

Provider Enrollment and Ongoing Responsibilities

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Provider Enrollment and Ongoing Responsibilities:Provider Enrollment

Topic #899

CLIA Certification or Waiver

Congress implemented CLIA (Clinical Laboratory Improvement Amendment) to improve the quality and safety of laboratory services. CLIA requires **all** laboratories and providers that perform tests (including waived tests) for health assessment or for the diagnosis, prevention, or treatment of disease or health impairment to comply with specific federal quality standards. This requirement applies even if only a single test is being performed.

CLIA Enrollment

The federal CMS (Centers for Medicare and Medicaid Services) sends CLIA enrollment information to ForwardHealth. The enrollment information includes CLIA identification numbers for all current laboratory sites. ForwardHealth verifies that laboratories are CLIA certified before Medicaid grants enrollment.

CLIA Regulations

ForwardHealth complies with the following federal regulations as initially published and subsequently updated:

- | Public Health Service Clinical Laboratory Improvement Amendments of 1988
- | Title 42 CFR Part 493, Laboratory Requirements

Scope of CLIA

CLIA governs all laboratory operations including the following:

- | Accreditation
- | Certification
- | Fees
- | Patient test management
- | Personnel qualifications
- | Proficiency testing
- | Quality assurance.
- | Quality control
- | Records and information systems
- | Sanctions
- | Test methods, equipment, instrumentation, reagents, materials, supplies
- | Tests performed

CLIA regulations apply to **all** providers who perform CLIA-monitored laboratory services, including, but not limited to, the following:

- | Clinics
- | HealthCheck providers
- | Independent clinical laboratories

- | Nurse midwives
- | Nurse practitioners
- | Osteopaths
- | Physician assistants
- | Physicians
- | Rural health clinics

CLIA Certification Types

The CMS regulations require providers to have a CLIA certificate that indicates the laboratory is qualified to perform a category of tests.

Clinics or groups with a single group billing certification, but multiple CLIA numbers for different laboratories, may wish to contact [Provider Services](#) to discuss various certification options. There are five types of CLIA certificates as defined by CMS:

1. **Certificate of Waiver.** This certificate is issued to a laboratory to perform only waived tests. The CMS website identifies the most current list of [waived procedures](#). BadgerCare Plus identifies allowable waived procedures in [maximum allowable fee schedules](#).
2. **Certificate for Provider-Performed Microscopy Procedures (PPMP).** This certificate is issued to a laboratory in which a physician, mid-level practitioner, or dentist performs no tests other than the microscopy procedures. This certificate permits the laboratory to also perform waived tests. The CMS website identifies the most current list of [CLIA-allowable provider-performed microscopy procedures](#). BadgerCare Plus identifies allowable provider-performed microscopy procedures in fee schedules.
3. **Certificate of Registration.** This certificate is issued to a laboratory and enables the entity to conduct moderate- or high-complexity laboratory testing, or both, until the entity is determined by survey to be in compliance with CLIA regulations.
4. **Certificate of Compliance.** This certificate is issued to a laboratory after an inspection that finds the laboratory to be in compliance with all applicable CLIA requirements.
5. **Certificate of Accreditation.** This is a certificate that is issued to a laboratory on the basis of the laboratory's accreditation by an accreditation organization approved by CMS. The six major approved accreditation organizations are:
 - | The Joint Commission
 - | CAP (College of American Pathologists)
 - | COLA
 - | American Osteopathic Association
 - | American Association of Blood Banks
 - | ASHI (American Society of Histocompatibility and Immunogenetics)

Applying for CLIA Certification

Use the CMS 116 CLIA application to apply for program certificates. Providers may obtain CMS 116 forms from the [CMS website](#) or from the following address:

Division of Quality Assurance
 Clinical Laboratory Section
 1 W Wilson St
 PO Box 2969
 Madison WI 53701-2969

Providers Required to Report Changes

Providers are required to notify Provider Enrollment within 30 days of any change(s) in ownership, name, location, or director. Also, providers are required to notify Provider Enrollment of changes in CLIA certificate types immediately and within six months when a specialty/subspecialty is added or deleted.

Providers may notify Provider Enrollment of changes by uploading supporting documentation using the [demographic maintenance tool](#) or by mailing supporting documentation to the following address:

Wisconsin Medicaid
 Provider Enrollment
 313 Blettner Blvd
 Madison WI 53784

If a provider has a new certificate type to add to its certification information on file with ForwardHealth, the provider should upload or mail a copy of the new certificate. When a provider sends ForwardHealth a copy of a new CLIA certificate, the effective date on the certificate will become the effective date for CLIA certification on file with ForwardHealth.

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 the following:

- ┆ Billing/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/Rendering Provider

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

Rendering-Only Provider

Enrollment as a rendering-only provider is given to those providers who practice under the professional supervision of another provider (e.g., physician assistants). Providers with a rendering provider enrollment cannot submit claims to ForwardHealth directly, but 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)

Enrollment as a billing-only provider is given to certain provider types when a separate rendering provider is required on 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 (Remittance Advice), and the 835 (835 Health Care Claim Payment/Advice) 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 (National Provider Identifier), 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 (Affordable Care Act), also known as federal health care reform, which affects several aspects of Wisconsin health care. ForwardHealth has been working toward ACA compliance by implementing some [new requirements for providers and provider screening processes](#). To meet federally mandated requirements, ForwardHealth is implementing 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 (Centers for Medicare and Medicaid Services) 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, reenrollment, 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](#) 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 #194

In-State Emergency Providers and Out-of-State Providers

ForwardHealth requires all in-state emergency providers and out-of-state providers who render services to BadgerCare Plus, Medicaid, or SeniorCare members to be [enrolled](#) in Wisconsin Medicaid. Information is available regarding the enrollment options for [in-state emergency providers](#) and [out-of-state providers](#).

In-state emergency providers and out-of-state providers who dispense covered outpatient drugs will be assigned a [professional dispensing fee](#) reimbursement rate of \$10.51.

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

ADAP (Wisconsin AIDS Drug Assistance Program) information. Future changes to policies and procedures are published in [ForwardHealth Updates](#).

Topic #17237

Professional Type Crosswalk for the Comprehensive Community Services Benefit

The table below provides a crosswalk for professional types in Wis. Admin. Code ch. [DHS \(Department of Health Services\) 36](#) to the standardized professional type that should be used for billing CCS (Comprehensive Community Services). Providers should refer to Wis. Admin. Code § [DHS 36.10\(2\)\(g\)](#) for additional guidance regarding required experience, licenses, and fields in which degrees should be earned to qualify under each CCS professional type.

Professional Type Specified in Wis. Admin. Code § DHS 36.10(2)(g)1-22	Standardized Professional Type
1. Psychiatrists	M.D.
2. Physicians	M.D.
3. Psychiatric residents	M.D.
4. Psychologists	Ph.D.
5. Licensed clinical social workers*	Masters
6. Licensed professional counselors and licensed marriage and family therapists*	Masters or Ph.D.
7. Adult psychiatric and mental health nurse practitioners	Masters
8. APNPs (advanced practice nurse prescribers)	APNP
9. Certified social workers, certified advance practice social workers, and certified independent social workers	Masters (includes Type II QTT (qualified treatment trainee)s)
10. Psychology residents	Ph.D.
11. Physician assistants	APNP
12. RNs (registered nurses)	RN
13. Occupational therapists	Bachelors, Masters, or Ph.D.
14. Master's level clinicians	Masters
15. Other professionals	Bachelors, Masters, or Ph.D.
16. Alcohol and drug abuse counselors**	Associate Degree, Bachelors, or Masters
17. Specialists in specific areas of therapeutic assistance, such as recreational and music therapists	Associate Degree, Bachelors, or Masters
18. COTAs (certified occupational therapy assistants)	Associate Degree
19. LPNs (licensed practical nurses)	Associate Degree
20. Certified peer specialists*	Certified Peer Specialist
21. Rehabilitation workers	Rehabilitation Worker
22. Clinical students	Type I QTT

* This professional type description has been updated from what appears in Wis. Admin. Code § DHS 36.10(2)(g). Wis. Admin. Code. § DHS 36.10(2)(g) describes "licensed clinical social workers" as "licensed independent clinical social workers," "licensed

professional counselors and licensed marriage and family therapists" as "professional counselors and marriage and family therapists," and "certified peer specialists" as "peer specialists." The professional type descriptions have been updated in this table to align with the current descriptions used in practice.

** Substance abuse counselors, certified substance abuse counselors, substance abuse counselors in training, and individuals that meet the requirement of [MPSW \(Marriage & Family Therapy, Professional Counseling & Social Worker\) 1.09](#) are considered part of Wis. Admin. Code § [DHS 36.10\(2\)\(g\)16](#).

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 (prior authorization) 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 #14317

Terminology to Know for Provider Enrollment

Due to the ACA (Affordable Care Act), ForwardHealth has adopted new terminology. The following table includes new terminology that will be 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.

New Terminology	Definition
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: ┆ 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) ┆ Any Medicare intermediary or carrier

	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
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: - Has an ownership interest totaling five percent or more in a disclosing entity - Has an indirect ownership interest equal to five percent or more in a disclosing entity - Has a combination of direct and indirect ownership interest equal to five percent or more in a disclosing entity - Owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or asset of the disclosing entity - Is an officer or director of a disclosing entity that is organized as a corporation - Is a person in a disclosing entity that is organized as a partnership
Subcontractor	- 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, - 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.
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 (Centers for Medicare and Medicaid Services) requires revalidation at least every five years. However, Wisconsin Medicaid will continue to revalidate providers every three years.

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:

- | 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.
- | 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 (National Provider Identifier) 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 \(Division of Quality Assurance\)](#) certification with current provider information before submitting a Medicaid enrollment change in ownership:

- | Ambulatory surgery centers
- | CHCs (Community Health Centers)
- | ESRD (End Stage Renal Disease) services providers
- | Home health agencies
- | Hospice providers
- | Hospitals (inpatient and outpatient)
- | Nursing homes
- | Outpatient rehabilitation facilities
- | Rehabilitation agencies
- | RHCs (Rural Health Clinics)
- | Tribal FQHCs (Federally Qualified Health Centers)

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:

- ı Sole proprietorships
 - ı Corporations
 - ı Partnerships
 - ı Limited Liability Companies
- ı Change of name and TIN (Tax Identification Number) associated with the provider's submitted enrollment application (for example, EIN (Employer Identification Number))
- ı 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:

- ı A sole proprietorship transfers title and property to another party.
- ı Two or more corporate clinics or centers consolidate, and a new corporate entity is created.
- ı There is an addition, removal, or substitution of a partner in a partnership.
- ı An incorporated entity merges with another incorporated entity.
- ı 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 (Department of Health Services) 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 (Dates of Service) 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 (Prior Authorization) 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](#).

Ongoing Responsibilities

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 (Americans With Disabilities Act) 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 (limited English proficient) 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 percent or 1,000, whichever is smaller, in the provider's area of service delivery

Note: Limiting practice by age is not age discrimination and specializing in certain conditions is not disability discrimination. For further information, see 45 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 (Department of Health Services) [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 (i.e., to the extent that needed changes can be accomplished without much difficulty or expense)
2. Provide auxiliary aids and services so that people with sensory or cognitive disabilities have access to effective means of communication, unless doing so would fundamentally alter the operation or result in undue burdens
3. Modify any policies, practices, or procedures that may be discriminatory or have a discriminatory effect, unless doing so would fundamentally alter the nature of the goods, services, facilities, or accommodations
4. Ensure that there are no unnecessary eligibility criteria that tend to screen out or segregate individuals with disabilities or limit their full and equal enjoyment of the place of public accommodation

Age Discrimination Act of 1975

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

Topic #198

Contracted Staff

Under a few circumstances (e.g., 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 (prior authorization) 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 (i.e., 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 (prior authorization), and/or financial

Note: Health care providers who are federally required to have an NPI (National Provider Identifier) 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 (Internal Revenue Service) 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 (e.g., Wisconsin Medicaid and WCDP (Wisconsin Chronic Disease Program)) 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 (Division of Quality Assurance) are required to notify the DQA of changes to physical address, changes of ownership, and facility closures by emailing 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 (Department of Health Services). Within DHS, DMS (Division of Medicaid Services) is directly responsible for managing these programs.

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 (e.g., 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 (prior authorization) 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 (e.g., 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 (e.g., 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 (Affordable Care Act) requires states to establish an RAC (Recovery Audit Contractor) 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 (Department of Health Services) has awarded the contract to HMS (Health Management Systems, Inc.) as the RAC for the state of Wisconsin.

Note: The RAC will not audit claims submitted for Family Planning Only Services, SeniorCare, WCDP (Wisconsin Chronic Disease Program), the WWWP (Wisconsin Well Woman Program), and ADAP (Wisconsin AIDS Drug Assistance Program).

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 (Department of Health Services) OIG (Office of Inspector General) 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 (Special Supplemental Nutrition Program for Women, Infants, and Children), 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

Topic #6277

1099 Miscellaneous Forms

ForwardHealth generates the 1099 Miscellaneous form in January of each year for earnings greater than \$600.00, per IRS (Internal Revenue Service) regulations. One 1099 Miscellaneous form per financial payer and per tax identification number is generated, regardless of how many provider IDs or NPIs (National Provider Identifier) share the same tax identification number. For example, a provider who conducts business with both Medicaid and WCDP (Wisconsin Chronic Disease Program) 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

The Wisconsin DHS (Department of Health Services) has the right to inspect, review, audit, and reproduce provider records pursuant to Wis. Admin. Code § [DHS 106.02\(9\)\(e\)](#). The DHS periodically requests provider records for compliance audits to match information against ForwardHealth's information on paid claims, PA (prior authorization) 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).

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

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

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

The reproduction of records requested by the PRO (Peer Review Organization) under contract with the 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 (Health Insurance Portability and Accountability Act of 1996) Privacy and Security regulations establish requirements regarding the confidentiality and proper disposal of health care and related records containing PHI (protected health information). 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 (Health Information Technology for Economic and Clinical Health) 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 (Department of Health and Human Services). 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 (i.e., 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 \(National Institute of Standards and Technology\) website](https://www.nist.gov/publications/800-88-guidelines-for-media-sanitization).

For more information regarding securing PHI, providers may refer to [Health Information Privacy](https://www.hhs.gov/hipaa/for-professionals/privacy/index) 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 #3727

Documentation Time

Wisconsin Medicaid reimburses the provision of services. Documenting the services provided is part of the provision of services.

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 \(Department of Health Services\) 106.02\(9\)\(b\)](#), a provider is required to include certain written documentation in a member's medical record.

Topic #3730

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

- ┆ Providers are required to have a paper or electronic back-up system for electronic medical records.
- ┆ Mental health and substance abuse service providers are required to have safeguards to prevent unauthorized access to the records (refer to [Confidentiality and Proper Disposal of Records](#) for more information).

Mental Health and Substance Abuse Services Documentation Requirements

Providers are responsible for meeting ForwardHealth's medical and financial documentation requirements. Refer to Wis. Admin. Code § [DHS 106.02\(9\)\(a\)](#) for preparation and maintenance documentation requirements and § [DHS 106.02\(9\)\(c\)](#) for financial record documentation requirements. The documentation must accurately reflect the services rendered and support the level of service submitted on the claim.

The following are the medical record documentation requirements (Wis. Admin. Code § DHS 106.02[9][b]) as they apply to all mental health and substance abuse services. In each element, the applicable administrative code language is in parentheses. Providers are required to maintain the following written documentation in the member's medical record, as applicable:

1. Date, department or office of the provider (as applicable), and provider name and profession
2. Presenting problem (chief medical complaint or purpose of the service or services)
3. Assessments (clinical findings, studies ordered, or diagnosis or medical impression)
 - a. Intake note signed by the therapist (clinical findings)
 - b. Information about past treatment, such as where it occurred, for how long, and by whom (clinical findings)
 - c. Mental status exam, including mood and affect, thought processes — principally orientation X3, dangerousness to others and self, and behavioral and motor observations. Other information that may be essential depending on presenting symptoms includes thought processes other than orientation X3, attitude, judgment, memory, speech, thought content, perception, intellectual functioning, and general appearance (clinical findings and/or diagnosis or medical impression)
 - d. Biopsychosocial history, which may include, depending on the situation, educational or vocational history, developmental history, medical history, significant past events, religious history, substance abuse history, past mental health treatment, criminal and legal history, significant past relationships and prominent influences, behavioral history, financial history, and overall life adjustment (clinical findings)
 - e. Psychological, neuropsychological, functional, cognitive, behavioral, and/or developmental testing as indicated (studies ordered)
 - f. Current status, including mental status, current living arrangements and social relationships, support system, current ADL (activities of daily living), current prescribed medications, current and recent substance abuse usage, current personal strengths, current vocational and educational status, and current religious attendance (clinical findings)
 - g. Substance abuse assessments are required to include documentation of nationally approved screening assessment to assure the appropriate level of care (e.g., the ASAM (American Society for Addiction Medicine) placement criteria)
4. Treatment plans, including treatment goals that are expressed in functional terms that provide measurable indices of performance, planned intervention, mechanics of intervention (frequency, duration, responsible party[ies]) (disposition, recommendations, and instructions given to the member, including any prescriptions and plans of care or treatment provided)
5. Progress notes (therapies or other treatments administered) must provide data relative to accomplishment of the treatment goals in measurable terms. Progress notes must also document significant events that are related to the person's treatment plan and assessments and that contribute to an overall understanding of the person's ongoing level and quality of functioning

Topic #17197

Comprehensive Community Services Documentation Requirements

CCS (Comprehensive Community Services) providers must maintain documentation in accordance with Wis. Admin. Code §§ [DHS 36.18](#) and [DHS 106](#) and other applicable laws and rules. The provider must be able to produce documentation upon request from the Wisconsin DHS, single audit firms, or federal auditors.

To support interim claims, providers should indicate whether the service provided was a face-to-face service and also the service length.

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 (dates of service) 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 percent of the applicable fees for providing one set of copies of the member's health care records.

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

The Wisconsin DHS (Department of Health Services) 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. Stats. § [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 (Health Insurance Portability and Accountability Act of 1996) Privacy Rule guidelines.

General Requirements

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

- ┆ 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 (e.g., what number is assigned to a specific rendering provider). This documentation must be kept confidential.
- ┆ The provider is required to have current policies and procedures regarding the use of electronic signatures. The Wisconsin DHS (Department of Health Services) 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.
- ┆ The provider is required to conduct or review a security risk analysis in accordance with the requirements under 45 CFR s. 164.308(a)(1).
- ┆ The provider is required to implement security updates as necessary and correct identified security deficiencies as part of its risk management process.
- ┆ 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 (electronic health record) that utilizes electronic signatures must meet the following requirements:

- ┆ 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 CFR Part 170) and any revisions including, but not limited to, the following:
 - ┆ 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.
 - ┆ Record actions related to electronic health information according to the standard set forth in 45 CFR s. 170.210.
 - ┆ 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 CFR s. 170.210.
 - ┆ Verify that a person or entity seeking access to electronic health information is the one claimed and is authorized to access such information.
 - ┆ 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.
 - ┆ Use a hashing algorithm with a security strength equal to or greater than SHA-1 (Secure Hash Algorithm 1) as specified by the NIST (National Institute of Standards and Technology) 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 (Information Technology) and/or security/privacy analyst.)
- ┆ Ensure the EHR provides:
 - ┆ Nonrepudiation — assurance that the signer cannot deny signing the document in the future
 - ┆ User authentication — verification of the signer's identity at the time the signature was generated
 - ┆ Integrity of electronically signed documents — retention of data so that each record can be authenticated and attributed to the signer
 - ┆ Message integrity — certainty that the document has not been altered since it was signed
 - ┆ 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
- ┆ 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 (managed care organizations), 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 (rural health clinics), 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 (protected health information).

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

The Wisconsin DHS (Department of Health Services) 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 #3733

Retention of Mental Health and Substance Abuse Records

Documentation of all services performed must be retained by providers for a period of at least seven years, according to Wis. Admin. Code § [DHS 92.12](#), (Wis. Admin. Code § DHS 92.12, supersedes Wis. Admin. Code § [DHS 106.02\[9\]](#), for DQA

(Division of Quality Assurance)-certified providers.)

Similarly, Medicaid-enrolled psychiatrists and Ph.D. psychologists in private practice are required to retain records for a period of five years according to Wis. Admin. Code § [DHS 106.02\(9\)\(e\)2](#).

(Note: 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. Refer to [Confidentiality and Proper Disposal of Records](#) for more information.)

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 (i.e., member is eligible for both Medicare and Wisconsin Medicaid or BadgerCare Plus) and is requesting materials pursuant to **Medicare** regulations.
- ┆ When the provider is attempting to exhaust all existing health insurance sources prior to submitting claims to 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 (Social Security number), if available
 - ┆ Member's DOB (date of birth)
 - ┆ DOS (date of service)
 - ┆ 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 (managed care organization), 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 (Department of Health Services) or the federal HHS (Department of Health and Human Services) 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 the DHS, as well as to provide copies of the corresponding patient health care records.

Provider Rights

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 (e.g., the member may not be enrolled, may be enrolled only for limited benefits, or the ForwardHealth card may be invalid). Providers may confirm the current enrollment of the member by using one of the [EVS \(Enrollment Verification System\) 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 (Department of Health Services) action or inaction for which due process is

required under Wis. Stat. ch. [227](#), may request a hearing by writing to the DHA (Division of Hearings and Appeals).

A provider who wishes to contest the DMS (Division of Medicaid Services)'s notice of intent to recover payment (e.g., 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 the DHS 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 the DMS (Division of Medicaid Services) 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 the 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.

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

Application

The 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, the federal CMS (Centers for Medicare and Medicaid Services), 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

Topic #211

Intermediate Sanctions

According to Wis. Admin. Code § [DHS 106.08\(3\)](#), the Wisconsin DHS (Department of Health Services) 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 the DHA (Division of Hearings and Appeals).

Topic #212

Involuntary Termination

The Wisconsin DHS (Department of Health Services) 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

The Wisconsin DHS (Department of Health Services) 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

Topic #3421

Provider Identification

Health Care Providers

Health care providers are required to indicate an NPI (National Provider Identifier) on enrollment applications and electronic and paper transactions submitted to ForwardHealth.

The NPI is a 10-digit number obtained through the NPPES (National Plan and Provider Enumeration System).

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 [NPPES website](#). The federal [CMS \(Centers for Medicare and Medicaid Services\) 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 (specialized medical vehicle) 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 (National Provider Identifier) 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 (National Provider Identifier) 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

2

Archive Date:06/03/2024

Covered and Noncovered Services:Noncovered Services

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 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 the following:

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

Missed Appointments

The federal CMS (Centers for Medicare and Medicaid Services) 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 (non-emergency medical transportation) manager contracted with the Wisconsin DHS (Department of Health Services). 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.

Interpretive services, which refer to interpretation of the spoken word or sign language, are a ForwardHealth-covered service. More information on interpretive services is [available](#).

Providers may not collect payment from a member, or authorized person acting on behalf of the member, for translation or interpretive services.

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

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

Topic #17157

Noncovered Services

The following services are not covered under the CCS (Comprehensive Community Services) benefit (*Note: Some of these services may be covered under other Medicaid and BadgerCare Plus benefits*):

- | Intensive In-home Mental Health and Substance Abuse Treatment Services for Children covered under the HealthCheck "Other Services" benefit
- | Child/Adolescent Day Treatment covered under the HealthCheck "Other Services" benefit
- | Crisis Intervention benefit (The CCS program can coordinate a member's crisis services, but cannot actually provide crisis services.)
- | CSP (Community Support Program) benefit (Members may not be enrolled in both CCS and CSP at the same time.)
- | Targeted case management benefit (Members may not be enrolled in both CCS and targeted case management at the same time.)
- | Narcotic Treatment benefit (opioid treatment programs) (The CCS program covers substance abuse services as defined in the [CCS Service Array](#). Substance abuse counseling is covered under CCS Service Array category #13 titled, "Substance Abuse Treatment.")
- | NEMT (Non-emergency Medical Transportation) benefit (The CCS program does not cover time spent solely to transport members. Members should use the NEMT benefit for transportation services. However, a CCS provider may provide a service covered under the CCS Service Array to a member while traveling with the member.)
- | Services to members residing in Residential Care Centers
- | Room and board
- | Autism services
- | Developmental disability services
- | Learning disorder services
- | Respite care
- | Sheltered workshop
- | Job development (The CCS program does not cover activities related to finding a member a specific job. The CCS program covers employment-related skill training as defined in the CCS Service Array category #9 titled, "Employment-Related Skill Training.")
- | Clubhouses (The CCS program does not cover time spent by a member working in a clubhouse. The CCS program covers time spent by clubhouse staff in providing psychosocial rehabilitation services, as defined in the CCS Service Array, for members.)
- | Operating While Intoxicated assessments
- | Urine analysis and drug screening
- | Prescription drug dispensing (The CCS program does not cover solely the dispensing of prescription drugs. The CCS program covers medication management services as defined in CCS Service Array category #5 titled, "Medication Management.")
- | Detoxification services

- ı Medically managed inpatient
 - ı Medically monitored residential
 - ı Ambulatory
- ı Residential intoxication monitoring services
- ı Medically managed inpatient treatment services
- ı Case management services provided under Wis. Admin. Code § [DHS 107.32](#), by a provider not enrolled in accordance with Wis. Admin. Code § [DHS 105.255](#), to provide services
- ı Services provided to a resident of an intermediate care facility, skilled nursing facility or an institution for mental diseases, or to a hospital patient unless the services are performed to prepare the member for discharge from the facility to reside in the community
- ı Services performed by volunteers (Out-of-pocket expenses incurred by volunteers in performing services may be covered. CCS programs may use volunteers to support the activities of CCS staff. Before a volunteer may work independently with a member or family member, the CCS program must conduct a background check on the volunteer. Each volunteer must be supervised by a qualified staff member and receive orientation and training. See Wis. Admin. Code § [DHS 36.10](#), for more information.)
- ı Services that are not rehabilitative, including services that are primarily recreation-oriented
- ı Legal advocacy performed by an attorney or paralegal

Codes

Topic #17220

Information is available for [DOS \(dates of service\) before October 1, 2023](#).

Place of Service Codes

Allowable POS (place of service) codes for the CCS (Comprehensive Community Services) benefit are listed in the following table.

POS Code	Description
01	Pharmacy
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
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
18	Place of Employment-Worksite
19	Off Campus—Outpatient Hospital
20	Urgent Care Facility
21	Inpatient Hospital
22	On Campus—Outpatient Hospital
23	Emergency Room—Hospital
26	Military Treatment Facility
27	Outreach Site/Street
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility

34	Hospice
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility-Partial Hospitalization
53	Community Mental Health Center
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Non-Residential Substance Abuse Treatment Facility
71	Public Health Clinic
72	Rural Health Clinic
99	Other Place of Service

Notes regarding POS codes:

- ▮ CCS provided to a resident of an ICF (intermediate care facility), SNF (skilled nursing facility), IMD (institution for mental disease), hospital, or other institutional facility are only covered if provided to prepare the CCS member for discharge from the facility to reside in the community.
- ▮ CCS do not cover any services provided to members residing in residential care centers.
- ▮ If staff in a CCS program is providing CCS covered services to a member while traveling with the member or attending a health appointment with the member, providers should use POS code 99.
- ▮ Although CCS can be provided in certain residential facilities, room and board is not allowable for CCS.

Topic #17277

Procedure Codes

Procedure codes and modifiers are required on all claims for CCS (Comprehensive Community Services). Claims or adjustments received without a procedure code are denied. Providers should refer to the [maximum allowable fee schedule](#) for maximum allowable fees.

The following table lists the procedure codes and modifiers that providers are required to use when submitting claims for CCS. Not all providers may be reimbursed for all CCS. A [crosswalk](#) between the provider type modifiers indicated in the table below and the service providers specified in Wis. Admin. Code § [DHS 36.10\(2\)\(g\)](#) is available.

Comprehensive Community Services Procedure Codes

Service Delivery Time and Documentation Time

Procedure Code	Description	Professional Provider Type and Modifier	Individual Service vs. Group Service and Modifier
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H2017	Psychosocial rehabilitation services, per 15 minutes	M.D.	UA	Individual	U5
				Group	HQ
		Ph.D.	HP	Individual	U5
				Group	HQ
		Bachelors degree level	HN	Individual	U5
				Group	HQ
		Masters degree level	HO	Individual	U5
				Group	HQ
		APNP (Advanced Practice Nurse Prescriber) with Psychiatric Specialty	UB	Individual	U5
				Group	HQ
		Registered Nurse	TD	Individual	U5
				Group	HQ
		Certified Peer Specialist	U8	Individual	U5
				Group	HQ
		Rehabilitation Worker	U9	Individual	U5
				Group	HQ
		Associate Degree	UD	Individual	U5
				Group	HQ
		QTT (qualified treatment trainee) Type 1	U7	Individual	U5
				Group	HQ
		QTT Type 2	U6	Individual	U5
				Group	HQ
		Other Provider Type	UC	Individual	U5
				Group	HQ

Provider Travel Time

Procedure Code	Description	Professional Provider Type and Modifier	Individual Service vs. Group Service and Modifier	Required Modifier (Travel)
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99199	Unlisted special service, procedure or report	M.D.	UA	Individual	U5	U3
				Group	HQ	U3
		Ph.D.	HP	Individual	U5	U3
				Group	HQ	U3
		Bachelors degree level	HN	Individual	U5	U3
				Group	HQ	U3
		Masters degree level	HO	Individual	U5	U3
				Group	HQ	U3
		APNP with Psychiatric Specialty	UB	Individual	U5	U3
				Group	HQ	U3
		Registered Nurse	TD	Individual	U5	U3
				Group	HQ	U3
		Certified Peer Specialist	U8	Individual	U5	U3
				Group	HQ	U3
		Rehabilitation Worker	U9	Individual	U5	U3
				Group	HQ	U3
		Associate Degree	UD	Individual	U5	U3
				Group	HQ	U3
		QTT Type 1	U7	Individual	U5	U3
				Group	HQ	U3
		QTT Type 2	U6	Individual	U5	U3
				Group	HQ	U3
		Other Provider Type	UC	Individual	U5	U3
				Group	HQ	U3

Topic #643

Unlisted Procedure Codes

According to the HCPCS (Healthcare Common Procedure Coding System) codebook, if a service is provided that is not accurately described by other HCPCS CPT (Current Procedural Terminology) procedure codes, the service should be reported using an unlisted procedure code.

Before considering using an unlisted, or NOC (not otherwise classified), 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 (prior authorization) 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 ((02/12)), 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 (Direct Data Entry) on the Portal, PES (Provider Electronic Solutions) software, or

837 (837 Health Care Claim) electronic transactions, the provider may do one of the following:

- i Include supporting documentation in the Notes field. The Notes field is limited to 80 characters.
- i 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.
- i [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 (prior authorization) requests, including diagnosis codes, revenue codes, HCPCS (Healthcare Common Procedure Coding System) codes, HIPPS (Health Insurance Prospective Payment System) codes, and CPT (Current Procedural Terminology) 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 (International Classification of Diseases) 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 (that is, 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 (that is, 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

Topic #17177

An Overview

CCS (Comprehensive Community Services) programs provide and arrange for the provision of psychosocial rehabilitation services. Psychosocial rehabilitation services are services and supportive activities that assist members with mental health and/or substance abuse conditions to achieve their highest possible level of independent functioning, stability, and independence and to facilitate recovery. All services must be non-institutional and fall within the definition of rehabilitative services as defined in 42 CFR s. 440.130(d). Members across the lifespan (minors, adults, and elders) can receive CCS.

Members enrolled in the Medicaid or BadgerCare Plus programs are eligible for CCS enrollment. All services provided under the CCS benefit are reimbursed fee-for-service regardless of whether the member is enrolled in a BadgerCare Plus HMO, a Medicaid SSI (Supplemental Security Income) HMO, or a special managed care program including Family Care, the PACE (Program of All-Inclusive Care for the Elderly), and the Family Care Partnership Program. Health care providers may refer potential members to their county or tribal human services department. Each county or tribe determines its access point for CCS and has policies and procedures on referral and screening for the program. Once members are evaluated through the functional screen, the members are informed of the services for which they are eligible and referred to those services in the manner the county or tribe has established.

Topic #19019

Concurrent Behavioral Treatment and Behavioral Health Services

ForwardHealth will allow for the concurrent delivery of behavioral treatment services with behavioral health services when both services are identified as medically necessary, per Wis. Admin. Code § [DHS 101.03\(96m\)](#).

ForwardHealth recognizes that coordinated services between behavioral treatment and behavioral health providers may be clinically appropriate.

Topic #22997

Coordination Between Comprehensive Community Services and Residential Substance Use Disorder Treatment

CCS (Comprehensive Community Services) must cover residential [SUD \(Substance Use Disorder\)](#) treatment in non-IMD (Institution for Mental Disease) settings and will not be reimbursed for treatment delivered in an IMD.

If members enrolled in a CCS program are unable to access residential SUD treatment through their CCS program, they may access services through the residential SUD treatment benefit. Documentation substantiating the member's inability to access residential SUD treatment through their CCS program will be required with the [PA request](#) for residential SUD treatment.

CCS services must be suspended during the member's residential SUD treatment; however, service planning and service facilitation may be provided within 30 days before discharge from the residential SUD facility to support discharge planning. CCS services may not duplicate case management provided by the residential SUD treatment provider.

Topic #17137

Covered Services

Both regional and non-regional CCS (Comprehensive Community Services) programs must serve all CCS-eligible members. A CCS program must provide all services covered under the CCS benefit that a member needs as determined by the assessment of all the domains in Wis. Admin. Code § [DHS \(Department of Health Services\) 36.16\(4\)](#). Providers should refer to the Comprehensive Community Services Program — Service Array table below for a description of the services covered under the CCS benefit. CCS programs may not deny a member access to CCS by claiming that the CCS program does not provide a service that is covered under the CCS benefit. If a CCS program does not provide a service that is covered under the CCS benefit, the CCS program must determine a way to provide a service that meets the needs of the member.

For members enrolled in a CCS program, the following services must be provided through the CCS program if needed by the member and cannot be reimbursed separately under any other Medicaid or BadgerCare Plus benefit per Wis. Admin. Code § [DHS 107.13\(7\)](#):

- ▮ Outpatient psychotherapy including outpatient psychotherapy services for children provided in the home
- ▮ Adult mental health day treatment

Additionally, members enrolled in a CCS program cannot also be enrolled in the targeted case management benefit.

For members enrolled in a CCS program, all other services covered under the CCS benefit not described above can be provided either through the CCS program or, if covered under another Medicaid or BadgerCare Plus benefit, through that other Medicaid or BadgerCare Plus benefit. An example of a service that can be provided either through a CCS program or through another Medicaid or BadgerCare Plus benefit is medication management provided by a psychiatrist.

Comprehensive Community Services Program — Service Array

The CCS program provides individuals with psychosocial rehabilitation services. All CCS programs must provide the services covered under the CCS benefit that a member needs as determined by the assessment of all the domains in Wis. Admin. Code § DHS 36.16(4). The assessment domains included in Wis. Admin. Code § DHS 36.16(4), are: (a) life satisfaction, (b) basic needs, (c) social network and family involvement, (d) community living skills, (e) housing issues, (f) employment, (g) education, (h) finances and benefits, (i) mental health, (j) physical health, (k) substance use, (l) trauma and significant life stressors, (m) medications, (n) crisis prevention and management, (o) legal status, and (p) any other domain identified by the CCS program. The service array describes the services that are covered under the CCS benefit. All services must be in compliance with Wis. Admin. Code § [DHS 36](#). All services should be person-centered and developed in partnership with the member.

Comprehensive Community Services Program — Service Array		
Service Category (Most Applicable DHS Wis. Admin. Code Sections)	Allowable Services	Allowable Provider Types
1. Screening and Assessment (Wis. Admin. Code §§	Screening and assessment services include: completion of initial and annual functional screens and completion of the initial comprehensive assessment and ongoing assessments as needed. The assessment must cover all the domains, including substance use, which may	Providers described in Wis. Admin. Code § DHS 36.10(2)(g)1-22 . [*] ‡

DHS 36.03, 36.13-36.16	include using the Uniform Placement Criteria or the American Society of Addiction Medicine Criteria. The assessment must address the strengths, needs, recovery goals, priorities, preferences, values, and lifestyle of the member and identify how to evaluate progress toward the member's desired outcomes. Assessments for minors must address the minor's and family's strengths, needs, recovery and/or resilience goals, priorities, preferences, values, and lifestyle of the member including an assessment of the relationships between the minor and his or her family. Assessments for minors should be age (developmentally) appropriate.	All providers are required to act within their scope of practice.
2. Service Planning (Wis. Admin. Code §§§ DHS 36.03, 36.16(7), 36.17)	Service planning includes the development of a written plan of the psychosocial rehabilitation services that will be provided or arranged for the member. All services must be authorized by a mental health professional and a substance abuse professional if substance abuse services will be provided. This can be a single professional for whom mental health and substance abuse services are in scope. The service plan is based on the assessed needs of the member. It must include measureable goals and the type and frequency of data that will be used to measure progress toward the desired outcomes. It must be completed within 30 days of the member's application for CCS services. The completed service plan must be signed by the member, a mental health or substance abuse professional, and the service facilitator. The service plan must be reviewed and updated based on the needs of the member or at least every six months. The review must include an assessment of the progress toward goals and member satisfaction with the services. The service plan review must be facilitated by the service facilitator in collaboration with the member and the recovery team.	Providers described in Wis. Admin. Code § DHS 36.10(2)(g)1-22.* ‡ All providers are required to act within their scope of practice.
3. Service Facilitation (Wis. Admin. Code §§§ DHS 36.03, 36.10(2)(e)4, 36.17)	Service facilitation includes activities that ensure the member receives: assessment services, service planning, service delivery, and supportive activities in an appropriate and timely manner. It also includes ensuring the service plan and service delivery for each member is coordinated, monitored, and designed to support the member in a manner that helps the member achieve the highest possible level of independent functioning. Service facilitation includes	Providers described in Wis. Admin. Code § DHS 36.10(2)(g)1-21.* ‡ All providers are required to act within their scope of practice.

	assisting the member in self-advocacy and helping the member obtain other necessary services such as medical, dental, legal, financial, and housing services. Service facilitation for minors includes advocating, and assisting the minor's family in advocating, for the minor to obtain necessary services. When working with a minor, service facilitation that is designed to support the family must be directly related to the assessed needs of the minor. Service facilitation includes coordinating a member's crisis services but not actually providing crisis services. Crisis services are provided by Wis. Admin. Code ch. DHS 34, certified programs. All services should be culturally, linguistically, and age (developmentally) appropriate.	
4. Diagnostic Evaluations	Diagnostic evaluations include specialized evaluations needed by the member, including, but not limited to, neuropsychological, geropsychiatric, specialized trauma, and eating disorder evaluations. For minors, diagnostic evaluations can also include functional behavioral evaluations and adolescent alcohol/drug assessment intervention program. The CCS program does not cover evaluations for autism, developmental disabilities, or learning disabilities.	Providers described in Wis. Admin. Code § DHS 36.10(2)(g)1-14.* All providers are required to be licensed/certified and acting within their scope of practice.
5. Medication Management	Medication management services for prescribers include: ▫ Diagnosing and specifying target symptoms ▫ Prescribing medication to alleviate the identified symptoms ▫ Monitoring changes in the member's symptoms and tolerability of side effects ▫ Reviewing data, including other medications, used to make medication decisions Prescribers may also provide all services the non-prescribers can provide as noted below. Medication management services for non-prescribers include: ▫ Supporting the member in taking their medications ▫ Increasing the member's understanding of the benefits of medication and the symptoms it is treating	Providers described in Wis. Admin. Code § DHS 36.10(2)(g)1-3, 7-8, and 11. All providers are required to be licensed/certified and acting within their scope of practice. Providers described in Wis. Admin. Code § DHS 36.10(2)(g)1-22.* ‡ All providers are required to act

	Monitoring changes in the member's symptoms and tolerability of side effects	within their scope of practice.
6. Physical Health Monitoring	Physical health monitoring services focus on how the member's mental health and/or substance abuse issues impact their ability to monitor and manage physical health and health risks. Physical health monitoring services include activities related to the monitoring and management of a member's physical health. Services may include assisting and training the member and the member's family to identify symptoms of physical health conditions, monitor physical health medications and treatments, and develop health monitoring and management skills.	Providers described in Wis. Admin. Code § DHS 36.10(2)(g)1-22.* ‡ All providers are required to act within their scope of practice.
7. Peer Support	Peer support services include a wide range of supports to assist the member and the member's family with mental health and/or substance abuse issues in the recovery process. These services promote wellness, self-direction, and recovery by enhancing the skills and abilities of members to meet their chosen goals. The services also help members negotiate the mental health and/or substance abuse systems with dignity and without trauma. Through a mutually empowering relationship, Certified Peer Specialists and members work as equals toward living in recovery.	Providers described in Wis. Admin. Code § DHS 36.10(2)(g)20.* ‡ Reminder: All CCS peer specialists are required to be Wisconsin Certified Peer Specialists as noted by the ‡ throughout the array. All providers are required to act within their scope of practice.
8. Individual Skill Development and Enhancement	Individual skill development and enhancement services include training in communication, interpersonal skills, problem solving, decision-making, self-regulation, conflict resolution, and other specific needs identified in the member's service plan. Services also include training in daily living skills related to personal care, household tasks, financial management, transportation, shopping, parenting, accessing and connecting to community resources and services (including health care services), and other specific daily living needs identified in the member's service plan. Services provided to minors should also focus on improving integration into and interaction with the minor's family, school, community, and other social networks. Services include assisting the minor's family in gaining skills to assist the minor with individual skill development and enhancement. Services that are designed to	Providers described in Wis. Admin. Code § DHS 36.10(2)(g)1-22.* ‡ All providers are required to act within their scope of practice.

	support the family must be directly related to the assessed needs of the minor. Skill training may be provided by various methods, including, but not limited to, modeling, monitoring, mentoring, supervision, assistance, and cuing. Skill training may be provided individually or in a group setting.	
9. Employment-Related Skill Training	Employment-related skill training services address the member's illness or symptom-related problems in finding, securing, and keeping a job. Services may include, but are not limited to, employment and education assessments; assistance in accessing or participating in educational and employment-related services; education about appropriate job-related behaviors; assistance with job preparation activities, such as personal hygiene, clothing, and transportation; on-site employment evaluation and feedback sessions to identify and manage work-related symptoms; assistance with work-related crises; and individual therapeutic support. The CCS program does not cover time spent by the member working in a clubhouse. The CCS program covers time spent by clubhouse staff in providing psychosocial rehabilitation services, as defined in the service array, for the member if those services are identified in the member's service plan.	Providers described in Wis. Admin. Code § DHS 36.10(2)(g)1-22. * ‡ All providers are required to act within their scope of practice.
10. Individual and/or Family Psychoeducation **	Psychoeducation services include: ▫ Providing education and information resources about the member's mental health and/or substance abuse issues ▫ Skills training ▫ Problem solving ▫ Ongoing guidance about managing and coping with mental health and/or substance abuse issues ▫ Social and emotional support for dealing with mental health and/or substance abuse issues Psychoeducation may be provided individually or in a group setting to the member or the member's family and natural supports (i.e., anyone the member identifies as being supportive in their recovery and/or resilience process). Psychoeducation is not psychotherapy. Family psychoeducation must be provided for the direct benefit of	Providers described in Wis. Admin. Code § DHS 36.10(2)(g)1-22. * ‡ All providers are required to act within their scope of practice.

	the member. Consultation to family members for treatment of their issues not related to the member is not included as part of family psychoeducation. Family psychoeducation may include anticipatory guidance when the member is a minor. If psychoeducation is provided without the other components of the Wellness Management and Recovery/Recovery Support Services service category (#11), it should be included under this service category.	
11. Wellness Management and Recovery **/Recovery Support Services	Wellness management and recovery services, which are generally provided as mental health services, include empowering members to manage their mental health and/or substance abuse issues, helping them develop their own goals, and teaching them the knowledge and skills necessary to help them make informed treatment decisions. These services include psychoeducation, behavioral tailoring, relapse prevention, development of a recovery action plan, recovery and/or resilience training, treatment strategies, social support building, and coping skills. Services can be taught using motivational, educational, and cognitive-behavioral strategies. If psychoeducation is provided without the other components of wellness management and recovery, it should be included under the Individual and/or Family Psychoeducation service category (#10). Recovery support services, which are generally provided as substance abuse services, include emotional, informational, instrumental, and affiliated support. Services include assisting the member in increasing engagement in treatment, developing appropriate coping strategies, and providing aftercare and assertive continuing care. Continuing care includes relapse prevention support and periodic follow-ups and is designed to provide less intensive services as the member progresses in recovery.	Providers described in Wis. Admin. Code § DHS 36.10(2)(g)1-22. * ‡ All providers are required to act within their scope of practice.
12. Psychotherapy	Psychotherapy includes the diagnosis and treatment of mental, emotional, or behavioral disorders, conditions, or addictions through the application of methods derived from established psychological or systemic principles for the purpose of assisting people in modifying their behaviors, cognitions, emotions, and other personal characteristics, which may include the purpose of understanding unconscious processes or intrapersonal, interpersonal, or	Providers described in Wis. Admin. Code § DHS 36.10(2)(g)1-10, 14, 22.* All providers are required to be licensed/certified and acting within their scope of practice.

	psychosocial dynamics. Psychotherapy may be provided in an individual or group setting.	
13. Substance Abuse Treatment	Substance abuse treatment services include counseling of persons affected by problems related to the abuse of alcohol or drugs including individual, group, and family counseling. Substance abuse treatment services can be provided in day treatment (Wis. Admin. Code § DHS 75.52), outpatient (Wis. Admin. Code §§ DHS 75.49, 75.50, or 75.51), and residential (Wis. Admin. Code § DHS 75.54 or Wis. Admin. Code § DHS 75.53) settings. Substance abuse treatment services can be in an individual or group setting. The other categories in the service array also include psychosocial rehabilitation substance abuse services that support members in their recovery. The CCS program does not cover Operating While Intoxicated assessments, urine analysis and drug screening, detoxification services, medically managed inpatient treatment services, or narcotic treatment services (opioid treatment programs). Some of these services may be covered under Medicaid and BadgerCare Plus outside the CCS program.	Providers described in Wis. Admin. Code §§ DHS 36.10(2)(g)1, 2 (with knowledge of addiction treatment), 4 (with knowledge of psychopharmacology and addiction treatment) and 16. Substance abuse professionals include: ▫ Licensed Psychotherapists ▫ Certified Substance Abuse Counselor ▫ Substance Abuse Counselor ▫ Substance Abuse Counselor in Training ▫ Certified Psychotherapists with MPSW (Marriage & Family Therapy, Professional Counseling & Social Worker) Examining Board 1.09 specialty All providers are required to be licensed/certified and acting within their scope of practice.

* Type I QTTs (qualified treatment trainees) are described in Wis. Admin. Code § [DHS 36.10\(2\)\(g\)22](#), (clinical students) and Type II QTTs are described in Wis. Admin. Code § [DHS 36.10\(2\)\(g\)9](#), (certified social workers, certified advance practice social workers, and certified independent social workers). Type I and Type II QTTs are required to be working through a Wis. Admin. Code § [DHS 35](#), certified outpatient clinic. For the purposes of the CCS program, all clinical students are required to be Type I QTTs. For the purposes of Medicaid reimbursement, APSWs (advanced practice social workers) and ISWs (independent social workers) are required to enroll as certified psychotherapists.

*** Information for these service categories is based on information provided by the federal SAMHSA (Substance Abuse and Mental Health Services Administration).

‡ Wis. Admin. Code § DHS 36.10(2)(g)20, describes peer specialists. For the purposes of the CCS program, all CCS peer

specialists are required to be Wisconsin Certified Peer Specialists. Individuals who are not Wisconsin Certified Peer Specialists could potentially act as rehabilitation workers if they meet the requirements described in Wis. Admin. Code § [DHS 36.10\(2\)\(g\) 21.](#) Refer to the service array for which services rehabilitation workers can provide.

Topic #17257

Covered Services Rendered by Qualified Treatment Trainees

CCS (Comprehensive Community Services) cover services rendered by two types of QTTs (qualified treatment trainees). QTTs can only work with Wis. Admin. Code ch. [DHS 35](#) certified outpatient mental health clinics. Type I QTTs are defined in Wis. Admin. Code § [DHS 35.03\(17m\)\(a\)](#) as "a graduate student who is enrolled in an accredited institution in psychology, counseling, marriage and family therapy, social work, nursing or a closely related field." Type 1 QTTs are covered under CCS provider type Wis. Admin. Code § [DHS 36.10\(2\)\(g\)22](#), which is for clinical students. Services rendered by Type I QTTs are only billable if the QTT is working through a Wis. Admin. Code ch. DHS 35 certified clinic that is contracted by the CCS program to provide services. For the purposes of CCS, all clinical students are required to be Type I QTTs.

Type II QTTs are defined in Wis. Admin. Code § [DHS 35.03\(17m\)\(b\)](#) as "a person with a graduate degree from an accredited institution and course work in psychology, counseling, marriage and family therapy, social work, nursing or a closely related field who has not yet completed the applicable supervised practice requirements described under ch. MPSW (Marriage & Family Therapy, Professional Counseling & Social Worker) 4, 12, or 16, or Psy 2 as applicable." Type II QTTs are covered under CCS provider type Wis. Admin. Code § [DHS 36.10\(2\)\(g\)9](#), which is for certified social workers, certified advance practice social workers, and certified independent social workers. For the purposes of Medicaid reimbursement, APSWs (advanced practice social workers) and ISWs (independent social workers) are required to enroll as certified psychotherapists. Services rendered by Type II QTTs are only billable if the QTT is working through a Wis. Admin. Code ch. DHS 35 certified clinic that is contracted by the CCS program to provide services.

Supervision

Types I and II QTTs are required to follow all supervision requirements detailed in the following sources:

- ┆ Requirements specified in Wis. Admin. Code chs. DHS 35 and [36](#)
- ┆ Requirements published in the ForwardHealth Online Handbook under the benefit in which services are provided
- ┆ All applicable Wisconsin DSPS (Department of Safety and Professional Services) regulations

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 #3724

Within the provision of mental health and substance abuse services, BadgerCare Plus encourages the concept of recovery for all persons who receive services. This includes consumer involvement in assessment, treatment planning, and outcomes. Also, BadgerCare Plus promotes the use of evidence-based and culturally competent practices.

Topic #85

Emergencies

Certain program requirements and reimbursement procedures are modified in emergency situations. Emergency services are defined in Wis. Admin. Code § [DHS 101.03\(52\)](#), as "those services that are necessary to prevent the death or serious impairment of the health of the individual." Emergency services are not reimbursed unless they are covered services.

Additional definitions and procedures for emergencies exist in other situations, such as dental and mental health.

Program requirements and reimbursement procedures may be modified in the following ways:

- ▮ PA (prior authorization) or other program requirements may be waived in emergency situations.
- ▮ [Non-U.S. citizens](#) may be eligible for covered services in emergency situations.

Topic #21337

Expectations and Documentation Requirements for Collaborating Providers

Whether or not PA (prior authorization) is required for a service, each provider must separately document their collaboration with the other provider in the member's medical record. The documentation must include services the member is receiving from the other provider and the current schedule of services or the frequency of services from both providers. This will ensure better coordination and continuity of care and will prevent duplication of services.

ForwardHealth requires providers to coordinate with each other at least once every six months, or more often if indicated by the member's condition.

The following shows care collaboration requirements for a collaborating behavioral health provider under two possible scenarios:

- ▮ If a behavioral health provider intends to provide a service that requires PA, the behavioral health provider must include the mode and frequency of the coordination between themselves and the collaborating behavioral treatment provider in the PA request and the member's medical record.
- ▮ If a behavioral health provider is providing a service that does not require PA, the behavioral health provider must document coordination between themselves and the collaborating behavioral treatment provider in the member's medical record.

Services That Require PA

Collaborating providers must include the following information in their PA request:

- ▮ The concurrent services received by the member
- ▮ The mode and frequency of the care collaboration between providers (for example, phone calls, meetings, the member's weekly schedule)

Note: ForwardHealth may request additional information, if needed, to establish the medical necessity of the service.

In the event a provider experiences challenges obtaining the required documentation from their collaborating provider, ForwardHealth recommends that the provider submit the PA request, detailing the barriers to obtaining the required documentation. ForwardHealth will consider the current barriers and may allow flexibility to authorize services as appropriate.

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 (limited English proficiency). 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 (Healthcare Common Procedure Coding System) 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 (date of service) 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 (managed care organizations). Providers should follow CPT (Current Procedural Terminology) 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 (Centers for Medicare & Medicaid Services) 2021 and 2023) in combination with BadgerCare Plus and Medicaid policy for [E&M \(evaluation and management\) 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 (prior authorization) 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 (Health Insurance Portability and Accountability Act of 1996) confidentiality requirements apply to interpretive services. When a covered entity or provider utilizes interpretive services that involve PHI (protected health information), 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 ((02/12)) (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 (place of service) codes for procedure code T1013.

Delivery Method of Interpretive Services	Definition for Sign Language and Foreign Language Interpreters		Modifiers
In person (foreign language and sign language)	When the interpreter is physically present with the member and provider		U1 or U3
Telehealth* (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 and GT or 93
	Phone (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 and 93
	Interactive video (foreign language only)	When the interpreter is not physically present with the member and the provider and interprets on interactive video	U1 or U3 and

	language and sign language)		GT
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*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 (place of service) code where the interpretive services are being provided.

Federally Qualified Health Centers

Non-tribal FQHCs (federally qualified health centers), also known as CHCs (community health centers), (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 (prospective payment system) 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 (Wisconsin Department of Health Services) 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 (rural health clinics) (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 (prior authorization) 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 #3726

Physician Prescription

The following prescription requirements apply to a physician or other health care provider initiating mental health and substance abuse treatment services for a Wisconsin Medicaid and BadgerCare Plus member.

Benefits That Require a Prescription or Order to Initiate Services

Wisconsin Medicaid and BadgerCare Plus require a prescription or order from a physician or other health care provider prior to initiating certain community-based mental health services for a Wisconsin Medicaid and BadgerCare Plus member. Examples of these services include the following:

- ┆ Community Support Programs
- ┆ Comprehensive Community Services

- HealthCheck "Other Services" Child/Adolescent Day Treatment
- HealthCheck "Other Services" Intensive In-Home Mental Health and Substance Abuse Treatment Services for Children

Benefits That Do Not Require a Prescription to Initiate Services

Wisconsin Medicaid and BadgerCare Plus do not require a prescription from a physician or other health care provider to initiate the following mental health and substance abuse treatment services for a Wisconsin Medicaid and BadgerCare Plus member:

- Outpatient mental health services provided in a Medicaid-enrolled outpatient mental health clinic or in the home for members under 21 years of age
- Outpatient substance abuse treatment provided in a Medicaid-enrolled substance abuse clinic
- Adult mental health day treatment
- Substance abuse day treatment
- Outpatient mental health and substance abuse services in the home or community for adults
- Outpatient mental health and substance abuse services performed in private practice by a Medicaid-enrolled psychiatrist, Ph.D. psychologist, APNP (Advanced Practice Nurse Prescriber) with psychiatric specialty, or a licensed psychotherapist (referred to as licensed mental health professional in Wisconsin law)

Topic #17117

Comprehensive Community Services Program Requirements

A CCS (Comprehensive Community Services) program must meet the requirements in Wis. Admin. Code ch. [DHS \(Department of Health Services\) 36](#) for services to be reimbursed by Medicaid. Key requirements include the following:

- Wis. Admin. Code § [DHS 36.13](#) — Any individual seeking CCS must complete a CCS application for the CCS program and sign an admission agreement. The CCS program must determine the individual's need for psychosocial rehabilitation services based on Wis. Admin. Code § [DHS 36.14](#).
- Wis. Admin. Code § [DHS 36.14](#) — The CCS program is available to individuals who, based on a DHS-approved functional screen, need more than outpatient counseling, but less than the services provided by the CSP (Community Support Program) benefit. Any individual seeking CCS must have a mental health or substance abuse diagnosis and a functional impairment that interferes with or limits one or more major life activities. If a CCS program determines that an individual needs CCS, it must conduct a comprehensive assessment under Wis. Admin. Code § [DHS 36.16](#).
- Wis. Admin. Code § [DHS 36.15](#) — All services must be authorized by the CCS program before a service is provided to a CCS member (and submitted for reimbursement). Services do not need to be prior authorized by ForwardHealth.
- Wis. Admin. Code §§ [DHS 36.16](#) and [36.17](#) — All CCS members must receive an assessment and have a service plan. The assessment and service plan must be completed within 30 days from the CCS application date. All CCS members must have a recovery team. All services provided must be documented in the member's service plan.
- Wis. Admin. Code § [DHS 36.18](#) — All CCS members must have a service record that contains information about their needs, outcomes, and progress. The service record includes the assessment, service plans, authorization of services statements, member requests, service delivery information, medication information, consent forms, legal documents, discharge information, and anything else that is appropriate.

CCS providers can provide services directly or may contract with other qualified providers to provide all or some of the services covered under the CCS benefit per Wis. Admin. Code § [DHS 105.257](#). A CCS program, as a Medicaid-enrolled provider, is required to ensure contracted agencies meet all [requirements](#). Medicaid requirements for CCS programs do not relieve any contracted agencies of their own regulatory requirements.

Services provided under the CCS benefit must meet the following additional ForwardHealth requirements to be reimbursed:

- Any individual seeking CCS must have a physician prescription to initiate services. The CCS provider must have a current prescription on file at all times.

- | Members cannot be enrolled in both CCS and CSP (Community Support Program) at the same time per Wis. Stat. § [49.45\(30\)\(e\)](#), Wis. Admin. Code §§ [DHS 107.13\(7\)](#), and DHS 36.14.
- | CCS providers can provide services directly or may contract with other qualified providers to provide all or some of the services covered under the CCS benefit per Wis. Admin. Code § [DHS 105.257](#). However, the Medicaid-enrolled provider retains all legal and fiscal responsibility for the services provided by contractors. ForwardHealth sends provider materials to Medicaid-enrolled providers only. It is the Medicaid-enrolled provider's responsibility to ensure that contractors are qualified to provide services and maintain records in accordance with the requirements for the provision of services. The Medicaid-enrolled provider is responsible for ensuring that contractors meet all program requirements and receive copies of ForwardHealth publications.

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 (prior authorization), 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 the Wisconsin DHS (Department of Health Services), the PRO (Peer Review Organization) 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

Topic #22737

Behavioral Health Telehealth Services

Behavioral health services should be indicated by the following modifiers.

Modifier	Description
FQ*	A telehealth service was furnished using audio-only communication technology
FR*	A supervising practitioner was present through a real-time two-way, audio/video communication technology
GQ	Via asynchronous telecommunications system
GT	Via interactive audio and video telecommunication systems

*Use for behavioral health services **only**.

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 (place of service) 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 (National Provider Identifier) using the lowest appropriate level office or outpatient visit procedure code or other appropriate CPT (Current Procedural Terminology) 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 (Health Professional Shortage Area)-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 (Federally Qualified Health Center) refers to Tribal and Out-of-State FQHCs. This topic does not apply to Community Health Centers subject to PPS (prospective payment system) reimbursement.

FQHCs and RHCs (rural health clinics) 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 (prospective payment system) 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 (personal care workers) and home health aides must be performed on site and in person by the RN (registered nurse). 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, dietitian 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 (National Provider Identifier). (Nurse practitioners, nurse midwives, and anesthetists 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:

- ▮ 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.
- ▮ 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.
- ▮ 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.
- ▮ [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.
- ▮ The Americans with Disabilities Act requires that health care entities provide full and equal access for people with disabilities.

Allowable Services

Providers should refer to the [Max Fee Schedules](#) page for a complete list of services allowed under permanent telehealth policy. Effective for dates of service on and after April 1, 2022, 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:

- ▮ 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.
- ▮ 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 either the GQ, GT, FQ, or 93 modifier in addition to any other required benefit-specific modifiers.

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.

Note: The GT, FQ or 93 modifiers may not be listed on the fee schedule, but it is still required on all claim submissions that use POS code 02 or 10 to indicate the telehealth service was performed synchronously. The GQ modifier is required to indicate the telehealth service was performed asynchronously.

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 following:

- ▮ 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 (Current Dental Terminology) 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 the following:

- ▮ 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 is no restriction on the location of a distant site provider. In addition, 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 (prior authorization)).

Providers are reminded that HIPAA (Health Insurance Portability and Accountability Act of 1996) confidentiality requirements apply to telehealth services. When a covered entity or provider utilizes a telehealth service that involves PHI (protected health information), 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

3

Archive Date:06/03/2024

Claims:Submission

Topic #17797

1500 Health Insurance Claim Form Completion Instructions

These instructions are for the completion of the 1500 Health Insurance Claim Form ((02/12)) for ForwardHealth. Refer to the [1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12](#), prepared by the NUCC (National Uniform Claim Committee) 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 (for example, commercial health insurance, Medicare, Medicare Advantage Plans) 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 (prior authorization) 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 (National Drug Codes) 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:

- ▮ Indicate the NDC qualifier N4, followed by the 11-digit NDC, with no space in between
- ▮ Indicate one space between the NDC and the unit qualifier
- ▮ 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 #17219

Claim Submission for Comprehensive Community Services

General Requirements

When submitting an interim claim for CCS (Comprehensive Community Services) services, providers are required to include the NPI (National Provider Identifier) of the Medicaid-enrolled prescribing/referring/ordering provider.

Each unit of time submitted on the interim claim represents 15 minutes of service. A unit of time has been reached when a provider has completed 51 percent of the designated time unit.

Billing and Rendering Providers

A single billing provider must be identified for each interim claim, and a single rendering provider must be identified for each interim claim detail. The billing and rendering provider information submitted on each interim claim is used to assign each interim claim detail to a specific county, tribe, or 51.42 entity for cost reporting and reconciliation purposes.

Billing and rendering providers are defined as follows:

- ▮ Billing provider — The county, tribe, or 51.42 entity that submits the claim.
- ▮ Rendering provider — The county, tribe, or 51.42 entity that incurred the direct cost of delivering the service. This may or may not be the same as the county, tribe, or 51.42 entity in which the member resides. The county, tribe, or 51.42 entity incurs the direct cost if (1) its employed staff rendered the service directly and the county, tribe, or 51.42 entity did not receive reimbursement for the service from another entity or (2) it incurred the cost of a contract with another public or private entity that rendered the service (which could include another county or tribe within its region).

For regional providers, the billing and rendering provider depends on the regional service model under which the CCS program operates:

- ▮ Population Based Model — The single county/tribe within the region must be identified as both the billing and rendering provider on all interim claim details.
- ▮ Shared Services Model — The county/tribe within the region that incurred the direct cost of delivering the service being submitted on the interim claim must be identified as both the billing and rendering provider on all interim claim details.
- ▮ Multi-County Model — The lead county/tribe must be identified as the billing provider on all interim claims for the region. The county/tribe within the region that incurred the direct cost of delivering the service being submitted on the interim claim detail must be identified as the rendering provider on that detail.

Note: Each detail can only include a single rendering provider.

- ▮ 51.42 Model — The 51.42 entity must be identified as both the billing and rendering provider on all interim claim details.

For non-regional CCS providers, the non-regional CCS provider must be identified as both the billing and rendering provider on all interim claim details.

Claims for Service Delivery Time and Documentation Time

In order to submit claims for service delivery time and documentation time, both the service delivery time and documentation time must be clearly documented in the member's medical record. Documentation should include the specific service provided and the specific time period spent documenting the service. Providers are required to submit HCPCS (Healthcare Common Procedure Coding System) procedure code H2017 (Psychosocial rehabilitation services, per 15 minutes) for all service delivery time and documentation time including service delivery time and documentation time provided in a residential setting.

On the claim detail for service delivery time and documentation time, CCS providers are required to include the following modifiers:

- ▮ In the first modifier position, the appropriate professional provider type modifier (e.g., M.D., Ph.D., Masters, Bachelors)
- ▮ In the second modifier position, the appropriate modifier to indicate whether the service was provided as an individual or group service

Claim details for which the DOS (date of service) and both modifiers are the same should be combined into one detail on the claim. For these claim details, time should be added up and rounded to the nearest 15-minute unit, per CPT (Current Procedural Terminology) rounding guidelines.

Claims for Provider Travel Time

In order to submit provider travel time on interim claims, the time and distance traveled in miles must be documented in the member's medical record. Providers are required to use CPT procedure code 99199 (Unlisted special service, procedure, or report) when submitting claim details for travel. Units must be rounded to the closest 15-minute unit, per CPT rounding guidelines. Provider travel time must be submitted on the same claim as the professional service in order to be reimbursable.

On the claim detail for provider travel time, CCS providers are required to include the following modifiers:

- ▮ In the first modifier position, the appropriate professional provider type modifier to identify the type of professional who is traveling
- ▮ In the second modifier position, the appropriate modifier to indicate whether the professional is traveling to provide an individual service or a group service
- ▮ In the third modifier position, modifier U3 to indicate that the unit of service represents provider travel time

Provider travel time to a group service should be submitted on the claim for each member in the group.

Claim details for which the DOS and all modifiers are the same should be combined into one detail on the claim. For these claim

details, time should be added up and rounded to the nearest 15-minute unit.

Providers should use POS (place of service) code 99 for all provider travel time.

Note: Units of provider travel time are included as part of the cost reporting and cost reconciliation process.

Interim Claim Reimbursement

Regional CCS providers will receive the federal and non-federal share of the statewide interim rate for each claim submitted. Non-regional CCS providers will receive only the federal share of the statewide interim rate.

Topic #15737

Claims for Services Prescribed, Referred, or Ordered

Claims for services that are prescribed, referred, or ordered must include the NPI (National Provider Identifier) of the Medicaid-enrolled provider who prescribed, referred, or ordered the service. Claims that do not include the NPI of a Medicaid-enrolled provider will be denied. (However, providers should **not** include the NPI of a provider who prescribes, refers, or orders services on claims for services that are not prescribed, referred, or ordered, as those claims will also deny if the provider is not Medicaid-enrolled.)

Note: Claims submitted for ESRD (end-stage renal disease) services do not require **referring** provider information; however, **prescribing** and **ordering** provider information will still be required on claims.

Contacting Prescribing/Referring/Ordering Provider After a Claim Denial

If a claim for services prescribed, referred, or ordered is denied because the prescribing/referring/ordering provider was not Medicaid-enrolled, the rendering provider should contact the prescribing/referring/ordering provider and do the following:

- ▮ Communicate that the prescribing/referring/ordering provider is required to be Medicaid-enrolled
- ▮ Inform the prescribing/referring/ordering provider of the limited enrollment available for prescribing/referring/ordering providers
- ▮ Resubmit the claim once the prescribing/referring/ordering provider has enrolled in Wisconsin Medicaid

Exception for Services Prescribed, Referred, or Ordered Prior to a Member's Medicaid Enrollment

Providers may submit claims for services prescribed, referred, or ordered by a non-Medicaid-enrolled provider if the member was not yet enrolled in Wisconsin Medicaid at the time the prescription, referral, or order was written (and the member has since enrolled in Wisconsin Medicaid). However, once the prescription, referral, or order expires, the prescribing/referring/ordering provider is required to enroll in Wisconsin Medicaid if they continue to prescribe, refer, or order services for the member.

The procedures for submitting claims for this exception depend on the type of claim submitted:

- ▮ Institutional, professional, and dental claims for this exception must be sent to the following address:

ForwardHealth
P.R.O. Exception Requests
Ste 50
313 Blettner Blvd

Madison WI 53784

A copy of the prescription, referral, or order must be included with the claim.

- ▮ Pharmacy and compound claims for this exception do **not** require any special handling. These claims include a prescription date, so they can be processed to bypass the prescriber Medicaid enrollment requirement in situations where the provider prescribed services before the member was Medicaid-enrolled.

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 (internal control number) along with the claim status.

Topic #5017

Correct Errors on Claims and Resubmit to ForwardHealth on the Portal

Providers can view [EOB \(Explanation of Benefits\) 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 (Direct Data Entry) 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 (Health Insurance Prospective Payment System) 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 (National Drug Codes)
- | 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 (durable medical equipment) or of DMS (disposable medical supplies) who submits noncompound drug claims, may submit these claims via DDE. All claims, including POS (Point-of-Sale) 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 #3925

Electronic Claim Submission for Comprehensive Community Services

Electronic claims for comprehensive community services must be submitted using the 837P (837 Health Care Claim: Professional) transaction. Electronic claims for comprehensive community 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 (Division of Medicaid Services) offers electronic billing software at no cost to the provider. The PES (Provider Electronic Solutions) software allows providers to submit electronic claims using the 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 \(Electronic Data Interchange\) 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 (managed care organization).

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 (Health Insurance Portability and Accountability Act of 1996), 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 #365

Extraordinary Claims

[Extraordinary claims](#) are claims that have been denied by a BadgerCare Plus HMO or SSI HMO and should be submitted to fee-for-service.

Topic #4837

HIPAA-Compliant Data Requirements

Procedure Codes

All fields submitted on paper and electronic claims are edited to ensure HIPAA (Health Insurance Portability and Accountability Act of 1996) compliance before being processed. Compliant code sets include CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) 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 (National Provider Identifiers) are required in all provider number fields on paper claims and 837 (837 Health Care Claim) transactions, including rendering, billing, referring, prescribing, attending, and "Other" provider fields.

Non-healthcare providers, including personal care providers, SMV (specialized medical vehicle) providers, blood banks, and CCOs (community care organizations) should enter valid provider numbers into fields that require a provider number.

Topic #562

Managed Care Organizations

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

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 (not otherwise classified), 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 (prior authorization).

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

A notes field is available on the ForwardHealth Portal DDE (Direct Data Entry) and PES (Provider Electronic Solutions) 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 (837 Health Care Claim) 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 ((02/12)) and UB-04 Claim Form are processed using OCR (Optical Character Recognition) 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 \(F-13073 \(04/2017\)\)](#) form and the [Noncompound Drug Claim \(F-13072 \(04/2017\)\)](#) 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

PICA										PICA									
1. MEDICARE ☐ MEDICAID ☒ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA ☐ BLK LUNG ☐ OTHER ☐										1a. INSURED'S ID. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
MEMBER, IM A										SAME									
5. PATIENT'S ADDRESS (No., Street)										7. INSURED'S ADDRESS (No., Street)									
609 WILLOW ST																			
CITY										CITY									
ANYTOWN										STATE									
STATE										STATE									
WI																			
ZIP CODE										ZIP CODE									
55555										()									
TELEPHONE (Include Area Code)										TELEPHONE (Include Area Code)									
(444) 444-4444																			
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									
b. RESERVED FOR NUCC USE										MM DD YY M F									
c. RESERVED FOR NUCC USE										b. OTHER CLAIM ID (Designated by NUCC)									
d. INSURANCE PLAN NAME OR PROGRAM NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME									
10. IS PATIENT'S CONDITION RELATED TO:										d. IS THERE ANOTHER HEALTH BENEFIT PLAN?									
a. EMPLOYMENT? (Current or Previous)										YES NO									
b. AUTO ACCIDENT?										YES NO									
c. OTHER ACCIDENT?										YES NO									
10d. CLAIM CODES (Designated by NUCC)										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
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									
SIGNED										DATE									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION									
MM DD YY QUAL										FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES									
I.M. REFERRING PROVIDER										FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB?									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										22. RESUBMISSION CODE									
A. XXXX.X										ORIGINAL REF. NO.									
B. L										23. PRIOR AUTHORIZATION NUMBER									
C. L																			
D. L																			
E. L																			
F. L																			
G. L																			
H. L																			
I. L																			
J. L																			
K. L																			
L. L																			
24. A. DATE(S) OF SERVICE										F. CHARGES									
From MM DD YY To MM DD YY										G. DAYS OF UNITS									
B. PLACE OF SERVICE										H. ICD-9-CM									
C. EMG										I. ID. QUAL									
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										J. RENDERING PROVIDER ID. #									
CPT/HCPCS MODIFIER																			
E. DIAGNOSIS POINTER																			
1 MM DD YY XX XXXXX XX X XXXXX 1																			
2																			
3																			
4																			
5																			
6																			
25. FEDERAL TAX ID. NUMBER										27. ACCEPT ASSIGNMENT?									
SSN EIN										YES NO									
1234JED										28. TOTAL CHARGE									
										\$ XXX XX									
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.)										29. AMOUNT PAID									
I.M. Provider MMDDCCYY										30. Resd for NUCC Use									
SIGNED DATE																			
32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH #									
I.M. PROVIDER										()									
1 W WILLIAMS ST																			
ANYTOWN WI 55555-1234																			
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

☐ PICA ☐ PICA									
1. MEDICARE ☐ MEDICAID ☒ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA ☐ OTHER ☐ (Medicare) (Medicaid) (DoD) (Member ID) (ID) (ID) (ID)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MEMBER, IM A					3. PATIENT'S BIRTH DATE MM DD YY				
5. PATIENT'S ADDRESS (No., Street) 609 WILLOW ST					4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME				
6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐					7. INSURED'S ADDRESS (No., Street)				
8. RESERVED FOR NUCC USE					11. INSURED'S POLICY GROUP OR FECA NUMBER				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 55555 (111) 444-4444					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐ b. AUTO ACCIDENT? YES ☐ NO ☐ c. OTHER ACCIDENT? YES ☐ NO ☐				
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				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE I.M. REFERRING PROVIDER					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? YES ☐ NO ☐ \$ CHARGES				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD 10d A. XXX.X B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____					22. REFERRAL CODE ORIGINAL REF. NO.				
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 OF UNITS H. ICD 10d I. QUAL J. RENDERING PROVIDER ID #					23. PRIOR AUTHORIZATION NUMBER				
1 MM DD YY XX XXXXX XX X					XXX XX 1				
2					NPI				
3					NPI				
4					NPI				
5					NPI				
6					NPI				
25. FEDERAL TAX ID, NUMBER SSN EIN ☐ ☐					26. PATIENT'S ACCOUNT NO. 1234JED				
27. ACCEPT ASSIGNMENT? YES ☐ 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.) J.M. Provider MMDDCCYY					32. SERVICE FACILITY LOCATION INFORMATION I.M. PROVIDER 1 W WILLIAMS ST ANYTOWN WI 55555-1234 022222220 ZZ123456789				
SIGNED _____ DATE _____					SIGNED _____ DATE _____				

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Comprehensive Community Services

Sample of an Incorrectly Aligned UB-04 Claim Form

1 IM BILLING PROVIDER 444 E CLAIREMONT ANYTOWN WI 55555-1234 (444) 444-4444		2		3a PAT CNTL # b MED REC # 117654321		4 TYPE OF BILL XXX	
8 PATIENT NAME MEMBER, IM A		9 PATIENT ADDRESS ON FILE		5 FED TAX NO. 01-2345678		6 STATEMENT COVERS PERIOD FROM MMDDCCYY MMDDCCYY	
10 BIRTHDATE		11 SEX		12 DATE		13 ADMISSION 13 HR 14 TYPE 15 SRC 16 DNR 17 STAT	
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26		27		28		29 ACCT STATE	
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Paper claims for comprehensive community services must be submitted using the 1500 Health Insurance Claim Form ((02/12)). ForwardHealth denies claims for comprehensive community services submitted on any other claim form.

Providers should use the appropriate claim form instructions for comprehensive community services when completing this form.

Obtaining the Claim Forms

ForwardHealth does not provide the 1500 Health Insurance Claim Form. The form 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 \(payment integrity review\)](#) 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 (date of service)
- | 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 (Office of the Inspector General) 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 (Explanation of Benefits) 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 (Remittance Advice) as paid but with a \$0 paid amount.

The reimbursement reduction applies to the following paper claims:

- ┆ 1500 Health Insurance Claim Form ((02/12))
- ┆ UB-04 (CMS 1450) Claim Form
- ┆ [Compound Drug Claim \(F-13073 \(04/2017\)\)](#) form
- ┆ [Noncompound Drug Claim \(F-13072 \(04/2017\)\)](#) 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 \(F-01160 \(06/2013\)\)](#) form
 - ┆ Sterilization claims must be submitted along with a paper [Consent for Sterilization \(F-01164 \(10/2008\)\)](#) form.
 - ┆ Claims submitted to Timely Filing appeals must be submitted on paper with a [Timely Filing Appeals Request \(F-13047 \(08/2015\)\)](#) form.
 - ┆ In certain circumstances, drug claims must be submitted on paper with a [Pharmacy Special Handling Request \(F-13074 \(04/2014\)\)](#) form.
 - ┆ Claims submitted with four or more NDCs (National Drug Codes) for compound and noncompound drugs with specific and non-specific HCPCS (Healthcare Common Procedure Coding System) procedure codes.

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 \(F-13470 \(03/2023\)\)](#). Providers are required to indicate an ACN (attachment control number) for paper attachment(s) submitted with electronic claims. (The ACN is an alphanumeric entry between 2 and 80 digits assigned by the provider to identify the attachment.) The ACN must be indicated on the cover page so that ForwardHealth can match the paper attachment(s) to the correct electronic claim.

ForwardHealth will hold an electronic claim transaction or a paper attachment(s) for up to 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 #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 (Joint Photographic Experts Group) (.jpg or .jpeg).
- | PDF (Portable Document Format) (.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 (Direct Data Entry) 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 (837 Health Care Claim) transactions are required to indicate attachments via the PWK segment. Providers submitting claims via PES (Provider Electronic Solutions) 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

Topic #516

Accuracy of Claims

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

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

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

Topic #22798

Payment Integrity Review Program

The PIR (Payment Integrity Review) program:

- ┆ Allows the OIG (Office of the Inspector General) 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 (Department of Health Services)-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 (Current Procedural Terminology) or HCPCS (Healthcare Common Procedure Coding System) 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 (Explanation of Benefits) 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
How claims are selected for review	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.
How providers are notified that selected claims are under review	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.
How to successfully exit the review	Claims are selected for review based on a pre-determined percentage of claim submissions of specific criteria. All providers who bill the service codes that are part of this criteria are subject to review, regardless of their compliance rates.	75 percent of a provider's reviewed claims over a three-month period must be paid as submitted. The number of claims submitted during the three-month period may not drop more than 10 percent of the provider's volume of submitted claims prior to pre-payment review.	The provider must meet parameters set during the sanction process.

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:

- ▮ 75 percent of the provider's reviewed claims over a three-month period are approved to be paid.
- ▮ The number of claims the provider submits during that three-month period may not drop more than 10 percent 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 (date of service). 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 \(level of care\)](#) or [liability amount](#)
- | Decision made by a court order, fair hearing, or the Wisconsin DHS (Department of Health Services)
- | 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 (General Relief)
- | 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 #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 copayment, providers should still indicate their usual and customary charge. The copayment amount collected from the member should not be deducted from the charge submitted. When applicable, ForwardHealth automatically deducts the copayment 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

Topic #540

An Overview of the Remittance Advice

The RA (Remittance Advice) 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 (text) 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 (comma-separated values) format.

Topic #5091

National Provider Identifier on the Remittance Advice

Health care providers who have a single NPI (National Provider Identifier) 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 (Remittance Advice) 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 (Explanation of Benefits) 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 (internal

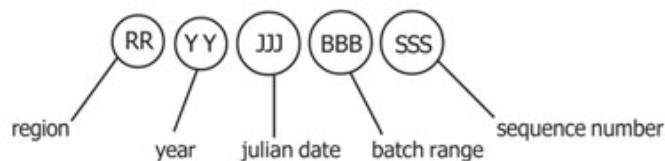
control number)). However, denied real-time compound and noncompound claims are not assigned an ICN, but receive an authorization number. Authorization numbers are not reported to the RA (Remittance Advice) or 835 (835 Health Care Claim Payment/Advice).

Interpreting Claim Numbers

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

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
Region — 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
Year — Two digits indicate the year ForwardHealth received the claim or adjustment request.	For example, the year 2008 would appear as 08.
Julian date — 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.
Batch range — Three digits indicate the batch range assigned to the claim.	The batch range is used internally by ForwardHealth.
Sequence number — 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 \(Automated Voice Response\)](#) system or the 276/277 (276/277 Health Care Claim Status Request and Response) 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 #22277

Claims Denial Adjustment/Review Request

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

- | Review ForwardHealth remittance information for the specific reason for the denial.
- | Review the claim submitted to ensure all information is accurate and complete.
- | Consult recent CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) publications to make sure proper coding instructions were followed.
- | Consult recent ForwardHealth publications to make sure current policy and billing instructions were followed.
- | Call Provider Services for further information or explanation.
- | Review the ForwardHealth Adjustment/Reconsideration Request process and submit a request if appropriate.

If a provider disagrees with a claim determination, the provider may take one of two actions.

- | If the claim is denied, the provider may resubmit the claim with supporting documentation to [Provider Services Written Correspondence](#) using the Written Correspondence (F-01170 (07/2012)) form with the "other (briefly explain the situation in question below)" box checked and the words "medical consultant review requested" written on the form.
- | If the original claim is in an allowed status, the provider may submit an [Adjustment/Reconsideration Request \(F-13046 \(08/2015\)\)](#) form with supporting documentation and the "medical consultant review requested" box checked on the form to Provider Services Written Correspondence.

Topic #644

Information is available for [DOS \(dates of service\) before February 12, 2022](#).

ClaimsXten Review

ForwardHealth monitors all professional claims for compliance with reimbursement policy using an automated procedure coding review software known as Change Healthcare ClaimsXten. ClaimsXten reviews claims submitted for billing inconsistencies and errors during claims processing. Medicaid programs in other states, insurance companies, and Medicare all use similar software.

EOB (Explanation of Benefits) codes specific to the ClaimsXten review appear in the TXT (text) RA (Remittance Advice) file and in the electronic 835 (835 Health Care Claim Payment/Advice) transactions.

ClaimsXten review does not change Medicaid or BadgerCare Plus policy on covered services but monitors compliance with policy more closely and reimburses providers appropriately.

ClaimsXten will be reviewed on a regular basis and changes will be made as needed based on industry best practices. In addition to adding new procedure codes, ClaimsXten may add or revise claim editing information based on an ongoing review of the software knowledge base. This ongoing process helps to ensure that the default clinical content used in ClaimsXten is clinically

appropriate and within national standards.

Areas Monitored by ClaimsXten

ClaimsXten uses rules to monitor certain claim situations.

ClaimsXten rules adopted by ForwardHealth are subject to change or revision. This is not a comprehensive list of all claim edits, but rather examples of areas where edit rules will be implemented via ClaimsXten. Reference to more specific ForwardHealth coverage and reimbursement policy, where applicable, is indicated.

ForwardHealth uses ClaimsXten software to monitor the following situations:

- ┆ Unbundled and rebundled procedures
- ┆ Incidental/integral procedures
- ┆ Mutually exclusive procedures
- ┆ Medical visit billing errors
- ┆ Preoperative and postoperative billing errors
- ┆ Assistant surgeon billing errors

ClaimsXten will not review claims that have been denied for general billing errors, such as an invalid member identification number or an invalid or missing provider number. Providers will need to correct the general billing error and resubmit the claim, at which point ClaimsXten will review the claim.

Unbundled and Rebundled Procedures

Unbundling occurs when two or more procedure codes are used to describe a procedure that may be better described by a single, more comprehensive procedure code. ClaimsXten considers the single, most appropriate procedure code for reimbursement when unbundling is detected.

If certain procedure codes are submitted, ClaimsXten rebundles them into the single most appropriate procedure code. For example, if a provider submits a claim with two or more procedure codes for the same type of wound with varying sizes, ClaimsXten rebundles them to a procedure code that would encompass the total size.

ClaimsXten will also total billed amounts for individual procedures. For example, if the provider bills three procedures at \$20, \$30, and \$25, ClaimsXten rebundles them into a single procedure code, adds the three amounts, and calculates the billed amount for a new rebundled code at \$75. Then, ForwardHealth reimburses the provider either the lesser of the billed amounts or the maximum allowable fee for that rebundled procedure code.

Incidental/Integral Procedures

Incidental procedures are those procedures performed at the same time as a more complex primary procedure. These require few additional provider resources and are generally not considered necessary to the performance of the primary procedure. For example, the removal of an asymptomatic appendix is considered an incidental procedure when done during hysterectomy surgery.

Integral procedures are those procedures performed as part of a more complex primary procedure. For example, when a member undergoes a transurethral incision of the prostate, the scope procedure is considered integral to the performance of the prostate procedure and would be denied as a separately billed item.

When a procedure is either incidental or integral to a major procedure, ClaimsXten considers only the primary procedure for reimbursement.

Mutually Exclusive Procedures

Mutually exclusive procedures are procedures that would not be performed on a single member on the same day or that use different codes to describe the same type of procedure.

An example of a mutually exclusive situation is when the repair of the organ can be performed by two different methods. One repair method must be chosen to repair the organ and must be reported. A second example is the reporting of an "initial" service and a "subsequent" service. It is contradictory for a service to be classified as both an initial and a subsequent service at the same time.

When two or more procedures are mutually exclusive, ForwardHealth considers for reimbursement the procedure code with the highest provider-billed amount and denies the other code.

Medical Visit Billing Errors

Medical visit billing errors occur if E&M (evaluation and management) services are reported separately when a substantial diagnostic or therapeutic procedure is performed. Under CMS (Centers for Medicare & Medicaid Services) guidelines, most E&M procedures are not allowed to be reported separately when a substantial diagnostic or therapeutic procedure is performed.

ClaimsXten monitors medical visits based on the type of E&M service (that is, initial or new patient; or follow-up or established patient services) and the complexity (that is, major or minor) of the accompanying procedure.

For example, if a provider submits a procedure code for a major surgical procedure as well as for the initial hospital care per day, ClaimsXten denies the initial hospital care procedure as a visit when submitted with the major procedure with the same date of service. The major procedure has a 90-day global surgical period and the postoperative visit is not separately reimbursable.

Preoperative and Postoperative Billing Errors

Preoperative and postoperative billing errors occur when E&M services are billed with surgical procedures during their preoperative and postoperative periods. ClaimsXten bases the preoperative and postoperative periods on designations in the CMS National Physician Fee Schedule.

For example, if a provider submits a procedure code for an office visit for E&M with a DOS of 11/02/21 and a related surgical procedure with a DOS of 11/03/21, ClaimsXten may deny the procedure code for the office visit as a preoperative visit.

Assistant Surgeon Billing Errors

ClaimsXten develops and maintains assistant surgeon values using the CMS Physician Fee Schedule as its primary source. Providers should refer to the Medicare Physician Fee Schedule for procedure codes where a surgery assistant may be paid. These codes are denoted with an indicator of "2" in the Assistant at Surgery column of the Medicare Physician Fee Schedule.

ForwardHealth's Assistant Surgeon Fee Schedule reflects procedure codes allowable with an assistant surgeon designation consistent with ClaimsXten.

For example, if a provider bills a procedure code for a surgery with a modifier representing an assistant surgeon, and ClaimsXten determines that the procedure does not require an assistant surgeon, the procedure-modifier combination will be denied.

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 copayment, spenddown amounts, deductibles, or patient liability amounts. Amounts indicated in a cutback field are subtracted from the total allowed reimbursement.

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

Note: Providers who receive [835 \(835 Health Care Claim Payment/Advice\)](#) 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 (Remittance Advices). 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 (text) format or from a CSV (comma-separated values) 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 \(835 Health Care Claim Payment/Advice\)](#) 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 (Provider Electronic Solutions) 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 \(Electronic Data Interchange\) Helpdesk](#).

Topic #4822

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

EOB (Explanation of Benefits) 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 (Remittance Advice) 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 (date of service) 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 (text) file.

CSV File

EOB codes are listed in the RA information from the CSV (comma-separated values) 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 (Explanation of Benefits) code 8234 noted on the RA (Remittance Advice).

The adjusted claim will be assigned a new claim number, known as an ICN (internal control number). 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 (Remittance Advice) reports the first 12 characters of the MRN (medical record number) and/or a PCN (patient control number), 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 (Patient Protection and Affordable Care Act) of 2010, the federal CMS (Centers for Medicare and Medicaid Services) are required to promote correct coding and control improper coding leading to inappropriate payment of claims under Medicaid. The NCCI (National Correct Coding Initiative) 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 (Current Procedural Terminology) or HCPCS (Healthcare Common Procedure Coding System) procedure codes for Wisconsin Medicaid, BadgerCare Plus, WCDP (Wisconsin Chronic Disease Program), and Family Planning Only Services for compliance with the following NCCI edits:

- ┆ MUE (Medically Unlikely Edits), 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 (date of service) for each CPT or HCPCS procedure code. If a detail on a claim is denied for MUE, providers will receive an EOB (Explanation of Benefits) code on the RA (Remittance Advice) 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 \(F-13046 \(08/2015\)\)](#) 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 (Remittance Advice). 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 (text) 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 (comma-separated values) 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 (Remittance Advice) 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
- | 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 ((02/12))
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, 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 (text) file, the Address page displays the provider name and "Pay to" address of the provider.

Banner Messages

The Banner Messages section of the RA (Remittance Advice) 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 (comma-separated values) file. Banner messages are posted in the "View Remittance Advices" menu on the provider's secure Portal account.

Explanation of Benefits Code Descriptions

[EOB \(Explanation of Benefits\) 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 (internal control number)." 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, ADAP (Wisconsin AIDS Drug Assistance Program), WCDP (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program)) 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 (Omnibus Budget Reconciliation Act of 1987) 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 (Remittance Advice) 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 (Explanation of Benefits) 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 (Remittance Advice) 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 (Explanation of Benefits) 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 9999999999					
XX										CHECK/EFT NUMBER 999999999					
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX XXXXX-XXXX										PAYMENT DATE MM/DD/CCYY					
--ICN--		PCN	MRN	SERVICE DATES		BILLED	OTH INS	SPENDDOWN							
				FROM	TO	AMOUNT	AMOUNT								
MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX MEMBER NO.: XXXXXXXXXXXXXXXX															
RRYYJJBBSSS XXXXXXXXXXXX XXXXXXXXXXXX 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								
					FROM	TO	BILLED AMT	DETAIL EOB							
XXXXX		XX XX XX XX		9999.99	MMDDYY	MMDDYY	XXX XXXXXXXXXXXXXXXX	XXXXXXX	9999 9999 9999 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						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						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						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 (Remittance Advice) 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 (Explanation of Benefits) 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 (835 Health Care Claim Payment/Advice) standards to balance between 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 AMT	INPAT DED	PAID AMT		
	MRN	FROM TO		DATE	ALLOWED AMT	SPENDDOWN AMT	OUTLIER AMT	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	111	1	
HEADER EOB: 1022 3091 9507 9932 9940 9959											
REV CD	SERVICE DATES	ALLU UNITS	PA NUMBER	INCENTIVES	PAID AMOUNT	DETAIL EOB					
121	FROM TO	BILLED AMT	ALLOWED AMT			9932					
	110521 110921	4.00									
		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			
TOTAL NO. PAID: 1											

Topic #4828

Remittance Advice Financial Cycles

Each financial payer (Medicaid, ADAP (Wisconsin AIDS Drug Assistance Program), WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program)) has separate financial cycles that occur on different days of the week. RAs (Remittance Advices) 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 (Remittance Advices) 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)
- | ADAP (Wisconsin AIDS Drug Assistance Program)
- | WCDP (Wisconsin Chronic Disease Program)
- | WWWP (Wisconsin Well Woman Program)

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 (National Provider Identifier) 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 (National Provider Identifier) 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 (Remittance Advice).)
- ┆ 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 (Remittance Advice) information in the TXT (text) file includes the following sections:

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

The RA information in the CSV (comma-separated values) 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, ADAP (Wisconsin AIDS Drug Assistance Program), WCDP (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program))
- | 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 (National Provider Identifier).
- | 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

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 (Remittance Advice) 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 \(837 Health Care Claim\) transaction](#).

Provider Electronic Solutions Software

The Wisconsin DHS (Department of Health Services) offers electronic billing software at no cost to providers. The PES (Provider Electronic Solutions) 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 \(Electronic Data Interchange\) 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 (date of service) 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 \(Electronic Data Interchange\) Helpdesk](#) for assistance with electronic adjustment requests

Topic #515

Paper

Paper adjustment requests must be submitted using the [Adjustment/Reconsideration Request \(F-13046 \(08/2015\)\)](#) 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 (e.g., 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

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 (Enrollment Verification System) 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 \(Express Enrollment\) 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 (Explanation of Benefits) 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

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 \(F-13047 \(08/2015\)\)](#) form with a paper claim or an [Adjustment/Reconsideration Request \(F-13046 \(08/2015\)\)](#) form to override the submission deadline. If claims or adjustment requests are submitted electronically, the entire amount of the claim will be recouped.

DOS (dates of service) 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 \(F-13047 \(08/2015\)\)](#) 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 \(F-13047 \(08/2015\)\)](#) 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 \(F-13046 \(08/2015\)\)](#) 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 (place of service) code, and all other required claims data elements effective for the DOS (date of service). 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.

Change in Nursing Home Resident's Level of Care or Liability Amount		
Description of the Exception	Documentation Requirements	Submission Address
This exception occurs when a nursing home claim is initially received within the submission deadline and reimbursed incorrectly due to a change in the member's authorized LOC (level of care) or liability amount.	To receive consideration, the request must be submitted within 455 days from the DOS. Include the following documentation as part of the request: ▮ The correct liability amount or LOC must be indicated on the Adjustment/Reconsideration Request (F-13046 (08/15)) form. ▮ The most recent claim number (also known as the ICN (internal control number)) must be indicated on the Adjustment/Reconsideration Request form. This number may be the result of a ForwardHealth-initiated adjustment. ▮ A copy of the Explanation of Medical Benefits form, if applicable.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
Decision Made by a Court, Fair Hearing, or the Wisconsin Department of Health Services		
Description of the Exception	Documentation Requirements	Submission Address
This exception occurs when a decision is made by a court, fair hearing, or the Wisconsin DHS (Department of Health Services).	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: ▮ A complete copy of the decision notice received from the court, fair hearing, or DHS	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
Denial Due to Discrepancy Between the Member's Enrollment Information in ForwardHealth interChange and the Member's Actual Enrollment		
Description of the Exception	Documentation Requirements	Submission Address
This exception occurs when a claim is initially received by the deadline but is denied due to a discrepancy between the member's enrollment information in ForwardHealth interChange and the member's actual enrollment.	To receive consideration, the request must be submitted within 455 days from the DOS. Include the following documentation as part of the request: ▮ A copy of remittance information showing the claim was submitted in a timely manner and denied with a qualifying enrollment-related explanation. ▮ A photocopy of one of the following indicating enrollment on	ForwardHealth Good Faith/Timely Filing Ste 50 313 Blettner Blvd Madison WI

	the DOS: ┆ Temporary Identification Card for Express Enrollment in BadgerCare Plus ┆ Temporary Identification Card for Express Enrollment in Family Planning Only Services ┆ The response received through Wisconsin's EVS (Enrollment Verification System) from a commercial eligibility vendor ┆ The transaction log number received through WiCall ┆ The enrollment tracking number received through the ForwardHealth Portal	53784
ForwardHealth Reconsideration or Recoupment		
Description of the Exception	Documentation Requirements	Submission Address
This exception occurs when ForwardHealth reconsiders a previously processed claim. ForwardHealth will initiate an adjustment on a previously paid claim.	If a subsequent provider submission is required, the request must be submitted within 90 days from the date of the RA (Remittance Advice) message. Include the following documentation as part of the request: ┆ A copy of the RA message that shows the ForwardHealth-initiated adjustment ┆ A copy of the Explanation of Medical Benefits form, if applicable	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
Retroactive Enrollment for Persons on General Relief		
Description of the Exception	Documentation Requirements	Submission Address
This exception occurs when the income maintenance or tribal agency requests a return of a GR (general relief) payment from the provider because a member has become retroactively enrolled for Wisconsin Medicaid or BadgerCare Plus.	To receive consideration, the request must be submitted within 180 days from the date the backdated enrollment was added to the member's enrollment information. Include the following documentation as part of the request: ┆ A copy of the Explanation of Medical Benefits form, if applicable And ┆ "GR retroactive enrollment" indicated on the claim Or ┆ A copy of the letter received from the income maintenance or tribal agency	ForwardHealth GR Retro Eligibility Ste 50 313 Blettner Blvd Madison WI 53784
Medicare Denial Occurs After the Submission Deadline		

Description of the Exception	Documentation Requirements	Submission Address
This exception occurs when claims submitted to Medicare (within 365 days of the DOS) are denied by Medicare after the 365-day submission deadline. A waiver of the submission deadline will not be granted when Medicare denies a claim for one of the following reasons: ▮ The charges were previously submitted to Medicare. ▮ The member name and identification number do not match. ▮ The services were previously denied by Medicare. ▮ The provider retroactively applied for Medicare enrollment and did not become enrolled.	To receive consideration, the request must be submitted within 90 days of the Medicare processing date. Include the following documentation as part of the request: ▮ A copy of the Medicare remittance information ▮ A copy of the Explanation of Medical Benefits form, if applicable	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
Refund Request from an Other Health Insurance Source		
Description of the Exception	Documentation Requirements	Submission Address
This exception occurs when an other health insurance source reviews a previously paid claim and determines that reimbursement was inappropriate.	To receive consideration, the request must be submitted within 90 days from the date of recoupment notification. Include the following documentation as part of the request: ▮ A copy of the recoupment notice ▮ An updated Explanation of Medical Benefits form, if applicable <i>Note:</i> When the reason for resubmitting is due to Medicare recoupment, ensure that the associated Medicare disclaimer code (i.e., M-7 or M-8) is included on the updated Explanation of Medical Benefits form.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
Retroactive Member Enrollment into Medicaid		
Description of the Exception	Documentation Requirements	Submission Address
This exception occurs when a claim cannot be submitted within the	To receive consideration, the request must be submitted within 180 days from the date the backdated enrollment was added to the	ForwardHealth Timely Filing

submission deadline due to a delay in the determination of a member's retroactive enrollment.	member's enrollment information. In addition, retroactive enrollment must be indicated by selecting "Retroactive member enrollment for ForwardHealth (attach appropriate documentation for retroactive period, if available)" box on the Timely Filing Appeals Request (F-13047 (08/15)) form.	Ste 50 313 Blettner Blvd Madison WI 53784
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Overpayments

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 (date of service).
- ▮ 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 (837 Health Care Claim) transaction when submitting adjustment requests.

Paper Adjustment Requests

For [paper adjustment requests](#), providers are required to do the following:

- ▮ Submit an [Adjustment/Reconsideration Request \(F-13046 \(08/2015\)\)](#) 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 (Remittance Advice) 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 (internal control number), the NPI (National Provider Identifier) (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 (Remittance Advice).

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

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

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

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

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

4

Archive Date:06/03/2024

Reimbursement:Payer of Last Resort

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 (General Assistance)
- | HCBS (Home and Community-Based Services) waiver programs
- | IDEA (Individuals with Disabilities Education Act)
- | Indian Health Service
- | Maternal and Child Health Services
- | WCDP (Wisconsin Chronic Disease Program):
 - | 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 #251

Other Health Insurance Sources

BadgerCare Plus reimburses only that portion of the allowed cost remaining after a member's other health insurance sources have been exhausted. Other health insurance sources include the following:

- | [Commercial fee-for-service plans](#)
- | [Commercial managed care plans](#)
- | Medicare supplements (e.g., Medigap)
- | Medicare
- | Medicare Advantage and Medicare Cost plans
- | TriCare
- | CHAMPVA (Civilian Health and Medical Plan of the Veterans Administration)
- | Other governmental benefits

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 (managed care organization).

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

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 (i.e., any amount paid by other health insurance sources, any BadgerCare Plus or Medicaid copayment or spenddown amounts paid by the member, and any amount paid by BadgerCare Plus, Medicaid, or ADAP (Wisconsin AIDS Drug Assistance Program)) 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 (i.e., 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 ADAP.

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 (electronic funds transfer) 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 (managed care organizations) 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 (specialized medical vehicle) 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 that 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 Remittance Advice 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 (e.g., a decimal point is omitted creating a \$50,000 keyed value for a \$500 claim), a reversal will take place to correct the error and resend the correct transaction value. ForwardHealth will notify the designated EFT contact person of an EFT reversal if a payment is made in error due to a system processing or manual data entry error.

Problem Resolution

If payment is not deposited into the designated EFT account according to the ForwardHealth payment cycle, providers should first check with their financial institution to confirm the payment was received. If the payment was not received, providers should then call [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 (text) or CSV (comma separated value) 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 (Healthcare Common Procedure Coding System), CPT (Current Procedural Terminology), or CDT (Current Dental Terminology) 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 (Wisconsin Chronic Disease Program) programs and WWWP (Wisconsin Well Woman Program).)

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.

Topic #8437

Reimbursement Rates

ForwardHealth will reimburse certifying agencies only for the federal share of its total costs for CCS (Comprehensive Community Services). Certifying agencies are required to provide the nonfederal share of the reimbursement rate for CCS as specified in [Wis. Stat. § 49.45\(45\)\(b\)](#). At the time the county seeks enrollment under [Wis. Admin. Code ch. DHS 36](#), the county provider needs to contact the DMS (Division of Medicaid Services) mental health/substance abuse policy analyst for developing individual county

rates.

Daily Maximum Reimbursement Amount Increased

The daily maximum reimbursement amount for CCS provided to an individual member is \$2,000.00.

Wisconsin Medicaid and BadgerCare Plus will reimburse providers for the federal share of the total daily costs provided to an individual member up to the maximum daily amount per DOS (date of service). Providers must incur the nonfederal share of the cost of services.

Topic #17218

Reimbursement of Comprehensive Community Services Program Costs

Overview

Reimbursement of CCS (Comprehensive Community Services) program costs consists of the following:

- ▮ Interim claims submission and reimbursement — The process throughout the calendar year during which CCS providers submit interim health care claims to ForwardHealth and receive interim reimbursement.
- ▮ Cost reporting/cost reconciliation — The process following the end of the calendar year during which CCS providers report to ForwardHealth the total cost of operating their CCS program for the calendar year and Wisconsin Medicaid adjusts the total interim reimbursement to reflect full reimbursement for allowable Medicaid costs.

Important Comprehensive Community Services Cost Category Concepts and Definitions

Wisconsin Medicaid has aligned cost definitions across all county-administered Medicaid programs that rely on cost-based reimbursement. These cost categories are important for proper interim claim submission and cost reporting/cost reconciliation purposes.

Direct Costs and General Overhead Costs

CCS program costs consist of direct costs and general overhead costs which are described below.

- ▮ Direct costs — These are costs that support direct program operation. Direct costs can include the following:
 - ▮ Service delivery time — Time spent by an allowable service provider providing a service identified on the [CCS Service Array](#). This includes time providing both face-to-face and non-face-to-face services identified on the CCS Service Array. Allowable service providers are described in Wis. Admin. Code § [DHS 36.10\(2\)\(g\)](#).
 - ▮ Provider travel time — Time for a service provider to travel to provide a CCS service to a member.
 - ▮ Documentation time — Time after service delivery for a service provider to complete a member's progress note/case note/medical record or otherwise document service delivery.
 - ▮ Staff training time directly related to CCS.
 - ▮ A CCS supervisor's time supervising other CCS staff.

Note: A CCS supervisor could also spend a portion of their time as an allowable service provider providing a service identified on the CCS Service Array. This time would represent service delivery time, not supervision time.

- ▮ CCS administrator's time spent on general CCS administration.

- i Time spent by staff not described in Wis. Admin. Code § DHS 36.10(2)(g), directly supporting the CCS program.
 - i Non-staff costs that directly contribute to the CCS program (e.g., CCS training materials and CCS supplies).
 - i All other direct CCS program support costs.
- i General overhead costs — These are costs that reflect central services related to overall agency operations that are allocable to all agency programs including CCS. Common examples of general overhead costs include the following:
 - i Accounting
 - i Billing
 - i Financial
 - i Human resources
 - i Legal
 - i Plant maintenance
 - i Agency administrator
 - i Agency director
 - i Software
 - i Lease and rental
 - i Utilities costs

Interim Claim Submission and Reimbursement

Wisconsin Medicaid reimburses interim claims for CCS based on statewide interim rates.

Statewide interim rates for CCS vary based on the type of professional providing the service and on whether the service was provided as an individual service or as a group service. The same interim rates apply to services provided by county/tribe staff and contracted staff. Interim rates may be adjusted on an annual basis.

Providers can only submit interim claims for reimbursement for the following types of direct costs, as defined previously:

- i Service delivery time
- i Provider travel time
- i Documentation time

A CCS provider may have higher or lower total program costs than the statewide interim rates for CCS services. Providers are required to indicate their [usual and customary charge](#) on claim details when submitting claims.

The usual and customary charge should represent the expected actual costs of providing the service regardless of whether it is greater than or less than the interim rate. CCS providers should not simply bill the interim rate. The difference between the actual costs and the interim payments is accounted for during the cost reporting and cost reconciliation process and may result in either a payment or recoupment to the county/tribe.

Providers are encouraged to submit claims on a timely basis. Timely claim submission ensures consistent cash flow to the CCS program and accurate cost reporting at the end of the calendar year.

Collecting Payment From Members

Topic #227

Conditions That Must Be Met

A member may request a noncovered service, a covered service for which PA (prior authorization) 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, copayment, or deductible. Therefore, a provider may not collect payment from a member, or authorized person acting on behalf of the member, for copayments required by other health insurance sources. Instead, the provider should collect from the member **only** the Medicaid or BadgerCare Plus copayment 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 [copayments](#) for certain services.
- ┆ Other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) 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 (prior authorization) 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.

Copayment

Topic #231

Exemptions

Wisconsin Medicaid and BadgerCare Plus Copay Exemptions

According to Wis. Admin. Code § [DHS 104.01\(12\)\(a\)](#), and [42 C.F.R. \(Code of Federal Regulations\) § 447.56](#), providers are prohibited from collecting any copays from the following Medicaid and BadgerCare Plus members:

- | Children under age 19
- | American Indians or Alaskan Natives, regardless of age or income level, who are receiving or have ever received items and services either directly from an Indian health care provider or through referral under contract health services (Note: Until further notice, Wisconsin Medicaid and BadgerCare Plus will apply this exemption policy for **all** services regardless of whether a tribal health care provider or a contracted entity provides the service. Providers may not collect copay from any individual identified in the EVS (Enrollment Verification System) as an American Indian or Alaskan Native.)
- | Terminally ill individuals receiving hospice care
- | Nursing home residents
- | Members enrolled in Wisconsin Well Woman Medicaid
- | Individuals eligible through EE (Express Enrollment)

The following services do not require copays from any member enrolled in Wisconsin Medicaid or BadgerCare Plus:

- | Behavioral treatment
- | Care coordination services (prenatal and child care coordination)
- | CRS (Community Recovery Services)
- | Crisis intervention services
- | CSP (community support program) services
- | Comprehensive community services
- | COVID-19-related care
- | Emergency services for medical conditions that meet the prudent layperson standard (the prudent layperson standard is defined by [42 C.F.R. \(Code of Federal Regulations\) § 438.114](#), and may be expanded to include a psychiatric emergency involving a significant risk or serious harm to oneself or others, a substance abuse emergency in which there is significant risk of serious harm to a member or others or there is likelihood of return to substance abuse without immediate treatment, or emergency dental care, which is defined as an immediate service needed to relieve the patient from pain, an acute infection, swelling, trismus, fever, or trauma)
- | EMTALA (Emergency Medical Treatment and Labor Act)-required medical screening exam and stabilization services
- | Family planning services and supplies, including sterilizations
- | HealthCheck services
- | Home care services (home health, personal care, and PDN (private duty nurse) services)
- | Hospice care services
- | Immunizations, including approved vaccines recommended to adults by the [ACIP \(Advisory Committee on Immunization Practices\)](#)
- | Independent laboratory services
- | Injections
- | Pregnancy-related services
- | Preventive services with an A or B rating^{*} from the [USPSTF \(U.S. Preventive Services Task Force\)](#)^{**}, including tobacco cessation services

- ┆ SBS (school-based services)
- ┆ Substance abuse day treatment services
- ┆ Surgical assistance
- ┆ Targeted case management services

Note: Providers may not impose cost sharing for health-care acquired conditions or other provider-preventable services as defined in federal law under [42 C.F.R. § 447.26\(b\)](#).

* Providers are required to add CPT (Current Procedural Terminology) modifier 33 to identify USPSTF services that are not specifically identified as preventive in nature. The definition for modifier 33 reads as follows:

When the primary purpose of the service is the delivery of an evidence based service in accordance with a U.S. Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.

Since many of the USPSTF recommendations are provided as part of a regular preventive medicine visit, ForwardHealth will not deduct a copayment for these services (CPT procedure codes 99381–99387 and 99391–99397).

** The USPSTF recommendations include screening tests, counseling, immunizations, and preventive medications for targeted populations. These services must be provided or recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice.

Topic #233

Limitations

Providers should verify that they are collecting the correct copay for services as some services have monthly or annual copay limits. Providers may not collect member copays in amounts that exceed copay limits.

Monthly Copay Limits

Per the federal limitations on premiums and cost sharing in 42 C.F.R. § 447.56(f), the combined amount of Medicaid premiums and copays a BadgerCare Plus or Medicaid member incurs each month may not exceed 5 percent of the member's monthly household income. To comply with federal limitations on premiums and cost sharing, ForwardHealth calculates each member's monthly premium and copay limit, which is a maximum allowable copay amount based on monthly income, for individual members. Members within the same household may have different individual copay limits, and children under age 19 are exempt from copays.

Providers must determine whether or not a BadgerCare Plus or Medicaid member is [exempt from paying copays or has reached their monthly copay limit](#) by accessing the [Enrollment Verification System](#) and receiving the message "No Copay" in response to an enrollment query.

Member Notification

Each member receives a letter in the mail that states their individual monthly copay limit. If a member has a change, such as a change in income or marital status, they will receive a letter with the updated individual monthly copay limit.

When a member reaches their monthly copay limit before the end of the month, they will receive a letter that informs them that they have met their copay limit for that month, and copays will resume on the first day of the following month.

Copay Collection

Once a member meets their individual monthly copay limit, copays will no longer be deducted from the provider's reimbursement. This is true even if subsequent claim adjustments reduce the member's incurred copay amount to below their monthly limit.

Providers may not collect copays from members who have met their individual monthly copay limit.

Topic #17178

Prohibited

Providers are prohibited from collecting copayments from members for services covered under the CCS (Comprehensive Community Services) benefit.

Topic #237

Refund/Collection

If a provider collects a copayment before providing a service and BadgerCare Plus does not reimburse the provider for any part of the service, the provider is required to return or credit the entire copayment amount to the member.

If BadgerCare Plus deducts less copayment than the member paid, the provider is required to return or credit the remainder to the member. If BadgerCare Plus deducts more copayment than the member paid, the provider may collect the remaining amount from the member.

Topic #239

Requirements

Federal law permits states to charge members a copayment for certain covered services. Providers are required to request copayments from members. Providers may not deny services to a Wisconsin Medicaid or BadgerCare Plus member who fails to make a copayment.

Wis. Stat. § [49.45\(18\)](#) requires providers to make a reasonable attempt to collect copayment from the member unless the provider determines that the cost of collecting the copayment exceeds the amount to be collected.

Reimbursement Not Available

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 (e.g., 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 (durable medical equipment) delivery charges are included in the reimbursement for DME items.

Cost Reporting

Topic #17217

Cost Reporting and Reconciliation Process Guidelines

Cost reporting and cost reconciliation occur following the end of each calendar year. Cost reporting is defined as the work conducted by each county/tribe or region to fulfill state and federal financial reporting requirements, whereas cost reconciliation represents activities completed by Wisconsin Medicaid that results in either payment to, or recoupment from, the county/tribe or region to fulfill CCS (Comprehensive Community Services) cost-based reimbursement under the program.

Guidelines for CCS Regional Structures

The following are general guidelines related to proper claim submission and cost reporting for CCS regions and participating counties/tribes under the CCS program.

General Cost Reporting Guidelines

Regions may only operate under one regional service model during each cost reporting and cost reconciliation period. For example, a single region may not operate under a Multi-County Model that uses a lead biller to submit certain interim claims for reimbursement while at the same time operating under a Shared Services Model to submit other interim claims. Additionally, a county/tribe may not participate in multiple CCS regions simultaneously.

- ▮ Cost reports for CCS regions represent the summation of county and/or tribal costs. This means that each region must disaggregate costs at the individual county or tribe level.
 - ▮ In a population-based region, one cost report is submitted.
 - ▮ In a shared services region, each county or tribe submits its own cost report.
 - ▮ In a multi-county region, each county or tribe is provided a section on a regional cost report to report its individual county or tribal costs.
 - ▮ In a 51.42 region, one cost report is submitted. The Wisconsin DHS (Department of Health Services) works with each 51.42 region individually on the details required for cost reporting.
- ▮ If a county or tribe participating in a CCS region wishes to claim direct or general overhead costs for reconciliation purposes, then these costs must appear in that county's or tribe's cost report or county/tribal-specific section of the regional cost report.
- ▮ Counties/tribes can only report general overhead costs if direct costs and billed service units are reported for that county or tribe. In other words, the county or tribe must incur at least one direct cost in order to report general overhead costs. General overhead costs function as an add-on to the direct service unit cost.
- ▮ On the cost report, counties/tribes are required to clearly state their actual direct costs and general overhead costs that relate to each county's or tribe's interim claims.
 - ▮ Actual general overhead cost allocations, not budgeted estimates, are needed for cost reporting.
 - ▮ Allowable allocation methods include allocations based on staff time reporting, full time equivalents related to CCS, and other allocation methods as allowed in 2 CFR Part 225.
 - ▮ Reported direct costs and general overhead costs within a cost report must align with units of service submitted on interim claims. For example, reported costs per county/tribe must have corresponding direct service units billed for proper reconciliation.
- ▮ Outlier costs are reviewed for reasonableness and may lead to future policy on per member limits for the CCS program.
- ▮ CCS are subject to audit.

Regional Contractual Arrangements

Counties/tribes have the flexibility to enter into contractual arrangements for service provision either among regional county or tribal entities or with non-county or tribal contractors. Additionally, a region may contract with a county or tribe outside of the region for services. This outside county or tribe is treated as the subcontracted county or tribe and does not have a county or tribal section on the contracting region's cost report.

If there is a contractual relationship that a county or tribe intends to have reflected in the cost reporting and financial reconciliation process, then certain coding rules must be followed. Specifically, where contracts exist, the interim claims submission would use the rendering provider number on claim details to attribute those interim claim detail costs to the county or tribe that incurred costs associated with those contracted units.

Cost Reconciliation Periods

Cost reporting and cost reconciliations for all DOS (dates of service) within calendar year 2014 will occur following the end of the calendar year. For DOS from January 1, 2014, through June 30, 2014, ForwardHealth will use the previous cost reconciliation process. For DOS between July 1, 2014, and December 31, 2014, ForwardHealth will use a revised cost reconciliation process based on the policy described previously.

If a county/tribe regionalizes after July 1, 2014, then the cost reconciliation for DOS between July 1, 2014, and December 31, 2014, will include the following two periods:

- ▮ The period from July 1, 2014, to the effective date of regionalization
- ▮ The period from the effective date of regionalization to December 31, 2014

If a county/tribe regionalizes after July 1, 2014, and adds an additional county/tribe or counties/tribes prior to the end of the year, then the cost reconciliation for DOS between July 1, 2014, and December 31, 2014, will include the following three periods:

- ▮ The period from July 1, 2014, to the effective date of regionalization
- ▮ The period from the effective date of regionalization to the effective date of the addition
- ▮ The period from the effective date of the addition to December 31, 2014

For example, if a region begins on August 1, 2014, and adds counties/tribes on October 1, 2014, the three reconciliation periods would be July 1, 2014, through July 31, 2014 (as a non-regional county), August 1, 2014, through September 30, 2014 (as the initial region), and October 1, 2014, through December 31, 2014 (as the revised region).

Calendar year 2015 reconciliations will be broken down into periods according to the start date of the region (for start dates within calendar year 2015) and to modifications made to the region during the calendar year.

Calendar year 2016 reconciliations will not be broken down into periods, as changes will only be allowed on a calendar year basis beginning January 1, 2016.

Member Information

5

Archive Date:06/03/2024

Member Information:Enrollment Categories

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 percent of the FPL (Federal Poverty Level)
- | Pregnant women with incomes at or below 300 percent of the FPL
- | Children (ages 18 and younger) with household incomes at or below 300 percent of the FPL
- | Childless adults with incomes at or below 100 percent of the FPL
- | Transitional medical assistance individuals, also known as members on extensions, with incomes over 100 percent 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 percent of the FPL. Transitional medical assistance individuals with incomes between 100 and 133 percent 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 percent 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 (e.g., claim submission procedures, PA (prior authorization) requirements) when providing services to these women.

Emergency Services for Non-U.S. Citizens

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

Topic #230

Express Enrollment for Children and Pregnant Women

The EE (Express Enrollment) 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 \(Express Enrollment\)](#).

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 (e.g., PT (physical therapy) 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 (e.g., mammograms and hysterectomies). If a medical condition, other than an STD (sexually transmitted disease), 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 (Department of Health Services) 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

- | ADAP (Wisconsin AIDS Drug Assistance Program)
- | WCDP (Wisconsin Chronic Disease Program)
- | WIR (Wisconsin Immunization Registry)
- | Wisconsin Medicaid
- | Wisconsin Well Woman Medicaid
- | WWWP (Wisconsin Well Woman Program)

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

Topic #229

Limited Benefit Categories Overview

Certain members may be enrolled in a limited benefit category. These limited benefit categories include the following:

- | BadgerCare Plus Prenatal Program
- | EE (Express Enrollment) for Children
- | EE for Pregnant Women
- | Family Planning Only Services, including EE for individuals applying for Family Planning Only Services
- | QDWI (Qualified Disabled Working Individuals)
- | QI-1 (Qualifying Individuals 1)
- | QMB Only (Qualified Medicare Beneficiary Only)
- | SLMB (Specified Low-Income Medicare Beneficiary)
- | Tuberculosis-Related Medicaid

Members may be enrolled in full-benefit Medicaid or BadgerCare Plus and also be enrolled in certain limited benefit programs, including QDWI, QI-1, QMB Only, and SLMB. In those cases, a member has full Medicaid or BadgerCare Plus coverage in addition to limited coverage for Medicare expenses.

Members enrolled in the BadgerCare Plus Prenatal Program, Family Planning Only Services, EE for Children, EE for Pregnant Women, or Tuberculosis-Related Medicaid cannot be enrolled in full-benefit Medicaid or BadgerCare Plus. These members receive benefits through the limited benefit category.

Providers should note that a member may be enrolled in more than one limited benefit category. For example, a member may be enrolled in Family Planning Only Services and Tuberculosis-Related Medicaid.

Providers are strongly encouraged to verify dates of enrollment and other coverage information using Wisconsin's EVS (Enrollment Verification System) to determine whether a member is in a limited benefit category, receives full-benefit Medicaid or BadgerCare Plus, or both.

Providers are responsible for knowing which services are covered under a limited benefit category. If a member of a limited benefit category requests a service that is not covered under the limited benefit category, the provider may collect payment from the member if certain [conditions](#) are met.

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 (Wisconsin Medical Assistance Program), MA (Medical Assistance), 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 (Supplemental Security Income)
- | WWWP (Wisconsin Well Woman Program)

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 (Social Security Administration) 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 (managed care organizations).

Topic #232

Qualified Disabled Working Individual Members

QDWI (Qualified Disabled Working Individual) members are a limited benefit category of Medicaid members. They receive payment of Medicare monthly premiums for Part A.

QDWI members are certified by their [income maintenance or tribal agency](#). To qualify, QDWI members are required to meet the following qualifications:

- | Have income under 200 percent of the FPL (Federal Poverty Level)
- | Be entitled to, but not necessarily enrolled in, Medicare Part A
- | Have income or assets too high to qualify for QMB-Only (Qualified Medicare Beneficiary-Only) and SLMB (Specified Low-Income Medicare Beneficiary)

Topic #234

Qualified Medicare Beneficiary-Only Members

QMB-Only (Qualified Medicare Beneficiary-Only) members are a limited benefit category of Medicaid members. They receive payment of the following:

- ┆ Medicare monthly premiums for Part A, Part B, or both
- ┆ Coinsurance, copayment, and deductible for Medicare-allowed services

QMB-Only members are certified by their [income maintenance or tribal agency](#). QMB-Only members are required to meet the following qualifications:

- ┆ Have an income under 100 percent of the FPL (Federal Poverty Level)
- ┆ Be entitled to, but not necessarily enrolled in, Medicare Part A

Topic #235

Qualifying Individual 1 Members

QI-1 (Qualifying Individual 1) members are a limited benefit category of Medicaid members. They receive payment of Medicare monthly premiums for Part B.

QI-1 members are certified by their [income maintenance or tribal agency](#). To qualify, QI-1 members are required to meet the following qualifications:

- ┆ Have income between 120 and 135 percent of the FPL (Federal Poverty Level)
- ┆ Be entitled to, but not necessarily enrolled in, Medicare Part A

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 \(identification\) 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 (Enrollment Verification System) 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.

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

To the Provider 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 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 FAMILY PLANNING ONLY SERVICES  <table border="0"> <tr> <td>Name:</td> <td>Program</td> <td>ID Number</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> 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.	Name:	Program	ID Number	IM A MEMBER	Family Planning Only	0987654321	DOB: 09/01/1984	Services	
Name:	Program	ID Number								
IM A MEMBER	Family Planning Only	0987654321								
DOB: 09/01/1984	Services									

Topic #236

Specified Low-Income Medicare Beneficiaries

SLMB (Specified Low-Income Medicare Beneficiary) members are a limited benefit category of Medicaid members. They receive payment of Medicare monthly premiums for Part B.

SLMB members are certified by their [income maintenance or tribal agency](#). To qualify, SLMB members are required to meet the following qualifications:

- ▮ Have an income under 120 percent of the FPL (Federal Poverty Level)
- ▮ Be entitled to, but not necessarily enrolled in, Medicare Part A

Topic #262

Tuberculosis-Related Medicaid

[Tuberculosis-Related Medicaid](#) is a limited benefit category that allows individuals with TB (tuberculosis) infection or disease to receive covered TB-related outpatient 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 (Wisconsin Well Woman Program) 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 (Wisconsin Well Woman Medicaid) are reimbursed through Medicaid fee-for-service.

Identification Cards

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 (Enrollment Verification System).

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 \(Automated Voice Response\)](#).

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.

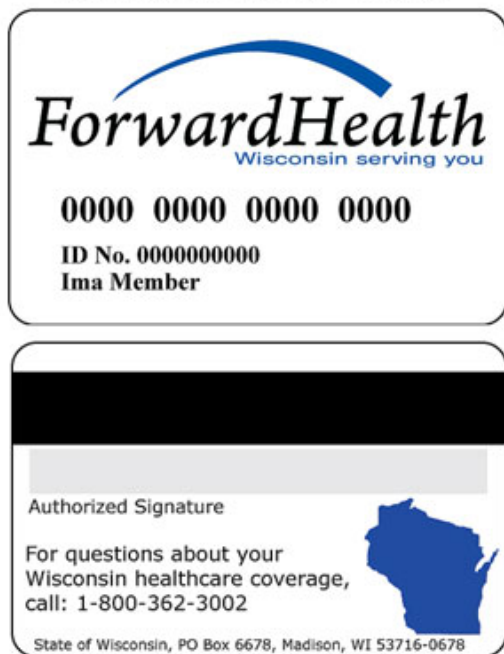
If a member lost their ForwardHealth card or never received one, the member may call [Member Services](#) to request a new one.

Managed Care Organization Enrollment Changes

Members do not receive a new ForwardHealth card if they are enrolled in a state-contracted MCO (managed care organization) 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 (e.g., white plastic cards, paper cards, or paper printouts), depending on the program and the method used to enroll (i.e., paper application or online application). Members who are temporarily enrolled in BadgerCare Plus or Family Planning Only Services receive temporary identification cards.

Enrollment Rights

Topic #246

Appealing Enrollment Determinations

Applicants and members have the right to appeal certain decisions relating to BadgerCare Plus, Medicaid, or ADAP (Wisconsin AIDS Drug Assistance Program) 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 (Division of Hearings and Appeals).

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, ADAP, or Wisconsin Medicaid was denied.
- ┆ Application for BadgerCare Plus, ADAP, 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 \(DHA-28 \(08/09\)\)](#) 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 ADAP Enrollment

If a claim is denied due to termination of ADAP 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
ADAP 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 ADAP Claims and Adjustments.

As a reminder, claims [submission deadlines](#) still apply even to those claims with hearing decisions.

Topic #247

Freedom of Choice

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

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 (Department of Health Services) 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 (Qualified Medicare Beneficiary-Only) members.

Enrollment Responsibilities

Topic #241

General Information

Members have certain responsibilities per Wis. Admin. Code § [DHS 104.02](#) and the [ForwardHealth Enrollment and Benefits \(P-00079 \(07/14\)\)](#) 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 \(Enrollment Verification System\)](#) or the ForwardHealth Portal prior to providing each service, even if an approved PA (prior authorization) 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 (date of service) 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 (durable medical equipment) 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

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 (prior authorization) has been granted to the out-of-state provider for provision of a nonemergency service
- ┆ When there are coinsurance, copayment, or deductible amounts remaining after Medicare payment or approval for dual eligibles

Note: Some providers located in a state that borders Wisconsin may be Wisconsin Medicaid 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 (end-stage renal disease) 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 (continuously eligible newborn) option. However, babies born to women with incomes over 300 percent of the FPL (Federal Poverty Level) are not eligible for CEN status. The baby may still qualify for BadgerCare Plus. These mothers should report the birth to the local agencies within ten calendar days.

A provider who gives emergency care to a non-U.S. citizen should refer 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 \(F-01162 \(02/2009\)\)](#) 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 (presumptive eligibility) 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 (Department of Corrections) 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 (prior authorization) 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 (date of service) 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 (Enrollment Verification System) (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 (date of service) 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 \(F-10109 \(02/2014\)\)](#) 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.

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 (Home and Community-Based Waiver) Medicaid
- | Institutional Medicaid
- | Katie Beckett Medicaid
- | MAPP (Medicaid Purchase Plan)
- | Medicare Savings Programs
- | Special Status Medicaid
- | SSI (Supplemental Security Income)-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.
- | 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 the Wisconsin DHS (Department of Health Services).

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

DHS has the following member resources available for more information regarding health care renewals and continuous coverage for children:

- ▮ [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](#)

Members With Dual Coverage

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. Families applying for BadgerCare Plus or Wisconsin Medicaid with a child still enrolled in Foster Care Medicaid or SSI Medicaid solely because of 12-month continuous coverage (for example, their SSI payments ended) may still enroll their child in BadgerCare Plus or Wisconsin Medicaid. These children may have dual coverage for a period of time. A family may also choose to enroll their child in BadgerCare Plus or Wisconsin Medicaid and request to end their child's Foster Care Medicaid or SSI Medicaid.

Dual Coverage Impact on HMO Enrollment

When families are enrolling children in BadgerCare Plus while the child continues to be enrolled in Foster Care Medicaid or SSI Medicaid solely because of 12-month continuous coverage, the child can be enrolled in a BadgerCare Plus HMO.

If the child is dually enrolled in Foster Care Medicaid and BadgerCare Plus, they will not be automatically enrolled in a BadgerCare Plus HMO. If their family wants to enroll them in a BadgerCare Plus HMO, they must:

- ▮ Call the Wisconsin Department of Children and Families at 833-543-5265 and request to end their child's Foster Care Medicaid
- ▮ Then contact the HMO [Enrollment Specialist](#) and request to enroll the child in a BadgerCare Plus HMO

If the child is dually enrolled in SSI Medicaid and BadgerCare Plus, they will be automatically enrolled in a BadgerCare Plus HMO. If their family wants to end their SSI Medicaid fee-for-service coverage, they should call [Member Services](#).

Misuse and Abuse of Benefits

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 (Drug Utilization Review), 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 Kepro. Kepro 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 Kepro
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 \(F-11183 \(03/2023\)\)](#) 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 Kepro.
- | 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 Kepro 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.

Birth to 3 Program

Topic #792

Administration and Regulations

In Wisconsin, Birth to 3 services are administered at the local level by county departments of community programs, human service departments, public health agencies, or any other public agency designated or contracted by the county board of supervisors. The Wisconsin DHS (Department of Health Services) monitors, provides technical assistance, and offers other services to county Birth to 3 agencies.

The enabling federal legislation for the Birth to 3 Program is 34 CFR Part 303. The enabling state legislation is Wis. Stats. [§ 51.44](#), and the regulations are found in Wis. Admin. Code [ch. DHS 90](#).

Providers may contact the appropriate county Birth to 3 agency for more information.

Topic #790

Enrollment Criteria

A child from birth up to (but not including) age 3 is eligible for Birth to 3 services if the child meets one of the following criteria:

- ▮ The child has a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.
- ▮ The child has at least a 25 percent delay in one or more of the following areas of development:
 - ▮ Cognitive development
 - ▮ Physical development, including vision and hearing
 - ▮ Communication skills
 - ▮ Social or emotional development
 - ▮ Adaptive development, which includes self-help skills
- ▮ The child has atypical development affecting their overall development, as determined by a qualified team using professionally acceptable procedures and informed clinical opinion.

BadgerCare Plus provides Birth to 3 information because many children enrolled in the Birth to 3 Program are also BadgerCare Plus members.

Topic #791

Individualized Family Service Plan

A Birth to 3 member receives an IFSP (Individualized Family Service Plan) developed by an interdisciplinary team that includes the child's family. The IFSP provides a description of the outcomes, strategies, supports, services appropriate to meet the needs of the child and family, and the natural environment settings where services will be provided. All Birth to 3 services must be identified in the child's IFSP.

Topic #788

Requirements for Providers

Title 34 CFR Part 303 for Birth to 3 services requires all health, social service, education, and tribal programs receiving federal funds, including Medicaid providers, to do the following:

- | Identify children who may be eligible for Birth to 3 services. These children must be referred to the appropriate county Birth to 3 program within **two working days** of identification. This includes children with developmental delays, atypical development, disabilities, and children who are substantiated as abused or neglected. For example, if a provider's health exam or developmental screen indicates that a child may have a qualifying disability or developmental delay, the child must be referred to the county Birth to 3 program for evaluation. (Providers are encouraged to explain the need for the Birth to 3 referral to the child's parents or guardians.)
- | Cooperate and participate with Birth to 3 service coordination as indicated in the child's IFSP (Individualized Family Services Plan). Birth to 3 services must be provided by providers who are employed by, or under agreement with, a Birth to 3 agency to provide Birth to 3 services.
- | Deliver Birth to 3 services in the child's natural environment, unless otherwise specified in the IFSP. The child's natural environment includes the child's home and other community settings where children without disabilities participate. (Hospitals contracting with a county to provide therapy services in the child's natural environment must receive separate enrollment as a therapy group to be reimbursed for these therapy services.)
- | Assist parents or guardians of children receiving Birth to 3 services to maximize their child's development and participate fully in implementation of their child's IFSP. For example, an occupational therapist is required to work closely with the child's parents and caretakers to show them how to perform daily tasks in ways that maximize the child's potential for development.

Topic #789

Services

The Birth to 3 Program covers the following types of services when they are included in the child's IFSP (Individualized Family Services Plan):

- | Evaluation and assessment
- | Special instruction
- | OT (occupational therapy)
- | PT (physical therapy)
- | SLP (speech and language pathology)
- | Audiology
- | Psychology
- | Social work
- | Assistive technology
- | Transportation
- | Service coordination
- | Certain medical services for diagnosis and evaluation purposes
- | Certain health services to enable the child to benefit from early intervention services
- | Family training, counseling, and home visits

Coordination of Benefits

6

Archive Date:06/03/2024

Coordination of Benefits:Other Coverage Information

Topic #4940

After Reporting Discrepancies

After receiving a [Commercial Other Coverage Discrepancy Report \(F-01159 \(04/2017\)\)](#) form or [Medicare Other Coverage Discrepancy Report \(F-02074 \(04/2018\)\)](#) 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 (Enrollment Verification System) that the member's other coverage information has been updated.
- ▮ The provider receives a written explanation.

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 #609

Insurance Disclosure Program

ForwardHealth receives policyholder files from most major commercial health insurance companies on a monthly basis. ForwardHealth then compares this information with member enrollment files. If a member has commercial health insurance, ForwardHealth revises the member's enrollment file with the most current information.

The insurance company is solely responsible for the accuracy of this data. If the insurance company provides information that is not current, ForwardHealth's files may be inaccurate.

Topic #610

Maintaining Accurate and Current Records

ForwardHealth uses many sources of information to keep accurate and current records of a member's other coverage, including the following:

- ▮ Insurance Disclosure program
- ▮ Providers who submit an [Commercial Other Coverage Discrepancy Report \(F-01159 \(04/2017\)\)](#) form or [Medicare Other Coverage Discrepancy Report \(F-02074 \(04/2018\)\)](#) form
- ▮ Member certifying agencies

- Members

The information about a member's other health insurance coverage in the member files may be incomplete or incorrect if ForwardHealth received inaccurate information from the other health insurance source or the member's certifying agency.

Topic #4942

Reporting Discrepancies

Providers are encouraged to report discrepancies to ForwardHealth by submitting the [Commercial Other Coverage Discrepancy Report \(F-01159 \(04/2017\)\)](#) form or [Medicare Other Coverage Discrepancy Report \(F-02074 \(04/2018\)\)](#) 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 (Enrollment Verification System).
- ▮ 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 (e.g., 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 (managed care organization).

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.

Commercial Health Insurance

Topic #601

Definition of Commercial Health Insurance

Commercial health insurance is defined as any type of health benefit not obtained from Medicare or Wisconsin Medicaid and BadgerCare Plus. The insurance may be employer-sponsored or privately purchased. Commercial health insurance may be provided on a fee-for-service basis or through a managed care plan.

Common types of commercial health insurance include HMOs, PPOs (preferred provider organizations), POS (point-of-service) plans, Medicare Advantage plans, Medicare supplemental plans, dental plans, vision plans, HRAs (health reimbursement accounts), and LTC (long term care) plans. Some commercial health insurance providers restrict coverage to a specified group of providers in a particular service area.

When commercial health insurance plans require members to use a designated network of providers, non-network (i.e., providers who do not have a contract with the member's commercial health insurance plan) will be reimbursed by the commercial health insurance plan **only** if they obtain a referral or provide an emergency service.

Except for emergency services and covered services that are not covered under the commercial health insurance plan, members enrolled in both a commercial health insurance plan and BadgerCare Plus or Wisconsin Medicaid (i.e., state-contracted MCO (managed care organization), fee-for-service) are required to receive services from providers affiliated with the commercial health insurance plan. In this situation, providers are required to refer the members to the commercial health insurance plan's network providers. This is necessary because commercial health insurance is always primary to BadgerCare Plus.

BadgerCare Plus and Wisconsin Medicaid will **not** reimburse the provider if the commercial health insurance plan denied or would deny payment because a service otherwise covered under the commercial health insurance plan was performed by a provider outside the plan. In addition, if a member receives a covered service outside their commercial health insurance plan, the provider cannot collect payment from the member.

Topic #18497

Explanation of Medical Benefits Form Requirement

An [Explanation of Medical Benefits \(F-01234 \(04/2018\)\)](#) form must be included for each other payer when other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) sources are indicated on a paper claim or paper adjustment.

Note: ADA (American Dental Association) 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 (i.e., 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 (837 Health Care Claim) transaction (including those submitted using PES (Provider Electronic Solutions) 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 (Wisconsin Chronic Disease Program). 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 (managed care organization).

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 (Optical Character Recognition) 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 #3760

Mental Health and Substance Abuse Services Requiring Other Health Insurance Billing

The following table lists mental health and substance abuse services that may require providers to bill other insurance sources before billing BadgerCare Plus.

Service	Bill Commercial Health Insurance?	Bill Medicare?
Adult Mental Health Day Treatment Services	Yes	Yes
Case Management for Mental Health/Substance Abuse Services	No	No
Central Nervous System Assessments/Tests	Yes	Yes
Child/Adolescent Day Treatment Services (HealthCheck "Other Services")	Yes	No
Clozapine Management Services	Yes	No
Community Recovery Services	No	No
Community Support Program Services	No	No
Comprehensive Community Services	No	No
Crisis Intervention Services	No	No
Health and Behavior Assessment/Intervention	Yes	Yes
In-Home Mental Health/Substance Abuse Treatment Services for Children (HealthCheck	Yes	Yes

"Other Services") rendered by providers at the master's degree level, doctoral level, and psychiatrist level		
In-Home Mental Health/Substance Abuse Treatment Services for Children (HealthCheck "Other Services") rendered by providers at the less than bachelor degree level, bachelor's degree level, QTT (qualified treatment trainee) level, or certified psychotherapist level	No	Yes
Narcotic Treatment Services	Yes	Yes
Outpatient Mental Health Services (Evaluation, Psychotherapy)	Yes	Yes
Outpatient Mental Health and/or Substance Abuse Services in the Home or Community for Adults	Yes	Yes
Outpatient Substance Abuse Services	Yes	Yes
Substance Abuse Day Treatment Services	Yes	Yes

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 (Comprehensive Community Services)
- | Crisis Intervention services
- | CRS (Community Recovery Services)
- | CSP (Community Support Program) 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 (qualified treatment trainee) level, or certified psychotherapist level
- | Personal care services
- | PNCC (prenatal care coordination) services
- | Preventive pediatric services
- | SMV (specialized medical vehicle) services

Medicare

Topic #672

Definition of Medicare

Medicare is a health insurance program for people 65 years of age or older, for certain people with disabilities under age 65, and for people with ESRD (end-stage renal disease). Medicare is a federal government program created under Title XVIII of the Social Security Act.

Medicare coverage is divided into four parts:

- ▮ Part A (i.e., Hospital Insurance). Part A helps to pay for medically necessary services, including inpatient hospital services, services provided in critical access hospitals (i.e., small facilities that give limited inpatient services and outpatient services to beneficiaries who reside in rural areas), services provided in skilled nursing facilities, hospice services, and some home health services.
- ▮ Part B (i.e., Supplemental Medical Insurance). Part B helps to pay for medically necessary services, including physician services, outpatient hospital services, and some other services that Part A does not cover (such as PT (physical therapy) services, OT (occupational therapy) services, and some home health services).
- ▮ Part C (i.e., Medicare Advantage). A commercial health plan that acts for Medicare Parts A and B, and sometimes Medicare Part D, for all Medicare covered services except hospice. Medicare Part A continues to provide coverage for hospice services. There are limitations on coverage outside of the carrier's provider network.
- ▮ Part D (i.e., drug benefit).

Provider-Based Billing

Topic #660

Purpose of Provider-Based Billing

The purpose of provider-based billing is to reduce costs by ensuring that providers receive maximum reimbursement from other health insurance sources that are primary to BadgerCare Plus or Wisconsin Medicaid. For example, a provider-based billing claim is created when BadgerCare Plus or Wisconsin Medicaid pays a claim and later discovers that other coverage exists or was made retroactive. Since BadgerCare Plus and Wisconsin Medicaid benefits are secondary to those provided by most other health insurance sources, providers are required to seek reimbursement from the primary payer, as stated in Wis. Admin. Code § [DHS 106.03\(7\)](#).

Topic #658

Questions About Provider-Based Billing

For questions about provider-based billing claims that are within the 120-day limit, providers may call the Coordination of Benefits Unit at 608-243-0676. Providers may fax the corresponding Provider-Based Billing Summary to 608-221-4567 at the time of the telephone call.

For questions about provider-based billing claims that are **not** within the 120-day limit, providers may call [Provider Services](#).

Topic #661

Receiving Notification

When a provider-based billing claim is created, the provider will receive the following:

- ▮ A notification letter.
- ▮ A Provider-Based Billing Summary. The summary lists each claim from which a provider-based billing claim was created. The summary also indicates the corresponding primary payer for each claim and necessary information for providers to review and handle each claim.

If a member has coverage through multiple other health insurance sources, the provider may receive additional provider-based billing summaries and provider-based billing claims for each other health insurance source that is on file.

Accessing Provider-Based Billing Summary Reports

Providers can retrieve provider-based billing summary reports through the Portal by logging in to their secure provider Portal account. Once logged in, providers can click the Provider Based Bills (PBB) link located in the Quick Links box of the Providers area of the Portal to access the Provider Based Billing page. This page has links for the provider to download provider-based summary reports in .csv or .pdf format.

Refer to the [Provider-Based Billing Retrieval User Guide](#) for step-by-step instructions on how to access the Provider Based Billing page and download provider-based summary reports.

Note: ForwardHealth also sends the paper provider-based billing summary report to the provider's "mail to" address on file in the Portal.

The provider-based billing process runs monthly on the first full weekend of every month and files are available once the process is completed.

Topic #659

Responding to ForwardHealth After 120 Days

If a response is not received within 120 days, the amount originally paid by BadgerCare Plus or Wisconsin Medicaid will be withheld from future payments. This is not a final action. To receive payment after the original payment has been withheld, providers are required to submit the required documentation to the appropriate address as indicated in the following tables. For DOS (dates of service) that are within claims submission deadlines, providers should refer to the first table. For DOS that are beyond claims submission deadlines, providers should refer to the second table.

Within Claims Submission Deadlines		
Scenario	Documentation Requirement	Submission Address
The provider discovers through the EVS (Enrollment Verification System) that ForwardHealth has removed or enddated the other health insurance coverage from the member's file.	A claim according to normal claims submission procedures (do not use the provider-based billing summary).	ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784
The provider discovers that the member's other coverage information (that is, enrollment dates) reported by the EVS is invalid.	- A Commercial Other Coverage Discrepancy Report (F-01159 (04/2017)) form or Medicare Other Coverage Discrepancy Report (F-02074 (04/2018)) form. - A claim according to normal claims submission procedures after verifying that the member's other coverage information has been updated by using the EVS (do not use the provider-based billing summary).	Send the Commercial Other Coverage Discrepancy Report form or Medicare Other Coverage Discrepancy Report form to the address indicated on the form. Send the claim to the following address: ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784
The other health insurance source reimburses or partially reimburses the provider-based billing claim.	- A claim according to normal claims submission procedures (do not use the provider-based billing summary). - The appropriate other insurance indicator on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.	ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784

	▮ The amount received from the other health insurance source on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.	
The other health insurance source denies the provider-based billing claim.	▮ A claim according to normal claims submission procedures (do not use the provider-based billing summary). ▮ The appropriate other insurance indicator or Medicare disclaimer code on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.	ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784
The commercial health insurance carrier does not respond to an initial and follow-up provider-based billing claim.	▮ A claim according to normal claims submission procedures (do not use the provider-based billing summary). ▮ The appropriate other insurance indicator on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.	ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784

Beyond Claims Submission Deadlines		
Scenario	Documentation Requirement	Submission Address
The provider discovers through the EVS that ForwardHealth has removed or enddated the other health insurance coverage from the member's file.	▮ A claim (do not use the provider-based billing summary). ▮ A Timely Filing Appeals Request (F-13047 (08/2015)) form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
The provider discovers that the member's other coverage information (that is, enrollment dates) reported by the EVS is invalid.	▮ A Commercial Other Coverage Discrepancy Report form or Medicare Other Coverage Discrepancy Report form. ▮ After using the EVS to verify that the member's other coverage information has been updated, include both of the following: ▮ A claim (do not use the provider-based billing summary.)	Send the Commercial Other Coverage Discrepancy Report form or Medicare Other Coverage Discrepancy Report form to the address indicated on the form. Send the timely filing appeals request to the following address:

	▫ A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
The commercial health insurance carrier reimburses or partially reimburses the provider-based billing claim.	▫ A claim (do not use the provider-based billing summary). ▫ Indicate the amount received from the commercial health insurance on the claim or complete and submit the Explanation of Medical Benefits form, as applicable. ▫ A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
The other health insurance source denies the provider-based billing claim.	▫ A claim. ▫ The appropriate other insurance indicator or Medicare disclaimer code on the claim or complete and submit the Explanation of Medical Benefits form, as applicable. ▫ A Timely Filing Appeals Request form according to normal timely filing appeals procedures. ▫ The Provider-Based Billing Summary. ▫ Documentation of the denial, including any of the following: ▫ Remittance information from the other health insurance source. ▫ A written statement from the other health insurance source identifying the reason for denial. ▫ A letter from the other health insurance source indicating a policy termination date that proves that the other health insurance source paid the member. ▫ A copy of the insurance card or other documentation from the other health insurance source that indicates that the policy provides limited coverage such as pharmacy, dental, or Medicare supplemental coverage only.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

	The DOS, other health insurance source, billed amount, and procedure code indicated on the documentation must match the information on the Provider-Based Billing Summary.	
The commercial health insurance carrier does not respond to an initial and follow-up provider-based billing claim.	- A claim (do not use the provider-based billing summary). - The appropriate other insurance indicator on the claim or complete and submit the Explanation of Medical Benefits form, as applicable. - A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

Topic #662

Responding to ForwardHealth Within 120 Days

Within 120 days of the date on the Provider-Based Billing Summary, the Provider-Based Billing Unit must receive documentation verifying that one of the following occurred:

- The provider discovers through the EVS (Enrollment Verification System) that ForwardHealth has removed or ended the other health insurance coverage from the member's file.
- The provider verifies that the member's other coverage information reported by ForwardHealth is invalid.
- The other health insurance source reimbursed or partially reimbursed the provider-based billing claim.
- The other health insurance source denied the provider-based billing claim.
- The other health insurance source failed to respond to an initial **and** follow-up provider-based billing claim.

When responding to ForwardHealth within 120 days, providers are required to submit the required documentation to the appropriate address as indicated in the following table. If the provider's response to ForwardHealth does not include all of the required documentation, the information will be returned to the provider. The provider is required to send the complete information within the original 120-day limit.

Scenario	Documentation Requirement	Submission Address
The provider discovers through the EVS that ForwardHealth has removed or ended the other health insurance coverage from the member's file.	- The Provider-Based Billing Summary. - Indication that the EVS no longer reports the member's other coverage.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax 608-221-4567
The provider discovers that the member's other coverage information (i.e., enrollment dates) reported by the EVS is invalid.	- The Provider-Based Billing Summary. - One of the following: - The name of the person with whom the provider spoke and the member's correct other coverage information.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax 608-221-4567

	▪ A printed page from an enrollment website containing the member's correct other coverage information.	
The other health insurance source reimburses or partially reimburses the provider-based billing claim.	▪ The Provider-Based Billing Summary. ▪ A copy of the remittance information received from the other health insurance source. ▪ The DOS (date of service), other health insurance source, billed amount, and procedure code indicated on the other insurer's remittance information must match the information on the Provider-Based Billing Summary. ▪ A copy of the Explanation of Medical Benefits form, as applicable. <i>Note:</i> In this situation, ForwardHealth will initiate an adjustment if the amount of the other health insurance payment does not exceed the allowed amount (even though an adjustment request should not be submitted). However, providers (except nursing home and hospital providers) may issue a cash refund. Providers who choose this option should include a refund check but should not use the Claim Refund form.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax 608-221-4567
The other health insurance source denies the provider-based billing claim.	▪ The Provider-Based Billing Summary. ▪ Documentation of the denial, including any of the following: ▪ Remittance information from the other health insurance source. ▪ A letter from the other health insurance source indicating a policy termination date that precedes the DOS. ▪ Documentation indicating that the other health insurance source paid the member. ▪ A copy of the insurance card or other	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax 608-221-4567

	documentation from the other health insurance source that indicates the policy provides limited coverage such as pharmacy, dental, or Medicare supplemental coverage. ▪ A copy of the Explanation of Medical Benefits form, as applicable. ▪ The DOS, other health insurance source, billed amount, and procedure code indicated on the documentation must match the information on the Provider-Based Billing Summary.	
The other health insurance source fails to respond to the initial and follow-up provider-based billing claim.	▪ The Provider-Based Billing Summary. ▪ Indication that no response was received by the other health insurance source. ▪ Indication of the dates that the initial and follow-up provider-based billing claims were submitted to the other health insurance source.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax 608-221-4567

Topic #663

Submitting Provider-Based Billing Claims

For each provider-based billing claim, the provider is required to send a claim to the appropriate other health insurance source. The provider should add all information required by the other health insurance source to the claim. The providers should also attach additional documentation (e.g., Medicare's remittance information) if required by the other health insurance source.

Reimbursement for Services Provided for Accident Victims

Topic #657

Billing Options

Providers may choose to seek payment from either of the following:

- ▮ Civil liabilities (e.g., injuries from an automobile accident)
- ▮ Worker's compensation

However, as stated in Wis. Admin. Code § [DHS 106.03\(8\)](#), BadgerCare Plus and Wisconsin Medicaid will not reimburse providers if they receive payment from either of these sources.

The provider may choose a different option for each DOS (date of service). For example, the decision to submit one claim to ForwardHealth does not mean that all claims pertaining to the member's accident must be submitted to ForwardHealth.

Topic #829

Points of Consideration

Providers should consider the time and costs involved when choosing whether to submit a claim to ForwardHealth or seek payment from a settlement.

Time

Providers are not required to seek payment from worker's compensation or civil liabilities, rather than seeking reimbursement from BadgerCare Plus or Wisconsin Medicaid, because of the time involved to settle these cases. While some worker's compensation cases and certain civil liability cases may be settled quickly, others may take several years before settlement is reached.

Costs

Providers may receive more than the allowed amount from the settlement; however, in some cases the settlement may not be enough to cover all costs involved.

Topic #826

Seeking Payment from Settlement

After choosing to seek payment from a settlement, the provider may **instead** submit the claim to ForwardHealth as long as it is submitted before the claims submission deadline. For example, the provider may instead choose to submit the claim to ForwardHealth because no reimbursement was received from the liability settlement or because a settlement has not yet been reached.

Topic #827

Submitting Claims to ForwardHealth

If the provider chooses to submit a claim to ForwardHealth, they may not seek further payment for that claim in any liability settlement that may follow. Once a claim is submitted to ForwardHealth, the provider may not decide to seek reimbursement for that claim in a liability settlement. Refunding payment and then seeking payment from a settlement may constitute a felony. If a settlement occurs, ForwardHealth retains the sole right to recover medical costs.

Providers are required to indicate an accident-related diagnosis code on claims when services are provided to an accident victim. If the member has other health insurance coverage, the provider is required to exhaust the other health insurance sources before submitting the claim to ForwardHealth.

Resources

7

Archive Date:06/03/2024

Resources: WiCall

Topic #257

Enrollment Inquiries

WiCall is an [AVR \(Automated Voice Response\)](#) 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 (date of service) 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 (Health Personnel Shortage Area) on the DOS or within the DOS range selected, HPSA information will be given.
- | MCO (managed care organization): 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 (National Provider Identifier). Because taxonomy codes are a combination of numbers and letters, telephone key pad combinations, shown in the table below, allow providers to successfully enter taxonomy code letters for WiCall functions (e.g., press *21 to enter an "A," press *72 to enter an "R").

Letter	Key Combination	Letter	Key Combination
A	*21	N	*62
B	*22	O	*63
C	*23	P	*71
D	*31	Q	*11
E	*32	R	*72
F	*33	S	*73
G	*41	T	*81
H	*42	U	*82
I	*43	V	*83
J	*51	W	*91
K	*52	X	*92
L	*53	Y	*93
M	*61	Z	*12

Additionally, providers may select option 9 and press "#" for an automated voice explanation of how to enter letters in WiCall.

Topic #466

Information Available Via WiCall

WiCall, ForwardHealth's AVR (Automated Voice Response) 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 (prior authorization) 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 (National Provider Identifier) 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, i.e., Wisconsin Medicaid, WCDP (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program)) and entering their provider ID, member identification number, DOS (date of service), 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 (Social Security number). 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 (i.e., NDC (National Drug Code), procedure code, revenue code, or ICD (International Classification of Diseases) 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.

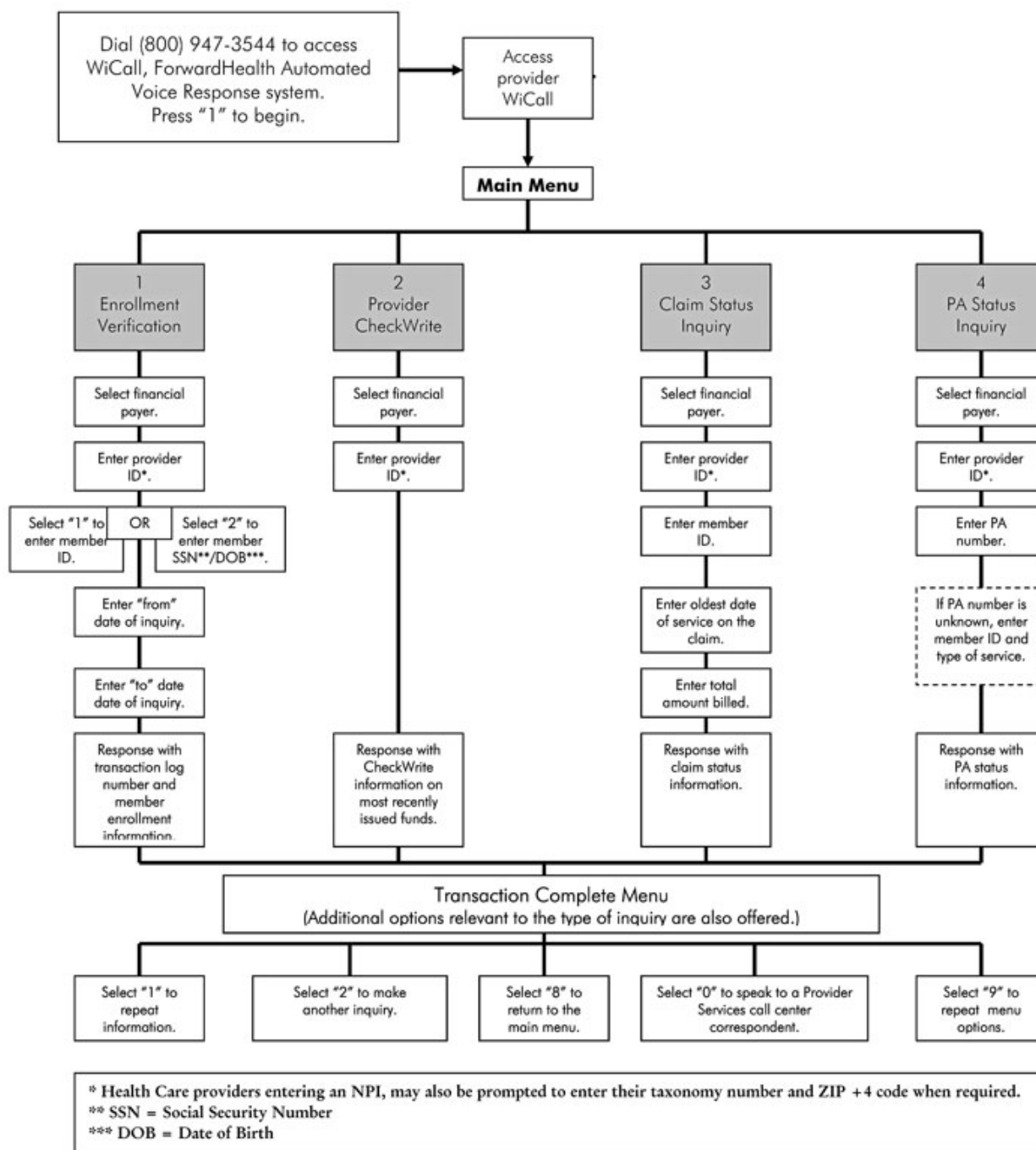
Note: PA information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

Topic #765

Quick Reference Guide

The WiCall [AVR \(Automated Voice Response\) Quick Reference Guide](#) displays the information available for WiCall inquiries.

Automated Voice Response Quick Reference Guide



Electronic Data Interchange

Topic #459

Companion Guides and NCPDP Version D.0 Payer Sheet

Companion guides and the NCPDP (National Council for Prescription Drug Programs) 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, ADAP (Wisconsin AIDS Drug Assistance Program), WCDP (Wisconsin Chronic Disease Program), and WWP (Wisconsin Well Woman Program). 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 (Health Insurance Portability and Accountability Act of 1996) implementation guides and highlight information that trading partners need to successfully exchange electronic transactions with ForwardHealth, including general topics such as the following:

- ┆ Methods of exchanging electronic information (e.g., exchange interfaces, transaction administration, and data preparation)
- ┆ Instructions for constructing the technical component of submitting or receiving electronic transactions (e.g., claims, RA (Remittance Advice), 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 (e.g., identification information, testing, and exchange preparation)
- ┆ Transaction administration (e.g., tracking claims submissions, contacting the [EDI \(Electronic Data Interchange\) 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 (e.g., 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 \(Electronic Data Interchange\) 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 (National Council for Prescription Drug Programs) D.0, 270/271 (270/271 Eligibility & Benefit Inquiry and Response), 276/277 (276/277 Health Care Claim Status Request and Response), or 278 (278 Health Care Services Review — Request for Review and Response) transactions via an approved clearinghouse

The EDI Helpdesk supports the exchange of the transactions for BadgerCare Plus, Medicaid, SeniorCare, ADAP (Wisconsin AIDS Drug Assistance Program), WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program).

Topic #461

Electronic Data Interchange Helpdesk

The [EDI \(Electronic Data Interchange\) 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 (Health Insurance Portability and Accountability Act of 1996) ASC (Accredited Standards Committee) X12 Version 5010 Companion Guides and the NCPDP (National Council for Prescription Drug Programs) 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 \(Electronic Data Interchange\) Helpdesk](#), trading partners may exchange the following electronic transactions:

- ▮ 270/271 (270/271 Eligibility & Benefit Inquiry and Response). The 270 is the electronic transaction for inquiring about a member's enrollment. The 271 is received in response to the inquiry.

- ▮ 276/277 (276/277 Health Care Claim Status Request and Response). The 276 is the electronic transaction for checking claim status. The 277 is received in response.
- ▮ 278 (278 Health Care Services Review — Request for Review and Response). The electronic transaction for health care service PA (prior authorization) requests.
- ▮ 835 (835 Health Care Claim Payment/Advice). The electronic transaction for receiving remittance information.
- ▮ 837 (837 Health Care Claim). The electronic transaction for submitting claims and adjustment requests.
- ▮ 999 (999 Acknowledgment for Health Care Insurance). 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 (Point-of-Sale) electronic transaction for submitting pharmacy claims.

Topic #463

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. PES (Provider Electronic Solutions) software allows providers to submit 837 (837 Health Care Claim) transactions and download the 999 (999 Acknowledgment for Health Care Insurance) and the 835 (835 Health Care Claim Payment/Advice) 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 \(Electronic Data Interchange\) 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 (Provider Electronic Solutions) 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 \(Electronic Data Interchange\) 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

Topic #256

270/271 Transactions

The [270/271 \(270/271 Health Care Eligibility/Benefit Inquiry and Information Response\)](#) 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 (National Provider Identifier), 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 (managed care organization) enrollment
- | Medicare enrollment
- | Limited benefits categories
- | Any other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) coverage
- | Exemption from copayments 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 (Enrollment Verification System) 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 (date of service) 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 (Enrollment Verification System) to receive the most current enrollment information through the following methods:

- ┆ ForwardHealth Portal
- ┆ [WiCall](#), Wisconsin's AVR (Automated Voice Response) system
- ┆ Commercial enrollment verification vendors
- ┆ 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Response) 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:

- ┆ Go to the ForwardHealth Portal.
- ┆ Establish a provider account.
- ┆ Log into the secure Portal.
- ┆ Click on the menu item for enrollment verification.

Providers will receive a unique transaction number for each enrollment verification inquiry. Providers may access a history of their enrollment inquiries using the Portal, which will list the date the inquiry was made and the enrollment information that was given on the date that the inquiry was made. For a more permanent record of inquiries, providers are advised to use the "print screen" function to save a paper copy of enrollment verification inquiries for their records or document the transaction number at the beginning of the response, for tracking or research purposes. This feature allows providers to access enrollment verification history when researching claim denials due to enrollment issues.

The Provider Portal is available 24 hours a day, seven days a week.

Topic #4900

Entering Dates of Service

Enrollment information is provided based on a "From" DOS (date of service) 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 (Wisconsin Chronic Disease Program) members:

- ┆ The "From" DOS is the earliest date the provider requires enrollment information.
- ┆ The "To" DOS must be within 365 days of the "From" DOS.
- ┆ If the date of the request is prior to the 20th of the current month, then providers may enter a "From" DOS and "To" DOS up to the end of the current calendar month.
- ┆ If the date of the request is on or after the 20th of the current month, then providers may enter a "From" DOS and "To" DOS up to the end of the following calendar month.

For example, if the date of the request was November 15, 2008, the provider could request dates up to and including November 30, 2008. If the date of the request was November 25, 2008, the provider could request dates up to and including December 31, 2008.

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 (Enrollment Verification System) 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 (Social Security number) 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 (date of service) 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 (Enrollment Verification System), 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 (Wisconsin Chronic Disease Program).
- | WWWP (Wisconsin Well Woman Program).

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

Topic #767

An Overview

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

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 (Portable Document Format) files, which can be viewed with Adobe Reader computer software. Providers may also complete and print fillable PDF files using Adobe Reader.

To complete a fillable PDF, follow these steps:

- ┆ Select a specific form.
- ┆ Save the form to the computer.
- ┆ Use the "Tab" key to move from field to field.

Note: The Portal provides instructions on how to obtain Adobe Reader at no charge from the Adobe 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:

- ┆ Select a specific form.
- ┆ Save the form to the computer.
- ┆ Use the "Tab" key to move from field to field.

Note: Providers may save fillable Microsoft Word documents to their computer by choosing "Save As" from the "File" menu, creating a file name, and selecting "Save" on their desktop.

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:

- ┆ Requesting a paper copy of the form by calling [Provider Services](#). Questions about forms may also be directed to Provider

Services.

- Submitting a written request and mailing it to ForwardHealth. Include a return address, the name of the form, and the form number and send the request to the following address:

ForwardHealth
Form Reorder
313 Blettner Blvd
Madison WI 53784

Updates

Topic #478

Accessing ForwardHealth Communications

[ForwardHealth Updates](#) announce changes in policy and coverage, prior authorization 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 e-mail subscription, providers and other interested parties are able to select, by program (for example, Wisconsin Medicaid, BadgerCare Plus, ADAP (Wisconsin AIDS Drug Assistance Program), or WCDP (Wisconsin Chronic Disease Program)), provider type (for example, physician, hospital, DME (durable medical equipment) vendor), and/or specific area of interest, (Trading Partner and ICD-10 (International Classification of Diseases, 10th Revision) 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 e-mail subscription and may select multiple subscription options.

Registering for E-mail Subscription

Users may sign up for an e-mail subscription by following these steps:

1. Click the [Register for E-mail Subscription](#) link on the ForwardHealth Portal home page.
2. The Subscriptions page will be displayed. In the E-Mail field in the New Subscriber section, enter the e-mail address to which messages should be sent.
3. Enter the e-mail address again in the Confirm E-Mail 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

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:

- ┆ Dental providers
- ┆ Milwaukee County

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 (prior authorization) 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 (Provider Electronic Solutions) 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 (protected health information), 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 (National Provider Identifier) 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:

- | Member's name
- | Member ID number
- | Claim number
- | DOS (date of service)

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 (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program) 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 (coordination of benefits) (for example, verifying a member's other health insurance coverage)
- | Assistance with completing forms
- | Assistance with remittance information and claim denials
- | Policy clarification
- | PA (prior authorization) 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 (National Provider Identifier) 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 (internal control number)
- ▮ PA number
- ▮ DOS (date of service)
- ▮ Amount billed
- ▮ RA (Remittance Advice)
- ▮ 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.-4:00 p.m. (CST), 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 \(F-01170 \(07/2012\)\)](#) 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.

ForwardHealth Portal	www.forwardhealth.wi.gov/	24 hours a day, seven days a week
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.		
WiCall Automated Voice Response System	800-947-3544	24 hours a day, seven days a week
WiCall, the ForwardHealth AVR (Automated Voice Response) system, provides responses to the following inquiries:		
- Checkwrite - Claim status - PA (prior authorization) - Member enrollment		
ForwardHealth Provider Services Call Center	800-947-9627	Call center representatives: Monday through Friday, 7 a.m. to 6 p.m. (Central time)* Virtual agent: 24 hours a day, seven days a week
To assist providers in the following programs:		
- BadgerCare Plus - Medicaid - SeniorCare - ADAP (Wisconsin AIDS Drug Assistance Program) - WCDP (Wisconsin Chronic Disease Program) - Wisconsin Medicaid and BadgerCare Plus Managed Care Programs - Wisconsin Well Woman Medicaid - WWWP (Wisconsin Well Woman Program)		
ForwardHealth Portal Helpdesk	866-908-1363	Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central time)*
To assist providers and trading partners with technical questions regarding Portal functions and capabilities, including Portal		

accounts, registrations, passwords, and submissions through the Portal.

Electronic Data Interchange Helpdesk	866-416-4979	Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central time)*
For providers, including trading partners, billing services, and clearinghouses with technical questions about the following:		
┆ Electronic transactions ┆ Companion documents ┆ PES (Provider Electronic Solutions) software		
Managed Care Provider Appeals	800-760-0001, Option 1	Monday through Friday, 7 a.m. to 6 p.m. (Central time)*
To assist BadgerCare Plus/Medicaid SSI (Supplemental Security Income) HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) providers with questions regarding their appeal status and other general managed care provider appeal information.		
Managed Care Ombudsman Program	800-760-0001	Monday through Friday, 7 a.m. to 6 p.m. (Central time)*
To assist managed care enrollees with questions about enrollment, rights, responsibilities, and general managed care information.		
Member Services	800-362-3002	Monday through Friday, 8 a.m. to 6 p.m. (Central time)*
To assist ForwardHealth members, or persons calling on behalf of members, with program information and requirements, enrollment, finding enrolled providers, and resolving concerns.		
Wisconsin AIDS Drug Assistance Program	800-991-5532	Monday through Friday, 8 a.m. to 4:30 p.m. (Central time)*
To assist ADAP 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

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 (managed care organization) data for long-term care MCOs.
- | Electronic messages
- | Enrollment verification by entering a member ID or SSN (Social Security number) with date of birth and a "from DOS (date of service)" 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 (i.e., paper, electronic, clearinghouse). If a claim contains an error, providers can correct it on the Portal and resubmit it to ForwardHealth.

Providers can submit an individual claim or adjust a claim through DDE (Direct Data Entry) 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 (personal identification number) 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 (National Provider Identifier) 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 (e.g., licenses, certifications) using the demographic maintenance tool. Documents in the following formats can be uploaded:

- ┆ JPEG (Joint Photographic Experts Group) (.jpg or .jpeg)
- ┆ PDF (Portable Document Format) (.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 (835 Health Care Claim Payment/Advice) 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 \(Electronic Data Interchange\) Helpdesk](#) or submit a [paper \(Trading Partner 835 Designation, F-13393 \(07/12\)\)](#) 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 (managed care organization)
- | 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 (Enrollment Verification System) (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 (managed care organization)
- | 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 (i.e., 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 \(Provider Electronic Solutions\)](#) 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 (managed care organizations) 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 (file transfer protocol).

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 (personal identification number). 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 (National Provider Identifier) and corresponding taxonomy code when requesting an account. Non-healthcare providers will need to supply their unique provider number.

Providers may request a PIN by following these steps:

1. Go to the [Portal](#).
2. Click on the "Providers" link or button.
3. Click the "Request Portal Access" link from the Quick Links box on the right side of the screen.
4. At the Request Portal Access screen, enter the following information:
 - a. Health care providers are required to enter their NPI and click "Search" to display a listing of ForwardHealth

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 (Social Security number) or TIN (Tax Identification Number).

- b. Non-healthcare providers are required to enter their provider number, financial payer, and SSN or TIN. (This option should only be used by non-healthcare providers who are exempt from NPI requirements).

The financial payer is one of the following:

- ┆ Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and Senior Care.)
- ┆ SSI (Supplemental Security Income)
- ┆ WCDP (Wisconsin Chronic Disease Program)
- ┆ The WWWP (Wisconsin Well Woman Program)

- 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, ADAP (Wisconsin AIDS Drug Assistance Program), and WCDP (Wisconsin Chronic Disease Program). 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 (Remittance Advice).
- ▮ Designate which trading partner is eligible to receive the provider's 835 (835 Health Care Claim Payment/Advice).
- ▮ 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 (electronic funds transfer).
- ▮ Track provider-submitted PA (prior authorization) 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 (managed care organization).
- ▮ 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 (Health Insurance Portability Accountability Act of 1996). 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 (protected health information) 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 (i.e., claims, PA (prior authorization), 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 (i.e., 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 (i.e., they may do member enrollment verification for one Portal account, and HealthCheck inquiries 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 (text) or CSV (comma separated value) files.

ForwardHealth Communications

[ForwardHealth Updates](#) announce changes in policy and coverage, PA (prior authorization) requirements, and claim submission requirements. They communicate new initiatives from the Wisconsin DHS (Department of Health Services) or new requirements from the federal CMS (Centers for Medicare & 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 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 (that is, 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 (application tracking number) 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 (prior authorization) 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 (i.e., paper, electronic, clearinghouse). If a claim contains an error, providers can correct it on the Portal and resubmit it to ForwardHealth.

Providers can submit an individual claim or adjust a claim via DDE (Direct Data Entry) 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 (Department of Health Services) 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 (managed care organization)
- | Whether or not the member has other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans), such as Medicare or commercial health insurance

Using the Portal to check enrollment may be more efficient than calling the AVR (Automated Voice Response) system or the EVS (Enrollment Verification System) (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 (Remittance Advices).
- | Designate which trading partner is eligible to receive the provider's 835 (835 Health Care Claim Payment/Advice) 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 (electronic funds transfer).
- | 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 (Provider Electronic Solutions) 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	Chrome v. 73 or higher, Edge v. 19 or higher,

150MB of free disk space	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 \(Provider Electronic Solutions\)](#) software and upgrade information
- | EDI (Electronic Data Interchange) [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

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 (e.g., 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 (Wisconsin Chronic Disease Program) or the WWWP (Wisconsin Well Woman Program)) 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 e-mail 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 e-mail 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 e-mail subscription, click "Register for E-mail Subscription" in the Quick Links box on the Provider page of the Portal.

Managed Care

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Archive Date:06/03/2024

Managed Care:Managed Care Information

Topic #401

BadgerCare Plus HMO Program

An HMO is a system of health care providers that provides a comprehensive range of medical services to a group of enrollees. HMOs receive a fixed, prepaid amount per enrollee from ForwardHealth (called a capitation payment) to provide medically necessary services.

BadgerCare Plus HMOs are responsible for providing or arranging all contracted covered medically necessary services to enrollees. BadgerCare Plus members enrolled in state-contracted HMOs are entitled to at least the same benefits as fee-for-service members; however, HMOs may establish their own requirements regarding PA (prior authorization), claims submission, adjudication procedures, etc., which may differ from fee-for-service policies and procedures. BadgerCare Plus HMO network providers should contact their HMO for more information about its policies and procedures.

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 (Children's Community Health Plan), 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 (automated voice response) 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 (prior authorization) and claim submission guidelines, if they are already a Care4Kids network provider

Topic #405

Managed Care

Managed Care refers to the BadgerCare Plus HMO program, the Medicaid SSI HMO program, and the following MLTC (managed long-term care) programs available: Family Care, Family Care Partnership, and PACE (Program of All-Inclusive Care for the Elderly).

The primary goals of the managed care programs are:

- ▮ To improve the quality of member care by providing continuity of care and improved access
- ▮ To reduce the cost of health care through better care management

Topic #402

Managed Care Contracts

The contract between the Wisconsin DHS (Department of Health Services) and the BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) takes precedence over other ForwardHealth provider publications. Information contained in ForwardHealth publications is used by DHS to resolve disputes regarding covered benefits that cannot be handled internally by HMOs or PIHPs. If there is a conflict, the HMO or PIHP contract prevails. If the contract does not specifically address a situation, Wisconsin Administrative Code ultimately prevails. HMO and PIHP contracts are available on the [Acute and Primary Managed Care page](#) (click the HMO Providers link, then the Resources and Help tab) for HMOs and on the [Children's Specialty Programs page](#) of the ForwardHealth Portal (click the Children's Specialty Managed Care Plans link, then the Policy tab) for PIHPs.

Topic #403

Managed Long-Term Care Programs

Wisconsin Medicaid has several MLTC (managed long-term care) programs that provide services to individuals who are elderly and/or who have disabilities. These members may be eligible to enroll in voluntary regional managed care programs such as Family Care, PACE (Program of All-Inclusive Care for the Elderly), and the Family Care Partnership Program. Additional information about these MLTC programs may be obtained from the Managed Care Organization area of the ForwardHealth Portal.

Topic #404

SSI HMO Program

Medicaid SSI HMOs provide the same benefits as Medicaid fee-for-service (e.g., medical, dental [in certain counties only], mental health/substance abuse, and vision) at no cost to their members through a care management model. Medicaid SSI members and SSI-related Medicaid members may be eligible to enroll in an SSI HMO.

SSI-related Medicaid members receive coverage from Wisconsin Medicaid because of a disability determined by the Disability Determination Bureau.

Member Enrollment

Certain eligible SSI members and SSI-related Medicaid adult members are required to enroll in an SSI HMO. The following groups are excluded from the requirement to enroll in an SSI HMO:

- ▮ Members under 19 years of age
- ▮ Members of a federally recognized tribe
- ▮ Dual eligible members
- ▮ MAPP (Medicaid Purchase Plan) eligible members
- ▮ Members enrolled in a LTC (long-term care) MCO (managed care organization) or waiver program

Continuity of Care

Special provisions are included in the contract for SSI HMOs for continuity of care for SSI members and SSI-related Medicaid members. These provisions include the following:

- ▮ Coverage of services provided by the member's current provider for the first 90 days of enrollment in the SSI program or until the first of the month following completion of an assessment and care plan, whichever comes later. The contracted provider should get a referral from the member's HMO after this.
- ▮ Honoring a PA (prior authorization) that is currently approved by ForwardHealth. The PA must be honored for 90 days or until the month following the HMO's completion of the assessment and care plan, whichever comes later.

To assure payment, non-contracted providers should contact the SSI HMO to confirm claim submission and reimbursement processes. If an SSI HMO is not honoring a PA that is currently approved by ForwardHealth, the provider should first contact the HMO. If the provider is not able to resolve their issue with the HMO, the provider should contact ForwardHealth Provider Services.

For new authorizations during the member's first 90 days of enrollment, the provider is required to follow the SSI HMO's PA process. SSI HMOs may use PA guidelines that differ from fee-for-service guidelines; however, these guidelines may not result in less coverage than fee-for-service.

Care Management

SSI HMO health plans employ a care management model to ensure high-quality care to members. The care management model provides each enrollee with the following:

- | An initial health assessment
- | A comprehensive care plan
- | Assistance in choosing providers and identifying a primary care provider
- | Assistance in accessing social and community services
- | Information about health education programs, treatment options, and follow-up procedures
- | Advocates on staff to assist members in choosing providers and accessing needed care

ForwardHealth requires all SSI HMO health plans to have dedicated care managers to assist providers in meeting the medical care needs of members. SSI HMOs, through their care management teams, will serve as single points of contact for providers who need assistance addressing the health care needs of members, especially those who have multiple points of contact within the health care system.

The SSI HMO care management teams will be responsible, when it is deemed appropriate, for notifying primary care providers of members' emergency room visits, hospital discharges, and other major medical events, as well as sharing patient-specific care management plans with appropriate providers to reduce hospital admissions and readmission, to reduce appointment no-shows, and to improve compliance with health care recommendations such as medication regimens.

Topic #20697

SSI Rate Regions

The map below shows the Wisconsin BadgerCare Plus and SSI (Supplemental Security Income) Rate Regions for the SSI HMO Program.

[SSI Rate Regions](#)



Enrollment

Topic #392

Disenrollment and Exemptions

In some situations, a member may be exempt from enrolling in a BadgerCare Plus HMO or Medicaid SSI HMO. Exempted members receive health care under fee-for-service. Exemptions allow members to complete a course of treatment with a provider who is not contracted with BadgerCare Plus HMO or SSI HMOs. For example, in certain circumstances, members seeing a specialist when they are enrolled in an HMO **may** qualify for an exemption if their specialty provider is not in the HMO networks.

The [contracts](#) between the Wisconsin DHS (Department of Health Services) and the HMOs provide more detail on the exemption and disenrollment requirements.

Topic #393

Enrollee Grievances

Enrollees have the right to file grievances about services or benefits provided by a BadgerCare Plus HMO or Medicaid SSI HMO. Enrollees also have the right to file a grievance when the HMO or SSI HMO refuses to provide a service. All HMOs and SSI HMOs are required to have written policies and procedures in place to handle enrollee grievances. Enrollees should be encouraged to work with their HMO's or SSI HMO's customer service department to resolve problems first.

If enrollees are unable to resolve problems by talking to their HMO or SSI HMO, or if they would prefer to speak with someone outside their HMO or SSI HMO, they should contact the [Enrollment Specialist](#) or the [Ombudsman Program](#).

The [contracts](#) between the Wisconsin DHS (Department of Health Services) and the HMO or SSI HMO describes the responsibilities of the HMO or SSI HMO and the DHS regarding enrollee grievances.

Topic #397

Enrollment Eligibility

BadgerCare Plus HMOs

Members enrolled in BadgerCare Plus are eligible for enrollment in a BadgerCare Plus HMO.

An individual who receives Tuberculosis-Related Medicaid, SeniorCare, or Wisconsin Well Woman Medicaid cannot be enrolled in a BadgerCare Plus HMO.

Information about a member's HMO enrollment status and other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) coverage may be verified by using Wisconsin's [EVS \(Enrollment Verification System\)](#) or the ForwardHealth Portal.

SSI HMOs

Members of the following subprograms are eligible for enrollment in a Medicaid SSI HMO:

- Individuals ages 19 and older who meet the SSI and SSI-related disability criteria
- Dual eligibles for Medicare and Medicaid

Individuals who are living in an institution, nursing home, or participating in a Home and Community-Based Waiver program are not eligible to enroll in an SSI MCO.

Topic #394

Enrollment Periods

BadgerCare Plus HMOs

Eligible enrollees are sent enrollment packets that explain the BadgerCare Plus HMOs and the enrollment process and provide contact information. Once enrolled in a BadgerCare Plus HMO, members may change their HMO assignment within the first 90 days of enrollment in an HMO (whether they chose the HMO or were auto-assigned). If an enrollee no longer meets the criteria, they will be disenrolled from the HMO.

SSI HMOs

Eligible enrollees are sent enrollment packets that explain the Medicaid SSI HMO enrollment process and provide contact information. Once enrolled in an SSI HMO, members may change their HMO assignment within the first 90 days of enrollment in an HMO (whether they chose the HMO or were auto-assigned).

Topic #395

Enrollment Specialist

The [Enrollment Specialist](#) provides objective enrollment, education, outreach, and advocacy services to BadgerCare Plus HMO and Medicaid SSI HMO enrollees. The Enrollment Specialist is a knowledgeable single point of contact for enrollees, solely dedicated to managed care issues. The Enrollment Specialist is not affiliated with any health care agency.

The Enrollment Specialist provides the following services to HMO and SSI HMO enrollees:

- Education regarding the correct use of HMO and SSI HMO benefits
- Telephone and face-to-face support
- Assistance with enrollment, disenrollment, and exemption procedures

Topic #398

Member Enrollment

HMOs

BadgerCare Plus HMO enrollment is either mandatory or voluntary based on ZIP code-defined enrollment areas as follows:

- Mandatory enrollment — Enrollment is mandatory for eligible members who reside in ZIP code areas served by two or more BadgerCare Plus HMOs. Some members may meet criteria for exemption from BadgerCare Plus HMO enrollment.
- Voluntary enrollment — Enrollment is voluntary for members who reside in ZIP code areas served by only one

BadgerCare Plus HMO.

Members living in areas where enrollment is mandatory are encouraged to choose their BadgerCare Plus HMO. Automatic assignment to a BadgerCare Plus HMO occurs if the member does not choose a BadgerCare Plus HMO. In general, all members of a member's immediate family eligible for enrollment must choose the same HMO.

Members in voluntary enrollment areas can choose whether or not to enroll in a BadgerCare Plus HMO. There is no automatic assignment for members who live within ZIP codes where enrollment is voluntary.

SSI HMOs

Medicaid SSI HMO enrollment is either mandatory or voluntary as follows:

- ▮ Mandatory enrollment — Most SSI and SSI-related members are required to enroll in an SSI HMO. A member may choose the SSI HMO in which he or she wishes to enroll.
- ▮ Voluntary enrollment — Some SSI and SSI-related members may choose to enroll in an SSI HMO on a voluntary basis.

Topic #396

Ombudsman Program

The [Ombudsmen](#), or Ombuds, are resources for enrollees who have questions or concerns about their BadgerCare Plus HMO or Medicaid SSI HMO. Ombuds provide advocacy and assistance to help enrollees understand their rights and responsibilities in the grievance and appeal process.

Ombuds can be contacted at the following address:

BadgerCare Plus HMO/Medicaid SSI HMO Ombudsmen
PO Box 6470
Madison WI 53716-0470

Topic #399

Release of Billing or Medical Information

ForwardHealth supports BadgerCare Plus HMO and Medicaid SSI HMO enrollee rights regarding the confidentiality of health care records. ForwardHealth has [specific standards](#) regarding the release of an HMO or SSI HMO enrollee's billing information or medical claim records.

Provider Information

Topic #406

Copayments

Providers cannot charge Medicaid SSI HMO enrollees copayments for covered services except in cases where the Medicaid SSI HMO does not cover services such as dental, chiropractic, and pharmacy. However, even in these cases, providers are prohibited from collecting copayment from members who are exempt from the copayment requirement.

When services are provided through fee-for-service or to members enrolled in a BadgerCare Plus HMO, copayments will apply, except when the member or the service is [exempt from the copayment requirement](#).

Topic #407

Emergencies

Non-network providers may provide services to BadgerCare Plus HMO and Medicaid SSI HMO enrollees in an emergency without authorization or in urgent situations when authorized by the HMO or SSI HMO. The [contract](#) between the Wisconsin DHS (Department of Health Services) and the HMO or SSI HMO defines an emergency situation and includes general payment requirements.

Unless the HMO or SSI HMO has a written agreement with the non-network provider, the HMO or SSI HMO is only liable to the extent fee-for-service would be liable for an emergency situation, as defined in 42 C.F.R. § 438.114. Billing procedures for emergencies may vary depending on the HMO or SSI HMO. For specific billing instructions, non-network providers should always contact the enrollee's HMO or SSI HMO.

Topic #408

Non-network Providers

Providers who do not have a contract with the enrollee's BadgerCare Plus HMO or Medicaid SSI HMO are referred to as non-network providers. (HMO and SSI HMO network providers agree to payment amounts and billing procedures in a contract with the HMO or SSI HMO.) Non-network providers are required to direct enrollees to HMO or SSI HMO network providers except in the following situations:

- ▮ When a non-network provider is treating an HMO or SSI HMO enrollee for an emergency medical condition as defined in the contract between the Wisconsin DHS (Department of Health Services) and the HMO or SSI HMO
- ▮ When the HMO or SSI HMO has authorized (in writing) an out-of-plan referral to a non-network provider
- ▮ When the service is not provided under the HMO's or SSI HMO's contract with the DHS (such as dental, chiropractic, and pharmacy services)

Non-network providers may not serve BadgerCare Plus HMO or Medicaid SSI HMO enrollees as private-pay patients.

Topic #409

Out-of-Area Care

BadgerCare Plus HMOs and Medicaid SSI HMOs may cover medically necessary care provided to enrollees when they travel outside the HMO's or SSI HMO's service area. The HMO or SSI HMO is required to authorize the services before the services are provided, except in cases of [emergency](#). If the HMO or SSI HMO does not authorize the services, the enrollee may be held responsible for the cost of those services.

Topic #410

Provider Participation

Providers interested in participating in a BadgerCare Plus HMO or Medicaid SSI HMO or changing HMO or SSI HMO network affiliations should contact the HMO or SSI HMO for more information. Conditions and terms of participation in an HMO or SSI HMO are pursuant to specific contract agreements between HMOs or SSI HMOs and providers. An HMO or SSI HMO has the right to choose whether or not to contract with any provider but must provide access to Medicaid-covered, medically-necessary services under the scope of their contract for enrolled members. Each HMO may have policies and procedures specific to their provider credentialing and contracting process that providers are required to meet prior to becoming an in-network provider for that HMO.

Topic #411

Referrals

Non-network providers may at times provide services to BadgerCare Plus HMO and Medicaid SSI HMO enrollees on a referral basis. Non-network providers are always required to contact the enrollee's HMO or SSI HMO. Before services are provided, the non-network provider and the HMO or SSI HMO should discuss and agree upon billing procedures and fees for all referrals. Non-network providers and HMOs or SSI HMOs should document the details of any referral in writing before services are provided.

Billing procedures for out-of-plan referrals may vary depending on the HMO or SSI HMO. For specific billing instructions, non-network providers should always contact the enrollee's HMO or SSI HMO.

Topic #412

Services Not Provided by HMOs or SSI HMOs

If an enrollee's BadgerCare Plus HMO or Medicaid SSI HMO benefit package does not include a covered service, such as chiropractic or dental services, any Medicaid-enrolled provider may provide the service to the enrollee and submit claims to fee-for-service.

Covered and Noncovered Services

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 (prior authorization) 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 (Community Recovery Services)
- | CSP (Community Support Programs)
- | CCS (Comprehensive Community Services)
- | Crisis intervention services
- | Directly observed therapy for individuals with tuberculosis
- | MTM (Medication therapy management)
- | NEMT (Non-emergency medical transportation) 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 (School-based services)
- | 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.

Topic #390

Covered Services

HMOs

HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements. Although ForwardHealth requires contracted HMOs and Medicaid SSI HMOs to provide all medically necessary covered services, the following services may be provided by BadgerCare Plus HMOs at their discretion:

- | Dental
- | Chiropractic

If the HMO does not include these services in their benefit package, the enrollee receives the services on a fee-for-service basis.

Topic #391

Noncovered Services

The following are not covered by BadgerCare Plus HMOs or Medicaid SSI HMOs but are provided to enrollees on a fee-for-service basis, provided the service is covered for the member and is medically necessary:

- | Behavioral treatment
- | County-based mental health programs, including CRS (Community Recovery Services), CSP (Community Support Program) benefits, and crisis intervention services
- | Environmental lead investigation services provided through local health departments
- | CCC (child care coordination) services provided through county-based programs
- | Pharmacy services and diabetic supplies
- | PNCC (prenatal care coordination) services
- | Physician-administered drugs

Note: The [Physician-Administered Drugs Carve-Out Procedure Codes table](#) indicates the status of procedure codes considered under the physician-administered drugs carve-out policy.

- | SBS (school-based services)
- | Targeted case management services
- | NEMT (non-emergency medical transportation) services
- | DOT (directly observed therapy) and monitoring for TB (tuberculosis)-Only Services

Providers that render these services to an SSI HMO member are required to submit claims directly to ForwardHealth on a fee-for-service basis.

Note: Members enrolled in an SSI HMO are not eligible for targeted case management services.

Prior Authorization

Topic #400

Prior Authorization Procedures

BadgerCare Plus HMOs and Medicaid SSI HMOs may develop PA (prior authorization) guidelines that differ from fee-for-service guidelines. However, the application of such guidelines may not result in less coverage than fee-for-service. Contact the enrollee's HMO or SSI HMO for more information regarding PA procedures.

Claims

Topic #384

Appeals to BadgerCare Plus/Medicaid SSI HMOs and Children's Specialty Managed Care PIHPs

BadgerCare Plus/Medicaid SSI HMO and Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) contracted and non-contracted providers are required to first file an appeal directly with the HMO/PIHP after the initial payment denial or reduction. Providers should refer to their signed contract with the HMO/PIHP or the HMO's/PIHP's website for specific filing timelines and responsibilities (for example, PA (prior authorization), claim filing timelines, and coordination of benefits requirements) pertaining to filing a claim reconsideration and/or filing a formal appeal. The provider's signed contract with the HMO/PIHP may dictate the final decision. Filing a claim reconsideration is not the same as filing a formal appeal.

Appeal documents must reach the HMO/PIHP within the time frame established by the HMO/PIHP. Special care should be taken to ensure the documents reach the HMO/PIHP by the timely, filing deadline by allowing enough time for U.S. Postal Service mail handling or by using a verifiable delivery method (for example, secure Portal, fax, certified mail, or secure email).

The HMO/PIHP has 45 calendar days to respond in writing to a formal appeal. The HMO/PIHP decides whether to pay the claim and sends a letter stating this decision. If the HMO/PIHP does not respond in writing within 45 calendar days or the provider is dissatisfied with the HMO's/PIHP's response, the provider may submit an appeal to ForwardHealth through the [Provider Appeals portal](#) within 60 calendar days from the end of the 45 calendar day timeline or the date of the HMO/PIHP response.

Topic #385

Appeals to ForwardHealth

ForwardHealth **will not review** appeals that were not first made to the [BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP \(Prepaid Inpatient Health Plan\)](#). If a provider sends an appeal directly to ForwardHealth without first filing it with the HMO/PIHP, the appeal will be returned to the provider., and the payment denial or reduction will be upheld.

The provider has 60 calendar days to file an appeal with ForwardHealth after the HMO/PIHP either does not respond in writing within 45 calendar days, or if the provider is dissatisfied with the HMO/PIHP response.

Appeals will only be reviewed for enrollees who were eligible for and who were enrolled in an HMO/PIHP on the DOS (date of service) in question.

Once all pertinent information is received, ForwardHealth has 45 calendar days to make a final decision. The provider and the HMO/PIHP will be notified by ForwardHealth of the final decision. If the decision is in the provider's favor, the HMO/PIHP is required to pay the provider within 45 calendar days of the final decision. The decision is final, and all parties are required to abide by the decision.

Providers are required to submit an appeal to ForwardHealth through the [Provider Appeals portal](#).

How to Begin Using the Provider Appeals Portal

Providers who contract with a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP and who need to appeal a claim decision will be required to register and set up a Provider Appeals portal account. Note: This portal account is separate from a provider's secure ForwardHealth Portal account.

To register for a Provider Appeals portal account, providers and HMOs/PIHPs can access the [Provider Appeals portal](#). Providers are required to complete and submit the registration form, available by clicking either the HMO Registration or Provider Registration button (as applicable) on the Provider Appeals portal home page. Examples of information required to complete the registration process include the following:

- | The provider's Medicaid ID or both their NPI (National Provider Identifier) and taxonomy code
- | Provider zip+4 code
- | DOS for the appeal
- | Contact information (name, email, phone number) for the person registering

Once ForwardHealth receives and processes the registration form, an account login ID and associated PIN (provider identification number) will be created. Providers will receive an email message with their Provider Appeals portal login ID and will receive their PIN information in a mailed letter.

Note: Third party administrators and out-of-state providers must call the EDI (Electronic Data Interchange) Helpdesk at 866-417-4979 or send an email to vedswiedi@wisconsin.gov to begin registration.

More information on registering for and using the Provider Appeals portal and additional portal resources, including the Provider Appeals Portal User Guide, is [available](#).

Portal Functionality

Providers can use the ForwardHealth appeals process through the Provider Appeals portal after exhausting the HMO/PIHP payment dispute process. Providers are required to use the Provider Appeals portal to:

- | Submit an appeal to ForwardHealth for a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP claim payment denial or reduced payment.
- | Submit documentation.
- | Check the status of an appeal.
- | Respond to requests for additional information.
- | View decision notices.

For assistance regarding submission of an appeal through the ForwardHealth Portal, providers can call the ForwardHealth Managed Care Unit at 800-760-0001, option 1.

Required Documentation

When submitting an appeal to ForwardHealth through the Provider Appeals portal, the following documentation must be submitted/attached in required fields:

- | The original claim submitted to the HMO/PIHP and all corrected claims submitted to the HMO/PIHP
- | All of the HMO's/PIHP's payment denial remittances showing the dates of denial and reason codes with descriptions of the exact reasons for the claim denial
- | The provider's written appeal to the HMO/PIHP
- | The HMO's/PIHP's response to the appeal
- | Relevant medical documentation for appeals regarding coding issues or emergency determination that supports the appeal (Providers should only submit relevant documentation that supports the appeal. Large medical records submitted with no indication of where supporting information is found will not be reviewed.)

- Any contract language that supports the provider's appeal with the exact language that supports overturning the payment denial indicated (Contract language submitted with no indication of where supporting information is found will not be reviewed, and the denial will be upheld.)
- Any other documentation that supports the appeal (for example, commercial insurance Explanation of Benefits/Explanation of Payment to support Wisconsin Medicaid as the payer of last resort)

Only relevant documentation should be included.

Appeal Decisions

A decision to uphold the HMO's/PIHP's original payment denial or to overturn the denial will be made based on the documentation submitted to ForwardHealth for review. Failure to submit the required documentation or submitting incomplete, insufficient, or illegible documentation may lead to the original denial being upheld. The decision to overturn an HMO's/PIHP's denial must be clearly supported by the documentation.

If the HMO/PIHP subsequently overturns their original denial and reprocesses and pays the claim for which an appeal has been submitted, providers must contact the ForwardHealth Managed Care Unit at 800-760-0001, option 1, and request that the appeal be withdrawn.

To check on the status of an appeal submitted to ForwardHealth, providers can:

- Access the [Provider Appeals portal](#).
- Call the ForwardHealth Managed Care Unit at 800-760-0001, option 1.

Topic #386

Claims Submission

BadgerCare Plus/Medicaid SSI HMOs and Children's Specialty Managed Care PIHPs (Prepaid Inpatient Health Plans) have requirements for timely filing of claims, and providers are required to follow the HMO/PIHP claims submission guidelines for each organization. Providers should contact the enrollee's HMO/PIHP for organization-specific submission deadlines.

Topic #387

Extraordinary Claims

Extraordinary claims are BadgerCare Plus or Medicaid claims for a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) enrollee that have been denied by an HMO/PIHP but may be paid as fee-for-service claims.

The following are some examples of extraordinary claims situations:

- The enrollee was not enrolled in an HMO/PIHP at the time they were admitted to an inpatient hospital, but then they enrolled in an HMO/PIHP during the hospital stay. In this case, all claims related to the stay (including physician claims) should be submitted to fee-for-service. For the physician claims associated with the inpatient hospital stay, the provider is required to include the date of admittance and date of discharge in Item Number 18 of the paper 1500 Health Insurance Claim Form ((02/12)).
- The claims are for orthodontia/prosthodontia services that began before HMO/PIHP coverage. The provider must include a record with the claim indicating when the bands were placed.

Submitting Extraordinary Claims

When submitting an extraordinary claim, providers must include the following:

- ▮ A legible copy of the completed claim form in accordance with billing guidelines
- ▮ A letter detailing the problem, any claim denials, and any steps taken to correct the situation
- ▮ A copy of the [Explanation of Medical Benefits form](#) as applicable

Submit extraordinary claims to:

ForwardHealth
Managed Care Extraordinary Claims
PO Box 6470
Madison WI 53716-0470

Topic #388

Medicaid as Payer of Last Resort

Wisconsin Medicaid is the payer of last resort for [most](#) covered services, even when a member is enrolled in a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan). Before submitting claims to HMOs/PIHPs, providers are required to submit claims to other health insurance sources. Providers should contact the enrollee's HMO/PIHP for more information about billing other health insurance sources.

Topic #389

Provider Appeals

When a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) denies a provider's claim, the HMO/PIHP is required to send the provider a notice informing them of the right to file an appeal.

An HMO/PIHP network or non-network provider may file an appeal to the HMO/PIHP when:

- ▮ A claim submitted to the HMO/PIHP is denied payment.
- ▮ The full amount of a submitted claim is not paid.

Providers are required to [file an appeal with the HMO/PIHP](#) **before** filing an appeal with ForwardHealth.

Promoting Interoperability Program

9

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Promoting Interoperability Program:An Overview

Topic #12170

Wisconsin Medicaid EHR Incentive Program

The following provider types may be eligible for the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program:

- | Advanced Practice Nurse Prescribers with a psychiatric specialty.
- | Nurse midwives.
- | Nurse practitioners.
- | Physicians (including anesthesiologists, psychiatrists, radiologists, pathologists, ophthalmologists).
- | PAs (physician assistants). Only PAs practicing predominantly in an FQHC (federally qualified health center) or RHC (rural health clinic) are considered eligible professionals.

Refer to the EHR Incentive Program section in the [Physician service area](#) for complete information regarding the Wisconsin Medicaid EHR Incentive Program.