Provider Enrollment and Ongoing Responsibilities

1

Archive Date:05/01/2024

Provider Enrollment and Ongoing Responsibilities:Provider Enrollment

Topic #21957

An Overview

CHCs (Community Health Centers) are a specialty of the provider type FQHC (Federally Qualified Health Center) and maintain CHC-specific billing policies, which are contained in this service area. For complete policy information applicable to CHCs, providers should refer to the appropriate service area of the ForwardHealth Online Handbook, such as:

- Adult Health Day Treatment
- Ambulance
- Anesthesiologist Assistant and Certified Registered Nurse Anesthetist
- Child/Adolescent Day Treatment, HealthCheck "Other Services"
- Chiropractic
- Community Support Program
- Dental
- End-Stage Renal Disease
- Family Planning
- HealthCheck (EPSDT)
- Hearing
- Home Health
- Non-emergency Medical Transportation
- Nurses in Independent Practice
- Outpatient Mental Health
- Outpatient Substance Abuse
- Personal Care
- Pharmacy
- Physician
- Podiatry
- Prenatal Care Coordination
- Substance Abuse Day Treatment
- Therapies: Physical, Occupational, and Speech and Language Pathology
- Vision

Topic #22037

Community Health Centers

A Federally Qualified Health Center, also known as a CHC (Community Health Center), is a clinic that meets one of the following:

- Receives a grant under the Public Health Services Act, Section 329, 330, or 340
- Has been designated by the secretary of the federal HHS as a facility that meets the requirements of receiving a grant (FQHC (Federally Qualified Health Center) Look Alike)
- Has been granted a temporary waiver of the grant requirements by the secretary of the federal HHS

CHC Main Service Location

Providers who are newly enrolling as FQHC Non-Tribal providers will automatically be enrolled as the main CHC service location.

CHC Off-Site Clinics

ForwardHealth defines an "off-site clinic" as a CHC's delivery site that is a location other than the CHC's main service location and is approved by HRSA (Health Resources & Services Administration) for the provision of CHC services. More information about HRSA is available on the HRSA website.

ForwardHealth requires a CHC to separately enroll each of its off-site clinics as the provider type FQHC Non-Tribal for billing and reimbursement purposes.

Note: All CHC off-site clinics must have the same tax ID as that of the associated CHC main service location.

CHC Retail Pharmacies

If a CHC also submits noncompound or compound drug claims for a retail pharmacy, a separate Medicaid provider enrollment is required to reflect the applicable individual provider type and specialty of Pharmacy. The pharmacy must have the same tax ID as that of the associated CHC main service location.

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

Examples of a Change in Ownership

Examples of a change in ownership include the following:

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

End Date of Previous Owner's Enrollment

The end date of the previous owner's enrollment will be one day prior to the effective date for the change in ownership. When the Wisconsin DHS (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.

Covered and Noncovered Services

2

Archive Date:05/01/2024

Covered and Noncovered Services:Codes

Topic #21957

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CHCs (Community Health Centers) are a specialty of the provider type FQHC (Federally Qualified Health Center) and maintain CHC-specific billing policies, which are contained in this service area. For complete policy information applicable to CHCs, providers should refer to the appropriate service area of the ForwardHealth Online Handbook, such as:

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Topic #21977

Associated Procedure Codes for Additional Dental Visits

For reimbursement to CHCs (Community Health Centers) for dental services requiring multiple visits, the procedure code that represents the final prosthesis or dental service is referred to as the base procedure code, and each additional visit is referred to as the associated procedure code. Base procedure codes and associated procedure codes will be considered direct services for PPS (Prospective Payment System) reimbursement purposes.

ForwardHealth has identified the following CDT procedure codes to represent the associated procedure codes:

- **D1999** (unspecified preventive procedure, by report): For preventive services that require additional visits. Coverage is limited to a maximum of 1 unit per member per preventive procedure.
- **D2999** (unspecified restorative procedure, by report): For restorative services that require additional visits. Coverage is

limited to a maximum of 1 allowable unit per member per restorative procedure.
- **D3999** (unspecified endodontic procedure, by report): For endodontic services that require additional visits. Coverage is limited to a maximum of 1 allowable unit per member per endodontic procedure.
- **D5899** (unspecified removable prosthodontic procedure, by report): For complete and partial denture services that require additional visits. Coverage is limited to a maximum of 4 allowable units per member per denture procedure.

Note: Providers are required to document the specific service(s) performed for each dental visit in the member's dental record.

Topic #22057

Required Procedure Code

CHCs (Community Health Centers) will identify encounters by indicating HCPCS (Healthcare Common Procedure Coding System) procedure code T1015 (Clinic visit/encounter, all-inclusive) on claims for services rendered. ForwardHealth will assign the appropriate encounter type to the claim detail associated with procedure code T1015 based on the provider type of the rendering provider.

Required Codes for Complete Dentures

CHCs (Community Health Centers) are required to include area of oral cavity codes on PA (prior authorization) requests and claims for encounters on the same DOS (date of service) to provide complete maxillary and complete mandibular dentures.

Covered Services and Requirements

Topic #21957

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CHCs (Community Health Centers) are a specialty of the provider type FQHC (Federally Qualified Health Center) and maintain CHC-specific billing policies, which are contained in this service area. For complete policy information applicable to CHCs, providers should refer to the appropriate service area of the ForwardHealth Online Handbook, such as:

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Topic #23077

Beyfortus Covered Through the Vaccines for Children Program

Beyfortus (nirsevimab), a monoclonal antibody, is used for the prevention of lower respiratory tract disease caused by RSV (respiratory syncytial virus) in infants or children.

The CDC (Centers for Disease Control and Prevention)'s ACIP (Advisory Committee on Immunization Practices) recommends the routine use of Beyfortus for the prevention of RSV for newborns and infants younger than 8 months of age born during or entering their first RSV season. The ACIP also recommends the routine use of Beyfortus for children aged 8 to 19 months who are at increased risk of severe RSV, which includes Alaska Native and American Indian children, as defined by the Indian Health

Care Improvement Act, who are entering their second RSV season.

Beyfortus Supplied Through the Vaccines for Children Program

The federal VFC (Vaccines for Children) Program was created to provide vaccines to eligible children through enrolled public and private providers. The VFC Program is part of a national approach to improving immunization services and levels.

Although not a vaccine, the ACIP voted to include Beyfortus in the VFC Program.

ForwardHealth covers Beyfortus consistent with current policies for immunization services. Therefore, providers are required to obtain Beyfortus for children from the VFC supply. ForwardHealth reimburses only an administration code for Beyfortus supplied through the VFC Program.

Providers may refer to the Wisconsin Immunization Program for contact information about enrolling in the VFC Program.

Topic #21958

Community Health Center Encounters

Under the PPS (Prospective Payment System), ForwardHealth reimburses CHCs (Community Health Centers) a PPS rate for each allowable CHC encounter. A CHC encounter is defined as a face-to-face visit on a single DOS (date of service) between a member and a Medicaid-enrolled CHC provider to provide diagnosis, treatment, or preventive service(s) at the CHC HRSA (Health Resources & Services Administration)-approved location including main and off-site locations.

Each CHC encounter is classified as either a medical, dental, or behavioral health encounter based on the provider type of the rendering provider. Encounters include the following:

- Direct services, which are defined as the core service(s) provided during the encounter. For example, preventive or routine office visits constitute direct services.
- Indirect services, which are defined as supplies and/or diagnostic or therapeutic ancillary services that are furnished as an adjunct to the core service(s) provided during the encounter. Indirect services include, but are not limited to, radiology, laboratory tests, medical supplies, durable medical equipment, ancillary provider services, and professional dispensing fees.

Allowable indirect costs are included as a portion of the total cost for encounter rate development under the PPS rate-setting methodology. Indirect services are Medicaid-covered services that serve to support core services provided during the encounter, but they do not count as individual encounters on their own.

Costs for CHC activities and services that are not required by ForwardHealth and not part of CHC-related services, included in state statute or administrative code, may not be submitted to ForwardHealth and are therefore non-reimbursable.

Costs categorized as non-reimbursable under the cost-based reimbursement method in effect prior to PPS implementation are not considered indirect costs. Non-reimbursable costs are not included in the PPS rate setting methodology.

Note: An indirect service is always considered part of the encounter and is not reimbursed separately, even if provided on a different DOS or at a different location than the associated encounter.

A service that is considered an encounter when performed in a CHC location is also considered an encounter when performed by a CHC provider in one of the following locations:

- Mobile units
- School visits
- Hospitals

- Members' homes
- Extended care facilities
- Primary sites of identified contracted clinicians

Any services provided to CHC members through referrals to a provider with whom the CHC has no contractual relationship and in which funding for the services is not borne by the CHC is **not** a CHC service or encounter.

All services provided as part of the CHC encounter must meet all applicable ForwardHealth program requirements, including, but not limited to, medical necessity, PA (prior authorization), claims submission, prescription requirements, and documentation requirements; however, all CHC services reimbursed under the PPS rate structure are exempt from member cost share and copayment requirements.

CHCs will identify encounters by indicating HCPCS (Healthcare Common Procedure Coding System) procedure code T1015 (Clinic visit/encounter, all-inclusive) on claims for services rendered. ForwardHealth will assign the appropriate encounter type to the claim detail associated with procedure code T1015 based on the provider type of the rendering provider.

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	When the interpreter is physically present with the member and provider	U1 or U3

language)			
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 and sign language)	When the interpreter is not physically present with the member and the provider and interprets on interactive video	U1 or U3 **and** GT

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

Dental Providers

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

Allowable Places of Service

Claims for interpretive services must include a valid POS (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 #23237

Over-the-Counter Contraception Standing Orders

The DMS (Division of Medicaid Services) chief medical officer issued the following standing orders for OTC (over-the-counter) contraception products:

- Standing Order for OTC Emergency Contraception for Members of Wisconsin's Medicaid Programs
- Standing Order for OTC Norgestrel (Opill) Pills for Members of Wisconsin's Medicaid Programs

The standing orders for OTC emergency contraception (levonorgestrel) and Opill (norgestrel) issued by the DMS chief medical officer enables enrolled BadgerCare Plus and Medicaid members to more easily obtain OTC oral contraception.

Over-the-Counter Emergency Contraception—Levonorgestrel

Levonorgestrel is a progestin-only emergency contraceptive indicated for the prevention of pregnancy following unprotected intercourse or a known or suspected contraceptive failure. Several manufacturers produce levonorgestrel emergency contraception products that are available for purchase by consumers without a prescription.

Over-the-Counter Oral Contraception—Opill (Norgestrel)

FDA (Food and Drug Administration)-approved Opill (norgestrel) is available without a prescription. Opill (norgestrel) is a progestin-only oral contraceptive for voluntary use by persons of reproductive potential to prevent pregnancy.

Information for Medicaid Pharmacy Providers

ForwardHealth covers oral contraceptives for members who are 10 through 65 years of age.

As a reminder, state Medicaid programs may only cover drugs produced by manufacturers who have signed a federal rebate agreement for the MDRP (Medicaid Drug Rebate Program). Non-participating manufacturers' products cannot be covered. Pharmacies can refer to the Drug Search Tool to confirm that a specific OTC contraceptive product is covered by ForwardHealth.

If a member has an existing prescription from their provider, that prescription should be used. The standing orders do not supplant individual prescriptions.

Prior to dispensing an OTC emergency contraception or Opill (norgestrel) under their standing order, the provider should ensure all requirements of the standing order have been met and direct the member to review the manufacturer's instructions for use.

Note: Numerous OTC and legend contraception products not included in the standing orders are also available for coverage by ForwardHealth for BadgerCare Plus and Medicaid members when prescribed by a Medicaid-enrolled provider.

Levonorgestrel

Pharmacy providers may apply the emergency contraception standing order to fill a prescription for OTC emergency contraception (levonorgestrel). This standing order fulfills the requirement of a prescription for BadgerCare Plus and Medicaid members to obtain covered FDA-authorized OTC oral emergency contraception. It further authorizes providers to dispense such OTC products to BadgerCare Plus and Medicaid members to the extent a prescription is required, including for insurance coverage, under the pharmacy benefit.

Pharmacies may dispense up to four tablets per prescription dispensed under the emergency contraception standing order. OTC levonorgestrel products have a quantity limit of eight tablets per member per month applied. Pharmacies may request an override of the monthly quantity limit by contacting the DAPO (Drug Authorization and Policy Override) Center.

Opill (Norgestrel)

Pharmacy providers may apply the standing order issued by the DMS chief medical officer to fill a prescription for Opill (norgestrel). This standing order fulfills the requirement of a prescription for BadgerCare Plus and Medicaid members to obtain covered FDA-authorized OTC oral contraception. It further authorizes providers to dispense such OTC products to BadgerCare Plus and Medicaid members to the extent a prescription is required, including for insurance coverage, under the pharmacy benefit.

Pharmacies may dispense up to 84 tablets for a three-month supply per prescription with PRN (pro re nata) or "as needed" refills, which will allow for up to a one-year supply to be authorized per use of the OTC oral contraception standing order.

Requirements for a Valid Prescription

Any prescription for members, including those based on standing orders, must be documented according to Wis. Admin Code § DHS 107.02(2m)(b). For documentation purposes, "the prescriber's MA provider number" in Wis. Admin. Code § DHS 107.02 (2m)(b) refers to that of the provider who authored the standing order. Providers must follow licensure scope of practice requirements when delegating dispensing or treatment authority per standing order.

Topic #3545

Vaccines for Children Program

The federal VFC (Vaccines for Children) Program was created to provide vaccines to eligible children through enrolled public and private providers. The VFC Program is part of a national approach to improving immunization services and levels.

Any child 18 years of age or younger who meets at least one of the following criteria is eligible for the VFC Program:

- Eligible for BadgerCare Plus or Medicaid.
- American Indian or Alaska Native, as defined by the Indian Health Care Improvement Act.
- Uninsured.
- Underinsured. (These children have health insurance but the benefit plan does not cover immunizations. Children in this category may only receive immunizations from a FQHC (federally qualified health center) or an RHC (rural health clinic); they cannot receive immunizations from a private health care provider using a VFC-supplied vaccine.)

When a vaccine becomes available through the VFC Program, the VFC Program notifies providers with clinical information about new vaccines, including the date they may begin ordering the vaccine. On the first of the month following that date, ForwardHealth will begin reimbursing only the administration fee for that vaccine.

Benefits of the Vaccines for Children Program

The VFC Program provides the following benefits:

- Vaccines are provided at no charge to public and private providers to immunize all eligible children.
- Eliminates or reduces vaccine costs as a barrier to the vaccination of eligible children.
- Vaccines recommended by the ACIP (Advisory Committee on Immunization Practices) are automatically covered after approval by the CDC (Centers for Disease Control and Prevention).

Reimbursement for Vaccines Provided to Children

If a vaccine is available through the VFC Program, providers are required to use vaccines from the VFC supply for members 18 years of age or younger. ForwardHealth reimburses only the administration fee for vaccines supplied by the VFC Program.

For vaccines that are not supplied by the VFC Program, providers may use a vaccine from a private stock. In these cases, ForwardHealth reimburses for the vaccine and the administration fee.

Beyfortus (nirsevimab), a monoclonal antibody, is used for the prevention of lower respiratory tract disease caused by RSV (respiratory syncytial virus) in infants or children. Although not a vaccine, the CDC's ACIP voted to include Beyfortus in the VFC Program. Providers are required to obtain Beyfortus for children from the VFC supply. ForwardHealth only reimburses an administration code for Beyfortus supplied through the VFC Program.

Telehealth

Topic #21997

Telehealth for Community Health Centers

CHCs (Community Health Centers) may serve as originating site and distant site providers for telehealth services.

Distant Site

Services billed with modifier GQ, GT, FQ, FR, or 93 will be considered under the PPS (Prospective Payment System) reimbursement. Billing HCPCS procedure codes T1015 (Clinic visit/encounter, all-inclusive) with a telehealth procedure code will result in a PPS for an allowable encounter.

Originating Site

CHCs should submit claims for originating site services on a professional claim form with HCPCS procedure code Q3014 (Telehealth originating site facility fee) and a POS (place of service) code that represents where the member is located during the service. Modifier GT should not be included with procedure code Q3014 for originating site services to be considered under the PPS reimbursement method. ForwardHealth will not separately reimburse the CHC for originating site services because all costs for providing originating site services have already been incorporated into the PPS rates for CHCs. However, claims billed by CHCs for originating site services may be used for future rate setting purposes, and CHC costs associated with telehealth services may be reported for change in scope adjustment consideration.

Claims

3

Archive Date:05/01/2024

Claims:Submission

Topic #21957

An Overview

CHCs (Community Health Centers) are a specialty of the provider type FQHC (Federally Qualified Health Center) and maintain CHC-specific billing policies, which are contained in this service area. For complete policy information applicable to CHCs, providers should refer to the appropriate service area of the ForwardHealth Online Handbook, such as:

- Adult Health Day Treatment
- Ambulance
- Anesthesiologist Assistant and Certified Registered Nurse Anesthetist
- Child/Adolescent Day Treatment, HealthCheck "Other Services"
- Chiropractic
- Community Support Program
- Dental
- End-Stage Renal Disease
- Family Planning
- HealthCheck (EPSDT)
- Hearing
- Home Health
- Non-emergency Medical Transportation
- Nurses in Independent Practice
- Outpatient Mental Health
- Outpatient Substance Abuse
- Personal Care
- Pharmacy
- Physician
- Podiatry
- Prenatal Care Coordination
- Substance Abuse Day Treatment
- Therapies: Physical, Occupational, and Speech and Language Pathology
- Vision

Responsibilities

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.

Submission

Topic #21959

Claim Submission Requirements for Community Health Centers

When submitting claims to ForwardHealth for CHC (Community Health Center) encounters, the CHC is required to do the following:

- Submit claims for encounters on either a professional claim form or the electronic equivalent (for example, 1500 Health Insurance Claim Form, 837P) or a dental claim form or the electronic equivalent (for example, ADA claim form, 837D), as applicable.
- Submit each encounter using HCPCS (Healthcare Common Procedure Coding System) procedure code T1015 (Clinic visit/encounter, all-inclusive). If a single claim is used to bill multiple encounter types, the claim should include a separate detail with procedure code T1015 for each encounter per DOS (Dates of Service).
- The billed amount for procedure code T1015 is not required to be the assigned PPS (Prospective Payment System) rate for each CHC. CHC providers may bill procedure code T1015 at any amount that they deem appropriate, including zero. The reimbursed amount for procedure code T1015 will be the CHC's assigned PPS rate.
- Procedure code T1015 will be allowable for one DOS per the detail(s) associated with one encounter type (that is, span billing is not allowed).
- The diagnosis most applicable to the encounter type must be associated with procedure code T1015.
- Include separate details for all direct and indirect services rendered as part of the encounter, in addition to billing procedure code T1015 for each encounter type. CHCs should use the most appropriate procedure codes to represent direct and indirect services. Each detail should identify the practitioner who delivered the direct or indirect service as the rendering provider. These services should be billed with the applicable charges.
- Include at least one allowable direct service associated with the encounter with the same rendering provider as procedure code T1015. Claims not meeting these requirements will not have a PPS rate applied.

Note: Indirect services alone, without an accompanying allowable direct service, are not encounters. Thus, claims for such instances may not submit procedure code T1015. If procedure code T1015 is present with indirect services only, procedure code T1015 will deny and all payable indirect services will process in a paid status with a $0 allowed amount.

- List as the rendering provider for procedure code T1015 the practitioner who delivered the services during the encounter. If multiple providers rendered services during a single encounter, the CHC should use its judgment based on its reporting capabilities to identify which provider is the most appropriate to list as the rendering provider for procedure code T1015.
- Submit claims for CHC services under the Medicaid enrollment of the physical CHC site where the service was provided. The appropriate billing provider will be determined by the location of the service as follows:
  - If the service was provided at the CHCs main service location, use the Medicaid enrollment of the CHC main site as the billing provider.
  - If the service was provided at a CHC off-site clinic, use the Medicaid enrollment of that CHC off-site clinic as the billing provider.
  - If the service was provided at a location other than the CHC's main service location or a CHC off-site clinic (for example, at a primary site of an identified contracted clinician), use the Medicaid enrollment of the CHC main site as the billing provider.
- If the service was provided at a CHC retail pharmacy, use the Medicaid enrollment of the separate retail pharmacy as the billing provider.

Services rendered by ancillary providers are considered indirect services. If a service by an ancillary provider is the only service provided during a visit, the CHC should not bill the ancillary provider service as an encounter with procedure code T1015. Instead, the CHC should bill the ancillary provider service. The claim detail for the ancillary provider service will process in a paid status with a $0 allowed amount.

Billing Guidelines

It is the CHC's responsibility to ensure that an encounter is only counted once across all providers involved in the encounter and to ensure documentation exists that supports the methodology used to assign the encounter to the most appropriate rendering provider. Services may not be arbitrarily delayed or split across multiple DOS in order to bill additional encounters.

Contracted Provider/Facility

As with other services, when a CHC member receives services from a CHC contracted provider or facility, the rendering provider listed on the claim detail should represent the contracted provider performing the service.

Subsequent Encounters

Claims that indicate more than one encounter for a given encounter type for the same member, same CHC organization, and same DOS will be denied. However, if the additional encounter represents a subsequent encounter as defined previously, providers may resubmit the claim, applicable medical documentation supporting the subsequent encounter, and the Written Correspondence Inquiry form via paper to ForwardHealth to review. On the Written Correspondence Inquiry form, providers should check the "Other" box in the Reason for Inquiry field and indicate "Request for review of medical necessity for subsequent encounter" in the space provided. Providers should follow the instructions on the form for submitting the claim, medical documentation, and form to ForwardHealth. A copy of the claim, medical documentation, and form should be retained by providers for their records.

Telehealth Services

CHCs may serve as originating site and distant site providers for telehealth services. CHC claims for services provided via telehealth must qualify as telehealth.

Services billed with modifier GT, FQ, or 93 will be considered under the PPS reimbursement. Billing HCPCS procedure codes T1015 (Clinic visit/encounter, all-inclusive) with a telehealth procedure code will result in a PPS rate for an allowable encounter.

CHCs should submit claims for originating site services on a professional claim form with HCPCS procedure code Q3014 (Telehealth originating site facility fee) and a POS (place of service) code that represents where the member is located during the service. Modifier GT should not be included with procedure code Q3014 for originating site services to be considered under the PPS reimbursement method. ForwardHealth will not separately reimburse the CHC for originating site services because all costs for providing originating site services have already been incorporated into the PPS rates for CHCs. However, claims billed by CHCs for originating site services may be used for future rate setting purposes, and CHC costs associated with telehealth services may be reported for change in scope adjustment consideration.

Dental Care

Global billing is not allowed under PPS reimbursement for dental services. CHCs providing orthodontic and prosthodontic dental services are required to submit claims for dental procedure codes per visit. CHCs will be reimbursed an encounter rate for each allowable face-to-face visit for dental services requiring more than one visit under the PPS reimbursement payment structure.

When billing for dental services requiring additional visits using associated procedure codes, CHCs must submit all face-to-face visits related to the dental service on a single claim on or after the date of completion or delivery.

CHCs must submit a single claim for the dental services requiring additional visits as follows:

- Include the base code and associated code(s) with their respective DOS as separate details.
- Include the HCPCS procedure code T1015, when applicable, for the base code and each associated procedure code per the PPS claims submission guidelines.
- Include area of oral cavity codes for encounters (indicated by HCPCS procedure code T1015) on the same DOS to provide complete maxillary and complete mandibular dentures. Note: Procedures that require an area of oral cavity code must be submitted on either the ADA 2006 Claim Form or the ADA 2012 Claim Form. They cannot be submitted on the 1500 Health Insurance Claim Form.

When a dental visit qualifies for a PPS rate by meeting all defined program requirements, providers will be reimbursed the PPS rate for the encounter (indicated by HCPCS procedure code T1015) for the base code and for each associated procedure code.

Denture repair, relines (excluding six-month post-care period), and tooth re-implantation base procedure codes can be used to represent the service per DOS per member per provider. There will not be associated procedure codes for these services.

If a provider would like consideration when a base procedure code is not rendered or is processed in a denied status (such as when the base procedure code does not meet program requirements for reimbursement), the Wisconsin DHS (Department of Health Services) will require a review of each associated procedure code service for compliance. Refer to the Subsequent Encounters section for instructions on submitting additional documentation for review. Provider reimbursement for the associated codes will be dependent on DHS review.

Obstetric Care

ForwardHealth offers providers choices of how and when to file claims for obstetric care.

For separate obstetric component procedure codes submitted as they are performed, CHCs will be reimbursed an encounter for each component billed.

For an appropriate global obstetric procedure code with the date of delivery as the DOS, CHCs will be reimbursed for only one encounter.

Carved-Out Services

Carved out services (physician-administered drugs and telehealth distant site services) may be submitted on the same claim as the encounter. Carved-out services will be reimbursed separately from the PPS rate at the same reimbursement rate as non-CHC providers.

CHCs that also submit claims for retail pharmacy services should continue to submit these services on a ForwardHealth noncompound or compound drug claim. A separate Medicaid provider enrollment is required for Pharmacy services, and the pharmacy must have the same tax ID as that of the associated CHC main service location. Pharmacy services submitted by a CHC-associated pharmacy will be reimbursed an ingredient cost rate for the covered outpatient drug billed. Pharmacy professional dispensing fees are not separately reimbursed and will price at $0, with the exception of claims for SeniorCare members. Payment for the professional dispensing fee is considered bundled into the PPS rate for the encounter.

Medicare Crossover Claims

Medicare crossover claims will process and reimburse outside the PPS reimbursement structure.

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 #23078

Claims Submission for Beyfortus

Beyfortus (nirsevimab), a monoclonal antibody, is used for the prevention of lower respiratory tract disease caused by RSV (respiratory syncytial virus) in infants or children.

Claims for Beyfortus must be submitted on professional claims.

On claims for Beyfortus, providers are required to indicate the applicable CPT (Current Procedural Terminology) procedure code listed in the following table with a zero-billed amount for the Beyfortus product administered. Providers must also include the **SL** modifier (State supplied vaccine) with the applicable CPT procedure code for Beyfortus obtained through the VFC (Vaccines for Children) Program.

Procedure Codes for Beyfortus
90380 (Respiratory syncytial virus, monoclonal antibody, seasonal dose; 0.5 mL dosage, for intramuscular use)
90381 (Respiratory syncytial virus, monoclonal antibody, seasonal dose; 1 mL dosage, for intramuscular use)

To receive reimbursement for the administration of Beyfortus, providers must also indicate **one** of the following CPT administration codes on claims submitted to ForwardHealth:

- **96380** (Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection, with counseling by physician or other qualified health care professional)
- **96381** (Administration of respiratory syncytial virus, monoclonal antibody, seasonal dose by intramuscular injection)

Providers may refer to the interactive maximum allowable fee schedules on the ForwardHealth Portal.

Reimbursement

4

Archive Date:05/01/2024

Reimbursement:Amounts

Topic #21957

An Overview

CHCs (Community Health Centers) are a specialty of the provider type FQHC (Federally Qualified Health Center) and maintain CHC-specific billing policies, which are contained in this service area. For complete policy information applicable to CHCs, providers should refer to the appropriate service area of the ForwardHealth Online Handbook, such as:

- Adult Health Day Treatment
- Ambulance
- Anesthesiologist Assistant and Certified Registered Nurse Anesthetist
- Child/Adolescent Day Treatment, HealthCheck "Other Services"
- Chiropractic
- Community Support Program
- Dental
- End-Stage Renal Disease
- Family Planning
- HealthCheck (EPSDT)
- Hearing
- Home Health
- Non-emergency Medical Transportation
- Nurses in Independent Practice
- Outpatient Mental Health
- Outpatient Substance Abuse
- Personal Care
- Pharmacy
- Physician
- Podiatry
- Prenatal Care Coordination
- Substance Abuse Day Treatment
- Therapies: Physical, Occupational, and Speech and Language Pathology
- Vision

Topic #22058

Community Health Center Encounter Reimbursement

Rates and Reimbursement

The PPS (Prospective Payment System) rate for a given encounter type is inclusive of all direct and indirect services provided to the member during the encounter.

ForwardHealth calculates a separate PPS rate for each CHC (Community Health Center) in accordance with the Benefits Improvement and Protection Act of 2000. At the end of each CHC fiscal year, ForwardHealth adjusts the PPS rate by the MEI (Medicare Economic Index) in effect at that time. In addition, ForwardHealth may adjust a CHC's PPS rates to account for changes in the CHC's scope of service.

ForwardHealth reimburses a CHC a maximum of one PPS rate per encounter type, per member, per DOS (date of service), unless the member, subsequent to the first encounter, suffers an illness or injury that requires additional diagnosis or treatment on the same day. A subsequent encounter is a unique situation that cannot be planned or anticipated. For example, a member sees their provider in the morning for a medical condition and later in the day has a fall and returns to the CHC. Subsequent encounters can be medical, dental, or behavioral health when the encounter satisfies the subsequent encounter requirements.

When a CHC member receives services of the same encounter type from more than one of the CHC's locations (for example, the main clinic, an off-site clinic, and/or a contracted facility) on a single day, the CHC will be reimbursed for only one encounter type, per DOS, unless the additional encounter qualifies as a subsequent encounter.

ForwardHealth will apply the PPS rate for the encounter type to the claim detail associated with HCPCS (Healthcare Common Procedure Coding System) procedure code T1015. All other payable claim details for direct and indirect services on the claim associated with the encounter will process in a paid status with a $0 allowed amount.

Services "Carved-Out" of the PPS Rate

Physician-administered drugs, telehealth distant site services, and certain retail pharmacy services are considered "carved out" of the PPS rate and are reimbursed separately.

Physician-Administered Drugs

Physician-administered drugs are defined as drugs administered by a provider in an office setting. The Physician-Administered Drug Resources page contains a list of procedure codes classified as physician-administered drugs that may be reimbursed outside the PPS rate. These services are subject to change and must meet all applicable ForwardHealth program requirements, including, but not limited to, medical necessity, PA (prior authorization), claims submission, prescription requirements, and documentation requirements.

Telehealth Services

The following apply to telehealth services:

- Telehealth services include "originating site" services and/or "distant site" services
- Telehealth services are counted as encounters and require following PPS methodology guidelines

CHC costs associated with telehealth services may be reported for change in scope adjustment consideration; therefore, telehealth service costs may be used for future rate setting purposes.

Retail Pharmacy Services

Some CHCs also provide retail pharmacy services billed on a ForwardHealth noncompound or compound drug claim. A separate Medicaid provider enrollment is required to reflect the applicable individual provider type and specialty of Pharmacy. The pharmacy must have the same tax ID as that of the associated CHC main service location.

Pharmacy reimbursement rates for noncompound or compound drug claims consist of a professional dispensing fee and an ingredient drug cost. For CHC-associated pharmacies, the professional dispensing fee is considered part of an encounter and is not reimbursed separately, even if provided on a different DOS or at a different location than the associated encounter. There is one exception; the professional dispensing fee will be carved out of the PPS rate and reimbursed separately on a pharmacy claim if the claim is for a SeniorCare member. The ingredient drug cost is carved out of the PPS rate and reimbursed separately on a pharmacy claim.

Cost Reporting

Topic #21957

An Overview

CHCs (Community Health Centers) are a specialty of the provider type FQHC (Federally Qualified Health Center) and maintain CHC-specific billing policies, which are contained in this service area. For complete policy information applicable to CHCs, providers should refer to the appropriate service area of the ForwardHealth Online Handbook, such as:

- Adult Health Day Treatment
- Ambulance
- Anesthesiologist Assistant and Certified Registered Nurse Anesthetist
- Child/Adolescent Day Treatment, HealthCheck "Other Services"
- Chiropractic
- Community Support Program
- Dental
- End-Stage Renal Disease
- Family Planning
- HealthCheck (EPSDT)
- Hearing
- Home Health
- Non-emergency Medical Transportation
- Nurses in Independent Practice
- Outpatient Mental Health
- Outpatient Substance Abuse
- Personal Care
- Pharmacy
- Physician
- Podiatry
- Prenatal Care Coordination
- Substance Abuse Day Treatment
- Therapies: Physical, Occupational, and Speech and Language Pathology
- Vision

Topic #22017

Cost Report Form

CHCs (Community Health Centers) are required to use the Federally Qualified Health Center Cost Report (F-02656 (01/2021)) for cost settlements.

The Federally Qualified Health Center cost report is available to providers in a single, fillable Microsoft Excel workbook. After opening the workbook, providers may click the navigation buttons in the document to display the form or worksheet needed. These forms will accurately perform all necessary calculations for the user and may be downloaded and saved to a computer's hard drive or a computer disk.

Topic #22018

Outstationed Enrollment for Community Health Centers

Following the end of the CHC (Community Health Center)'s fiscal year, the CHC will complete and submit to ForwardHealth the Federally Qualified Health Center Outstationed Enrollment Survey (F-02758 (01/2021)) form. The CHC will have 120 days to fill out the form following its fiscal year end.

ForwardHealth will review reported outstationed enrollment expenditures and calculate the difference between the known portions of the PPS (prospective payment systems) rate that is outstationed enrollment and the actual outstationed enrollment cost incurred during the fiscal year.

Through the reconciliation process, Medicaid payments associated with outstationed enrollment will equal 100 percent of CHC allowable outstationed enrollment expenditures.

Coordination of Benefits

5

Archive Date:05/01/2024

Coordination of Benefits:Commercial Health Insurance

Topic #21957

An Overview

CHCs (Community Health Centers) are a specialty of the provider type FQHC (Federally Qualified Health Center) and maintain CHC-specific billing policies, which are contained in this service area. For complete policy information applicable to CHCs, providers should refer to the appropriate service area of the ForwardHealth Online Handbook, such as:

- Adult Health Day Treatment
- Ambulance
- Anesthesiologist Assistant and Certified Registered Nurse Anesthetist
- Child/Adolescent Day Treatment, HealthCheck "Other Services"
- Chiropractic
- Community Support Program
- Dental
- End-Stage Renal Disease
- Family Planning
- HealthCheck (EPSDT)
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- Home Health
- Non-emergency Medical Transportation
- Nurses in Independent Practice
- Outpatient Mental Health
- Outpatient Substance Abuse
- Personal Care
- Pharmacy
- Physician
- Podiatry
- Prenatal Care Coordination
- Substance Abuse Day Treatment
- Therapies: Physical, Occupational, and Speech and Language Pathology
- Vision

Topic #21978

Coordination of Benefits for Community Health Centers

CHCs (Community Health Centers) are required to bill a member's commercial health insurance first, if applicable, with all applicable procedure codes, including HCPCS (Healthcare Common Procedure Coding System) procedure code T1015 (Clinic visit/encounter, all-inclusive) as appropriate. After commercial health insurance has processed a claim, the CHC may submit the claim to ForwardHealth using the same CDT (Code on Dental Procedures and Nomenclature), CPT (Current Procedural Terminology), or HCPCS procedure codes used on the commercial health insurance claim. CHCs are required to indicate the appropriate other insurance information on the claim or include a completed Explanation of Medical Benefits form if the claim was submitted on paper. CHCs are required to submit the commercial health insurance information at the level it was processed by the commercial health insurance (that is, header or detail level).

All payments from commercial health insurance will be deducted from the PPS (Prospective Payment System) rate, per encounter

type, authorized by ForwardHealth under HCPCS procedure code T1015.

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.

Member Information

6

Archive Date:05/01/2024

Member Information:Special Enrollment Circumstances

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.