Claims

1

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Claims:Adjustment Requests

Topic #814

Allowed Claim

An allowed claim (or adjustment request) contains at least one service that is reimbursable. Allowed claims display on the Paid Claims Section of the RA (Remittance Advice) with a dollar amount greater than "0" in the allowed amount fields. Only an allowed claim, which is also referred to as a claim in an allowed status, may be adjusted.

Topic #815

Denied Claim

A claim that was completely denied is considered to be in a denied status. To receive reimbursement for a claim that was completely denied, it must be corrected and submitted as a new claim.

Topic #512

Electronic

837 Transaction

Even if the original claim was submitted on paper, providers may submit electronic adjustment requests using an 837 (837 Health Care Claim) transaction.

Provider Electronic Solutions Software

The DHS (Department of Health Services) offers electronic billing software at no cost to providers. The PES (Provider Electronic Solutions) software allows providers to submit electronic adjustment requests using an 837 transaction. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI (Electronic Data Interchange) Helpdesk.

Portal Claim Adjustments

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

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

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

Topic #513

Follow-Up

Providers who believe an error has occurred or their issues have not been satisfactorily resolved have the following options:

- Submit a new adjustment request if the previous adjustment request is in an allowed status.
- Submit a new claim for the services if the adjustment request is in a denied status.
- Contact Provider Services for assistance with paper adjustment requests.
- Contact the EDI (Electronic Data Interchange) Helpdesk for assistance with electronic adjustment requests.

Topic #515

Paper

Paper adjustment requests must be submitted using the Adjustment/Reconsideration Request (F-13046 (08/15)) form.

Topic #816

Processing

Within 30 days of receipt, ForwardHealth generally reprocesses the original claim with the changes indicated on the adjustment request and responds on ForwardHealth remittance information.

Topic #514

Purpose

After reviewing both the claim and ForwardHealth remittance information, a provider may determine that an allowed claim needs to be adjusted. Providers may file adjustment requests for reasons including the following:

- To correct billing or processing errors.
- To correct inappropriate payments (overpayments and underpayments).
- To add and delete services.
- To supply additional information that may affect the amount of reimbursement.
- To request professional consultant review (e.g., medical, dental).

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

Topic #4857

Submitting Paper Attachments with Electronic Claim Adjustments

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

Good Faith Claims

Topic #518

Definition of Good Faith Claims

A good faith claim may be submitted when a claim is denied due to a discrepancy between the member's enrollment information in the claims processing system and the member's actual enrollment. If a member presents a temporary identification card for BadgerCare Plus or Family Planning Only Services, the provider should check the member's enrollment via Wisconsin's EVS (Enrollment Verification System) and, if the enrollment is not on file yet, make a photocopy of the member's temporary identification card.

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

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

Overpayments

Topic #528

Adjustment Request vs. Cash Refund

Except for nursing home and hospital providers, cash refunds may be submitted to ForwardHealth in lieu of an adjustment request. However, whenever possible, providers should submit an adjustment request for returning overpayments since both of the following are true:

- A cash refund does not provide documentation for provider records as an adjustment request does. (Providers may be required to submit proof of the refund at a later time.)
- Providers are not able to further adjust the claim after a cash refund is done if an additional reason for adjustment is determined.

Topic #532

Adjustment Requests

When correcting an overpayment through an adjustment request, providers may submit the adjustment request electronically or on paper. Providers should not submit provider-based billing claims through adjustment processing channels.

ForwardHealth processes an adjustment request if the provider is all of the following:

- Medicaid-enrolled on the DOS (date of service).
- Not currently under investigation for Medicaid fraud or abuse.
- Not subject to any intermediate sanctions under DHS 106.08, Wis. Admin. Code.
- Claiming and receiving ForwardHealth reimbursement in sufficient amounts to allow the recovery of the overpayment within a very limited period of time. The period of time is usually no more than 60 days.

Electronic Adjustment Requests

Wisconsin Medicaid will deduct the overpayment when the electronic adjustment request is processed. Providers should use the companion guide for the appropriate 837 (837 Health Care Claim) transaction when submitting adjustment requests.

Paper Adjustment Requests

For paper adjustment requests, providers are required to do the following:

- Submit an Adjustment/Reconsideration Request (F-13046 (08/15)) form through normal processing channels (not timely filing), regardless of the DOS.
- Indicate the reason for the overpayment, such as a duplicate reimbursement or an error in the quantity indicated on the claim.

After the paper adjustment request is processed, Wisconsin Medicaid will deduct the overpayment from future reimbursement amounts.

Topic #533

Cash Refunds

When submitting a personal check to ForwardHealth for an overpayment, providers should include a copy of the RA (Remittance Advice) for the claim to be adjusted and highlight the affected claim on the RA. If a copy of the RA is not available, providers should indicate the ICN (internal control number), the NPI (National Provider Identifier) (if applicable), and the payee ID from the RA for the claim to be adjusted. The check should be sent to the following address:

ForwardHealth
Financial Services Cash Unit
313 Blettner Blvd
Madison WI 53784

Topic #531

ForwardHealth-Initiated Adjustments

ForwardHealth may initiate an adjustment when a retroactive rate increase occurs or when an improper or excess payment has been made. ForwardHealth has the right to pursue overpayments resulting from computer or clerical errors that occurred during claims processing.

If ForwardHealth initiates an adjustment to recover overpayments, ForwardHealth remittance information will include details of the adjustment in the Claims Adjusted Section of the paper RA (Remittance Advice).

Topic #530

Requirements

As stated in DHS 106.04(5), Wis. Admin. Code, the provider is required to refund the overpayment within 30 days of the date of the overpayment if a provider receives overpayment for a claim because of duplicate reimbursement from ForwardHealth or other health insurance sources.

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

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

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

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

Topic #8417

Voiding Claims

Providers may void claims on the ForwardHealth Portal to return overpayments. This way of returning overpayments may be a more efficient and timely way for providers as a voided claim is a complete recoupment of the payment for the entire claim. Once a claim is voided, the claim can no longer be adjusted; however, the services indicated on the voided claim may be resubmitted on a new claim.

Responses

Topic #540

An Overview of the Remittance Advice

The RA (Remittance Advice) provides important information about the processing of claims and adjustment requests as well as additional financial transactions such as refunds or recoupment amounts withheld. ForwardHealth provides electronic RAs to providers on their secure ForwardHealth Portal accounts when at least one claim, adjustment request, or financial transaction is processed. RAs are generated from the appropriate ForwardHealth program when at least one claim, adjustment request, or financial transaction is processed. An RA is generated regardless of how a claim or adjustment is submitted (electronically or on paper). Generally, payment information is released and an RA is generated by ForwardHealth no sooner than the first state business day following the financial cycle.

Providers are required to access their secure ForwardHealth provider Portal account to obtain their RA.

RAs are accessible to providers in a TXT (text) format via the secure Provider area of the Portal. Providers are also able to download the RA from their secure provider Portal account in a CSV (comma-separated values) format.

Topic #5091

National Provider Identifier on the Remittance Advice

Health care providers who have a single NPI (National Provider Identifier) that is used for multiple enrollments will receive an RA for each enrollment with the same NPI reported on each of the RAs. For instance, if a hospital has obtained a single NPI and the hospital has a clinic, a lab, and a pharmacy that are all enrolled in Wisconsin Medicaid, the clinic, the lab, and the pharmacy will submit separate claims that indicate the same NPI as the hospital. Separate RAs will be generated for the hospital, the clinic, the lab, and the pharmacy.

Topic #4818

Calculating Totals on the Remittance Advice for Adjusted and Paid Claims

The total amounts for all adjusted or paid claims reported on the RA (Remittance Advice) appear at the end of the adjusted claims and paid claims sections. ForwardHealth calculates the total for each section by adding the net amounts for all claims listed in that section. Cutback amounts are subtracted from the allowed amount to reach the total reimbursement for the claims.

Note: Some cutbacks that are reported in detail lines will appear as EOB (Explanation of Benefits) codes and will not display an exact dollar amount.

Topic #534

Claim Number

Each claim or adjustment request received by ForwardHealth is assigned a unique claim number (also known as the ICN (internal

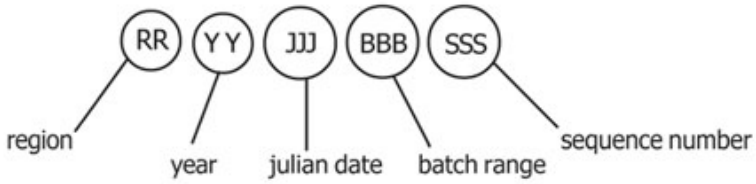
control number)). However, denied real-time compound and noncompound claims are not assigned an ICN, but receive an authorization number. Authorization numbers are not reported to the RA (Remittance Advice) or 835 (835 Health Care Claim Payment/Advice).

Interpreting Claim Numbers

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

Interpreting Claim Numbers

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



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

Topic #535

Claim Status

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

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

Topic #644

ClaimCheck Review

ForwardHealth monitors all professional claims for compliance with reimbursement policy using an automated procedure coding review software known as McKesson ClaimCheck®. ClaimCheck reviews claims submitted for billing inconsistencies and errors during claims processing. Insurance companies, Medicare, and other state Medicaid programs use similar software.

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

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

Areas Monitored by ClaimCheck

ForwardHealth uses ClaimCheck software to monitor the following situations:

- Unbundled procedures.
- Incidental/integral procedures.
- Mutually exclusive procedures.
- Medical visit billing errors.
- Preoperative and postoperative billing errors.
- Medically obsolete procedures.
- Assistant surgeon billing errors.
- Gender-related billing errors.

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

Unbundled Procedures

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

If certain procedure codes are submitted, ClaimCheck rebundles them into the single most appropriate procedure code. For example, if a provider submits a claim with procedure codes 12035 (Repair, intermediate, wounds of scalp, axillae, trunk and/or

extremities [excluding hands and feet]; 12.6 cm to 20.0 cm) and 12036 (Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities [excluding hands and feet]; 20.1 cm to 30.0 cm), ClaimCheck rebundles them to procedure code 12037 (Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities [excluding hands and feet]; over 30.0 cm).

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

Incidental/Integral Procedures

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

Integral procedures are those procedures performed as part of a more complex primary procedure. For example, when a member undergoes a transurethral incision of the prostate, the cystourethroscopy (procedure code 52000) is considered integral to the performance of the prostate procedure and would be denied.

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

Mutually Exclusive Procedures

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

For example, procedure code 58260 (Vaginal hysterectomy, for uterus 250 g or less) and procedure code 58150 (Total abdominal hysterectomy [corpus and cervix], with or without removal of tube[s], with or without removal of ovary[s]) are mutually exclusive — either one or the other, but not both procedures, is performed.

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

Medical Visit Billing Errors

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

Medical visit edits monitor services included in CPT (Current Procedural Terminology) procedure ranges 92002-92019, 99024 (postoperative follow-up), 99026-99058 (special services), 99201-99456 (E&M codes) and HCPCS (Healthcare Common Procedure Coding System) codes S0620, S0621 (routine ophthalmological examinations).

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

For example, if a provider submits procedures 22630 (Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace [other than for decompression], single interspace; lumbar) and 99221 (Initial hospital care, per day), ClaimCheck denies procedure 99221 as a visit when submitted with procedure 22630 with the same DOS (date of service). Procedure code 22630 is a major procedure with a 90-day global surgical period.

Preoperative and Postoperative Billing Errors

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

For example, if a provider submits procedure code 99212 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making [10 minutes]) with a DOS of 11/02/08 and procedure 27750 (Closed treatment of tibial shaft fracture [with or without fibular fracture]; without manipulation) with a DOS of 11/03/08, ClaimCheck will deny procedure code 99212 as a preoperative visit because it is submitted with a DOS one day prior to the DOS for procedure code 27750.

Medically Obsolete Procedures

Obsolete procedures are procedures that are no longer performed under prevailing medical standards. Claims for procedures designated as obsolete are denied.

Assistant Surgeon Billing Errors

ClaimCheck development and maintenance of assistant surgeon values includes two designations, *always* and *never*. ClaimCheck uses the ACS (American College of Surgeons) as its primary source for determining assistant surgeon designations. ForwardHealth's list of procedure codes allowable with an assistant surgeon designation is consistent with ClaimCheck.

For example, if a provider bills procedure code 10040 (Acne surgery [eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules]) with modifier 80 (assistant surgeon), ClaimCheck determines that the procedure does not require an assistant surgeon and denies the procedure code.

Gender-Related Billing Errors

Gender-related billing errors occur when a provider submits a gender-specific procedure for a patient of the opposite sex. ForwardHealth has adopted ClaimCheck's designation of gender for procedure codes.

For example, if a provider submits procedure code 58150 (Total abdominal hysterectomy [corpus and cervix], with or without removal of tube[s], with or without removal of ovary[s]) for a male, ClaimCheck will deny the procedure based on the fact that procedure code 58150 is a female gender-specific procedure.

Payments Denied as a Result of the ClaimCheck Review

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

- Review ForwardHealth remittance information for the specific reason for the denial.
- Review the claim submitted to ensure all information is accurate and complete.
- Consult current CPT and HCPCS publications to make sure proper coding instructions were followed.
- Consult current ForwardHealth publications to make sure current policy and billing instructions were followed.
- Call Provider Services for further information or explanation.

If a provider disagrees with ClaimCheck's determination, the provider may resubmit the claim with supporting documentation to Provider Service Written Correspondence. If the original claim is in an allowed status, the provider may submit an Adjustment/Reconsideration Request (F-13046 (08/15)) with supporting documentation and the words "medical consultant

review requested" written on the form to Provider Services Written Correspondence.

Topic #4746

Cutback Fields on the Remittance Advice for Adjusted and Paid Claims

Cutback fields indicate amounts that reduce the allowed amount of the claim. Examples of cutbacks include other insurance, member copayment, spenddown amounts, deductibles, or patient liability amounts. Amounts indicated in a cutback field are subtracted from the total allowed reimbursement.

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

Note: Providers who receive 835 (835 Health Care Claim Payment/Advice) transactions will be able to see all deducted amounts on paid and adjusted claims.

Topic #537

Electronic Remittance Information

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

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

RAs are accessible to providers in a TXT (text) format or from a CSV (comma-separated values) file via the secure Provider area of the Portal.

Text File

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

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

Comma-Separated Values Downloadable File

A CSV file is a file format accepted by a wide range of computer software programs. Downloadable CSV-formatted RAs allow users the benefits of building a customized RA specific to their use and saving the file to their computer. The CSV file on a provider's Portal appears as linear text separated by commas until it is downloaded into a compatible software program. Once downloaded, the file may be saved to a user's computer and the data manipulated, as desired.

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

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

The CSV file may be downloaded into a Microsoft Office Excel spreadsheet or into another compatible software program, such as Microsoft Office Access or OpenOffice 2.2.1. OpenOffice is a free software program obtainable from the Internet. Google Docs and ZDNet also offer free spreadsheet applications. Microsoft Office Excel, a widely used program, is a spreadsheet application for Microsoft Windows and Mac OS X. For maximum file capabilities when downloading the CSV file, the 1995 Office Excel for Windows (Version 7.0) included in Office 95 or a newer version is recommended. Earlier versions of Microsoft Office Excel will work with the CSV file; however, files exceeding 65,000 lines may need to be split into smaller files when downloading using earlier versions. Microsoft Office Access can manage larger data files.

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

835

Electronic remittance information may be obtained using the 835 (835 Health Care Claim Payment/Advice) transaction. It provides useful information regarding the processing of claims and adjustment requests, which includes the status or action taken on a claim, claim detail, adjustment, or adjustment detail for all claims and adjustments processed that week, regardless of whether they are reimbursed or denied. However, a real-time compound or noncompound claim will not appear on remittance information if the claim is denied by ForwardHealth. ForwardHealth releases payment information to the 835 no sooner than on the first state business day following the financial cycle.

Provider Electronic Solutions Software

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

Topic #4822

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

EOB (Explanation of Benefits) codes are four-digit numeric codes specific to ForwardHealth that correspond to a printed message about the status or action taken on a claim, claim detail, adjustment, or adjustment detail.

The claim processing sections of the RA (Remittance Advice) report EOBs for the claim header information and detail lines, as appropriate. Header information is a summary of the information from the claim, such as the DOS (date of service) that the claim covers or the total amount paid for the claim. Detail lines report information from the claim details, such as specific procedure codes or revenue codes, the amount billed for each code, and the amount paid for a detail line item.

Header EOBs are listed below the claim header information and pertain only to the header information. Detail line EOBs are listed after each detail line and pertain only to the detail line.

TEXT File

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

CSV File

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

Topic #13437

ForwardHealth-Initiated Claim Adjustments

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

Claims that are subject to this type of ForwardHealth-initiated claim adjustment will have EOB (Explanation of Benefits) code 8234 noted on the RA (Remittance Advice).

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

Topic #4820

Identifying the Claims Reported on the Remittance Advice

The RA (Remittance Advice) reports the first 12 characters of the MRN (medical record number) and/or a PCN (patient control number), also referred to as Patient Account Number, submitted on the original claims. The MRN and PCN fields are located beneath the member's name on any section of the RA that reports claims processing information.

Providers are strongly encouraged to enter these numbers on claims. Entering the MRN and/or the PCN on claims may assist providers in identifying the claims reported on the RA.

Note: Claims processing sections for dental and drug claims do not include the MRN or the PCN.

Topic #11537

National Correct Coding Initiative

As part of the federal PPACA (Patient Protection and Affordable Care Act) of 2010, the CMS (Centers for Medicare and Medicaid Services) are required to promote correct coding and control improper coding leading to inappropriate payment of claims under Medicaid. The NCCI (National Correct Coding Initiative) is the CMS response to this requirement. The NCCI includes the creation and implementation of claims processing edits to ensure correct coding on claims submitted for Medicaid

reimbursement.

ForwardHealth is required to implement the NCCI in order to monitor all professional claims and outpatient hospital claims submitted with CPT (Current Procedural Terminology) or HCPCS (Healthcare Common Procedure Coding System) procedure codes for Wisconsin Medicaid, BadgerCare Plus, WCDP (Wisconsin Chronic Disease Program), and Family Planning Only Services for compliance with the following NCCI edits:

- MUE (Medically Unlikely Edits), or units-of-service detail edits.
- Procedure-to-procedure detail edits.

The NCCI editing will occur in addition to/along with current procedure code review and editing completed by McKesson ClaimCheck® and in ForwardHealth interChange.

Medically Unlikely Detail Edits

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

An example of an MUE would be if procedure code 11100 (i.e., biopsy of skin lesion) was billed with a quantity of two or more. This procedure is medically unlikely to occur more than once; therefore, if it is billed with units greater than one, the detail will be denied.

Procedure-to-Procedure Detail Edits

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

An example of a procedure-to-procedure edit would be if procedure codes 11451 (i.e., removal of a sweat gland lesion) and 93000 (i.e., electrocardiogram) were billed on the same claim for the same DOS. Procedure code 11451 describes a more complex service than procedure code 93000, and therefore, the secondary procedure would be denied.

Quarterly Code List Updates

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

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

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

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

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

- Complete the Adjustment/Reconsideration Request (F-13046 (08/15)) form. In Element 16, select the "Consultant review requested" checkbox and the "Other/comments" checkbox. In the "Other/comments" text box, indicate "Reconsideration of an NCCI denial."
- Attach notes/supporting documentation.
- Submit a claim, Adjustment/Reconsideration Request, and additional notes/supporting documentation to ForwardHealth for processing.

Topic #539

Obtaining the Remittance Advice

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

Providers who do not have a ForwardHealth provider Portal account may request one.

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

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

Topic #4745

Overview of Claims Processing Information on the Remittance Advice

The claims processing sections of the RA (Remittance Advice) include information submitted on claims and the status of the claims. The claim status designations are paid, adjusted, or denied. The RA also supplies information about why the claim was adjusted or denied or how the reimbursement was calculated for the payment.

The claims processing information in the RA is grouped by the type of claim and the status of the claim. Providers receive claims processing sections that correspond to the types of claims that have been finalized during the current financial cycle.

The claims processing sections reflect the types of claims submitted, such as the following:

- Compound drug claims
- Dental claims
- Noncompound drug claims
- Inpatient claims
- Long term care claims
- Medicare crossover institutional claims
- Medicare crossover professional claims
- Outpatient claims

- Professional claims

The claims processing sections are divided into the following status designations:

- Adjusted claims
- Denied claims
- Paid claims

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

Topic #4418

Reading Non-Claims Processing Sections of the Remittance Advice

Address Page

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

Banner Messages

The Banner Messages section of the RA (Remittance Advice) contains important, time-sensitive messages for providers. For example, banner messages might inform providers of claim adjustments initiated by ForwardHealth, claim submission deadlines, and dates of upcoming training sessions. It is possible for each RA to include different messages; therefore, providers who receive multiple RAs should read all of their banner messages.

Banner messages appear on the TXT file, but not on the CSV (comma-separated values) file. Banner messages are posted in the "View Remittance Advices" menu on the provider's secure Portal account.

Explanation of Benefits Code Descriptions

EOB (Explanation of Benefits) code descriptions are listed in the RA information in the TXT file.

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

Financial Transactions Page

The Financial Transactions section details the provider's weekly financial activity. Financial transactions reported on the RA include payouts, refunds, accounts receivable, and payments for claims.

Payouts are payments made to the provider by ForwardHealth that do not correspond to a specific claim (i.e., nursing home assessment reimbursement).

Refunds are payments made to providers for overpayments.

The Accounts Receivable section displays the accounts receivable for amounts owed by providers. The accounts receivable is set to automatically recover any outstanding balance so that money owed is automatically recouped from the provider. If the full amount cannot be recouped during the current financial cycle, an outstanding balance will appear in the "Balance" column.

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

For each claim adjustment listed on the RA, a separate accounts receivable will be established and will be listed in the Financial Transactions section. The accounts receivable will be established for the entire amount of the original paid claim. This reflects the way ForwardHealth adjusts claims — by first recouping the entire amount of the original paid claim.

Each new claim adjustment is assigned an identification number called the "Adjustment ICN (internal control number)." For other financial transactions, the adjustment ICN is determined by the following formula.

Type of Character and Description	Applicable Characters and Description
Transaction — The first character indicates the type of financial transaction that created the accounts receivable.	V — Capitation adjustment 1 — OBRA Level 1 screening void request 2 — OBRA Nurse Aide Training/Testing void request
Identifier — 10 additional numbers are assigned to complete the Adjustment ICN.	The identifier is used internally by ForwardHealth.

Service Code Descriptions

The Service Code Descriptions section lists all the service codes (i.e., procedure codes or revenue codes) reported on the RA with their corresponding descriptions.

Summary

The Summary section reviews the provider's claim activity and financial transactions with the payer (Medicaid, ADAP (Wisconsin AIDS Drug Assistance Program), WCDP (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program)) for the current financial cycle, the month-to-date, and the year-to-date, if applicable.

Under the "Claims Data" heading, providers can review the total number of claims that have been paid, adjusted, or denied along with the total amount reimbursed for all paid and adjusted claims. Only WWWP providers will see amounts reported for "Claims in Process." Other providers will always see zeroes in these fields.

Under the "Earnings Data" heading, providers will see total reimbursement amounts for other financial transactions, such as reimbursement for OBRA (Omnibus Budget Reconciliation Act of 1987) Level 1 screening, reimbursement for OBRA Nurse Aid Training/Testing, and capitation payments.

Note: HMOs should note that capitation payments are only reported in the Summary section of the RA. HMOs receive supplemental reports of their financial transactions from ForwardHealth.

The "Earnings Data" portion also summarizes refunds and voids and reports the net payment for the current financial cycle, the month-to-date, and the year-to-date, if applicable.

Providers should note that the Summary section will include outstanding checks 90 days after issuance and/or payments made to lien holders, if applicable.

Topic #368

Reading the Claim Adjustments Section of the Remittance Advice

Providers receive a Claim Adjustments section in the RA (Remittance Advice) if any of their claims were adjusted during the current financial cycle. A claim may be adjusted because one of the following occurred:

- An adjustment request was submitted by the provider.
- ForwardHealth initiated an adjustment.
- A cash refund was submitted to ForwardHealth.

To adjust a claim, ForwardHealth recoups the *entire amount* of the original paid claim and calculates a new payment amount for the claim adjustment. ForwardHealth does not recoup the *difference* — or pay the *difference* — between the original claim amount and the claim adjustment amount.

In the Claim Adjustments section, the original claim information in the claim header is surrounded by parentheses. Information about the claim adjustment appears directly below the original claim header information. Providers should check the Adjustment EOB (Explanation of Benefits) code(s) for a summary of why the claim was adjusted; other header EOBs will provide additional information.

The Claim Adjustments section only lists detail lines for a claim adjustment if that claim adjustment has detail line EOBs. This section does not list detail lines for the original paid claim.

Note: For adjusted compound and noncompound claims, only the compound drug sections include detail lines.

Below the claim header and the detail information will be located one of three possible responses with a corresponding dollar amount: "Additional Payment," "Overpayment To Be Withheld," or "Refund Amount Applied." The response indicated depends on the difference between the original claim amount and the claim adjustment amount.

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

If the difference is a negative dollar amount, indicating that the provider owes ForwardHealth additional monies, then the amount appears in the "Overpayment To Be Withheld" line. ForwardHealth automatically withholds this amount from payments made to the provider during the same financial cycle or during subsequent financial cycles, if necessary. This amount also appears in the Financial Transactions section as an outstanding balance under "Accounts Receivable."

An amount appears for "Refund Amount Applied" if ForwardHealth makes a payment to refund a cash receipt to a provider.

Topic #4824

Reading the Claims Denied Section of the Remittance Advice

Providers receive a Claims Denied section in the RA (Remittance Advice) if any of their claims were denied during the current financial cycle.

In the denied claims section, providers will see the original claim header information reported along with EOB (Explanation of Benefits) codes for the claim header and the detail lines, as applicable. Providers should refer to the EOB Code Description section of the RA to determine why the claim was denied.

Sample Professional Services Claims Denied Section of the Remittance Advice

Remittance Advice — Professional Service Claims Denied Sample

```
REPORT:   CRA-HCDN-R                              FORWARDHEALTH INTERCHANGE                                   DATE:  MM/DD/CCYY
  RA#:    999999999                               <Financial Cycle Description>                               PAGE:        9,999
 PAYER:   XXXX                                    PROVIDER REMITTANCE ADVICE
                                                 PROFESSIONAL SERVICE CLAIMS DENIED

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                     PAYEE ID       999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                        NPI                 9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                        CHECK/EFT NUMBER     999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                         PAYMENT DATE        MM/DD/CCYY

  --ICN--         PCN           MRN         SERVICE DATES    BILLED           OTH INS          SPENDDOWN
                                             FROM    TO      AMOUNT           AMOUNT           AMOUNT

MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MEMBER NO.: XXXXXXXXXXXX
RRYYJJJBBBSSS  XXXXXXXXXXXX  XXXXXXXXXXXX  MMDDYY MMDDYY  999,999,999.99   9,999,999.99    999,999.99


HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999


                                 SERVICE DATES                            PA NUMBER
PROC CD  MODIFIERS   ALLW UNITS  FROM    TO      RENDERING PROVIDER       BILLED AMT      DETAIL EOBS
 XXXXX   XX XX XX XX   9999.99   MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX        XXXXXXXXXX      9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                          9,999,999.99    9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XXXXX   XX XX XX XX   9999.99   MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX        XXXXXXXXXX      9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                          9,999,999.99    9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XXXXX   XX XX XX XX   9999.99   MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX        XXXXXXXXXX      9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                          9,999,999.99    9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XXXXX   XX XX XX XX   9999.99   MMDDYY MMDDYY XXX XXXXXXXXXXXXXXX        XXXXXXXXXX      9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                                                          9,999,999.99    9999 9999 9999 9999 9999 9999 9999 9999 9999 9999


            TOTAL PROFESSIONAL SERVICE CLAIMS DENIED:  9,999,999,999.99  99,999,999.99  9,999,999.99
TOTAL NO. DENIED:  999,999
```

Topic #4825

Reading the Claims Paid Section of the Remittance Advice

Providers receive a Claims Paid section in the RA (Remittance Advice) if any of their claims were determined payable during the current financial cycle.

In a paid claims section, providers will see the original claim information reported along with EOB (Explanation of Benefits) codes for both the header and the detail lines, if applicable. Providers should refer to the EOB Code Description section of the RA for more information about how the reimbursement amount was determined.

Sample Professional Services Claims Paid Section of the Remittance Advice

Remittance Advice — Professional Service Claims Paid Sample

```
REPORT:   CRA-HCPD-R                                        FORWARDHEALTH INTERCHANGE                              DATE:  MM/DD/CCYY
  RA#:    999999999                                       <Financial Cycle Description>                            PAGE:       9,999
 PAYER:   XXXX                                             PROVIDER REMITTANCE ADVICE
                                                         PROFESSIONAL SERVICE CLAIMS PAID

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                      PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                         NPI                9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                                         CHECK/EFT NUMBER    999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                                          PAYMENT DATE       MM/DD/CCYY


  --ICN--         PCN           MRN        SERVICE DATES      BILLED AMT       OTH INS AMT     COPAY AMT        PAID AMT
                                           FROM     TO        ALLOWED AMT     SPENDDOWN AMT    CO-INS CB       OUTPAT DED

MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX    MEMBER NO.: XXXXXXXXXXXX
RRYYJJJBBBSSS  XXXXXXXXXXXX  XXXXXXXXXXXX  MMDDYY MMDDYY    9,999,999.99     9,999,999.99     999,999.99     9,999,999.99
                                                            9,999,999.99       999,999.99     999,999.99       999,999.99

HEADER EOBS:  9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

                     SERVICE DATES ALLW UNITS RENDERING PROVIDER         PA NUMBER
PROC CD  MODIFIERS   FROM    TO    COPAY AMT  BILLED AMT   ALLOWED AMT  PAID AMT     DETAIL EOBS
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX       XXXXXXXXXX   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX       XXXXXXXXXX   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX       XXXXXXXXXX   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
 XXXXX  XX XX XX XX  MMDDYY MMDDYY 9999.99    XXX XXXXXXXXXXXXXXX       XXXXXXXXXX   9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
                                   999,999.99 9,999,999.99 9,999,999.99 9,999,999.99 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999


            TOTAL PROFESSIONAL SERVICE CLAIMS PAID:      99,999,999.99    99,999,999.99   9,999,999.99    99,999,999.99
                                                         99,999,999.99     9,999,999.99   9,999,999.99     9,999,999.99
TOTAL NO. PAID: 999,999
```

Topic #4828

Remittance Advice Financial Cycles

Each financial payer (Medicaid, ADAP (Wisconsin AIDS Drug Assistance Program), WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program)) has separate financial cycles that occur on different days of the week. RAs (Remittance Advices) are generated and posted to secure provider Portal accounts after each financial cycle is completed. Therefore, RAs may be generated and posted to secure provider ForwardHealth Portal accounts from different payers on different days of the week.

Certain financial transactions may run on a daily basis, including non-claim related payouts and stop payment reissues. Providers may have access to the RAs generated and posted to secure provider Portal accounts for these financial transactions at any time during the week.

Topic #4827

Remittance Advice Generated by Payer and by Provider Enrollment

RAs (Remittance Advices) are generated and posted to secure provider Portal accounts from one or more of the following ForwardHealth financial payers:

- Wisconsin Medicaid (Wisconsin Medicaid is the financial payer for the Medicaid, BadgerCare Plus, and SeniorCare

programs)
- ADAP (Wisconsin AIDS Drug Assistance Program)
- WCDP (Wisconsin Chronic Disease Program)
- WWWP (Wisconsin Well Woman Program)

A separate Portal account is required for each financial payer.

Note: Each of the four payers generate separate RAs for the claims, adjustment requests, or other financial transactions submitted to the payer. A provider who submits claims, adjustment requests, or other financial transactions to more than one of these payers may receive several RAs.

The RA is generated per provider enrollment. Providers who have a single NPI (National Provider Identifier) that is used for multiple enrollments should be aware that an RA will be generated for each enrollment, but the same NPI will be reported on each of the RAs.

For instance, a hospital has obtained a single NPI. The hospital has a clinic, a lab, and a pharmacy that are all enrolled with ForwardHealth. The clinic, the lab, and the pharmacy submit separate claims that indicate the same NPI as the hospital. Separate RAs will be generated for the hospital, the clinic, the lab, and the pharmacy.

Topic #6237

Reporting a Lost Check

To report a lost check to ForwardHealth, providers are required to mail or fax a letter to ForwardHealth Financial Services. Providers are required to include the following information in the letter:

- Provider's name and address, including the ZIP+4 code.
- Provider's identification number.
  - For healthcare providers, include the NPI (National Provider Identifier) and taxonomy code.
  - For non-healthcare providers, include the provider identification number.
- Check number, check date, and check amount. (This should be recorded on the RA (Remittance Advice).)
- A written request to stop payment and reissue the check.
- The signature of an authorized financial representative. (An individual provider is considered his or her own authorized financial representative.)

Fax the letter to ForwardHealth at (608) 221-4567 or mail it to the following address:

ForwardHealth
Financial Services
313 Blettner Blvd
Madison WI 53784

Topic #5018

Searching for and Viewing All Claims on the Portal

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

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

- Go to the Portal.

- Log in to the secure Provider area of the Portal.
- The most recent claims processed by ForwardHealth will be viewable on the provider's home page or the provider may select "claim search" and enter the applicable information to search for additional claims.
- Select the claim the provider wants to view.

Topic #4829

Sections of the Remittance Advice

The RA (Remittance Advice) information in the TXT (text) file includes the following sections:

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

The RA information in the CSV (comma-separated values) file includes the following sections:

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

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

Remittance Advice Header Information

The first page of each section of the RA (except the address page of the TXT file) displays the same RA header information.

The following fields are on the left-hand side of the header:

- The technical name of the RA section (e.g., CRA-TRAN-R), which is an internal ForwardHealth designation
- The RA number, which is a unique number assigned to each RA that is generated
- The name of the payer (Medicaid, ADAP (Wisconsin AIDS Drug Assistance Program), WCDP (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program))

- The "Pay to" address of the provider. The "Pay to" address is used for mailing purposes.

The following information is in the middle of the header:

- A description of the financial cycle
- The name of the RA section (e.g., "Financial Transactions" or "Professional Services Claims Paid")

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

- The date of the financial cycle and date the RA was generated
- The page number
- The "Payee ID" of the provider. A payee ID is defined as the identification number of a unique entity receiving payment for goods and/or services from ForwardHealth. The payee ID is up to 15 characters long and may be based on a pre-existing identification number, such as the Medicaid provider number. The payee ID is an internal ForwardHealth designation. The Medicaid provider number will display in this field for providers who do not have an NPI (National Provider Identifier).
- The NPI of the provider, if applicable. This field will be blank for those providers who do not have an NPI.
- The number of the check issued for the RA, if applicable
- The date of payment on the check, if applicable

Topic #544

Verifying Accuracy of Claims Processing

After obtaining ForwardHealth remittance information, providers should compare it to the claims or adjustment requests to verify that ForwardHealth processed elements of the claims or adjustment requests as submitted. To ensure correct reimbursement, providers should do the following:

- Identify and correct any discrepancy that affected the way a claim processed.
- Correct and resubmit claims that are denied.
- Submit an adjustment request for allowed claims that require a change or correction.

When posting a payment or denial to a member's account, providers should note the date on the ForwardHealth remittance information that indicates that the claim or adjustment has finalized. Providers are required to supply this information if further follow-up actions are necessary.

Responsibilities

Topic #516

Accuracy of Claims

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

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

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

Topic #547

Submission Deadline

ForwardHealth recommends that providers submit claims at least on a monthly basis. Billing on a monthly basis allows the maximum time available for filing and refiling before the mandatory submission deadline.

With few exceptions, state and federal laws require that providers submit correctly completed claims before the submission deadline.

Providers are responsible for resolving claims. Members are not responsible for resolving claims. To resolve claims before the submission deadline, ForwardHealth encourages providers to use all available resources.

Claims

To receive reimbursement, claims and adjustment requests must be received within 365 days of the DOS (date of service). This deadline applies to claims, corrected claims, and adjustments to claims.

Crossover Claims

To receive reimbursement for services that are allowed by Medicare, claims and adjustment requests for coinsurance, copayment, and deductible must be received within 365 days of the DOS or within 90 days of the Medicare processing date, whichever is later. This deadline applies to all claims, corrected claims, and adjustments to claims. Providers should submit these claims through normal processing channels (not timely filing).

Exceptions to the Submission Deadline

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

- Change in a nursing home resident's LOC (level of care) or liability amount.

- Decision made by a court order, fair hearing, or the DHS (Department of Health Services).
- Denial due to discrepancy between the member's enrollment information in ForwardHealth interChange and the member's actual enrollment.
- Reconsideration or recoupment.
- Retroactive enrollment for persons on GR (General Relief).
- Medicare denial occurs after ForwardHealth's submission deadline.
- Refund request from an other health insurance source.
- Retroactive member enrollment.

ForwardHealth has no authority to approve any other exceptions to the submission deadline.

Claims or adjustment requests that meet one of the exceptions to the submission deadline may be submitted to Timely Filing.

Topic #517

Usual and Customary Charges

For most services, providers are required to indicate their usual and customary charge when submitting claims. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to the program's benefits. For providers using a sliding fee scale, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-program patients. For providers who have not established usual and customary charges, the charge should be reasonably related to the provider's cost for providing the service.

Providers may not discriminate against BadgerCare Plus or Medicaid members by charging a higher fee for the same service than that charged to a private-pay patient.

For services requiring a member copayment, providers should still indicate their usual and customary charge. The copayment amount collected from the member should not be deducted from the charge submitted. When applicable, ForwardHealth automatically deducts the copayment amount.

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

Submission

Topic #17797

1500 Health Insurance Claim Form Completion Instructions

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

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

Members enrolled in BadgerCare Plus or Medicaid receive a ForwardHealth member identification card. Always verify a member's enrollment before providing nonemergency services to determine if there are any limitations to covered services and to obtain the correct spelling of the member's name.

When submitting a claim with multiple pages, providers are required to indicate page numbers using the format "Page X of X" in the upper right corner of the claim form.

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

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

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

Item Number 6 — Patient Relationship to Insured
Enter "X" in the "Self" box to indicate the member's relationship to insured when Item Number 4 is completed. Only one box can be marked.

Item Number 9 — Other Insured's Name (not required)
This field is not required on the claim.

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

Item Number 9a — Other Insured's Policy or Group Number (not required)
This field is not required on the claim.

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

Item Number 9d — Insurance Plan Name or Program Name (not required)
This field is not required on the claim.

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

Item Number 10d — Claim Codes (Designated by NUCC)
When applicable, enter the Condition Code. The Condition Codes approved for use on the 1500 Health Insurance Claim Form are available on the NUCC website under Code Sets.

Item Number 11 — Insured's Policy Group or FECA Number (not required)
This field is not required on the claim.

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

Item Number 11d — Is There Another Health Benefit Plan?
This field is not used for processing by ForwardHealth.

Item Number 19 — Additional Claim Information (Designated by NUCC)
When applicable, enter provider identifiers or taxonomy codes. A list of applicable qualifiers are defined by the NUCC and can be found in the NUCC 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12, prepared by the NUCC.

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

Item Number 22 — Resubmission Code and/or Original Reference Number
This field is not used for processing by ForwardHealth.

Section 24
The six service lines in section 24 have been divided horizontally. Enter service information in the bottom, unshaded area of the six service lines. The horizontal division of each service line is not intended to allow the billing of 12 lines of service.

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

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

For additional information about submitting a 1500 Health Insurance Claim Form with supplemental NDC information, refer to the completion instructions located under "Section 24" in the Field Specific Instructions section of the NUCC's 1500 Health Insurance

Claim Form Reference Instruction Manual for Form Version 02/12.

Item Number 24C — EMG
Enter a "Y" in the unshaded area for each procedure performed as an emergency. If the procedure was not an emergency, leave this field blank.

Item Number 29 — Amount Paid (not required)
This field is not required on the claim.

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

Topic #542

Attached Documentation

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

Topic #6957

Copy Claims on the ForwardHealth Portal

Providers can copy institutional, professional, and dental paid claims on the ForwardHealth Portal. Providers can open any paid claim, click the "Copy" button, and all of the information on the claim will be copied over to a new claim form. Providers can then make any desired changes to the claim form and click "Submit" to submit as a new claim. After submission, ForwardHealth will issue a response with a new ICN (internal control number) along with the claim status.

Topic #5017

Correct Errors on Claims and Resubmit to ForwardHealth on the Portal

Providers can view EOB (Explanation of Benefits) codes and descriptions for any claim submitted to ForwardHealth on the ForwardHealth Portal. The EOBs help providers determine why a claim did not process successfully, so providers may correct the error online and resubmit the claim. The EOB appears on the bottom of the screen and references the applicable claim header or detail.

Topic #4997

Direct Data Entry of Professional and Institutional Claims on the Portal

Providers can submit the following claims to ForwardHealth via DDE (Direct Data Entry) on the ForwardHealth Portal:

- Professional claims.
- Institutional claims.

- Dental claims.
- Compound drug claims.
- Noncompound drug claims.

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

When submitting claims via DDE, required fields are indicated with an asterisk next to the field. If a required field is left blank, the claim will not be submitted and a message will appear prompting the provider to complete the specific required field(s). Portal help is available for each online application screen. In addition, search functions accompany certain fields so providers do not need to look up the following information in secondary resources.

On professional claim forms, providers may search for and select the following:

- Procedure codes.
- Modifiers.
- Diagnosis codes.
- Place of service codes.

On institutional claim forms, providers may search for and select the following:

- Type of bill.
- Patient status.
- Visit point of origin.
- Visit priority.
- Diagnosis codes.
- Revenue codes.
- Procedure codes.
- Modifiers.

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

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

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

- Diagnosis codes.
- NDCs (National Drug Codes).
- Place of service codes.
- Professional service codes.
- Reason for service codes.
- Result of service codes.

Using DDE, providers may submit claims for compound drugs and single-entity drugs. Any provider, including a provider of DME (durable medical equipment) or of DMS (disposable medical supplies) who submits noncompound drug claims, may submit these claims via DDE. All claims, including POS (Point-of-Sale) claims, are viewable via DDE.

Topic #344

Electronic Claim Submission

Providers are encouraged to submit claims electronically. Electronic claim submission does the following:

- Adapts to existing systems.
- Allows flexible submission methods.
- Improves cash flow.
- Offers efficient and timely payments.
- Reduces billing and processing errors.
- Reduces clerical effort.

Topic #1707

Electronic Claim Submission for Case Management Services

Electronic claims for case management services must be submitted using the 837P (837 Health Care Claim: Professional) transaction. Electronic claims for case management services submitted using any transaction other than the 837P will be denied.

Providers should use the companion guide for the 837P transaction when submitting these claims.

Provider Electronic Solutions Software

The DMS (Division of Medicaid Services) offers electronic billing software at no cost to providers. The PES (Provider Electronic Solutions) software allows providers to submit electronic claims using an 837 transaction. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI (Electronic Data Interchange) Helpdesk.

Topic #16937

Electronic Claims and Claim Adjustments with Other Commercial Health Insurance Information

Effective for claims and claim adjustments submitted electronically via the Portal or PES software on and after June 16, 2014, other insurance information must be submitted at the detail level on professional, institutional, and dental claims and adjustments if it was processed at the detail level by the primary insurance. Except for a few instances, Wisconsin Medicaid or BadgerCare Plus is the payer of last resort for any covered services; therefore, providers are required to make a reasonable effort to exhaust all existing other health insurance sources before submitting claims to ForwardHealth or to a state-contracted MCO (managed care organization).

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

Under HIPAA (Health Insurance Portability and Accountability Act of 1996), claims and adjustments submitted using an 837 transaction must include detail-level information for other insurance if they were processed at the detail level by the primary insurance.

Adjustments to Claims Submitted Prior to June 16, 2014

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

Topic #365

Extraordinary Claims

Extraordinary claims are claims that have been denied by a BadgerCare Plus HMO (health maintenance organization) or SSI (Supplemental Security Income) HMO and should be submitted to fee-for-service.

Topic #4837

HIPAA-Compliant Data Requirements

Procedure Codes

All fields submitted on paper and electronic claims are edited to ensure HIPAA (Health Insurance Portability and Accountability Act of 1996) compliance before being processed. Compliant code sets include CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) procedure codes entered into all fields, including those fields that are "Not Required" or "Optional."

If the information in all fields is not valid and recognized by ForwardHealth, the claim will be denied.

Provider Numbers

For health care providers, NPIs (National Provider Identifiers) are required in all provider number fields on paper claims and 837 (837 Health Care Claim) transactions, including rendering, billing, referring, prescribing, attending, and "Other" provider fields.

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

Topic #10837

Note Field for Most Claims Submitted Electronically

In some instances, ForwardHealth requires providers to include a description of a service identified by an unlisted, or NOC (not otherwise classified), procedure code. Providers submitting claims electronically should include a description of an NOC procedure code in a "Notes" field, if required. The Notes field allows providers to enter up to 80 characters. In some cases, the Notes field allows providers to submit NOC procedure code information on a claim electronically instead of on a paper claim or with a paper attachment to an electronic claim.

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

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

A notes field is available on the ForwardHealth Portal DDE (Direct Data Entry) and PES (Provider Electronic Solutions) software when providers submit the following types of claims:

- Professional.
- Institutional.
- Dental.

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

Claims Submitted via 837 Health Care Claim Transactions

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

Topic #561

Paper Claim Form Preparation and Data Alignment Requirements

Optical Character Recognition

Paper claims submitted to ForwardHealth on the 1500 Health Insurance Claim Form ((02/12)) and UB-04 Claim Form are processed using OCR (Optical Character Recognition) software that recognizes printed, alphanumeric text. OCR software increases efficiency by alleviating the need for keying in data from paper claims.

The data alignment requirements do not apply to the Compound Drug Claim (F-13073 (04/17)) and the Noncompound Drug Claim (F-13072 (04/17)).

Speed and Accuracy of Claims Processing

OCR software processes claim forms by reading text within fields on claim forms. After a paper claim form is received by ForwardHealth, the claim form is scanned so that an image can be displayed electronically. The OCR software reads the electronic image on file and populates the information into the ForwardHealth interChange system. This technology increases accuracy by removing the possibility of errors being made during manual keying.

OCR software speeds paper claim processing, but only if providers prepare their claim forms correctly. In order for OCR software to read the claim form accurately, the quality of copy and the alignment of text within individual fields on the claim form need to be precise. If data are misaligned, the claim could be processed incorrectly. If data cannot be read by the OCR software, the process will stop and the electronic image of the claim form will need to be reviewed and keyed manually. This will cause an increase in processing time.

Handwritten Claims

Submitting handwritten claims should be avoided whenever possible. ForwardHealth accepts handwritten claims; however, it is very difficult for OCR software to read a handwritten claim. If a handwritten claim cannot be read by the OCR software, it will need to be keyed manually from the electronic image of the claim form. Providers should avoid submitting claims with handwritten corrections as this can also cause OCR software processing delays.

Use Original Claim Forms

Only original 1500 Health Insurance Claim Forms and UB-04 Claim Forms should be submitted. Original claim forms are printed in red ink and may be obtained from a federal forms supplier. ForwardHealth does not provide these claim forms. Claims that are submitted as photocopies cannot be read by OCR software and will need to be keyed manually from an electronic image of the claim form. This could result in processing delays.

Use Laser or Ink Jet Printers

It is recommended that claims are printed using laser or ink jet printers rather than printers that use DOT matrix. DOT matrix printers have breaks in the letters and numbers, which may cause the OCR software to misread the claim form. Use of old or worn ink cartridges should also be avoided. If the claim form is read incorrectly by the OCR software, the claim may be denied or reimbursed incorrectly. The process may also be stopped if it is unable to read the claim form, which will cause a delay while it is manually reviewed.

Alignment

Alignment within each field on the claim form needs to be accurate. If text within a field is aligned incorrectly, the OCR software may not recognize that data are present within the field or may not read the data correctly. For example, if a reimbursement amount of $300.00 is entered into a field on the claim form, but the last "0" is not aligned within the field, the OCR software may read the number as $30.00, and the claim will be reimbursed incorrectly.

To get the best alignment on the claim form, providers should center information vertically within each field, and align all information on the same horizontal plane. Avoid squeezing two lines of text into one of the six line items on the 1500 Health Insurance Claim Form.

The following sample claim forms demonstrate correct and incorrect alignment:

- Correct alignment for the 1500 Health Insurance Claim Form.
- Incorrect alignment for the 1500 Health Insurance Claim Form.
- Correct alignment for the UB-04 Claim Form.
- Incorrect alignment for the UB-04 Claim Form.

Clarity

Clarity is very important. If information on the claim form is not clear enough to be read by the OCR software, the process may stop, prompting manual review.

The following guidelines will produce the clearest image and optimize processing time:

- Use 10-point or 12-point Times New Roman or Courier New font.
- Type all claim data in uppercase letters.
- Use only black ink to complete the claim form.
- Avoid using italics, bold, or script.
- Make sure characters do not touch.
- Make sure there are no lines from the printer cartridge anywhere on the claim form.
- Avoid using special characters such as dollar signs, decimals, dashes, asterisks, or backslashes, unless it is specified that these characters should be used.
- Use Xs in check boxes. Avoid using letters such as "Y" for "Yes," "N" for "No," "M" for "Male," or "F" for "Female."
- Do not highlight any information on the claim form. Highlighted information blackens when it is imaged, and the OCR software will be unable to read it.

Note: The above guidelines will also produce the clearest image for claims that need to be keyed manually from an electronic image.

Staples, Correction Liquid, and Correction Tape

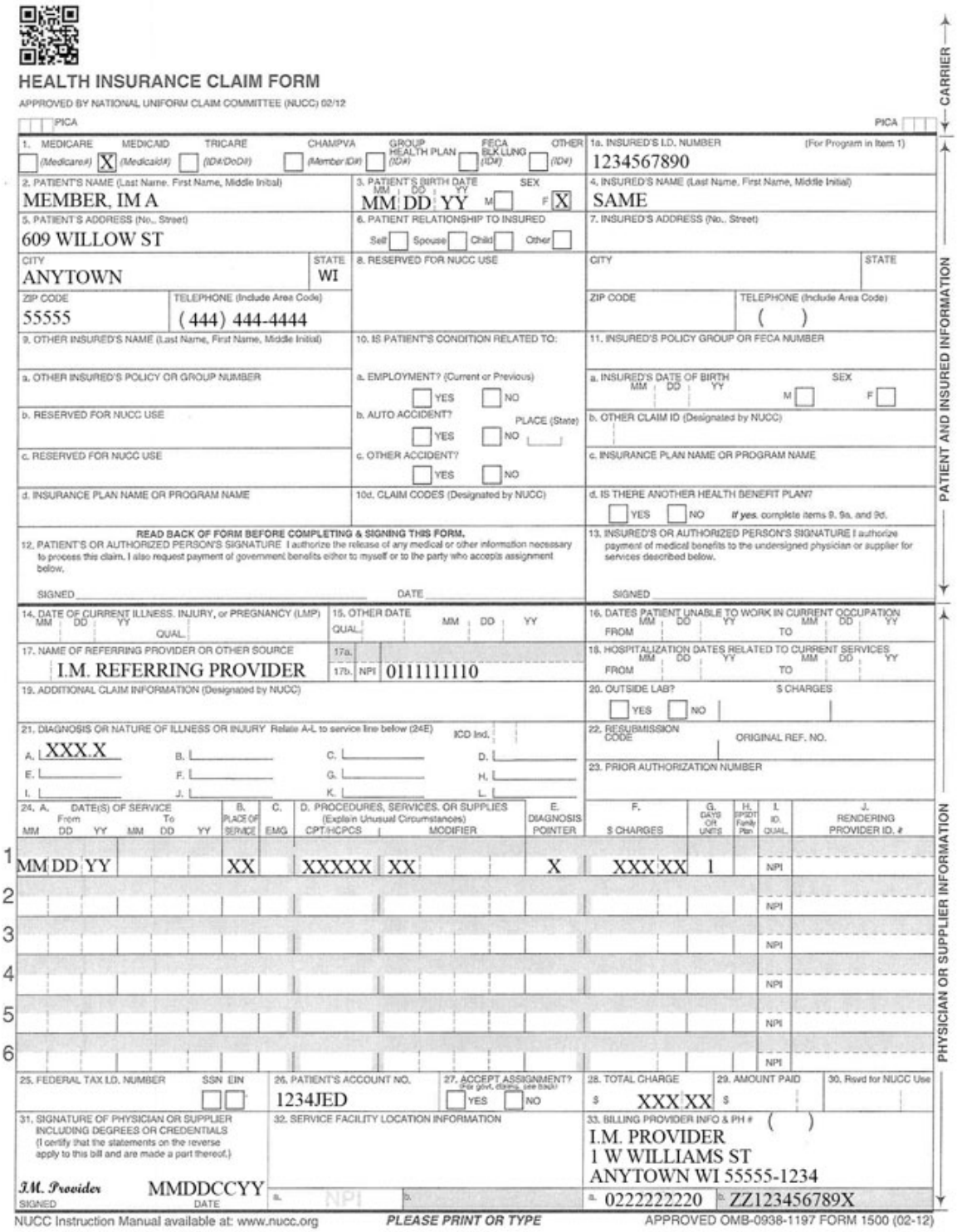
The use of staples, correction liquid, correction tape, labels, or stickers on claim forms should be avoided. Staples need to be removed from claim forms before they can be imaged, which can damage the claim and cause a delay in processing time. Correction liquid, correction tape, labels, and stickers can cause data to be read incorrectly or cause the OCR process to stop,

prompting manual review. If the form cannot be read by the OCR software, it will need to be keyed manually from an electronic image.

Additional Diagnosis Codes

ForwardHealth will accept up to 12 diagnosis codes in Item Number 21 of the 1500 Health Insurance Claim Form.

Sample of a Correctly Aligned 1500 Health Insurance Claim Form



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) | MEDICAID [X] (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MEMBER, IM A

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY | SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 609 WILLOW ST

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN | STATE: WI

8. RESERVED FOR NUCC USE

CITY: | STATE:

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (444) 444-4444

ZIP CODE: | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: I.M. REFERRING PROVIDER

17a.

17b. NPI 0111111110

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. XXX.X B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 MM DD YY		XX		XXXXX	XX	X	XXX XX	1		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Provider SIGNED MMDDCCYY DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

I.M. PROVIDER
1 W WILLIAMS ST
ANYTOWN WI 55555-1234

a. 0222222220 b. ZZ123456789X

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

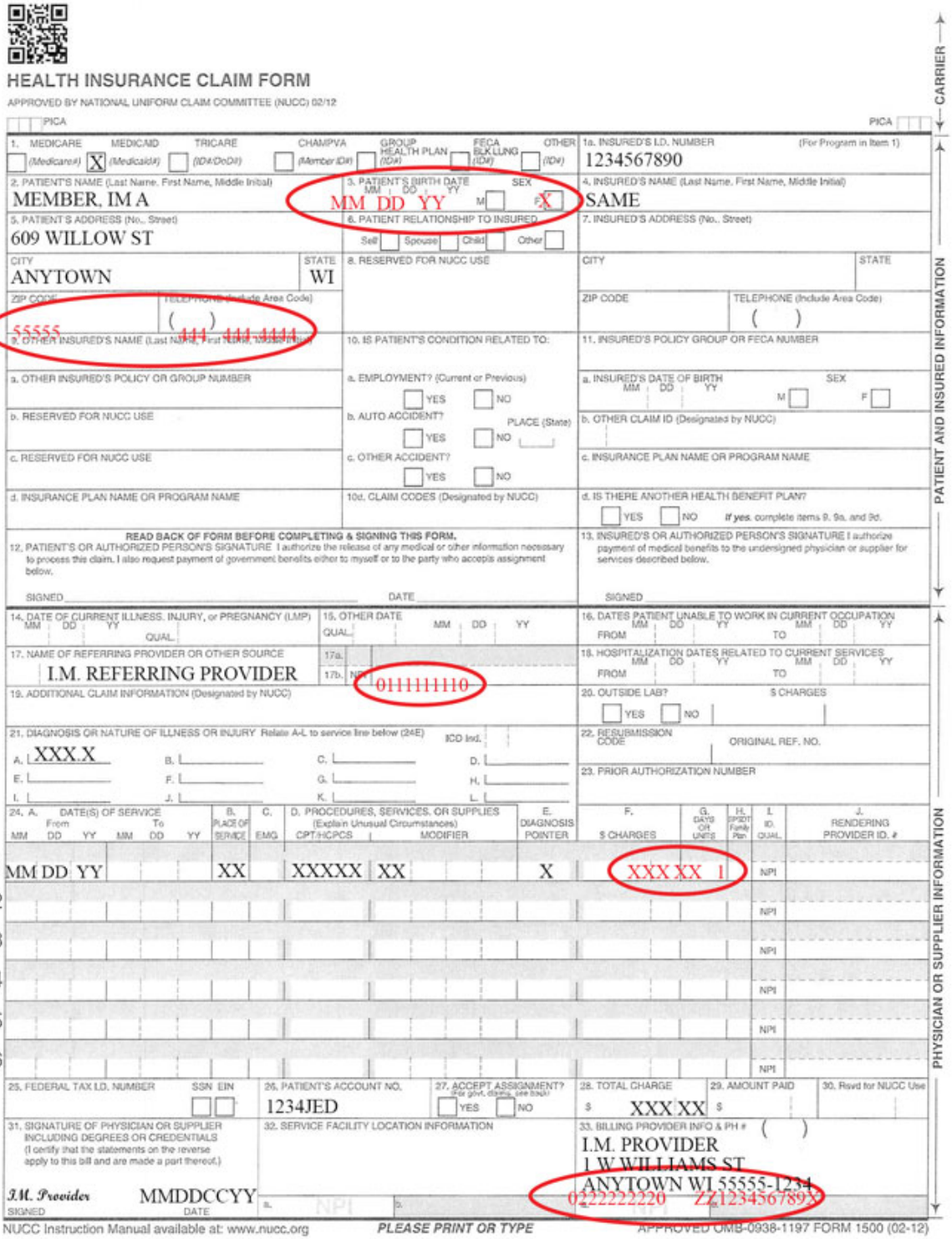
APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample of an Incorrectly Aligned 1500 Health Insurance Claim Form



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

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3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M [ ] F [X]

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6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WI

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): ( ) 111 111 1111

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: I.M. REFERRING PROVIDER

17a.

17b. NPI 011111110

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. XXX.X B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 MM DD YY		XX		XXXXX	XX	X	XXX XX	1		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO. 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Provider SIGNED MMDDCCYY DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

I.M. PROVIDER
1 W WILLIAMS ST
ANYTOWN WI 55555-1234
0222222220 ZZ123456789X

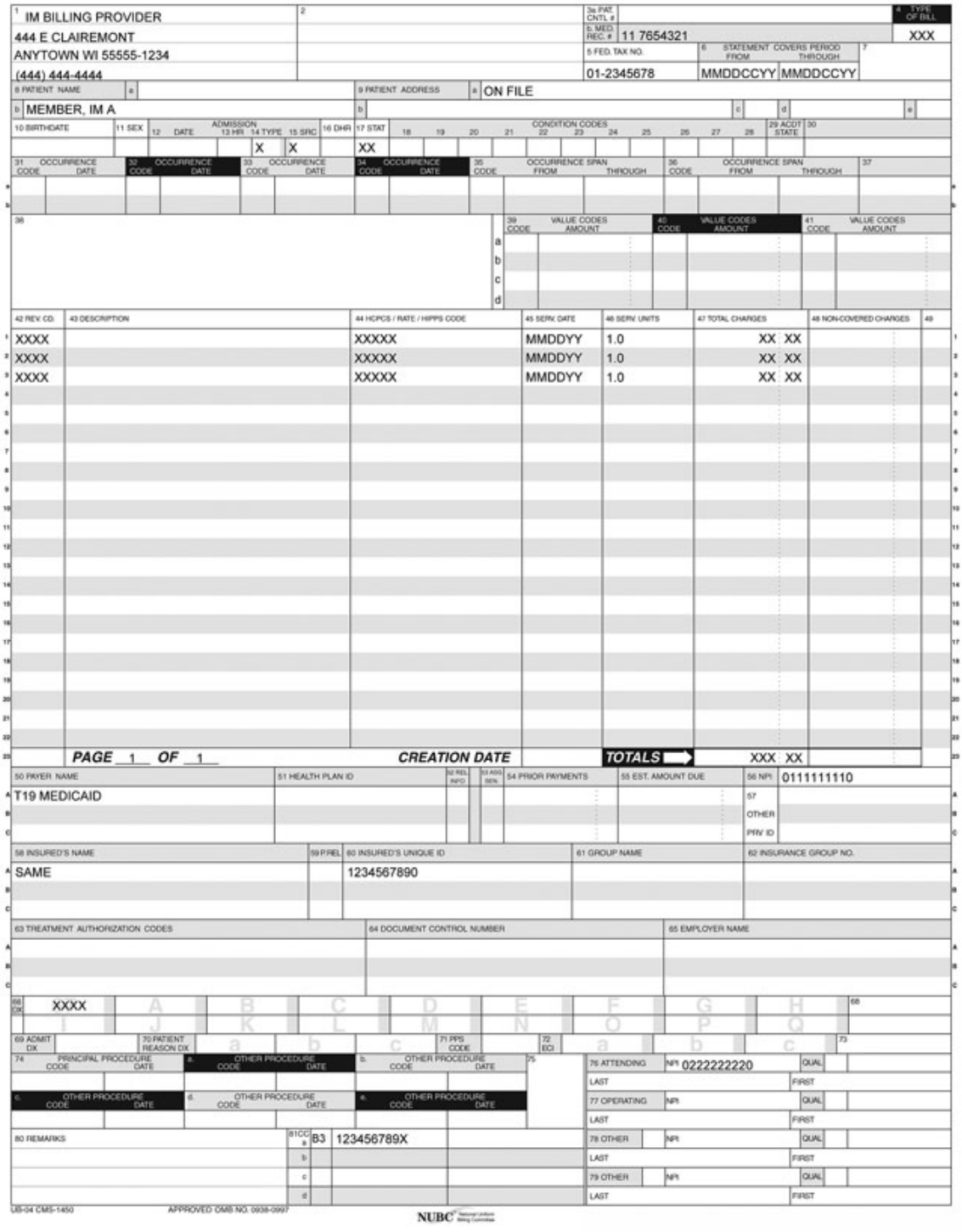
CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Sample of a Correctly Aligned UB-04 Claim Form



1 IM BILLING PROVIDER 444 E CLAIREMONT ANYTOWN WI 55555-1234 (444) 444-4444	3a PAT. CNTL # b. MED. REC. # 11 7654321 4 TYPE OF BILL: XXX 5 FED. TAX NO. 01-2345678 6 STATEMENT COVERS PERIOD FROM MMDDCCYY THROUGH MMDDCCYY
8 PATIENT NAME: MEMBER, IM A	9 PATIENT ADDRESS: ON FILE
10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE: X	15 SRC: X	16 DHR	17 STAT: XX	18–28 CONDITION CODES	29 ACDT STATE	30
31–37 OCCURRENCE CODE / DATE; OCCURRENCE SPAN CODE / FROM / THROUGH	
38	39–41 VALUE CODES / AMOUNT (a, b, c, d)	

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
XXXX		XXXXX	MMDDYY	1.0	XX XX		
XXXX		XXXXX	MMDDYY	1.0	XX XX		
XXXX		XXXXX	MMDDYY	1.0	XX XX		
	PAGE 1 OF 1	CREATION DATE		TOTALS	XXX XX		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI: 0111111110
T19 MEDICAID						57 OTHER PRV ID

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
SAME		1234567890		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX: XXXX (A–Q) 68

69 ADMIT DX | 70 PATIENT REASON DX (a–c) | 71 PPS CODE | 72 ECI (a–c) | 73

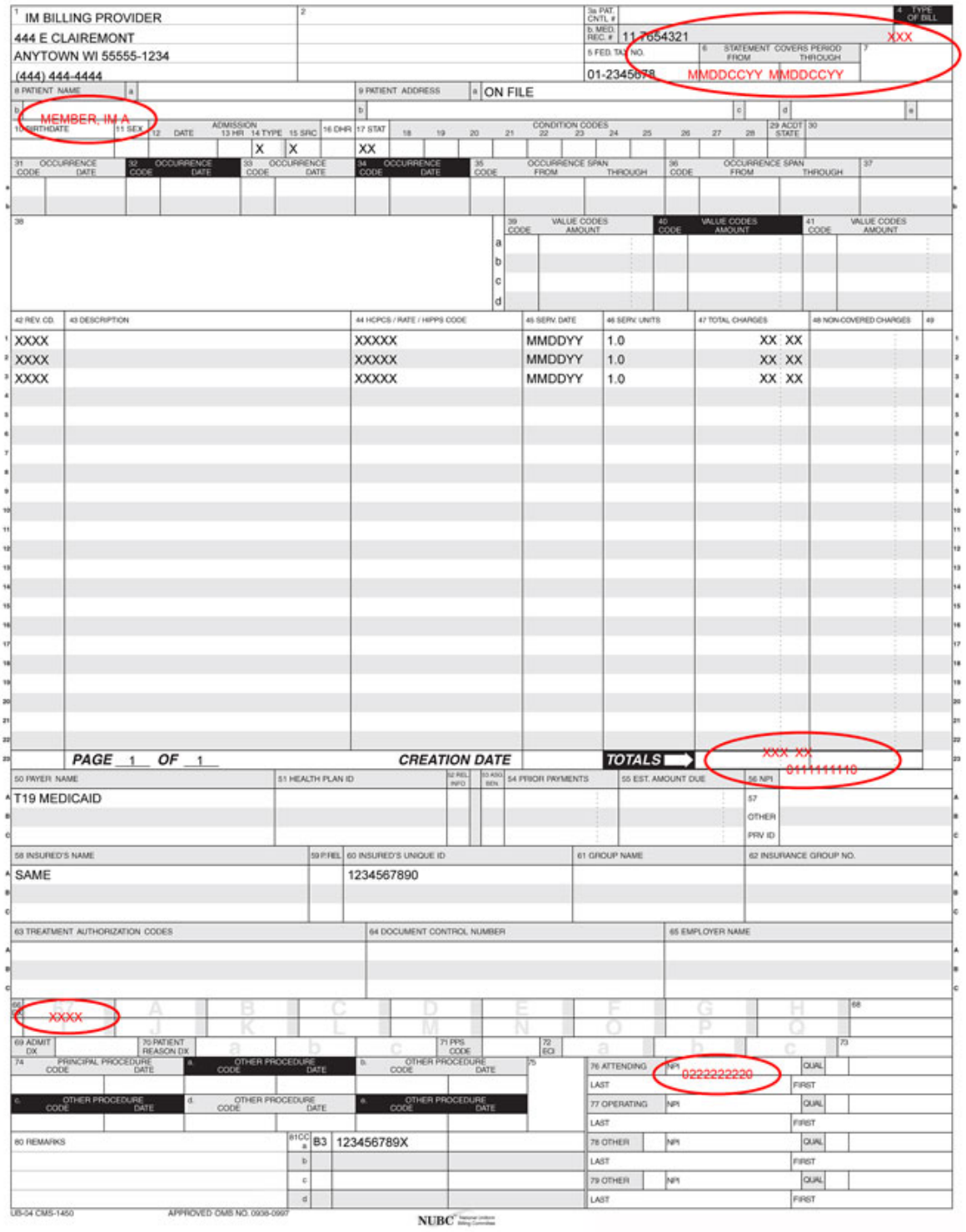
74 PRINCIPAL PROCEDURE CODE / DATE	a. OTHER PROCEDURE CODE / DATE	b. OTHER PROCEDURE CODE / DATE	75
c. OTHER PROCEDURE CODE / DATE	d. OTHER PROCEDURE CODE / DATE	e. OTHER PROCEDURE CODE / DATE	

76 ATTENDING	NPI 0222222220	QUAL	LAST / FIRST
77 OPERATING	NPI	QUAL	LAST / FIRST
78 OTHER	NPI	QUAL	LAST / FIRST
79 OTHER	NPI	QUAL	LAST / FIRST

80 REMARKS | 81CC a: B3 123456789X (b, c, d)

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC

Sample of an Incorrectly Aligned UB-04 Claim Form



Topic #1706

Paper Claim Submission

Paper claims for case management services must be submitted using the 1500 Health Insurance Claim Form ((02/12)). Claims for case management services submitted on any other paper claim form are denied.

Providers should use the appropriate claim form instructions for case management services when submitting these claims.

Obtaining the Claim Forms

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

Topic #10637

Reimbursement Reduction for Most Paper Claims

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

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

If a paid claim's total reimbursement amount is less than $1.10, ForwardHealth will reduce the payment up to a $1.10. The claim will show on the RA (Remittance Advice) as paid but with a $0 paid amount.

The reimbursement reduction applies to the following paper claims:

- 1500 Health Insurance Claim Form ((02/12)).
- UB-04 (CMS 1450) Claim Form.
- Compound Drug Claim (F-13073 (04/17)) form.
- Noncompound Drug Claim (F-13072 (04/17)) form.

Exceptions to Paper Claim Reimbursement Reduction

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

- In-state emergency providers.
- Out-of-state providers.
- Medicare crossover claims.
- Any claims that ForwardHealth requires additional supporting information to be submitted on paper. For example:
    - Hysterectomy claims must be submitted along with an Acknowledgment of Receipt of Hysterectomy Information (F-01160 (06/13)) form.
    - Sterilization claims must be submitted along with a paper Consent for Sterilization (F-01164 (10/08)) form.
    - Claims submitted to Timely Filing appeals must be submitted on paper with a Timely Filing Appeals Request (F-13047 (08/15)) form.
    - In certain circumstances, drug claims must be submitted on paper with a Pharmacy Special Handling Request (F-13074 (07/12)) form.
    - Claims submitted with four or more NDCs (National Drug Codes) for compound and noncompound drugs with specific and non-specific HCPCS (Healthcare Common Procedure Coding System) procedure codes.

Topic #4817

Submitting Paper Attachments with Electronic Claims

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

Paper attachments that go with electronic claim transactions must be submitted with the Claim Form Attachment Cover Page (F-13470 (10/08)). Providers are required to indicate an ACN (attachment control number) for paper attachment(s) submitted with electronic claims. (The ACN is an alphanumeric entry between 2 and 80 digits assigned by the provider to identify the attachment.) The ACN must be indicated on the cover page so that ForwardHealth can match the paper attachment(s) to the correct electronic claim.

ForwardHealth will hold an electronic claim transaction or a paper attachment(s) for up to 30 calendar days to find a match. If a match cannot be made within 30 days, the claim will be processed without the attachment and will be denied if an attachment is required. When such a claim is denied, both the paper attachment(s) and the electronic claim will need to be resubmitted.

Providers are required to send paper attachments relating to electronic claim transactions to the following address:

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

This does not apply to compound and noncompound claims.

Topic #11677

Uploading Claim Attachments Via the Portal

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

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

Claim Types

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

- Professional.
- Institutional.
- Dental.

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

Document Formats

Providers are able to upload documents in the following formats:

- JPEG (Joint Photographic Experts Group) (.jpg or .jpeg).

- PDF (Portable Document Format) (.pdf).
- Rich Text Format (.rtf).
- Text File (.txt).

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

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

Uploading Claim Attachments

Claims Submitted by Direct Data Entry

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

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

Claims will suspend for 30 days before denying for not receiving the attachment.

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

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

Claims will suspend with 30 days before denying for not receiving the attachment.

Timely Filing Appeals Requests

Topic #549

Requirements

When a claim or adjustment request meets one of the exceptions to the submission deadline, the provider is required to mail ForwardHealth a Timely Filing Appeals Request form (F-13047 (08/15)) with a paper claim or an Adjustment/Reconsideration Request form (F-13046 (08/15)) to override the submission deadline. If claims or adjustment requests are submitted electronically, the entire amount of the claim will be recouped.

DOS (dates of service) that are beyond the submission deadline should be submitted separately from DOS that are within the deadline. Claims or adjustment requests received that contain both current and late DOS are processed through normal channels without review by Timely Filing and late DOS will be denied.

Topic #551

Resubmission

Decisions on Timely Filing Appeals Requests (F-13047 (08/15)) cannot be appealed. Providers may resubmit the claim to Timely Filing if both of the following occur:

- The provider submits additional documentation as requested.
- ForwardHealth receives the documentation before the specified deadline for the exception to the submission deadline.

Topic #744

Submission

To receive consideration for an exception to the submission deadline, providers are required to submit the following:

- A properly completed Timely Filing Appeals Request (F-13047 (08/15)) form for each claim and each adjustment to allow for documentation of individual claims and adjustments submitted to ForwardHealth
- A legible claim or Adjustment/Reconsideration Request (F-13046 (08/15)) form
- All required documentation as specified for the exception to the submission deadline
- A properly completed Explanation of Medical Benefits form for paper claims and paper claim adjustments where other health insurance sources are indicated

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

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

When completing the claim or adjustment request, providers are required to indicate the procedure code, diagnosis code, POS (place of service) code, and all other required claims data elements effective for the DOS (date of service). However, providers should use the current claim form and instructions or adjustment request form and instructions. Reimbursement for Timely Filing Appeals Requests is contingent upon the claim or adjustment request meeting program requirements for the DOS.

The following table lists the filing deadlines and additional documentation requirements as they correspond to each of the eight allowable exceptions.

Change in Nursing Home Resident's Level of Care or Liability Amount		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a nursing home claim is initially received within the submission deadline and reimbursed incorrectly due to a change in the member's authorized LOC (level of care) or liability amount.	To receive consideration, the request must be submitted within 455 days from the DOS. Include the following doucmentation as part of the request: • The correct liability amount or LOC must be indicated on the Adjustment/Reconsideration Request (F-13046 (08/15)) form. • The most recent claim number (also known as the ICN (internal control number)) must be indicated on the Adjustment/Reconsideration Request form. This number may be the result of a ForwardHealth-initiated adjustment. • A copy of the Explanation of Medical Benefits form, if applicable.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
Decision Made by a Court, Fair Hearing, or the Wisconsin Department of Health Services		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a decision is made by a court, fair hearing, or the Wisconsin DHS (Department of Health Services).	To receive consideration, the request must be submitted within 90 days from the date of the decision of the hearing. Include the following documentation as part of the request: • A complete copy of the decision notice received from the court, fair hearing, or DHS	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
Denial Due to Discrepancy Between the Member's Enrollment Information in ForwardHealth interChange and the Member's Actual Enrollment		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a claim is initially received by the deadline but is denied due to a discrepancy between the member's enrollment information in ForwardHealth interChange and the member's actual enrollment.	To receive consideration, the request must be submitted within 455 days from the DOS. Include the following documentation as part of the request: • A copy of remittance information showing the claim was submitted in a timely manner and denied with a qualifying enrollment-related explanation. • A photocopy of **one** of the following indicating enrollment on	ForwardHealth Good Faith/Timely Filing Ste 50 313 Blettner Blvd Madison WI

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

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

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

Coordination of Benefits

2

Archive Date:01/02/2019

Coordination of Benefits:Commercial Health Insurance

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 sources (e.g., commercial insurance, Medicare) are indicated on a paper claim or paper adjustment.

Note: ADA (American Dental Association) claims and claim adjustments and compound and noncompound drug claims and claim adjustments are **not** subject to the requirements regarding use of the Explanation of Medical Benefits form.

Paper claims or adjustment requests that have other health insurance indicated may be returned to the provider unprocessed or denied if they are submitted without the Explanation of Medical Benefits form for each other payer. Paper claims or adjustments submitted with incorrect or incomplete Explanation of Medical Benefits forms will also be returned or denied.

Use of the ForwardHealth Explanation of Medical Benefits form is mandatory; providers are required to use an exact copy. ForwardHealth will not accept alternate versions (i.e., retyped or otherwise reformatted) of the Explanation of Medical Benefits form.

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

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

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

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

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

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

Topic #603

Services Not Requiring Commercial Health Insurance

Billing

Providers are not required to bill commercial health insurance sources before submitting claims for the following:

- Case management services
- CCS (Comprehensive Community Services)
- Crisis Intervention services
- CRS (Community Recovery Services)
- CSP (Community Support Program) services
- Family planning services
- In-home mental health/substance abuse treatment services for children (HealthCheck "Other Services") rendered by providers at the less than bachelor degree level, bachelor's degree level, or QTT (qualified treatment trainee) level
- Personal care services
- PNCC (prenatal care coordination) services
- Preventive pediatric services
- SMV (specialized medical vehicle) services

Covered and Noncovered Services

3

Archive Date:01/02/2019

Covered and Noncovered Services:Assessments and Case Plans

Topic #1705

Additional Assessment Requirements for At-Risk Children

In addition to completing the 14 required assessment components described in this section for the identified at-risk child, the assessment for families with a child at risk of physical, mental, or emotional dysfunction (Group B target population) must also include the following components:

1. Assessment of the primary caregiver's needs, when that person's condition (e.g., mental illness, substance abuse disorder, or maltreatment) is the primary reason for the child being at risk. The assessment must include those components of the comprehensive assessment that are applicable to the caregiver's situation. This component of the assessment is not necessary if the caregiver already has a Medicaid case manager.
2. Assessment of the needs of the family's other child(ren) when the conditions placing the identified child at risk might also place the other child(ren) at risk (e.g., maltreatment). The assessment must include only those components of the comprehensive assessment applicable to the other child(ren). Where components of the assessment apply equally to the identified at-risk child and other child(ren) in the family, do not duplicate these components in the assessments of the family's other child(ren) (e.g., needs of the primary caregiver). This component of the assessment is not necessary if the other child(ren) already has/have a Medicaid case manager.
3. Assessment of the family's functioning as a system as it impacts the family's ability to provide for the identified at-risk child's needs and the family's other child(ren) deemed at risk after further assessment. The following are *examples* of factors for further assessment:
    - *Family communication* — whether family communication is open, clear, and effective, or interfering with healthy family functioning.
    - *Family organization and structure* — within the family, whether appropriate boundaries exist between adults and children, or if the family is cohesive and organized, or unstable and chaotic.
    - *Family relationships* — whether relationships are satisfying, how emotions are expressed, and if there is a history of violence.
    - *Family decision-making* — if the family has an effective problem-solving process.
    - *Family resources/support* — how the family uses formal and informal community resources, and what support is available to the family.
    - *Family integration into the community* — whether the family is isolated or involved with the community.
    - *Family demographics* — how work, housing, child care, or health issues impact the family, and how the family handles stress from these factors.
4. Identification of other case managers who are working with members of the family and their activities with the family.

Topic #1704

Additional Case Plan Requirements for At-Risk Children

For family case management, the case plan must address the case plan components as they apply to the needs assessment of the identified at-risk child, caregivers enrolled in BadgerCare Plus or Wisconsin Medicaid, and the family's other children enrolled in BadgerCare Plus or Wisconsin Medicaid.

Also, when multiple family members have case managers, the case plan must identify how the activities of the various case managers are coordinated. Services may not be duplicated. This policy applies even if the other case manager's services are not related to the specific conditions placing the identified child at risk. The family's preferences concerning which case manager should provide different services must be considered when the case managers' roles overlap.

Topic #1703

Assessing Children and Adolescents

Some COP (Community Options Program) assessment components use language more applicable to adults. Case managers must interpret the assessment components in a manner consistent with the member's needs. Educational needs, for instance, may include an infant's need for cognitive stimulation by the caregivers, even when "formal" education is not required. The safety of the physical environment may require, for example, outlet plugs in homes with toddlers.

A variety of children's assessment instruments evaluate the child's progress toward basic developmental milestones (Denver II, Wisconsin Model for Ongoing Child Protective Services) and measure all or some of the following areas:

- Self-care/adaptive activities.
- Receptive and expressive language/communication.
- Learning/cognitive development.
- Mobility/physical development.
- Self direction/social and emotional development.

These assessment instruments are considered to meet the requirements for reviewing the member's performance while performing ADL (activities of daily living) and his or her social status and skills. In the absence of other psychiatric symptoms which require further professional evaluation, these assessment instruments also meet the requirements to evaluate mental and emotional status.

Topic #1702

Completion Prior to Ongoing Monitoring and Service Coordination

A complete assessment and case plan must predate any covered ongoing monitoring and service coordination, except in emergency situations. Providers need not have billed Wisconsin Medicaid for either an assessment or a case plan prior to billing for ongoing monitoring and service coordination. Providers meet the requirements if the assessment is complete and a current case plan meeting the standards for Medicaid reimbursement is in the member's file. "Current" is defined within the context of applicable departmental statutes, rules, and guidelines for the agencies or programs performing case management, if any.

When ongoing care coordination services are provided in an urgent situation, the provider is required to do the following:

- Document the nature of the urgent situation.
- Complete the assessment and case plan as soon as possible but no later than 60 days following the actions taken to alleviate the urgent situation.

Due to the public health risk presented by TB (tuberculosis)-infected members, ongoing monitoring and service coordination is covered for up to 90 days before completion of an assessment and case plan for members in the TB target population. Providers are required to complete the assessment and case plan as soon as possible, but not later than 90 days following the start of case management.

Topic #1701

Comprehensive Assessment Versus Ongoing Evaluation

The comprehensive assessment is the assessment of all components described in DHS 107.32(1)(b), Wis. Admin. Code, and in this service area of the Online Handbook. The time spent by all the individuals participating in that assessment is covered.

The ongoing evaluation is the review of the case plan or of the member's status. This activity must be performed by the single designated case manager and may be billed as ongoing monitoring and service coordination.

Topic #1700

Frequency for Group A Target Populations

The following are covered:

1. One comprehensive assessment and one case plan development per member, per calendar year for Group A target populations, unless the member's county of residence changes. If the member's county of residence changes, a second assessment or case plan from an enrolled case management provider in the member's new county of residence is covered.
2. No more than two comprehensive assessments and case plans per calendar year, even if the member's county of residence changes more than once.

Topic #1699

Frequency for Group B Target Populations

Up to two comprehensive case management assessments and the development of two case plans per calendar year are covered for the Group B target populations, even when members have not changed county of residence. The member's record must indicate the rationale for a new comprehensive assessment. More than two comprehensive assessments and/or case plans per calendar year are not covered, even if the member subsequently changes county of residence.

Topic #1698

Frequency of Case Plan Reviews

At a minimum, the case manager must review the case plan in writing every six months. If the individuals developing the case plan decide to review the case plan more frequently, the case manager must document this in the case plan. This review must include input from the case manager and the member or parent/guardian or both and must be documented in the member's record. The case manager and member or parent/guardian may agree to include other persons. The case manager must sign or initial and date all updates to the case plan.

Topic #1697

General Requirements

More than one individual is allowed to complete the comprehensive case management assessment and to prepare the case plan.

Services provided by any individual involved in case management *assessment* are covered if the following requirements are met:

- The individual meets the qualifications in this service area of the Online Handbook for performing case management assessments.
- The case record documents the participation of each individual in the assessment process.
- The case management agency incurred a cost for that individual providing the assessment.

Services provided by any individual involved in case planning are covered if the following requirements are met:

- The case record documents the individual's participation in the case planning process.
- The case management agency incurred a cost for that individual providing the case planning service.

Some assessment or case planning activities are covered under other Medicaid benefits. In this case, bill the activity to the other benefit. For example, if a Medicaid-enrolled OT (occupational therapist) conducts an assessment of adult ADL (activities of daily living) that meets the covered service requirements for OT, the services are covered as OT services *only*, not as case management services.

Case managers must calculate the time spent on assessment and case planning for a member meeting these requirements and bill using the appropriate code. Since Wisconsin Medicaid reimburses assessments and case plans only once or twice per year (depending on the target population), providers are required to bill all assessment time together and all case planning time together.

Topic #1696

Required Case Plan Components

Following the assessment and determination of case management needs, the case manager develops a written POC (plan of care) (case plan) to address the member's needs and, if appropriate, to enable the member to live in the community. To the maximum extent possible, the case plan development is a group process involving the member, family or other support system, and case manager. This negotiated agreement of short and long term care objectives includes:

- Development of a support system, including a description of the member's informal support system.
- Documentation of unfulfilled needs and gaps in service.
- Goals to be achieved.
- Identification of all formal services arranged for the member, including costs and the service provider's names.
- Identification of individuals who participated in the case plan development.
- Problems identified during the assessment.
- Schedules of initiation and frequency of the various services available to the member.

For every member receiving case management services, the written case plan must guide the case management services. Providers may create their own form, as long as their created form contains the same information as the sample form provided by Wisconsin Medicaid. The case manager must sign and date the case plan.

Sample Case Management Case Plan

CLIENT: Im A. Recipient	Wisconsin Medicaid #: 1234567890	Case Manager: Im A. Case Manager, MSW
CASE PLAN PARTICIPANTS: Im A. Recipient's daughter, Case Manager		

PROBLEM	GOALS/OUTCOME	SERVICE TYPE	UNIT COST*	PROVIDER	UNITS OF SERVICE	START DATE
Recipient is recovering from a broken left hip and cannot ambulate without assistance.	Independent ambulation (within six weeks)	Physical therapy	xxx.xx	Wisconsin Medicaid, PT-certified provider	2 PT appointments per week-6 weeks	2/24 to 4/1
Recipient has no means of transportation to medical appointments.	Access to all medical appointments	Medical transport services	xxx.xx	Safe-T Transport	As needed	Ongoing
Recipient is unable to manage her medications.	Evaluation of all meds and support for proper intake of all meds by 3-1	RN visit and evaluation with RX	xxx.xx	Visiting nurses	2 visits	2/24 and 3/1
Recipient cannot perform her own personal care, i.e., bathing, dressing, toileting.	Assistance and instruction to meet personal care needs	Personal Care	xxx.xx	Wisconsin Medicaid service provider	7 days/wk. 1 hr. a.m., 1 hr. p.m.	Ongoing
Recipient has no assistive devices in her home.	Occupational therapy evaluation for assistive devices at home by 3-5	Occupational therapy	xxx.xx	Wisconsin Medicaid, OT-certified provider	1 evaluation 1 installation	2/27 3/5

*State, if applicable, "Medicaid reimbursement" and indicate copayment amount when appropriate.

Other support systems:
List unmet needs and/or gaps in service:
Client Case Plan Review
I do not wish to participate further in the Medicaid case management program at this time. Date — Signature (Client, Guardian, or Responsible Caregiver)
I agree with the plan above and have participated in the planning process. MM/DD/YY — J.M Recipient Date — Signature (Client, Guardian, or Responsible Caregiver)
This plan is approved for implementation. MM/DD/YY — Lisa A. Case Manager, MSW Date — Signature (Case Manager)

Topic #1695

Required Components of Assessments

Per DHS 107.32(1)(b), Wis. Admin. Code, case managers must perform a written comprehensive assessment of a person's abilities, deficits, and needs. Case managers should use persons from relevant disciplines to document service gaps and unmet needs. All services appropriate to the member's needs, regardless of availability or accessibility of providers, must be included in this comprehensive assessment.

Include any of the following as appropriate services regardless of whether they are covered or not:

- Educational.
- Medical.
- Rehabilitative.
- Social.
- Vocational.

Per DHS 105.51,Wis. Admin. Code, enrolled case management providers are required to offer all three case management components described in this section. However, not all members assessed need case management. Based on the assessment, the case management agency may determine that further case management is not appropriate for a given member.

The individual(s) performing the assessment must document the following information in writing:

- Member identifying information.
- Record of physical and dental health assessments and consideration of potential for rehabilitation.
- A review of the member's performance in carrying out ADL (activities of daily living)s (e.g., mobility levels, personal care, household chores, personal business, and the amount of assistance required).
- Social interactive skills and activities.
- Record of psychiatric symptomatology and mental and emotional status.
- Identification of social relationships and support (e.g., informal caregivers, family, friends, volunteers, formal service providers, significant issues in relationships, social environments).
- A description of the member's physical environment, especially regarding in-home mobility and accessibility.
- In-depth financial resource analysis, including identification of and coordination with insurance, veterans' benefits, and other sources of financial assistance.
- The member's need for housing, residential support, adaptive equipment, and assistance with decision making.
- Vocational and educational status and daily structure, if appropriate (e.g., prognosis for employment; educational/vocational needs; appropriateness/availability of educational, rehabilitation, and vocational programs).
- Legal status, if appropriate (e.g., guardian relationships, involvement with the legal system).
- For any member identified as a person who is severely emotionally disturbed under age 21, a record of the multidisciplinary team evaluation required under s. 49.45(25), Wis. Stats., or evidence of his/her admission to an integrated services program meeting the requirements of s. 46.56, Wis. Stats.
- Access to community resources that the member needs or wants.
- Assessment of drug and/or alcohol use and misuse for members identified as alcohol or drug dependent or both.

Providers are not required to use a specific assessment tool.

Case Management for Children with Medical Complexity

Topic #20737

An Overview for Children with Medical Complexity Benefit

Case management is one aspect of an integrated approach to providing comprehensive, integrated care to CMC (children with medical complexity). CMC is one of the target groups covered under the Medicaid-targeted case management benefit. Targeted case management services are defined as services to assist members and, when appropriate, their families in gaining access to and coordinating a full array of services, including medical, social, educational, vocational, and other services. Case management services do not include a direct provision of care.

The CMC benefit is administered fee-for-service for all Medicaid-enrolled members who demonstrate medical necessity for covered services. The CMC benefit is "carved out" of MCOs (managed care organizations), which include BadgerCare Plus and Medicaid SSI (supplemental security income) HMOs and special managed care plans. Special managed care plans include Children Come First, Wraparound Milwaukee, Care4Kids, Family Care, PACE (Program of All-Inclusive Care for the Elderly), and the Family Care Partnership Program.

Refer to the Managed Care section for general managed care information.

Topic #20819

Case Management Documentation

Providers are required to maintain case records for each member receiving case management services. The case records must document all of the following:

- The member's name
- The full name and title of the person who made the contact (If initials are used in the case records, the file must contain a signature page showing the full name of the person who initialed the record.)
- The nature and content of the contact and whether or not the goals specified in the care plan have been achieved
- The date the contact was made
- Where the contact was made
- How much time was spent
- Whether the member declined services in the care plan
- The need for, and occurrences of, coordination with other case managers
- A timeline for obtaining needed services
- A timeline for re-evaluation of the care plan

Refer to the Provider Enrollment and Ongoing Responsibilities section for additional documentation and other requirements.

Topic #20797

Case Management Services Are Voluntary

Providers cannot compel a member to accept case management services. For members, participation in the case management program is voluntary. Members have the right to refuse case management services at any time. The member voluntarily participates in case management services by maintaining contact with and receiving services from the case management agency. If a member declines services, the provider is required to document the refusal in the care plan.

Topic #20837

Claim Submission

Allowable Claim Types

Claims for case management services must be submitted on a professional claim form. Providers may submit claims for allowable case management activities via any of the following:

- The 1500 Health Insurance Claim Form ((02/12))
- The 837P (Health Care Claim: Professional) transaction
- DDE (Direct Data Entry) on the ForwardHealth Portal
- PES (Provider Electronic Solutions) claims submission software

Claims for case management services submitted on any other claim format will be denied.

Allowable Procedure Codes

All claims submitted to ForwardHealth for case management services provided to CMC (children with medical complexity) must include one of the following allowable HCPCS (Healthcare Common Procedure Coding System) procedure codes:

HCPCS Procedure Codes for Targeted Case Management Services for Eligible Pediatric Members with Medical Complexity

HCPCS Code	Description	Use	Limitations
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)	This code must be used when billing for activities related to the initial, comprehensive assessment and completion of the care plan.	• Limited to one unit of service every (rolling) three years, per provider, per member. • Not reimbursable for DOS (dates of service) in the same calendar month for the same provider and member as T2023.
T2023	Targeted case management, per month	Targeted case management, ongoing care coordination, referral, monitoring and follow-up activities.	• Limited to one unit of service per calendar month, per provider, per member. • Not reimbursable for DOS in the same calendar month for the same provider and member as G0506.

Claims or adjustment requests received without the appropriate HCPCS codes will be denied.

Dates of Service

Providers should adhere to the following guidelines when determining the DOS to indicate on the professional claim:

- For activities related to the comprehensive assessment and care plan development, (indicated by HCPCS procedure code G0506), the DOS is the date the care plan is completed.
- For activities related to ongoing care coordination and monitoring (indicated by HCPCS procedure code T2023), indicate the last date the service was performed in the month as the DOS on the claim form.

Note: The actual DOS must be identified when documenting each case management activity.

Diagnosis Codes

ForwardHealth does not require a specific diagnosis code for case management services provided to CMC. However, providers are required to use valid, nationally-recognized ICD (International Classification of Diseases) diagnosis codes when submitting claims.

Place of Service

Providers should use a valid two-digit POS (place of service) code to indicate the setting in which services were provided. If services occurred in multiple settings, providers may bill using the most frequently occurring POS code.

Note: The actual POS must be indicated when documenting each case management activity.

Units of Service

The unit of service for each CMC benefit-allowable HCPCS code is one. Claims submitted with more than one unit of service on a detail will be denied.

Refer to the Claims section for additional information.

Topic #20798

Covered Services

The Case Management for Children with Medical Complexity benefit covers the following services:

- A comprehensive assessment and periodic reassessment of the member's needs
- The development (and periodic revision) of a member-centric care plan
- Ongoing monitoring and service coordination

Comprehensive Assessment

Case management services include a comprehensive assessment to determine the member's need for any medical, educational, social or other services. The assessment could include:

- Taking the member's history.
- Identifying the member's needs and strengths.
- Gathering information from other sources such as family members, medical providers, social workers, and educators.

The assessment must be documented in writing. Periodic assessments are covered as ongoing monitoring and service coordination.

Development of Care Plan

Following the assessment, the case manager is required to develop a written care plan that is based on the information collected as part of the comprehensive assessment. At a minimum, the care plan must:

- Specify the goals and actions to address the medical, social, educational, and any other identified need.
- Identify a course of action to respond to the member's assessed needs.
- Include timeframes for initiating and/or completing the identified actions.

A physician or advance practice provider (e.g., nurse practitioner or physician assistant) is required to have a face-to-face visit with the member, as part of the care plan development. To the maximum extent possible, the provider is required to ensure that the member (or the member's parent, guardian or caregiver) is actively involved in the development of the care plan.

At a minimum, care plans must be reviewed and updated every six months, or as the member's needs change.

Periodic reviews and updates of the care plan are covered as ongoing monitoring and service coordination.

Ongoing Monitoring and Service Coordination

Following the development of the care plan, members are assigned to a care team with an identified primary point of contact.

Ongoing monitoring and service coordination includes:

- Periodic reassessment of need.
- Periodic review and updating of the care plan.
- Referrals and related activities (e.g. assisting with the scheduling of appointments) such as ensuring referrals are coordinated and effective by:
    - Obtaining verbal and/or written release of information, as appropriate.
    - Providing written referrals that includes the reason for the referral, if necessary.
    - Informing members if the service has a cost, including whether or not there will be a copayment.
    - Assisting the member in gaining access to the needed service, if necessary.
    - Tracking, following up, and documenting the results of referrals.
    - Closing referrals when the service has been initiated.
    - Communicating with the member, and others when necessary, to ensure the referral met the intended need.
- Monitoring and follow-up activities, including:
    - Activities that are necessary to implement the care plan.
    - Ongoing supportive contacts to ensure that the member is able to access services and/or is receiving the services and care specified in the care plan. Ongoing supportive contacts must include (as appropriate):
        - Arranging acute care visits.
        - Attending specialty appointments.
        - Making rounds during the member's inpatient stay.
        - Following up with the member within three business days of a hospital discharge.
    - Periodic assessment of member satisfaction and participation.
    - Contacts with the member, the member's family, service providers and other collaterals to determine if there are changes in the member's health or psychosocial needs that would necessitate a care plan review or update.
    - Conducting monitoring activities as frequently as necessary, including at least one annual monitoring activity to

determine whether or not the following conditions are met:

- Services are being provided in accordance with the member's care plan.
- Services in the care plan are adequate.
- Changes in the needs or status of the member are reflected in the care plan. Monitoring and follow-up activities include making any necessary adjustments in the care plan and service arrangements with providers.

Ongoing monitoring and service coordination activities include face-to-face, telephone, or written contacts with, or on behalf of, the member.

Primary Point of Contact

For ongoing monitoring and service coordination, the provider is required to identify a primary point of contact for members and ensure that members are given the information they need to contact the team when necessary. Care coordination teams consisting of an RN (registered nurse) and care coordination assistant dyad have been shown to be effective in meeting members' primary coordination needs, as well as serving as the primary point of contact for families.

Frequency of Ongoing Monitoring

ForwardHealth does not have a frequency of contact requirement for case management services provided to CMC (children with medical complexity); however, the case manager is required to discuss and document the proposed frequency of contacts with the member (or the member's parent, guardian, or caregiver). This discussion must include the frequency of contacts with the member, care providers instrumental to the implementation of the care plan, and other individuals directly related to mobilizing services and support on behalf of the member.

If the frequency of member contacts will be less than a monthly visit or reciprocal contact, the case manager is required to note the reason in the member's record. The case manager should consider the following when discussing the frequency of ongoing monitoring:

- The stability or frailty of the member's health
- The member's or family's ability to direct needed care and services
- The strength of supports in the home or the member's informal supports
- Stability of, and satisfaction with, service care staff (e.g., is there a history of high staff turnover?)
- Stability of the care plan (e.g., is there a history of numerous plan changes?)

Contacts with Non-Members

Face-to-face and telephone contacts with collaterals are covered to the extent that those contacts are directly related to:

- Identifying the member's needs and care.
- Helping the member access services.
- Identifying needs and supports to assist the member in obtaining services.
- Providing useful feedback to case managers.
- Alerting case managers to changes in the member's needs.

Collaterals include service providers and other individuals who are instrumental to addressing the member's needs or who have direct supportive contacts with the member. Collaterals could include paid providers, family members, guardians, school representatives, volunteers, and others involved with the member. Collateral contacts include case management staff time spent on case-specific staffing and formal case consultation with the unit supervisor and other professionals regarding the needs of a specific member.

The role of collaterals must be identified in the care plan or other member-specific documentation.

Case Management During an Inpatient Stay

Case management services may be provided during an inpatient stay, but are limited to the 180 days prior to the member's discharge. Case management services are not available to members who are not within 180 days of discharge.

Discharge Planning

Case management activities must be coordinated with, and should not duplicate, institutional discharge planning. Targeted case management services are covered only if the activities are distinctly different and are not duplicative of the discharge planning activities typically covered as part of the hospital reimbursement.

Topic #20818

Duplication of Services

Non-Duplication Across Agencies

Members should not receive case management/care coordination services from more than one case management provider. Providers are required to make every effort to determine if there are other case management providers working with the member. If other case management providers are identified, it is the hospital's responsibility to communicate with the member and with the other agency/provider to eliminate duplication, reduce fragmentation, and to ensure there are no gaps in care. The family's preferences concerning which agency should provide services must be considered when the roles overlap.

This requirement applies whether or not ForwardHealth covers the other case manager's services. The need for more than one service coordinator in the family must be reassessed after one year (i.e. 12 months).

Providing Services to More Than One Family Member

Wisconsin Medicaid ordinarily reimburses only one family case manager/team per family. If more than one child in a family meets the criteria for case management services for CMC (children with medical complexity), the provider may submit claims for each child only if there is clear documentation that each child requires a separate care plan, and the ensuing case management activities are not duplicative.

When multiple case managers/teams are providing case management to the family, these case managers are required to communicate with the family and with each other to avoid service duplication.

Documenting Overlap

A family case manager and other case managers working with family members are covered only if documentation shows that their activities have been coordinated through the care planning process to avoid duplication of efforts.

The documentation should include the following information:

- The need for more than one case manager for the child/family
- The identification of the other case management provider or team
- Evidence that the member was included in any decision-making
- The member's care plan includes a clear delineation of the role of each care coordinator (regardless of whether the care coordinators are employed by the same or different agencies)
- Ongoing communication and frequency of contacts between the care coordinators, including the need to periodically assess the need for continued involvement of both providers

Topic #20758

Eligible Members

Children under age 26 diagnosed with chronic health conditions are eligible to receive case management services under this benefit if the child meets both of the following health condition criteria:

- Involves three or more organ systems
- Requires three or more medical or surgical specialists

Additionally, during the preceding year (i.e., 12 months), the child had at least one of the following utilization criteria:

- One or more hospital admissions totaling five or more days
- Ten or more visits to tertiary clinics (Clinic visits count only if they are with a medical or surgical subspecialist.)

Children too young to have met the above utilization criteria may still be eligible if they meet the above health condition criteria and both of the following are true:

- The child had a stay in a hospital totaling five or more days.
- Clinicians anticipate that the child will continue to be an intensive user of health resources without comprehensive care management services and care coordination.

Providers are required to retain documentation showing the member's:

- Eligibility for case management services for CMC (children with medical complexity).
- Need for comprehensive care management services to attain or maintain stability and optimal health status. This includes care coordination to prevent progression of the disease, deterioration, or gaps in care.
- Voluntary consent to program enrollment. A statement regarding the member's acceptance meets this criteria.

Members Not Eligible

Care management services are not available to the following:

- Inmates of public institutions
- Members between the ages of 21 and 26 who are served in institutions for mental disease
- Members who are inpatients and are not within 180 days of a hospital discharge (*Note:* Members are expected to be in the inpatient setting for more than 180 days from the initiation of case management services.)

Refer to the Member Information section for additional member-related information.

Topic #20777

Members' 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.

Members have the freedom to choose any qualified case management provider. Providers may not "lock-in" members or deny members' freedom to choose their care providers. Further, members are allowed to participate to the full extent of their ability in all decisions regarding appropriate services and providers.

The case manager and the member (or the member's parent, guardian, or caregiver) are required to discuss care plan changes and mutually agree to reduce or terminate services. If the case management provider needs to reduce or terminate services for any reason, the case manager is required to notify the member in advance and document this in the record.

Topic #20817

Noncovered Services

Case management services do not include services that constitute the direct delivery of the underlying medical, educational, social, or other services to which a member has been referred. Further, case management services do not include activities that are an integral and inseparable component of another Medicaid-covered service.

For additional information related to noncovered services, refer to the Noncovered Services chapter of the Covered and Noncovered Services section.

Topic #20738

Provider Enrollment

Medicaid-enrolled children's hospitals with pediatric medical and surgical specialty areas are eligible to enroll in Wisconsin Medicaid as a provider of Case Management for Children with Medical Complexity. Additionally, the hospital is required to have:

- The ability to support full integration of psychosocial and clinical care.
- Sufficient documentation that demonstrates staff has adequate knowledge and experience to provide comprehensive and specialized case management services to children with complex medical and psychosocial needs.
- Referral and/or effective working relationships with key health care and other service providers that are essential to the care of children with complex medical and psychosocial needs (for example, primary care team, private duty nurses, specialists and sub-specialists, and community and social service organizations).

Topic #20820

Provider Reporting Requirements

To monitor and evaluate the Case Management for Children with Medical Complexity program, ForwardHealth may require the hospital provider to collect and report certain information to ForwardHealth. To the extent possible, ForwardHealth will use its own paid claims data for monitoring and evaluation and will only rely on the hospital provider for data not available through the claim system. Providers are required to respond to data requests as a condition of continued participation in the Case Management for Children with Medical Complexity program.

In addition, providers participating in the program are required to submit monthly enrollment and patient-staffing reports, as well as annual member satisfaction surveys to the Wisconsin DHS (Department of Health Services).

Monthly Enrollment Report

The hospital provider is required to submit a cumulative enrollment report to DHS on a monthly basis that includes the following elements:

- Member last name
- Member first name
- Member date of birth

- Member Medicaid ID
- Enrollment date
- Discharge date
- Discharge reason
- Referral date
- Referral type
- Inpatient admission date
- Inpatient discharge date
- Post discharge contact indicator
- Eligibility criteria attestation indicator

Patient-Staffing Summary Report

The hospital provider is required to submit a patient caseload and staffing summary to DHS on a monthly basis. The report must include the following elements:

- Number of all currently enrolled members
- Number of currently enrolled Wisconsin Medicaid members
- Staff type (e.g. physician, advance practice provider [e.g., nurse practitioner or physician assistant]), RN (registered nurse))
- Number of individual staff
- Staff FTE (full-time equivalent)

The patient-staffing report may be submitted with the monthly enrollment report.

Member Satisfaction Survey

The hospital provider is required to conduct annual member satisfaction surveys. The purpose of the survey is to obtain feedback from each member regarding their satisfaction with the assistance and support received from the program. Providers may be required to periodically share the survey and the survey results with DHS. Hospital providers are required to document any action taken to improve services or the approach to care based on feedback received from members.

ForwardHealth may collaborate with the hospital provider to change reporting requirements at any time. Providers may be required to submit additional data to ForwardHealth upon request.

Topic #20857

Reimbursement

Comprehensive Assessment and Care Planning

Providers receive a flat fee per eligible child for the completion of a comprehensive assessment and care planning that meets the coverage criteria, including a face-to-face contact with a physician or advance practice provider (e.g., nurse practitioner or physician assistant) as part of the care planning process.

These activities are reimbursable only for members who meet the criteria of a child with medical complexity and who agree to participate. Members agree to participate by actively engaging in the care plan development process.

Periodic reassessments and reviews and updates of the care plan are reimbursable as part of the ongoing monitoring and service coordination activities.

Ongoing Monitoring and Service Coordination Activities

Ongoing case management activities are reimbursable for eligible members who have a completed care plan. Services are reimbursable only if an individual on the member's core team has at least one face-to-face or reciprocal telephone or written contact with the member (or the member's parent, guardian or caregiver) during the billable month.

Billing the Usual and Customary Charge

Providers are required to bill their usual and customary charge for case management services provided to CMC (children with medical complexity). Reimbursement is the lesser of the usual and customary charge, or the maximum allowable fee established.

Copayment

Case management services are not subject to copayment; however, members are still responsible for applicable cost sharing for other Medicaid and BadgerCare Plus services they receive.

Refer to the Reimbursement and Resources sections for additional information about reimbursement.

Topic #20757

Staff Qualifications

To provide comprehensive and specialized case management services, staff providing case management services for CMC (children with medical complexity) are required to have adequate knowledge and experience of the following:

- Local service delivery system
- Needs of the population
- Available resources (or the gaps in resources)

Core Team Requirements

The hospital provider is required to identify a core team of health care professionals who are knowledgeable about the care and needs of CMC and high-resource utilization, local health care, and social services delivery systems. Core team members may include the following staff:

- Advance practice providers (e.g. nurse practitioners or physician assistants)
- Paraprofessionals (serving as care coordination assistants)
- Physicians
- RNs (registered nurses)
- Social workers

A physician or advance practice provider is required to be an integral part of all teams. The core team may include care coordination assistants to assist professional staff in coordinating care for the member. The primary case manager or care coordinator cannot be a paraprofessional.

Codes

Topic #1694

Diagnosis Codes

All codes indicated on submissions to ForwardHealth are required to be valid codes.

Target groups and allowable ICD (International Classification of Diseases) diagnosis codes for case management are listed in the following table.

Target Group	ICD Diagnosis Code	Description
Developmentally Disabled	R41.841	Cognitive communication deficit
Birth to 3	R62.50	Unspecified lack of expected normal physiological development in childhood
Alcohol and Other Drug Abuse	F19.20	Other psychoactive substance dependence, uncomplicated
Chronically Mentally Ill	F69	Unspecified disorder of adult personality and behavior
Alzheimer's Disease or Related Dementia	G30.9	Alzheimer's disease, unspecified
Tuberculosis	Z86.11	Personal history of tuberculosis
Women Age 45 to 64	Z91.89	Other specified personal risk factors, not elsewhere classified
Physically Disabled	Z73.6	Limitation of activities due to disability
Elderly Age 65 and Over	Z73.89	Other problems related to life management difficulty
Under Age 21 and Severely Emotionally Disturbed	F93.9	Childhood emotional disorder, unspecified
Child with Asthma	J45.909	Unspecified asthma, uncomplicated
Child At-Risk	Z65.8	Other specified problems related to psychosocial circumstances
HIV (human immunodeficiency virus)	Z21	Asymptomatic human immunodeficiency virus [HIV] infection status

Topic #17918

Modifiers

The following table lists the modifiers that providers are required to use when submitting claims for case management services. These are national modifiers that are state defined. Providers are required to use two modifiers per detail when submitting claims

for case management services: one to distinguish which service is being provided and an additional modifier to identify if the member is part of the COP (Community Options Program) or not (non-COP). Claims details that do not include two modifiers as indicated below are denied.

Modifier	Description	Notes
U1	Comprehensive Assessment	Use this modifier when submitting a claim for comprehensive assessments. Do not use for assessment updates.
U2	Case Plan Development	Use this modifier when submitting a claim for the development of a case plan. Do not use for case plan reviews and updates.
U3	Ongoing Monitoring and Services Coordination	Use this modifier when submitting a claim for activities related to ongiong monitoring and service coordination, including updates to the assessment and case plan.
U4	Discharge Planning	Use this modifier when submitting a claim for discharge planning activities.
U5	COP	Use this modifier in addition to modifier U1, U2, U3, or U4 when submitting a claim for a member who is a COP participant.
U6	Non-COP	Use this modifier in addition to modifier U1, U2, U3, or U4 when submitting a claim for a member who is *not* a COP participant.

Topic #1693

Place of Service Codes

Allowable POS (place of service) codes for case management are listed in the following table.

POS Code	Description
03	School
04	Homeless shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
19	Off Campus — Outpatient Hospital
21	Inpatient Hospital
22	On Campus — Outpatient Hospital
23	Emergency Room — Hospital

31	Skilled Nursing Facility
32	Nursing Facility
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
54	Intermediate Care Facility/Individuals with Intellectual Disabilities
71	State or Local Public Health Clinic
72	Rural Health Clinic
99	Other Place of Service

Topic #1692

Procedure Codes

All claims submitted to ForwardHealth must include allowable HCPCS (Healthcare Common Procedure Coding System) codes for case management services. Claims or adjustment requests received without the appropriate HCPCS codes will be denied. The following are allowable HCPCS procedure codes for case management services.

Procedure Code and Description	First Service Modifier and Description	Second Service Modifier (Community Options Program or Non-Community Options Program)
T1017 Targeted case management, each 15 minutes	**U1** (assessment)	**U5** — COP **U6** — non-COP
T1017 Targeted case management, each 15 minutes	**U2** (case planning)	**U5** — COP **U6** — non-COP
T1017 Targeted case management, each 15 minutes	**U3** (ongoing monitoring and service coordination)	**U5** — COP **U6** — non-COP
T1017 Targeted case management, each 15 minutes	**U4** (discharge planning)	**U5** — COP **U6** — non-COP

Topic #17917

Rounding Guidelines

Providers are required to bill ongoing monitoring and service coordination only once per month. *On individual DOS (dates of service)*, case managers may either record their actual time (e.g., 3 minutes, 45 minutes) or accumulate the time spent on case management services on that day and round the time using the rounding guidelines for case management services.

On a monthly basis, case managers are required to add up the time for the individual DOS. If actual time was recorded on individual DOS, round the accumulated time at the end of the month using the rounding guidelines for case management services.

Accumulated Time	Unit(s) Billed
1-5 minutes	0.3
6-10 minutes	0.7
11-15 minutes	1.0

For example, a case manager has billable contacts on three days during a month: a one hour and 15-minute meeting with a member (including travel and recording time), a five-minute telephone call with a collateral, and another 20-minute telephone call with a collateral.

If the case manager records actual time, these are accumulated at the end of the month to one hour and 40 minutes and billed to Wisconsin Medicaid as 6.7 units of service. If these are rounded on individual days (to 5.0 units, 0.3 units, and 1.3 units), they are accumulated at the end of the month and billed to Wisconsin Medicaid as 6.6 units of service.

Topic #643

Unlisted Procedure Codes

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

Before considering using an unlisted, or NOC (not otherwise classified), procedure code, a provider should determine if there is another more specific code that could be indicated to describe the procedure or service being performed/provided. If there is no more specific code available, the provider is required to submit the appropriate documentation, which could include a PA (prior authorization) request, to justify use of the unlisted procedure code and to describe the procedure or service rendered. Submitting the proper documentation, which could include a PA request, may result in more timely claims processing.

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

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

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

For most unlisted codes, ForwardHealth requires additional documentation.

Unlisted Codes That Require Prior Authorization

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

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

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

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

Unlisted Codes That Do Not Require Prior Authorization

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

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

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

How to Submit Claims and Related Documentation

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

- If submitting on paper using the 1500 Health Insurance Claim Form ((02/12)), the provider may do either of the following:
  - Include supporting information/description in Item Number 19 of the claim form.
  - Include supporting documentation on a separate paper attachment. This option should be used if Item Number 19 on the 1500 Health Insurance Claim Form does not allow enough space for the description or when billing multiple unlisted procedure codes. Providers should indicate "See Attachment" in Item Number 19 of the claim form and send the supporting documentation along with the claim form.
- If submitting electronically using DDE (Direct Data Entry) on the Portal, PES (Provider Electronic Solutions) software, or 837 (837 Health Care Claim) electronic transactions, the provider may do one of the following:
  - Include supporting documentation in the Notes field. The Notes field is limited to 80 characters.
  - Indicate that supporting documentation will be submitted separately on paper. This option should be used if the Notes field does not allow enough space for the description or when billing multiple unlisted procedure codes. Providers should indicate "See Attachment" in the Notes field of the electronic transaction and submit the supporting documentation on paper.
  - Upload claim attachments via the secure Provider area of the Portal.

Topic #830

Valid Codes Required on Claims

ForwardHealth requires that all codes indicated on claims and PA (prior authorization) requests, including diagnosis codes, revenue codes, HCPCS (Healthcare Common Procedure Coding System) codes, and CPT (Current Procedural Terminology) codes be valid codes. Claims received without valid diagnosis codes, revenue codes, and HCPCS or CPT codes will be denied; PA requests received without valid codes will be returned to the provider. Providers should refer to current national coding and billing manuals for information on valid code sets.

Code Validity

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

Code Specificity for Diagnosis

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

Comprehensive Care Coordination Benefit for Members with HIV or AIDS

Topic #14177

An Overview of HIV/AIDS Care Coordination Benefit

The comprehensive care coordination benefit for members diagnosed with HIV (Human Immunodeficiency Virus) infection or AIDS (Acquired Immune Deficiency Syndrome) was created by 2009 Wisconsin Act 221. It is available to eligible members who are enrolled in BadgerCare Plus or Wisconsin Medicaid.

Providers who render services under the benefit are located in Milwaukee, Kenosha, Dane, and Brown counties once the DHS (Wisconsin Department of Health Services) determines that a provider meets the requirements outlined in Qualifying Providers. Services are **not** restricted based on a member's county of residence.

Use of Health Home Model

The care coordination benefit for members diagnosed with HIV infection or AIDS is established using a patient-centered health home model as described under s. 1945 of the Social Security Act. Health homes provide comprehensive care coordination for individuals with chronic conditions. Health home providers coordinate care across all health care settings, including medical, behavioral, dental, pharmaceutical, and institutional. They also coordinate care between health and community care settings.

Covered health home services for members diagnosed with HIV infection or AIDS include all of the following:

- Comprehensive care management.
- Care coordination, monitoring, and follow-up.
- Health promotion and self-care.
- Comprehensive transitional care.
- Member and family support (including authorized representatives).
- Referral to community and social support services, as appropriate.

Topic #14357

Claims Submission

Procedure Codes

Health home providers are required to use the following HCPCS (Healthcare Common Procedure Coding System) procedure codes when submitting professional claims for reimbursement under the HIV (Human Immunodeficiency Virus)/AIDS (Acquired Immune Deficiency Syndrome) care coordination benefit:

Procedure Codes for HIV/AIDS Care Coordination Services		
HCPCS Code	**Description**	**Use**

S0280	Medical home program, comprehensive care coordination and planning, initial plan	This code must be used when billing for activities related to the initial assessment, care plan development, and comprehensive annual reassessments.
S0281	Medical home program, comprehensive care coordination and planning, maintenance of plan	This code must be used when billing for activities related to ongoing care coordination.

Medicaid reimbursement amounts for HIV/AIDS care coordination services can be found in the Health Home for Individuals with HIV/AIDS maximum allowable fee schedule.

To receive reimbursement, providers are required to submit HIV/AIDS care coordination services on a professional claim: an 837P (837 Health Care Claim: Professional) transaction or a 1500 Health Insurance Claim Form ((02/12)).

Copayment

Health home services are not subject to copayment; however, members are still responsible for applicable cost sharing for other Medicaid and BadgerCare Plus services they receive.

Diagnosis Codes

Claims submitted for reimbursement under the HIV/AIDS care coordination benefit must include a primary diagnosis code related to HIV infection.

All diagnosis codes indicated on claims must be the most specific ICD (International Classification of Diseases) diagnosis code. Providers are responsible for keeping current with diagnosis code changes. Etiology and manifestation codes may not be used as a primary diagnosis.

Dates of Service

Health home providers should adhere to the following guidelines when determining the DOS (date of service) to indicate on the professional claim:

- For activities related to the initial assessment, care plan development, and annual reassessments (indicated by HCPCS procedure code S0280), if the service was performed on more than one DOS, indicate the last DOS on the claim form.
- For activities related to ongoing care coordination (indicated by HCPCS procedure code S0281), if the service was performed on more than one DOS within the month, indicate the last date the service was performed in each month as the DOS on the claim form.

Place of Service Codes

Providers should use a valid two-digit POS (place of service) code to indicate the setting in which services were provided. If services occurred in multiple settings, providers should indicate POS code 99 (Other Place of Service) on the claim.

Note: The actual POS must be indicated when documenting health home activities.

Topic #14178

Core Team of Health Care Professionals

Health home providers are required to identify a core team of health care professionals for each member that includes professionals who are experienced in the care and treatment of individuals diagnosed with HIV (Human Immunodeficiency Virus) infection or AIDS (Acquired Immune Deficiency Syndrome). The member's primary health care provider (physician, physician assistant, or nurse practitioner) is *required* to be a part of the core team.

Core Team Requirements

At a minimum, the core team must also include the following professionals:

- An RN (registered nurse).
- A social worker or nurse case manager.
- A mental health or substance abuse professional.
- A dentist.
- A pharmacist.

The core team is central to the initial comprehensive assessment, annual reassessments, and the development of the care plan. The team should include other professionals as dictated by the member's health status and social and personal situation.

Designation of Team Lead and Care Coordinator

From the group of core team members, health home providers are required to designate a team lead and a care coordinator. The role of the team lead includes, but is not limited to, the following:

- Ensuring that the member's care and treatment needs are addressed using a multidisciplinary team approach. This includes identifying individuals the member deems central to addressing his or her health care and social services needs.
- Ensuring that the member is at the center of the team and is identified as an active and informed participant in his or her own care.
- Ensuring that the member and providers on the team know each other.
- Ensuring that the role and responsibility of each person on the team is defined for the member.
- Ensuring that there is communication, consultation, and coordination among individuals on the team. For example, the team lead is required to ensure that team members share information regarding the member's care, treatment, medications prescribed, and recommended self-care.
- Ensuring that each member has an identified care coordinator.

The team lead and the care coordinator can be the same individual.

The responsibilities of the care coordinator are outlined under "Care Coordination, Monitoring, and Follow-up" in Covered Health Home Services.

Topic #14197

Covered Health Home Services

Health home services for members diagnosed with HIV (Human Immunodeficiency Virus) infection or AIDS (Acquired Immune Deficiency Syndrome) are comprehensive and, at a minimum, include all of the activities outlined below. These activities must be provided using a "whole person" approach and within a culture of continuous quality improvement. Health home services must also be provided in accordance with national and state best practices for person-centered health home services.

Comprehensive Care Management

Comprehensive care management involves the use of evidence-based guidelines to provide systematic, responsive, and

coordinated management of all aspects of primary and specialty care (physical and behavioral) for members diagnosed with HIV infection or AIDS. The responsibilities of health home providers for comprehensive care management include, but are not limited to, the following:

- Early identification of members who meet the eligibility criteria.
- The identification of a core team of health care professionals, including a team lead and care coordinator, involved in each member's care.
- The identification of individuals involved in the member's support network, including the member's authorized representative.
- An initial comprehensive assessment of each member's strengths and needs, the development of a care plan, annual reassessments, and ongoing care coordination, monitoring, referral, and follow-up.

Care Coordination, Monitoring, and Follow-up

Care coordination involves the ongoing management of a member's medical and community care needs. The designated care coordinator is responsible for the overall coordination of care. All care coordination, monitoring, and follow-up activities should be documented in the member's record.

The responsibilities of the care coordinator include, but are not limited to, the following:

- Ensuring that the member has a current, written, individualized POC (plan of care) that includes all aspects of the member's care. The care plan must be patient-centered and must:
    - Be multidisciplinary and be based on a comprehensive assessment of the member's health care needs, including personal support and personal care needs.
    - Identify everyone involved in the development of the care plan.
    - Specifically identify the member's primary health care provider, the team lead, and the care coordinator.
    - Identify the member's care and treatment goals.
    - Indicate the frequency and methods of member contacts. The health home provider should consider the member's health status, interventions, and care and treatment goals in determining the frequency of contacts.
    - Indicate the frequency and methods of communication among the health care professionals on the team.
    - Address coordination of treatment approaches among the multidisciplinary team, including how differences in treatment directions to the member will be resolved.
    - Address team access and updates to the care plan, including timeliness and accuracy of updates.

- Ensuring that the member has an identified primary care physician.
- Ensuring that the member's primary care physician is an integral part of the core team.
- Ensuring that the member, legal guardian, or other designated support person is actively involved in the development of the treatment plan and ongoing care.
- Identifying all services the member is receiving, including pertinent psychosocial services. To the extent appropriate, this should include coordinating with the member's family and other community-based service providers to ensure that identified non-medical needs are addressed (e.g., housing, transportation, and nutrition).
- Ensuring that health care is coordinated across all medical subspecialties, home care providers, hospitals, and other health care facilities.
- Ensuring that eligible members receive depression and substance abuse screenings and intervention (i.e., SBIRT (Screening, Brief Intervention, and Referral to Treatment)). These screenings must be carried out using an evidence-based screening tool administered by staff with the appropriate education and training.
- Ensuring timely follow-up regarding care concerns, including missed appointments, health care referrals, hospital discharges, emergency room visits, and lack of treatment adherence.
- Obtaining ongoing feedback from each member regarding his or her satisfaction with the assistance and support received from the health home.
- Ensuring that members have timely access to their primary health care provider and to other participants of the core team.
- Ensuring that members have 24-hour access seven days a week to the health home provider and are informed of how to access care and support. Health home providers may designate a staff person or an on-call provider, or they may identify

other means of ensuring timely access.
- Verifying that members are aware of clinic hours and referral sources.
- Verifying members' contact information and preferred methods of contact.

Health Promotion and Self-Care

Health promotion and self-care involve assisting members in better understanding their disease and participating in directing the care and treatment they receive. A member's care plan should include health promotion and self-care activities. The responsibilities of health home providers for health promotion and self-care include, but are not limited to, the following:

- Risk assessments and referral to counseling, as appropriate (e.g., for smoking, diet, mental health, or drug use).
- Monitoring of medication adherence and referral to counseling, as appropriate.
- Ongoing HIV disease and self-management education.
- Chronic disease management education, as appropriate.
- Active promotion of member self-management through education, motivational interviewing, modeling, mentoring, and monitoring (both in clinic and home settings, as appropriate). Self-management should also be promoted through access and/or referral to support groups and through family/caregiver engagement in care. Members should be adequately trained and encouraged to gradually take over many of the activities performed by the medical home team in terms of care coordination.
- HIV risk reduction education and counseling, and continuous active referral to the Wisconsin HIV Partner Services program.
- Education about proper nutrition and referral to a nutritionist or dietitian, if appropriate.
- Ongoing education on stress management.
- Active involvement in providing risk-reduction counseling, promoting self-care activities, and addressing self-esteem issues.
- Tracking of member progress towards self-management over time.
- Ongoing mental health services, as needed.

Comprehensive Transitional Care

Comprehensive transitional care involves the establishment of an automatic referral arrangement between local institutional care providers and the health home provider to ensure that health home members who are admitted to the institution or are seen in the emergency room are immediately referred to the health home.

The automatic referral arrangement should include the establishment of policies and procedures to ensure that there is systematic and timely sharing of information related to the member's institutional or emergency room care.

To the extent possible, the referral arrangement between the health home provider and institutional care provider should include an agreement for immediate direct contact between the institution and a health home representative. (Direct contact between the institutional provider and the health home provider will improve communication and coordination across these settings, which in turn should improve the member's transition back to community care.)

The responsibilities of health home providers for comprehensive transitional care include, but are not limited to, the following:

- Responding to referrals by contacting the institution or member within 24 hours and collaborating with the following individuals, as appropriate:
    - The member's primary care physician.
    - The institutional discharge planner.
    - The pharmacist.
    - The home care team.
    - The member.

- Reviewing the discharge summary with the member and assisting him or her in following through on written orders.

- Ensuring that the member has a comprehensive transitional care plan that addresses the following:
  - An immediate appointment with the member's primary health care provider.
  - Education on self-care.
  - Adherence to medication schedules.
  - Identification of symptoms to monitor.
  - A plan to address unnecessary or inappropriate use of emergency rooms, including education to help the member understand the difference between the need for urgent care and the need for emergency care.
  - Scheduled home visits and contacts with the member and caregivers.

- Making face-to-face or telephone contact with the member (or the member's authorized representative) within 24 hours of an emergency room visit or a hospital or nursing home discharge.
- Updating the member's comprehensive care plan to reflect the transitional care and follow-up. This includes documenting all transitional care activities.

Member and Family Support (Including Authorized Representatives)

Member and family support services involve advocating on the member's behalf. Member and family support services include imparting information in a manner that is simple, clear, straightforward, and culturally appropriate. The member's record should include documentation of these activities.

The responsibilities of health home providers for member and family support services include, but are not limited to, the following:

- Mobilizing services and support for the member.
- Periodically observing and monitoring the delivery of services and support to the member.
- Providing timely supportive contacts with the member or authorized representative to ensure that the member is receiving the services specified in the care plan. Supportive contacts include contacts made to ensure that there are no new gaps or barriers to receiving the services specified in the care plan.
- Assisting the member in communicating effectively with his or her health care and community services providers.
- Following up with the member or authorized representative to ensure that identified health care services are adequately meeting the member's needs. These contacts should be made within two weeks of receipt of the identified service.
- Checking with the member or authorized representative regarding the member's participation in and satisfaction with identified community and home care services.
- Adjusting the care plan as needed to reflect new information based on direct observation or on feedback from the member (or authorized representative) or his or her family support.

Referral to Community and Social Support Services

Health home providers are required to ensure that members have access to the community and social support services identified in the care plan by identifying and, if necessary, establishing meaningful working relationships with critical community resources. These resources include, but are not limited to, the following:

- Housing assistance/rent subsidy programs.
- Personal care services.
- Transportation services.
- Meal programs/food pantry.
- Legal services.
- Faith-based services.
- Health-related support groups.
- Child care assistance/day care programs.
- Interpreter services.
- Budgeting/financial workshops.
- Violence intervention programs.

- Anger management.
- Grief counseling.
- Fitness activities.

Health home providers are required to make referrals to community and social support services, as appropriate (to the extent possible, referrals must be in written form). Referrals must include any steps necessary to ensure that the member is able to access the service to which he or she is referred. For example:

- Assisting the member in identifying free or low-cost options for needed services.
- Informing the member if there is a charge for the service.
- Assisting the member in making transportation arrangements.
- Asking if the member needs a reminder call.
- Working directly with the referral agency, if appropriate.

The care coordinator is required to follow up on all referrals to determine the outcome and to identify instances in which additional referrals or follow-up are needed. Follow-up on referrals must occur no later than two weeks after the referral is given. All referrals, outcomes, and actions taken (including additional referrals and follow-up) should be documented in the member's record.

Topic #14217

Limitations

Ongoing care management is limited to one claim per member per month. Reimbursement for comprehensive assessments is limited to one claim every 365 days. Case management and medication therapy management are not separately reimbursed.

Topic #14257

Member Contacts

Health home providers are required to meet the following minimum requirements for frequency of member contacts:

- Review the care plan at least once every six months.
- Make a face-to-face contact with the member at least once every three months.
- Make at least one contact with the member, or with a collateral, at least monthly. A collateral is anyone involved in the member's care or in mobilizing services and support on the member's behalf. Collaterals could include health care providers, community advocates, social services providers, family members, or friends.

The member's record should include documentation that these contacts were made or provide rationale for contacts that are less frequent. The health home provider is required to make at least five attempts, using different means of communication, before indicating that a member is "loss to follow-up."

Health home providers are required to notify the member prior to reducing or terminating contacts. A decision to reduce or terminate health home services should be mutually agreed upon by the provider and the member.

Providers may be required to report on members lost to follow-up and members who refuse continued care.

Topic #14237

Member Eligibility

Members Eligible for HIV/AIDS Care Coordination Benefit

Members eligible for the HIV (Human Immunodeficiency Virus)/AIDS (Acquired Immune Deficiency Syndrome) care coordination benefit are those members enrolled in BadgerCare Plus or Wisconsin Medicaid who have a diagnosis of HIV infection and who meet one of the following two criteria:

1. Are infected with HIV and have at least one other chronic condition. Chronic conditions include, but are not limited to, the following:
    - Mental health conditions.
    - Substance use disorders.
    - Asthma.
    - Diabetes.
    - Heart disease.
    - Being overweight (having a BMI (body mass index) greater than 25 kg/m2).
2. Are infected with HIV and are at risk of having a second chronic condition. Members "at risk" for developing a second chronic condition include:
    - Members having a CD4 (T-cell) count of less than 200 cells/uL or CD4 cells accounting for fewer than 14 percent of all lymphocytes.
    - Members with a BMI less than 18.5 kg/m2.
    - Members whose fasting plasma blood sugar is 100-125 mg/dL or hemoglobin A1c 5.7 percent to 6.4 percent.
    - Members with systolic pressure between 120 and 139 mm Hg or diastolic pressure between 80 and 89 mm Hg.
    - Members with hyperlipidemia:
        - Total cholesterol greater than 200 mg/dL.
        - HDL (High-density lipoprotein) levels below 40 mg/dL for men and below 50 mg/dL for women.
        - LDL (Low-density lipoprotein) levels above 130 mg/dL.

Health home providers are required to retain documentation showing both of the following:

- The member's eligibility for health home services.
- That the member requires comprehensive care management services to attain or maintain stability and optimal health status. This includes care coordination to prevent progression of the disease, deterioration, or gaps in care.

Note: For the purposes of this benefit, a chronic condition is defined as one that has lasted at least six months, can reasonably be expected to continue for six months, or is likely to recur.

Members Not Eligible

Coverage for coordinated care under the HIV/AIDS care coordination benefit is *not* available to any member who is:

- Receiving targeted case management services.
- Receiving prenatal care coordination services.
- Residing in an institution, unless the care is provided within 30 days from the date of discharge.

Topic #14258

Member Freedom of Choice

Health home providers may automatically enroll any member meeting the eligibilty criteria; however, providers are required to explicitly inform members, in writing and verbally, that their participation in the health home is voluntary and that they have the right to "opt out" at any time.

Health home providers are required to assist members in making an informed decision regarding continued participation in the health home. If a member is receiving targeted case management or prenatal care coordination services, the health home provider is required to specifically notify the member that he or she will need to make a choice between those services and health home services. Members agree to health home services by actively participating in the development and execution of the care plan and by maintaining contact with the health home.

Health home providers may not "lock in" a member or deny a member's freedom to choose his or her providers of care. Coverage of other Medicaid and BadgerCare Plus services is determined by the individual service policies.

Members must be allowed to participate, to the full extent of their ability, in all decisions regarding appropriate services and providers. A member may designate an authorized representative to help make decisions on his or her behalf.

A member's participation in the process must be specifically documented. The documentation should include, but should not be limited to, the following:

- Documentation regarding notice to the member of his or her right to "opt out" and his or her freedom to choose service providers.
- Documentation of the member's acceptance of the responsibility to participate in the care program and maintain contact with the health home.

Topic #14277

Member Outreach and Communication

Health home providers are responsible for member outreach and communication. Outreach and communication efforts include, but are not limited to, the following:

- Identifying potential eligible members.
- Educating members regarding the enrollment process and freedom of choice. Freedom of choice includes allowing the member to decide between receiving health home services or other case management/care coordination services.
- Contacting enrolled members to explain the patient-centered health home model of care. Communication with the member should be made in language that is clear, straightforward, and culturally appropriate.
- Explaining the patient-centered health home model to other health care providers and the community, as appropriate.

Note: There is no separate reimbursement for outreach and communication activities.

Topic #14377

Noncovered Services

The following services are *not* covered under the health home benefit:

- Direct services. Health home services do not include direct health care (medical, dental, behavioral) provided to members. Members receive these services separately. Providers should separately bill for direct services according to the Medicaid or BadgerCare Plus requirements for the service (if covered by Medicaid or BadgerCare Plus).
- Travel time or other overhead costs incurred as part of coordinating care for the member.
- Translation services or any other social or supportive services, including transportation services.

Topic #14297

Program Evaluation and Data Reporting

Reporting Requirements

Federal laws governing the provision of health home services include a requirement that states must report to the CMS (Centers for Medicare and Medicaid Services) on the "nature, extent, and use of the health home model of service delivery." In particular, states are required to report on the following:

- Hospital admission rates.
- Chronic disease management.
- Coordination of care.
- The state's assessment of program implementation.
- Processes and lessons learned.
- Assessment of quality improvements and clinical outcomes.
- Estimates of cost savings.

To comply with the evaluation and data reporting requirements, ForwardHealth may require that health home providers collect and report certain information to ForwardHealth. To the extent possible, ForwardHealth will use its own paid claims data for reporting and will only rely on providers for data not available through the claims system or through public health surveillance data. Providers are required to respond to data requests as a condition of continued participation as a designated health home for members with HIV (Human Immunodeficiency Virus) or AIDS (Acquired Immune Deficiency Syndrome).

Member Satisfaction Surveys

Health home providers are required to conduct annual member satisfaction surveys. The purpose of the surveys is to obtain feedback from each member regarding his or her satisfaction with the assistance and support received from the health home. The areas to be assessed include, but are not limited to, the following:

- Timeliness of and access to care.
- The level of the member's involvement in the POC (plan of care).
- The level and method of communication from the member's core team (i.e., whether or not the member was able to get needed information).
- The team's recognition and consideration of the member's life circumstances (e.g., home environment, level of strength or frailty, personal support, ability to manage own care).
- The information the member received related to health promotion and self-care.

Providers may be required to periodically share the survey and the survey results with the Wisconsin DHS (Department of Health Services). Health home providers are required to document any action taken to improve services or the approach to care based on feedback received from members.

Quality Measures

Under federal health home laws, states are required to identify and report on certain quality indicators for services provided to members enrolled in the health home. ForwardHealth will identify quality indicators to address clinical outcome, experience of care, and quality of care for each of the covered health home service areas below:

- Comprehensive care management.
- Care coordination and health promotion.
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up care.
- Member and family support, which includes authorized representatives.
- Referral to community and social support services.

- Use of information technology to link services, as feasible and appropriate.

To the extent possible, ForwardHealth will use its own paid claims data for the quality measures. Providers may be required to submit additional outcome data from the member's medical record. Depending on the final measures, the additional data could include members with at least one paid claim. Providers are required to respond to data requests as a condition of continued health home participation.

Topic #14318

Program Monitoring, Review, and Audit

The DHS (Department of Health Services) conducts regular site visits for the purposes of program monitoring, review, and audit. The DHS may use information obtained from site visits to respond to federal reporting requirements, particularly in regard to "processes and lessons learned" and the "assessment of program implementation."

Topic #14319

Qualifying Providers

Providers qualified to offer the HIV (Human Immunodeficiency Virus)/AIDS (Acquired Immune Deficiency Syndrome) care coordination benefit are Medicaid-enrolled targeted case management providers funded by the DHS (Department of Health Services) under s. 252.12(2)(a)8, Wis. Stats., for purposes of providing life care services to members diagnosed with HIV infection.

Qualified providers in the selected counties are required to submit written proof that they meet the requirements outlined under "Health Home Provider Requirements" below if they would like to offer these services to members. The DHS will then evaluate and make a determination as to whether the provider meets these requirements.

Note: Medicaid-enrolled providers who offer this benefit are required to meet all other Medicaid or BadgerCare Plus program requirements.

Health Home Provider Requirements

Under the HIV/AIDS care coordination benefit, qualifying health home providers are subject to a number of system, documentation, and quality assurance requirements. To meet these requirements, health home providers are required to meet all three of the following criteria:

1. Be located in a setting that integrates medical, behavioral health, pharmaceutical, oral health, and psychosocial care.
2. Be accredited by a nationally recognized accreditation program as a patient-centered health home, or meet the requirements detailed below:
    - Have systems and infrastructure in place to provide comprehensive health home services to members diagnosed with HIV infection or AIDS.
    - Provide written support, from the highest level of the provider organization, for coordinated care through the use of a health home model.
    - Meet all of the qualification standards outlined below:
        - Adopt written standards, based on best practices, for member access and member communication.
        - Use data to show that standards for member access and member communication are being met.
        - Use electronic charting tools to organize clinical information.
        - Use data to identify diagnoses and conditions among individual providers' patients that have a lasting detrimental effect on health.
        - Adopt and implement guidelines that are based on evidence for treating and managing HIV- and AIDS-

related conditions.
- Actively support and promote member self-management.
- Systematically track member test results, and have a systematic way to identify abnormal member test results.
- Establish procedures to systematically accept referrals from hospitals (inpatient and outpatient) that treat individuals diagnosed with HIV infection or AIDS.
- Systematically track referrals using an electronic system.
- Measure the quality of the performance of individual providers, and of individuals who perform services on behalf of these providers. This includes measuring the provision of clinical services, member outcomes, and member safety.
- Report on the quality of the performance of individual providers, and of individuals who perform services on behalf of these providers. These reports should be made to employees and contractors of the provider, as well as other persons, as appropriate.

3. Agree to the following practices in providing services:
    - Provide quality-driven, cost-effective, culturally appropriate, and patient- and family-centered health home services.
    - Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines.
    - Coordinate and provide access to preventive and health promotion services, including services to help prevent mental illness and substance use disorders.
    - Coordinate and provide access to medication management and mental health and substance abuse services.
    - Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care.
    - Coordinate and provide access to chronic disease management, including self-management support to members and their families.
    - Coordinate and provide access to member and family supports, including referral to community, social support, and recovery services.
    - Coordinate and provide access to long-term care supports and services.
    - Develop a patient-centered care plan for each member that coordinates and integrates all of his or her clinical and non-clinical health-care-related needs and services.
    - Use health information technology, as feasible and appropriate, to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to providers.
    - Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management. (*Note:* The DHS will identify specific quality indicators and specific outcomes to be measured in a separate communication to the provider.)

Topic #14337

Reimbursement

Initial Assessment, Care Plan Development, and Annual Reassessments

Health home providers receive a flat fee for each eligible member for the initial comprehensive assessment of needs, development of the integrated care plan, and annual reassessments.

The initial assessment, care plan development, and annual reassessments are reimbursable only for members who meet the eligibility criteria and who agree to participate in the health home. Members agree to participate by actively engaging in the initial assessment, care plan development, and annual reassessments.

Reimbursement for the initial assessment, care plan development, and annual reassessments is on a fee-for-service basis and is limited to the lesser of the amount billed or the established maximum fee. The reimbursement is the same regardless of the amount of time involved or the number of individuals participating.

ForwardHealth will recoup the reimbursement provided for the initial assessment, care plan development, and annual reassessments if the provider's documentation does not support the member's eligibility for health home services, or if the assessments or care plan are not multidisciplinary, as required for this benefit.

Ongoing Care Management

Health home providers are reimbursed one care management fee per eligible member per month. A participant of the member's core team must engage in at least one care management activity during the month for which the provider is billing. This fee is reimbursable only for eligible health home members who have gone through the assessment and care plan development process and who have an assigned care coordinator. All care management activities must be identified in the member's care plan. Care management activities do not include the direct provision of services.

Reimbursement for all care management services is on a fee-for-service basis and is limited to the lesser of the amount billed or the established maximum fee. The reimbursement is the same regardless of the frequency or intensity of care management activities provided within the month. The monthly care management fee includes activities related to medication therapy management.

Care management services are billed following the last DOS (date of service) in the billable month, which means the last day on which there was care management activity in the month.

ForwardHealth will recoup the monthly care management fee for months in which there is no documentation of at least one care management activity involving a participant of the core team.

Billing the Usual and Customary Charge

Health home providers are required to bill their usual and customary charge for services provided under the HIV (Human Immunodeficiency Virus)/AIDS (Acquired Immune Deficiency Syndrome) care coordination benefit. Reimbursement is the lesser of the usual and customary charge or the Medicaid maximum established fee for the service.

Covered Services and Requirements

Topic #1691

A Comprehensive Overview

Per DHS 107.32(1)(a)1, Wis. Admin. Code, case management services assist members and, when appropriate, their families *gain access to and coordinate* a full array of services, including medical, social, educational, vocational, and other services. These case management services include all of the following:

- Assessment [DHS 107.32(1)(b), Wis. Admin. Code].
- Case plan development [DHS 107.32(1)(c), Wis. Admin. Code].
- Ongoing monitoring and service coordination [DHS 107.32(1)(d), Wis. Admin. Code].

Case Management and Non-Medicaid Services

Case management includes gaining access to or coordinating Medicaid or BadgerCare Plus services or non-Medicaid or BadgerCare Plus services. Examples of gaining access to or coordinating non-Medicaid or BadgerCare Plus services include, but are not limited to, the following:

- Assisting members in accessing energy assistance.
- Assisting members in accessing housing.
- Assisting members in accessing legal advocacy.
- Assisting members in accessing social services.
- Setting up a volunteer/supportive home care worker to take a members shopping.

Case Management Does Not Include Service Provision

Service provision as part of the case management benefit is not covered. The following are examples of activities *not* covered as case management services. (Some of these activities may be covered under another benefit. For example, some skill training may be covered under the CSP (Community Support Program) benefit.) Activities not covered as case management services include, but are not limited to, the following:

- Medication set-up.
- Money management.
- Skill training.
- Taking a client shopping.
- Transporting clients.

Topic #1690

Birth to 3 Service Coordination

Activities of the service coordinator and other personnel who provide case management services are covered when the Birth to 3 Program is enrolled as a case management provider (or is part of a county department that is a Medicaid-enrolled program).

Providers are required to comply with Medicaid requirements (DHS 101-108, Wis. Admin. Code, and this service area of the Online Handbook) and Birth to 3 early intervention services rules (DHS 90, Wis. Admin. Code) when billing for case

management services provided under the Birth to 3 Program. These documents describe the covered services and requirements needed to bill for these services.

The following highlights case management policies about member enrollment, provider qualifications, and covered services.

Examples of Billable Case Management Activities and Related Limitations

1. Billable case management services are limited to members enrolled in BadgerCare Plus or Wisconsin Medicaid who meet one of the target group definitions listed in this service area of the Online Handbook. All children enrolled in the Birth to 3 Program are eligible for case management.
2. Providers may submit claims to ForwardHealth for the following case management activities when performed by the service coordinator (the provider is required also to meet the qualifications under DHS 105.51(2)(b) and DHS 90.11(1)(c), Wis. Admin. Code):
    - The activities of the service coordinator when arranging for an eligible child's evaluation and assessment (DHS 90, Wis. Admin. Code).
    - Developing, writing, monitoring, and evaluating the written IFSP (Individualized Family Service Plan).
    - Providing service coordination activities.
3. The time of providers qualified to provide early intervention services, as defined by DHS 90, Wis. Admin. Code, who participate in assessments, IFSP development, or annual review of the IFSP is billable if the enrolled case management provider pays for the provider's time involved and it is not billable as another service.
4. When compiling an eligible child's medical history, the case manager should request any dental history information and note this as a part of the review of the child's medical and health records.
5. The case plan must list goals, outcomes, and specific services that are directly related to the member's unmet needs or gaps in services identified in the assessment. The Birth to 3 Program meets all the requirements for case plan development if the program follows the procedures specified in DHS 90 and DHS 101-108, Wis. Admin. Code, and ForwardHealth publications, and records the required information in the IFSP and/or the child's early intervention record.
6. A complete assessment and case plan must predate any billed ongoing monitoring and service coordination, except in urgent situations. In urgent situations, complete the assessment and case plan within 30 days of initiating service coordination.
7. Providers may submit claims for record keeping time if it is noted in the early intervention record and there was contact with the family (collateral) or child (member) during the billable month.
8. Providers may submit claims for the service coordination time spent assisting the family locate and access services identified in the IFSP as ongoing service coordination if:
    - The other services relate to supporting the child's needs.
    - The other services relate to supporting the member's family needs to enable the member to gain access to necessary services identified in the IFSP (e.g., coordination with medical services, locating a specialized day care or respite services).

Topic #1675

Case Management Requirements

The following requirements apply to the case management benefit:

1. Ongoing monitoring and service coordination is not covered for members residing in hospitals, intermediate care, or skilled nursing facilities. These facilities are expected to provide these services as part of their reimbursement.
2. Ongoing monitoring services for members in home and community-based waiver programs is not covered after the first month of waiver eligibility. Under the case management benefit, ongoing monitoring during the first month of waiver eligibility is covered.
3. Institutional discharge planning is covered if:
    - The services do not duplicate the discharge planning services that the hospital, intermediate care, or nursing facility is

expected to provide as part of inpatient services.
    - The service is provided within the 30 days prior to discharge from the facility.
4. For members in Group A target populations, more than one assessment or case plan development per member, per calendar year are not covered, unless the member's county of residence changes. If the county of residence changes, a second assessment or case plan is covered for an enrolled case management agency in the new county of residence. More than two assessments or case plans per year for members in target populations A or B are not covered.
5. Although hour limits on ongoing monitoring are not established, ongoing monitoring can only be billed once for any given calendar month, unless the member's county of residence changes. If the member's county of residence changes, Wisconsin Medicaid may reimburse a second claim for ongoing monitoring to an enrolled case management agency in the new county of residence. Wisconsin Medicaid does not reimburse more than two providers for ongoing monitoring occurring in any month.
6. Wisconsin Medicaid does not reimburse the costs associated with ongoing monitoring and service coordination by more than one identifiable, individual case manager except in the case of a qualified, temporary replacement used when the designated case manager is unavailable due to illness, vacation, death, or client crisis.

Topic #44

Definition of Covered Services

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

Topic #1689

Frequently Asked Questions

ForwardHealth provides answers to some commonly asked questions about case management. The questions cover topics in these six areas:

- Billing split travel time.
- HealthCheck Outreach case management.
- Other service providers and case management.
- PNCC (prenatal care coordination) and case management.
- Targeted case management.
- Transportation services.

Common Questions About Medicaid Case Management

1. If I transport a recipient to case management services, is this covered as case management?

On occasion, case managers are expected to accompany recipients to services. The purpose is both to ensure that the service provider is aware of the overall case plan and to monitor the services the provider is delivering. If the case manager transports the recipient on these occasions, Wisconsin Medicaid covers this transportation under case management.

2. How do I bill split travel time when case management is not the only service provided?

When a case manager travels to a recipient's home and provides both case management and other services, the travel time must be prorated so that only the appropriate portion of travel is claimed as case management.

> For example, the case manager must travel one half-hour each way to a recipient's house and provide one half-hour of case management and one half-hour of assistance with personal tasks (which is not case management). Bill only half of the travel time (one half-hour) to case management.

Wisconsin Medicaid may cover the remainder of the travel time if both of the following apply:

- The other service is Medicaid covered.
- The policies for that service allow travel time to be separately reimbursable.

> For example, a provider travels one half-hour each way to a recipient's house. The provider provides one half-hour of case management and one and a half hours of in-home psychotherapy. Since travel time is billable with in-home psychotherapy, the provider should bill 15 minutes of the travel to case management and 45 minutes to in-home psychotherapy.

If the case manager travels to a location, such as a group home, where he or she sees more than one recipient, the case management time should be allocated on a prorated basis to the different recipients.

> For example, the case manager must travel one half-hour each way to see two recipients at one site. One half-hour of travel should be billed on behalf of each recipient.

3. Let's say I travel to a recipient's residence, but I don't make contact with the recipient. Does Wisconsin Medicaid cover travel time if there is no billable service?

No. If a case manager travels to see a recipient or collateral, but does not actually make a contact (because the person was not home or available), Wisconsin Medicaid does not cover that travel time. Travel time is only covered when it is provided as a part of a covered service. Since no service took place, the travel time is not covered.

4. I'm a service provider, but not a case management provider. Can I become a case management provider?

Yes. Wisconsin Medicaid does not prohibit providers of other services (whether Medicaid covered or not) from being case managers. For instance, staff of a day treatment program or a sheltered workshop may be case managers. However, the case manager must not bill services which are associated with his/her role as a service provider as Medicaid case management.

> For example, a provider of in-home treatment for a child with severe emotional disturbance is also providing case management. As the child's case manager, the provider completes the comprehensive case management assessment and also convenes an interagency team to complete the case plan. Wisconsin Medicaid covers these activities under case management. In-home treatment is one of the services identified on the case plan. The in-home team develops a treatment plan for the in-home services. Wisconsin Medicaid does not cover this treatment plan's development under case management.
>
> Similarly, Wisconsin Medicaid does not cover the documentation of the in-home treatment as case management. This documentation is considered part of the in-home service. Only documentation of the case management activities in support of the case management case plan are covered as case management documentation time.

If case management is a component of the other services being provided and included in the Medicaid payment for that service, do not separately bill it under case management.

5. I have seen case management referred to as "targeted case management." Why?

Wisconsin Medicaid sometimes uses the term targeted case management to refer to the case management provided to certain populations as described in HFS 107.32, Wis. Admin. Code, and in this handbook. This is because case management is a covered service for *only certain target populations*.

6. What is HealthCheck Outreach case management?

Wisconsin Medicaid also reimburses certain agencies to ensure that HealthCheck-eligible recipients (individuals under 21 years of age) receive their HealthCheck screens according to the periodicity schedule and obtain referrals to services recommended because of the screen. This is referred to as HealthCheck Outreach and Case Management. If the same agency provides HealthCheck Outreach and case management and targeted case management, bill the service as targeted case management. Why? Ensuring access to HealthCheck screens and related necessary services is a component of targeted case management.

7. If HealthCheck Outreach and case management are provided by a different agency from the agency providing targeted case management, who does Wisconsin Medicaid pay?

Wisconsin Medicaid covers services by both agencies for their activities only if the activities are not duplicative. The targeted case manager must ensure that the activities are coordinated. The purpose of HealthCheck Outreach and Case Management is to get the child screened and make referrals based on the screening. Targeted case management coordinates a broader array of services identified in the child's case plan.

8. What is Prenatal Care Coordination (PNCC)? Who is eligible for PNCC?

Women who are pregnant with a high risk of an adverse birth outcome are eligible for Medicaid PNCC services. The PNCC agency is responsible for ensuring that the woman gets necessary prenatal care and also addressing other issues which might put the woman at risk (e.g., substance abuse, domestic abuse).

9. How do PNCC and targeted case management work together?

Wisconsin Medicaid reimburses both the PNCC agency and the targeted case management agency for providing services to the same recipient at the same time if the services are not duplicative. Since PNCC is time limited (to 60 days after the birth), the targeted case manager must take responsibility for coordinating the two agencies' efforts to avoid duplication of effort. The targeted case manager and the PNCC case manager must decide, along with the recipient, which agency will provide what services.

For example, a woman with a significant history of substance abuse is admitted to a PNCC program because of the risk of an adverse birth outcome. The woman has a Medicaid case manager because of her substance abuse disorder. The "targeted" case manager has been working with the woman to help her find treatment and is also working on housing and nutrition needs.

After the woman's admission to the PNCC program, the targeted case manager revises the woman's case plan to identify her involvement with PNCC and the need to coordinate efforts with the PNCC agency. The targeted case manager meets with the PNCC staff and discusses their responsibilities with the recipient. The targeted case manager continues to work with the recipient on accessing substance abuse treatment and on housing issues. The PNCC agency works on accessing prenatal care, educating the recipient on perinatal health issues, and addressing nutrition needs.

Topic #1688

Institutional Discharge Planning

If the member enters an inpatient hospital, nursing facility, or ICF/IID (Intermediate Care Facility for Individuals with Intellectual Disabilities), case management is covered for up to 30 days prior to discharge from the institutional setting. Institutional discharge planning may not duplicate discharge planning services that the institution normally is expected to provide as part of inpatient services.

Expenditures are not allowed for services to an individual who is a resident of an IMD (institution for mental disease) unless either of the following is true:

- The person is under 21 years of age or over 64 years of age.
- The person was a resident of the IMD immediately before turning 21 years of age and has been a resident since turning 21.

However, case management services are covered for individuals on convalescent leave from an IMD.

An IMD is a hospital or nursing home primarily for the care and treatment of persons with a mental illness. A psychiatric unit of a general hospital is *not* an IMD.

Topic #1687

Local Health Department Coordination

The following information applies to local health departments providing case management services. It highlights the natural fit between public health nursing practice and case management requirements.

All Wisconsin local health departments are required to provide a general public health nursing program, as specified in s. 250.06 and s. 251.04(8), Wis. Stats. Every local health department requires a public health nurse. Public health nurses promote and protect the health of individuals, families, and the community using knowledge from nursing, social, and public health sciences. Health departments may vary in their resource capacity to directly provide case management services. However, it is important for other case management providers to understand the role and nature of preventive and therapeutic services provided by local health departments for the purposes of coordinating and assuring member access to health services.

Assessments

Case management assessments must include all required components, as identified in DHS 107.32(1)(b), Wis. Admin. Code, and in the Assessments and Case Plans chapter of the case management service area of the Online Handbook. If certain components are not applicable, e.g., no legal involvements, the provider must indicate this in the member's record.

The Wisconsin DSPS (Department of Safety and Professional Services) issues licenses to all qualified nurses in Wisconsin under ch. 441, Wis. Stats. In addition, the Wisconsin DHS (Department of Health Services) requires that any nurse who practices as a public health nurse in a local health department must meet the standards of the DHS as set forth in DHS 139, Wis. Admin. Code. The contemporary scope of public health nursing practice is defined in DHS 140.04(1)(a), Wis. Admin. Code. A public health nurse's practice is interdisciplinary and characterized by use of the nursing process, which is a systematic process for the following:

- Assessing actual and potential health needs generally consistent with the components identified in DHS 107.32(1)(b), Wis. Admin. Code, and in the Assessments and Case Plans chapter of this service area.
- Developing plans of care to meet actual and potential member needs.
- Carrying out or assuring effective, efficient, and equitable plans in collaboration with other health disciplines and service providers.
- Evaluating plans of care to determine results and benefits to the member.

Case Plans

The case plan requirements are outlined in DHS 107.32(1)(c), Wis. Admin. Code, and in the Assessments and Case Plans chapter of this service area. Public health case managers must identify *all formal services* arranged for the members, not just those provided through the local health department. It is important to identify who, beside the public health nurse, will provide services and when these services will be initiated.

Ongoing Monitoring and Service Coordination

Since public health case managers provide services to the member and family as well as conducting case management activities, *care must be taken not to submit claims for "direct" services as case management*. Case management includes those activities required to help a member and the member's family gain access to, coordinate, or monitor necessary medical, social,

educational, vocational, and other services. The following are *not* allowable as case management activities:

- Providing counseling on good health practices, parenting, nutrition, and self care.
- Providing education to the member and family about a disease, disease transmission, and the drug treatment.
- Administering tuberculosis tests or medication (including directly observed therapy).
- Providing other direct health care services.

Medicaid-covered case management activities include arranging for the member, or the family of the member enrolled in BadgerCare Plus or Wisconsin Medicaid, to receive any of the above services from another provider (as indicated in the case plan).

The following case management activities are allowed when included in the case plan:

1. Monitoring whether the services on the case plan are meeting the members' needs and modifying the plan as needed. This may include direct observation of the member receiving services from other providers.
2. Providing information and referral to community resources, as identified in the case plan.
3. Providing client-specific advocacy necessary to assist the member and the family in gaining access to services and resources identified on the case plan.
4. Having face-to-face, telephone, or written contacts with collaterals — including care providers, informal support persons, and others involved with the family — for the purpose of implementing the case plan and monitoring the member's response to services.
5. Holding client-specific staffings and formal case supervision.

Topic #84

Medical Necessity

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

Topic #86

Member Payment for Covered Services

Under state and federal laws, a Medicaid-enrolled provider may not collect payment from a member, or authorized person acting on behalf of the member, for covered services even if the services are covered but do not meet program requirements. Denial of a claim by ForwardHealth does not necessarily render a member liable. However, a covered service for which PA (prior authorization) was denied is treated as a noncovered service. (If a member chooses to receive an originally requested service instead of the service approved on a modified PA request, it is also treated as a noncovered service.) If a member requests a covered service for which PA was denied (or modified), the provider may collect payment from the member if certain conditions are met.

If a provider collects payment from a member, or an authorized person acting on behalf of the member, for a covered service, the provider may be subject to program sanctions including termination of Medicaid enrollment.

Topic #66

Program Requirements

For a covered service to meet program requirements, the service must be provided by a qualified Medicaid-enrolled provider to an enrolled member. In addition, the service must meet all applicable program requirements, including, but not limited to, medical necessity, PA (prior authorization), claims submission, prescription, and documentation requirements.

Topic #824

Services That Do Not Meet Program Requirements

As stated in DHS 107.02(2), Wis. Admin. Code, BadgerCare Plus and Wisconsin Medicaid may deny or recoup payment for covered services that fail to meet program requirements.

Examples of covered services that do not meet program requirements include the following:

- Services for which records or other documentation were not prepared or maintained.
- Services for which the provider fails to meet any or all of the requirements of DHS 106.03, Wis. Admin. Code, including, but not limited to, the requirements regarding timely submission of claims.
- Services that fail to comply with requirements or state and federal statutes, rules, and regulations.
- Services that the DHS (Department of Health Services), the PRO (Peer Review Organization) review process, or BadgerCare Plus determines to be inappropriate, in excess of accepted standards of reasonableness or less costly alternative services, or of excessive frequency or duration.
- Services provided by a provider who fails or refuses to meet and maintain any of the enrollment requirements under DHS 105, Wis. Admin. Code.
- Services provided by a provider who fails or refuses to provide access to records.
- Services provided inconsistent with an intermediate sanction or sanctions imposed by the DHS.

Noncovered Services

Topic #68

Definition of Noncovered Services

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

Topic #104

Member Payment for Noncovered Services

A provider may collect payment from a member for noncovered services if certain conditions are met.

Providers may not collect payment from a member, or authorized person acting on behalf of the member, for certain noncovered services or activities provided in connection with covered services, including the following:

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

Missed Appointments

The federal CMS (Centers for Medicare and Medicaid Services) does not allow state Medicaid programs to permit providers to collect payment from a member, or authorized person acting on behalf of the member, for a missed appointment.

Avoiding Missed Appointments

ForwardHealth offers the following suggestions to help avoid missed appointments:

- Remind members of upcoming appointments (by telephone or postcard) prior to scheduled appointments.
- If a member needs assistance in obtaining transportation to a medical appointment, encourage the member to call MTM, Inc. (Medical Transportation Management, Inc.) for NEMT (non-emergency medical transportation). Most Medicaid and BadgerCare Plus members may receive NEMT services through MTM, Inc. if they have no other way to receive a ride. Refer to the NEMT service area for more information.
- If the appointment is made through the HealthCheck screening or targeted case management programs, encourage the staff from those programs to ensure that the scheduled appointments are kept.

Translation Services

Translation services are considered part of the provider's overhead cost and are not separately reimbursable. Providers may not collect payment from a member, or authorized person acting on behalf of the member, for translation services.

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

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

Ongoing Monitoring and Service Coordination

Topic #1685

A Comprehensive Overview

According to DHS 107.32(1)(d), Wis. Admin. Code, ongoing case management services include the following:

1. Face-to-face and telephone contacts with members for the purpose of assessing or reassessing needs, or planning or monitoring services. This includes the case manager's travel time when providing the covered case management service.
2. Face-to-face and telephone contact with collaterals (anyone who has direct supportive contacts with the member) when mobilizing services and support, advocating on behalf of a specific member enrolled in BadgerCare Plus or Wisconsin Medicaid, educating collaterals on member needs and the goals and services specified in the plan, and evaluating and coordinating services specified in the plan. Collaterals include paid providers, family members, guardians, housemates, school representatives, friends, volunteers, and others involved with the member.

   Document all collateral contacts. This includes travel time incurred when providing the covered case management service. Collateral contacts include case management staff time spent on case-specific staffing and formal case consultation with the unit supervisor and other professionals regarding the needs of a specific member.

3. Record keeping as necessary for case planning, coordination, and service monitoring. Record keeping includes all of the following:
   - Entering notes about case activity into the member file.
   - Gathering data.
   - Preparing and responding to correspondence with member and collaterals.
   - Preparing application forms for supportive home care, COP (Community Options Program), CIP (community integration project)-IA, CIP-IB, family support, and other community-based care programs.
   - Preparing court reports.
   - Updating case plans.

Case managers must document all time spent on the above services in the case record. Wisconsin Medicaid does not reimburse for record keeping unless there was also a member or collateral face-to-face or telephone contact during the calendar month.

For ongoing monitoring and service coordination, the case manager does all of the following:

- Determines on an ongoing basis which services identified in the case plan have been or are being delivered.
- Determines if the services are adequate for the member's needs.
- Provides supportive contact to ensure that the member is able to access services, is actually receiving services, or is engaging in activities specified in the case plan.
- Monitors member and family satisfaction and participation.
- Identifies any change in the member's condition that would require an adjustment in the case plan.

This monitoring function may include independent monitoring for purposes of evaluating quality assurance.

For ongoing monitoring and service coordination, the case manager must:

- Monitor services to ensure that quality service is provided and to evaluate whether a particular service is effectively meeting the member's needs.
- Periodically observe the actual delivery of services.

- Periodically have the member evaluate the quality, relevance, and desirability of the services he or she is receiving.
- Record all monitoring and quality assurance activities and place the original records in the member's file.

Topic #1684

Case-Specific Staffing and Meetings

DHS 107.32(1)(d), Wis. Admin. Code, includes case-specific staffing and meetings with unit supervisors in the definition of collateral contacts when the member's issues are discussed. These activities under case management are covered even if no other collateral or member contacts occurred during the month. Staffing or supervision time that is not client-specific is not covered as a case management service.

Topic #1683

Children in Out-of-Home Placement

Covered case management services for children in out-of-home placement who are determined eligible for Title IV-E are limited to activities that relate to the assessment, case planning, and monitoring of medical care needs.

Medical care needs include all services that may be covered. Wisconsin Medicaid does not reimburse for case management activities that relate directly to the provision of foster care benefits and services. For example, Wisconsin Medicaid may reimburse case management activities related to finding a mental health provider, scheduling an appointment, and arranging for transportation to the appointment; however, case management activities related to making child placement arrangements or arranging for transportation to a new foster home would not be covered because they relate directly to the administration of the foster care program.

Wisconsin Medicaid will reimburse the state DCF (Department of Children and Families) for case management services provided to children in foster care who are determined to be ineligible for federal foster care payments. Providers should not submit case management claims for these children. Although these claims may be reimbursed initially, they would be subject to recoupment.

Topic #1682

Court-Related Service Coordination

Wisconsin Medicaid reimburses court-related service coordination with Medicaid case management in certain situations.

Members Become Court Involved in a Variety of Ways

Members receiving case management services may become involved with the court system in many ways:

- As a child in need of protective services.
- As an individual who requires guardianship and protective services.
- As an individual believed or found to require civil commitment to treatment services.
- As an individual who has been accused of, or found guilty of, a criminal offense or a juvenile alleged or adjudicated delinquent for an act that would be a crime if committed by an adult.

Covered Court-Related Services

The court's actions have an impact on the services available to the member. The court may order the member to receive certain

services. Wisconsin Medicaid reimburses case management activities related to the court system when they are necessary for one of the following reasons:

- Advise the court on the member's service needs.
- Coordinate the court orders with other requirements the member is obligated to meet.
- Assist the member in participating in the legal process and comply with the order of the court.

These activities may include the preparation of reports to the court, communication (face-to-face, telephone, or written) with court personnel, actual court appearances, and activities to ensure compliance with the court order.

Covered case management activities must be identified in the member's treatment plan, and the case manager must revise the treatment plan or indicate through notes in the member's record the reason for the court involvement and the activities required by the case manager as a result of the court involvement.

Limitations on Court-Related Services

Case management services for individuals in hospitals or nursing homes are not covered, except for the 30 days prior to discharge from the facility. Therefore, Wisconsin Medicaid does not reimburse any of these court-related activities (e.g., WATTS reviews) when a member is in one of these facilities, unless they are discharged within 30 days of the DOS (date of service) (the calendar date on which a specific service is performed).

Persons detained by legal process are not eligible for Medicaid or BadgerCare Plus services. Therefore, Wisconsin Medicaid does not reimburse any of these court-related services on days when an adult is in jail or a youth is in secure detention. Jailed individuals who have Huber work-release privileges are not eligible for services. *Exception:* Individuals who have Huber privileges to provide care for a family member in the home are eligible for services.

The case manager ensures that the court is aware of the member's treatment needs and available resources. Wisconsin Medicaid does not reimburse case management activities when case managers may be acting in the capacity of legal counsel or attorney.

Case Management Examples

The following are examples of case management activities covered when provided to members enrolled in Medicaid or BadgerCare Plus:

1. Reporting assessment findings that meet the criteria for comprehensive case management assessments. Examples of members who may be receiving court-related services include the following:
    - Children believed to be in need of protective services.
    - Individuals believed to be in need of guardianship services.

    This reporting could be a written report to the court or an actual court appearance.

2. Participating in dispositional/commitment hearings, when the case manager is required to do one of the following:
    - Advise the court on the services required by, and/or available to, the member.
    - Assist the member in understanding the court orders and participating in the dispositional process.
3. Preparing reports to the court periodically as required.
4. Providing activities necessary to recruit and retain a guardian or guardian ad litem for a member when the court orders a guardian.

The recruitment must be specific to members for whom the case management provider is claiming reimbursement. If one or more case managers meet with a group of potential guardians, or individuals who have agreed to be guardians, and there are two or more identified members for whom guardians are being recruited, the case manager's(s') time should be equally divided and billed on behalf of the different members. Recruitment activities include, but are not limited to, the following:

- Preparing informational literature for a guardian.
- Meetings with potential guardians, or individuals who have agreed to be guardians, to explain the position's roles and responsibilities.
- Providing ongoing assistance to the guardian so the guardian can fulfill the position's responsibilities. This may include educating the guardian on the member's service needs, the service system in general, and the condition or conditions leading to the member requiring guardianship. This also includes assisting the guardian in completing any required reports to the court.
- Activities necessary to recruit and retain payees when a payee is required by the SSA (Social Security Administration).

Allowable activities are those identified above for guardian recruitment and retention. The provision of payee services directly to the member as a case management service is not covered.

Topic #1681

Designated Case Manager

For the purposes of ongoing monitoring, the member must have a single, designated case manager. Ongoing monitoring on the member's behalf is covered if provided by the single, designated case manager only. However, if the designated case manager is unavailable due to illness, vacation, or client crisis, Wisconsin Medicaid reimburses the time spent by a qualified temporary replacement providing ongoing monitoring services on the member's behalf. The reason for the substitution must be documented in the member's record.

Persons in both Group A and Group B target populations are eligible for ongoing monitoring and service coordination (if they are enrolled in Medicaid or BadgerCare Plus on the DOS (date of service)), provided that all of the following apply:

- The member is eligible for and receiving services, in addition to case management, from an agency or through Wisconsin Medicaid or BadgerCare Plus that enables the member to live in a community setting.
- A case plan for this person is in the agency's files.
- The person is not receiving covered hospital or nursing home services at the time the case management services are being provided, except that institutional discharge planning may be reimbursed as described in the Case Management service area of the Online Handbook.

Topic #1680

Duplication of Services

Wisconsin Medicaid ordinarily reimburses only one family case manager per family. If more than one BadgerCare Plus-enrolled child in a family is considered at risk, the single family case manager is responsible for assessing the needs of all of these children. If multiple case managers are providing case management to the family, these case managers must communicate with the family and with each other to determine which provider will provide the family case management.

A family may have a child at risk of physical, mental, or emotional dysfunction while another family member is part of another eligible case management target population. This is highly likely when the parent's condition puts the child at risk (e.g., a parent with a mental illness or developmental disability). Since each case manager requires different knowledge, both case managers may remain involved with the individuals and family.

A family case manager and other case managers working with family members are covered only if documentation shows that their activities have been coordinated through the case planning process to avoid duplication of efforts.

A given child may have coverage for case management under more than one target population (e.g., as a child at risk and as a

child with developmental disabilities). The child's needs may bring that child in contact with multiple agencies that can provide case management (e.g., the Birth to 3 Program and the local health department. However, Wisconsin Medicaid reimburses only one case manager for that individual child). Providers are expected to communicate with each other and the family to determine which agency will submit claims to ForwardHealth for case management activities.

Submit claims for family case management under the member identification number of an at-risk child.

Providers should review information on potential duplication of services between targeted case management, HealthCheck outreach and case management, and PNCC (prenatal care coordination) prior to providing services.

Common Questions About Medicaid Case Management

1. If I transport a recipient to case management services, is this covered as case management?

On occasion, case managers are expected to accompany recipients to services. The purpose is both to ensure that the service provider is aware of the overall case plan and to monitor the services the provider is delivering. If the case manager transports the recipient on these occasions, Wisconsin Medicaid covers this transportation under case management.

2. How do I bill split travel time when case management is not the only service provided?

When a case manager travels to a recipient's home and provides both case management and other services, the travel time must be prorated so that only the appropriate portion of travel is claimed as case management.

> For example, the case manager must travel one half-hour each way to a recipient's house and provide one half-hour of case management and one half-hour of assistance with personal tasks (which is not case management). Bill only half of the travel time (one half-hour) to case management.

Wisconsin Medicaid may cover the remainder of the travel time if both of the following apply:

- The other service is Medicaid covered.
- The policies for that service allow travel time to be separately reimbursable.

> For example, a provider travels one half-hour each way to a recipient's house. The provider provides one half-hour of case management and one and a half hours of in-home psychotherapy. Since travel time is billable with in-home psychotherapy, the provider should bill 15 minutes of the travel to case management and 45 minutes to in-home psychotherapy.

If the case manager travels to a location, such as a group home, where he or she sees more than one recipient, the case management time should be allocated on a prorated basis to the different recipients.

> For example, the case manager must travel one half-hour each way to see two recipients at one site. One half-hour of travel should be billed on behalf of each recipient.

3. Let's say I travel to a recipient's residence, but I don't make contact with the recipient. Does Wisconsin Medicaid cover travel time if there is no billable service?

No. If a case manager travels to see a recipient or collateral, but does not actually make a contact (because the person was not home or available), Wisconsin Medicaid does not cover that travel time. Travel time is only covered when it is provided as a part of a covered service. Since no service took place, the travel time is not covered.

4. I'm a service provider, but not a case management provider. Can I become a case management provider?

Yes. Wisconsin Medicaid does not prohibit providers of other services (whether Medicaid covered or not) from being case managers. For instance, staff of a day treatment program or a sheltered workshop may be case managers. However, the case manager must not bill services which are associated with his/her role as a service provider as Medicaid case management.

> For example, a provider of in-home treatment for a child with severe emotional disturbance is also providing case management. As the child's case manager, the provider completes the comprehensive case management assessment and also convenes an interagency team to complete the case plan. Wisconsin Medicaid covers these activities under case management. In-home treatment is one of the services identified on the case plan. The in-home team develops a treatment plan for the in-home services. Wisconsin Medicaid does not cover this treatment plan's development under case management.
>
> Similarly, Wisconsin Medicaid does not cover the documentation of the in-home treatment as case management. This documentation is considered part of the in-home service. Only documentation of the case management activities in support of the case management case plan are covered as case management documentation time.

If case management is a component of the other services being provided and included in the Medicaid payment for that service, do not separately bill it under case management.

5. I have seen case management referred to as "targeted case management." Why?

Wisconsin Medicaid sometimes uses the term targeted case management to refer to the case management provided to certain populations as described in HFS 107.32, Wis. Admin. Code, and in this handbook. This is because case management is a covered service for *only certain target populations*.

6. What is HealthCheck Outreach case management?

Wisconsin Medicaid also reimburses certain agencies to ensure that HealthCheck-eligible recipients (individuals under 21 years of age) receive their HealthCheck screens according to the periodicity schedule and obtain referrals to services recommended because of the screen. This is referred to as HealthCheck Outreach and Case Management. If the same agency provides HealthCheck Outreach and case management and targeted case management, bill the service as targeted case management. Why? Ensuring access to HealthCheck screens and related necessary services is a component of targeted case management.

7. If HealthCheck Outreach and case management are provided by a different agency from the agency providing targeted case management, who does Wisconsin Medicaid pay?

Wisconsin Medicaid covers services by both agencies for their activities only if the activities are not duplicative. The targeted case manager must ensure that the activities are coordinated. The purpose of HealthCheck Outreach and Case Management is to get the child screened and make referrals based on the screening. Targeted case management coordinates a broader array of services identified in the child's case plan.

8. What is Prenatal Care Coordination (PNCC)? Who is eligible for PNCC?

Women who are pregnant with a high risk of an adverse birth outcome are eligible for Medicaid PNCC services. The PNCC agency is responsible for ensuring that the woman gets necessary prenatal care and also addressing other issues which might put the woman at risk (e.g., substance abuse, domestic abuse).

9. How do PNCC and targeted case management work together?

Wisconsin Medicaid reimburses both the PNCC agency and the targeted case management agency for providing services to the same recipient at the same time if the services are not duplicative. Since PNCC is time limited (to 60 days after the birth), the targeted case manager must take responsibility for coordinating the two agencies' efforts to avoid duplication of effort. The targeted case manager and the PNCC case manager must decide, along with the recipient, which agency will provide what services.

For example, a woman with a significant history of substance abuse is admitted to a PNCC program because of the risk of an adverse birth outcome. The woman has a Medicaid case manager because of her substance abuse disorder. The "targeted" case manager has been working with the woman to help her find treatment and is also working on housing and nutrition needs.

After the woman's admission to the PNCC program, the targeted case manager revises the woman's case plan to identify her involvement with PNCC and the need to coordinate efforts with the PNCC agency. The targeted case manager meets with the PNCC staff and discusses their responsibilities with the recipient. The targeted case manager continues to work with the recipient on accessing substance abuse treatment and on housing issues. The PNCC agency works on accessing prenatal care, educating the recipient on perinatal health issues, and addressing nutrition needs.

Topic #1679

Family Members Who Are Not Enrolled in BadgerCare Plus or Wisconsin Medicaid

Case management with a family member not enrolled in BadgerCare Plus or Wisconsin Medicaid (on a member's behalf) is covered when:

- The case manager assists the family member to gain access to services and resources that are required because of the member's condition. For example, a child enrolled in BadgerCare Plus or Wisconsin Medicaid is eligible for case management because of cerebral palsy. The parent needs to find specialized transportation so the child, who uses a power wheelchair, can receive treatment services. Wisconsin Medicaid reimburses the case manager assisting the parent in locating an appropriate transportation provider, even if the parent is not enrolled in BadgerCare Plus or Wisconsin

Medicaid.
- The family member would not require access to the services or resources if the member did not have the condition that makes him or her eligible for case management. For example, a child enrolled in BadgerCare Plus or Wisconsin Medicaid is found to be eligible for case management because of cerebral palsy. The parent requires education to learn about the disability and how to best care for the child. Wisconsin Medicaid reimburses a case manager for assisting the parent in accessing an education group.

Wisconsin Medicaid does not reimburse a case manager assisting a family member not enrolled in BadgerCare Plus or Wisconsin Medicaid to gain access to services that the family member would require even in the absence of the member's eligibility for case management services. For example, a child enrolled in BadgerCare Plus or Wisconsin Medicaid is eligible for case management because of risk of abuse. The parent is found to require substance abuse treatment. Wisconsin Medicaid does not reimburse the case manager assisting a parent who is not enrolled in BadgerCare Plus or Wisconsin Medicaid to obtain substance abuse treatment, even though it might indirectly reduce the child's risk. The substance abuse treatment meets the parent's primary treatment needs.

When the other family member is enrolled in BadgerCare Plus or Wisconsin Medicaid, Wisconsin Medicaid reimburses those activities identified on the family case plan aimed at the other family member's service needs. This occurs even if the activities do not directly benefit the at-risk child in the family.

Topic #1678

Frequency of Ongoing Monitoring

As part of the case planning process, the case manager must discuss and document the frequency of ongoing monitoring with the member/parent/guardian. This must include an indication of the frequency of contact with all of the following:

- Member.
- Parents/guardians.
- Collaterals, if applicable. Collaterals are other family, friends, providers, or anyone instrumental to the care plan.

The case manager must note the rationale for the frequency of monitoring in the member's record if the frequency of monitoring is less than the following:

- A face-to-face member/family/guardian contact every three months.
- A face-to-face or telephone contact with the member/family/guardian or a face-to-face, telephone, or written contact with a collateral contact every month.

The case manager must base the rationale for the frequency of ongoing monitoring on one or more of the following factors:

- The stability or frailty of the member's health.
- The member's or family's ability to direct the care.
- The strength of supports in the home or the member's informal supports.
- Stability of, and satisfaction with, service care staff. (e.g., Is there a history of high staff turnover?)
- Stability of the case plan. (Is there a history of numerous plan changes?)

Topic #1677

Information and Referral

Information and referral is considered a covered case management service. Information and referral means providing members with information about available resources and programs as part of the process of helping members gain access to services. Case

managers must inform members if the service has a cost. If it is a covered service, case managers are required to provide the member with copayment information, if appropriate. Case managers should ensure timely follow-up on all referrals.

Topic #1676

Ongoing Review of the Case Plan

A single, designated case manager is expected to review the case plan's appropriateness on an ongoing basis and make any needed changes. The case manager must sign or initial and date all changes to the case plan. The case manager may include this review in the monthly billings for ongoing monitoring and service coordination.

Target Populations

Topic #1674

Assessments

Case managers may complete some components of the comprehensive assessment as part of a determination that a member meets any target population's enrollment criteria. Bill the time for completing this as part of the case management assessment when the person is found eligible for case management. If the member is found ineligible for case management in any of the target populations, the assessment will not be covered.

Topic #1673

Description

In addition to meeting other enrollment requirements in the Case Management service area, members must belong to at least one of the following target populations, per s. 49.45(25), Wis. Stats., and be served by a Medicaid-enrolled case management provider that elected to serve members in the corresponding target populations.

Note: For the purposes of identifying which policies apply to which populations, the target populations are divided by when they were authorized in Wisconsin Statutes. Group A target populations refer to those populations authorized in statutes *before* July 29, 1995. Group B target populations refer to those populations authorized in the 1995-97 budget and effective on and after July 29, 1995.

Group A Target Populations

The Group A target populations include all of the following:

1. Persons age 65 or over.
2. Persons with a physician's diagnosis of Alzheimer's disease or related dementia, as defined under s. 46.87(1)(a), Wis. Stats.
3. Persons who can be defined as having:
    - A developmental disability, as defined under s. 51.01(5)(a), Wis. Stats.
    - A chronic mental illness, as defined under DHS 101.03(25), Wis. Admin. Code, and who are age 21 or over.
    - A physical or sensory disability, as defined in DHS 101.03(122m), Wis. Admin. Code.
    - An alcohol or drug dependency, as defined under s. 51.01(1m) or s. 51.01(8), Wis. Stats., respectively.
4. Persons diagnosed as having HIV (Human Immunodeficiency Virus) infection, as defined under s. 252.01(2), Wis. Stats.
5. Persons who are SED (severely emotionally disturbed) and under age 21, as defined under s. 49.45(25)(a), Wis. Stats.

In order for a member to be considered SED, one of the following must occur:

- A three-person team of mental health experts (one must be a psychiatrist or psychologist) appointed by the provider are required to find that the child is SED. The finding and activities leading to the determination that a child is SED are not covered as part of Medicaid case management services. Providers are required to document and retain these findings in the member's clinical record.
- The member meets the requirements under s. 46.56, Wis. Stats. This makes the member eligible for admission to an Integrated Services Project as a child with severe emotional and behavioral problems.

ForwardHealth provides definitions of the above illnesses and disabilities.

Group B Target Populations

The Group B target populations include all of the following:

1. Families with a child/children at risk of serious physical, mental, or emotional dysfunction (also referred to as family case management). This target population has five subgroups:
    - Families with a child/children with special health care needs, including children with lead poisoning.
    - Families with a child/children who is/are at risk of maltreatment.
    - Families with a child/children involved in the juvenile justice system.
    - Families where the primary caregiver has a mental illness, developmental disability, or substance abuse disorder.
    - Families where the mother required PNCC (prenatal care coordination) services.
2. Children enrolled in a Birth to 3 Program under DHS 90, Wis. Admin. Code.
3. Children with asthma.
4. Individuals infected with tuberculosis.
5. Women age 45 to 64.

ForwardHealth provides information on Group B target population enrollment requirements, required documentation, and target population definitions.

Definitions of Illnesses and Disabilities

Illness and Statute Reference	Definition
Developmentally Disabled 51.01(5)(a), Wis. Stats.	"A disability attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi Syndrome, mental retardation, or another neurological condition closely related to mental retardation or requiring treatment similar to that required for mental retardation, which has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the afflicted individual. 'Developmental disability' does not include senility which is primarily caused by the process of aging or the infirmities of aging."
Alcoholism 51.01(1m), Wis. Stats.	"A disease which is characterized by the dependency of a person on the drug alcohol, to the extent that the person's health is substantially impaired or endangered or his or her social or economic functioning is substantially disrupted."
Drug Dependent 51.01(8), Wis.Stats.	"A person who uses one or more drugs to the extent that the person's health is substantially impaired or his or her social or economic functioning is substantially disrupted."
Chronic Mental Illness 51.01(3g), Wis. Stats.	"A mental illness which is severe in degree and persistent in duration, which causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life, which may lead to an inability to maintain stable adjustment and independent functioning without long-term treatment and support which may be of lifelong duration. 'Chronic mental illness' includes schizophrenia as well as a wide spectrum of psychotic and other severely disabling psychiatric diagnostic categories, but does not include infirmities of aging or a primary diagnosis of mental retardation or of alcohol or drug dependence."
Alzheimer's Disease 46.87(1)(a), Wis. Stats.	"A degenerative disease of the central nervous system characterized especially by premature senile mental deterioration, and also includes any other irreversible deterioration of intellectual faculties without concomitant emotional disturbance resulting from organic brain disorder."
Physically or Sensory Disabled 101.03(122m), Wis. Stats.	"A condition which affects a person's physical or sensory functioning by limiting his or her mobility or ability to see or hear, is the result of injury, disease or congenital deficiency, and significantly interferes with or limits one or more major life activities and the performance of major personal or social roles."
Severely Emotionally Disturbed 49.45(25)(a), Wis. Stats.	"An individual under 21 years of age who has emotional or behavioral problems that are severe in degree; are expected to persist for at least one year; substantially interfere with the individual's functioning in his or her family, school, or community and with his or her ability to cope with ordinary demands of life; and cause the individual to need services from 2 or more agencies or organization that provide social services or services or treatment for mental health, juvenile justice, child welfare, special education, or health."

Severely Emotionally Disturbed (continued)
49.45(25)(a), Wis. Stats.

"Case management services under this subsection may not be provided to a person under the category of severely emotionally disturbed child unless any of the following is true:

1. A team of mental health experts appointed by the case management provider determine that the person is a severely emotionally disturbed child. The team shall consist of at least three members. The case management provider shall appoint at least one member of the team who is a licensed psychologist or a physician specializing in psychiatry. The case management provider shall appoint at least two members of the team who are members of the professions of school psychologist, school social worker, registered nurse, social worker, child care worker, occupational therapist, or teacher of emotionally disturbed children. The case management provider shall appoint as a member of the team at least one person who personally participated in a psychological evaluation of the child.

2. A service coordination agency has determined under Section 46.56 (8) (d) that the person is a child with emotional and behavioral disabilities that meet the requirements under 46.56 (1) (c) 1. to 4."

Group B Target Populations
Eligibility Requirements and Required Documentation

Families with Children at Risk of Physical, Mental, or Emotional Dysfunction

This target population includes five subgroups. They are described in this section. "Child" is defined as an individual under age 21. Case management services for this group are sometimes referred to as *"family case management."*

1. Families with a Child with Special Health Care Needs

Children Included in This Category

A child with a special health care need exhibits biological or environmental characteristics associated with a heightened probability of developing a chronic physical, developmental, behavioral, or emotional condition. This special health care need requires health or health-related services of a type or amount beyond that generally required by children.

The following are examples of conditions that cause a child to be considered a child with special health care needs when they meet the criteria outlined in the required documentation section:

- Congenital conditions, e.g., cerebral palsy, spina bifida, congenital heart disease.
- Acquired illnesses or injuries, e.g., spinal cord injury, intracranial injury. Children with lead poisoning are eligible under this category if the child has a blood lead level of ≥ 20ug/dL (venous) or persistent (at least three months duration) blood lead levels of 15-19ug/dL (venous).
- Behavioral health conditions, e.g., substance abuse, attention deficit disorder.
- Chronic health conditions, e.g., seizure disorders, juvenile diabetes.
- Physical or sensory disorders, e.g., sensorineural hearing loss.

Required Documentation

The record must contain documentation from a physician that the child's condition:

- Is severe enough to restrict the child's growth, physical or emotional development, or ability to engage in usual activities.
- Has been, or is, likely to persist for at least 12 months.
- Is of sufficient complexity to require specialized health care services. A licensed, Medicaid-certified psychologist may create the documentation for a child with an emotional disturbance.

The above documentation is not a requirement for children with lead poisoning. The required documentation for children with lead poisoning is the blood lead test results from a health care provider and information that supports the need for ongoing service coordination and monitoring.

2. Families with a Child Who Is at Risk of Maltreatment

Required Documentation

The county agency responsible for child protective services documents a finding that abuse or neglect has or is likely to occur. The county makes this finding through the use of a structured assessment tool, which assesses all of the following:

- The manner in which the caregiver(s) parents the child.
- The child's current level of daily functioning.
- The caregiver's(s') level of functioning (including mental health functioning).

- The family's functioning, ability to cope with current stressors, and the resources available to help the family cope.
- The risk of maltreatment to other children in the family.
- Past allegations of maltreatment.

3. Families with Children Involved in the Juvenile Justice System

Required Documentation

Documentation that the youth is at risk of, involved in, or alleged to be involved in antisocial behavior. Documentation is one of the following:

- The youth has been referred to juvenile court intake because he/she is either alleged or adjudicated delinquent under s.938.12, Wis. Stats.
- The youth is an alleged or adjudicated juvenile in need of protection or services (JIPS) under s. 938.13(4), (6), (6m), (7), (9), or (12), Wis. Stats.

Typically, although not required, the referral is made via one of two forms: Court Referral — Juvenile (Law Enforcement Referrals) or Court Referral — Juvenile (non-Law Enforcement Referrals).

4. Families Where the Primary Caregiver Has a Mental Illness, Developmental Disability, or Substance Abuse Disorder

Required Documentation

The caregiver has a diagnosis of a developmental disability, alcohol or other drug abuse or dependence, or mental illness. A qualified professional must make the diagnosis. In addition to this diagnosis, the case management agency documents that the caregiver's disability restricts the child's physical or emotional development or ability to engage in usual activities.

5. Families Where the Mother Required Prenatal Care Coordination (PNCC) Services

Required Documentation

Documentation needed for eligibility includes one of the following:

- Evidence that the mother was involved in a Medicaid PNCC program.
- A completed Medicaid PNCC risk assessment showing that the mother was at risk for an adverse pregnancy outcome (even though the woman may not have participated in the PNCC program).

In addition, the provider must document that coordination activities continue to be required to ensure the best possible health outcome for the child.

Children Enrolled in a Birth to 3 Program Certified Under HFS 90, Wis. Admin. Code

Required Documentation

The child is eligible to participate in the Birth to 3 Program according to criteria in HFS 90.08, Wis. Admin. Code.

Children with Asthma

Children Included in This Category

This population consists of asthmatic individuals under 21 years of age.

Required Documentation

Documentation needed for eligibility includes all of the following:

- A physician's diagnosis of asthma.
- Documentation that the severity of the asthma is moderate to severe, requiring active management to ensure the best possible clinical outcome.

Individuals Infected with Tuberculosis (TB)

Recipients Included in This Category

There is no age limit on this group.

Required Documentation

Documentation needed for eligibility includes *one* of the following:

- A positive TB skin test. (If the skin test was done more than six months before the date case management was initiated, the provider must document that the recipient has not been treated or still requires treatment.)
- A positive sputum culture for the TB organism within the past six months.
- A physician's certification that the individual requires TB-related drug/or surgical therapy (even when the TB test is negative).
- A physician's order for testing to confirm the presence (or absence) of the TB organism.
- A TB-related diagnosis by a physician.

Women Age 45 to 64

Recipients Included in This Category

This group includes women age 45 to 64 who may be unaware of the importance of obtaining regular preventive health care services and the resources available to access those services.

Required Documentation

Documentation needed for eligibility includes all of the following:

- Documentation of age.
- Documentation that recipient is not a nursing home resident.
- Documentation that recipient is not obtaining regular preventative health care services.

In addition, the provider must document that the woman needs assistance in identifying and accessing needed preventive health care services (such as screenings for breast and cervical cancer, depression, osteoporosis, diabetes, and high blood pressure) and other community resources.

Topic #1672

Selection

Eligible public entities and independent living centers may serve all BadgerCare Plus and Medicaid target populations; however, providers are required to indicate during enrollment which target populations they plan to cover. Private, nonprofit entities funded under s. 252.12(2)(a)8, Wis. Stats., are eligible for Medicaid reimbursement for case management services provided only to persons diagnosed with HIV (Human Immunodeficiency Virus).

After the initial enrollment process, providers may change the target populations they are serving at any time using the demographic maintenance tool. Existing information will not be displayed in the demographic maintenance tool; however, providers only need to indicate changes to existing information.

Managed Care

4

Archive Date:01/02/2019

Managed Care:Claims

Topic #385

Appeals to ForwardHealth

The provider has 60 calendar days to file an appeal with BadgerCare Plus or Wisconsin Medicaid after the HMO or SSI HMO either does not respond in writing within 45 calendar days or if the provider is dissatisfied with the HMO's or SSI HMO's response.

BadgerCare Plus or Wisconsin Medicaid will not review appeals that were not first made to the HMO or SSI HMO. If a provider sends an appeal directly to BadgerCare Plus or Wisconsin Medicaid without first filing it with the HMO or SSI HMO, the appeal will be returned to the provider.

Appeals will only be reviewed for enrollees who were eligible for and who were enrolled in a BadgerCare Plus HMO or Medicaid SSI HMO on the date(s) of service in question.

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

Providers are required to submit an appeal with legible copies of all of the following documentation, regardless of whether the Managed Care Program Provider Appeal (F-12022 (07/17)) form or their own appeal letter is used:

- A copy of the original claim submitted to the HMO (If applicable, include a copy of all corrected claims submitted to the HMO.)
- A copy of all of the HMO's payment denial remittance(s) showing the date(s) of denial and reason code with a description of the exact reason(s) for the claim denial
- A copy of the provider's written appeal to the HMO
- A copy of the HMO response to the appeal
- A copy of the medical record for appeals regarding coding issues, medical necessity, or emergency determination (Providers should only send relevant medical documentation that supports the appeal. Large documents should be submitted on a CD.)
- A copy of any contract language that supports your appeal (If contract language is submitted, indicate the exact language that supports overturning the payment denial.)
- Any other documentation that supports the appeal (e.g., commercial insurance Explanation of Benefits/Explanation of Payment to support Wisconsin Medicaid as the payer of last resort)

Appeals may be faxed to ForwardHealth at 608-224-6318 or mailed to the following address:

BadgerCare Plus and Medicaid SSI
Managed Care Unit — Provider Appeal
PO Box 6470
Madison WI 53716-0470

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

Providers should notify ForwardHealth if the HMO subsequently overturns their original denial and reprocesses and pays the claim for which they have submitted an appeal. Notifications should be faxed to ForwardHealth at 608-224-6318. This documentation will be added to the original appeal documentation to complete the record.

Contact ForwardHealth Provider Services (Managed Care Unit) at 800-760-0001, option 1, to check on the status of an appeal submitted to the department.

Topic #384

Appeals to HMOs and SSI HMOs

BadgerCare Plus and Medicaid SSI (Supplemental Security Income) managed care contracted and non-contracted providers are required to first file an appeal directly with the BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI HMO after the initial payment denial or reduction. Providers should refer to their signed contract with the HMO or the HMO's website for specific filing timelines and responsibilities (e.g., PA, claim filing timelines, and coordination of benefits requirements) pertaining to filing a claim reconsideration and/or filing a formal appeal. The provider's signed contract with the HMO may dictate the final decision. Filing a claim reconsideration is not the same as filing a formal appeal.

Appeal documents must reach the HMO within the time frame established by the HMO. Special care should be taken to ensure the documents reach the HMO timely by allowing enough time for USPS mail handling or by using a verifiable delivery method (e.g., fax, certified mail or secure email).

The HMO or SSI HMO has 45 calendar days to respond in writing to an appeal. The HMO or SSI HMO decides whether or not to pay the claim and sends a letter stating this decision. If the HMO or SSI HMO does not respond in writing within 45 calendar days, or if the provider is dissatisfied with the HMO's or SSI HMO's response, the provider may send a written appeal to ForwardHealth within 60 calendar days from the end of the 45 calendar day timeline or the date of the HMO response.

Topic #386

Claims Submission

BadgerCare Plus HMOs (health maintenance organizations) and Medicaid SSI (Supplemental Security Income) HMOs have requirements for timely filing of claims, and providers are required to follow HMO and SSI HMO claims submission guidelines. Contact the enrollee's HMO or SSI HMO for organization-specific submission deadlines.

Topic #387

Extraordinary Claims

Extraordinary claims are BadgerCare Plus or Medicaid claims for a BadgerCare Plus HMO or Medicaid SSI (Supplemental Security Income) HMO enrollee that have been denied by an HMO or SSI HMO but may be paid as fee-for-service claims.

The following are some examples of extraordinary claims situations:

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

with the claim of when the bands were placed.

Submitting Extraordinary Claims

When submitting an extraordinary claim, include the following:

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

Submit extraordinary claims to:

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

Topic #388

Medicaid as Payer of Last Resort

Wisconsin Medicaid is the payer of last resort for most covered services, even when a member is enrolled in a BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) HMO. Before submitting claims to HMOs and SSI HMOs, providers are required to submit claims to other health insurance sources. Contact the enrollee's HMO or SSI HMO for more information about billing other health insurance sources.

Topic #389

Provider Appeals

When a BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) HMO denies a provider's claim, the HMO or SSI HMO is required to send the provider a notice informing him or her of the right to file an appeal.

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

- A claim submitted to the HMO or SSI HMO is denied payment.
- The full amount of a submitted claim is not paid.

Providers are required to file an appeal with the HMO or SSI HMO *before* filing an appeal with ForwardHealth.

Covered and Noncovered Services

Topic #16197

Care4Kids Program Benefit Package

Covered Services

Members enrolled in the Care4Kids program are eligible to receive all medically necessary services covered under Wisconsin Medicaid; however, Care4Kids will have the flexibility to provide services in a manner that best meets the unique needs of children in out-of-home care, including streamlining PA (prior authorization) requirements and offering select services in home settings. Members will also be allowed to go to any Medicaid-enrolled provider for emergency medical services or family planning services.

Noncovered Services

The following services are not provided as covered benefits through the Care4Kids program, but can be reimbursed for eligible Medicaid members on a fee-for-service basis:

- Behavioral treatment.
- Chiropractic services.
- CRS (Community Recovery Services).
- CSP (Community Support Programs).
- CCS (Comprehensive Community Services).
- Crisis intervention services.
- Directly observed therapy for individuals with tuberculosis.
- MTM (Medication therapy management).
- NEMT (Non-emergency medical transportation) services.
- Prescription and over-the-counter drugs and diabetic supplies dispensed by the pharmacy.
- Provider-administered drugs and their administration, and the administration of Synagis.
- SBS (School-based services).
- Targeted case management.

Children's Hospital of Wisconsin will establish working relationships, defined in writing through a memorandum of understanding, with providers of the following services:

- CSP.
- CCS.
- Crisis intervention services.
- SBS.
- Targeted case management services.

Providers of these services must coordinate with Care4Kids to help assure continuity of care, eliminate duplication, and reduce fragmentation of services.

Topic #390

Covered Services

HMOs

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

- Dental.
- Chiropractic.

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

Topic #391

Noncovered Services

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

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

  *Note:*The Provider-Administered Drugs Carve-Out Procedure Codes table indicates the status of procedure codes considered under the provider-administered drugs carve-out policy.

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

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

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

Enrollment

Topic #392

Disenrollment and Exemptions

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

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

Topic #393

Enrollee Grievances

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

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

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

Topic #397

Enrollment Eligibility

BadgerCare Plus HMOs

Members enrolled in BadgerCare Plus are eligible for enrollment in a BadgerCare Plus HMO (health maintenance organization).

An individual who receives the TB-Only (Tuberculosis-Related Services-Only) benefit, SeniorCare, or Wisconsin Well Woman Medicaid cannot be enrolled in a BadgerCare Plus HMO.

Information about a member's HMO enrollment status and commercial health insurance coverage may be verified by using Wisconsin's EVS (Enrollment Verification System) or the ForwardHealth Portal.

SSI HMOs

Members of the following subprograms are eligible for enrollment in a Medicaid SSI (Supplemental Security Income) HMO:

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

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

Topic #394

Enrollment Periods

BadgerCare Plus HMOs

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

SSI HMOs

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

Topic #395

Enrollment Specialist

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

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

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

Topic #398

Member Enrollment

HMOs

BadgerCare Plus HMO (health maintenance organization) enrollment is either mandatory or voluntary based on ZIP code-defined enrollment areas as follows:

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

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

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

SSI HMOs

Medicaid SSI (Supplemental Security Income) HMO enrollment is either mandatory or voluntary as follows:

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

Topic #396

Ombudsman Program

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

Ombuds can be contacted at the following address:

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

Topic #399

Release of Billing or Medical Information

ForwardHealth supports BadgerCare Plus HMO (health maintenance organization) and Medicaid SSI (Supplemental Security Income) 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 (health maintenance organization) is a system of health care providers that provides a comprehensive range of medical services to a group of enrollees. HMOs receive a fixed, prepaid amount per enrollee from ForwardHealth (called a capitation payment) to provide medically necessary services.

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

Topic #16177

Care4Kids Program Overview

Care4Kids is a health care program for children and youth in out-of-home care in Wisconsin. The Care4Kids program will offer comprehensive, coordinated services that are intended to improve the quality and timeliness of and access to health services for these children.

The Care4Kids program will serve children in out-of-home care placements (other than residential care centers) in Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha counties. Member participation will be voluntary and enrollment will be allowed to continue for up to 12 months after the child leaves the out-of-home care system, as long as the child remains Medicaid-eligible and resides within one of the six counties.

Care4Kids is required to provide at least the same benefits as those provided under fee-for-service arrangements.

Program Administration

Children's Hospital of Wisconsin is currently the only integrated health system certified by ForwardHealth to administer the Care4Kids program. Children's Hospital of Wisconsin will be responsible for providing or arranging for the provision of all services covered under Medicaid, with a small number of exceptions. The services not included in the Care4Kids program will be reimbursed as fee-for-service benefits. Children's Hospital of Wisconsin's integrated network of health care providers, which includes specialty and primary care physicians and clinics within the Children's Hospital System as well as providers who are participating in CCHP (Children's Community Health Plan), is intended to provide coordinated care and services to meet the individualized needs of each of the children enrolled across multiple disciplines, including physical, behavioral health, and dental care.

Care4Kids will be responsible for providing or arranging for the provision of all medically necessary services covered by Wisconsin Medicaid to enrollees. Providers are required to be part of the CCHP network to get reimbursed by Care4Kids. Providers interested in being a part of the network should contact CCHP. Out-of-network providers are required to call Care4Kids prior to providing services to a Care4Kids enrollee. In situations where emergency medical services are needed, out-of-network providers are required to contact Care4Kids within 24 hours of providing services.

Member Enrollment Verification

Providers should verify a member's enrollment before providing services to determine if the member is enrolled in Care4Kids. Members enrolled in Care4Kids will present a ForwardHealth member identification card.

Providers verifying enrollment on the ForwardHealth Portal will see Care4Kids under the MC Program heading in the Managed Care Enrollment panel.

For 271 response transactions, Care4Kids enrollment will be identified in the EB segment of the 2110C loop. Identified by "MC" in the EB01, "HM" in the EB04, and "Care4Kids" in the EB05. The MC provider contact information will be reported in the NM1 (name info), N3 (address info), and PER (telephone numbers) segments within the 2120C loop.

The WiCall AVR (automated voice response) system will identify Care4Kids as the state-contracted managed care program in which the member is enrolled.

Contact Information

Providers can contact CCHP at (800) 482-8010 for the following:

- To become part of the CCHP network.
- For coverage policy and procedure information, including PA (prior authorization) and claim submission guidelines, if they are already a Care4Kids network provider.

Topic #405

Managed Care

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

The primary goals of the managed care programs are:

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

Topic #402

Managed Care Contracts

The contract between the DHS (Department of Health Services) and the BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) HMO takes precedence over other ForwardHealth provider publications. Information contained in ForwardHealth publications is used by the DHS to resolve disputes regarding covered benefits that cannot be handled internally by HMOs and SSI HMOs. If there is a conflict, the HMO or SSI HMO contract prevails. If the contract does not specifically address a situation, Wisconsin Administrative Code ultimately prevails. HMO and SSI HMO contracts can be found on the Managed Care Organization area of the ForwardHealth Portal.

Topic #403

Managed Long-Term Care Programs

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

Topic #1671

Medicaid HMOs and Case Management Services

Case management services are covered on a fee-for-service basis for members enrolled in Medicaid and BadgerCare Plus HMOs. Since Medicaid and BadgerCare Plus HMOs and case management providers are responsible for coordinating care to members, guidelines have been developed to address the roles and responsibilities of each entity.

HMO Rights and Responsibilities

1. The HMO must designate at least one individual to serve as a contact person for case management providers. If the HMO chooses to designate more than one contact person, the HMO must identify the target populations for which each contact person is responsible.
2. The HMO may make referrals to case management agencies when they identify a member from an eligible target population who they believe could benefit from case management services.
3. If the member or case manager requests the HMO to conduct an assessment, the HMO determines whether there are signs and symptoms indicating the need for an assessment. If the HMO finds that an assessment is needed, the HMO determines the most appropriate level for an assessment to be conducted (e.g., primary care physician, specialist, etc.). If the HMO determines that no assessment is needed, the HMO documents the rationale for this decision.
4. The HMO must determine the need for medical treatment of those services covered under the HMO contract based on the results of the assessment and the medical necessity of the treatment recommended.
5. The HMO case management liaison, or other appropriate staff as designated by the HMO, must participate in case planning with the case management agency, unless no services provided through the HMO are required:
    - The case planning may be done through telephone contact or means of communication other than attending a formal case planning meeting.
    - The HMO must informally discuss differences in opinion regarding the HMO's determination of treatment needs if requested by the member or case manager.
    - The HMO case management liaison and the case manager must discuss who is responsible for ensuring that the member receives the services authorized by and provided through the HMO.
    - The HMO's role in the case planning may be limited to a confirmation of the services the HMO authorizes if the member and case manager find these acceptable.

Case Management Agency Rights and Responsibilities

1. The case management provider is responsible for initiating contact with the HMO to coordinate services to member(s) they have in common and providing the HMO with the name and telephone number of the case manager(s).
2. If the HMO refers a member to the case management provider, the case management provider must conduct an initial screening based on their usual procedures and policies. The case management provider must determine whether or not they will provide case management services and notify the HMO of this decision.
3. The case manager must complete a comprehensive assessment of the member's needs according to the requirements in the Case Management service area of the Online Handbook. This includes a review of the member's physical and dental health needs.
4. If the case manager requires copies of the member's medical records, the case manager must obtain the records directly

from the service provider, not the HMO.

5. The case manager must identify whether the member has additional service or treatment needs. As a part of this process, the case manager and the member may seek additional assessment of conditions that the HMO may be expected to treat under the terms of its contract, if the HMO determines there are specific signs and symptoms indicating the need for an assessment.
6. The case management provider may not determine the need for specific medical care covered under the HMO contract, nor may the case manager make referrals directly to specific providers of medical care covered through the HMO.
7. The case manager must complete a comprehensive case plan according to the requirements in the Case Management service area of the Online Handbook. The plan must include the medical services the member requires as determined by the HMO.
8. If the case manager specifically requests the HMO liaison to attend a planning meeting in person, the case management provider must reimburse the HMO for the costs associated with attending the planning meeting. These are allowable costs for case management reimbursement through Wisconsin Medicaid.

Nothing in these guidelines precludes the HMO and the case management agency from entering into a formal contract or MOU (Memorandum of Understanding) to address issues not outlined here.

Topic #404

SSI HMO Program

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

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

Member Enrollment

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

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

Continuity of Care

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

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

To assure payment, non-contracted providers should contact the SSI HMO to confirm claim submission and reimbursement

processes. If an SSI HMO is not honoring a PA that is currently approved by ForwardHealth, the provider should first contact the HMO. If the provider is not able to resolve their issue with the HMO, the provider should contact ForwardHealth Provider Services.

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

Care Management

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

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

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

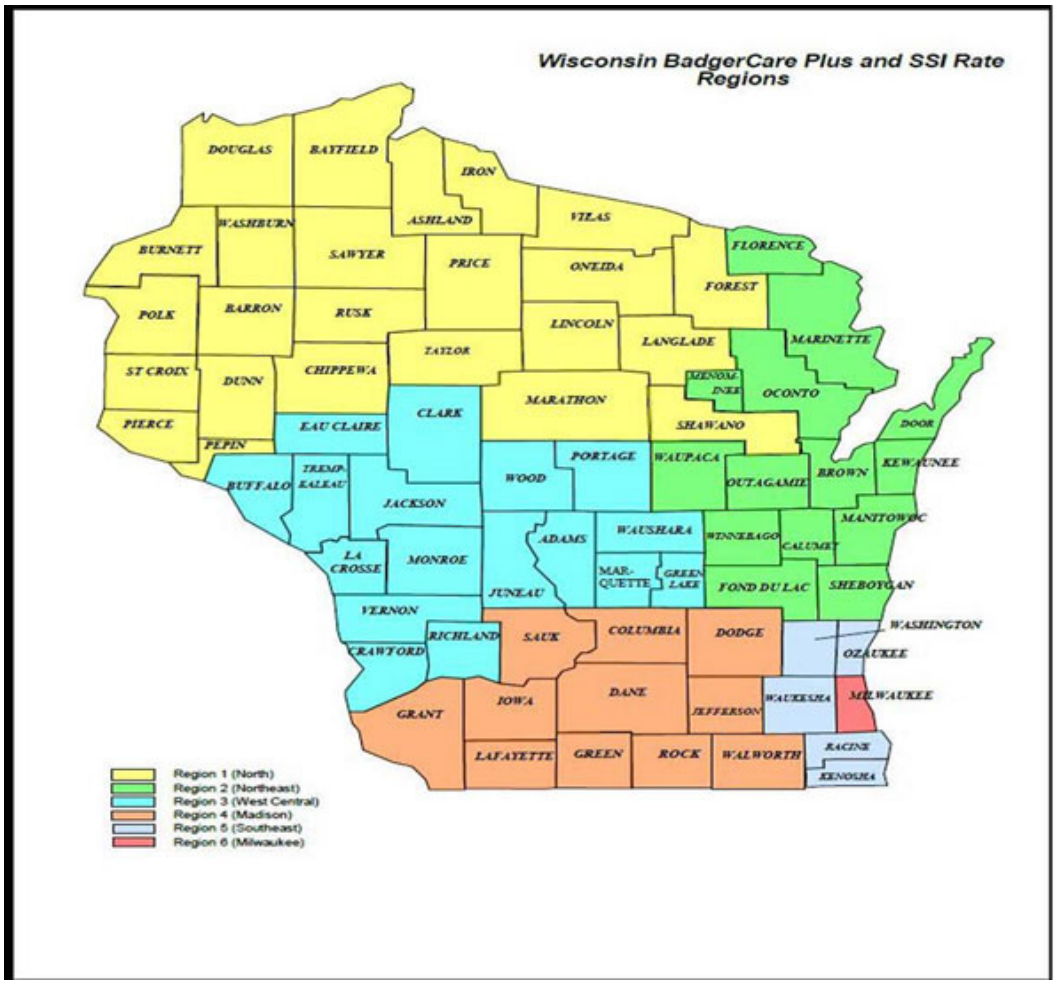
The SSI HMO care management teams will be responsible, when it is deemed appropriate, for notifying primary care providers of members' emergency room visits, hospital discharges, and other major medical events, as well as sharing patient-specific care management plans with appropriate providers to reduce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

Topic #20697

SSI Rate Regions

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

SSI Rate Regions



Topic #1670

Special Managed Care Programs and Case Management

The following special managed care programs include case management as a covered service; therefore, case management may not be billed separately to Wisconsin Medicaid for persons enrolled in these programs:

- CCF (Children Come First).
- CCE (Community Care for the Elderly).
- Community Health Partnership.
- Community Living Alliance.
- Elder Care Options.
- WAM (Wraparound Milwaukee).

For more information on case management for members enrolled in these special managed care programs, contact the special managed care program directly.

Family Care

ForwardHealth does not separately cover case management services for members enrolled in Family Care. For more information on case management services for members enrolled in Family Care, contact the CMO (care management organization). A list of

CMOs is included in the Family Care service area of the Online Handbook.

Prior Authorization

Topic #400

Prior Authorization Procedures

BadgerCare Plus HMOs (health maintenance organizations) and Medicaid SSI (Supplemental Security Income) 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

Copayments

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

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

Topic #407

Emergencies

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

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

Topic #408

Non-network Providers

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

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

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

Topic #409

Out-of-Area Care

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

Topic #410

Provider Participation

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

Topic #411

Referrals

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

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

Topic #412

Services Not Provided by HMOs or SSI HMOs

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

Member Information

5

Archive Date:01/02/2019

Member Information:Enrollment Categories

Topic #225

BadgerCare Plus

Populations Eligible for BadgerCare Plus

The following populations are eligible for BadgerCare Plus:

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

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

Premiums

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

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

Topic #16677

BadgerCare Plus Benefit Plan Changes

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

- BadgerCare Plus Benchmark Plan.
- BadgerCare Plus Core Plan.
- BadgerCare Plus Basic Plan.

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

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

Topic #785

BadgerCare Plus Prenatal Program

As a result of 2005 Wisconsin Act 25, the 2005-07 biennial budget, BadgerCare has expanded coverage to the following individuals:

- Pregnant non-U.S. citizens who are not qualified aliens but meet other eligibility criteria for BadgerCare.
- Pregnant individuals detained by legal process who meet other eligibility criteria for BadgerCare.

The BadgerCare Plus Prenatal Program is designed to provide better birth outcomes.

Women are eligible for all covered services from the first of the month in which their pregnancy is verified or the first of the month in which the application for BadgerCare Plus is filed, whichever is later. Members are enrolled through the last day of the month in which they deliver or the pregnancy ends. Postpartum care is reimbursable *only* if provided as part of global obstetric care. Even though enrollment is based on pregnancy, these women are eligible for *all* covered services. (They are not limited to pregnancy-related services.)

These women are not presumptively eligible. Providers should refer them to the appropriate county/tribal social or human services agency where they can apply for this coverage.

Fee-for-Service

Pregnant non-U.S. citizens who are not qualified aliens and pregnant individuals detained by legal process receive care only on a fee-for-service basis. Providers are required to follow all program requirements (e.g., claim submission procedures, PA (prior authorization) requirements) when providing services to these women.

Emergency Services for Non-U.S. Citizens

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

Topic #226

Family Planning Only Services

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

Note: Members who meet the enrollment criteria may receive routine contraceptive management or related services *immediately* by temporarily enrolling in Family Planning Only Services through EE (Express Enrollment).

The goal of Family Planning Only Services is to provide members with information and services to assist them in preventing pregnancy, making BadgerCare Plus enrollment due to pregnancy less likely. Providers should explain the purpose of Family Planning Only Services to members and encourage them to contact their certifying agency to determine their enrollment options if

they are not interested in, or do not need, contraceptive services.

Members enrolled in Family Planning Only Services receive routine services to prevent or delay pregnancy and are not eligible for other services (e.g., PT (physical therapy) services, dental services). Even if a medical condition is discovered during a family planning visit, treatment for the condition is not covered under Family Planning Only Services unless the treatment is identified in the list of allowable procedure codes for Family Planning Only Services.

Members are also not eligible for certain other services that are covered under Wisconsin Medicaid and BadgerCare Plus (e.g., mammograms and hysterectomies). If a medical condition, other than an STD (sexually transmitted disease), is discovered during routine contraceptive management or related services, treatment for the medical condition is not covered under Family Planning Only Services.

Colposcopies and treatment for STDs are only covered through Family Planning Only Services if they are determined medically necessary during routine contraceptive management or related services. A colposcopy is a covered service when an abnormal result is received from a pap test, prior to the colposcopy, while the member is enrolled in Family Planning Only Services and receiving contraceptive management or related services.

Family Planning Only Services members diagnosed with cervical cancer, precancerous conditions of the cervix, or breast cancer may be eligible for Wisconsin Well Woman Medicaid. Providers should assist eligible members with the enrollment process for Well Woman Medicaid.

Providers should inform members about other coverage options and provide referrals for care not covered by Family Planning Only Services.

Topic #4757

ForwardHealth and ForwardHealth interChange

ForwardHealth brings together many DHS (Department of Health Services) health care programs with the goal to create efficiencies for providers and to improve health outcomes for members. ForwardHealth interChange is the DHS claims processing system that supports multiple state health care programs and Web services, including:

- BadgerCare Plus.
- BadgerCare Plus and Medicaid managed care programs.
- SeniorCare.
- ADAP (Wisconsin AIDS Drug Assistance Program).
- WCDP (Wisconsin Chronic Disease Program).
- WIR (Wisconsin Immunization Registry).
- Wisconsin Medicaid.
- Wisconsin Well Woman Medicaid.
- WWWP (Wisconsin Well Woman Program).

ForwardHealth interChange is supported by the state's fiscal agent, DXC Technology.

Topic #228

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for selected groups of people who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Wisconsin Medicaid is also known as the Medical Assistance Program, WMAP (Wisconsin Medical Assistance Program), MA (Medical Assistance), Title XIX, or T19.

A Medicaid member is any individual entitled to benefits under Title XIX of the Social Security Act and under the Medical Assistance State Plan as defined in ch. 49, Wis. Stats.

Wisconsin Medicaid enrollment is determined on the basis of financial need and other factors. A citizen of the United States or a "qualified immigrant" who meets low-income financial requirements may be enrolled in Wisconsin Medicaid if he or she is in one of the following categories:

- Age 65 and older.
- Blind.
- Disabled.

Some needy and low-income people become eligible for Wisconsin Medicaid by qualifying for programs such as:

- Katie Beckett.
- Medicaid Purchase Plan.
- Subsidized adoption and foster care programs.
- SSI (Supplemental Security Income).
- WWWP (Wisconsin Well Woman Program).

Providers may advise these individuals or their representatives to contact their certifying agency for more information. The following agencies certify people for Wisconsin Medicaid enrollment:

- Local county or tribal agencies.
- Medicaid outstation sites.
- SSA (Social Security Administration) offices.

In limited circumstances, some state agencies also certify individuals for Wisconsin Medicaid.

Medicaid fee-for-service members receive services through the traditional health care payment system under which providers receive a payment for each unit of service provided. Some Medicaid members receive services through state-contracted MCOs (managed care organizations).

Topic #18777

Real-Time Eligibility Determinations

ForwardHealth may complete real-time eligibility determinations for BadgerCare Plus and/or Family Planning Only Services applicants who meet pre-screening criteria and whose reported information can be verified in real time while applying in ACCESS Apply for Benefits. Once an applicant is determined eligible through the real-time eligibility process, he or she is considered eligible for BadgerCare Plus and/or Family Planning Only Services and will be enrolled for 12 months, unless changes affecting eligibility occur before the 12-month period ends.

A member determined eligible through the real-time eligibility process will receive a temporary ID (identification) card for BadgerCare Plus and/or Family Planning Only Services. Each member will get his or her own card, and each card will include the member's ForwardHealth ID number. The temporary ID card will be valid for the dates listed on the card and will allow the member to get immediate health care or pharmacy services.

Eligibility Verification

When a member is determined eligible for BadgerCare Plus and/or Family Planning Only Services through the real-time eligibility process, providers are able to see the member's eligibility information in Wisconsin's EVS (Enrollment Verification System) in real time. Providers should always verify eligibility through EVS prior to providing services.

On rare occasions, it may take up to 48 hours for eligibility information to be available through interChange. In such instances, if a member presents a valid temporary ID card, **the provider is still required to provide services**, even if eligibility cannot be verified through EVS.

Sample Temporary Identification Card for Badger Care Plus

To the Provider

The individual listed on this card has been enrolled in BadgerCare Plus. This card entitles the listed individual to receive health care services, including pharmacy services, through BadgerCare Plus from any Medicaid-enrolled provider. For additional information, call Provider Services at 800-947-9627 or refer to the ForwardHealth Online Handbook at *www.forwardhealth.wi.gov*.

NOTE:

It is important to provide services when this card is presented. Providers who render services based on the enrollment dates on this card will receive payment for those services, as long as other reimbursement requirements are met. All policies regarding covered services apply for this individual, including the prohibition against billing members. If "Pending Assignment" is indicated after the name on this card, the member identification (ID) number will be assigned within one business day; the card is still valid. Refer to the ForwardHealth Online Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card.

WISCONSIN DEPARTMENT OF HEALTH SERVICES

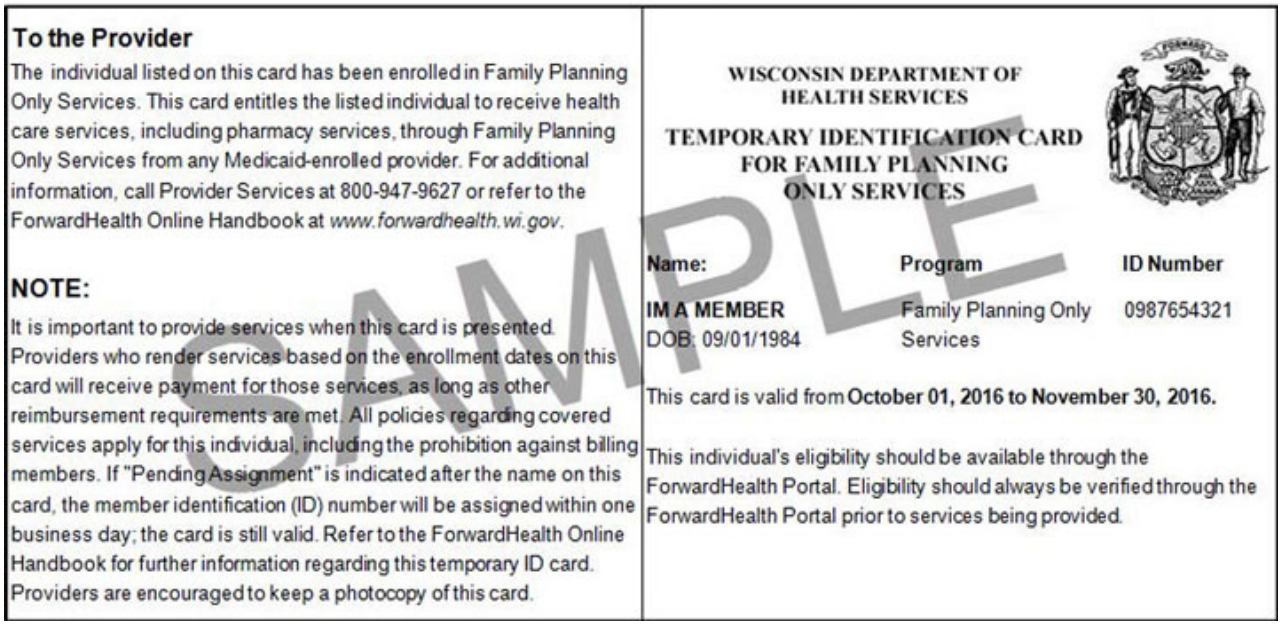
TEMPORARY IDENTIFICATION CARD FOR BADGERCARE PLUS

Name:	Program	ID Number
IM A MEMBER	BadgerCare Plus	0987654321
DOB: 09/01/1984		

This card is valid from **October 01, 2016 to November 30, 2016.**

This individual's eligibility should be available through the ForwardHealth Portal. Eligibility should always be verified through the ForwardHealth Portal prior to services being provided.

Sample Temporary Identification Card for Family Planning Only Services



To the Provider

The individual listed on this card has been enrolled in Family Planning Only Services. This card entitles the listed individual to receive health care services, including pharmacy services, through Family Planning Only Services from any Medicaid-enrolled provider. For additional information, call Provider Services at 800-947-9627 or refer to the ForwardHealth Online Handbook at *www.forwardhealth.wi.gov*.

NOTE:

It is important to provide services when this card is presented. Providers who render services based on the enrollment dates on this card will receive payment for those services, as long as other reimbursement requirements are met. All policies regarding covered services apply for this individual, including the prohibition against billing members. If "Pending Assignment" is indicated after the name on this card, the member identification (ID) number will be assigned within one business day; the card is still valid. Refer to the ForwardHealth Online Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card.

WISCONSIN DEPARTMENT OF HEALTH SERVICES

TEMPORARY IDENTIFICATION CARD FOR FAMILY PLANNING ONLY SERVICES

Name:	Program	ID Number
IM A MEMBER DOB: 09/01/1984	Family Planning Only Services	0987654321

This card is valid from **October 01, 2016 to November 30, 2016.**

This individual's eligibility should be available through the ForwardHealth Portal. Eligibility should always be verified through the ForwardHealth Portal prior to services being provided.

SAMPLE

Topic #262

Tuberculosis-Related Services-Only Benefit

The TB-Only (Tuberculosis-Related Services-Only) Benefit is a limited benefit category that allows individuals with TB (tuberculosis) infection or disease to receive covered TB-related outpatient services.

Topic #240

Wisconsin Well Woman Medicaid

Wisconsin Well Woman Medicaid provides full Medicaid benefits to underinsured or uninsured women ages 35 to 64 who have been screened and diagnosed by WWWP (Wisconsin Well Woman Program) or Family Planning Only Services, meet all other enrollment requirements, and are in need of treatment for any of the following:

- Breast cancer.
- Cervical cancer.
- Precancerous conditions of the cervix.

Services provided to women who are enrolled in WWWMA (Wisconsin Well Woman Medicaid) are reimbursed through Medicaid fee-for-service.

Enrollment Responsibilities

Topic #241

General Information

Members have certain responsibilities per DHS 104.02, Wis. Admin. Code, and the ForwardHealth Enrollment and Benefits (P-00079 (07/14)) booklet.

Topic #243

Loss of Enrollment — Financial Liability

Some covered services consist of a series of sequential treatment steps, meaning more than one office visit is required to complete treatment.

In most cases, if a member loses enrollment midway through treatment, BadgerCare Plus and Medicaid will *not* reimburse services (including prior authorized services) after enrollment has lapsed.

Members are financially responsible for any services received after their enrollment has been terminated. If the member wishes to continue treatment, it is a decision between the provider and the member whether the service should be given and how the services will be paid. The provider may collect payment from the member if the member accepts responsibility for payment of a service and certain conditions are met.

To avoid misunderstandings, it is recommended that providers remind members that they are financially responsible for any continued care after enrollment ends.

To avoid potential reimbursement problems that can arise when a member loses enrollment midway through treatment, the provider is encouraged to verify the member's enrollment using the EVS (Enrollment Verification System) or the ForwardHealth Portal prior to providing each service, even if an approved PA (prior authorization) request is obtained for the service.

Topic #707

Member Cooperation

Members are responsible for giving providers full and accurate information necessary for the correct submission of claims. If a member has other health insurance, it is the member's obligation to give full and accurate information to providers regarding the insurance.

Topic #269

Members Should Present Card

It is important that providers determine a member's enrollment and other insurance coverage *prior to* each DOS (date of service) that services are provided. Pursuant to DHS 104.02(2), Wis. Admin. Code, a member should inform providers that he or she is enrolled in BadgerCare Plus or Wisconsin Medicaid and should present a current ForwardHealth identification card before

receiving services.

Note: Due to the nature of their specialty, certain providers — such as anesthesiologists, radiologists, DME (durable medical equipment) suppliers, independent laboratories, and ambulances — are not always able to see a member's ForwardHealth identification card because they might not have direct contact with the member prior to providing the service. In these circumstances, it is still the provider's responsibility to obtain member enrollment information.

Topic #244

Prior Identification of Enrollment

Except in emergencies that preclude prior identification, members are required to inform providers that they are receiving benefits and must present their ForwardHealth identification card before receiving care. If a member forgets his or her ForwardHealth card, providers may verify enrollment without it.

Topic #245

Reporting Changes to Caseworkers

Members are required to report certain changes to their caseworker at their certifying agency. These changes include, but are not limited to, the following:

- A new address or a move out of state.
- A change in income.
- A change in family size, including pregnancy.
- A change in other health insurance coverage.
- Employment status.
- A change in assets for members who are over 65 years of age, blind, or disabled.

Enrollment Rights

Topic #246

Appealing Enrollment Determinations

Applicants and members have the right to appeal certain decisions relating to BadgerCare Plus, Medicaid, or ADAP (Wisconsin AIDS Drug Assistance Program) enrollment. An applicant, a member, or authorized person acting on behalf of the applicant or member, or former member may file the appeal with the DHA (Division of Hearings and Appeals).

Pursuant to HA 3.03, Wis. Admin. Code, an applicant, member, or former member may appeal any adverse action or decision by an agency or department that affects their benefits. Examples of decisions that may be appealed include, but are not limited to, the following:

- Individual was denied the right to apply.
- Application for BadgerCare Plus, ADAP, or Wisconsin Medicaid was denied.
- Application for BadgerCare Plus, ADAP, or Wisconsin Medicaid was not acted upon promptly.
- Enrollment was unfairly discontinued, terminated, suspended, or reduced.

In the case when enrollment is cancelled or terminated, the date the member, or authorized person acting on behalf of the member, files an appeal with the DHA determines what continuing coverage, if any, the member will receive until the hearing decision is made. The following scenarios describe the coverage allowed for a member who files an appeal:

- If a member files an appeal before his or her enrollment ends, coverage will continue pending the hearing decision.
- If a member files an appeal within 45 days after his or her enrollment ends, a hearing is allowed but coverage is not reinstated.

If the member files an appeal more than 45 days after his or her enrollment ends, a hearing is not allowed. Members may file an appeal by submitting a Request for Fair Hearing (DHA-28 (08/09)) form.

Claims for Appeal Reversals

Claim Denial Due to Termination of BadgerCare Plus or Wisconsin Medicaid Enrollment

If a claim is denied due to termination of BadgerCare Plus or Wisconsin Medicaid enrollment, a hearing decision that reverses that determination will allow the claim to be resubmitted and paid. The provider is required to obtain a copy of the appeal decision from the member, attach the copy to the previously denied claim, and submit both to ForwardHealth at the following address:

ForwardHealth
Specialized Research
Ste 50
313 Blettner Blvd
Madison WI 53784

If a provider has not yet submitted a claim, the provider is required to submit a copy of the hearing decision along with a paper claim to Specialized Research.

As a reminder, claims submission deadlines still apply even to those claims with hearing decisions.

Claim Denial Due to Termination of ADAP Enrollment

If a claim is denied due to termination of ADAP enrollment, a hearing decision that reverses that determination will allow the claim to be resubmitted and paid. The provider is required to obtain a copy of the appeal decision from the member, attach the copy to the previously denied claim, and submit both to ForwardHealth at the following address:

ForwardHealth
ADAP Claims and Adjustments
PO Box 8758
Madison WI 53708

If a provider has not yet submitted a claim, the provider is required to submit a copy of the hearing decision along with a paper claim to ADAP Claims and Adjustments.

As a reminder, claims submission deadlines still apply even to those claims with hearing decisions.

Topic #247

Freedom of Choice

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

Topic #1669

Members Receiving Case Management Services

For members, participation in the case management program is voluntary. The member voluntarily participates in case management services by maintaining contact with and receiving services from the case management agency. The case management provider may not "lock-in" members or deny the member's freedom to choose providers. Members may participate, to the full extent of their ability, in all decisions regarding appropriate services and providers. For ongoing monitoring and service coordination, there is one, individual case manager known by and available to the member or guardian.

For a member receiving case management services, the following people may choose and, if necessary, request a change in the case manager who is performing ongoing monitoring and service coordination (subject to the case management provider's or agency's capacity to provide services under DHS 107.32(2), Wis. Admin. Code):

- The member.
- The member's parents, if the member is a minor child.
- A guardian, if the member has been judged incompetent by the courts.

The case manager and member/parent/guardian must discuss case plan changes and mutually agree to reduce or terminate services. If the case management provider or agency needs to reduce or terminate services for any reason, the case manager must notify the member in advance and document this in the record.

Topic #248

General Information

Members are entitled to certain rights per DHS 103, Wis. Admin. Code.

Topic #250

Notification of Discontinued Benefits

When the DHS (Department of Health Services) intends to discontinue, suspend, or reduce a member's benefits, or reduce or eliminate coverage of services for a general class of members, the DHS sends a written notice to members. This notice is required to be provided at least 10 days before the effective date of the action.

Topic #252

Prompt Decisions on Enrollment

Individuals applying for BadgerCare Plus or Wisconsin Medicaid have the right to prompt decisions on their applications. Enrollment decisions are made within 60 days of the date the application was signed for those with disabilities and within 30 days for all other applicants.

Topic #254

Requesting Retroactive Enrollment

An applicant has the right to request retroactive enrollment when applying for BadgerCare Plus or Wisconsin Medicaid. Enrollment may be backdated to the first of the month three months prior to the date of application for eligible members. Retroactive enrollment does not apply to QMB-Only (Qualified Medicare Beneficiary-Only) members.

Identification Cards

Topic #266

ForwardHealth Identification Cards

Each enrolled member receives an identification card. Possession of a program identification card does not guarantee enrollment. It is possible that a member will present a card during a lapse in enrollment; therefore, it is essential that providers verify enrollment before providing services. Members are told to keep their cards even though they may have lapses in enrollment.

ForwardHealth Identification Card Features

The ForwardHealth identification card includes the member's name, 10-digit member ID, magnetic stripe, signature panel, and the Member Services telephone number. The card also has a unique, 16-digit card number on the front for internal program use.

The ForwardHealth card does not need to be signed to be valid; however, adult members are encouraged to sign their cards. Providers may use the signature as another means of identification.

The toll-free number on the back of each of the cards is for member use only. The address on the back of each card is used to return a lost card to ForwardHealth if it is found.

If a provider finds discrepancies with the identification number or name between what is indicated on the ForwardHealth card and the provider's file, the provider should verify enrollment with Wisconsin's EVS (Enrollment Verification System).

Identification Number Changes

Some providers may question whether services should be provided if a member's 10-digit identification number on his or her ForwardHealth card does not match the EVS response. If the EVS indicates the member is enrolled, services should be provided.

A member's identification number may change, and the EVS will reflect that change. However, ForwardHealth does not automatically send a replacement ForwardHealth card with the new identification number to the member. ForwardHealth cross-references the old and new identification numbers so a provider may submit claims with either number. The member may request a replacement ForwardHealth card that indicates the new number.

Member Name Changes

If a member's name on the ForwardHealth card is different than the response given from Wisconsin's EVS, providers should use the name from the EVS response. When a name change is reported and on file, a new card will automatically be sent to the member.

Deactivated Cards

When any member identification card has been replaced for any reason, the previous identification card is deactivated. If a member presents a deactivated card, providers should encourage the member to discard the deactivated card and use only the new card.

Although a member identification card may be deactivated, the member ID is valid and the member still may be enrolled in a ForwardHealth program.

If a provider swipes a ForwardHealth card using a magnetic stripe card reader and finds that it has been deactivated, the provider may request a second form of identification if he or she does not know the member. After the member's identity has been verified, providers may verify a member's enrollment by using one of the EVS methods such as AVR (Automated Voice Response).

Defective Cards

If a provider uses a card reader for a ForwardHealth card and the magnetic stripe is defective, the provider should encourage the member to call Member Services at the number listed on the back of the member's card to request a new card.

If a member presents a ForwardHealth card with a defective magnetic stripe, providers may verify the member's enrollment by using an alternate enrollment verification method. Providers may also verify a member's enrollment by entering the member ID or 16-digit card number on a touch pad, if available, or by calling WiCall or Provider Services.

Lost Cards

If a member needs a replacement ForwardHealth card, he or she may call Member Services to request a new one.

If a member lost his or her ForwardHealth card or never received one, the member may call Member Services to request a new one.

Managed Care Organization Enrollment Changes

Members do not receive a new ForwardHealth card if they are enrolled in a state-contracted MCO (managed care organization) or change from one MCO to another. Providers should verify enrollment with the EVS every time they see a member to ensure they have the most current managed care enrollment information.

Topic #1435

Types of Identification Cards

ForwardHealth members receive an identification card upon initial eligibility determination. Identification cards may be presented in different formats (e.g., white plastic cards, paper cards, or paper printouts), depending on the program and the method used to enroll (i.e., paper application or online application). Members who are temporarily enrolled in BadgerCare Plus or Family Planning Only Services receive temporary identification cards.

Misuse and Abuse of Benefits

Topic #271

Examples of Member Abuse or Misuse

Examples of member abuse or misuse are included in DHS 104.02(5), Wis. Admin. Code.

Topic #274

Pharmacy Services Lock-In Program

Overview of the Pharmacy Services Lock-In Program

The purpose of the Pharmacy Services Lock-In Program is to coordinate the provision of health care services for members who abuse or misuse Medicaid, BadgerCare Plus, or SeniorCare benefits by seeking duplicate or medically unnecessary services, particularly for controlled substances. The Pharmacy Services Lock-In Program focuses on the abuse or misuse of prescription benefits for controlled substances. Abuse or misuse is defined under Recipient Duties in DHS 104.02, Wis. Admin. Code.

Coordination of member health care services is intended to:

- Curb the abuse or misuse of controlled substance medications.
- Improve the quality of care for a member.
- Reduce unnecessary physician utilization.

The Pharmacy Services Lock-In Program focuses on the abuse or misuse of prescription benefits for controlled substances. Abuse or misuse is defined under Recipient Duties in DHS 104.02, Wis. Admin. Code. The abuse and misuse definition includes:

- Not duplicating or altering prescriptions.
- Not feigning illness, using false pretense, providing incorrect enrollment status, or providing false information to obtain service.
- Not seeking duplicate care from more than one provider for the same or similar condition.
- Not seeking medical care that is excessive or not medically necessary.

The Pharmacy Services Lock-In Program applies to members in fee-for-service as well as members enrolled in Medicaid SSI (Supplemental Security Income) HMOs (health maintenance organizations) and BadgerCare Plus HMOs. Members remain enrolled in the Pharmacy Services Lock-In Program for two years and are continuously monitored for their prescription drug usage. At the end of the two-year enrollment period, an assessment is made to determine if the member should continue enrollment in the Pharmacy Services Lock-In Program.

Members enrolled in the Pharmacy Services Lock-In Program will be locked into one pharmacy where prescriptions for restricted medications must be filled and one prescriber who will prescribe restricted medications. Restricted medications are most controlled substances, carisoprodol, and tramadol. Referrals will be required only for restricted medication services.

Fee-for-service members enrolled in the Pharmacy Services Lock-In Program may choose physicians and pharmacy providers from whom to receive prescriptions and medical services not related to restricted medications. Members enrolled in an HMO must comply with the HMO's policies regarding care that is not related to restricted medications.

Referrals of members as candidates for lock-in are received from retrospective DUR (Drug Utilization Review), physicians, pharmacists, other providers, and through automated surveillance methods. Once a referral is received, six months of pharmacy claims and diagnoses data are reviewed. A recommendation for one of the following courses of action is then made:

- No further action.
- Send an intervention letter to the physician.
- Send a warning letter to the member.
- Enroll the member in the Pharmacy Services Lock-In Program.

Medicaid, BadgerCare Plus, and SeniorCare members who are candidates for enrollment in the Pharmacy Services Lock-In Program are sent a letter of intent, which explains the restriction that will be applied, how to designate a primary prescriber and a pharmacy, and how to request a hearing if they wish to contest the decision for enrollment (i.e., due process). If a member fails to designate providers, the Pharmacy Services Lock-In Program may assign providers based on claims' history. In the letter of intent, members are also informed that access to emergency care is not restricted.

Letters of notification are sent to the member and to the lock-in primary prescriber and pharmacy. Providers may designate alternate prescribers or pharmacies for restricted medications, as appropriate. Members remain in the Pharmacy Services Lock-In Program for two years. The primary lock-in prescriber and pharmacy may make referrals for specialist care or for care that they are otherwise unable to provide (e.g., home infusion services). The member's utilization of services is reviewed prior to release from the Pharmacy Services Lock-In Program, and lock-in providers are notified of the member's release date.

Excluded Drugs

The following scheduled drugs will be excluded from monitoring by the Pharmacy Services Lock-In Program:

- Anabolic steroids.
- Barbiturates used for seizure control.
- Lyrica®.
- Provigil® and Nuvigil®.
- Weight loss drugs.

Pharmacy Services Lock-In Program Administrator

The Pharmacy Services Lock-In Program is administered by HID (Health Information Designs, Inc.). HID may be contacted by telephone at (800) 225-6998, extension 3045, by fax at (800) 881-5573, or by mail at the following address:

Pharmacy Services Lock-In Program
c/o Health Information Designs
391 Industry Dr
Auburn AL 36832

Pharmacy Services Lock-In Prescribers Are Required to Be Enrolled in Wisconsin Medicaid

To prescribe restricted medications for Pharmacy Services Lock-In Program members, prescribers are required to be enrolled in Wisconsin Medicaid. Enrollment for the Pharmacy Services Lock-In Program is not separate from enrollment in Wisconsin Medicaid.

Role of the Lock-In Prescriber and Pharmacy Provider

The Lock-In prescriber determines what restricted medications are medically necessary for the member, prescribes those

medications using his or her professional discretion, and designates an alternate prescriber if needed. If the member requires an alternate prescriber to prescribe restricted medications, the primary prescriber should complete the Pharmacy Services Lock-In Program Designation of Alternate Prescriber for Restricted Medication Services (F-11183 (12/10)) form and return it to the Pharmacy Services Lock-In Program and to the member's HMO, if applicable.

To coordinate the provision of medications, the Lock-In prescriber may also contact the Lock-In pharmacy to give the pharmacist(s) guidelines as to which medications should be filled for the member and from whom. The primary Lock-In prescriber should also coordinate the provision of medications with any other prescribers he or she has designated for the member.

The Lock-In pharmacy fills prescriptions for restricted medications that have been written by the member's Lock-In prescriber(s) and works with the Lock-In prescriber(s) to ensure the member's drug regimen is consistent with the overall care plan. The Lock-In pharmacy may fill prescriptions for medications from prescribers other than the Lock-In prescriber only for medications not on the list of restricted medications. If a pharmacy claim for a restricted medication is submitted from a provider who is not a designated Lock-In prescriber, the claim will be denied.

Designated Lock-In Pharmacies

The Pharmacy Services Lock-In Program pharmacy fills prescriptions for restricted medications that have been written by the member's Lock-In prescriber(s) and works with the Lock-In prescriber(s) to ensure the member's drug regimen is consistent with the overall care plan. The Lock-In pharmacy may fill prescriptions for medications from prescribers other than the Lock-In prescriber only for medications not on the list of restricted medications. If a pharmacy claim for a restricted medication is submitted from a provider who is not a designated Lock-In prescriber, the claim will be denied.

Alternate Providers for Members Enrolled in the Pharmacy Services Lock-In Program

Members enrolled in the Pharmacy Services Lock-In Program do not have to visit their Lock-In prescriber to receive medical services unless an HMO requires a primary care visit. Members may see other providers to receive medical services; however, other providers cannot prescribe restricted medications for Pharmacy Services Lock-In Program members unless specifically designated to do so by the primary Lock-In prescriber. For example, if a member sees a cardiologist, the cardiologist may prescribe a statin for the member, but the cardiologist may not prescribe restricted medications unless he or she has been designated by the Lock-In prescriber as an alternate provider.

A referral to an alternate provider for a Pharmacy Services Lock-In Program member is necessary only when the member needs to obtain a prescription for a restricted medication from a provider other than his or her Lock-In prescriber or Lock-In pharmacy.

If the member requires alternate prescribers to prescribe restricted medications, the primary Lock-In prescriber is required to complete the Pharmacy Services Lock-In Program Designation of Alternate Prescriber for Restricted Medication Services form. Referrals for fee-for-service members must be on file with the Pharmacy Services Lock-In Program. Referrals for HMO members must be on file with the Pharmacy Service Lock-In Program and the member's HMO.

Designated alternate prescribers are required to be enrolled in Wisconsin Medicaid.

Claims from Providers Who Are Not Designated Pharmacy Services Lock-In Providers

If the member brings a prescription for a restricted medication from a non-Lock-In prescriber to the designated Lock-In pharmacy, the pharmacy provider cannot fill the prescription.

If a pharmacy claim for a restricted medication is submitted from a provider who is not the designated Lock-In prescriber, alternate prescriber, Lock-In pharmacy, or alternate pharmacy, the claim will be denied. If a claim is denied because the

prescription is not from a designated Lock-In prescriber, the Lock-In pharmacy provider cannot dispense the drug or collect a cash payment from the member because the service is a nonreimbursable service. However, the Lock-In pharmacy provider may contact the Lock-In prescriber to request a new prescription for the drug, if appropriate.

To determine if a provider is on file with the Pharmacy Services Lock-In Program, the Lock-In pharmacy provider may do one of the following:

- Speak to the member.
- Call HID.
- Call Provider Services.
- Use the ForwardHealth Portal.

Claims are not reimbursable if the designated Lock-In prescriber, alternate Lock-In prescriber, Lock-In pharmacy, or alternate Lock-In pharmacy provider is not on file with the Pharmacy Services Lock-In Program.

For More Information

Providers may call HID with questions about the Pharmacy Services Lock-In Program. Pharmacy providers may also refer to the list of restricted medications data table or call Provider Services with questions about the following:

- Drugs that are restricted for Pharmacy Services Lock-In Program members.
- A member's enrollment in the Pharmacy Services Lock-In program.
- A member's designated Lock-In prescriber or Lock-In pharmacy.

Topic #273

Providers May Refuse to Provide Services

Providers may refuse to provide services to a BadgerCare Plus or Medicaid member in situations when there is reason to believe that the person presenting the ForwardHealth identification card is misusing or abusing it.

Members who abuse or misuse BadgerCare Plus or Wisconsin Medicaid benefits or their ForwardHealth card may have their benefits terminated or be subject to limitations under the Pharmacy Services Lock-In Program or to criminal prosecution.

Topic #275

Requesting Additional Proof of Identity

Providers may request additional proof of identity from a member if they suspect fraudulent use of a ForwardHealth identification card. If another form of identification is not available, providers can compare a person's signature with the signature on the back of the ForwardHealth identification card if it is signed. (Adult members are encouraged to sign the back of their cards; however, it is not mandatory for members to do so.)

Verifying member identity, as well as enrollment, can help providers detect instances of fraudulent ForwardHealth card use.

Special Enrollment Circumstances

Topic #276

Medicaid Members from Other States

Wisconsin Medicaid does not pay for services provided to members enrolled in other state Medicaid programs. Providers are advised to contact other state Medicaid programs to determine whether the service sought is a covered service under that state's Medicaid program.

Topic #279

Members Traveling Out of State

When a member travels out of state but is within the United States (including its territories), Canada, or Mexico, BadgerCare Plus and Wisconsin Medicaid cover medical services in any of the following circumstances:

- An emergency illness or accident.
- When the member's health would be endangered if treatment were postponed.
- When the member's health would be endangered if travel to Wisconsin were undertaken.
- When PA (prior authorization) has been granted to the out-of-state provider for provision of a nonemergency service.
- When there are coinsurance, copayment, or deductible amounts remaining after Medicare payment or approval for dual eligibles.

Note: Some providers located in a state that borders Wisconsin may be Wisconsin Medicaid enrolled as a border-status provider if the provider notifies ForwardHealth in writing that it is common practice for members in a particular area of Wisconsin to seek his or her medical services. Border-status providers follow the same policies as Wisconsin providers.

Topic #277

Non-U.S. Citizens — Emergency Services

Certain non-U.S. citizens who are not qualified aliens are eligible for services only in cases of acute emergency medical conditions. Providers should use the appropriate diagnosis code to document the nature of the emergency.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of such severity that one could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the person's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Due to federal regulations, BadgerCare Plus and Wisconsin Medicaid do not cover services for non-U.S. citizens who are not qualified aliens related to routine prenatal or postpartum care, major organ transplants (e.g., heart, liver), or ongoing treatment for chronic conditions where there is no evidence of an acute emergent state. For the purposes of this policy, all labor and delivery is considered an emergency service.

Note: Babies born to certain non-qualifying immigrants are eligible for Medicaid enrollment under the CEN (continuously eligible newborn) option. However, babies born to women with incomes over 300 percent of the FPL (Federal Poverty Level) are not eligible for CEN status. The baby may still qualify for BadgerCare Plus. These mothers should report the birth to the local agencies within ten calendar days.

A provider who gives emergency care to a non-U.S. citizen should refer him or her to the local county or tribal agency or ForwardHealth outstation site for a determination of BadgerCare Plus enrollment. Providers may complete the Certification of Emergency for Non-U.S. Citizens (F-01162 (02/09)) form for clients to take to the local county or tribal agency in their county of residence where the BadgerCare Plus enrollment decision is made.

Providers should be aware that a client's enrollment does not guarantee that the services provided will be reimbursed by BadgerCare Plus.

Topic #278

Persons Detained by Legal Process

Most individuals detained by legal process are *not* eligible for BadgerCare Plus or Wisconsin Medicaid benefits.

Note: "Detained by legal process" means a person who is incarcerated (including some Huber Law prisoners) because of law violation or alleged law violation, which includes misdemeanors, felonies, delinquent acts, and day-release prisoners.

Pregnant women detained by legal process who qualify for the BadgerCare Plus Prenatal Program and state prison inmates who qualify for Wisconsin Medicaid or BadgerCare Plus during inpatient hospital stays may receive certain benefits. Additionally, inmates of county jails admitted to a hospital for inpatient services who are expected to remain in the hospital for 24 hours or more will be eligible for PE (presumptive eligibility) determinations for BadgerCare Plus by qualified hospitals. Refer to the Presumptive Eligibility chapter of either the Inpatient or Outpatient Hospital service area for more information on the PE determination process.

The DOC (Department of Corrections) oversees health care-related needs for individuals detained by legal process who do not qualify for the BadgerCare Plus Prenatal Program or for state prison inmates who do not qualify for Wisconsin Medicaid or BadgerCare Plus during an inpatient hospital stay.

Topic #280

Retroactive Enrollment

Retroactive enrollment occurs when an individual has applied for BadgerCare Plus or Medicaid and enrollment is granted with an effective date prior to the date the enrollment determination was made. A member's enrollment may be backdated to allow retroactive coverage for medical bills incurred prior to the date of application.

The retroactive enrollment period may be backdated up to three months prior to the month of application if all enrollment requirements were met during the period. Enrollment may be backdated more than three months if there were delays in determining enrollment or if court orders, fair hearings, or appeals were involved.

Reimbursing Members in Cases of Retroactive Enrollment

When a member receives retroactive enrollment, he or she has the right to request the return of payments made to a Medicaid-enrolled provider for a covered service during the period of retroactive enrollment, according to DHS 104.01(11), Wis. Admin. Code. A Medicaid-enrolled provider is required to submit claims to ForwardHealth for covered services provided to a member during periods of retroactive enrollment. Medicaid cannot directly refund the member.

If a service(s) that requires PA (prior authorization) was performed during the member's period of retroactive enrollment, the provider is required to submit a PA request and receive approval from ForwardHealth *before* submitting a claim.

If a provider receives reimbursement from Medicaid for services provided to a retroactively enrolled member and the member has paid for the service, the provider is required to reimburse the member or authorized person acting on behalf of the member (e.g., local General Relief agency) the full amount that the member paid for the service.

If a claim cannot be filed within 365 days of the DOS (date of service) due to a delay in the determination of a member's retroactive enrollment, the provider is required to submit the claim to Timely Filing within 180 days of the date the retroactive enrollment is entered into Wisconsin's EVS (Enrollment Verification System) (if the services provided during the period of retroactive enrollment were covered).

Topic #281

Spenddown to Meet Financial Enrollment Requirements

Occasionally, an individual with significant medical bills meets all enrollment requirements except those pertaining to income. These individuals are required to "spenddown" their income to meet financial enrollment requirements.

The certifying agency calculates the individual's spenddown (or deductible) amount, tracks all medical costs the individual incurs, and determines when the medical costs have satisfied the spenddown amount. (A payment for a medical service does not have to be made by the individual to be counted toward satisfying the spenddown amount.)

When the individual meets the spenddown amount, the certifying agency notifies ForwardHealth and the provider of the last service that the individual is eligible beginning on the date that the spenddown amount was satisfied.

If the individual's last medical bill is greater than the amount needed to satisfy the spenddown amount, the certifying agency notifies the affected provider by indicating the following:

- The individual is eligible for benefits as of the DOS (date of service) on the last bill.
- A claim for the service(s) on the last bill should be submitted to ForwardHealth. (The claim should indicate the full cost of the service.)
- The portion of the last bill that the individual must pay to the provider.

The certifying agency also informs ForwardHealth of the individual's enrollment and identifies the following:

- The DOS of the final charges counted toward satisfying the spenddown amount.
- The provider number of the provider of the last service.
- The spenddown amount remaining to be satisfied.

When the provider submits the claim, the spenddown amount will automatically be deducted from the provider's reimbursement for the claim. The spenddown amount is indicated in the Member's Share element on the Medicaid Remaining Deductible Update (F-10109 (02/14)) form sent to providers by the member's certifying agency. The provider's reimbursement is then reduced by the amount of the member's obligation.

Provider Enrollment and Ongoing Responsibilities

6

Archive Date:01/02/2019

Provider Enrollment and Ongoing Responsibilities:Documentation

Topic #6277

1099 Miscellaneous Forms

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

The 1099 Miscellaneous forms are sent to the address designated as the "1099 mailing address."

Topic #1640

Availability of Records to Authorized Personnel

The DHS (Department of Health Services) has the right to inspect, review, audit, and reproduce provider records pursuant to DHS 106.02(9)(e), Wis. Admin. Code. The DHS periodically requests provider records for compliance audits to match information against ForwardHealth's information on paid claims, PA (prior authorization) requests, and enrollment. These records include, but are not limited to, medical/clinical and financial documents. Providers are obligated to ensure that the records are released to an authorized DHS staff member(s).

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

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

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

The reproduction of records requested by the PRO (Peer Review Organization) under contract with the DHS is reimbursed at a rate established by the PRO.

Topic #1715

Case Note Examples

The following are examples of complete and incomplete case notes. The first example meets the minimum requirements for case notes.

Complete Case Note Example

ABC County Case Management log notes

Member: John Doe

Case Manager: Sue Smith, MSW

01/01/03

Consultation with county personal care provider at county office regarding personal care services for member since he is having problems performing all cares. Supervising nurse from personal care agency will set up appointment with member to do assessment within the next week.

Will talk to her after the assessment to see if Mr. Doe qualifies for personal care.

15 minutes

Sue Smith, MSW

Incomplete Case Note Example

The following example does *not* meet the minimum requirements for case notes. The example does not clearly establish that case management was performed or that the service was linked to a case plan.

ABC County Case Management log notes

Member: John Doe

Case Manager: Sue Smith, MSW

Visit with John Doe. There was a problem with his home care service.

ForwardHealth provides samples of the member face sheet and monthly log. Providers may create their own forms, as long as their created forms contain the same information as the forms in ForwardHealth's sample record keeping forms.

Wisconsin Medicaid Case Management Recipient Face Sheet Sample

Agency Name: _____ Case Manager: _____

Date Completed: _____

General Information			
Name		Telephone Number	
Address		Birth Date	
Target Group		Medicaid ID #	
Other Insurance	Income and/or Income Source		

Emergency Contact Information		
Guardian's Name	Emergency Contact's Name	Relationship to Recipient
Telephone Number	Telephone Number	
Address	Address	

Other Contact Information			
	Name	Address	Telephone Number
Primary Care Physician			
Primary Medical Contact			
HMO			
Pharmacy			
Hospital Preference			
Other Support			

Case Plan Summary				
Service	Provider's Name	Telephone Number	Frequency and Hours of Contact	Funding Source

Sample Monthly Log for Ongoing Monitoring and Service Coordination

Client (Last, First, MI): Doe, John J.

MA ID Number: 1234567890

Agency: ABC County

Case Manager – Name: Sue Smith

Title: MSW

Description Codes (to be used in the second column below)

BF = Beneficiary Contact – Face to Face
BT = Beneficiary Contact – Telephone
T = Travel Time to Provide Services under BF
CF = Collateral Contact – Face to Face
CT = Collateral Contact – Telephone
S = Staffing/Consultation
R = Record Keeping

Date	Code	Place of Service	Hours	Minutes	Documentation of Activities (sign or initial each entry)
1/1/03	S	County Office		15	Consultation with county personal care provider at county office regarding arranging personal care service for client, John Doe, since he is having problems performing cares. Supervising nurse, Jessie Jones, from ABC personal care agency will set up appointment with client to do assessment within the next week. Will talk to her after the assessment to see if Mr. Doe qualifies for personal care. S.S., MSW

Monthly Total: _____

Total Units: _____

Signature/Title: Sue Smith, MSW

Date: MM/DD/YY

Topic #1714

Case Record Maintenance

According to DHS 106.02(9) and DHS 107.32(1)(d), Wis. Admin. Code, providers are required to maintain case records, in writing or in electronic format that can be reduced to writing, which indicate all case management contacts with, and on behalf of, members. The case manager or individuals providing assessment and case planning must individually list the services in the case record. The case records must document the following:

- Name of member.
- The full name and title of the person who made the contact. Additionally, if initials are used in the case records, the file must contain a signature page showing the full name of the person who initialed the record.
- What the content of the contact was.
- Why the contact was made.
- How much time was spent.
- The date the contact was made.
- Where the contact was made.

ForwardHealth provides a completed sample monthly log for ongoing monitoring and service coordination. Providers may create their own form, as long as their created form contains the same information as the sample monthly log. It is the enrolled case management provider's responsibility to comply with the standards for monthly logs for ongoing monitoring and service coordination, whether for its own or subcontracted staff.

Sample Monthly Log for Ongoing Monitoring and Service Coordination

Client (Last, First, MI): Doe, John J.					
MA ID Number: 1234567890				**Case Manager – Name:** Sue Smith	
Agency: ABC County				**Title:** MSW	
Description Codes (to be used in the second column below) **BF = Beneficiary Contact – Face to Face** **CF = Collateral Contact – Face to Face** **S = Staffing/Consultation** **BT = Beneficiary Contact – Telephone** **CT = Collateral Contact – Telephone** **R = Record Keeping** **T = Travel Time to Provide Services under BF**					
Date	**Code**	**Place of Service**	**Hours**	**Minutes**	**Documentation of Activities (sign or initial each entry)**
1/1/03	S	County Office		15	Consultation with county personal care provider at county office regarding arranging personal care service for client, John Doe, since he is having problems performing cares. Supervising nurse, Jessie Jones, from ABC personal care agency will set up appointment with client to do assessment within the next week. Will talk to her after the assessment to see if Mr. Doe qualifies for personal care. S.S., MSW

Monthly Total: _____ **Total Units:** _____

Signature/Title: Sue Smith, MSW **Date:** MM/DD/YY

Topic #200

Confidentiality and Proper Disposal of Records

ForwardHealth supports member rights regarding the confidentiality of health care and other related records, including an applicant or member's billing information or medical claim records. An applicant or member has a right to have this information safeguarded, and the provider is obligated to protect that right. Use or disclosure of any information concerning an applicant or member (including an applicant or member's billing information or medical claim records) for any purpose not connected with program administration is prohibited unless authorized by the applicant or member (program administration includes contacts with third-party payers that are necessary for pursuing third-party payment and the release of information as ordered by the court).

Federal HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy and Security regulations establish requirements regarding the confidentiality and proper disposal of health care and related records containing PHI (protected health information). These requirements apply to all providers (who are considered "covered entities") and their business associates who create, retain, and dispose of such records.

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

HIPAA Privacy and Security Regulations

Definition of Protected Health Information

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

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

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

Requirements Regarding "Unsecured" Protected Health Information

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

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

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

Actions Required for Proper Disposal of Records

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

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

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

For more information regarding securing PHI, providers may refer to Health Information Privacy on the HHS Web site.

Wisconsin Confidentiality Laws

Section 134.97, Wis. Stats., requires providers and their business partners who are not subject to HIPAA regulations to comply with Wisconsin confidentiality laws pertaining to the disposal of health care and related records containing PHI.

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

"Personally Identifiable Data" Protected

According to s.134.97(1)(e), Wis. Stats., the types of records protected are those containing "personally identifiable data."

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

Actions Required for Proper Disposal of Records

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

Businesses Affected

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

Continuing Responsibilities for All Providers After Ending Participation

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

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

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

Penalties for Violations

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

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

For entities not subject to HIPAA, s.134.97(4), Wis. Stats., imposes penalties for violations of confidentiality laws. Any provider or provider's business partner who violates Wisconsin confidentiality laws may be subject to fines up to $1,000 per incident or occurrence.

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

Topic #928

Electronic

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

- Providers are required to have a paper or electronic back-up system for electronic documentation. This could include having files saved on disk or CD in case of computer failure.
- For audits conducted by the DMS (Division of Medicaid Services), providers are required to produce paper copies of electronic records upon request.
- Providers are required to have safeguards to prevent unauthorized access to the records.

Providers are required to have the signature of the individual performing each service and maintain each signature in their records. This individual is referred to as the "performer."

Topic #201

Financial Records

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

Topic #202

Medical Records

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

Topic #199

Member Access to Records

Providers are required to allow members access to their health care records, including those related to ForwardHealth services, maintained by a provider in accordance with Wisconsin Statutes, excluding billing statements.

Fees for Health Care Records

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

Per s. 146.81(4), Wis. Stats., health care records are all records related to the health of a patient prepared by, or under the supervision of, a health care provider.

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

Note: A provider may charge members 100 percent of the applicable fees for providing a second or additional set of copies of the

member's health care records.

The DHS (Department of Health Services) adjusts the amounts a provider may charge for providing copies of a member's health care records yearly per s. 146.83(3f)(c), Wis. Stats.

Topic #16157

Policy Requirements for Use of Electronic Signatures on Electronic Health Records

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

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

Electronic Signature Definition

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

Some examples include:

- Typed name (performer may type his or her complete name).
- Number (performer may type a number unique to him or her).
- Initials (performer may type initials unique to him or her).

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

Benefits of Using Electronic Signatures

The use of electronic signatures will allow providers to:

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

Electronic Signature Requirements

By following the general electronic signature requirements below, the use of electronic signatures provides a secure alternative to written signatures. These requirements align with HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rule guidelines.

General Requirements

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

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

Electronic Health Record Signature Requirements

An EHR (electronic health record) that utilizes electronic signatures must meet the following requirements:

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

Topic #203

Preparation and Maintenance of Records

All providers who receive payment from Wisconsin Medicaid, including state-contracted MCOs (managed care organizations), are required to maintain records that fully document the basis of charges upon which all claims for payment are made, according to DHS 106.02(9)(a), Wis. Admin. Code. This required maintenance of records is typically required by any third-party insurance

company and is not unique to ForwardHealth.

Topic #204

Record Retention

Providers are required to retain documentation, including medical and financial records, for a period of not less than five years from the date of payment, except RHCs (rural health clinics), which are required to retain records for a minimum of six years from the date of payment.

According to DHS 106.02(9)(d), Wis. Admin. Code, providers are required to retain all evidence of billing information.

Ending participation as a provider does not end a provider's responsibility to retain and provide access to fully maintained records unless an alternative arrangement of record retention and maintenance has been established.

Maintaining Confidentiality of Records

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

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

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

Reviews and Audits

The DHS (Department of Health Services) periodically reviews provider records. The DHS has the right to inspect, review, audit, and photocopy the records. Providers are required to permit access to any requested record(s), whether in written, electronic, or micrographic form.

Topic #205

Records Requests

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

- When the member is a dual eligible (i.e., member is eligible for both Medicare and Wisconsin Medicaid or BadgerCare Plus) and is requesting materials pursuant to *Medicare* regulations.
- When the provider is attempting to exhaust all existing health insurance sources prior to submitting claims to ForwardHealth.

Request from a Member or Authorized Person

If the request for a member's billing information or medical claim records is from a member or authorized person acting on behalf of a member, the provider is required to do the following:

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

    The letter must be sent to the following address:

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

Request from an Attorney, Insurance Company, or Power of Attorney

If the request for a member's billing information or medical claim records is from an attorney, insurance company, or power of attorney, the provider is required to do the following:

1. Obtain a release signed by the member or authorized representative.
2. Furnish the requested material to the requester, marked "BILLED TO FORWARDHEALTH" or "TO BE BILLED TO FORWARDHEALTH," with a copy of the release signed by the member or authorized representative. Approval from ForwardHealth is not necessary.
3. Send a copy of the material furnished to the requestor, along with a copy of their original request and medical authorization release to:

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

Request for Information About a Member Enrolled in a State-Contracted Managed Care Organization

If the request for a member's billing information or medical claim records is for a member enrolled in a state-contracted MCO (managed care organization), the provider is required to do the following:

1. Obtain a release signed by the member or authorized representative.
2. Send a copy of the letter requesting the information, along with the release signed by the member or authorized representative, directly to the MCO.

The MCO makes most benefit payments and is entitled to any recovery that may be available.

Request for a Statement from a Dual Eligible

If the request is for an itemized statement from a dual eligible, pursuant to HR 2015 (Balanced Budget Act of 1997) s. 4311, a dual eligible has the right to request and receive an itemized statement from his or her Medicare-enrolled health care provider. The Act requires the provider to furnish the requested information to the member. The Act does *not* require the provider to notify

ForwardHealth.

Topic #1646

Release of Billing Information to Government Agencies

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

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

Ongoing Responsibilities

Topic #220

Accommodating Members with Disabilities

All providers, including ForwardHealth providers, operating an existing public accommodation have requirements under Title III of the Americans with Disabilities Act of 1990 (nondiscrimination).

Topic #219

Civil Rights Compliance (Nondiscrimination)

Providers are required to comply with all federal laws relating to Title XIX of the Social Security Act and state laws pertinent to ForwardHealth, including the following:

- Title VI and VII of the Civil Rights Act of 1964.
- The Age Discrimination Act of 1975.
- Section 504 of the Rehabilitation Act of 1973.
- The ADA (Americans with Disabilities Act) of 1990.

The previously listed laws require that all health care benefits under ForwardHealth be provided on a nondiscriminatory basis. No applicant or member can be denied participation in ForwardHealth or be denied benefits or otherwise subjected to discrimination in any manner under ForwardHealth on the basis of race, color, national origin or ancestry, sex, religion, age, disability, or association with a person with a disability.

Any of the following actions may be considered discriminatory treatment when based on race, color, national origin, disability, or association with a person with a disability:

- Denial of aid, care, services, or other benefits.
- Segregation or separate treatment.
- Restriction in any way of any advantage or privilege received by others. (There are some program restrictions based on eligibility classifications.)
- Treatment different from that given to others in the determination of eligibility.
- Refusing to provide an oral language interpreter to persons who are considered LEP (limited English proficient) at no cost to the LEP individual in order to provide meaningful access.
- Not providing translation of vital documents to the LEP groups who represent five percent or 1,000, whichever is smaller, in the provider's area of service delivery.

Note: Limiting practice by age is not age discrimination and specializing in certain conditions is not disability discrimination. For further information, see 45 CFR Part 91.

Providers are required to be in compliance with the previously mentioned laws as they are currently in effect or amended. Providers who employ 25 or more employees and receive $25,000 or more annually in Medicaid reimbursement are also required to comply with the DHS (Department of Health Services) Affirmative Action and Civil Rights Compliance Plan requirements. Providers that employ less than 25 employees and receive less than $25,000 annually in Medicaid reimbursement are required to comply by submitting a Letter of Assurance and other appropriate forms.

Providers without Internet access may obtain copies of the DHS Affirmative Action and Civil Rights Compliance Plan (including the Letter of Assurance and other forms) and instructions by calling the Affirmative Action and Civil Rights Compliance Officer at (608) 266-9372. Providers may also write to the following address:

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

For more information on the acts protecting members from discrimination, refer to the civil rights compliance information in the Enrollment and Benefits booklet. The booklet is given to new ForwardHealth members by local county or tribal agencies. Potential ForwardHealth members can request the booklet by calling Member Services.

Title VI of the Civil Rights Act of 1964

This act requires that all benefits be provided on a nondiscriminatory basis and that decisions regarding the provision of services be made without regard to race, color, or national origin. Under this act, the following actions are prohibited, if made on the basis of race, color, or national origin:

- Denying services, financial aid, or other benefits that are provided as a part of a provider's program.
- Providing services in a manner different from those provided to others under the program.
- Aggregating or separately treating clients.
- Treating individuals differently in eligibility determination or application for services.
- Selecting a site that has the effect of excluding individuals.
- Denying an individual's participation as a member of a planning or advisory board.
- Any other method or criteria of administering a program that has the effect of treating or affecting individuals in a discriminatory manner.

Title VII of the Civil Rights Act of 1964

This act prohibits differential treatment, based solely on a person's race, color, sex, national origin, or religion, in the terms and conditions of employment. These conditions or terms of employment are failure or refusal to hire or discharge compensation and benefits, privileges of employment, segregation, classification, and the establishment of artificial or arbitrary barriers to employment.

Federal Rehabilitation Act of 1973, Section 504

This act prohibits discrimination in both employment and service delivery based solely on a person's disability.

This act requires the provision of reasonable accommodations where the employer or service provider cannot show that the accommodation would impose an undue hardship in the delivery of the services. A reasonable accommodation is a device or service modification that will allow the disabled person to receive a provider's benefits. An undue hardship is a burden on the program that is not equal to the benefits of allowing that handicapped person's participation.

A handicapped person means any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

In addition, Section 504 requires "program accessibility," which may mean building accessibility, outreach, or other measures that allow for full participation of the handicapped individual. In determining program accessibility, the program or activity will be viewed in its entirety. In choosing a method of meeting accessibility requirements, the provider shall give priority to those methods that offer a person who is disabled services that are provided in the most integrated setting appropriate.

Americans with Disabilities Act of 1990

Under Title III of the ADA (Americans with Disabilities Act) of 1990, any provider that operates an existing public accommodation has four specific requirements:

1. Remove barriers to make his or her goods and services available to and usable by people with disabilities to the extent that it is readily achievable to do so (i.e., to the extent that needed changes can be accomplished without much difficulty or expense).
2. Provide auxiliary aids and services so that people with sensory or cognitive disabilities have access to effective means of communication, unless doing so would fundamentally alter the operation or result in undue burdens.
3. Modify any policies, practices, or procedures that may be discriminatory or have a discriminatory effect, unless doing so would fundamentally alter the nature of the goods, services, facilities, or accommodations.
4. Ensure that there are no unnecessary eligibility criteria that tend to screen out or segregate individuals with disabilities or limit their full and equal enjoyment of the place of public accommodation.

Age Discrimination Act of 1975

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

Topic #198

Contracted Staff

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

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

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

Providers are also responsible for informing a contracted agency of ForwardHealth requirements. Providers should refer those with whom they contract for services to ForwardHealth publications for program policies and procedures. ForwardHealth references and publications include, but are not limited to, the following:

- Wisconsin Administrative Code.
- *ForwardHealth Updates*.
- The Online Handbook.

Providers should encourage contracted agencies to visit the ForwardHealth Portal regularly for the most current information.

Topic #216

Examples of Ongoing Responsibilities

Responsibilities for which providers are held accountable are described throughout the Online Handbook. Medicaid-enrolled providers have responsibilities that include, but are not limited to, the following:

- Providing the same level and quality of care to ForwardHealth members as private-pay patients.
- Complying with all state and federal laws related to ForwardHealth.
- Obtaining PA (prior authorization) for services, when required.
- Notifying members in advance if a service is not covered by ForwardHealth and the provider intends to collect payment from the member for the service.
- Maintaining accurate medical and billing records.
- Retaining preparation, maintenance, medical, and financial records, along with other documentation, for a period of not less than five years from the date of payment, except rural health clinic providers who are required to retain records for a minimum of six years from the date of payment.
- Billing only for services that were actually provided.
- Allowing a member access to his or her records.
- Monitoring contracted staff.
- Accepting Medicaid reimbursement as payment in full for covered services.
- Keeping provider information (i.e., address, business name) current.
- Notifying ForwardHealth of changes in ownership.
- Responding to Medicaid revalidation notifications.
- Safeguarding member confidentiality.
- Verifying member enrollment.
- Keeping up-to-date with changes in program requirements as announced in ForwardHealth publications.

Topic #217

Keeping Information Current

Changes That Require ForwardHealth Notification

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

- Address(es) — practice location and related information, mailing, PA (prior authorization), and/or financial.

  Note: Health care providers who are federally required to have an NPI (National Provider Identifier) are cautioned that changes to their practice location address on file with ForwardHealth may alter their ZIP+4 code information that is required on transactions.

- Business name.
- Contact name.
- Federal Tax ID number (IRS (Internal Revenue Service) number).
- Group affiliation.
- Licensure.
- NPI.
- Ownership.
- Professional certification.
- Provider specialty.
- Supervisor of nonbilling providers.
- Taxonomy code.
- Telephone number, including area code.

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

- Incorrect reimbursement.
- Misdirected payment.
- Claim denial.
- Suspension of payments or cancellation of provider file if provider mail is returned to ForwardHealth for lack of a current address.

Entering new information on a claim form or PA request is **not** adequate notification of change.

Notifying ForwardHealth of Changes

Providers can notify ForwardHealth of changes using the demographic maintenance tool.

Providers Enrolled in Multiple Programs

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

Providers Licensed or Certified by the Division of Quality Assurance

Providers licensed or certified by the DQA (Division of Quality Assurance) are required to notify the DQA of changes to physical address, changes of ownership, and facility closures by emailing Lisa.Imhof@dhs.wisconsin.gov.

Topic #577

Legal Framework

The following laws and regulations provide the legal framework for BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid:

- Federal Law and Regulation:
  - Law — United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
  - Regulation — Title 42 CFR Parts 430-498 and Parts 1000-1008 (Public Health).
- Wisconsin Law and Regulation:
  - Law — Wisconsin Statutes: 49.43-49.499, 49.665, and 49.473.
  - Regulation — Wisconsin Administrative Code, Chapters DHS 101, 102, 103, 104, 105, 106, 107, and 108.

Laws and regulations may be amended or added at any time. Program requirements may not be construed to supersede the provisions of these laws and regulations.

The information included in the ForwardHealth Portal applies to BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid. BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid are administered by the DHS (Department of Health Services). Within the DHS, the DMS (Division of Medicaid Services) is directly responsible for managing these programs.

Topic #1710

Section 49.45(25), Wis. Stats. and DHS 105.51 and DHS 107.32, Wis. Admin. Code, provide the legal framework for case management services.

Topic #17097

Licensure Information

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

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

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

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

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

Topic #15157

Recovery Audit Contractor Audits

The ACA (Affordable Care Act) requires states to establish an RAC (Recovery Audit Contractor) program to enable the auditing of Medicaid claim payments to providers. In Wisconsin, the RAC will audit claim payments from Wisconsin Medicaid and BadgerCare Plus. The Wisconsin DHS (Department of Health Services) has awarded the contract to HMS (Health Management Systems, Inc.) as the RAC for the state of Wisconsin.

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

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

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

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

Affected Providers

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

Additional Information

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

Topic #13277

Reporting Suspected Waste, Fraud, and Abuse

The DHS (Department of Health Services) OIG (Office of Inspector General) investigates fraud and abuses including, but not limited to, the following:

- Billing Medicaid for services or equipment that were not provided.
- Submitting false applications for a DHS-funded assistance program such as Medicaid, BadgerCare Plus, WIC (Special Supplemental Nutrition Program for Women, Infants, and Children), or FoodShare.
- Trafficking FoodShare benefits.
- Crime, misconduct, and/or mismanagement by a DHS employee, official, or contractor.

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

Section 49.49, Wis. Stats., defines actions that represent member misuse or abuse of benefits and the resulting sanctions that may be imposed. Providers are under no obligation to inform the member that they are misusing or abusing their benefits. A provider may not confiscate a ForwardHealth card from a member in question.

Reporting Suspected Fraud and Abuse

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

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

- Going to the OIG fraud and abuse reporting Web site.
- Calling the DHS fraud and abuse hotline at (877) 865-3432.

The following information is helpful when reporting fraud and abuse:

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

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

Topic #1711

Submitting Cost Reports

The WIMCR (Wisconsin Medicaid Cost Reporting) initiative is a cost-based payment system for counties enrolled as Medicaid providers of community-based services that provides additional funding for Wisconsin Medicaid while remaining cost neutral for counties.

All counties enrolled as Medicaid providers of community-based services are required to submit cost reports to ForwardHealth. Cost reports are required under WIMCR for the following services provided and billed to Wisconsin Medicaid by county providers:

- Case management services.
- Child/adolescent day treatment.
- Community support program services.
- Home health services.
- Medical day treatment services.
- Mental health crisis intervention services.
- Outpatient mental health and substance abuse services, including evaluation, psychotherapy, and substance abuse counseling and intensive in-home mental health services for children under HealthCheck.
- Outpatient mental health and substance abuse services provided in the home and community. (The non-federal share of this service is provided by the county.)
- Personal care services.
- PNCC (Prenatal Care Coordination) services.
- Substance abuse day treatment.

If Wisconsin Medicaid is not billed by the county for case management services, no cost report is required.

Cost Reporting Web Tool

Counties are required to submit cost reports online by using the WIMCR Web tool. After registering on the Web site, the user will be directed to the WIMCR home page where the following information is located:

- Certification of Medicaid Operating Deficit and Application for Distribution of Federal Financial Participation.
- Past WIMCR Cost Reports.
- The WIMCR Cost Report Instruction Manual.
- Other WIMCR reference documents.

WIMCR Initiative Information

For further information about the WIMCR initiative, refer to the document titled, "Questions and Answers Regarding Wisconsin Medicaid Cost Reporting Including Medicaid Payments, CSDRB, CBMAC, and the State/County Contracts."

Provider Enrollment

Topic #3969

Categories of Enrollment

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

- Billing/rendering provider.
- Rendering-only provider.
- Billing-only provider (including group billing).

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

Billing/Rendering Provider

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

Rendering-Only Provider

Enrollment as a rendering-only provider is given to those providers who practice under the professional supervision of another provider (e.g., physician assistants). Providers with a rendering provider enrollment cannot submit claims to ForwardHealth directly, but they have reimbursement rates established for their provider type. Claims for services provided by a rendering provider must include the supervising provider or group provider as the billing provider.

Billing-Only Provider (Including Group Billing)

Enrollment as a billing-only provider is given to certain provider types when a separate rendering provider is required on claims.

Group Billing

Groups of individual practitioners are enrolled as billing-only providers as an accounting convenience. This allows the group to receive one reimbursement, one RA (Remittance Advice), and the 835 (835 Health Care Claim Payment/Advice) transaction for covered services rendered by individual practitioners within the group.

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

Individual practitioners within group practices are required to be Medicaid-enrolled because these groups are required to identify the provider who rendered the service on claims. Claims indicating these group billing providers that are submitted without a rendering provider are denied.

Topic #14137

Enrollment Requirements Due to the Affordable Care Act

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

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

Topic #1720

Entities Providing Case Management Services

Throughout the Case Management service area of the Online Handbook, three different names are used to signify who may provide case management services. These names are *not* interchangeable. The following list defines the three types of entities:

- *Case Management Provider* — denotes the entity that meets the requirements as an enrolled case management provider and is assigned the NPI (National Provider Identifier).
- *Case Management Agency* — organization with whom the provider contracts.
- *Case Manager* — individual who is providing case management services to members.

Topic #193

Materials for New Providers

On an ongoing basis, providers should refer to the Online Handbook for the most current BadgerCare Plus, Medicaid, and ADAP (Wisconsin AIDS Drug Assistance Program) information. Future changes to policies and procedures are published in *ForwardHealth Updates*. *Updates* are available for viewing and downloading on the ForwardHealth Publications page.

Topic #4457

Provider Addresses

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

- *Practice location address and related information.* This address is where the provider's office is physically located and where records are normally kept. Additional information for the practice location includes the provider's office telephone number and the telephone number for members' use. With limited exceptions, the practice location and telephone number for members' use are published in a provider directory made available to the public.
- *Mailing address.* This address is where ForwardHealth will mail general information and correspondence. Providers should indicate accurate address information to aid in proper mail delivery.
- *PA (prior authorization) address.* This address is where ForwardHealth will mail PA information.
- *Financial addresses.* Two separate financial addresses are stored for ForwardHealth. The checks address is where ForwardHealth will mail paper checks. The 1099 mailing address is where ForwardHealth will mail IRS Form 1099.

Providers may submit additional address information or modify their current information using the demographic maintenance tool.

Note: Providers are cautioned that any changes to their practice location on file with Wisconsin Medicaid may alter their ZIP+4 code information required on transactions. Providers may verify the ZIP+4 code for their address on the U.S. Postal Service website.

Topic #14157

Provider Enrollment Information Home Page

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

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

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

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

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

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

Topic #1931

Provider Type and Specialty Changes

Provider Type

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

Provider Specialty

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

Providers should contact Provider Services with any questions about adding or changing a specialty.

Topic #1716

Staff Qualifications

Qualifications for Performing Assessments and Case Plans

As defined in DHS 105.51(2), Wis. Admin. Code, case managers performing assessments and case planning must meet both of the following requirements:

- Knowledge of the local service delivery system, the target group's needs, the need for integrated services, and the resources available or needing to be developed.
- A degree in a human services-related field and one year of supervised experience, or two years of supervised experience working with people in the target population, or an equivalent combination of training and experience.

The enrolled case management provider is responsible for ensuring that its own or subcontracted staff meet these requirements.

Determining a Human Services-Related Field

BadgerCare Plus and Wisconsin Medicaid rules do not define a human services-related field. Since degree requirements vary, case management providers are required to review the prospective case manager's records to identify the amount of course work completed in areas relevant to case management. Some examples of relevant course work might be human development, long term care, and psychology.

Case management providers must look at training, experience, or a combination of training and experience to make a determination of equivalency to the standards.

For the purposes of meeting these requirements, an RN (registered nurse) with a Bachelor's degree in nursing is considered to have a degree in a human services-related field.

Qualifications for Providing Ongoing Monitoring and Service Coordination

Case managers providing ongoing monitoring and service coordination must have knowledge of the following:

- Local service delivery system.
- Target population's needs.
- Need for integrated services.
- Resources available or needing development.

Case managers typically gain such knowledge through one year of supervised experience working with people in the designated target populations.

For example, an enrolled substance abuse counselor qualifies to provide case management services for a person with alcohol or drug dependence. However, for an elderly member, that substance abuse counselor may *not* qualify to perform case management services. The case management provider must have, available upon request, its policies and procedures for determining an individual case manager's qualifications, as well as documentation of its case manager's qualifications. A case management provider must make and document any determination of qualifications based on equivalency using written guidelines and procedures. The enrolled case management provider is responsible for the determination of equivalence for its own or subcontracted staff.

Topic #14317

Terminology to Know for Provider Enrollment

Due to the ACA (Affordable Care Act), ForwardHealth has adopted new terminology. The following table includes new terminology that will be useful to providers during the provider enrollment and revalidation processes. Providers may refer to the Medicaid rule 42 CFR s. 455.101 for more information.

New Terminology	Definition
Agent	Any person who has been delegated the authority to obligate or act on behalf of a provider.
Disclosing entity	A Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent.
Federal health care programs	Federal health care programs include Medicare, Medicaid, Title XX, and Title XXI.
Other disclosing agent	Any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVII, or XX of the Act. This includes: • Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or HMO that participates in Medicare (Title XVIII) • Any Medicare intermediary or carrier • Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or XX of the Act
Indirect ownership	An ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership in the disclosing entity.
Managing employee	A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.
Ownership interest	The possession of equity in the capital, the stock, or the profits of the disclosing entity.
	A person or corporation for which one or more of the following applies:

Person with an ownership or control interest	• Has an ownership interest totaling five percent or more in a disclosing entity • Has an indirect ownership interest equal to five percent or more in a disclosing entity • Has a combination of direct and indirect ownership interest equal to five percent or more in a disclosing entity • Owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or asset of the disclosing entity • Is an officer or director of a disclosing entity that is organized as a corporation • Is a person in a disclosing entity that is organized as a partnership
Subcontractor	• An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or, • An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.
Re-enrollment	Re-enrollment of a provider whose Medicaid enrollment has ended for any reason other than sanctions or failure to revalidate may be re-enrolled as long as all licensure and enrollment requirements are met. Providers should note that when they re-enroll, application fees and screening activities may apply. Re-enrollment was formerly known as re-instate.
Revalidation	All enrolled providers are required to revalidate their enrollment information every three years to continue their participation with Wisconsin Medicaid. Revalidation was formerly known as recertification.

Note: Providers should note that the CMS (Centers for Medicare and Medicaid Services) requires revalidation at least every five years. However, Wisconsin Medicaid will continue to revalidate providers every three years.

Provider Numbers

Topic #3421

Provider Identification

Health Care Providers

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

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

Providers should ensure that they have obtained an appropriate NPI prior to beginning their enrollment application. There are two kinds of NPIs:

- Entity Type 1 NPIs are for individuals who provide health care, such as physicians, dentists, and chiropractors.
- Entity Type 2 NPIs are for organizations that provide health care, such as hospitals, group practices, pharmacies, and home health agencies.

It is possible for a provider to qualify for both Entity Type 1 and Entity Type 2 NPIs. For example, an individual physical therapist may also be the owner of a therapy group that is a corporation and have two Wisconsin Medicaid enrollments — one enrollment as an individual physical therapist and the other enrollment as the physical therapy group. A Type 1 NPI for the individual enrollment and a Type 2 NPI for the group enrollment are required.

NPIs and classifications may be viewed on the NPPES Web site. The CMS (Centers for Medicare and Medicaid Services) Web site includes more information on Type 1 and Type 2 NPIs.

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

Non-healthcare Providers

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

Topic #5096

Taxonomy Codes

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

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

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

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

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

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

Topic #5097

ZIP Code

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

When a ZIP+4 code is required to identify a provider, omission of it will cause claims and other transactions to be denied or delayed in processing.

Providers may verify the ZIP+4 code for their address on the U.S. Postal Service Web site.

Provider Rights

Topic #208

A Comprehensive Overview of Provider Rights

Medicaid-enrolled providers have certain rights including, but not limited to, the following:

- Limiting the number of members they serve in a nondiscriminatory way.
- Ending participation in Wisconsin Medicaid.
- Applying for a discretionary waiver or variance of certain rules identified in Wisconsin Administrative Code.
- Collecting payment from a member under limited circumstances.
- Refusing services to a member if the member refuses or fails to present a ForwardHealth identification card. However, possession of a ForwardHealth card does not guarantee enrollment (e.g., the member may not be enrolled, may be enrolled only for limited benefits, or the ForwardHealth card may be invalid). Providers may confirm the current enrollment of the member by using one of the EVS (Enrollment Verification System) methods, including calling Provider Services.

Topic #207

Ending Participation

Providers other than home health agencies and nursing facilities may terminate participation in ForwardHealth according to DHS 106.05, Wis. Admin. Code.

Providers choosing to withdraw should promptly notify their members to give them ample time to find another provider.

When withdrawing, the provider is required to do the following:

- Provide a written notice of the decision at least 30 days in advance of the termination.
- Indicate the effective date of termination.

Providers will not receive reimbursement for nonemergency services provided on and after the effective date of termination. Voluntary termination notices can be sent to the following address:

Wisconsin Medicaid
Provider Enrollment
313 Blettner Blvd
Madison WI 53784

If the provider fails to specify an effective date in the notice of termination, ForwardHealth may terminate the provider on the date the notice is received.

Topic #14117

Ending Participation as a Case Management Provider

To provide case management services, the case management provider's county, village, or town board of supervisors, city council, or Indian tribal government must elect to provide the services, as outlined in s. 49.45(25)(am), Wis. Stats. Therefore, at any time,

a county, city, village, town, or tribal government may send notice of termination of, or amendment to, participation as a case management provider to ForwardHealth. Such notice supersedes any prior action by the case management provider within the county, city, village, town, or tribal jurisdiction.

Topic #209

Hearing Requests

A provider who wishes to contest a DHS (Department of Health Services) action or inaction for which due process is required under s. 227, Wis. Stats., may request a hearing by writing to the DHA (Division of Hearings and Appeals).

A provider who wishes to contest the DMS (Division of Medicaid Services)'s notice of intent to recover payment (e.g., to recoup for overpayments discovered in an audit by DMS) is required to request a hearing on the matter within the time period specified in the notice. The request, which must be in writing, should briefly summarize the provider's basis for contesting the DHS decision to withhold payment.

Refer to DHS 106, Wis. Admin. Code, for detailed instructions on how to file an appeal.

If a timely request for a hearing is not received, the DHS may recover those amounts specified in its original notice from future amounts owed to the provider.

Note: Providers are not entitled to administrative hearings for billing disputes.

Topic #210

Limiting the Number of Members

If providers choose to limit the number of members they see, they cannot accept a member as a private-pay patient. Providers should instead refer the member to another ForwardHealth provider.

Persons applying for or receiving benefits are protected against discrimination based on race, color, national origin, sex, religion, age, disability, or association with a person with a disability.

Topic #206

Requesting Discretionary Waivers and Variances

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

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

Requirements

A request for a waiver or variance may be made at any time; however, all applications must be made in writing to the DMS. All applications are required to specify the following:

- The rule from which the waiver or variance is requested.

- The time period for which the waiver or variance is requested.
- If the request is for a variance, the specific alternative action proposed by the provider.
- The reasons for the request.
- Justification that all requirements for a discretionary waiver or variance would be satisfied.

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

Application

The DMS may grant a discretionary waiver or variance if it finds that all of the following requirements are met:

- The waiver or variance will not adversely affect the health, safety, or welfare of any member.
- Either the strict enforcement of a requirement would result in unreasonable hardship on the provider or on a member, or an alternative to a rule is in the interests of better care or management. An alternative to a rule would include a new concept, method, procedure or technique, new equipment, new personnel qualifications, or the implementation of a pilot project.
- The waiver or variance is consistent with all applicable state and federal statutes and federal regulations.
- Federal financial participation is available for all services under the waiver or variance, consistent with the Medicaid state plan, the federal CMS (Centers for Medicare and Medicaid Services), and other applicable federal program requirements.
- Services relating to the waiver or variance are medically necessary.

To apply for a discretionary waiver or variance, providers are required to send their application to the following address:

Division of Medicaid Services
Waivers and Variances
PO Box 309
Madison WI 53701-0309

Sanctions

Topic #211

Intermediate Sanctions

According to DHS 106.08(3), Wis. Admin. Code, the DHS (Department of Health Services) may impose intermediate sanctions on providers who violate certain requirements. Common examples of sanctions that the DHS may apply include the following:

- Review of the provider's claims before payment.
- Referral to the appropriate peer review organization, licensing authority, or accreditation organization.
- Restricting the provider's participation in BadgerCare Plus.
- Requiring the provider to correct deficiencies identified in a DHS audit.

Prior to imposing any alternative sanction under this section, the DHS will issue a written notice to the provider in accordance with DHS 106.12, Wis. Admin. Code.

Any sanction imposed by the DHS may be appealed by the provider under DHS 106.12, Wis. Admin. Code. Providers may appeal a sanction by writing to the DHA (Division of Hearings and Appeals).

Topic #1709

Case Management Audit Adjustments and Disallowances

According to DHS 106.09(2), Wis. Admin. Code, the enrolled case management provider is liable for the entire amount of an audit adjustment or disallowance attributed to the provider by the federal government or DHS (Department of Health Services).

Case management providers may use the Wisconsin Medicaid Case Management Agency Self-Audit Checklist (F-00023 (02/09)) to assess their level of compliance with case management policies and procedures. The use of this checklist is strictly voluntary.

Topic #212

Involuntary Termination

The DHS (Department of Health Services) may suspend or terminate the Medicaid enrollment of any provider according to DHS 106.06, Wis. Admin. Code.

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

- The DHS finds that any of the grounds for provider termination are applicable.
- The suspension or termination will not deny members access to services.

Reasonable notice and an opportunity for a hearing within 15 days will be given to each provider whose enrollment is terminated by the DHS. Refer to DHS 106.07, Wis. Admin. Code, for detailed information regarding possible sanctions.

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

Topic #213

Sanctions for Collecting Payment from Members

Under state and federal laws, if a provider inappropriately collects payment from an enrolled member, or authorized person acting on behalf of the member, that provider may be subject to program sanctions including termination of Medicaid enrollment. In addition, the provider may also be fined not more than $25,000, or imprisoned not more than five years, or both, pursuant to 42 USC s. 1320a-7b(d) or s. 49.49(3m), Wis. Stats.

There may be narrow exceptions on when providers may collect payment from members.

Topic #214

Withholding Payments

The DHS (Department of Health Services) may withhold full or partial Medicaid provider payments without prior notification if, as the result of any review or audit, the DHS finds reliable evidence of fraud or willful misrepresentation.

"Reliable evidence" of fraud or willful misrepresentation includes, but is not limited to, the filing of criminal charges by a prosecuting attorney against the provider or one of the provider's agents or employees.

The DHS is required to send the provider a written notice within five days of taking this action. The notice will generally set forth the allegations without necessarily disclosing specific information about the investigation.

Reimbursement

7

Archive Date:01/02/2019

Reimbursement:Amounts

Topic #258

Acceptance of Payment

The amounts allowed as payment for covered services must be accepted as payment in full. Therefore, total payment for the service (i.e., any amount paid by other health insurance sources, any BadgerCare Plus or Medicaid copayment or spenddown amounts paid by the member, and any amount paid by BadgerCare Plus, Medicaid, or ADAP (Wisconsin AIDS Drug Assistance Program)) may not exceed the allowed amount. As a result, providers may not collect payment from a member, or authorized person acting on behalf of the member, for the difference between their usual and customary charge and the allowed amount for a service (i.e., balance billing).

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

Topic #694

Billing Service and Clearinghouse Contracts

According to DHS 106.03(5)(c)2, Wis. Admin. Code, contracts with outside billing services or clearinghouses may not be based on commission in which compensation for the service is dependent on reimbursement from BadgerCare Plus. This means compensation must be unrelated, directly or indirectly, to the amount of reimbursement or the number of claims and is not dependent upon the actual collection of payment.

Topic #8117

Electronic Funds Transfer

EFT (electronic funds transfer) allows ForwardHealth to directly deposit payments into a provider's designated bank account for a more efficient delivery of payments than the current process of mailing paper checks. EFT is secure, eliminates paper, and reduces the uncertainty of possible delays in mail delivery.

Only in-state and border-status providers who submit claims and MCOs (managed care organizations) are eligible to receive EFT payments.

Provider Exceptions

EFT payments are not available to the following providers:

- In-state emergency providers.
- Out-of-state providers.
- Out-of-country providers.
- SMV (specialized medical vehicle) providers during their provisional enrollment period.

Enrolling in Electronic Funds Transfer

A ForwardHealth Portal account is required to enroll into EFT as all enrollments must be completed via a secure Provider Portal account or a secure MCO Portal account. Paper enrollments are not accepted. A separate EFT enrollment is required for each financial payer a provider bills.

Providers who do not have a Portal account may Request Portal Access online. Providers may also call the Portal Helpdesk for assistance in requesting a Portal account.

The following guidelines apply to EFT enrollment:

- Only a Portal Administrator or a clerk that has been assigned the "EFT" role on the Portal may complete the EFT enrollment information.
- Organizations cannot revert back to receiving paper checks once enrolled in EFT.
- Organizations may change their EFT information at any time.
- Organizations will continue to receive their Remittance Advice as they do currently.

Refer to the Electronic Funds Transfer User Guide on the Portal User Guides page of the Portal for instructions and more information about EFT enrollment.

Providers will continue to receive payment via paper check until the enrollment process moves into "Active" status and the provider's ForwardHealth EFT enrollment is considered complete.

Recoupment and Reversals

Enrollment in EFT does not change the current process of recouping funds. Overpayments and recoupment of funds will continue to be conducted through the reduction of payments.

Note: Enrolling in EFT does not authorize ForwardHealth to make unauthorized debits to the provider's EFT account; however, in some instances an EFT reversal of payment may be necessary. For example, if the system generates a payment twice or the amount entered manually consists of an incorrect value (e.g., a decimal point is omitted creating a $50,000 keyed value for a $500 claim), a reversal will take place to correct the error and resend the correct transaction value. ForwardHealth will notify the designated EFT contact person of an EFT reversal if a payment is made in error due to a system processing or manual data entry error.

Problem Resolution

If payment is not deposited into the designated EFT account according to the ForwardHealth payment cycle, providers should first check with their financial institution to confirm the payment was received. If the payment was not received, providers should then call Provider Services to resolve the issue and payment by paper check will be reinstated until the matter has been resolved.

Topic #897

Fee Schedules

Maximum allowable fee information is available on the ForwardHealth Portal in the following forms:

- Interactive fee schedule
- Downloadable fee schedule in TXT (text) files

Certain fee schedules are interactive. Interactive fee schedules provide coverage information as well as maximum allowable fees for all reimbursable procedure codes. The downloadable TXT files are free of charge and provide basic maximum allowable fee information for BadgerCare Plus by provider service area.

A provider may request a paper copy of a fee schedule by calling Provider Services.

Providers may call Provider Services in the following cases:

- Internet access is not available.
- There is uncertainty as to which fee schedule should be used.
- The appropriate fee schedule cannot be found on the Portal.
- To determine coverage or maximum allowable fee of procedure codes not appearing on a fee schedule.

Topic #1668

Matching Fund Requirements

Wisconsin Medicaid is funded by a combination of state/local and federal funds. In order for the state to collect the approximately 60 percent federal share, Wisconsin Medicaid has to secure approximately 40 percent as the state share. For Medicaid case management, existing state and local funding constitutes this state match. This could be county tax levy, COP (Community Options Program) funds, Family Support monies, Alzheimer's Caregiver Support funds, Life Care Services Program funds under s. 252.12, Wis. Stats., funding for Independent Living Centers under s. 46.96, Wis. Stats., or any state GPR (general program revenue) aids allocated to county agencies administering case management services to eligible members.

Medicaid-enrolled case management agencies must have sufficient state or local funding to serve as the nonfederal share of case management reimbursement and must maintain an audit trail to document expenditures for eligible members.

There are two limitations on funds allowable for matching funds:

1. Federal monies cannot be used to match the federal share of Medicaid dollars, unless the federal funds are authorized for this purpose.
2. Local funds already being used to match other federal funds cannot be used as a match for case management. Examples of this include:
    1. The same local funds cannot be claimed as a match for community support program services and case management.
    2. The same local funds may not be claimed as a match for maternal/child health block grants and case management.

Topic #260

Maximum Allowable Fees

Maximum allowable fees are established for most covered services. Maximum allowable fees are based on various factors, including a review of usual and customary charges submitted, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. Maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law.

Providers are reimbursed at the lesser of their billed amount and the maximum allowable fee for the procedure.

Topic #1667

Terms of Reimbursement

Medicaid reimbursement is based on a uniform, contracted hourly rate set by Wisconsin Medicaid. This hourly rate applies to all services provided by the enrolled case management provider or by agencies or individuals contracted by that provider for case

management services. The provider receives the federal share of the hourly contracted rate for all hours of allowable service.

Collecting Payment From Members

Topic #227

Conditions That Must Be Met

A member may request a noncovered service, a covered service for which PA (prior authorization) was denied (or modified), or a service that is not covered under the member's limited benefit category. The charge for the service may be collected from the member if the following conditions are met *prior* to the delivery of that service:

- The member accepts responsibility for payment.
- The provider and member make payment arrangements for the service.

Providers are strongly encouraged to obtain a *written* statement in advance documenting that the member has accepted responsibility for the payment of the service.

Furthermore, the service must be separate or distinct from a related, covered service. For example, a vision provider may provide a member with eyeglasses but then, upon the member's request, provide and charge the member for anti-glare coating, which is a noncovered service. Charging the member is permissible in this situation because the anti-glare coating is a separate service and can be added to the lenses at a later time.

Topic #538

Cost Sharing

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

Topic #224

Situations When Member Payment Is Allowed

Providers may not collect payment from a member, or authorized person acting on behalf of the member, **except** for the following:

- Required member copayments for certain services.
- Commercial insurance payments made to the member.
- Spenddown.
- Charges for a private room in a nursing home if meeting the requirements stated in Wis. Admin. Code § DHS 107.09(4)(k), or in a hospital if meeting the requirements stated in Wis. Admin. Code § DHS 107.08(3)(a)2.
- Noncovered services if certain conditions are met.
- Covered services for which PA (prior authorization) was denied (or an originally requested service for which a PA request was modified) if certain conditions are met. These services are treated as noncovered services.
- Services provided to a member in a limited benefit category when the services are not covered under the limited benefit and

if certain conditions are met.

If a provider inappropriately collects payment from a member, or authorized person acting on behalf of the member, that provider may be subject to program sanctions including termination of Medicaid enrollment.

Copayment

Topic #1666

Prohibited

Providers are prohibited from collecting copayment for case management services.

Payer of Last Resort

Topic #242

Instances When Medicaid Is Not Payer of Last Resort

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

- Birth to 3.
- Crime Victim Compensation Fund.
- GA (General Assistance).
- HCBS (Home and Community-Based Services) waiver programs.
- IDEA (Individuals with Disabilities Education Act).
- Indian Health Service.
- Maternal and Child Health Services.
- WCDP (Wisconsin Chronic Disease Program).
    - Adult Cystic Fibrosis.
    - Chronic Renal Disease.
    - Hemophilia Home Care.

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

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

Topic #253

Payer of Last Resort

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

Topic #255

Primary and Secondary Payers

The terms "primary payer" and "secondary payer" indicate the relative order in which insurance sources are responsible for paying claims.

In general, commercial health insurance is primary to Medicare, and Medicare is primary to Wisconsin Medicaid and BadgerCare Plus. Therefore, Wisconsin Medicaid and BadgerCare Plus are secondary to Medicare, and Medicare is secondary to commercial health insurance.

Reimbursement Not Available

Topic #1665

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 case management services:

1. Diagnosis, evaluation, or treatment of a physical, dental, or mental illness. (However, referral to these services is considered a component of case management services.)
2. Monitoring of clinical symptoms.
3. Administration of medications.
4. Client education and training.
5. Legal advocacy by an attorney or paralegal.
6. Provision of supportive home care or personal care.
7. Information and referral services that are not based on a member's current POC (plan of care).
8. Services other than case management that are covered elsewhere when performed by persons who are enrolled with Wisconsin Medicaid for that service. For example, services provided by home health agencies, psychotherapists, occupational therapists, etc., whose services can be billed and paid for as therapy (or evaluation) may not be billed as case management. Staffing and other involvement in assessments or case plans by these professionals are not covered services, unless they cannot be covered as a service other than case management.

Topic #695

Reimbursement Not Available Through a Factor

BadgerCare Plus will not reimburse providers through a factor, either directly or by virtue of a power of attorney given to the factor by the provider. A factor is an organization (e.g., a collection agency) or person who advances money to a provider for the purchase or transferal of the provider's accounts receivable. The term "factor" does not include business representatives, such as billing services, clearinghouses, or accounting firms, which render statements and receive payments in the name of the provider.

Topic #51

Services Not Separately Reimbursable

If reimbursement for a service is included in the reimbursement for the primary procedure or service, it is not separately reimbursable. For example, routine venipuncture is not separately reimbursable, but it is included in the reimbursement for the laboratory procedure or the laboratory test preparation and handling fee. Also, DME (durable medical equipment) delivery charges are included in the reimbursement for DME items.

Topic #1664

Case Management Services for Nursing Home Members

Case management is *not* a separately payable service when provided to nursing home members, except within 30 days before nursing home discharge.

Case Management Services for Members in Community Support Programs

Wisconsin Medicaid does not reimburse case management providers for case management services provided to members receiving Medicaid-reimbursed CSP (Community Support Program) services. Case management services provided to CSP members should be billed under the Medicaid CSP benefit, not the case management benefit. Information on CSP services can be found in the Community Support Program service area of the Online Handbook.

Topic #1686

Severely Emotionally Disturbed Determination

Wisconsin Medicaid does not reimburse for the three-person team determination that a child is SED (severely emotionally disturbed).

Resources

8

Archive Date:01/02/2019

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

Provider Relations Representatives

The Provider Relations representatives, also known as field representatives, conduct training sessions on various ForwardHealth topics for both large and small groups of providers and billers. In addition to provider education, 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.

Field Representative Specialization

The field representatives are assigned to specific regions of the state. In addition, the field representatives have specialized in a group of provider types. This specialization allows the field representatives to most efficiently and effectively address provider inquiries. To better direct inquiries, providers should contact the field representative in their region who specializes in their provider type.

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 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 ForwardHealth 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 (e.g., telephone or written

correspondence).
- Referrals by a Provider Services telephone correspondent.
- Complex issues that require extensive explanation.

Field representatives primarily 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 e-mail, providers should ensure that no individually identifiable health information, known as PHI (protected health information), is included in the message. PHI can include things such as the member's name combined with his/her identification number or SSN (Social Security number).

Information to Have Ready

Providers or their representatives should have the following information ready when they call:

- 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.
- Telephone number, including area code.
- A concise statement outlining concern.
- Days and times when available.

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

- Member's name.
- Member identification number.
- Claim number.
- DOS (date of service).

Topic #474

Provider Services

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

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

Ways Provider Services Can Help

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

- Billing and claim submissions.
- Provider enrollment.
- COB (coordination of benefits) (e.g., 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.
- 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 member identification number.
- Claim number.
- PA number.
- DOS (dates 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 Correspondent Team

The ForwardHealth call center correspondents are organized to respond to telephone calls from providers. Correspondents offer assistance and answer inquiries specific to the program (i.e., Medicaid, WCDP, or WWWP) or to the service area (i.e., pharmacy services, hospital services) in which they are designated.

Call Center Menu Options and Inquiries

Providers contacting Provider Services are prompted to select from the following menu options:

- Member enrollment — for member enrollment inquiries and verification.
- Claim and PA status — for claim and PA status inquiries.
- Pharmacy — for drug claim, policy, and drug authorization inquiries.
- Dental — for dental inquiries.
- Policy — for all policy questions except those for pharmacy and dental.
- Provider enrollment — for provider enrollment and revalidation questions.
- EHR (Electronic Health Records) — for EHR inquiries.

Walk-in Appointments

Walk-in appointments offer face-to-face assistance for providers at the Provider Services office. Providers are encouraged to contact the Provider Services Call Center to schedule a walk-in appointment.

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 (07/12)) form. The Written Correspondence Inquiry form may be photocopied or downloaded via a link from the Portal. Written correspondence should be sent to the following address:

ForwardHealth
Provider Services Written Correspondence
313 Blettner Blvd
Madison WI 53784

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

Topic #475

Provider Suggestions

The DMS (Division of Medicaid Services) is interested in improving its program for providers and members. Providers who would like to suggest a revision of any policy or procedure stated in provider publications or who wish to suggest new policies are encouraged to submit recommendations on the Provider Suggestion (F-01016 (02/09)) form.

Topic #4456

Resources Reference Guide

The Provider Services and Resources Reference Guide lists services and resources available to providers and members with contact information and hours of availability.

Provider Services and Resources Reference Guide

The Provider Services and Resources Reference Guide lists services and resources available to providers and members with contact information and hours of availability.

ForwardHealth Portal	***www.forwardhealth.wi.gov/***	**24 hours a day, seven days a week**
Public and secure access to ForwardHealth information with direct link to contact Provider Services for up-to-date access to ForwardHealth programs information, including publications, fee schedules, and forms.		
WiCall Automated Voice Response System	**(800) 947-3544**	**24 hours a day, seven days a week**
WiCall, the ForwardHealth Automated Voice Response system, provides responses to the following inquiries: • Checkwrite. • Claim status. • Prior authorization. • Member enrollment.		
ForwardHealth Provider Services Call Center	**(800) 947-9627**	**Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Standard Time)***
To assist providers in the following programs: • BadgerCare Plus. • Medicaid. • SeniorCare. • Wisconsin Well Woman Medicaid. • Wisconsin Chronic Disease Program (WCDP). • Wisconsin Well Woman Program (WWWP). • Wisconsin Medicaid and BadgerCare Plus Managed Care Programs.		
ForwardHealth Portal Helpdesk	**(866) 908-1363**	**Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central Standard Time)***
To assist providers and trading partners with technical questions regarding Portal functions and capabilities, including Portal accounts, registrations, passwords, and submissions through the Portal.		
Electronic Data Interchange Helpdesk	**(866) 416-4979**	**Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central Standard Time)***
For providers, trading partners, billing services, and clearinghouses with technical questions about the following: • Electronic transactions. • Companion documents. • Provider Electronic Solutions (PES) software.		
Managed Care Provider Appeals	**(800) 760-0001, Option 1**	**Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Standard Time)***
To assist BagderCare Plus and Medicaid Supplemental Security Income (SSI) managed care providers with questions regarding their appeal status and other general managed care provider appeal information.		
Managed Care Ombudsman Program	**(800) 760-0001**	**Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Standard Time)***
To assist managed care enrollees with questions about enrollment, rights, responsibilities, and general managed care information.		
Member Services	**(800) 362-3002**	**Monday through Friday, 8:00 a.m. to 6:00 p.m. (Central Standard Time)***
To assist ForwardHealth members or persons calling on behalf of members with program information and requirements, enrollment, finding certified providers, and resolving concerns.		
Wisconsin AIDS Drug Assistance Program (ADAP)	**(800) 991-5532**	**Monday through Friday, 8:00 a.m. to 4:30 p.m.**

		(Central Standard Time)*
To assist ADAP providers and members, or persons calling on behalf of members, with program information and requirements, enrollment, finding enrolled providers, and resolving concerns.		

*With the exception of state-observed holidays.

Electronic Data Interchange

Topic #459

Companion Guides and NCPDP Version D.0 Payer Sheet

Companion guides and the NCPDP (National Council for Prescription Drug Programs) version D.0 payer sheet are available for download on the ForwardHealth Portal.

Purpose of Companion Guides

ForwardHealth companion guides and payer sheet provide trading partners with useful technical information on ForwardHealth's standards for nationally recognized electronic transactions.

The information in companion guides and payer sheet applies to BadgerCare Plus, Medicaid, SeniorCare, ADAP (Wisconsin AIDS Drug Assistance Program), WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program). Companion guides and payer sheet are intended for information technology and systems staff who code billing systems or software.

The companion guides and payer sheet complement the federal HIPAA (Health Insurance Portability and Accountability Act of 1996) implementation guides and highlight information that trading partners need to successfully exchange electronic transactions with ForwardHealth, including general topics such as the following:

- Methods of exchanging electronic information (e.g., exchange interfaces, transaction administration, and data preparation).
- Instructions for constructing the technical component of submitting or receiving electronic transactions (e.g., claims, RA (Remittance Advice), and enrollment inquiries).

Companion guides and payer sheet do *not* include program requirements, but help those who create the electronic formats for electronic data exchange.

Companion guides and payer sheet cover the following specific subjects:

- Getting started (e.g., identification information, testing, and exchange preparation).
- Transaction administration (e.g., tracking claims submissions, contacting the EDI (Electronic Data Interchange) Helpdesk).
- Transaction formats.

Revisions to Companion Guides and Payer Sheet

Companion guides and payer sheet may be updated as a result of changes to federal requirements. When this occurs, ForwardHealth will do the following:

- Post the revised companion guides and payer sheet on the ForwardHealth Portal.
- Post a message on the banner page of the RA.
- Send an e-mail to trading partners.

Trading partners are encouraged to periodically check for revised companion guides and payer sheet on the Portal. If trading partners do not follow the revisions identified in the companion guides or payer sheet, transactions may not process successfully (e.g., claims may deny or process incorrectly).

A change summary located at the end of the revised companion guide lists the changes that have been made. The date on the companion guide reflects the date the revised companion guide was posted to the Portal. In addition, the version number located in the footer of the first page is changed with each revision.

Revisions to the payer sheet are listed in Appendix A. The date on the payer sheet reflects the date the revised payer sheet was posted to the Portal.

Topic #460

Data Exchange Methods

The following data exchange methods are supported by the EDI (Electronic Data Interchange) Helpdesk:

- Remote access server dial-up, using a personal computer with a modem, browser, and encryption software.
- Secure Web, using an Internet Service Provider and a personal computer with a modem, browser, and encryption software.
- Real-time, by which trading partners exchange the NCPDP (National Council for Prescription Drug Programs) D.0, 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Information Response), 276/277 (276/277 Health Care Claim Status Request and Response), or 278 (278 Health Care Services Review — Request for Review and Response) transactions via an approved clearinghouse.

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

Topic #461

Electronic Data Interchange Helpdesk

The EDI (Electronic Data Interchange) Helpdesk assists anyone interested in becoming a trading partner with getting started and provides ongoing support pertaining to electronic transactions. Providers, billing services, and clearinghouses are encouraged to contact the EDI Helpdesk for test packets and/or technical questions.

Providers with policy questions should call Provider Services.

Topic #462

Electronic Transactions

HIPAA (Health Insurance Portability and Accountability Act of 1996) ASC (Accredited Standards Committee) X12 Version 5010 Companion Guides and the NCPDP (National Council for Prescription Drug Programs) Version D.0 Payer Sheet are available for download on the HIPAA Version 5010 Companion Guides and NCPDP Version D.0 Payer Sheet Page of the ForwardHealth Portal.

Trading partners may submit claims and adjustment requests, inquire about member enrollment, claim status, and ForwardHealth payment advice by exchanging electronic transactions.

Through the EDI (Electronic Data Interchange) Helpdesk, trading partners may exchange the following electronic transactions:

- 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Information Response). The 270 is the electronic transaction

for inquiring about a member's enrollment. The 271 is received in response to the inquiry.
- 276/277 (276/277 Health Care Claim Status Request and Response). The 276 is the electronic transaction for checking claim status. The 277 is received in response.
- 278 (278 Health Care Services Review - Request for Review and Response). The electronic transaction for health care service PA (prior authorization) requests.
- 835 (835 Health Care Claim Payment/Advice). The electronic transaction for receiving remittance information.
- 837 (837 Health Care Claim). The electronic transaction for submitting claims and adjustment requests.
- 999 (999 Functional Acknowledgment). The electronic transaction for reporting whether a transaction is accepted or rejected.
- TA1 interChange Acknowledgment. The electronic transaction for reporting a transaction that is rejected for interChange-level errors.
- NCPDP D.0 Telecommunication Standard for Retail Pharmacy claims. The real-time POS (Point-of-Sale) electronic transaction for submitting pharmacy claims.

Topic #463

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. PES (Provider Electronic Solutions) software allows providers to submit 837 (837 Health Care Claim) transactions and download the 999 (999 Functional Acknowledgment) and the 835 (835 Health Care Claim Payment/Advice) transactions. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI (Electronic Data Interchange) Helpdesk.

Topic #464

Trading Partner Profile

A Trading Partner Profile must be completed and signed for each billing provider number that will be used to exchange electronic transactions.

In addition, billing providers who do not use a third party to exchange electronic transactions, billing services, and clearinghouses are required to complete a Trading Partner Profile.

To determine whether a Trading Partner Profile is required, providers should refer to the following:

- Billing providers who do not use a third party to exchange electronic transactions, including providers who use the PES (Provider Electronic Solutions) software, are required to complete the Trading Partner Profile.
- Billing providers who use a third party (billing services and clearinghouses) to exchange electronic transactions are required to submit a Trading Partner Profile.
- Billing services and clearinghouses, including those that use PES software, that are authorized by providers to exchange electronic transactions on a provider's behalf, are required to submit a Trading Partner Profile.

Providers who change billing services and clearinghouses or become a trading partner should keep their information updated by contacting the EDI (Electronic Data Interchange) Helpdesk.

Topic #465

Trading Partners

ForwardHealth exchanges nationally recognized electronic transactions with trading partners. A "trading partner" is defined as a covered entity that exchanges electronic health care transactions. The following covered entities are considered trading partners:

- Providers who exchange electronic transactions directly with ForwardHealth.
- Billing services and clearinghouses that exchange electronic transactions directly with ForwardHealth on behalf of a billing provider.

Enrollment Verification

Topic #256

270/271 Transactions

The 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Information Response) transactions allow for batch enrollment verification, including information for the current benefit month or for any date of eligibility the member has on file, through a secure Internet connection. The 270 is the electronic transaction for inquiring about a member's enrollment. The 271 is received in response to the inquiry.

For those providers who are federally required to have an NPI (National Provider Identifier), an NPI is required on the 270/271 transactions. The NPI indicated on the 270 is verified to ensure it is associated with a valid enrollment on file with ForwardHealth. The 271 response will report the NPI that was indicated on the 270.

For those providers exempt from NPI, a provider ID is required on the 270/271 transactions. The provider ID indicated on the 270 is verified to ensure it is associated with a valid enrollment on file with ForwardHealth. The 271 response will report the provider ID that was indicated on the 270.

Topic #469

An Overview

Providers should always verify a member's enrollment before providing services, both to determine enrollment for the current date (since a member's enrollment status may change) and to discover any limitations to the member's coverage. Each enrollment verification method allows providers to verify the following prior to services being rendered:

- A member's enrollment in a ForwardHealth program(s).
- State-contracted MCO (managed care organization) enrollment.
- Medicare enrollment.
- Limited benefits categories.
- Any other commercial health insurance coverage.
- Exemption from copayments for BadgerCare Plus members.

Topic #259

Commercial Enrollment Verification Vendors

ForwardHealth has agreements with several commercial enrollment verification vendors to offer enrollment verification technology to ForwardHealth providers. Commercial enrollment verification vendors have up-to-date access to the ForwardHealth enrollment files to ensure that providers have access to the most current enrollment information. Providers may access Wisconsin's EVS (Enrollment Verification System) to verify member enrollment through one or more of the following methods available from commercial enrollment verification vendors:

- Magnetic stripe card readers.
- Personal computer software.
- Internet.

Vendors sell magnetic stripe card readers, personal computer software, Internet access, and other services. They also provide ongoing maintenance, operations, and upgrades of their systems. Providers are responsible for the costs of using these enrollment verification methods.

Note: Providers are *not* required to purchase services from a commercial enrollment verification vendor. For more information on other ways to verify member enrollment or for questions about ForwardHealth identification cards, contact Provider Services.

The real-time enrollment verification methods allow providers to print a paper copy of the member's enrollment information, including a transaction number, for their records. Providers should retain this number or the printout as proof that an inquiry was made.

Magnetic Stripe Card Readers

The magnetic stripe card readers resemble credit card readers. Some ForwardHealth identification cards have a magnetic stripe and signature panel on the back, and a unique, 16-digit card number on the front. The 16-digit card number is valid only for use with a magnetic card reader.

Providers receive current member enrollment information after passing the ForwardHealth card through the reader or entering the member identification number or card number into a keypad and entering the DOS (date of service) about which they are inquiring.

Personal Computer Software

Personal computer software can be integrated into a provider's current computer system by using a modem and can access the same information as the magnetic stripe card readers.

Internet Access

Some enrollment verification vendors provide real-time access to enrollment from the EVS through the Internet.

Topic #4903

Copayment Information

If a member is enrolled in BadgerCare Plus or Wisconsin Medicaid and is exempt from paying copayments for services, providers will receive the following response to an enrollment query from all methods of enrollment verification:

- The name of the benefit plan.
- The member's enrollment dates.
- The message, "No Copay."

If a member is enrolled in BadgerCare Plus, Medicaid, or SeniorCare and is required to pay a copayment, the provider will be given the name of the benefit plan in which the member is enrolled and the member's enrollment dates for the benefit plan only.

Topic #264

Enrollment Verification System

Member enrollment issues are the primary reason claims are denied. To reduce claim denials, providers should *always* verify a

member's enrollment before providing services, both to determine enrollment for the current date (since a member's enrollment status may change) and to discover any limitations to the member's coverage. Providers may want to verify the member's enrollment a second time before submitting a claim to find out whether the member's enrollment information has changed since the appointment.

Providers can access Wisconsin's EVS (Enrollment Verification System) to receive the most current enrollment information through the following methods:

- ForwardHealth Portal.
- WiCall, Wisconsin's AVR (Automated Voice Response) system.
- Commercial enrollment verification vendors.
- 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Response) transactions.
- Provider Services.

Providers cannot charge a member, or authorized person acting on behalf of the member, for verifying his or her enrollment.

The EVS does not indicate other government programs that are secondary to Wisconsin Medicaid.

Topic #4901

Enrollment Verification on the Portal

The secure ForwardHealth Portal offers real-time member enrollment verification for all ForwardHealth programs. Providers will be able to use this tool to determine:

- The benefit plan(s) in which the member is enrolled.
- If the member is enrolled in a state-contracted managed care program (for Medicaid and BadgerCare Plus members).
- If the member has any other coverage, such as Medicare or commercial health insurance.
- If the member is exempted from copayments (BadgerCare Plus members only).

To access enrollment verification via the ForwardHealth Portal, providers will need to do the following:

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

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

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

Topic #4900

Entering Dates of Service

Enrollment information is provided based on a "From" DOS (date of service) and a "To" DOS that the provider enters when

making the enrollment inquiry. For enrollment inquires, a "From" DOS is the earliest date for which the provider is requesting enrollment information and the "To" DOS is the latest date for which the provider is requesting enrollment information.

Providers should use the following guidelines for entering DOS when verifying enrollment for Wisconsin Medicaid, BadgerCare Plus, SeniorCare, or WCDP (Wisconsin Chronic Disease Program) members:

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

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

Topic #265

Member Forgets ForwardHealth Identification Card

Even if a member does not present a ForwardHealth identification card, a provider can use Wisconsin's EVS (Enrollment Verification System) to verify enrollment; otherwise, the provider may choose not to provide the service(s) until a member brings in a ForwardHealth card.

A provider may use a combination of the member's name, date of birth, ForwardHealth identification number, or SSN (Social Security number) with a "0" at the end to access enrollment information through the EVS.

A provider may call Provider Services with the member's full name and date of birth to obtain the member's enrollment information if the member's identification number or SSN is not known.

Topic #4899

Member Identification Card Does Not Guarantee Enrollment

Most members receive a member identification card, but possession of a program identification card does not guarantee enrollment. Periodically, members may become ineligible for enrollment, only to re-enroll at a later date. Members are told to keep their cards even though they may have gaps in enrollment periods. It is possible that a member will present a card when he or she is not enrolled; therefore, it is essential that providers verify enrollment before providing services. To reduce claim denials, it is important that providers verify the following information prior to each DOS (date of service) that services are provided:

- If a member is enrolled in any ForwardHealth program, including benefit plan limitations.
- If a member is enrolled in a managed care organization.
- If a member is in primary provider lock-in status.
- If a member has Medicare or other insurance coverage.

Topic #4898

Responses Are Based on Financial Payer

When making an enrollment inquiry through Wisconsin's EVS (Enrollment Verification System), the returned response will provide information on the member's enrollment in benefit plans based on financial payers.

There are three financial payers under ForwardHealth:

- Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and SeniorCare).
- WCDP (Wisconsin Chronic Disease Program).
- WWWP (Wisconsin Well Woman Program).

Within each financial payer are benefit plans. Each member is enrolled under at least one of the three financial payers, and under each financial payer, is enrolled in at least one benefit plan. An individual member may be enrolled under more than one financial payer. (For instance, a member with chronic renal disease may have health care coverage under BadgerCare Plus and the WCDP chronic renal disease program. The member is enrolled under two financial payers, Medicaid and WCDP.) Alternatively, a member may have multiple benefits under a single financial payer. (For example, a member may be covered by the TB-Only (Tuberculosis-Related Services Only) Benefit and Family Planning Only Services at the same time, both of which are administered by Medicaid.)

Forms

Topic #767

An Overview

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

Topic #470

Fillable Forms

Most forms may be obtained from the Forms page of the ForwardHealth Portal.

Forms on the Portal are available as fillable PDF (Portable Document Format) files, which can be viewed with Adobe Reader® computer software. Providers may also complete and print fillable PDF files using Adobe Reader®.

To complete a fillable PDF, follow these steps:

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

Note: The Portal provides instructions on how to obtain Adobe Reader® at no charge from the Adobe® Web site. Adobe Reader® only allows providers to view and print completed PDFs. It does not allow users to save completed fillable PDFs to their computer; however, if Adobe Acrobat® is purchased, providers may save completed PDFs to their computer. Refer to the Adobe® Web site for more information about fillable PDFs.

Selected forms are also available in fillable Microsoft® Word format on the Portal. The fillable Microsoft® Word format allows providers to complete and print the form using Microsoft® Word. To complete a fillable Microsoft® Word form, follow these steps:

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

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

Topic #766

Telephone or Mail Requests

Providers who do not have Internet access or who need forms that are not available on the ForwardHealth Portal may obtain them by doing either of the following:

- Requesting a paper copy of the form by calling Provider Services. Questions about forms may also be directed to Provider Services.
- Submitting a written request and mailing it to ForwardHealth. Include a return address, the name of the form, and the form number and send the request to the following address:

    ForwardHealth
    Form Reorder
    313 Blettner Blvd
    Madison WI 53784

Portal

Topic #4904

Claims and Adjustments Using the ForwardHealth Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, copy claims, and determine what claims are in "pay" status on the ForwardHealth Portal. Providers have the ability to search for and view the status of all their finalized claims, regardless of how they were submitted (i.e., paper, electronic, clearinghouse). If a claim contains an error, providers can correct it on the Portal and resubmit it to ForwardHealth.

Providers can submit an individual claim or adjust a claim through DDE (Direct Data Entry) through the secure Portal.

Topic #8524

Conducting Revalidation Via the ForwardHealth Portal

Providers can conduct revalidation online via a secure revalidation area of the ForwardHealth Portal.

Topic #5157

Cost Share Reports for Long-Term Managed Care Organizations

Individual cost share reports for long-term care MCOs (managed care organizations) that provide Family Care, Family Care Partnership, and PACE (Program of All-Inclusive Care for the Elderly) services are available via the secure area of the ForwardHealth Portal and can be downloaded as an Excel file.

Topic #4345

Creating a Provider Account

Each provider needs to designate one individual as an administrator of the ForwardHealth Portal account. This user establishes the administrative account once his or her PIN (personal identification number) is received. The administrative user is responsible for this provider account and is able to add accounts for other users (clerks) within his or her organization and assign security roles to clerks that have been established. To establish an administrative account after receiving a PIN, the administrative user is required to follow these steps:

1. Go to the ForwardHealth Portal.
2. Click the **Providers** button.
3. Click **Logging in for the first time?**.
4. Enter the Login ID and PIN. The Login ID is the provider's NPI (National Provider Identifier) or provider number.
5. Click **Setup Account**.
6. At the Account Setup screen, enter the user's information in the required fields.

7. Read the security agreement and click the checkbox to indicate agreement with its contents.
8. Click **Submit** when complete.

Once in the secure Provider area of the Portal, the provider may conduct business online with ForwardHealth via a secure connection. Providers may also perform the following administrative functions from the Provider area of the Portal:

- Establish accounts and define access levels for clerks.
- Add other organizations to the account.
- Switch organizations.

Refer to the Account User Guide on the Portal User Guides page of the Portal for more detailed instructions on performing these functions.

Topic #16737

Demographic Maintenance Tool

The demographic maintenance tool allows providers to update information online that they are required to keep current with ForwardHealth. To access the demographic maintenance tool, providers need a ForwardHealth Portal account. After logging into their Portal account, providers should select the Demographic Maintenance link located in the Home Page box on the right side of the secure Provider home page.

Note: The Demographic Maintenance link will only display for administrative accounts or for clerk accounts that have been assigned the Demographic Maintenance role. The Account User Guide provides specific information about assigning roles.

The demographic maintenance tool contains general panels which are available to all or most providers as well as specific panels which are only available to certain provider types and specialties. The Demographic Maintenance Tool User Guide provides further information about general and provider-specific panels.

Uploading Supporting Documentation

Providers can upload enrollment-related supporting documentation (e.g., licenses, certifications) using the demographic maintenance tool. Documents in the following formats can be uploaded:

- JPEG (Joint Photographic Experts Group) (.jpg or .jpeg).
- PDF (Portable Document Format) (.pdf).

To avoid delays in processing, ForwardHealth strongly encourages providers to upload their documents.

Submitting Information

After making *all* their changes, providers are required to submit their information in order to save it. After submitting information, providers will receive one of the following messages:

- "Your information was *updated* successfully." This message indicates that providers' files were immediately updated with the changed information.
- "Your information was *uploaded* successfully." This message indicates that ForwardHealth needs to verify the information before providers' files can be updated. Additionally, an Application Submitted panel will display and indicate next steps.

Verification

ForwardHealth will verify changes within 10 business days of submission. If the changes can be verified, ForwardHealth will update providers' files. In some cases, providers may receive a Change Notification letter indicating what information ForwardHealth updated. Providers should carefully review the Provider File Information Change Summary included with the letter to verify the accuracy of the changes. If any of the changes are inaccurate, providers can correct the information using the demographic maintenance tool. Providers may contact Provider Services if they have questions regarding the letter.

Regardless of whether or not providers are notified that their provider files were updated, changed information is not considered approved until 10 business days after the information was changed. If the changes cannot be verified within 10 business days, ForwardHealth will notify providers by mail that their provider files were not updated, and providers will need to make corrections using the demographic maintenance tool.

Topic #4340

Designating a Trading Partner to Receive 835 Health Care Claim Payment/Advice Transactions

Providers must designate a trading partner to receive their 835 (835 Health Care Claim Payment/Advice) transaction for ForwardHealth interChange.

Providers who wish to submit their 835 designation via the Portal are required to create and establish a provider account to have access to the secure area of the Portal.

To designate a trading partner to receive 835 transactions, providers must first complete the following steps:

- Access the Portal and log into their secure account by clicking the Provider link/button.
- Click on the Designate 835 Receiver link on the right-hand side of the secure home page.
- Enter the identification number of the trading partner that is to receive the 835 in the Trading Partner ID field.
- Click Save.

Providers who are unable to use the Portal to designate a trading partner to receive 835 transactions may call the EDI (Electronic Data Interchange) Helpdesk or submit a paper (Trading Partner 835 Designation, F-13393 (07/12)) form.

Topic #5087

Electronic Communications

The secure ForwardHealth Portal contains a one-way message center where providers can receive electronic notifications and provider publications from ForwardHealth. All new messages display on the provider's main page within the secure Portal.

Topic #5088

Enrollment Verification

The secure ForwardHealth Portal offers real time member enrollment verification for all ForwardHealth programs. Providers are able to use this tool to determine:

- The health care program(s) in which the member is enrolled.
- Whether or not the member is enrolled in a state-contracted MCO (managed care organization).
- Whether or not the member has any third-party liability, such as Medicare or commercial health insurance.

- Whether or not the member is enrolled in the Pharmacy Services Lock-In Program and the member's Lock-In pharmacy, primary care provider, and referral providers (if applicable).

Using the Portal to check enrollment may be more effective than calling WiCall or the EVS (Enrollment Verification System) (although both are available).

Providers are assigned a unique enrollment verification number for each inquiry. Providers can also use the "print screen" function to print a paper copy of enrollment verification inquiries for their records.

Topic #4338

ForwardHealth Portal

Providers, members, trading partners, managed care programs, and partners have access to public *and* secure information through the ForwardHealth Portal.

The Portal has the following areas:

- Providers (public and secure).
- Trading Partners.
- Members.
- MCO (managed care organization).
- Partners.

The secure Portal allows providers to conduct business and exchange electronic transactions with ForwardHealth. The public Portal contains general information accessible to all users. Members can access general health care program information and apply for benefits online.

Topic #4441

ForwardHealth Portal Helpdesk

Providers and trading partners may call the ForwardHealth Portal Helpdesk with technical questions on Portal functions, including their Portal accounts, registrations, passwords, and submissions through the Portal.

Topic #4451

Inquiries to ForwardHealth Via the Portal

Providers are able to contact Provider Services through the ForwardHealth Portal by clicking the Contact link and entering the relevant inquiry information, including selecting the preferred method of response (i.e., telephone call or e-mail). Provider Services will respond to the inquiry by the preferred method of response indicated within five business days.

Topic #4400

Internet Connection Speed

ForwardHealth recommends providers have an Internet connection that will provide an upload speed of at least 768 Kbps and a download speed of at least 128 Kbps in order to efficiently conduct business with ForwardHealth via the Portal.

For PES (Provider Electronic Solutions) users, ForwardHealth recommends an Internet connection that will provide a download speed of at least 128 Kbps for downloading PES software and software updates from the Portal.

These download speeds are generally not available through a dial-up connection.

Topic #4351

Logging in to the Provider Area of the Portal

Once an administrative user's or other user's account is set up, he or she may log in to the Provider area of the ForwardHealth Portal to conduct business. To log in, the user is required to click the "Provider" link or button, then enter his or her username and password and click "Go" in the Login to Secure Site box at the right side of the screen.

Topic #4743

Managed Care Organization Portal

Information and Functions Through the Portal

The MCO (managed care organization) area of the ForwardHealth Portal allows state-contracted MCOs to conduct business with ForwardHealth. The Public MCO page offers easy access to key MCO information and web tools. A log-in is required to access the secure area of the Portal to submit or retrieve account and member information that may be sensitive.

The following information is available through the Portal:

- Listing of all Medicaid-enrolled providers
- Coordination of Benefits Extract/Insurance Carrier Master List information updated quarterly
- Data Warehouse, which is linked from the Portal to Business Objects. The Business Objects function allows for access to MCO data for long-term care MCOs.
- Electronic messages
- Enrollment verification by entering a member ID or SSN (Social Security number) with date of birth and a "from DOS (date of service)" and a "to DOS" range. A transaction number is assigned to track the request.
- Member search function for retrieving member information such as medical status codes and managed care and Medicare information
- Provider search function for retrieving provider information such as the address, telephone number, provider ID, taxonomy code (if applicable), and provider type and specialty
- HealthCheck information
- MCO contact information
- Technical contact information (Entries may be added via the Portal.)

Topic #5158

Managed Care Organization Portal Reports

The following reports are generated to MCOs (managed care organizations) through their account on the ForwardHealth MCO Portal:

- Capitation Payment Listing Report.
- Cost Share Report (long-term MCOs only).

- Enrollment Reports.

MCOs are required to establish a Portal account in order to receive reports from ForwardHealth.

Capitation Payment Listing Report

The Capitation Payment Listing Report provides "payee" MCOs with a detailed listing of the members for whom they receive capitation payments. ForwardHealth interChange creates adjustment transaction information weekly and regular capitation transaction information monthly. The weekly batch report includes regular and adjustment capitation transactions. MCOs have the option of receiving both the Capitation Payment Listing Report and the 820 Payroll Deducted and Other Group Premium Payment for Insurance Products transactions.

Initial Enrollment Roster Report

The Initial Enrollment Roster Report is generated according to the annual schedules detailing the number of new and continuing members enrolled in the MCO and those disenrolled before the next enrollment month.

Final Enrollment Roster Report

The Final Enrollment Roster Report is generated the last business day of each month and includes members who have had a change in status since the initial report and new members who were enrolled after the Initial Enrollment Roster Report was generated.

Other Reports

Additional reports are available for BadgerCare Plus HMOs, SSI HMOs, and long-term MCOs. Some are available via the Portal and some in the secure FTP (file transfer protocol).

Topic #4744

Members ForwardHealth Portal

Members can access ForwardHealth information by going to the ForwardHealth Portal. Members can search through a directory of providers by entering a ZIP code, city, or county. Members can also access all member-related ForwardHealth applications and forms. Members can use ACCESS to check availability, apply for benefits, check current benefits, and report any changes.

Topic #4344

Obtaining a Personal Identification Number

To establish an account on the ForwardHealth Portal, providers are required to obtain a PIN (personal identification number). The PIN is a unique, nine-digit number assigned by ForwardHealth interChange for the sole purpose of allowing a provider to establish a Portal account. It is used in conjunction with the provider's login ID. Once the Portal account is established, the provider will be prompted to create a username and password for the account, which will subsequently be used to log in to the Portal.

Note: The PIN used to create the provider's Portal account is not the same PIN used for revalidation. Providers will receive a separate PIN for revalidation.

A provider may need to request more than one PIN if he or she is a provider for more than one program or has more than one

type of provider enrollment. A separate PIN will be needed for each provider enrollment. Health care providers will need to supply their NPI (National Provider Identifier) and corresponding taxonomy code when requesting an account. Non-healthcare providers will need to supply their unique provider number.

Providers may request a PIN by following these steps:

1. Go to the Portal.
2. Click on the "Providers" link or button.
3. Click the "Request Portal Access" link from the Quick Links box on the right side of the screen.
4. At the Request Portal Access screen, enter the following information:
    a. Health care providers are required to enter their NPI and click "Search" to display a listing of ForwardHealth enrollments. Select the correct enrollment for the account. The taxonomy code, ZIP+4 code, and financial payer for that enrollment will be automatically populated. Enter the SSN (Social Security number) or TIN (Tax Identification Number).
    b. Non-healthcare providers are required to enter their provider number, financial payer, and SSN or TIN. (This option should only be used by non-healthcare providers who are exempt from NPI requirements).

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

    c. Click **Submit**.
    d. Once the Portal Access Request is successfully completed, ForwardHealth will send a letter with the provider's PIN to the address on file.

Topic #4459

Online Handbook

The Online Handbook allows providers access to all policy and billing information for Wisconsin Medicaid, BadgerCare Plus, ADAP (Wisconsin AIDS Drug Assistance Program), and WCDP (Wisconsin Chronic Disease Program) in one centralized place. A secure ForwardHealth Portal account is not required to use the Online Handbook as it is available to all Portal visitors.

Revisions to policy information are incorporated immediately after policy changes have been issued in *ForwardHealth Updates*. The Online Handbook also links to the ForwardHealth Publications page, an archive section that providers can use to research past policy and procedure information.

The Online Handbook, which is available through the public area of the Portal, is designed to sort information based on user-entered criteria, such as program and provider type. It is organized into sections and chapters. Sections within each handbook may include the following:

- Claims.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Managed Care.
- Member Information.
- Prior Authorization.
- Provider Enrollment and Ongoing Responsibilities.
- Reimbursement.
- Resources.

Each section consists of separate chapters (e.g., claims submission, procedure codes), which contain further detailed information.

Advanced Search Function

The Online Handbook has an advanced search function, which allows providers to search for a specific word or phrase within a user type, program, service area, or throughout the entire Online Handbook.

Providers can access the advanced search function by following these steps:

1. Go to the Portal.
2. Click the "Online Handbooks" link in the upper left "Providers" box.
3. Complete the two drop-down selections at the right to narrow the search by program and service area, if applicable. This is not needed if providers wish to search the entire Online Handbook.
4. Click "Advanced Search" to open the advanced search options.
5. Enter the word or phrase you would like to search.
6. Select "Search within the options selected above" or "Search all handbooks, programs and service areas."
7. Click the "Search" button.

ForwardHealth Publications Archive Area

The ForwardHealth Publications page of the Online Handbook allows providers to view old *Updates* and previous versions of the Online Handbook.

Providers can access the archive information area by following these steps:

1. Go to the Portal.
2. Click the "Online Handbooks" link in the upper left "Providers" box.
3. Click on the "Updates and Handbooks" link. (This link is below the three drop-down menus.)

Topic #5089

Other Business Enhancements Available on the Portal

The secure Provider area of the ForwardHealth Portal enables providers to do the following:

- Verify member enrollment.
- View RAs (Remittance Advice).
- Designate which trading partner is eligible to receive the provider's 835 (835 Health Care Claim Payment/Advice).
- Update and maintain provider file information. Providers have the choice to indicate separate addresses for different business functions.
- Receive electronic notifications and provider publications from ForwardHealth.
- Enroll in EFT (electronic funds transfer).
- Track provider-submitted PA (prior authorization) requests.

Topic #4911

Portal Account Administrators

Portal administrators are responsible for requesting, creating, and managing accounts to access these features for their

organization.

There must be one administrator assigned for each Portal account and all users established for that account. The responsibilities of the Portal administrator include:

- Ensuring the security and integrity of all user accounts (clerk administrators and clerks) created and associated with their Portal account.
- Ensuring clerks or clerk administrators are given the appropriate authorizations they need to perform their functions for the provider, trading partner, or MCO (managed care organization).
- Ensuring that clerks or clerk administrator accounts are removed/deleted promptly when the user leaves the organization.
- Ensuring that the transactions submitted are valid and recognized by ForwardHealth.
- Ensuring that all users they establish know and follow security and guidelines as required by HIPAA (Health Insurance Portability Accountability Act of 1996). As Portal administrators establish their Portal account and create accounts for others to access private information, administrators are reminded that all users must comply with HIPAA. The HIPAA privacy and security rules require that the confidentiality, integrity, and availability of PHI (protected health information) are maintained at all times. The HIPAA Privacy Rule provides guidelines governing the disclosure of PHI. The HIPAA Security Rule delineates the security measures to be implemented for the protection of electronic PHI. If Portal administrators have any questions concerning the protection of PHI, visit the Portal for additional information.

Portal administrators have access to all secure functions for their Portal account.

Establish an Administrator Account

All Portal accounts require an administrator account. The administrator is a selected individual who has overall responsibility for management of the account. Therefore, he or she has complete access to all functions within the specific secure area of his or her Portal and are permitted to add, remove, and manage other individual roles.

Topic #4912

Portal Clerk Administrators

A Portal administrator may choose to delegate some of the authority and responsibility for setting up and managing the users within their ForwardHealth Portal account. If so, the Portal administrator may establish a clerk administrator. An administrator or clerk administrator can create, modify, manage or remove clerks for a Portal account. When a clerk is created, the administrator or clerk administrator must grant permissions to the clerks to ensure they have the appropriate access to the functions they will perform. A clerk administrator can only grant permissions that they themselves have. For example, if an administrator gives a clerk administrator permission only for enrollment verification, then the clerk administrator can only establish clerks with enrollment verification permissions.

Even if a Portal administrator chooses to create a clerk administrator and delegate the ability to add, modify, and remove users from the same account, the Portal administrator is still responsible for ensuring the integrity and security of the Portal account.

Topic #4913

Portal Clerks

The administrator (or the clerk administrator if the administrator has granted them authorization) may set up clerks within their ForwardHealth Portal account. Clerks may be assigned one or many roles (i.e., claims, PA (prior authorization), member enrollment verification). Clerks do not have the ability to establish, modify, or remove other accounts.

Once a clerk account is set up, the clerk account does not have to be established again for a separate Portal account. Clerks can

easily be assigned a role for different Portal accounts (i.e., different ForwardHealth enrollments). To perform work under a different Portal account for which they have been granted authorization, a clerk can use the "switch org" function and toggle between the Portal accounts to which they have access. Clerks may be granted different authorization in each Portal account (i.e., they may do member enrollment verification for one Portal account, and HealthCheck inquires for another).

Topic #4740

Public Area of the Provider Portal

The public Provider area of the ForwardHealth Portal offers a variety of important business features and functions that will greatly assist in daily business activities with ForwardHealth programs.

Maximum Allowable Fee Schedules

Within the Portal, all maximum allowable fee schedules for Medicaid, BadgerCare Plus, and WCDP (Wisconsin Chronic Disease Program) are interactive and searchable. Providers can enter the DOS (date of service), along with other information such as procedure code, category of supplies, or provider type, to find the maximum allowable fee. Providers can also download all fee schedules.

Online Handbook

The Online Handbook is the single source for all current policy and billing information for ForwardHealth. The Online Handbook is designed to sort information based on user-entered criteria, such as program and provider type.

Revisions to policy information are incorporated into the Online Handbook in conjunction with published *Updates*. The Online Handbook also links to the ForwardHealth Publications page, an archive section where providers can research previously published *Updates*.

ForwardHealth Publications Archive Section

The ForwardHealth Publications page, available via the Quick Links box, lists *Updates*, *Update Summaries*, archives of provider Handbooks and provider guides, and monthly archives of the Online Handbook. The ForwardHealth Publications page contains both current and obsolete information for research purposes only. Providers should use the Online Handbook for current policy and procedure questions. The *Updates* are searchable by provider type or program (e.g., physician or HealthCheck "Other Services") and by year of publication.

Training

Providers can register for all scheduled trainings and view online trainings via the Portal Training page, which contains an up-to-date calendar of all available training. Additionally, providers can view Webcasts of select trainings.

Contacting Provider Services

Providers and other Portal users will have an additional option for contacting Provider Services through the Contact link on the Portal. Providers can enter the relevant inquiry information, including selecting the preferred method of response (i.e., telephone call or e-mail) the provider wishes to receive back from Provider Services. Provider Services will respond to the inquiry within five business days. Information will be submitted via a secure connection.

Online Enrollment

Providers can speed up the enrollment process for Medicaid by completing a provider enrollment application via the Portal. Providers can then track their application by entering their ATN (application tracking number) given to them on completion of the application.

Other Business Enhancements Available on the Portal

The public Provider area of the Portal also includes the following features:

- A "What's New?" section for providers that links to the latest provider publication summaries and other new information posted to the Provider area of the Portal.
- Home page for the provider. Providers have administrative control over their Portal homepage and can grant other employees access to specified areas of the Portal, such as claims and PA (prior authorization).
- E-mail subscription service for *Updates*. Providers can register for e-mail subscription to receive notifications of new provider publications via e-mail. Users are able to select, by program and service area, which publication notifications they would like to receive.
- A forms library.

Topic #4741

Secure Area of the Provider Portal

Providers can accomplish many processes via the ForwardHealth Portal, including submitting, adjusting, and correcting claims, submitting and amending PA (prior authorization) requests, and verifying enrollment.

Claims and Adjustments Using the Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, and determine what claims are in "pay" status on the Portal. Providers have the ability to search for and view the status of all of their finalized claims, regardless of how they were submitted (i.e., paper, electronic, clearinghouse). If a claim contains an error, providers can correct it on the Portal and resubmit it to ForwardHealth.

Providers can submit an individual claim or adjust a claim via DDE (Direct Data Entry) through the secure Portal.

Submitting Prior Authorization and Amendment Requests Via the Portal

Nearly all service areas can submit PA requests via the Portal. Providers can do the following:

- Correct errors on PA or amendment requests via the Portal, regardless of how the PA request was originally submitted.
- View all recently submitted and finalized PA and amendment requests.
- Save a partially completed PA request and finish completing it at a later time. (*Note:* Providers are required to submit or re-save a PA request within 30 calendar days of the date the PA request was last saved.)
- View all saved PA requests and select any to continue completing or delete.
- View the latest provider review and decision letters.
- Receive messages about PA and amendment requests that have been adjudicated or returned for provider review.

Electronic Communications

The secure Portal contains a one-way message center where providers can receive electronic notifications and provider publications from ForwardHealth. All new messages display on the provider's main page within the secure Portal.

Enrollment Verification

The secure Portal offers real-time member enrollment verification for all ForwardHealth programs. Providers are able to use this tool to determine:

- The health care program(s) in which the member is enrolled.
- Whether or not the member is enrolled in a state-contracted MCO (managed care organization).
- Whether or not the member has any third-party liability, such as Medicare or commercial health insurance.

Using the Portal to check enrollment may be more efficient than calling the AVR (Automated Voice Response) system or the EVS (Enrollment Verification System) (although both are available).

Providers will be assigned a unique enrollment verification number for each inquiry. Providers can also use the "print screen" function to print a paper copy of enrollment verification inquiries for their records.

Other Business Enhancements Available on the Portal

The secure Provider area of the Portal enables providers to do the following:

- Verify member enrollment.
- View RAs (Remittance Advices).
- Designate which trading partner is eligible to receive the provider's 835 (835 Health Care Claim Payment/Advice) transaction.
- Update and maintain provider file information. Providers will have the choice to indicate separate addresses for different business functions.
- Receive electronic notifications and provider publications from ForwardHealth.
- Enroll in EFT (electronic funds transfer).
- Track provider-submitted PA requests.

Topic #4401

System and Browser Requirements

The following table lists the recommended system and browser requirements for using the ForwardHealth Portal. PES (Provider Electronic Solutions) users should note that the Windows-based requirements noted in the table apply; PES cannot be run on Apple-based systems.

Recommended System Requirements	**Recommended Browser Requirements**
Windows-Based Systems	
Computer with at least a 500Mhz processor, 256 MB of RAM, and 100MB of free disk space	Microsoft Internet Explorer v. 6.0 or higher, or Firefox v. 1.5 or higher
Windows XP or higher operating system	
Apple-Based Systems	
Computer running a PowerPC G4 or Intel processor, 512 MB of RAM, and 150MB of free disk space	Safari, or

Mac OS X 10.2.x or higher operating system	Firefox v. 1.5 or higher

Topic #4742

Trading Partner Portal

The following information is available on the public trading partner area of the ForwardHealth Portal:

- Trading partner testing packets.
- Trading partner profile submission.
- PES (Provider Electronic Solutions) software and upgrade information.
- EDI (Electronic Data Interchange) companion guides.

In the secure Trading Partner area of the Portal, trading partners can exchange electronic transactions with ForwardHealth.

Trading partners using PES should be sure to enter the Web logon and Web password associated with the ForwardHealth Trading Partner ID that will be used on PES transactions. Prior to submitting transactions through PES, trading partners must also make sure their trading partner account is entered as the "Default Provider ID" on the Switch Organization page of the secure trading partner account on the Portal.

Training Opportunities

Topic #12757

Training Opportunities

The Provider Relations representatives conduct training sessions in a variety of formats on both program-specific and topic-specific subjects. There is no fee for attending/accessing these training sessions.

On-Site Sessions

On-site training sessions are offered at various locations (e.g., hotel conference rooms, provider facilities) throughout the state. These training sessions include general all-provider sessions, service-specific and/or topic-specific sessions, and program-specific (such as WCDP (Wisconsin Chronic Disease Program) or the WWWP (Wisconsin Well Woman Program)) sessions.

Registration is required to attend on-site sessions. Online registration is available on the Trainings page of the Providers area of the Portal.

Online (Real-Time, Web-Based) Sessions

Online (real-time, web-based) training sessions are available and are facilitated through HPE® MyRoom. MyRoom sessions are offered on many of the same topics as on-site sessions, but online sessions offer the following advantages:

- Participants can attend training at their own computers without leaving the office.
- Sessions are interactive as participants can ask questions during the session.
- If requested or needed, a session can be quickly organized to cover a specific topic for a small group or office.

For some larger training topics (such as ForwardHealth Portal Fundamentals), the training may be divided into individual modules, with each module focused on a particular subject. This allows participants to customize their training experience.

Registration, including an e-mail address, is required to attend Virtual Room sessions, so important session information can be sent to participants prior to the start of the session. Online registration is available on the Trainings page of the Portal.

Recorded Webcasts

Recorded Webcasts are available on a variety of topics, including some of the same topics as on-site and online sessions. Like Virtual Room sessions, some recorded Webcasts on larger training topics may be divided into individual Webcast modules, allowing participants to customize their training experience. Recorded Webcasts allow providers to view the training at their convenience on their own computers.

Registration is not required to view a recorded Webcast. Related training materials are available to download and print from the specific Webcast training session page on the Portal.

Notification of Training Opportunities

In addition to information on the Trainings page of the Portal, upcoming training session information is distributed directly through messages to providers who have secure Portal accounts and to providers who have registered for the ForwardHealth e-mail subscription service.

To sign up for a secure Portal account, click the "Request Portal Access" link in the Quick Links box on the Provider page of the Portal. To sign up for e-mail subscription, click "Register for E-mail Subscription" in the Quick Links box on the Provider page of the Portal.

Updates

Topic #478

Accessing ForwardHealth Publications

ForwardHealth Updates are the first source of provider information. *Updates* announce the latest information on policy and coverage changes, PA (prior authorization) submission requirements, claims submission requirements, and training announcements.

The *ForwardHealth Update Summary* is posted to the ForwardHealth Portal on a monthly basis and contains an overview of *Updates* published that month. Providers with a ForwardHealth Portal account are notified through their Portal message inbox when the *Update Summary* is available on the Portal.

Updates included in the *Update Summary* are posted in their entirety on the Provider area of the Portal. Providers may access *Updates* from direct links in the electronic *Update Summary* as well as navigate to other Medicaid information available on the Portal.

Revisions to policy information are incorporated into the Online Handbook in conjunction with published *Updates*. The Online Handbook also includes a link to the ForwardHealth Publications page, an archive section where providers can research previously published *Updates*.

Topic #4458

Electronic Notifications from ForwardHealth

ForwardHealth sends electronic messaging via Portal Account messaging and e-mail subscription messaging to notify of newly released *ForwardHealth Updates* and the monthly *ForwardHealth Update Summary*. ForwardHealth also uses electronic messaging to communicate training opportunities and other timely information. Providers who have established a ForwardHealth Portal account automatically receive notifications from ForwardHealth in their Portal Messages inbox. Providers and other interested parties may register to receive e-mail subscription notifications.

E-mail Subscription

When registering for e-mail subscription, providers and other interested parties are able to select, by program (Wisconsin Medicaid, BadgerCare Plus, ADAP (Wisconsin AIDS Drug Assistance Program), or WCDP (Wisconsin Chronic Disease Program)), provider type (e.g., physician, hospital, DME (durable medical equipment) vendor), and/or specific information of interest, (Trading Partner and ICD-10 (International Classification of Diseases, 10th Revision) Project Information) to designate what information they would like to receive. Any number of staff or other interested parties from an organization may sign up for an e-mail subscription and may select multiple subscription options.

Registering for E-mail Subscription

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

1. Click the Register for E-mail Subscription link on the ForwardHealth Portal home page.
2. In the Quick Links section on the right side of the screen, click Register for E-mail Subscription.
3. The Subscriptions page will be displayed. In the E-Mail field in the New Subscriber section, enter the e-mail address to which messages should be sent.

4. Enter the e-mail address again in the Confirm E-Mail field.
5. Click Register. A message will be displayed at the top of the Subscriptions page indicating the registration was successful. If there are any problems with the registration, an error message will be displayed instead.
6. Once registration is complete, click the program for which you want to receive messages in the Available Subscriptions section of the Subscriptions page. The selected program will expand and a list of service areas will be displayed.
7. Select the service area(s) for which you want to receive messages. Click Select All if you want to receive messages for all service areas.
8. When service area selection is complete, click Save at the bottom of the page.

The selected subscriptions will load and a confirmation message will appear at the top of the page.

Topic #4460

Full Text Publications Available

Providers without Internet access may call Provider Services to request that a paper copy of a *ForwardHealth Update* be mailed to them. To expedite the call, correspondents will ask providers for the *Update* number. Providers should allow seven to 10 business days for delivery.

WiCall

Topic #257

Enrollment Inquiries

WiCall is an AVR (Automated Voice Response) system that allows providers with touch-tone telephones direct access to enrollment information.

Information from WiCall will be returned in the following order if applicable to the member's current enrollment:

- Transaction number: A number will be given as a transaction confirmation that providers should keep for their records.
- Benefit enrollment: All benefit plans the member is enrolled in on the DOS (date of service) or within the DOS range selected for the financial payer.
- County code: The member's county code will be provided if available. The county code is a two-digit code between 01 and 72 that represents the county in which member resides. If the enrollment response reflects that the member resides in a designated HPSA (Health Personnel Shortage Area) on the DOS or within the DOS range selected, HPSA information will be given.
- MCO (managed care organization): All information about state-contracted MCO enrollment, including MCO names and telephone numbers, that exists on the DOS or within the DOS range selected will be listed. This information is applicable to Medicaid and BadgerCare Plus members only.
- Hospice: If the member is enrolled in the hospice benefit on the DOS or within the DOS range that the provider selected, the hospice information will be given. This information is applicable to Medicaid and BadgerCare Plus members only.
- Lock-in: Information about the Pharmacy Services Lock-In Program that exists on the DOS or within the DOS range selected will be provided. This information is applicable to Medicaid, BadgerCare Plus, and SeniorCare members only.
- Medicare: All information about Medicare coverage, including type of coverage and Medicare member ID, if available, that exists on the DOS or within the DOS range selected will be listed.
- Other commercial insurance coverage: All information about commercial coverage, including carrier names and telephone numbers, if available, that exists on the DOS or within the DOS range selected will be listed.
- Transaction completed: After the member's enrollment information has been given using the financial payer that was selected, providers will be given the following options to:
    - Hear the information again.
    - Request enrollment information for the same member using a different financial payer.
    - Hear another member's enrollment information using the same financial payer.
    - Hear another member's enrollment information using a different financial payer.
    - Return to the main menu.

WiCall is available 24 hours a day, seven days a week. If for some reason the system is unavailable, providers may call Provider Services.

Transaction Number

The AVR system issues a transaction number every time a provider verifies enrollment, even when an individual is *not* enrolled in BadgerCare Plus or Wisconsin Medicaid. The provider should retain this transaction number. It is proof that an inquiry was made about the member's enrollment. If a provider thinks a claim was denied in error, the provider can reference the transaction number to ForwardHealth to confirm the enrollment response that was actually given.

Topic #6257

Entering Letters into WiCall

For some WiCall inquries, health care providers are required to enter their taxonomy code with their NPI (National Provider Identifier). Because taxonomy codes are a combination of numbers and letters, telephone key pad combinations, shown in the table below, allow providers to successfully enter taxonomy code letters for WiCall functions (e.g., press *21 to enter an "A," press *72 to enter an "R").

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

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

Topic #466

Information Available Via WiCall

WiCall, ForwardHealth's AVR (Automated Voice Response) system, gathers inquiry information from callers through voice prompts and accesses ForwardHealth interChange to retrieve and "speak" back the following ForwardHealth information:

- Claim status.
- Enrollment verification.
- PA (prior authorization) status.
- Provider CheckWrite information.

Note: ForwardHealth releases CheckWrite information to WiCall no sooner than on the first state business day following the financial cycle.

Providers are prompted to enter NPI (National Provider Identifier) or provider ID and in some cases, NPI-related data, to retrieve query information.

In all inquiry scenarios, WiCall offers the following options after information is retrieved and reported back to the caller:

- Repeat the information.
- Make another inquiry of the same type.
- Return to the main menu.
- Repeat the options.

Claim Status

Providers may check the status of a specific claim by selecting the applicable program ("financial payer" option, i.e., Wisconsin Medicaid, WCDP (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program) by entering their provider ID, member identification number, DOS (date of service), and the amount billed.

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

Enrollment Verification

Providers may request enrollment status for any date of eligibility the member has on file by entering their provider ID and the member ID. If the member ID is unknown, providers may enter the member's date of birth and SSN (Social Security number). Additionally, the provider is prompted to enter the "From DOS" and the "To DOS" for the inquiry. The "From" DOS is the earliest date the provider requires enrollment information and the "To" DOS must be within 365 days of the "From" DOS.

Each time a provider verifies member enrollment, the enrollment verification is saved and assigned a transaction number as transaction confirmation. Providers should note the transaction number for their records.

Prior Authorization Status

Except in certain instances, providers may obtain the status of PA requests for Medicaid and WCDP via WiCall by entering their provider ID and the applicable PA number. If the provider does not know the PA number, there is an option to bypass entering the PA number and the caller will be prompted to enter other PA information such as member ID and type of service (i.e., NDC (National Drug Code), procedure code, revenue code, or ICD (International Classification of Diseases) procedure code.) When a match is found, WiCall reports back the PA status information, including the PA number for future reference, and the applicable program.

Information on past PAs is retained indefinitely. Paper PAs require a maximum of 20 working days from receipt to be processed and incorporated into WiCall's PA status information.

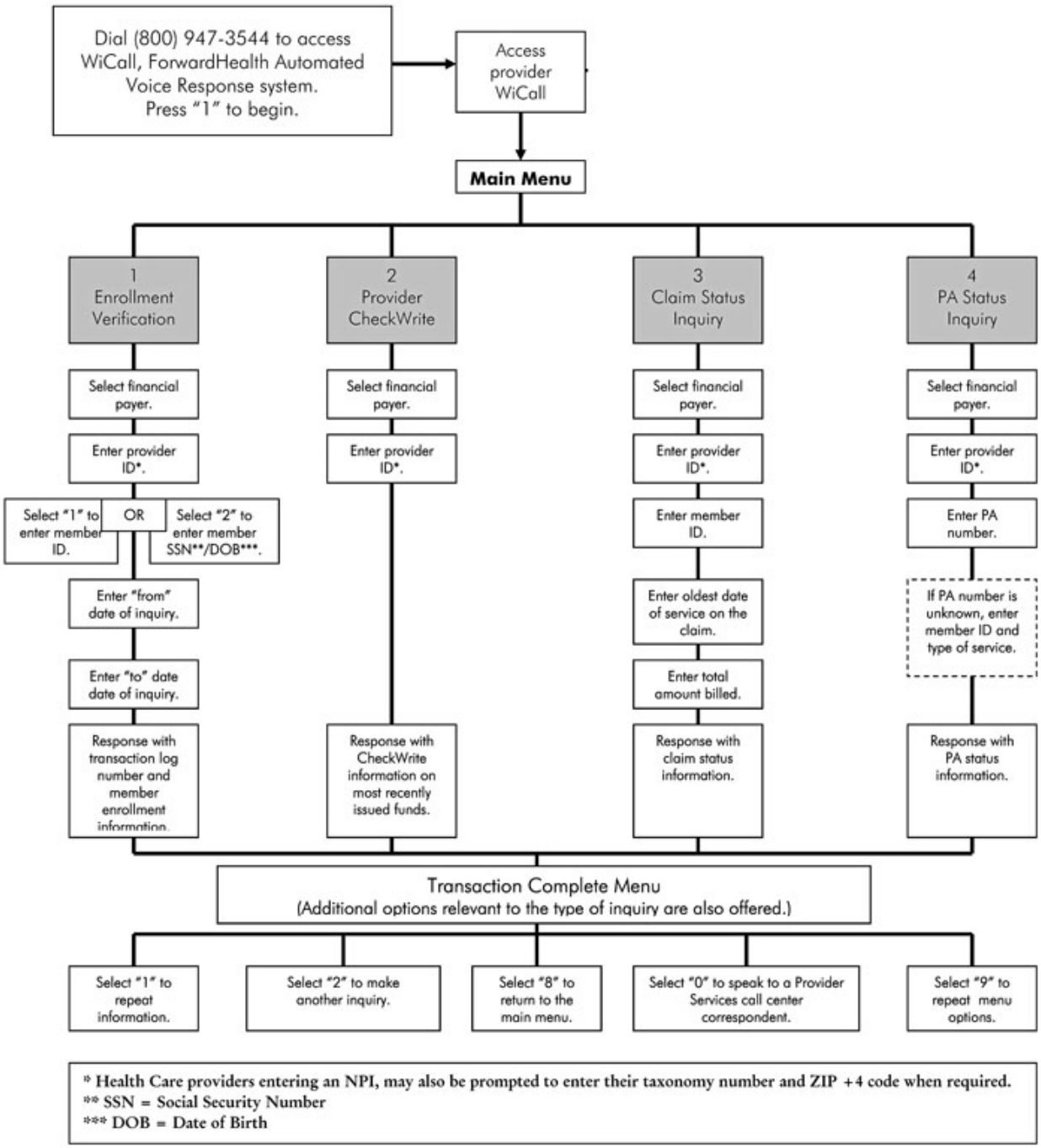
Note: PA information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

Topic #765

Quick Reference Guide

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

Automated Voice Response Quick Reference Guide



* Health Care providers entering an NPI, may also be prompted to enter their taxonomy number and ZIP +4 code when required.
** SSN = Social Security Number
*** DOB = Date of Birth