Certification and Ongoing Responsibilities

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Certification and Ongoing Responsibilities:Certification

Topic #3969

Categories of Certification

Wisconsin Medicaid certifies providers in four billing categories. Each billing category has specific designated uses and restrictions. These categories include the following:

- Billing/rendering provider.
- Rendering provider.
- Group billing that requires a rendering provider.
- Group billing that does not require a rendering provider.

Providers should refer to their certification materials or to service-specific information in the Online Handbook to identify what types of certification categories they may apply for or be assigned.

Billing/Rendering Provider

Certification as 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 Provider

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

Group Billing

Certification as a group billing provider is issued primarily as an accounting convenience. This allows a group billing provider to receive one reimbursement, one RA (Remittance Advice), and the 835 (835 Health Care Claim Payment/Advice) transaction for covered services rendered by individual providers within the group.

Group billing providers may not have more than one group certified by Wisconsin Medicaid, WCDP (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program) with the same ZIP+4 address, NPI (National Provider Identifier), and taxonomy code combination. Providers at the same ZIP+4 address are required to differentiate their certification using an NPI or taxonomy code that uniquely identifies their group.

Group Billing That Requires a Rendering Provider

Individual providers within certain groups are required to be Medicaid certified 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.

Group Billing That Does Not Require a Rendering Provider

Other groups (e.g., rehabilitation agencies) are not required to indicate a rendering provider on claims.

Group billing providers should refer to their certification materials or to service-specific information in the Online Handbook to determine whether or not a rendering provider is required on claims.

Topic #467

Certification Application

To participate in Wisconsin Medicaid, providers are required to be certified by Wisconsin Medicaid as described in DHS 105, Wis. Admin. Code. Providers certified by Wisconsin Medicaid may render services to members enrolled in Wisconsin Medicaid, BadgerCare Plus, and SeniorCare.

Providers interested in becoming certified by Wisconsin Medicaid are required to complete a provider application that consists of the following forms and information:

- General certification information.
- Certification requirements.
- TOR (Terms of Reimbursement).
- Provider application.
- Provider Agreement and Acknowledgement of Terms of Participation.
- Other forms related to certification.

Providers may submit certification applications by mail or through the ForwardHealth Portal.

General Certification Information

This section of the provider application contains information on contacting ForwardHealth, certification effective dates, notification of certification decisions, provider agreements, and terms of reimbursement.

Certification Requirements

Wisconsin Administrative Code contains requirements that providers must meet in order to be certified with Wisconsin Medicaid; applicable Administrative Code requirements and any special certification materials for the applicant's provider type are included in the certification requirements document.

To become Medicaid certified, providers are required to do the following:

- Meet all certification requirements for their provider type.
- Submit a properly completed provider application, provider agreement, and other forms, as applicable, that are included in the certification packet.

Providers should carefully complete the certification materials and send all applicable documents demonstrating that they meet the stated Medicaid certification criteria. Providers may call Provider Services for assistance with completing these materials.

Terms of Reimbursement

Wisconsin Medicaid certification materials include Wisconsin Medicaid's TOR, which describes the methodology by which providers are reimbursed for services provided to BadgerCare Plus, Medicaid, and SeniorCare members. Providers should retain a copy of the TOR in their files. TOR are subject to change during a certification period.

Provider Application

A key part of the certification process is the completion of the Wisconsin Medicaid Provider Application. On the provider application, the applicant furnishes contact, address, provider type and specialty, license, and other information needed by Wisconsin Medicaid to make a certification determination.

Provider Agreement and Acknowledgement of Terms of Participation

As part of the application for certification, providers are required to sign a provider agreement with the DHS (Department of Health Services). Providers applying for certification through the Portal will be required to print, sign and date, and send the provider agreement to Wisconsin Medicaid. Providers who complete a paper provider application will need to sign and date the provider agreement and submit it with the other certification materials.

By signing a provider agreement, the provider certifies that the provider and each person employed by the provider, for the purpose of providing services, holds all licenses or similar entitlements and meets other requirements specified in DHS 101 through DHS 109, Wis. Admin. Code, and required by federal or state statute, regulation, or rule for the provision of the service.

The provider's certification to participate in Wisconsin Medicaid may be terminated by the provider as provided at DHS 106.05, Wis. Admin. Code, or by the DHS upon grounds set forth in DHS 106.06, Wis. Admin. Code.

This provider agreement remains in effect as long as the provider is certified to participate in Wisconsin Medicaid.

Topic #190

Completing Certification Applications

Health care providers are required to include their NPI (National Provider Identifier) on the certification application.

Note: Obtaining an NPI does not replace the Wisconsin Medicaid certification process.

Portal Submission

Providers may apply for Medicaid certification directly through the ForwardHealth Portal. Though the provider certification application is available via the public Portal, the data are entered and transmitted through a secure connection to protect personal data. Applying for certification through the Portal offers the following benefits:

- Fewer returned applications. Providers who apply through the Portal are taken through a series of screens that are designed to guide them through the application process. This ensures that required information is captured and therefore reduces the instances of applications returned for missing or incomplete information.
- Instant submission. At the end of the online application process, applicants instantly submit their application to ForwardHealth and are given an ATN (application tracking number) to use in tracking the status of their application.
- Indicates documentation requirements. At the end of the online process, applicants are also given detailed instructions about what actions are needed to complete the application process. For example, the applicant will be instructed to print the provider agreement and any additional forms that Wisconsin Medicaid must receive on paper and indicates whether supplemental information (e.g., transcripts, copy of license) is required. Applicants are also able to save a copy of the application for their records.

Paper Submission

Providers may also submit provider applications on paper. To request a paper provider application, providers should do one of

the following:

- Contact Provider Services.
- Click the "Contact Us" link on the Portal and send the request via e-mail.
- Send a request in writing to the following address:

ForwardHealth
Provider Maintenance
313 Blettner Blvd
Madison WI 53784

Written requests for certification materials must include the following:

- The number of provider applications requested and each applicant's/provider's name, address, and telephone number (a provider application must be completed for each applicant/provider).
- The provider's NPI (for health care providers) that corresponds to the type of application being requested.
- The program for which certification is requested (Wisconsin Medicaid).
- The type of provider (e.g., physician, physician clinic or group, speech-language pathologist, hospital) or the type of services the provider intends to provide.

Paper provider applications are assigned an ATN at the time the materials are requested. As a result, examples of the provider application are available on the Portal for reference purposes only. These examples should not be downloaded and submitted to Wisconsin Medicaid. For the same reason, providers are not able to make copies of a single paper provider application and submit them for multiple applicants. These policies allow Wisconsin Medicaid to efficiently process and track certifications and assign effective dates.

Once completed, providers should mail certification materials to the address indicated on the application cover letter. Sending certification materials to any other Wisconsin Medicaid address may cause a delay.

Topic #191

Effective Date of Medicaid Certification

When assigning an initial effective date, ForwardHealth follows these regulations:

1. The date the provider submits his or her online provider application to ForwardHealth or contacts ForwardHealth for a paper application is the earliest effective date possible and will be the initial effective date if the following are true:
    - ❍ The provider meets all applicable licensure, certification, authorization, or other credential requirements as a prerequisite for Wisconsin Medicaid on the date of notification. Providers should not hold their application for pending licensure, Medicare, or other required certification but submit it to ForwardHealth. ForwardHealth will keep the provider's application on file and providers should send ForwardHealth proof of eligibility documents immediately, once available, for continued processing.
    - ❍ ForwardHealth received the provider agreement and any supplemental documentation within 30 days of submission of the online provider application.
    - ❍ ForwardHealth received the paper application within 30 days of the date the paper application was mailed.
2. If ForwardHealth receives the provider agreement and any applicable supplemental documents more than 30 days after the provider submitted the online application or receives the paper application more than 30 days after the date the paper application was mailed, the provider's effective date will be the date the complete application was received at ForwardHealth.
3. If ForwardHealth receives the provider's application within the 30-day deadline described above and it is incomplete or unclear, the provider will be granted one 30-day extension to respond to ForwardHealth's request for additional information. ForwardHealth must receive a response to the request for additional information within 30 days from the date

on the letter requesting the missing information or item(s). This extension allows the provider additional time to obtain proof of eligibility (such as license verification, transcripts, or other certification).

4. If the provider does not send complete information within the original 30-day deadline or 30-day extension, the initial effective date will be based on the date ForwardHealth receives the complete and accurate application materials.

Group Certification Effective Dates

Group billing certifications are given as a billing convenience. Groups (except providers of mental health services) may submit a written request to obtain group billing certification with a certification effective date back 365 days from the effective date assigned. Providers should mail requests to backdate group billing certification to the following address:

ForwardHealth
Provider Maintenance
313 Blettner Blvd
Madison WI 53784

Request for Change of Effective Date

If providers believe their initial certification effective date is incorrect, they may request a review of the effective date. The request should include documentation that indicates the certification criteria that were incorrectly considered. Requests for changes in certification effective dates should be sent to Provider Maintenance.

Medicare Enrollment

ForwardHealth requires certain types of providers to be enrolled in Medicare as a condition for Medicaid certification. This requirement is specified in the certification materials for these provider groups.

The enrollment process for Medicare is separate from Wisconsin Medicaid's certification process. Providers applying for Medicare enrollment *and* Medicaid certification are encouraged to apply for Wisconsin Medicaid certification at the same time they apply for Medicare enrollment, even though Medicare enrollment must be finalized first. By applying for Medicare enrollment and Medicaid certification simultaneously, it may be possible for ForwardHealth to assign a Medicaid certification effective date that is the same as the Medicare enrollment date.

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 a certified 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 #1719

General Requirements

Under **DHS 105.51**, Wis. Admin. Code, Wisconsin Medicaid certifies qualified entities electing to participate as case

management providers. To become certified, providers must have:

- Qualified staff, as identified in the Case Management service area of the Online Handbook.
- The ability to deliver all case management elements, as identified in the Case Management service area of the Online Handbook.

Topic #193

Materials for New Providers

On an ongoing basis, providers should refer to the Online Handbook for the most current BadgerCare Plus and Medicaid information. Future changes to policies and procedures are published in *ForwardHealth Updates*.

Certain providers may opt not to receive these materials by completing the Deletion from Publications Mailing List (F-11015 (10/08)) form in the certification materials. Providers who opt out of receiving publications are still bound by ForwardHealth's rules, policies, and regulations even if they choose not to receive *Updates* on an ongoing basis. *Updates* are available for viewing and downloading on the ForwardHealth Portal.

Topic #3410

Multiple Locations

The number of Medicaid certifications allowed or required per location is based on licensure, registration, certification by a state or federal agency, or an accreditation association identified in the Wisconsin Administrative Code. Providers with multiple locations should inquire if multiple applications must be completed when requesting a Medicaid certification application.

Topic #654

Multiple Services

Providers who offer a variety of services may be required to complete a separate Medicaid certification packet for each specified service/provider type.

Health care providers who are federally required to have an NPI (National Provider Identifier) are responsible for obtaining the appropriate certification for their NPI.

If a Medicaid-certified provider begins offering a new service *after* he or she has become initially certified, it is recommended that he or she call Provider Services to inquire if another application must be completed.

Topic #4449

Notice of Certification Decision

Wisconsin Medicaid will notify the provider of the status of the certification usually within 10 business days, but no longer than 60 days, after receipt of the complete application for certification. Wisconsin Medicaid will either approve the application and issue the certification or deny the application. If the application for certification is denied, Wisconsin Medicaid will give the applicant reasons, in writing, for the denial.

Providers who meet the certification requirements will be sent a welcome letter and a copy of the signed provider agreement.

Included with the letter is an attachment with important information such as effective dates and assigned provider type and specialty. This information will be used when conducting business with BadgerCare Plus, Medicaid, or SeniorCare.

The welcome letter will also notify non-healthcare providers (e.g., SMV (specialized medical vehicle) providers, personal care agencies, blood banks) of their Medicaid provider number. This number will be used on claim submissions, PA (prior authorization) requests, and other communications with ForwardHealth programs.

Topic #1718

Private Nonprofit Entities

The following private, nonprofit entities are eligible for certification:

1. Independent Living Centers, as defined under s. 46.96(1)(ah), Wis. Stats.
2. Private, nonprofit agencies 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 persons diagnosed as having HIV (Human Immunodeficiency Virus).

Topic #4457

Provider Addresses

ForwardHealth interChange has the capability of storing the following types of addresses and related information, such as contact information and telephone numbers:

- *Practice location address and related information (formally known as physical address).* 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 telephone number for member's use. With limited exceptions, the practice location and telephone number for member's 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 concise address information to aid in proper mail delivery.
- *PA (prior authorization) address.* This address is where ForwardHealth will mail PA information.
- *Financial addresses (formally known as payee address).* Two separate financial addresses are stored in ForwardHealth interChange. The checks address is where Wisconsin Medicaid will mail paper checks. The 1099 mailing address is where Wisconsin Medicaid will mail IRS Form 1099.

Providers may submit additional address information or modify their current information through the ForwardHealth Portal or by using the Provider Change of Address or Status (F-1181 (10/08)) form.

Note: Providers are cautioned that any changes to their practice location on file with ForwardHealth 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 Web site.

Provider addresses are stored separately for each program (i.e., Medicaid, WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program)) for which the provider is certified. Providers should consider this when supplying additional address information and keeping address information current. Providers who are certified for multiple programs and have an address change that applies to more than one program should provide this information for each program. Providers who submit these changes on paper need to submit *one* Provider Change of Address or Status form if changes are applicable for multiple programs.

Topic #1931

Provider Type and Specialty Changes

Providers who want to add a certification type or make a change to their certification type should call Provider Services.

Topic #1717

Public Entities

Any of the following public entities (as defined by the relevant state statutes) are eligible to be certified case management providers:

1. County or tribal departments of community programs (51.42 and 51.42/.437 boards).
2. County or tribal departments of social services.
3. County or tribal departments of human services.
4. County or tribal aging units.
5. County or tribal departments of developmental disabilities services (51.437 boards).
6. County/tribal, city, village, town, or combined city/county/tribal public health agency, and multiple county/tribal health departments (as defined under s. 251.02, Wis. Stats.).

Per DHS 105.51(7), Wis. Admin. Code, public entities are eligible for case management certification if the local government has elected to participate in this service. Also, the local government must have state statutory authority to operate community programs necessary for the population(s) to assure effective monitoring and coordination of these critical services.

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.

Eligible private, nonprofit entities do not need approval from a county, village, or town board of supervisors, city council, or tribal agency.

Topic #1932

Reinstating Certification

Providers whose Medicaid certification has ended for any reason other than sanctions or failure to be recertified may have their certification reinstated as long as all licensure and certification requirements are met. The criteria for reinstating certification vary, depending upon the reason for the cancellation and when the provider's certification ended.

If it has been less than 365 days since a provider's certification has ended, the provider is required to submit a letter or the Provider Change of Address or Status (F-1181 (10/08)) form, stating that he or she wishes to have his or her Medicaid certification reinstated.

If it has been more than 365 days since a provider's certification has ended, the provider is required to submit new certification materials. This can be done by completing them through the ForwardHealth Portal or submitting a paper provider application.

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 certified case management provider is responsible for ensuring that its own or subcontracted staff meet these requirements.

Determining a Human Services-Related Field

Wisconsin Medicaid and BadgerCare Plus Standard Plan 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, a certified 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 certified case management provider is responsible for the determination of equivalence for its own or subcontracted staff.

Topic #4448

Tracking Certification Materials

Wisconsin Medicaid allows providers to track the status of their certification application either through the ForwardHealth Portal or by calling Provider Services. Providers who submitted their application through the Portal will receive the ATN (application tracking number) upon submission, while providers who request certification materials from Wisconsin Medicaid will receive an ATN on the application cover letter sent with their provider application. Regardless of how certification materials are submitted, providers may use one of the methods listed to track the status of their certification application.

Note: Providers are required to wait for the Notice of Certification Decision as official notification that certification has been approved. This notice will contain information the provider needs to conduct business with BadgerCare Plus, Medicaid, or SeniorCare; therefore, an approved or enrolled status alone does not mean the provider may begin providing or billing for services.

Tracking Through the Portal

Providers are able to track the status of a certification application through the Portal by entering their ATN. Providers will receive current information on their application, such as whether it's being processed or has been returned for more information.

Tracking Through Provider Services

Providers may also check on the status of their submitted application by contacting Provider Services and giving their ATN.

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 DHCAA (Division of Health Care Access and Accountability) has the right to inspect, review, audit, and reproduce provider records pursuant to [DHS 106.02(9)(e)](), Wis. Admin. Code. The DHCAA 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 DHCAA staff member(s).

Wisconsin Medicaid reimburses providers $0.06 per page for the cost of reproducing records requested by the DHCAA to conduct a compliance audit. A letter of request for records from the DHCAA 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 DHCAA and a provider, such as reproduction costs for submitting PA requests and claims.

Also, state-contracted MCOs (managed care organizations), including HMOs (health maintenance organizations) and SSI (Supplemental Security Income) HMOs, are not reimbursed for the reproduction costs covered in their contract with the DHS (Department of Health Services).

The reproduction of records requested by the PRO (Peer Review Organization) under contract with the DHCAA 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

Published Policy Through May 31, 2012

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			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 #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 certified 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

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. Therefore, use or disclosure of any information concerning applicants and members for any purpose not connected with program administration, including contacts with third-party payers that are necessary for pursuing third-party payment and the release of information as ordered by the court, is prohibited unless authorized by the applicant or member.

To comply with the standards, providers are required to follow the procedures outlined in the Online Handbook to ensure the proper release of this information. ForwardHealth providers, like other health care providers, are also subject to other laws protecting confidentiality of health care information including, but not limited to, the following:

- s. 146.81-146.84, Wis. Stats., Wisconsin health care confidentiality of health care information regulations.
- 42 USC s. 1320d - 1320d-8 (federal HIPAA (Health Insurance Portability and Accountability Act of 1996)) and accompanying regulations.

Any person violating this regulation may be fined an amount from $25 up to $500 or imprisoned in the county jail from 10 days up to one year, or both, for each violation.

A provider is not subject to civil or criminal sanctions when releasing records and information regarding applicants or members if

such release is for purposes directly related to administration or if authorized in writing by the applicant or member.

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 DHCF (Division of Health Care Financing), 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."

Electronic Signature Standards

Wisconsin Medicaid accepts electronic signatures as long as the provider has established policies and procedures regarding the use of electronic signatures. Providers are required to meet the following guidelines when using electronic signatures:

- The electronic signature of the performing provider must be under the sole control of that individual. Only the performer has the authority to use his or her electronic signature.
- Documentation must show the electronic signature that belongs to each performer. For example, if a performer uses a number, the provider is required to maintain a confidential list that contains the performer's name and corresponding electronic signature number.

The following are examples of electronic signatures:

- 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.

No one may sign on behalf of the performer. Also, the performer is required to review, sign, and date each entry in a member's record when information is entered on the performer's behalf.

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 DHS 106.02(9)(b), Wis. Admin. Code, 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.

For information regarding fees that may be charged to members for copies of health care records, refer to s. 146.83(3f), Wis. Stats.

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), who 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.

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 ForwardHealth may come from a variety of individuals including attorneys, insurance adjusters, and members. Providers are required to notify ForwardHealth by contacting Provider Services when releasing billing information or medical claim records relating to charges for covered services except the following:

- 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 the member, the provider should send a copy of the requested billing information or medical claim records, along with the name and address of the requester, to the following address:

Department of Health Services
Casualty/Subrogation Program
PO Box 6243
Madison WI 53791

ForwardHealth will process and forward the requested information to the requester.

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 should 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-certified 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 #215

Change in Ownership

New certification materials, including a provider agreement, must be completed whenever a change in ownership occurs. ForwardHealth defines a "change in ownership" as when a different party purchases (buys out) or otherwise obtains ownership or effective control over a practice or facility. Examples of a change in ownership include the following:

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

The following provider types require Medicare enrollment and/or DQA (Division of Quality Assurance) certification for Wisconsin Medicaid certification change in ownerships:

- Ambulatory surgery centers.
- ESRD (end-stage renal disease) services providers.
- FQHCs (federally qualified health centers).
- Home health agencies.
- Hospice providers.
- Hospitals (inpatient and outpatient).
- Nursing homes.
- Outpatient rehabilitation facilities.
- Rehabilitation agencies.
- RHCs (rural health clinics).

All changes in ownership must be reported in writing to ForwardHealth and new certification materials must be completed *before* the effective date of the change. The affected provider numbers should be noted in the letter. When the change in ownership is complete, the provider(s) will receive written notification of his or her provider number and the new Medicaid certification effective date in the mail.

Providers with questions about change in ownership should call Provider Services.

Repayment Following Change in Ownership

Medicaid-certified providers who sell or otherwise transfer their business or business assets are required to repay ForwardHealth for any erroneous payments or overpayments made to them by Wisconsin Medicaid. If necessary, the provider to whom a

transfer of ownership is made will also be held liable by ForwardHealth for repayment. Therefore, prior to final transfer of ownership, the provider acquiring the business is responsible for contacting ForwardHealth to ascertain if he or she is liable under this provision.

The provider acquiring the business is responsible for making payments within 30 days after receiving notice from the DHS (Department of Health Services) that the amount shall be repaid in full.

Providers may send inquiries about the determination of any pending liability on the part of the owner to the following address:

> Division of Health Care Access and Accountability
> Bureau of Program Integrity
> PO Box 309
> Madison WI 53701-0309

ForwardHealth has the authority to enforce these provisions within four years following the transfer of a business or business assets. Refer to s. 49.45(21), Wis. Stats., for complete information.

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 certified agencies for services. Providers are legally, programmatically, and fiscally responsible for the services provided by their contractors and their contractor's services.

When contracting services, providers are required to monitor the contracted agency to ensure that the agency is meeting member needs and adhering 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-certified 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 recertification 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

Types of Changes

Providers are required to notify ForwardHealth of changes, including the following:

- Address(es) — practice location and related information, mailing, PA (prior authorization), and/or financial.
- Business name.
- Contact name.
- Federal Tax ID number (IRS (Internal Revenue Service) number).
- Group affiliation.
- Licensure.
- NPI (National Provider Identifier).
- 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 in the event that 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.

Address Changes

Healthcare providers who are federally required to have an NPI 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.

Submitting Changes in Address or Status

Once certified, providers are required to submit changes in address or status as they occur, either through the Portal or on paper.

ForwardHealth Portal Submission

After establishing a provider account on the ForwardHealth Portal, providers may make changes to their demographic information online. Changes made through the Portal instantly update the provider's information in ForwardHealth interChange. In addition, since the provider is allowed to make changes directly to his or her information, the process does not require re-entry by ForwardHealth.

Providers should note, however, that the demographic update function of the Portal limits certain providers from modifying some types of information. Providers who are not able to modify certain information through the Portal may make these changes using the Provider Change of Address or Status (F-01181 (09/11)) form.

Paper Submission

Providers must use the Provider Change of Address or Status form. Copies of old versions of this form will not be accepted and will be returned to the provider so that he or she may complete the current version of the form or submit changes through the Portal.

Change Notification Letter

When a change is made to certain provider information, either through the use of the Provider Change of Address or Status form or through the Portal, ForwardHealth will send a letter notifying the provider of the change(s) made. Providers should carefully review the Provider File Information Change Summary included with the letter. If any information on this summary is incorrect, providers may do one of the following:

- If the provider made an error while submitting information on the Portal, he or she should correct the information through the Portal.
- If the provider submitted incorrect information using the Provider Change of Address or Status form, he or she should either submit a corrected form or correct the information through the Portal.
- If the provider submitted correct information on the Provider Change of Address or Status form and believes an error was made in processing, he or she can contact Provider Services to have the error corrected or submit the correct information via the Portal.

Notify Division of Quality Assurance of Changes

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 calling (608) 266-8481.

Providers licensed or certified by the DQA are required to notify the DQA of these changes *before* notifying ForwardHealth. The DQA will then forward the information to ForwardHealth.

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 DHCAA (Division of Health Care Access and Accountability) 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 #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 certified as Medicaid providers of community-based services that provides additional funding for Wisconsin Medicaid while remaining cost neutral for counties.

All counties certified 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 Numbers

Topic #3421

National Provider Identifier

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

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

Providers should ensure that they have obtained an appropriate NPI to correspond to their certification.

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 certifications — one certification as an individual physical therapist and the other certification as the physical therapy group. A Type 1 NPI for the individual certification and a Type 2 NPI for the group certification 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 Type 1 and Type 2 NPI information.

Multiple Certifications

Some providers hold multiple certifications with Wisconsin Medicaid. For example, a health care organization may be certified according to the type of services their organization provides (e.g., physician group, therapy group, home health agency) or the organization may have separate certification for each practice location. Wisconsin Medicaid maintains a separate provider file for each certification that stores information used for processing electronic and paper transactions (e.g., provider type and specialty, certification begin and end dates). When a single NPI is reported for multiple certifications, ForwardHealth requires additional data to identify the provider and to determine the correct provider file to use when processing transactions.

The following additional data are required with an NPI when a single NPI corresponds to multiple certifications:

- The provider's taxonomy code on file with ForwardHealth.
- The ZIP+4 code (complete, nine digits) that corresponds to the practice location address on file with ForwardHealth.

When conducting business with ForwardHealth following certification, a taxonomy code is required when the NPI reported to ForwardHealth corresponds to more than one certification and the provider's practice location ZIP+4 code does not uniquely identify the provider. Omission of the required data will cause claims and other transactions to be denied or delayed in processing.

Topic #5096

Taxonomy Codes

Taxonomy codes are standard code sets used to provide information about provider type and specialty for the provider's certification. 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 certifications 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 certification. 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; this primary code will be used by ForwardHealth for identification purposes.

Providers who wish to change their taxonomy code or add additional taxonomy codes may do so using the demographic maintenance link found in the secure Provider area of the ForwardHealth Portal. Alternatively, providers may use the Provider Change of Address or Status (F-01181 (09/11)) form to report new taxonomy codes.

Most taxonomy code changes entered through demographic maintenance will take effect in real time; providers may use the new codes immediately on transactions. Providers who submit new taxonomy codes using the Provider Change of Address or Status form will need to check demographic maintenance to verify ForwardHealth has received and added the new taxonomy codes prior to using them 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 certification 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 certifications 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 United States Postal Service Web site.

Provider Rights

Topic #208

A Comprehensive Overview of Provider Rights

Medicaid-certified 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:

> ForwardHealth
> Provider Maintenance
> 313 Blettner Blvd
> Madison WI 53784

If the provider fails to specify an effective date in the notice of termination, ForwardHealth may terminate the provider on the date the notice is received.

Topic #209

Hearing Requests

A provider who wishes to contest a 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 DHCAA's (Division of Health Care Access and Accountability) notice of intent to recover payment (e.g., to recoup for overpayments discovered in an audit by DHCAA) 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 DHCAA (Division of Health Care Access and Accountability) 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 DHCAA. 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 DHCAA may also require additional information from the provider or the member prior to acting on the request.

Application

The DHCAA 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 Health Care Access and Accountability
Waivers and Variances
PO Box 309
Madison WI 53701-0309

Recertification

Topic #8517

An Overview

Each year approximately one-third of all Medicaid-certified providers undergo recertification. During provider recertification, providers update their information and sign the Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation. Providers are required to complete the provider recertification process to continue their participation with Wisconsin Medicaid. For most providers, recertification will be conducted online at the ForwardHealth Portal. Providers will be notified when they need to be recertified and will be provided with instructions on how to complete the recertification process.

Topic #8521

Checking the Status of a Recertification Application

Providers may check the status of their recertification on the ForwardHealth Portal by entering the ATN (application tracking number) from the Provider Recertification Notice and pressing "Search."

Providers will receive one of the following status responses:

- "Approved." ForwardHealth has reviewed the recertification materials and all requirements have been met. ForwardHealth is completing updates to provider files.
- "Awaiting Additional Info." ForwardHealth has reviewed the recertification materials and has requested additional information from the provider. Providers will receive a letter via mail when additional materials or information are required to complete processing of the recertification materials.
- "Awaiting Follow-On Documents." ForwardHealth requires additional paper documents to process the recertification. After the provider has submitted recertification information online via the Portal, the final screen will list additional documents the provider must mail to ForwardHealth. ForwardHealth cannot complete processing until these documents are received. This status is primarily used for SMV (specialized medical vehicle) provider recertification.
- "Denied." The provider's recertification has been denied.
- "Failure to Recertify." The provider has not recertified by the established recertification deadline.
- "In Process." The recertification materials are in the process of being reviewed by ForwardHealth.
- "Paper Requested." The provider requested a paper recertification application and ForwardHealth has not received the paper application yet.
- "Recert Initiated." The Provider Recertification Notice and PIN (personal identification number) letter have been sent to the provider. The provider has not started the recertification process yet.
- "Recertified." The provider has successfully completed recertification. There are no actions necessary by the provider.
- "Referred To DHS." ForwardHealth has referred the provider recertification materials to the State Certification Specialist for recertification determination.

Topic #8519

Notification Letters

Providers undergoing recertification will receive two important letters in the mail from ForwardHealth:

- The Provider Recertification Notice. This is the first notice to providers. The Provider Recertification Notice contains identifying information about the provider who is required to complete recertification, the recertification deadline, and the ATN (application tracking number) assigned to the provider. The ATN is used when logging in to the ForwardHealth Portal to complete recertification and also serves as the tracking number when checking the status of the provider's recertification.
- The PIN (personal identification number) letter. Providers will receive this notice a few days after the Provider Recertification Notice. The PIN letter will contain a recertification PIN and instructions on logging in to the Portal to complete recertification.

The letters are sent to the mailing address on file with Wisconsin Medicaid. Providers should read these letters carefully and keep them for reference. The letters contain information necessary to log in to the secure Recertification area of the Portal to complete recertification. If a provider needs to replace one of the letters, the recertification process will be delayed.

Topic #8523

Paper Recertification Applications

Providers who do not have Internet access or who are not able to complete recertification via the ForwardHealth Portal should contact Provider Services to request a paper recertification application. Providers who request a paper application are required to complete the recertification process on paper and not online via the Portal to avoid duplicate recertification submissions.

Topic #8522

Recertification Completed by an Authorized Representative

A provider has several options for submitting information to the DHS (Department of Health Services), including electronic and Web-based submission methodologies that require the input of secure and discrete access codes but not written provider signatures.

The provider has sole responsibility for maintaining the privacy and security of any access code the provider uses to submit information to the DHS, and any individual who submits information using such access code does so on behalf of the provider, regardless of whether the provider gave the access code to the individual or had knowledge that the individual knew the access code or used it to submit information to the DHS.

Topic #8520

Recertification on the ForwardHealth Portal

Logging in to the Secure Recertification Area of the Portal

Once a provider has received the Provider Recertification Notice and PIN (personal identification number) letter, the provider may log in to the Recertification area of the ForwardHealth Portal to begin the recertification process.

The Recertification area of the Portal is not part of a Provider Portal account. Providers do not need a Provider Portal account to participate in recertification via the Portal. Providers are not able to access the Recertification area of the Portal by logging in to a Provider Portal account; providers must use the ATN (application tracking number) from the Provider Recertification Notice and PIN from the PIN letter to log in to the Recertification area of the Portal.

The Portal will guide providers through the recertification process. On each screen, providers are required to complete or verify information.

Completing Recertification

Providers are required to complete all of the recertification screens in a single session. The Portal will not save a provider's partial progress through the recertification screens. If a provider does not complete all of the recertification screens in a single session, the provider will be required to start over when logging in to the Recertification area of the Portal again.

It is important to read the final screen carefully and follow all instructions before exiting the recertification process. After exiting the recertification process, providers will not be able to retrieve the provider recertification documents for their records.

The final screen of the recertification process gives providers the option to print and save a PDF (Portable Document Format) version of the recertification information submitted to ForwardHealth. Providers whose recertification is approved immediately will also be able to print a copy of the approval letter and the Provider Agreement signed by the DHS (Department of Health Services).

In other cases, the final screen will give providers additional instructions to complete recertification, such as the following:

- The recertification application requires review. Providers are mailed the approval letter and other materials when the application is approved.
- Some providers may be required to send additional paper documentation to ForwardHealth.

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 certified 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 certification 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 certification 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 certification 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 certification. 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.

Claims

2

Archive Date:06/01/2012

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 DHCAA (Division of Health Care Access and Accountability) 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 found, the provider can alter the claim to reflect the desired change and resubmit it to ForwardHealth. Any claim ForwardHealth has paid can be adjusted and resubmitted on the Portal, regardless of how the claim was originally submitted.

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 (10/08)) 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

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 card or an EE (Express Enrollment) card, BadgerCare Plus encourages providers to check the member's enrollment and, if the enrollment is not on file yet, make a photocopy of the member's temporary card or EE card. If Wisconsin's EVS (Enrollment Verification System) indicates that the member is not enrolled in BadgerCare Plus, providers should check enrollment again in two days or wait one week to submit a claim to ForwardHealth. If the EVS indicates that the member still is not enrolled after two days, or if the claim is denied with an enrollment-related EOB (Explanation of Benefits) code, providers 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 certified 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

ForwardHealth 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 (10/08)) 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, ForwardHealth 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 certifications will receive an RA for each certification 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 certified by 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 outpatient visit for the evaluation and management of an established patient) 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 (10/08)), 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 97 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

The DHCAA (Division of Health Care Access and Accountability) offers electronic billing software at no cost to the provider. The PES (Provider Electronic Solutions) software allows providers 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 #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 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 CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT (Current Procedural Terminology) manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. 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 submitted with CPT or HCPCS (Healthcare Common Procedure Coding System) procedure codes for Wisconsin Medicaid, BadgerCare Plus, and Family Planning Only Services for compliance with the following NCCI edits:

- MUE (Medically Unlikely Edits), or units-of-service detail edits, for claims submitted on and after March 21, 2011, regardless of DOS (dates of service).
- Procedure-to-procedure detail edits for claims submitted on and after April 1, 2011, regardless of DOS.

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 for each CPT/HCPCS code the maximum units of service that a provider would report under most circumstances for a single member on a single DOS. 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 procedure code 11100 (i.e., biopsy of skin lesion). 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/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 procedure code 11451 (i.e., removal of a sweat gland lesion). This is a more complex service than procedure code 93000 (i.e., electrocardiogram) 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 Web site 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 about 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 (10/08)) 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 97 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) includes 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.
- 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 on the Remittance Advice and Corresponding Provider Types

Claim Types	Provider Types
Dental claims	Dentists, dental hygienists, HealthCheck agencies that provide dental services.
Drug and compound drug claims	Pharmacies and dispensing physicians.
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.
Outpatient claims	Outpatient hospital providers and hospice providers.
Professional claims	Ambulance providers, ambulatory surgery centers, anesthesiologist assistants, audiologists, case management providers, certified registered nurse anesthetists, chiropractors, community care organizations, community support programs, crisis intervention providers, day treatment providers, family planning clinics, federally qualified health centers, HealthCheck providers, HealthCheck "Other Services" providers, hearing instrument specialists, home health agencies, independent labs, individual medical supply providers, medical equipment vendors, mental health/substance abuse clinics, nurses in independent practice, nurse practitioners, occupational therapists, opticians, optometrists, personal care agencies, physical therapists, physician assistants, physician clinics, physicians, podiatrists, portable X-ray providers, prenatal care coordination providers, psychologists, rehabilitation agencies, respiratory therapists, rural health clinics, school-based services providers, specialized medical vehicle providers, speech and hearing clinics, speech-language pathologists, therapy groups.

Topic #4418

Reading Non-Claims Processing Sections of the Remittance Advice

Address Page

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

Banner Messages

The Banner Messages section of the RA (Remittance Advice) contains important, time-sensitive messages for providers. For

example, banner messages might inform providers of claim adjustments initiated by ForwardHealth, claim submission deadlines, and dates of upcoming training sessions. It is possible for each RA to include different messages; therefore, providers who receive multiple RAs should read all of their banner messages.

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

Explanation of Benefits Code Descriptions

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

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

Financial Transactions Page

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

Payouts are payments made to the provider by ForwardHealth that do not correspond to a specific claim (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	The identifier is used internally

complete the Adjustment ICN.	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, 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

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

  --ICN--         PCN           MRN        SERVICE DATES   BILLED        OTH INS        SPENDDOWN
                                           FROM    TO      AMOUNT        AMOUNT         AMOUNT
MEMBER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX     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

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX               PAYEE ID         999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          NPI              9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXX                                  CHECK/EFT NUMBER  999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, 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

              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 XXXXXXXXXXXXXX   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 XXXXXXXXXXXXXX   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 XXXXXXXXXXXXXX   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 XXXXXXXXXXXXXX   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, 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 Certification

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).

- WCDP (Wisconsin Chronic Disease Program).
- WWWP (Wisconsin Well Woman Program).

A separate Portal account is required for each financial payer.

Note: Each of the three 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 certification. Providers who have a single NPI (National Provider Identifier) that is used for multiple certifications should be aware that an RA will be generated for each certification, 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 certified 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.
- 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, 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 #548

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 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 #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).

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 or the maximum allowable fee established.

Submission

Topic #1708

1500 Health Insurance Claim Form Completion Instructions for Case Management Services

A [sample 1500 Health Insurance Claim Form](#) is available for case management services.

Use the following claim form completion instructions, not the claim form's printed descriptions, to avoid denial or inaccurate claim payment. Complete all required elements as appropriate. Be advised that every code used, even if it is entered in a non-required element, is required to be a valid code. Do not include attachments unless instructed to do so.

Members enrolled in BadgerCare Plus or Medicaid receive a ForwardHealth identification card. Always verify a member's enrollment before providing nonemergency services to determine if there are any limitations on 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.

Submit completed paper claims to the following address:

> ForwardHealth
> Claims and Adjustments
> 313 Blettner Blvd
> Madison WI 53784

Element 1 — Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Blk Lung, Other
Enter "X" in the Medicaid check box.

Element 1a — Insured's ID Number
Enter the member identification number. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS (Wisconsin's Enrollment Verification System) to obtain the correct member ID.

Element 2 — Patient's Name
Enter the member's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS.

Element 3 — Patient's Birth Date, Sex
Enter the member's birth date in MMDDYY format (e.g., February 3, 1955, would be 020355) or in MMDDCCYY format (e.g., February 3, 1955, would be 02031955). Specify whether the member is male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name
Data are required in this element for OCR (Optical Character Recognition) processing. Any information populated by a provider's computer software is acceptable data for this element (e.g., "Same"). If computer software does not automatically complete this element, enter information such as the member's last name, first name, and middle initial.

Element 5 — Patient's Address
Enter the complete address of the member's place of residence, if known.

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name (not required)

Element 9a — Other Insured's Policy or Group Number (not required)

Element 9b — Other Insured's Date of Birth, Sex (not required)

Element 9c — Employer's Name or School Name (not required)

Element 9d — Insurance Plan Name or Program Name (not required)

Element 10a-10c — Is Patient's Condition Related to: (not required)

Element 10d — Reserved for Local Use (not required)

Element 11 — Insured's Policy Group or FECA Number (not required)

Element 11a — Insured's Date of Birth, Sex (not required)

Element 11b — Employer's Name or School Name (not required)

Element 11c — Insurance Plan Name or Program Name (not required)

Element 11d — Is there another Health Benefit Plan? (not required)

Element 12 — Patient's or Authorized Person's Signature (not required)

Element 13 — Insured's or Authorized Person's Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Element 17 — Name of Referring Provider or Other Source (not required)

Element 17a (not required)

Element 17b — NPI (not required)

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use (not required)

Element 20 — Outside Lab? $Charges (not required)

Element 21 — Diagnosis or Nature of Illness or Injury
Enter the ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) diagnosis code assigned to the target population.

ForwardHealth accepts up to eight diagnosis codes. To enter more than four diagnosis codes:

- Enter the fifth diagnosis code in the space between the first and third diagnosis codes.
- Enter the sixth diagnosis code in the space between the second and fourth diagnosis codes.
- Enter the seventh diagnosis code in the space to the right of the third diagnosis code.
- Enter the eighth diagnosis code in the space to the right of the fourth diagnosis code.

When entering fifth, sixth, seventh, and eighth diagnosis codes, do not number the diagnosis codes (e.g., do not include a "5." before the fifth diagnosis code).

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number (not required)

Element 24
The six service lines in Element 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.

Element 24A — Date(s) of Service
Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one DOS (date of service), enter the date in MMDDYY or MMDDYYYY format in the "From" field.
- For assessments and case planning, if the service was performed on more than one DOS, indicate the last DOS on the claim form.
- For ongoing monitoring and service coordination, 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.

Although a given month's ongoing monitoring may only be billed once, more than one month's ongoing monitoring maybe billed on a single claim form. In that case, use one detail line for each month's ongoing monitoring with the DOS determined as described above.

Element 24B — Place of Service
Enter the appropriate two-digit POS (place of service) code for each item used or service performed.

Element 24C — EMG (not required)

Element 24D — Procedures, Services, or Supplies
Enter the single most appropriate five-character procedure code. ForwardHealth denies claims received without an appropriate procedure code.

Modifiers
Enter the appropriate (up to four per procedure code) modifier(s) in the "Modifier" column of Element 24D.

Element 24E — Diagnosis Pointer
Enter the number(s) that corresponds to the appropriate ICD-9-CM diagnosis code(s) listed in Element 21. Up to four diagnosis pointers per detail may be indicated. Valid diagnosis pointers, digits 1 through 8, should not be separated by commas or spaces.

Element 24F — $ Charges
Enter the total charge for each line item.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

Providers are to bill ForwardHealth their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to ForwardHealth benefits.

Element 24G — Days or Units
Enter the number of days or units. Only include a decimal when billing fractions (e.g., 1.50).

Element 24H — EPSDT/Family Plan (not required)

Element 24I — ID Qual (not required)

Element 24J — Rendering Provider ID. # (not required)

Element 25 — Federal Tax ID Number (not required)

Element 26 — Patient's Account No. (not required)
Optional — Providers may enter up to 14 characters of the patient's internal office account number. This number will appear on the RA (Remittance Advice) and/or the 835 (835 Health Care Claim Payment/Advice) transaction.

Element 27 — Accept Assignment? (not required)

Element 28 — Total Charge
Enter the total charges for this claim. If submitting a multiple-page claim, enter the total charge for the claim (i.e., the sum of all details from all pages of the claim) *only on the last page of the claim*.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

Element 29 — Amount Paid (not required)

Element 30 — Balance Due
Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28. If submitting a multiple-page claim, enter the balance due for the claim (i.e., the sum of all details from all pages of the claim minus the amount paid by commercial insurance) *only on the last page of the claim*.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

Element 31 — Signature of Physician or Supplier, Including Degrees or Credentials
The provider or authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MMDDYY or MMDDCCYY format.

Note: The signature may be a computer-printed or typed name and date or a signature stamp with the date.

Element 32 — Service Facility Location Information (not required)

Element 32a — NPI (not required)

Element 32b (not required)

Element 33 — Billing Provider Info & Ph #
Enter the name of the provider submitting the claim and the practice location address. The minimum requirement is the provider's name, street, city, state, and ZIP+4 code. Do not enter a Post Office Box or a ZIP+4 code associated with a PO Box. The practice location address entered must correspond with the NPI listed in element 33a and match the practice location address on the provider's file maintained by ForwardHealth.

Element 33a — NPI
Enter the NPI (National Provider Identifier) of the billing provider.

Element 33b
If an NPI was entered in Element 33a, enter qualifier "PXC" followed by the appropriate 10-digit provider taxonomy code on file with ForwardHealth. Do not include a space between the qualifier "PXC" and the provider taxonomy code.

Sample 1500 Health Insurance Claim Form for Case Management Services

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 Claims Submission

Providers are encouraged to submit claims electronically. Electronic claims 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 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 DHCAA (Division of Health Care Access and Accountability) 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 #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 #367

Noncertified Providers

Claims from noncertified in-state providers must meet additional requirements.

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 a 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 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 (09/11)) and the Noncompound Drug Claim (F-13072 (09/11)).

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 eight diagnosis codes in Element 21 of the 1500 Health Insurance Claim Form. To correctly add additional diagnosis codes in this element so that it can be read properly by the OCR software, providers should indicate the fifth diagnosis code between the first and third diagnosis code blanks, the sixth diagnosis code between the second and fourth diagnosis code blanks, the seventh diagnosis code to the right of the third diagnosis code blank, and the eighth diagnosis code to the right of the fourth diagnosis code blank. Providers should not number any additional diagnosis codes.

Anchor Fields

Anchor fields are areas on the 1500 Health Insurance Claim Form and the UB-04 Claim Form that the OCR software uses to identify what type of form is being processed. The following fields on the 1500 Health Insurance Claim Form are anchor fields:

- Element 2 (Patient's Name).
- Element 4 (Insured's Name).
- Element 24 (Detail 1).

The following fields on the UB-04 Claim Form are anchor fields:

- Form Locator 4 (Type of Bill).
- Form Locator 5 (Fed. Tax No.).
- Form Locator 9 (Patient Address).
- Form Locator 58A (Insured's Name).

Since ForwardHealth uses these fields to identify the form as a 1500 Health Insurance Claim Form or a UB-04 Claim Form, it is required that these fields are completed for processing.

Sample of a Correctly Aligned 1500 Health Insurance Claim Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | | | PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE MEDICAID TRICARE CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
(Medicare #) [X] (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (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 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. PATIENT STATUS
Single [ ] Married [ ] Other [ ]
Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

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)
OI-P

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT?
YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

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 _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

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

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

17a.
17b. NPI 0111111110

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

19. RESERVED FOR LOCAL USE

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. XXX . X   3. _____ . _____
2. _____ . _____   4. _____ . _____

22. MEDICAID 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 $ XX XX

30. BALANCE DUE $ XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
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. PXC123456789X

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Sample of an Incorrectly Aligned 1500 Health Insurance Claim Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

| | PICA | | | | | | PICA | | |

1. MEDICARE   MEDICAID   TRICARE CHAMPUS   CHAMPVA   GROUP HEALTH PLAN   FECA BLK LUNG   OTHER
(Medicare #) [X] (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (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   SEX
MM DD YY   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. PATIENT STATUS
Single   Married   Other
Employed   Full-Time Student   Part-Time Student

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)
OI-P

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   SEX
MM DD YY   M   F

b. OTHER INSURED'S DATE OF BIRTH   SEX
MM DD YY   M   F

b. AUTO ACCIDENT?   PLACE (State)
YES   NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT?
YES   NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
YES   NO   If yes, return to and complete item 9 a-d.

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 (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE   MM DD YY

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

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

17a.
17b. NPI   0111111110

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? $ CHARGES
YES   NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. XXX . X
2.
3.
4.

22. MEDICAID 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
$ XX XX

30. BALANCE DUE
$ XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
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   PXC123456789X

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample of a Correctly Aligned UB-04 Claim Form

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 (dated 08/05). 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.
- UB-04 (CMS 1450) Claim Form.
- Compound Drug Claim (F-13073 (09/11)) form.
- Noncompound Drug Claim (F-13072 (09/11)) 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 a paper Acknowledgment of Receipt of Hysterectomy Information (F-1160A (10/08)) form.
  - Sterilization claims must be submitted along with a paper Consent for Sterilization (F-1164 (10/08)) form.
  - Claims submitted to Timely Filing appeals must be submitted on paper with a Timely Filing Appeals Request (F-13047 (10/08)) form.
  - In certain circumstances, drug claims must be submitted on paper with a Pharmacy Special Handling Request (F-13074 (04/11)) form.

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 submit a [Timely Filing Appeals Request (F-13047 (10/08))](#) form with a paper claim or an [Adjustment/Reconsideration Request (F-13046 (10/08))](#) form to override the submission deadline.

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 (10/08))](#) 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 (10/08))](#) form for each claim and each adjustment to allow for electronic documentation of individual claims and adjustments submitted to ForwardHealth.
- A legible claim or adjustment request.
- All required documentation as specified for the exception to the submission deadline.

To receive consideration, a Timely Filing Appeals Request must be received before the deadline specified for the exception to the submission deadline.

When completing the claim or adjustment request, providers are required to indicate the procedure code, diagnosis code, POS (place of service) code, etc., as 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 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 level of care or liability amount.	To receive consideration, the request must be submitted within 455 days from the DOS and the correct liability amount or level of care must be indicated on the Adjustment/Reconsideration Request (F-13046 (10/08)) 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.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

Decision Made by a Court, Fair Hearing, or the 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 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. A complete copy of the notice received from the court, fair hearing, or DHS must be submitted with the request.	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 following documentation must be submitted within 455 days from the DOS:
	
	• 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 the DOS:
	   ○ White paper BadgerCare Plus EE (Express Enrollment) for pregnant women or children identification card.
	   ○ Green paper temporary identification card.
	   ○ White paper TE (Temporary Enrollment) for Family Planning Only Services identification card.
	   ○ The response received through Wisconsin's EVS (Enrollment Verification System) from a commercial eligibility vendor.
	   ○ The transaction log number
		ForwardHealth Good Faith/Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

	received through [WiCall](#).	

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. A copy of the RA message that shows the ForwardHealth-initiated adjustment must be submitted with the request.	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. The request must be submitted with one of the following: • "GR retroactive enrollment" indicated on the claim. • 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 following must be submitted within 90 days of the Medicare processing date: • A copy of the Medicare remittance information. • The appropriate Medicare disclaimer code must be indicated on the claim.	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	To receive consideration, the following documentation must be submitted within 90 days from the date of recoupment notification:	ForwardHealth Timely Filing Ste 50

reimbursement was inappropriate.	• A copy of the commercial health insurance remittance information. • A copy of the remittance information showing recoupment for crossover claims when Medicare is recouping payment.	313 Blettner Blvd Madison WI 53784

Retroactive Member Enrollment		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a claim cannot be submitted within the submission deadline due to a delay in the determination of a member's retroactive enrollment.	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. In addition, "retroactive enrollment" must be indicated on the claim.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

Covered and Noncovered Services

3

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 Medicaid or the BadgerCare Plus Standard Plan, and the family's other children enrolled in Medicaid or the Standard Plan.

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 a certified 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-certified 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.

- 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.

All assessments must meet the standards for COP (Community Options Program) assessments, as defined in s. 46.27(6), Wis. Stats. Providers are not required to use a specific assessment tool.

To obtain a copy of the DHS (Department of Health Services) COP *Model Long-Term Care Assessment Tool*, write:

> Bureau of Aging and Long Term Care Resources
> DDES (Division of Disability and Elder Services)
> Rm 450
> PO Box 7851
> Madison WI 53707-7851

Codes

Topic #830

Diagnosis Codes

All diagnosis codes indicated on claims (and PA (prior authorization) requests when applicable) must be the most specific ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) diagnosis code. Providers are responsible for keeping current with diagnosis code changes. Etiology and manifestation codes may not be used as a primary diagnosis.

The required use of valid diagnosis codes includes the use of the most specific diagnosis code. Valid, most specific diagnosis codes may have up to five digits. Claims submitted with three- or four-digit codes where four- and five-digit codes are available may be denied.

Topic #1694

Target groups and allowable diagnosis codes for case management are listed in the following table.

Target Group	Diagnosis Code	Description
Developmentally Disabled	315.9	Unspecified delay in development
Birth to Three	V79.3	Developmental handicaps in early childhood
Alcohol and Other Drug Abuse	304.90	Unspecified drug dependence
Chronically Mentally Ill	V40.9	Unspecified mental or behavioral problem
Alzheimer's Disease or Related Dementia	294.8	Other specified organic brain syndromes (chronic)
Tuberculosis	V12.01	Tuberculosis
Women Age 45 to 64	V15.9	Unspecified personal history presenting hazards to health
Physically Disabled	V12.40	Unspecified disorder of the nervous system and sense organs
Elderly Age 65 and Over	V62.9	Unspecified psychosocial circumstance
Under Age 21 and Severely Emotionally Disturbed	313.9	Unspecified emotional disturbance of childhood or adolescence
Child with Asthma	493.90	Asthma, unspecified
Child At-Risk	V61.8	Other unspecified family circumstances
HIV	V08	Asymptomatic HIV (human immunodeficiency virus) infection status

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
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room — Hospital
31	Skilled Nursing Facility
32	Nursing Facility
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
54	Facilities for Developmental Disabilities
71	State or Local Public Health Clinic
72	Rural Health Clinic
99	Other Place of Service

Topic #1692

Procedure Codes

Covered case management services are identified by the allowable HCPCS (Healthcare Common Procedure Coding System) procedure code and modifiers listed in the following table.

Procedure Code and Description	First Service Modifier	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

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 must 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	.3
6-10 minutes	.7
11-15 minutes	1.0

For example, a case manager has billable contacts on three days during a month: a 1 hour and 15-minute meeting with a member (including travel and recording time), a 5-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 1 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, .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) code book, 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:

- On paper with supporting information/description included in Element 19 of the 1500 Health Insurance Claim Form.
- On paper with supporting documentation submitted on paper. This option should be used if Element 19 does not allow enough space for the description or when billing multiple unlisted procedure codes. Providers should indicate "See Attachment" in Element 19 of the paper claim and send the supporting documentation along with the paper claim.
- Electronically, either using DDE (Direct Data Entry) through the ForwardHealth Portal, PES (Provider Electronic Solutions) transactions, or 837 Health Care Claim electronic transactions, with supporting documentation included electronically in the Notes field. The Notes field is limited to 80 characters.
- Electronically with an indication 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.

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 the BadgerCare Plus Standard Plan services or non-Medicaid or the Standard Plan services. Examples of gaining access to or coordinating non-Medicaid or the Standard Plan 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 certified as a case management provider (or is part of a county department that is a Medicaid-certified 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 Medicaid or the BadgerCare Plus Standard Plan 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 certified 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 a certified 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 a certified 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-MR (intermediate care facility-mentally retarded), 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 Wisconsin Medicaid or the BadgerCare Plus Standard Plan, 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 DHS 101.03(96m), Wis. Admin. Code. 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-certified 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 certification.

Topic #66

Program Requirements

For a covered service to meet program requirements, the service must be provided by a qualified Medicaid-certified 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 #7897

Resetting Service Limitations

Service limitations used by a member enrolled in the BadgerCare Plus Benchmark Plan and the BadgerCare Plus Core Plan within their continuous 12-month enrollment year will reset in the following situations:

- A fee-for-service member is enrolled in an HMO (health maintenance organization).
- A member switches from one HMO to another HMO (only allowable within the first 90 days of Core Plan enrollment).
- A member is disenrolled from an HMO and moves to fee-for-service.

Note: When a member goes from fee-for-service into an HMO and subsequently moves back to fee-for-service, service limitations will not be reset for the services that were received under the initial fee-for-service enrollment period.

PA (prior authorization) requests for services beyond the covered service limitations will be denied.

Resetting service limitations does not change a member's Benchmark Plan enrollment year or a member's Core Plan enrollment year.

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 certification 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 #9337

Basic Plan Noncovered Services

The following are among the services that are not covered under the BadgerCare Plus Basic Plan:

- Case management.
- Certain visits over the 10-visit limit.
- CRS (Community Recovery Services).
- Enteral nutrition.
- HealthCheck.
- Health education services.
- Hearing services, including hearing instruments, cochlear implants, and bone-anchored hearing aids, hearing aid batteries, and repairs.
- Home care services (home health, personal care, PDN (private duty nursing)).
- Inpatient mental health and substance abuse treatment services.
- Non-emergency transportation (i.e., common carrier, SMV (specialized medical vehicle)).
- Nursing home.
- Obstetrical care and delivery.
- Outpatient mental health and substance abuse services.
- PNCC (prenatal care coordination).
- Provider-administered drugs.
- Routine vision examinations billed with CPT (Current Procedural Terminology) codes 92002-92014 (without a qualifying diagnosis), determination of refractive state billed with CPT code 92015; vision materials such as glasses, contact lenses, and ocular prosthetics; repairs to vision materials; and services related to the fitting of contact lenses and spectacles.
- SBS (school-based services).
- Transplants and transplant-related services.

Billing Members for Noncovered Services

Basic Plan members may request noncovered services from providers. In those cases, providers may collect payment for the noncovered service from the member if the member accepts responsibility for payment and makes payment arrangements with the provider. Providers are strongly encouraged to obtain a written statement in advance documenting that the member has accepted responsibility for payment of the service.

Providers may bill members up to their usual and customary charge for noncovered services. Basic Plan members do not have appeal rights for noncovered services.

Topic #4777

Benchmark Plan Noncovered Services

Case management services are not covered under the BadgerCare Plus Benchmark Plan.

Topic #5517

Core Plan Noncovered Services

The following services are not covered under the BadgerCare Plus Core Plan:

- Case management.
- CRS (Community Recovery Services).
- Enteral nutrition products.
- Hearing services, including hearing instruments, cochlear implants, bone-anchored hearing aids, hearing aid batteries, and repairs.
- Home care services (home health, personal care, PDN (private duty nursing)).
- Inpatient mental health and substance abuse treatment services.
- Non-emergency transportation (i.e., common carrier, SMV (specialized medical vehicle)).
- Nursing home.
- PNCC (prenatal care coordination).
- Routine vision examinations billed with CPT (Current Procedural Terminology) codes 92002-92014 (without a qualifying diagnosis), determination of refractive state billed with CPT code 92015; vision materials such as glasses, contact lenses, and ocular prosthetics; repairs to vision materials; and services related to the fitting of contact lenses and spectacles.
- SBS (school-based services).

Services that exceed a service limitation established under the Core Plan are considered noncovered. Providers are required to follow certain procedures for billing members who receive these services.

Billing Members for Noncovered Services

Services rendered during a noncovered home health visit will not be reimbursed by ForwardHealth. Providers are encouraged to inform the member when he or she has reached a service limitation. If a member requests a service that exceeds the limitation, the member is responsible for payment. Providers should make payment arrangements with the member in advance. Providers may bill members up to their usual and customary charges for noncovered services.

Topic #68

Definition of Noncovered Services

A noncovered service is a service, item, or supply for which reimbursement is not available. DHS 101.03(103) and 107, Wis. Admin. Code, contain more information about noncovered services. In addition, DHS 107.03, Wis. Admin. Code, 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.
- Encourage the member to call for NEMT (non-emergency medical transportation) services. Most members may receive NEMT services through LogistiCare. 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 Medicaid or the BadgerCare Plus Standard Plan, 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 Medicaid or the Standard Plan

Case management with a family member not enrolled in Wisconsin Medicaid or the BadgerCare Plus Standard Plan (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 Medicaid or the Standard Plan 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 Medicaid or the Standard Plan.

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- 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 Medicaid or the Standard Plan 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 Medicaid or the Standard Plan 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 Medicaid or the Standard Plan 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 Medicaid or the Standard Plan 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 Medicaid or the Standard Plan, 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.

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-certified 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 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 "Case management services under this subsection may not be provided to a person under
(continued) the category of severely emotionally disturbed child unless any of the following is true:
49.45(25)(a), Wis. Stats.

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 $\geq$ 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 in their certification paperwork 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 certification process, during which initial target population selection(s) is made, providers may add or delete target populations anytime by completing the Target Population Change Request form subject to the following provisions:

1. Providers adding target population(s) must specify if they want the population added retroactive to the first day of the calendar quarter or when ForwardHealth receives the form.
2. Providers subtracting population(s) must specify if they want the subtraction(s) effective when ForwardHealth receives the form, or at a date after ForwardHeatlh receives the form, as specified on the form.

Case Management Target Population "Change Request" Form

Please send this form to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

Please note that you may add target populations at any time. If you *add* a target population, specify whether you want the population added retroactive to the first day of the calendar quarter or when Wisconsin Medicaid receives this form. You may also subtract target populations at any time. If you *subtract* a population, the subtraction is effective when Wisconsin Medicaid receives this form or at a date after Wisconsin Medicaid receives this form, as specified on this form.

NAME: _____   TITLE: _____

ADDRESS: _____

COUNTY: _____   PROVIDER NUMBER: _____

SIGNATURE: _____   DATE SIGNED: _____

By signing this form, I am indicating to the Division of Health Care Financing (DHCF) the approval of this change by my County Board of Supervisors or Indian Tribal Government as required under s. 49.45 (25), Wis. Stats.

Indicate populations you will be adding or subtracting:

	ADDING	OR SUBTRACTING
Persons who are age 65 or older	( )	( )
Persons who have a diagnosis of Alzheimer's disease or related dementia	( )	( )
Persons with a physical or sensory disability	( )	( )
Persons with a developmental disability	( )	( )
Persons with a chronic mental illness	( )	( )
Persons with alcohol and/or drug dependency	( )	( )
Persons who are severely emotionally disturbed and are under the age of 21	( )	( )
Persons diagnosed as having Human Immunodeficiency Virus infection	( )	( )
Families with child at risk of serious physical, mental, or emotional dysfunction	( )	( )
Children enrolled in a Birth to 3 program	( )	( )
Children with asthma	( )	( )
Persons infected with tuberculosis	( )	( )
Women age 45-64	( )	( )

Complete one of the following:
1. EFFECTIVE UPON RECEIPT?   Y   N
      or
2. EFFECTIVE ON: _____
               (Specify date)

Managed Care

4

Topic #385

Appeals to BadgerCare Plus and Wisconsin Medicaid

The provider has 60 calendar days to file an appeal with BadgerCare Plus or Wisconsin Medicaid after the HMO (health maintenance organization) or SSI (Supplemental Security Income) 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 of service in question.

Appeals must be made in writing and must include:

- A letter, clearly marked "APPEAL," explaining why the claim should be paid or a completed Managed Care Program Provider Appeal (Managed Care Program Provider Appeal, F-12022 (03/09)) form.
- A copy of the claim, clearly marked "APPEAL."
- A copy of the provider's letter to the HMO or SSI HMO.
- A copy of the HMO's or SSI HMO's response to the provider.
- Any documentation that supports the case.

The appeal will be reviewed and any additional information needed will be requested from the provider or the HMO or SSI HMO. Once all pertinent information is received, BadgerCare Plus or Wisconsin Medicaid has 45 calendar days to make a final decision.

The provider and the HMO or SSI HMO will be notified in writing of the final decision. If the decision is in favor of the provider, 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 must abide by the decision.

Topic #384

Appeals to HMOs and SSI HMOs

Providers are required to first file an appeal directly with the BadgerCare Plus HMO (health maintenance organization) or Medicaid SSI (Supplemental Security Income) HMO within 60 calendar days of receipt of the initial denial. Providers are required to include a letter explaining why the HMO or SSI HMO should pay the claim. The appeal should be sent to the address indicated on the HMO's or SSI HMO's denial notice.

The HMO or SSI HMO then has 45 calendar days to respond in writing to the appeal. The HMO or SSI HMO decides whether to pay the claim and sends the provider a letter stating the 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.

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 (health maintenance organization) 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 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 Element 18 of the paper 1500 Health Insurance Claim Form.
- 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.

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 #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 (health maintenance organizations) or Medicaid SSI (Supplemental Security Income) HMOs but are provided to enrollees on a fee-for-service basis provided the member's fee-for-service plan covers the service:

- CRS (Community Recovery Services).
- CSP (Community Support Program) benefits.
- Crisis intervention services.
- Environmental lead inspections.
- CCC (child care coordination) services.
- Pharmacy services and diabetic supplies.
- PNCC (prenatal care coordination) services.
- Provider-administered drugs, including all "J" codes, drug-related "Q" codes, and a limited number of related administration codes.
- SBS (school-based services).
- Targeted case management services.
- NEMT (non-emergency medical transportation) services for most Wisconsin Medicaid and BadgerCare Plus members. Wisconsin Medicaid and BadgerCare Plus members who are enrolled in an HMO in Milwaukee, Waukesha, Washington, Ozaukee, Kenosha, and Racine counties receive NEMT services from their respective HMOs.
- DOT (directly observed therapy) and monitoring for TB-Only (Tuberculosis-Only Related Services).

Enrollment

Topic #392

Disenrollment and Exemptions

In some situations, a member may be exempt from enrolling in a BadgerCare Plus HMO (health maintenance organization) 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 the member's HMO or SSI HMO. For example, in certain circumstances, women in high-risk pregnancies or women who are in the third trimester of pregnancy when they are enrolled in an HMO or SSI HMO *may* qualify for an exemption.

The [contracts](#) between the DHS (Department of Health Services) and the HMO or SSI HMO 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 the BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, and the BadgerCare Plus Core Plan 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

HMOs

Members are sent enrollment packets that explain the BadgerCare Plus HMOs (health maintenance organizations) and the enrollment process and provide contact information. Once enrolled, enrollees 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

Members are sent enrollment packets that explain the Medicaid SSI (Supplemental Security Income) HMO's enrollment process and provide contact information. Once enrolled, enrollees may disenroll after a 60-day trial period and up to 120 days after enrollment and return to Medicaid fee-for-service if they choose.

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 #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 several special managed care programs available.

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 #1671

Medicaid HMOs and Case Management Services

Case management services are covered on a fee-for-service basis for members enrolled in BadgerCare Plus HMOs, including iCare (Independent Care) in Milwaukee. Since 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 (health maintenance organizations) provide the same benefits as Medicaid fee-for-service (e.g. medical, dental, mental health/substance abuse, vision, and prescription drug coverage) at no cost to their enrollees through a care management model. Medicaid members and SSI-related Medicaid members in certain counties 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

Members who meet the following criteria are eligible to enroll in an SSI HMO:

- Medicaid-eligible individuals living in a service area that has implemented an SSI managed care program.
- Individuals ages 19 and older.
- Individuals who are enrolled in Wisconsin Medicaid and SSI or receive SSI-related Medicaid.

Individuals who are living in an institution or nursing home or are participating in a home and community-based waiver program or FamilyCare are not eligible to enroll in an SSI HMO.

Ozaukee and Washington Counties

Most SSI and SSI-related Medicaid members who reside in Ozaukee and Washington counties are required to choose the HMO in which they wish to enroll. Dual eligibles (members receiving Medicare and Wisconsin Medicaid) are not required to enroll. After a 60-day trial period and up to 120 days after enrollment, enrollees may disenroll and return to Medicaid fee-for-service if they choose.

Southwestern Wisconsin Counties

SSI members and SSI-related Medicaid members who reside in Buffalo, Jackson, La Crosse, Monroe, Trempealeau, and Vernon counties may choose to receive coverage from the HMO or remain in Wisconsin Medicaid fee-for-service.

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 60 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 Wisconsin Medicaid. The PA must be honored for 60 days or until the month following the HMO's completion of the assessment and care plan, whichever comes later.
- Coverage of drugs that an SSI member is currently taking until a prescriber orders different drugs.

Topic #403

Special Managed Care Programs

Wisconsin Medicaid has several special managed 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, the PACE (Program of All-Inclusive Care for the Elderly), and the Family Care Partnership Program. Additional information about these special managed care programs may be obtained from the Managed Care Organization area of the ForwardHealth Portal.

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

Wisconsin Medicaid 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. When services are provided through fee-for-service or to members enrolled in a BadgerCare Plus HMO, copayments will apply.

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.

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-certified provider may provide the service to the enrollee and submit claims to fee-for-service.

Member Information

5

Member Information:Enrollment Categories

Topic #785

BadgerCare Expansion for Certain Pregnant Women

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 Expansion for Certain Pregnant Women 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., claims 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 #9297

BadgerCare Plus Basic Plan

The BadgerCare Plus Basic Plan is a self-funded plan that focuses on providing BadgerCare Plus Core Plan waitlist members with access to vital, cost-effective primary and preventive care. This option will allow members to have some minimal form of coverage until space becomes available in the Core Plan and will help prevent bankruptcy due to excessive medical debt.

Member participation or non-participation in the Basic Plan does not affect an individual's status on the Core Plan waitlist.

Services for the Basic Plan are covered under fee-for-service. Basic Plan members will not be enrolled in state-contracted HMOs (health maintenance organizations).

As of March 19, 2011, new enrollment into the Basic Plan ended. The Basic Plan will continue for members already enrolled in the Basic Plan.

Conditions That End Member Enrollment in the Basic Plan

A member's enrollment in the Basic Plan will end if the member:

- Becomes eligible for Medicare, Medicaid, the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, or the Core Plan.
- Becomes incarcerated or becomes institutionalized in an IMD (institution for mental disease).
- Becomes pregnant. (*Note:* A Basic Plan member who becomes pregnant should be referred to Member Services for more information about enrollment in the Standard Plan or the Benchmark Plan.)
- No longer resides in the state of Wisconsin.
- Obtains health insurance coverage.
- Turns 65 years of age.
- Fails to pay the monthly premium.

Note: Enrollment in the Basic Plan does not end if the member's income increases.

Providers are reminded that the Basic Plan does not cover obstetrical services or delivery services.

Providers are required to notify ForwardHealth if they have reason to believe that a person is misusing or abusing BadgerCare Plus or Medicaid benefits or the ForwardHealth identification card.

Basic Plan Member Fact Sheets

Fact sheets providing additional member information about the Basic Plan are available.

Enrollment Certification Period for Basic Plan Members

A member's enrollment will begin on the first of the month and will continue through the end of the 12th month. For example, if the individual's enrollment in the Basic Plan begins on July 1, 2010, the enrollment certification period will continue through June 30, 2011, unless conditions occur that end enrollment.

Premium payments are due on the fifth of each month, prior to the month of coverage. Members who fail to pay the monthly premium will have their benefits terminated and will also be subject to a 12-month restrictive re-enrollment period.

Basic Plan Members Enrolled in Wisconsin Chronic Disease Program

For Basic Plan members who are also enrolled in WCDP (Wisconsin Chronic Disease Program), providers should submit claims for all covered services to the Basic Plan first and then to WCDP. For pharmacy services, if both programs deny the pharmacy claim, providers should submit the claim to BadgerRx Gold.

Basic Plan Members and HIRSP Coverage

Basic Plan members may also be enrolled in the HIRSP (Health Insurance Risk-Sharing Plan) as long as the member meets the eligibility requirements for both the Basic Plan and HIRSP. For Basic Plan members who are also enrolled in HIRSP, providers should submit claims for all Basic Plan covered services to HIRSP first and then to the Basic Plan.

Basic Plan members may not be enrolled in the Basic Plan and the Federal Temporary High Risk Insurance Pool. Information that

is being distributed to Core Plan members on the waitlist regarding HIRSP and the Federal Temporary High Risk Insurance Pool is [available](#).

Alternatives to the BadgerCare Plus Basic Plan

Before enrolling in the BadgerCare Plus Basic Plan, you should consider two other insurance options available to some Wisconsin residents. Enrolling in BadgerCare Plus Basic will make you ineligible for coverage under the Federal Pool option described below.

Option 1:   Health Insurance Risk-Sharing Plan (HIRSP)

You may qualify for HIRSP if:

1. You recently lost your employer-sponsored insurance coverage; or
2. You have been rejected for coverage in the private insurance market; or
3. You have HIV/AIDS; or
4. You have Medicare because of a disability.

HIRSP offers comprehensive medical and pharmacy benefits including coverage of brand name drugs and $150 of first dollar coverage on routine/preventive services. HIRSP will not cover medical services for a preexisting condition for the first six months of coverage. The preexisting condition waiting period does not apply to drug coverage. The medical services preexisting condition waiting period does not apply if you qualify for HIRSP because you have recently lost your employer-sponsored coverage.

If your annual household income is below $33,000, you may be entitled to a premium and deductible subsidy. For example, a 25 year old man with an annual income of less than $10,000 would pay $89 per month for a $2,500 deductible insurance plan.

HIRSP members can also be enrolled in the BadgerCare Plus Basic or Core Plan.

Option 2: Federal Temporary High Risk Insurance Pool

You may qualify for the new Federal Pool if:

1. You are a citizen or national of the United States, or are lawfully present;
2. You have a preexisting medical condition; and
3. You have been uninsured for at least 6 months before applying for coverage.

The Federal Pool will offer the same medical and drug benefits as HIRSP. There is no preexisting condition waiting period under the Federal Pool.

In most cases, the Federal Pool premium will be lower than the HIRSP premium.
Enrollment is expected to begin in July 2010, for coverage beginning August 1, 2010.

If you enroll in BadgerCare Plus Basic or HIRSP now, you will not be eligible for the Federal Pool. You should determine which program best serves your needs. For more information about HIRSP or the Federal Pool and your insurance options, please contact HIRSP Customer Service at 1.800.828.4777 or visit *www.hirsp.org*

Topic #5557

BadgerCare Plus Core Plan

The BadgerCare Plus Core Plan covers basic health care services including primary care, preventive care, certain generic and OTC (over-the-counter) drugs, and a limited number of brand name drugs.

Applicant Enrollment Requirements

An applicant must meet the following enrollment requirements in order to qualify for the Core Plan:

- Is a Wisconsin resident.
- Is a United States citizen or legal immigrant.
- Is between the ages of 19 and 64.
- Does not have any children under age 19 under his or her care.
- Is not pregnant.
- Is not eligible for or enrolled in Medicaid, the BadgerCare Plus Standard Plan, or the BadgerCare Plus Benchmark Plan. This would not include benefits provided under Family Planning Only Services or those benefits provided to individuals who qualify for the TB-Only (Tuberculosis-Related Services Only) Benefit.
- Is not eligible for or enrolled in Medicare.
- Has a monthly gross income that does not exceed 200 percent of the FPL (Federal Poverty Level).
- Is not covered by health insurance currently or in the previous 12 months.
- Has not had access to employer-sponsored insurance in the previous 12 months and does not have access to employer-subsidized insurance during the month of application or any of the three months following application.

Application Process for New Members

Individuals who wish to enroll may apply for the Core Plan using the ACCESS tool online or via the ESC (Enrollment Services Center). A pre-screening tool will help determine which individuals may be eligible to enroll in the Core Plan. Applications for Core Plan members will be processed centrally by the ESC, not by county agencies.

To complete the application process, applicants must meet the following requirements:

- Complete a Health Survey.
- Pay a non-refundable, annual processing fee of $60.00 per individual or per couple for married couples. The fee will be waived for homeless individuals. There are no monthly premiums.

Medicaid-certified providers cannot pay the $60.00 application processing fee on behalf of Core Plan applicants. An offer by a Medicaid-certified provider to pay a fee on behalf of a prospective Medicaid member may violate federal laws against kickbacks. These laws are federal criminal statutes that are interpreted and enforced by federal agencies such as the United States DOJ (Department of Justice) and the Department of HHS (Health and Human Services') OIG (Office of the Inspector General).

Conditions That End Member Enrollment in the Core Plan

A member's enrollment will end if the member:

- Becomes eligible for Medicare, Medicaid, the Standard Plan, or the Benchmark Plan.
- Becomes incarcerated or institutionalized in an IMD (institution for mental disease).
- Becomes pregnant.
- No longer resides in the state of Wisconsin.
- Obtains health insurance coverage.
- Turns 65 years of age.

Providers are reminded that the Core Plan does not cover obstetrical services, including the delivery of a child or children. A Core Plan member who becomes pregnant should be referred to the ESC for more information about enrollment in the Standard Plan or the Benchmark Plan.

Enrollment Certification Period for Core Plan Members

Once determined eligible for enrollment in the Core Plan, a member's enrollment will begin either on the first or 15th of the month, whichever is first, and will continue through the end of the 12th month. For example, if the individual submits all of his or her application materials, including the application fee, by September 17, 2009, and the DHS (Department of Health Services) reviews the application and approves it on October 6, 2009, the individual is eligible for enrollment beginning on October 15, 2009, the next possible date of enrollment. The enrollment certification period will continue through October 31, 2010.

The enrollment certification period for individuals who qualify for the Core Plan is 12 months, regardless of income changes.

Core Plan Members Enrolled in Wisconsin Chronic Disease Program

For Core Plan members who are also enrolled in WCDP (Wisconsin Chronic Disease Program), providers should submit claims for all covered services to the Core Plan first and then to WCDP. For pharmacy services, if both programs deny the pharmacy claim, providers should submit claims to BadgerRx Gold.

Core Plan Members with HIRSP Coverage

Core Plan members may also be enrolled in HIRSP (Health Insurance Risk Sharing Plan) as long as the member meets the eligibility requirements for both the Core Plan and HIRSP. For Core Plan members who are also enrolled in HIRSP, providers should submit claims for all Core Plan covered services to the Core Plan. For services not covered by the Core Plan, providers should submit claims to HIRSP. For members enrolled in the Core Plan, HIRSP is always the payer of last resort.

Note: HIRSP will only cover noncovered Core Plan services if the services are covered under the HIRSP benefit.

Topic #225

BadgerCare Plus Standard Plan and Benchmark Plan

BadgerCare Plus is a state-sponsored health care program that expands coverage of Wisconsin residents and ensures that all children in Wisconsin have access to affordable health care.

The key initiatives of BadgerCare Plus are:

- To ensure that all Wisconsin children have access to affordable health care.
- To ensure that 98 percent of Wisconsin residents have access to affordable health care.
- To streamline program administration and enrollment rules.
- To expand coverage and provide enhanced benefits for pregnant women.
- To promote prevention and healthy behaviors.

BadgerCare Plus expands enrollment in state-sponsored health care to the following:

- All uninsured children.
- More pregnant women.
- More parents and caretaker relatives.
- Parents with children in foster care who are working to reunify their families.
- Young adults exiting out-of-home care, such as foster care, because they have turned 18 years of age.

- Certain farmers and other self-employed parents and caretaker relatives.

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.

Topic #6917

Benefit Plans Under BadgerCare Plus

BadgerCare Plus is comprised of four benefit plans, the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, the BadgerCare Plus Core Plan, and the BadgerCare Plus Basic Plan.

BadgerCare Plus Standard Plan

The Standard Plan covers children, parents and caretaker relatives, young adults aging out of foster care, and pregnant women with incomes at or below 200 percent of the FPL (Federal Poverty Level). The services covered under the Standard Plan are the same as the Wisconsin Medicaid program.

BadgerCare Plus Benchmark Plan

The Benchmark Plan was adapted from Wisconsin's largest commercial, low-cost health care plan. The Benchmark Plan is for children and pregnant women with incomes above 200 percent of the FPL and certain self-employed parents, such as farmers with incomes above 200 percent of the FPL. The services covered under the Benchmark Plan are more limited than those covered under the Wisconsin Medicaid program.

BadgerCare Plus Core Plan

The Core Plan provides adults who were previously not eligible to enroll in state and federal health care programs with access to basic health care services including primary care, preventive care, certain generic and OTC (over-the-counter) drugs, and a limited number of brand name drugs.

BadgerCare Plus Basic Plan

The Basic Plan provides Core Plan waitlist members with access to vital, cost-effective primary and preventive care. This option allows members to have some form of minimal coverage until space becomes available in the Core Plan.

Topic #226

Family Planning Only Services

Family Planning Only Services is a limited benefit program that provides routine contraceptive-related services to low-income individuals who are at least 15 years of age who are otherwise not eligible for Wisconsin Medicaid or BadgerCare Plus. There is no upper age limit for Family Planning Only Services enrollment as long as the member is of childbearing age. Members receiving Family Planning Only Services must be receiving routine contraceptive-related services.

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 the Wisconsin Medicaid and BadgerCare Plus family planning benefit (e.g., mammograms and hysterectomies). If a medical condition, other than an STD (sexually transmitted disease), is discovered during contraceptive-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-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-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 service options and provide referrals for care not covered by Family Planning Only Services.

Temporary Enrollment for Family Planning Only Services

Members whose providers are submitting an initial Family Planning Only Services application on their behalf and who meet the enrollment criteria may receive routine contraceptive-related services immediately through TE (temporary enrollment) for Family Planning Only Services for up to two months. Services covered under the TE for Family Planning Only Services are the same as those covered under Family Planning Only Services and must be related to routine contraceptive management.

To determine enrollment for Family Planning Only Services, providers should use the income limit for 300 percent of the FPL (Federal Poverty Level).

TE for Family Planning Only Services providers may issue white paper TE for Family Planning Only Services identification cards for members to use until they receive a ForwardHealth identification card. Providers should remind members that the benefit is temporary, despite their receiving a ForwardHealth card.

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.
- 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, HP (Hewlett-Packard).

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 #10217

Members Enrolled in the Wisconsin Well Woman

Program and the BadgerCare Plus Basic Plan

Women may be enrolled in the WWWP (Wisconsin Well Woman Program) and the BadgerCare Plus Basic Plan at the same time. Women who are diagnosed with breast cancer or cervical cancer while enrolled in WWWP are eligible to be enrolled in WWWMA (Wisconsin Well Woman Medicaid) through the WWWP. WWWMA covers the same services as Wisconsin Medicaid; therefore, enrollment in WWWMA enables members to receive comprehensive treatment, including services not related to their diagnosis.

Once a woman is enrolled in WWWMA, she is no longer eligible for the Basic Plan.

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.

Members Enrolled into Wisconsin Well Woman Medicaid from Benchmark Plan or Core Plan

Women diagnosed with breast cancer or cervical cancer while enrolled in the BadgerCare Plus Benchmark Plan or BadgerCare Plus Core Plan are eligible to be enrolled in WWWMA. Wisconsin Well Woman Medicaid covers the same services as Wisconsin Medicaid and enables members to receive comprehensive treatment, including services not related to their diagnosis.

Women who are diagnosed with breast cancer, cervical cancer, or a precancerous condition of the cervix must have the diagnosis of their condition confirmed by one of the following Medicaid-certified providers:

- Nurse practitioners, for cervical conditions only.
- Osteopaths.
- Physicians.

Women with Medicare or other insurance that covers treatment for her cancer are not allowed to be enrolled into WWWMA.

Covered and Noncovered Services

Wisconsin Well Woman Medicaid covers the same services as Wisconsin Medicaid regardless of whether the service is related to her cancer treatment.

Reimbursement

Providers will be reimbursed for services provided to members enrolled in WWWMA at the Wisconsin Medicaid rate of reimbursement for covered services.

Copayments

There are no copayments for any Medicaid-covered service for WWWMA members who have been enrolled into WWWMA from the Benchmark or the Core Plan. Providers are required to reimburse members for any copayments members paid on or after the date of diagnosis while still enrolled in the Benchmark Plan or the Core Plan.

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 (10/11)) 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 or Medicaid 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 or Wisconsin Medicaid was denied.
- Application for BadgerCare Plus 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

If a claim is denied due to termination of 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.

Topic #247

Freedom of Choice

Members may receive covered services from *any* willing Medicaid-certified 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 #9357

ForwardHealth Basic Plan Identification Cards

Members enrolled in the BadgerCare Plus Basic Plan will receive a ForwardHealth Basic Plan card. All identification cards include the member's name and 10-digit member identification number. The identification cards may be used to verify a member's enrollment, but possession of an identification card does not guarantee enrollment. 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.

Providers should always check enrollment for a member who presents a ForwardHealth card to verify if the member is enrolled in the Basic Plan or in one of the other ForwardHealth programs. (Providers may use the same methods of enrollment verification under the Basic Plan as they do for other ForwardHealth programs such as Medicaid. These methods include the ForwardHealth Portal, WiCall, magnetic stripe readers, and the 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Information Response) transactions.) Members who present a ForwardHealth card or a ForwardHealth Basic Plan card may have been enrolled in a different plan since the card was issued. Providers should be careful to verify the plan in which the member is enrolled and know which services are covered under that plan.

Basic Plan members should call Member Services with questions about premiums and covered services. The ForwardHealth Basic Plan cards include the Member Services telephone number on the back.

Sample ForwardHealth Basic Plan Card

ForwardHealth Basic Plan
Wisconsin serving you

0000 0000 0000 0000
ID No. 0000000000
Ima Member

Authorized Signature

For questions about your Basic Plan coverage, call: 1-800-362-3002.

If you are a provider, call 1-800-947-9627.
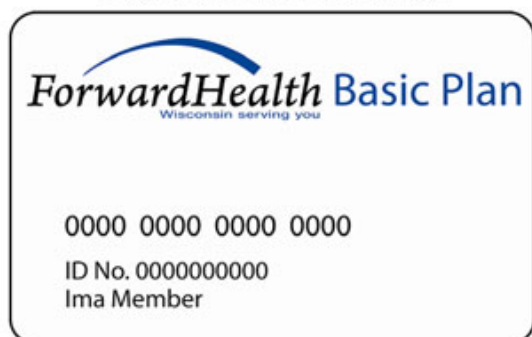State of Wisconsin, PO Box 6678, Madison, WI 53716-0678

Topic #6977

ForwardHealth Core Plan Identification Cards

Members enrolled in the BadgerCare Plus Core Plan will receive a ForwardHealth Core Plan card. All identification cards include the member's name and 10-digit member identification number. The identification cards may be used to verify a member's enrollment, but possession of an identification card does not guarantee enrollment. 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.

Core Plan members should call Member Services with questions about enrollment criteria, HMO (health maintenance organization) enrollment, and covered services.

Providers should always check enrollment for a member who presents a ForwardHealth card to verify if the member is enrolled in the Core Plan or in one of the other ForwardHealth programs. Members who present a ForwardHealth card or a ForwardHealth Core Plan card may have been enrolled in a different plan since the card was issued. Providers should be careful to verify the plan in which the member is enrolled and know which services are covered under that plan.

Sample ForwardHealth Core Plan Card

ForwardHealth Core Plan
Wisconsin serving you

0000 0000 0000 0000

ID No. 0000000000
Ima Member

Authorized Signature

For questions about your Core Plan coverage, call: 1-800-291-2002

State of Wisconsin, PO Box 7190, Madison, WI 53707-7190

If you are a provider, call 1-800-947-9627.

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

Published Policy Through May 31, 2012

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 #268

Temporary Enrollment for Family Planning Only Services Identification Cards

Qualified providers may issue white paper TE (Temporary Enrollment) for Family Planning Only Services identification cards for members to use temporarily until they receive a ForwardHealth identification card. The identification card is included with the TE for Family Planning Only Services Application (F-10119).

The TE for Family Planning Only Services identification cards have the following message printed on them: "Temporary Identification Card for Temporary Enrollment for Family Planning Only Services." Providers should accept the white TE for Family Planning Only Services identification cards as proof of enrollment for the dates provided on the cards and are encouraged to keep a photocopy of the card.

Topic #267

Temporary Express Enrollment Cards

There are two types of temporary EE (Express Enrollment) identification cards. One is issued for pregnant women and the other for children that are enrolled in BadgerCare Plus through EE. The EE cards are valid for 14 days. Samples of temporary EE cards for children and pregnant women are available.

Providers may assist pregnant women with filling out an application for temporary ambulatory prenatal care benefits through the online EE process. EE identification cards are included on the bottom portion of the enrollment notice that is printed out and provided to the member after the online enrollment process is completed.

The paper application may also be used to apply for temporary ambulatory prenatal benefits for pregnant women. A beige paper identification card is attached to the last page of the application and provided to the woman after she completes the enrollment process.

The online EE process is also available for adults to apply for full BadgerCare Plus benefits for children. EE identification cards are included on the bottom portion of the enrollment notice that is printed out and provided to the member after the online enrollment process is completed. This temporary identification card is different, since providers may see more than one child listed if multiple children in one household are enrolled through EE. However, each child will receive his or her own ForwardHealth card after the application is submitted.

Each member who is enrolled through EE will receive a ForwardHealth card usually within three business days after the EE application is submitted and approved. To ensure children and pregnant women receive needed services in a timely manner, providers should accept the printed paper EE cards for children and either the printed paper EE card or the beige identification cards for pregnant women as proof of enrollment for the dates provided on the cards. Providers may use Wisconsin's EVS (Enrollment Verification System) to verify enrollment for DOS (dates of service) after those printed on the card. Providers are encouraged to keep a photocopy of the card.

Sample Express Enrollment Cards

Which benefit?	Status of your benefits?
BadgerCare Plus temporary enrollment for pregnant women	You applied for BadgerCare Plus Express Enrollment on **06/26/2008**. You are temporarily enrolled in BadgerCare Plus for outpatient pregnancy-related services. Your enrollment will end on or before **07/31/2008**. To learn more, see your Rights and Responsibilities. To get regular BadgerCare Plus or Wisconsin Medicaid, you must apply online, by mail or in person: • Online at http://access.wi.gov • By mail or in person at: Dane County Job Center 1819 Aberg Ave. Madison, WI 53704 (608) 242-7400

To learn more, see your Rights and Responsibilities.

To the Provider

The individual listed has been temporarily enrolled through BadgerCare Plus Express Enrollment in accordance with Wis. Stat. s. 49.471. This card entitles this individual to receive pregnancy related outpatient care including pharmacy services through BadgerCare Plus from any certified BadgerCare Plus provider for the period specified on this card. (See card effective dates.) For additional information, call Provider Services at (800) 947-9627 or see the All Provider Handbook.

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 during the temporary enrollment period, including the prohibition against billing recipients. Refer to the All Provider Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card.

WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES

IDENTIFICATION CARD FOR TEMPORARY ENROLLMENT IN BADGERCARE PLUS FOR PREGNANT WOMEN

Name:	ID Number:
Jane Smith	0454782131

Effective Dates: 06/26/2008- 07/31/2008

Which benefit?	Status of your benefits?
BadgerCare Plus temporary enrollment for children	You applied for BadgerCare Plus Express Enrollment on **06/26/2008**. The following individual(s) is/are temporarily enrolled in BadgerCare Plus: • **Joe Smith** • **Sara Smith** This temporary enrollment will end on or before **07/31/2008**. To learn more, see your Rights and Responsibilities. In order to continue receiving BadgerCare Plus you must apply through one of the following methods: • Online at http://access.wi.gov • By mail or in person at: Dane County Job Center 1819 Aberg Ave. Madison, WI 53704 (608) 242-7400

To learn more, see your Rights and Responsibilities.

To the Provider

The children listed have been temporarily enrolled through BadgerCare Plus Express Enrollment in accordance with Wis. Stat. s. 49.471. This card entitles this individual to receive services through BadgerCare Plus from any certified BadgerCare Plus provider for the period specified on this card. (See card effective dates.) For additional information, call Provider Services at (800) 947-9627 or see the All Provider Handbook.

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 during the temporary enrollment period, including the prohibition against billing recipients. Refer to the All Provider Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card.

WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES

IDENTIFICATION CARD FOR TEMPORARY ENROLLMENT IN BADGERCARE PLUS FOR CHILDREN

Name: ID Number:

Joe Smith 0321434543

Sara Smith 0787451231

Effective Dates: 06/26/2008- 07/31/2008

Topic #270

Temporary ForwardHealth Identification Cards

All Medicaid certifying agencies have the authority to issue green paper temporary identification cards to applicants who meet enrollment requirements. Temporary cards are usually issued only when an applicant is in need of medical services prior to receiving the ForwardHealth card. Providers should accept temporary cards as proof of enrollment. Eligible applicants may receive covered services for the dates shown on the card.

Providers are encouraged to keep a photocopy of the temporary card and should delay submitting claims for one week from the enrollment start date until the enrollment information is transmitted to ForwardHealth.

ForwardHealth accepts properly completed and submitted claims for covered services provided to applicants possessing a temporary card as long as the DOS (date of service) is within the dates shown on the card.

If a claim is denied with an enrollment-related explanation, even though the provider verified the member's enrollment before providing the service, a good faith claim may be submitted.

Sample Temporary Medicaid Card

THIS IS YOUR NEW ID CARD. IT IS VALID FOR THE DATES SHOWN.

SEPARATE IT FROM THE REST OF THE FORM BY TEARING ALONG THE DOTTED LINES.

AGENCY		ELIGIBLE FOR DATES			
ID NUMBER	ELIGIBLE RECIPIENT	BIRTHDATE	SEX	OTHER COVERAGE	

OUT-OF-STATE NON-EMERGENCY SERVICES REQUIRE PRIOR AUTHORIZATION. YOUR *PROVIDER* MUST WRITE TO:
WISCONSIN MEDICAID
OUT-OF-STATE PRIOR AUTHORIZATION
STE 88
6406 BRIDGE RD
MADISON WI 53784-0088

SERIAL NO.

STATE OF WISCONSIN MEDICAID
FOSTER CARE PROGRAM
TEMPORARY IDENTIFICATION CARD
FXXXXXX   VOID

WISCONSIN MEDICAID
RECIPIENT SERVICES
PO BOX 6678
MADISON WI 53716-0678

NOTICE TO PROVIDERS:

THIS TEMPORARY MEDICAID IDENTIFICATION CARD IS BEING USED WHILE MEDICAID ELIGIBILITY IS PROCESSED FOR THE FOSTER CHILD NAMED ON THE FRONT. THE INFORMATION ON THIS CARD IS MANUALLY COMPLETED BY THE FOSTER CARE AGENCY, AND **THE CARD WILL OFTEN BE PRESENTED BEFORE THE ELIGIBILITY INFORMATION IS TRANSMITTED TO THE MEDICAID FISCAL AGENT.** ELIGIBILITY IS GUARANTEED FOR THE DATES SHOWN ON THE FRONT AND IT IS IMPORTANT TO PROVIDE SERVICES WHEN THIS CARD IS PRESENTED. REFER TO THE ALL-PROVIDER HANDBOOK FOR FURTHER INFORMATION REGARDING THE TEMPORARY IDENTIFICATION CARD. PROVIDERS ARE ENCOURAGED TO KEEP A PHOTOCOPY OF THIS CARD.

NOTICE TO CARDHOLDERS:

THIS IS A TEMPORARY MEDICAID IDENTIFICATION CARD FOR THE CHILD IN YOUR CARE. IT IS VALID FOR THE DATES SHOWN ON THE FRONT. KEEP THIS CARD WITH YOU UNTIL IT EXPIRES OR UNTIL YOU RECEIVE A REPLACEMENT IDENTIFICATION CARD FOR THE CHILD.

FOR QUESTIONS REGARDING:
MEDICAID ELIGIBILITY, CALL THE CERTIFYING FOSTER CARE AGENCY.
MEDICAID SERVICES COVERAGE, CALL 1-800-362-3002 (TTY AVAILABLE).   Void

Topic #1435

Types of Identification Cards

ForwardHealth members receive an identification card upon initial eligibility determination. Identification cards may be in any of the following formats:

- White plastic ForwardHealth cards.
- White plastic ForwardHealth Core Plan cards.
- White plastic ForwardHealth Basic Plan cards.
- White plastic SeniorCare cards.
- Green paper temporary cards.
- Paper printout temporary card for EE (Express Enrollment) for children.
- Paper printout temporary card for EE for pregnant women.
- Beige paper temporary card for EE for pregnant women.

- White paper TE (Temporary Enrollment) for Family Planning Only Services 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 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, 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 Certified by Wisconsin Medicaid

To prescribe restricted medications for Pharmacy Services Lock-In Program members, prescribers are required to be certified by Wisconsin Medicaid. Certification for the Pharmacy Services Lock-In Program is not separate from certification by 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 certified by 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.

Exceptions

Certain exceptions will be made regarding Pharmacy Services Lock-In Program requirements. The following are exempt from Pharmacy Services Lock-In Program requirements:

- Out-of-state providers who are not certified by Wisconsin Medicaid.
- Administration of drugs during an emergency room visit.

If a member enrolled in the Pharmacy Services Lock-In Program presents a prescription for a restricted medication from an emergency room visit or an out-of-state provider, the pharmacist at the Lock-In pharmacy must attempt to contact the Lock-In prescriber to verify the appropriateness of filling the prescription. If the pharmacy provider is unable to contact the Lock-In prescriber, the pharmacist should use his or her professional judgment to determine whether or not the prescription should be filled. If the prescription is filled, the claim must be submitted on paper using the Pharmacy Special Handling Request (F-13074 (04/11)) form.

The ForwardHealth emergency medication dispensing policy does not apply to the Pharmacy Services Lock-In Program. Drugs dispensed in an emergency to Pharmacy Services Lock-In Program members are nonreimbursable services except as noted above. Providers cannot collect payment from Pharmacy Services Lock-In Program members for nonreimburseable services.

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 certified 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-1162 (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 #724

Out-of-State Youth Program

The OSY (Out-of-State Youth) program is responsible for health care services provided to Wisconsin children placed outside the state in foster and subsidized adoption situations. These children are eligible for coverage. The objective is to assure that these children receive quality medical care.

Out-of-state providers not located in border-status-eligible communities may qualify as border-status providers if they deliver services as part of the OSY program. However, providers who have border status as part of the OSY program are reimbursed only for services provided to the specific foster care or subsidized adopted child. In order to receive reimbursement for services provided to other members, the provider is required to follow rules for out-of-state noncertified providers.

For subsidized adoptions, benefits are usually determined through the adoption assistance agreement and are provided by the state where the child lives. However, some states will not provide coverage to children with state-only funded adoption assistance. In these cases, Wisconsin will continue to provide coverage.

OSY providers are subject to the same regulations and policies as other certified border-status providers. For more information about the OSY program, call Provider Services or write to ForwardHealth at the following address:

> ForwardHealth
> Out-of-State Youth
> Ste 50
> 313 Blettner Blvd
> Madison WI 53784

Topic #278

Persons Detained by Legal Process

Most individuals detained by legal process are *not* eligible for BadgerCare Plus or Wisconsin Medicaid benefits. Only those individuals who qualify for the BadgerCare Plus Expansion for Certain Pregnant Women may receive benefits.

"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. The justice system oversees health care-related needs for individuals detained by legal process who do not qualify for the BadgerCare Plus Expansion for Certain Pregnant Women.

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-certified provider for a covered service during the period of retroactive enrollment, according to DHS 104.01(11), Wis. Admin. Code. A Medicaid-certified provider is required to submit claims to Medicaid 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 Medicaid *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 (07/08)) 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.

Reimbursement

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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 or Medicaid) 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 or Medicaid.

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 certification 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-certified 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 certified 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 or hospital.
- 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 certification.

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 certified or certifiable 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

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Resources:Contact Information

Topic #476

Member Services

Providers should refer ForwardHealth members with questions to <u>Member Services</u>. 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 <u>specific regions</u> of the state. In addition, the field representatives have <u>specialized</u> 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 <u>their region who specializes in their provider type</u>.

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 certified 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 <u>Providers Trainings page</u> 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.
- Certification.
- 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:

- WCDP and WWWP (for inquiries from all providers regarding WCDP or WWWP).
- Dental (for all inquiries regarding dental services).
- Medicaid or SeniorCare Pharmacy (for pharmacy providers) or STAT-PA (Specialized Transmission Approval Technology-Prior Authorization) for STAT-PA inquiries, including inquiries from pharmacies, DME (durable medical equipment) providers for orthopedic shoes, and HealthCheck providers for environmental lead inspections.
- Medicaid and BadgerCare Plus institutional services (for inquiries from providers who provide hospital, nursing home, home health, personal care, ESRD (end-stage renal disease), and hospice services or NIP (nurses in independent practice)).
- Medicaid and BadgerCare Plus professional services (for inquiries from all other providers not mentioned in the previous menu prompts).

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-1170 (07/09))](#) 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 DHCAA (Division of Health Care Access and Accountability) 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-1016 (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

Services and resources, contact information, and hours of availability are effective after ForwardHealth implementation, unless otherwise noted.

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 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 Time)*
To assist providers and trading partners with technical questions regarding Portal functions and capabilities, including Portal accounts, registrations, passwords, and submissions through the Portal.		
Electronic Data Interchange Helpdesk	(866) 416-4979	Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central Time)*
For providers, trading partners, billing services, and clearing houses with technical questions about the following: • Electronic transactions. • Companion documents. • Provider Electronic Solutions (PES) software.		
Managed Care Ombudsman Program	(800) 760-0001	Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Time)*
To assist managed care enrollees with questions about enrollment, rights, responsibilities, and general managed care information.		
Member Services	(800) 362-3002	Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Time)*
To assist ForwardHealth members or persons calling on behalf of members with program information and requirements, enrollment, finding certified 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, 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 revision log located at the end of the revised companion guide lists the changes that have been made. The date on the

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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, 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 certification 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 certification 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.

Note: The BadgerCare Plus Core Plan may also charge different copayments for hospital services depending on the member's income level. Members identified as "BadgerCare Plus Core Plan 1" are subject to lower copayments for hospital services. Members identified as "BadgerCare Plus Core Plan 2" are subject to higher copayments for hospital services.

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 the BadgerCare Plus Standard Plan 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 Recertification Via the ForwardHealth Portal

Providers can conduct recertification online via a secure recertification 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 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 <u>Portal User Guides page</u> of the Portal for more detailed instructions on performing these functions.

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 <u>835</u> 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 <u>EDI (Electronic Data Interchange) Helpdesk</u> or submit a <u>paper (Trading Partner 835 Designation, F-13393 (08/08))</u> 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 <u>enrollment verification</u> 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 which may be sensitive.

The following information is available through the Portal:

- Certified Provider Listing of all Medicaid-certified 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 code, and managed care and Medicare information.
- Provider search function for retrieving provider information such as 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 recertification on the Portal. Providers will receive a separate PIN for recertification.

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 certification. A separate PIN will be needed for each provider certification. 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 certifications. Select the correct certification for the account. The taxonomy code, ZIP+4 code, and financial payer for that certification 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, SeniorCare, 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:

- Certification.
- Claims.
- Coordination of Benefits.

- Managed Care.
- Member Information.
- Prior Authorization.
- 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, 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 certifications). 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 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 Certification

Providers can speed up the certification process for Medicaid by completing a provider certification 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 PAs via the Portal. Providers can do the following:

- Correct errors on PAs or amendment requests via the Portal, regardless of how the PA was originally submitted.
- View all recently submitted and finalized PA and amendment requests.
- 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).
- 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 Firefox v. 1.5 or higher
Mac OS X 10.2.x or higher operating system	

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 [HP® Virtual Room](#). Virtual Room 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 #4460

Full Text Publications Available

Providers may request full-text versions of *ForwardHealth Updates* to be mailed to them by calling [Provider Services](#).

Topic #478

General Information

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 box 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 iinformation available on the Portal.

Providers without Internet access may call [Provider Services](#) to request a paper copy of an *Update*. To expedite the call, correspondents will ask providers for the *Update* number. Providers should allow seven to 10 business days for delivery.

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

Multiple Ways to Access ForwardHealth Publications

Users may register for e-mail subscription service. Providers who have established a ForwardHealth Portal account will automatically receive notification of *ForwardHealth Updates* and the monthly *ForwardHealth Update Summary* in their Portal message box. Providers will receive notification via their Portal accounts or e-mail subscription.

E-mail Subscription Service

Providers and other interested parties may register for e-mail subscription on the Portal to receive e-mail notifications of new provider publications. Users are able to select, by program (Wisconsin Medicaid, BadgerCare Plus, or WCDP (Wisconsin Chronic Disease Program)) and provider type (e.g., physician, hospital, DME (durable medical equipment) vendor), and which publication notifications they would like to receive. Any number of staff or other interested parties from an organization may sign up for an e-mail subscription.

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

1. Click the Providers link on the ForwardHealth Portal at www.forwardhealth.wi.gov/.
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.
9. The selected subscriptions will load and a confirmation message will appear at the top of the page.

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 number, 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.
  - To request enrollment information for the same member using a different financial payer.
  - To hear another member's enrollment information using the same financial payer.
  - To hear another member's enrollment information using a different financial payer.
  - To 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.

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- 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-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) diagnosis 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

Dial (800) 947-3544 to access WiCall, ForwardHealth Automated Voice Response system. Press "1" to begin.

Access provider WiCall

Main Menu

1 Enrollment Verification	2 Provider CheckWrite	3 Claim Status Inquiry	4 PA Status Inquiry
Select financial payer.	Select financial payer.	Select financial payer.	Select financial payer.
Enter provider ID*.	Enter provider ID*.	Enter provider ID*.	Enter provider ID*.
Select "1" to enter member ID. OR Select "2" to enter member SSN**/DOB***.		Enter member ID.	Enter PA number.
Enter "from" date of inquiry.		Enter oldest date of service on the claim.	If PA number is unknown, enter member ID and type of service.
Enter "to" date date of inquiry.		Enter total amount billed.	
Response with transaction log number and member enrollment information.	Response with CheckWrite information on most recently issued funds.	Response with claim status information.	Response with PA status information.

Transaction Complete Menu
(Additional options relevant to the type of inquiry are also offered.)

Select "1" to repeat information.	Select "2" to make another inquiry.	Select "8" to return to the main menu.	Select "0" to speak to a Provider Services call center correspondent.	Select "9" to repeat menu options.

* 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