

# Key Child Care Coordination Requirements

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# Key Child Care Coordination Requirements:Overview

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Topic #23839

## Overview and Best Practices

The Key Child Care Coordination Requirements section is intended to highlight the Wisconsin Medicaid requirements that are unique to the CCC (child care coordination) benefit.

CCC providers must meet all additional requirements described in the [Provider Enrollment and Ongoing Responsibilities](#), [Covered and Noncovered Services](#), [Claims](#), [Reimbursement](#), [Member Information](#), [Coordination of Benefits](#), [Resources](#), and [Managed Care](#) sections.

## Member Eligibility

CCC is a benefit for BadgerCare Plus and Medicaid members:

- ┆ Up to their seventh birthday for members living in Milwaukee County.
- ┆ Up to their second birthday for members living in the City of Racine.

Members must also have either received a Wisconsin DHS (Department of Health Services)-approved initial assessment [Child Care Coordination \(CCC\) Family Questionnaire Domains and Questions \(F-01118 \(07/2025\)\)](#) within eight weeks following their birth.

## Child Care Coordination Goals

CCC helps a member and, when appropriate, the member's family gain access to needed medical, social, educational, and other services identified during the assessment. The goals of the CCC benefit are to improve child health outcomes and promote positive parenting and child safety.

The main objectives for obtaining these goals include ensuring that members and their family:

- ┆ Are identified for assessment as early as possible.
- ┆ Receive services based on their individual needs and family strengths.
- ┆ Receive early and continuous care coordination to help meet their care plan goals.
- ┆ Receive assistance accessing and obtaining needed health, developmental, behavioral, community, and social services, as appropriate.

## Child Care Coordination Providers

CCC providers may include public and private organizations and individuals.

Per Wis. Admin. Code § [DHS 105.525](#), CCC providers must meet certain requirements. They must:

- ┆ Be located in the area that they will serve.
- ┆ Already be [enrolled](#) as a PNCC (prenatal care coordination) provider.
- ┆ Have the ability and willingness to deliver services in a way that meets the community's needs.
- ┆ Arrange for supportive services from a variety of funding sources.

- ┆ Have the capability to provide ongoing care coordination and monitoring services to ensure that all needed services are obtained.
- ┆ Have qualified professionals on staff.

Most Medicaid members receive Medicaid coverage through HMOs. An HMO is an insurance company that is responsible for coordinating most healthcare services for the member. CCC providers and HMOs must coordinate with one another to avoid duplication of services and to facilitate coordination of CCC services to members.

CCC is a carved-in service. CCC providers must bill all claims for CCC services provided to members enrolled in an HMO directly to that HMO. Claims for CCC services provided to a member enrolled in fee-for-service Medicaid must be billed to ForwardHealth.

## Child Care Coordination Services

CCC services include all of the following:

- ┆ [Initial, comprehensive assessment](#): An assessment using the Wisconsin DHS-approved Child Care Coordination (CCC) Family Questionnaire Domains and Questions to identify whether the member is eligible to receive subsequent CCC services and determine the member and their family's needs and strengths.
- ┆ [Care plan development](#): The initial development of the member's written care plan based on the strengths and needs identified during the initial assessment.
- ┆ [Ongoing care coordination and monitoring](#): Regular contacts with the member and member's family—as well as formal and informal supportive individuals—to provide the member and the member's family with information and referral to services based on the care plan. The service also includes time spent on recordkeeping, such as updating the member's assessment or care plan.

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

## Child Care Coordination Best Practices

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

Providers should follow best practices in service delivery to help ensure that quality services are provided and that activities are directed toward the CCC benefit objectives and goal.

In the course of providing services, CCC providers may identify during the assessment that a child's immediate family member or caregiver has behavioral health needs that impact the child. For example, they may face challenges with relationships and support systems, personal safety or safety of other family members, past or current physical or substance abuse, depression or other mental health conditions, as well as stress from barriers to meeting basic needs like food and shelter.

To address the immediate family member or caregiver's behavioral health needs, providers should provide information and assistance and provide resources to connect the individual with appropriate services and supports.

CCC providers may also be eligible to provide certain mental health and substance abuse screening services under the [SBIRT \(Screening, Brief Intervention, and Referral to Treatment\) benefit](#). Provision of this screening service is separate from the CCC benefit.

### Initial Assessment

CCC providers must complete the initial assessment in partnership with the member and member's parent or caregiver, using the

Wisconsin DHS-approved Child Care Coordination (CCC) Family Questionnaire Domains and Questions. The parent or caregiver must be engaged in the initial assessment or assessment updates.

Prior to completing the Family Questionnaire with the member, providers should:

- | Read and familiarize themselves with the Family Questionnaire instructions, including background information behind each question, as well as additional follow-up questions that may be useful when periodically updating the assessment.
- | Describe the initial assessment and care plan development processes. Help the member understand what to expect from this process.
- | Acknowledge the intrusiveness of some of the questions.
- | Describe the background of each question and how the information is important to identify the member and family's strengths and needs.
- | Share confidentiality policies with the parent or caregiver, including who will have access to the information provided.
- | If possible, use a conversational-style interaction with the member to collect the information needed to complete the assessment. The Family Questionnaire has information on this approach.

After completing the Family Questionnaire, inform the parent or caregiver whether their child is eligible to receive CCC services. If the member is eligible but the parent or caregiver is not interested in having their child receive services, try to determine the reason. Give them the provider's contact information and ask them to contact the provider if they change their mind. If a parent or caregiver does not want to address all the needs identified, try to document the reason.

## **Ongoing Care Coordination and Monitoring**

### ***Information and Referral***

On an ongoing basis, the CCC provider should, in partnership with the member's parent or caregiver:

- | Determine, with the member, which services identified in the member's care plan have been or are being delivered.
- | Determine, with the member, if the services are adequately meeting the member's needs.
- | Provide supportive contact for the member to ensure that the member and their parent or caregiver are able to access services, are actually receiving services, or are engaging in activities specified in the care plan.
- | Ask the parent or caregiver if they are satisfied with the service and ask them to evaluate the service quality and relevance to the strengths, goals, and needs specified on the care plan.
- | Identify whether the member or family's circumstances have changed and if the assessment and/or care plan should be updated accordingly.

Provide information on community resources and referrals to other agencies when appropriate. Whenever possible, provide written referrals. Written referrals should include:

- | The name of the referred provider.
- | The reason for referral.
- | The date the referral was made.
- | Any authorizations for release of information.
- | All communication and follow-up on the referral with both the member's parent or caregiver and the referred provider. The record should indicate whether the member declined a service identified in the care plan.

When making a referral:

- | Inform the parent or caregiver of all available options for obtaining the needed service.
- | Ensure that the parent or caregiver understands the reason and need for the referral.
- | Explain any costs involved or limitation in the service.
- | Assist the parent or caregiver in accessing the service for which the referral was made.
- | Follow up with the provider to which the member is referred, including appropriate advocacy on behalf of the member and

their parent or caregiver to ensure that services are provided.

- | Follow up on referrals within two weeks.
- | Assist the parent or caregiver in accessing the health care delivery system. For example, ensure that the parent or caregiver:
  - | Can identify the member's primary care provider, clinic, and HMO, if applicable.
  - | Has the health care providers' contact information.
  - | Knows how to schedule, reschedule, and cancel appointments.
  - | Knows how to obtain medical information or health care after hours.
  - | Knows how to obtain specialty care, for example, mental health/substance abuse treatment.
  - | Knows when to use the hospital emergency room.
  - | Can obtain information and access the health care delivery system as appropriate.
  - | Can access community or behavioral health services for members with complex behavioral health needs.

If the member, family member, or caregiver exhibits behavior that may be dangerous to themselves or others, immediately refer them to their health care or behavioral health provider in the community. Ensure follow-up within 24 hours.

Ensure that the intensity and frequency of contacts with the member and their parent or caregiver corresponds to the level of need identified by the member's initial assessment. For example, schedule frequent face-to-face visits if the member, parent, or caregiver is in crisis; if there is violence in the home; or if the member's parent or caregiver is a first-time parent with no support system. If necessary, call or visit the member daily or weekly.

At a minimum, contacts or visits should occur no less than every 30 days.

Ongoing care coordination and monitoring also includes updates to the member's assessment and care plan.

CCC providers should reassess the member at least once per trimester, and sooner if the member experiences a significant change. A reassessment should include a re-evaluation of the member's strengths and needs across the Family Questionnaire domains and then inform changes to the care plan.

The CCC provider must review and—if necessary—update the care plan at least every 60 days, or earlier if the member's needs change. Updates to the care plan should be informed by the member's assessment, and the care plan should always reflect the member's individual strengths and needs.

## Child Care Coordination Resources

Additional CCC [information and resources](#) are available.

# Enrollment and Documentation Requirements

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Topic #961

## Ongoing Documentation Requirements

Wis. Admin. Code § DHS [106.02\(9\)](#) requires that all providers 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. Providers are required to meet state and federal privacy and security regulations.

After enrolling in Wisconsin Medicaid, CCC (child care coordination) providers must maintain certain documentation for review and audit, per Wis. Admin. Code §§ DHS [105.525\(4\)](#), [105.525\(6\)](#), [105.525\(7\)](#), and [105.525\(8\)](#).

A list of CCC forms is [available](#).

## Plan of Operation Requirement

As defined in Wis. Admin. Code § DHS 105.525(6), the agency must document and implement a plan of operation. The plan of operation must demonstrate:

- | That the provider is located in or near the area it will serve.
- | That the provider has a variety of techniques to identify low-income children and families who are appropriate for services under this section.
- | That the provider will provide the name, location, and telephone number of the following resources to individuals in the area to be served:
  - | WIC (Special Supplemental Nutrition Program for Women, Infants, and Children) programs
  - | Maternal and child health services
  - | The county, city, or combined city and county public health agency
  - | Child day care services
  - | Mental health and alcohol or other drug abuse prevention and treatment agencies
  - | The county protective service agency
  - | Domestic abuse agencies
  - | Translator and interpreter services, including services for the hearing-impaired
  - | Family support services
  - | Transportation services
  - | Food programs
  - | Housing resources and programs
  - | Medicaid-certified primary care and pediatric providers, including HMOs participating in the medical assistance program's HMO program
- | That the provider has the ability and willingness to deliver services in a manner that is sensitive to the particular characteristics of the racial or ethnic group or groups with which it intends to work as documented by one or more of the following:
  - | Records showing the racial and ethnic composition of the population served in the past
  - | Records showing that the agency has developed, implemented and evaluated programs specifically targeted toward the racial or ethnic group or groups
  - | Records showing that the provider has performed health care services in a geographic area where a significant percentage of the population was the same as the provider's targeted racial or ethnic group or groups
  - | Evidence that the provider's board or administration has a significant amount of representation from the targeted

- group or groups
  - | Letters of support from minority health service organizations which represent the targeted group or groups
  - | Evidence of the provider's ability to address pertinent cultural issues such as cultural norms and beliefs, language, outreach networking, and extended family relationships
- | That the provider has the ability and willingness to arrange for supportive services provided by other funding sources such as county transportation, county protective services, interpreter services, child care services, and housing. This description must include the methods, techniques, and contacts which will be used to offer and provide assistance in accessing the services.
- | That the provider has the capability to provide ongoing CCC monitoring for children and families and to ensure that all necessary services are obtained. This includes:
  - | Coordinating with other health and social service agencies in the service area, including managed care providers and community resource providers, to avoid duplication of services and to facilitate coordination of child care services to clients.
  - | Coordinating with Medicaid-certified primary and pediatric care providers in the service area to communicate the services the CCC provider renders, and documenting and retaining these contacts in the provider's administrative records.
- | That the provider hired or contracted at least one qualified professional meeting required criteria.
- | That the provider has a process for referrals, service delivery, assessment, care planning, and follow-up activities.
- | That the provider has a personnel management system and training plan as described below.
- | That the provider has quality assurance procedures and documentation requirements.
- | That the provider has adequate resources to maintain a cash flow sufficient to cover operating expenses for 60 days.

## Personnel Management System and Training Plan Requirement

Per Wis. Admin. Code § DHS 105.525(7), the agency must document and implement a personnel management system and training plan. The personnel management system and training plan must include:

- | The provider's plan to hire, support, and train staff to provide services that are family centered and culturally appropriate.
- | All of the following if more than one qualified professional or care coordinator is employed or under contract with the provider:
  - | The training plan has a process for periodically evaluating every care coordinator and qualified professional supervisor employed by or under contract with the provider in accordance with the provider's quality assurance procedures.
  - | The training plan has a process for following up on all evaluations with appropriation action to ensure the employee can competently perform all assigned duties.
- | A requirement that no employee or subcontractor may be assigned any duty that they are not trained for. The CCC provider will provide or arrange for training for employed or subcontracted care coordinators as necessary.
- | Procedures for ensuring all qualified professionals and care coordinators receive orientation and ongoing instruction including:
  - | Requirements that orientation and training must be completed by a qualified professional or care coordinator before they provide services to a member.
  - | The names and titles of persons responsible for conducting orientation and training.
  - | Dates of the trainings and a description of the course content and length of training.
  - | Topics covered in orientation, which include training on all of the following, at minimum:
    - The goals, mission, and priorities of the provider
    - Specific job duties, including each skill the care coordinator is assigned and a successful demonstration of each skill by the care coordinator to a qualified trainer under the supervision of the qualified professional supervisor (Each job duty must be successfully demonstrated under supervision prior to providing the service to a member independently. The qualified professional or qualified trainer will document the care coordinator's successful demonstration of each skill and maintain the information in their personnel file.)
    - The functions of the CCC provider staff and how they interrelate and communicate with each other in providing services
    - Health and safety procedures for working in a home environment

- o Responding to medical and non-medical emergencies
  - o Ethics, confidentiality of member information, and member rights
- o A process for providing instruction when an evaluation of the qualified professional's or care coordinator's performance or competency indicates additional instruction may be needed.
- o Standards for qualified professional supervision of services rendered by a care coordinator, including the frequency and duration of supervision. When supervision reveals a failure to follow the member's care plan, the CCC provider will provide counseling, education or retraining to ensure the care coordinator is adequately trained to complete their job responsibilities. In the case of child care coordinators who are not employees of the CCC provider, a plan specifying all required training, qualifications, and services to be performed in a written care coordinator provider contract between the CCC provider and care coordinators, and maintain a copy of that contract on file.
- o A process for documenting performance of care coordination services by care coordinators by maintaining time sheets of care coordinators which document the types and duration of services provided, by funding source.
- o Requirements for ongoing training, including all of the following requirements:
  - o CCC provider staff or contractors must have a minimum of five hours of annual training if they are expected to have regular and direct contact with participants. Annual training must be related to early intervention, education, case management, or similar social service continuing education. Training may be in-service training, conferences, workshops, earning of continuing education credits or earning of higher education credits.
  - o A process must exist for required additional training, as identified by the supervising qualified professional.
  - o A process must exist for documenting staff completion of ongoing training requirements in the employee's file.

## Member Record

As defined in Wis. Admin. Code § DHS 105.525(8), a member's file must include the following documents, as appropriate:

- 1 The member's completed [CCC Family Questionnaire Domains and Questions \(Child Care Coordination Family Questionnaire Domains and Questions F-01118 \(07/2025\)\)](#) assessment. The assessment must be scored, signed, and dated.
- 1 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. The care plan must identify the name and title of the member's designated care coordinator.
- 1 A log that clearly and concisely documents all care coordination activities. All entries must be signed and dated.
- 1 Completed consent document(s) for release of information.
- 1 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.
  - 1 The collateral contact's name. The name and role of the collateral contact must be identified in the care plan.
  - 1 The date of the contact.
  - 1 The full name and title of the person who made the contact.
  - 1 A clear description of the reason for and nature of the contact. The description must link the contact to a specific care plan goal or activity.
  - 1 The results of the contact, including whether the goal or activity specified in the care plan was achieved.
  - 1 The length of time of the contact (the number of minutes or the exact time (for example, 9:15 a.m.—10:05 a.m.)).
  - 1 Where or how the contact was made.
- 1 Referrals and follow up including:
  - 1 The name of the referred provider.
  - 1 The reason for referral.
  - 1 The date the referral was made.
  - 1 Any authorizations for release of information.
  - 1 All communication and follow-up on the referral with both the member's parent or caregiver and the referred provider.
- 1 The record should indicate whether the member declined a service identified in the care plan.
- 1 All pertinent correspondence (to the member or on behalf of the member) relating to coordination of the member's care.



Topic #962

## Provider Enrollment Requirements

There are key CCC (child care coordination) qualifications and requirements that agencies must satisfy in order to enroll and participate as a CCC provider with Wisconsin Medicaid including [CCC ongoing documentation requirements](#). Additionally, agencies must ensure that they meet general Wisconsin Medicaid [provider enrollment requirements](#) and [ongoing responsibilities](#).

Per Wis. Admin. Code § [DHS 105.525\(1\)\(b\)](#), CCC services may only be provided to members who are residents of Milwaukee County or the City of Racine. Providers who serve members in the City of Racine are required to participate in a program to reduce fetal and infant mortality and morbidity, under Wis. Stat. § [253.16](#).

Prior to enrolling as a CCC provider, a provider must first enroll as a PNCC (prenatal care coordination) provider. To enroll, providers must complete and submit an [enrollment application](#) for each program.

## Qualifying Applicant Categories

Per Wis. Admin. Code § [DHS 105.525\(1\)\(a\)](#), the agency must be one of the following:

- | Community-based health organizations
- | Community-based social services agencies or organizations
- | County, city, or combined city and county public health agencies
- | County departments of human services under Wis. Stat. § [46.23](#), or social services under Wis. Stat. §§ [46.215](#) or [46.22](#)
- | Home visiting programs as defined under [42 USC 711](#)
- | FQHCs (Federally Qualified Health Centers) as defined in [42 C.F.R. § 405.2401](#)
- | Independent physician associations
- | Hospitals
- | Physicians' offices or clinics
- | RHCs (Rural health clinics) certified under Wis. Admin. Code § [DHS 105.35](#)
- | Tribal agency health centers
- | Local agencies that participate in WIC (Special Supplemental Nutrition Program for Women, Infants, and Children) as described under [42 USC 1786](#)

## Ownership Requirements

Per Wis. Admin. Code § [DHS 105.525\(4\)](#), an agency seeking to enroll as a CCC provider may not be approved until the department determines that the "applicant" and "principal" are fit and qualified to provide CCC services.

An "applicant" is defined as the person seeking Medicaid certification as a CCC services provider. A "principal" is defined as an administrator or a person with management responsibility for the agency who owns directly or indirectly 5% or more of the shares or other evidences of ownership of a corporate applicant, a partner in a partnership who is an applicant, or the owner of a sole proprietorship who is an applicant.

Specific fit and qualified criteria considered by the Wisconsin DHS (Department of Health Services) for all applicants and principals include:

- | Whether the applicant or any principal with the agency have convictions for a crime involving:
  - | Neglect or abuse of patients.
  - | Assaultive behavior or wanton disregard for the health and safety of others.
  - | Delivery of health care services or items.
  - | Misappropriation, theft, or fraud.

- ┆ Whether the applicant or any principal with the agency has a finding of abuse or neglect of a client, or misappropriation of client property under Wis. Stat. § [146.40\(4r\)\(b\)](#).
- ┆ The applicant and any principal with the agency's financial stability, including outstanding debts or amounts due to the department or other government agencies, including unpaid forfeitures and fines, that resulted in bankruptcy under chapter 11 of the United States Bankruptcy Code.
- ┆ Whether the applicant and any principal with the agency has experience through education or at least one year of continuous work experience in child health and family services.

## Qualified Professional Qualifications

Per Wis. Admin. Code § [DHS 105.525\(2\)](#), CCC agencies must employ or contract with at least one qualified professional, and all qualified professionals must meet the following qualifications.

Each qualified professional employed or contracted with the CCC agency must have:

- ┆ At least two years of experience in coordinating services for at-risk or low income children and families.
- ┆ The necessary skills and relevant education to supervise assessment and ongoing care coordination and monitoring performed by care coordinators.

Additionally, an individual must also hold one of the following credentials or job titles and meet the associated qualification requirements to be a CCC qualified professional.

Individuals Qualified to be a Child Care Coordination Qualified Professional	
Credential or Title	Qualification Requirements
Nurse Practitioner	Licensed as a registered nurse pursuant to Wis. Stat. § <a href="#">441.06</a> and currently certified by the American Nurses Association, the Pediatric Nursing Certification Board
Public Health Nurse	Meets the qualifications of Wis. Admin. Code § <a href="#">DHS 139.08</a>
Physician	Licensed under Wis. Stat. ch. <a href="#">448</a> to practice medicine or osteopathy
Physician Assistant	Certified under Wis. Stat. ch. 448
Licensed Clinical Social Worker	Certified under Wis. Stat. § <a href="#">457.08(4)</a>
Registered Nurse	Has at least two years of experience in pediatric nursing, community health services, or a combination of pediatric nursing and community health services
Employee	Either: <ul style="list-style-type: none"> <li>┆ Has at least a Bachelor's degree and two years of experience in health promotion, health advocacy, health education, case management or care coordination, child/family social work, community outreach, or child welfare or related field</li> <li>┆ Has IMH-E (Infant Mental Health Endorsement)</li> </ul>
Health Educator	Either: <ul style="list-style-type: none"> <li>┆ Certified Health Education Specialist credential from the National Commission for Health Education Credentialing</li> <li>┆ Has a Master's degree in health education and at least two years of experience in health promotion, health advocacy, health education, case management or care</li> </ul>

	coordination, child/family social work, community outreach, or child welfare or related field
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CCC qualified professionals must also be able to:

- ┆ Supervise tasks assigned to care coordinators.
- ┆ Administer or review and sign each comprehensive assessment and assessment update performed.
- ┆ Develop and sign the individualized plan of care based on the needs identified in the assessment.
- ┆ Confer with the care coordinator regarding the member's progress towards goals and outcomes identified in the member's plan of care.

## Care Coordinator Qualifications

Per Wis. Admin Code § [DHS 105.525\(3\)](#), CCC agencies must ensure care coordinators meet the following qualifications.

All care coordinators must:

- ┆ Be at least 18 years old.
- ┆ Have a minimum of a high school or GED diploma.
- ┆ Have the skills, education, experience, and ability to fulfill the employee's job requirements.
- ┆ Be trained under the CCC agency's training plan and assigned skills before serving members.

All care coordinators must be able to:

- ┆ Perform tasks assigned by the qualified professional supervisor.
- ┆ Report in writing to the qualified professional supervisor on each comprehensive assessment and assessment update administered.
- ┆ Confer with the qualified professional supervisor regarding the member's progress towards goals and outcomes identified in the member's plan of care.

## Sufficiency of Agency Certification Requirement

Per Wis. Admin Code §§ DHS [105.525\(4\)\(a\) and \(b\)](#), to enroll as a CCC provider, agencies must also:

- ┆ Maintain a list of all agency staff and contractors who provide or supervise CCC services. The list must include the credentials of all listed qualified professionals. Agencies are required to report changes in qualified professional staff or contractors, whether hiring or terminating, to ForwardHealth within 10 business days using the [Demographic Maintenance Tool](#) on the Portal.
- ┆ Obtain and document employee caregiver background checks following the procedures in Wis. Stat. § [50.065](#) and Wis. Admin. Code ch. DHS [12](#) for all employed and/or contracted care coordinators and qualified professionals. Background checks must be conducted at the time of hire or contract, and every four years thereafter.

## High-Risk Background Check Requirement

In accordance with federal regulations at 42 CFR § 455.434, providers classified as [high-risk](#) during Medicaid enrollment, re-enrollment, or revalidation are required to be fingerprinted. **PNCC and CCC providers are currently classified as high-risk providers.**

This requirement applies to high-risk providers, as well as any person with a [5% or more direct or indirect ownership interest](#). Applicants will be notified of this requirement via the [Fingerprint Notification](#) panel when they submit their Medicaid enrollment, re-enrollment, or revalidation application on the ForwardHealth Portal.

## Enrollment Documentation and Attestation Requirements

As a part of the Wisconsin Medicaid enrollment process, applicants must upload certain documentation and attest that they meet certain requirements to demonstrate that they meet enrollment criteria under Wis. Admin. Code § [DHS 105.525](#).

Applicants must upload, at minimum (applicants may be required to submit additional documentation):

- ┆ A current resume for each qualified professional and agency staff member, per Wis. Admin. Code § DHS 105.525(4).
- ┆ A current resume for each person with an ownership or control interest that documents the minimum experience in child health and family services, through education or at least one year of continuous work experience, needed to provide ongoing CCC monitoring to children and families and to ensure that these individuals obtain all necessary services, per Wis. Admin. Code § [DHS 105.525\(5\)\(b\)\(4\)](#).
- ┆ A documented and implemented plan of operation that meets the requirements listed in Wis. Admin. Code § [DHS 105.525\(6\)](#).
- ┆ A documented and implemented training plan for all employed and contracted staff that meets the requirements listed in Wis. Admin. Code § [DHS 105.525\(7\)](#).

CCC providers must also maintain certain [documentation](#) after enrollment for review and audit.

## Subcontracting for Child Care Coordination Services

Medicaid-enrolled CCC providers may provide CCC services by subcontracting with individuals or organizations that provide these services but do not enroll in Wisconsin Medicaid. The Medicaid-enrolled provider retains all legal and fiscal responsibility for the services provided by subcontractors.

The Medicaid-enrolled provider is responsible for ensuring that its subcontractors meet all Medicaid program requirements for providing CCC services, including service delivery and recordkeeping. The Medicaid-enrolled provider must maintain records of its contracts or agreements with any subcontracted individuals or organizations, per Wis. Admin. Code § [DHS 105.02\(6\)\(a\)](#).

Wisconsin Medicaid will only send provider materials to the Medicaid-enrolled provider or subcontractors who specifically request materials. The Medicaid-enrolled provider is responsible for ensuring that its subcontractors receive copies of materials distributed by Wisconsin Medicaid.

The Medicaid-enrolled provider may submit claims for CCC services conducted by a subcontractor, but ForwardHealth will only reimburse the Medicaid-enrolled provider.

Topic #958

## Wisconsin Medicaid and Managed Care

### Contracting With HMOs

All CCC (child care coordination) providers must have a contract with a Wisconsin Medicaid HMO to be reimbursed for services provided to members enrolled in their health plans. Prior to being able to contract with HMOs, CCC providers need to be Medicaid-enrolled.

Contracts with HMOs may cover information such as:

- ┆ Scope of services
- ┆ Payment terms

- | Billing processes and timelines
- | Quality standards and reporting
- | Dispute resolution processes
- | Termination and renewal terms

Note: CCC providers who render services to members who are **not** enrolled in HMOs are not required to have contracts or a Memorandum of Understanding with HMOs to be reimbursed for CCC services.

The [Child Care Coordination Enrollment Provider Checklist](#) provides more information about contracting with HMOs to provide services to their members. Providers should save a copy of their signed provider agreement with each HMO that describes reimbursement for services.

# Service Requirements

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Topic #984

## Care Plan Development

Care plan development is the development of a Medicaid member's written care plan. It is based on the physical, social, and emotional needs and strengths identified during the initial assessment.

Per Wis. Admin. Code § [DHS 107.345\(1\)\(c\)](#), the care plan must:

- ┆ Be developed by a qualified professional under Wis. Admin. Code § [DHS 105.525\(2\)\(c\)](#).
- ┆ Be developed with the member and, to the maximum extent possible, in collaboration with the family or other supportive persons.
- ┆ Be signed and dated by the parent, guardian or caregiver, qualified professional, and care coordinator.
- ┆ Include:
  - ┆ The member's strengths, needs, and possible services that will reduce the probability of adverse outcomes.
  - ┆ All possible needed services related to the needs identified in the assessment, regardless of the funding source.
  - ┆ Identification and prioritization of all needs found during the assessment, with an attached copy of the assessment.
  - ┆ Identification and prioritization of all services to be arranged for the member by the care coordinator and the names of the service providers, including medical providers.
  - ┆ A description of the member's informal support system, including collaterals and any activities to strengthen it.
  - ┆ Identification of individuals who participated in the development of the plan of care.
  - ┆ Arrangements for various services to be made available to the member, the frequency of those services, and the expected outcome for each service.
  - ┆ Documentation of unmet needs and gaps in service.
  - ┆ Responsibilities of the family and child.

Note: Providers should note in the care plan if the member does not want to address needs identified in the [CCC Family Questionnaire Domains and Questions \(Child Care Coordination Family Questionnaire Domains and Questions F-01118 \(07/2025\)\)](#).

Each member must have their own individualized [CCC Care Plan \(Child Care Coordination Care Plan F-03391 \(07/2025\)\)](#). When multiple members are receiving CCC within one family (for example two siblings are both receiving CCC services), and they have shared goals within their care plans, providers must document the shared goal in each member's individual care plan.

## Care Plan Updates

CCC providers are required to review and—if necessary—update the member's care plan at least every 60 days during the child's first year of life and at minimum, every 180 days thereafter, or earlier if the member's needs change. Care plan updates are part of [ongoing care coordination and monitoring services](#).

All updates must be made in writing on a new care plan form and signed by the parent, guardian or caregiver, qualified professional, and care coordinator.

Providers should inform the member:

- ┆ That the care plan can be changed at any time and as often as necessary.
- ┆ How to request changes to the care plan.

Topic #983

## Initial and Yearly Comprehensive Assessments

The assessment is a CCC (child care coordination) service to identify whether a Medicaid member is eligible to receive subsequent CCC services and to determine the individual's needs and strengths.

Care coordinators or qualified professionals are required to:

- ┆ Administer at least an initial assessment to all members within eight weeks, including members whose mothers received PNCC (prenatal care coordination) services.
- ┆ Complete every section on the [CCC Family Questionnaire Domains and Questions \(Child Care Coordination Family Questionnaire Domains and Questions F-01118 \(07/2025\)\)](#) unless the member objects to a particular section.

The assessment informs care plan development to connect members to needed resources and services. Providers must complete the Child Care Coordination Family Questionnaire Domains and Questions for the assessment and assessment updates. The questionnaire focuses on identifying the needs of the member and their family.

Per Wis. Admin. Code § DHS [107.345\(1\)](#), the assessment must meet the following requirements:

- ┆ An employee of the CCC agency completes the Wisconsin DHS (Department of Health Services)-approved Child Care Coordination Family Questionnaire Domains and Questions.
- ┆ The completed Family questionnaire is:
  - ┆ Reviewed and signed by a qualified professional under Wis. Admin. Code § DHS [105.525](#).
  - ┆ Reviewed and finalized in a face-to-face contact with the member and parent, guardian or caregiver.
  - ┆ Signed by the member's primary caregiver.
  - ┆ Documented in the member's file.
  - ┆ Administered at least every 365 days or earlier if the member's needs change.

## Assessment Updates

CCC providers may reassess a member at any time. If the member experiences significant changes, providers should use the Child Care Coordination Family Questionnaire Domains and Questions to reassess the member's needs and strengths and inform changes to the member's care plan. Assessment updates are part of ongoing care coordination and monitoring services.

Topic #990

## Ongoing Coordination and Monitoring

Ongoing care coordination and monitoring is a CCC (child care coordination) service performed by a care coordinator or qualified professional that includes:

- ┆ Contacts with formal and informal collaterals after obtaining the member's informed consent to discuss their care with specified collaterals.
- ┆ Providing the member and their family with information and referral to services.
- ┆ Updating the member's assessment and care plan.
- ┆ Recordkeeping.

Ongoing care coordination and monitoring services must be:

- ┆ Based on the member's care plan.
- ┆ In alignment with the member's needs and strengths identified in the assessment (including intensity and frequency of service).
- ┆ Supervised, as defined in Wis. Admin. Code § DHS [101.03\(173\)](#), by a qualified professional under Wis. Admin. Code § DHS [105.525\(2\)](#). Supervision should include face-to-face contact every 30 days, at minimum, between the qualified professional and the staff member providing care coordination services.

Except for urgent care situations, providers are required to complete the [CCC Family Questionnaire Domains and Questions \(Child Care Coordination Family Questionnaire Domains and Questions F-01118 \(07/2025\)\)](#) and develop 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 initial, comprehensive assessment and care plan.

## Contacts

Members who receive CCC services are children under the age of seven; because of this, providers will contact immediate family members such as parents as well as caregivers.

Contacts may be made face-to-face or by phone and:

- ┆ May be made for the purpose of determining if arranged services from the care plan have been received and are effective.
- ┆ May be made if the care plan requires reassessing needs and revision.

There is no limit on the number of contacts providers may have with a member or their family. However, reimbursement for ongoing care coordination is limited to a [maximum amount per month](#).

## Contacts With Family Members

Services to the member's immediate family members, including caregivers, may be covered:

- ┆ If the need for care coordination services provided to family members or caregivers is identified in the member's care plan.
- ┆ If the service is directly related to meeting the goals and objectives of the benefit.

For example, if a provider is providing services to a family of three, where the child has special health care needs and the father has a substance use disorder, CCC services related to assisting the father in locating and accessing educational or other resources necessary to help him better meet the child's needs can be covered. However, care coordination activities related to assisting the father in accessing needed substance use disorder treatment services for himself will not be covered, even if provided.

## Collateral Contacts

Collaterals include formal and informal contacts who have direct supportive contact with the member receiving CCC services.

- ┆ Formal collaterals may include medical, and other service providers as well as guardians or school officials.
- ┆ Informal collaterals may include extended family members or family friends, outside of the member's immediate family or caregivers.

The CCC provider is required to identify the role of each collateral in the member's care plan and obtain the member's informed consent to discuss their care with each specified collateral.

Collateral contacts are face-to-face, telephone, or written communication with any collateral to:

- ┆ Inform collaterals of the member's needs as well as the goals and services specified in the member's care plan.
- ┆ Mobilize services and support for the member.



- ┆ Advocate on behalf of the member.
- ┆ Coordinate services specified in the member's care plan.

For example, collateral contacts may include time spent:

- ┆ Discussing the member's care with the member's medical provider to communicate the member's needs and goals specified in the care plan.
- ┆ Advocating on the member's behalf.
- ┆ Coordinating the services identified in the care plan.

Collateral contacts also include time spent on client-specific meetings and formal case consultations with other professionals or supervisors.

Time spent discussing or meeting on non-client-specific issues or time spent on general program issues are not included.

ForwardHealth will not reimburse collateral contacts if there is no member contact during the month for which the provider is billing. All collateral contacts—including time spent on client-specific meetings and formal case consultations with other professionals or supervisors—must be documented in the member's file. Documentation must provide an accurate record of the contact.

## Frequency of Member and Collateral Contacts

Providers must document in the member's care plan the planned frequency of member contacts and collateral contacts to be completed during ongoing care coordination and monitoring. At a minimum, member contacts should occur every 30 days.

## Information and Referral

Information and referral means providing members and their families with current information about available resources and programs to help them gain access to services needed. The information and resources provided are:

- ┆ To educate members and their families of services and supports, as identified in their care plan.
- ┆ To address their needs identified in the assessment.

This may include providing information and resources to the member on the referral resource and how it supports goals from the care plan and ensuring the member and their family have the necessary support, resources, and understanding to access and navigate the resources being provided.

Providers may complete a [Child Care Coordination Referral](#), which contains reasons for the referral and the member's parent, guardian or caregiver's signature authorizing the sharing of information, if appropriate. Providers are required to confirm whether the services referred were provided to the member, and whether the services provided were consistent with the goals and objectives of the member's care plan within two weeks, unless otherwise stated. The amount of service provided must correspond with specific factors addressed in the care plan and the overall need.

## Assessment and Care Plan Updates

ForwardHealth reimburses updates to the member's assessment and care plan as ongoing care coordination and monitoring. Care plan updates must be made in writing and signed by the member and the agency staff member, per Wis. Admin. Code § DHS [107.345\(1\)\(c\)](#). Information about updating an existing assessment is [available](#).

## Recordkeeping

ForwardHealth considers recordkeeping a reimbursable ongoing care coordination and monitoring activity. Reimbursable recordkeeping activities include time spent on:

- ┆ Updating member assessment or 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.

When services are provided to multiple members in the same household, a provider should separately document time spent providing care coordination to each specific member. For example, when a care coordinator spends two hours delivering ongoing care coordination to a family who has two children receiving the CCC benefit, the care coordinator should document the amount of time spent coordinating care in both children's case files. The 45 minutes spent on ongoing care coordination for the older child would be documented in the older child's records, and the hour and fifteen minutes spent on ongoing care coordination for the younger child would be documented in the younger child's record. This would all have occurred within a two-hour visit.

## Provision of Services in Urgent Situations

In urgent situations, CCC providers may offer ongoing care coordination and monitoring services without first performing an initial assessment or developing a care plan. In an urgent situation (for example, the family is homeless or lacks food), the provider is required to:

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

ForwardHealth requires a modifier (UD billed with U3) to indicate when ongoing care coordination was delivered in an urgent situation to members under eight weeks of age. Subsequent DOS must indicate an initial comprehensive assessment (modifier U1) and care plan development (U2) were completed to reimburse for ongoing CCC services.

Topic #10857

## Service Limitations

ForwardHealth has established quantity limits for CCC services. All of the following quantity limits for CCC services are accumulated per member regardless of the provider of service:

Type of Service	Requirements
Comprehensive Assessment (T1016 with modifier U1)	Limited to eight units per 365 days per member. Only one provider will receive reimbursement in a 365-day period. One comprehensive assessment is reimbursable per 365 days. This includes the initial comprehensive assessment and subsequent comprehensive assessments.
Care Plan Development (T1016 with modifier U2)	Limited to eight units per 365 days per member. Only one provider will receive reimbursement in a 365-day period. One comprehensive care plan is reimbursable per 365 days.
Ongoing Care Coordination and Monitoring (T1016 with modifier U3)	Limited to 40 units per month per member. Only one provider will receive reimbursement in a calendar month.

One unit of service equals 15 minutes. Providers are required to add up their time on a daily basis and round time units using the [CCC rounding guidelines](#).

Only one comprehensive assessment (modifier U1) and one comprehensive care plan (modifier U2) are allowed per member per 365 days. Updates to the assessment or care plan are covered under ongoing care coordination (modifier U3).

When services are provided to multiple members in the same household, a provider may only bill for the actual time spent providing care coordination to each specific member.

## Additional Limitations

According to § DHS [107.345\(2\)](#), CCC is available to a member as an inpatient in a hospital only if it is not included in the usual reimbursement to the facility, such as coordinating housing, supplies, or intervention services for the member upon discharge.

## Noncovered Services

ForwardHealth may deny or recoup payment for covered services that fail to meet program requirements. Medicaid reimbursement is also not available for [noncovered services](#). These services are not covered under CCC:

- | Child day care
- | Providing incentives to encourage a member to obtain services
- | Diagnosis of a physical or mental illness
- | Follow-up of clinical symptoms
- | Administration of medications
- | Any other professional health or clinical service such as nutrition counseling, health screenings, health education, or behavioral health services
- | Member vocational training
- | Legal advocacy by an attorney or paralegal
- | Transportation
- | Goods and supplies
- | Personal care services
- | Home health services, supportive home care, and respite-services
- | Collateral contacts regarding non-member-specific issues or general program issues
- | Care coordination and monitoring not based on the plan of care
- | Care coordination and monitoring which is not reasonable and necessary to improve child health outcomes
- | General classroom instruction and programming commensurate to that licensed or administered by the Department of Public Instruction
- | Any other covered service provided by an enrolled BadgerCare Plus and Medicaid provider
- | Any services that constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs
- | Interpreter services
- | Missed appointments (no shows)

Information regarding the following service-specific requirements is available:

- | [Initial and yearly comprehensive assessments](#)
- | [Care plan development](#)
- | [Ongoing care coordination and monitoring](#)

## Billing and Reimbursement

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Topic #23840

### Billing Requirements

The following requirements apply when billing ForwardHealth for CCC services:

- ▮ Providers may only submit one claim per member for each calendar month; providers must bill all the services they provided to the member in the month on the same claim.
- ▮ Providers must indicate each DOS for services provided throughout the month on a separate claim detail.
- ▮ Providers may not bill for services until after those services have been provided and may not submit a claim early in the month in anticipation of services to be provided later in that month, per Wis. Admin. Code § [DHS 106.06\(3\)\(a\)](#).

Claims for CCC services should reflect the cumulative services provided to the Medicaid member during the month.

Topic #976

### Diagnosis Codes on Claims for Child Care Coordination Services

All codes indicated on submissions to ForwardHealth are required to be [valid codes](#).

When submitting claims for CCC services, providers must include either ICD diagnosis codes Z65.8 (Other specified problems related to psychosocial circumstances) or Z65.9 (Problem related to unspecified psychosocial circumstances) to indicate a member with a need identified on the [CCC Family Questionnaire Domains and Questions](#).

ForwardHealth will deny claims if providers indicate diagnosis codes other than the diagnosis codes listed above as the primary diagnosis when submitting claims for CCC services. Providers may use additional ICD diagnosis codes in the secondary positions as appropriate.

Topic #971

### Procedure Codes and Modifiers

Providers must include the allowable HCPCS code and applicable modifiers for CCC services. ForwardHealth will deny claims or adjustment requests received without the appropriate HCPCS code and modifiers.

When submitting claims for CCC services, providers are required to submit two modifiers along with HCPCS procedure code T1016 (Case Management, each 15 minutes). One modifier must identify the location where the CCC service was provided; the other modifier must identify the specific type of care coordination service provided. Additional modifiers (such as UD) may be required as needed.

Location Modifiers		
Modifier	Description	Notes
UB	CCC service provided in	Used to indicate where the CCC service was provided.

	Milwaukee	
UC	CCC service provided in Racine	Used to indicate where the CCC service was provided.
Service Modifiers		
Modifier	Description	Notes
U1	Comprehensive Assessment	Used to indicate the initial, comprehensive assessment and subsequent comprehensive assessments (limited to 1 per 365 days).
U2	Care plan development	Used to indicate the initial care plan development and subsequent care plan development (limited to 1 per 365 days).
U3	Ongoing care coordination and monitoring	Used to indicate ongoing activities including updates to the assessment and care plan.
Other Modifiers		
Modifier	Description	Notes
UD	Care Coordination in an urgent situation	Used to indicate care coordination services delivered in an urgent situation to a member less than eight weeks of age (along with procedure code T1016 and modifier U3).

\*Information [limits](#) is available.

Topic #970

## Rounding Guidelines

Providers are required to round time units using the following rounding guidelines when submitting claims for ongoing care coordination and monitoring using HCPCS procedure code T1016 with modifier U3.

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

## Additional Requirements

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Topic #966

### Concurrent Services

A member may not receive CCC services from more than one provider. It is the providers' responsibility to eliminate the overlap by communicating with the member and with each other to determine which provider will continue to provide the services.

However, the member must ultimately choose the provider from whom they wish to receive services. Members may choose to switch providers at any time for any reason. Providers may not limit a [member's choice](#) of provider.

Information about [quantity limits for CCC services](#) and [reducing or ending ongoing care coordination services](#) is available.

Topic #957

### Freedom of Choice

Members may receive covered services from **any** willing Medicaid-enrolled provider, unless they are enrolled in a state-contracted MCO or assigned to the [Pharmacy Services Lock-In Program](#).

Under 42 CFR 440.168, members have the freedom to refuse case management services. This means that participation in the CCC benefit is voluntary, and providers may not lock in members. Specifically:

- ▮ Members do not have to receive CCC services if they do not want to.
- ▮ Members can choose to reduce or end CCC services at any time.
- ▮ Members may choose to transfer providers at any time. However, a member may not receive CCC services from more than one provider [concurrently](#).

In circumstances when a member transfers from one CCC provider to another, the new provider should review the member's assessment for accuracy and ensure it continues to reflect the member's needs. If the assessment does not reflect the member's needs, the provider can complete a new assessment. Information about updating an existing assessment is [available](#). The provider should document this review in the member's record.

Members may participate, to the full extent of their ability, in all decisions regarding appropriate services and providers.

Topic #955

### Prohibited

Providers are prohibited from collecting a copay for CCC services.

Topic #23843

## Reducing or Ending Ongoing Care Coordination

## Services

If it is necessary to reduce or end services early, the provider and member and parent, guardian, or caregiver must discuss care plan changes and mutually agree to reduce or end services early. Additionally, providers must meet certain documentation requirements.

### Provider and Member Agree to Reduce or End Services Early

According to Wis. Admin. Code § [107.345\(2\)](#), a CCC service provider will not terminate provision of services to a member it has agreed to provide services for unless the member initiates or agrees to the termination. If services are terminated, the termination must be documented in writing, and the member must sign the statement to indicate agreement.

In circumstances when the provider is unable to obtain a signature from the member and parent, guardian, or caregiver for the termination of services (for example, the family consistently misses meetings with the provider and does not follow through on referrals, but indicates they want 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.

### Provider Chooses to Reduce or End Services Early

As defined in Wis. Admin. Code § DHS [105.525\(9\)](#), if an agency chooses to reduce or end services early, the agency is required to:

- ▮ Provide written notice to each member, the member's legal representative, if any; the member's attending physician, and the department at least 30 business days before closure.
- ▮ Provide assistance to members in arranging for continuity of necessary services. This includes coordination with other CCC providers to ensure necessary services identified in the care plan are sustained or initiated.

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 that a provider may reopen a member's case. The provider must document in the member's record why the case has been closed and reopened.

Topic #23858

## Transportation to Medical Appointments

ForwardHealth does not cover transportation services as part of the CCC benefit. However, CCC providers should assist members in making transportation arrangements to obtain needed services.

Most Medicaid members may receive NEMT [services](#) through ForwardHealth's NEMT manager.

All providers may be asked to verify that a Medicaid member received Medicaid-covered services at their site on a particular date.

## Resources

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Topic #23841

### An Overview

ForwardHealth requires providers to use a variety of forms for PA, claims processing, and documenting special circumstances.

### Division of Medicaid Services Publications

The following CCC publications are available from DMS and can be obtained from the [Forms](#) page of the ForwardHealth Portal:

- | [CCC Family Questionnaire Domains and Questions](#)
- | [CCC Care Plan](#)
- | [Child Care Coordination Care Coordinator Visit Checklist](#)
- | [Child Care Coordination Referral](#)
- | [Child Care Coordination Monthly Time Log for Ongoing Care Coordination and Monitoring](#)
- | [Child Care Coordination Plan of Operation](#)
- | [Child Care Coordination Personnel and Training Plan](#)



# Provider Enrollment and Ongoing Responsibilities

## 2

Archive Date:08/01/2025

## Provider Enrollment and Ongoing Responsibilities:Provider Enrollment

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Topic #3969

### Categories of Enrollment

Wisconsin Medicaid enrolls providers in three billing categories. Each billing category has specific designated uses and restrictions. These categories include:

- | Billing and rendering provider
- | Rendering-only provider
- | Billing-only provider (including group billing)

Providers should refer to the service-specific information in the Online Handbook or the Information for Specific Provider Types page on the Provider Enrollment Information home page to identify which category of enrollment is applicable.

### **Billing and Rendering Provider**

Enrollment as a billing and 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-Only Provider**

A provider enrolled as a rendering-only provider who practices under the professional supervision of another provider. Rendering-only providers enrollment cannot submit claims to ForwardHealth directly. Instead, they 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.

### **Billing-Only Provider (Including Group Billing)**

Billing-only providers can submit claims to ForwardHealth while a separate rendering-only provider is required on those claims.

#### **Group Billing**

Groups of individual practitioners are enrolled as billing-only providers as an accounting convenience. This allows the group to receive one reimbursement, one RA, and the 835 transaction for covered services rendered by individual practitioners within the group.

Providers may not have more than one group practice enrolled in Wisconsin Medicaid with the same zip+4 code address, NPI, and taxonomy code combination. Provider group practices located at the same zip+4 code address are required to differentiate their enrollment using an NPI or taxonomy code that uniquely identifies each group practice.

Individual practitioners within group practices are required to be Medicaid-enrolled 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.

Topic #14137

# Enrollment Requirements Due to the Affordable Care Act

In 2010, the federal government signed into law the ACA, also known as federal health care reform, which affects several aspects of Wisconsin health care. ForwardHealth worked toward ACA compliance by implementing [requirements for providers and provider screening processes](#). To meet federally mandated requirements, ForwardHealth implemented changes in phases, the first of which began in 2012. A high-level list of the changes included under ACA is as follows:

- ▮ Providers are assigned a risk level of limited, moderate, or high. Most of the risk levels have been established by the federal CMS based on an assessment of potential fraud, waste, and abuse for each provider type.
- ▮ Providers are [screened according to their assigned risk level](#). Screenings are conducted during enrollment, re-enrollment, and revalidation.
- ▮ Certain provider types are subject to an [application fee](#). This fee has been federally mandated and may be adjusted annually. The fee is used to offset the cost of conducting screening activities.
- ▮ Providers are required to undergo revalidation every three years.
- ▮ All [physicians and other professionals who prescribe, refer, or order services](#) and other providers who receive Medicaid funds are required to be enrolled as a participating Medicaid provider.
- ▮ Payment suspensions are imposed on providers based on a credible allegation of fraud.
- ▮ Providers are required to submit personal information about all persons with an [ownership or controlling interest, agents, and managing employees](#) at the time of enrollment, re-enrollment, and revalidation.

Topic #193

## Materials for New Providers

On an ongoing basis, providers should refer to the Online Handbook for the most current BadgerCare Plus, Medicaid, and HDAP information. Future changes to policies and procedures are published in [ForwardHealth Updates](#).

Topic #4457

## Provider Addresses

ForwardHealth has the capability to store the following types of addresses and contact information:

- ▮ **Practice location address and related information.** 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 the telephone number for members' use. With limited exceptions, the practice location and telephone number for members' 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 accurate address information to aid in proper mail delivery.
- ▮ **PA address.** This address is where ForwardHealth will mail PA information.
- ▮ **Financial addresses.** Two separate financial addresses are stored for ForwardHealth. The checks address is where ForwardHealth will mail paper checks. The 1099 mailing address is where ForwardHealth will mail IRS Form 1099.

Providers may submit additional address information or modify their current information using the [demographic maintenance tool](#).

Note: Providers are cautioned that any changes to their practice location on file with Wisconsin Medicaid 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](#)

[website](#).

Topic #14157

## Provider Enrollment Information Home Page

ForwardHealth has consolidated all information providers will need for the enrollment process in one location on the ForwardHealth Portal. For information related to enrollment criteria and to complete online provider enrollment applications, providers should refer to the [Provider Enrollment Information home page](#).

The Provider Enrollment Information home page includes enrollment applications for each provider type and specialty eligible for enrollment with Wisconsin Medicaid. Prior to enrolling, providers may consult a provider enrollment criteria menu, which is a reference for each individual provider type detailing the information the provider may need to gather before beginning the enrollment process, including:

- | Links to enrollment criteria for each provider type
- | Provider terms of reimbursement
- | Disclosure information
- | Category of enrollment
- | Additional documents needed (when applicable)

Providers will also have access to a list of links related to the enrollment process, including:

- | General enrollment information
- | Regulations and forms
- | Provider type-specific enrollment information
- | In-state and out-of-state emergency enrollment information
- | Contact information

Information regarding enrollment policy and billing instructions may still be found in the Online Handbook.

Topic #1931

## Provider Type and Specialty Changes

### Provider Type

Providers who want to add a provider type or change their current provider type are required to complete a new [enrollment application](#) for each provider type they want to add or change to because they need to meet the enrollment criteria for each provider type.

### Provider Specialty

Providers who have the option to add or change a provider specialty can do so using the [demographic maintenance tool](#). After adding or changing a specialty, providers may be required to submit documentation to ForwardHealth, either by uploading through the demographic maintenance tool or by mail, supporting the addition or change.

Providers should contact [Provider Services](#) with any questions about adding or changing a specialty.

Topic #22257

# Providers Have 35 Days to Report a Change in Ownership

Medicaid-enrolled providers are required to notify ForwardHealth of a change in ownership within 35 calendar days after the effective date of the change, in accordance with the Centers for Medicare & Medicaid Services Final Rule 42 C.F.R. § 455.104 (c)(1)(iv).

Failure to report a change in ownership within 35 calendar days may result in denial of payment, per 42 C.F.R. § 455.104(e).

Note: For demographic changes that do not constitute a change in ownership, providers should update their current information using the [demographic maintenance tool](#).

## Written Notification and a New Enrollment Application Are Required

Any time a change in ownership occurs, providers are required to do **one** of the following:

- 1 Mail a change in ownership notification to ForwardHealth. After mailing the notification, providers are required to complete a new [Medicaid provider enrollment application](#) on the Portal.
- 1 Upload a change in ownership notification as an attachment when completing a new [Medicaid provider enrollment application](#) on the Portal.

ForwardHealth must receive the change in ownership notification, which must include the affected provider number (NPI or provider ID), within 35 calendar days **after** the effective date of the change in ownership.

Providers will receive written notification of their new Medicaid enrollment effective date in the mail once their provider file is updated with the change in ownership.

## Special Requirements for Specific Provider Types

The following provider types require Medicare enrollment and/or Wisconsin [DQA](#) certification with current provider information before submitting a Medicaid enrollment change in ownership:

- 1 Ambulatory surgery centers
- 1 CHCs
- 1 ESRD services providers
- 1 Home health agencies
- 1 Hospice providers
- 1 Hospitals (inpatient and outpatient)
- 1 Nursing homes
- 1 Outpatient rehabilitation facilities
- 1 Rehabilitation agencies
- 1 RHCs
- 1 Tribal FQHCs

## Events That ForwardHealth Considers a Change in Ownership

ForwardHealth defines a change in ownership as an event where a different party purchases (buys out) or otherwise obtains ownership or effective control over a practice or facility.

The following events are considered a change in ownership and require the completion of a new provider enrollment application:

- ┆ Change from one type of business structure to another type of business structure. Business structures include the following:
  - ┆ Sole proprietorships
  - ┆ Corporations
  - ┆ Partnerships
  - ┆ Limited Liability Companies
- ┆ Change of name and TIN associated with the provider's submitted enrollment application (for example, EIN)
- ┆ Change (addition or removal) of names identified as owners of the provider

## **Examples of a Change in Ownership**

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.

## **End Date of Previous Owner's Enrollment**

The end date of the previous owner's enrollment will be one day prior to the effective date for the change in ownership. When the Wisconsin DHS is notified of a change in ownership, the original owner's enrollment will automatically be end-dated.

## **Repayment Following a Change in Ownership**

Medicaid-enrolled 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. If the previous owner does not repay ForwardHealth for any erroneous payments or overpayments, the new owner's application will be denied.

If necessary, ForwardHealth will hold responsible for repayment the provider to whom a transfer of ownership is made prior to the final transfer of ownership. The provider acquiring the business is responsible for contacting ForwardHealth to ascertain if they are liable under this provision.

The provider acquiring the business is responsible for full repayment within 30 days after receiving such a notice from ForwardHealth.

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

Office of the Inspector General  
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 Wis. Stat. § [49.45\(21\)](#) for complete information.

## **Automatic Recoupment Following a Change in Ownership**

ForwardHealth will automatically recover payments made to providers whose enrollment has ended in the ForwardHealth system due to a change in ownership. This automatic recoupment for previous owners occurs about 45 days after DHS is notified of the change in ownership. The recoupment will apply to all claims processed with DOS after the provider's new end date.

## New Prior Authorization Requests Must Be Submitted After a Change in Ownership

Medicaid-enrolled providers are required to submit new PA requests when there is a change in billing providers. New PA requests must be submitted with the new billing provider's name and billing provider number. The expiration date of the new PA request will remain the same as the original PA request.

The provider is required to send the following to ForwardHealth with the new PA request:

- | A copy of the original PA request, if possible
- | The new PA request, including the required attachments and supporting documentation indicating the new billing provider's name, address, and billing provider number
- | A letter requesting to enddate the original PA request (may be a photocopy), which should include the following information:
  - | The previous billing provider's name and billing provider number, if known
  - | The new billing provider's name and billing provider number
  - | The reason for the change of billing provider (The new billing provider may want to verify with the member that the services from the previous billing provider have ended. The new billing provider may include this verification in the letter).
  - | The requested effective date of the change

## Submitting Claims After a Change in Ownership

The provider acquiring the business may submit claims with DOS on and after the change in ownership effective date.

Additional information on [submission](#) of timely filing requests or adjustment reconsideration requests is available.

## How to Bill for a Hospital Stay That Spans a Change in Ownership

When a change in hospital ownership occurs, use the NPI that is current on the date of discharge. For example: A change in ownership occurs on July 1. A patient stay has DOS from June 26 to July 2. The hospital submits the claim using the NPI effective July 1.

## How to Bill for a Nursing Home Stay That Spans a Change in Ownership

When a change in nursing home ownership occurs, use the NPI that is current on the date of discharge. For example: A change in ownership occurs on July 1. A nursing home patient stay has DOS from June 26 to July 2. The nursing home submits the claim using the NPI effective July 1.

## For Further Questions

Providers with questions about changes in ownership may call [Provider Services](#).

Topic #14317

## Terminology to Know for Provider Enrollment

ForwardHealth adopted terminology due to the ACA, which is included in the following table. This terminology is useful to providers during the provider enrollment and revalidation processes. Providers may refer to the Medicaid rule 42 C.F.R. § s. 455.101 for more information.

<b>Terminology</b>	<b>Definition</b>
Agent	Any person who has been delegated the authority to obligate or act on behalf of a provider.
Disclosing entity	A Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent.
Federal health care programs	Federal health care programs include Medicare, Medicaid, Title XX, and Title XXI.
Other disclosing agent	Any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVII, or XX of the Act. This includes: <ul style="list-style-type: none"> <li>┆ Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or HMO that participates in Medicare (Title XVIII)</li> <li>┆ Any Medicare intermediary or carrier</li> <li>┆ Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or XX of the Act</li> </ul>
Indirect ownership	An ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership in the disclosing entity.
Managing employee	A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.
Ownership interest	The possession of equity in the capital, the stock, or the profits of the disclosing entity.
Person with an ownership or control interest	A person or corporation for which one or more of the following applies: <ul style="list-style-type: none"> <li>┆ Has an ownership interest totaling 5% or more in a disclosing entity</li> <li>┆ Has an indirect ownership interest equal to 5% or more in a disclosing entity</li> <li>┆ Has a combination of direct and indirect ownership interest equal to 5% or more in a disclosing entity</li> <li>┆ Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5% of the value of the property or asset of the disclosing entity</li> <li>┆ Is an officer or director of a disclosing entity that is organized as a corporation</li> <li>┆ Is a person in a disclosing entity that is organized as a partnership</li> </ul>
Subcontractor	<ul style="list-style-type: none"> <li>┆ An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or,</li> <li>┆ An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.</li> </ul>



Re-enrollment	Re-enrollment of a provider whose Medicaid enrollment has ended for any reason other than sanctions or failure to revalidate may be re-enrolled as long as all licensure and enrollment requirements are met. Providers should note that when they re-enroll, application fees and screening activities may apply. Re-enrollment was formerly known as re-instate.
Revalidation	All enrolled providers are required to revalidate their enrollment information every three years to continue their participation with Wisconsin Medicaid. Revalidation was formerly known as recertification.

**Note:** Providers should note that the federal CMS requires revalidation at least every five years. However, Wisconsin Medicaid revalidates providers every three years.

## Ongoing Responsibilities

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Topic #220

### 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 \(nondiscrimination\)](#).

Topic #219

### 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 meaningful access
- ┆ Not providing translation of vital documents to the LEP groups who represent 5% 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 C.F.R. 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 Wisconsin 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 their goods and services available to and usable by people with disabilities to the extent that it is readily achievable to do so (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.

Topic #198

## Contracted Staff

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

When contracting services, providers are required to ensure contracted agencies are qualified to provide services, meet all ForwardHealth and program requirements, and maintain records in accordance with the requirements for the provision of services.

Medicaid requirements do not relieve contracted agencies of their own regulatory requirements. Contracted agencies are required to continue to meet their own regulatory requirements, in addition 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.

Topic #216

## Examples of Ongoing Responsibilities

Responsibilities for which providers are held accountable are described throughout the Online Handbook. Medicaid-enrolled 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, and 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 their records
- | Monitoring contracted staff
- | Accepting Medicaid reimbursement as payment in full for covered services
- | Keeping provider information (for example, address, business name) current
- | Notifying ForwardHealth of changes in ownership
- | Responding to Medicaid revalidation notifications
- | Safeguarding member confidentiality
- | Verifying member enrollment
- | Keeping up-to-date with changes in program requirements as announced in ForwardHealth publications

Topic #217

## Keeping Information Current

### Changes That Require ForwardHealth Notification

Providers are required to notify ForwardHealth of any changes to their demographic information, including the following, as they occur:

- | [Address\(es\)](#) — practice location and related information, mailing, PA, and/or financial

Note: Health care providers who are federally required 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.

- | Business name
- | Contact name
- | Federal Tax ID number (IRS number)
- | Group affiliation
- | Licensure
- | NPI
- | [Ownership](#)
- | Professional certification
- | [Provider specialty](#)
- | Supervisor of nonbilling providers
- | [Taxonomy code](#)
- | Telephone number, including area code

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

- | Incorrect reimbursement
- | Misdirected payment

- ┆ Claim denial
- ┆ Suspension of payments or cancellation of provider file if 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.

## Notifying ForwardHealth of Changes

Providers can notify ForwardHealth of changes using the [demographic maintenance tool](#).

## Providers Enrolled in Multiple Programs

If demographic information changes, providers enrolled in multiple programs (for example, Wisconsin Medicaid and WCDP) will need to change the demographic information for each program. By toggling between accounts using the Switch Organization function of the Portal, providers who have a Portal account for each program can change their information for each program using the demographic maintenance tool. The [Account User Guide](#) provides specific information about switching organizations.

## Providers Licensed or Certified by the Division of Quality Assurance

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 emailing [Lisa.Imhof@dhs.wisconsin.gov](mailto:Lisa.Imhof@dhs.wisconsin.gov).

Topic #577

## 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 C.F.R. Parts 430-498 and Parts 1000-1008 (Public Health)
- ┆ Wisconsin Law and Regulation:
  - ┆ Law — Wis. Stat. §§ [49.43–49.499](#), [49.665](#), and [49.473](#)
  - ┆ Regulation — Wis. Admin. Code chs. [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 Wisconsin DHS. Within DHS, DMS is directly responsible for managing these programs.

Topic #959

Wisconsin Stat. § [49.46\(2\)\(b\)12m](#) 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 members in Milwaukee County.

Topic #17097

# Licensure Information

Licensed providers are required to keep all licensure information, including license number, grant and expiration dates, and physical location as applicable (for example, hospital providers), current with ForwardHealth.

If providers do not keep their licensure information, including their license number, current with ForwardHealth, any of the following may occur:

- ▮ Providers' enrollment may be deactivated. As a result, providers would not be able to submit claims or PA requests or be able to function as [prescribing/referring/ordering providers](#), if applicable, until they update their licensure information.
- ▮ Providers may experience a lapse in enrollment. If a lapse occurs, providers may need to re-enroll, which may result in another application fee being assessed.

Providers may change the grant and expiration dates for their current license(s) and enter information for a new license(s), such as the license number, licensing state, and grant and expiration dates, using the [demographic maintenance tool](#). After entering information for their new license(s), some providers (for example, out-of-state providers) will also be required to upload a copy of their license using the demographic maintenance tool. Provided licensure information must correspond with the information on file with the applicable licensing authority.

In some cases, ForwardHealth will need to verify licensure information with the applicable licensing authority, which may take up to 10 business days after submission. Providers updating their license information should plan accordingly so that they do not experience any of the indicated interruptions in enrollment. If provided licensure information (for example, grant and expiration dates) does not correspond with the licensing authority's information, the licensing authority's information will be retained and will display in the demographic maintenance tool once verified by ForwardHealth.

Topic #15157

## Recovery Audit Contractor Audits

The ACA requires states to establish an RAC program to enable the auditing of Medicaid claim payments to providers. In Wisconsin, the RAC will audit claim payments from Wisconsin Medicaid and BadgerCare Plus. The Wisconsin DHS has awarded the contract to HMS as the RAC for the state of Wisconsin.

Note: The RAC will not audit claims submitted for Family Planning Only Services, SeniorCare, WCDP, the WWWP, and HDAP.

The overall goal of the RAC program is to identify and decrease improper payments. The audits will ensure that payments are for services covered under the programs in which the member was enrolled and that the services were actually provided and properly billed and documented. The audits are being conducted under Generally Accepted Government Auditing Standards.

Providers will be selected for audits based on data analysis by the RAC and referrals by state agencies. The RAC will ensure that its audits neither duplicate state audits of the same providers nor interfere with potential law enforcement investigations.

Providers who receive a notification regarding an audit should follow the instructions as outlined in the notification within the requested time frames.

## Affected Providers

Any provider may be audited, including, but not limited to, fee-for-service providers, institutional and non-institutional providers, as well as managed care entities.

## Additional Information

Any questions regarding the RAC program should be directed to HMS at 855-699-6289. Refer to the [RAC website](#) for additional information regarding HMS RAC activities.

Topic #13277

## Reporting Suspected Waste, Fraud, and Abuse

The Wisconsin DHS OIG investigates fraud and abuses including, but not limited to, the following:

- ┆ Billing Medicaid for services or equipment that were not provided
- ┆ Submitting false applications for a DHS-funded assistance program such as Medicaid, BadgerCare Plus, WIC, or FoodShare
- ┆ Trafficking FoodShare benefits
- ┆ Crime, misconduct, and/or mismanagement by a DHS employee, official, or contractor

Those who suspect fraudulent activity in Medicaid programs are required to notify the OIG if they have reason to believe that a person is misusing or abusing any DHS health care program or the ForwardHealth identification card.

Wisconsin Stat. § [49.49](#) 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 misusing or abusing their benefits. A provider may not confiscate a ForwardHealth card from a member in question.

## Reporting Suspected Fraud and Abuse

Those who suspect any form of fraud, waste, or abuse of a program by providers, trading partners, billing services, agencies, or recipients of any government assistance program are required to report it. Those reporting allegations of fraud and abuse may remain anonymous. However, not providing contact information may prevent OIG from fully investigating the complaint if questions arise during the review process.

If a provider suspects that someone is committing fraudulent activities or is misusing his or her ForwardHealth card, the provider is required to notify ForwardHealth by one of the following methods:

- ┆ Going to the OIG fraud and abuse reporting [website](#)
- ┆ Calling the DHS fraud and abuse hotline at 877-865-3432

The following information is helpful when reporting fraud and abuse:

- ┆ A description of the fraud, waste, and/or abuse, including the nature, scope, and timeframe of the activity in question (The description should include sufficient detail for the complaint to be evaluated.)
- ┆ The names and dates of birth (or approximate ages) of the people involved, as well as the number of occurrences and length of the suspected activity
- ┆ The names and date(s) of other people or agencies to which the activity may have been reported

After the allegation is received, DHS OIG will evaluate it and take appropriate action. If the name and contact information of the person reporting the allegation was provided, the OIG may be in contact to verify details or ask for additional information.



## Documentation

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Topic #6277

### 1099 Miscellaneous Forms

ForwardHealth generates the 1099 Miscellaneous form in January of each year for earnings greater than \$600, per IRS 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.

Topic #1640

### Availability of Records to Authorized Personnel

Wisconsin DHS has the right to inspect, review, audit, and reproduce provider records pursuant to Wis. Admin. Code § [DHS 106.02\(9\)\(e\)](#). DHS 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 DHS staff member(s).

If Wisconsin Medicaid requires a provider to submit hard copies of records instead of scanning or accepting electronic records during a compliance audit, DHS reimburses providers \$0.06 per page. A letter of request for records from DHS will be sent to a provider when records are required, with instructions on how to submit records electronically or if physical records are required.

Reimbursement is not made for other reproduction costs included in the provider agreement between DHS 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 DHS.

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

Topic #200

### Confidentiality and Proper Disposal of Records

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. Use or disclosure of any information concerning an applicant or member (including an applicant or member's billing information or medical claim records) for any purpose not connected with program administration is prohibited unless authorized by the applicant or member (program administration includes contacts with third-party payers that are necessary for pursuing third-party payment and the release of information as ordered by the court).

Federal HIPAA Privacy and Security regulations establish requirements regarding the confidentiality and proper disposal of health care and related records containing PHI. These requirements apply to all providers (who are considered "covered entities") and

their business associates who create, retain, and dispose of such records.

For providers and their business partners who are not subject to HIPAA, Wisconsin confidentiality laws have similar requirements pertaining to proper disposal of health care and related records.

## HIPAA Privacy and Security Regulations

### Definition of Protected Health Information

As defined in the HIPAA privacy and security regulations, PHI is protected health information (including demographic information) that:

- ▮ Is created, received, maintained, or transmitted in any form or media.
- ▮ Relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the payment for the provision of health care to an individual.
- ▮ Identifies the individual or provides a reasonable basis to believe that it can be used to identify the individual.

A member's name combined with their member identification number or Social Security number is an example of PHI.

### Requirements Regarding "Unsecured" Protected Health Information

Title XIII of the American Recovery and Reinvestment Act of 2009 (also known as the HITECH Act) included a provision that significantly expanded the scope, penalties, and compliance challenges of HIPAA. This provision imposes new requirements on covered entities and their business associates to notify patients, the federal government, and the media of breaches of "unsecured" PHI (refer to 45 C.F.R. Parts 160 and 164 and § 13402 of the HITECH Act).

Unsecured PHI is PHI that has not been rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of physical destruction approved by the U.S. HHS. According to HHS, destruction is the only acceptable method for rendering PHI unusable, unreadable, or indecipherable.

As defined by federal law, unsecured PHI includes information in **any** medium, not just electronic data.

### Actions Required for Proper Disposal of Records

Under the HIPAA privacy and security regulations, health care and related records containing PHI must be disposed of in such a manner that they cannot be reconstructed. This includes ensuring that the PHI is secured (for example, rendered unusable, unreadable, or indecipherable) prior to disposal of the records.

To secure PHI, providers and their business associates are required to use one of the following destruction methods approved by the HHS:

- ▮ Paper, film, labels, or other hard copy media should be shredded or destroyed such that the PHI cannot be read or otherwise reconstructed.
- ▮ Electronic media should be cleared, purged, or destroyed such that the PHI cannot be retrieved according to National Institute of Standards and Technology Special Publication 800-88, Guidelines for Media Sanitization, which can be found on the [NIST website](#).

For more information regarding securing PHI, providers may refer to [Health Information Privacy](#) on the HHS website.

## Wisconsin Confidentiality Laws

Wis. Stat. § [134.97](#) requires providers and their business partners who are not subject to HIPAA regulations to comply with

Wisconsin confidentiality laws pertaining to the disposal of health care and related records containing PHI.

Wis. Stat. § [146.836](#) specifies that the requirements apply to "all patient health care records, including those on which written, drawn, printed, spoken, visual, electromagnetic or digital information is recorded or preserved, regardless of physical form or characteristics." Paper **and** electronic records are subject to Wisconsin confidentiality laws.

## **"Personally Identifiable Data" Protected**

According to Wis. Stat. § [134.97\(1\)\(e\)](#), the types of records protected are those containing "personally identifiable data."

As defined by the law, personally identifiable data is information about an individual's medical condition that is not considered to be public knowledge. This may include account numbers, customer numbers, and account balances.

## **Actions Required for Proper Disposal of Records**

Health care and related records containing personally identifiable data must be disposed of in such a manner that no unauthorized person can access the personal information. For the period of time between a record's disposal and its destruction, providers and their business partners are required to take actions that they reasonably believe will ensure that no unauthorized person will have access to the personally identifiable data contained in the record.

## **Businesses Affected**

Wis. Stat. §§ [134.97](#) and [134.98](#), governing the proper disposal of health care and related records, apply to medical businesses as well as financial institutions and tax preparation businesses. For the purposes of these requirements, a medical business is any for-profit or nonprofit organization or enterprise that possesses information — other than personnel records — relating to a person's physical or mental health, medical history, or medical treatment. Medical businesses include sole proprietorships, partnerships, firms, business trusts, joint ventures, syndicates, corporations, limited liability companies, or associates.

## **Continuing Responsibilities for All Providers After Ending Participation**

Ending participation in a ForwardHealth program does not end a provider's responsibility to protect the confidentiality of health care and related records containing PHI.

Providers who no longer participate in a ForwardHealth program are responsible for ensuring that they and their business associates/partners continue to comply with all federal and state laws regarding protecting the confidentiality of members' PHI. Once record retention requirements expire, records must be disposed of in such a manner that they cannot be reconstructed — according to federal and state regulations — in order to avoid penalties.

All ForwardHealth providers and their business associates/partners who cease practice or go out of business should ensure that they have policies and procedures in place to protect all health care and related records from any unauthorized disclosure and use.

## **Penalties for Violations**

Any covered entity provider or provider's business associate who violates federal HIPAA regulations regarding the confidentiality and proper disposal of health care and related records may be subject to criminal and/or civil penalties, including any or all of the following:

- ┆ Fines up to \$1.5 million per calendar year
- ┆ Jail time
- ┆ Federal HHS Office of Civil Rights enforcement actions

For entities not subject to HIPAA, Wis. Stat. § [34.97\(4\)](#) imposes penalties for violations of confidentiality laws. Any provider or

provider's business partner who violates Wisconsin confidentiality laws may be subject to fines up to \$1,000 per incident or occurrence.

For more specific information on the penalties for violations related to members' health care records, providers should refer to § 13410(d) of the HITECH Act, which amends 42 USC § 1320d-5, and Wis. Stat. §§ [134.97\(3\)](#), [\(4\)](#) and [146.84](#).

Topic #928

## 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 DMS, 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."

Topic #201

## Financial Records

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

Topic #202

## Medical Records

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

Topic #199

## 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.

## Fees for Health Care Records

Per Wis. Stat. § [146.83](#), providers may charge a fee for providing one set of copies of health care records to members who are enrolled in Wisconsin Medicaid or BadgerCare Plus programs on the date of the records request. This applies regardless of the member's enrollment status on the DOS contained within the health care records.

Per Wis. Stat. § [146.81\(4\)](#), health care records are all records related to the health of a patient prepared by, or under the

supervision of, a health care provider.

Providers are limited to charging members enrolled in state-funded health care programs 25% of the applicable fees for providing one set of copies of the member's health care records.

Note: A provider may charge members 100% of the applicable fees for providing a second or additional set of copies of the member's health care records.

Wisconsin DHS adjusts the [amounts](#) a provider may charge for providing copies of a member's health care records yearly per Wis. Stat. § [146.83\(3f\)\(c\)](#).

Topic #16157

## Policy Requirements for Use of Electronic Signatures on Electronic Health Records

For ForwardHealth policy areas where a signature is required, electronic signatures are acceptable as long as the signature meets the requirements. When ForwardHealth policy specifically states that a handwritten signature is required, an electronic signature will not be accepted. When ForwardHealth policy specifically states that a written signature is required, an electronic signature will be accepted.

Reimbursement for services paid to providers who do not meet all electronic signature requirements may be subject to recoupment.

### Electronic Signature Definition

An electronic signature, as stated in Wis. Stat. § [137.11\(8\)](#), is "an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record."

Some examples include:

- | Typed name (performer may type their complete name)
- | Number (performer may type a number unique to them)
- | Initials (performer may type initials unique to them)

All examples above must also meet all of the electronic signature requirements.

### Benefits of Using Electronic Signatures

The use of electronic signatures will allow providers to:

- | Save time by streamlining the document signing process.
- | Reduce the costs of postage and mailing materials.
- | Maintain the integrity of the data submitted.
- | Increase security to aid in non-repudiation.

### Electronic Signature Requirements

By following the general electronic signature requirements below, the use of electronic signatures provides a secure alternative to written signatures. These requirements align with HIPAA Privacy Rule guidelines.

## General Requirements

When using an electronic signature, all of the following requirements must be met:

- 1 The electronic signature must be under the sole control of the rendering provider. Only the rendering provider or designee has the authority to use the rendering provider's electronic signature. Providers are required to maintain documentation that shows the electronic signature that belongs to each rendering provider if a numbering or initial system is used (for example, what number is assigned to a specific rendering provider). This documentation must be kept confidential.
- 1 The provider is required to have current policies and procedures regarding the use of electronic signatures. Wisconsin DHS recommends the provider conduct an annual review of policies and procedures with those using electronic signatures to promote ongoing compliance and to address any changes in the policies and procedures.
- 1 The provider is required to conduct or review a security risk analysis in accordance with the requirements under 45 C.F.R. s. 164.308(a)(1).
- 1 The provider is required to implement security updates as necessary and correct identified security deficiencies as part of its risk management process.
- 1 The provider is required to establish administrative, technical, and physical safeguards in compliance with the HIPAA Security Rule.

## Electronic Health Record Signature Requirements

An EHR that utilizes electronic signatures must meet the following requirements:

- 1 The certification and standard criteria defined in the Health Information Technology Initial Set of Standards, Implementation Specifications, Certification Criteria for Electronic Health Record Technology Final Rule (45 C.F.R. Part 170) and any revisions including, but not limited to, the following:
  - 1 Assign a unique name and/or number for identifying, tracking user identity, and establishing controls that permit only authorized users to access electronic health information.
  - 1 Record actions related to electronic health information according to the standard set forth in 45 C.F.R. s. 170.210.
  - 1 Enable a user to generate an audit log for a specific time period. The audit log must also have the ability to sort entries according to any of the elements specified in the standard 45 C.F.R. s. 170.210.
  - 1 Verify that a person or entity seeking access to electronic health information is the one claimed and is authorized to access such information.
  - 1 Record the date, time, patient identification, and user identification when electronic health information is created, modified, accessed, or deleted. An indication of which action(s) occurred and by whom must also be recorded.
  - 1 Use a hashing algorithm with a security strength equal to or greater than SHA-1 as specified by the NIST in FIPS PUB 180-3 (October 2008) to verify that electronic health information has not been altered. (Providers unsure whether or not they meet this guideline should contact their IT and/or security/privacy analyst.)
- 1 Ensure the EHR provides:
  - 1 Nonrepudiation (assurance that the signer cannot deny signing the document in the future).
  - 1 User authentication (verification of the signer's identity at the time the signature was generated).
  - 1 Integrity of electronically signed documents (retention of data so that each record can be authenticated and attributed to the signer).
  - 1 Message integrity (certainty that the document has not been altered since it was signed).
  - 1 Capability to convert electronic documents to paper copy. (The paper copy must indicate the name of the individual who electronically signed the form as well as the date electronically signed.)
- 1 Ensure electronically signed records created by the EHR have the same back-up and record retention requirements as paper records.

Topic #203

## 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 Wis. Admin. Code § [DHS 106.02\(9\)\(a\)](#). This required maintenance of records is typically required by any third-party insurance company and is not unique to ForwardHealth.

Topic #204

## 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, which are required to retain records for a minimum of six years from the date of payment.

According to Wis. Admin. Code § [DHS 106.02\(9\)\(d\)](#), 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.

## Maintaining Confidentiality of Records

Ending participation in a ForwardHealth program does not end a provider's responsibility to protect the confidentiality of health care and related records containing PHI.

Providers who no longer participate in a ForwardHealth program are responsible for ensuring that they and their business associates/partners continue to comply with all federal and state laws regarding protecting the confidentiality of members' PHI. Once record retention requirements expire, records must be disposed of in such a manner that they cannot be reconstructed—according to federal and state regulations—in order to avoid penalties. For more information on the proper disposal of records, refer to [Confidentiality and Proper Disposal of Records](#).

All ForwardHealth providers and their business associates/partners who cease practice or go out of business should ensure that they have policies and procedures in place to protect all health care and related records from any unauthorized disclosure and use.

## Reviews and Audits

Wisconsin DHS periodically reviews provider records. 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.

Topic #205

## Records Requests

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

- ┆ When the member is a dual eligible (for example, 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 ForwardHealth.

## 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 a member, the provider is required to do the following:

1. Send a copy of the requested billing information or medical claim records to the requestor.
2. Send a letter containing the following information to ForwardHealth:
  - ▮ Member's name
  - ▮ Member's ForwardHealth identification number or SSN, if available
  - ▮ Member's DOB
  - ▮ DOS
  - ▮ Entity requesting the records, including name, address, and telephone number

The letter must be sent to the following address:

Wisconsin Casualty Recovery — HMS  
 Ste 100  
 5615 Highpoint Dr  
 Irving TX 75038-9984

## 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 is required to 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 copy of the material furnished to the requestor, along with a copy of their original request and medical authorization release to:

Wisconsin Casualty Recovery — HMS  
 Ste 100  
 5615 Highpoint Dr  
 Irving TX 75038-9984

## 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) § 4311, a dual eligible has the right to request and receive an itemized statement from their Medicare-enrolled 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.

Topic #1646

## **Release of Billing Information to Government Agencies**

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

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

## Provider Rights

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Topic #208

### A Comprehensive Overview of Provider Rights

Medicaid-enrolled 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 (for example, 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](#).

Topic #207

### Ending Participation

Providers other than home health agencies and nursing facilities may terminate participation in ForwardHealth according to Wis. Admin. Code § [DHS 106.05](#).

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:

Wisconsin Medicaid  
 Provider Enrollment  
 313 Blettner Blvd  
 Madison WI 53784

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.

Topic #209

### Hearing Requests

A provider who wishes to contest a Wisconsin DHS action or inaction for which due process is required under Wis. Stat. ch.

[DHS 227](#), may request a hearing by writing to the DHA.

A provider who wishes to contest DMS's notice of intent to recover payment (for example, to recoup for overpayments discovered in an audit by DMS) 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 DHS's decision to withhold payment.

Refer to Wis. Admin. Code ch. [DHS 106](#) for detailed instructions on how to file an appeal.

If a timely request for a hearing is not received, 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.

Topic #210

## 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.

Topic #206

## Requesting Discretionary Waivers and Variances

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

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

## Requirements

A request for a waiver or variance may be made at any time; however, all applications must be made in writing to DMS. 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.

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

## Application

DMS 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, 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 Medicaid Services  
Waivers and Variances  
PO Box 309  
Madison WI 53701-0309

## Sanctions

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Topic #211

### Intermediate Sanctions

According to Wis. Admin. Code § [DHS 106.08\(3\)](#), Wisconsin DHS may impose intermediate sanctions on providers who violate certain requirements. Common examples of sanctions that 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, DHS will issue a written notice to the provider in accordance with Wis. Admin. Code § [DHS 106.12](#).

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

Topic #212

### Involuntary Termination

Wisconsin DHS may suspend or terminate the Medicaid enrollment of any provider according to Wis. Admin. Code § [DHS 106.06](#).

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

- ┆ 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 enrollment is terminated by DHS. Refer to Wis. Admin. Code § [DHS 106.07](#) for detailed information regarding possible sanctions.

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

Topic #213

### 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 enrollment. 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 § 1320a-7b(d) or Wis. Stat. § [49.49\(3m\)](#).

There may be narrow exceptions on when providers may [collect payment from members](#).

Topic #214

## Withholding Payments

Wisconsin DHS may withhold full or partial Medicaid provider payments without prior notification if, as the result of any review or audit, 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.

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.

## Provider Numbers

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Topic #3421

## Provider Identification

### Health Care Providers

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

The NPI is a 10-digit number obtained through the NPES.

Providers should ensure that they have obtained an appropriate NPI prior to beginning their enrollment application. 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 enrollments — one enrollment as an individual physical therapist and the other enrollment as the physical therapy group. A Type 1 NPI for the individual enrollment and a Type 2 NPI for the group enrollment are required.

NPIs and classifications may be viewed on the [NPES website](#). The federal [CMS website](#) includes more information on Type 1 and Type 2 NPIs.

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

### Non-Healthcare Providers

Non-healthcare providers, such as SMV providers, personal care agencies, and blood banks, are exempt from federal NPI requirements. Providers exempt from federal NPI requirements are assigned a Medicaid provider number once their enrollment application is accepted; they are required to indicate this Medicaid provider number on electronic and paper transactions submitted to ForwardHealth.

Topic #5096

## Taxonomy Codes

Taxonomy codes are standard code sets used to provide information about provider type and specialty for the provider's enrollment. ForwardHealth uses taxonomy codes as additional data for correctly matching the NPI to the provider file.

Providers are required to use a taxonomy code when the NPI reported to ForwardHealth corresponds to multiple enrollments and the provider's practice location zip+4 code does not uniquely identify the provider.

Providers are allowed to report multiple taxonomy codes to ForwardHealth as long as the codes accurately describe the provider type and specialty for the provider's enrollment. When doing business with ForwardHealth, providers may use any one of the reported codes. Providers who report multiple taxonomy codes will be required to designate one of the codes as the primary taxonomy code; ForwardHealth will use this primary code for identification purposes.

Providers who wish to change their taxonomy code or add additional taxonomy codes may do so using the [demographic maintenance tool](#). Most taxonomy code changes entered through the demographic maintenance tool will take effect in real time; providers may use the new codes immediately on transactions.

Omission of a taxonomy code when it is required as additional data to identify the provider will cause claims and other transactions to be denied or delayed in processing.

Note: Taxonomy codes do not change provider enrollment or affect reimbursement terms.

Topic #5097

## ZIP Code

The zip code of a provider's practice location address on file with ForwardHealth must be a zip+4 code. The zip+4 code helps to identify a provider when the NPI reported to ForwardHealth corresponds to multiple enrollments and the reported taxonomy code does not uniquely identify the provider.

When a zip+4 code is required to identify a provider, omission of it 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 website](#).



# Covered and Noncovered Services

## 3

Archive Date:08/01/2025

## Covered and Noncovered Services:Noncovered Services

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Topic #68

### Definition of Noncovered Services

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

Topic #104

### 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:

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

### Missed Appointments

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.
- | If a member needs assistance in obtaining transportation to a medical appointment, encourage the member to call the NEMT manager contracted with Wisconsin DHS. Most Medicaid and BadgerCare Plus members may receive NEMT services through the NEMT manager if they have no other way to receive a ride. Refer to the [NEMT service area](#) for more information.
- | 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 and Interpretive Services

Translation services, which refer to translation of the written word, 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.

Interpretive services, which refer to interpretation of the spoken word or sign language, are a covered service. More information

on interpretive services can be found in the [Interpretive Services](#) topic.

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

## Codes

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Topic #973

### Place of Service Codes

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

POS Code	Description
02	Telehealth Provided Other Than in Patient's Home
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
10	Telehealth Provided in Patient's Home
11	Office
12	Home
19	Off Campus—Outpatient Hospital
21	Inpatient Hospital
22	On Campus—Outpatient Hospital
23	Emergency Room—Hospital
27	Outreach Site/Street
31	Skilled Nursing Facility
32	Nursing Facility
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
54	Intermediate Care Facility/Individuals With Intellectual Disabilities
71	Public Health Clinic
72	Rural Health Clinic
99	Other Place of Service

Topic #643

### Unlisted Procedure Codes

According to the HCPCS codebook, if a service is provided that is not accurately described by other HCPCS CPT procedure

codes, the service should be reported using an unlisted procedure code.

Before considering using an unlisted, or NOC, procedure code, a provider should determine if there is another more specific code that could be indicated to describe the procedure or service being performed/provided. If there is no more specific code available, the provider is required to submit the appropriate documentation, which could include a PA request, to justify use of the unlisted procedure code and to describe the procedure or service rendered. Submitting the proper documentation, which could include a PA request, may result in more timely claims processing.

Unlisted procedure codes should not be used to request adjusted reimbursement for a procedure for which there is a more specific code available.

## Unlisted Codes That Do Not Require Prior Authorization or Additional Supporting Documentation

For a limited group of unlisted procedure codes, ForwardHealth has established specific policies for their use and associated reimbursement. These codes do not require PA or additional documentation to be submitted with the claim. Providers should refer to their service-specific area of the Online Handbook on the ForwardHealth Portal for details about these unlisted codes.

For most unlisted codes, ForwardHealth requires additional documentation.

## Unlisted Codes That Require Prior Authorization

Certain unlisted procedure codes require PA. Providers should follow their service-specific PA instructions and documentation requirements for requesting PA. For a list of procedure codes for which ForwardHealth requires PA, refer to the service-specific [interactive maximum allowable fee schedule](#).

In addition to a properly completed PA request, documentation submitted on the service-specific PA attachment or as additional supporting documentation with the PA request should provide the following information:

- ┆ Specifically identify or describe the name of the procedure/service being performed or billed under the unlisted code.
- ┆ List/justify why other codes are not appropriate.
- ┆ Include only relevant documentation.
- ┆ Include all required clinical/supporting documentation.

For most situations, once the provider has an approved PA request for the unlisted procedure code, there is no need to submit additional documentation along with the claim.

## Unlisted Codes That Do Not Require Prior Authorization

If an unlisted procedure code does not require PA, documentation submitted with the claim to justify use of the unlisted code and to describe the procedure/service rendered must be sufficient to allow ForwardHealth to determine the nature and scope of the procedure and to determine whether or not the procedure is covered and was medically necessary, as defined in Wisconsin Administrative Code.

The documentation submitted should provide the following information related to the unlisted code:

- ┆ Specifically identify or describe the name of the procedure/service being performed or billed under the unlisted code.
- ┆ List/justify why other codes are not appropriate.
- ┆ Include only relevant documentation.

## How to Submit Claims and Related Documentation

Claims including an unlisted procedure code and supporting documentation may be submitted to ForwardHealth in the following ways:

- ┆ If submitting on paper using the 1500 Health Insurance Claim Form, the provider may do either of the following:
  - ┆ Include supporting information/description in Item Number 19 of the claim form.
  - ┆ Include supporting documentation on a separate paper attachment. This option should be used if Item Number 19 on the 1500 Health Insurance Claim Form does not allow enough space for the description or when billing multiple unlisted procedure codes. Providers should indicate See Attachment in Item Number 19 of the claim form and send the supporting documentation along with the claim form.
- ┆ If submitting electronically using DDE on the Portal, PES software, or 837 electronic transactions, the provider may do one of the following:
  - ┆ Include supporting documentation in the Notes field. The Notes field is limited to 80 characters.
  - ┆ Indicate that supporting documentation will be submitted separately on paper. This option should be used if the Notes field does not allow enough space for the description or when billing multiple unlisted procedure codes. Providers should indicate See Attachment in the Notes field of the electronic transaction and submit the supporting documentation on paper.
  - ┆ [Upload claim attachments](#) via the secure Provider area of the Portal.

Topic #830

## Valid Codes Required on Claims

ForwardHealth requires that all codes indicated on claims and PA requests, including diagnosis codes, revenue codes, HCPCS codes, HIPPS codes, and CPT codes be valid codes. Claims received without valid diagnosis codes, revenue codes, and HCPCS, HIPPS, or CPT codes will be denied; PA requests received without valid codes will be returned to the provider. Providers should refer to current national coding and billing manuals for information on valid code sets.

### Code Validity

In order for a code to be valid, it must reflect the highest number of required characters as indicated by its national coding and billing manual. If a stakeholder uses a code that is not valid, ForwardHealth will deny the claim or return the PA request, and it will need to be resubmitted with a valid code.

### Code Specificity for Diagnosis

All codes allow a high level of detail for a condition. The level of detail for ICD diagnosis codes is expressed as the level of specificity. In order for a code to be valid, it must reflect the highest level of specificity (contain the highest number of characters) required by the code set. For some codes, this could be as few as three characters. If a stakeholder uses an ICD diagnosis code that is not valid (not to the specific number of characters required), ForwardHealth will deny the claim or return the PA request, and it will need to be resubmitted with a valid ICD diagnosis code.

## Covered Services and Requirements

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Topic #986

### 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 ForwardHealth for ongoing care coordination services (T1016 with modifier U3). 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.

This situation is the exception, and generally a member should not receive care coordination services from more than one provider. Further information regarding [concurrent services](#) is available.

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 child, regardless of the age of the child at the time of the referral.

Topic #993

### Coordinating Prenatal Care Coordination Services and Child Care Coordination Services

The PNCC benefit covers the period during and after pregnancy per Wis. Admin. Code § [DHS 107.34\(1\)\(a\)2](#). During the postpartum period, CCC providers may be reimbursed through the CCC benefit for administering the initial, comprehensive assessment using the [Child Care Coordination Family Questionnaire Domains and Questions](#) and developing a care plan (T1016 with modifier U2) for eligible child members enrolled in BadgerCare Plus or Medicaid. However, providers may not submit claims for ongoing care and coordination monitoring CCC services (T1016 with modifier U3) provided to members with parents/mothers receiving PNCC services, except as outlined below.

Ongoing care coordination and monitoring CCC services provided to a child member with parents/mothers receiving PNCC

services are covered if the following information is documented in the child member's record:

- ▮ The child 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, they live with an abusive partner who is often absent for days at a time. They receive little or no emotional support from family members and is not sure they are 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 with a child 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 child 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 and their parent/legal guardian, which care coordinator will provide or follow up on which services.
- ▮ The services provided by the care coordinators are not duplicative.
- ▮ The child 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.

Topic #44

## Definition of Covered Services

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

Topic #22917

## Interpretive Services

ForwardHealth reimburses interpretive services provided to BadgerCare Plus and Medicaid members who are deaf or hard of hearing or who have LEP. A member with LEP is someone who does not speak English as their primary language and who has a limited ability to read, speak, write, or understand English.

Interpretive services are defined as the provision of spoken or signed language communication by an interpreter to convey a message from the language of the original speaker into the language of the listener in real time (synchronous) with the member present. This task requires the language interpreter to reflect both the tone and the meaning of the message.

Only services provided by interpreters of the spoken word or sign language will be covered with the HCPCS procedure code T1013 (Sign language or oral interpretive services, per 15 minutes). Translation services for written language are not reimbursable with T1013, including services provided by professionals trained to interpret written text.

## Covered Interpretive Services

ForwardHealth covers interpretive services for deaf or hard of hearing members or members with LEP when the interpretive service and the medical service are provided to the member on the same DOS and during the same time as the medical service. A Medicaid-enrolled provider must submit for interpretive services on the same claim as the medical service, and the DOS they are



provided to the member must match. Interpretive services cannot be billed by HMOs and MCOs. Providers should follow CPT and HCPCS coding guidance to appropriately document and report procedure codes related to interpretive and medical services on the applicable claim form. Time billed for interpretive services should reflect time spent providing interpretation to the member. At least three people must be present for the services to be covered: the provider, the member, and the interpreter.

Interpreters may provide services either in-person or via telehealth. [Services provided via telehealth](#) must be functionally equivalent to an in-person visit, meaning that the transmission of information must be of sufficient quality as to be the same level of service as an in-person visit. Transmission of voices, images, data, or video must be clear and understandable. Both the distant and originating sites must have the requisite equipment and staffing necessary to provide the telehealth service.

Billing time for [documentation of interpretive services](#) will be considered part of the service performed. BadgerCare Plus and Wisconsin Medicaid have adopted the federal "Documentation Guidelines for Evaluation and Management Services" (CMS 2021 and 2023) in combination with BadgerCare Plus and Medicaid policy for [E&M Services](#).

Most Medicaid-enrolled providers, including border-status or out-of-state providers, are able to submit claims for interpretive services.

Standard ForwardHealth policy applies to the reimbursement for interpretive services for out-of-state providers, including PA requirements.

## **Interpretive Services Provided Via Telehealth for Out-of-State Providers**

ForwardHealth requirements for services provided via telehealth by out-of-state providers are the same as the ForwardHealth policy for services provided in-person by out-of-state providers. Requirements for [out-of-state providers](#) for interpretive services are the same whether the service is provided via telehealth or in-person. Out-of-state providers who are not enrolled as either border-status or telehealth-only border-status providers are required to obtain PA before providing services via telehealth to BadgerCare Plus or Medicaid members. The PA would indicate that interpretive services are needed.

## **Documentation**

While not required for submitting a claim for interpretive services, providers must include the following information in the member's file:

- | The interpreter's name and/or company
- | The date and time of interpretation
- | The duration of the interpretive service (time in and time out or total duration)
- | The amount submitted by the medical provider for interpretive services reimbursement
- | The type of interpretive service provided (foreign language or sign language)
- | The type of covered service(s) the provider is billing for

## **Third-Party Vendors and In-House Interpreters**

Providers may be reimbursed for the use of third-party vendors or in-house interpreters supplying interpretive services.

Providers are reminded that HIPAA confidentiality requirements apply to interpretive services. When a covered entity or provider utilizes interpretive services that involve PHI, the entity or provider will need to conduct an accurate and thorough assessment of the potential risks and vulnerabilities to PHI confidentiality, integrity, and availability. Each entity or provider must assess what are reasonable and appropriate measures for their situation.

## **Limitations**

There are no limitations for how often members may utilize interpretive services when the interpretive service is tied to another billable medical service for the member for the same DOS.

## Claims Submission

To receive reimbursement, providers may bill for interpretive services on one of the following claim forms:

- ▮ 1500 Health Insurance Claim Form (for dental, professional, and professional crossover claims)
- ▮ Institutional UB-04 (CMS 1450) claim form (for outpatient crossover claims and home health/personal care claims)

## Noncovered Services

The following will not be eligible for reimbursement with procedure code T1013:

- ▮ Interpretive services provided in conjunction with a noncovered, non-reimbursable, or excluded service
- ▮ Interpretive services provided by the member's family member, such as a parent, spouse, sibling, or child
- ▮ The interpreter's waiting time and transportation costs, including travel time and mileage reimbursement, for interpreters to get to or from appointments
- ▮ The technology and equipment needed to conduct interpretive services
- ▮ Interpretive services provided directly by the HMOs and MCOs are not billable to ForwardHealth for reimbursement via procedure code T1013

## Cancellations or No Shows

Providers cannot submit a claim for interpretive services if an appointment is cancelled, the member or the interpreter is a no-show (is not present), or the interpreter is unable to perform the interpretation needed to complete the appointment successfully.

## Procedure Code and Modifiers

Providers must submit claims for interpretive services and the medical service provided to the member on separate details on the same claim.

Procedure code T1013 is a time-based code, with 15-minute increments. Rounding up to the 15-minute mark is allowable if at least eight minutes of interpretation were provided.

Providers should use the following rounding guidelines for procedure code T1013.

Time (Minutes)	Number of Interpretation Units Billed
8–22 minutes	1.0 unit
23–37 minutes	2.0 units
38–52 minutes	3.0 units
53–67 minutes	4.0 units
68–82 minutes	5.0 units
83–97 minutes	6.0 units

Claims for interpretive services must include HCPCS procedure code T1013 and the appropriate modifier(s):

- ▮ U1 (Spoken language)
- ▮ U3 (Sign Language)
- ▮ GT (Via interactive audio and video telecommunication systems)
- ▮ 93 (Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications)

system)

Providers should refer to the [interactive maximum allowable fee schedules](#) for the reimbursement rate, covered provider types and specialties, modifiers, and the allowable POS codes for procedure code T1013.

<b>Delivery Method of Interpretive Services</b>	<b>Definition for Sign Language and Foreign Language Interpreters</b>		<b>Modifiers</b>
<b>In person</b> (foreign language and sign language)	When the interpreter is physically present with the member and provider		U1 or U3
<b>Telehealth*</b> (foreign language and sign language)	When the member is located at an originating site and the interpreter is available remotely (via audio-visual or audio only) at a distant site		U1 or U3 <b>and</b> GT or 93
	<b>Phone</b> (foreign language only)	When the interpreter is not physically present with the member and the provider and interprets via audio-only through the phone	U1 <b>and</b> 93
	<b>Interactive video</b> (foreign language and sign language)	When the interpreter is not physically present with the member and the provider and interprets on interactive video	U1 or U3 <b>and</b> GT

\*Any telehealth service must be provided using HIPAA-compliant software or delivered via an app or service that includes all the necessary privacy and security safeguards to meet the requirements of HIPAA.

## Dental Providers

Dental providers submitting claims for interpretive services are not required to include a modifier with procedure code T1013. Dental providers should retain documentation of the interpretive service in the member's records.

## Allowable Places of Service

Claims for interpretive services must include a valid POS code where the interpretive services are being provided.

## Federally Qualified Health Centers

Non-tribal FQHCs, also known as CHCs, (POS code 50), will not receive direct reimbursement for interpretive services as these are indirect services assumed to be already included in the FQHC's bundled PPS rate. However, CHCs can still bill the T1013 code as an indirect procedure code when providing interpretive services. This billing process is similar to that of other indirect services provided by non-tribal FQHCs. This will enable DHS to better track how FQHCs provide these services and process any future change in scope adjustment to increase their PPS rate that includes providing interpretive services.

## Rural Health Clinics

RHCs (POS code 72) receives direct reimbursement for interpretive services. Procedure code T1013 should be billed when providing interpretive services.

## Interpreter Qualifications

The two types of allowable interpreters include:

- ▮ Sign language interpreters—Professionals who facilitate the communication between a hearing individual and a person who is deaf or hard of hearing and uses sign language to communicate
- ▮ Foreign language interpreters—Professionals who are fluent in both English and another language and listen to a communication in one language and convert it to another language while retaining the same meaning.

### Qualifications for Sign Language Interpreters

For Medicaid-enrolled providers to receive reimbursement, sign language interpreters must be licensed in Wisconsin under Wis. Stat. § [440.032](#) and must follow the specific requirements regarding education, training, and locations where they are able to interpret. The billing provider is responsible for determining the sign language interpreter's licensure and must retain all documentation supporting it.

### Qualifications for Foreign Language Interpreters

There is not a licensing process in Wisconsin for foreign language interpreters. However, Wisconsin Medicaid strongly recommends that providers work through professional agencies that can verify the qualifications and skills of their foreign language interpreters.

A competent foreign language interpreter should:

- ▮ Be at least 18 years of age.
- ▮ Be able to interpret effectively, accurately, and impartially, both receptively and expressively, using necessary specialized vocabulary.
- ▮ Demonstrate proficiency in English and another language and have knowledge of the relevant specialized terms and concepts in both languages.
- ▮ Be guided by the standards developed by the National Council on Interpreting Health Care.
- ▮ Demonstrate cultural responsiveness regarding the LEP language group being served including values, beliefs, practices, languages, and terminology.

Topic #84

## Medical Necessity

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

Topic #86

## Member Payment for Covered Services

Under state and federal laws, a Medicaid-enrolled 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 enrollment.

Topic #989

## Other Care Coordinators

When multiple family members have care coordinators (case managers), the [Child Care Coordination \(CCC\) 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.

Topic #66

## Program Requirements

For a covered service to meet program requirements, the service must be provided by a qualified Medicaid-enrolled 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.

Topic #824

## Services That Do Not Meet Program Requirements

As stated in Wis. Admin. Code § [DHS 107.02\(2\)](#), BadgerCare Plus and Wisconsin Medicaid 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 Wis. Admin. Code § [DHS 106.03](#), 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 Wisconsin 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 enrollment requirements under Wis. Admin. Code ch. [DHS 105](#)
- ┆ 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 DHS

# Telehealth

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Topic #22739

## Originating and Distant Sites

The originating site is where the member is located during a telehealth visit. Only the provider at the originating site can bill for an originating site fee for hosting the member. The originating site should not use telehealth modifiers on the claims since all services are provided in-person. The distant site is where the provider is located during the telehealth visit. The provider who is providing health care services to the member via telehealth cannot bill the originating site fee because they are not hosting the member.

The following locations are eligible for the originating site fee under permanent telehealth policy:

- | Office or clinic:
  - | Medical
  - | Dental
  - | Therapies (physical therapy, occupational therapy, speech and language pathology)
  - | Behavioral and mental health agencies
- | Hospital
- | Skilled nursing facility
- | Community mental health center
- | Intermediate care facility for individuals with intellectual disabilities
- | Pharmacy
- | Day treatment facility
- | Residential substance use disorder treatment facility

## Claims Submission and Reimbursement for Distant Site Providers

Claims for services provided via telehealth by distant site providers must be billed with the same procedure code as would be used for a face-to-face encounter along with modifiers GQ, GT, FQ, or 93.

Note: Only the service rendered from the distant site must be billed with modifier GQ. The originating site for asynchronous services is not eligible to receive an originating site fee.

Claims must also include either POS code 02 or 10. ForwardHealth reimburses the service rendered by distant site providers at the same rate as when the service is provided face-to-face.

### Ancillary Providers

Claims for services provided via telehealth by distant site ancillary providers should continue to be submitted under the supervising physician's NPI using the lowest appropriate level office or outpatient visit procedure code or other appropriate CPT code for the service performed. These services must be provided under the direct on-site supervision of a physician who is located at the same physical site as the ancillary provider and must be documented in the same manner as services that are provided face to face.

Refer to the [Supervision](#) topic for additional information.

### Pediatric and Health Professional Shortage Area-Eligible Services

Claims for services provided via telehealth by distant site providers may additionally qualify for pediatric (services for members 18

years of age and under) or HPSA-enhanced reimbursement. Pediatric and HPSA-eligible providers are required to indicate POS code 02 or 10, along with modifier GQ, GT, FQ, or 93 and the applicable pediatric or HPSA modifier, when submitting claims that qualify for [enhanced reimbursement](#).

## Claims Submission and Reimbursement for Originating Site Fee

In addition to reimbursement to the distant site provider, ForwardHealth reimburses an originating site fee for the staff and equipment at the originating site requisite to provide a service via telehealth. Eligible providers who serve as the originating site should bill the fee with HCPCS procedure code Q3014 (Telehealth originating site fee). Modifier GQ, GT, FQ, or 93 should not be included with procedure code Q3014.

Outpatient hospitals, including emergency departments, must bill HCPCS procedure code Q3014 on an institutional claim form as a separate line item with revenue code 0780. ForwardHealth will reimburse hospitals for the fee based on the standard hospital reimbursement methodology. ForwardHealth will reimburse these providers for the fee based on the provider's standard reimbursement methodology.

All other providers should bill HCPCS procedure code Q3014 with a POS code that represents where the member is located during the service. The POS must be a ForwardHealth-allowable originating site for HCPCS procedure code Q3014 in order to be reimbursed for the originating site fee. Billing-only provider types must include an allowable rendering provider on the claim form. The originating site fee is reimbursed based on a [maximum allowable fee](#).

Although FQHCs are not directly reimbursed an originating site fee, HCPCS procedure code Q3014 should be billed for tracking purposes and for consideration in any potential future changes in scope.

To receive reimbursement, the originating site must:

- ▮ Utilize an interactive audiovisual telecommunications system that permits real-time communication between the provider at the distant site and the member at the originating site.
- ▮ Be in a physical location that ensures privacy.
- ▮ Provide access to broadband internet with sufficient bandwidth to transmit audio and video data.
- ▮ Provide access to support staff to assist with technical components of the telehealth visit.
- ▮ Be compliant with Health Insurance Portability and Accountability Act of 1996 standards.

## Federally Qualified Health Centers and Rural Health Clinics

For the purpose of this Online Handbook topic, FQHC refers to Tribal and Out-of-State FQHCs. This topic does not apply to Community Health Centers subject to PPS reimbursement.

FQHCs and RHCs may serve as originating site and distant site providers for telehealth services.

### Distant Site

FQHCs and RHCs may report services provided via telehealth on the cost settlement report when the FQHC or RHC served as the distant site and the member is an established patient of the FQHC or RHC at the time of the telehealth service. For currently covered services, services that are considered direct when provided in-person will be considered direct when provided via telehealth for FQHCs.

Services billed with modifier GQ, GT, FQ, or 93 will be considered under the PPS reimbursement method for non-tribal FQHCs. Billing HCPCS procedure code T1015 (Clinic visit/encounter, all-inclusive) with a telehealth procedure code will result in a PPS rate for fee-for-service encounters. Fee-for-service claims must include HCPCS procedure code T1015 when services are provided via telehealth in order for proper reimbursement.

### Originating Site

The originating site fee is not a FQHC or RHC reportable encounter on the cost report. Any reimbursement for the originating site fee must be reported as a deductive value on the cost report.

Topic #22757

## Supervision

Supervision requirements and respective telehealth allowances vary depending on service and provider type. Some supervision requirements necessitate the physical presence of the supervising provider to meet the requirements of appropriate delivery of supervision. Such requirements cannot be met through the provision of telehealth, including audio-visual delivery.

Providers who deliver services with supervision requirements are reminded to review ForwardHealth policy, including permanent telehealth policy, and the requirements of their licensing and/or certifying authorities to determine if the supervisory components of the service can be met via telehealth.

### Supervision of Paraprofessional Providers

Paraprofessional providers are subject to supervision requirements. Paraprofessional providers are providers who do not hold a license to practice independently but are providing services under the direction of a licensed provider. Providers who supervise paraprofessionals are responsible for confirming if the required components of supervision can be met through telehealth delivery.

### Personal Care/Home Health Provider Supervision

Supervision of PCWs and home health aides must be performed on site and in person by the RN. State rules and regulations necessitate supervising providers to physically visit a member's home and directly observe the paraprofessional providing services.

### Direct Supervision for Ancillary Care Providers

[Ancillary providers](#) have specific requirements when providing care via telehealth. These providers are health care professionals that are not enrolled in Wisconsin Medicaid, such as staff nurses, dietician counselors, nutritionists, health educators, genetic counselors, and some nurse practitioners who practice under the direct supervision of a physician and bill under the supervising physician's NPI. (Nurse practitioners, nurse midwives, and anesthesiologists who are Medicaid-enrolled should refer to their service-specific area of the Online Handbook for billing information).

For telehealth services, the supervising physician is not required to be onsite, but they must be able to interact with the member using real-time audio or audiovisual communication, if needed. For supervision of ancillary providers, remote supervision is allowed in circumstances where the physician feels the member is not at risk of an adverse event that would require hands-on intervention from the physician.

### Supervision for Behavioral Health Services

The FR modifier should be used for behavioral health services where the supervising provider is present through audio-visual means and the patient and supervised provider are in-person.

### Documenting Supervision Method

Providers should include how the service and the required supervision occurred in the member record and, if applicable, indicate the appropriate modifier on the claim form. For example, for a behavioral health service where the supervising provider is present through audio-visual means and the patient and supervised provider are in-person, modifier FR should be indicated on the claim.



Topic #22837

# Telehealth Definitions

## General Telehealth Definitions

**Telehealth** means the use of telecommunications technology by a Medicaid-enrolled provider to deliver functionally equivalent health care services including: assessment, diagnosis, consultation, treatment, and transfer of medically relevant data. Telehealth may include real-time interactive audio-only communication. Telehealth does not include communication between a provider and a member that consists solely of an email, text, or fax transmission.

**Synchronous telehealth services** are two-way, real-time, interactive communications. They may include audio-only (telephone) or audio-visual communications.

**Asynchronous telehealth services** are defined as telehealth that is used to transmit medical data about a patient to a provider when the transmission is not a two-way, real-time, interactive communication.

**Functionally equivalent** means that when a service is provided via telehealth, the transmission of information must be of sufficient quality as to be the same level of service as an in-person visit. Transmission of voices, images, data, or video must be clear and understandable.

## Telehealth Service Definitions

The following are definitions to clarify the meaning of existing terms that describe different modes of telehealth service delivery in telehealth policy.

**In-person** refers to when the provider rendering a service and the member receiving that service are located together physically in the same space. In-person services are not considered to be delivered through telehealth, including audio-visual telehealth, unless there are applicable supervision components and requirements that are rendered through telehealth outside of the direct patient contact by the provider.

**Face-to-face** refers to requirements that can be met either in-person or through real-time, interactive audio-visual telehealth. An interactive telehealth service with face-to-face components must be functionally equivalent to an in-person service. It is delivered from outside the physical presence of a Medicaid member by using audio-visual technology, and there is no reduction in quality, safety, or effectiveness. ForwardHealth does not consider a face-to-face requirement to be met by audio-only or asynchronous delivery of services.

Under telehealth policy, **direct** refers to an in-person contact between a member and a provider. Direct services often require a provider to physically touch or examine the recipient and delegation is not appropriate.

Topic #510

## Telehealth Policy

Both synchronous (two-way, real-time, interactive communications) and asynchronous (information stored and forwarded to a provider for later review) services identified under permanent policy may be reimbursed when provided via telehealth (also known as telemedicine). ForwardHealth will require providers to follow permanent billing guidelines for both synchronous and asynchronous telehealth services.

Telehealth enables a provider who is located at a distant site to render the service remotely to a member located at an originating site using a combination of interactive video, audio, and externally acquired images through a networking environment.

Telehealth means the use of telecommunications technology by a Medicaid-enrolled provider to deliver functionally equivalent health care services including assessment, diagnosis, consultation, treatment, and transfer of medically relevant data. Telehealth may include real-time interactive audio-only communication. Telehealth does not include communication between a provider and a member that consists solely of an email, text, or fax transmission.

Functionally equivalent means that when a service is provided via telehealth, the transmission of information must be of sufficient quality as to be the same level of service as an in-person visit. Transmission of voices, images, data, or video must be clear and understandable.

Note: Temporary telehealth policy that will become permanent policy shortly after the Federal Health Emergency expires is included in this topic.

## Telehealth Policy Requirements

The following requirements apply to the use of telehealth:

- 1 Both the member and the provider of the health care service must agree to the service being performed via telehealth. If either the member or provider decline the use of telehealth for any reason, the service should be performed in-person.
- 1 The member retains the option to refuse the delivery of health care services via telehealth at any time without affecting their right to future care or treatment and without risking the loss or withdrawal of any program benefits to which they would otherwise be entitled.
- 1 Medicaid-enrolled providers must be able and willing to refer members to another provider if necessary, such as when telehealth services are not appropriate or cannot be functionally equivalent, or the member declines a telehealth visit.
- 1 [Title VI](#) of the Civil Rights Act of 1964 requires recipients of federal financial assistance to take reasonable steps to make their programs, services, and activities accessible by eligible persons with limited English proficiency.
- 1 The Americans with Disabilities Act requires that health care entities provide full and equal access for people with disabilities.

## Allowable Services

The [Max Fee Schedules](#) include a complete list of services allowed under permanent telehealth policy. Procedure codes for services allowed under permanent telehealth policy have POS codes 02 and 10 listed as an allowable POS in the fee schedule. Complete descriptions of these POS codes are as follows:

- 1 POS code 02: Telehealth Provided Other Than in Patient's Home—The location where health services and health related services are provided or received through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.
- 1 POS code 10: Telehealth Provided in Patient's Home—The location where health services and health related services are provided or received through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.

Claims for services delivered via telehealth must include all modifiers required by the existing benefit coverage policy in order to reimburse the claim correctly. Telehealth delivery of the service is shown on the claim by indicating POS code 02 or 10 and including a telehealth modifier in addition to any other required benefit-specific modifiers, unless the procedure code includes the method of delivery in the official procedure code description.

County-administered programs, school-based services, and any other programs that utilize cost reporting must include required modifiers, such as renderer credentials and group versus individual services, as well as correct details for cost reporting to ensure

correct reimbursement.

## Services Not Appropriate Via Telehealth

Certain types of benefits or services that are not appropriately delivered via telehealth include:

- ┆ Services that are not covered when provided in-person.
- ┆ Services that do not meet applicable laws, regulations, licensure requirements, or procedure code definitions if delivered via telehealth.
- ┆ Services where a provider is required to physically touch or examine the recipient and delegation is not appropriate.
- ┆ Services the provider declines to deliver via telehealth.
- ┆ Services the recipient declines to receive via telehealth.
- ┆ Transportation services.
- ┆ Services provided by personal care workers, home health aides, private duty nurses, or school-based service care attendants.

## Reimbursement for Covered Services

The health care provider at the distant site must determine:

- ┆ The service delivered via telehealth meets the procedural definition and components of the CPT or HCPCS procedure code, as defined by the American Medical Association, or the CDT procedure code, as defined by the American Dental Association.
- ┆ The service is functionally equivalent to an in-person service for the individual member and circumstances.

Reimbursement is not available for services that cannot be provided via telehealth due to technical or equipment limitations.

## Documentation Requirements

Documentation requirements for a telehealth service are the same as for an in-person visit and must accurately reflect the service rendered. Documentation must identify the delivery mode of the service when provided via telehealth and document:

- ┆ Whether the service was provided via audio-visual telehealth, audio-only telehealth, or via telehealth externally acquired images
- ┆ Whether the service was provided synchronously or asynchronously

Additional information for which documentation is recommended, but not required, includes:

- ┆ Provider location (for example, clinic [city/name], home, other)
- ┆ Member location (for example, clinic [city/name], home)
- ┆ All clinical participants, as well as their roles and actions during the encounter (This could apply if, for example, a member presents at a clinic and receives telehealth services from a provider at a different location.)

As a reminder, documentation for originating sites must support the member's presence in order to submit a claim for the originating site fee. In addition, if the originating site provides and bills for services in addition to the originating site fee, documentation in the member's medical record should distinguish between the unique services provided.

## Audio-Only Guidelines

When possible, telehealth services should include both an audio and visual component. In circumstances where audio-visual telehealth is not possible due to member preference or technology limitations, telehealth may include real-time interactive audio-only communication if the provider feels the service is functionally equivalent to the in-person service and there are no face-to-face

or in-person restrictions listed in the procedural definition of the service.

Documentation should include that the service was provided via interactive synchronous audio-only telehealth.

Modifier 93 should be used for any service performed via audio-only telehealth. The GT modifier should only be used to indicate services that were performed using audio-visual technology.

## **Member Consent Guidelines for Telehealth**

On at least an annual basis, providers should supply and document that:

- ┆ The member expressed an understanding of their right to decline services provided via telehealth.
- ┆ Providers should develop and implement their own methods of informed consent to verify that a member agrees to receive services via telehealth. These methods must comply with all federal and state regulations and guidelines.
- ┆ Providers have flexibility in determining the most appropriate method to capture member consent for telehealth services. Examples of allowable methods include educating the member and obtaining verbal consent prior to the start of treatment or telehealth consent and privacy considerations as part of the notice of privacy practices.

## **Privacy and Security**

Providers are required to follow federal laws to ensure member privacy and security. This may include ensuring that:

- ┆ The location from which the service is delivered via telehealth protects privacy and confidentiality of member information and communications.
- ┆ The platforms used to connect to the member to the telehealth visit are secure.

## **Group Treatment**

Additional privacy considerations apply to members participating in group treatment via telehealth. Group leaders should provide members with information on the risks, benefits, and limits to confidentiality related to group telehealth and document the member's consent prior to the first session. Group leaders should adhere to and uphold the highest privacy standards possible for the group.

Group members should be instructed to respect the privacy of others by not disclosing group members' images, names, screenshots, identifying details, or circumstances. Group members should also be reminded to prevent non-group members from seeing or overhearing telehealth sessions.

Providers may not compel members to participate in telehealth-based group treatment and should make alternative services available for members who elect not to participate in telehealth-based group treatment.

## **Costs Member Cannot Be Billed For**

The following cannot be billed to the member:

- ┆ Telehealth equipment like tablets or smart devices
- ┆ Charges for mailing or delivery of telehealth equipment
- ┆ Charges for shipping and handling of:
  - ┆ Diagnostic tools
  - ┆ Equipment to allow the provider to assess, diagnose, repair, or set up medical supplies online such as hearing aids, cochlear implants, power wheelchairs, or other equipment

## **Allowable Providers**

There are no limitations on what provider types may be reimbursed for telehealth services.

## Requirements and Restrictions

Services provided via telehealth must be of sufficient audio and visual fidelity and clarity as to be functionally equivalent to a face-to-face visit where both the rendering provider and member are in the same physical location. Both the distant and originating sites must have the requisite equipment and staffing necessary to provide the telehealth service.

Coverage of a service provided via telehealth is subject to the same restrictions as when the service is provided face to face (for example, allowable providers, multiple service limitations, PA).

Providers are reminded that HIPAA confidentiality requirements apply to telehealth services. When a covered entity or provider utilizes a telehealth service that involves PHI, the entity or provider will need to conduct an accurate and thorough assessment of the potential risks and vulnerabilities to PHI confidentiality, integrity, and availability. Each entity or provider must assess what are reasonable and appropriate security measures for their situation.

Note: Providers may not require the use of telehealth as a condition of treating a member. Providers must develop and implement their own methods of informed consent to verify that a member agrees to receive services via telehealth. These methods must comply with all federal and state regulations and guidelines.

## Noncovered Services

Services that are not covered when delivered in person are not covered as telehealth services. In addition, services that are not functionally equivalent to the in-person service when provided via telehealth are not covered.

## Additional Policy for Certain Types of Providers

### Out-of-State Providers

ForwardHealth policy for services provided via telehealth by [out-of-state providers](#) is the same as ForwardHealth policy for services provided face to face by out-of-state providers.

Out-of-state providers who meet the definition of a border-status provider as described in Wis. Admin. Code § DHS [101.03\(19\)](#) and who provide services to Wisconsin Medicaid members only via telehealth, may apply for enrollment as Wisconsin telehealth-only border-status providers if they are licensed in Wisconsin under applicable Wisconsin statute and administrative code.

Out-of-state providers who do not have border status enrollment with Wisconsin Medicaid are required to obtain PA before providing services via telehealth to BadgerCare Plus or Medicaid members.

Note: Wisconsin Medicaid is prohibited from paying providers located outside of the United States and its territories, including the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

# Claims

# 4

Archive Date:08/01/2025

## Claims:Submission

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Topic #17797

# 1500 Health Insurance Claim Form Completion Instructions

These instructions are for the completion of the 1500 Health Insurance Claim Form for ForwardHealth. Refer to the [1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12](#), prepared by the NUCC and available on their website, to view instructions for all item numbers not listed below.

Use the following claim form completion instructions, in conjunction with the 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12, prepared by the NUCC, to avoid denial or inaccurate claim payment. Be advised that every code used is required to be a valid code, even if it is entered in a non-required field. Do not include attachments unless instructed to do so.

Members enrolled in BadgerCare Plus or Medicaid receive a ForwardHealth member identification card. Always verify a member's enrollment before providing nonemergency services to determine if there are any limitations to 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.**

Other health insurance sources must be billed prior to submitting claims to ForwardHealth, unless the service does not require commercial health insurance billing as determined by ForwardHealth. When submitting paper claims, if the member has any other health insurance sources, providers are required to complete and submit an [Explanation of Medical Benefits form](#), along with the completed paper claim.

Submit completed paper claims and the completed Explanation of Medical Benefits form, as applicable, to the following address:

ForwardHealth  
Claims and Adjustments  
313 Blettner Blvd  
Madison WI 53784

### **Item Number 6 — Patient Relationship to Insured**

Enter "X" in the "Self" box to indicate the member's relationship to insured when Item Number 4 is completed. Only one box can be marked.

### **Item Number 9 — Other Insured's Name (not required)**

This field is not required on the claim.

Note: When submitting paper claims to ForwardHealth, if the member has any other health insurance sources (for example, commercial health insurance, Medicare, Medicare Advantage Plans), providers are required to complete and submit a separate [Explanation of Medical Benefits form](#) for each other payer as an attachment(s) to their completed paper claim.

### **Item Number 9a — Other Insured's Policy or Group Number (not required)**

This field is not required on the claim.

Note: When submitting paper claims to ForwardHealth, if the member has any other health insurance sources (for example, commercial health insurance, Medicare, Medicare Advantage Plans), providers are required to complete and submit a separate [Explanation of Medical Benefits form](#) for each other payer as an attachment(s) to their completed paper claim.

**Item Number 9d — Insurance Plan Name or Program Name (not required)**

This field is not required on the claim.

Note: When submitting paper claims to ForwardHealth, if the member has any other health insurance sources (for example, commercial health insurance, Medicare, Medicare Advantage Plans), providers are required to complete and submit a separate [Explanation of Medical Benefits form](#) for each other payer as an attachment(s) to their completed paper claim.

**Item Number 10d — Claim Codes (Designated by NUCC)**

When applicable, enter the Condition Code. The Condition Codes approved for use on the 1500 Health Insurance Claim Form are available on the [NUCC website under Code Sets](#).

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

This field is not required on the claim.

Note: When submitting paper claims to ForwardHealth, if the member has any other health insurance sources (for example, commercial health insurance, Medicare, Medicare Advantage Plans), providers are required to complete and submit a separate [Explanation of Medical Benefits form](#) for each other payer as an attachment(s) to their completed paper claim.

**Item Number 11d — Is There Another Health Benefit Plan?**

This field is not used for processing by ForwardHealth.

**Item Number 19 — Additional Claim Information (Designated by NUCC)**

When applicable, enter provider identifiers or taxonomy codes. A list of applicable qualifiers are defined by the NUCC and can be found in the NUCC 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12, prepared by the NUCC.

If a provider bills an [unlisted \(or not otherwise classified\) procedure code](#), a description of the procedure must be indicated in this field. If a more specific code is not available, the provider is required to submit the appropriate documentation, which could include a PA request, to justify use of the unlisted procedure code and to describe the procedure or service rendered.

**Item Number 22 — Resubmission Code and/or Original Reference Number**

This field is not used for processing by ForwardHealth.

**Section 24**

The six service lines in section 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.

**For physician-administered drugs:** NDCs must be indicated in the shaded area of Item Numbers 24A-24G. Each NDC must be accompanied by an NDC qualifier, unit qualifier, and units. To indicate an NDC, providers should do the following:

- 1. Indicate the NDC qualifier N4, followed by the 11-digit NDC, with no space in between.
- 1. Indicate one space between the NDC and the unit qualifier.
- 1. Indicate one unit qualifier (F2 [International unit], GR [Gram], ME [Milligram], ML [Milliliter], or UN [Unit]), followed by the NDC units, with no space in between.

For additional information about submitting a 1500 Health Insurance Claim Form with supplemental NDC information, refer to the completion instructions located under "Section 24" in the Field Specific Instructions section of the NUCC's 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12.



**Item Number 24C — EMG**

Enter a "Y" in the unshaded area for each procedure performed as an emergency. If the procedure was not an emergency, leave this field blank.

**Item Number 29 — Amount Paid (not required)**

This field is not required on the claim.

Note: When submitting paper claims to ForwardHealth, if the member has any other health insurance sources (for example, commercial health insurance, Medicare, Medicare Advantage Plans), providers are required to complete and submit a separate [Explanation of Medical Benefits form](#) for each other payer as an attachment(s) to their completed paper claim.

Topic #542

## Attached Documentation

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

Topic #6957

## Copy Claims on the ForwardHealth Portal

Providers can copy institutional, professional, and dental 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.

Topic #5017

## 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 ForwardHealth Portal. The EOBs help providers determine why a claim did not process successfully, so providers may correct the error online and resubmit the claim. The EOB appears on the bottom of the screen and references the applicable claim header or detail.

Topic #4997

## Direct Data Entry of Professional and Institutional Claims on the Portal

Providers can submit the following claims to ForwardHealth via DDE on the ForwardHealth Portal:

- | Professional claims
- | Institutional claims
- | Dental claims
- | Compound drug claims
- | Noncompound drug claims

DDE is an online application that allows providers to submit claims directly to ForwardHealth.

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
- | Visit point of origin
- | Visit priority
- | Diagnosis codes
- | Revenue codes
- | Procedure codes
- | HIPPS codes
- | Modifiers

On dental claims, providers may search for and select the following:

- | Procedure codes
- | Rendering providers
- | Area of the oral cavity
- | Place of service codes

On compound and noncompound drug claims, providers may search for and select the following:

- | Diagnosis codes
- | NDCs
- | Place of service codes
- | Professional service codes
- | Reason for service codes
- | Result of service codes

Using DDE, providers may submit claims for compound drugs and single-entity drugs. Any provider, including a provider of DME or of DMS who submits noncompound drug claims, may submit these claims via DDE. All claims, including POS claims, are viewable via DDE.

Topic #344

## Electronic Claim Submission

Providers are encouraged to submit claims electronically. Electronic claim 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

Topic #964

## Electronic Claim Submission for Child Care Coordination Services

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 guide](#) for the 837P transaction when submitting these claims.

## Provider Electronic Solutions Software

The DMS 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 from the [ForwardHealth Portal](#). For assistance installing and using PES software, providers may call the [EDI Helpdesk](#).

Topic #16937

## Electronic Claims and Claim Adjustments With Other Commercial Health Insurance Information

Effective for claims and claim adjustments submitted electronically via the Portal or PES software on and after June 16, 2014, other insurance information must be submitted at the detail level on professional, institutional, and dental claims and adjustments if it was processed at the detail level by the primary insurance. Except for a few instances, Wisconsin Medicaid or BadgerCare Plus is the payer of last resort for any covered services; therefore, providers are 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.

Other insurance information that is submitted at the detail level via the Portal or PES software will be processed at the detail level by ForwardHealth.

Under HIPAA, claims and adjustments submitted using an 837 transaction must include detail-level information for other insurance if they were processed at the detail level by the primary insurance.

### Adjustments to Claims Submitted Prior to June 16, 2014

Providers who submit professional, institutional, or dental claim adjustments electronically on and after June 16, 2014, for claims originally submitted prior to June 16, 2014, are required to submit other insurance information at the detail level on the adjustment if it was processed at the detail level by the primary insurance.

Topic #4837

## 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 is 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.

Topic #10837

## Note Field for Most Claims Submitted Electronically

In some instances, ForwardHealth requires providers to include a description of a service identified by an unlisted, or NOC, procedure code. Providers submitting claims electronically should include a description of an NOC procedure code in a Notes field, if required. The Notes field allows providers to enter up to 80 characters. In some cases, the Notes field allows providers to submit NOC procedure code information on a claim electronically instead of on a paper claim or with a paper attachment to an electronic claim.

The Notes field should only be used for NOC procedure codes that do not require PA.

## Claims Submitted via the ForwardHealth Portal Direct Data Entry or Provider Electronic Solutions

A notes field is available on the ForwardHealth Portal DDE and PES software when providers submit the following types of claims:

- ┆ Professional
- ┆ Institutional
- ┆ Dental

On the professional form, the Notes field is available on each detail. On the institutional and dental forms, the Notes field is only available on the header.

## Claims Submitted via 837 Health Care Claim Transactions

ForwardHealth accepts and utilizes information submitted by providers about NOC procedure codes in certain loops/segments on the 837 transactions. Refer to the [companion guides](#) for more information.

Topic #561

## 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](#) form and the [Noncompound Drug Claim](#) form.

## 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 12 diagnosis codes in Item Number 21 of the 1500 Health Insurance Claim Form.

## Sample of a Correctly Aligned 1500 Health Insurance Claim Form



## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> PICA										<input type="checkbox"/> PICA									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare#) (Medicaid#) (IDA/DoDI#) (Member ID#) (ID#) (ID#) (ID#)										1a. INSURED'S ID. NUMBER (For Program in Item 1) <b>1234567890</b>									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>MEMBER, IM A</b>										4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>SAME</b>									
5. PATIENT'S ADDRESS (No., Street) <b>609 WILLOW ST</b>										7. INSURED'S ADDRESS (No., Street)									
CITY <b>ANYTOWN</b>										CITY									
STATE <b>WI</b>										STATE									
ZIP CODE <b>55555</b>										ZIP CODE									
TELEPHONE (Include Area Code) <b>(444) 444-4444</b>										TELEPHONE (Include Area Code)									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
b. RESERVED FOR NUCC USE										b. OTHER CLAIM ID (Designated by NUCC)									
c. RESERVED FOR NUCC USE										c. INSURANCE PLAN NAME OR PROGRAM NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.									
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
SIGNED										SIGNED									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL										15. OTHER DATE MM DD YY QUAL									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE <b>I.M. REFERRING PROVIDER</b>										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.										22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. <b>XXX.X</b> B. C. D. E. F. G. H. I. J. K. L.										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MODIFIER E. DIAGNOSIS POINTER										F. \$ CHARGES G. DAYS OR UNITS H. ICD-9 PT/PA Plan I. ID. QUAL J. RENDERING PROVIDER ID. #									
1 MM DD YY XX XXXXX XX X XXXXX 1 NPI																			
2																			
3																			
4																			
5																			
6																			
25. FEDERAL TAX ID. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.									
27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ XXX XX									
29. AMOUNT PAID										30. Resd for NUCC Use									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION									
<b>I.M. Provider</b> MMDDCCYY										<b>I.M. PROVIDER</b> <b>1 W WILLIAMS ST</b> <b>ANYTOWN WI 55555-1234</b>									
SIGNED DATE										a. 0222222220 b. ZZ123456789X									

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)



## Sample of an Incorrectly Aligned 1500 Health Insurance Claim Form



## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

<input type="checkbox"/> PICA <span style="float: right;"><input type="checkbox"/> PICA</span>									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare) (Medicaid) (DoD) (Member ID) (ID) (ID) (ID)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>MEMBER, IM A</b>					3. PATIENT'S BIRTH DATE <b>MM DD YY</b>				
4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>SAME</b>					5. PATIENT'S ADDRESS (No., Street) <b>609 WILLOW ST</b>				
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)				
8. RESERVED FOR NUCC USE					9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <b>55555 ( ) 444-444-4444</b>				
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					11. INSURED'S POLICY GROUP OR FECA NUMBER				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____ DATE _____				
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL					15. OTHER DATE MM DD YY QUAL				
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					17. NAME OF REFERRING PROVIDER OR OTHER SOURCE <b>I.M. REFERRING PROVIDER</b>				
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) <b>011111110</b>				
20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO					21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD 10d.				
22. REFERRAL CODE					23. PRIOR AUTHORIZATION NUMBER				
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. CHARGES G. DAYS OF UNITS H. ICD 10d. I. QUAL. J. RENDERING PROVIDER ID. #					25. FEDERAL TAX ID, NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 28. TOTAL CHARGE \$ XXX XX 29. AMOUNT PAID \$ 30. Resd for NUCC Use				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <b>J.M. Provider</b> MMDDCCYY					32. SERVICE FACILITY LOCATION INFORMATION <b>I.M. PROVIDER</b> <b>1 W WILLIAMS ST</b> <b>ANYTOWN WI 55555-1234</b> <b>022222220 ZZ123456789</b>				

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED UMB-0938-1197 FORM 1500 (02-12)





## Sample of an Incorrectly Aligned UB-04 Claim Form

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Paper claims for CCC services must be submitted using the 1500 Health Insurance Claim Form. ForwardHealth 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

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

Topic #22797

## Payment Integrity Review Supporting Documentation

Providers are notified that an individual claim is subject to [PIR](#) through a message on the Portal when submitting claims. When this occurs, providers have seven calendar days to submit the supporting documentation that must be retained in the member's record for the specific service billed. This documentation must be [attached to the claim](#). The following are examples of documentation providers may attach to the claim; however, this list is not exhaustive, and providers may submit any documentation available to substantiate payment:

- | Case management or consultation notes
- | Durable medical equipment or supply delivery receipts or proof of delivery and itemized invoices or bills
- | Face-to-face encounter documentation
- | Individualized plans of care and updates
- | Initial or program assessments and questionnaires to indicate the start DOS
- | Office visit documentation
- | Operative reports
- | Prescriptions or test orders
- | Session or service notice for each DOS
- | Testing and lab results
- | Transportation logs
- | Treatment notes

Providers must attach this documentation to the claim at the time of, or up to seven days following, submission of the claim. A claim may be denied if the supporting documentation is not submitted. If a claim is denied, providers may submit a new claim with the required documentation for reconsideration. To reduce provider impact, claims reviewed by the OIG will be processed as quickly as possible, with an expected average adjudication of 30 days.

Topic #10637

## Reimbursement Reduction for Most Paper Claims

As a result of the Medicaid Rate Reform project, ForwardHealth will reduce reimbursement on most claims submitted to ForwardHealth on paper. Most paper claims will be subject up to a \$1.10 reimbursement reduction per claim.

For each claim that a reimbursement reduction was applied, providers will receive an EOB to notify them of the payment reduction. For claims with reimbursement reductions, the EOB will state the following, "This claim is eligible for electronic submission. Up to a \$1.10 reduction has been applied to this claim payment."

If a paid claim's total reimbursement amount is less than \$1.10, ForwardHealth will reduce the payment up to a \$1.10. The claim

will show on the RA as paid but with a \$0 paid amount.

The reimbursement reduction applies to the following paper claims:

- | 1500 Health Insurance Claim Form
- | UB-04 (CMS 1450) Claim Form
- | [Compound Drug Claim](#) form
- | [Noncompound Drug Claim](#) form

## Exceptions to Paper Claim Reimbursement Reduction

The reimbursement reduction will not affect the following providers or claims:

- | In-state emergency providers
- | Out-of-state providers
- | Medicare crossover claims
- | Any claims that ForwardHealth requires additional supporting information to be submitted on paper, such as:
  - | Hysterectomy claims must be submitted along with an [Acknowledgment of Receipt of Hysterectomy Information](#) form.
  - | Sterilization claims must be submitted along with a paper [Consent for Sterilization](#) form.
  - | Claims submitted to Timely Filing appeals must be submitted on paper with a [Timely Filing Appeals Request](#) form.
  - | In certain circumstances, drug claims must be submitted on paper with a [Pharmacy Special Handling Request](#) form.
  - | Claims submitted with four or more NDCs for compound and noncompound drugs with specific and non-specific HCPCS procedure codes.

Topic #968

## Submitting Claims Under the Child's Identification Number

Providers are required to submit claims to Medicaid for CCC services using the eligible child's Medicaid identification number.

Topic #4817

## 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 guides](#) 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 two 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 seven calendar days to find a match. If a match cannot be made within seven 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  
 313 Blettner Blvd  
 Madison WI 53784

This does not apply to compound and noncompound claims.

Topic #562

## Managed Care Organizations

Claims for services that are covered in a member's state-contracted MCO should be submitted to that MCO.

Topic #11677

## Uploading Claim Attachments Via the Portal

Providers are able to upload attachments for most claims via the secure Provider area of the ForwardHealth Portal. This allows providers to submit all components for claims electronically.

Providers are able to upload attachments via the Portal when a claim is suspended and an attachment was indicated but not yet received. Providers are able to upload attachments for any suspended claim that was submitted electronically. Providers should note that all attachments for a suspended claim must be submitted within the same business day.

### Claim Types

Providers will be able to upload attachments to claims via the Portal for the following claim types:

- | Professional
- | Institutional
- | Dental

The submission policy for compound and noncompound drug claims does not allow attachments.

### Document Formats

Providers are able to upload documents in the following formats:

- | JPEG (.jpg or .jpeg)
- | PDF (.pdf)
- | Rich Text Format (.rtf)
- | Text File (.txt)

JPEG files must be stored with a .jpg or .jpeg extension; text files must be stored with a .txt extension; rich text format files must be stored with a .rtf extension; and PDF files must be stored with a .pdf extension.

Microsoft Word files (.doc) cannot be uploaded but can be saved and uploaded in Rich Text Format or Text File formats.

### Uploading Claim Attachments

## **Claims Submitted by Direct Data Entry**

When a provider submits a DDE claim and indicates an attachment will also be included, a feature button will appear and link to the DDE claim screen where attachments can be uploaded.

Providers are still required to indicate on the DDE claim that the claim will include an attachment via the Attachments panel.

Claims will suspend for seven days before denying for not receiving the attachment.

## **Claims Submitted by Provider Electronic Software and 837 Health Care Claim Transactions**

Providers submitting claims via 837 transactions are required to indicate attachments via the PWK segment. Providers submitting claims via PES software will be required to indicate attachments via the attachment control field. Once the claim has been submitted, providers will be able to search for the claim on the Portal and upload the attachment via the Portal. Refer to the Implementation Guides for how to use the PWK segment in 837 transactions and the [PES Manual](#) for how to use the attachment control field.

Claims will suspend for seven days before denying for not receiving the attachment.

## Responsibilities

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Topic #516

### Accuracy of Claims

Billing providers are responsible for the accuracy and completeness of all claims submitted either by the provider or by an outside billing service or clearinghouse.

ForwardHealth requires that all codes indicated on claims and PA requests be valid, including:

- | Diagnosis codes
- | Revenue codes
- | HCPCS codes
- | HIPPS codes
- | CPT codes

Providers should refer to current national coding and billing manuals for information on valid code sets. ForwardHealth will:

- | Deny claims received without valid diagnosis codes, revenue codes, and HCPCS, HIPPS, or CPT codes.
- | Return PA requests received without valid codes to the provider.

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.

Topic #22798

### Payment Integrity Review Program

The PIR program:

- | Allows the OIG to review claims prior to payment.
- | Requires providers to [submit all required documentation](#) to support approval and payment of PIR-selected claims.

The goal of the PIR program is to further safeguard the integrity of Wisconsin DHS-administered public assistance programs, such as BadgerCare Plus and Wisconsin Medicaid, from fraud, waste, and abuse by:

- | Proactively reviewing claims prior to payment to ensure federal and state requirements are met.
- | Providing enhanced, compliance-based technical assistance to meet the specific needs of providers.
- | Increasing the monitoring of benefit and service areas that are at high risk for fraud, waste, and abuse.

Fraud, waste, and abuse includes the potential overutilization of services or other practices that directly or indirectly result in unnecessary program costs, such as:

- | Billing for items or services that were not rendered.
- | Incorrect or excessive billing of CPT or HCPCS procedure codes.
- | Unit errors, duplicate charges, and redundant charges.
- | Billing for services outside of the provider specialty.
- | Insufficient documentation in the medical record to support the charges billed.
- | Lack of medical necessity or noncovered services.

Note: Review of claims in the PIR process does not preclude claims from future post-payment audits or review.

## Payment Integrity Review Program Overview

When a provider submits a claim electronically via the ForwardHealth Portal, the system will display a message if the claim is subject to PIR. The message will instruct providers to [submit supporting documentation](#) with the claim. Providers have seven days to attach documentation to claims. The claim will automatically be denied if documentation is not attached within seven days.

Claims that meet PIR requirements may be eligible for payment once they are accurate and complete. Claims that do not meet PIR requirements may be denied or repriced. In these cases, providers are encouraged to:

- | Review the EOB for billing errors.
- | Refer to the Online Handbook for claims documentation and program policy requirements.
- | Correct the PIR billing errors and resubmit the claim.

## Types of Payment Integrity Review

There are three types of review in the PIR program:

- | Claims Review
- | Pre-Payment Review
- | Intermediate Sanctions

For each type of review, providers must submit supporting documentation that substantiates the CPT and/or HCPCS procedure codes on the claim.

	Claims Review	Pre-Payment Review	Intermediate Sanction
<b>How claims are selected for review</b>	A sampling of claims is selected from providers, provider types, benefit areas, or service codes identified by the OIG.	The OIG has reasonable suspicion that a provider is violating program rules.	The OIG has established cause that a provider is violating program rules.
<b>How providers are notified that selected claims are under review</b>	The provider receives a message on the Portal.	The provider receives a Provider Notification letter and message on the Portal.	The provider receives a Notice of Intermediate Sanction letter and message on the Portal.
<b>How to successfully exit the review</b>	Claims are selected for review based on a pre-determined percentage of claim submissions of specific criteria. All providers who bill the	75% of a provider's reviewed claims over a three-month period must be paid as submitted. The number of claims submitted during the	The provider must meet parameters set during the sanction process.



	service codes that are part of this criteria are subject to review, regardless of their compliance rates.	three-month period may not drop more than 10% of the provider's volume of submitted claims prior to pre-payment review.	
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## Claims Review

In accordance with Wis. Admin. Code § [DHS 107.02\(2\)](#), the OIG may identify providers, provider types, benefit areas, or procedure codes, and based on those criteria, choose a sampling of claims to review prior to payment. When a claim submitted through the Portal that meets one of these criteria is selected for review, a message will appear on the Portal to notify the provider that the claim must be submitted with all necessary supporting documentation within seven calendar days. The claim will automatically be denied if documentation is not attached within seven days.

## Pre-Payment Review

In accordance with Wis. Admin Code § [DHS 106.11](#), if the OIG has cause to suspect that a provider is prescribing or providing services that are not necessary for members, are in excess of the medical needs of members, or do not conform to applicable professional practice standards, the provider's claims may be subject to review prior to payment. Providers who are subject to this type of review will receive a Pre-Payment Review Initial Notice letter, explaining that the OIG has identified billing practice or program integrity concerns in the provider's claims that warrant the review. This notice details the steps the provider must follow to substantiate their claims and the length of time their claims will be subject to review. Additionally, a message will appear on the Portal when the provider submits claims to notify the provider that certain claims must be submitted with all necessary supporting documentation within seven calendar days. The claim will automatically be denied if documentation is not attached within seven days.

For a provider to be considered for removal from pre-payment review, both of the following conditions must be met:

- 1 75% of the provider's reviewed claims over a three-month period are approved to be paid.
- 1 The number of claims the provider submits during that three-month period may not drop more than 10% from their submitted claim amount prior to pre-payment review.

The OIG reserves the right to adjust these thresholds according to the facts of the case.

## Intermediate Sanction Review

In accordance with Wis. Admin. Code § [DHS 106.08\(3\)\(d\)](#), if the OIG has established cause that a provider is violating program rules, the OIG may impose an intermediate sanction that requires the provider's claims to be reviewed prior to payment. Providers who are subject to this type of review will be sent an official Intermediate Sanction Notice letter from the OIG that details the program integrity concerns that warrant the sanction, the length of time the sanction will apply, and the provider's right to appeal the sanction. The provider also will receive a message on the Portal when submitting claims that indicates certain claims must be submitted with the necessary supporting documentation within seven calendar days. The claim will automatically be denied if documentation is not attached within seven days.

For a provider to be considered for removal from an intermediate sanction, the provider must meet the parameters set during the sanction process.

Topic #547

# 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).

## Exceptions to the Submission Deadline

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

- | Change in a nursing home resident's [LOC](#) or [liability amount](#)
- | Decision made by a court order, fair hearing, or the Wisconsin 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](#).

Topic #23157

## Child Care Coordination Claims Submitted by Prenatal Care Coordination Providers

All claims that are submitted by currently enrolled PNCC providers that include CCC service procedure codes and modifiers are reviewed through the PIR program. This means claims are not paid until each claim submission and any supporting documentation is reviewed individually and approved.

Under PIR, ForwardHealth reviews CCC claims to ensure the claims and services meet program requirements. These include

claims for the following services using the codes and modifiers listed:

- | Assessment: Procedure code T1016 with required modifiers U1, UB, UC.
- | Care plan development: Procedure code T1016 with required modifiers U2, UB, UC.
- | Ongoing care coordination: Procedure code T1016 with required modifiers U3, UB, UC.

Topic #517

## 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 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 copay, providers should still indicate their usual and customary charge. The copay amount collected from the member should not be deducted from the charge submitted. When applicable, ForwardHealth automatically deducts the copay amount.

For most services, ForwardHealth reimburses the lesser of the provider's usual and customary charge, plus a professional dispensing fee, if applicable, or the maximum allowable fee established.

## Responses

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Topic #540

### 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. ForwardHealth provides [electronic RAs](#) to providers on their secure ForwardHealth Portal accounts when at least one claim, adjustment request, or financial transaction is processed. RAs are generated from the appropriate ForwardHealth program when at least one claim, adjustment request, or financial transaction is processed. An RA is generated regardless of how a claim or adjustment is submitted (electronically or on paper). Generally, payment information is released and an RA is generated by ForwardHealth no sooner than the first state business day following the financial cycle.

Providers are required to access their secure [ForwardHealth provider Portal account](#) to obtain their RA.

RAs are accessible to providers in a TXT format via the secure Provider area of the Portal. Providers are also able to download the RA from their secure provider Portal account in a CSV format.

Topic #5091

### National Provider Identifier on the Remittance Advice

Health care providers who have a single NPI that is used for multiple enrollments will receive an RA for each enrollment 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 enrolled in Wisconsin 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.

Topic #4818

### 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 for each section by adding the net amounts for all claims listed in that section. 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.

Topic #534

### Claim Number

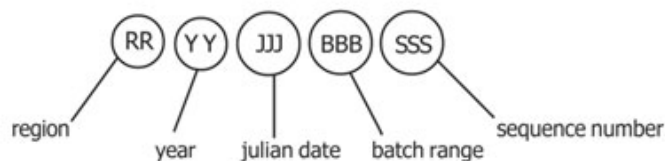
Each claim or adjustment request received by ForwardHealth is assigned a unique claim number (also known as the ICN). However, denied real-time compound and noncompound claims are not assigned an ICN, but receive an authorization number. Authorization numbers are not reported to the RA or 835.

## Interpreting Claim Numbers

The [ICN](#) consists of 13 digits that identify valuable information (for example, the date the claim was received by ForwardHealth, how the claim was submitted) about the claim or adjustment request.

### Interpreting Claim Numbers

Each claim and adjustment received by ForwardHealth is assigned a unique claim number (also known as the internal control number or ICN). This number identifies valuable information about the claim and adjustment request. The following diagram and table provide detailed information about interpreting the claim number.



Type of Number and Description	Applicable Numbers and Description
<b>Region</b> — Two digits indicate the region. The region indicates how ForwardHealth received the claim or adjustment request.	10 — Paper Claims with No Attachments 11 — Paper Claims with Attachments 20 — Electronic Claims with No Attachments 21 — Electronic Claims with Attachments 22 — Internet Claims with No Attachments 23 — Internet Claims with Attachments 25 — Point-of-Service Claims 26 — Point-of-Service Claims with Attachments 40 — Claims Converted from Former Processing System 45 — Adjustments Converted from Former Processing System 50–59 — Adjustments 67 — Cash Payment Applied 80 — Claim Resubmissions 90–91 — Claims Requiring Special Handling
<b>Year</b> — Two digits indicate the year ForwardHealth received the claim or adjustment request.	For example, the year 2008 would appear as 08.
<b>Julian date</b> — Three digits indicate the day of the year, by Julian date, that ForwardHealth received the claim or adjustment request.	For example, February 3 would appear as 034.
<b>Batch range</b> — Three digits indicate the batch range assigned to the claim.	The batch range is used internally by ForwardHealth.
<b>Sequence number</b> — Three digits indicate the sequence number assigned within the batch range.	The sequence number is used internally by ForwardHealth.

Topic #535

## 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.

Topic #4746

## 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 copays, 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 copays 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.

Topic #537

## Electronic Remittance Information

Providers are required to access their secure [ForwardHealth provider Portal account](#) to obtain their RAs. Electronic RAs on the Portal are not available to the following providers because these providers are not allowed to establish Portal accounts by their Provider Agreements:

- ┆ In-state emergency providers
- ┆ Out-of-state providers
- ┆ Out-of-country providers

RAs are accessible to providers in a TXT format or from a CSV file via the secure Provider area of the Portal.

### Text File

The TXT format file is generated by financial payer and listed by RA number and RA date on the secure provider Portal account under the "View Remittance Advices" menu. RAs from the last 121 days are available in the TXT format. When a user clicks on an RA, a pop-up window displays asking if the user would like to "Open" or "Save" the file. If "Open" is chosen, the document opens based on the user's application associated with opening text documents. If "Save" is chosen, the "Save As" window will open. The user can then browse to a location on their computer or network to save the document.

Users should be aware that "Word Wrap" must be turned off in the Notepad application. If it is not, it will cause distorted formatting. Also, users may need to resize the Notepad window to view all of the data. Providers wanting to print their files must ensure that the "Page Setup" application is set to the "Landscape" setting; otherwise, the printed document will not contain all the information.

### Comma-Separated Values Downloadable File

A CSV file is a file format accepted by a wide range of computer software programs. Downloadable CSV-formatted RAs allow users the benefits of building a customized RA specific to their use and saving the file to their computer. The CSV file on a

provider's Portal appears as linear text separated by commas until it is downloaded into a compatible software program. Once downloaded, the file may be saved to a user's computer and the data manipulated, as desired.

To access the CSV file, providers should select the "View Remittance Advices" menu at the top of the provider's Portal home page.

The CSV files are generated per financial payer and listed by RA number and RA date. A separate CSV file is listed for the last 10 RAs. Providers can select specific sections of the RA by date to download, making the information easy to read and organize.

The CSV file may be downloaded into a Microsoft Office Excel spreadsheet or into another compatible software program, such as Microsoft Office Access or OpenOffice. OpenOffice is a free software program obtainable from the internet. Google Docs and ZDNet also offer free spreadsheet applications. Microsoft Office Excel, a widely used program, is a spreadsheet application for Microsoft Windows and Mac OS. The 1995 Office Excel for Windows (Version 7.0) included in Office 95 or a newer version is recommended for maximum file capabilities when downloading the CSV file. Earlier versions of Microsoft Office Excel will work with the CSV file; however, files exceeding 65,000 lines may need to be split into smaller files when downloading using earlier versions. Microsoft Office Access can manage larger data files.

Refer to the CSV User Guide on the [User Guides page](#) of the Portal for instructions about Microsoft Office Excel functions that can be used to manipulate RA data downloaded from the CSV file.

## 835

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 real-time compound or noncompound claim will not appear on remittance information if the claim is denied by ForwardHealth. ForwardHealth releases payment information to the 835 no sooner than on the first state business day following the financial cycle.

## Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. The PES software allows providers to submit electronic claims and claim reversals and to download the 835 transaction. To obtain PES software, providers may download it from the [ForwardHealth Portal](#). For assistance installing and using PES software, providers may call the [EDI Helpdesk](#).

Topic #4822

## 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 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.



## TEXT File

EOB codes and descriptions are listed in the RA information in the TXT file.

## CSV File

EOB codes are listed in the RA information from the CSV file; however, the printed messages corresponding to the codes do not appear in the file. The [EOB Code Listing](#) matching standard EOB codes to explanation text is available on the Portal for reference.

Topic #13437

## ForwardHealth-Initiated Claim Adjustments

There are times when ForwardHealth must initiate a claim adjustment to address claim issues that do not require provider action and do not affect reimbursement.

Claims that are subject to this type of ForwardHealth-initiated claim adjustment will have EOB code 8234 noted on the RA.

The adjusted claim will be assigned a new claim number, known as an ICN. The new ICN will begin with "58." If the provider adjusts this claim in the future, the new ICN will be required when resubmitting the claim.

Topic #4820

## 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.

Topic #11537

## National Correct Coding Initiative

As part of the federal PPACA of 2010, the federal CMS are required to promote correct coding and control improper coding leading to inappropriate payment of claims under Medicaid. The NCCI is the CMS response to this requirement. The NCCI includes the creation and implementation of claims processing edits to ensure correct coding on claims submitted for Medicaid reimbursement.

ForwardHealth is required to implement the NCCI in order to monitor all professional claims and outpatient hospital claims submitted with CPT or HCPCS procedure codes for Wisconsin Medicaid, BadgerCare Plus, WCDP, and Family Planning Only Services for compliance with the following NCCI edits:



- ┆ MUE, or units-of-service detail edits
- ┆ Procedure-to-procedure detail edits

The NCCI editing will occur in addition to/along with current procedure code review and editing completed by Change Healthcare ClaimsXten and in ForwardHealth interChange.

## Medically Unlikely Detail Edits

MUE, or units-of-service detail edits, define the maximum units of service that a provider would report under most circumstances for a single member on a single DOS for each CPT or HCPCS procedure code. If a detail on a claim is denied for MUE, providers will receive an EOB code on the RA indicating that the detail was denied due to NCCI.

An example of an MUE would be if procedure code 11102 (tangential biopsy of skin [eg, shave, scoop, saucerize, curette]; single lesion) was billed by a provider on a professional claim with a quantity of two or more. This procedure is medically unlikely to occur more than once; therefore, if it is billed with units greater than one, the detail will be denied.

## Procedure-to-Procedure Detail Edits

Procedure-to-procedure detail edits define pairs of CPT or HCPCS codes that should not be reported together on the same DOS for a variety of reasons. This edit applies across details on a single claim or across different claims. For example, an earlier claim that was paid may be denied and recouped if a more complete code is billed for the same DOS on a separate claim. If a detail on a claim is denied for procedure-to-procedure edit, providers will receive an EOB code on the RA indicating that the detail was denied due to NCCI.

An example of a procedure-to-procedure edit would be if procedure codes 11451 (excision of skin and subcutaneous tissue for hidradenitis, axillary; with complex repair) and 93000 (electrocardiogram, routine ECG with at least 12 leads; with interpretation and report) were billed on the same claim for the same DOS. Procedure code 11451 describes a more complex service than procedure code 93000, and therefore, the secondary procedure would be denied.

## Quarterly Code List Updates

CMS will issue quarterly revisions to the table of codes subject to NCCI edits that ForwardHealth will adopt and implement. Refer to the [CMS Medicaid website](#) for downloadable code lists.

## Claim Details Denied as a Result of National Correct Coding Initiative Edits

Providers should take the following steps if they are uncertain why particular services on a claim were denied:

- ┆ Review ForwardHealth remittance information for the EOB message related to the denial.
- ┆ Review the claim submitted to ensure all information is accurate and complete.
- ┆ Consult current CPT and HCPCS publications to make sure proper coding instructions were followed.
- ┆ Consult current ForwardHealth publications, including the Online Handbook, to make sure current policy and billing instructions were followed.
- ┆ Call [Provider Services](#) for further information or explanation.

If reimbursement for a claim or a detail on a claim is denied due to an MUE or procedure-to-procedure edit, providers may appeal the denial. Following are instructions for submitting an appeal:

- ┆ Complete the [Adjustment/Reconsideration Request](#) form. In Element 16, select the "Consultant review requested" checkbox and the "Other/comments" checkbox. In the "Other/comments" text box, indicate "Reconsideration of an NCCI denial."

- | Attach notes/supporting documentation.
- | Submit a claim, Adjustment/Reconsideration Request, and additional notes/supporting documentation to ForwardHealth for processing.

Topic #539

## Obtaining the Remittance Advice

Providers are required to access their secure ForwardHealth provider Portal account to obtain RAs. The secure Portal allows providers to conduct business and exchange electronic transactions with ForwardHealth. A separate Portal account is required for each financial payer.

Providers who do not have a [ForwardHealth provider Portal account](#) may request one.

RAs are accessible to providers in a TXT format via the secure provider Portal account. The TXT format file is generated per financial payer and listed by RA number and RA date on the secure provider Portal account under "View Remittance Advices" menu at the top of the provider's Portal home page. RAs from the last 121 days are available in the TXT format.

Providers can also access RAs in a CSV format from their secure provider Portal account. The CSV files are generated per financial payer and listed by RA number and RA date on the secure provider Portal account under "View Remittance Advices" menu at the top of the provider's Portal home page. A separate CSV file is listed for the last 10 RAs.

Topic #4745

## Overview of Claims Processing Information on the Remittance Advice

The claims processing sections of the RA include 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
- | Noncompound 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

## 1 Paid claims

Claim Types	Provider Types
Dental claims	Dentists, dental hygienists, HealthCheck agencies that provide dental services
Inpatient claims	Inpatient hospital providers and institutes for mental disease providers
Long term care claims	Nursing homes
Medicare crossover institutional claims	Most providers who submit claims on the UB-04
Medicare crossover professional claims	Most providers who submit claims on the 1500 Health Insurance Claim Form
Noncompound and compound drug claims	Pharmacies and dispensing physicians
Outpatient claims	Outpatient hospital providers and hospice providers
Professional claims	Ambulance providers, ambulatory surgery centers, anesthesiologist assistants, audiologists, case management providers, certified registered nurse anesthetists, chiropractors, community care organizations, community support programs, crisis intervention providers, day treatment providers, family planning clinics, federally qualified health centers, HealthCheck providers, HealthCheck "Other Services" providers, hearing instrument specialists, home health agencies, independent labs, individual medical supply providers, medical equipment vendors, mental health/substance abuse clinics, nurses in independent practice, nurse practitioners, occupational therapists, opticians, optometrists, personal care agencies, pharmacists, physical therapists, physician assistants, physician clinics, physicians, podiatrists, portable X-ray providers, prenatal care coordination providers, psychologists, rehabilitation agencies, respiratory therapists, rural health clinics, school-based services providers, specialized medical vehicle providers, speech and hearing clinics, speech-language pathologists, therapy groups

Topic #4418

# Reading Non-Claims Processing Sections of the Remittance Advice

## Address Page

In the TXT file, the Address page displays the provider name and "Pay to" address of the provider.

## 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; therefore, providers who receive multiple RAs should read all of their banner messages.

Banner messages appear on the TXT file but not on the CSV file. Banner messages are posted in the "View Remittance Advices" menu on the provider's secure Portal account.

## Explanation of Benefits Code Descriptions

[EOB code descriptions](#) are listed in the RA information in the TXT file.

EOB codes are listed in the RA information from the CSV file; however, the printed messages corresponding to the codes do not appear in the file.

## 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 (that is, 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 in the "Balance" column.

In the Accounts Receivable section, the "Amount Recouped In Current Cycle" column, when applicable, shows the recoupment amount for the financial cycle as a separate number from the "Recoupment Amount To Date." The "Recoupment Amount To Date" column shows the total amount recouped for each accounts receivable, **including** the amount recouped in the current cycle. The "Total Recoupment" **line** shows the sum of all recoupments to date in the "Recoupment Amount To Date" column and the sum of all recoupments for the current financial cycle in the "Amount Recouped In Current Cycle" column.

For decreasing claim adjustments listed on the RA, a separate accounts receivable will be established and will be listed in the Financial Transactions section. The accounts receivable will be established for the entire amount of the original paid claim. Providers will see net difference between the claim and the adjustment reflected on the RA.

Each new claim adjustment is assigned an identification number called the "Adjustment ICN." 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 (that is, 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, HDAP, 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.

Topic #368

## 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.

To adjust a claim, ForwardHealth recoups the **difference**—or pays the **difference**—between the original claim amount and the claim adjustment amount. This difference will be reflected on the RA.

In the Claim Adjustments section, the original claim information in the claim header is surrounded by parentheses. Information about the claim adjustment 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 only lists detail lines for a claim adjustment if that claim adjustment has detail line EOBs. This section does not list detail lines for the original paid claim.

Note: For adjusted compound and noncompound 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. The response indicated depends on the difference between the original claim amount and the claim adjustment amount.

If the difference is a positive dollar amount, indicating that ForwardHealth owes additional monies to the provider, then the amount appears in the Additional Payment line.

If the difference is a negative dollar amount, indicating that the provider owes ForwardHealth additional monies, then the amount appears in the Overpayment To Be Withheld line. 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.

Topic #4824

## 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.

## Sample Professional Services Claims Denied Section of the Remittance Advice

Remittance Advice — Professional Service Claims Denied Sample														
REPORT: CRA-HCDN-R					FORWARDHEALTH INTERCHANGE					DATE: MM/DD/CCYY				
RA#: 999999999					<Financial Cycle Description>					PAGE: 9,999				
PAYER: XXXX					PROVIDER REMITTANCE ADVICE									
PROFESSIONAL SERVICE CLAIMS DENIED														
XX										PAYER ID 9999999999999999				
XX										NPI 999999999999				
XX										CHECK/EFT NUMBER 9999999999				
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX XXXX-XXXX										PAYMENT DATE MM/DD/CCYY				
--ICN--	PCN	MRN	SERVICE DATES		BILLED	OTH INS	SPENDDOWN							
			FROM	TO	AMOUNT	AMOUNT	AMOUNT							
MEMBER NAME: XX MEMBER NO.: XXXXXXXXXXXXXXXX														
RRYYJJBBSSS XXXXXXXXXXXXXXX XXXXXXXXXXXXXXX MMDDYY MMDDYY 999,999,999.99 9,999,999.99 999,999.99														
HEADER EOB: 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999														
PROC CD	MODIFIERS	ALLW UNITS	SERVICE DATES		PA NUMBER	DETAIL EOB								
XXXXX	XX XX XX XX	9999.99	MMDDYY	MMDDYY	XXX XXXXXXXXXXXXXXXX	XXXXXXX	9999	9999	9999	9999	9999	9999	9999	9999
9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999														
XXXXX	XX XX XX XX	9999.99	MMDDYY	MMDDYY	XXX XXXXXXXXXXXXXXXX	XXXXXXX	9999	9999	9999	9999	9999	9999	9999	9999
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XXXXX	XX XX XX XX	9999.99	MMDDYY	MMDDYY	XXX XXXXXXXXXXXXXXXX	XXXXXXX	9999	9999	9999	9999	9999	9999	9999	9999
9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999														
XXXXX	XX XX XX XX	9999.99	MMDDYY	MMDDYY	XXX XXXXXXXXXXXXXXXX	XXXXXXX	9999	9999	9999	9999	9999	9999	9999	9999
9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999														
TOTAL PROFESSIONAL SERVICE CLAIMS DENIED: 9,999,999,999.99 99,999,999.99 9,999,999.99														
TOTAL NO. DENIED: 999,999														

Topic #4825

## 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. The Incentives column is calculated in accordance with the 835 standards to balance among the service line, the claim, and the transaction.

### Sample Inpatient Claims Paid Section of the Remittance Advice

REPORT: CRA-IPPD-R			FORWARDHEALTH INTERCHANGE				DATE: 06/02/2022			
RA#: 2280110			WISCONSIN FORWARDHEALTH				PAGE: 1			
PAYER: TXIX			PROVIDER REMITTANCE ADVICE							
			INPATIENT CLAIMS PAID							
PARKVILLE HOSPITAL INC							PAYEE ID		00000000	MCD
200 S PARKVILLE RD							NPI		1234567890	
ANYTOWN, WI 55555							CHECK/EFT NUMBER		000000000	
							PAYMENT DATE		06/03/2022	
--ICN--	PCN	SERVICE DATES	C DAYS	ADMIT	BILLED AMT		OTH INS ANT	COPAY ANT	INPAT DED	PAID ANT
	MRN	FROM TO		DATE	ALLOWED AMT	INCENTIVES	SPENDDOWN ANT	OUTLIER ANT	CO-INS CB	DRG CD SOI
MEMBER NAME: JAM MEDER				MEMBER NO.: 9076543210						
2222153001023	8110744885	110521 110921	4	110521	500.00		200.00	0.00	0.00	200.00
					500.00	-3,357.55	0.00	0.00	0.00	111 1
HEADER EOB#S: 1022 3091 9507 9932 9940 9959										
	SERVICE DATES	ALLU UNITS	PA NUMBER							
REV CD	FROM TO	BILLED AMT	ALLOWED AMT	INCENTIVES	PAID AMOUNT	DETAIL EOB#				
121	110521 110921	4.00				9932				
		500.00	500.00	500.00	0.00					
TOTAL INPATIENT CLAIMS PAID:					500.00		200.00	0.00	0.00	200.00
					500.00	-3,357.55	0.00	0.00	0.00	
TOTAL NO. PAID:					1					

Topic #4828

## Remittance Advice Financial Cycles

Each financial payer (Medicaid, HDAP, WCDP, and WWWP) has separate financial cycles that occur on different days of the week. RAs are generated and posted to secure provider Portal accounts after each financial cycle is completed. Therefore, RAs may be generated and posted to secure provider ForwardHealth Portal accounts 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 have access to the RAs generated and posted to secure provider Portal accounts for these financial transactions at any time during the week.

Topic #4827

## Remittance Advice Generated by Payer and by Provider Enrollment

RAs are generated and posted to secure provider Portal accounts 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)
- | HDAP
- | WCDP
- | WWWP

A separate Portal account is required for each financial payer.



Note: Each of the four 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 enrollment. Providers who have a single NPI that is used for multiple enrollments should be aware that an RA will be generated for each enrollment, 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 enrolled 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.

Topic #6237

## 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 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  
313 Blettner Blvd  
Madison WI 53784

Topic #5018

## Searching for and Viewing All Claims on the Portal

All claims, including compound, noncompound, and dental claims, are available for viewing on the ForwardHealth Portal.

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

- ┆ Go to the 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.

Topic #4829

## Sections of the Remittance Advice

The RA information in the TXT file includes the following sections:

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

The RA information in the CSV file includes the following sections:

- | Payment
- | Payment hold
- | Service codes and descriptions
- | Financial transactions
- | Summary
- | Inpatient claims
- | Outpatient claims
- | Professional claims
- | Medicare crossovers—Professional
- | Medicare crossovers—Institutional
- | Compound drug claims
- | Noncompound drug claims
- | Dental claims
- | Long term care claims
- | Financial transactions
- | Summary
- | Claim sequence numbers

Providers can select specific sections of the RA in the CSV file within each RA date to be downloaded making the information easy to read and to organize.

## Remittance Advice Header Information

The first page of each section of the RA (except the address page of the TXT file) 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 (for example, 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, HDAP, 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 (for example, Financial Transactions or Professional Services Claims Paid)

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

- | The date of the financial cycle and date 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

Topic #544

## 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.

## Adjustment Requests

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Topic #814

### 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.

Topic #815

### 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.

Topic #512

## Electronic

### 837 Transaction

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

### Provider Electronic Solutions Software

The Wisconsin DHS 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 from the [ForwardHealth Portal](#). For assistance installing and using PES software, providers may call the [EDI Helpdesk](#).

### Portal Claim Adjustments

Providers can submit claim adjustments via the Portal. Providers may use the search function to find the specific claim to adjust. Once the claim is found, the provider can alter it to reflect the desired change and resubmit it to ForwardHealth. Any claim ForwardHealth has paid within 365 days of the DOS can be adjusted and resubmitted on the Portal, regardless of how the claim was originally submitted.

Claim adjustments with DOS beyond the 365-day submission deadline should **not** be submitted electronically. Providers who attempt to submit a claim adjustment electronically for DOS beyond 365 days will have the entire amount of the claim recouped.

Requests for adjustments to claims with DOS beyond the 365-day submission deadline may be submitted using the [timely filing](#) process (a paper process) if the claim adjustment meets one of the [exceptions](#) to the claim submission deadline.

Topic #513

## 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.

Topic #515

## Paper

Paper adjustment requests must be submitted using the [Adjustment/Reconsideration Request](#) form.

Topic #816

## 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.

Topic #514

## 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 (for example, medical, dental)

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

Topic #4857

## Submitting Paper Attachments with Electronic Claim Adjustments

Providers may submit [paper attachments to accompany electronic claim adjustments](#). Providers should refer to their [companion guides](#) for directions on indicating that a paper attachment will be submitted by mail.

## Good Faith Claims

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Topic #518

### Definition of Good Faith Claims

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 identification card for BadgerCare Plus or Family Planning Only Services, the provider should check the member's enrollment via Wisconsin's EVS and, if the enrollment is not on file yet, make a photocopy of the member's temporary identification card.

When a member presents a [temporary ID card for EE in BadgerCare Plus or Family Planning Only Services](#) but the member's enrollment is not on file yet in the EVS, the provider should check enrollment again in two days or wait one week to submit a claim to ForwardHealth. If, after two days, the EVS indicates that the member still is not enrolled or the claim is denied with an enrollment-related EOB code, the provider should contact [Provider Services](#) for assistance.

When a member who received a real-time eligibility determination presents a temporary ID card but the member's enrollment is not on file yet in the EVS, the provider should wait up to one week to submit a claim to ForwardHealth. If the claim is denied with an enrollment-related EOB code, the provider should contact Provider Services for assistance.

# Timely Filing Appeals Requests

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Topic #549

## Requirements

When a claim or adjustment request meets one of the [exceptions](#) to the submission deadline, the provider is required to mail ForwardHealth a [Timely Filing Appeals Request](#) form with a paper claim or an [Adjustment/Reconsideration Request](#) form to override the submission deadline. If claims or adjustment requests are submitted electronically, the entire amount of the claim will be recouped.

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.

Topic #551

## 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.

Topic #744

## 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 for each claim and each adjustment to allow for documentation of individual claims and adjustments submitted to ForwardHealth
- ┆ A legible claim or [Adjustment/Reconsideration Request](#) form
- ┆ All required documentation as specified for the exception to the submission deadline
- ┆ A properly completed [Explanation of Medical Benefits form](#) for paper claims and paper claim adjustments where other health insurance sources are indicated

Note: Providers are reminded to complete and submit the most current versions of these forms supported by ForwardHealth.

To receive consideration for an exception, a Timely Filing Appeals Request form must be received by ForwardHealth before the applicable submission deadlines specified for the exception.

When completing the claim or adjustment request, providers are required to indicate the procedure code, diagnosis code, POS code, and all other required claims data elements 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 additional documentation requirements as they correspond to each of the eight allowable exceptions.

<b>Change in Nursing Home Resident's Level of Care or Liability Amount</b>		
<b>Description of the Exception</b>	<b>Documentation Requirements</b>	<b>Submission Address</b>
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 LOC or liability amount.	<p>To receive consideration, the request must be submitted within 455 days from the DOS. Include the following documentation as part of the request:</p> <ul style="list-style-type: none"> <li>▮ The correct liability amount or LOC must be indicated on the Adjustment/Reconsideration Request form.</li> <li>▮ The most recent claim number (also known as the ICN) must be indicated on the Adjustment/Reconsideration Request form. This number may be the result of a ForwardHealth-initiated adjustment.</li> <li>▮ A copy of the <a href="#">Explanation of Medical Benefits form</a>, if applicable.</li> </ul>	<p>ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784</p>
<b>Decision Made by a Court, Fair Hearing, or the Wisconsin Department of Health Services</b>		
<b>Description of the Exception</b>	<b>Documentation Requirements</b>	<b>Submission Address</b>
This exception occurs when a decision is made by a court, fair hearing, or the Wisconsin DHS.	<p>To receive consideration, the request must be submitted within 90 days from the date of the decision of the hearing. Include the following documentation as part of the request:</p> <ul style="list-style-type: none"> <li>▮ A complete copy of the decision notice received from the court, fair hearing, or DHS</li> </ul>	<p>ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784</p>
<b>Denial Due to Discrepancy Between the Member's Enrollment Information in ForwardHealth interChange and the Member's Actual Enrollment</b>		
<b>Description of the Exception</b>	<b>Documentation Requirements</b>	<b>Submission Address</b>
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.	<p>To receive consideration, the request must be submitted within 455 days from the DOS. Include the following documentation as part of the request:</p> <ul style="list-style-type: none"> <li>▮ A copy of remittance information showing the claim was submitted in a timely manner and denied with a qualifying enrollment-related explanation.</li> <li>▮ A photocopy of <b>one</b> of the following indicating enrollment on the DOS:</li> </ul>	<p>ForwardHealth Good Faith/Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784</p>



	<ul style="list-style-type: none"> <li>i Temporary Identification Card for Express Enrollment in BadgerCare Plus</li> <li>i Temporary Identification Card for Express Enrollment in Family Planning Only Services</li> <li>i The response received through Wisconsin's EVS from a commercial eligibility vendor</li> <li>i The transaction log number received through <a href="#">WiCall</a></li> <li>i The enrollment tracking number received through the ForwardHealth Portal</li> </ul>	
<b>ForwardHealth Reconsideration or Recoupment</b>		
<b>Description of the Exception</b>	<b>Documentation Requirements</b>	<b>Submission Address</b>
This exception occurs when ForwardHealth reconsiders a previously processed claim. ForwardHealth will initiate an adjustment on a previously paid claim.	<p>If a subsequent provider submission is required, the request must be submitted within 90 days from the date of the RA message. Include the following documentation as part of the request:</p> <ul style="list-style-type: none"> <li>i A copy of the RA message that shows the ForwardHealth-initiated adjustment</li> <li>i A copy of the <a href="#">Explanation of Medical Benefits form</a>, if applicable</li> </ul>	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
<b>Retroactive Enrollment for Persons on General Relief</b>		
<b>Description of the Exception</b>	<b>Documentation Requirements</b>	<b>Submission Address</b>
This exception occurs when the income maintenance 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.	<p>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. Include the following documentation as part of the request:</p> <ul style="list-style-type: none"> <li>i A copy of the <a href="#">Explanation of Medical Benefits form</a>, if applicable</li> </ul> <p><b>And</b></p> <ul style="list-style-type: none"> <li>i GR retroactive enrollment indicated on the claim</li> </ul> <p><b>Or</b></p> <ul style="list-style-type: none"> <li>i A copy of the letter received from the income maintenance or tribal agency</li> </ul>	ForwardHealth GR Retro Eligibility Ste 50 313 Blettner Blvd Madison WI 53784
<b>Medicare Denial Occurs After the Submission Deadline</b>		
<b>Description of the Exception</b>	<b>Documentation Requirements</b>	<b>Submission Address</b>
This exception occurs when claims	To receive consideration, the request must be submitted within 90	ForwardHealth

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:	days of the Medicare processing date. Include the following documentation as part of the request: <ul style="list-style-type: none"> <li>A copy of the Medicare remittance information</li> <li>A copy of the <a href="#">Explanation of Medical Benefits form</a>, if applicable</li> </ul>	Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
<b>Refund Request from an Other Health Insurance Source</b>		
<b>Description of the Exception</b>	<b>Documentation Requirements</b>	<b>Submission Address</b>
This exception occurs when an other health insurance source reviews a previously paid claim and determines that reimbursement was inappropriate.	<p>To receive consideration, the request must be submitted within 90 days from the date of recoupment notification. Include the following documentation as part of the request:</p> <ul style="list-style-type: none"> <li>A copy of the recoupment notice</li> <li>An updated <a href="#">Explanation of Medical Benefits form</a>, if applicable</li> </ul> <p>Note: When the reason for resubmitting is due to Medicare recoupment, ensure that the associated Medicare disclaimer code (M-7 or M-8) is included on the updated Explanation of Medical Benefits form.</p>	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
<b>Retroactive Member Enrollment into Medicaid</b>		
<b>Description of the Exception</b>	<b>Documentation Requirements</b>	<b>Submission Address</b>
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 enrollment.	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 by selecting Retroactive member enrollment for ForwardHealth (attach appropriate documentation for retroactive	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd

	period, if available) box on the <a href="#">Timely Filing Appeals Request</a> form.	Madison WI 53784
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## Overpayments

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Topic #528

### 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.

Topic #532

### 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-enrolled on the DOS.
- ┆ Not currently under investigation for Medicaid fraud or abuse.
- ┆ Not subject to any intermediate sanctions under Wis. Admin. Code § [DHS 106.08](#).
- ┆ 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

Wisconsin Medicaid will deduct the overpayment when the [electronic adjustment request](#) is processed. Providers should use the [companion guide](#) 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, Wisconsin Medicaid will deduct the overpayment from future reimbursement amounts.

Topic #533

## 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  
313 Blettner Blvd  
Madison WI 53784

Topic #531

## 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.

Topic #530

## Requirements

As stated in Wis. Admin. Code § [DHS 106.04\(5\)](#), 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 (for example, 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.

Topic #8417

# 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.

# Reimbursement

# 5

Archive Date:08/01/2025

## Reimbursement:Payer of Last Resort

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Topic #242

### 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:

- | Birth to 3
- | Crime Victim Compensation Fund
- | GA
- | HCBS waiver programs:
  - | CLTS
  - | Family Care
  - | Family Care Partnership
  - | IRIS
- | 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.

Topic #253

### Payer of Last Resort

Except for a few instances, Wisconsin Medicaid or BadgerCare Plus is the payer of last resort for any covered services. Therefore, the provider is required to make a reasonable effort to exhaust all other existing health insurance sources before submitting claims to ForwardHealth or to a state-contracted MCO.

Topic #255

### 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.

## Amounts

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Topic #258

### Acceptance of Payment

The amounts allowed as payment for covered services must be accepted as payment in full. Therefore, total payment for the service (for example, any amount paid by other health insurance sources, any BadgerCare Plus or Medicaid copay or spenddown amounts paid by the member, and any amount paid by BadgerCare Plus, Medicaid, or HDAP) may not exceed the 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 allowed amount for a service (for example, balance billing).

Other health insurance payments may exceed the allowed amount if no additional payment is received from the member or BadgerCare Plus, Medicaid, or HDAP.

Topic #694

### Billing Service and Clearinghouse Contracts

According to Wis. Admin. Code § [DHS 106.03\(5\)\(c\)2](#), 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.

Topic #8117

### 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. EFT 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 enrollment 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 who has been assigned the EFT role on the Portal may complete the EFT enrollment information.
- ┆ Organizations can revert back to receiving paper checks by disenrolling in EFT.
- ┆ Organizations may change their EFT information at any time.
- ┆ Organizations will continue to receive their RA as they do currently.

Refer to the Electronic Funds Transfer User Guide on the [User Guides](#) page of the Portal 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 (for example, 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 [Provider Services](#) to resolve the issue and payment by paper check will be reinstated until the matter has been resolved.

Topic #897

## Fee Schedules

Maximum allowable fee information is available on the [Max Fee Schedules](#) page of the ForwardHealth Portal in the following forms:

- ┆ An interactive maximum allowable fee schedule
- ┆ Downloadable fee schedules by service area only in TXT or CSV files

Policy information is not displayed in the fee schedules. Providers should refer to their specific service area in the Online Handbook for more information about coverage policy related to a specific procedure code.

Certain fee schedules are interactive. On the interactive fee schedule, providers have more search options for looking up some

coverage information, as well as the maximum allowable fees, as appropriate, for reimbursable HCPCS, CPT, or CDT procedure codes for most services.

Providers have the ability to independently search by:

- | A single HCPCS, CPT, or CDT procedure code
- | Multiple HCPCS, CPT, or CDT procedure codes
- | A pre-populated code range
- | A service area (Service areas listed in the interactive fee schedule more closely align with the provider service areas listed in the Online Handbook, including the WCDP programs and WWWP.)

The downloadable fee schedules, which are updated monthly, provide basic maximum allowable fee information by provider service area.

Through the interactive fee schedule, providers can export their search results for a single code, multiple codes, a code range, or by service area. The export function of the interactive fee schedule will return a .zip file that includes seven CSV files containing the results.

Note: The interactive fee schedule will export all associated information related to the provider's search criteria except the procedure code descriptions.

Providers may call [Provider Services](#) in the following cases:

- | The ForwardHealth Portal 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.

Topic #260

## 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

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Topic #227

### 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.

Topic #538

### Cost Sharing

According to federal regulations, providers cannot hold a member responsible for any commercial or Medicare cost-sharing amount such as coinsurance, copay, or deductible. Therefore, a provider may not collect payment from a member, or authorized person acting on behalf of the member, for copays required by other health insurance sources. Instead, the provider should collect from the member **only** the Medicaid or BadgerCare Plus copay amount indicated on the member's remittance information.

Topic #224

### 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 [copays](#) for certain services.
- ┆ Other health insurance payments made to the member.
- ┆ [Spendeddown](#).
- ┆ Charges for a [private room](#) in a nursing home if meeting the requirements stated in Wis. Admin. Code § [DHS 107.09\(4\)\(k\)](#), or in a hospital if meeting the requirements stated in Wis. Admin. Code § [DHS 107.08\(3\)\(a\)2](#).
- ┆ 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 enrollment.

## Reimbursement Not Available

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Topic #695

### 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 (for example, a collection agency) or person who advances money to a provider for the purchase or transfer 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.

Topic #51

### 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.

Topic #1033

## 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 ambulance services:

- | Additional charges to pick up a member's personal belongings
- | Ambulance trips to obtain physical, occupational or speech therapy, audiology, chiropractic, or psychotherapy services
- | Charges for a member's failure to cancel a scheduled transport
- | Excessive mileage
- | Extra charges for nights, weekends, or holiday services
- | Medical personnel who care for the member in transit (other than those employed by the ambulance provider)
- | No member conveyance
- | Processes, treatments, or services which are an integral part of care while in transit (for example, complex bandaging procedures, ECG monitoring, drugs used in transit or for starting intravenous solutions)
- | Reusable devices and equipment such backboards, neckboards, and inflatable splints
- | Sales tax
- | Specialty care transport in combination with other ambulance service base rates
- | Transportation of lab specimens
- | Trips for the purpose of locating a member closer to their family or home
- | Trips to relocate a member for the sole purpose of improving the member's mental, psychological, or emotional health
- | Trips to facilities where no medical services are received (for example, a daycare center or sheltered workshop)
- | Vehicle sterilization





# Member Information

# 6

Archive Date:08/01/2025

## Member Information:Enrollment Categories

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Topic #225

### BadgerCare Plus

#### Populations Eligible for BadgerCare Plus

The following populations are eligible for BadgerCare Plus:

- | Parents and caretakers with incomes at or below 100% of the FPL.
- | Pregnant women with incomes at or below 300% of the FPL.
- | Children (ages 18 and younger) with household incomes at or below 300% of the FPL.
- | Childless adults with incomes at or below 100% of the FPL.
- | Transitional medical assistance individuals, also known as members on extensions, with incomes over 100% of the FPL.

Where available, BadgerCare Plus members are 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.

#### Premiums

The following members are required to pay premiums to be enrolled in BadgerCare Plus:

- | Transitional medical assistance individuals with incomes over 133% of the FPL. Transitional medical assistance individuals with incomes between 100 and 133% FPL are exempt from premiums for the first six months of their eligibility period.
- | Children (ages 18 and younger) with household incomes greater than 200% with the following exceptions:
  - | Children under age 1 year.
  - | Children who are tribal members or otherwise eligible to receive Indian Health Services.

Topic #16677

### BadgerCare Plus Benefit Plan Changes

Effective April 1, 2014, all members eligible for BadgerCare Plus were enrolled in the BadgerCare Plus Standard Plan. As a result of this change, the following benefit plans were discontinued:

- | BadgerCare Plus Benchmark Plan
- | BadgerCare Plus Core Plan
- | BadgerCare Plus Basic Plan

Members who are enrolled in the Benchmark Plan or the Core Plan who met new income limits for BadgerCare Plus eligibility were automatically transitioned into the BadgerCare Plus Standard Plan on April 1, 2014. In addition, the last day of BadgerRx Gold program coverage for all existing members was March 31, 2014.

Providers should refer to the [March 2014 Online Handbook archive](#) of the appropriate service area for policy information pertaining to these discontinued benefit plans.

Topic #785

# BadgerCare Plus Prenatal Program

As a result of 2005 Wisconsin Act 25, 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 Plus Prenatal Program 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 [income maintenance or tribal 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 (for example, claim 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 (for example, a woman who delivers on June 20, 2006, would be enrolled through the end of August 2006).

Topic #230

# Express Enrollment for Children and Pregnant Women

The 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.

The EE for Children Benefit allows certain members through 18 years of age to receive BadgerCare Plus benefits 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 [income maintenance or tribal agency](#).

Topic #226

## Family Planning Only Services

Family Planning Only Services is a limited benefit program that provides routine contraceptive management or related services to low-income individuals who are of childbearing/reproductive age (typically 15 years of age or older) and who are otherwise not eligible for Wisconsin Medicaid or BadgerCare Plus. Members receiving Family Planning Only Services must be receiving routine contraceptive management or related services.

Note: Members who meet the enrollment criteria may receive routine contraceptive management or related services **immediately** by temporarily enrolling in Family Planning Only Services through [EE](#).

The goal of Family Planning Only Services is to provide members 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 Family Planning Only Services to members and encourage them to contact their certifying agency to determine their enrollment options if they are not interested in, or do not need, contraceptive services.

Members enrolled in Family Planning Only Services receive routine services to prevent or delay pregnancy and are not eligible for other services (for example, PT services, dental services). Even if a medical condition is discovered during a family planning visit, treatment for the condition is not covered under Family Planning Only Services unless the treatment is identified in the list of [allowable procedure codes](#) for Family Planning Only Services.

Members are also not eligible for certain other services that are covered under Wisconsin Medicaid and BadgerCare Plus (for example, mammograms and hysterectomies). If a medical condition, other than an STD, is discovered during routine contraceptive management or related services, treatment for the medical condition is not covered under Family Planning Only Services.

Colposcopies and treatment for STDs are only covered through Family Planning Only Services if they are determined medically necessary during routine contraceptive management or 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 enrolled in Family Planning Only Services and receiving contraceptive management or related services.

Family Planning Only Services 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 members about other coverage options and provide referrals for care not covered by Family Planning Only Services.

Topic #4757

## ForwardHealth and ForwardHealth interChange

ForwardHealth brings together many Wisconsin 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
- | HDAP
- | WCDP
- | WIR

- | Wisconsin Medicaid
- | Wisconsin Well Woman Medicaid
- | WWWP

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

Topic #228

## 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 Wis. Stat. ch. [49](#).

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 they are 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
- | Foster care or adoption assistance 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:

- | Income maintenance 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.

Topic #18777

## Real-Time Eligibility Determinations

ForwardHealth may complete real-time eligibility determinations for BadgerCare Plus and/or Family Planning Only Services applicants who meet pre-screening criteria and whose reported information can be verified in real time while applying in [ACCESS Apply for Benefits](#). Once an applicant is determined eligible through the real-time eligibility process, they are considered eligible for BadgerCare Plus and/or Family Planning Only Services and will be enrolled for 12 months, unless changes affecting eligibility occur before the 12-month period ends.

A member determined eligible through the real-time eligibility process will receive a [temporary ID card for BadgerCare Plus](#) and/or [Family Planning Only Services](#). Each member will get their own card, and each card will include the member's ForwardHealth ID number. The temporary ID card will be valid for the dates listed on the card and will allow the member to get immediate health care or pharmacy services.

## Eligibility Verification

When a member is determined eligible for BadgerCare Plus and/or Family Planning Only Services through the real-time eligibility process, providers are able to see the member's eligibility information in Wisconsin's EVS in real time. Providers should always verify eligibility through EVS prior to providing services.

On rare occasions, it may take up to 48 hours for eligibility information to be available through interChange. In such instances, if a member presents a valid temporary ID card, [the provider is still required to provide services](#), even if eligibility cannot be verified through EVS.

# Sample Temporary Identification Card for Badger Care Plus

## To the Provider

The individual listed on this card has been enrolled in BadgerCare Plus. This card entitles the listed individual to receive health care services, including pharmacy services, through BadgerCare Plus from any Medicaid-enrolled provider. For additional information, call Provider Services at 800-947-9627 or refer to the ForwardHealth Online Handbook at [www.forwardhealth.wi.gov](http://www.forwardhealth.wi.gov).

## NOTE:

It is important to provide services when this card is presented. Providers who render services based on the enrollment dates on this card will receive payment for those services, as long as other reimbursement requirements are met. All policies regarding covered services apply for this individual, including the prohibition against billing members. If "Pending Assignment" is indicated after the name on this card, the member identification (ID) number will be assigned within one business day; the card is still valid. Refer to the ForwardHealth Online Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card.

## WISCONSIN DEPARTMENT OF HEALTH SERVICES

### TEMPORARY IDENTIFICATION CARD FOR BADGERCARE PLUS




Name:	Program	ID Number
IM A MEMBER	BadgerCare Plus	0987654321
DOB: 09/01/1984		

This card is valid from **October 01, 2016 to November 30, 2016.**

This individual's eligibility should be available through the ForwardHealth Portal. Eligibility should always be verified through the ForwardHealth Portal prior to services being provided.



## Sample Temporary Identification Card for Family Planning Only Services

<p><b>To the Provider</b></p> <p>The individual listed on this card has been enrolled in Family Planning Only Services. This card entitles the listed individual to receive health care services, including pharmacy services, through Family Planning Only Services from any Medicaid-enrolled provider. For additional information, call Provider Services at 800-947-9627 or refer to the ForwardHealth Online Handbook at <a href="http://www.forwardhealth.wi.gov">www.forwardhealth.wi.gov</a>.</p> <p><b>NOTE:</b></p> <p>It is important to provide services when this card is presented. Providers who render services based on the enrollment dates on this card will receive payment for those services, as long as other reimbursement requirements are met. All policies regarding covered services apply for this individual, including the prohibition against billing members. If "Pending Assignment" is indicated after the name on this card, the member identification (ID) number will be assigned within one business day; the card is still valid. Refer to the ForwardHealth Online Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card.</p>	<p>WISCONSIN DEPARTMENT OF HEALTH SERVICES</p> <p><b>TEMPORARY IDENTIFICATION CARD FOR FAMILY PLANNING ONLY SERVICES</b></p>  <table border="0"> <tr> <td><b>Name:</b></td> <td><b>Program</b></td> <td><b>ID Number</b></td> </tr> <tr> <td>IM A MEMBER</td> <td>Family Planning Only</td> <td>0987654321</td> </tr> <tr> <td>DOB: 09/01/1984</td> <td>Services</td> <td></td> </tr> </table> <p>This card is valid from <b>October 01, 2016 to November 30, 2016.</b></p> <p>This individual's eligibility should be available through the ForwardHealth Portal. Eligibility should always be verified through the ForwardHealth Portal prior to services being provided.</p>	<b>Name:</b>	<b>Program</b>	<b>ID Number</b>	IM A MEMBER	Family Planning Only	0987654321	DOB: 09/01/1984	Services	
<b>Name:</b>	<b>Program</b>	<b>ID Number</b>								
IM A MEMBER	Family Planning Only	0987654321								
DOB: 09/01/1984	Services									

Topic #240

## 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 Family Planning Only Services, 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 WWWMA are reimbursed through Medicaid fee-for-service.



# Identification Cards

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Topic #266

## 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.

### Digital ForwardHealth Identification Cards

Members can access [digital versions of their ForwardHealth cards](#) on the MyACCESS mobile app. Members are able to save PDFs and print out paper copies of their cards from the app. The digital and paper printout versions of the cards are identical to the physical cards for the purposes of accessing Medicaid-covered services. All policies that apply to the physical cards mailed by ForwardHealth to the member also apply to the digital or printed versions that members may present.

A member may still access their digital ForwardHealth card on the MyACCESS app when they are no longer enrolled. The MyACCESS app will display a banner message noting that the member is not currently enrolled in a ForwardHealth program. Providers should always 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 their 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 they do 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, they may call Member Services to request a new one.

If a member lost their 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.



## Sample ForwardHealth Identification Card



Topic #1435

## Types of Identification Cards

ForwardHealth members receive an identification card upon initial eligibility determination. Identification cards may be presented in different formats (for example, white plastic cards, paper cards, or paper printouts), depending on the program and the method used to enroll (for example, paper application or online application). Members who are temporarily enrolled in BadgerCare Plus or Family Planning Only Services receive temporary identification cards.

# Enrollment Rights

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Topic #246

## Appealing Enrollment Determinations

Applicants and members have the right to appeal certain decisions relating to BadgerCare Plus, Medicaid, or HDAP 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 Wis. Admin. Code § [HA 3.03](#), 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, HDAP, or Wisconsin Medicaid was denied.
- ┆ Application for BadgerCare Plus, HDAP, 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

### Claim Denial Due to Termination of BadgerCare Plus or Wisconsin Medicaid Enrollment

If a claim is denied due to termination of BadgerCare Plus or Wisconsin Medicaid 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  
313 Blettner Blvd  
Madison WI 53784

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.

## Claim Denial Due to Termination of HDAP Enrollment

If a claim is denied due to termination of HDAP 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  
HDAP Claims and Adjustments  
PO Box 8758  
Madison WI 53708

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 HDAP Claims and Adjustments.

As a reminder, claims [submission deadlines](#) still apply even to those claims with hearing decisions.

Topic #248

## General Information

Members are entitled to certain rights per Wis. Admin. Code ch. [DHS 103](#).

Topic #250

## Notification of Discontinued Benefits

When DHS intends to discontinue, suspend, or reduce a member's benefits, or reduce or eliminate coverage of services for a general class of members, 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.

Topic #252

## 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.

Topic #254

## 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.

## Enrollment Responsibilities

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Topic #241

### General Information

Members have certain responsibilities per Wis. Admin. Code § [DHS 104.02](#) and the [ForwardHealth Enrollment and Benefits](#) booklet.

Topic #243

### 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 and Medicaid 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.

Topic #707

### 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.

Topic #269

### 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 Wis. Admin. Code § [DHS 104.02\(2\)](#), a member should inform providers that they are 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.

Topic #244

## 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 their ForwardHealth card](#), providers may verify enrollment without it.

Topic #245

## 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

## Special Enrollment Circumstances

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Topic #276

### 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.

Topic #279

### 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 and Wisconsin Medicaid cover 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 provider for provision of a nonemergency service
- | When there are coinsurance, copay, or deductible amounts remaining after Medicare payment or approval for dual eligibles

Travel expenses such as lodging or food are not reimbursable by Wisconsin Medicaid.

Note: Some providers located in a state that borders Wisconsin may be Wisconsin Medicaid enrolled 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 their medical services. Border-status providers follow the same policies as Wisconsin providers.

Topic #277

### Non-U.S. Citizens — Emergency Services

Certain non-U.S. citizens who are not qualified aliens are eligible for services only in cases of acute emergency medical conditions. Providers should use the appropriate 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 and Wisconsin Medicaid do not cover services for non-U.S. citizens who are not qualified aliens related to routine prenatal or postpartum care, major organ transplants (for example, heart, liver), or ongoing treatment for chronic conditions where there is no evidence of an acute emergent state. For the purposes of this policy, services for ESRD and all labor and delivery are considered emergency services.



Note: Babies born to certain non-qualifying 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 10 calendar days.

A provider who gives emergency care to a non-U.S. citizen should refer them to the [income maintenance or tribal agency](#) or ForwardHealth outpost 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 income maintenance 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.

Topic #278

## Persons Detained by Legal Process

Most individuals detained by legal process who are eligible for BadgerCare Plus or Wisconsin Medicaid benefits will have their eligibility suspended during their detention period. During the suspension, ForwardHealth will only cover inpatient services received while the member is outside of jail or prison for 24 hours or more.

Note: Detained by legal process means a person who is incarcerated because of law violation or alleged law violation, which includes misdemeanors, felonies, delinquent acts, and day-release prisoners. Inmates who are released from jail under the Huber Program to return home to care for their minor children may be eligible for full benefit BadgerCare Plus or Wisconsin Medicaid without suspension.

Pregnant women detained by legal process who qualify for the [BadgerCare Plus Prenatal Program](#) and state prison inmates who qualify for Wisconsin Medicaid or BadgerCare Plus during inpatient hospital stays may receive certain benefits and are not subject to eligibility suspension. Additionally, inmates of county jails admitted to a hospital for inpatient services who are expected to remain in the hospital for 24 hours or more will be eligible for PE determinations for BadgerCare Plus by qualified hospitals. Refer to the Presumptive Eligibility chapter of either the [Inpatient](#) or [Outpatient](#) Hospital service area for more information on the PE determination process.

The DOC or county jail oversee health care-related needs for individuals detained by legal process who do not qualify for the BadgerCare Plus Prenatal Program or for state prison inmates who do not qualify for Wisconsin Medicaid or BadgerCare Plus during an inpatient hospital stay.

Topic #280

## 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-enrolled provider for a covered service during the period of retroactive enrollment, according to Wis. Admin. Code § [DHS 104.01\(11\)](#). A Medicaid-enrolled provider is required to submit claims to ForwardHealth 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 ForwardHealth **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 (for example, 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).

Topic #281

## 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.

Topic #23277

# 12-Month Continuous Health Care Coverage for Children

Most children enrolled in BadgerCare Plus or Medicaid programs will keep their health insurance coverage for 12 months. Even if their family has a change in income or other circumstances, children under age 19 will have coverage at least until their next renewal. This policy is required by the federal Consolidated Appropriations Act, 2023.

Children enrolled in Foster Care Medicaid or SSI Medicaid will have 12-months of continuous coverage even if their out-of-home placement, subsidized guardianship, court-ordered kinship care, adoption assistance agreement, or SSI payment ends.

## Qualifying Programs

Members under age 19 in the following programs qualify for continuous coverage:

- | [BadgerCare Plus](#)
- | Emergency Services Medicaid
- | [Family Planning Only Services](#)
- | Foster Care Medicaid
- | HCBW Medicaid
- | Institutional Medicaid
- | Katie Beckett Medicaid
- | MAPP
- | Medicare Savings Programs
- | Special Status Medicaid
- | SSI-Related Medicaid
- | SSI Medicaid
- | [Tuberculosis-Related Medicaid](#)
- | [Wisconsin Well Woman Medicaid](#)

## Exceptions to Continuous Coverage

Continuous coverage does not apply to children:

- | Enrolled under presumptive eligibility, also known as [Express Enrollment](#).
- | Enrolled by meeting a deductible. These are members who become eligible for up to a six-month period based on their medical expenses.

Children remain eligible for the 12 months until their next renewal unless:

- | They turn 19.
- | They move out of Wisconsin.
- | Their citizenship or immigration status is not verified.
- | Their eligibility was based on inaccurate information or agency error.
- | The family asks to end their coverage.

## Assisting Members Through Enrollment Renewals

Helping families through the health care renewal process remains vital to keeping children covered. Providers are asked to remind BadgerCare Plus and other Wisconsin Medicaid program members to renew their coverage, even if they think their situation will change in the future. Members should also be reminded to tell their agency about any changes to their address, phone number, or

email to ensure they continue to receive important information about their health care coverage from Wisconsin DHS.

## Member Resources

### Free Health Insurance Application and Renewal Assistance

Members who need help with applying for or renewing health care coverage can access the following resources:

- | Covering Wisconsin (free expert help with health insurance), available at the [WisCovered](#) website
- | [211 Wisconsin](#) at 211 or 877-947-2211

### Continuous Coverage and Health Care Renewal Information

Additional member resources regarding health care renewals and continuous coverage for children are available:

- | [Medicaid: Programs for Children](#) web page
- | [Health Care Renewals](#) web page
- | "Keeping Kids Covered" [12-Month Continuous Coverage for Children fact sheet](#)
- | [BadgerCare Plus: Frequently Asked Questions](#)

Additional policy information on continuous coverage for children is [available](#) in the BadgerCare Plus Handbook.

# Misuse and Abuse of Benefits

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Topic #271

## Examples of Member Abuse or Misuse

Examples of member abuse or misuse are included in Wis. Admin. Code § [DHS 104.02\(5\)](#).

Topic #274

## Pharmacy Services Lock-In Program

### Overview of the Pharmacy Services Lock-In Program

The purpose of the Pharmacy Services Lock-In Program is to coordinate the provision of health care services for members who abuse or misuse Medicaid, BadgerCare Plus, or SeniorCare benefits by seeking duplicate or medically unnecessary services, particularly for controlled substances. The Pharmacy Services Lock-In Program focuses on the abuse or misuse of prescription benefits for controlled substances. Abuse or misuse is defined under Recipient Duties in Wis. Admin. Code § [DHS 104.02](#).

Coordination of member health care services is intended to:

- | Curb the abuse or misuse of controlled substance medications.
- | Improve the quality of care for a member.
- | Reduce unnecessary physician utilization.

The Pharmacy Services Lock-In Program focuses on the abuse or misuse of prescription benefits for controlled substances. Abuse or misuse is defined under Recipient Duties in Wis. Admin. Code § DHS 104.02. The abuse and misuse definition includes:

- | Not duplicating or altering prescriptions
- | Not feigning illness, using false pretense, providing incorrect enrollment status, or providing false information to obtain service
- | Not seeking duplicate care from more than one provider for the same or similar condition
- | Not seeking medical care that is excessive or not medically necessary

The Pharmacy Services Lock-In Program applies to members in fee-for-service as well as members enrolled in Medicaid SSI HMOs and BadgerCare Plus HMOs. Members remain enrolled in the Pharmacy Services Lock-In Program for two years and are continuously monitored for their prescription drug usage. At the end of the two-year enrollment period, an assessment is made to determine if the member should continue enrollment in the Pharmacy Services Lock-In Program.

Members enrolled in the Pharmacy Services Lock-In Program will be locked into one pharmacy where prescriptions for restricted medications must be filled and one prescriber who will prescribe restricted medications. [Restricted medications](#) are most controlled substances, carisoprodol, and tramadol. Referrals will be required only for restricted medication services.

Fee-for-service members enrolled in the Pharmacy Services Lock-In Program may choose physicians and pharmacy providers from whom to receive prescriptions and medical services not related to restricted medications. Members enrolled in an HMO must comply with the HMO's policies regarding care that is not related to restricted medications.

Referrals of members as candidates for lock-in are received from retrospective DUR, physicians, pharmacists, other providers, and through automated surveillance methods. Once a referral is received, six months of pharmacy claims and diagnoses data are reviewed. A recommendation for one of the following courses of action is then made:

- ┆ No further action.
- ┆ Send an intervention letter to the physician.
- ┆ Send a warning letter to the member.
- ┆ Enroll the member in the Pharmacy Services Lock-In Program.

Medicaid, BadgerCare Plus, and SeniorCare members who are candidates for enrollment in the Pharmacy Services Lock-In Program are sent a letter of intent, which explains the restriction that will be applied, how to designate a primary prescriber and a pharmacy, and how to request a hearing if they wish to contest the decision for enrollment (that is, due process). If a member fails to designate providers, the Pharmacy Services Lock-In Program may assign providers based on claims' history. In the letter of intent, members are also informed that access to emergency care is not restricted.

Letters of notification are sent to the member and to the lock-in primary prescriber and pharmacy. Providers may designate alternate prescribers or pharmacies for restricted medications, as appropriate. Members remain in the Pharmacy Services Lock-In Program for two years. The primary lock-in prescriber and pharmacy may make referrals for specialist care or for care that they are otherwise unable to provide (for example, home infusion services). The member's utilization of services is reviewed prior to release from the Pharmacy Services Lock-In Program, and lock-in providers are notified of the member's release date.

## Excluded Drugs

The following scheduled drugs will be excluded from monitoring by the Pharmacy Services Lock-In Program:

- ┆ Anabolic steroids
- ┆ Barbiturates used for seizure control
- ┆ Lyrica
- ┆ Provigil and Nuvigil
- ┆ Weight loss drugs

## Pharmacy Services Lock-In Program Administrator

The Pharmacy Services Lock-In Program is administered by Acentra. Acentra may be contacted by phone at 877-719-3123, by fax at 800-881-5573, or by mail at the following address:

Pharmacy Services Lock-In Program  
c/o Acentra  
PO Box 3570  
Auburn AL 36831-3570

## Pharmacy Services Lock-In Prescribers Are Required to Be Enrolled in Wisconsin Medicaid

To prescribe restricted medications for Pharmacy Services Lock-In Program members, prescribers are required to be [enrolled in Wisconsin Medicaid](#). Enrollment for the Pharmacy Services Lock-In Program is not separate from enrollment in Wisconsin Medicaid.

## Role of the Lock-In Prescriber and Pharmacy Provider

The lock-in prescriber determines what restricted medications are medically necessary for the member, prescribes those

medications using their professional discretion, and designates an alternate prescriber if needed. If the member requires an alternate prescriber to prescribe restricted medications, the primary prescriber should complete the [Pharmacy Services Lock-In Program Designation of Alternate Prescriber for Restricted Medication Services](#) form and return it to the Pharmacy Services Lock-In Program and to the member's HMO, if applicable.

To coordinate the provision of medications, the lock-in prescriber may also contact the lock-in pharmacy to give the pharmacist (s) guidelines as to which medications should be filled for the member and from whom. The primary lock-in prescriber should also coordinate the provision of medications with any other prescribers they have designated for the member.

The lock-in pharmacy fills prescriptions for restricted medications that have been written by the member's lock-in prescriber(s) and works with the lock-in prescriber(s) to ensure the member's drug regimen is consistent with the overall care plan. The lock-in pharmacy may fill prescriptions for medications from prescribers other than the lock-in prescriber only for medications not on the list of restricted medications. If a pharmacy claim for a restricted medication is submitted from a provider who is not a designated lock-in prescriber, the claim will be denied.

## **Designated Lock-In Pharmacies**

The Pharmacy Services Lock-In Program pharmacy fills prescriptions for restricted medications that have been written by the member's lock-in prescriber(s) and works with the lock-in prescriber(s) to ensure the member's drug regimen is consistent with the overall care plan. The lock-in pharmacy may fill prescriptions for medications from prescribers other than the lock-in prescriber only for medications not on the list of restricted medications. If a pharmacy claim for a restricted medication is submitted from a provider who is not a designated lock-in prescriber, the claim will be denied.

## **Alternate Providers for Members Enrolled in the Pharmacy Services Lock-In Program**

Members enrolled in the Pharmacy Services Lock-In Program do not have to visit their lock-in prescriber to receive medical services unless an HMO requires a primary care visit. Members may see other providers to receive medical services; however, other providers cannot prescribe restricted medications for Pharmacy Services Lock-In Program members unless specifically designated to do so by the primary lock-in prescriber. For example, if a member sees a cardiologist, the cardiologist may prescribe a statin for the member, but the cardiologist may not prescribe restricted medications unless they have been designated by the lock-in prescriber as an alternate provider.

A referral to an alternate provider for a Pharmacy Services Lock-In Program member is necessary only when the member needs to obtain a prescription for a restricted medication from a provider other than their lock-in prescriber or lock-in pharmacy.

If the member requires alternate prescribers to prescribe restricted medications, the primary lock-in prescriber is required to complete the Pharmacy Services Lock-In Program Designation of Alternate Prescriber for Restricted Medication Services form. Referrals for fee-for-service members must be on file with the Pharmacy Services Lock-In Program. Referrals for HMO members must be on file with the Pharmacy Service Lock-In Program and the member's HMO.

Designated alternate prescribers are required to be enrolled in Wisconsin Medicaid.

## **Claims from Providers Who Are Not Designated Pharmacy Services Lock-In Providers**

If the member brings a prescription for a restricted medication from a non-lock-in prescriber to the designated lock-in pharmacy, the pharmacy provider cannot fill the prescription.

If a pharmacy claim for a restricted medication is submitted from a provider who is not the designated lock-in prescriber, alternate prescriber, lock-in pharmacy, or alternate pharmacy, the claim will be denied. If a claim is denied because the prescription is not



from a designated lock-in prescriber, the lock-in pharmacy provider cannot dispense the drug or collect a cash payment from the member because the service is a nonreimbursable service. However, the lock-in pharmacy provider may contact the lock-in prescriber to request a new prescription for the drug, if appropriate.

To determine if a provider is on file with the Pharmacy Services Lock-In Program, the lock-in pharmacy provider may do one of the following:

- | Speak to the member.
- | Call Acentra.
- | Call Provider Services.
- | Use the ForwardHealth Portal.

Claims are not reimbursable if the designated lock-in prescriber, alternate lock-in prescriber, lock-in pharmacy, or alternate lock-in pharmacy provider is not on file with the Pharmacy Services Lock-In Program.

## For More Information

Providers may call Acentra with questions about the Pharmacy Services Lock-In Program. Pharmacy providers may also refer to the list of restricted medications data table or call Provider Services with questions about the following:

- | Drugs that are restricted for Pharmacy Services Lock-In Program members
- | A member's enrollment in the Pharmacy Services Lock-In Program
- | A member's designated lock-in prescriber or lock-in pharmacy

Topic #273

## 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 [Pharmacy Services Lock-In Program](#) or to criminal prosecution.

Topic #275

## 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.



# Coordination of Benefits

## 7

Archive Date:08/01/2025

## Coordination of Benefits:Commercial Health Insurance

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Topic #18497

### Explanation of Medical Benefits Form Requirement

An [Explanation of Medical Benefits](#) form must be included for each other payer when other health insurance sources are indicated on a paper claim or paper adjustment.

Note: ADA claims and claim adjustments and compound and noncompound drug claims and claim adjustments are **not** subject to the requirements regarding use of the Explanation of Medical Benefits form.

Paper claims or adjustment requests that have other health insurance indicated may be returned to the provider unprocessed or denied if they are submitted without the Explanation of Medical Benefits form for each other payer. Paper claims or adjustments submitted with incorrect or incomplete Explanation of Medical Benefits forms will also be returned or denied.

Use of the ForwardHealth Explanation of Medical Benefits form is mandatory; providers are required to use an exact copy. ForwardHealth will not accept alternate versions (for example, retyped or otherwise reformatted) of the Explanation of Medical Benefits form.

The Explanation of Medical Benefits form requirement for paper claims and adjustments is intended to help ensure consistency with electronic claims and adjustments submitted via the ForwardHealth Portal or using an 837 transaction (including those submitted using PES software or through a clearinghouse or software vendor).

The Explanation of Medical Benefits form requirement applies to paper claims and paper adjustments submitted to Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and the WCDP. Providers are reminded that, except for a few instances, Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and WCDP are payers of last resort for any covered service. Therefore, providers are required to make a reasonable effort to exhaust all other existing health insurance sources before submitting claims to ForwardHealth or to a state-contracted MCO.

Wisconsin Medicaid and BadgerCare Plus are not payers of last resort for members who receive coverage from [certain governmental programs](#). Providers should ask members if they have coverage from these other government programs.

If a member becomes retroactively enrolled in Wisconsin Medicaid or BadgerCare Plus after the provider has already been reimbursed by one of these government programs, the provider may be required to submit the claims to ForwardHealth and refund the payment from the government program.

### Ink, Data Alignment, and Quality Standards for Paper Claim Submission

In order for OCR software to read paper claim forms accurately, the claim forms must comply with certain ink standards, as well as other data alignment and quality standards. The Explanation of Medical Benefits form will also need to comply with [these standards](#).

Topic #596

### Exhausting Commercial Health Insurance Sources

Providers are required to exhaust commercial health insurance sources before submitting claims to ForwardHealth. This is

accomplished by following the process indicated in the following steps. Providers are required to prepare complete and accurate documentation of efforts to bill commercial health insurance to substantiate other insurance indicators used on any claim.

### **Step 1. Determine if the Member Has Commercial Health Insurance**

**If Wisconsin's EVS does not indicate that the member has commercial health insurance**, the provider may submit a claim to ForwardHealth unless the provider is otherwise aware of commercial health insurance coverage.

**If the member disputes the information as it is indicated in the EVS**, the provider should submit a [real-time Other Coverage Discrepancy Report via the ForwardHealth Portal](#) or submit a completed [Commercial Other Coverage Discrepancy Report](#) form. Unless the service does not require other health insurance billing, the provider should allow at least two weeks before proceeding to Step 2.

### **Step 2. Determine if the Service Requires Other Health Insurance Billing**

**If the service requires other health insurance billing**, the provider should proceed to Step 3.

**If the service does not require other health insurance billing**, the provider should proceed in one of the following ways:

- ▮ The provider is encouraged to bill commercial health insurance if they believe that benefits are available. Reimbursement from commercial health insurance may be greater than the Medicaid-allowed amount. If billing commercial health insurance first, the provider should proceed to Step 3.
- ▮ The provider may submit a claim without indicating an other insurance indicator on the claim or on the [Explanation of Medical Benefits form](#), as applicable.

The provider may not bill Wisconsin Medicaid and commercial health insurance simultaneously. Simultaneous billing may constitute fraud and interferes with Wisconsin Medicaid's ability to recover prior payments.

### **Step 3. Identify Assignment of Commercial Health Insurance Benefits**

The provider should verify whether commercial health insurance benefits may be assigned to the provider. (As indicated by commercial health insurance, the provider may be required to obtain approval from the member for this assignment of benefits.)

The provider should proceed in one of the following ways:

- ▮ **If the provider is assigned benefits**, the provider should bill commercial health insurance and proceed to Step 4.
- ▮ **If the member is assigned insurance benefits**, the provider may submit a claim (without billing commercial health insurance) using the appropriate other insurance indicator or complete the Explanation of Medical Benefits form, as applicable.

If the commercial health insurance reimburses the member, the provider may collect the payment from the member. If the provider receives reimbursement from Wisconsin Medicaid and the member, the provider is required to return the lesser amount to Wisconsin Medicaid.

### **Step 4. Bill Commercial Health Insurance and Follow Up**

**If commercial health insurance denies or partially reimburses the provider for the claim**, the provider may proceed to Step 5.

**If commercial health insurance does not respond within 45 days**, the provider should follow up the original claim with an inquiry to commercial health insurance to determine the disposition of the claim. If commercial health insurance does not respond within 30 days of the inquiry, the provider may proceed to Step 5.

## Step 5. Submit Claim to ForwardHealth

**If only partial reimbursement is received, if the correct and complete claim is denied by commercial health insurance, or if commercial health insurance does not respond to the original and follow-up claims,** the provider may submit a claim to ForwardHealth using the appropriate other insurance indicator or complete the Explanation of Medical Benefits form, as applicable. Commercial remittance information should not be attached to the claim.

Topic #595

## Assignment of Insurance Benefits

Assignment of insurance benefits is the process by which a specified party (for example, provider or policyholder) becomes entitled to receive payment for claims in accordance with the insurance company policies.

Other health insurance companies may permit reimbursement to the provider or member. Providers should verify whether other health insurance benefits may be assigned to the provider. As indicated by the other health insurance, providers may be required to obtain approval from the member for this assignment of benefits.

If the provider is assigned benefits, providers should bill the other health insurance.

If the member is assigned insurance benefits, it is appropriate to submit a claim to ForwardHealth without billing the other health insurance. In this instance providers should indicate the appropriate other insurance indicator or complete the [Explanation of Medical Benefits form](#), as applicable. ForwardHealth will bill the other health insurance.

Topic #603

## Services Not Requiring Commercial Health Insurance Billing

Providers are not required to bill commercial health insurance sources before submitting claims for the following:

- | Case management services
- | CCS
- | Crisis Intervention services
- | CRS
- | CSP services
- | Family planning services
- | In-home mental health/substance abuse treatment services for children (HealthCheck "Other Services") rendered by providers at the less than bachelor's degree level, bachelor's degree level, QTT level, or certified psychotherapist level
- | Personal care services
- | PNCC services
- | Preventive pediatric services
- | SMV services

Topic #844

## Claims for Services Denied by Commercial Health Insurance

If commercial health insurance denies or recoups payment for services that are covered by BadgerCare Plus and Wisconsin Medicaid, the provider may submit a claim for those services. To allow payment in this situation, providers are encouraged to follow the requirements (for example, request PA before providing the service for covered services that require PA). If the requirements are followed, ForwardHealth may reimburse for the service up to the allowed amount (less any payments made by other health insurance sources).

Note: The provider is required to demonstrate that a correct and complete claim was denied by the commercial health insurance company for a reason other than that the provider was out of network.

## Other Coverage Information

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Topic #4942

### Reporting Discrepancies

Providers are encouraged to report discrepancies to ForwardHealth by submitting the [Commercial Other Coverage Discrepancy Report](#) form or [Medicare Other Coverage Discrepancy Report](#) form. Providers are asked to complete the form in the following situations:

- ▮ The provider is aware of other coverage information that is not indicated by Wisconsin's EVS.
- ▮ The provider received other coverage information that contradicts the information indicated by the EVS.
- ▮ A claim is denied because the EVS indicates commercial managed care coverage but the coverage is not available to the member (for example, the member does not live in the plan's service area).

Providers should not use the Commercial Other Coverage Discrepancy Report form or Medicare Other Coverage Discrepancy Report form to update any information regarding a member's coverage in a state-contracted MCO.

When reporting discrepancies, providers should include photocopies of current insurance cards and any available documentation, such as remittance information and benefit coverage dates or denials.

Topic #4941

### Coverage Discrepancies

Maintaining complete and accurate insurance information may result in fewer claim denials. Providers are an important source of other coverage information as they are frequently the first to identify coverage discrepancies.

Topic #4940

### After Reporting Discrepancies

After receiving a [Commercial Other Coverage Discrepancy Report](#) form or [Medicare Other Coverage Discrepancy Report](#) form, ForwardHealth confirms the information and updates the member files.

It may take up to two weeks to process and update the member's enrollment information. During that time, ForwardHealth verifies the insurance information submitted and adds, changes, or removes the member's other coverage information as appropriate. If verification contradicts the provider's information, a written explanation is sent to the provider. The provider should wait to submit claims until one of the following occurs:

- ▮ The provider verifies through Wisconsin's EVS that the member's other coverage information has been updated.
- ▮ The provider receives a written explanation.

# Medicare

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Topic #671

## Crossover Claims

A Medicare crossover claim is a Medicare-allowed claim for a dual eligible or QMB-Only member sent to ForwardHealth for payment of coinsurance, copayment, and deductible.

Submit Medicare claims first, as appropriate, to one of the following:

- | Medicare Part A fiscal intermediary
- | Medicare Part B carrier
- | Medicare DME regional carrier
- | Medicare Advantage Plan or Medicare Cost Plan
- | Railroad Retirement Board carrier (also known as the Railroad Medicare carrier)

There are two types of crossover claims based on who submits them:

- | Automatic crossover claims
- | Provider-submitted crossover claims

## Automatic Crossover Claims

An automatic crossover claim is a claim that Medicare automatically forwards to ForwardHealth by the COBC.

Claims will be forwarded if the following occur:

- | Medicare has identified that the services were provided to a dual eligible or a QMB-Only member.
- | The claim is for a member who is not enrolled in a Medicare Advantage Plan.

Providers are advised to wait 30 days before billing for claims submitted to Medicare to allow time for the automatic crossover process to complete. If automatic crossover claims do not appear on the ForwardHealth and/or the MCO's RA after 30 days of the Medicare processing date, providers are required to resubmit the claim directly to ForwardHealth or the MCO using the NPI that was reported to ForwardHealth as the primary NPI.

If the service is covered by the MCO, the ForwardHealth RA will indicate EOB code 0287 (Member is enrolled in a State-contracted managed care program). If the service is covered on a fee-for-service basis, the MCO RA will indicate that the service is not covered. If the crossover claim is submitted without error, the responsible entity (either ForwardHealth or the MCO) will process the claim to a payable status.

## Provider-Submitted Crossover Claims

A provider-submitted crossover claim is a Medicare-allowed claim that a provider directly submits to ForwardHealth when the Medicare claim did not automatically cross over. Providers should submit a provider-submitted crossover claim in the following situations:

- | The automatic crossover claim does not appear on the ForwardHealth or MCO RA within 30 days of the Medicare processing date.

- | The automatic crossover claim is denied, and additional information may allow payment.
- | The claim is for a member who was not enrolled in BadgerCare Plus or Wisconsin Medicaid at the time the service was submitted to Medicare for payment, but the member was retroactively determined enrolled in BadgerCare Plus or Medicaid.
- | The claim is for a member who is enrolled in a Medicare Advantage Plan or Medicare Cost Plan.
- | The claim is for a member who is enrolled in Medicare and commercial health insurance that is secondary to Medicare (for example, Medicare Supplemental).

When submitting crossover claims directly, the following additional data may be required on the claim to identify the billing and rendering provider:

- | The NPI that ForwardHealth has on file for the provider
- | The taxonomy code that ForwardHealth has on file for the provider
- | The zip+4 code that corresponds to the practice location address on file with ForwardHealth

Providers may initiate a provider-submitted claim in one of the following ways:

- | DDE through the ForwardHealth Provider Portal
- | 837I transaction, as applicable
- | 837P transaction, as applicable
- | PES software
- | Paper claim form

Topic #666

## Claims Denied for Errors

Medicare claims that were denied for provider billing errors must be corrected and resubmitted to Medicare before the claim may be submitted to ForwardHealth.



# Resources

8

Archive Date:08/01/2025

## Resources:WiCall

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Topic #257

### Enrollment Inquiries

WiCall is an [AVR](#) system that allows providers with phones direct access to enrollment information.

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 the [Pharmacy Services Lock-In Program](#) 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 member ID, if available, that exists on the DOS or within the DOS range selected will be listed.
- | Commercial health 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.
  - | Request enrollment information for the same member using a different financial payer.
  - | Hear another member's enrollment information using the same financial payer.
  - | Hear another member's enrollment information using a different financial payer.
  - | 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.

Topic #6257

### Entering Letters into WiCall

For some WiCall inquiries, 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 (for example, 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.

Topic #466

## 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

Note: ForwardHealth releases CheckWrite information to WiCall no sooner than on the first state business day following the financial cycle.

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 financial payer program, (for example, Wisconsin Medicaid, WCDP, or WWWP) and 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.

## PA 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 (for example, NDC, procedure code, revenue code, or ICD procedure 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.

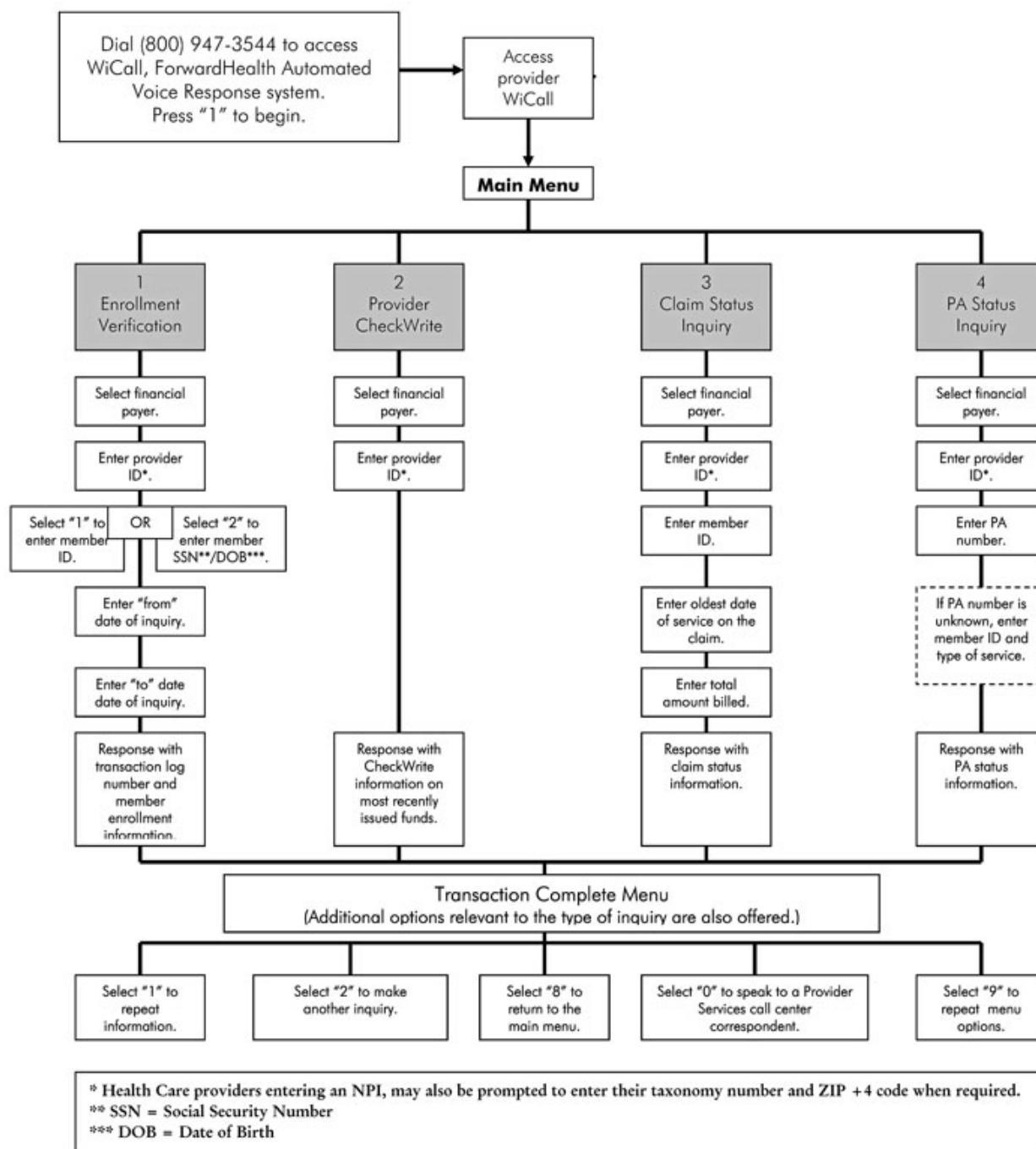
Note: PA information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

Topic #765

# Quick Reference Guide

The WiCall [AVR Quick Reference Guide](#) displays the information available for WiCall inquiries.

## Automated Voice Response Quick Reference Guide



# Electronic Data Interchange

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Topic #459

## Companion Guides and NCPDP Version D.0 Payer Sheet

Companion guides and the NCPDP version D.0 payer sheet are available for download on the ForwardHealth Portal.

### Purpose of Companion Guides

ForwardHealth [companion guides and payer sheet](#) provide trading partners with useful technical information on ForwardHealth's standards for nationally recognized electronic transactions.

The information in companion guides and payer sheet applies to BadgerCare Plus, Medicaid, SeniorCare, HDAP, WCDP, and WWWP. Companion guides and payer sheet are intended for information technology and systems staff who code billing systems or software.

The companion guides and payer sheet 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 (for example, exchange interfaces, transaction administration, and data preparation)
- ┆ Instructions for constructing the technical component of submitting or receiving electronic transactions (for example, claims, RA, and enrollment inquiries)

Companion guides and payer sheet do **not** include program requirements, but help those who create the electronic formats for electronic data exchange.

Companion guides and payer sheet cover the following specific subjects:

- ┆ Getting started (for example, identification information, testing, and exchange preparation)
- ┆ Transaction administration (for example, tracking claims submissions, contacting the [EDI Helpdesk](#))
- ┆ Transaction formats

### Revisions to Companion Guides and Payer Sheet

Companion guides and payer sheet may be updated as a result of changes to federal requirements. When this occurs, ForwardHealth will do the following:

- ┆ Post the revised companion guides and payer sheet on the ForwardHealth Portal.
- ┆ Post a message on the banner page of the RA.
- ┆ Send an email to trading partners.

Trading partners are encouraged to periodically check for revised companion guides and payer sheet on the Portal. If trading partners do not follow the revisions identified in the companion guides or payer sheet, transactions may not process successfully (for example, claims may deny or process incorrectly).

A change summary located at the end of the revised companion guide lists the changes that have been made. The date on the

companion guide reflects the date the revised companion guide was posted to the Portal. In addition, the version number located in the footer of the first page is changed with each revision.

Revisions to the payer sheet are listed in Appendix A. The date on the payer sheet reflects the date the revised payer sheet was posted to the Portal.

Topic #460

## Data Exchange Methods

The following data exchange methods are supported by the [EDI Helpdesk](#):

- ┆ 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 D.0, 270/271, 276/277, or 278 transactions via an approved clearinghouse

The EDI Helpdesk supports the exchange of the transactions for BadgerCare Plus, Medicaid, SeniorCare, HDAP, WCDP, and WWWP.

Topic #461

## 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](#).

Topic #462

## Electronic Transactions

HIPAA ASC X12 Version 5010 Companion Guides and the NCPDP Version D.0 Payer Sheet are available for download on the [HIPAA Version 5010 Companion Guides and NCPDP Version D.0 Payer Sheet](#) page of the ForwardHealth Portal.

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 Helpdesk](#), 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.
- ┆ 278: The electronic transaction for health care service PA requests.
- ┆ 835: The electronic transaction for receiving remittance information.
- ┆ 837: The electronic transaction for submitting claims and adjustment requests.
- ┆ 999: 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 D.0 Telecommunication Standard for Retail Pharmacy claims: The real-time POS electronic transaction for submitting pharmacy claims.

Topic #463

## Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. PES software allows providers to submit 837 transactions and download the 999 and the 835 transactions. To obtain PES software, providers may download it from the [ForwardHealth Portal](#). For assistance installing and using PES software, providers may call the [EDI Helpdesk](#).

Topic #464

## Trading Partner Profile

A [Trading Partner Profile](#) 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 Trading Partner Profile.

To determine whether a Trading Partner Profile 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 Trading Partner Profile.
- ┆ Billing providers who use a third party (billing services and clearinghouses) to exchange electronic transactions are required to submit a Trading Partner Profile.
- ┆ 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 Trading Partner Profile.

Providers who change billing services and clearinghouses or become a trading partner should keep their information updated by contacting the [EDI Helpdesk](#).

Topic #465

## 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

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Topic #256

### 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 enrollment 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 enrollment on file with ForwardHealth. The 271 response will report the provider ID that was indicated on the 270.

Topic #469

### 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 health insurance coverage
- | Exemption from copays for BadgerCare Plus members

Topic #259

### 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.

Topic #4903

## Copay Information

### No Copay

If a member is enrolled in BadgerCare Plus or Wisconsin Medicaid and is exempt from paying copays 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, Wisconsin Medicaid, or SeniorCare and is required to pay a copay, the provider 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.

### Copay

If a member is enrolled in BadgerCare Plus, Wisconsin Medicaid, or SeniorCare and is required to pay a copay, 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

## Non-Emergent Copay

If a member is enrolled in BadgerCare Plus and is eligible for the \$8 non-emergent copay, 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, Member Eligible for Non-Emergent Copay or Eligible for Non-Emergent Copay

The messages Member Eligible for Non-Emergent Copay and Eligible for Non-Emergent Copay indicate that a member is a BadgerCare Plus childless adult, and they are eligible for the copay if they do not meet the prudent layperson standard and seek and receive additional post-stabilization care in the emergency department after being informed of the \$8 copay and availability of alternative providers with lesser or no cost share.

Topic #264

## 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 their enrollment.

The EVS does not indicate other government programs that are secondary to Wisconsin Medicaid.

Topic #4901

## 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 copays (BadgerCare Plus and Medicaid members only).

To access enrollment verification via the ForwardHealth Portal, providers will need to do the following:

- 1 Go to the ForwardHealth Portal.
- 1 Establish a provider account.
- 1 Log into the secure Portal.
- 1 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.

Topic #4900

## 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 inquiries, 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:

- 1 The From DOS is the earliest date the provider requires enrollment information.
- 1 The To DOS must be within 365 days of the From DOS.
- 1 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.
- 1 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.

Topic #265

## 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 or displays a digital ForwardHealth Card on the MyACCESS app.

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.

Topic #4899

## 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 they are 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.

Topic #4898

## 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 BadgerCare Plus 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 Tuberculosis-Related Medicaid and Family Planning Only Services at the same time, both of which are administered by Medicaid.)

## Forms

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Topic #470

### 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:

- 1 Select a specific form.
- 1 Save the form to the computer.
- 1 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 website. 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 website](#) 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:

- 1 Select a specific form.
- 1 Save the form to the computer.
- 1 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.

Topic #766

### 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:

- 1 Requesting a paper copy of the form by calling [Provider Services](#). Questions about forms may also be directed to Provider Services.
- 1 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  
313 Blettner Blvd  
Madison WI 53784





## Updates

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Topic #478

### Accessing ForwardHealth Communications

[ForwardHealth Updates](#) announce changes in policy and coverage, PA requirements, and claim submission requirements. They communicate new initiatives from the Wisconsin Department of Health Services or new requirements from the federal Centers for Medicare and Medicaid Services and the Wisconsin state legislature.

Updates reflect current policy at the time of publication; this information may change over time and be revised by a subsequent Update. Update information is added to the Online Handbook after the Update is posted, unless otherwise noted.

Providers should refer to the [ForwardHealth Online Handbook](#) for current information. The Online Handbook is the source for current ForwardHealth policy and contains provider-specific information for various services and benefits.

Topic #4458

### Electronic Notifications from ForwardHealth

ForwardHealth sends electronic messaging using both email subscription and secure Portal messaging to notify providers of newly released ForwardHealth Updates. ForwardHealth also uses electronic messaging to communicate training opportunities and other timely information.

#### Secure Portal Messages

Providers who have established a secure ForwardHealth Portal account automatically receive messages from ForwardHealth in their secure Portal Messages inbox.

#### E-mail Subscription Messages

Providers and other interested parties may register to receive e-mail subscription notifications. When registering for email subscription, providers and other interested parties are able to select, by program (for example, Wisconsin Medicaid, BadgerCare Plus, HDAP, or WCDP), provider type (for example, physician, hospital, DME vendor), and/or specific area of interest, (Trading Partner and ICD-10 Project Information) to designate what information they would like to receive. Any number of staff or other interested parties from an organization may sign up for an email subscription and may select multiple subscription options.

#### Registering for Email Subscription

Users may sign up for an email subscription by following these steps:

1. Click the [Register for Email Subscription](#) link on the ForwardHealth Portal home page.
2. The Subscriptions page will be displayed. In the Email field in the New Subscriber section, enter the email address to which messages should be sent.
3. Enter the email address again in the Confirm Email field.
4. Click Register. A message will be displayed at the top of the Subscriptions page indicating the registration was successful.

If there are any problems with the registration, an error message will be displayed instead.

5. Once registration is complete, click the program for which you want to receive messages in the Available Subscriptions section of the Subscriptions page. The selected program will expand and a list of service areas will be displayed.
6. Select the service area(s) for which you want to receive messages. Click Select All if you want to receive messages for all service areas.
7. When service area selection is complete, click Save at the bottom of the page.

The selected subscriptions will load and a confirmation message will appear at the top of the page.

Topic #4460

## Full Text Publications Available

Providers without internet access may call [Provider Services](#) to request that a paper copy of a ForwardHealth Update be mailed to them. To expedite the call, correspondents will ask providers for the Update number. Providers should allow seven to 10 business days for delivery.

## Contact Information

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Topic #476

## Member Services

Providers should refer ForwardHealth members with questions to [Member Services](#). The telephone number for Member Services is for member use only.

Topic #473

## Professional Field Representatives

Professional field representatives, also known as 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.

The field representatives are assigned to [specific regions](#) of the state. Most professional field representatives can address inquiries for all provider types. However, certain dedicated professional field representatives are assigned to the following:

- | Adult long-term care
- | Dental providers
- | Milwaukee County
- | PNCC and CCC
- | WWWP

## 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 enrolled 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 ForwardHealth 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 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 (for example, phone or written)

correspondence)

- | Referrals by a Provider Services phone correspondent
- | Complex issues that require extensive explanation

At times, professional field representatives 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](#).

If contacting a field representative by email, providers should ensure that no individually identifiable health information, known as PHI, is included in the message. Discuss the appropriate method of sending emails with your assigned field representative to ensure secure transmission of information.

Providers or their representatives should have the following information ready when they contact their professional field representative:

- | Name or alternate contact
- | County and city where services are provided
- | Name of facility or provider whom they are representing
- | NPI or provider number
- | Phone 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:

- | Claim number
- | DOS

Topic #474

## 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 submission
- | Provider enrollment
- | Member enrollment
- | COB (for example, verifying a member's other health insurance coverage)
- | Assistance with completing forms
- | Assistance with remittance information and claim denials
- | Policy clarification
- | PA status

- ┆ Claim 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 ID
- ┆ Claim ICN
- ┆ PA number
- ┆ DOS
- ┆ Amount billed
- ┆ RA
- ┆ Procedure code of the service in question
- ┆ Reference to any provider publications that address the inquiry

## Call Center Representatives

The ForwardHealth call center representatives are organized to respond to phone calls from providers. Representatives offer assistance and answer inquiries specific to the program (for example, Medicaid, WCDP, or WWWP) or to the service area (for example, pharmacy services, hospital services) in which they are designated.

In addition to trained call center representatives, Provider Services employs an automated tool for assisting callers. The virtual agent is available 24 hours a day, seven days a week to answer questions that do not require a call center representative, such as inquiries related to:

- ┆ Claim status
- ┆ PA status
- ┆ Provider payment status
- ┆ Member enrollment verification

## Walk-in Appointments

Walk-in appointments offer face-to-face assistance for providers at the Provider Services office. Providers must schedule an appointment in advance by contacting Provider Services at 800-947-9627. Appointments for in-person provider assistance are available Monday through Friday, 7:30 a.m. – 4 p.m. (Central time), except for state-observed holidays. Providers without an appointment may not receive in-person assistance and may have to schedule an appointment for a later date.

## 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  
 313 Blettner Blvd  
 Madison WI 53784

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.

Topic #4456

## 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.

<b>ForwardHealth Portal</b>	<a href="http://www.forwardhealth.wi.gov/">www.forwardhealth.wi.gov/</a>	<b>24 hours a day, seven days a week</b>
Public and secure access to ForwardHealth information with direct link to contact Provider Services for up-to-date access to ForwardHealth programs information, including publications, fee schedules, and forms.		
<b>WiCall Automated Voice Response System</b>	<b>800-947-3544</b>	<b>24 hours a day, seven days a week</b>
WiCall, the ForwardHealth AVR system, provides responses to the following inquiries:		
<ul style="list-style-type: none"> <li>  Checkwrite</li> <li>  Claim status</li> <li>  PA</li> <li>  Member enrollment</li> </ul>		
<b>ForwardHealth Provider Services Call Center</b>	<b>800-947-9627</b>	<b>Call center representatives:</b> <b>Monday – Friday, 7 a.m. – 6 p.m.</b> <b>(Central time)*</b> <b>Virtual agent: 24 hours a day, seven days a week</b>
To assist providers in the following programs:		
<ul style="list-style-type: none"> <li>  BadgerCare Plus</li> <li>  Medicaid</li> <li>  SeniorCare</li> <li>  Family Care</li> <li>  Family Care Partnership</li> <li>  IRIS</li> <li>  PACE</li> <li>  HDAP</li> <li>  WCDP</li> <li>  Wisconsin Medicaid and BadgerCare Plus Managed Care Programs</li> <li>  Wisconsin Well Woman Medicaid</li> </ul>		

<ul style="list-style-type: none"> <li>WWW</li> </ul>		
<b>ForwardHealth Portal Helpdesk</b>	<b>866-908-1363</b>	<b>Monday – Friday, 8:30 a.m. – 4:30 p.m. (Central time)*</b>
To assist providers and trading partners with technical questions regarding Portal functions and capabilities, including Portal accounts, registrations, passwords, and submissions through the Portal.		
<b>Electronic Data Interchange Helpdesk</b>	<b>866-416-4979</b>	<b>Monday – Friday, 8:30 a.m. – 4:30 p.m. (Central time)*</b>
For providers, including trading partners, billing services, and clearinghouses with technical questions about the following:		
<ul style="list-style-type: none"> <li>Electronic transactions</li> <li>Companion documents</li> <li>PES software</li> </ul>		
<b>Managed Care Provider Appeals</b>	<b>800-760-0001, Option 1</b>	<b>Monday – Friday, 7 a.m. – 6 p.m. (Central time)*</b>
To assist BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP providers with questions regarding their appeal status and other general managed care provider appeal information.		
<b>Managed Care Ombudsman Program</b>	<b>800-760-0001</b>	<b>Monday – Friday, 7 a.m. – 6 p.m. (Central time)*</b>
To assist managed care enrollees with questions about enrollment, rights, responsibilities, and general managed care information.		
<b>Member Services</b>	<b>800-362-3002</b>	<b>Monday – Friday, 8 a.m. – 6 p.m. (Central time)*</b>
To assist ForwardHealth members, or persons calling on behalf of members, with program information and requirements, enrollment, finding enrolled providers, and resolving concerns.		
<b>Wisconsin HIV Drug Assistance Program</b>	<b>800-991-5532</b>	<b>Monday – Friday, 8 a.m. – 4:30 p.m. (Central time)*</b>
To assist HDAP providers and members, or persons calling on behalf of members, with program information and requirements, enrollment, finding enrolled providers, and resolving concerns.		

\*With the exception of state-observed holidays.

## Portal

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Topic #4743

# Acute and Primary Managed Care Portal

## Information and Functions Through the Portal

The [acute and primary managed care area](#) of the ForwardHealth Portal allows state-contracted HMOs to conduct business with ForwardHealth. The public HMO page offers easy access to key HMO information and web tools. A login is required to access the secure area of the Portal to submit or retrieve account and member information that may be sensitive.

The following information is available through the Portal:

- | Listing of all Medicaid-enrolled 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 codes and managed care and Medicare information
- | Provider search function for retrieving provider information such as the address, phone number, provider ID, taxonomy code (if applicable), and provider type and specialty
- | HealthCheck information
- | MCO contact information
- | Technical contact information (Entries may be added via the Portal.)

Topic #4904

# 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 ForwardHealth Portal. Providers have the ability to [search for and view](#) the status of all their finalized claims, regardless of how they were submitted (for example, 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.

Topic #8524

# Conducting Revalidation Via the ForwardHealth Portal

Providers can conduct [revalidation](#) online via a secure revalidation area of the ForwardHealth Portal.



Topic #4345

## 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 their PIN is received. The administrative user is responsible for this provider account and can add accounts for other users (clerks) within their 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 ForwardHealth 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. Enter a backup 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

Refer to the Account User Guide on the [User Guides](#) page of the Portal for more detailed instructions on performing these functions.

Topic #16737

## Demographic Maintenance Tool

The demographic maintenance tool allows providers to update information online that they are required to keep [current](#) with ForwardHealth. To access the demographic maintenance tool, providers need a ForwardHealth Portal account. After logging into their Portal account, providers should select the Demographic Maintenance link located in the Home Page box on the right side of the secure Provider home page.

Note: The Demographic Maintenance link will only display for administrative accounts or for clerk accounts that have been assigned the Demographic Maintenance role. The [Account User Guide](#) provides specific information about assigning roles.

The demographic maintenance tool contains general panels which are available to all or most providers as well as specific panels which are only available to certain provider types and specialties. The [Demographic Maintenance Tool User Guide](#) provides further information about general and provider-specific panels.

## Uploading Supporting Documentation

Providers can upload enrollment-related supporting documentation (for example, licenses, certifications) using the demographic maintenance tool. Documents in the following formats can be uploaded:

- ┆ JPEG (.jpg or .jpeg)
- ┆ PDF (.pdf)

To avoid delays in processing, ForwardHealth strongly encourages providers to upload their documents.

## Submitting Information

After making **all** their changes, providers are required to submit their information in order to save it. After submitting information, providers will receive one of the following messages:

- ┆ Your information was **updated** successfully. This message indicates that providers' files were immediately updated with the changed information.
- ┆ Your information was **uploaded** successfully. This message indicates that ForwardHealth needs to verify the information before providers' files can be updated. Additionally, an Application Submitted panel will display and indicate next steps.

## Verification

ForwardHealth will verify changes within 10 business days of submission. If the changes can be verified, ForwardHealth will update providers' files. In some cases, providers may receive a Change Notification letter indicating what information ForwardHealth updated. Providers should carefully review the Provider File Information Change Summary included with the letter to verify the accuracy of the changes. If any of the changes are inaccurate, providers can correct the information using the demographic maintenance tool. Providers may contact [Provider Services](#) if they have questions regarding the letter.

Regardless of whether or not providers are notified that their provider files were updated, changed information is not considered approved until 10 business days after the information was changed. If the changes cannot be verified within 10 business days, ForwardHealth will notify providers by mail that their provider files were not updated, and providers will need to make corrections using the demographic maintenance tool.

Topic #4340

## 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:

1. Access the Portal and log into their secure account by clicking the Provider link/button.
2. Click on the Designate 835 Receiver link on the right-hand side of the secure home page.
3. Enter the identification number of the trading partner that is to receive the 835 in the Trading Partner ID field.
4. 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.

Topic #5088

## Enrollment Verification

The secure ForwardHealth 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
- | Whether or not the member is enrolled in the [Pharmacy Services Lock-In Program](#) and the member's Lock-In pharmacy, primary care provider, and referral providers (if applicable)

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.

Topic #4338

## 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](#).

Topic #4441

## 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.

Topic #4451

## 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 (for example, telephone call or email). Provider Services will respond to the inquiry by the preferred method of response indicated within five business days.

Topic #4400

## 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.

Topic #4351

## Logging in to the Provider Area of the Portal

Once an administrative user's or other user's account is set up, they may log in to the Provider area of the ForwardHealth Portal to conduct business. To log in, the user is required to click the Provider link or button, then enter their username and password and click Go in the Login to Secure Site box at the right side of the screen.

If a user has forgotten their username, they can recover their username by choosing from the following options:

- | Ask the Portal Helpdesk to do one of the following:
  - | Send the Portal account username to the email account on record.
  - | Verify the request with the designated account backup.
- | Ask the Portal Helpdesk to remove the Portal account's current credentials and create a new account.

Topic #5158

## 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.

Topic #4744

## 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.

Topic #4344

## Obtaining a Personal Identification Number

To establish an account on the ForwardHealth 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.

Note: The PIN used to create the provider's Portal account is not the same PIN used for revalidation. Providers will receive a separate PIN for revalidation.

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 enrollment. A separate PIN will be needed for each provider enrollment. 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 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 enrollments. Select the correct enrollment for the account. The taxonomy code, ZIP+4 code, and financial payer for that enrollment 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 SeniorCare.)
- | SSI
- | WCDP
- | WWP

- 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.

Topic #4459

## Online Handbook

The Online Handbook gives providers access to all policy and billing information for Wisconsin Medicaid, BadgerCare Plus, HDAP, and WCDP. A secure ForwardHealth Portal account is not required to use the Online Handbook, as it is available to all Portal visitors.

Revisions to Online Handbook information are incorporated after policy changes have been issued in ForwardHealth Updates, typically on the policy effective date. The Online Handbook also links to the [Communication Home](#) page, which takes users to ForwardHealth Updates, user guides, and other communication pages.

The Online Handbook is designed to sort information based on user-entered criteria, such as program and provider type. It is organized into sections, chapters, and topics. Sections within each handbook may include the following:

- | Claims
- | Coordination of Benefits
- | Covered and Noncovered Services
- | Managed Care
- | Member Information
- | Prior Authorization
- | Provider Enrollment and Ongoing Responsibilities
- | Reimbursement
- | Resources

Each section consists of separate chapters (for example, claims submission, procedure codes), which contain further detailed information in individual topics.

## Search Function

The Online Handbook has a search function that allows providers to search for a specific word, phrase, or topic number within a user type, program, service area, or throughout the entire Online Handbook.

Providers can access the search function by following these steps:

1. Go to the Portal.
2. Click **Online Handbooks** under the Policy and Communication heading.
3. Complete the two drop-down selections at the left to narrow the search by program and service area, if applicable. This is not needed if searching the entire Online Handbook.
4. Enter the word, phrase, or topic number you would like to search.
5. Select **Search within the options selected above** or **Search all handbooks, programs and service areas; or Search**

by **Topic Number**.

6. Click **Search**.

## Saving Preferences

Providers can select Save Preferences when performing a search (by service area, section, chapter, topic number) and will receive confirmation that their preferences have been saved. This will save the program (for example, BadgerCare Plus and Medicaid) and service area (for example, Anesthesiologist) combinations that are selected from the drop-down menus. The next time the provider accesses the Online Handbook, they will be taken to their default preferences page. The provider can also click the Preferences Home link, which returns the provider to the saved area of the Online Handbook with their default preferences.

## ForwardHealth Publications Archive Area

The Handbook Archives page allows providers to view 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 **Communication Home** link under the Policy and Communication heading.
3. Click the **Online Handbooks** link on the left sidebar menu.
4. Click on the **ForwardHealth Handbook Archives** link at the bottom of the page.

Topic #5089

## Other Business Enhancements Available on the Portal

The secure Provider area of the ForwardHealth Portal enables providers to do the following:

- | Verify member enrollment.
- | View RAs.
- | Designate which trading partner is eligible to receive the provider's 835.
- | Update and maintain provider file information. Providers have the choice to indicate separate addresses for different business functions.
- | Receive electronic notifications and provider publications from ForwardHealth.
- | Enroll in EFT.
- | Track provider-submitted PA requests.

Topic #4911

## 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, they have complete access to all functions within the specific secure area of their Portal and are permitted to add, remove, and manage other individual roles.

### **Add Backup Contact Information for Provider Administrator Accounts**

Provider administrators must set up a backup contact for their Portal accounts to ensure that requests and changes can be verified as legitimate. Provider administrators will not be able to use the same contact information for both the administrator account and the backup contact.

Topic #4912

## **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 ForwardHealth 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.

Topic #4913

## **Portal Clerks**

The administrator (or the clerk administrator if the administrator has granted them authorization) may set up clerks within their ForwardHealth Portal account. Clerks may be assigned one or many roles (for example, claims, PA, member 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 (for example, different ForwardHealth enrollments). 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 (for



example, they may do member enrollment verification for one Portal account and HealthCheck inquires for another).

Topic #4740

## 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 assist in daily business activities with ForwardHealth programs.

### Interactive Maximum Allowable Fee Schedule

Within the Portal, are [maximum allowable fee schedules](#) for most services. Providers can search the interactive maximum allowable fee schedule by a single procedure code, multiple codes, a code range, or by a service area to find the maximum allowable fee. Through the interactive fee schedule, providers also can export their search results for a single code, multiple codes, a code range, or by service area. The downloadable fee schedules, which are updated monthly, are downloadable only by service area as TXT or CSV files.

### ForwardHealth Communications

[ForwardHealth Updates](#) announce changes in policy and coverage, PA requirements, and claim submission requirements. They communicate new initiatives from the Wisconsin DHS or new requirements from the federal CMS and the Wisconsin state legislature.

Updates reflect current policy at the time of publication; this information may change over time and be revised by a subsequent Update. Update information is added to the ForwardHealth Online Handbook after the Update is posted, unless otherwise noted.

Providers should refer to the Online Handbook for current information. The Online Handbook is the source for current ForwardHealth policy and contains provider-specific information for various services and benefits.

### Trainings

Providers can register for all scheduled trainings and view online trainings via the [Trainings](#) 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 (for example, a phone call or email) 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 Enrollment

Providers can speed up the enrollment process for Medicaid by completing a [provider enrollment application](#) via the Portal. Providers can then track their application by entering their ATN given to them on completion of the application.

### Other Resources 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 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.)
- | [Email subscription](#) service for Updates. (Providers can register for email subscription to receive notifications of new provider publications via email. Users are able to select, by program and service area, which publication notifications they would like to receive.)
- | A [forms library](#).

Topic #4741

## 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 can search for and view the status of all of their finalized claims, regardless of how they were submitted (for example, 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 PA and Amendment Requests Via the Portal

Nearly all service areas can submit PA requests via the Portal. Providers can do the following:

- | Correct errors on PA or amendment requests via the Portal, regardless of how the PA request was originally submitted.
- | View all recently submitted and finalized PA and amendment requests.
- | Save a partially completed PA request and finish completing it at a later time. (Note: providers are required to submit or re-save a PA request within 30 calendar days of the date the PA request was last saved.)
- | View all saved PA requests and select any to continue completing or delete.
- | 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 two-way message center where providers can send and receive electronic notifications as well as receive links to ForwardHealth provider publications. Providers will be able to send secure messages to select Wisconsin DHS groups/staff by selecting a recipient from a drop-down menu; options in the drop-down menu will differ based on the provider's security role. All new messages will be displayed on the provider's secure Portal messages inbox.

Providers can sign up to receive notifications about the availability of new ForwardHealth messages through email, text, or both. After signing up, the user will receive a verification email to register their device. Once registered, providers will receive notifications by the requested method(s).

### 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 other health insurance, 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 enables providers to do the following:

- ┆ Verify member enrollment.
- ┆ View RAs.
- ┆ Designate which trading partner is eligible to receive the provider's 835 transaction.
- ┆ Update and maintain provider file information; providers will have the choice to indicate separate addresses for different business functions.
- ┆ Receive electronic notifications and provider publications from ForwardHealth.
- ┆ Enroll in EFT.
- ┆ Track provider-submitted PA requests.

Topic #4401

## System and Browser Requirements

The following table lists the recommended system and browser requirements for using the ForwardHealth 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	Chrome v. 73 or higher, Edge v. 19 or higher, Firefox v. 38 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	Chrome v. 73 or higher, Edge v. 19 or higher, Safari v. 14 or higher, Firefox v. 38 or higher
Mac OS X 10.2 or higher operating system	

Topic #4742

## Trading Partner Portal

The following information is available on the public [Trading Partners](#) area of the ForwardHealth Portal:

- ┆ Trading partner [testing packets](#)

- | [Trading partner profile](#) submission
- | [PES](#) software and upgrade information
- | EDI [companion guides](#)

In the secure Trading Partners area of the Portal, trading partners can exchange electronic transactions with ForwardHealth.

Trading partners using PES should be sure to enter the web logon and web password associated with the ForwardHealth Trading Partner ID that will be used on PES transactions. Prior to submitting transactions through PES, trading partners must also make sure their trading partner account is entered as the Default Provider ID on the Switch Organization page of the secure trading partner account on the Portal.

# Training Opportunities

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Topic #12757

## Training Opportunities

The [Provider Relations representatives](#) conduct training sessions in a variety of formats on both program-specific and topic-specific subjects. There is no fee for attending/accessing these training sessions.

### On-Site Sessions

On-site training sessions are offered at various locations (for example, hotel conference rooms, provider facilities) throughout the state. These training sessions include general all-provider sessions, service-specific and/or topic-specific sessions, and program-specific (such as WCDP or the WWWP) sessions.

Registration is required to attend on-site sessions. Online registration is available on the [Trainings](#) page of the Providers area of the Portal.

### Online (Real-Time, Web-Based) Sessions

Online (real-time, web-based) training sessions are available and are facilitated through [HPE MyRoom](#). MyRoom sessions are offered on many of the same topics as on-site sessions, but online sessions offer the following advantages:

- | Participants can attend training at their own computers without leaving the office.
- | Sessions are interactive as participants can ask questions during the session.
- | If requested or needed, a session can be quickly organized to cover a specific topic for a small group or office.

For some larger training topics (such as ForwardHealth Portal Fundamentals), the training may be divided into individual modules, with each module focused on a particular subject. This allows participants to customize their training experience.

Registration, including an email address, is required to attend Virtual Room sessions, so important session information can be sent to participants prior to the start of the session. Online registration is available on the [Trainings](#) page of the Portal.

### Recorded Webcasts

Recorded Webcasts are available on a variety of topics, including some of the same topics as on-site and online sessions. Like Virtual Room sessions, some recorded Webcasts on larger training topics may be divided into individual Webcast modules, allowing participants to customize their training experience. Recorded Webcasts allow providers to view the training at their convenience on their own computers.

Registration is not required to view a recorded Webcast. Related training materials are available to download and print from the specific [webcast training session](#) page on the Portal.

### Notification of Training Opportunities

In addition to information on the Trainings page of the Portal, upcoming training session information is distributed directly through messages to providers who have secure Portal accounts and to providers who have registered for the ForwardHealth email subscription service.

To sign up for a secure Portal account, click the Request Portal Access link in the Quick Links box on the [Provider](#) page of the Portal. To sign up for email subscription, click Register for Email Subscription in the Quick Links box on the Provider page of the Portal.

# Managed Care

# 9

Archive Date:08/01/2025

## Managed Care:Managed Care Information

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Topic #16177

### Care4Kids Program Overview

Care4Kids is a health care program for children and youth in out-of-home care in Wisconsin. The Care4Kids program will offer comprehensive, coordinated services that are intended to improve the quality and timeliness of and access to health services for these children.

The Care4Kids program will serve children in out-of-home care placements (other than residential care centers) in Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha counties. Member participation will be voluntary, and enrollment will be allowed to continue for up to 12 months after the child leaves the out-of-home care system, as long as the child remains Medicaid-eligible and resides within one of the six counties.

Care4Kids is required to provide at least the same benefits as those provided under fee-for-service arrangements.

### Program Administration

Children's Hospital of Wisconsin is currently the only integrated health system certified by ForwardHealth to administer the Care4Kids program. Children's Hospital of Wisconsin will be responsible for providing or arranging for the provision of all services covered under Medicaid, with a small number of exceptions. The services not included in the Care4Kids program will be reimbursed as fee-for-service benefits. Children's Hospital of Wisconsin's integrated network of health care providers, which includes specialty and primary care physicians and clinics within the Children's Hospital System as well as providers who are participating in CCHP, is intended to provide coordinated care and services to meet the individualized needs of each of the children enrolled across multiple disciplines, including physical, behavioral health, and dental care.

Care4Kids will be responsible for providing or arranging for the provision of all medically necessary [services covered](#) by Wisconsin Medicaid to enrollees. Providers are required to be part of the CCHP network to get reimbursed by Care4Kids. Providers interested in being a part of the network should contact CCHP. Out-of-network providers are required to call Care4Kids prior to providing services to a Care4Kids enrollee. In situations where emergency medical services are needed, out-of-network providers are required to contact Care4Kids within 24 hours of providing services.

### Member Enrollment Verification

Providers should [verify a member's enrollment](#) before providing services to determine if the member is enrolled in Care4Kids. Members enrolled in Care4Kids will present a ForwardHealth member identification card.

Providers verifying enrollment on the ForwardHealth Portal will see Care4Kids under the MC Program heading in the Managed Care Enrollment panel.

For 271 response transactions, Care4Kids enrollment will be identified in the EB segment of the 2110C loop. Identified by MC in the EB01, HM in the EB04, and Care4Kids in the EB05. The MC provider contact information will be reported in the NM1 (name info), N3 (address info), and PER (telephone numbers) segments within the 2120C loop.

The WiCall AVR system will identify Care4Kids as the state-contracted managed care program in which the member is enrolled.

### Contact Information



Providers can contact CCHP at 800-482-8010 for the following:

- | To become part of the CCHP network
- | For coverage policy and procedure information, including PA and claim submission guidelines, if they are already a Care4Kids network provider

## Covered and Noncovered Services

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Topic #16197

### Care4Kids Program Benefit Package

#### Covered Services

Members enrolled in the [Care4Kids program](#) are eligible to receive all medically necessary services covered under Wisconsin Medicaid; however, Care4Kids will have the flexibility to provide services in a manner that best meets the unique needs of children in out-of-home care, including streamlining PA requirements and offering select services in home settings. Members will also be allowed to go to any Medicaid-enrolled provider for emergency medical services or family planning services.

#### Noncovered Services

The following services are not provided as covered benefits through the Care4Kids program, but can be reimbursed for eligible Medicaid members on a fee-for-service basis:

- | Behavioral treatment
- | Chiropractic services
- | CRS
- | CSP
- | CCS
- | Crisis intervention services
- | Directly observed therapy for individuals with tuberculosis
- | MTM
- | NEMT services
- | Prescription and over-the-counter drugs and diabetic supplies dispensed by the pharmacy
- | [Physician-administered drugs](#) and their administration, and the administration of [Synagis](#)
- | SBS
- | Targeted case management

Children's Hospital of Wisconsin will establish working relationships, defined in writing through a memorandum of understanding, with providers of the following services:

- | CSP
- | CCS
- | Crisis intervention services
- | SBS
- | Targeted case management services

Providers of these services must coordinate with Care4Kids to help assure continuity of care, eliminate duplication, and reduce fragmentation of services.