Claims

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Archive Date:08/01/2023

Claims: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.	Seventy-five 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:

- Seventy-five 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 #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 #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.

Coordination of Benefits

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Archive Date:08/01/2023

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)
- 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 #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.

Covered and Noncovered Services

3

Archive Date:08/01/2023

Covered and Noncovered Services:Codes

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:

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- End-Stage Renal Disease
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- 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 #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

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 #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.

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.

Provider Enrollment and Ongoing Responsibilities

4

Archive Date:08/01/2023

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
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- 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.

Reimbursement

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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.