encouraged to inform the member when he or she has reached a service limitation. If a member requests a service that exceeds the limitation, the member is responsible for payment. Providers should make payment arrangements with the member in advance. Providers may bill members up to their usual and customary charges for noncovered services.

Definition of Noncovered Services

A noncovered service is a service, item, or supply for which reimbursement is not available. DHS 101.03(103) and 107, Wis. Admin. Code, contain more information about noncovered services. In addition, DHS 107.03, Wis. Admin. Code, contains a general list of noncovered services.

Member Payment for Noncovered Services

A provider may collect payment from a member for noncovered services if certain conditions are met.

Providers may not collect payment from a member, or authorized person acting on behalf of the member, for certain noncovered services or activities provided in connection with covered services, including the following:

- Charges for missed appointments.
- Charges for telephone calls.
- Charges for time involved in completing necessary forms, claims, or reports.
- Translation services.

Missed Appointments

The federal CMS does not allow state Medicaid programs to permit providers to collect payment from a member, or authorized person acting on behalf of the member, for a missed appointment.

Avoiding Missed Appointments

ForwardHealth offers the following suggestions to help avoid missed appointments:

- Remind members of upcoming appointments (by telephone or postcard) prior to scheduled appointments.
- Encourage the member to call his or her local county or tribal agency if transportation is needed.
- If the appointment is made through the HealthCheck screening or targeted case management programs, encourage the staff from those programs to ensure that the scheduled appointments are kept.

Translation Services

Translation services are considered part of the provider's overhead cost and are not separately reimbursable. Providers may not collect payment from a member, or authorized person acting on behalf of the member, for translation services.

Providers should call the Affirmative Action and Civil Rights Compliance Officer at (608) 266-9372 for information about when translation services are required by federal law. Providers may also write to the following address:

AA/CRC Office
1 W Wilson St Rm 561
PO Box 7850
Madison WI 53707-7850

Member Information

4

Member Information:Enrollment Categories

BadgerCare Expansion for Certain Pregnant Women

As a result of 2005 Wisconsin Act 25, the 2005-07 biennial budget, BadgerCare has expanded coverage to the following individuals:

- Pregnant non-U.S. citizens who are not qualified aliens but meet other eligibility criteria for BadgerCare.
- Pregnant individuals detained by legal process who meet other eligibility criteria for BadgerCare.

The BadgerCare Expansion for Certain Pregnant Women is designed to provide better birth outcomes.

Women are eligible for all covered services from the first of the month in which their pregnancy is verified or the first of the month in which the application for BadgerCare Plus is filed, whichever is later. Members are enrolled through the last day of the month in which they deliver or the pregnancy ends. Postpartum care is reimbursable *only* if provided as part of global obstetric care. Even though enrollment is based on pregnancy, these women are eligible for *all* covered services. (They are not limited to pregnancy-related services.)

These women are not presumptively eligible. Providers should refer them to the appropriate county/tribal social or human services agency where they can apply for this coverage.

Fee-for-Service

Pregnant non-U.S. citizens who are not qualified aliens and pregnant individuals detained by legal process receive care only on a fee-for-service basis. Providers are required to follow all program requirements (e.g., claims submission procedures, PA requirements) when providing services to these women.

Emergency Services for Non-U.S. Citizens

When BadgerCare Plus enrollment ends for pregnant non-U.S. citizens who are not qualified aliens, they receive coverage for emergency services. These women receive emergency coverage for 60 days after the pregnancy ends; this coverage continues through the end of the month in which the 60th day falls (e.g., a woman who delivers on June 20, 2006, would be enrolled through the end of August 2006).

BadgerCare Plus Core Plan

The BadgerCare Plus Core Plan covers basic health care services including primary care, preventive care, certain generic and OTC drugs, and a limited number of brand name drugs.

Core Plan Implementation

In the first phase of Core Plan implementation, individuals enrolled in the Milwaukee GAMP and certain other counties' GA medical programs were automatically transitioned into the Core Plan effective January 1, 2009. Services were covered under fee-for-service. Effective April 1, 2009, members transitioned from GAMP began their enrollment process in one of the state-contracted HMOs that serve Wisconsin's Medicaid and BadgerCare Plus population.

In the second phase of implementation, BadgerCare Plus began accepting applications from the general public for enrollment in the Core Plan as of June 15, 2009. The second phase opens enrollment to certain low-income adults with no dependent children. The earliest date of coverage and benefits is July 15, 2009. Services will be covered under fee-for-service until members are enrolled in

an HMO. All new Core Plan members will be required to enroll in an HMO under the following circumstances: there are two or more HMOs in the member's area, or there is one HMO in the member's area and the member resides in a designated rural county where federal requirements allow mandatory HMO enrollment. New Core Plan members will receive HMO enrollment materials in the mail to select an HMO. The earliest date of HMO enrollment for new Core Plan members will be October 1, 2009.

Applicant Enrollment Requirements

An applicant must meet the following enrollment requirements in order to qualify for the Core Plan:

- Is a Wisconsin resident.
- Is a United States citizen or legal immigrant.
- Is between the ages of 19 and 64.
- Does not have any children under age 19 under his or her care.
- Is not pregnant.
- Is not eligible for or enrolled in Medicaid, the BadgerCare Plus Standard Plan, or the BadgerCare Plus Benchmark Plan. This would not include benefits provided under the FPW or those benefits provided to individuals who qualify for TB-Only.
- Is not eligible for or enrolled in Medicare.
- Has a monthly gross income that does not exceed 200 percent of the FPL.
- Is not covered by health insurance currently or in the previous 12 months.
- Has not had access to employer-sponsored insurance in the previous 12 months and does not have access to employer-subsidized insurance during the month of application or any of the three months following application.

Application Process for New Members

The Core Plan application process will be streamlined and user-friendly. Individuals who wish to enroll may apply for the Core Plan using the Access tool online or via the ESC toll-free telephone number, (800) 291-2002. A pre-screening tool will help determine which individuals may be eligible to enroll in the Core Plan. Applications for Core Plan members will be processed centrally by the ESC, not by county agencies.

To complete the application process, applicants must meet the following requirements:

- Complete a Health Survey.
- Pay a non-refundable, annual processing fee of $60.00 per individual or per couple for married couples. The fee will be waived for homeless individuals. There are no monthly premiums.

Medicaid-certified providers cannot pay the $60.00 application processing fee on behalf of Core Plan applicants. An offer by a Medicaid-certified provider to pay a fee on behalf of a prospective Medicaid member may violate federal laws against kickbacks. These laws are federal criminal statutes that are interpreted and enforced by federal agencies such as the United States DOJ and the Department of HHS's OIG.

Conditions That End Member Enrollment in the Core Plan

A member's enrollment will end if the member:

- Becomes eligible for Medicare, Medicaid, the Standard Plan, or the Benchmark Plan.
- Becomes incarcerated or institutionalized in an IMD.
- Becomes pregnant.
- No longer resides in the state of Wisconsin.
- Obtains health insurance coverage.
- Turns 65 years of age.

Providers are reminded that the Core Plan does not cover obstetrical services, including the delivery of a child or children. A Core

Plan member who becomes pregnant should be referred to the ESC at (800) 291-2002 for more information about enrollment in the Standard Plan or the Benchmark Plan.

Enrollment Certification Period for Core Plan Members

Once determined eligible for enrollment in the Core Plan, a member's enrollment will begin either on the first or 15th of the month, whichever is first, and will continue through the end of the 12th month. For example, if the individual submits all of his or her application materials, including the application fee, by September 17, 2009, and the DHS reviews the application and approves it on October 6, 2009, the individual is eligible for enrollment beginning on October 15, 2009, the next possible date of enrollment. The enrollment certification period will continue through October 31, 2010.

The enrollment certification period for individuals who qualify for the Core Plan is 12 months, regardless of income changes.

Core Plan Members Enrolled in Wisconsin Chronic Disease Program

For Core Plan members who are also enrolled in WCDP, providers should submit claims for all covered services to the Core Plan first and then to WCDP. For pharmacy services, if both programs deny the pharmacy claim, providers should submit claims to BadgerRx Gold.

Core Plan Members with HIRSP Coverage

Core Plan members may also be enrolled in HIRSP as long as the member meets the eligibility requirements for both the Core Plan and HIRSP. For Core Plan members who are also enrolled in HIRSP, providers should submit claims for all Core Plan covered services to the Core Plan. For services not covered by the Core Plan, providers should submit claims to HIRSP. HIRSP is always the payer of last resort.

Note: HIRSP will only cover noncovered Core Plan services if the services are covered under the HIRSP benefit.

BadgerCare Plus Standard Plan and Benchmark Plan

BadgerCare Plus is a state-sponsored health care program that expands coverage of Wisconsin residents and ensures that all children in Wisconsin have access to affordable health care.

The key initiatives of BadgerCare Plus are:

- To ensure that all Wisconsin children have access to affordable health care.
- To ensure that 98 percent of Wisconsin residents have access to affordable health care.
- To streamline program administration and enrollment rules.
- To expand coverage and provide enhanced benefits for pregnant women.
- To promote prevention and healthy behaviors.

BadgerCare Plus expands enrollment in state-sponsored health care to the following:

- All uninsured children.
- More pregnant women.
- More parents and caretaker relatives.
- Parents with children in foster care who are working to reunify their families.
- Young adults exiting out-of-home care, such as foster care, because they have turned 18 years of age.
- Certain farmers and other self-employed parents and caretaker relatives.

Where available, BadgerCare Plus members will be enrolled in BadgerCare Plus HMOs. In those areas of Wisconsin where HMOs are not available, services will be reimbursed on a fee-for-service basis.

Benefit Plans Under BadgerCare Plus

BadgerCare Plus is comprised of three benefit plans, the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, and the BadgerCare Plus Core Plan.

BadgerCare Plus Standard Plan

The Standard Plan covers children, parents and caretaker relatives, young adults aging out of foster care, and pregnant women with incomes at or below 200 percent of the FPL. The services covered under the Standard Plan are the same as the Wisconsin Medicaid program.

BadgerCare Plus Benchmark Plan

The Benchmark Plan was adapted from Wisconsin's largest commercial, low-cost health care plan. The Benchmark Plan is for children and pregnant women with incomes above 200 percent of the FPL and certain self-employed parents, such as farmers with incomes above 200 percent of the FPL. The services covered under the Benchmark Plan are more limited than those covered under the Wisconsin Medicaid program.

BadgerCare Plus Core Plan

The Core Plan provides adults who were previously not eligible to enroll in state and federal health care programs with access to basic health care services including primary care, preventive care, certain generic and OTC drugs, and a limited number of brand name drugs.

Express Enrollment for Children and Pregnant Women

EE for Pregnant Women Benefit is a limited benefit category that allows a pregnant woman to receive immediate pregnancy-related outpatient services while her application for full-benefit BadgerCare Plus is processed. Enrollment is not restricted based on the member's other health insurance coverage. Therefore, a pregnant woman who has other health insurance may be enrolled in the benefit.

To determine enrollment for EE for Pregnant Women, providers should use the income limits for 200 percent and 300 percent of the [FPL](#).

The EE for Children Benefit allows certain members under 18 years of age to receive BadgerCare Plus benefits under the BadgerCare Plus Standard Plan while an application for BadgerCare Plus is processed.

Fee-for-Service

Women and children who are temporarily enrolled in BadgerCare Plus through the EE process are not eligible for enrollment in an HMO until they are determined eligible for full benefit BadgerCare Plus by the county/tribal office.

Family Planning Waiver

The FPW is a limited benefit program that provides routine contraceptive-related services to low-income women age 15 through 44 who are otherwise not eligible for Wisconsin Medicaid or BadgerCare Plus. Members receiving FPW services must be receiving routine contraceptive-related services.

The goal of the FPW is to provide women with information and services to assist them in preventing pregnancy, making BadgerCare Plus enrollment due to pregnancy less likely. Providers should explain the purpose of the FPW to women and encourage them to contact their local county or tribal agency to determine their enrollment options if they are not interested in receiving, or do not wish to receive, contraceptive services.

Members enrolled in the FPW receive routine services to prevent or delay pregnancy. In addition, FPW members may receive certain reproductive health services if the services are determined medically necessary during contraceptive-related FPW services. Only services *clearly* related to contraceptive management are covered under the FPW.

Providers should inform women about other service options and provide referrals for care not covered by the FPW.

FPW members are not eligible for other services that are covered under full-benefit Medicaid and BadgerCare Plus (e.g., PT services, dental services). Even if a medical condition is discovered during a contraceptive-related FPW service, treatment for the condition is not covered under the FPW unless the treatment is identified in the list of allowable procedure codes for FPW services. They are also not eligible for other family planning services that are covered under full-benefit Wisconsin Medicaid and BadgerCare Plus (e.g., mammograms and hysterectomies). If a medical condition, other than an STD, is discovered during contraceptive-related services, treatment for the medical condition is not covered under the FPW.

Colposcopies and treatment for STDs are only covered through the FPW if they are determined medically necessary during routine contraceptive-related services. A colposcopy is a covered service when an abnormal result is received from a pap test, prior to the colposcopy, while the member is in the FPW program and receiving contraceptive-related services.

FPW members diagnosed with cervical cancer, precancerous conditions of the cervix, or breast cancer may be eligible for Wisconsin Well Woman Medicaid. Providers should assist eligible members with the enrollment process for Well Woman Medicaid.

Providers should inform women about other service options and provide referrals for care not covered by FPW.

Temporary Enrollment for the Family Planning Waiver

Women whose providers are submitting an initial FPW application on their behalf and who meet the enrollment criteria may receive routine contraceptive-related services immediately through TE for the FPW for up to three months. Services covered under the TE for the FPW are the same as those covered under the FPW and must be clearly related to routine contraceptive management.

To determine enrollment for the FPW, providers should use the income limit for 200 percent of the FPL.

TE for the FPW providers may issue white paper TE for BadgerCare Plus FPW Plan temporary identification cards for women to use until they receive a ForwardHealth identification card. Providers should remind women that the benefit is temporary, despite their receiving a ForwardHealth card.

ForwardHealth and ForwardHealth interChange

ForwardHealth brings together many DHS health care programs with the goal to create efficiencies for providers and to improve health outcomes for members. ForwardHealth interChange is the DHS claims processing system that supports multiple state health care programs and Web services, including:

- BadgerCare Plus.
- BadgerCare Plus and Medicaid managed care programs.
- SeniorCare.
- WCDP.
- WIR.
- Wisconsin Medicaid.
- Wisconsin Well Woman Medicaid.

- WWWP.

ForwardHealth interChange is supported by the state's fiscal agent, HP.

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for selected groups of people who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Wisconsin Medicaid is also known as the Medical Assistance Program, WMAP, MA, Title XIX, or T19.

A Medicaid member is any individual entitled to benefits under Title XIX of the Social Security Act and under the Medical Assistance State Plan as defined in ch. 49, Wis. Stats.

Wisconsin Medicaid enrollment is determined on the basis of financial need and other factors. A citizen of the United States or a "qualified immigrant" who meets low-income financial requirements may be enrolled in Wisconsin Medicaid if he or she is in one of the following categories:

- Age 65 and older.
- Blind.
- Disabled.

Some needy and low-income people become eligible for Wisconsin Medicaid by qualifying for programs such as:

- Katie Beckett.
- Medicaid Purchase Plan.
- Subsidized adoption and foster care programs.
- SSI.
- WWWP.

Providers may advise these individuals or their representatives to contact their certifying agency for more information. The following agencies certify people for Wisconsin Medicaid enrollment:

- Local county or tribal agencies.
- Medicaid outstation sites.
- SSA offices.

In limited circumstances, some state agencies also certify individuals for Wisconsin Medicaid.

Medicaid fee-for-service members receive services through the traditional health care payment system under which providers receive a payment for each unit of service provided. Some Medicaid members receive services through state-contracted MCOs.

Wisconsin Well Woman Medicaid

Wisconsin Well Woman Medicaid provides full Medicaid benefits to underinsured or uninsured women ages 35 to 64 who have been screened and diagnosed by WWWP or the FPW, meet all other enrollment requirements, and are in need of treatment for any of the following:

- Breast cancer.
- Cervical cancer.

- Precancerous conditions of the cervix.

Services provided to women who are enrolled in Well Woman Medicaid are reimbursed through Medicaid fee-for-service.

Members Enrolled into Wisconsin Well Woman Medicaid from Benchmark Plan or Core Plan

Women diagnosed with breast cancer or cervical cancer while enrolled in the BadgerCare Plus Benchmark Plan or BadgerCare Plus Core Plan for Adults with No Dependent Children are eligible to be enrolled in Wisconsin Well Woman Medicaid. Wisconsin Well Woman Medicaid covers the same services as Wisconsin Medicaid and enables members to receive comprehensive treatment, including services not related to their diagnosis.

Women who are diagnosed with breast cancer, cervical cancer, or a precancerous condition of the cervix must have the diagnosis of their condition confirmed by one of the following Medicaid-certified providers:

- Nurse practitioners, for cervical conditions only.
- Osteopaths.
- Physicians.

Women with Medicare or other insurance that covers treatment for her cancer are not allowed to be enrolled into WWWMA.

Covered and Noncovered Services

Wisconsin Well Woman Medicaid covers the same services as Wisconsin Medicaid regardless of whether the service is related to her cancer treatment.

Reimbursement

Providers will be reimbursed for services provided to members enrolled in WWWMA at the Wisconsin Medicaid rate of reimbursement for covered services. Providers are required to reimburse members for any copayments members paid on or after the date of diagnosis while still enrolled in the Benchmark Plan or the Core Plan.

Copayments

There are no copayments for any Medicaid covered service for WWWMA members who have been enrolled into WWWMA from the Benchmark or the Core Plan.

Enrollment Responsibilities

General Information

Members have certain responsibilities per DHS 104.02, Wis. Admin. Code, and the Medicaid Enrollment and Benefits booklet or the BadgerCare Plus Enrollment and Benefits booklet.

Loss of Enrollment — Financial Liability

Some covered services consist of a series of sequential treatment steps, meaning more than one office visit is required to complete treatment.

In most cases, if a member loses enrollment midway through treatment, BadgerCare Plus will *not* reimburse services (including prior authorized services) after enrollment has lapsed.

Members are financially responsible for any services received after their enrollment has been terminated. If the member wishes to continue treatment, it is a decision between the provider and the member whether the service should be given and how the services will be paid. The provider may collect payment from the member if the member accepts responsibility for payment of a service and certain conditions are met.

To avoid misunderstandings, it is recommended that providers remind members that they are financially responsible for any continued care after enrollment ends.

To avoid potential reimbursement problems that can arise when a member loses enrollment midway through treatment, the provider is encouraged to verify the member's enrollment using the EVS or the ForwardHealth Portal prior to providing each service, even if an approved PA request is obtained for the service.

Member Cooperation

Members are responsible for giving providers full and accurate information necessary for the correct submission of claims. If a member has other health insurance, it is the member's obligation to give full and accurate information to providers regarding the insurance.

Members Should Present Card

It is important that providers determine a member's enrollment and other insurance coverage *prior to* each DOS that services are provided. Pursuant to DHS 104.02(2), Wis. Admin. Code, a member should inform providers that he or she is enrolled in BadgerCare Plus or Wisconsin Medicaid and should present a current ForwardHealth identification card before receiving services.

Note: Due to the nature of their specialty, certain providers — such as anesthesiologists, radiologists, DME suppliers, independent laboratories, and ambulances — are not always able to see a member's ForwardHealth identification card because they might not have direct contact with the member prior to providing the service. In these circumstances, it is still the provider's responsibility to obtain member enrollment information.

Prior Identification of Enrollment

Except in emergencies that preclude prior identification, members are required to inform providers that they are receiving benefits and must present their ForwardHealth identification card before receiving care. If a member forgets his or her ForwardHealth card, providers may verify enrollment without it.

Reporting Changes to Caseworkers

Members are required to report certain changes to their caseworker at their certifying agency. These changes include, but are not limited to, the following:

- A new address or a move out of state.
- A change in income.
- A change in family size, including pregnancy.
- A change in other health insurance coverage.
- Employment status.
- A change in assets for members who are over 65 years of age, blind, or disabled.

Enrollment Rights

Appealing Enrollment Determinations

Applicants and members have the right to appeal certain decisions relating to BadgerCare Plus or Medicaid enrollment. An applicant, a member, or authorized person acting on behalf of the applicant or member, or former member may file the appeal with the DHA.

Pursuant to HA 3.03, Wis. Admin. Code, an applicant, member, or former member may appeal any adverse action or decision by an agency or department that affects their benefits. Examples of decisions that may be appealed include, but are not limited to, the following:

- Individual was denied the right to apply.
- Application for BadgerCare Plus or Wisconsin Medicaid was denied.
- Application for BadgerCare Plus or Wisconsin Medicaid was not acted upon promptly.
- Enrollment was unfairly discontinued, terminated, suspended, or reduced.

In the case when enrollment is cancelled or terminated, the date the member, or authorized person acting on behalf of the member, files an appeal with the DHA determines what continuing coverage, if any, the member will receive until the hearing decision is made. The following scenarios describe the coverage allowed for a member who files an appeal:

- If a member files an appeal before his or her enrollment ends, coverage will continue pending the hearing decision.
- If a member files an appeal within 45 days after his or her enrollment ends, a hearing is allowed but coverage is not reinstated.

If the member files an appeal more than 45 days after his or her enrollment ends, a hearing is not allowed. Members may file an appeal by submitting a Request for Fair Hearing form.

Claims for Appeal Reversals

If a claim is denied due to termination of enrollment, a hearing decision that reverses that determination will allow the claim to be resubmitted and paid. The provider is required to obtain a copy of the appeal decision from the member, attach the copy to the previously denied claim, and submit both to ForwardHealth at the following address:

ForwardHealth
Specialized Research
Ste 50
6406 Bridge Rd
Madison WI 53784-0050

If a provider has not yet submitted a claim, the provider is required to submit a copy of the hearing decision along with a paper claim to Specialized Research.

As a reminder, claims submission deadlines still apply even to those claims with hearing decisions.

Freedom of Choice

Members may receive covered services from *any* willing Medicaid-certified provider, unless they are enrolled in a state-contracted MCO or assigned to the Member Lock-In Program.

For members, participation in the CCC program is voluntary. The member voluntarily participates in the program by maintaining

contact with and receiving services from the care coordination provider. The care coordination provider may not "lock-in" members or deny the members' freedom to choose providers. Members may participate, to the full extent of their ability, in all decisions regarding appropriate services and providers.

General Information

Members are entitled to certain rights per DHS 103, Wis. Admin. Code.

Notification of Discontinued Benefits

When the DHS intends to discontinue, suspend, or reduce a member's benefits, or reduce or eliminate coverage of services for a general class of members, the DHS sends a written notice to members. This notice is required to be provided at least 10 days before the effective date of the action.

Prompt Decisions on Enrollment

Individuals applying for BadgerCare Plus or Wisconsin Medicaid have the right to prompt decisions on their applications. Enrollment decisions are made within 60 days of the date the application was signed for those with disabilities and within 30 days for all other applicants.

Requesting Retroactive Enrollment

An applicant has the right to request retroactive enrollment when applying for BadgerCare Plus or Wisconsin Medicaid. Enrollment may be backdated to the first of the month three months prior to the date of application for eligible members. Retroactive enrollment does not apply to QMB-Only members.

Identification Cards

ForwardHealth Core Plan Identification Cards

Beginning in July 2009, new members enrolled in the BadgerCare Plus Core Plan will receive a [ForwardHealth Core Plan card](). All identification cards include the member's name and 10-digit member identification number. The identification cards may be used to verify a member's enrollment, but possession of an identification card does not guarantee enrollment. It is possible that a member will present a card when he or she is not enrolled; therefore, it is essential that providers verify enrollment before providing services.

Core Plan members should call the ESC with questions about enrollment criteria, HMO enrollment, and covered services. The ForwardHealth Core Plan cards include the Enrollment Services Center telephone number, (800) 291-2002, on the back.

Members who transitioned from Milwaukee's GAMP or other counties' GA medical programs in January 2009 currently have ForwardHealth cards and will begin receiving ForwardHealth Core Plan cards when they re-enroll in the Core Plan in 2010.

Providers should always check enrollment for a member who presents a ForwardHealth card to verify if the member is enrolled in the Core Plan or in one of the other ForwardHealth programs. Members who present a ForwardHealth card or a ForwardHealth Core Plan card may have been enrolled in a different plan since the card was issued. Providers should be careful to verify the plan in which the member is enrolled and know which services are covered under that plan.

ForwardHealth Identification Cards

Each enrolled member receives an identification card. Possession of a program identification card does not guarantee enrollment. It is possible that a member will present a card during a lapse in enrollment; therefore, it is essential that providers verify enrollment before providing services. Members are told to keep their cards even though they may have lapses in enrollment.

ForwardHealth Identification Card Features

The [ForwardHealth identification card]() includes the member's name, 10-digit member ID, magnetic stripe, signature panel, and the Member Services telephone number. The card also has a unique, 16-digit card number on the front for internal program use.

The ForwardHealth card does not need to be signed to be valid; however, adult members are encouraged to sign their cards. Providers may use the signature as another means of identification.

The toll-free number on the back of each of the cards is for member use only. The address on the back of each card is used to return a lost card to ForwardHealth if it is found.

If a provider finds discrepancies with the identification number or name between what is indicated on the ForwardHealth card and the provider's file, the provider should verify enrollment with Wisconsin's EVS.

Identification Number Changes

Some providers may question whether services should be provided if a member's 10-digit identification number on his or her ForwardHealth card does not match the EVS response. If the EVS indicates the member is enrolled, services should be provided.

A member's identification number may change, and the EVS will reflect that change. However, ForwardHealth does not automatically send a replacement ForwardHealth card with the new identification number to the member. ForwardHealth cross-references the old and new identification numbers so a provider may submit claims with either number. The member may request a replacement

ForwardHealth card that indicates the new number.

Member Name Changes

If a member's name on the ForwardHealth card is different than the response given from Wisconsin's EVS, providers should use the name from the EVS response. When a name change is reported and on file, a new card will automatically be sent to the member.

Deactivated Cards

When any member identification card has been replaced for any reason, the previous identification card is deactivated. If a member presents a deactivated card, providers should encourage the member to discard the deactivated card and use only the new card.

Although a member identification card may be deactivated, the member ID is valid and the member still may be enrolled in a ForwardHealth program.

If a provider swipes a ForwardHealth card using a magnetic stripe card reader and finds that it has been deactivated, the provider may request a second form of identification if he or she does not know the member. After the member's identity has been verified, providers may verify a member's enrollment by using one of the EVS methods such as AVR.

Defective Cards

If a provider uses a card reader for a ForwardHealth card and the magnetic stripe is defective, the provider should encourage the member to call Member Services at the number listed on the back of the member's card to request a new card.

If a member presents a ForwardHealth card with a defective magnetic stripe, providers may verify the member's enrollment by using an alternate enrollment verification method. Providers may also verify a member's enrollment by entering the member ID or 16-digit card number on a touch pad, if available, or by calling WiCall or Provider Services.

Lost Cards

If a member needs a replacement ForwardHealth card, he or she may call Member Services to request a new one.

If a member lost his or her ForwardHealth card or never received one, the member may call Member Services to request a new one.

Managed Care Organization Enrollment Changes

Members do not receive a new ForwardHealth card if they are enrolled in a state-contracted MCO or change from one MCO to another. Providers should verify enrollment with the EVS every time they see a member to ensure they have the most current managed care enrollment information.

Temporary Enrollment for BadgerCare Plus Family Planning Waiver Plan Temporary Cards

Qualified providers may issue white paper TE for BadgerCare Plus FPW Plan identification cards for women to use temporarily until they receive a ForwardHealth identification card. The identification card is included with the TE for BadgerCare Plus FPW Plan Application.

The TE for the FPW identification cards have the following message printed on them: "BadgerCare Plus Temporary Identification Card for Temporary Enrollment for the Family Planning Waiver Plan." Providers should accept the white TE for the FPW identification cards as proof of enrollment for the dates provided on the cards and are encouraged to keep a photocopy of the card.

Temporary Express Enrollment Cards

There are two types of temporary EE identification cards. One is issued for pregnant women and the other for children that are enrolled in BadgerCare Plus through EE. The EE cards are vaild for 14 days. Samples of temporary EE cards for children and pregnant women are available.

Providers may assist pregnant women with filling out an application for temporary ambulatory prenatal care benefits (formerly known as PE) through the online EE process. Express Enrollment identification cards are included on the bottom portion of the enrollment notice that is printed out and provided to the member after the on-line enrollment process is completed.

The paper application may also be used to apply for temporary ambulatory prenatal benefits for pregnant women. The beige paper identification card is attached to the last page of the application and provided to the woman after she completes the enrollment process. A sample of an EE temporary card from the back of the EE application is available.

The online EE process is also available for adults to apply for full BadgerCare Plus benefits for children. EE identification cards are included on the bottom portion of the enrollment notice that is printed out and provided to the member after the online enrollment process is completed. This temporary identification card is different, since providers may see more than one child listed if multiple children in one household are enrolled through EE. However; each child will receive his or her own ForwardHealth card after the application is submitted.

Each member who is enrolled through EE will receive a ForwardHealth card usually within three business days after the EE application is submitted and approved. To ensure children and pregnant women receive needed services in a timely manner, providers should accept the printed paper EE cards for children and either the printed paper EE card or the beige identification cards for pregnant women as proof of enrollment for the dates provided on the cards. Providers may use Wisconsin's EVS to verify enrollment for dates of service after those printed on the card. Providers are encouraged to keep a photocopy of the card.

Information is available for dates of service before April 1, 2009.

Temporary ForwardHealth Identification Cards

All Medicaid certifying agencies have the authority to issue green paper temporary identification cards to applicants who meet enrollment requirements. Temporary cards are usually issued only when an applicant is in need of medical services prior to receiving the ForwardHealth card. Providers should accept temporary cards as proof of enrollment. Eligible applicants may receive covered services for the dates shown on the card.

Providers are encouraged to keep a photocopy of the temporary card and should delay submitting claims for one week from the enrollment start date until the enrollment information is transmitted to ForwardHealth.

ForwardHealth accepts properly completed and submitted claims for covered services provided to applicants possessing a temporary card as long as the DOS is within the dates shown on the card.

If a claim is denied with an enrollment-related explanation, even though the provider verified the member's enrollment before providing the service, a good faith claim may be submitted.

Types of Identification Cards

ForwardHealth members receive an identification card upon initial eligibility determination. Identification cards may be in any of the following formats:

- White plastic ForwardHealth cards.

- White plastic ForwardHealth Core Plan cards.
- Green paper temporary cards.
- Paper printout temporary card for EE for children.
- Paper printout temporary card for EE for pregnant women.
- Beige paper temporary card for EE for pregnant women.
- White paper TE for the FPW cards.

Misuse and Abuse of Benefits

Examples of Member Abuse or Misuse

Examples of member abuse or misuse are included in DHS 104.02(5), Wis. Admin. Code.

Member Lock-In Program

If ForwardHealth determines that a member is abusing BadgerCare Plus or Medicaid services, the member may be required to designate a health care provider under the Member Lock-In Program. (A member has the right to appeal this action.) Members are required to designate, in any or all categories of health care, a Medicaid-certified provider of their choice. If a member fails to choose a provider, ForwardHealth may designate one based on claims data.

ForwardHealth notifies the member's chosen health care provider by letter. Another letter is also sent to the member. The provider has the option to decline to act as the selected health care provider for the member.

A member in the Lock-In Program who has already designated a provider can only receive the locked-in services from his or her designated provider. A provider who is *not* the designated provider of a Lock-In Program member for the locked-in services should not perform services for that member unless a referral is in place from the Lock-In provider.

Claims for restricted, nonemergency services performed by a provider who is not the designated provider are reviewed by ForwardHealth and may be denied.

Providers may obtain Lock-In information by using any of the enrollment verification methods. To obtain the name of the designated Lock-In provider, call Provider Services.

Providers May Make Referrals

The designated Lock-In provider may make referrals to other providers of medical services. ForwardHealth supplies Lock-In Program providers with referral forms that should be used when it is necessary to refer the member to another provider.

Reimbursement is made if the referral can be documented as medically necessary and the services are covered.

Providers may receive reimbursement for emergency services given without a referral to a locked-in member if the claim is accompanied by a full explanation of the emergency circumstances.

The designated provider is required to maintain all appropriate documentation in the member's medical records.

Notifying ForwardHealth

Providers are required to notify ForwardHealth if they have reason to believe that a person is misusing or abusing BadgerCare Plus or Medicaid benefits or the ForwardHealth identification card. Section 49.49, Wis. Stats., defines actions that represent member misuse or abuse of benefits and the resulting sanctions that may be imposed. Providers are under no obligation to inform the member that they are doing so. A provider may not confiscate a ForwardHealth card from a member in question.

If a provider suspects that a member is abusing his or her benefits or misusing his or her ForwardHealth card, providers are required to notify ForwardHealth by calling Provider Services or by writing to the following office:

Division of Health Care Access and Accountability
Bureau of Program Integrity
PO Box 309
Madison WI 53701-0309

ForwardHealth monitors member records and can impose sanctions on those who misuse or abuse their benefits. For more information on member misuse and abuse and the resulting sanctions, refer to s. 49.49, Wis. Stats.

Providers May Refuse to Provide Services

Providers may refuse to provide services to a BadgerCare Plus or Medicaid member in situations when there is reason to believe that the person presenting the ForwardHealth identification card is misusing or abusing it.

Members who abuse or misuse BadgerCare Plus or Wisconsin Medicaid benefits or their ForwardHealth card may have their benefits terminated or be subject to limitations under the Member Lock-In Program or to criminal prosecution.

Requesting Additional Proof of Identity

Providers may request additional proof of identity from a member if they suspect fraudulent use of a ForwardHealth identification card. If another form of identification is not available, providers can compare a person's signature with the signature on the back of the ForwardHealth identification card if it is signed. (adult members are encouraged to sign the back of their cards; however, it is not mandatory for members to do so.)

Verifying member identity, as well as enrollment, can help providers detect instances of fraudulent ForwardHealth card use.

Special Enrollment Circumstances

Medicaid Members from Other States

Wisconsin Medicaid does not pay for services provided to members enrolled in other state Medicaid programs. Providers are advised to contact other state Medicaid programs to determine whether the service sought is a covered service under that state's Medicaid program.

Members Traveling Out of State

When a member travels out of state but is within the United States (including its territories), Canada, or Mexico, BadgerCare Plus covers medical services in any of the following circumstances:

- An emergency illness or accident.
- When the member's health would be endangered if treatment were postponed.
- When the member's health would be endangered if travel to Wisconsin were undertaken.
- When PA has been granted to the out-of-state provider for provision of a nonemergency service.
- When there are coinsurance, copayment, or deductible amounts remaining after Medicare payment or approval for dual eligibles.

Note: Some providers located in a state that borders Wisconsin may be Wisconsin Medicaid certified as a border-status provider if the provider notifies ForwardHealth in writing that it is common practice for members in a particular area of Wisconsin to seek his or her medical services. Border-status providers follow the same policies as Wisconsin providers.

Non-U.S. Citizens — Emergency Services

Certain non-U.S. citizens who are not qualified aliens are eligible for BadgerCare Plus services only in cases of acute emergency medical conditions. Providers should use the appropriate ICD-9-CM diagnosis code to document the nature of the emergency.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of such severity that one could reasonably expect the absence of immediate medical attention to result in the following:

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

Due to federal regulations, BadgerCare Plus does not cover services for non-U.S. citizens who are not qualified aliens related to routine prenatal or postpartum care, major organ transplants (e.g., heart, liver), or ongoing treatment for chronic conditions where there is no evidence of an acute emergent state. For the purposes of this policy, all labor and delivery is considered an emergency service.

Note: Babies born to certain non-qualifiying immigrants are eligible for Medicaid enrollment under the CEN option. However, babies born to women with incomes over 300 percent of the FPL are not eligible for CEN status. The baby may still qualify for BadgerCare Plus. These mothers should report the birth to the local agencies within ten calendar days.

A provider who gives emergency care to a non-U.S. citizen should refer him or her to the local county or tribal agency or ForwardHealth outstation site for a determination of BadgerCare Plus enrollment. Providers may complete the Certification of Emergency for Non-U.S. Citizens form, for clients to take to the local county or tribal agency in their county of residence where the

BadgerCare Plus enrollment decision is made.

Providers should be aware that a client's enrollment does not guarantee that the services provided will be reimbursed by BadgerCare Plus.

Information for DOS before January 1, 2009, is available.

Out-of-State Youth Program

The OSY program is responsible for health care services provided to Wisconsin children placed outside the state in foster and subsidized adoption situations. These children are eligible for coverage. The objective is to assure that these children receive quality medical care.

Out-of-state providers not located in border-status-eligible communities may qualify as border-status providers if they deliver services as part of the OSY program. However, providers who have border status as part of the OSY program are reimbursed only for services provided to the specific foster care or subsidized adopted child. In order to receive reimbursement for services provided to other members, the provider is required to follow rules for out-of-state noncertified providers.

For subsidized adoptions, benefits are usually determined through the adoption assistance agreement and are provided by the state where the child lives. However, some states will not provide coverage to children with state-only funded adoption assistance. In these cases, Wisconsin will continue to provide coverage.

OSY providers are subject to the same regulations and policies as other certified border-status providers. For more information about the OSY program, call Provider Services or write to ForwardHealth at the following address:

> ForwardHealth
> Out-of-State Youth
> Ste 50
> 6406 Bridge Rd
> Madison WI 53784-0050

Persons Detained by Legal Process

Most individuals detained by legal process are *not* eligible for BadgerCare Plus or Wisconsin Medicaid benefits. Only those individuals who qualify for the BadgerCare Plus Expansion for Certain Pregnant Women may receive benefits.

"Detained by legal process" means a person who is incarcerated (including some Huber Law prisoners) because of law violation or alleged law violation, which includes misdemeanors, felonies, delinquent acts, and day-release prisoners. The justice system oversees health care-related needs for individuals detained by legal process who do not qualify for the BadgerCare Plus Expansion for Certain Pregnant Women.

Retroactive Enrollment

Retroactive enrollment occurs when an individual has applied for BadgerCare Plus or Medicaid and enrollment is granted with an effective date prior to the date the enrollment determination was made. A member's enrollment may be backdated to allow retroactive coverage for medical bills incurred prior to the date of application.

The retroactive enrollment period may be backdated up to three months prior to the month of application if all enrollment requirements were met during the period. Enrollment may be backdated more than three months if there were delays in determining enrollment or if court orders, fair hearings, or appeals were involved.

Reimbursing Members in Cases of Retroactive Enrollment

When a member receives retroactive enrollment, he or she has the right to request the return of payments made to a Medicaid-certified provider for a covered service during the period of retroactive enrollment, according to DHS 104.01(11), Wis. Admin. Code. A Medicaid-certified provider is required to submit claims to Medicaid for covered services provided to a member during periods of retroactive enrollment. Medicaid cannot directly refund the member.

If a service(s) that requires PA was performed during the member's period of retroactive enrollment, the provider is required to submit a PA request and receive approval from Medicaid *before* submitting a claim.

If a provider receives reimbursement from Medicaid for services provided to a retroactively enrolled member and the member has paid for the service, the provider is required to reimburse the member or authorized person acting on behalf of the member (e.g., local General Relief agency) the full amount that the member paid for the service.

If a claim cannot be filed within 365 days of the DOS due to a delay in the determination of a member's retroactive enrollment, the provider is required to submit the claim to Timely Filing within 180 days of the date the retroactive enrollment is entered into Wisconsin's EVS (if the services provided during the period of retroactive enrollment were covered).

Spenddown to Meet Financial Enrollment Requirements

Occasionally, an individual with significant medical bills meets all enrollment requirements except those pertaining to income. These individuals are required to "spenddown" their income to meet financial enrollment requirements.

The certifying agency calculates the individual's spenddown (or deductible) amount, tracks all medical costs the individual incurs, and determines when the medical costs have satisfied the spenddown amount. (A payment for a medical service does not have to be made by the individual to be counted toward satisfying the spenddown amount.)

When the individual meets the spenddown amount, the certifying agency notifies ForwardHealth and the provider of the last service that the individual is eligible beginning on the date that the spenddown amount was satisfied.

If the individual's last medical bill is greater than the amount needed to satisfy the spenddown amount, the certifying agency notifies the affected provider by indicating the following:

- The individual is eligible for benefits as of the DOS on the last bill.
- A claim for the service(s) on the last bill should be submitted to ForwardHealth. (The claim should indicate the full cost of the service.)
- The portion of the last bill that the individual must pay to the provider.

The certifying agency also informs ForwardHealth of the individual's enrollment and identifies the following:

- The DOS of the final charges counted toward satisfying the spenddown amount.
- The provider number of the provider of the last service.
- The spenddown amount remaining to be satisfied.

When the provider submits the claim, the spenddown amount will automatically be deducted from the provider's reimbursement for the claim. The spenddown amount is indicated in the Member's Share element on the Medicaid Remaining Deductible Update form sent to providers by the member's certifying agency. The provider's reimbursement is then reduced by the amount of the member's obligation.

Reimbursement

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Reimbursement:Amounts

Acceptance of Payment

The amounts allowed as payment for covered services must be accepted as payment in full. Therefore, total payment for the service (i.e., any amount paid by other health insurance sources, any BadgerCare Plus or Medicaid copayment or spenddown amounts paid by the member, and any amount paid by BadgerCare Plus) may not exceed the BadgerCare Plus-allowed amount. As a result, providers may not collect payment from a member, or authorized person acting on behalf of the member, for the difference between their usual and customary charge and the BadgerCare Plus-allowed amount for a service (i.e., balance billing).

Other health insurance payments may exceed the BadgerCare Plus-allowed amount if no additional payment is received from the member or BadgerCare Plus.

Billing Service and Clearinghouse Contracts

According to [DHS 106.03(5)(c)2](), Wis. Admin. Code, contracts with outside billing services or clearinghouses may not be based on commission in which compensation for the service is dependent on reimbursement from BadgerCare Plus. This means compensation must be unrelated, directly or indirectly, to the amount of reimbursement or the number of claims and is not dependent upon the actual collection of payment.

Electronic Funds Transfer

EFT allows ForwardHealth to directly deposit payments into a provider's designated bank account for a more efficient delivery of payments than the current process of mailing paper checks. Electronic Funds Transfer is secure, eliminates paper, and reduces the uncertainty of possible delays in mail delivery.

Only in-state and border-status providers who submit claims and MCOs are eligible to receive EFT payments.

Provider Exceptions

EFT payments are not available to the following providers:

- In-state emergency providers.
- Out-of-state providers.
- Out-of-country providers.
- SMV providers during their provisional certification period.

Enrolling in Electronic Funds Transfer

A ForwardHealth Portal account is required to enroll into EFT as all enrollments must be completed via a secure Provider Portal account or a secure MCO Portal account. Paper enrollments are not accepted. A separate EFT enrollment is required for each financial payer a provider bills.

Providers who do not have a Portal account may [Request Portal Access]() online. Providers may also call the [Portal Helpdesk]() for assistance in requesting a Portal account.

The following guidelines apply to EFT enrollment:

- Only a Portal Administrator or a clerk that has been assigned the new "EFT" role on the Portal may complete the EFT enrollment information.
- Organizations cannot revert back to receiving paper checks once enrolled in EFT.
- Organizations may change their EFT information at any time.
- Organizations will continue to receive their Remittance Advice as they do currently.

Refer to the ForwardHealth Portal Electronic Funds Transfer User Guide and the Electronic Funds Transfer Fact Page for instructions and more information about EFT enrollment.

Providers will continue to receive payment via paper check until the enrollment process moves into "Active" status and the provider's ForwardHealth EFT enrollment is considered complete.

Recoupment and Reversals

Enrollment in EFT does not change the current process of recouping funds. Overpayments and recoupment of funds will continue to be conducted through the reduction of payments.

Note: Enrolling in EFT does not authorize ForwardHealth to make unauthorized debits to the provider's EFT account; however, in some instances an EFT reversal of payment may be necessary. For example, if the system generates a payment twice or the amount entered manually consists of an incorrect value (e.g., a decimal point is omitted creating a $50,000 keyed value for a $500 claim), a reversal will take place to correct the error and resend the correct transaction value. ForwardHealth will notify the designated EFT contact person of an EFT reversal if a payment is made in error due to a system processing or manual data entry error.

Problem Resolution

If payment is not deposited into the designated EFT account according to the ForwardHealth payment cycle, providers should first check with their financial institution to confirm the payment was received. If the payment was not received, providers should then call ForwardHealth Provider Services to resolve the issue and payment by paper check will be reinstated until the matter has been resolved.

Fee Schedules

Maximum allowable fee information is available on the ForwardHealth Portal in the following forms:

- Interactive fee schedule.
- Downloadable fee schedule in TXT files.

Certain fee schedules are interactive. Interactive fee schedules provide coverage information as well as maximum allowable fees for all reimbursable procedure codes. The downloadable TXT files are free of charge and provide basic maximum allowable fee information for BadgerCare Plus by provider service area.

A provider may request a paper copy of a fee schedule by calling Provider Services.

Providers may call Provider Services in the following cases:

- Internet access is not available.
- There is uncertainty as to which fee schedule should be used.
- The appropriate fee schedule cannot be found on the Portal.
- To determine coverage or maximum allowable fee of procedure codes not appearing on a fee schedule.

Maximum Allowable Fees

Maximum allowable fees are established for most covered services. Maximum allowable fees are based on various factors, including a review of usual and customary charges submitted, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. Maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law.

Providers are reimbursed at the lesser of their billed amount and the maximum allowable fee for the procedure.

Collecting Payment From Members

Conditions That Must Be Met

A member may request a noncovered service, a covered service for which PA was denied (or modified), or a service that is not covered under the member's limited benefit category. The charge for the service may be collected from the member if the following conditions are met *prior* to the delivery of that service:

- The member accepts responsibility for payment.
- The provider and member make payment arrangements for the service.

Providers are strongly encouraged to obtain a *written* statement in advance documenting that the member has accepted responsibility for the payment of the service.

Furthermore, the service must be separate or distinct from a related, covered service. For example, a vision provider may provide a member with eyeglasses but then, upon the member's request, provide and charge the member for anti-glare coating, which is a noncovered service. Charging the member is permissible in this situation because the anti-glare coating is a separate service and can be added to the lenses at a later time.

Cost Sharing

According to federal regulations, providers cannot hold a member responsible for any commercial or Medicare cost-sharing amount such as coinsurance, copayment, or deductible. Therefore, a provider may not collect payment from a member, or authorized person acting on behalf of the member, for copayments required by other health insurance sources. Instead, the provider should collect *only* the copayment amount from the member.

Situations When Member Payment Is Allowed

Providers may not collect payment from a member, or authorized person acting on behalf of the member, *except* for the following:

- Required member copayments for certain services.
- Commercial insurance payments made to the member.
- Spenddown.
- Charges for a private room in a nursing home or hospital.
- Noncovered services if certain conditions are met.
- Covered services for which PA was denied (or an originally requested service for which a PA request was modified) if certain conditions are met. These services are treated as noncovered services.
- Services provided to a member in a limited benefit category when the services are not covered under the limited benefit and if certain conditions are met.

If a provider inappropriately collects payment from a member, or authorized person acting on behalf of the member, that provider may be subject to program sanctions including termination of Medicaid certification.

Copayment

Prohibited

Providers are prohibited from collecting copayment for CCC services.

Payer of Last Resort

Instances When Medicaid Is Not Payer of Last Resort

Wisconsin Medicaid or BadgerCare Plus are *not* the payer of last resort for members who receive coverage from certain governmental programs, such as:

- B-3.
- Crime Victim Compensation Fund.
- GA.
- HCBS waiver programs.
- IDEA.
- Indian Health Service.
- Maternal and Child Health Services.
- WCDP.
    - Adult Cystic Fibrosis.
    - Chronic Renal Disease.
    - Hemophilia Home Care.

Providers should ask members if they have coverage from these other governmental programs.

If the member becomes retroactively enrolled in Wisconsin Medicaid or BadgerCare Plus, providers who have already been reimbursed by one of these government programs may be required to submit the claims to ForwardHealth and refund the payment from the government program.

Other Health Insurance Sources

BadgerCare Plus reimburses only that portion of the allowed cost remaining after a member's other health insurance sources have been exhausted. Other health insurance sources include the following:

- [Commercial fee-for-service plans](.)..
- [Commercial managed care plans](.).
- Medicare supplements (e.g., Medigap).
- Medicare.
- Medicare Advantage.
- TriCare.
- CHAMPVA.
- Other governmental benefits.

Payer of Last Resort

Except for a few instances, Wisconsin Medicaid or BadgerCare Plus are the payer of last resort for any covered services. Therefore, the provider is required to make a reasonable effort to exhaust all existing other health insurance sources before submitting claims to ForwardHealth or to a state-contracted MCO.

Primary and Secondary Payers

The terms "primary payer" and "secondary payer" indicate the relative order in which insurance sources are responsible for paying claims.

In general, commercial health insurance is primary to Medicare, and Medicare is primary to Wisconsin Medicaid and BadgerCare Plus. Therefore, Wisconsin Medicaid and BadgerCare Plus are secondary to Medicare, and Medicare is secondary to commercial health insurance.

Reimbursement Not Available

Wisconsin Medicaid may deny or recoup payment for covered services that fail to meet program requirements. Medicaid reimbursement is also not available for noncovered services.

The following are not reimbursable as PNCC or CCC services:

- The provision of diagnostic, treatment, or other direct services, except for health education and nutrition counseling for PNCC providers. Direct services include, but are not limited to, diagnosis of a physical or mental illness and administration of medications.
- Member vocational training.
- Legal advocacy by an attorney or paralegal.
- Ongoing care coordination and monitoring services that are not based on the member's current care plan.
- Ongoing care coordination and monitoring services that are not necessary to meet the CCC or PNCC benefit goal.
- Transportation (provider or recipient mileage or travel time).
- Interpreter services.
- Missed appointments (no shows).

Reimbursement Not Available Through a Factor

BadgerCare Plus will not reimburse providers through a factor, either directly or by virtue of a power of attorney given to the factor by the provider. A factor is an organization (e.g., a collection agency) or person who advances money to a provider for the purchase or transferal of the provider's accounts receivable. The term "factor" does not include business representatives, such as billing services, clearinghouses, or accounting firms, which render statements and receive payments in the name of the provider.

Services Not Separately Reimbursable

If reimbursement for a service is included in the reimbursement for the primary procedure or service, it is not separately reimbursable. For example, routine venipuncture is not separately reimbursable, but it is included in the reimbursement for the laboratory procedure or the laboratory test preparation and handling fee. Also, DME delivery charges are included in the reimbursement for DME items.

Resources

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Archive Date:03/01/2010
Resources:Contact Information

Member Services

Providers should refer ForwardHealth members with questions to Member Services. The telephone number for Member Services is for member use only.

Provider Relations Representatives

The Provider Relations representatives, also known as field representatives, conduct training sessions on various ForwardHealth topics for both large and small groups of providers and billers. In addition to provider education, field representatives are available to assist providers with complex billing and claims processing questions. Field representatives are located throughout the state to offer detailed assistance to all ForwardHealth providers and all ForwardHealth programs.

Field Representative Specialization

The field representatives are assigned to specific regions of the state. In addition, the field representatives have specialized in a group of provider types. This specialization allows the field representatives to most efficiently and effectively address provider inquiries. To better direct inquiries, providers should contact the field representative in their region who specializes in their provider type.

Provider Education

The field representatives' primary focus is provider education. They provide information on ForwardHealth programs and topics in the following ways:

- Conducting provider training sessions throughout the state.
- Providing training and information for newly certified providers and/or new staff.
- Participating in professional association meetings.

Providers may also contact the field representatives if there is a specific topic, or topics, on which they would like to have an individualized training session. This could include topics such as use of the Portal (information about claims, enrollment verification, and PA requests on the Portal). Refer to the Providers Trainings page for the latest information on training opportunities.

Additional Inquiries

Providers are encouraged to initially obtain information through the ForwardHealth Portal, WiCall, and Provider Services. If these attempts are not successful, field representatives may be contacted for the following types of inquiries:

- Claims, including discrepancies regarding enrollment verification and claim processing.
- PES claims submission software.
- Claims processing problems that have not been resolved through other channels (e.g., telephone or written correspondence).
- Referrals by a Provider Services telephone correspondent.
- Complex issues that require extensive explanation.

Field representatives primarily work outside their offices to provide on-site service; therefore, providers should be prepared to leave a complete message when contacting field representatives, including all pertinent information related to the inquiry. Member inquiries should not be directed to field representatives. Providers should refer members to Member Services at (800) 362-3002.

If contacting a field representative by e-mail, providers should ensure that no individually identifiable health information, known as PHI, is included in the message. PHI can include things such as the member's name combined with his/her identification number or Social Security number.

Information to Have Ready

Providers or their representatives should have the following information ready when they call:

- Name or alternate contact.
- County and city where services are provided.
- Name of facility or provider whom they are representing.
- NPI or provider number.
- Telephone number, including area code.
- A concise statement outlining concern.
- Days and times when available.

For questions about a specific claim, providers should also include the following information:

- Member's name.
- Member identification number.
- Claim number.
- DOS.

Provider Services

Providers should call Provider Services to answer enrollment, policy, and billing questions. Members should call Member Services for information. Members should *not* be referred to Provider Services.

The Provider Services Call Center provides service-specific assistance to Medicaid, BadgerCare Plus, WCDP, and WWWP providers.

Ways Provider Services Can Help

The Provider Services Call Center is organized to include program-specific and service-specific assistance to providers. The Provider Services call center supplements the ForwardHealth Portal and WiCall by providing information on the following:

- Billing and claim submissions.
- Certification.
- COB (e.g., verifying a member's other health insurance coverage).
- Assistance with completing forms.
- Assistance with remittance information and claim denials.
- Policy clarification.
- PA status.
- Verifying covered services.

Information to Have Ready

When contacting or transferring from WiCall to the call center, callers will be prompted to enter their NPI or provider ID. Additionally, to facilitate service, providers are recommended to have all pertinent information related to their inquiry on hand when contacting the call center, including:

- Provider name and NPI or provider ID.

- Member name and member identification number.
- Claim number.
- PA number.
- DOS.
- Amount billed.
- RA.
- Procedure code of the service in question.
- Reference to any provider publications that address the inquiry.

Call Center Correspondent Team

The ForwardHealth call center correspondents are organized to respond to telephone calls from providers. Correspondents offer assistance and answer inquiries specific to the program (i.e., Medicaid, WCDP, or WWWP) or to the service area (i.e., pharmacy services, hospital services) in which they are designated.

Call Center Menu Options and Inquiries

Providers contacting Provider Services are prompted to select from the following menu options:

- WCDP and WWWP (for inquiries from all providers regarding WCDP or WWWP).
- Dental (for all inquiries regarding dental services).
- Medicaid or SeniorCare Pharmacy (for pharmacy providers) or STAT-PA for STAT-PA inquiries, including inquiries from pharmacies, DME providers for orthopedic shoes, and HealthCheck providers for environmental lead inspections.
- Medicaid and BadgerCare Plus institutional services (for inquiries from providers who provide hospital, nursing home, home health, personal care, ESRD, and hospice services or NIP).
- Medicaid and BadgerCare Plus professional services (for inquiries from all other providers not mentioned in the previous menu prompts).

Walk-in Appointments

Walk-in appointments offer face-to-face assistance for providers at the Provider Services office. Providers are encouraged to contact the Provider Services Call Center to schedule a walk-in appointment.

Written Inquiries

Providers may contact Provider Services through the Portal by selecting the "Contact Us" link. Provider Services will respond to the inquiry by the preferred method of response indicated within five business days. All information is transmitted via a secure connection to protect personal health information.

Providers may submit written inquiries to ForwardHealth by mail using the Written Correspondence Inquiry form. The Written Correspondence Inquiry form may be photocopied or downloaded via a link from the Portal. Written correspondence should be sent to the following address:

ForwardHealth
Provider Services Written Correspondence
6406 Bridge Rd
Madison WI 53784-0005

Providers are encouraged to use the other resources before mailing a written request to ForwardHealth. Provider Services will respond to written inquiries in writing unless otherwise specified.

Provider Suggestions

The DHCAA is interested in improving its program for providers and members. Providers who would like to suggest a revision of any policy or procedure stated in provider publications or who wish to suggest new policies are encouraged to submit recommendations on the Provider Suggestion form.

Resources Reference Guide

The Provider Services and Resources Reference Guide lists services and resources available to providers and members with contact information and hours of availability.

Electronic Data Interchange

Companion Documents

Purpose of Companion Documents

ForwardHealth companion documents provide trading partners with useful technical information on ForwardHealth's standards for nationally recognized electronic transactions.

The information in companion documents applies to BadgerCare Plus, Medicaid, SeniorCare, WCDP, and WWWP. Companion documents are intended for information technology and systems staff who code billing systems or software.

The companion documents complement the federal HIPAA Implementation Guides and highlight information that trading partners need to successfully exchange electronic transactions with ForwardHealth, including general topics such as the following:

- Methods of exchanging electronic information (e.g., exchange interfaces, transaction administration, and data preparation).
- Instructions for constructing the technical component of submitting or receiving electronic transactions (e.g., claims, RA, and enrollment inquiries).

Companion documents do *not* include program requirements, but help those who create the electronic formats for electronic data exchange.

Companion documents cover the following specific subjects:

- Getting started (e.g., identification information, testing, and exchange preparation).
- Transaction administration (e.g., tracking claims submissions, contacting the EDI Helpdesk).
- Transaction formats.

Revisions to Companion Documents

Companion documents may be updated as a result of changes to federal requirements. When this occurs, ForwardHealth will do the following:

- Post the revised companion document on the ForwardHealth Portal.
- Post a message on the banner page of the RA.
- Send an e-mail to trading partners.

Trading partners are encouraged to periodically check for the revised companion documents on the Portal. If trading partners do not follow the revisions identified in the companion document, transactions may not process successfully (e.g., claims may deny or process incorrectly).

A revision log located at the front of the revised companion document lists the changes that have been made. The date on the companion document reflects the last date the companion document was revised. In addition, the version number located in the footer of the first page is changed with each revision.

Data Exchange Methods

The following data exchange methods are supported by the EDI Department:

- Remote access server dial-up, using a personal computer with a modem, browser, and encryption software.
- Secure Web, using an Internet Service Provider and a personal computer with a modem, browser, and encryption software.
- Real-time, by which trading partners exchange the NCPDP 5.1 (pharmacies only), 270/271, or 276/277 transactions via an approved clearinghouse.

The EDI Department supports the exchange of the transactions for BadgerCare Plus, Medicaid, SeniorCare, WCDP, and WWWP.

Electronic Data Interchange Helpdesk

The EDI Helpdesk assists anyone interested in becoming a trading partner with getting started and provides ongoing support pertaining to electronic transactions. Providers, billing services, and clearinghouses are encouraged to contact the EDI Helpdesk for test packets and/or technical questions.

Providers with policy questions should call Provider Services.

Electronic Transactions

Trading partners may submit claims and adjustment requests, inquire about member enrollment, claim status, and ForwardHealth payment advice by exchanging electronic transactions.

Through the EDI Department, trading partners may exchange the following electronic transactions:

- 270/271. The 270 is the electronic transaction for inquiring about a member's enrollment. The 271 is received in response to the inquiry.
- 276/277. The 276 is the electronic transaction for checking claim status. The 277 is received in response.
- 835. The electronic transaction for receiving remittance information.
- 837. The electronic transaction for submitting claims and adjustment requests.
- 997. The electronic transaction for reporting whether a transaction is accepted or rejected.
- TA1 Interchange Acknowledgment. The electronic transaction for reporting a transaction that is rejected for interchange level errors.
- NCPDP 5.1 Telecommunication Standard for Retail Pharmacy Claims. The real-time POS electronic transaction for submitting pharmacy claims.

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. The PES software allows providers to submit 837 transactions and download the 997 and the 835 transactions. To obtain PES software, providers may download it from the ForwardHealth Portal or may request it from the EDI Helpdesk.

Trading Partner Profile

A TPP must be completed and signed for each billing provider number that will be used to exchange electronic transactions.

In addition, billing providers who do not use a third party to exchange electronic transactions, billing services, and clearinghouses are required to complete a TPP.

To determine whether a TPP is required, providers should refer to the following:

- Billing providers who do not use a third party to exchange electronic transactions, including providers who use the PES software, are required to complete the TPP.

- Billing providers who use a third party (billing services and clearinghouses) to exchange electronic transactions are required to submit a TPP.
- Billing services and clearinghouses, including those that use PES software, that are authorized by providers to exchange electronic transactions on a provider's behalf, are required to submit a TPP.

Providers who change billing services and clearinghouses or become a trading partner should keep their information updated by contacting the EDI Helpdesk.

Trading Partners

ForwardHealth exchanges nationally recognized electronic transactions with trading partners. A "trading partner" is defined as a covered entity that exchanges electronic health care transactions. The following covered entities are considered trading partners:

- Providers who exchange electronic transactions directly with ForwardHealth.
- Billing services and clearinghouses that exchange electronic transactions directly with ForwardHealth on behalf of a billing provider.

Enrollment Verification

270/271 Transactions

The 270/271 transactions allow for batch enrollment verification, including information for the current benefit month or for any date of eligibility the member has on file, through a secure Internet connection. The 270 is the electronic transaction for inquiring about a member's enrollment. The 271 is received in response to the inquiry.

For those providers who are federally required to have an NPI, an NPI is required on the 270/271 transactions. The NPI indicated on the 270 is verified to ensure it is associated with a valid certification on file with ForwardHealth. The 271 response will report the NPI that was indicated on the 270.

For those providers exempt from NPI, a provider ID is required on the 270/271 transactions. The provider ID indicated on the 270 is verified to ensure it is associated with a valid certification on file with ForwardHealth. The 271 response will report the provider ID that was indicated on the 270.

An Overview

Providers should always verify a member's enrollment before providing services, both to determine enrollment for the current date (since a member's enrollment status may change) and to discover any limitations to the member's coverage. Each enrollment verification method allows providers to verify the following prior to services being rendered:

- A member's enrollment in a ForwardHealth program(s).
- State-contracted MCO enrollment.
- Medicare enrollment.
- Limited benefits categories.
- Any other commercial health insurance coverage.
- Exemption from copayments for BadgerCare Plus members.

Commercial Enrollment Verification Vendors

ForwardHealth has agreements with several commercial enrollment verification vendors to offer enrollment verification technology to ForwardHealth providers. Commercial enrollment verification vendors have up-to-date access to the ForwardHealth enrollment files to ensure that providers have access to the most current enrollment information. Providers may access Wisconsin's EVS to verify member enrollment through one or more of the following methods available from commercial enrollment verification vendors:

- Magnetic stripe card readers.
- Personal computer software.
- Internet.

Vendors sell magnetic stripe card readers, personal computer software, Internet access, and other services. They also provide ongoing maintenance, operations, and upgrades of their systems. Providers are responsible for the costs of using these enrollment verification methods.

Note: Providers are *not* required to purchase services from a commercial enrollment verification vendor. For more information on other ways to verify member enrollment or for questions about ForwardHealth identification cards, contact Provider Services.

The real-time enrollment verification methods allow providers to print a paper copy of the member's enrollment information, including

a transaction number, for their records. Providers should retain this number or the printout as proof that an inquiry was made.

Magnetic Stripe Card Readers

The magnetic stripe card readers resemble credit card readers. Some ForwardHealth identification cards have a magnetic stripe and signature panel on the back, and a unique, 16-digit card number on the front. The 16-digit card number is valid only for use with a magnetic card reader.

Providers receive current member enrollment information after passing the ForwardHealth card through the reader or entering the member identification number or card number into a keypad and entering the DOS about which they are inquiring.

Personal Computer Software

Personal computer software can be integrated into a provider's current computer system by using a modem and can access the same information as the magnetic stripe card readers.

Internet Access

Some enrollment verification vendors provide real-time access to enrollment from the EVS through the Internet.

Copayment Information

If a member is enrolled in BadgerCare Plus and is exempted from paying copayments for services, providers will receive the following response to an enrollment query from all methods of enrollment verification:

- The name of the benefit plan.
- The member's enrollment dates.
- The message, "No Copay."

If a member is enrolled in BadgerCare Plus and is required to pay copayments, providers will be given the name of the benefit plan in which the member is enrolled and the member's enrollment dates for the benefit plan only.

Note: The BadgerCare Plus Core Plan may also charge different copayments for hospital services depending on the member's income level. Members identified as "BadgerCare Plus Core Plan 1" are subject to lower copayments for hospital services. Members identified as "BadgerCare Plus Core Plan 2" are subject to higher copayments for hospital services.

Enrollment Verification System

Member enrollment issues are the primary reason claims are denied. To reduce claim denials, providers should *always* verify a member's enrollment before providing services, both to determine enrollment for the current date (since a member's enrollment status may change) and to discover any limitations to the member's coverage. Providers may want to verify the member's enrollment a second time before submitting a claim to find out whether the member's enrollment information has changed since the appointment.

Providers can access Wisconsin's EVS to receive the most current enrollment information through the following methods:

- ForwardHealth Portal.
- WiCall, Wisconsin's AVR system.
- Commercial enrollment verification vendors.
- 270/271 transactions.
- Provider Services.

Providers cannot charge a member, or authorized person acting on behalf of the member, for verifying his or her enrollment.

The EVS does not indicate other government programs that are secondary to Wisconsin Medicaid.

Enrollment Verification on the Portal

The secure ForwardHealth Portal offers real-time member enrollment verification for all ForwardHealth programs. Providers will be able to use this tool to determine:

- The benefit plan(s) in which the member is enrolled.
- If the member is enrolled in a state-contracted managed care program (for Medicaid and BadgerCare Plus members).
- If the member has any other coverage, such as Medicare or commercial health insurance.
- If the member is exempted from copayments (BadgerCare Plus members only).

To access enrollment verification via the ForwardHealth Portal, providers will need to do the following:

- Go to the ForwardHealth Portal.
- Establish a provider account.
- Log into the secure Portal.
- Click on the menu item for enrollment verification.

Providers will receive a unique transaction number for each enrollment verification inquiry. Providers may access a history of their enrollment inquiries using the Portal, which will list the date the inquiry was made and the enrollment information that was given on the date that the inquiry was made. For a more permanent record of inquiries, providers are advised to use the "print screen" function to save a paper copy of enrollment verification inquiries for their records or document the transaction number at the beginning of the response, for tracking or research purposes. This feature allows providers to access enrollment verification history when researching claim denials due to enrollment issues.

The Provider Portal is available 24 hours a day, seven days a week.

Entering Dates of Service

Enrollment information is provided based on a "From" DOS and a "To" DOS that the provider enters when making the enrollment inquiry. For enrollment inquires, a "From" DOS is the earliest date for which the provider is requesting enrollment information and the "To" DOS is the latest date for which the provider is requesting enrollment information.

Providers should use the following guidelines for entering DOS when verifying enrollment for Wisconsin Medicaid, BadgerCare Plus, SeniorCare, or WCDP members:

- The "From" DOS is the earliest date the provider requires enrollment information.
- The "To" DOS must be within 365 days of the "From" DOS.
- If the date of the request is prior to the 20th of the current month, then providers may enter a "From" DOS and "To" DOS up to the end of the current calendar month.
- If the date of the request is on or after the 20th of the current month, then providers may enter a "From" DOS and "To" DOS up to the end of the following calendar month.

For example, if the date of the request was November 15, 2008, the provider could request dates up to and including November 30, 2008. If the date of the request was November 25, 2008, the provider could request dates up to and including December 31, 2008.

Member Forgets ForwardHealth Identification Card

Even if a member does not present a ForwardHealth identification card, a provider can use Wisconsin's EVS to verify enrollment, otherwise, the provider may choose not to provide the service(s) until a member brings in a ForwardHealth card.

A provider may use a combination of the member's name, date of birth, ForwardHealth identification number, or SSN with a "0" at the end to access enrollment information through the EVS.

A provider may call Provider Services with the member's full name and date of birth to obtain the member's enrollment information if the member's identification number or SSN is not known.

Member Identification Card Does Not Guarantee Enrollment

Most members receive a member identification card, but possession of a program identification card does not guarantee enrollment. Periodically, members may become ineligible for enrollment, only to re-enroll at a later date. Members are told to keep their cards even though they may have gaps in enrollment periods. It is possible that a member will present a card when he or she is not enrolled; therefore, it is essential that providers verify enrollment before providing services. To reduce claim denials, it is important that providers verify the following information prior to each DOS that services are provided:

- If a member is enrolled in any ForwardHealth program, including benefit plan limitations.
- If a member is enrolled in a managed care organization.
- If a member is in primary provider lock-in status.
- If a member has Medicare or other insurance coverage.

Responses Are Based on Financial Payer

When making an enrollment inquiry through Wisconsin's EVS, the returned response will provide information on the member's enrollment in benefit plans based on financial payers.

There are three financial payers under ForwardHealth:

- Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and SeniorCare).
- WCDP.
- WWWP.

Within each financial payer are benefit plans. Each member is enrolled under at least one of the three financial payers, and under each financial payer, is enrolled in at least one benefit plan. An individual member may be enrolled under more than one financial payer. (For instance, a member with chronic renal disease may have health care coverage under the BadgerCare Plus Standard Plan and the WCDP chronic renal disease program. The member is enrolled under two financial payers, Medicaid and WCDP.) Alternatively, a member may have multiple benefits under a single financial payer. (For example, a member may be covered by the TB-Only Benefit and the FPW at the same time, both of which are administered by Medicaid.)

Forms

An Overview

ForwardHealth requires providers to use a variety of forms for PA, claims processing, and documenting special circumstances.

Division of Health Care Access and Accountability Publications

The following CCC and PNCC publications are available from the DHCAA at the address listed below. There is no charge for these publications.

Form Title	Document Number
Child Care Coordination Family Questionnaire	F-1118
Prenatal Care Coordination Pregnancy Questionnaire (Risk Assessment Form)	F-1105
Guidance Manual for the Pregnancy Questionnaire	POH 1043
HealthCheck Brochure (Spanish)	POH 1007S
HealthCheck Brochure (Hmong)	POH 1007H
HealthCheck Brochure (English)	POH 1007
HealthCheck Poster (8 1/2 x 14)	POH 1041
HealthCheck Stuffer/Handbill	POH 1041A
HealthCheck Stickers	POH 1041C

The forms are available from the following address:

Division of Health Care Access and Accountability
Bureau of Fee-for-Service Health Care Benefits
Attn: Forms Manager
PO Box 309
Madison WI 53701-0309

Division of Public Health Publications

The following CCC and PNCC publications are available from the DHS Forms Center. There is minimal or no charge for the following documents.

Form Title	Document Number
Family Health Resource Catalog (a list of maternal and child health education materials)	PPH 4536
If I'm Pregnant, Can the Chemicals I Work with Harm my Baby?	DPH 7074
Child Growth Grid - Boy	DOH 4517
Child Growth Grid - Girl	DOH 4518
Prenatal Weight Gain Grid	DOH 4056
Planning a Healthy Pregnancy: Self Care Handbook	PPH 9322

Planning a Healthy Pregnancy: Self Care Handbook (Spanish)	PPH 9322-S
Caring for Your Baby: A Newborn and Infant Care Handbook	PPH 9321
Caring for Your Baby: A Newborn and Infant Care Handbook (Spanish)	PPH 9321-S

The forms are available from the following address:

Department of Health Services Forms Center
PO Box 7850
Madison WI 53701-7850

Children's Trust Fund

The following information is available from the Children's Trust Fund:

- Information on child abuse and neglect.
- Positive Parenting Kit.

Providers may call the Children's Trust Fund at (866) 640-3936, or write to the following address:

110 E. Main St
Ste 614
Madison WI 53703

Family Questionnaire

Providers are required to complete every section on the Child Care Coordination Family Questionnaire unless the member objects to a particular section.

The Family Questionnaire must be the following:

- Reviewed and finalized in a face-to-face contact with the member.
- Signed and dated by the agency staff member who completed the questionnaire.

The person administering the Family Questionnaire must be an employee of the Medicaid-certified care coordination agency or an employee of an agency under contract to the care coordination agency.

Qualified professionals are required to review and initial all Family Questionnaires completed by paraprofessional staff.

According to DHS 105.52, Wis. Admin. Code, types of qualified professionals include:

- A nurse practitioner licensed as a certified nurse pursuant to s. 441.06, Wis. Stats., and currently certified by the American Nurses' Association, the National Board of Pediatric Nurse Practitioners and Associates or the Nurses' Association of the American College of Obstetricians and Gynecologists' Certification Corporation.
- A nurse midwife certified under DHS 105.201, Wis. Admin. Code.
- A public health nurse meeting the qualifications of DHS 139.08, Wis. Admin. Code.
- A physician licensed under ch. 448, Wis. Stats., to practice medicine or osteopathy.
- A physician assistant certified under ch. 448, Wis. Stats.
- A dietitian certified or eligible for registration by the Commission on Dietetic Registration of the American Dietetic Association with at least two years of community health experience. (Per proposed rule change, the following is also acceptable: A dietician certified by the State of Wisconsin [CD] or registered by the American Dietetic Association [RD] with at least two years of community health experience.)

- A certified nurse with at least two years of experience in maternity nursing and/or community health service.
- A social worker with at least a Bachelor's degree and two years of experience in a health care or family services program.
- A health educator with a Master's degree in health education and at least two years of experience in community health services.

Wisconsin Medicaid reimburses for the administration of the Family Questionnaire regardless of the member's score. Members may be reassessed at any time, but providers need only readminister the entire Family Questionnaire if the member's situation changes significantly.

Fillable Forms

Most forms may be obtained from the Forms page of the ForwardHealth Portal.

Forms on the Portal are available as fillable PDF files, which can be viewed with Adobe Reader® computer software. Providers may also complete and print fillable PDF files using Adobe Reader®.

To complete a fillable PDF, follow these steps:

- Select a specific form.
- Save the form to the computer.
- Use the "Tab" key to move from field to field.

Note: The Portal provides instructions on how to obtain Adobe Reader® at no charge from the Adobe® Web site. Adobe Reader® only allows providers to view and print completed PDFs. It does not allow users to save completed fillable PDFs to their computer; however, if Adobe Acrobat® is purchased, providers may save completed PDFs to their computer. Refer to the Adobe® Web site for more information about fillable PDFs.

Selected forms are also available in fillable Microsoft® Word format on the Portal. The fillable Microsoft® Word format allows providers to complete and print the form using Microsoft® Word. To complete a fillable Microsoft® Word form, follow these steps:

- Select a specific form.
- Save the form to the computer.
- Use the "Tab" key to move from field to field.

Note: Providers may save fillable Microsoft® Word documents to their computer by choosing "Save As" from the "File" menu, creating a file name, and selecting "Save" on their desktop.

Telephone or Mail Requests

Providers who do not have Internet access or who need forms that are not available on the ForwardHealth Portal may obtain them by doing either of the following:

- Requesting a paper copy of the form by calling Provider Services. Questions about forms may also be directed to Provider Services.
- Submitting a written request and mailing it to ForwardHealth. Include a return address, the name of the form, and the form number and send the request to the following address:

  ForwardHealth
  Form Reorder
  6406 Bridge Rd
  Madison WI 53784-0003

Portal

Claims and Adjustments Using the ForwardHealth Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, copy claims, and determine what claims are in "pay" status on the Portal. Providers have the ability to search for and view the status of all their finalized claims, regardless of how they were submitted (i.e., paper, electronic, clearinghouse). If a claim contains an error, providers can correct it on the Portal and resubmit it to ForwardHealth.

Providers can submit an individual claim or adjust a claim through DDE through the secure Portal.

Cost Share Reports for Long-Term Managed Care Organizations

Individual cost share reports for long-term care MCOs that provide Family Care, Family Care Partnership, and PACE services are available via the secure area of the ForwardHealth Portal and can be downloaded as an Excel file.

Creating a Provider Account

Each provider needs to designate one individual as an administrator of the ForwardHealth Portal account. This user establishes the administrative account once his or her PIN is received. The administrative user is responsible for this provider account and is able to add accounts for other users (clerks) within his or her organization and assign security roles to clerks that have been established. To establish an administrative account after receiving a PIN, the administrative user is required to follow these steps:

1. Go to the ForeardHealth Portal.
2. Click the **Providers** button.
3. Click **Logging in for the first time?**.
4. Enter the Login ID and PIN. The Login ID is the provider's NPI or provider number.
5. Click **Setup Account**.
6. At the Account Setup screen, enter the user's information in the required fields.
7. Read the security agreement and click the checkbox to indicate agreement with its contents.
8. Click **Submit** when complete.

Once in the secure Provider area of the Portal, the provider may conduct business online with ForwardHealth via a secure connection. Providers may also perform the following administrative functions from the Provider area of the Portal:

- Establish accounts and define access levels for clerks.
- Add other organizations to the account.
- Switch organizations.

A user's guide containing detailed instructions for performing these functions can be found on the Portal.

Designating a Trading Partner to Receive 835 Health Care Claim Payment/Advice Transactions

Providers must designate a trading partner to receive their 835 transaction for ForwardHealth interChange.

Providers who wish to submit their 835 designation via the Portal are required to create and establish a provider account to have access to the secure area of the Portal.

To designate a trading partner to receive 835 transactions, providers must first complete the following steps:

- Access the Portal and log into their secure account by clicking the Provider link/button.
- Click on the Designate 835 Receiver link on the right-hand side of the secure home page.
- Enter the identification number of the trading partner that is to receive the 835 in the Trading Partner ID field.
- Click Save.

Providers who are unable to use the Portal to designate a trading partner to receive 835 transactions may call the EDI Helpdesk or submit a paper form.

Electronic Communications

The secure Portal contains a one-way message center where providers can receive electronic notifications and provider publications from ForwardHealth. All new messages display on the provider's main page within the secure Portal.

Enrollment Verification

The secure Portal offers real time member enrollment verification for all ForwardHealth programs. Providers are able to use this tool to determine:

- The health care program(s) in which the member is enrolled.
- Whether or not the member is enrolled in a state-contracted MCO.
- Whether or not the member has any third-party liability, such as Medicare or commercial health insurance.

Using the Portal to check enrollment may be more effective than calling WiCall or the EVS (although both are available).

Providers are assigned a unique enrollment verification number for each inquiry. Providers can also use the "print screen" function to print a paper copy of enrollment verification inquiries for their records.

ForwardHealth Portal

Providers, members, trading partners, managed care programs, and partners have access to public *and* secure information through the ForwardHealth Portal.

The Portal has the following areas:

- Providers (public and secure).
- Trading Partners.
- Members.
- MCO.
- Partners.

The secure Portal allows providers to conduct business and exchange electronic transactions with ForwardHealth. The public Portal contains general information accessible to all users. Members can access general health care program information and apply for benefits online.

ForwardHealth Portal Helpdesk

Providers and trading partners may call the ForwardHealth Portal Helpdesk with technical questions on Portal functions, including their Portal accounts, registrations, passwords, and submissions through the Portal.

Inquiries to ForwardHealth Via the Portal

Providers are able to contact Provider Services through the ForwardHealth Portal by clicking the Contact link and entering the relevant inquiry information, including selecting the preferred method of response (i.e., telephone call or e-mail). Provider Services will respond to the inquiry by the preferred method of response indicated within five business days.

Internet Connection Speed

ForwardHealth recommends providers have an Internet connection that will provide an upload speed of at least 768 Kbps and a download speed of at least 128 Kbps in order to efficiently conduct business with ForwardHealth via the Portal.

For PES users, ForwardHealth recommends an Internet connection that will provide a download speed of at least 128 Kbps for downloading PES software and software updates from the Portal.

These download speeds are generally not available through a dial-up connection.

Logging in to the Provider Area of the Portal

Once an administrative user's or other user's account is set up, he or she may log in to the Provider area of the Portal to conduct business. To log in, the user is required to click the "Provider" link or button, then enter his or her username and password and click "Go" in the Login to Secure Site box at the right side of the screen.

Managed Care Organization Portal

Information and Functions Through the Portal

The MCO area of the ForwardHealth Portal allows state-contracted MCOs to conduct business with ForwardHealth. The Public MCO page offers easy access to key MCO information and Web tools. A log-in is required to access the secure area of the Portal to submit or retrieve account and member information which may be sensitive.

The following information is available through the Portal:

- Certified Provider Listing of all Medicaid-certified providers.
- Coordination of Benefits Extract/Insurance Carrier Master List information updated quarterly.
- Data Warehouse, which is linked from the Portal to Business Objects. The Business Objects function allows for access to MCO data for long term care MCOs.
- Electronic messages.
- Enrollment verification by entering a member ID or SSN with date of birth and a "from DOS" and a "to DOS" range. A transaction number is assigned to track the request.
- Member search function for retrieving member information such as medical status code, and managed care and Medicare information.
- Provider search function for retrieving provider information such as address, telephone number, provider ID, and taxonomy code (if applicable), and provider type and specialty.
- HealthCheck information.

- MCO contact information.
- Technical contact information. Entries may be added via the Portal.

Managed Care Organization Portal Reports

The following reports are generated to MCOs through their account on the ForwardHealth MCO Portal:

- Capitation Payment Listing Report.
- Cost Share Report (long-term MCOs only).
- Enrollment Reports.

MCOs are required to establish a Portal account in order to receive reports from ForwardHealth.

Capitation Payment Listing Report

The Capitation Payment Listing Report provides "payee" MCOs with a detailed listing of the members for whom they receive capitation payments. ForwardHealth interChange creates adjustment transaction information weekly and regular capitation transaction information monthly. The weekly batch report includes regular and adjustment capitation transactions. MCOs have the option of receiving both the Capitation Payment Listing Report and the 820 Payroll Deducted and Other Group Premium Payment for Insurance Products transactions.

Initial Enrollment Roster Report

The Initial Enrollment Roster Report is generated according to the annual schedules detailing the number of new and continuing members enrolled in the MCO and those disenrolled before the next enrollment month.

Final Enrollment Roster Report

The Final Enrollment Roster Report is generated the last business day of each month and includes members who have had a change in status since the initial report and new members who were enrolled after the Initial Enrollment Roster Report was generated.

Other Reports

Additional reports are available for BadgerCare Plus HMOs, SSI HMOs, and long-term MCOs. Some are available via the Portal and some in the secure FTP.

Members ForwardHealth Portal

Members can access ForwardHealth information by going to the ForwardHealth Portal. Members can search through a directory of providers by entering a ZIP code, city, or county. Members can also access all member-related ForwardHealth applications and forms. Members can use ACCESS to check availability, apply for benefits, check current benefits, and report any changes.

Obtaining a Personal Identification Number

To establish an account on the Portal, providers are required to obtain a PIN. The PIN is a unique, nine-digit number assigned by ForwardHealth interChange for the sole purpose of allowing a provider to establish a Portal account. It is used in conjunction with the provider's login ID. Once the Portal account is established, the provider will be prompted to create a username and password for the account, which will subsequently be used to log in to the Portal.

A provider may need to request more than one PIN if he or she is a provider for more than one program or has more than one type of provider certification. A separate PIN will be needed for each provider certification. Health care providers will need to supply their NPI and corresponding taxonomy code when requesting an account. Non-healthcare providers will need to supply their unique provider number.

Providers may request a PIN by following these steps:

1. Go to the Portal.
2. Click on the "Providers" link or button.
3. Click the "Request Portal Access" link from the Quick Links box on the right side of the screen.
4. At the Request Portal Access screen, enter the following information:
    a. Health care providers are required to enter their NPI and click "Search" to display a listing of ForwardHealth certifications. Select the correct certification for the account. The taxonomy code, ZIP+4 code, and financial payer for that certification will be automatically populated. Enter the SSN or TIN.
    b. Non-healthcare providers are required to enter their provider number, financial payer, and SSN or TIN. (This option should only be used by non-healthcare providers who are exempt from NPI requirements).

       The financial payer is one of the following:
       - Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and Senior Care).
       - SSI.
       - WCDP.
       - The WWWP.

    c. Click **Submit**.
    d. Once the Portal Access Request is successfully completed, ForwardHealth will send a letter with the provider's PIN to the address on file.

Online Handbook

The Online Handbook allows providers access to all policy and billing information for Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and WCDP in one centralized place. A secure ForwardHealth Portal account is not required to use the Online Handbook as it is available to all Portal visitors.

Revisions to policy information are incorporated immediately after policy changes have been issued in *ForwardHealth Updates*. The Online Handbook also links to the ForwardHealth Publications page, an archive section that providers can use to research past policy and procedure information.

The Online Handbook, which is available through the public area of the Portal, is designed to sort information based on user-entered criteria, such as program and provider type. It is organized into sections and chapters. Sections within each handbook may include the following:

- Certification.
- Claims.
- Coordination of Benefits.
- Managed Care.
- Member Information.
- Prior Authorization.
- Reimbursement.
- Resources.

Each section consists of separate chapters (e.g, claims submission, procedure codes), which contain further detailed information.

Advanced Search Function

The Online Handbook has an advanced search function, which allows providers to search for a specific word or phrase within a user type, program, service area, or throughout the entire Online Handbook.

Providers can access the advanced search function by following these steps:

1. Go to the Portal.
2. Click the "Online Handbooks" link in the upper left "Providers" box.
3. Complete the two drop-down selections at the right to narrow the search by program and service area, if applicable. This is not needed if providers wish to search the entire Online Handbook.
4. Click "Advanced Search" to open the advanced search options.
5. Enter the word or phrase you would like to search.
6. Select "Search within the options selected above" or "Search all handbooks, programs and service areas."
7. Click the "Search" button.

ForwardHealth Publications Archive Area

The ForwardHealth Publications page of the Online Handbook allows providers to view old *Updates* and previous versions of the Online Handbook.

Providers can access the archive information area by following these steps:

1. Go to the Portal.
2. Click the "Online Handbooks" link in the upper left "Providers" box.
3. Click on the "Updates and Handbooks" link. (This link is below the three drop-down menus.)

Other Business Enhancements on the Portal

The secure Provider area of the Portal enables providers to do the following:

- View RAs.
- Designate which trading partner is eligible to receive the provider's 835.
- Update and maintain provider file information. Providers will have the choice to indicate separate addresses for different business functions.

Portal Account Administrators

Portal administrators are responsible for requesting, creating, and managing accounts to access these features for their organization.

There must be one administrator assigned for each Portal account and all users established for that account. The responsibilities of the Portal administrator include:

- Ensuring the security and integrity of all user accounts (clerk administrators and clerks) created and associated with their Portal account.
- Ensuring clerks or clerk administrators are given the appropriate authorizations they need to perform their functions for the provider, trading partner, or MCO.
- Ensuring that clerks or clerk administrator accounts are removed/deleted promptly when the user leaves the organization.
- Ensuring that the transactions submitted are valid and recognized by ForwardHealth.
- Ensuring that all users they establish know and follow security and guidelines as required by HIPAA. As Portal administrators establish their Portal account and create accounts for others to access private information, administrators are reminded that all

users must comply with HIPAA. The HIPAA privacy and security rules require that the confidentiality, integrity, and availability of PHI are maintained at all times. The HIPAA Privacy Rule provides guidelines governing the disclosure of PHI. The HIPAA Security Rule delineates the security measures to be implemented for the protection of electronic PHI. If Portal administrators have any questions concerning the protection of PHI, visit the Portal for additional information.

Portal administrators have access to all secure functions for their Portal account.

Establish an Administrator Account

All Portal accounts require an administrator account. The administrator is a selected individual who has overall responsibility for management of the account. Therefore, he or she has complete access to all functions within the specific secure area of his or her Portal and are permitted to add, remove, and manage other individual roles.

Portal Clerk Administrators

A Portal administrator may choose to delegate some of the authority and responsibility for setting up and managing the users within their Portal account. If so, the Portal administrator may establish a clerk administrator. An administrator or clerk administrator can create, modify, manage or remove clerks for a Portal account. When a clerk is created, the administrator or clerk administrator must grant permissions to the clerks to ensure they have the appropriate access to the functions they will perform. A clerk administrator can only grant permissions that they themselves have. For example, if an administrator gives a clerk administrator permission only for enrollment verification, then the clerk administrator can only establish clerks with enrollment verification permissions.

Even if a Portal administrator chooses to create a clerk administrator and delegate the ability to add, modify, and remove users from the same account, the Portal administrator is still responsible for ensuring the integrity and security of the Portal account.

Portal Clerks

The administrator (or the clerk administrator if the administrator has granted them authorization) may set up clerks within their Portal account. Clerks may be assigned one or many roles (i.e., claims, PA, enrollment verification). Clerks do not have the ability to establish, modify, or remove other accounts.

Once a clerk account is set up, the clerk account does not have to be established again for a separate Portal account. Clerks can easily be assigned a role for different Portal accounts (i.e., different ForwardHealth certifications). To perform work under a different Portal account for which they have been granted authorization, a clerk can use the "switch org" function and toggle between the Portal accounts to which they have access. Clerks may be granted different authorization in each Portal account (i.e., they may do enrollment verification for one Portal account, and HealthCheck inquires for another).

Public Area of the Provider Portal

The public Provider area of the ForwardHealth Portal offers a variety of important business features and functions that will greatly assist in daily business activities with ForwardHealth programs.

Maximum Allowable Fee Schedules

Within the Portal, all fee schedules for Medicaid, BadgerCare Plus, and WCDP are interactive and searchable. Providers can enter the DOS, along with other information such as procedure code, category of supplies, or provider type, to find the maximum allowable fee. Providers can also download all fee schedules.

Online Handbook

The Online Handbook is the single source for all current policy and billing information for ForwardHealth. The Online Handbook is designed to sort information based on user-entered criteria, such as program and provider type.

Revisions to information are incorporated immediately after policy changes have been issued in *Updates*. The Online Handbook also links to the ForwardHealth Publications page, an archive section where providers can research past policy changes.

ForwardHealth Publications Archive Section

The ForwardHealth Publications page, available via the Quick Links box, lists *Updates*, *Update Summaries*, archives of provider Handbooks and provider guides, and monthly archives of the Online Handbook. The ForwardHealth Publications page contains both current and obsolete information for research purposes only. Providers should use the Online Handbook for current policy and procedure questions. The *Updates* are searchable by provider type or program (e.g., physician or HealthCheck "Other Services") and by year of publication.

Training

Providers can register for all scheduled trainings and view online trainings via the Portal Training page, which contains an up-to-date calendar of all available training. Additionally, providers can view Webcasts of select trainings.

Contacting Provider Services

Providers and other Portal users will have an additional option for contacting Provider Services through the Contact link on the Portal. Providers can enter the relevant inquiry information, including selecting the preferred method of response (i.e., telephone call or e-mail) the provider wishes to receive back from Provider Services. Provider Services will respond to the inquiry within five business days. Information will be submitted via a secure connection.

Online Certification

Providers can speed up the certification process for Medicaid by completing a provider certification application via the Portal. Providers can then track their application by entering their ATN given to them on completion of the application.

Other Business Enhancements Available on the Portal

The public Provider area of the Portal also includes the following features:

- A "What's New?" section for providers that links to the latest provider publication summaries and other new information posted to the Provider area of the Portal.
- Home page for the provider. Providers have administrative control over their Portal homepage and can grant other employees access to specified areas of the Portal, such as claims and PA.
- E-mail subscription service for *Updates*. Providers can sign up to receive notifications of new provider publications via e-mail. Users are able to select, by program and service area, which publication notifications they would like to receive.
- A forms library.

Secure Area of the Provider Portal

Providers can accomplish many processes via the ForwardHealth Portal, including submitting, adjusting, and correcting claims, submitting and amending PA requests, and verifying enrollment.

Claims and Adjustments Using the Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, and determine what claims are in "pay" status on the Portal. Providers have the ability to search for and view the status of all of their finalized claims, regardless of how they were submitted (i.e., paper, electronic, clearinghouse). If a claim contains an error, providers can correct it on the Portal and resubmit it to ForwardHealth.

Providers can submit an individual claim or adjust a claim via DDE through the secure Portal.

Submitting Prior Authorization and Amendment Requests Via the Portal

Nearly all service areas can submit PAs via the Portal. Providers can do the following:

- Correct errors on PAs or amendment requests via the Portal, regardless of how the PA was originally submitted.
- View all recently submitted and finalized PA and amendment requests.
- View the latest provider review and decision letters.
- Receive messages about PA and amendment requests that have been adjudicated or returned for provider review.

Electronic Communications

The secure Portal contains a one-way message center where providers can receive electronic notifications and provider publications from ForwardHealth. All new messages display on the provider's main page within the secure Portal.

Enrollment Verification

The secure Portal offers real-time member enrollment verification for all ForwardHealth programs. Providers are able to use this tool to determine:

- The health care program(s) in which the member is enrolled.
- Whether or not the member is enrolled in a state-contracted MCO.
- Whether or not the member has any third-party liability, such as Medicare or commercial health insurance.

Using the Portal to check enrollment may be more efficient than calling the AVR system or the EVS (although both are available).

Providers will be assigned a unique enrollment verification number for each inquiry. Providers can also use the "print screen" function to print a paper copy of enrollment verification inquiries for their records.

Other Business Enhancements Available on the Portal

The secure Provider area of the Portal also enables providers to do the following:

- View RAs.
- Designate which trading partner is eligible to receive the provider's 835.
- Update and maintain provider file information. Providers will have the choice to indicate separate addresses for different business functions.

System and Browser Requirements

The following table lists the recommended system and browser requirements for using the Portal. PES users should note that the Windows-based requirements noted in the table apply; PES cannot be run on Apple-based systems.

Recommended System Requirements	Recommended Browser Requirements

Windows-Based Systems	
Computer with at least a 500Mhz processor, 256 MB of RAM, and 100MB of free disk space	Microsoft Internet Explorer v. 6.0 or higher, or Firefox v. 1.5 or higher
Windows XP or higher operating system	
Apple-Based Systems	
Computer running a PowerPC G4 or Intel processor, 512 MB of RAM, and 150MB of free disk space	Safari, or Firefox v. 1.5 or higher
Mac OS X 10.2.x or higher operating system	

Trading Partner Portal

The following information is available on the public Trading Partner area of the Portal:

- Trading partner testing packets.
- Trading Partner Profile submission.
- PES software and upgrade information.
- EDI companion documents.

In the secure Trading Partner area of the Portal, trading partners can exchange electronic transactions with ForwardHealth.

Updates

Full-Text Publications Available

Providers may request full-text versions of *ForwardHealth Updates* to be mailed to them by calling <u>Provider Services</u>.

General Information

ForwardHealth Updates are the first source of provider information. *Updates* announce the latest information on policy and coverage changes, PA submission requirements, claims submission requirements, and training announcements.

The *ForwardHealth Update Summary* is distributed on a monthly basis and contains an overview of *Updates* published that month. Providers with a ForwardHealth Portal account will be notified through their Portal mailbox when the *Update Summary* is available on the Portal. Providers without a Portal account will receive a paper copy of the *Update Summary* unless they have opted out of receiving paper publications.

Providers may obtain copies of *Updates* listed in the *Update Summary* from the Portal. A Web address that directly links providers to a list of each month's *Updates* is listed in the *Update Summary*. Providers may then print specific articles to keep on paper as well as navigate to other Medicaid information available on the Portal.

Providers without Internet access may call <u>Provider Services</u> to request a paper copy of an *Update*. To expedite the call, correspondents will ask providers for the *Update* number. Providers should allow seven to 10 business days for delivery.

Revisions to policy information are incorporated into the Online Handbook immediately after policy changes have been issued in *Updates*. The Online Handbook also includes a link to the <u>ForwardHealth Publications page</u>, an archive section where providers can research past changes.

Multiple Ways to Access ForwardHealth Publications

Providers may choose to receive notification on paper via U.S. mail or through a new e-mail subscription service. Providers who have established a ForwardHealth Portal account will automatically receive notification of *ForwardHealth Updates* and the monthly *ForwardHealth Update Summary* in their Portal message box. Providers will receive notification via their Portal accounts or e-mail subscription much sooner than on paper. Certain providers may choose not to receive *Updates* and the monthly *Update Summary*.

ForwardHealth Portal Account

Providers who establish a Portal account will not receive the *Update Summary* on paper through the U.S. mail. Providers are still bound to the program's rules, policies, and regulations even if they do not receive the *Update Summary* through the mail.

Mail

ForwardHealth will mail the monthly *Update Summary* to providers who do not have a Portal account.

E-mail Subscription Service

Providers and other interested parties may sign up on the Portal to receive e-mail notifications of new provider publications. Users are able to select, by program (Wisconsin Medicaid, BadgerCare Plus, or WCDP) and provider type (e.g., physician, hospital, DME

vendor), and which publication notifications they would like to receive. Any number of staff or other interested parties from an organization may sign up for an e-mail subscription. Providers who sign up for an e-mail subscription will continue to receive paper copies of the monthly *Update Summary* unless they have a Portal account or have opted out of receiving paper publications.

Users may sign up for an e-mail subscription by following these steps:

1. Go to the Portal.
2. Click on the "Providers" link or button.
3. Click the "Subscribe to Provider Notifications" link from the Quick Links box on the right side of the screen.
4. Register by supplying e-mail address.

Users may register for additional electronic subscriptions by adding service areas listed under "Available Subscriptions" on the right side of the subscriptions page.

WiCall

Enrollment Inquiries

WiCall is an AVR system that allows providers with touch-tone telephones direct access to enrollment information. A WiCall Quick Reference Guide for Enrollment Inquiries is available.

Information from WiCall will be returned in the following order if applicable to the member's current enrollment:

- Transaction number: A number will be given as a transaction confirmation that providers should keep for their records.
- Benefit enrollment: All benefit plans the member is enrolled in on the DOS or within the DOS range selected for the financial payer.
- County Code: The member's county code will be provided if available. The county code is a two-digit code between 01 and 72 that represents the county in which member resides. If the enrollment response reflects that the member resides in a designated HPSA on the DOS or within the DOS range selected, HPSA information will be given.
- MCO: All information about state-contracted MCO enrollment, including MCO names and telephone numbers (that exists on the DOS or within the DOS range selected), will be listed. This information is applicable to Medicaid and BadgerCare Plus members only.
- Hospice: If the member is enrolled in the hospice benefit on the DOS or within the DOS range that the provider selected, the hospice information will be given. This information is applicable to Medicaid and BadgerCare Plus members only.
- Lock-in: Information about member lock-in that exists on the DOS or within the DOS range selected will be provided. This information is applicable to Medicaid, BadgerCare Plus, and SeniorCare members only.
- Medicare: All information about Medicare coverage, including type of coverage and Medicare number, if available, that exists on the DOS or within the DOS range selected will be listed.
- Other Commercial Insurance Coverage: All information about commercial coverage, including carrier names and telephone numbers, if available, that exists on the DOS or within the DOS range selected will be listed.
- Transaction Completed: After the member's enrollment information has been given using the financial payer that was selected, providers will be given the following options:
  - To hear the information again.
  - To request enrollment information for the same member using a different financial payer.
  - To hear another member's enrollment information using the same financial payer.
  - To hear another member's enrollment information using a different financial payer.
  - To return to the main menu.

WiCall is available 24 hours a day, seven days a week. If for some reason the system is unavailable, providers may call Provider Services.

Transaction Number

The AVR system issues a transaction number every time a provider verifies enrollment, even when an individual is *not* enrolled in BadgerCare Plus or Wisconsin Medicaid. The provider should retain this transaction number. It is proof that an inquiry was made about the member's enrollment. If a provider thinks a claim was denied in error, the provider can reference the transaction number to ForwardHealth to confirm the enrollment response that was actually given.

Entering Letters into WiCall

For some WiCall inquries, health care providers are required to enter their taxonomy code with their NPI. Because taxonomy codes are a combination of numbers and letters, telephone key pad combinations, shown in the table below, allow providers to successfully enter taxonomy code letters for WiCall functions (e.g., press *21 to enter an "A," press *72 to enter an "R").

Letter	Key Combination	Letter	Key Combination
A	*21	N	*62
B	*22	O	*63
C	*23	P	*71
D	*31	Q	*11
E	*32	R	*72
F	*33	S	*73
G	*41	T	*81
H	*42	U	*82
I	*43	V	*83
J	*51	W	*91
K	*52	X	*92
L	*53	Y	*93
M	*61	Z	*12

Additionally, providers may select option 9 and press "#" for an automated voice explanation of how to enter letters in WiCall.

Information Available Via WiCall

WiCall, ForwardHealth's AVR system, gathers inquiry information from callers through voice prompts and accesses ForwardHealth interChange to retrieve and "speak" back the following ForwardHealth information:

- Claim status.
- Enrollment verification.
- PA status.
- Provider CheckWrite information.

Providers are prompted to enter NPI or provider ID and in some cases, NPI-related data, to retrieve query information.

In all inquiry scenarios, WiCall offers the following options after information is retrieved and reported back to the caller:

- Repeat the information.
- Make another inquiry of the same type.
- Return to the main menu.
- Repeat the options.

Claim Status

Providers may check the status of a specific claim by selecting the applicable program ("financial payer" option, i.e., Wisconsin Medicaid, WCDP, or WWWP by entering their provider ID, member identification number, DOS, and the amount billed.

Note: Claim information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

Enrollment Verification

Providers may request enrollment status for any date of eligibility the member has on file by entering their provider ID and the member ID. If the member ID is unknown, providers may enter the member's date of birth and SSN. Additionally, the provider is

prompted to enter the "From DOS" and the "To DOS" for the inquiry. The "From" DOS is the earliest date the provider requires enrollment information and the "To" DOS must be within 365 days of the "From" DOS.

Each time a provider verifies member enrollment, the enrollment verification is saved and assigned a transaction number as transaction confirmation. Providers should note the transaction number for their records.

Prior Authorization Status

Except in certain instances, providers may obtain the status of PA requests for Medicaid and WCDP via WiCall by entering their provider ID and the applicable PA number. If the provider does not know the PA number, there is an option to bypass entering the PA number and the caller will be prompted to enter other PA information such as member ID and type of service (i.e., NDC/procedure code, revenue code, or ICD-9-CM diagnosis code.) When a match is found, WiCall reports back the PA status information, including the PA number for future reference, and the applicable program.

Information on past PAs is retained indefinitely. Paper PAs require a maximum of 20 working days from receipt to be processed and incorporated into WiCall's PA status information.

Note: PA information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

Quick Reference Guide

The WiCall AVR Quick Reference Guide displays the information available for WiCall inquiries.