

Claims

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Claims:Responses

Topic #535

Claim Status

ForwardHealth generally processes claims and adjustment requests within 30 days of receipt. Providers may check the status of a claim or adjustment request using the [AVR \(Automated Voice Response\)](#) system or the 276/277 (276/277 Health Care Claim Status Request and Response) transaction.

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

ForwardHealth claims generally fall into one of three statuses:

- ┆ Pay—The claim has been approved for payment.
- ┆ Deny—The claim was not approved for payment.
- ┆ Suspend—The claim is awaiting further review by ForwardHealth before a decision is made on how the claim will be adjudicated.

Refer to the ForwardHealth Portal Claim Status Information Instruction Sheet on the [User Guides](#) page of the Portal for additional information regarding claim status.

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% 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% 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% 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% 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 Encounters

For the purposes of this Online Handbook topic:

- | A [PPS \(prospective payment system\)](#) rate applies to CHCs (community health centers) and Tribal FQHCs (federally qualified health centers).
- | An [AIR \(all-inclusive rate\)](#) applies to Tribal FQHCs only.

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

When CHCs and Tribal FQHCs submit claims to ForwardHealth for [encounters](#), they must:

- ▮ Submit claims on either a dental or professional claim form or the electronic equivalent (for example, ADA (American Dental Association) 2012 Claim Form, 1500 Health Insurance Claim Form, 837 Health Care Claim: Dental or Professional transaction), as applicable.
- ▮ Submit each encounter using HCPCS code T1015 in the first detail line. If a single claim is used to bill multiple encounter types (for example, a medical encounter and a dental encounter), the claim should include a separate detail with procedure code T1015 for each encounter per DOS (date of service).
- ▮ Enter procedure code T1015 on only one DOS for the detail(s) associated with one encounter type. Note: Submitting one claim detail for services given over multiple consecutive days is not allowed and will result in a denied claim. The exception is for dentures when the upper and lower dentures are delivered to the member on the same DOS.
- ▮ Understand that the billed amount for HCPCS code T1015 is not required to be the assigned PPS or AIR for each CHC or Tribal FQHC. CHC and Tribal FQHC providers may bill procedure code T1015 for any amount that they deem appropriate, including zero. The reimbursed amount for procedure code T1015 will be the CHC's or Tribal FQHC's assigned PPS rate or AIR.
- ▮ Understand that procedure code T1015 will be allowable for one DOS per the detail(s) associated with one encounter type (span billing is not allowed).
- ▮ List 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 and Tribal FQHCs should use the most appropriate procedure codes to represent [direct and indirect services](#). Each detail should identify the provider 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 or AIR applied. Note: Indirect services alone, without an accompanying allowable direct service, are not encounters. Claims for such instances may not include procedure code T1015. The claim will be denied if procedure code T1015 is present with indirect services only and all payable indirect services will process in a paid status with a \$0 allowed amount.
- ▮ List the provider who delivered the services during the encounter as the rendering provider for procedure code T1015. If multiple providers rendered services during a single encounter, the CHC or Tribal FQHC 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 services under the NPI (National Provider Identifier) of the CHC or Tribal FQHC based on the physical site where the service was provided. The appropriate billing provider will be determined by the location of the service.
 - ▮ Use the NPI of the CHC or Tribal FQHC main site as the billing provider for **services provided at the main service location**.
 - ▮ Use the NPI of the CHC or Tribal FQHC off-site clinic as the billing provider for **services provided at an off-site clinic**.
 - ▮ Use the NPI of the CHC or Tribal FQHC main site as the billing provider for **services provided at a location other than the CHC's or Tribal FQHC's the main service location or off-site clinic** (for example, at a primary site of an identified contracted clinician).
 - ▮ Use the NPI of the separate pharmacy as the billing provider for **services provided at a CHC or Tribal FQHC pharmacy**.

Federally Qualified Health Center Responsibilities

CHCs and Tribal FQHCs are responsible for ensuring that an encounter is only counted once across all providers involved in that encounter. ForwardHealth pays up to one procedure code T1015 encounter for **each** encounter type (dental, medical, or mental health) per member, per day.

For a single DOS, CHCs and Tribal FQHCs could bill up to three instances of HCPCS code T1015—one for each encounter type. Encounters are assigned an encounter type based on the rendering provider.

Providers may not delay or split services across multiple DOS to bill additional encounters. These actions could result in an OIG (Office of the Inspector General) audit and/or investigation, which could lead to DSPS (Department of Safety and Professional Services) and DOJ (Department of Justice) referrals.

Contracted Provider or Facility

When a member receives services, the contracted provider who performs the service should be listed as the rendering provider on the claim. The billing provider (the CHC or Tribal FQHC) will submit the claim.

Subsequent Encounters

A subsequent encounter is a unique situation that is unplanned or not anticipated. For example, a member sees their provider in the morning for a medical condition and later that same day has a fall and returns to the CHC or Tribal FQHC. Subsequent encounters can be medical, dental, or mental health when the encounter satisfies the subsequent encounter requirements.

Typically, claims are denied if they indicate more than one encounter for a given encounter type for the same member, same CHC or Tribal FQHC organization, and same DOS. However, when the additional encounter represents a subsequent encounter, providers may resubmit the claim with these documents to ForwardHealth for review:

- ▮ The applicable medical documentation supporting the subsequent encounter
- ▮ The Written Correspondence Inquiry form by mail

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, clinical documentation, and form to ForwardHealth. Providers should keep a copy of the claim, clinical documentation, and form for their records.

Telehealth Services

CHCs and Tribal FQHCs may be both [originating site and distant site providers for telehealth services](#).

CHCs and Tribal FQHCs may only submit claims for [qualified telehealth services](#). Procedure codes for services allowed under permanent telehealth policy have POS (place of service) codes 02 (Telehealth Provided Other than in Patient's Home) and 10 (Telehealth Provided in Patient's Home) listed as an allowable POS in the [fee schedules](#).

ForwardHealth assigns a PPS rate for an allowable encounter when CHCs and Tribal FQHCs bill HCPCS code T1015 with a telehealth procedure code.

ForwardHealth includes services billed with these modifiers in PPS reimbursement:

- ▮ FQ (The service was furnished using audio-only communication technology)
- ▮ GT (Via interactive audio and video telecommunication systems)
- ▮ 93 (Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System)

CHCs and Tribal FQHCs 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 code that indicates where the member received the service.

Providers will not be reimbursed for originating site services under PPS or AIR methods if they use the modifier GT with procedure code Q3014.

ForwardHealth does not separately reimburse the CHC or Tribal FQHC for originating site services because costs of providing originating site services are incorporated into the CHC's or Tribal FQHC's PPS rate or AIR. However, CHC and Tribal FQHC

claims for originating site services may be used for future PPS rate-setting purposes, and CHC and Tribal FQHC costs associated with telehealth services may be reported for changes in scope adjustment consideration.

Teledentistry

On a claim form, dental providers must:

- ▮ Identify if the [teledentistry](#) encounter was either:
 - ▮ Synchronous with procedure code D9995 (Teledentistry synchronous; real-time encounter)
 - ▮ Asynchronous with procedure code D9996 (Teledentistry asynchronous; information stored and forwarded to dentist for subsequent review)
- ▮ Include the applicable evaluation procedure codes.

Obstetric Care

ForwardHealth offers providers two choices of how and when to file claims for [obstetric care](#):

- ▮ CHCs and Tribal FQHCs will be reimbursed an encounter for each component for separate obstetric components that are billed as they are performed.
- ▮ CHCs and Tribal FQHCs will be reimbursed for only one encounter for an appropriate global obstetric procedure code with the date of delivery as the DOS.

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 procedure codes will be reimbursed using fee-for-service reimbursement.

For example, if a member receives mental health and substance abuse services and also receives an injectable medication with a procedure code found on the [physician-administered drugs crosswalk](#), then the CHC or Tribal FQHC may submit the encounter with the mental health and substance abuse service procedure code to receive the PPS rate **and** the physician-administered drug code to receive the fee-for-service rate.

Some CHCs and Tribal FQHCs provide pharmacy services and bill for them on a ForwardHealth compound or noncompound drug claim. A CHC or Tribal FQHC pharmacy provider must [enroll as a separate Medicaid provider](#) under the applicable pharmacy provider type and specialty. The pharmacy must have the same tax ID as the main service location of the associated CHC or Tribal FQHC.

Medicare Crossover Claims

A Medicare-crossover claim is a Medicare-allowed claim for a dual eligible or Qualified Medicare Beneficiary-Only member sent to ForwardHealth for payment of coinsurance, copay, and deductible corresponding with the fee schedule.

PPS and AIR reimbursement are carved out of (not included in) Medicare Crossover coverage. For Medicare Crossover claims, the total reimbursement for a Medicare Part B-covered service may not exceed the Medicare-allowed amount. This includes any amount paid by other health insurance sources, any copay or spenddown amounts paid by the member, and any amount paid by Wisconsin Medicaid.

Therefore, Medicaid reimbursement for coinsurance or copay of a Medicare Part B-covered service is the lesser of:

- ▮ The **Medicare**-allowed amount less any amount paid by other health insurance sources and any copay or spenddown amounts paid by the member.
- ▮ The **Medicaid**-allowed amount less any amount paid by other health insurance sources and any copay or spenddown amounts paid by the member.

If a service is not allowable by Medicare or a claim is denied by Medicare, then PPS and AIR could be used. When submitting these claims, the billing provider must include the appropriate [Medicare disclaimer code](#).

If the service is covered by Medicare, then the Tribal FQHC cannot use procedure code T1015.

Topic #24125

Dental Services

Direct and Indirect Dental Services

Services related to direct dental services are typically considered indirect services. For example, depending on the procedure being performed, a radiograph (X-ray) **may or may not** be an indirect service. An X-ray taken as part of a comprehensive exam is considered a direct service, but an X-ray taken during a root canal procedure is considered an indirect service. As an indirect service, the X-ray is not a billable procedure.

If an indirect service is the only service provided during a visit and the CHC or Tribal FQHC bills for that service as an encounter with HCPCS (Healthcare Common Procedure Coding System) code T1015, the claim will deny. Instead, the CHC or Tribal FQHC should bill for the ancillary (indirect) service **without HCPCS code T1015**. The claim detail for the [ancillary service](#) will process in a paid status with a \$0 allowed amount.

Prior Authorization Requirements

Providers must submit claims for multiple visits when an existing PA (prior authorization) request's effective date spans dates before and after a Tribal FQHC is removed from T1015 exemption. Refer to the Multiple Dental Visits section of this topic to determine the appropriate [associated procedure codes](#) for DOS on and after a Tribal FQHC is removed from T1015 exemption.

Tribal FQHC providers must [submit PA](#) requests as required.

Codes designated as associated codes do not require PA. ForwardHealth will deny a PA request submitted for associated codes.

Tribal FQHCs must indicate area of oral cavity [codes](#) on PA requests and claims for encounters on the same DOS for complete maxillary and mandibular dentures. The area of oral cavity codes are:

- ┆ "01" for maxillary.
- ┆ "02" for mandibular.

The claim will deny if the area of oral cavity code isn't indicated on both the PA request and the claim. HCPCS code T1015 is associated with this requirement, even though this code isn't required on the PA.

Multiple Dental Visits

There may be situations where certain dental services require more than one face-to-face visit for completion of the service. When billing for dental services that require additional visits, Tribal FQHCs must use the appropriate dental procedure codes. Tribal FQHCs 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. Tribal FQHCs 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 HCPCS code T1015, when applicable, for the base code and each associated code per the [PPS and AIR](#) claims submission guidelines.

If a provider would like consideration when a base code is not rendered or a claim is denied (such as when the base code does not meet program requirements for reimbursement), Wisconsin DHS (Department of Health Services) will review each associated code service for compliance.

For example, if a patient stops coming to a dental office before the final denture is delivered, the dental provider can [request to be reimbursed](#) for the accrued lab services. Providers can submit a lab bill to ForwardHealth explaining why the final denture(s) wasn't delivered. If the provider has not submitted a claim for any dental steps yet, they may attach the lab bill to the claim when submitting it.

If the provider has submitted a claim with the dental steps, they may complete an [Adjustment/Reconsideration Request \(F-13046 \(02/2025\)\)](#) form, by checking the "Consultant review requested" box in Element 16 and attaching the lab bill, and submit it to:

BadgerCare Plus
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

ForwardHealth will consider reimbursing providers for the lab fees on a case-by-case basis.

Dental Services That Only Need Base Codes

The following types of codes do not need associated codes and can be used to represent the service once per DOS per member per provider:

- ┆ Denture repair codes
- ┆ Relines (excluding the six-month post-care period)
- ┆ Tooth re-implantation base codes

Dental Services and Face-to-Face Visits

A face-to-face visit is a direct, in-person interaction between a member and a provider that:

- ┆ Requires a condition and/or reason for payment.
- ┆ Results in the provider documenting why the encounter was necessary and what occurred during the encounter.

When billing for dental services that require additional visits, Tribal FQHCs 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 using associated procedure codes.

Tribal FQHCs must submit a single claim for dental services requiring additional visits and include:

- ┆ The base code and associated code(s) with their respective DOS as separate details.
- ┆ HCPCS code T1015, when applicable, for the base code and each associated procedure code per PPS or AIR claims submission guidelines.
- ┆ Area of oral cavity codes for encounters (indicated by HCPCS 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 (American Dental Association) 2006 Claim Form, the ADA 2012 Claim Form, or the ADA 2024 Claim Form.

ForwardHealth does not allow global billing under PPS reimbursement for dental services.

Note: ForwardHealth will deny a claim submitted with one claim detail for services given over multiple consecutive days.

Orthodontic and Prosthodontic Services

Tribal FQHCs providing orthodontic and prosthodontic dental services must submit claims for dental procedure codes per visit. ForwardHealth will reimburse Tribal FQHCs an encounter rate for each allowable face-to-face visit for dental services requiring more than one visit under PPS or AIR.

Reimbursement Based on Date of Service

For DOS between January 1, 2024, and the date a Tribal FQHC implemented the PPS or AIR reimbursement model, providers should not indicate the associated procedure code for additional dental visits. These visits will be accounted under the cost-settlement process.

For DOS on and after the date in which a Tribal FQHC implemented the PPS or AIR reimbursement model, providers must indicate the associated procedure code for each additional dental visit as appropriate on a single claim with the base code and associated codes listed as separate details.

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.

Topic #562

HMOs and Managed Care Organizations

Claims for services covered by the member's state-contracted HMO or MCO (managed care organization) should be submitted to the HMO or MCO provider services.

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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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 #595

Assignment of Insurance Benefits

Assignment of insurance benefits is the process by which a specified party (for example, provider or policyholder) becomes entitled to receive payment for claims in accordance with the insurance company policies.

Other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) companies may permit reimbursement to the provider or member. Providers should verify whether other health insurance benefits may be assigned to the provider. As indicated by the other health insurance, providers may be required to obtain approval from the member for this assignment of benefits.

If the provider is assigned benefits, providers should bill the other health insurance.

If the member is assigned insurance benefits, it is appropriate to submit a claim to ForwardHealth without billing the other health insurance. In this instance providers should indicate the appropriate other insurance indicator or complete the [Explanation of Medical Benefits form](#), as applicable. ForwardHealth will bill the other health insurance.

Topic #844

Claims for Services Denied by Commercial Health Insurance

If commercial health insurance denies or recoups payment for services that are covered by BadgerCare Plus and Wisconsin Medicaid, the provider may submit a claim for those services. To allow payment in this situation, providers are encouraged to follow the requirements (for example, request PA (prior authorization) before providing the service for covered services that require PA). If the requirements are followed, ForwardHealth may reimburse for the service up to the allowed amount (less any payments made by other health insurance sources).

Note: The provider is required to demonstrate that a correct and complete claim was denied by the commercial health insurance company for a reason other than that the provider was out of network.

Topic #598

Commercial Fee-for-Service

Fee-for-service commercial health insurance is the traditional health care payment system under which providers receive a payment for each unit of service provided rather than a capitation payment for each member. Such insurance usually does not restrict health care to a particular network of providers.

When commercial health insurance plans give the member the option of getting care within or outside a provider network, non-network providers **may** be reimbursed by the commercial health insurance company for covered services if they follow the commercial health insurance plan's billing rules.

Topic #21978

Coordination of Benefits

For the purposes of this Online Handbook topic:

- A [PPS \(prospective payment system\)](#) rate applies to CHCs (community health centers) and Tribal FQHCs (federally qualified health centers).
- An [AIR \(all-inclusive rate\)](#) applies to Tribal FQHCs only.

If the member becomes retroactively enrolled in Wisconsin Medicaid or BadgerCare Plus, providers who have already been reimbursed by one of these government programs may be required to submit the claims to ForwardHealth and refund the payment from the government program.

For services rendered between January 1, 2024, and the date when the Tribal FQHC implemented PPS or AIR reimbursement, all payments from commercial health insurance, per encounter type, will be deducted from PPS or AIR, per encounter type, through a reconciliation.

For services rendered after a Tribal FQHC implemented the PPS or AIR model, payments from commercial insurance, per

encounter type, will be deducted from PPS or AIR per encounter type authorized by ForwardHealth under HCPCS (Healthcare Common Procedure Coding System) code T1015 up to the PPS rate or AIR.

Note: G0466–G0470 are Medicare codes for FQHC bundled services, similar to the T1015 code with Wisconsin Medicaid. ForwardHealth does not recognize the G-series for fee-for-service claims. However, when G-series codes are on Medicare cross-over claims, ForwardHealth policy provides reimbursement for deductible copay and co-insurance. These codes should not be used in combination with HCPCS code T1015.

For Non-Tribal Members

If applicable, CHCs and Tribal FQHCs must bill a non-Tribal member's commercial health insurance first with all appropriate procedure codes, including HCPCS procedure code T1015. After commercial health insurance has processed a claim, the CHC or Tribal FQHC may submit the claim to ForwardHealth using the same CDT (Current Dental Terminology), CPT (Current Procedural Terminology), or HCPCS procedure codes used on the commercial health insurance claim. CHCs and Tribal FQHCs must 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 and Tribal FQHCs must submit the commercial health insurance information at the level it was processed by the commercial health insurance (header or detail level).

ForwardHealth will deduct all payments from commercial health insurance from the PPS or AIR per encounter type authorized under HCPCS code T1015.

For Tribal Members

For Tribal members who receive coverage from IHS (Indian Health Services), Wisconsin Medicaid and BadgerCare Plus are not the payer of last resort. Providers should ask members if they have coverage from these other governmental programs.

If a member has Tribal coverage and there is concern about billing Wisconsin Medicaid as the primary due to rejected claims, their provider should [contact their field representative](#).

Topic #601

Definition of Commercial Health Insurance

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

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

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

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

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

Topic #602

Discounted Rates

Providers of services that are discounted by other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) should include the following information on claims or on the [Explanation of Medical Benefits form](#), as applicable:

- ▮ Their [usual and customary charge](#)
- ▮ The appropriate claim adjustment reason code, NCPDP (National Council for Prescription Drug Programs) reject code, or other insurance indicator
- ▮ The amount, if any, actually received from other health insurance as the amount paid by other health insurance

Topic #596

Exhausting Commercial Health Insurance Sources

Providers are required to exhaust commercial health insurance sources before submitting claims to ForwardHealth. This is accomplished by following the process indicated in the following steps. Providers are required to prepare complete and accurate documentation of efforts to bill commercial health insurance to substantiate other insurance indicators used on any claim.

Step 1. Determine if the Member Has Commercial Health Insurance

If Wisconsin's EVS (Enrollment Verification System) does not indicate that the member has commercial health insurance, the provider may submit a claim to ForwardHealth unless the provider is otherwise aware of commercial health insurance coverage.

If the member disputes the information as it is indicated in the EVS, the provider should submit a [real-time Other Coverage Discrepancy Report via the ForwardHealth Portal](#) or submit a completed [Commercial Other Coverage Discrepancy Report \(F-01159 \(04/2017\)\)](#) form. Unless the service does not require other health insurance billing, the provider should allow at least two weeks before proceeding to Step 2.

Step 2. Determine if the Service Requires Other Health Insurance Billing

If the service requires other health insurance billing, the provider should proceed to Step 3.

If the service does not require other health insurance billing, the provider should proceed in one of the following ways:

- ▮ The provider is encouraged to bill commercial health insurance if they believe that benefits are available. Reimbursement from commercial health insurance may be greater than the Medicaid-allowed amount. If billing commercial health insurance first, the provider should proceed to Step 3.
- ▮ The provider may submit a claim without indicating an other insurance indicator on the claim or on the [Explanation of Medical Benefits form](#), as applicable.

The provider may not bill Wisconsin Medicaid and commercial health insurance simultaneously. Simultaneous billing may

constitute fraud and interferes with Wisconsin Medicaid's ability to recover prior payments.

Step 3. Identify Assignment of Commercial Health Insurance Benefits

The provider should verify whether commercial health insurance benefits may be assigned to the provider. (As indicated by commercial health insurance, the provider may be required to obtain approval from the member for this assignment of benefits.)

The provider should proceed in one of the following ways:

- **If the provider is assigned benefits**, the provider should bill commercial health insurance and proceed to Step 4.
- **If the member is assigned insurance benefits**, the provider may submit a claim (without billing commercial health insurance) using the appropriate other insurance indicator or complete the Explanation of Medical Benefits form, as applicable.

If the commercial health insurance reimburses the member, the provider may collect the payment from the member. If the provider receives reimbursement from Wisconsin Medicaid and the member, the provider is required to return the lesser amount to Wisconsin Medicaid.

Step 4. Bill Commercial Health Insurance and Follow Up

If commercial health insurance denies or partially reimburses the provider for the claim, the provider may proceed to Step 5.

If commercial health insurance does not respond within 45 days, the provider should follow up the original claim with an inquiry to commercial health insurance to determine the disposition of the claim. If commercial health insurance does not respond within 30 days of the inquiry, the provider may proceed to Step 5.

Step 5. Submit Claim to ForwardHealth

If only partial reimbursement is received, if the correct and complete claim is denied by commercial health insurance, or if commercial health insurance does not respond to the original and follow-up claims, the provider may submit a claim to ForwardHealth using the appropriate other insurance indicator or complete the Explanation of Medical Benefits form, as applicable. Commercial remittance information should not be attached to the claim.

Topic #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 (for example, retyped or otherwise reformatted) of the Explanation of Medical Benefits form.

The Explanation of Medical Benefits form requirement for paper claims and adjustments is intended to help ensure consistency with electronic claims and adjustments submitted via the ForwardHealth Portal or using an 837 (837 Health Care Claim) transaction (including those submitted using PES (Provider Electronic Solutions) software or through a clearinghouse or software vendor).

The Explanation of Medical Benefits form requirement applies to paper claims and paper adjustments submitted to Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and the WCDP (Wisconsin Chronic Disease Program). Providers are reminded that, except for a few instances, Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and WCDP are payers of last resort for any covered service. Therefore, providers are required to make a reasonable effort to exhaust all other existing health insurance sources before submitting claims to ForwardHealth or to a state-contracted MCO (managed care organization).

Wisconsin Medicaid and BadgerCare Plus are not payers of last resort for members who receive coverage from [certain governmental programs](#). Providers should ask members if they have coverage from these other government programs.

If a member becomes retroactively enrolled in Wisconsin Medicaid or BadgerCare Plus after the provider has already been reimbursed by one of these government programs, the provider may be required to submit the claims to ForwardHealth and refund the payment from the government program.

Ink, Data Alignment, and Quality Standards for Paper Claim Submission

In order for OCR (Optical Character Recognition) software to read paper claim forms accurately, the claim forms must comply with certain ink standards, as well as other data alignment and quality standards. The Explanation of Medical Benefits form will also need to comply with [these standards](#).

Topic #263

Members Unable to Obtain Services Under Managed Care Plan

Sometimes a member's enrollment file shows commercial managed care coverage, but the member is unable to receive services from the managed care plan. Examples of such situations include the following:

- ┆ Children enrolled in a commercial managed care plan by a noncustodial parent if the custodial parent refuses to use the coverage.
- ┆ Members enrolled in a commercial managed care plan who reside outside the service area of the managed care plan.
- ┆ Members enrolled in a commercial managed care plan who enter a nursing facility that limits the member's access to managed care providers.

In these situations, Wisconsin Medicaid will reimburse services covered by both BadgerCare Plus or Medicaid and the commercial managed care plan even though the services are obtained from providers outside the plan.

When submitting claims for these members, providers should do one of the following:

- ┆ Indicate the other insurance information on the [Explanation of Medical Benefits Form](#) for paper claims.
- ┆ Refer to the Wisconsin [PES \(Provider Electronic Solutions\) manual](#) or the appropriate [837 \(837 health care claim\) companion guide](#) to determine the appropriate other insurance indicator for [electronic claims](#).

Topic #604

Non-Reimbursable Commercial Health Insurance Services

Providers are not reimbursed for the following:

- ┆ Services covered by a commercial health insurance plan, except for coinsurance, copay, or deductible
- ┆ Services for which providers contract with a commercial health insurance plan to receive a capitation payment for services

Topic #605

Other Insurance Indicators

Other insurance indicators are used to report results of commercial health insurance billing and to report when existing insurance was not billed according to Wisconsin Medicaid expectations. Providers are required to use these indicators as applicable on professional, institutional, or dental claims or on the [Explanation of Medical Benefits form](#), as applicable, submitted for members with commercial health insurance. The intentional misuse of other insurance indicators to obtain inappropriate reimbursement constitutes fraud.

Other insurance indicators identify the status and availability of commercial health insurance. The indicators allow providers to be reimbursed correctly when the following occur:

- ┆ Commercial health insurance exists, does not apply, or when, for some valid reason, the provider is unable to obtain such reimbursement by reasonable means.
- ┆ Commercial health insurance does not cover the service provided.
- ┆ Full or partial payment was made by commercial health insurance.

Code	Description
OI-P	PAID in part or in full by commercial health insurance, and/or was applied toward the deductible, coinsurance, copay, blood deductible, or psychiatric reduction. Indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance following submission of a correct and complete claim. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the member has commercial health insurance coverage, but it was not billed for reasons including, but not limited to, the following: ┆ The member denied coverage or will not cooperate. ┆ The provider knows the service in question is not covered by the carrier. ┆ The member's commercial health insurance failed to respond to initial and follow-up claims. ┆ Benefits are not assignable or cannot get assignment. ┆ Benefits are exhausted.

Note: The provider may not use OI-D or OI-Y if the member is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by ForwardHealth except for the copay and deductible amounts. Providers who receive a capitation payment

from the commercial HMO may not bill ForwardHealth for services that are included in the capitation payment.

Providers should not use other insurance indicators when the following occur:

- | Wisconsin's EVS (Enrollment Verification System) indicates no commercial health insurance for the DOS (date of service).
- | The service does not require other health insurance billing.
- | Claim denials from other payers relating to NPI (National Provider Identifier) and related data should be resolved with that payer and not submitted to ForwardHealth. Payments made in these situations may be recouped.

Documentation Requirements

Providers are required to prepare and maintain truthful, accurate, complete, legible, and concise documentation of efforts to bill commercial health insurance sources to substantiate other insurance indicators used on any claim, according to Wis. Admin. Code § [DHS 106.02\(9\)\(a\)](#).

Topic #769

Services Requiring Commercial Health Insurance Billing

If ForwardHealth indicates that the member has other commercial health insurance, the provider is required to bill the following services to commercial health insurance before submitting claims to ForwardHealth:

- | Ambulance services, if provided as emergency services
- | Anesthetist services
- | Audiology services, unless provided in a nursing home or SNF (skilled nursing facility)
- | Behavioral treatment
- | Blood bank services
- | Chiropractic services
- | Dental services
- | DME (durable medical equipment) (rental or purchase), prosthetics, and hearing aids if the billed amount is over \$10 per item
- | Home health services (excluding PC (personal care) services)
- | Hospice services
- | Hospital services, including inpatient or outpatient
- | Independent nurse, nurse practitioner, or nurse midwife services
- | Laboratory services
- | Medicare-covered services for members who have Medicare and commercial health insurance
- | In-home mental health/substance abuse treatment services for children (HealthCheck Other Services) rendered by providers at the master's degree level, doctoral level, and psychiatrist level
- | Outpatient mental health/substance abuse services
- | Mental health/substance abuse day treatment services, including child and adolescent day treatment
- | Narcotic treatment services
- | PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services, unless provided in a nursing home or SNF
- | Physician assistant services
- | Physician services, including surgery, surgical assistance, anesthesiology, or any service to a hospital inpatient (however, physician services provided to a woman whose primary diagnosis indicates a high-risk pregnancy do not require commercial health insurance billing)
- | Pharmacy services for members with verified drug coverage
- | Podiatry services
- | PDN (private duty nursing) services
- | Radiology services

- | RHC (rural health clinic) services
- | Skilled nursing home care, if any DOS (date of service) is within 120 days of the date of admission; if benefits greater than 120 days are available, the nursing home is required to continue to bill for them until those benefits are exhausted
- | Vision services over \$50, unless provided in a home, nursing home, or SNF

If ForwardHealth indicates the member has other vision coverage, the provider is required to bill the following services to commercial health insurance before submitting claims to ForwardHealth:

- | Ophthalmology services
- | Optometrist services

If ForwardHealth indicates the member has Medicare supplemental plan coverage, the provider is required to bill the following services to commercial health insurance before submitting claims to ForwardHealth:

- | Alcohol, betadine, and/or iodine provided by a pharmacy or medical vendor
- | Ambulance services
- | Ambulatory surgery center services
- | Breast reconstruction services
- | Chiropractic services
- | Dental anesthesia services
- | Home health services (excluding PC services)
- | Hospital services, including inpatient or outpatient
- | Medicare-covered services
- | Osteopath services
- | Physician services
- | Skilled nursing home care, if any DOS is within 100 days of the date of admission; if benefits greater than 100 days are available, the nursing home is required to continue to bill for them until those benefits are exhausted

ForwardHealth has identified [services requiring Medicare Advantage billing](#).

Medicare

Topic #664

Acceptance of Assignment

In Medicare, **assignment** is a process through which a provider agrees to accept the Medicare-allowed amount as payment in full. A provider who agrees to this amount is said to **accept assignment**.

A Medicare-enrolled provider performing a Medicare-covered service for a dual eligible or [QMB-Only \(Qualified Medicare Beneficiary-Only\)](#) member is required to accept assignment of the member's Medicare Part A benefits. Therefore, Wisconsin Medicaid's total reimbursement for a Medicare Part A-covered inpatient hospital service (for example, any amount paid by other health insurance sources, any copay or deductible amounts paid by the member, and any amount paid by Wisconsin Medicaid or BadgerCare Plus) may not exceed the Medicare-allowed amount.

Topic #666

Claims Denied for Errors

Medicare claims that were denied for provider billing errors must be corrected and resubmitted to Medicare before the claim may be submitted to ForwardHealth.

Topic #668

Claims Processed by Commercial Health Insurance That Is Secondary to Medicare

If a crossover claim is also processed by commercial health insurance that is secondary to Medicare (for example, Medicare supplemental), the claim will not be forwarded to ForwardHealth. After the claim has been processed by the commercial health insurance, the provider should submit a provider-submitted crossover claim to ForwardHealth with the appropriate other insurance indicator or [Explanation of Medical Benefits form](#), as applicable.

Topic #670

Claims That Do Not Require Medicare Billing

For services provided to dual eligibles, professional, institutional, and dental claims should be submitted to ForwardHealth without first submitting them to Medicare in the following situations:

- ▮ The provider cannot be enrolled in Medicare.
- ▮ The service is not allowed by Medicare under any circumstance. Providers should note that claims are denied for services that Medicare has determined are not medically necessary.

In these situations, providers should not indicate a Medicare disclaimer code on the claim.

Topic #704

Claims That Fail to Cross Over

ForwardHealth must be able to identify the billing provider in order to report paid or denied Medicare crossover claims information on the RA (Remittance Advice). Claims with an NPI (National Provider Identifier) that fails to appear on the provider's RA are an indication that there is a problem with the matching and identification of the billing provider and the claims were denied.

ForwardHealth is not able to identify the billing provider on automatic crossover claims submitted by health care providers in the following situations:

- ▮ The billing provider's NPI has not been reported to ForwardHealth.
- ▮ The taxonomy code has not been reported to ForwardHealth or is not indicated on the automatic crossover claim.
- ▮ The billing provider's practice location ZIP+4 code on file with ForwardHealth is required to identify the provider and is not indicated on the automatic crossover claim.

If automatic crossover claims do not appear on the ForwardHealth and/or the MCO's (managed care organization) RA after 30 days of the Medicare processing date, providers are required to resubmit the claim directly to ForwardHealth or the MCO using the NPI that was reported to ForwardHealth as the primary NPI. Additionally, the taxonomy code and the ZIP+4 code of the practice location on file with ForwardHealth are required when additional data is needed to identify the provider.

Topic #667

Claims for Services Denied by Medicare

If Medicare denies or recoups payment for services provided to dual eligibles that are covered by BadgerCare Plus or Wisconsin Medicaid, the provider may submit a claim for those services directly to ForwardHealth. To allow payment by ForwardHealth in this situation, providers are encouraged to follow BadgerCare Plus and Medicaid requirements (for example, request PA (prior authorization) before providing the service for covered services that require PA). If the requirements are followed, ForwardHealth may reimburse for the service up to the allowed amount (less any payments made by other health insurance sources).

Topic #671

Crossover Claims

A Medicare crossover claim is a Medicare-allowed claim for a dual eligible or QMB-Only (Qualified Medicare Beneficiary-Only) member sent to ForwardHealth for payment of coinsurance, copay, and deductible.

Submit Medicare claims first, as appropriate, to one of the following:

- ▮ Medicare Part A fiscal intermediary
- ▮ Medicare Part B carrier
- ▮ Medicare DME (durable medical equipment) regional carrier
- ▮ Medicare Advantage Plan or Medicare Cost Plan
- ▮ Railroad Retirement Board carrier (also known as the Railroad Medicare carrier)

There are two types of crossover claims based on who submits them:

- ▮ Automatic crossover claims

- Provider-submitted crossover claims

Automatic Crossover Claims

An automatic crossover claim is a claim that Medicare automatically forwards to ForwardHealth by the COBC (Coordination of Benefits Contractor).

Claims will be forwarded if the following occur:

- Medicare has identified that the services were provided to a dual eligible or a QMB-Only member.
- The claim is for a member who is not enrolled in a Medicare Advantage Plan.

Providers are advised to wait 30 days before billing for claims submitted to Medicare to allow time for the automatic crossover process to complete. If automatic crossover claims do not appear on the ForwardHealth and/or the MCO (managed care organization)'s RA (Remittance Advice) after 30 days of the Medicare processing date, providers are required to resubmit the claim directly to ForwardHealth or the MCO using the NPI (National Provider Identifier) that was reported to ForwardHealth as the primary NPI.

If the service is covered by the MCO, the ForwardHealth RA will indicate EOB (Explanation of Benefits) code 0287 (Member is enrolled in a State-contracted managed care program). If the service is covered on a fee-for-service basis, the MCO RA will indicate that the service is not covered. If the crossover claim is submitted without error, the responsible entity (either ForwardHealth or the MCO) will process the claim to a payable status.

Provider-Submitted Crossover Claims

A provider-submitted crossover claim is a Medicare-allowed claim that a provider directly submits to ForwardHealth when the Medicare claim did not automatically cross over. Providers should submit a provider-submitted crossover claim in the following situations:

- The automatic crossover claim does not appear on the ForwardHealth or MCO RA within 30 days of the Medicare processing date.
- The automatic crossover claim is denied, and additional information may allow payment.
- The claim is for a member who was not enrolled in BadgerCare Plus or Wisconsin Medicaid at the time the service was submitted to Medicare for payment, but the member was retroactively determined enrolled in BadgerCare Plus or Medicaid.
- The claim is for a member who is enrolled in a Medicare Advantage Plan or Medicare Cost Plan.
- The claim is for a member who is enrolled in Medicare and commercial health insurance that is secondary to Medicare (for example, Medicare Supplemental).

When submitting crossover claims directly, the following additional data may be required on the claim to identify the billing and rendering provider:

- The NPI that ForwardHealth has on file for the provider
- The taxonomy code that ForwardHealth has on file for the provider
- The ZIP+4 code that corresponds to the practice location address on file with ForwardHealth

Providers may initiate a provider-submitted claim in one of the following ways:

- DDE (Direct Data Entry) through the ForwardHealth Provider Portal
- 837I (837 Health Care Claim: Institutional) transaction, as applicable
- 837P (837 Health Care Claim: Professional) transaction, as applicable
- PES (Provider Electronic Solutions) software

- ┆ Paper claim form

Topic #672

Definition of Medicare

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

Medicare coverage is divided into four parts:

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

Topic #684

Dual Eligibles

Dual eligibles are members who are eligible for coverage from Medicare (either Medicare Part A, Part B, or both) **and** Wisconsin Medicaid or BadgerCare Plus.

Dual eligibles may receive coverage for the following:

- ┆ Medicare monthly premiums for Part A, Part B, or both
- ┆ Coinsurance, copay, and deductible for Medicare-allowed services
- ┆ BadgerCare Plus or Medicaid-covered services, even those that are not allowed by Medicare

Topic #669

Exhausting Medicare Coverage

Providers are required to exhaust Medicare coverage before submitting claims to ForwardHealth. This is accomplished by following these instructions. Providers are required to prepare complete and accurate documentation of efforts to bill Medicare to substantiate Medicare disclaimer codes used on any claim.

Adjustment Request for Crossover Claim

The provider may submit a paper or electronic adjustment request. If submitting a paper [Adjustment/Reconsideration Request \(F-13046 \(02/2025\)\)](#) form, the provider should complete and submit the [Explanation of Medical Benefits form](#), as applicable.

Provider-Submitted Crossover Claim

The provider may submit a provider-submitted crossover claim in the following situations:

- ▮ The automatic crossover claim is not processed by ForwardHealth within 30 days of the Medicare processing date.
- ▮ ForwardHealth denied the automatic crossover claim, and additional information may allow payment.
- ▮ The claim is for a member who is enrolled in a Medicare Advantage Plan.
- ▮ The claim is for a member who is enrolled in Medicare and commercial health insurance that is secondary to Medicare (**for example**, Medicare Supplemental).
- ▮ The claim is for a member who was not enrolled in BadgerCare Plus at the time the service was submitted to Medicare for payment, but the member was retroactively enrolled.*

When submitting provider-submitted crossover claims, the provider is required to follow all claims submission requirements in addition to the following:

- ▮ For electronic claims, indicate the Medicare payment.
- ▮ For paper claims, complete the [Explanation of Medical Benefits form](#).

When submitting provider-submitted crossover claims for members enrolled in Medicare and commercial health insurance that is secondary to Medicare, the provider is also required to do the following:

- ▮ Refrain from submitting the claim to ForwardHealth until after the claim has been processed by the commercial health insurance.
- ▮ Indicate the appropriate other insurance indicator on the claim or the [Explanation of Medical Benefits form](#), as applicable.

* In this situation, a timely filing appeals request may be submitted if the services provided are beyond the claims submission deadline. The provider is required to indicate "retroactive enrollment" on the provider-submitted crossover claim and submit the claim with the [Timely Filing Appeals Request \(F-13047 \(08/2015\)\)](#) form and [Explanation of Medical Benefits form](#), as applicable. The provider is required to submit the timely filing appeals request within 180 days from the date the backdated enrollment was added to the member's file.

Claim for Services Denied by Medicare

When Medicare denies payment for a service provided to a dual eligible that is covered by BadgerCare Plus or Wisconsin Medicaid, the provider may proceed as follows:

- ▮ Bill commercial health insurance, if applicable.
- ▮ Submit a claim to ForwardHealth using the appropriate Medicare disclaimer code. If applicable, the provider should indicate the appropriate other insurance indicator on the claim or the [Explanation of Medical Benefits form](#), as applicable. A copy of Medicare remittance information should not be attached to the claim.

Crossover Claim Previously Reimbursed

A crossover claim may have been previously reimbursed by Wisconsin Medicaid when one of the following has occurred:

- ▮ Medicare reconsiders services that were previously not allowed.
- ▮ Medicare retroactively determines a member eligible.

In these situations, the provider should proceed as follows:

- ▮ Refund or adjust Medicaid payments for services previously reimbursed by Wisconsin Medicaid.

- Bill Medicare for the services and follow ForwardHealth's procedures for submitting crossover claims.

Topic #687

Medicare Advantage

Medicare services may be provided to dual eligibles or QMB-Only (Qualified Medicare Beneficiary-Only) members on a fee-for-service basis or through a Medicare Advantage Plan. Medicare Advantage Plans have a special arrangement with the federal CMS (Centers for Medicare and Medicaid Services) and agree to provide all Medicare benefits to Medicare beneficiaries for a fee. Providers may contact Medicare for a list of Medicare Advantage Plans in Wisconsin and the insurance companies with which they are associated.

ForwardHealth has identified [services requiring Medicare Advantage billing](#).

Paper Crossover Claims

Providers are required to complete and submit an [Explanation of Medical Benefits form](#), along with provider-submitted paper crossover claims for services provided to members enrolled in a Medicare Advantage Plan.

Reimbursement Limits

Reimbursement limits on Medicare Part B services are applied to all Medicare Advantage Plan copay amounts in accordance with federal law. This may reduce reimbursement amounts in some cases.

Topic #20677

Medicare Cost

Providers are required to bill the following services to the Medicare Cost Plan before submitting claims to ForwardHealth if the member was enrolled in the Medicare Cost Plan at the time the service was provided:

- Ambulance services
- ASC (ambulatory surgery center) services
- Chiropractic services
- Dental anesthesia services
- Home health services (excluding PC (personal care) services)
- Hospital services, including inpatient or outpatient
- Medicare-covered services
- Osteopath services
- Physician services

Providers who are not within the member's Medicare Cost network and are not providing an emergency service or Medicare-allowed service with a referral may submit a claim to traditional Medicare Part A or Medicare Part B for the Medicare-allowed service prior to billing ForwardHealth.

Topic #688

Medicare Disclaimer Codes

Medicare disclaimer codes are used to ensure consistent reporting of common billing situations for dual eligibles. Refer to claim instructions for Medicare disclaimer codes and their descriptions. The intentional misuse of Medicare disclaimer codes to obtain inappropriate reimbursement from ForwardHealth constitutes fraud.

Medicare disclaimer codes identify the status and availability of Medicare benefits. The code allows a provider to be reimbursed correctly by ForwardHealth when Medicare benefits exist or when, for some valid reason, the provider is unable to obtain such benefits by reasonable means.

When submitting a claim for a covered service that was denied by Medicare, providers should resubmit the claim **directly** to ForwardHealth using the appropriate Medicare disclaimer code on the claim or the [Explanation of Medical Benefits form](#), as applicable.

Code	Description
M-7	Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the member's lifetime benefit, or yearly allotment of available benefits is exhausted. For Medicare Part A, use M-7 in the following instances (all three criteria must be met): ▮ The provider is identified in ForwardHealth files as enrolled in Medicare Part A. ▮ The member is eligible for Medicare Part A. ▮ The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or exhausted benefits. For Medicare Part B, use M-7 in the following instances (all three criteria must be met): ▮ The provider is identified in ForwardHealth files as enrolled in Medicare Part B. ▮ The member is eligible for Medicare Part B. ▮ The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or exhausted benefits.
M-8	Noncovered Medicare service. This code may be used when Medicare was not billed because the service is not covered in this circumstance. For Medicare Part A, use M-8 in the following instances (all three criteria must be met): ▮ The provider is identified in ForwardHealth files as enrolled in Medicare Part A. ▮ The member is eligible for Medicare Part A. ▮ The service is usually covered by Medicare Part A but not in this circumstance (for example, member's diagnosis). For Medicare Part B, use M-8 in the following instances (all three criteria must be met): ▮ The provider is identified in ForwardHealth files as enrolled in Medicare Part B. ▮ The member is eligible for Medicare Part B. ▮ The service is usually covered by Medicare Part B but not in this circumstance (for example, member's diagnosis).

Documentation Requirements

Providers are required to prepare and maintain truthful, accurate, complete, legible, and concise documentation of efforts to bill Medicare to substantiate Medicare disclaimer codes used on any claim, according to Wis. Admin. Code [§ DHS 106.02\(9\)\(a\)](#).

Topic #8457

Medicare Late Fees

Medicare assesses a late fee when providers submit a claim after Medicare's claim submission deadline has passed. Claims that cross over to ForwardHealth with a Medicare late fee are denied for being out of balance. To identify these claims, providers should reference the Medicare remittance information and check for ANSI (American National Standards Institute) code B4 (late filing penalty), which indicates a late fee amount deducted by Medicare.

ForwardHealth considers a late fee part of Medicare's paid amount for the claim because Medicare would have paid the additional amount if the claim had been submitted before the Medicare claim submission deadline. ForwardHealth will not reimburse providers for late fees assessed by Medicare.

Resubmitting Medicare Crossover Claims with Late Fees

Providers may resubmit to ForwardHealth crossover claims denied because the claim was out of balance due to a Medicare late fee. The claim may be submitted on paper, submitted electronically using the ForwardHealth Portal, or submitted as an 837 (837 Health Care Claim) transaction.

Paper Claim Submissions

When resubmitting a crossover claim on paper, include a copy of the Medicare remittance information so ForwardHealth can determine the amount of the late fee and apply the correct reimbursement amount.

Electronic Claim Submissions

When resubmitting a claim via the Portal or an electronic 837 transaction (including PES (Provider Electronic Solutions) software submissions), providers are required to balance the claim's paid amount to reflect the amount Medicare would have paid before Medicare subtracted a late fee. This is the amount that ForwardHealth considers when adjudicating the claim. To balance the claim's paid amount, add the late fee to the paid amount reported by Medicare. Enter this amount in the Medicare paid amount field.

For example, the Medicare remittance information reports the following amounts for a crossover claim:

- | Billed Amount: \$110
- | Allowed Amount: \$100
- | Coinsurance: \$20
- | Late Fee: \$5
- | Paid Amount: \$75

Since ForwardHealth considers the late fee part of the paid amount, providers should add the late fee to the paid amount reported on the Medicare remittance. In the example above, add the late fee of \$5 to the paid amount of \$75 for a total of \$80. The claim should report the Medicare paid amount as \$80.

Topic #689

Medicare Provider Enrollment

Some providers may become retroactively enrolled in Medicare. Providers should contact Medicare for more information about retroactive enrollment.

Services for Dual Eligibles

As stated in Wis. Admin. Code § [DHS 106.03\(7\)](#), a provider is required to be enrolled in Medicare if both of the following are true:

- ▮ They provide a Medicare Part A service to a dual eligible.
- ▮ They can be enrolled in Medicare.

If a provider can be enrolled in Medicare but chooses **not** to be, the provider is required to refer dual eligibles to another Medicaid-enrolled provider who is enrolled in Medicare.

Services for Qualified Medicare Beneficiary-Only Members

Because QMB-Only (Qualified Medicare Beneficiary-Only) members receive coverage from Wisconsin Medicaid only for services allowed by Medicare, providers who are not enrolled in Medicare are required to refer QMB-Only members to another Medicaid-enrolled provider who is enrolled in Medicare.

Topic #690

Medicare Retroactive Eligibility — Member

If a member becomes retroactively eligible for Medicare, the provider is required to refund or adjust any payments for the retroactive period. The provider is required to then bill Medicare for the services and follow ForwardHealth's procedures for submitting crossover claims. Claims found to be in conflict with this program requirement will be recouped.

Topic #895

Modifier for Catastrophe/Disaster-Related Crossover Claims

ForwardHealth accepts modifier CR (Catastrophe/disaster related) on Medicare crossover claims (both [837P](#) (837 Health Care Claim: Professional) transactions and 1500 Health Insurance Claim Forms) to accommodate the emergency health care needs of dual eligibles and QMB-Only (Qualified Medicare Beneficiary-Only) members affected by disasters. The [CMS \(Centers for Medicare and Medicaid Services\) website](#) contains more information.

Topic #4957

Provider-Submitted Crossover Claims

A provider-submitted crossover claim is a Medicare-allowed claim that a provider directly submits to ForwardHealth when the

Medicare claim did not automatically crossover to ForwardHealth.

Electronic Professional Crossover Claims

Providers submitting crossover claims electronically must indicate all Medicare coinsurance, copay, and psychiatric reduction amounts at the detail level. If the Medicare coinsurance, copay, and psychiatric reduction amounts are indicated at the header level, the claim will be denied. Providers may indicate deductibles in either the header or detail level.

When submitting electronic Medicare crossover claims, providers should not submit paper EOMB (Explanation of Medicare Benefits) as an attachment. Providers should, however, be sure to complete Medicare CAS segments when submitting 837 (837 Health Care Claim) transactions.

Paper Professional Crossover Claims

All paper provider-submitted crossover claims submitted on the 1500 Health Insurance Claim Form ((02/12)) require a provider signature and date in Item Number 31. The words "signature on file" are not acceptable. Provider-submitted crossover claims without a signature or date are denied or are subject to recoupment. The provider signature requirement for paper crossover claims is the same requirement for all other paper 1500 Health Insurance Claims.

In addition, when submitting a paper provider-submitted crossover claim, providers are required to complete and submit an [Explanation of Medical Benefits form](#), as applicable.

Topic #692

Qualified Medicare Beneficiary-Only Members

QMB-Only (Qualified Medicare Beneficiary-Only) members are a limited benefit category of Medicaid members. They are eligible for coverage from Medicare (either Part A, Part B, or both) **and** limited coverage from Wisconsin Medicaid. QMB-Only members receive Medicaid coverage for the following:

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

QMB-Only members do not receive coverage from Wisconsin Medicaid for services not allowed by Medicare. Therefore, Wisconsin Medicaid will not reimburse for services if either of the following occur:

- ┆ Medicare does not cover the service.
- ┆ The provider is not enrolled in Medicare.

Topic #686

Reimbursement for Crossover Claims

Professional Crossover Claims

State law limits reimbursement for coinsurance and copay of Medicare Part B-covered services provided to dual eligibles and QMB-Only (Qualified Medicare Beneficiary-Only) members.

Total payment for a Medicare Part B-covered service (for example, any amount paid by other health insurance sources, any copay or spenddown amounts paid by the member, and any amount paid by Wisconsin Medicaid) may not exceed the Medicare-

allowed amount. Therefore, Medicaid reimbursement for coinsurance or copay of a Medicare Part B-covered service is the lesser of the following:

- ▮ The **Medicare**-allowed amount less any amount paid by other health insurance sources and any copay or spenddown amounts paid by the member.
- ▮ The **Medicaid**-allowed amount less any amount paid by other health insurance sources and any copay or spenddown amounts paid by the member.

The following table provides three examples of how the limitations are applied.

Reimbursement for Coinsurance or Copay of Medicare Part B-Covered Services			
Explanation	Example		
	1	2	3
Provider's billed amount	\$120	\$120	\$120
Medicare-allowed amount	\$100	\$100	\$100
Medicaid-allowed amount (for example, maximum allowable fee)	\$90	\$110	\$75
Medicare payment	\$80	\$80	\$80
Medicaid payment	\$10	\$20	\$0

Outpatient Hospital Crossover Claims

Detail-level information is used to calculate pricing for all outpatient hospital crossover claims and adjustments. Details that Medicare paid in full or that Medicare denied in full will not be considered when pricing outpatient hospital crossover claims. Medicare deductibles are paid in full.

Inpatient Hospital Services

State law limits reimbursement for coinsurance, copay and deductible of Medicare Part A-covered inpatient hospital services for dual eligibles and QMB-Only members.

Wisconsin Medicaid's total reimbursement for a Medicare Part A-covered inpatient hospital service (for example, any amount paid by other health insurance sources, any copay or deductible amounts paid by the member, and any amount paid by Wisconsin Medicaid or BadgerCare Plus) may not exceed the Medicare-allowed amount. Therefore, Medicaid reimbursement for coinsurance, copay, and deductible of a Medicare Part A-covered inpatient hospital service is the **lesser** of the following:

- ▮ The difference between the **Medicaid**-allowed amount and the **Medicare**-paid amount.
- ▮ The sum of Medicare coinsurance, copay, and deductible.

The following table provides three examples of how the limitations are applied.

Reimbursement for Medicare Part A-Covered Inpatient Hospital Services Provided To Dual Eligibles			
Explanation	Example		
	1	2	3
Provider's billed amount	\$1,200	\$1,200	\$1,200
Medicare-allowed amount	\$1,000	\$1,000	\$1,000
Medicaid-allowed amount (for example, diagnosis-related group or per diem)	\$1,200	\$750	\$750
Medicare-paid amount	\$1,000	\$800	\$500
Difference between Medicaid-allowed amount and Medicare-paid amount	\$200	(\$-50)	\$250

Medicare coinsurance, copay and deductible	\$0	\$200	\$500
Medicaid payment	\$0	\$0	\$250

Nursing Home Crossover Claims

Medicare deductibles, coinsurance, and copays are paid in full.

Community Health Center and Tribal Federally Qualified Health Center Crossover Claims

CHC (Community health center) and Tribal FQHC (federally qualified health center) encounters subject to [PPS \(prospective payment system\)](#) and [AIR \(all-inclusive rate\)](#) reimbursement are carved out of (not included in) [Medicare Crossover coverage](#).

Topic #4977

Rendering Provider on Professional Crossover Claims

Providers are required to indicate the rendering provider on electronic and paper crossover claims when ForwardHealth service-specific policy requires a rendering provider. However, professional crossover claims received by ForwardHealth from Medicare may not have the taxonomy code of the billing provider indicated on the transaction. Medicare will not accept the 837P (837 Health Care Claim: Professional) transaction when a taxonomy code is reported in both the Billing/Pay-to Provider Loop and in the Rendering Provider Loop if the billing and rendering providers are different. For example, a transaction with a physician group indicated as the billing provider and the individual physician indicated as the rendering provider.

Providers should resubmit professional crossover claims to ForwardHealth when the taxonomy code is required to identify the billing provider and it is not indicated on the crossover claim received from Medicare. Taxonomy codes for billing and rendering providers may be required if the provider has a single NPI for multiple ForwardHealth provider enrollments. Providers should refer to the [837 companion guides](#) for information on using taxonomy codes on standard claim transactions. ForwardHealth will accept the 837P transaction when a taxonomy code is reported in both the Billing/Pay-to Provider Loop and in the Rendering Provider Loop and the billing and rendering providers are different.

This ForwardHealth requirement is inconsistent with the instructions in the 837P Implementation Guide; however, the federal CMS (Centers for Medicare & Medicaid Services) has acknowledged that health plans may need the billing provider taxonomy in order to accurately process claims.

Topic #770

Services Requiring Medicare Advantage Billing

Providers are required to bill the following services to the Medicare Advantage Plan before submitting claims to ForwardHealth:

- | Ambulance services
- | ASC (ambulatory surgery center) services
- | Chiropractic services
- | Dental anesthesia services
- | Home health services (excluding PC (personal care) services)
- | Hospital services, including inpatient or outpatient
- | Medicare-covered services
- | Osteopath services

- Physician services

Providers who are not within the member's Medicare Advantage network and are not providing an emergency service or Medicare-allowed service with a referral are required to refer the member to a provider within their network.

ForwardHealth has identified [services requiring commercial health insurance billing](#).

Other Coverage Information

Topic #4940

After Reporting Discrepancies

After receiving a [Commercial Other Coverage Discrepancy Report \(F-01159 \(04/2017\)\)](#) form or [Medicare Other Coverage Discrepancy Report \(F-02074 \(04/2018\)\)](#) form, ForwardHealth confirms the information and updates the member files.

It may take up to two weeks to process and update the member's enrollment information. During that time, ForwardHealth verifies the insurance information submitted and adds, changes, or removes the member's other coverage information as appropriate. If verification contradicts the provider's information, a written explanation is sent to the provider. The provider should wait to submit claims until one of the following occurs:

- ▮ The provider verifies through Wisconsin's EVS (Enrollment Verification System) that the member's other coverage information has been updated.
- ▮ The provider receives a written explanation.

Topic #4941

Coverage Discrepancies

Maintaining complete and accurate insurance information may result in fewer claim denials. Providers are an important source of other coverage information as they are frequently the first to identify coverage discrepancies.

Topic #609

Insurance Disclosure Program

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

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

Topic #610

Maintaining Accurate and Current Records

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

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

- ┆ Member certifying agencies
- ┆ Members

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

Topic #4942

Reporting Discrepancies

Providers are encouraged to report discrepancies to ForwardHealth by submitting the [Commercial Other Coverage Discrepancy Report \(F-01159 \(04/2017\)\)](#) form or [Medicare Other Coverage Discrepancy Report \(F-02074 \(04/2018\)\)](#) form. Providers are asked to complete the form in the following situations:

- ┆ The provider is aware of other coverage information that is not indicated by Wisconsin's EVS (Enrollment Verification System).
- ┆ The provider received other coverage information that contradicts the information indicated by the EVS.
- ┆ A claim is denied because the EVS indicates commercial managed care coverage but the coverage is not available to the member (for example, the member does not live in the plan's service area).

Providers should not use the Commercial Other Coverage Discrepancy Report form or Medicare Other Coverage Discrepancy Report form to update any information regarding a member's coverage in a state-contracted MCO (managed care organization).

When reporting discrepancies, providers should include photocopies of current insurance cards and any available documentation, such as remittance information and benefit coverage dates or denials.

Covered and Noncovered Services

3

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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:

- | [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 #21977

Associated Procedure Codes for Additional Dental Visits

For reimbursement to CHCs (community health centers) and Tribal FQHCs (federally qualified 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 (Current Dental Terminology) procedure codes to represent the associated procedure codes:

- | **D1999** (unspecified preventive procedure, by report): This procedure code is 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): This procedure code is 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): This procedure code is 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): This procedure code is 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

Encounters Procedure Code

CHCs (community health centers) and Tribal FQHCs (federally qualified health centers) will identify [encounters](#) on claims by using HCPCS (Healthcare Common Procedure Coding System) procedure code T1015 (Clinic visit/encounter, all-inclusive) for services rendered. ForwardHealth assigns the appropriate encounter type to the claim detail associated with procedure code T1015 based on the provider type of the rendering provider.

Topic #24143

Required Codes for Complete Dentures

For complete maxillary and complete mandibular dentures, CHCs and Tribal FQHCs must indicate [area of oral cavity codes](#) on PA (prior authorization) requests and claims for encounters on the same DOS (date of service).

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 #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

Encounters

Unless otherwise stated, for the purposes of this Online Handbook topic:

- ▮ A [PPS \(prospective payment system\)](#) rate applies to CHCs (community health centers) and Tribal FQHCs (federally qualified health centers).
- ▮ An [AIR \(all-inclusive rate\)](#) applies to Tribal FQHCs only.

Community Health Centers

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. Under PPS, ForwardHealth reimburses CHCs a PPS rate for each allowable CHC encounter.

Tribal FQHCs

Per State Plan Amendment WI 24-0008, a Tribal FQHC encounter is a qualifying visit between a client and a qualified Medicaid Tribal FQHC provider who delivers a Medicaid-covered medical, dental, and/or behavioral ambulatory service on a single day at an approved Tribal FQHC location (including main and off-site locations) for a diagnosis, treatment, or preventative service. Only one medical, one dental, and one mental health encounter will be paid per member per day.

Outpatient Encounters

ForwardHealth considers a service as an encounter when it is:

- ▮ Performed in a CHC or Tribal FQHC location.
- ▮ Performed by a CHC or Tribal FQHC provider in a location such as:
 - ▮ Ambulatory surgical centers
 - ▮ Extended care facilities
 - ▮ Hospitals
 - ▮ Members' homes
 - ▮ Mobile units

- Primary sites of rendering providers (dentists contracted to provide services at FQHCs)
- School visits

The [interactive maximum allowable fee schedules](#) has all allowable POS (place of service) codes.

All services provided as part of the CHC or Tribal FQHC encounter must meet all applicable ForwardHealth program requirements, including medical necessity, PA (prior authorization), [claims submission](#), prescription requirements, and documentation requirements.

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

- Direct services—These are core services provided during the encounter. For example, preventive or routine office visits are direct services.
- Indirect services—These are supplies and/or diagnostic or therapeutic ancillary services that are delivered as part of the core service(s) provided during the encounter. Indirect services include radiology, laboratory tests, medical supplies, durable medical equipment, ancillary provider services, and professional dispensing fees.

When a Tribal FQHC member is referred to a provider, that provider may only submit a claim for a Tribal FQHC service or encounter if they are under contract with a Tribal FQHC **and** the Tribal FQHC pays for the service.

Indirect Services

Indirect services are Medicaid-covered services that support core services provided during the encounter, but they do not count as individual encounters on their own.

Costs of allowable indirect services are included as a portion of the total cost in the PPS and AIR-setting method.

Indirect costs not allowed under cost-based reimbursement are not included in PPS or AIR.

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.

CHCs and Tribal FQHCs identify encounters on claims by using HCPCS (Healthcare Common Procedure Coding System) procedure code T1015 (Clinic visit/encounter, all-inclusive) for services rendered.

Topic #22917

Interpretive Services

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

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

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

Covered Interpretive Services

ForwardHealth covers interpretive services for deaf or hard of hearing members or members with LEP when the interpretive service and the medical service are provided to the member on the same DOS (date of service) and during the same time as the medical service. A Medicaid-enrolled provider must submit for interpretive services on the same claim as the medical service, and the DOS they are provided to the member must match. Interpretive services cannot be billed by HMOs and MCOs (managed care organizations). Providers should follow CPT (Current Procedural Terminology) and HCPCS coding guidance to appropriately document and report procedure codes related to interpretive and medical services on the applicable claim form. Time billed for interpretive services should reflect time spent providing interpretation to the member. At least three people must be present for the services to be covered: the provider, the member, and the interpreter.

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

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

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

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

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

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

Documentation

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

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

Third-Party Vendors and In-House Interpreters

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

Providers are reminded that HIPAA (Health Insurance Portability and Accountability Act of 1996) confidentiality requirements apply to interpretive services. When a covered entity or provider utilizes interpretive services that involve PHI (protected health information), the entity or provider will need to conduct an accurate and thorough assessment of the potential risks and vulnerabilities to PHI confidentiality, integrity, and availability. Each entity or provider must assess what are reasonable and appropriate measures for their situation.

Limitations

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

Claims Submission

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

- ▮ 1500 Health Insurance Claim Form ((02/12)) (for dental, professional, and professional crossover claims)
- ▮ Institutional UB-04 (CMS 1450) claim form (for outpatient crossover claims and home health/personal care claims)

Noncovered Services

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

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

Cancellations or No Shows

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

Procedure Code and Modifiers

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

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

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

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

68–82 minutes	5.0 units
83–97 minutes	6.0 units

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

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

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

Delivery Method of Interpretive Services	Definition for Sign Language and Foreign Language Interpreters		Modifiers
In person (foreign language and sign language)	When the interpreter is physically present with the member and provider		U1 or U3
Telehealth* (foreign language and sign language)	When the member is located at an originating site and the interpreter is available remotely (via audio-visual or audio only) at a distant site		U1 or U3 and GT or 93
	Phone (foreign language only)	When the interpreter is not physically present with the member and the provider and interprets via audio-only through the phone	U1 and 93
	Interactive video (foreign language 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), and Tribal FQHCs (POS codes 50 and XX), will not receive direct reimbursement for interpretive services as these are indirect services assumed to be already included in the bundled [PPS \(prospective payment system\)](#) (or [AIR \(all-inclusive rate\)](#) for Tribal FQHCs) rate. However, CHCs and Tribal FQHCs 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 Wisconsin DHS (Department of Health Services) to better track how CHCs and Tribal 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 #510

Telehealth Policy

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

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

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

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

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

Telehealth Policy Requirements

The following requirements apply to the use of telehealth:

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

Allowable Services

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

- ▮ POS code 02: Telehealth Provided Other Than in Patient's Home—The location where health services and health related

services are provided or received through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.

- ┆ POS code 10: Telehealth Provided in Patient's Home—The location where health services and health related services are provided or received through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.

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

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

Services Not Appropriate via Telehealth

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

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

Reimbursement for Covered Services

The health care provider at the distant site must determine:

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

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

Documentation Requirements

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

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

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

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

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

Audio-Only Guidelines

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

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

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

Member Consent Guidelines for Telehealth

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

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

Privacy and Security

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

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

Group Treatment

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

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

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

Costs Member Cannot Be Billed For

The following cannot be billed to the member:

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

Allowable Providers

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

Requirements and Restrictions

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

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

Providers are reminded that HIPAA (Health Insurance Portability and Accountability Act of 1996) confidentiality requirements apply to telehealth services. When a covered entity or provider utilizes a telehealth service that involves PHI (protected health information), the entity or provider will need to conduct an accurate and thorough assessment of the potential risks and vulnerabilities to PHI confidentiality, integrity, and availability. Each entity or provider must assess what are reasonable and appropriate security measures for their situation.

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

Noncovered Services

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

Additional Policy for Certain Types of Providers

Out-of-State Providers

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

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

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

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

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.

Managed Care

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Archive Date:10/01/2026

Managed Care: Covered and Noncovered Services

Topic #391

Noncovered Services

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

- | [Behavioral treatment services](#) (for example, autism services)
- | Chiropractic services, unless the HMO elects to provide chiropractic services
- | County-based mental health programs, including CCS (comprehensive community services), CRS (Community Recovery Services), CSP (community support program) benefits, and crisis intervention services
- | Dental

Note: HMOs must provide dental services in Milwaukee, Waukesha, Racine, Kenosha, Ozaukee, and Washington counties.

- | Environmental lead investigation services provided through local health departments
- | Hub and Spoke Health Home or SUD (substance use disorder) pilot programs (integrated recovery support services)
- | Medication therapy management
- | Pharmacy services and diabetic supplies
- | PNCC (Prenatal care coordination) services
- | Physician-administered drugs

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

- | Residential SUD treatment
- | SBS (School-based services)
- | Targeted case management services
- | NEMT (Non-emergency medical transportation) services
- | DOT (Directly observed therapy) and monitoring for TB (tuberculosis)-Only Services

Providers who render any of these services to a BadgerCare Plus or Medicaid SSI HMO member should submit PA (prior authorization) requests and claims directly to ForwardHealth for coverage.

Enrollment

Topic #392

Disenrollment and Exemptions

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

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

Topic #393

Member Grievances

Members have the right to file a grievance with their HMO if they are unsatisfied with the services of the HMO or its providers. A member can file a grievance at any time for issues like:

- | Service quality.
- | Disrespect from a provider or an employee.
- | Violations of their member rights.

Members should contact the Wisconsin HMO [Ombudsman Program](#) to help solve the problem or write a formal grievance to the HMO. The SSI External Advocate can help SSI HMO members with filing a grievance.

Topic #399

Release of Billing or Medical Information

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

Managed Care Information

Topic #401

BadgerCare Plus HMO Program

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

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

Topic #402

Managed Care Contracts

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

Prior Authorization

Topic #400

Prior Authorization Procedures

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

Provider Information

Topic #406

Copays

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

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

Member Information

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Archive Date:10/01/2026

Member Information:Enrollment Categories

Topic #225

BadgerCare Plus

Populations Eligible for BadgerCare Plus

The following populations are eligible for BadgerCare Plus:

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

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

Premiums

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

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

Enrollment Rights

Topic #247

Freedom of Choice

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

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.

Children enrolled in Foster Care Medicaid or SSI Medicaid will have 12-months of continuous coverage even if their out-of-home placement, subsidized guardianship, court-ordered kinship care, adoption assistance agreement, or SSI payment ends.

Qualifying Programs

Members under age 19 in the following programs qualify for continuous coverage:

- | [BadgerCare Plus](#)
- | Emergency Services Medicaid
- | [Family Planning Only Services](#)
- | Foster Care Medicaid
- | HCBW (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.
- | Their eligibility was based on inaccurate information or agency error.
- | The family asks to end their coverage.

Assisting Members Through Enrollment Renewals

Helping families through the health care renewal process remains vital to keeping children covered. Providers are asked to remind BadgerCare Plus and other Wisconsin Medicaid program members to renew their coverage, even if they think their situation will change in the future. Members should also be reminded to tell their agency about any changes to their address, phone number, or email to ensure they continue to receive important information about their health care coverage from Wisconsin DHS (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

Additional member resources regarding health care renewals and continuous coverage for children are available:

- ▮ [Medicaid: Programs for Children](#) web page
- ▮ [Health Care Renewals](#) web page
- ▮ "Keeping Kids Covered" [12-Month Continuous Coverage for Children fact sheet](#)
- ▮ [BadgerCare Plus: Frequently Asked Questions](#)

Additional policy information on continuous coverage for children is [available](#) in the BadgerCare Plus Handbook.

Provider Enrollment and Ongoing Responsibilities

6

Archive Date:10/01/2026

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 must notify ForwardHealth of a change in ownership within 35 calendar days after the effective date of the change per CMS (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.

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

New Enrollment Application Is Required

Any time a change in ownership occurs, providers must complete a new [Medicaid provider enrollment application](#) on the Portal. Indicate that this is a change of ownership on the application.

ForwardHealth must receive the change in ownership application, 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

These 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)

Additional Requirements for Providers Required to Use EVV

Providers required to use EVV when rendering [certain services](#) can ensure a successful transition by:

- ┆ Reviewing the [EVV and Provider Agency Change of Ownership document, P-03819](#).
- ┆ Contacting Wisconsin EVV Customer Care at vdxc.contactevv@wisconsin.gov or 833-931-2035 Monday–Friday, 7 a.m.–6 p.m. Central Time.

Events 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.

These 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
 - ┆ LLCs (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:

- ┆ 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 must repay ForwardHealth for any incorrect payments or overpayments made to them. The new owner's application will be denied if the previous owner does not repay ForwardHealth for any incorrect payments or overpayments.

If necessary, ForwardHealth will hold the provider who receives the transfer of ownership before the final transfer of ownership responsible for repayment. The provider acquiring the business is responsible for contacting ForwardHealth to find out if they are liable under this provision.

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

Providers may send inquiries about determining of any pending liability:

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.

Providers Must Submit New Prior Authorization Requests After a Change in Ownership

Medicaid-enrolled providers must submit new PA (prior authorization) requests when there is a change in billing providers. Providers must submit new PA requests with the new billing provider's name and billing provider number. The expiration date of the new PA request will stay the same as the original PA request.

The provider must send this information 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 end date the original PA request (may be a photocopy), which should include:
 - ┆ 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–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–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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Archive Date:10/01/2026

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](#)
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- | [Chiropractic](#)
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- | [Substance Abuse Day Treatment](#)
- | [Therapies: Physical, Occupational, and Speech and Language Pathology](#)
- | [Vision](#)

Topic #24124

Dental Services

For the purposes of this Online Handbook topic:

- | A [PPS \(prospective payment system\)](#) rate applies to CHCs (community health centers) and Tribal FQHCs (federally qualified health centers).
- | An [AIR \(all-inclusive rate\)](#) applies to Tribal FQHCs only.

ForwardHealth will reimburse CHCs and Tribal FQHCs an encounter rate for each allowed dental visit. A dental visit qualifies for PPS or AIR by meeting all defined program requirements:

- | The rendering provider must be enrolled with Wisconsin Medicaid.

- ▮ The services provided must qualify as [direct services](#).
- ▮ The services provided must be [covered procedure codes](#).

ForwardHealth reimburses Tribal FQHCs for dental services requiring [multiple visits](#) when:

- ▮ The provider bills the procedure code, or base code, that represents the final prosthesis or dental service.
- ▮ Each additional visit that occurs before completing the final procedure is represented on the claim by an associated code.

Note: Not every base code requires an associated procedure code.

Wisconsin DHS (Department of Health Services) requires a compliance review of each associated procedure code service when a base procedure code is not rendered or is denied (such as when the base procedure code does not meet program requirements for reimbursement). Provider reimbursement for the associated codes depends on [DHS review](#).

Topic #22058

Prospective Payment System Reimbursement

For the purposes of this Online Handbook topic:

- ▮ A [PPS \(prospective payment system\)](#) rate applies to CHCs (community health centers) and Tribal FQHCs (federally qualified health centers).
- ▮ An [AIR \(all-inclusive rate\)](#) applies to Tribal FQHCs only.

Rates and Reimbursement

Under PPS, ForwardHealth reimburses CHCs and Tribal FQHCs for an encounter rate which includes all direct and indirect services provided to a member during an encounter.

ForwardHealth will apply the PPS rate or AIR for the encounter type to a 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.

ForwardHealth only reimburses Tribal FQHCs for covered services and does not reimburse providers for the cost of any Tribal FQHC activities and services that:

- ▮ Are not required by ForwardHealth.
- ▮ Are part of Tribal FQHC-related services included in state statute or administrative code.

Calculation of the Prospective Payment System Rate

ForwardHealth calculates a separate PPS rate for each CHC or Tribal FQHC per the Benefits Improvement and Protection Act of 2000.

At the end of each CHC or Tribal FQHC fiscal year, ForwardHealth adjusts the PPS rate using FQHC market basket in effect at the time, which replaced the MEI (Medicare Economic Index) in 2017. In addition, ForwardHealth may adjust a CHC's or Tribal FQHC's PPS rate to account for changes in the CHC's or Tribal FQHC's scope of service.

Reimbursement Guidelines

ForwardHealth reimburses a CHC or Tribal FQHC a maximum of one PPS rate per encounter type, per member, per DOS

(date of service) **unless** the member suffers an illness or injury **after the first encounter** that requires additional diagnosis or treatment on the same day.

When a CHC or Tribal FQHC member receives services of the same encounter type in a single day at more than one CHC or Tribal FQHC location (for example, the main clinic, an off-site clinic, and/or a contracted facility), ForwardHealth will reimburse the CHC or Tribal FQHC for only one encounter type per DOS—unless the additional encounter qualifies as a subsequent encounter.

Reimbursement for Services Provided by a Pharmacist

If the billing provider is a CHC or Tribal FQHC and the rendering provider is the pharmacist, then the CHC or Tribal FQHC may bill for covered medical services provided by the CHC's or Tribal FQHC's pharmacist. However, because the pharmacist is providing medical services, the one payer per service per day rule still applies. Encounter counting logic for PPS rates applies when all conditions are met for qualified encounters.

Services "Carved-Out" of the PPS Rate

Physician-administered drugs, telehealth distant site services, and certain pharmacy services are "carved out" of (not included in) PPS and are reimbursed separately.

Pharmacy Services

Some CHCs and Tribal FQHCs provide pharmacy services and bill for them on a ForwardHealth compound or noncompound drug claim. A CHC or Tribal FQHC pharmacy provider must enroll as a separate Medicaid provider under the applicable pharmacy provider type and specialty. The pharmacy must have the same tax ID as the main service location of the associated CHC or Tribal FQHC.

If a Tribal FQHC adds pharmacy services to their practice, they may qualify for a change in scope that may increase their PPS rate.

Physician-Administered Drugs

Physician-administered drugs are drugs administered by a provider in an office setting. The [Physician-Administered Drugs Resources](#) page contains a list of procedure codes classified as physician-administered drugs that may be reimbursed in addition to the PPS rate for an encounter. These services are subject to change and must meet all applicable ForwardHealth program requirements, including medical necessity, PA (prior authorization), claims submission, prescription requirements, and documentation requirements.

Telehealth Services

[Telehealth services](#) include "originating site" services and/or "distant site" services.

- ▮ Originating site services are not eligible for PPS.
- ▮ Distance site services are counted as encounters and must meet PPS rates guidelines.

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

Cost Reporting

Topic #21957

An Overview

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- | [Ambulance](#)
- | [Anesthesiologist Assistant and Certified Registered Nurse Anesthetist](#)
- | [Child/Adolescent Day Treatment, HealthCheck Other Services](#)
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- | [Podiatry](#)
- | [Prenatal Care Coordination](#)
- | [Substance Abuse Day Treatment](#)
- | [Therapies: Physical, Occupational, and Speech and Language Pathology](#)
- | [Vision](#)

Topic #24126

Community Health Center Interim Report Form

For the purposes of this Online Handbook topic, FQHC (federally qualified health center) refers to CHCs (community health centers) and out-of-state FQHCs.

CHCs and Out-of-State FQHCs receiving [PPS \(prospective payment system\)](#) reimbursement may self-report encounters when PPS are excluded from T1015 payment by completing supplemental interim reports, also known as wrap reports. The report details estimated eligible encounters that are not reimbursed using PPS, such as HMO claims or fee-for-service Medicare Crossover claims. CHCs and out-of-state FQHCs can use the interim form as a cash flow option to be paid for the difference between the max fee paid via the claims engine and the PPS rate. The payment amount is estimated until it is officially reconciled to pull actual encounters and revenue.

Wisconsin DHS (Department of Health Services) checks claims for reasonability and issues payment based on the requested amount on the form. Supplemental interim forms are risk-based and later reconciled against actual encounters using an encounter reconciliation process. An encounter reconciliation results in either a payment, recoupment, or no action. No action occurs when self-reported encounters from the interim forms fall within 5% variance of actual encounters. Payment or recoupment occurs when self-reported encounters on interim forms falls outside the 5% variance of actual encounters by either over-reporting or under-reporting.

Submission Frequency

Interim forms should be submitted no less than quarterly but may be submitted monthly.

Supplement Interim Report Form

CHCs and out-of-state FQHCs may use the Federally Qualified Health Center Interim Report form to report non-PPS rate and request the difference up to their PPS rate.

CHCs and out-of-state FQHCs may request current Interim Report Forms for their CHC or out-of-state FQHC and submit completed forms by emailing DHS Wisconsin FQHC (for Non-Tribal) at DHSWIFQHC@dhs.wisconsin.gov.

Topic #22017

Cost Report Form

CHCs (Community health centers) and Tribal FQHCs (federally qualified 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

Following the end of a CHC (community health center)'s or Tribal FQHC's (federally qualified health center's) fiscal year, the CHC or Tribal FQHC must complete a [Federally Qualified Health Center Outstationed Enrollment Survey \(F-02758 \(01/2021\)\)](#) form:

- ▮ CHCs should send the completed form to DHSWIFQHC@dhs.wisconsin.gov.
- ▮ Tribal FQHCs should send the completed form to DHSTRIBALFQHC@dhs.wisconsin.gov.

The CHC or Tribal FQHC has 120 days to fill out this form after the end of their fiscal year.

ForwardHealth will review reported outstationed enrollment expenditures and calculate the difference between the known portions of the [PPS \(prospective payment system\)](#) 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% of the CHC or Tribal FQHC allowable outstationed enrollment expenditures.

Payer of Last Resort

Topic #242

Instances When Medicaid is Not Payer of Last Resort

Wisconsin Medicaid or BadgerCare Plus are **not** the payer of last resort for members who receive coverage from certain governmental programs, such as:

- ┆ Birth to 3
- ┆ Crime Victim Compensation Fund
- ┆ GA (General Assistance)
- ┆ HCBS (Home and Community-Based Services) waiver programs:
 - ┆ CLTS (Children's Long-Term Support Program)
 - ┆ Family Care
 - ┆ Family Care Partnership
 - ┆ IRIS (Include, Respect, I Self-Direct)
- ┆ IDEA (Individuals with Disabilities Education Act)
- ┆ Indian Health Service
- ┆ Maternal and Child Health Services
- ┆ WCDP (Wisconsin Chronic Disease Program):
 - ┆ Adult Cystic Fibrosis
 - ┆ Chronic Renal Disease
 - ┆ Hemophilia Home Care

Providers should ask members if they have coverage from these other governmental programs.

If the member becomes retroactively enrolled in Wisconsin Medicaid or BadgerCare Plus, providers who have already been reimbursed by one of these government programs may be required to submit the claims to ForwardHealth and refund the payment from the government program.

Reimbursement Not Available

Topic #1033

Reimbursement Not Available

Wisconsin Medicaid may deny or recoup payment for covered services that fail to meet program requirements. Medicaid reimbursement is also not available for noncovered services.

The following are not reimbursable as ambulance services:

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

Resources

8

Archive Date:10/01/2026

Resources:Contact Information

Topic #476

Member Services

Providers should refer ForwardHealth members with questions to [Member Services](#). The telephone number for Member Services is for member use only.

Topic #473

Professional Field Representatives

Professional field representatives, also known as field representatives, are available to assist providers with complex billing and claims processing questions. Field representatives are located throughout the state to offer detailed assistance to all ForwardHealth providers and all ForwardHealth programs.

The field representatives are assigned to [specific regions](#) of the state. Most professional field representatives can address inquiries for all provider types. However, certain dedicated professional field representatives are assigned to the following:

- | Adult long-term care
- | Dental providers
- | Milwaukee County
- | PNCC (Prenatal care coordination) and CCC (child care coordination)
- | WWP (Wisconsin Well Woman Program)

Provider Education

The field representatives' primary focus is provider education. They provide information on ForwardHealth programs and topics in the following ways:

- | Conducting provider training sessions throughout the state
- | Providing training and information for newly enrolled providers and/or new staff
- | Participating in professional association meetings

Providers may also contact the field representatives if there is a specific topic, or topics, on which they would like to have an individualized training session. This could include topics such as use of the ForwardHealth Portal (information about claims, enrollment verification, and PA (prior authorization) requests on the Portal). Refer to the [Providers Trainings page](#) for the latest information on training opportunities.

Additional Inquiries

Providers are encouraged to initially obtain information through the Portal, WiCall, and Provider Services. If these attempts are not successful, field representatives may be contacted for the following types of inquiries:

- | Claims, including discrepancies regarding enrollment verification and claim processing
- | PES (Provider Electronic Solutions) claims submission software
- | Claims processing problems that have not been resolved through other channels (for example, phone or written)

correspondence)

- ┆ Referrals by a Provider Services phone correspondent
- ┆ Complex issues that require extensive explanation

At times, professional field representatives work outside their offices to provide on-site service; therefore, providers should be prepared to leave a complete message when contacting field representatives, including all pertinent information related to the inquiry. Member inquiries should not be directed to field representatives. Providers should refer members to [Member Services](#).

If contacting a field representative by email, providers should ensure that no individually identifiable health information, known as PHI (protected health information), is included in the message. Discuss the appropriate method of sending emails with your assigned field representative to ensure secure transmission of information.

Providers or their representatives should have the following information ready when they contact their professional field representative:

- ┆ Name or alternate contact
- ┆ County and city where services are provided
- ┆ Name of facility or provider whom they are representing
- ┆ NPI (National Provider Identifier) or provider number
- ┆ Phone number, including area code
- ┆ A concise statement outlining concern
- ┆ Days and times when available

For questions about a specific claim, providers should also include the following information:

- ┆ Claim number
- ┆ DOS (date of service)

Topic #474

Provider Services

Providers should call [Provider Services](#) to answer enrollment, policy, and billing questions. Members should call [Member Services](#) for information. Members should **not** be referred to Provider Services.

The Provider Services Call Center provides service-specific assistance to Medicaid, BadgerCare Plus, WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program) providers.

Ways Provider Services Can Help

The Provider Services Call Center is organized to include program-specific and service-specific assistance to providers. The Provider Services Call Center supplements the ForwardHealth Portal and WiCall by providing information on the following:

- ┆ Billing and claim submission
- ┆ Provider enrollment
- ┆ Member enrollment
- ┆ COB (coordination of benefits) (for example, verifying a member's other health insurance coverage)
- ┆ Assistance with completing forms
- ┆ Assistance with remittance information and claim denials
- ┆ Policy clarification
- ┆ PA (prior authorization) status
- ┆ Claim status

- ▮ Verifying covered services

Information to Have Ready

When contacting or transferring from WiCall to the call center, callers will be prompted to enter their NPI (National Provider Identifier) or provider ID. Additionally, to facilitate service, providers are recommended to have all pertinent information related to their inquiry on hand when contacting the call center, including:

- ▮ Provider name and NPI or provider ID
- ▮ Member name and ID
- ▮ Claim ICN (internal control number)
- ▮ PA number
- ▮ DOS (date of service)
- ▮ Amount billed
- ▮ RA (Remittance Advice)
- ▮ Procedure code of the service in question
- ▮ Reference to any provider publications that address the inquiry

Call Center Representatives

The ForwardHealth call center representatives are organized to respond to phone calls from providers. Representatives offer assistance and answer inquiries specific to the program (for example, Medicaid, WCDP, or WWWP) or to the service area (for example, pharmacy services, hospital services) in which they are designated.

In addition to trained call center representatives, Provider Services employs an automated tool for assisting callers. The virtual agent is available 24 hours a day, seven days a week to answer questions that do not require a call center representative, such as inquiries related to:

- ▮ Claim status
- ▮ PA status
- ▮ Provider payment status
- ▮ Member enrollment verification

Walk-in Appointments

Walk-in appointments offer face-to-face assistance for providers at the Provider Services office. Providers must schedule an appointment in advance by contacting Provider Services at 800-947-9627. Appointments for in-person provider assistance are available Monday through Friday, 7:30 a.m. – 4 p.m. (Central time), except for state-observed holidays. Providers without an appointment may not receive in-person assistance and may have to schedule an appointment for a later date.

Written Inquiries

Providers may contact Provider Services through the Portal by selecting the Contact Us link. Provider Services will respond to the inquiry by the preferred method of response indicated within five business days. All information is transmitted via a secure connection to protect personal health information.

Providers may submit written inquiries to ForwardHealth by mail using the [Written Correspondence Inquiry \(F-01170 \(07/2012\)\)](#) form. The Written Correspondence Inquiry form may be photocopied or downloaded via a link from the Portal. Written correspondence should be sent to the following address:

ForwardHealth

Provider Services Written Correspondence
313 Blettner Blvd
Madison WI 53784

Providers are encouraged to use the other resources before mailing a written request to ForwardHealth. Provider Services will respond to written inquiries in writing unless otherwise specified.