Certification and Ongoing Responsibilities

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Certification and Ongoing Responsibilities:Certification

Border Status Providers

A provider in a state that borders Wisconsin may be eligible for border-status certification. Border-status providers need to notify ForwardHealth in writing that it is common practice for members in a particular area of Wisconsin to seek their medical services.

Exceptions to this policy include:

- Nursing homes and public entities (e.g., cities, counties) outside Wisconsin are not eligible for border status.
- All out-of-state independent laboratories are eligible to be border-status providers regardless of location in the United States.

Providers who have been denied Medicaid certification in their own state are automatically denied certification by Wisconsin Medicaid unless they were denied because the services they provide are not a covered benefit in their state.

Certified border-status providers are subject to the same program requirements as in-state providers, including coverage of services and PA and claims submission procedures. Reimbursement is made in accordance with ForwardHealth policies.

For more information about out-of-state providers, refer to DHS 105.48, Wis. Admin. Code.

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, and the 835 transaction for covered services rendered by individual providers within the 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., physician pathology, radiology groups, and 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.

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.
- 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. 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.

Completing Certification Applications

Health care providers are required to include their NPI 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 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
  6406 Bridge Rd
  Madison WI 53784-0006

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.

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
6406 Bridge Rd
Madison WI 53784-0006

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.

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 *Updates*.

Certain providers may opt not to receive these materials by completing the Deletion from Publications Mailing List 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.

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.

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 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.

Medicaid-certified nursing homes, pharmacies, and other types of providers may be reimbursed for providing DME services without obtaining certification as a DME provider. The DME maximum allowable fee index indicates the allowable provider types for each procedure code. All providers are required to follow the policies of the DME service area when providing DME services.

Noncertified In-State Providers

Wisconsin Medicaid reimburses noncertified in-state providers for providing emergency medical services to a member or providing services to a member during a time designated by the governor as a state of emergency. The emergency situation or the state of emergency must be sufficiently documented on the claim. Reimbursement rates are consistent with rates for Wisconsin Medicaid-certified providers rendering the same service.

Claims from noncertified in-state providers must be submitted with an In-State Emergency Provider Data Sheet. The In-State Emergency Provider Data Sheet provides ForwardHealth with minimal tax and licensure information.

Noncertified in-state providers may call Provider Services with questions.

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, assigned provider type and specialty, and taxonomy code. This information will be used when conducting business with BadgerCare Plus, Medicaid, or SeniorCare (for example, health care providers will need to include their taxonomy code, designated by Wisconsin Medicaid, on claim submissions and requests for PA).

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

Out-of-State Providers

Out-of-state providers are limited to those providers who are licensed in the United States (and its territories), Mexico, and Canada. Out-of-state providers are required to be licensed in their own state of practice.

Wisconsin Medicaid reimburses out-of-state providers for providing emergency medical services to a BadgerCare Plus or Medicaid member or providing services to a member during a time designated by the governor as a state of emergency. The emergency situation or the state of emergency must be sufficiently documented on the claim. Reimbursement rates are consistent with rates for Wisconsin Medicaid-certified providers providing the same service.

Out-of-state providers are reimbursed for services provided to eligible BadgerCare Plus or Medicaid members in either of the following situations:

- The service was provided in an emergency situation, as defined in DHS 101.03(52), Wis. Admin. Code.
- PA was obtained from ForwardHealth *before* the nonemergency service was provided.

Claims from noncertified out-of-state providers must be submitted with an Out-of-State Provider Data Sheet. The Out-of-State Provider Data Sheet provides Wisconsin Medicaid with minimal tax and licensure information.

Out-of-state providers may contact Provider Services with questions.

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 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 and RA address is where Wisconsin Medicaid will mail checks and RAs. 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 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, and WWWP) 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.

Provider Eligibility and Certification

Any individual, corporation, business, or organization that sells or rents medical equipment, supplies, oxygen supplies, prosthetic, or orthotic devices may be Wisconsin Medicaid certified. Any DME provider may furnish DME, enteral nutrition products, and DMS. Refer to the Enteral Nutrition Products service area and the DMS service area for policy, PA, and claim submission information.

Pharmacies and home health providers may dispense DME without separate certification. Pharmacies and home health agencies must follow the coverage limitations in the DME service area.

Orthotic and Prosthetic Provider Certification

Only providers who meet specific criteria may be certified by Wisconsin Medicaid as specializing in orthotics or prosthetics.

To receive specialized Medicaid certification, providers must meet one of the following requirements:

- Be certified by the ABC in Orthotics and Prosthetics, Incorporated. The ABC certification must designate the provider as a certified orthotist or certified prosthetist.
- Be a facility accredited in orthotics or prosthetics by the ABC.
- Be a non-accredited ABC facility, but have a staff member who is ABC accredited in orthotics or prosthetics.

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

Health care providers who are federally required to have an NPI are cautioned that any changes to their provider type and/or specialty information on file with ForwardHealth may alter the applicable taxonomy code for a provider's certification.

Recertification

Periodically, ForwardHealth conducts provider recertifications that require providers to update their information. Providers will be notified when they need to be recertified and will be provided with instructions on how to complete the recertification process.

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 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.

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 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 clicking on the "Certification Tracking Search" quick link in the Provider area of the Portal and 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

1099 Miscellaneous Forms

ForwardHealth generates the 1099 Miscellaneous form in January of each year for earnings greater than $600.00, per 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 share the same tax identification number. For example, a provider who conducts business with both Medicaid and WCDP will receive separate 1099 Miscellaneous forms for each program.

The 1099 Miscellaneous forms are sent to the address designated as the "1099 mailing address." The address formerly known as the "payee address" is used as the 1099 mailing address unless a provider has reported a separate address for the 1099 mailing address to ForwardHealth.

Availability of Records to Authorized Personnel

The DHCAA 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 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, including HMOs and SSI HMOs, are not reimbursed for the reproduction costs covered in their contract with the DHS.

The reproduction of records requested by the PRO under contract with the DHCAA is reimbursed at a rate established by the PRO.

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) 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.

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.

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.

Additional Documentation Requirements for Core Plan Home Health Services Following an Inpatient Hospital Stay

In addition to the documentation requirements specified by the Wisconsin Administrative Code and other documentation requirements, providers are required to maintain a copy of the member?s hospital discharge plan when billing for home health services provided to Core Plan members. The hospital discharge plan must include the following detail:

- A clear statement declaring that discharge from the hospital is contingent on the member obtaining medically necessary prescribed home health services.
- The name of the home health agency that has agreed to provide the prescribed home health services and to accept the patient for care immediately after discharge from the hospital.
- The specific prescribed medically necessary services the home health agency is to provide to the member.

Documentation for Durable Medical Equipment

Providers are required to prepare and maintain truthful, accurate, complete, legible, and concise documentation of the member's continuing use of the equipment, as well as documentation of all DME services as stated in DHS 106.02(9)(a), Wis. Admin. Code. A current, signed, and dated physician prescription is required for each DME for each DOS when requesting Medicaid reimbursement.

Additional Requirements for Compression Garments

Providers are required to maintain the following supporting documentation in their records for compression garments:

- Signed and dated physician prescription that includes the following:
  - Diagnosis.
  - Amount of compression ordered.
  - Prescribed garment.
  - Body part for which the garment was prescribed.
- Manufacturer's invoice for the compression garment that was provided.
- Date of delivery of the compression garment, signature of the person receiving the delivery, and instructions given for use and care.
- Clinical information, including the following:
  - Specific documented measurements required for the garment ordered (this information may be found on the manufacturer's order form).
  - Date(s) on which measurements were taken.
  - Appropriate periodic circumferential measurements, using consistent units of measurement (e.g., centimeters used at every measurement).
- Documentation submitted with a PA request.

- Documentation submitted with a claim.

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.

Preparation and Maintenance of Records

All providers who receive payment from Wisconsin Medicaid, including state-contracted MCOs, 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.

Prescriptions

All services, with few exceptions, require a current, separate, physician's prescription. This requirement applies to both routine and nonroutine repairs for DME.

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, 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 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.

Records Requests

Requests for billing or medical claim information regarding services reimbursed by BadgerCare Plus 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 BadgerCare Plus.

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 notice of the material furnished to the requester to Coordination of Benefits at the previously listed address with a copy of the signed release.

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, 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.

For More Information

For additional information about requests for billing information or medical claim records, providers should call Provider Services. Providers may also write to the following address:

Division of Health Services
Estate and Casualty Recovery Section
PO Box 309
Madison WI 53701-0309

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 or the federal HHS to perform any function related to program administration, such as auditing, program monitoring, and evaluation.

Providers are authorized under BadgerCare Plus 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

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).

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 certification for Wisconsin Medicaid certification change in ownerships:

- Ambulatory surgery centers.
- ESRD services providers.
- Federally qualified health centers.
- Home health agencies.
- Hospice providers.
- Hospitals (inpatient and outpatient).
- Nursing homes.
- Outpatient rehabilitation facilities.
- Rehabilitation agencies.
- RHCs.

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 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.

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 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 at no cost to the LEP individual in order to provide meaning 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 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 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.

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.

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 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, 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.

Keeping Information Current

Types of Changes

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

- Address(s) — practice location and related information, mailing, PA, and/or financial.
- Telephone number, including area code.
- Business name.
- Contact name.
- Federal Tax ID number (IRS number).
- Group affiliation.
- Licensure.
- Medicare NPI for health care providers or Medicare provider number for providers of *non-healthcare* services.
- Ownership.
- Professional certification.
- Provider specialty.
- Supervisor of nonbilling providers.

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 reuired 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 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 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.

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. Within the DHS, the DHCAA is directly responsible for managing these programs.

Section 49, Wis. Stats., and DHS 105.40 and DHS 107.24, Wis. Admin. Code, provide the legal framework for DME provider services.

Provider Numbers

National Provider Identifier

Health care providers are required to indicate an NPI on electronic and paper transactions submitted to ForwardHealth.

The NPI is a 10-digit number obtained through NPPES.

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 Centers for Medicare and Medicaid Services Web site includes more Type 1 and Type 2 NPI information.

Some providers hold multiple certifications with ForwardHealth. 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. ForwardHealth 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.

Either or both of the following additional data is required with NPI when a single NPI corresponds to multiple certifications:

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

Omission of the additional required data will cause claims and other transactions to be denied or delayed in processing.

Taxonomy Codes

Taxonomy codes are standard code sets used to provide information about provider type and specialty for the provider's certification. Providers are required to use the taxonomy code designated by ForwardHealth 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.

ForwardHealth designates a taxonomy code as additional data to be used to correctly match NPI to the correct provider file. The designated taxonomy code may be different than the taxonomy code providers originally submitted to NPPES when obtaining their NPI as not all national taxonomy code options are recognized by ForwardHealth. For example, some taxonomy codes may correspond to provider types not certifiable with ForwardHealth, or they may represent services not covered by ForwardHealth.

Omission of a taxonomy code when it is required as additional data to identify the provider or indicating a taxonomy code that is not

designated by ForwardHealth will cause claims and other transactions to be denied or delayed in processing.

Refer to the ForwardHealth-designated taxonomy codes for the appropriate taxonomy code for your certification.

Note: The ForwardHealth-designated taxonomy code does not change provider certification or affect reimbursement terms.

ZIP Code

The ZIP+4 code is the ZIP code of a provider's practice location address on file with ForwardHealth. Providers are required to use the ZIP+4 code when the NPI reported to ForwardHealth corresponds to multiple certifications and the designated texonomy code does not uniquely identify the provider.

Omission of the ZIP+4 code of the provider's practice location address when it is required as additional data to identify the provider will cause claims and other transactions to be denied or delayed in processing.

Providers may verify the ZIP+4 code for their address on the U.S. Postal Service Web site.

Provider Rights

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 methods, including calling Provider Services.

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
6406 Bridge Rd
Madison WI 53784-0006

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.

Hearing Requests

A provider who wishes to contest a DHS action or inaction for which due process is required under s. 227, Wis. Stats., may request a hearing by writing to the DHA.

A provider who wishes to contest the DHCAA's 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.

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.

Requesting Discretionary Waivers and Variances

In rare instances, a provider or member may apply for, and the DHCAA 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 HFS 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, 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

Sanctions

Intermediate Sanctions

According to DHS 106.08(3), Wis. Admin. Code, the DHS 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.

Involuntary Termination

The DHS 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.

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 49.49(3m), Wis. Stats.

There may be narrow exceptions on when providers may collect payment from members.

Withholding Payments

The DHS 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:03/01/2010

Claims:Adjustment Requests

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 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.

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.

Electronic

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

Provider Electronic Solutions Software

The DHCAA offers electronic billing software at no cost to providers. The PES software allows providers to submit electronic adjustment requests using an 837 transaction. To obtain PES software, providers may download it or contact the EDI Helpdesk.

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 Helpdesk for assistance with electronic adjustment requests.

Paper

Paper adjustment requests must be submitted using the Adjustment/Reconsideration Request form.

Portal Claim Adjustments

Providers can submit claim adjustments via the Portal. Providers may use the search function to find the specific claim they would like to adjust. Once found, the provider can alter the claim to reflect the desired change and resubmit it to ForwardHealth. Any claim (excluding dental and pharmacy) ForwardHealth has paid can be modified on the Portal and resubmitted, regardless of how the claim was originally submitted.

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.

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.

Submitting Paper Attachments with Electronic Claim Adjustments

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

Good Faith Claims

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 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 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 code, providers should contact Provider Services for assistance.

Overpayments

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.

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.
- 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 document for the appropriate 837 transaction when submitting adjustment requests.

Paper Adjustment Requests

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

- Submit an Adjustment/Reconsideration Request 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.

Cash Refunds

When submitting a personal check to ForwardHealth for an overpayment, providers should include a copy of the RA 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, the NPI (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

6406 Bridge Rd
Madison WI 53784-0004

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.

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.

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

An Overview of the Remittance Advice

The RA provides important information about the processing of claims and adjustment requests as well as additional financial transactions such as refunds or recoupment amounts withheld. Providers will receive an RA from the appropriate ForwardHealth program when they have at least one claim, adjustment request, or financial transaction processed. An RA is generated regardless of how a claim or adjustment is submitted (electronically or on paper).

National Provider Identifier on the Remittance Advice

Providers who have a single NPI 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.

Calculating Totals on the Remittance Advice for Adjusted and Paid Claims

The total amounts for all adjusted or paid claims reported on the RA appear at the end of the adjusted claims and paid claims sections. ForwardHealth calculates the total by adding the amounts for all of the claims; 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 codes and will not display an exact dollar amount.

Claim Number

Each claim or adjustment request received by ForwardHealth is assigned a unique claim number (also known as the ICN). However, denied claims submitted using the NCPDP 5.1 transaction are not assigned an ICN.

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.

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 system or the 276/277 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.

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; the detail line EOB codes inform providers that an amount was deducted from the total reimbursement but may not indicate the exact amount.

Note: Providers who receive 835 transactions will be able to see all deducted amounts on paid and adjusted claims.

Electronic Remittance Information

Electronic remittance information may be obtained using the 835 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 claim submitted by a pharmacy using the NCPDP 5.1 transaction will not appear on remittance information if the claim is denied by ForwardHealth.

Provider Electronic Solutions Software

The DHCAA offers electronic billing software at no cost to the provider. The PES software allows providers to download the 835 transaction. To obtain PES software, providers may request the software through the ForwardHealth Portal. Providers may also obtain the software by contacting the EDI Helpdesk.

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

EOB 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 report EOBs for the claim header information and for the detail lines, as appropriate. Header information is a summary of the information from the claim, such as the DOS 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.

Identifying the Claims Reported on the Remittance Advice

The RA reports the first 12 characters of the MRN and/or a PCN, 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.

Obtaining the Remittance Advice

One paper copy of each RA is mailed to the provider.

Providers who receive the paper RA may also access RAs through their secure ForwardHealth Portal accounts. The main page of the secure Portal account lists the last 10 RAs issued to the provider.

Providers may choose to opt out of receiving a paper RA by sending a written request to the following address:

ForwardHealth
Provider Maintenance
Madison WI 53784-0006

Note: Providers who do not receive a paper RA can not view the RA on the Portal. Providers who opt out of receiving the paper RA should make sure they receive the electronic 835 transaction.

Providers may obtain additional paper copies of the RA by sending a written request to the following address:

ForwardHealth
Written Correspondence
6406 Bridge Rd
Madison WI 53784-0005

Providers may call Provider Services to request additional paper copies of the RA.

Overview of Claims Processing Information on the Remittance Advice

The claims processing sections of the RA 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.

Prior Authorization Number on the Remittance Advice

The RA reports PA numbers used to process the claim. PA numbers appear in the detail lines of claims processing information.

Reading Non-Claims Processing Sections of the Remittance Advice

Address Page

The Address page displays the provider name and "Pay to" address of the provider for purposes of mailing the paper RA.

Banner Messages

The Banner Messages section of the RA 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, so providers who receive multiple RAs should read all of their banner messages.

Explanation of Benefits Code Descriptions

The EOB Code Descriptions section lists all EOB codes reported on the RA with corresponding descriptions.

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 under "Accounts Receivable." The "Total Recoupment" field lists the cumulative amount recovered for the accounts receivable.

Every financial transaction that results in the creation of an accounts receivable is assigned an identification number called the "adjustment ICN." The adjustment ICN for an adjusted claim matches the original ICN assigned to the adjusted claim. For other financial transactions, the adjustment ICN is determined by the following formula.

Type of Character and Description	Applicable Characters and Description
Transaction — The first character indicates the type of financial transaction that created the accounts receivable.	V — Capitation adjustment 1 — OBRA Level 1 screening void request

	2 — OBRA Nurse Aide Training/Testing void request
Identifier — 10 additional numbers are assigned to complete the Adjustment ICN.	The identifier is used internally by ForwardHealth.

Service Code Descriptions

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

Summary

The Summary section reviews the provider's claim activity and financial transactions with the payer (Medicaid, WCDP, or WWWP) 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 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.

Reading the Claim Adjustments Section of the Remittance Advice

Providers receive a Claim Adjustments section in the RA 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.

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

The claim adjustments section lists detail lines only for the adjusted claim with detail line EOBs. Details from the original claim will not be reported on the adjusted claims sections of the RA.

Note: For adjusted drug 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."

An amount appears for "additional payment" if ForwardHealth owes additional monies to the provider after the claim has been adjusted. This amount will be added to the provider's total reimbursable amount for the RA.

An amount appears for "overpayment to be withheld" if ForwardHealth determines, as the result of an adjustment to the original claim, that the provider owes ForwardHealth monies. 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.

Reading the Claims Denied Section of the Remittance Advice

Providers receive a Claims Denied section in the RA 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 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.

Reading the Claims Paid Section of the Remittance Advice

Providers receive a Claims Paid section in the RA 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 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.

Remittance Advice Financial Cycles

Each financial payer (Medicaid, WCDP, and WWWP) has separate financial cycles that occur on different days of the week. RAs are produced and mailed to providers after each financial cycle is completed. Therefore, providers might receive RAs 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 receive the RAs generated by these financial transactions at any time during the week.

Remittance Advice Generated by Payer and by Provider Certification

Providers may receive an RA 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.
- WWWP.

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 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.

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 and ForwardHealth-issued 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.)
- 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
6406 Bridge Rd
Madison WI 53784-0005

Searching for and Viewing All Claims on the Portal

All claims, including pharmacy and dental, will be available for viewing on the Portal.

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

- Go to the ForwardHealth 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.

Sections of the Remittance Advice

The RA includes the following sections:

- Address page.
- Banner messages.
- Paper check, if applicable.

- Claims processing information.
- EOB code descriptions.
- Financial transactions.
- Service code descriptions.
- Summary.

Remittance Advice Header Information

The first page of each section of the RA (except the address page) 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, or WWWP).
- 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 during which 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.
- 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.

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

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.

Integrity in Submitting Claims

Providers may not submit a claim to ForwardHealth for a covered service that was not provided in order to apply the reimbursement toward the cost of a noncovered service.

Copayment Amounts

Copayment amounts collected from members should not be deducted from the charges submitted on claims. Providers should indicate their usual and customary charges for all services provided.

In addition, copayment amounts should not be included when indicating the amount paid by other health insurance sources.

The appropriate copayment amount is automatically deducted from allowed payments. Remittance information reflects the automatic deduction of applicable copayment amounts.

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.
- 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.
- 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.

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. 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).

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, BadgerCare Plus automatically deducts the copayment amount.

For most services, BadgerCare Plus reimburses the lesser of the provider's usual and customary charge or the maximum allowable fee established.

Submission

1500 Health Insurance Claim Form Completion Instructions for Durable Medical Equipment

A sample 1500 Health Insurance Claim Form is available for DME.

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. 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
6406 Bridge Rd
Madison WI 53784-0002

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 Wisconsin's EVS 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 MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/CCYY format (e.g., February 3, 1955, would be 02/03/1955). 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 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
Commercial health insurance must be billed prior to submitting claims to ForwardHealth, unless the service does not require commercial health insurance billing as determined by ForwardHealth.

If the EVS indicates that the member has dental ("DEN") insurance only or has no commercial health insurance, leave Element 9 blank.

If the EVS indicates that the member has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), Medicare Supplement ("SUP"), TriCare ("CHA"), Vision only ("VIS"), a health maintenance organization ("HMO"), or some other ("OTH") commercial health insurance, and the service requires other insurance billing, one of the following three OI explanation codes must be indicated in the first box of Element 9. If submitting a multiple-page claim, providers are required to indicate OI explanation codes on the *first page* of the claim.

The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Element 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the member has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to, the following: • The member denied coverage or will not cooperate. • The provider knows the service in question is not covered by the carrier. • The member's commercial health insurance failed to respond to initial and follow-up claims. • Benefits are not assignable or cannot get assignment. • Benefits are exhausted.

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

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
Use the first box of this element only. (Elements 11a, 11b, 11c, and 11d are not required.) Element 11 should be left blank when one or more of the following statements are true:

- Medicare never covers the procedure in any circumstance.
- ForwardHealth indicates the member does not have any Medicare coverage including Medicare Cost ("MCC") or Medicare + Choice ("MPC") for the service provided. For example, the service is covered by Medicare Part A, but the member does not have Medicare Part A.
- ForwardHealth indicates that the provider is not Medicare enrolled.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

If none of the previous statements are true, a Medicare disclaimer code is necessary. If submitting a multiple-page claim, indicate Medicare disclaimer codes on the first page of the claim. The following Medicare disclaimer codes may be used when appropriate.

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

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
Enter the referring physician's name.

Element 17a — (not required)

Element 17b — NPI
Enter the NPI of the referring physician.

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

Element 19 — Reserved for Local Use
If a provider bills an unlisted (or not otherwise specified) procedure code, a description of the procedure must be indicated in this element. If Element 19 does not provide enough space for the procedure description, or if a provider is billing multiple unlisted procedure codes, documentation must be attached to the claim describing the procedure(s). In this instance, indicate "See Attachment" in Element 19.

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

Element 21 — Diagnosis or Nature of Illness or Injury
Enter a valid ICD-9-CM diagnosis code for each symptom or condition related to the services provided. The required use of valid diagnosis codes includes the use of the most specific diagnosis codes. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. The diagnosis description is not required.

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 to and from DOS in MM/DD/YY or MM/DD/CCYY format. If the service was provided on only one DOS, enter the date under "From." Leave "To" blank or re-enter the "From" date.

If the service was provided on consecutive days, those dates may be indicated as a range of dates by entering the first date as the "From" DOS and the last date as the "To" DOS in MM/DD/YY or MM/DD/CCYY format.

A range of dates may be indicated only if the POS, the procedure code (and modifiers, if applicable), the charge, the units, and the rendering provider were identical for each DOS within the range.

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

Element 24C — EMG
Enter a "Y" for each procedure performed as an emergency. If the procedure was not an emergency, leave this element blank.

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 appropriate 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 and/or the 835 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
Enter the actual amount paid by commercial health insurance. If submitting a multiple-page claim, indicate the amount paid by commercial health insurance only on the *first 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.

If a dollar amount indicated in Element 29 is greater than zero, "OI-P" must be indicated in Element 9. If the commercial health insurance denied the claim, enter "000." Do not enter Medicare-paid amounts in this field.

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 MM/DD/YY or MM/DD/CCYY 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.

Element 33a — NPI
Enter the NPI of the billing provider.

Element 33b
Enter qualifier "ZZ" followed by the 10-digit provider taxonomy code. Do not include a space between the qualifier ("ZZ") and the provider taxonomy code.

Attached Documentation

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

Bilateral Appliances

The DME maximum allowable fee index identifies items that may be dispensed as a pair, referred to as "bilateral" appliances. Bilateral appliances may be purchased singly (each) or as a pair, and may be billed with a quantity of one or more.

If bilateral appliances are billed for the same DOS, indicate a quantity of "2" or more in element 24G of the 1500 Health Insurance Claim Form.

If bilateral appliances are billed for different DOS, indicate modifier "50" with the procedure code of the additional appliance billed. If the modifier is not indicated with the second claim, the additional service is denied.

For example, if a left "Wrist Hand Finger Orthosis, Dorsal Wrist" is billed with a 2/3/08 DOS, and a right "Wrist Hand Finger Orthosis, Dorsal Wrist" is billed for the same member with a 3/6/08 DOS, the claim for the additional appliance must use modifier "50" and a quantity of one. The modifier differentiates the additional appliance from the first. Without the modifier, the claim for the additional appliance would be denied.

Copy Claims on the ForwardHealth Portal

Providers can copy both institutional and professional 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 along with the claim status.

Correct Errors on Claims and Resubmit to ForwardHealth on the Portal

Providers can view EOB codes and descriptions for any claim submitted to ForwardHealth on the Portal. The EOBs will be useful for providers to determine why a claim did not process successfully, so the provider may correct the error online and resubmit the claim. The EOB will appear on the bottom of the screen and will reference the applicable claim header or detail.

Dates of Service

Rental services billed to ForwardHealth must have "from" and "to" DOS. The "to" DOS requirement does not apply to Medicare crossover claims. Rental items must be ranged within the same calendar month per detail line.

The number of days indicated must equal the number of days within the range.

For purchased items, indicate only one specific DOS for each purchase, not a range of dates. A range of two consecutive dates is acceptable, such as May 4, 2008, to May 5, 2008.

Direct Data Entry of Professional and Institutional Claims on the Portal

Providers can submit professional and institutional claims to ForwardHealth via DDE on the Portal. DDE is an online application that allows providers to submit claims directly to ForwardHealth. DDE is not available for dental or pharmacy claims at this time.

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.
- Admission source.
- Admission type.
- Diagnosis codes.
- Revenue codes.
- Procedure codes.
- Modifiers.

Fields within the claim form will automatically calculate totals for providers, eliminating potential clerical errors.

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.

Electronic claims for DME must be submitted using the 837P transaction. Electronic claims for DME submitted using any transaction other than the 837P will be denied.

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

Provider Electronic Solutions Software

The DHCAA offers electronic billing software at no cost to providers. The PES software allows providers to submit electronic claims using an 837 transaction. To obtain PES software, providers may download it or contact the EDI Helpdesk.

Extraordinary Claims

Extraordinary claims are claims that have been denied by a BadgerCare Plus HMO or SSI HMO and should be submitted to fee-for-service.

HIPAA-Compliant Data Requirements

Procedure Codes

All fields submitted on paper and electronic claims are edited to ensure HIPAA compliance before being processed. Compliant code sets include CPT and HCPCS procedure codes entered into all fields, including those fields that are "Not Required" or "Optional."

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

Provider Numbers

For health care providers, NPIs are required in all provider number fields on paper claims and 837 transactions, including rendering, billing, referring, prescribing, attending, and "Other" provider fields.

Non-healthcare providers, including personal care providers, SMV providers, blood banks, and CCOs should enter valid provider numbers into fields that require a provider number.

Managed Care Organizations

Claims for services that are covered in a member's state-contracted MCO should be submitted to that MCO.

Noncertified Providers

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

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 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 and the Noncompound Drug Claim.

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.

Paper Claim Submission

Paper claims for DME must be submitted using the 1500 Health Insurance Claim Form (dated 08/05). Claims for DME submitted on any other claim form will be denied.

Providers should use the appropriate claim form instructions for DME 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.

Referring Providers

Claims for DME require the referring provider's name and NPI.

Requirements for Compression Garments

The following table indicates claims submission requirements for compression garments. When submitting claims for HCPCS procedure codes A6530 to A6542 and S8420 to S8429, providers are required to include on or with the claim all of the checked information in the table that corresponds to the procedure code on the claim. A blank cell indicates that the requirement does not apply to the corresponding procedure code.

Procedure Code	ICD-9-CM* Diagnosis Code	RT and/or LT Modifier Required?	Include Copy of Order Form That Includes Measurements Taken	Include Copy of Manufacturer's Invoice	Include Copy of Physician's Prescription
A6530	X	Yes			
A6531	X	Yes			
A6532	X	Yes			
A6533	X	Yes			
A6534	X	Yes			
A6535	X	Yes			
A6536	X	Yes			
A6537	X	Yes			
A6538	X	Yes			
A6539	X				
A6540	X				
A6541	X				
A6542	X	Yes	X	X	X
S8420	X	Yes	X	X	X
S8421	X	Yes			
S8422	X	Yes	X	X	X
S8423	X	Yes	X	X	X
S8424	X	Yes			
S8425	X	Yes	X	X	X
S8426	X	Yes	X	X	X
S8427	X	Yes			
S8428	X	Yes			
S8429	X	Yes	X	X	X

* *International Classification of Diseases, Ninth Revision, Clinical Modification*

Modifiers "RT" and "LT" Required on Claims

Providers are required to include modifier "RT" and/or "LT" on claims submitted for procedure codes A6530 to A6538, A6542, and S8420 to S8429. Modifier "RT" is used to reference a garment applied to a right extremity. Modifier "LT" is used to reference a garment applied to a left extremity. Procedure codes A6530 to A6538, A6542, and S8420 to S8429 are incomplete without modifier "RT" or "LT."

If there is a bilateral need, providers are required to submit two separate details on claims, with modifier "RT" on one detail and modifier "LT" on a second detail. ForwardHealth will not accept modifier "50" (Bilateral) for processing claims for compression garments.

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 documents 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. Providers are required to indicate an ACN 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
6406 Bridge Rd
Madison WI 53784-0002

Timely Filing Appeals Requests

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 form with a paper claim or an Adjustment/Reconsideration Request form to override the submission deadline.

DOS 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.

Resubmission

Decisions on Timely Filing Appeals Requests 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.

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 form.
- 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 code, etc., as effective for the DOS. 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 form. The most recent claim number (also known as the ICN) must be indicated on the Adjustment/Reconsideration	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

	Request form. This number may be the result of a ForwardHealth-initiated adjustment.	

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.	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 6406 Bridge Rd Madison WI 53784-0050

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 for pregnant women or children identification card. ◦ Green paper temporary identification card. ◦ White paper PE for the FPW identification card. ◦ The response received through the EVS from a commercial eligibility vendor. ◦ The transaction log number received through WiCall.	ForwardHealth Good Faith/Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

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 message. A copy of the RA message that shows the ForwardHealth-initiated adjustment must be submitted with the request.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Retroactive Enrollment for Persons on General Relief		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when the local	To receive consideration, the request must be submitted	ForwardHealth

county or tribal agency requests a return of a GR payment from the provider because a member has become retroactively enrolled for Wisconsin Medicaid or BadgerCare Plus.	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.	GR Retro Eligibility Ste 50 6406 Bridge Rd Madison WI 53784-0050

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 6406 Bridge Rd Madison WI 53784-0050

Refund Request from an Other Health Insurance Source		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when an other health insurance source reviews a previously paid claim and determines that reimbursement was inappropriate.	To receive consideration, the following documentation must be submitted within 90 days from the date of recoupment notification: • 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.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

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 6406 Bridge Rd Madison WI 53784-0050

Coordination of Benefits

3

Archive Date:03/01/2010

Coordination of Benefits:Commercial Health Insurance

Assignment of Insurance Benefits

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

Commercial health insurance companies may permit reimbursement to the provider or member. Providers should verify whether commercial health insurance benefits may be assigned to the provider. As indicated by the commercial health insurance, providers may be required to obtain approval from the member for this assignment of benefits.

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

If the member is assigned insurance benefits, it is appropriate to submit a claim to ForwardHealth without billing the commercial health insurance. In this instance providers should indicate the appropriate other insurance indicator. ForwardHealth will bill the commercial health insurance.

Claims for Services Denied by Commercial Health Insurance

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

Commercial Fee-for-Service

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

Commercial Managed Care

A commercial managed care plan provides coverage through a specified group of providers in a particular service area. The providers may be under contract with the commercial health insurance and receive payment based on the number of patients seen (i.e., capitation payment).

Commercial managed care plans require members to use a designated network of providers. Non-network providers (i.e., providers who do not have a contract with the member's commercial managed care plan) will be reimbursed by the commercial managed care plan *only* if they obtain a referral or provide an emergency service.

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

BadgerCare Plus will *not* reimburse the provider if the commercial managed care plan denied or would deny payment because a

service otherwise covered under the commercial managed care plan was performed by a provider outside the plan. In addition, if a member receives a covered service outside his or her commercial managed care plan, the provider cannot collect payment from the member.

Definition of Commercial Health Insurance

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

Discounted Rates

Providers of services that are discounted by commercial health insurance should include the following on claims submitted:

- Their usual and customary charge.
- The appropriate other insurance indicator.
- The amount, if any, actually received from commercial health insurance as the amount paid by commercial health insurance.

Exhausting Commercial Health Insurance Sources

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

Step 1. Determine if the Member Has Commercial Health Insurance
If Wisconsin's EVS does not indicate that the member has commercial health insurance, the provider may submit a claim to ForwardHealth unless the provider is otherwise aware of commercial health insurance coverage. **If the member disputes the information as it is indicated in the EVS,** the provider should submit a completed Other Coverage Discrepancy Report form. Unless the service does not require other health insurance billing, the provider should allow at least two weeks before proceeding to Step 2.
Step 2. Determine if the Service Requires Other Health Insurance Billing
If the service requires other health insurance billing, the provider should proceed to Step 3. **If the service does not require other health insurance billing,** the provider should proceed in one of the following ways: • The provider is encouraged to bill commercial health insurance if he or she believes that benefits are available. Reimbursement from commercial health insurance may be greater than the BadgerCare Plus-allowed amount. If billing commercial health insurance first, the provider should proceed to Step 3. • The provider may submit a claim without indicating an other insurance indicator on the claim. The provider may not bill BadgerCare Plus and commercial health insurance simultaneously. Simultaneous billing may constitute fraud and interferes with BadgerCare Plus's ability to recover prior payments.
Step 3. Identify Assignment of Commercial Health Insurance Benefits
The provider should verify whether commercial health insurance benefits may be assigned to the provider. (As indicated by commercial health insurance, the provider may be required to obtain approval from the member for this assignment of benefits.) The provider should proceed in one of the following ways:

- **If the provider is assigned benefits,** the provider should bill commercial health insurance and proceed to Step 4.
- **If the member is assigned insurance benefits,** the provider may submit a claim (without billing commercial health insurance) using the appropriate other insurance indicator.

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

Step 4. Bill Commercial Health Insurance and Follow Up
If commercial health insurance denies or partially reimburses the provider for the claim, the provider may proceed to Step 5. **If commercial health insurance does not respond within 45 days,** the provider should follow up the original claim with an inquiry to commercial health insurance to determine the disposition of the claim. If commercial health insurance does not respond within 30 days of the inquiry, the provider may proceed to Step 5.

Step 5. Submit Claim to ForwardHealth
If only partial reimbursement is received, if the correct and complete claim is denied by commercial health insurance, or if commercial health insurance does not respond to the original and follow-up claims, the provider may submit a claim to ForwardHealth using the appropriate other insurance indicator. Commercial remittance information should not be attached to the claim.

Members Unable to Obtain Services Under Managed Care Plan

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

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

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

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

- Indicate "OI-Y" on paper claims.
- Refer to the Wisconsin Provider Electronic Solutions Manual or the appropriate 837 companion document to determine the appropriate other insurance indicator for electronic claims.

Non-Reimbursable Commercial Managed Care Services

Providers are not reimbursed for the following:

- Services covered by a commercial managed care plan, except for coinsurance, copayment, or deductible.
- Services for which providers contract with a commercial managed care plan to receive a capitation payment for services.

Other Insurance Indicators

Other insurance indicators are used to report results of commercial health insurance billing and to report when existing insurance was not billed. Providers are required to use these indicators as applicable on claims submitted for members with commercial health insurance. The intentional misuse of other insurance indicators to obtain inappropriate reimbursement constitutes fraud.

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

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

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

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

Documentation Requirements

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

Services Not Requiring Commercial Health Insurance Billing

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

- Case management services.
- Family planning services.
- PNCC services.
- Preventive pediatric services.
- SMV services.

Services Requiring Commercial Health Insurance Billing

If the EVS indicates the code **"DEN"** for "Other Coverage," the provider is required to bill dental services to commercial health insurance before submitting claims to ForwardHealth.

If the EVS indicates that the member has Wausau Health Protection Plan (**"HPP"**), BlueCross & BlueShield (**"BLU"**), Wisconsin Physicians Service (**"WPS"**), TriCare (**"CHA"**), or some other (**"OTH"**) commercial health insurance, the provider is required to bill the following services to commercial health insurance before submitting claims to ForwardHealth:

- Ambulance services, if provided as emergency services.
- Anesthetist services.
- Audiology services, unless provided in a nursing home or SNF.
- Blood bank services.
- Chiropractic services.

- CSP services.
- Dental services.
- DME (rental or purchase), prosthetics, and hearing aids if the billed amount is over $10.00 per item.
- Home health services (excluding PC services).
- Hospice services.
- Hospital services, including inpatient or outpatient.
- Independent nurse, nurse practitioner, or nurse midwife services.
- Laboratory services.
- Medicare-covered services for members who have Medicare and commercial health insurance.
- Mental health/substance abuse services, including services delivered by providers other than physicians, regardless of POS.
- PT, OT, and SLP services, unless provided in a nursing home or SNF.
- Physician assistant services.
- Physician services, including surgery, surgical assistance, anesthesiology, or any service to a hospital inpatient. However, physician services provided to a woman whose primary diagnosis indicates a high-risk pregnancy do not require commercial health insurance billing.
- Pharmacy services for members with verified drug coverage.
- Podiatry services.
- PDN services for ventilator-dependent members.
- Radiology services.
- RHC services.
- Skilled nursing home care, if any DOS is within 30 days of the date of admission. If benefits greater than 30 days are available, the nursing home is required to continue to bill for them until those benefits are exhausted.
- Vision services over $50, unless provided in a home, nursing home, or SNF.

If the EVS indicates the code **"VIS"** for "Other Coverage", the provider is required to bill the following services to commercial health insurance before submitting claims to ForwardHealth:

- Ophthalmology services.
- Optometrist services.

If the EVS indicates the code **"HMO"** for "Other Coverage," the provider is required to bill the following services to commercial health insurance before submitting claims to ForwardHealth:

- Ambulance services, if provided as emergency services.
- Anesthetist services.
- Audiology services, unless provided in a nursing home or SNF.
- Blood bank services.
- Chiropractic services.
- CSP services.
- Dental services.
- DME (rental or purchase), prosthetics, and hearing aids if the billed amount is over $10.00 per item.
- Home health services (excluding PC services).
- Hospice services.
- Hospital services, including inpatient or outpatient regardless of the type of hospital.
- Independent nurse, nurse practitioner, or nurse midwife services.
- Laboratory services.
- Medicare-covered services billed for a member who has both Medicare and commercial health insurance.
- Mental health/substance abuse services, including services delivered by providers other than physicians, regardless of POS.
- Pharmacy services for members with verified drug coverage.
- PT, OT, and SLP services, unless provided in a nursing home or SNF.
- Physician and physician assistant services.
- Podiatry services.
- PDN services for ventilator-dependent members.
- Radiology services.

- RHC services.
- Skilled nursing home care, if any DOS is within 30 days of the date of admission. If benefits greater than 30 days are available, the nursing home is required to continue to bill for them until those benefits are exhausted.
- Vision services over $50, unless provided in a home, nursing home, or SNF.

If the EVS indicates Medicare Supplemental Plan Coverage (**"SUP"**), the provider is required to bill the following services to commercial health insurance before submitting claims to ForwardHealth:

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

BadgerCare Plus has identified services requiring Medicare billing.

Medicare

Acceptance of Assignment

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

A Medicare-enrolled provider performing a Medicare-covered service for a dual eligible or QMB-Only member is required to accept assignment of the member's Medicare Part B benefits. Therefore, total payment for the service (i.e., any amount paid by other health insurance sources, any copayment or spenddown amounts paid by the member, and any amount paid by Wisconsin Medicaid) may not exceed the Medicare-allowed amount.

Claims Denied for Errors

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

Claims Processed by Commercial Insurance That Is Secondary to Medicare

If a crossover claim is also processed by commercial health insurance that is secondary to Medicare (e.g., Medicare supplemental), the claim will not be forwarded to ForwardHealth. After the claim has been processed by the commercial health insurance, the provider should submit a provider-submitted crossover claim to ForwardHealth with the appropriate other insurance indicator.

Claims That Do Not Require Medicare Billing

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

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

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

Claims That Fail to Cross Over

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

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

- The billing provider's NPI has not been reported to ForwardHealth.
- The taxonomy code designated by ForwardHealth is required to identify the billing provider and is not indicated on the

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

If automatic crossover claims do not appear on the RA after 30 days of the Medicare processing date, providers are required to resubmit the claim directly to ForwardHealth using the NPI that was reported to ForwardHealth as the primary NPI. Additionally, the taxonomy code designated by ForwardHealth and the ZIP+4 code of the practice location on file with ForwardHealth are required when an additional date is needed to identify the provider.

Claims for Services Denied by Medicare

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

Crossover Claims

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

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

- Medicare Part A fiscal intermediary.
- Medicare Part B carrier.
- Medicare DME regional carrier.
- Medicare Advantage Plan.
- Railroad Retirement Board carrier (also known as the Railroad Medicare carrier).

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

- Automatic crossover claims.
- Provider-submitted crossover claims.

Automatic Crossover Claims

An automatic crossover claim is a claim that Medicare automatically forwards to ForwardHealth by the COBC.

Claims will be forwarded if the following occur:

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

Provider-Submitted Crossover Claims

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

- The automatic crossover claim does not appear on the ForwardHealth RA within 30 days of the Medicare processing date.

- The automatic crossover claim is denied and additional information may allow payment.
- The claim is for a member who is enrolled in Medicare and commercial health insurance that is secondary to Medicare (e.g., Medicare Supplemental).
- The claim is for a member who was not enrolled in BadgerCare Plus at the time the service was submitted to Medicare for payment, but the member was retroactively determined enrolled in BadgerCare Plus.
- The claim is for a member who is enrolled in a Medicare Advantage Plan.

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

- The NPI that ForwardHealth has on file for the provider.
- Taxonomy code that is required by ForwardHealth.
- The ZIP+4 code that corresponds to the practice location address on file with ForwardHealth.

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

- DDE through the ForwardHealth Provider Portal.
- 837I transaction, as applicable.
- 837P transaction, as applicable.
- PES software.
- Paper claim form.

Definition of Medicare

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

Medicare coverage is divided into four parts:

- Part A (i.e., Hospital Insurance). Part A helps to pay for medically necessary services, including inpatient hospital services, services provided in critical access hospitals (i.e., small facilities that give limited inpatient services and outpatient services to beneficiaries who reside in rural areas), services provided in skilled nursing facilities, hospice services, and some home health services.
- Part B (i.e., Supplemental Medical Insurance). Part B helps to pay for medically necessary services, including physician services, outpatient hospital services, and some other services that Part A does not cover (such as PT services, OT services, and some home health services).
- Part C (i.e., Medicare Advantage).
- Part D (i.e., drug benefit).

Dual Eligibles

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

Dual eligibles may receive coverage for the following:

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

Exhausting Medicare Coverage

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

Adjustment Request for Crossover Claim
The provider may submit a paper or electronic adjustment request. If submitting a paper Adjustment/Reconsideration Request form, the provider should attach a copy of Medicare remittance information. (If this is a Medicare reconsideration, copies of the original and subsequent Medicare remittance information should be attached.)

Provider-Submitted Crossover Claim

The provider may submit a provider-submitted crossover claim in the following situations:
 	
• The claim is for a member who is enrolled in a Medicare Advantage Plan.
• The automatic crossover claim is not processed by ForwardHealth within 30 days of the Medicare processing date.
• ForwardHealth denied the automatic crossover claim and additional information may allow payment.
• The claim is for a member who is enrolled in Medicare and commercial health insurance that is secondary to Medicare (e.g., Medicare Supplemental).
• The claim is for a member who was not enrolled in BadgerCare Plus at the time the service was submitted to Medicare for payment, but the member was retroactively enrolled.*
 	
When submitting provider-submitted crossover claims, the provider is required to follow all claims submission requirements in addition to the following:
 	
• For electronic claims, indicate the Medicare payment.
• For paper claims, the provider is required to the do the following:
  ○ Attach Medicare's remittance information and refrain from indicating the Medicare payment.
  ○ Indicate "MMC" in the upper right corner of the claim for services provided to members enrolled in a Medicare Advantage Plan.
 	
When submitting provider-submitted crossover claims for members enrolled in Medicare and commercial health insurance that is secondary to Medicare, the provider is also required to do the following:
 	
• Refrain from submitting the claim to ForwardHealth until after the claim has been processed by the commercial health insurance.
• Indicate the appropriate other insurance indicator.
 	
* In this situation, a timely filing appeals request may be submitted if the services provided are beyond the claims submission deadline. The provider is required to indicate "retroactive enrollment" on the provider-submitted crossover claim and submit the claim with the Timely Filing Appeals Request form. The provider is required to submit the timely filing appeals request within 180 days from the date the backdated enrollment was added to the member's file.

Claim for Services Denied by Medicare
When Medicare denies payment for a service provided to a dual eligible that is covered by BadgerCare Plus, the provider may proceed as follows: • Bill commercial health insurance, if applicable. • Submit a claim to ForwardHealth using the appropriate Medicare disclaimer code. If applicable, the provider should indicate the appropriate other insurance indicator. A copy of Medicare remittance information should not be attached to the claim.

Crossover Claim Previously Reimbursed
A crossover claim may have been previously reimbursed by Wisconsin Medicaid when one of the following has occured:

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

In these situations, the provider should proceed as follows:

- Refund or adjust Medicaid payments for services previously reimbursed by Wisconsin Medicaid.
- Bill Medicare for the services and follow BadgerCare Plus's procedures for submitting crossover claims.

Medicare Advantage

Medicare services may be provided to dual eligibles or QMB-Only members on a fee-for-service basis or through a Medicare Advantage Plan. Medicare Advantage was formerly known as Medicare Managed Care (MMC), Medicare + Choice (MPC), or Medicare Cost (Cost). Medicare Advantage Plans have a special arrangement with the federal CMS and agree to provide all Medicare benefits to Medicare beneficiaries for a fee. Providers may contact Medicare for a list of Medicare Advantage Plans in Wisconsin and the insurance companies with which they are associated.

Paper Crossover Claims

Providers are required to indicate "MMC" in the upper right corner of provider-submitted crossover claims for services provided to members enrolled in a Medicare Advantage Plan. The claim must be submitted with a copy of the Medicare EOMB. This is necessary in order for ForwardHealth to distinguish whether the claim has been processed as commercial managed care or Medicare managed care.

Reimbursement Limits

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

Medicare Disclaimer Codes

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

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

When submitting a claim for a covered service that was denied by Medicare, providers should resubmit the claim *directly* to ForwardHealth using the appropriate Medicare disclaimer code.

Documentation Requirements

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

Medicare Enrollment

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

retroactive enrollment.

Services for Dual Eligibles

As stated in DHS 106.03(6) and 106.03(7)(b), Wis. Admin. Code, a provider is required to be enrolled in Medicare if both of the following are true:

- He or she provides a Medicare Part B service to a dual eligible.
- He or she can be enrolled in Medicare.

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

To receive Medicaid reimbursement for a Medicare Part B service provided to a dual eligible, a provider who is not enrolled in Medicare but can be is required to apply for retroactive enrollment.

Services for Qualified Medicare Beneficiary-Only Members

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

Medicare Late Fees

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

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

Resubmitting Medicare Crossover Claims with Late Fees

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

Paper Claim Submissions

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

Electronic Claim Submissions

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

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

- Billed Amount: $110.00.

- Allowed Amount: $100.00.
- Coinsurance: $20.00.
- Late Fee: $5.00.
- Paid Amount: $75.00.

Since ForwardHealth considers the late fee part of the paid amount, providers should add the late fee to the paid amount reported on the Medicare remittance. In the example above, add the late fee of $5.00 to the paid amount of $75.00 for a total of $80.00. The claim should report the Medicare paid amount as $80.00.

Medicare Retroactive Eligibility

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

Modifier for Catastrophe/Disaster-Related Crossover Claims

ForwardHealth accepts modifier "CR" (Catastrophe/disaster related) on Medicare crossover claims (both 837P transactions and 1500 Health Care Claim Forms) to accommodate the emergency health care needs of dual eligibles and QMB-Only members affected by disasters. The CMS Web site contains more information.

National Provider Identifier and Related Data on Crossover Claims

An NPI and related data are required on crossover claims, in most instances. However, in some cases the taxonomy code designated by ForwardHealth may not be indicated on automatic crossover claims received from Medicare.

Secondary NPI

Medicare requires that certain subparts of an organization obtain separate NPIs and use the NPI for billing Medicare (e.g., hospital psychiatric unit). If an organization has identified subparts for the purpose of submitting claims to Medicare, and the NPIs appear on automatic crossover claims to ForwardHealth, ForwardHealth considers the NPIs submitted to Medicare to be secondary NPIs. ForwardHealth will process automatic crossover claims using secondary NPIs in cases where the provider has reported a secondary NPI to ForwardHealth. Along with the NPI, providers should also indicate the taxonomy and ZIP+4 code information.

Taxonomy Code Designated by ForwardHealth

The taxonomy code indicated on automatic crossover claims received from Medicare may be different than the taxonomy designated by ForwardHealth. Providers should resubmit the claim to ForwardHealth when the taxonomy code designated by ForwardHealth is required to identify the provider and is not indicated on the crossover claim received from Medicare.

Provider-Submitted Crossover Claims

A provider-submitted crossover claim is a Medicare-allowed claim that a provider directly submits to ForwardHealth when the Medicare claim did not automatically crossover to ForwardHealth.

Electronic Professional Crossover Claims

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

When submitting electronic Medicare crossover claims, providers should not submit paper EOMB as an attachment. Providers should, however, be sure to complete Medicare CAS segments when submitting 837 transactions.

Paper Professional Crossover Claims Require Provider Signature

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

Qualified Medicare Beneficiary-Only Members

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

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

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

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

Reimbursement for Crossover Claims

Professional Crossover Claims

State law limits reimbursement for coinsurance and copayment of Medicare Part B services provided to dual eligibles and QMB-Only members.

Total payment for a Medicare Part B service (i.e., any amount paid by other health insurance sources, any copayment or spenddown amounts paid by the member, and any amount paid by Wisconsin Medicaid) may not exceed the Medicare-allowed amount. Therefore, Medicaid reimbursement for coinsurance or copayment of a Medicare Part B service is the lesser of the following:

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

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

Reimbursement for Coinsurance or Copayment of Medicare Part B Services

Explanation	Example		
	1	2	3
Provider's billed amount	$120	$120	$120
Medicare-allowed amount	$100	$100	$100
Medicaid-allowed amount (e.g., maximum allowable fee, rate-per-visit)	$90	$110	$75
Medicare payment	$80	$80	$80
Medicaid payment	$10	$20	$0

Outpatient Hospital Crossover Claims

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

Providers may use the following steps to determine how reimbursement was calculated:

1. Sum all of the detail Medicare paid amounts to establish the Claim Medicare paid amount.
2. Sum all of the detail Medicare coinsurance or copayment amounts to establish the Claim Medicare coinsurance or copayment amount.
3. Multiply the number of DOS by the provider's rate-per-visit. For example, $100 (rate-per-visit) x 3 (DOS) = $300. This is the Medicaid gross allowed amount.
4. Compare the Medicaid gross allowed amount calculated in step 3 to the Claim Medicare paid amount calculated in step 1. If the Medicaid gross allowed amount is less than or equal to the Medicare paid amount, Wisconsin Medicaid will make no further payment to the provider for the claim. If the Medicaid gross allowed amount is greater than the Medicare paid amount, the difference establishes the Medicaid net allowed amount.
5. Compare the Medicaid net allowed amount calculated in step 4 and the Medicare coinsurance or copayment amount calculated in step 2. Wisconsin Medicaid reimburses the lower of the two amounts.

Services Requiring Medicare Billing

If the EVS indicates Medicare + Choice (**"MPC"**) for "Medicare Managed Care Coverage," the provider is required to bill the following services to the Medicare Advantage Plan before submitting claims to ForwardHealth:

- Ambulance services.
- Ambulatory service center services.
- Chiropractic services.
- Dental anesthesia services.
- Home health services (excluding PC services).
- Hospital services, including inpatient or outpatient.
- Medicare-covered services.
- Osteopath services.
- Physician services.

If the EVS indicates Medicare Cost (**"MCC"**) for "Medicare Managed Care Coverage," the provider is required to bill the following services to the Medicare Advantage Plan before submitting claims to ForwardHealth:

- Ambulance services.
- Home health services (excluding PC services).
- Medicare-covered services.

ForwardHealth has identified services requiring commercial health insurance billing.

Other Coverage Information

After Reporting Discrepancies

After receiving an Other Coverage Discrepancy Report, ForwardHealth confirms the information and updates the member files.

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

- The provider verifies through Wisconsin's EVS that the member's other coverage information has been updated.
- The provider receives a written explanation.

Coverage Discrepancies

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

Insurance Disclosure Program

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

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

Maintaining Accurate and Current Records

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

- Insurance Disclosure program.
- Providers who submit an Other Coverage Discrepancy Report form.
- Member certifying agencies.
- Members.

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

Reporting Discrepancies

Providers are encouraged to report discrepancies to ForwardHealth by submitting the Other Coverage Discrepancy Report form. Providers are asked to complete the form in the following situations:

- The provider is aware of other coverage information that is not indicated by Wisconsin's EVS.

- The provider received other coverage information that contradicts the information indicated by the EVS.
- A claim is denied because the EVS indicates commercial managed care coverage but the coverage is not available to the member (e.g., the member does not live in the plan's service area).

Providers should not use the Other Coverage Discrepancy Report form to update any information regarding a member's coverage in a state-contracted MCO.

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

Provider-Based Billing

Purpose of Provider-Based Billing

The purpose of provider-based billing is to reduce costs by ensuring that providers receive maximum reimbursement from other health insurance sources that are primary to BadgerCare Plus. For example, a provider-based billing claim is created when BadgerCare Plus pays a claim and later discovers that other coverage exists or was made retroactive. Since BadgerCare Plus benefits are secondary to those provided by most other health insurance sources, providers are required to seek reimbursement from the primary payer, as stated in DHS 106.03(7), Wis. Admin. Code.

Questions About Provider-Based Billing

For questions about provider-based billing claims that are within the 120-day limit, providers may call the Coordination of Benefits Unit at (608) 221-4746. Providers may fax the corresponding Provider-Based Billing Summary to (608) 221-4567 at the time of the telephone call.

For questions about provider-based billing claims that are *not* within the 120-day limit, providers may call Provider Services.

Receiving Notification

When a provider-based billing claim is created, the provider will receive the following:

- A notification letter.
- A Provider-Based Billing Summary. The Summary lists each claim from which a provider-based billing claim was created. The summary also indicates the corresponding primary payer for each claim.
- Provider-based billing claim(s). For each claim indicated on the Provider-Based Billing Summary, the provider will receive a prepared provider-based billing claim. This claim may be used to bill the other health insurance source; the claim includes all of the other health insurance source's information that is available.

If a member has coverage through multiple other health insurance sources, the provider may receive additional Provider-Based Billing Summaries and provider-based billing claims for each other health insurance source that is on file.

Responding to ForwardHealth After 120 Days

If a response is not received within 120 days, the amount originally paid by BadgerCare Plus will be withheld from future payments. This is not a final action. To receive payment after the original payment has been withheld, providers are required to submit the required documentation to the appropriate address as indicated in the following tables. For DOS that are within claims submission deadlines, providers should refer to the first table. For DOS that are beyond claims submission deadlines, providers should refer to the second table.

Within Claims Submission Deadlines		
Scenario	**Documentation Requirement**	**Submission Address**
The provider discovers through the EVS that ForwardHealth has removed or enddated the other health insurance coverage from the member's file.	A claim according to normal claims submission procedures (do *not* use the prepared provider-based billing claim).	ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002
The provider discovers that the member's	• An Other Coverage Discrepancy Report form.	Send the Other Coverage

other coverage information (i.e., enrollment dates) reported by the EVS is invalid.	• A claim according to normal claims submission procedures after verifying that the member's other coverage information has been updated by using the EVS (do *not* use the prepared provider-based billing claim).	Discrepancy Report form to the address indicated on the form. Send the claim to the following address: ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002
The other health insurance source reimburses or partially reimburses the provider-based billing claim.	• A claim according to normal claims submission procedures (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator. • The amount received from the other health insurance source.	ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002
The other health insurance source denies the provider-based billing claim.	• A claim according to normal claims submission procedures (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator or Medicare disclaimer code.	ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002
The commercial health insurance carrier does not respond to an initial *and* follow-up provider-based billing claim.	• A claim according to normal claims submission procedures (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator.	ForwardHealth Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002

Beyond Claims Submission Deadlines		
Scenario	**Documentation Requirement**	**Submission Address**
The provider discovers through the EVS that ForwardHealth has removed or enddated the other health insurance coverage from the member's file.	• A claim (do *not* use the prepared provider-based billing claim). • A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050
The provider discovers that the member's other coverage information (i.e., enrollment dates) reported by the EVS is invalid.	• An Other Coverage Discrepancy Report form. • *After* using the EVS to verify that the member's other coverage information has been updated, include both of the following: ◦ A claim (do *not* use the prepared provider-based billing claim.) ◦ A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	Send the Other Coverage Discrepancy Report form to the address indicated on the form. Send the timely filing appeals request to the following address: ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050
The commercial health insurance carrier reimburses or partially	• A claim (do *not* use the prepared provider-based billing claim).	ForwardHealth Timely Filing

reimburses the provider-based billing claim.	• Indicate the appropriate other insurance indicator. • Indicate the amount received from the commercial insurance. • A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	Ste 50 6406 Bridge Rd Madison WI 53784-0050
The other health insurance source denies the provider-based billing claim.	• A claim (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator or Medicare disclaimer code. • A Timely Filing Appeals Request form according to normal timely filing appeals procedures. • The Provider-Based Billing Summary. • Documentation of the denial, including any of the following: ◦ Remittance information from the other health insurance source. ◦ A written statement from the other health insurance source identifying the reason for denial. ◦ A letter from the other health insurance source indicating a policy termination date that proves that the other health insurance source paid the member. ◦ A copy of the insurance card or other documentation from the other health insurance source that indicates that the policy provides limited coverage such as pharmacy, dental, or Medicare supplemental coverage only. • The DOS, other health insurance source, billed amount, and procedure code indicated on the documentation must match the information on the Provider-Based Billing Summary.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050
The commercial health insurance carrier does not respond to an initial and follow-up provider-based billing claim.	• A claim (do *not* use the prepared provider-based billing claim). • The appropriate other insurance indicator. • A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 6406 Bridge Rd Madison WI 53784-0050

Responding to ForwardHealth Within 120 Days

Within 120 days of the date on the Provider-Based Billing Summary, the Provider-Based Billing Unit must receive documentation verifying that one of the following occurred:

- The provider discovers through the EVS that ForwardHealth has removed or enddated the other health insurance coverage from the member's file.
- The provider verifies that the member's other coverage information reported by ForwardHealth is invalid.
- The other health insurance source reimbursed or partially reimbursed the provider-based billing claim.
- The other health insurance source denied the provider-based billing claim.

- The other health insurance source failed to respond to an initial *and* follow-up provider-based billing claim.

When responding to ForwardHealth within 120 days, providers are required to submit the required documentation to the appropriate address as indicated in the following table. If the provider's response to ForwardHealth does not include all of the required documentation, the information will be returned to the provider. The provider is required to send the complete information within the original 120-day limit.

Scenario	Documentation Requirement	Submission Address
The provider discovers through the EVS that ForwardHealth has removed or enddated the other health insurance coverage from the member's file.	• The Provider-Based Billing Summary. • Indication that the EVS no longer reports the member's other coverage.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567
The provider discovers that the member's other coverage information (i.e., enrollment dates) reported by the EVS is invalid.	• The Provider-Based Billing Summary. • One of the following: ○ The name of the person with whom the provider spoke and the member's correct other coverage information. ○ A printed page from an enrollment Web site containing the member's correct other coverage information.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567
The other health insurance source reimburses or partially reimburses the provider-based billing claim.	• The Provider-Based Billing Summary. • A copy of the remittance information received from the other health insurance source. • The DOS, other health insurance source, billed amount, and procedure code indicated on the other insurer's remittance information must match the information on the Provider-Based Billing Summary. *Note:* In this situation, ForwardHealth will initiate an adjustment if the amount of the other health insurance payment does not exceed the allowed amount (even though an adjustment request should not be submitted). However, providers (except nursing home and hospital providers) may issue a cash refund. Providers who choose this option should include a refund check but should not use the Claim Refund form.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567
The other health insurance source denies the provider-based billing claim.	• The Provider-Based Billing Summary. • Documentation of the denial, including any of the following: ○ Remittance information from the other health insurance source. ○ A letter from the other health insurance source indicating a policy termination date that precedes the DOS. ○ Documentation indicating that the other health insurance source paid the member. ○ A copy of the insurance card or other documentation from the other health insurance source that indicates the policy provides limited coverage such as pharmacy, dental, or Medicare supplemental coverage. • The DOS, other health insurance source, billed amount, and procedure code indicated on the documentation must match the information on the Provider-Based Billing Summary.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567
The other health insurance	• The Provider-Based Billing Summary.	ForwardHealth

source fails to respond to the initial *and* follow-up provider-based billing claim.	• Indication that no response was received by the other health insurance source. • Indication of the dates that the initial and follow-up provider-based billing claims were submitted to the other health insurance source.	Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax (608) 221-4567

Submitting Provider-Based Billing Claims

For each provider-based billing claim, the provider is required to send a claim to the appropriate other health insurance source. The provider may use the claim prepared by ForwardHealth or produce his or her own claim. If the other health insurance source requires information beyond what is indicated on the prepared claim, the provider should add that information to the claim. The providers should also attach additional documentation (e.g., Medicare's remittance information) if required by the other health insurance source.

Reimbursement for Services Provided for Accident Victims

Billing Options

Providers may choose to seek payment from either of the following:

- Civil liabilities (e.g., injuries from an automobile accident).
- Worker's compensation.

However, as stated in DHS 106.03(8), Wis. Admin. Code, BadgerCare Plus will not reimburse providers if they receive payment from either of these sources.

The provider may choose a different option for each DOS. For example, the decision to submit one claim to ForwardHealth does not mean that all claims pertaining to the member's accident must be submitted to ForwardHealth.

Points of Consideration

Providers should consider the time and costs involved when choosing whether to submit a claim to ForwardHealth or seek payment from a settlement.

Time

Providers are not required to seek payment from worker's compensation or civil liabilities, rather than seeking reimbursement from BadgerCare Plus, because of the time involved to settle these cases. While some worker's compensation cases and certain civil liability cases may be settled quickly, others may take several years before settlement is reached.

Costs

Providers may receive more than the allowed amount from the settlement; however, in some cases the settlement may not be enough to cover all costs involved.

Seeking Payment from Settlement

After choosing to seek payment from a settlement, the provider may *instead* submit the claim to ForwardHealth as long as it is submitted before the claims submission deadline. For example, the provider may instead choose to submit the claim to ForwardHealth because no reimbursement was received from the liability settlement or because a settlement has not yet been reached.

Submitting Claims to ForwardHealth

If the provider chooses to submit a claim to ForwardHealth, he or she may not seek further payment for that claim in any liability settlement that may follow. Once a claim is submitted to ForwardHealth, the provider may not decide to seek reimbursement for that claim in a liability settlement. Refunding payment and then seeking payment from a settlement may constitute a felony. If a settlement occurs, ForwardHealth retains the sole right to recover medical costs.

Providers are required to indicate when services are provided to an accident victim on claims submitted to ForwardHealth. If the member has other health insurance coverage, the provider is required to exhaust the other health insurance sources before submitting the claim to ForwardHealth.

Covered and Noncovered Services

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Archive Date:03/01/2010

Covered and Noncovered Services:Back-up Durable Medical Equipment

Back-up Durable Medical Equipment

Back-up or secondary DME is defined as an identical or similar piece of DME to one already in use that is used to meet the same medical need for the member. The purchase or rental of a second, identical or similar piece of DME is covered when the medical necessity criteria for its use is met or when it is determined that, if the primary piece of DME breaks down or malfunctions, it could result in immediate life-threatening consequences for the member.

The maximum reimbursement for back-up or secondary DME is one-half the maximum allowable fee for purchase or one-half the maximum daily rental reimbursement for the primary piece of DME.

Providers are required to use modifier "TW" (backup equipment) when requesting PA and submitting claims for:

- Two identical or similar pieces of DME.
- A back-up/secondary piece of DME that is identical or similar to DME already in use.

The following list of procedure codes includes all DME for which Wisconsin Medicaid allows reimbursement. If a DME item is not on the list, then Wisconsin Medicaid does not provide reimbursement for the back-up or secondary piece of the item.

Allowable Modifiers	
52 = Reduced services	RR = Rental
TW = Back-up equipment	
QE = Prescribed amount of oxygen is less than 1 liter per minute (LPM)	
QG = Prescribed amount of oxygen is greater than 4 liters per minute (LPM)	

Procedure Code	Modifier (s)	Description
B9002	TW	Enteral nutrition infusion pump with alarm
B9002	RR, TW	Enteral nutrition infusion pump with alarm
B9004	TW	Parenteral nutrition infusion pump, portable
B9004	RR, TW	Parenteral nutrition infusion pump, portable
B9006	TW	Parenteral nutrition infusion pump, stationary
B9006	RR, TW	Parenteral nutrition infusion pump, stationary
E0424	RR, TW	Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0424	RR, TW, QE	Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0424	RR, TW, QG	Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0431	RR, TW	Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing
E0434	RR, TW	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing

E0439	RR, TW	Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0439	RR, TW, QE	Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0439	RR, TW, QG	Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0450	RR, TW	Volume ventilator, stationary or portable, with backup rate feature, used with invasive interface (e.g., tracheostomy tube)
E0450	RR, TW, 52	Volume ventilator, stationary or portable, with backup rate feature, used with invasive interface (e.g., tracheostomy tube)
E0454	RR, TW	Pressure ventilator with pressure control, pressure support and flow triggering features
E0454	RR, TW, 52	Pressure ventilator with pressure control, pressure support and flow triggering features
E0460	TW	Negative pressure ventilator; portable or stationary
E0460	RR, TW	Negative pressure ventilator; portable or stationary
E0472	TW	Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous positive airway pressure device)
E0472	RR, TW	Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous positive airway pressure device)
E0472	RR, TW, 52	Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous positive airway pressure device)
E0550	TW	Humidifier, durable for extensive supplemental humidification during IPPB treatments or oxygen delivery
E0550	RR, TW	Humidifier, durable for extensive supplemental humidification during IPPB treatments or oxygen delivery
E0560	TW	Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery
E0560	RR, TW	Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery
E0565	TW	Compressor, air power source for equipment which is not self-contained or cylinder driven
E0565	RR, TW	Compressor, air power source for equipment which is not self-contained or cylinder driven
E0570	TW	Nebulizer, with compressor
E0570	RR, TW	Nebulizer, with compressor
E0571	TW	Aerosol compressor, battery powered, for use with small volume nebulizer
E0571	RR, TW	Aerosol compressor, battery powered, for use with small volume nebulizer
E0575	TW	Nebulizer, ultrasonic, large volume
E0575	RR, TW	Nebulizer, ultrasonic, large volume
E0580	TW	Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter
E0585	TW	Nebulizer, with compressor and heater
E0585	RR, TW	Nebulizer, with compressor and heater
E0600	TW	Respiratory suction pump, home model, portable or stationary, electric
E0600	RR, TW	Respiratory suction pump, home model, portable or stationary, electric
E0776	TW	IV pole
E0776	RR, TW	IV pole

E0781	TW	Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient
E0781	RR, TW	Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient
E0791	TW	Parenteral infusion pump, stationary, single or multichannel
E0791	RR, TW	Parenteral infusion pump, stationary, single or multichannel
E1372	TW	Immersion external heater for nebulizer
E1372	RR, TW	Immersion external heater for nebulizer
E1390	TW	Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate
E1390	RR, TW	Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate
E1390	RR, TW, QE	Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate
E1390	RR, TW, QG	Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate

Codes

Adaptive Equipment

The following table lists the adaptive equipment covered by BadgerCare Plus, along with the "U" modifiers, life expectancies, maximum allowable fees, and quantity limits for the equipment. Each "U" modifier assigned with HCPCS procedure code A9900 (Miscellaneous DME supply, accessory, and/or service component of another HCPCS code) represents a specific piece of adaptive equipment. For example, code A9900 with modifier "U6" represents a universal cuff.

Providers should use code A9900 and the applicable "U" modifier when submitting claims for covered adaptive equipment. PA is not required for the equipment in the table. The only allowable POS code for adaptive equipment is "12" (home).

Adaptive Equipment	Procedure Code	Modifier	Life Expectancy	Quantity Limit
Adaptive eating utensil, weighted handle, any size, style, or shape (limit one each: knife, fork, and spoon, as needed)	A9900	U1	2 years	3
Adaptive eating utensil, non-weighted handle, any size, style, or shape (limit one each: knife, fork, and spoon, as needed)	A9900	U2	2 years	3
Rocker knife	A9900	U3	3 years	1
Plate guard	A9900	U4	2 years	1
Scoop dish	A9900	U5	3 years	1
Universal cuff	A9900	U6	1 year	1
Dycem (any size or shape)	A9900	U7	4 years	1
Sock/stocking aid	A9900	U9	3 years	1
Dressing stick	A9900	UA	2 years	1
Long-handled shoe horn	A9900	UB	2 years	1
Hand-held shower (includes diverter spout)	A9900	UC	8 years	1
Adaptive hygiene aids, such as long-handled sponge	A9900	UD	1-3 years	1

Chapter DHS 107.24(2), Wis. Admin. Code, states that covered services are limited to items contained in the DME maximum allowable fee index. Items not listed in the preceding table require PA; they may be submitted for consideration using procedure code E1399 (Durable medical equipment, miscellaneous). Documentation submitted with the PA request must include a complete description of the nature, extent, and medical need for the equipment.

Bone-Anchored Hearing Devices

Providers should indicate the following procedure codes on claims for bone-anchored hearing devices and replacement parts. All procedure codes in this table are separately reimbursable for members residing in a nursing home. Refer to the DME maximum allowable fee index for maximum allowable fees.

Bone-Anchored Hearing Devices	
Code	**Description**
L7510	Repair of prosthetic device, repair or replace minor parts
L8690	Auditory osseointegrated device, includes all internal and external components

L8691	Auditory osseointegrated device, external sound processor, replacement
V5266	Battery for use in hearing device
V5298	Hearing aid, not otherwise classified [use when a processor and headband is worn and surgery is not required.]

Cochlear Implants

Providers should indicate the following procedure codes on PA requests and claims for cochlear implants. All procedure codes in this table are separately reimbursable for members residing in a nursing home. Refer to the DME maximum allowable fee index for maximum allowable fees.

Cochlear Implant Hearing Devices	
Code	**Description**
L7510	Repair of prosthetic device, repair or replace minor parts
L8614	Cochlear device, includes all internal and external components
L8615	Headset/headpiece for use with cochlear implant device, replacement
L8616	Microphone for use with cochlear implant device, replacement
L8617	Transmitting coil for use with cochlear implant device, replacement
L8618	Transmitter cable for use with cochlear implant device, replacement
L8619	Cochlear implant external speech processor, replacement
L8621	Zinc air battery for use with cochlear implant device, replacement, each
L8622	Alkaline battery for use with cochlear implant device, any size, replacement, each
L8623	Lithium ion battery for use with cochlear implant device speech processor; other than ear level, replacement, each
L8624	ear level, replacement, each

Replacement Parts for Cochlear Implants

The following cochlear implant device and bone-anchored hearing device replacement parts are reimbursable under procedure code L7510 (Repair of prosthetic device, repair or replace minor parts).

Cochlear Implant Devices	
Replacement Parts	**Life Expectancy**
Battery charger kit	1 per 3 years
Cochlear auxiliary cable adapter	1 per 3 years
Cochlear belt clip	1 per 3 years
Cochlear harness extension adapter	1 per 3 years
Cochlear signal checker	1 per 3 years
Microphone cover	1 per year
Pouch	1 per year

Diagnosis Codes

All diagnosis codes indicated on claims (and PA requests when applicable) must be the most specific ICD-9-CM 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.

If a specific ICD-9-CM diagnosis code is unavailable, "V539" (other and unspecified device) may be used as the diagnosis code.

Diagnosis Codes for Orthopedic or Corrective Footwear

One of the following ICD-9-CM diagnosis codes is required when submitting a claim for procedure codes L3201, L3202, L3206, L3208, L3209, L3212, and L3213:

- 732.5
- 736.30
- 736.41
- 736.42
- 736.72
- 754.5
- 754.51 — 754.53
- 754.59
- 754.6
- 754.60
- 754.62
- 754.69
- 754.7 — 754.71
- 754.79
- 755.02
- 755.3 — 755.34
- 755.36 — 755.39
- 755.64 — 755.67
- 755.69
- 895 — 895.1
- 896 — 896.3
- 928 — 928.3
- 928.8 — 928.9
- 945.2 — 945.4
- 996.95 — 996.96

One of the following diagnosis codes is required for procedure code L3204:

- 732.5
- 736.30
- 736.41
- 736.42
- 736.72
- 754.5
- 754.51 — 754.53
- 754.59
- 754.6
- 754.60
- 754.62
- 754.69
- 754.7 — 754.71

- 754.79
- 755.02
- 755.3 — 755.34
- 755.36 — 755.39
- 755.64 — 755.67
- 895 — 895.1
- 896 — 896.3
- 928 — 928.3
- 928.8 — 928.9
- 945.2 — 945.4
- 996.95 — 996.96

Diagnosis Codes for Compression Garments

When submitting claims for ready-to-wear gradient compression garments, custom-made gradient compression garments, non-elastic binders, and over-the-counter garments, providers are required to include on the claim the member's diagnosis, which must be one of the allowable ICD-9-CM diagnosis codes listed in the table below. Providers are responsible for keeping current with diagnosis code changes. Providers are reminded to use the complete allowable diagnosis code.

Allowable Diagnosis Codes	Diagnosis Code Definition
342.00 to 342.92	Hemiplegia and hemiparesis
344.0 to 344.9	Other paralytic syndromes
451.0 to 451.9	Phlebitis and thrombophlebitis
454.0 to 454.9	Varicose veins of lower extremities
457.0	Postmastectomy lymphedema syndrome
457.1	Other lymphedema
458.0	Orthostatic hypotension
459.1 to 459.19	Postphlebitic syndrome
459.2	Compression of vein
459.81	Venous (peripheral) insufficiency, unspecified
646.1	Edema or excessive weight gain in pregnancy, without mention of hypertension
707.1 to 707.19	Ulcer of lower limbs, except pressure ulcer
757.0	Hereditary edema of legs
782.3	Edema

Durable Medical Equipment Maximum Allowable Fee Index

HCPCS codes are required on all DME PA requests, claims, and adjustment requests. DME PA requests, claims, and adjustment requests received without HCPCS codes are denied.

The DME maximum allowable fee index provides a complete list of allowable DME procedure codes and provides a full description of policies and limitations, including applicable copayment amounts. Changes to the index are updated on a quarterly basis and posted on the ForwardHealth Portal.

Providers may also check "What's New on the ForwardHealth Portal" in the monthly *ForwardHealth Update Summary* to see if the

DME maximum allowable fee index has been updated.

"Not Otherwise Classified" Procedure Codes

If a DME item is prescribed that does not have a specific procedure code in the DME maximum allowable fee index, the provider must request PA for the DME item using the appropriate "not otherwise classified" procedure code in the DME maximum allowable fee index.

Use a quantity of "1.0" when billing "not otherwise classified" procedure codes. If a modifier was assigned in PA, the modifier is required when billing the service.

Life Expectancy

The life expectancy for each DME item is listed in the DME maximum allowable fee index. Replacement of an item before the end of its life expectancy always requires PA.

Modifiers

Modifiers for Durable Medical Equipment

Allowable modifiers for DME are listed in the following table.

Modifier	Description
52	Reduced services
59	Distinct procedural service
KH	Durable medical equipment, prosthetics, orthotics, and supply item, initial claim, purchase or first month rental
KS	Glucose monitor supply for diabetic beneficiary not treated with insulin
KX	Specific required documentation on file [glucose monitor supply for diabetic beneficiary treated with insulin]
LT	Left side
QE	Prescribed amount of oxygen is less than one liter per minute (LPM)
QG	Prescribed amount of oxygen is greater than four liters per minute (LPM)
RB	Replacement and repair
RR	Rental
RT	Right side
TW	Back-up equipment

Modifiers to Designate Item Number

Allowable modifiers for DME item numbers that providers are required to use on DME claims are listed in the following table. Item numbers are assigned on approved PA requests. For items 14 through 25, providers will be required to list two national modifiers to accurately designate the item number.

Modifier	Description
U1	First item
U2	Second item
U3	Third item
U4	Fourth item
U5	Fifth item
U6	Sixth item
U7	Seventh item
U8	Eighth item
U9	Ninth item
UA	10th item
UB	11th item
UC	12th item
UD	13th item
UD + U1	14th item
UD + U2	15th item
UD + U3	16th item
UD + U4	17th item
UD + U5	18th item
UD + U6	19th item
UD + U7	20th item
UD + U8	21st item
UD + U9	22nd item
UD + UA	23rd item
UD + UB	24th item
UD + UC	25th item

Place of Service Codes

Allowable POS codes for DME services are listed in the following table.

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
15	Mobile Unit

20	Urgent Care Facility
22	Outpatient Hospital
23	Emergency Room - Hospital
24	Ambulatory Surgical Center
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
50	Federally Qualified Health Center
54	Intermediate Care Facility/Mentally Retarded
60	Mass Immunization Center
62	Comprehensive Outpatient Rehabilitation Facility
65	End-Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service

Procedure Codes

Covered DME services are identified by HCPCS procedure codes listed in the DME maximum allowable fee index. Providers are required to indicate procedure codes that are allowable for the DOS and that most accurately identify the service on PA requests, claims, and adjustment requests.

Replacement Parts for Cochlear Implant and Bone-Anchored Hearing Devices

The following cochlear implant device and bone-anchored hearing device replacement parts are reimbursable under procedure codes L8615, L8616, L8617, L8618, and L7510.

Cochlear Implant Devices	
Replacement Parts	**Life Expectancy**
Battery charger kit	1 per 3 years
Cochlear auxiliary cable adapter	1 per 3 years
Cochlear belt clip	1 per 3 years
Cochlear harness extension adapter	1 per 3 years
Cochlear signal checker	1 per 3 years
Disposable batteries for ear-level processors	72 per 6 months
Headset (three-piece component)	1 per 3 years
Headset cochlear coil (individual component)	1 per year
Headset cochlear magnet (individual component)	1 per year
Headset microphone (individual component)	1 per year

Headset cable or cord	4 per 6 months
Microphone cover	1 per year
Pouch	1 per year
Rechargeable batteries (per set of two)	1 per year
Transmitter cable or cord	4 per 6 months

Bone-Anchored Hearing Devices	
Replacement Parts	Life Expectancy
Headband	1 per year
Batteries	72 per 6 months
Processor	1 per 5 years

Covered Services and Requirements

Benchmark Plan Covered Durable Medical Equipment

DME covered under the BadgerCare Plus Benchmark Plan is the same as that covered under the BadgerCare Plus Standard Plan except for the following:

- Bone-anchored hearing devices (surgeries and materials).
- Cochlear implants (surgeries and materials).
- Hearing aids and hearing aid batteries.

Bone-anchored hearing devices, cochlear implants, hearing aids, and hearing aid batteries are not covered under the Benchmark Plan.

Service Limitations

The Benchmark Plan will reimburse up to $2,500.00 for DME per member per enrollment year.

Benchmark Plan Enrollment Year

Under the BadgerCare Plus Benchmark Plan, an enrollment year is defined as the continuous 12-month period beginning the first day of the calendar month in which a member is enrolled in the Benchmark Plan and ending on the last day of the 12th calendar month.

For example, a member completes her BadgerCare Plus application materials by September 25, 2008. During the month of October, the DHS reviews the application materials and determines that the member is eligible for the Benchmark Plan effective September 1, 2008, the first day of the calendar month that the application materials were completed; however, the enrollment year for this member will not begin until October 1, 2008, the first day of the calendar month in which the DHS actively enrolled the member in the Benchmark Plan. The Benchmark Plan enrollment year for this member is defined as October 1, 2008, through September 30, 2009. Services received after eligibility is established and before the enrollment year begins are covered under the Benchmark Plan but do not count toward the service limitations.

Subsequent enrollment years begin on the first day of the calendar month immediately following the end of the previous enrollment year, if there is no coverage gap. If there is a coverage gap for more than one day, the enrollment year will reset to begin on the first day of the month in which the DHS re-enrolls the member into the Benchmark Plan.

If a member switches from the Benchmark Plan to the BadgerCare Plus Standard Plan, the Benchmark Plan enrollment year does not reset. For example, a member's enrollment year under the Benchmark Plan begins March 1, 2008. During the third month, the member's income status changes and she is now eligible for the Standard Plan effective June 1, 2008. During August, the DHS determines that the member is no longer eligible for the Standard Plan and effective September 1, 2008, the member returns to the Benchmark Plan. Since there is not a gap in coverage, the initial Benchmark Plan enrollment year is still active. The member must adhere to limits for services received while covered under the Benchmark Plan during the enrollment year period March 1, 2008, through February 28, 2009.

The Benchmark Plan enrollment year is the time period used to determine service limitations for members in the Benchmark Plan. Services received while covered under the Standard Plan do not count toward the enrollment year service limitations in the Benchmark Plan and vice versa. If a member switches between the two plans during one enrollment year, service limitations will accumulate separately under each plan.

Core Plan Covered Durable Medical Equipment

DME covered under the BadgerCare Plus Core Plan for Childless Adults is the same as the DME covered under the BadgerCare Plus Benchmark Plan. Cochlear implants and bone-anchored hearing devices are not covered under the Core Plan.

Service Limitations for the Core Plan

The Core Plan will reimburse up to $2,500.00 for DME per member per enrollment year. The cost of DME repairs counts toward this service limitation. DME that exceeds $2,500.00 is considered noncovered and any costs after the $2,500.00 threshold are the responsibility of the member.

Core Plan Enrollment Year

The BadgerCare Plus Core Plan enrollment year is the time period used to determine service limitations for members in the Core Plan. Services received while covered under the BadgerCare Plus Standard Plan or the BadgerCare Plus Benchmark Plan do not count toward the enrollment year service limitations in the Core Plan and vice versa.

The Core Plan enrollment year is defined as the continuous 12-month period beginning on the first day of enrollment (either the first or the 15th day of the month) in the Core Plan and ending on the last day of the 12th full calendar month.

The Core Plan enrollment year will reset if there is a gap in coverage for more than a full calendar month. For example, a member's situation changes for a few months and the member is temporarily ineligible for the Core Plan. More than one month later, the member becomes eligible again and re-applies for the Core Plan. When the member's application is approved and Core Plan coverage begins, the Core Plan enrollment year resets. Core Plan service limitations for this member also reset.

When a member exceeds his or her service limitations, the service is considered noncovered and the member is responsible for payment of the service.

Enrollment Year for Transitioned Members

For persons who transitioned from Milwaukee's GAMP and certain other counties' GA medical programs on January 1, 2009, the Core Plan enrollment year will be a continuous period of enrollment that begins on January 1, 2009, and ends during January, February, or March of 2010. (The earliest end date for the enrollment year would be January 1, 2010, and the latest end date would be March 31, 2010.) The enrollment year is staggered over three months to allow adequate time for the DHS to process renewal applications.

If a member who transitioned from GAMP or GA loses eligibility for the Core Plan, that member cannot reapply for enrollment in the Core Plan until June 15, 2009, when the plan becomes available for new members.

If the member becomes eligible for and switches into the Benchmark Plan, the member's enrollment year will reset under the Benchmark Plan.

Note: When the member's 2010 enrollment year begins, it will follow the same conditions as that of a nontransitioned member.

Enrollment Year for Members Switching Between the Core Plan and the Benchmark Plan

Special conditions apply to the enrollment year for members who switch between the Core Plan and the Benchmark Plan.

If a member is in the Core Plan and subsequently becomes eligible for and enrolls in the Benchmark Plan, his or her enrollment year in the Core Plan automatically ends. A new enrollment year under the Core Plan will begin if the member re-enrolls in the Core Plan at a later date.

If a member is in the Benchmark Plan, becomes temporarily eligible for and enrolls in the Core Plan, then switches back into the Benchmark Plan, the enrollment year for the Benchmark Plan will reset if there has been a gap in coverage for more than one full calendar month. If there has not been a gap in coverage for more than one full calendar month, and if the date of re-enrollment in the Benchmark Plan is within the initially established enrollment year dates, the Benchmark Plan enrollment year will not reset.

For example, a member is enrolled in the Benchmark Plan as of July 1, 2009. That member's Benchmark Plan enrollment year is defined as July 1, 2009, through June 30, 2010. The member loses her eligibility for the Benchmark Plan as of September 30, 2009. The member applies for the Core Plan and her enrollment begins on October 15, 2009. (The gap in coverage for this member is less than one full calendar month.) The member becomes ineligible for the Core Plan and the member's enrollment ends on March 31, 2010. The member re-enrolls in the Benchmark Plan, effective April 1, 2010. (The date of re-enrollment in the Benchmark Plan is within the dates of the previous Benchmark Plan enrollment year.) The member's enrollment year under the Benchmark Plan does not reset and is still defined as July 1, 2009 through June 30, 2010.

Definition

DME are medically necessary devices that can withstand repeated use. All DME primarily serve a medical purpose and are not useful to a person without an illness or injury. The item must be necessary and reasonable for treating an illness, injury, or for improving the function of a malformed body member. All items must be suitable for use in the member's place of residence.

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.

Emergencies

Certain program requirements and reimbursement procedures are modified in emergency situations. Emergency services are defined in DHS 101.03(52), Wis. Admin. Code, as "those services that are necessary to prevent the death or serious impairment of the health of the individual." Emergency services are not reimbursed unless they are covered services.

Additional definitions and procedures for emergencies exist in other situations, such as dental and mental health.

Program requirements and reimbursement procedures may be modified in the following ways:

- PA or other program requirements may be waived in emergency situations.
- Noncertified providers may be reimbursed for emergency services.
- Non-U.S. citizens may be eligible for covered services in emergency situations.

Life Expectancy

The CMS has established that the reasonable useful lifetime of most DME is five years. The DME maximum allowable fee index indicates the life expectancy for each DME item. Life expectancy is measured based on when the item is delivered to the member, not the age of the item itself.

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.

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 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.

Prescriptions

All DME, including repairs, must be prescribed by a physician, podiatrist, nurse practitioner, or chiropractor. Podiatrists, nurse practitioners, and chiropractors may prescribe DME only within their scope of practice. The prescribed item must be necessary and reasonable for treating an illness, injury, or for improving the function of a malformed body member. All items must be suitable for use in the member's place of residence.

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, claims submission, prescription, and documentation requirements.

Rental Guidelines

The following guidelines apply to all DME except for certain, specified items of respiratory equipment and home health equipment.

Initial Rental Period

The daily rental max fee rate is payable monthly to providers until the purchase price max fee listed in the DME maximum allowable fee index is reached. Use HCPCS modifier "RR" (Rental) with the equipment procedure code on the claim form.

Continued Rental Period

When cumulative rental payments are equal to the purchase price max fee of the item, providers will continue to receive rental reimbursement for the equipment if it is determined to be most beneficial for the member. However, providers may not submit claims for repair and nonroutine service of the equipment. Repair and nonroutine service is considered part of the rental reimbursement and is not separately reimbursable.

Equipment Purchase

If at any time it is determined that it is most beneficial for the member that the DME be purchased, the provider will be reimbursed the remaining portion of the purchase price max fee and rental reimbursement will end. The provider may then submit claims only for repair and nonroutine service of the equipment.

Providers may be reimbursed for repair or nonroutine services no earlier than six months (181 days) after the end of the initial rental period, extended rental period, or the date of conversion to purchase.

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.
- 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 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.

Services That Do Not Meet Program Requirements

As stated in DHS 107.02(2), Wis. Admin. Code, BadgerCare Plus 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, the PRO 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.

HealthCheck "Other Services"

Definition of HealthCheck "Other Services"

HealthCheck is a federally mandated program known nationally as EPSDT. HealthCheck services consist of a comprehensive health screening of members under 21 years of age. On occasion, a HealthCheck screening may identify the need for health care services that are not otherwise covered by or that exceed coverage limitations. These services are called HealthCheck "Other Services." Federal law requires that these services be reimbursed through HealthCheck "Other Services" if they are medically necessary and prior authorized. The purpose of HealthCheck "Other Services" is to assure that medically necessary medical services are available to BadgerCare Plus Standard Plan and Medicaid members under 21 years of age.

HealthCheck "Other Services" are not available to members enrolled in the BadgerCare Plus Benchmark Plan except for child/adolescent mental health day treatment.

Prior Authorization

To receive PA for HealthCheck "Other Services," providers are required to submit a PA request via the ForwardHealth Portal or to submit the following via fax or mail:

- A completed PA/RF (or PA/DRF, or PA/HIAS1).
  - The provider should mark the checkbox titled "HealthCheck Other Services" at the top of the form.
  - The provider may omit the procedure code if he or she is uncertain what it is. The ForwardHealth consultant will assign one for approved services.
- The appropriate service-specific PA attachment.
- Verification that a comprehensive HealthCheck screening has been provided within 365 days prior to ForwardHealth's receipt of the PA request. The date and provider of the screening must be indicated.
- Necessary supporting documentation.

Providers may call Provider Services for more information about HealthCheck "Other Services" and to determine the appropriate PA attachment.

Requirements

For a service to be reimbursed through HealthCheck "Other Services," the following requirements must be met:

- The condition being treated is identified in a HealthCheck screening that occurred within 365 days of the PA request for the service.
- The service is provided to a member who is under 21 years of age.
- The service may be covered under federal Medicaid law.
- The service is medically necessary and reasonable.
- The service is prior authorized before it is provided.
- Services currently covered are not considered acceptable to treat the identified condition.

BadgerCare Plus has the authority to do all of the following:

- Review the medical necessity of all requests.
- Establish criteria for the provision of such services.
- Determine the amount, duration, and scope of services as long as limitations are reasonable and maintain the preventive intent of the HealthCheck program.

Home Health Equipment

Adaptive Equipment

Covered adaptive equipment is limited to basic items for independence in self-care tasks. Selected adaptive equipment are covered when the equipment is the following:

- Medically necessary.
- Prescribed by a physician.
- Required for a member's independence in self-care tasks.

As stated in DHS 107.24(2)(c), Wis. Admin. Code, adaptive equipment is the category of DME used in the home to assist a person with a disability to achieve independence in performing daily self-care tasks.

ForwardHealth has assigned modifiers "U1"-"U9" and "UA"-"UD" to HCPCS procedure code A9900 (Miscellaneous DME supply, accessory, and/or service component of another HCPCS code). The "U" modifiers used with procedure code A9900 identify specific pieces of adaptive equipment.

Noncovered Adaptive Equipment

The following adaptive equipment items are not covered:

- Items determined not to be medically necessary, for example:
  - Duplicative adaptive equipment (more than one item per member or items that serve the same purpose).
  - Items or equipment that may be helpful but do not significantly change the member's level of functional independence.
- Adaptive equipment for homemaking, recreation, or other activities, such as adaptive cutting boards, key holders, page turners, book holders, and doorknob extensions.
- Items that are commercially available, such as pencil grips, elastic shoe laces, jar openers, and flexible mounting hardware to hold appliances, telephones, beverages, etc.

An Overview

Home health equipment is DME used in a member's home to increase the independence of a disabled person or modify certain disabling conditions. Examples of home health equipment are hospital beds, adaptive hygiene equipment, food pumps, glucose monitors, adaptive positioning equipment, and adaptive eating utensils.

Augmentative Communication Devices

Rentals

When submitting claims to ForwardHealth for the rental of any augmentative communication device, a quantity of "1.0" equals one day.

Providers may submit claims for the rental of augmentative communication devices by indicating a range of dates. The DOS within the range must be consecutive and within the same calendar month. In addition, the procedure code, modifier, POS code, diagnosis code, rendering provider, and charge must be the same for all DOS. To indicate a range of dates, the provider should enter the first DOS in the "From" field. The last DOS within the range should be indicated in the "To" field by listing only the date of the month. For example, "01/01/09" in the "From" field and "30" in the "To" field would indicate a range from January 1, 2009, to January 30, 2009. In this

case, the quantity would equal "30.0."

Providers are required to indicate modifier "RR" (Rental) when submitting claims for the rental of augmentative communication devices.

Providers are reminded to indicate their usual and customary charge when submitting claims to ForwardHealth. Wisconsin Medicaid reimburses the lesser of the provider's usual and customary charge or the maximum allowable fee established by ForwardHealth.

Member Booklet

A booklet titled "A Guide to Obtaining Augmentative Communication Devices and Accessories Through Wisconsin Medicaid" is available to providers, members, and their families. This booklet covers a wide variety of topics, including a list of devices that are covered and a description of the PA process.

Additional copies of the booklet may be ordered by writing to the following address:

Forms Manager
Division of Health Care Access and Accountability
Bureau of Fee-for-Service Health Care Benefits
PO Box 309
Madison WI 53701-0309

Providers should indicate the booklet number (P-11065) and the quantity needed when requesting the guide.

Repairs

Procedure code V5336 is used for repairs or modifications due to a mechanical failure or to enhance the physical operating condition of the augmentative communication device. This procedure code does not cover the creation of communication pages or any other services involved in programming the device by an SLP provider.

Breast Pumps

According to the criteria listed below, breast pumps are covered. *All* of the following criteria must be met:

- The member recently delivered a baby and a physician has ordered or recommended mother's breastmilk for the infant.
- Documentation indicates there is the potential for adequate milk production.
- Documentation indicates there is a long-term need for and planned use of the breast pump to obtain a milk supply for the infant.
- The member is capable of being trained to use the breast pump as indicated by the physician or provider.
- Current or expected physical separation of mother and infant (e.g., illness, hospitalization, work) would make breastfeeding difficult or there is difficulty with "latch on" due to physical, emotional, or developmental problems of the mother or infant.

The provider who supplies the breast pump equipment is required to obtain and maintain on file the physician's orders documenting the clinical requirements of the individual's need for a breast pump.

The maximum allowable fees include starter/accessory kits for all breast pumps. This includes single or double pumping kits. These kits are dispensed at the time the member is given the initial breast pump and cannot be reused by another individual.

For Purchase

Manual breast pumps of any type, including pedal powered, are covered under procedure code E0602.

All types of electric breast pumps, AC or DC, are covered under procedure code E0603, that meet the following specifications:

- The pump must utilize suction and rhythm equivalent to the hospital-grade breast pump. This means it must have an adjustable suction pressure between 100 mm Hg and 250 mm Hg and a mechanism to prevent suction beyond 250 mm Hg.
- The pump must have an adjustable pumping speed capable of reaching 60 cycles per minute.

Breast pumps that do not meet these specifications are not covered.

For Rental

Heavy duty, hospital grade electric breast pumps are covered under procedure code E0604.

For the rental of a breast pump, a higher per day reimbursement rate is allowed during the initial 30-day rental period for the costs associated with providing a new starter/accessory kit.

To obtain reimbursement for the new starter/accessory kit, providers are reminded to use modifier "KH" with procedure code E0604 for the initial 30-day rental period. Providers using the "KH" modifier will receive a total reimbursement rate of $3.06 per day during the initial 30-day rental period to cover costs for the initial starter/accessory kit as well as the breast pump rental.

Modifier "KH" may only be used with procedure code E0604 for the initial 30-day rental period. Claims with the "KH" modifier beyond the initial 30-day rental period for procedure code E0604 are denied.

Breast Pump Order Form

Providers are recommended to use the Breast Pump Order form; however, the use of this form is voluntary and providers may develop their own form as long as it includes all the information on the form.

The Breast Pump Order form is to be completed by the physician, given to the provider of the breast pump, and kept in the member's medical file as required under DHS 106.02(9), Wis. Admin. Code.

Diabetic Equipment

Blood glucose monitoring equipment and supplies are covered when the medically necessary requirements according to DHS 101.03 (96m), Wis. Admin. Code, are met:

- The member is under the care of a physician or nurse practitioner.
- The frequency of testing is determined by the physician or nurse practitioner treating the member's diabetes.
- The appropriate documentation is maintained in the member's medical record, and is available to the DHS on request, per DHS 106.02(9), Wis. Admin. Code.

A home blood glucose monitor (a device for monitoring blood sugar values) is covered when *all* the following conditions are met:

- The member is being treated by a physician or nurse practitioner for diabetes ICD-9-CM codes 250.00-250.9, 648.0 and 648.8.
- The member is insulin dependent and this condition is noted in the physician's orders which are maintained on file.
- The member's diabetic equipment and supplies have been ordered by the treating physician or nurse practitioner.
- The member, or the member's caregiver, has completed or is scheduled to begin training on how to use the equipment.
- The member, or the member's caregiver, is capable of using the test results to verify the member's glycemic control.

Additional Requirements for the Special Features Home Blood Glucose Monitor

Blood glucose monitors with additional features (i.e. voice synthesizers and specially designed arrangements of supplies and materials for the visually impaired) are covered when all the following conditions are met:

- All coverage requirements listed above for the standard home blood glucose monitors are met.
- The member's impairment is severe enough to require use of this special monitoring system.
- The member must be able to use the blood glucose monitor with special features.

Prescriber's Orders

The physician or nurse practitioner treating the member's diabetes must include the following information on an order:

- The items, supplies, and accessories needed.
- The quantities to be dispensed.
- The frequency of use.

In addition, the provider is responsible for documenting the diagnosis (ICD-9-CM code or narrative) of diabetes (250.00-250.9, 648.0 and 648.8). The provider is also responsible for documenting the source of this information, e.g. the prescriber or the patient.

Other requirements and limitations for the prescriber's orders for diabetic equipment and supplies include:

- The order is valid for up to 12 months must be renewed with new written orders by the treating physician or nurse practitioner.
- For continued coverage of test strips and lancets, the treating physician or nurse practitioner, the member, or the member's caregiver must initiate the renewal order. A supplier may not initiate the renewal order for these items.
- The renewal order must contain the same information as described above for prescriber's orders.
- An initial or renewal order for supplies and equipment "as needed" is not valid.

Modifiers for Diabetic Equipment

When submitting claims to ForwardHealth for all diabetic monitors, accessories, and supplies, follow these procedures:

- Enter one of the following modifiers in Element 24D of the 1500 Health Insurance Claim Form for *each* procedure code billed:
  - "KS": Non-insulin treated diabetes member. (Type II diabetes)
  - "KX": Insulin-treated diabetes member. (Type I diabetes)
- Include the ICD-9-CM diagnosis code (250.00-250.9, 648.0, and 648.8) describing the condition that necessitates glucose testing in Element 24E of the 1500 Health Insurance Claim Form for *each* procedure code indicated.

Long-Term Rentals for Certain Infusion Pumps

The following table outlines specific repair and service guidelines for procedure codes B9002, B9004, B9006, E0619, E0781, and E0791:

Procedure code	Description	Initial rental period		Purchase max fee	Extended rental period	
		Modifier	Daily rental max fee		Modifier	Daily rental max fee
B9002	Enteral nutrition infusion pump with alarm	RR[1]	$2.49	$1121.97	During the extended rental period for	
B9004	Parenteral nutrition infusion pump, portable	RR	$4.97	$2261.35		
B9006	Parenteral nutrition infusion pump, stationary	RR	$4.97	$2261.35		

E0619	Apnea monitor, with recording feature	RR	$5.06	$1890.69	equipment listed in this table, providers will be reimbursed only for repair and nonroutine service using the appropriate procedure codes.
E0781	Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient	RR	$7.53	$3426.15	
E0791	Parenteral infusion pump, stationary, single or multichannel	RR	$7.90	$3594.50	

[1] RR = Rental.

Initial Rental Period

The daily rental max fee rate is payable monthly to providers until the purchase price max fee of the DME is reached. Use HCPCS modifier "RR" (Rental) with the equipment procedure code on the claim form.

Used Equipment

If used equipment is dispensed at the beginning of the initial rental period, the provider must comply with one of the following:

- Supply the recipient with working equipment in good condition for five years (the life expectancy of the same type of new equipment).
- Substitute new equipment by the end of the initial rental period.

A new initial rental period may only be started with new equipment if the DME reaches its life expectancy, the member still needs the equipment, and one of the following is true:

- The DME no longer functions properly.
- The DME can no longer be repaired.

A PA request must be filed for each new initial rental period and must include all of the following:

- The original delivery date.
- The age of the equipment.
- An explanation of why the equipment is no longer functional.

Extended Rental Period

When cumulative rental payments total the purchase price max fee of the item, the extended rental period begins. Providers must continue to provide the DME to the member until one of the following happens:

- The life expectancy of the equipment is reached and a different piece of equipment is dispensed.
- The member no longer needs the equipment.

A new PA request for replacement equipment will be considered if the DME has reached its life expectancy.

During the extended rental period, providers may be reimbursed for repair or nonroutine services only. Providers may begin receiving reimbursement for repair or nonroutine services no earlier than six months (181 days) after the end of the initial rental period or after the remaining portion up to the purchase price max fee is paid to the provider. After the purchase price max fee of the equipment has been reached, ownership of the equipment remains with the provider. The provider is responsible for long-term support over the life of the DME.

Passive Motion Exercise Device

Rental of passive motion devices is covered with PA for members who receive a total knee replacement. The member must begin using the device within two days after surgery for coverage. ForwardHealth has determined that more than 21 days of rental of a passive motion exercise device per knee surgery is not medically necessary.

Rental of the device for use only in the member's home is covered.

Implants

Cochlear Implants and Bone-Anchored Hearing Devices

Separate Reimbursement

DME providers are separately reimbursed for cochlear implants and bone-anchored hearing devices when the implant surgery is performed in an ASC or outpatient hospital and there is an approved or modified PA request on file from the performing surgeon. The POS codes for these facilities are as follows:

- "11" (Office).
- "22" (Outpatient Hospital).
- "24" (Ambulatory Surgical Center).

Cochlear Implants

Cochlear equipment manufacturers, outpatient hospitals, and ASCs certified as DME providers should use procedure codes L8614 (Cochlear device, includes all internal and external components) or L8619 (Cochlear implant external speech processor, replacement) when billing for the cochlear implant devices.

Note: For the initial cochlear implant, providers should only bill procedure code L8614. Procedure code L8619 is billed when replacing the external speech processor.

Bone-Anchored Hearing Devices

Bone-anchored hearing device manufacturers, outpatient hospitals, and ASCs certified as DME providers should use procedure code L8690 (Auditory osseointegrated device, includes all internal and external components) when requesting PA and claims submissions for bone-anchored hearing devices.

If a member uses a processor and headband rather than the implanted device, providers are required to obtain PA for the processor and headband equipment and should use procedure code V5298 (Hearing aid, not otherwise classified).

Hearing Device Repairs and Replacements

DME providers should use the following procedure codes when billing for repairs of and replacement parts for cochlear and bone-anchored hearing devices:

- L8615 (Headset/headpiece for use with cochlear implant device, replacement).
- L8616 (Microphone for use with cochlear implant device, replacement).
- L8617 (Transmitting coil for use with cochlear implant device, replacement).
- L8618 (Transmitter cable for use with cochlear implant device, replacement).
- L7510 (Repair of prosthetic device, repair or replace minor parts). Use this procedure code for all other repairs or replacement parts not listed above.

Prior authorization is required if the total repair exceeds $150.00.

Note: "U" modifiers are assigned to multiple items listed on PA requests to indicate separate approval of DME items (i.e., accessories).

Facilities Must Be Medicaid-Certified Durable Medical Equipment Providers

Cochlear and bone-anchored hearing device manufacturers, outpatient hospitals, and ASCs are required to obtain separate Medicaid certification and a unique provider number as a DME provider before billing for the cochlear or bone-anchored hearing devices. The device manufacturers, outpatient hospitals, and ASCs are required to indicate their DME provider number on the 1500 Health Insurance Claim Form or 837P electronic transaction when submitting claims for reimbursement.

Note: Audiologists and speech and hearing clinics, as well as DME providers, may submit PA requests and bill for replacement parts and accessories.

Vagus Nerve Stimulators

Certified medical equipment vendors are separately reimbursed for vagus nerve stimulators when the implant surgery is performed in an ASC or outpatient hospital and when the performing surgeon has an approved PA for the surgery. The POS codes for these facilities are as follows:

- "22" (Outpatient Hospital).
- "24" (Ambulatory Surgical Center).

Providers are required to use one of the following procedure codes when submitting claims for the vagus nerve stimulator device:

- L8685 (Implantable neurostimulator pulse generator, single array, rechargeable, includes extension).
- L8686 (Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension).
- L8687 (Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension).
- L8688 (Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension).

The above procedure codes are reimbursable only for the vagus nerve stimulator device; no other implant device is reimbursed under these procedure codes.

Providers are required to use procedure code L8680 (Implantable neurostimulator electrode, each) when submitting claims for vagus nerve stimulator electrodes. Procedure code L8680 includes the tunneling tool.

On the claim form, indicate the date of the surgery as the DOS.

Noncovered Services

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.

Noncovered Durable Medical Equipment and Services

BadgerCare Plus does not cover the following durable medical equipment and services. PA requests for these items and services are denied. This list is not all-inclusive and may be revised periodically:

- **Foot orthoses or orthopedic or corrective shoes for the following conditions:**
  - Flattened arches, regardless of the underlying pathology.
  - Incomplete dislocation or subluxation metatarsalgia with no associated deformities.
  - Arthritis with no associated deformities.
  - Hypoallergenic conditions.
- **Services denied by *Medicare* for lack of medical necessity.**
- **Items which are not primarily medical in nature, including:**
  - Air conditioners and air purifiers.
  - Auditory/listening music programs.
  - Baby/infant exercise saucers.
  - Ceiling lifts.
  - Cleaning and disinfectant supplies.
  - Cold air humidifiers.
  - Computers.
  - Copy machines.
  - Dehumidifiers.
  - Educational learning computer programs.
  - Electric page turners.
  - Emergency alert contact systems/services.
  - Exercise and fitness equipment (stationary bicycles, treadmills, pulleys, weights, exercise therapy mats, rowing machines, physioballs, therapy putty, or therapy bands).
  - Extended warranty.
  - Fax machine.
  - Home and environmental modifications (electronic or mechanical devices to control lighting, appliances, etc.).
  - Homemaking equipment (microwaves, food carts, cutting boards, or other adaptive equipment for cooking, cleaning, etc.).
  - Hydrocollator equipment or other devices for heat or cold.
  - Hypoallergenic items including bedding.
  - Intercom monitors.
  - Laptop computers.
  - Lights, horns, flags, or signs for mobility bases.
  - Masks other than those allowable with Medicaid covered respiratory equipment.
  - Pacemaker monitors.
  - Playground and recreation equipment (swings, jungle gyms, tunnels, parachutes, obstacle courses, tricycles, or other adapted or specialized toys).
  - Power door openers.
  - Reading machines.

    - Restraints.
    - Ring walkers.
    - Safety equipment (gait belts, harnesses, vests, alarm systems, wanderguard, medical alert bracelets or other types of monitoring equipment, or fences).
    - Service animals.
    - Telephone modems.
    - Telephones, cell phones, and speaker phones.
    - Van or vehicle modifications.
    - Video games.
- **Items which are not appropriate for home usage, including:**
    - Oscillating beds.
    - Paraffin baths.
- **Items which are not generally accepted by the medical profession as being therapeutically effective.** These items include heat and massage foam cushion pads.
- **Items which do not contribute to the improvement of the member's medical condition, including:**
    - Alcohol swabs.
    - Alcohol wipes.
    - Assistive listening devices, as follows:
        - Telephone amplifier, any type.
        - Alerting, any type.
        - Television amplifier, any type.
        - Television caption decoder.
        - Telecommunications Device for the Deaf (TDD).
    - Baskets or backpacks for use with walkers, wheelchairs, or scooters.
    - Bolsters and wedges (pillows, such as cervical and/or lumbar supports).
    - Canopies, umbrellas, or sun shades (free standing or for attachment to a mobility base).
    - Cushion lift power seats.
    - Disposable washcloths.
    - Disposable wipes or diaper wipes.
    - Elevators, stair glides, or stair lifts.
    - Equipment, supplies, or products designed to change the calming or stimulating factors in any environment.
    - Chlorhexidine topical antiseptic.
    - Iodine solution.
    - Iodine swabs.
    - Moisturizing skin cream or lotion.
    - Over-the-bed or bedside tables.
    - Ramps (home, wheelchair, van/vehicle lifts or carriers).
    - Seat lift chairs.
    - Standers with hydraulic/automated lift mechanisms.
    - Standers with mobility bases.
    - Sunscreens.
    - Trays for walkers, standers, and gait trainers.
    - Weighted blankets and/or vests.
    - Wheelchair lifts.
    - Wheelchair gloves.
    - Whirlpools or hot tubs.
    - Wigs.
- **Repair, maintenance, or modification of rented durable medical equipment.**
- **Delivery or set-up charges for equipment as a separate service, including:**
    - Installation of equipment or labor charges to mount equipment in a home.
    - Shipping and handling as a separate charge.
    - Travel to and from the member's residence.
- **Fitting, adapting, adjusting, or modifying a prosthetic or orthotic device or corrective or orthopedic shoes as a separate service.**

- **All repairs of a hearing aid or other assistive listening device performed by a dealer within 12 months after the purchase of the hearing aid or other assistive listening device.** These are included in the purchase payment and are not separately reimbursable.
- **Hearing aid or other assistive listening device batteries which are provided in excess of the guidelines enumerated in the Hearing services area.**
- **Items that are provided for the purpose of enhancing the prospects of fertility in males or females.**
- **Impotence devices, including, but not limited to, penile prostheses.**
- **Testicular prosthesis.**
- **Food.**
- **Infant formula and enteral nutritional products except as allowed under DHS 107.10(2)(c) Wis. Admin. Code.**

As stated in DFS 107.10(2)(c), Wis. Admin. Code, exceptions include: Medically necessary, specially formulated nutritional supplements and replacement products, including enteral and parenteral products used for the treatment of severe health conditions, such as pathologies of the gastrointestinal tract or metabolic disorders.

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 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 his or her local county or tribal agency if transportation is needed.
- 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

Nursing Home Members and Durable Medical Equipment

An Overview

The DME maximum allowable fee index indicates which DME items are separately reimbursable for nursing home members. Most DME is reimbursed by Wisconsin Medicaid through the nursing home's daily rate or as a nursing home ancillary cost.

Exceptional Supplies

Most DME and DMS are included in the daily rate for nursing homes and are not separately reimbursable. However, providers may receive reimbursement for certain DME and DMS provided to nursing home members whose medical conditions make them eligible for exceptional supplies. As defined in DHS 101.03(96m) and DHS 107.24(3), Wis. Admin. Code, members who have exceptional supply needs may either:

- Be ventilator dependent.
- Have a tracheostomy that requires extensive care at least twice in an eight-hour period of time.

The exceptional supply procedure code E1399 (Durable medical equipment, miscellaneous) allows Wisconsin Medicaid to separately reimburse certain supplies and equipment that are usually included in the nursing home daily rate.

Exceptional supplies require PA. Unnecessary, unreasonable, or inappropriate items as determined by nurse consultants are not covered.

Providers are required to document the need for exceptional supplies in the physician's orders, progress notes, and treatment sheets.

Respiratory Equipment

The DME maximum allowable fee index indicates which oxygen-related services are separately reimbursable in a nursing home. For example, nursing homes may be reimbursed for stationary system rental codes E0424, E0439, and E1390 even if the member is using equipment that is owned by the nursing home (e.g. liquid oxygen administered from a wall unit.)

Rental of respiratory equipment for a nursing home resident is reimbursed only for the days it is actually used by the member, except for Medicare approved rental services. This policy is monitored on a postpayment basis.

Repairs of oxygen equipment in a nursing home is not separately reimbursable.

Wheelchairs

Wheelchairs Reimbursed Through the Nursing Home Daily Rate

Wheelchairs must be provided by nursing facilities in sufficient quantity to meet the health needs of patients who are Medicaid or BadgerCare Plus members.

Nursing homes that specialize in providing rehabilitative services and treatment for the developmentally or physically disabled, or both, shall provide the special equipment, including wheelchairs adapted to the member's disability, and other adaptive prosthetics, orthotics, and equipment necessary for the provision of these services. The facility must provide replacement wheelchairs for members who have changing wheelchair needs. All standard manual wheelchairs are reimbursed through the nursing home daily rate.

Wheelchairs Separately Reimbursable

Powered mobility equipment and wheelchair custom positioning systems are not included in the nursing home daily rate. They are separately reimbursable, when medically necessary and when prior authorized by Wisconsin Medicaid under the following conditions:

- A medically necessary wheelchair custom positioning system is personalized in nature and custom-made to fit one member only, and is used only by that member.
- The powered mobility equipment is justified by the diagnosis, prognosis, and occupational or vocational activities of the member.

Manual Wheelchair Rentals

Manual wheelchair rentals for members residing in a nursing home are not separately reimbursable.

Custom Seating Systems or Powered Mobility Equipment

Wisconsin Medicaid separately reimburses providers for custom wheelchair positioning exclusive of the wheelchair or for powered mobility equipment for nursing home residents with a physician's prescription when both of the following are true:

- The wheelchair seating system is custom-made to fit one member only, and is used only by that member.
- The wheelchair is justified by the diagnosis, prognosis, and the occupational or vocational activities of the member.

A standard manual wheelchair may be approved if the member is transferring from a nursing home to a more independent setting. In this situation, the PA request must include documentation from the physician of the discharge date and new setting location.

Wheelchair Repairs

Wisconsin Medicaid reimburses providers for repairs to member-owned wheelchairs only when the repairs are for custom positioning equipment or when the repairs are for powered mobility equipment.

Claims submitted for manual wheelchair repairs are denied, even if the wheelchair is owned by the member.

Repair of a member-owned standard manual wheelchair in a nursing home is not covered by Medicaid unless the member is about to transfer to a more independent setting. (The nursing home is, however, responsible for providing a wheelchair as needed.)

Repair of a member-owned power wheelchair or adaptive wheelchair positioning system is reimbursed separately by Medicaid.

Orthopedic Shoes, Modifications, and Transfers

An Overview

Orthopedic or corrective footwear are:

- Shoes attached to a brace or prosthesis; mismatched shoes involving a difference of a full size or more.
- Shoes that are modified to take into account discrepancy in limb length or a rigid foot deformation.

Where there is a discrepancy in limb length, an elevation of a half inch or more is required to qualify as an orthopedic shoe. Arch supports are not considered a brace.

Examples of orthopedic or corrective shoes are supinator and pronator shoes, surgical shoes for braces, and custom-molded shoes.

Orthopedic or corrective shoes are covered for all ages. PA is required for junior and adult orthopedic shoes. Coverage of orthopedic or corrective shoes is based on individual assessment.

Coverage of orthopedic shoes for all ages requires certain diagnoses or medical conditions and applicable ICD-9-CM codes for reimbursement.

Orthopedic Footwear for Infants and Children

Procedure codes L3201, L3202, L3204, L3206, L3208, L3209, L3212, and L3213 for orthopedic footwear for infants and children have diagnosis code restrictions. Wisconsin Medicaid reimburses providers for these procedure codes when one or more of the diagnosis codes is indicated on the claim.

Orthotic Devices

An Overview

Orthoses are devices that limit or assist motion of any segment of the human body. They are designed to stabilize a weakened body part or correct a structural problem. Examples of orthotic devices are arm braces and leg braces.

Wisconsin Medicaid reimburses up to four of the following joints/hardware:knee joints, additions to knee joints, joints used in addition to shoe-ankle-skin-knee orthoses, droplock retainers, and knee controls (condylar pads only). Consult the DME maximum allowable fee index for other limitations.

Prosthetic Procedures

An Overview

Prostheses are devices that replace all or part of a body organ to prevent or correct a physical disability or malfunction. Examples of prostheses are artificial arms, artificial legs, and mastectomy forms.

Compression Garments

Types of Compression Garments

The following types of compression garments are defined below:

- Ready-to-wear compression garments.
- Custom-made compression garments.
- Non-elastic binders.
- Over-the-counter garments.

Ready-to-Wear Gradient Compression Garments

Ready-to-wear gradient compression garments (e.g., Jobst, SigVarus, Venes) are defined as pre-made and having a gradient pressure of 18 mmHg or more. A signed and dated physician's prescription is required to identify both the member's diagnosis and the specific garment needed, as well as to prescribe the amount of compression required. Circumferential and length measurements are required for fitting. Ready-to-wear garments may be equipped with zippers and/or reinforced areas, such as heels.

Allowable HCPCS procedure codes for ready-to-wear gradient compression garments include the following: A6530-A6541, S8421, S8424, S8427, and S8428.

Reimbursement for ready-to-wear gradient compression garments includes the following:

- Consideration for small to extra-large and short to tall ready-to-wear sizes.
- The addition of liners and zippers in ready-to-wear sizes when liners and/or zippers are medically necessary.

Custom-Made Gradient Compression Garments

Custom-made gradient compression garments are defined as garments that are uniquely sized and/or shaped and custom made to fit the exact dimensions of the affected extremity (circumferential measurements every 1.5 to two inches) and provide accurate and consistent gradient compression to manage the member's symptoms. A signed and dated physician's prescription is required to identify both the member's diagnosis and the specific garment needed, as well as to prescribe the amount of compression required. Circumferential and length measurements are required for fitting. Garments with zippers and/or reinforced areas alone are not considered as meeting the definition of a custom-made garment.

The following are examples of custom-made gradient compression garments:

- A garment requiring a unique fit due to the size and/or shape of the member's limb (circumferential measurements every 1.5 to two inches).
- A garment requiring the application of unique materials (e.g., Elvarex). Zippers or reinforced areas, such as heels, are not considered to be unique materials.

Allowable HCPCS procedure codes for custom-made gradient compression garments include the following: A6542, S8420, S8422, S8425, and S8426.

Reimbursement for custom-made gradient compression garments includes the following:

- Consideration for small to extra-large and short to tall ready-to-wear sizes.
- The addition of liners and zippers in ready-to-wear sizes when liners and/or zippers are medically necessary.

Non-Elastic Binders

Non-elastic binders (e.g., CircAid, LegAssist, Reid Sleeve) are defined as garments that provide continuous compression using adjustable hook and loop or buckle straps. A signed and dated physician's prescription is required to identify both the member's diagnosis and the specific garment needed, as well as to prescribe the amount of compression required. Circumferential and length measurements are required for fitting.

HCPCS procedure code S8429 is allowed for non-elastic binder compression garments.

Reimbursement for non-elastic binder compression garments includes the following:

- Consideration for small to extra-large and short to tall ready-to-wear sizes.
- The addition of liners and zippers in ready-to-wear sizes when liners and/or zippers are medically necessary.

Over-the-Counter Garments

Wisconsin Medicaid does not reimburse providers for compression garments purchased over-the-counter with or without a prescription and having a pressure of less than 18 mmHg (e.g., elastic stockings, surgical leggings, anti-embolism stockings T.E.D. hose, or pressure leotards).

Medical Necessity Requirements

Medical necessity is defined in DHS 101.03(96m), Wis. Admin. Code. Individually fitted prescription gradient compression garments (stockings, sleeves, gauntlets, gloves) and non-elastic binders are generally considered medically necessary and do not require PA for members who have any of the following medical conditions:

- Treatment of any of the following documented complications of chronic venous insufficiency:
  - Varicose veins (except spider veins).
  - Stasis dermatitis (venous eczema).
  - Venous ulcers (stasis ulcers).
  - Venous edema.
  - Lipodermatosclerosis.
- Prevention of thrombosis in immobilized persons (e.g., immobilization due to surgery, trauma, debilitation).
- Post thrombotic syndrome (post phlebitic syndrome).
- Chronic lymphedema.
- Edema following surgery, fracture, burns, or other trauma.
- Post sclerotherapy.
- Clinically significant postural hypotension with documented changes in systolic/diastolic pressures.
- Severe edema in pregnancy.
- Edema secondary to paraplegia, quadriplegia, etc.

Additional Requirements for Non-Elastic Binders

In addition to the medical necessity requirements for compression garments, non-elastic binders (e.g., LegAssist, CircAid) may be additionally medically necessary for members who meet the following criteria:

- The member's continuing requirement for bandaging 23 hours per day after completion of intensive lymphedema treatment, *or*
- The member's requirement for nighttime compression,

and

- The documented inability of the member or an available caregiver to perform bandaging independently.

Contraindications

The use of compression garments for members with severe peripheral arterial disease or septic phlebitis is generally contraindicated. Gradient compression garments should be used with caution in the case of decreased or absent sensation in the extremity, allergy to the compression material, moderate peripheral arterial disease, or infection in the extremity. Reimbursement for compression garments for any of these medical conditions requires submission of a PA request if one of these contraindications is present.

Life Expectancy

For all covered compression garments, life expectancy is established at three garments per twelve months. Providers may issue new garments only when a new garment is medically necessary. It is medically necessary to replace a garment when the garment's integrity cannot be restored or repaired. PA is not required until greater than three garments per procedure code per twelve months is medically necessary.

Repair of Durable Medical Equipment

General Policy

All DME repairs must be prescribed by a physician, podiatrist, nurse practitioner, or chiropractor. Podiatrists, nurse practitioners, and chiropractors may prescribe DME only within their scope of practice.

Repairs are per complete service, not per DOS.

An estimate of the cost of providing the complete service must be made before the service is initiated to determine whether or not the service exceeds the dollar threshold for PA. If the provider is unsure whether the total cost of providing the service will exceed the dollar threshold amount in the DME maximum allowable fee index, the provider should submit a PA request to avoid a claim denial for not having PA.

Wisconsin Medicaid does not reimburse for excessive repairs when a new item would be more cost effective, nor approve purchase of a new item when only simple repairs are needed.

Providers should indicate their usual and customary charges when billing for repairs.

Labor Costs for Repairs

Use procedure code E1340 to request reimbursement for each 15 minutes of labor (actual time spent repairing equipment). In other words, if 15 minutes are spent repairing equipment, providers must indicate a unit of one in the unit field on the claim form. Two units in the unit field equal 30 minutes. A decimal point may be used to indicate a fraction of a whole unit. Time indicated on the claim is subject to PA or post-pay review, using industry standards for repair time.

Providers should submit claims with their usual and customary hourly rate. PA is required if the amount to be billed exceeds $84.00.

Travel

Wisconsin Medicaid does not provide additional reimbursement for travel. Thus, providers may not request reimbursement for travel as part of labor time. Submit claims for time actually spent repairing equipment only. Reimbursement for E1340 is all-inclusive, so it includes reimbursement for expenses such as overhead, travel, and delivery.

Parts Used in Repairs

Repair Parts for Home Health Equipment (i.e., Hospital Beds, Lifts, and Commodes)

To request reimbursement from Wisconsin Medicaid for repair parts for hospital beds, lifts, and commodes, providers should select a procedure code for the part as follows:

1. Find in the DME maximum allowable fee index a procedure code matching the specific part.
2. If no procedure code has been found, use E1399 for the part. Procedure code E1399 always requires PA.

Hospital Beds

Procedure Code	Description
E0250	Hospital bed, fixed height, with any type side rails, with mattress
E0251	Hospital bed, fixed height, with any type side rails, without mattress
E0255	Hospital bed, variable height, hi-lo, with any type side rails, with mattress
E0256	Hospital bed, variable height, hi-lo, with any type side rails, without mattress
E0260	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress
E0261	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress
E0265	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, with mattress
E0266	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, without mattress
E0290	Hospital bed, fixed height, without side rails, with mattress
E0291	Hospital bed, fixed height, without side rails, without mattress
E0292	Hospital bed, variable height, hi-lo, without side rails, with mattress
E0293	Hospital bed, variable height, hi-lo, without side rails, without mattress
E0294	Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress
E0295	Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress
E0296	Hospital bed, total electric (head, foot, and height adjustments), without side rails, with mattress
E0297	Hospital bed, total electric (head, foot, and height adjustments), without side rails, without mattress
E0301	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress
E0302	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress
E0303	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress
E0304	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress

Lifts	
Procedure Code	**Description**
E0630	Patient lift, hydraulic, with seat or sling
E0635	Patient lift, electric, with seat or sling

Commode Chairs	
Procedure Code	**Description**
E0163	Commode chair, stationary, with fixed arms
E0164	Commode chair, mobile, with fixed arms
E0168	Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type, each
E0240	Bath/shower chair, with or without wheels, any size
E0247	Transfer bench for tub or toilet with or without commode opening

Repair Parts for Orthotics

Use procedure code L4210 to request reimbursement from Wisconsin Medicaid for parts to repair orthotic devices.

Repair Parts for Prosthetics

Use procedure code L7510 to request reimbursement from Wisconsin Medicaid for parts to repair prosthetic devices.

Repair Parts for Wheelchairs

To request reimbursement from Wisconsin Medicaid for repair parts for wheelchairs, providers should select the procedure code for the part as follows:

1. Find in the DME maximum allowable fee index a procedure code matching the specific part.
2. If no procedure code has been found, use E1399 for the part. Procedure code E1399 always requires PA.

Wheelchairs	
Procedure Code	**Description**
K0001	Standard wheelchair
K0002	Standard hemi (low seat) wheelchair
K0003	Lightweight wheelchair
K0004	High strength, lightweight wheelchair
K0005	Ultralightweight wheelchair
K0006	Heavy-duty wheelchair
K0007	Extra heavy-duty wheelchair
K0009	Other manual wheelchair/base
K0010	Standard-weight frame motorized/power wheelchair
K0011	Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking
K0012	Lighweight portable motorized/power wheelchair
K0014	Other motorized/power wheelchair base
K0800	Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds
K0801	Power operated vehicle, group 1 heavy duty, patient weight capacity 301 to 450 pounds
K0802	Power operated vehicle, group 1 very heavy duty, patient weight capacity 451 to 600 pounds
K0806	Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds
K0807	Power operated vehicle, group 2 heavy duty, patient weight capacity 301 to 450 pounds
K0808	Power operated vehicle, group 2 very heavy duty, patient weight capacity 451 to 600 pounds
K0812	Power operated vehicle, not otherwise classified

Repair Parts for All Other Durable Medical Equipment

When submitting claims to ForwardHealth for repair parts for all other DME, providers should select the procedure code for the part as follows:

1. Find in the DME maximum allowable fee index a procedure code matching the specific part.
2. If no procedure code has been found, use E1399 for the part. Procedure code E1399 always requires PA.

Respiratory Equipment

Chest Wall Oscillation Systems

Wisconsin Medicaid reimburses providers for HCPCS code E0483 (High frequency chest wall oscillation air-pulse generator system, [includes hoses and vest], each) according to a daily rental maximum allowable fee rate until the purchase price max fee has been reached. Once the purchase price max fee has been reached, an extended rental period begins. Ownership of the equipment remains with the provider.

During the extended rental period, the provider is responsible for the long-term support of the equipment, including the lifetime warranty and all services covered under the warranty, such as repairs and any necessary supplies, until the equipment is no longer medically necessary. Once the extended rental period begins, providers will no longer receive reimbursement from Wisconsin Medicaid for this equipment.

Definition

Respiratory equipment is medical equipment used for the administration of oxygen or to assist with respiratory functions. Examples of covered respiratory equipment include oxygen concentrators, oxygen enricher systems, humidifiers, nebulizers, and oxygen tents. The DME maximum allowable fee index lists all covered respiratory equipment.

Extended Rental for Procedure Codes E0445 and E0471

The following table outlines specific repair and service guidelines for procedure codes E0445 and E0471:

Procedure code	Description	Initial rental period		Purchase max fee	Extended rental period	
		Modi-fier	Daily rental max fee		Modifier	Daily rental max fee
E0445	Oximeter device for measuring blood oxygen levels non-invasively	RR[1]	$2.07	$941.85	During the extended rental period for equipment listed in this table, providers will be reimbursed only for repair and nonroutine service using the appropriate procedure codes.	
E0471	Respiratory assist device, bi-level pressure capability, with backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	RR	$6.36	$2893.80		

[1] RR = Rental.

Initial Rental Period

The daily rental max fee rate is payable monthly to providers until the purchase price max fee of the DME is reached. Use HCPCS modifier "RR" (Rental) with the equipment procedure code on the claim form.

Used Equipment

If used equipment is dispensed at the beginning of the initial rental period, the provider must comply with one of the following:

- Supply the member with working equipment in good condition for five years (the life expectancy of the same type of new equipment).
- Substitute new equipment by the end of the initial rental period.

A new initial rental period may only be started with new equipment if the DME reaches its life expectancy, the member still needs the equipment, and one of the following is true:

- The DME no longer functions properly.
- The DME can no longer be repaired.

A PA request must be filed for each new initial rental period and must include all of the following:

- The original delivery date.
- The age of the equipment.
- An explanation of why the equipment is no longer functional.

Extended Rental Period

When cumulative rental payments total the purchase price max fee of the item, the extended rental period begins. Providers must continue to provide the DME to the member until one of the following happens:

- The life expectancy of the equipment is reached and a different piece of equipment is dispensed.
- The member no longer needs the equipment.

A new PA request for replacement equipment will be considered if the DME has reached its life expectancy.

During the extended rental period, providers may be reimbursed for repair or nonroutine services only. Providers may begin receiving reimbursement for repair or nonroutine services no earlier than six months (181 days) after the end of the initial rental period or after the remaining portion up to the purchase price max fee is paid to the provider. After the purchase price max fee of the equipment has been reached, ownership of the equipment remains with the provider. The provider is responsible for long-term support over the life of the DME.

Extended Rental for Procedure Codes E0450 and E0472

The following table outlines specific repair and service guidelines for procedure codes E0450 and E0472:

Procedure code	Description	Initial rental period		Purchase max fee	Extended rental period	
		Modi-fier	Daily rental max fee		Modi-fier	Daily rental max fee
E0450	Volume ventilator, stationary or portable, with backup rate feature, used with invasive interface (e.g., tracheostomy tube)	RR[1]	$15.50	$7052.50	RR and 52[2]	$7.75
E0472	Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous positive airway pressure device)	RR	$13.43	$5104.35	RR and 52	$6.72

[1] RR = Rental.

[2] 52 = Reduced services. Modifier "52" must be billed with modifier "RR" during the extended rental period.

Initial Rental Period

The daily rental max fee rate is payable monthly to providers until the purchase price max fee listed in the DME maximum allowable fee index is reached. Use HCPCS modifier "RR" (Rental) with the equipment procedure code on the claim form.

Used Equipment

If used equipment is dispensed at the beginning of the initial rental period, the provider must comply with one of the following:

- Supply the member with working equipment in good condition for five years (the life expectancy of the same type of new equipment).
- Substitute new equipment by the end of the initial rental period.

A new initial rental period may only be started with new equipment if the DME reaches its life expectancy, the member still needs the equipment, and one of the following is true:

- The DME no longer functions properly.
- The DME can no longer be repaired.

A PA request must be filed for each new initial rental period and must include all of the following:

- The original delivery date.
- The age of the equipment.
- An explanation of why the equipment is no longer functional.

Extended Rental Period

When cumulative rental payments total the purchase price max fee of the item, the extended rental period begins. Providers must continue to provide the DME to the member until one of the following happens:

- The life expectancy of the equipment is reached and a different piece of equipment is dispensed.
- The member no longer needs the equipment.

A new PA request for replacement equipment will be considered if the DME has reached its life expectancy.

During the extended rental period, providers may be reimbursed up to one half of the rental max fee per month to cover the costs associated with long-term rental. To receive this reimbursement:

- The DME must be in the extended rental period.
- Providers must indicate modifier "52" (Reduced services) and HCPCS modifier "RR" with the equipment procedure code on the PA request and claim form.

After the purchase price max fee of the equipment has been reached, ownership of the equipment remains with the provider. The provider is responsible for long-term support (repairs and necessary supplies) over the life of the DME. Providers may continue to receive up to one half of the rental max fee monthly, for as long as the member continues to use the equipment.

Reimbursement using modifier "52" is intended to cover all provider costs associated with repairs and service including temporary replacement equipment, supplies, and provider-installed accessories including, but not limited to, manifolds, valves, AC/DC chargers, air/oxygen mixers, battery packs, filters, power cables, pressure alarms, and pressure hoses. Member supplies such as face/tracheostomy masks and tubing continue to be covered separately.

Medical Necessity for Oxygen Services

Whether a member resides in a SNF or at home, providers are required to establish medical necessity *before* oxygen services are provided. Medical necessity is established by the measurement of arterial oxygen saturation. For members in SNFs, medical necessity must be established *before* the member receives oxygen whether it is to be administered at the time of admission or later during the member's stay. Providers are required to review the medical necessity of any service provided to a member on an ongoing basis.

Documentation and medical necessity requirements apply to all types of oxygen services, including portable oxygen. The extent of the member's mobility and need for portable oxygen must be documented in the member's medical record.

Oxygen Contents

Oxygen contents may be purchased only. Oxygen contents are reimbursable only for member or nursing home-owned systems, not for rented oxygen delivery systems.

When billing for oxygen contents, one unit of service indicated on the claim form is equal to one month's use, consistent with the HCPCS code descriptions. PA is required for oxygen contents after 30 days.

Oxygen Delivery Systems

Purchased Oxygen Delivery Systems

Oxygen delivery systems may be purchased with PA. Wisconsin Medicaid includes the cost of oxygen system components within the reimbursement for the purchase of oxygen delivery systems. This includes the oxygen container, carts, stands, demurrage, and regulators.

The replacement parts for a purchased oxygen system can be billed separately using the appropriate procedure codes in the DME maximum allowable fee index.

Rented Oxygen Delivery Systems

Oxygen delivery systems may be rented for up to 30 days without PA. Reimbursement for rented systems (including portable systems) procedure codes include oxygen contents. This may differ from commercial health insurance and private payers' definition of the oxygen service that may not include contents. If this is the case, the provider's billed amount to Wisconsin Medicaid will differ from the amount billed to the private payer.

Providers should not submit additional claims for the contents with the rental of stationary or portable oxygen systems for the same time period, for the same member.

The provider indicates the prescribed oxygen flow rate for rented, stationary, liquid or gaseous systems as follows:

- "QE" modifier — prescribed amount of oxygen is less than one liter per minute (reimbursement is 50 percent of maximum allowable fee).
- No modifier — prescribed amount of oxygen is from one to four liters per minute (reimbursement is the full maximum allowable fee).
- "QG" modifier — prescribed amount of oxygen is greater than four liters per minutes (reimbursement is 150 percent of maximum allowable fee).

For oxygen equipment rental, one unit of service indicated on the claim form is equal to one day's use.

A provider may submit a claim for both a portable and a stationary oxygen system for the same member on the same DOS as long as the appropriate physician prescription and documentation to support medical necessity and actual oxygen use is maintained.

Prescriptions for Oxygen Services

The FDA identifies oxygen as a legend drug, and prescriptions are required for legend drugs. Therefore, providers are required to have a physician's prescription *before* administering oxygen. Verbal orders for oxygen services are acceptable for initiating the administration of oxygen when the following requirements are met:

- The verbal orders are given to a licensed or certified individual of the nursing home or the home care services provider.
- The verbal orders are followed up with a signed and dated physician's written prescription within 10 days, whether the member resides in a nursing home or receives home care services.

A physician's prescription for oxygen services should indicate a specific liter flow; however, a range (e.g., O2 @ 2-4 liters per minute) is acceptable if the prescription also indicates that a certain blood saturation level must be maintained during unstable periods. When the prescription indicates a range, and not a specific liter flow, Wisconsin Medicaid requires that the following be documented in the member's file:

- Frequent monitoring of oxygen saturation levels.
- Varying liter flow.

Changes to Oxygen Liter Flow

PA request approval is based on *average* liter flow. If the liter flow increases or decreases on a temporary basis, providers should make no changes to the PA request. If the liter flow increases or decreases for an extended period of time, providers may submit a Prior Authorization Amendment Request.

Wheelchairs and Wheelchair Accessories

Overview

Standard wheelchairs are usually specially designed to accommodate individual disabilities and provide mobility. Examples of standard wheelchairs are a standard weight wheelchair, a lightweight wheelchair and a power/motorized wheelchair. All wheelchairs require PA. The member's diagnosis, prognosis, and living arrangements are considered before approving a wheelchair.

Power-Operated Vehicles (Scooters)

Providers are required to indicate HCPCS procedure codes K0800-K0812 for power-operated vehicles (scooters). All power-operated vehicles require PA.

Power-operated vehicles are generally not separately reimbursable in a nursing home. However, providers may request special consideration on their PA requests for the purchase of power-operated vehicles for nursing home residents.

Wisconsin Medicaid considers reimbursement for K0800-K0812 as all-inclusive. Separate reimbursement is not allowed for batteries and battery chargers at the initial issue of a power-operated vehicle. Separate additional reimbursement for accessories may be considered on a PA request but the manufacturer price list must validate the additional charge. Accessories are subject to all Medicaid rules and regulations, including DHS 101.03(96m), Wis. Admin. Code, for medical necessity. Wisconsin Medicaid does not cover certain accessories such as baskets, lights, horns, or flags.

Required Modifiers for Procedure Codes E2381-E2396

Providers are required to include modifier "RT" (Right side) and/or "LT" (Left side) on claims submitted for procedure codes E2381-E2396. These procedure codes are incomplete without modifier "RT" or "LT."

If the DME item is needed bilaterally, providers are required to submit two separate details on claims, with modifier "RT" on one detail and modifier "LT" on the second detail.

Two Types of Wheelchairs for One Member

If a member owns a power/motorized wheelchair, the purchase of a manual wheelchair is approved only when the provider demonstrates medical necessity. Based on past determinations, the following are examples that may be considered not medically necessary (DHS 107.24(2)(b) and DHS 107.24(3), Wis. Admin. Code):

- The power/motorized wheelchair cannot be transported in the family vehicle.
- A physician's office, dentist's office, or school is inaccessible with the power/motorized wheelchair.
- The member could more readily socialize by using a manual wheelchair.
- A manual wheelchair is requested as a backup while a power/motorized wheelchair is being repaired.

The rental of a second wheelchair is covered while a member's wheelchair is being repaired.

Wheelchair Definitions

Manual Wheelchair

Manually propelled, wheeled mobility base, sized to accommodate individual measurements in member size, weight, and height, including all variations of arm, leg, and foot rests.

Powered Wheelchair

Wheeled mobility base propelled by a motor, sized to accommodate individual measurements in member size, weight, and height, including all variations of arm, leg, and foot rests.

Custom Wheelchair

A wheelchair that is uniquely designed, form a model or detailed measurement of a member, and is constructed to meet a member's exceptional medical needs as specified and documented by the member's attending physician. This does not include equipment that is modified, fabricated, or fit from pre-manufactured components or modules.

Standard Wheelchair

Manual and power wheelchairs not meeting the definition of custom, but including frame adaptations designed to accommodate individual disabilities and provide mobility. Examples of standard wheelchairs are:

- Extra-wide.
- Narrow.
- Tall.
- Ultra-light.
- Supra-light.
- Ultra-hemi.
- Supra-hemi.
- One-arm drive.
- Amputee.
- Pediatric.
- Heavy-duty.
- Reclining.
- Semi-reclining.
- Light-weight.
- High-strength.
- Hemi-height.
- Tilt-in-space.

Wheelchair Evaluations

According to DHS 101.03(96m)(b)7, Wis. Admin. Code, medical services cannot be provided solely for the convenience of the member, the member's family, or a provider. When a DME provider is originating the purchase of equipment and requests a therapist evaluation to justify that purchase, that evaluation is not separately reimbursable by Wisconsin Medicaid.

Wheelchair Seated Positioning Systems

Wheelchair seated position components or total seating systems affixed to a member's wheelchair are not considered orthoses or orthotics. These wheelchair components or systems require PA and must be billed using wheelchair accessory procedure codes.

When deciding what mobility device to provide, the provider must always consider the place of use and the member's ability level.

Only procedure codes in the wheelchair category of the DME maximum allowable fee index should be used when submitting claims

for wheelchair seated positioning systems or wheelchair modifications. Do not use orthotic or home health procedure codes for these services.

Managed Care

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Archive Date:03/01/2010

Managed Care:Claims

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 or SSI HMO either does not respond in writing within 45 calendar days or if the provider is dissatisfied with the HMO's or SSI HMO's response.

BadgerCare Plus or Wisconsin Medicaid will not review appeals that were not first made to the HMO or SSI HMO. If a provider sends an appeal directly to BadgerCare Plus or Wisconsin Medicaid without first filing it with the HMO or SSI HMO, the appeal will be returned to the provider.

Appeals will only be reviewed for enrollees who were eligible for and who were enrolled in a BadgerCare Plus HMO or Medicaid SSI HMO on the date 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 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.

Appeals to HMOs and SSI HMOs

Providers are required to first file an appeal directly with the BadgerCare Plus HMO or Medicaid SSI 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.

Claims Submission

BadgerCare Plus HMOs and Medicaid SSI 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.

Extraordinary Claims

Extraordinary claims are BadgerCare Plus or Medicaid claims for a BadgerCare Plus HMO or Medicaid SSI 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. These claims (including physician claims) must include admittance and discharge dates.
- 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

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 or Medicaid SSI 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.

Provider Appeals

When a BadgerCare Plus HMO or Medicaid SSI 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 MCO 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

Covered Services

HMOs

Although BadgerCare Plus requires contracted 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.

SSI HMOs

Wisconsin Medicaid requires contracted Medicaid SSI HMOs to provide all medically necessary Medicaid-covered services. If the SSI HMO does not include services such as chiropractic or dental, the enrollee receives these services on a Medicaid fee-for-service basis.

Noncovered Services

The following are not covered by BadgerCare Plus HMOs or Medicaid SSI HMOs but are provided to enrollees on a fee-for-service basis:

- CSP benefits.
- Crisis intervention services.
- Environmental lead inspections.
- Milwaukee CCC services.
- Pharmacy services and some drug-related supplies.
- PNCC services.
- Provider-administered drugs, including all "J" codes, drug-related "Q" codes, procedure code S4993 (Contraceptive pills for birth control), and a limited number of related administration codes.
- SBS.
- Targeted case management services.
- Transportation by common carrier (unless the HMO has made arrangements to provide this service as a benefit). Milwaukee HMOs and SSI HMOs are mandated to provide transportation for their enrollees.
- Directly observed therapy and monitoring for TB-only.

Enrollment

Disenrollment and Exemptions

In some situations, a member may be exempt from enrolling in a BadgerCare Plus HMO or Medicaid SSI HMO. Exempted members receive health care under fee-for-service. Exemptions allow members to complete a course of treatment with a provider who is not contracted with 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 and the HMO or SSI HMO provide more detail on the exemption and disenrollment requirements.

Enrollee Grievances

Enrollees have the right to file grievances about services or benefits provided by a BadgerCare Plus HMO or Medicaid SSI 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 and the HMO or SSI HMO describes the responsibilities of the HMO or SSI HMO and the DHS regarding enrollee grievances.

Enrollment Eligibility

BadgerCare Plus HMOs

Members enrolled in the BadgerCare Plus Standard Plan and the BadgerCare Plus Benchmark Plan are eligible for enrollment in a BadgerCare Plus HMO. BadgerCare Plus Core Plan members are enrolled in BadgerCare Plus HMOs.

An individual who receives the FPW program, the TB-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 or the ForwardHealth Portal.

SSI HMOs

Members of the following subprograms are eligible for enrollment in a Medicaid SSI 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.

Enrollment Periods

HMOs

Members are sent enrollment packets that explain the BadgerCare Plus HMOs 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 HMO's enrollment process and provide contract 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.

Enrollment Specialist

The Enrollment Specialist provides objective enrollment, education, outreach, and advocacy services to BadgerCare Plus HMO and Medicaid SSI 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.

Member Enrollment

HMOs

BadgerCare Plus HMO 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 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.

Ombudsman Program

The Ombudsmen, or Ombuds, are resources for enrollees who have questions or concerns about their BadgerCare Plus HMO or Medicaid SSI HMO. Ombuds provide advocacy and assistance to help enrollees understand their rights and responsibilities in the grievance and appeal process.

BadgerCare Plus HMO/Medicaid SSI HMO Ombudsmen
PO Box 6470
Madison WI 53716-0470

Release of Billing or Medical Information

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

Managed Care Information

BadgerCare Plus HMO Program

An HMO is a system of health care providers that provides a comprehensive range of medical services to a group of enrollees. HMOs receive a fixed, prepaid amount per enrollee from BadgerCare Plus (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, claims submission, adjudication procedures, etc., which may differ from BadgerCare Plus fee-for-service policies and procedures. BadgerCare Plus HMO network providers should contact their HMO for more information about its policies and procedures.

Managed Care

Managed Care refers to the BadgerCare Plus HMO program, the Medicaid SSI 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.

Managed Care Contracts

The contract between the DHS and the BadgerCare Plus HMO or Medicaid SSI 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.

SSI HMO Program

Medicaid SSI HMOs 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 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.

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, 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.

Prior Authorization

Enrollment Changes

A PA granted by BadgerCare Plus fee-for-service for DME is not applicable once a member enrolls in a managed care program. Likewise, a PA granted by a managed care program (such as an HMO, CMO, or special managed care program) for DME is not applicable once a BadgerCare Plus enrollee disenrolls and enters BadgerCare Plus FFS. The reimbursement system, either FFS or a managed care program, in which the member is enrolled on the DOS is responsible for the payment of medically necessary covered equipment and services. The DOS for the purchase of DME items is the date of delivery. Providers should verify the member's enrollment and managed care status before delivering purchased DME items.

Managed Care Enrollment Policy

Enrollment in BadgerCare Plus HMOs and in the special managed care program, Independent Care, is generally effective on the first of the month and continues through the end of the calendar month. For all other special managed care programs and for Family Care CMOs, enrollment and disenrollment can occur at any time.

When a Fee-for-Service Member Enrolls in a Managed Care Program

The following procedures apply when a member, who has an approved PA from BadgerCare Plus FFS for a DME item, enrolls in a managed care program:

- The BadgerCare Plus FFS provider should contact the member's managed care program for its policies and procedures before delivering the equipment.
- If the managed care program decides it will not purchase the DME item that was previously approved by BadgerCare Plus FFS, the member may file a grievance with the managed care program or the state as described in the Enrollee Handbook.
- If the DME provider has already processed an order for an individualized piece of equipment, such as orthotics, and cannot either cancel the order or recoup its loss, the provider may request that the member's managed care program pay for the piece of equipment. If the managed care program denies payment, the provider can appeal the decision through the provider appeal process outlined in the managed care program's contract.
- If the managed care program decides it will not purchase the DME item or denies payment for the item, then the DHS has the final determination on whether the MCO is responsible for providing and paying for the DME item. If the MCO is required to pay for the item that was authorized under FFS, the MCO will pay an amount no greater than it would have paid its network provider.

When a Managed Care Enrollee Returns to Fee-for-Service

The following procedures apply when an enrollee, who has an approved PA from the managed care program for a DME item, disenrolls and returns to BadgerCare Plus FFS:

- Follow BadgerCare Plus FFS policies and procedures, including PA requirements, before delivering the equipment.
- If the DME item requires a FFS PA and FFS denies the PA request, the member can file an appeal.

Reimbursement Policy

A summary of reimbursement follows:

- Managed care programs have their own network of Medicaid-certified DME providers. Managed care programs are not required to do business with a DME provider who is not in their provider network.

- If the member has changed from managed care to FFS or from FFS to managed care since the DME was authorized, the DME provider should request approval and payment from whatever system (i.e., managed care or FFS) the member is enrolled in at the time of the provider's request.
- Members have the right to appeal the BadgerCare Plus FFS or managed care program's decision to deny the PA of a DME item. Members also have the right to appeal the managed care program's decision not to reimburse the provider for the purchase of a DME item that was prior authorized by FFS.

Special Managed Care Programs that Cover Durable Medical Equipment

The following special managed care programs cover DME:

- Community Care for the Elderly, Milwaukee County.
- Community Health Partnership, Chippewa, Dunn, and Eau Claire Counties.
- Community Living Alliance, Dane County.
- Elder Care, Dane County.
- Independent Care, Milwaukee County.
- Family Care care management organizations*.
    - Creative Care Options of Fond du Lac County.
    - La Crosse County Care Management Organization.
    - Community Care of Portage County.
    - Aging and Disability Services of Richland County.
    - Milwaukee County Care Management Organization.

* The Family Care Guide identifies DME included in the Family Care benefit package.

Prior Authorization Procedures

BadgerCare Plus HMOs and Medicaid SSI HMOs may develop PA 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

Copayments

Providers cannot charge Medicaid SSI HMO 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.

Emergencies

Non-network providers may provide services to BadgerCare Plus HMO and Medicaid SSI HMO enrollees in an emergency without authorization or in urgent situations when authorized by the HMO or SSI HMO. The contract between the DHS 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.

Non-network Providers

Providers who do not have a contract with the enrollee's BadgerCare Plus HMO or Medicaid SSI 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 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.

Out-of-Area Care

BadgerCare Plus HMOs and Medicaid SSI 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.

Provider Participation

Providers interested in participating in a BadgerCare Plus HMO or Medicaid SSI 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.

Referrals

Non-network providers may at times provide services to BadgerCare Plus HMO and Medicaid SSI 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.

Services Not Provided by HMOs or SSI HMOs

If an enrollee's BadgerCare Plus HMO's or Medicaid SSI HMO's 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

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Archive Date:03/01/2010

Member Information:Enrollment Categories

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 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).

BadgerCare Plus Core Plan

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

Core Plan Implementation

In the first phase of Core Plan implementation, individuals enrolled in the Milwaukee GAMP and certain other counties' GA medical programs were automatically transitioned into the Core Plan effective January 1, 2009. Services were covered under fee-for-service. Effective April 1, 2009, members transitioned from GAMP began their enrollment process in one of the state-contracted HMOs that serve Wisconsin's Medicaid and BadgerCare Plus population.

In the second phase of implementation, BadgerCare Plus began accepting applications from the general public for enrollment in the Core Plan as of June 15, 2009. The second phase opens enrollment to certain low-income adults with no dependent children. The earliest date of coverage and benefits is July 15, 2009. Services will be covered under fee-for-service until members are enrolled in an HMO. All new Core Plan members will be required to enroll in an HMO under the following circumstances: there are two or more

HMOs in the member's area, or there is one HMO in the member's area and the member resides in a designated rural county where federal requirements allow mandatory HMO enrollment. New Core Plan members will receive HMO enrollment materials in the mail to select an HMO. The earliest date of HMO enrollment for new Core Plan members will be October 1, 2009.

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 the FPW or those benefits provided to individuals who qualify for TB-Only.
- Is not eligible for or enrolled in Medicare.
- Has a monthly gross income that does not exceed 200 percent of the FPL.
- 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

The Core Plan application process will be streamlined and user-friendly. Individuals who wish to enroll may apply for the Core Plan using the Access tool online or via the ESC toll-free telephone number, (800) 291-2002. 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 and the Department of HHS's OIG.

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.
- 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 at (800) 291-2002 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 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, 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 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. 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.

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

Benefit Plans Under BadgerCare Plus

BadgerCare Plus is comprised of three benefit plans, the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, and the BadgerCare Plus Core 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. 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 drugs, and a limited number of brand name drugs.

Express Enrollment for Children and Pregnant Women

EE for Pregnant Women Benefit is a limited benefit category that allows a pregnant woman to receive immediate pregnancy-related outpatient services while her application for full-benefit BadgerCare Plus is processed. Enrollment is not restricted based on the member's other health insurance coverage. Therefore, a pregnant woman who has other health insurance may be enrolled in the benefit.

To determine enrollment for EE for Pregnant Women, providers should use the income limits for 200 percent and 300 percent of the FPL.

The EE for Children Benefit allows certain members under 18 years of age to receive BadgerCare Plus benefits under the BadgerCare Plus Standard Plan while an application for BadgerCare Plus is processed.

Fee-for-Service

Women and children who are temporarily enrolled in BadgerCare Plus through the EE process are not eligible for enrollment in an HMO until they are determined eligible for full benefit BadgerCare Plus by the county/tribal office.

Family Planning Waiver

The FPW is a limited benefit program that provides routine contraceptive-related services to low-income women age 15 through 44 who are otherwise not eligible for Wisconsin Medicaid or BadgerCare Plus. Members receiving FPW services must be receiving routine contraceptive-related services.

The goal of the FPW is to provide women 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 the FPW to women and encourage them to

contact their local county or tribal agency to determine their enrollment options if they are not interested in receiving, or do not wish to receive, contraceptive services.

Members enrolled in the FPW receive routine services to prevent or delay pregnancy. In addition, FPW members may receive certain reproductive health services if the services are determined medically necessary during contraceptive-related FPW services. Only services *clearly* related to contraceptive management are covered under the FPW.

Providers should inform women about other service options and provide referrals for care not covered by the FPW.

FPW members are not eligible for other services that are covered under full-benefit Medicaid and BadgerCare Plus (e.g., PT services, dental services). Even if a medical condition is discovered during a contraceptive-related FPW service, treatment for the condition is not covered under the FPW unless the treatment is identified in the list of allowable procedure codes for FPW services. They are also not eligible for other family planning services that are covered under full-benefit Wisconsin Medicaid and BadgerCare Plus (e.g., mammograms and hysterectomies). If a medical condition, other than an STD, is discovered during contraceptive-related services, treatment for the medical condition is not covered under the FPW.

Colposcopies and treatment for STDs are only covered through the FPW 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 in the FPW program and receiving contraceptive-related services.

FPW 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 women about other service options and provide referrals for care not covered by FPW.

Temporary Enrollment for the Family Planning Waiver

Women whose providers are submitting an initial FPW application on their behalf and who meet the enrollment criteria may receive routine contraceptive-related services immediately through TE for the FPW for up to three months. Services covered under the TE for the FPW are the same as those covered under the FPW and must be clearly related to routine contraceptive management.

To determine enrollment for the FPW, providers should use the income limit for 200 percent of the FPL.

TE for the FPW providers may issue white paper TE for BadgerCare Plus FPW Plan temporary identification cards for women to use until they receive a ForwardHealth identification card. Providers should remind women that the benefit is temporary, despite their receiving a ForwardHealth card.

ForwardHealth and ForwardHealth interChange

ForwardHealth brings together many DHS 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.
- WIR.
- Wisconsin Medicaid.
- Wisconsin Well Woman Medicaid.
- WWWP.

ForwardHealth interChange is supported by the state's fiscal agent, HP.

Limited Benefit Categories Overview

Certain members may be enrolled in a limited benefit category. These limited benefit categories include the following:

- BadgerCare Plus Expansion for Certain Pregnant Women.
- EE for Children.
- EE for Pregnant Women.
- FPW, including the PE for the FPW.
- QDWI.
- QI-1.
- QMB Only.
- SLMB.
- TB-Only Benefit.

Members may be enrolled in full-benefit Medicaid or BadgerCare Plus and also be enrolled in certain limited benefit programs, including QDWI, QI-1, QMB Only, and SLMB. In those cases, a member has full Medicaid or BadgerCare Plus coverage in addition to limited coverage for Medicare expenses.

Members enrolled in BadgerCare Plus Expansion for Certain Pregnant Women, FPW, EE for Children, EE for Pregnant Women, or the TB-Only Benefit cannot be enrolled in full-benefit Medicaid or BadgerCare Plus. These members receive benefits through the limited benefit category.

Providers should note that a member may be enrolled in more than one limited benefit category. For example, a member may be enrolled in the FPW and the TB-Only Benefit.

Providers are strongly encouraged to verify dates of enrollment and other coverage information using the EVS to determine whether a member is in a limited benefit category, receives full-benefit Medicaid or BadgerCare Plus, or both.

Providers are responsible for knowing which services are covered under a limited benefit category. If a member of a limited benefit category requests a service that is not covered under the limited benefit category, the provider may collect payment from the member if certain conditions are met.

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, MA, 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.
- WWWP.

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 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.

Qualified Disabled Working Individual Members

QDWI members are a limited benefit category of Medicaid members. They receive payment of Medicare monthly premiums for Part A.

QDWI members are certified by their local county or tribal agency. To qualify, QDWI members are required to meet the following qualifications:

- Have income under 200 percent of the FPL.
- Be entitled to, but not necessarily enrolled in, Medicare Part A.
- Have income or assets too high to qualify for QMB Only and SLMB.

Qualified Medicare Beneficiary-Only Members

QMB-Only members are a limited benefit category of Medicaid members. They receive payment of the following:

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

QMB-Only members are certified by their local county or tribal agency. QMB-Only members are required to meet the following qualifications:

- Have an income under 100 percent of the FPL.
- Be entitled to, but not necessarily enrolled in, Medicare Part A.

Qualifying Individual 1 Members

QI-1 members are a limited benefit category of Medicaid members. They receive payment of Medicare monthly premiums for Part B.

QI-1 members are certified by their local county or tribal agency. To qualify, QI-1 members are required to meet the following qualifications:

- Have income between 120 and 135 percent of the FPL.
- Be entitled to, but not necessarily enrolled in, Medicare Part A.

Specified Low-Income Medicare Beneficiaries

SLMB members are a limited benefit category of Medicaid members. They receive payment of Medicare monthly premiums for Part B.

SLMB members are certified by their local county or tribal agency. To qualify, SLMB members are required to meet the following qualifications:

- Have an income under 120 percent of the FPL.
- Be entitled to, but not necessarily enrolled in, Medicare Part A.

Tuberculosis-Related Services-Only Benefit

The TB-Only Benefit is a limited benefit category that allows individuals with TB infection or disease to receive covered TB-related outpatient services.

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 or the FPW, 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 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 for Adults with No Dependent Children are eligible to be enrolled in Wisconsin Well Woman Medicaid. 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. 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.

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.

Enrollment Responsibilities

General Information

Members have certain responsibilities per DHS 104.02, Wis. Admin. Code, and the Medicaid Enrollment and Benefits booklet or the BadgerCare Plus Enrollment and Benefits booklet.

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 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 or the ForwardHealth Portal prior to providing each service, even if an approved PA request is obtained for the service.

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.

Members Should Present Card

It is important that providers determine a member's enrollment and other insurance coverage *prior to* each DOS 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 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.

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.

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

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.

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 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
6406 Bridge Rd
Madison WI 53784-0050

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.

Freedom of Choice

Members may receive covered services from *any* willing Medicaid-certified provider, unless they are enrolled in a state-contracted MCO or assigned to the Member Lock-In Program.

General Information

Members are entitled to certain rights per DHS 103, Wis. Admin. Code.

Notification of Discontinued Benefits

When the DHS 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.

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.

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 members.

Identification Cards

ForwardHealth Core Plan Identification Cards

Beginning in July 2009, new 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 the ESC with questions about enrollment criteria, HMO enrollment, and covered services. The ForwardHealth Core Plan cards include the Enrollment Services Center telephone number, (800) 291-2002, on the back.

Members who transitioned from Milwaukee's GAMP or other counties' GA medical programs in January 2009 currently have ForwardHealth cards and will begin receiving ForwardHealth Core Plan cards when they re-enroll in the Core Plan in 2010.

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.

ForwardHealth Identification Cards

Each enrolled member receives an identification card. Possession of a program identification card does not guarantee enrollment. It is possible that a member will present a card during a lapse in enrollment; therefore, it is essential that providers verify enrollment before providing services. Members are told to keep their cards even though they may have lapses in enrollment.

ForwardHealth Identification Card Features

The ForwardHealth identification card includes the member's name, 10-digit member ID, magnetic stripe, signature panel, and the Member Services telephone number. The card also has a unique, 16-digit card number on the front for internal program use.

The ForwardHealth card does not need to be signed to be valid; however, adult members are encouraged to sign their cards. Providers may use the signature as another means of identification.

The toll-free number on the back of each of the cards is for member use only. The address on the back of each card is used to return a lost card to ForwardHealth if it is found.

If a provider finds discrepancies with the identification number or name between what is indicated on the ForwardHealth card and the provider's file, the provider should verify enrollment with Wisconsin's EVS.

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.

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 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.

Temporary Enrollment for BadgerCare Plus Family Planning Waiver Plan Temporary Cards

Qualified providers may issue white paper TE for BadgerCare Plus FPW Plan identification cards for women to use temporarily until they receive a ForwardHealth identification card. The identification card is included with the TE for BadgerCare Plus FPW Plan Application.

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

Temporary Express Enrollment Cards

There are two types of temporary EE 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 vaild 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 (formerly known as PE) through the online EE process. Express Enrollment identification cards are included on the bottom portion of the enrollment notice that is printed out and provided to the member after the on-line enrollment process is completed.

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

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 to verify enrollment for dates of service after those printed on the card. Providers are encouraged to keep a photocopy of the card.

Information is available for dates of service before April 1, 2009.

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 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.

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.

- Green paper temporary cards.
- Paper printout temporary card for EE for children.
- Paper printout temporary card for EE for pregnant women.
- Beige paper temporary card for EE for pregnant women.
- White paper TE for the FPW cards.

Misuse and Abuse of Benefits

Examples of Member Abuse or Misuse

Examples of member abuse or misuse are included in DHS 104.02(5), Wis. Admin. Code.

Member Lock-In Program

If ForwardHealth determines that a member is abusing BadgerCare Plus or Medicaid services, the member may be required to designate a health care provider under the Member Lock-In Program. (A member has the right to appeal this action.) Members are required to designate, in any or all categories of health care, a Medicaid-certified provider of their choice. If a member fails to choose a provider, ForwardHealth may designate one based on claims data.

ForwardHealth notifies the member's chosen health care provider by letter. Another letter is also sent to the member. The provider has the option to decline to act as the selected health care provider for the member.

A member in the Lock-In Program who has already designated a provider can only receive the locked-in services from his or her designated provider. A provider who is *not* the designated provider of a Lock-In Program member for the locked-in services should not perform services for that member unless a referral is in place from the Lock-In provider.

Claims for restricted, nonemergency services performed by a provider who is not the designated provider are reviewed by ForwardHealth and may be denied.

Providers may obtain Lock-In information by using any of the enrollment verification methods. To obtain the name of the designated Lock-In provider, call Provider Services.

Providers May Make Referrals

The designated Lock-In provider may make referrals to other providers of medical services. ForwardHealth supplies Lock-In Program providers with referral forms that should be used when it is necessary to refer the member to another provider.

Reimbursement is made if the referral can be documented as medically necessary and the services are covered.

Providers may receive reimbursement for emergency services given without a referral to a locked-in member if the claim is accompanied by a full explanation of the emergency circumstances.

The designated provider is required to maintain all appropriate documentation in the member's medical records.

Notifying ForwardHealth

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. 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 doing so. A provider may not confiscate a ForwardHealth card from a member in question.

If a provider suspects that a member is abusing his or her benefits or misusing his or her ForwardHealth card, providers are required to notify ForwardHealth by calling Provider Services or by writing to the following office:

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

ForwardHealth monitors member records and can impose sanctions on those who misuse or abuse their benefits. For more information on member misuse and abuse and the resulting sanctions, refer to s. 49.49, Wis. Stats.

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 Member Lock-In Program or to criminal prosecution.

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

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.

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 covers 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 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.

Non-U.S. Citizens — Emergency Services

Certain non-U.S. citizens who are not qualified aliens are eligible for BadgerCare Plus services only in cases of acute emergency medical conditions. Providers should use the appropriate ICD-9-CM 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 does 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-qualifiying immigrants are eligible for Medicaid enrollment under the CEN option. However, babies born to women with incomes over 300 percent of the FPL 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 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.

Information for DOS before January 1, 2009, is available.

Out-of-State Youth Program

The OSY 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
6406 Bridge Rd
Madison WI 53784-0050

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.

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 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 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 (if the services provided during the period of retroactive enrollment were covered).

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 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 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.

Prior Authorization

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Archive Date:03/01/2010

Prior Authorization:"Not Otherwise Classified" Procedure Codes

"Not Otherwise Classified" Procedure Codes

PA is required for "not otherwise classified" procedure codes. Requests must be submitted on the PA/RF. Use the following process when submitting a PA/RF for "not otherwise classified" procedure codes:

- Include a description of each item with specific detail to allow Wisconsin Medicaid to determine the maximum allowable reimbursement. The description must include the manufacturer's item description (e.g., name and model number), and the number of items (e.g., two wheels, four bearings).
- Always indicate a quantity of "1.0" in Element 22 of the PA/RF. If requesting two identical items within a not otherwise classified procedure code, identify this as a "pair" or bilateral in the description. If requesting a series of items (e.g., serial splints) include the number of splints in the description and a quantity of "1.0" in Element 22 of the PA/RF.

The approved PA/RF indicates the maximum allowable reimbursement in Element 23 of the form. If one or more items are approved under one "not otherwise classified" code, procedure code modifiers (U1 through UD) are assigned to Element 19 to each approved item on the PA/RF.

If a "not otherwise classified" procedure code is assigned a modifier, the same modifier must be used by the provider billing the service.

Back-up Durable Medical Equipment

Back-up Durable Medical Equipment

For back-up or secondary DME, the following PA requirements apply:

- When requesting PA for two identical or similar pieces of DME on the same PA request, the provider is required to indicate the pieces of DME on separate detail lines using the "TW" modifier with the back-up or secondary piece of DME.
- If the provider has already had PA granted for the primary DME and is requesting a back-up or secondary piece of identical or similar DME, the provider is required to submit a new PA request with both pieces of DME included on separate detail lines. On the new PA request, the provider is required to request an end date for the primary DME on the old PA. PA requests not meeting these conditions will be returned.
- The PA approval criteria that apply to the primary DME, also apply to the back-up or secondary DME.

Decisions

Approved Requests

PA requests are approved for varying periods of time based on the clinical justification submitted. The provider receives a copy of a PA decision notice when a PA request for a service is approved. Providers may then begin providing the approved service on the grant date given.

An approved request means that the requested *service*, not necessarily the code, was approved. For example, a similar procedure code may be substituted for the originally requested procedure code. Providers are encouraged to review approved PA requests to confirm the services authorized and confirm the assigned grant and expiration dates.

Listing Procedure Codes Approved as a Group on the Decision Notice Letter

In certain circumstances, ForwardHealth will approve a PA request for a group of procedure codes with a total quantity approved for the entire group. When this occurs, the quantity approved for the entire group of codes will be indicated with the first procedure code. All of the other approved procedure codes within the group will indicate a quantity of zero.

Providers may submit claims for any combination of the procedure codes in the group up to the approved quantity.

Communicating Prior Authorization Decisions

ForwardHealth will make a decision regarding a provider's PA request within 20 working days from the receipt of all the necessary information. After processing the PA request, ForwardHealth will send the provider either a decision notice letter or a returned provider review letter. Providers will receive a decision notice letter for PA requests that were approved, approved with modifications, or denied. Providers will receive a returned provider review letter for PA requests that require corrections or additional information. The decision notice letter or returned provider review letter will clearly indicate what is approved or what correction or additional information ForwardHealth needs to continue adjudicating the PA request.

Providers submitting PA requests via the ForwardHealth Portal will receive a decision notice letter or returned provider review letter via the Portal.

If the provider submitted a PA request via mail or fax and the provider has a Portal account, the decision notice letter or returned provider review letter will be sent to the provider via the Portal as well as by mail.

If the provider submitted a paper PA request via mail or fax and does not have a Portal account, the decision notice letter or returned provider review letter will be sent to the address indicated in the provider's file as his or her PA address (or to the physical address if there is no PA address on file), *not* to the address the provider wrote on the PA request.

The decision notice letter or returned provider review letter will not be faxed back to providers who submitted their paper PA request via fax. Providers who submitted their paper PA request via fax will receive the decision notice letter or returned provider letter via mail.

Correcting Returned Prior Authorization Requests and Request Amendments on the Portal

If a provider received a returned provider review letter or an amendment provider review letter, he or she will be able to correct the

errors identified on the returned provider review letter directly on the ForwardHealth Portal. Once the provider has corrected the error(s), the provider can resubmit the PA request or amendment request via the Portal to ForwardHealth for processing.

Decision Notice Letters and Returned Provider Review Letters on the Portal

Providers can view PA decision notices and provider review letters via the secure area of the ForwardHealth Portal. Prior authorization decision notices and provider review letters can be viewed when the PA is selected on the Portal.

Note: The PA decision notice or the provider review letter will not be available until the day after the PA request is processed by ForwardHealth.

Denied Requests

When a PA request is denied, both the provider and the member are notified. The provider receives a PA decision notice, including the reason for PA denial. The member receives a Notice of Appeal Rights letter that includes a brief statement of the reason PA was denied and information about his or her right to a fair hearing. Only the *member, or authorized person acting on behalf of the member*, can appeal the denial.

Providers may call Provider Services for clarification of why a PA request was denied.

Providers are required to discuss a denied PA request with the member and are encouraged to help the member understand the reason the PA request was denied.

Providers have three options when a PA request is denied:

- Not provide the service.
- Submit a *new* PA request. Providers are required to submit a copy of the original denied PA request and additional supporting clinical documentation and medical justification along with a new PA/RF, PA/DRF, or PA/HIAS1.
- Provide the service as a noncovered service.

If the member does not appeal the decision to deny the PA request or appeals the decision but the decision is upheld and the member chooses to receive the service anyway, the member may choose to receive the service(s) as a noncovered service.

Modified Requests

Modification is a change in the services originally requested on a PA request. Modifications could include, but are not limited to, either of the following:

- The authorization of a procedure code different than the one originally requested.
- A change in the frequency or intensity of the service requested.

When a PA request is modified, both the provider and the member are notified. The provider will be sent a decision notice letter. The decision notice letter will clearly indicate what is approved or what correction or additional information is needed to continue adjudicating the PA request. The member receives a Notice of Appeal Rights letter that includes a brief statement of the reason PA was modified and information on his or her right to a fair hearing. Only the *member, or authorized person acting on behalf of the member*, can appeal the modification.

Providers are required to discuss with the member the reasons a PA request was modified.

Providers have the following options when a PA request is approved with modification:

- Provide the service as authorized.
- Submit a request to amend the modified PA request. Additional supporting clinical documentation and medical justification must be included.
- Not provide the service.
- Provide the service as originally requested as a noncovered service.

If the member does not appeal the decision to modify the PA request or appeals the decision but the decision is upheld and the member chooses to receive the originally requested service anyway, the member may choose to receive the service(s) as a noncovered service.

Providers may call Provider Services for clarification of why a PA request was modified.

Returned Provider Review Letter Response Time

Thirty Days to Respond to the Returned Provider Review Letter

ForwardHealth must receive the provider's response within 30 calendar days of the date on the returned provider review letter, whether the letter was sent to the provider by mail or through the ForwardHealth Portal. If the provider's response is received within 30 calendar days, ForwardHealth still considers the original receipt date on the PA request when authorizing a grant date for the PA.

If ForwardHealth does not receive the provider's response within 30 calendar days of the date the returned provider review letter was sent, the PA status becomes inactive and the provider is required to submit a new PA request. This results in a later grant date if the PA request is approved. Providers will not be notified when their PA request status changes to inactive, but this information will be available on the Portal and through WiCall.

If ForwardHealth receives additional information from the provider after the 30-day deadline has passed, a letter will be sent to the provider stating that the PA request is inactive and the provider is required to submit a new PA request.

Returned Requests

A PA request may be returned to the provider when forms are incomplete, inaccurate, or additional clinical information or corrections are needed. When this occurs, the provider will be sent a provider review letter.

Returned Provider Review Letter

The returned provider review letter will indicate the PA number assigned to the request and will specify corrections or additional information needed on the PA request. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth. Providers can also correct PAs that have been placed in returned provider review status in the ForwardHealth Portal.

The provider's paper documents submitted with the PA request will not be returned to the provider when corrections or additional information are needed; however, X-rays, photographs, and dental molds will be returned once the PA is finalized for dentists, physicians, and DME providers. Therefore, providers are required to make a copy of their PA requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if more information is required about the PA request.

Note: When changing or correcting the PA request, providers are reminded to revise or update the documentation retained in their records.

Emergent and Urgent Situations

Emergency Services

In emergency situations, the PA requirement may be waived for services that normally require PA. Emergency services are defined in DHS 101.03(52), Wis. Admin. Code, as "those services which are necessary to prevent the death or serious impairment of the health of the individual."

Reimbursement is not guaranteed for services that normally require PA that are provided in emergency situations. As with all covered services, emergency services must meet all program requirements, including medical necessity, to be reimbursed by Wisconsin Medicaid. For example, reimbursement is contingent on, but not limited to, eligibility of the member, the circumstances of the emergency, and the medical necessity of the services provided.

Wisconsin Medicaid will not reimburse providers for noncovered services provided in any situation, including emergency situations.

Urgent Services

Telephone consultations with DHCAA staff regarding a prospective PA request can be given only in urgent situations when medically necessary. An urgent, medically necessary situation is one where a delay in authorization would result in undue hardship for the member or unnecessary costs for Medicaid as determined by the DHCAA. All telephone consultations for urgent services should be directed to the DHCAA's Bureau of Program Integrity at (608) 266-2521. Providers should have the following information ready when calling:

- Member's name.
- Member identification number.
- Service(s) needed.
- Reason for the urgency.
- Diagnosis of the member.
- Procedure code of the service(s) requested.

Providers are required to submit a PA request to ForwardHealth within 14 calendar days after the date of the telephone consultation. PA may be denied if the request is received more than two weeks after the consultation. If the PA request is denied in this case, the provider cannot request payment from the member.

Exceptional Supplies for Nursing Home Members

Exceptional Supplies for Nursing Home Members

For Wisconsin Medicaid to consider reimbursement, providers are required to obtain PA before dispensing exceptional supplies.

Submit requests for PA on the PA/RF and the PA/DMEA. On the PA/RF, providers are required to use procedure code E1399 for both purchased and rented exceptional supplies. To indicate rental items, providers are required to use E1300 with modifier "RR." For purchase items, providers should indicate E1399 without the "RR" modifier. All needed supplies must be billed under this one procedure code.

Providers are also required to submit the following with the PA/RF:

- Documentation indicating that the member is ventilator dependent or has a tracheostomy that requires exceptional supplies.
- A physician's prescription detailing the equipment and/or quantity of needed supplies. A PRN (from the Latin term, meaning "as needed") prescription will not be considered as a substitute for a physician prescription.
- Treatment sheets or a medical checklist documenting the actual use and frequency of use of the supplies and equipment.
- A record of the exact quantity of supplies used in the time period preceding the PA request.

Providers are required to include the "per unit" charge for each supply item, the frequency of use, and the estimated monthly quantity needed by the member. The total estimated monthly charge for all supplies must be indicated in Element 24 of the PA/RF.

Wisconsin Medicaid authorizes reimbursement for exceptional supplies at an average daily maximum dollar amount, based on the average daily use. The average daily maximum dollar amount is figured by multiplying the frequency of use per 30-day period by the reimbursement rate for each item, adding all of the sums, and dividing by 30. Wisconsin Medicaid will not reimburse for exceptional supplies at any rate higher than the average daily maximum dollar amount.

If using attachments, please write the PA number on each page, in case they are separated from the PA/RF during processing.

Follow-Up to Decisions

Amendment Decisions

ForwardHealth will make a decision regarding a provider's amendment request within 20 working days from the receipt of all the information necessary. If the provider submitted the amendment request via the ForwardHealth Portal, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal.

If the provider submitted an amendment request via mail or fax and the provider has a Portal account, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal as well as by mail.

If the provider submitted a paper amendment request via mail or fax and does not have a Portal account, the decision notice letter or returned amendment provider review letter will be sent to the address indicated in the provider's file as his or her PA address (or to the physical address if there is no PA address on file), *not* to the address the provider wrote on the amendment request.

Neither the decision notice letter nor the returned amendment provider review letter will be faxed back to providers who submitted their paper amendment request via fax. Providers who submitted their paper amendment request via fax will receive the decision notice letter or returned amendment provider review letter via mail.

Amendments

Providers are required to use the Prior Authorization Amendment Request to amend an approved or modified PA request.

ForwardHealth does not accept a paper amendment request submitted on anything other than the Prior Authorization Amendment Request. The Prior Authorization Amendment Request may be submitted through the ForwardHealth Portal as well as by mail or fax. If ForwardHealth receives a PA amendment on a previous version of the Prior Authorization Amendment Request form, a letter will be sent to the provider stating that the provider is required to submit a new PA amendment request using the proper forms.

Examples of when providers may request an amendment to an approved or modified PA request include the following:

- To temporarily modify a member's frequency of a service when there is a short-term change in his or her medical condition.
- To change the rendering provider information when the billing provider remains the same.
- To change the ForwardHealth Member Identification Number.
- To add or change a procedure code.

Note: ForwardHealth recommends that, under most circumstances, providers should enddate the current PA request and submit a new one if there is a significant, long-term change in services required.

Appeals

If a PA request is denied or modified by ForwardHealth, only a member, or authorized person acting on behalf of the member, may file an appeal with the DHA. Decisions that may be appealed include the following:

- Denial or modification of a PA request.
- Denial of a retroactive authorization for a service.

The member is required to file an appeal within 45 days of the date of the Notice of Appeal Rights letter.

To file an appeal, members may complete and submit a Request for Fair Hearing form.

Though providers cannot file an appeal, they are encouraged to remain in contact with the member during the appeal process. Providers may offer the member information necessary to file an appeal and help present his or her case during a fair hearing.

Fair Hearing Upholds ForwardHealth's Decision

If the hearing decision upholds the decision to deny or modify a PA request, the DHA notifies the member and ForwardHealth in writing. The member may choose to receive the service (or in the case of a modified PA request, the originally requested service) as a noncovered service, not receive the service at all, or appeal the decision.

Fair Hearing Overturns ForwardHealth's Decision

If the hearing decision overturns the decision to deny or modify the PA request, the DHA notifies ForwardHealth, the member, and the provider. The letter includes instructions for the provider and for ForwardHealth.

If the DHA letter instructs the provider to submit a claim for the service, the provider should submit the following to ForwardHealth after the service(s) has been performed:

- A paper claim with "HEARING DECISION ATTACHED" written in red ink at the top of the claim.
- A copy of the hearing decision.
- A copy of the denied PA request.

Providers are required to submit claims with hearing decisions to the following address:

ForwardHealth
Specialized Research
Ste 50
6406 Bridge Rd
Madison WI 53784-0050

Claims with hearing decisions sent to any other address may not be processed appropriately.

If the DHA letter instructs the provider to submit a new PA request, the provider is required to submit the *new* PA request along with a copy of the hearing decision to the PA Unit at the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

ForwardHealth will then approve the PA request with the revised process date. The provider may then submit a claim following the usual claims submission procedures after providing the service(s).

Financial Responsibility

If the member asks to receive the service *before* the hearing decision is made, the provider is required to notify the member before rendering the service that the member will be responsible for payment if the decision to deny or modify the PA request is upheld.

If the member accepts responsibility for payment of the service before the hearing decision is made, and if the appeal decision *upholds* the decision to deny or modify the PA request, the provider may collect payment from the member if certain conditions are met.

If the member accepts responsibility for payment of the service before the hearing decision is made, and if the appeal decision

overturns the decision to deny or modify a PA request, the provider may submit a claim to ForwardHealth. If the provider collects payment from the member for the service before the appeal decision is overturned, the provider is required to refund the member for the *entire* amount of payment received from the member after the provider receives Medicaid's reimbursement.

Wisconsin Medicaid does not directly reimburse member.

Enddating

Providers are required to use the Prior Authorization Amendment Request to enddate most PA requests. ForwardHealth does not accept requests to enddate a PA request for any service, except drugs, on anything other than the Prior Authorization Amendment Request. PA for drugs may be enddated by using STAT-PA in addition to submitting a Prior Authorization Amendment Request.

Providers may submit a Prior Authorization Amendment Request on the ForwardHealth Portal, or by fax or mail.

If a request to enddate a PA is not submitted on the Prior Authorization Amendment Request, a letter will be sent to the provider stating that the provider is required to submit the request using the proper forms.

Examples of when a PA request should be enddated include the following:

- A member chooses to discontinue receiving prior authorized services.
- A provider chooses to discontinue delivering prior authorized services.

Examples of when a PA request should be enddated and a new PA request should be submitted include the following:

- There is an interruption in a member's continual care services.
- There is a change in the member's condition that warrants a long-term change in services required.
- The service(s) is no longer medically necessary.

Returned Amendment Provider Review Letter

If the amendment request needs correction or additional information, a returned amendment provider review letter will be sent. The letter will show how the PA appears currently in the system and providers are required to respond by correcting errors identified on the letter. Providers are required to make the corrections or supply the requested information in the space provided on the letter or attach additional information to the letter before mailing the letter to ForwardHealth. Providers can also correct an amendment request that has been placed in returned provider review status in the ForwardHealth Portal.

ForwardHealth must receive the provider's response within 30 calendar days of the date the returned amendment provider review letter was sent. After 30 days the amendment request status becomes inactive and the provider is required to submit a new amendment request. The ForwardHealth interChange system will continue to use the original approved PA request for processing claims.

The provider's paper documents submitted with the amendment request will not be returned to the provider when corrections or additional information are needed; however, X-rays, photographs, and dental models will be returned once the amendment request is finalized for dentists, physicians, and DME providers. Therefore, providers are required to make a copy of their amendment requests (including attachments and any supplemental information) before mailing the requests to ForwardHealth. The provider is required to have a copy on file for reference purposes if ForwardHealth requires more information about the amendment request.

Note: When changing or correcting the amendment request, providers are reminded to revise or update the documentation retained in their records.

Searching for Previously Submitted Prior Authorization

Requests on the Portal

Providers will be able to search for all previously submitted PA requests, regardless of how the PA was initially submitted. If the provider knows the PA number, he or she can enter the number to retrieve the PA information. If the provider does not know the PA number, he or she can search for a PA by entering information in one or more of the following fields:

- Member identification number.
- Requested start date.
- Prior authorization status.
- Amendment status.

If the provider does not search by any of the information above, providers will retrieve all their PA requests submitted to ForwardHealth.

Forms and Attachments

An Overview

Depending on the service being requested, most PA requests must be comprised of the following:

- The PA/RF, PA/DRF, or PA/HIAS1.
- A service-specific PA attachment(s).
- Additional supporting clinical documentation.

Attachments

In addition to the PA/RF, PA/HIAS1, or PA/DRF, a service-specific PA attachment must be submitted with each PA request. The PA attachment allows a provider to document the clinical information used to determine whether or not the standards of medical necessity are met for the requested service(s). Providers should include adequate information for ForwardHealth to make a reasonable judgment about the case.

ForwardHealth will scan each form with a barcode as it is received, which will allow greater efficiencies for processing PA requests.

Prior Authorization/Durable Medical Equipment Attachment

The purpose of the PA/DMEA is to document the medical necessity of DME requiring PA.

Prior Authorization/Oxygen Attachment

The purpose of the PA/OA is to document the medical necessity of respiratory equipment requiring PA.

The following are reminders about the PA/OA:

- Element 13 is optional unless the height and weight of the member are related to the respiratory diagnosis.
- Element 18 requires providers to demonstrate the medical necessity of oxygen by indicating the diagnosis code *and* the specific description of the respiratory diagnosis that accurately describes the member's condition. Past experience has shown a high likelihood of providers indicating an incorrect diagnosis code related to oxygen use when only the diagnosis code is indicated in Element 18.
- Element 25 is used to explain the individual's conditions or symptoms and the need for oxygen that is not already provided elsewhere on the PA/OA. For example, it would not be necessary to indicate in this element that a member has a chronic condition such as a diagnosis of congestive heart failure and has an oxygen saturation level of 85 percent at rest, since that information would already be indicated in Elements 18 and 19.

However, the provider should use Element 25 to explain the special needs of the child receiving oxygen, or to indicate that the member experiences seizures. If the member was on oxygen at the time the test was taken, this also should be noted in Element 25.

The rendering provider is required to provide documentation in the member's medical record that supports the information given in Element 25 of the PA/OA and the medical necessity for oxygen services.

Record of Actual Daily Oxygen Use

The Record of Actual Daily Oxygen Use must be submitted with the PA/RF and the PA/OA for respiratory equipment requiring PA when the member resides in a nursing home.

Obtaining Forms and Attachments

Providers may obtain paper versions of all PA forms and attachments. In addition, providers may download and complete most PA attachments from the ForwardHealth Portal.

Paper Forms

Paper versions of all PA forms and PA attachments are available by writing to ForwardHealth. Include a return address, the name of the form, the form number (if applicable), and mail the request to the following address:

ForwardHealth
Form Reorder
6406 Bridge Rd
Madison WI 53784-0003

Providers may also call Provider Services to order paper copies of forms.

Downloadable Forms

Most PA attachments can be downloaded and printed in their original format from the Portal. Many forms are available in fillable PDF and fillable Microsoft® Word formats.

Web Prior Authorization Via the Portal

Certain providers may complete the PA/RF and PA attachments through the Portal. Providers may then print the PA/RF (and in some cases the PA attachment), and send the PA/RF, service-specific PA attachments, and any supporting documentation on paper by mail or fax to ForwardHealth.

Prior Authorization Request Form

The PA/RF is used by ForwardHealth and is mandatory for most providers when requesting PA. The PA/RF serves as the cover page of a PA request.

Providers are required to complete the basic provider, member, and service information on the PA/RF. Each PA request is assigned a unique ten-digit number. ForwardHealth remittance information will report to the provider the PA number used to process claim for prior authorized services.

Prior Authorization Request Form Completion Instructions for Durable Medical Equipment

The following sample PA/RFs for DME services are available:

- Sample PA/RF for DME.
- Sample PA/RF for exceptional supplies.

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible

members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (DHS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing PA requests, or processing provider claims for reimbursement. The use of the PA/RF is mandatory to receive PA for certain items. Failure to supply the information requested by the form may result in denial of PA or payment for the service.

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. Providers may submit PA requests, along with the PA/DMEA by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — PROVIDER INFORMATION

Element 1 — HealthCheck "Other Services" and Wisconsin Chronic Disease Program (WCDP)
Enter an "X" in the box next to HealthCheck "Other Services" if the services requested on the PA/RF are for HealthCheck "Other Services." Enter an "X" in the box next to WCDP if the services requested on the PA/RF are for a WCDP member.

Element 2 — Process Type
Enter the appropriate three-digit process type from the list below. The process type is a three-digit code used to identify a category of service requested. Use process type 999 (Other) only if the requested category of service is not found in the list. PA requests will be returned without adjudication if no process type is indicated.

130 — DME (wheelchairs, accessories, home health equipment)
139 — DME (respiratory equipment or exceptional supplies)
140 — DME (orthotics, footwear, prosthetics)
999 — Other (use only if the requested category or service is not listed above)

Element 3 — Telephone Number — Billing Provider
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 4 — Name and Address — Billing Provider
Enter the name and complete address (street, city, state, and ZIP+4 code) of the billing provider. Providers are required to include both the ZIP code and four-digit extension for timely and accurate billing. The name listed in this element must correspond with the billing provider number listed in Element 5a.

Element 5a — Billing Provider Number
Enter the NPI of the billing provider. The NPI in this element must correspond with the provider name listed in Element 4.

Element 5b — Billing Provider Taxonomy Code
Enter the national 10-digit alphanumeric taxonomy code that corresponds to the NPI in Element 5a.

SECTION II — MEMBER INFORMATION

Element 6 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth identification card or the EVS to obtain the correct number.

Element 7 — Date of Birth — Member
Enter the member's date of birth in MM/DD/CCYY format.

Element 8 — Address — Member
Enter the complete address of the member's place of residence, including the street, city, state, and ZIP code. If the member is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 9 — Name — Member
Enter the member's last name, followed by his or her 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 10 — Gender — Member
Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 11 — Diagnosis — Primary Code and Description
Enter the appropriate ICD-9-CM diagnosis code and description most relevant to the service/procedure requested.

Element 12 — Start Date — SOI (not required)

Element 13 — First Date of Treatment — SOI (not required)

Element 14 — Diagnosis — Secondary Code and Description
Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable.

Element 15 — Requested PA Start Date (not required)

Element 16 — Rendering Provider Number (not required)

Element 17 — Rendering Provider Taxonomy Code (not required)

Element 18 Procedure Code
Enter the appropriate HCPCS code for each service/procedure/item requested.

Element 19 — Modifiers
Enter the modifier(s) corresponding to the procedure code listed if a modifier is required.

Element 20 — POS
Enter the appropriate POS code designating where the requested service/procedure/item would be provided/performed/dispensed.

Element 21 — Description of Service
Enter a written description corresponding to the appropriate HCPCS code for each service/procedure/item requested.

Element 22 — QR
Enter the appropriate quantity (e.g., number of services) requested for the procedure code listed.

Element 23 — Charge
Enter the provider's usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1.0," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

*Note:*The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to provider *Terms of Reimbursement* issued by the DHS.

Element 24 — Total Charges
Enter the anticipated total charges for this request.

Element 25 — Signature — Requesting Provider
The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

Element 26 — Date Signed
Enter the month, day, and year the PA/RF was signed (in MM/DD/CCYY format).

STAT-PA Orthopedic Shoes Worksheet

When using STAT-PA, providers are required to use the STAT-PA Orthopedic Shoes Worksheet for documenting the need for orthopedic shoes, including the member's previous experience with orthopedic shoes, the manufacturer of the shoes, and the member's mobility, diagnosis, and need levels. Providers are required to fill in all blanks on the worksheet.

Providers may use the STAT-PA system when requesting PA for the following HCPCS orthopedic shoe procedure codes:

- L3216 — Orthopedic footwear, ladies shoes; oxford — depth inlay.
  (Quantity: 1 = one pair).
- L3221 — Orthopedic footwear, mens shoes; oxford — depth inlay.
  (Quantity: 1 = one pair).
- A5500 — For diabetics only, fitting (including follow-up), custom preparation and supply of off-the-shelf depth inlay shoe manufactured to accommodate multi-density insert(s), *per shoe*.
  (Quantity: 2 = two shoes).
- BadgerCare Plus will automatically authorize a quantity of one for procedure code L3257 (Orthopedic footwear, additional charge for split size) with the above procedure codes when split size is medically necessary. Providers do not need to separately request procedure code L3257.

Note: If a member requires orthopedic shoes designed for the opposite gender, the provider is required to submit the PA request on paper rather than through STAT-PA.

Providers are required to maintain a paper copy of the completed worksheet and all other documentation that supports the worksheet responses in their records for not less than five years for documentation purposes. In addition, providers choosing to resubmit returned STAT-PA requests on paper are required to submits a copy of the completed worksheet with the paper PA request.

Supporting Clinical Documentation

Certain PA requests may require additional supporting clinical documentation to justify the medical necessity for a service(s). Supporting documentation may include, but is not limited to, X-rays, photographs, a physician's prescription, clinical reports, and other materials related to the member's condition.

All supporting documentation submitted with a PA request must be clearly labeled and identified with the member's name and member identification number. Securely packaged X-rays and photographs will be returned to providers with the finalized PA request. X-rays and photographs must be mailed with the PA request. Mailing dental models with PA requests is recommended.

General Information

An Overview

The PA review process continues to include both a clerical review and a clinical review. The PA request will have one of the statuses detailed in the following table.

Prior Authorization Status	Description
Approved	The PA request was approved.
Approved with Modifications	The PA request was approved with modifications to what was requested.
Denied	The PA request was denied.
Returned — Provider Review	The PA request was returned to the provider for correction or for additional information.
Pending — Fiscal Agent Review	The PA request is being reviewed by the Fiscal Agent.
Pending — Dental Follow-up	The PA request is being reviewed by a Fiscal Agent dental specialist.
Pending — State Review	The PA request is being reviewed by the State.
Suspend — Provider Sending Information	The PA request was submitted via the ForwardHealth Portal and the provider indicated they will be sending additional supporting information on paper.
Inactive	The PA request is inactive due to no response within 30 days to the returned provider review letter and cannot be used for PA or claims processing.

Communication with Members

ForwardHealth recommends that providers inform members that PA is required for certain specified services *before* delivery of the services. Providers should also explain that, if required to obtain PA, they will be submitting member records and information to ForwardHealth on the member's behalf. Providers are required to keep members informed of the PA request status throughout the *entire* PA process.

Member Questions

A member may call Member Services to find out whether or not a PA request has been submitted and, if so, when it was received by ForwardHealth. The member will be advised to contact the provider if more information is needed about the status of an individual PA request.

Definition

PA is the electronic or written authorization issued by ForwardHealth to a provider prior to the provision of a service. In most cases, providers are required to obtain PA *before* providing services that require PA. When granted, a PA request is approved for a specific period of time and specifies the type and quantity of service allowed.

Designating an Address for Prior Authorization Correspondence

Correspondence related to PA will be sent to the practice location address on file with ForwardHealth unless the provider designates a separate address for receipt of PA correspondence. This policy applies to all PA correspondence, including decision notice letters, returned provider review letters, returned amendment provider letters, and returned supplemental documentation such as X-rays and photographs.

Providers who want to designate a separate address for PA correspondence have the following options:

- Update demographic information online via the ForwardHealth Portal. (This option is only available to providers who have established a provider account on the Portal.)
- Submit a Provider Change of Address or Status form.

Medicare/Medicaid Dual Eligibles and Prior Authorization

Members covered under Medicare and Wisconsin Medicaid are called dual eligibles. Claims for Medicare-covered services provided to dual eligibles must be billed to Medicare prior to billing Wisconsin Medicaid.

Services covered by Medicare do not require PA; however, providers are strongly encouraged to always obtain PA for dual eligibles, either at the time of initial claim submission or following a post payment reconsideration. This ensures Medicaid reimbursement in the event that Medicare denies coverage.

Other Insurance Coverage and Prior Authorization

Wisconsin Medicaid is the payer of last resort for any covered service for most situations. If the member is covered under third-party insurance, Wisconsin Medicaid reimburses the portion of the allowable cost remaining after all other third-party sources are exhausted.

Providers are required to obtain PA for services requiring PA. Failure to do so results in non-payment of the remaining otherwise allowable cost by Wisconsin Medicaid.

Prior Authorization Numbers

Upon receipt of the PA/RF, ForwardHealth will assign a PA number to each PA request.

The PA number consists of 10 digits, containing valuable information about the PA (e.g., the date the PA request was received by ForwardHealth, the medium used to submit the PA request).

Each PA request is assigned a unique PA number. This number identifies valuable information about the PA. The following diagram and table provides detailed information about interpreting the PA number.

Type of Number and Description	Applicable Numbers and Description
Media — One digit indicates media type.	Digits are identified as follows: 1= paper; 2 = fax; 3 = STAT-PA; 4 = STAT-PA; 5 = Portal; 6 = Portal; 7 = NCPDP transaction
Year — Two digits indicate the year ForwardHealth received the PA 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 PA request.	For example, February 3 would appear as 034.
Sequence number — Four digits indicate the sequence number.	The sequence number is used internally by ForwardHealth.

Purchase or Rental

ForwardHealth reserves the right to determine whether an item is purchased or rented for the member. In most cases, the item is purchased. If short-term use only is needed, or the member's prognosis is poor, equipment rental is approved.

Reasons for Prior Authorization

Only about four percent of all services covered by Wisconsin Medicaid require PA. PA requirements vary for different types of services. Refer to ForwardHealth publications and DHS 107, Wis. Admin. Code, for information regarding services that require PA. According to DHS 107.02(3)(b), Wis. Admin. Code, PA is designed to do the following:

- Safeguard against unnecessary or inappropriate care and services.
- Safeguard against excess payments.
- Assess the quality and timeliness of services.
- Promote the most effective and appropriate use of available services and facilities.
- Determine if less expensive alternative care, services, or supplies are permissible.
- Curtail misutilization practices of providers and members.

PA requests are processed based on criteria established by the DHS.

Providers should not request PA for services that do not require PA simply to determine coverage or establish a reimbursement rate for a manually priced procedure code. Also, new technologies or procedures do not necessarily require PA. PA requests for services that do not require PA are typically returned to the provider. Providers having difficulties determining whether or not a service requires PA may call Provider Services.

Referrals to Out-of-State Providers

PA may be granted to non-certified out-of-state providers when nonemergency services are necessary to help a member attain or regain his or her health and ability to function independently. The PA request may be approved only when the services are not reasonably accessible to the member in Wisconsin.

Out-of-state providers are required to meet Wisconsin Medicaid's guidelines for PA approval. This includes sending PA requests, required attachments, and supporting documentation to ForwardHealth before the services are provided.

Note: Emergency services provided out-of-state do not require PA; however, claims for such services must include appropriate documentation (e.g., anesthesia report, medical record) to be considered for reimbursement. Providers are required to submit claims with supporting documentation on paper.

When a Wisconsin Medicaid provider refers a member to an out-of-state, non-certified provider, the referring provider should refer the out-of-state provider to the ForwardHealth Portal or Provider Services to obtain appropriate certification materials, PA forms, and claim instructions.

All out-of-state nursing homes, regardless of location, are required to obtain PA for all services. All other out-of-state non-border-status providers are required to obtain PA for all nonemergency services except for home dialysis supplies and equipment.

Reimbursement Not Guaranteed

Wisconsin Medicaid may decline to reimburse a provider for a service that has been prior authorized if one or more of the following program requirements is not met:

- The service authorized on the approved PA request is the service provided.
- The service is provided within the grant and expiration dates on the approved PA request.
- The member is eligible for the service on the date the service is provided.
- The provider is certified by Wisconsin Medicaid on the date the service is provided.
- The service is billed according to service-specific claim instructions.
- The provider failed to meet other program requirements.

Providers may not collect payment from a member for a service requiring PA under any of the following circumstances:

- The provider failed to seek PA before the service was provided.
- The service was provided before the PA grant date or after the PA expiration date.
- The provider obtained PA but failed to meet other program requirements.
- The service was provided before a decision was made, the member did not accept responsibility for the payment of the service before the service was provided, and the PA was denied.

There are certain situations when a provider may collect payment for services in which PA was denied.

Other Health Insurance Sources

Providers are encouraged, but not required, to request PA from ForwardHealth for covered services that require PA when members have other health insurance coverage. This is to allow payment by Wisconsin Medicaid for the services provided in the event that the other health insurance source denies or recoups payment for the service. If a service is provided before PA is obtained, ForwardHealth will not consider backdating a PA request solely to enable the provider to be reimbursed.

Sources of Information

Providers should verify that they have the most current sources of information regarding PA. It is critical that providers and staff have access to these documents:

- Wisconsin Administrative Code: Chapters DHS 101 through DHS 109 are the rules regarding Medicaid administration.
- Wisconsin Statutes: Sections 49.43 through 49.99 provide the legal framework for Wisconsin Medicaid.
- ForwardHealth Portal: The Portal gives the latest policy information for all providers, including information about Medicaid managed care enrollees.

Status Inquiries

Providers may inquire about the status of a PA request through one of the following methods:

- Accessing WiCall, ForwardHealth's AVR system.
- Calling Provider Services.

Providers should have the 10-digit PA number available when making inquiries.

Two Providers Requesting the Same Equipment for One Member

A second PA request will not be approved when a PA request for the same member and the same equipment has already been approved for another provider. Since the second requestor has no way of knowing whether the equipment has been provided, ForwardHealth, upon request, will identify the original provider.

Grant and Expiration Dates

Backdating

Backdating an initial PA request to a date prior to ForwardHealth's initial receipt of the request may be allowed in limited circumstances.

A request for backdating may be approved if all of the following conditions are met:

- The provider specifically requests backdating in writing on the PA request.
- The request includes clinical justification for beginning the service before PA was granted.
- The request is received by ForwardHealth within 14 calendar days of the start of the provision of services.

Expiration Date

The expiration (end) date of an approved or modified PA request is the date through which services are prior authorized. PA requests are granted for varying periods of time. Expiration dates may vary and do not automatically expire at the end of the month or calendar year. In addition, providers may request a specific expiration date. Providers should carefully review all approved and modified PA requests and make note of the expiration dates.

Grant Date

The grant (start) date of an approved or modified PA request is the first date in which services are prior authorized and will be reimbursed under this PA number. On a PA request, providers may request a specific date that they intend services to begin. If no grant date is requested or the grant date is illegible, the grant date will typically be the date the PA request was reviewed by ForwardHealth.

Renewal Requests

To prevent a lapse in coverage or reimbursement for ongoing services, all renewal PA requests (i.e., subsequent PA requests for ongoing services) must be received by ForwardHealth *prior to the expiration date* of the previous PA request. Each provider is solely responsible for the timely submission of PA request renewals. Renewal requests will not be backdated for continuation of ongoing services.

Home Health Equipment

Adaptive Equipment

PA is not required for the adaptive equipment in the following list:

- Adaptive eating utensil, weighted handle, any size, style, or shape.
- Adaptive eating utensil, non-weighted handle, any size, style, or shape.
- Rocker knife.
- Plate guard.
- Scoop dish.
- Universal cuff.
- Dycem, any size or shape.
- Reacher.
- Sock/stocking aid.
- Dressing stick.
- Long-handled shoe horn.
- Hand-held shower, including a diverter spout.
- Adaptive hygiene aids, such as a long-handled sponge.

PA is required for other adaptive equipment not listed above. Use HCPCS procedure code E1399 (Durable medical equipment, miscellaneous) when submitting PA requests for these items.

Providers are required to complete a PA/RF and a PA/DMEA. The PA request must adequately describe the DME item.

Modifiers "U1"-"U9" and "UA"-"UD" will be assigned on approved PA requests to distinguish between items when procedure code E1399 is used more than once. If submitting the PA request via the ForwardHealth Portal, providers should specify the requested equipment with the requested charges in the additional space on the PA/DMEA.

The PA request for adaptive equipment should include sufficient information to confirm the medical necessity of the requested item(s), including the following:

- A complete description of the item being requested with brand/model number.
- The member's diagnosis(es) and the date of onset.
- The specific medical condition that necessitates the use of the requested equipment.
- A description of the member's ability to complete ADL independently, with a caregiver, or with adaptive equipment.
- Caregiver information (e.g., availability, duties, and whether the caregiver is a spouse, other family member, home health aid).
- Specific results of trial use of the adaptive equipment or report of therapy service, if available.

Augmentive Communication Device

PA is required in the following situations:

- More than 60 days of rental are required during a 365-day period for the following procedure codes:
  - E2506 (Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time).
  - E2508 (Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device).
  - E2510 (Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access).

- Another provider has provided the rental of an augmentative communication device to the member.
- Starting with the first day of rental for the following procedure codes:
  - E2500 (Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time).
  - E2502 (Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time).
  - E2504 (Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time).
  - E2511 (Speech generating software program, for personal computer or personal digital assistant).
  - E2512 (Accessory for speech generating device, mounting system).
  - E2599 (Accessory for speech generating device, not otherwise classified).

When submitting a PA request for these procedure codes (E2500, E2502, E2504, E2511, E2512, E2599), providers are required to include a copy of the manufacturer's estimate indicating the list price that will be charged for the device. Wisconsin Medicaid's reimbursement rate for these devices is determined on a case-specific basis when the PA request is approved.

Requesting Prior Authorization

The guidelines below should be used when requesting PA for an augmentative communication device:

- Have a physician's prescription.
- Have a complete clinical evaluation by a speech pathologist indicating a brief social/clinical history and current level of functioning, including cognition, behavior, language skills, oral/motor skills, speech production, swallowing, vision, hearing, and positioning.
- List what (if any) communication devices were tested. Describe why is this device the most appropriate.
- Give a trial period. Usually eight weeks is suggested. Give specific measurable results week by week, including carryover.

When requesting PA for the rental of any augmentative communication device, providers will be required to indicate the number of days that the rental of a device is requested instead of indicating a quantity of "1.0" for four to eight weeks. A quantity of "1.0" will now equal one day. Providers should continue to indicate modifier "RR" (Rental).

When requesting PA for the purchase of an augmentative communication device, documentation must be submitted indicating all augmentative communication devices tried by the member, dates of the trial periods, and the amounts billed to Wisconsin Medicaid for the trial periods.

Automated Medication Dispenser

An automated medication dispenser is programmed to the individual member's prescribed medications and dosages. The guidelines below should be used when requesting PA for an automated medication dispenser:

- The diagnosis must involve conditions resulting from the member's functional limitation in taking medication properly.
- The physician must indicate that these conditions have occurred prior to automated medication dispenser use or will occur if an automated medication dispenser is not used (in the physician's professional opinion).
- The documentation must state that the member is currently receiving a complex medically necessary medication regime consisting of more than two oral legend medications and more that two daily medication administration times.
- The physician must indicate that other methods of assuring compliance have been tried, but have not been successful.
- The use of an automated medication dispenser will avoid or reduce the need for home health care services.
- The documentation must state that the member is physically and cognitively able to remove the medication from the medication drawer.

Automated medication dispensers are initially approved for a rental period of 60 days. If the member remains compliant with the medication regime, and documentation show that home health costs have been avoided or reduced, approval may be given for purchase of the device.

Blood Pressure Monitor

A blood pressure monitor is a device for measuring blood pressure. The guidelines below should be used when requesting PA for a blood pressure monitor:

- The approved diagnoses are heart, heart-lung, lung, liver, and kidney transplant or kidney dialysis.
- At least daily monitoring of blood pressure must be documented as medically necessary.

Breast Pumps

PA is required if rental of a breast pump (E0604) exceeds 60 days. This 60-day period includes the initial 30-day rental (E0604, modifier "KH").

Decubitus Pads and Mattresses

Decubitus pads and mattresses are devices used to relieve pressure and prevent the occurrence of decubitus ulcers. Certain Decubitus pads require PA. The pads include: gel, air, dry and water pressure pads for mattresses, and mattress-size pads. Decubitus cushions for wheelchairs require PA. The PA request must indicate that:

- The member has a history of decubitus ulcers.
- The member's physical condition necessitates positioning the body in a way that would not be feasible in an ordinary bed.
- The documentation records the member's nutritional status, cleanliness, and skin care or treatment.

Enteral and Parenteral Pumps and IV Poles

Enteral and Parenteral pumps and IV poles are systems used to deliver food or medication at a controlled rate via the enteral or parenteral route. The PA request must document one of the following:

- A member's need for nutrition other than by mouth.
- A member's need for time-release medication over a 24-hour period.

Extra-Uterine Monitor

An extra-uterine monitor is a device used to monitor the presence of significant uterine contractions. A PA request must document:

- One of the following complications or abnormalities:
  - An obstetrical complication (including, but limited to, hyperemesis, premature labor, gestational diabetes, preeclampsia, placental disorders).
  - A gynecological complication (including, but not limited to, incompetent cervix, uterine anomaly or tumor, infection, or sexually transmitted disease).
  - A fetal abnormality (including, but not limited to, multiple pregnancy, hydramnios, lung immaturity, transplacental infection, congenital anomaly).
- The need for a continued follow-up of stable diagnosis of pregnancy.
- The member is willing and capable of compliance with the prescribed treatment.

Hospital Beds

An ordinary bed is one which is typically sold as furniture. It consists of a frame, box spring, and mattress. It has a fixed height and no head or leg elevation adjustments. An ordinary bed accommodates most transfers to a chair, wheelchair, or standing position. If needed, it can almost always be adapted to accommodate these transfers. The need for a particular bed height by itself would rarely justify the need for a hospital bed.

Hospital Beds, Fixed Height and Variable Height

A fixed height hospital bed is one with manual head and leg elevation adjustments but no height adjustment. A variable height hospital bed is one with manual height adjustment and manual head and leg elevation adjustments.

The PA request must document all of the following:

- The member requires positioning of the body in ways not feasible with an ordinary bed due to a medical condition that is expected to last for at least one month.
- The member requires the head of the bed to be elevated more that 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been tried and failed.
- The member has a condition that requires special attachments (such as a trapeze, foot board, or traction equipment) that cannot be fixed and used on an ordinary home bed.

In addition to all of the requirements above, requests for a variable height bed must document that the member requires a bed height different than a fixed height hospital bed to permit safe transfers to a chair or for adequate bed care.

Hospital Bed, Semi-Electric

A semi-electric hospital bed is one with manual height adjustment and electric head and leg elevation adjustments. The PA request must document all of the following:

- The member requires positioning of the body in ways not feasible with an ordinary bed due to a medical condition that is expected to last at least one month. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed.
- The member has a condition which requires special attachments (such as a trapeze, foot board, or traction equipment) that cannot be fixed and used on an ordinary home bed.
- The member requires a bed height different than a fixed height hospital bed to permit safe transfers to a chair or for adequate bed care.
- The member is alone for extended periods of time, requires frequent and immediate changes in body position and a can operate the bed controls independently.

Hospital Bed, Total Electric

A total electric hospital bed is one with electric height adjustment and electric head and leg elevation adjustments. The PA request must document all of the following:

- The member requires positioning of the body in ways not feasible with ordinary bed due to a medical condition that is expected to last at least one month. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed.
- The member has a condition which requires special attachments (such as a trapeze, foot board, or traction equipment) that cannot be fixed and used on an ordinary home bed.
- The recipient requires a bed height different than a fixed height hospital bed to permit safe transfers to a chair or for adequate bed care.
- The member is alone for extended periods of time, requires frequent and immediate changes in body position, and can operate the bed controls independently.

In addition to the requirements noted above, documentation submitted on the PA request must indicate one of the following:

- The member has tried multiple means of transfer and can only transfer with a total electric bed.
- The member has a care giver with a documented medical condition stating an inability to use a crank on a semi-electric bed.

Hospital Bed, Institutional Type, Includes: Oscillating, Circulating and Styker Frame

Oscillating beds are never covered according to DHS 107.24(5)(d). Circulating and stryker beds are only rarely medically necessary.

Six-way Electric Beds

Six-way hospital beds are rarely authorized for the following reasons:

- Semi-electric or four-way beds can be set to a safe height for transfer.
- Commodes and wheelchair heights can be adjusted so that one setting can be used for transfer.
- The member has power controls for the head and foot of the bed.

The medical need for raising total bed height must be addressed to consider authorization for a six-way bed.

Needle-Free Injection Device

A needle-free injection device delivers multiple pressurized injections without the use of needles and without skin trauma. A PA request must document the following:

- The member requires three or more daily injections and that this injection frequency is a long-term medical need.
- The member requires a needle-free injection device because of a skin condition.

Phototherapy (Bilirubin) Light, Bilirubin Blanket

A phototherapy (bilirubin) light and a bilirubin blanket are devices used to reduce an elevated bilirubin level in newborns. A PA request must include the following:

- Documentation of hyperbilirubinemia (jaundice) in the newborn.
- Serum Bilirubin levels of 12mg/100ml or greater in the healthy infant.
- A birth weight above 5 pounds and normal feedings.
- An indication that the parents are able to carry the home therapy program.
- Documentation that laboratory and nursing services (in home, clinic, or doctor's office) are provided daily during the use of the phototherapy unit.

Pressure Relief Beds

Pressure relief beds include both of the following types of beds:

- Air fluidized. A system that uses warm air under pressure to set small ceramic beads in motion to stimulate the movement of fluid.
- Air flotation. A powered system in which water, air, mud, or sand within the mattress is kept in constant motion. Procedure code E0193 is for a complete bed and cannot be used for a mattress overlay or replacement system.

The PA request for a pressure relief bed must include the following:

- Documentation on the lesions, the member's condition, positioning, nutritional status (including serum albumen and total protein levels with the initial request), and detailed descriptions of prior treatments used and the outcomes of the treatments.
- Documentation showing the presence of stage three or stage four decubitus ulcers affecting at least two pressure bearing surfaces.
- For subsequent PA requests, documentation must show signs of healing. The presence of new decubiti must be explained and may be a basis for denial without extenuating circumstances.

Standing Frames

Prone standers, supine standers, tilt tables, and standing frames are devices that allow a person to stand unaided. This does not include orthotics (except L1500 and L1510), prosthetics, various transfer devices, or wheelchairs.

Key elements for the approval of PA requests for prone standers, supine standers, tilt tables, and standing frames include the following:

- Standers are generally appropriate only for children.
- Allowable diagnoses are cerebral palsy, spina bifida, developmental delay, congenital anomalies, brain injury, meningomyelocele, and muscular dystrophy.
- The member must be involved in an active PT program. The program must include specific and measurable goals for significant improvement (not maintenance) expected in the areas of standing pivot transfers and/or ambulation skills.
- The member must be unable to work on the goals specified in the preceding point without the assistance of two people.
- Documentation must include a written carry over plan for caretakers to actively work toward specific therapy goals.
- Documentation must include the stander's brand and model number. Additional positioning features, for which additional reimbursement is requested, must include manufacturer information clearly documenting that these features are not standard with the basic stander.
- The stander must be size-appropriate for the member. Growth features are not medically necessary.
- Motorized, hydraulic, or electric standers, and standers with wheels for mobility will not be approved because these features are not medically necessary.
- Multi-positional standers are considered institutional equipment and will not be approved.

Note: The specific code for the stander's style and size must be used. Miscellaneous or "not otherwise classified" codes will not be approved.

Trial Period

Certain DME must be used on a trial basis before PA is required. There are other DME items that require PA for the trial period. The trial period allows Wisconsin Medicaid and BadgerCare Plus to determine if the DME is providing benefits to the member. The following items must be used on a trial period for at least two months before PA is requested:

- TENS units.
- Neuromuscular stimulators.
- Lymphedema pumps.

The following DME items require PA for the trial period:

- Communication devices.
- Dynasplints.

The documentation of trial results must be noted on the prescription or the PA request.

Implants

Requirements for Rendering Surgeon for Cochlear Implants and Bone-Anchored Hearing Devices

The rendering surgeon is required to obtain PA for the cochlear and bone-anchored hearing device implant surgeries. Claims for services and equipment relating to the surgery will be denied unless there is an approved PA on file from the rendering surgeon for the surgery.

A separate PA request is not required for the equipment. ForwardHealth will verify that the surgeon's PA request was approved before reimbursing the DME provider's claim, so the DME providers should not indicate the surgeon's PA number on claims for services and equipment relating to the surgery. Including a PA number on the DME claim may cause the DME claim to deny. Wisconsin Medicaid will deny the DME provider's claims if an approved PA request from the rendering surgeon is not on file.

When submitting PA requests, the rendering surgeon must submit a completed PA/RF and PA/PA for cochlear and bone-anchored hearing device implant surgery.

Member Eligibility Changes

Loss of Enrollment During Treatment

Some covered services consist of sequential treatment steps, meaning more than one office visit or service is required to complete treatment.

In most cases, if a member loses enrollment midway through treatment, or at any time between the grant and enddates, Wisconsin Medicaid will *not* reimburse services (including prior authorized services) provided during an enrollment lapse. Providers should not assume Wisconsin Medicaid covers completion of services after the member's enrollment has been terminated.

To avoid potential reimbursement problems when a member loses enrollment during treatment, providers should follow these procedures:

- Ask to see the member's ForwardHealth identification card to verify the member's enrollment or consult Wisconsin's EVS before the services are provided at each visit.
- When the PA request is approved, verify that the member is still enrolled and eligible to receive the service before providing it. An approved PA request does not guarantee payment and is subject to the enrollment of the member.

Members are financially responsible for any services received after their enrollment has ended. 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 payment will be made for the service.

To avoid misunderstandings, providers should remind members that they are financially responsible for any continued care after their enrollment ends.

Retroactive Disenrollment from State-Contracted MCOs

Occasionally, a service requiring fee-for-service PA is performed during a member's enrollment period in a state-contracted MCO. After the service is provided, and it is determined that the member should be retroactively disenrolled from the MCO, the member's enrollment is changed to fee-for-service for the DOS. The member is continuously eligible for BadgerCare Plus or Wisconsin Medicaid but has moved from MCO enrollment to fee-for-service status.

In this situation, the state-contracted MCO would deny the claim because the member was not enrolled on the DOS. Fee-for-service would also deny the claim because PA was not obtained.

Providers may take the following steps to obtain reimbursement in this situation:

- For a service requiring PA for fee-for-service members, the provider is required to submit a retroactive PA request. For a PA request submitted on paper, indicate "RETROACTIVE FEE-FOR-SERVICE" along with a written description of the service requested/provided under "Description of Service." Also indicate the actual date(s) the service(s) was provided. For a PA request submitted via the ForwardHealth Portal, indicate "RETROACTIVE FEE-FOR-SERVICE" along with a description of the service requested/provided under the "Service Code Description" field or include additional supporting documentation. Also indicate the actual date(s) the service(s) was provided.
- If the PA request is approved, the provider is required to follow fee-for-service policies and procedures for claims submission.
- If the PA request is denied, Wisconsin Medicaid will not reimburse the provider for the services. A PA request would be denied for reasons such as lack of medical necessity. A PA request would not be denied due to the retroactive fee-for-service status of the member.

Retroactive Enrollment

If a service(s) that requires PA was performed during a member's retroactive enrollment period, the provider is required to submit a PA request and receive approval from ForwardHealth *before* submitting a claim. For a PA request submitted on paper, indicate the words "RETROACTIVE ENROLLMENT" at the top of the PA request along with a written description explaining that the service was provided at a time when the member was retroactively enrolled under "Description of Service." Also include the actual date(s) the service(s) was provided. For a PA request submitted via the ForwardHealth Portal, indicate the words "RETROACTIVE ENROLLMENT" along with a description explaining that the service was provided at a time when the member was retroactively eligible under the "Service Code Description" field or include additional supporting documentation. Also include the actual date(s) the service(s) was provided.

If the member was retroactively enrolled, and the PA request is approved, the service(s) may be reimbursable, and the earliest effective date of the PA request will be the date the member receives retroactive enrollment. If the PA request is denied, the provider will not be reimbursed for the service(s). Members have the right to appeal the decision to deny a PA request.

If a member requests a service that requires PA before his or her retroactive enrollment is determined, the provider should explain to the member that he or she may be liable for the full cost of the service if retroactive enrollment is not granted and the PA request is not approved. This should be documented in the member's record.

Orthopedic Shoes, Modifications, and Transfers

Orthopedic Shoes, Hightop Orthopedic Shoes, and Mismate Shoes

The following PA documentation and clinical requirements for the purchase of non-custom adult orthopedic shoes, hightop orthopedic shoes, and mismate shoes are not all inclusive. The requirements apply to procedure codes L3216, L3217, L3221, L3222, and L3257.

Orthopedic or corrective shoes are shoes attached to a brace or prosthesis, or shoes that are modified to take into account discrepancy in limb length or a rigid foot deformation. Mismate (split size) shoes are mismatched shoes involving a difference of a full size or more.

Key elements for the approval of PA requests for orthopedic shoes, hightop orthopedic shoes, and mismate shoes are as follows:

- The PA request must indicate at least one of the following diagnoses or clinical conditions:
  - 250.0 — Diabetes without complications.
  - 355.6 — Morton's neuroma.
  - 700 — Corns/callouses, pre-ulcerative.
  - 707.1 — Foot ulcer.
  - 713.5 — Charcot's joint.
  - 735.0 — Hallux valgus > 35 degrees.
  - 735.2 — Hallux rigidus.
  - 735.3 — Hallux malleus with dorsal callous.
  - 735.4 — Other hammer toe with dorsal callous.
  - 735.5 — Claw toe.
  - 735.8 — Other acquired toe deformity (overlapping toes).
  - 736.71 — Acquired equinovarus.
  - 736.72 — Equinus deformities.
  - 736.73 — Cavus foot.
  - 736.74 — Claw foot, acquired.
  - 736.75 — Cavo varus, acquired.
  - 736.81 — Acquired leg length discrepancy > 1/2 inch.
  - 754.50 — Congenital talipes varus.
  - 754.51 — Congenital talipes equinovarus.
  - 754.52 — Congenital metatarsus primusvarus.
  - 754.53 — Congenital metarsus varus.
  - 754.71 Congenital talipes cavus.
  - 755.30 — Congenital leg length discrepancy > 1/2 inch.
  - 895 — Traumatic toe amputation.
  - 895.0 — Traumatic toe amputation with complications.
  - 895.1 — Traumatic toe amputation without complications.
  - 896 — Foot amputation.
  - 896.0 — Foot amputation, unilateral without complications.
  - 896.1 — Foot amputation, unilateral with complications.
  - 896.2 — Foot amputation, bilateral without complications.
  - 896.3 — Foot amputation, bilateral with complications.
  - * — Other diagnosis that would require an AFO or KAFO.
- One of the following must be documented:
  - Orthopedic shoes are needed for ambulation and/or transfers.

    - Orthopedic shoes are used with orthotics. (arch supports are not considered orthotics.)
    - Orthopedic shoes are required to accommodate a leg length discrepancy of 1/2 inch or more.
    - There are bony deformities of the feet and mismatched shoes of one fill size or greater are required.
- Shoes must be chosen based on medical need, activities of the member and member's environment. Documentation must reflect medical need; activity level; environmental conditions; age, condition, brand and type of current shoes. Coverage for replacement orthopedic shoes is allowed for medical reasons.
- The request must include brand, model number, and size(s).
- Codes L3216 and L3221, for female and male respectively, are allowed when all other listed criteria are met and ankles are stable. Hightop orthopedic shoes, codes L3217 and L3222, for female and male respectively, are allowed when criteria are met and ankles are unstable. When the criteria for mismatched shoes are met, the additional charge (L3257) is allowed.
- Shoes/orthotics to treat flat feet are not covered.

Orthotic Devices

Orthotic Devices

Most orthotic devices do not require PA unless the frequency limitation is exceeded. Orthotic devices must be purchased. The PA request must indicate that the member will receive maximal stability in a specified area or prevent an increase in severity of a deformity.

Bilateral appliances can be provided within the life expectancy of the item without PA if the single appliance does not require PA. Keep in mind that life expectancy requirements still apply for single appliances.

Prosthetic Procedures

ForwardHealth requires PA for compression garments in the following situations:

- When life expectancy has been exceeded (i.e., when greater than three garments per procedure code per twelve months are medically necessary).
- When the member's diagnosis is other than what is listed for allowed diagnoses for compression garments.

When submitting a PA request for compression garments, providers are required to include the following:

- PA/RF.
- PA/DMEA.
- Member's diagnosis or medical condition.
- Copy of the signed and dated physician's prescription.
- Description of the service to be provided (e.g., the garment will be custom-made).
- Type of compression garment.
- Modifier "RT" and/or "LT," when applicable.
- Clinical information, including the following:
    - Specific documented measurements required for the garment ordered (this information may be found on the manufacturer's order form).
    - Date(s) on which measurements were taken.
    - Appropriate periodic circumferential measurements, using consistent units of measurement (e.g., centimeters used at every measurement).

Providers are required to include modifier "RT" and/or "LT" on PA requests submitted for procedure codes A6530 to A6538, A6542, and S8420 to S8429. These procedure codes are incomplete without modifier "RT" or "LT" for these procedure codes.

Providers are reminded that if the above PA request submission requirements are not followed, the request will be returned for the missing or appropriate information.

Repairs

Augmentative Communication Device Repairs

PA is required for repairs and modifications performed on augmentative communication devices (V5336) when they exceed $300.

Providers are reminded that Wisconsin Medicaid does not reimburse for shipping and handling. The $300 threshold does not include the cost of shipping and handling.

General Guidelines for Repairs

PA is required in any of the following situations:

- When a total repair is estimated to exceed $150 for labor and parts, including both miscellaneous parts billed with E1399 and parts billed with specific codes. The estimate should not include any costs associated with shipping and handling. (The PA dollar threshold for the repair of an augmentative communication device is $300.)
- When labor alone is estimated to exceed $84 (two hours).
- When parts requiring PA, as listed in the DME Index, are used in a repair.
- When replacing a part before the end of its life expectancy. (This always requires PA.)

As part of the PA process, Wisconsin Medicaid and BadgerCare Plus determine if it is more cost-effective to purchase an item than to repair it and determine if the requested modifications are medically necessary.

The PA request must include an estimate of the cost for the entire service, an itemized list of needed parts, and the approximate cost of each part.

When requesting PA for a repair, providers are required to include documentation of what is being done to repair the item (e.g., repair of joy stick), the reason for the repair, and charges listed separately for parts and labor. A copy of the work order may be attached to the PA request if it provides this information. Reimbursement will be limited to a total of 30 days rental reimbursement if specific repairs and parts are not itemized on the PA request.

Modifier "RP" for Miscellaneous Repair Parts

Procedures codes with the "RP" modifier do not require PA if all of the following are true:

- The DME is more than one year old. Claims submitted during the first year with the "RP" modifier and without PA will be denied.
- The charge for the repair parts is $50.00 or less ($100 for powered mobility equipment).
- ForwardHealth purchased the DME being repaired.

Repair Parts for Orthotics and Prosthetics

Orthotics

Use procedure code L4210 to request reimbursement from Wisconsin Medicaid for parts to repair orthotic devices.

Prosthetics

Use procedure code L7510 to request reimbursement from Wisconsin Medicaid for parts to repair prosthetic devices.

Repair Parts for Home Health Equipment, Wheelchair Equipment, and Other Durable Medical Equipment

To request reimbursement from Wisconsin Medicaid for repair parts for hospital beds, lifts, and commodes, providers should select a procedure code for the part as follows:

1. Look in the Interactive maximum allowable fee schedule for a a procedure code matching the specific part.
2. If the part is less than $50 (or $100 for powered mobility equipment), providers can submit a claim with the "RP" modifier. PA is not required in this instance.
3. If the part needing repair isn't described by a procedure code in the max fee index and is more than $50 (or $100 for powered mobility equipment), providers can submit a claim with procedure code E1399. PA is needed in this case.

Home Health Equipment (i.e. Hospital Beds, Lifts, and Commodes)

Providers may use the "RP" modifier with the following procedure codes for home health.

Hospital Beds	
Procedure Code	**Description**
E0250	Hospital bed, fixed height, with any type side rails, with mattress
E0251	Hospital bed, fixed height, with any type side rails, without mattress
E0255	Hospital bed, variable height, hi-lo, with any type side rails, with mattress
E0256	Hospital bed, variable height, hi-lo, with any type side rails, without mattress
E0260	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress
E0261	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress
E0265	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, with mattress
E0266	Hospital bed, total electric (head, foot, and height adjustments), with any type side rails, without mattress
E0290	Hospital bed, fixed height, without side rails, with mattress
E0291	Hospital bed, fixed height, without side rails, without mattress
E0292	Hospital bed, variable height, hi-lo, without side rails, with mattress
E0293	Hospital bed, variable height, hi-lo, without side rails, without mattress
E0294	Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress
E0295	Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress
E0296	Hospital bed, total electric (head, foot, and height adjustments), without side rails, with mattress
E0297	Hospital bed, total electric (head, foot, and height adjustments), without side rails, without mattress
E0301	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress
E0302	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress
E0303	Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress
E0304	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress

Lifts	
Procedure Code	**Description**
E0630	Patient lift, hydraulic, with seat or sling
E0635	Patient lift, electric, with seat or sling

Commode Chairs	
Procedure Code	**Description**
E0163	Commode chair, stationary, with fixed arms
E0164	Commode chair, mobile, with fixed arms
E0168	Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type, each
E0240	Bath/shower chair, with or without wheels, any size
E0247	Transfer bench for tub or toilet with or without commode opening

Repair Parts for Wheelchairs

To request reimbursement from Wisconsin Medicaid for repair parts for wheelchairs, providers should select the procedure code for the part as follows:

1. Find in the DME maximum allowable fee index a procedure code matching the specific part.
2. If no procedure code has been found, use E1399 for the part. Procedure code E1399 always requires PA.

Wheelchairs	
Procedure Code	**Description**
K0001	Standard wheelchair
K0002	Standard hemi (low seat) wheelchair
K0003	Lightweight wheelchair
K0004	High strength, lightweight wheelchair
K0005	Ultralightweight wheelchair
K0006	Heavy-duty wheelchair
K0007	Extra heavy-duty wheelchair
K0009	Other manual wheelchair/base
K0010	Standard-weight frame motorized/power wheelchair
K0011	Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking
K0012	Lighweight portable motorized/power wheelchair
K0014	Other motorized/power wheelchair base
K0800	Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds
K0801	Power operated vehicle, group 1 heavy duty, patient weight capacity 301 to 450 pounds
K0802	Power operated vehicle, group 1 very heavy duty, patient weight capacity 451 to 600 pounds
K0806	Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds
K0807	Power operated vehicle, group 2 heavy duty, patient weight capacity 301 to 450 pounds
K0808	Power operated vehicle, group 2 very heavy duty, patient weight capacity 451 to 600 pounds

K0812	Power operated vehicle, not otherwise classified

Repair Parts for All Other Durable Medical Equipment

When submitting claims to ForwardHealth for repair parts for all other DME, providers should select the procedure code for the part as follows:

1. Find in the DME maximum allowable fee index a procedure code matching the specific part.
2. If no procedure code has been found, use E1399 for the part. Procedure code E1399 always requires PA.

Respiratory Equipment

Airway Clearance Devices

An airway clearance device is a self-administered chest PT system, consisting of a mechanical device that promotes airway clearance by HFCC.

Key elements for the approval of PA requests for airway clearance devices are as follows:

- The member must require, as a daily activity, percussion of the chest in order to facilitate the removal of lung secretions.
- The request indicates that use of the airway clearance device will allow the member more independence in performing his or her own percussing. Routine home health care will no longer be needed or be greatly reduced for percussing.
- The one-time charge for purchase of the device covers all replacements per the manufacturer.

An Overview of Oxygen Services Requiring Prior Authorization

According to the DME Index, PA is required for all oxygen-related services covered by these procedure codes, as follows:

- All rented and portable and stationary gaseous, liquid systems or concentrators require PA after 30 days of use.
- All oxygen content procedure codes require PA after 30 days of use.
- All portable and stationary oxygen systems for purchase require PA with the initial request.

Required Prior Authorization Forms

Providers are required to submit both the PA/RF and the PA/OA for oxygen-related services, including stationary and portable oxygen systems, oxygen contents, and oxygen concentrators. PA requests for members who reside in nursing homes must include a Record of Actual Daily Oxygen Use form along with the PA/RF and PA/OA. Providers may also be required to submit additional supporting documentation, when applicable.

Providers may attach a photocopy of the physician's prescription to the completed PA/OA or the prescribing physician may sign and date the PA/OA in lieu of attaching the prescription. The prescription (or PA/OA) must be signed and dated within 30 days prior to the date of receipt by ForwardHealth or the requested start date of the PA request. Attach the PA/OA to the PA/RF and send it to ForwardHealth. Standing orders are not acceptable.

Signatures

Providers are required to keep a copy of the physician's signed and dated PA/OA *or* the physician's signed and dated prescription in the member's file. As a reminder, the written copy must match what is stated in the PA request. Web PA users must type in the name of the person who is required to sign the forms for the elements that need a signature. Providers may print a copy of the forms submitted via the Portal and have them signed for their own records.

Record of Actual Daily Oxygen Use Form for Nursing Home Residents

If a member is in an SNF, the PA request must include a record of the actual daily usage of oxygen for at least the first 15 days of the initial 30-day rental period. A provider should submit a PA request for a member in a nursing home even if the member does not use oxygen for 15 *consecutive* days within the 30-day period but uses it a minimum of 15 days within the 30-day period. The provider should explain the situation on the PA request. These PA requests are considered on a case-by-case basis.

When requesting PA, nursing homes are required to indicate with an "X" on the Record of Actual Daily Oxygen Use form each shift that a member uses oxygen or submit a copy of the nursing home's record of the member's oxygen use. Documentation of medication administration is required during every shift for prescription drugs (e.g., oxygen) administered in a nursing home by nursing home staff.

Prior Authorization Requests for Infants Younger than 24 Months

Providers currently are required to indicate the appropriate "Q" modifier on a PA request based on the flow rate indicated in the prescription. However, a specific flow rate is not always specified on the prescription for infants younger than 24 months.

PA requests may be approved without a modifier for infants younger than 24 months if the prescription does not specify a flow rate but specifies maintenance of a certain oxygen saturation level. This applies to the following oxygen systems:

- E0424 — Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flow meter, humidifier, nebulizer, cannula or mask, and tubing.
- E0439 — Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing.
- E1390 — Oxygen concentrator, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate.

Providers are required to submit a new PA request with a specified flow rate when the child reaches 24 months of age.

Apnea Monitor

An apnea monitor is a device used to monitor respirations, heart rate, or both, and alert the caregiver when these are outside the limits set by the physician.

The apnea monitor rental includes the alarm, cables, electrodes, and lead wires. These items are not separately reimbursed.

Key elements for the approval of PA requests for apnea monitors are as follows:

- Documentation must include the alarm settings for the apnea monitor.
- For members up to the age of six months, documentation must include one of the following:
  - Documented family history of apnea, SIDS, or near-miss SIDS.
  - One or more incidences of apnea within the past six months, as well as the intervention and outcome that occurred for each incident. Documentation must also include the response plan when the monitor sounds an alarm.
  - Presence of an artificial airway and the type of required assisted breathing device or ventilator, if used.
- For members over the age of six months, documentation must include all of the following:
  - Presence of an artificial airway and the type of required assisted breathing device or ventilator, if used, including the frequency and amount of time the apnea monitor is used as ordered by the physician.
  - One or more incidences of apnea within the past six months, the response plan when the monitor sounds an alarm, as well as the intervention and outcome which occurred for each incident; abnormal blood gases; or an event recording (histogram) showing abnormalities if the absence of apnea is noted within the past six months.
  - For recurrent apnea, evidence of abnormal blood gases or a clogged airway and information on what has been used to prevent or decrease episodes of a clogged artificial airway.
- Apnea monitors are rarely indicated for members four years of age or over.

C-Pap, BiPap

A C-Pap is a non-invasive positive airway pressure device that, by forcing air under pressure into the pharynx and bronchial tubes, prevents structures in the throat from blocking air movement in and out of the lungs during sleep. C-Pap = continuous. BiPap = one level for inspiration, another for expiration.

Key elements for the approval of PA requests for C-Pap or BiPap are as follows:

- Documentation of a trial of C-Pap or an explanation by the physician of why C-Pap would not be appropriate for the member must accompany requests for Bi-Pap. If the member is unable to tolerate C-Pap, Bi-Pap may be authorized.
- C-Pap and Bi-Pap may be authorized for a diagnosis of obstructive sleep apnea.
- A copy of the member's sleep lab evaluation is required.

Carbon Dioxide Respiration Monitor

A carbon dioxide respiration monitor is a device that measures end tidal carbon dioxide and is used to monitor carbon dioxide trends.

Key elements for the approval of PA requests for carbon dioxide respiration monitors are as follows:

- There must be a documented medical need to monitor the inspirations/expirations of the member.
- Documentation from the provider must include recorded carbon dioxide values dated within 30 days of the date the request is received.

Humidifier

A humidifier is a device used to increase moisture in the air and which may be attached to ventilation/oxygen equipment.

A key element for the approval of humidifiers is that humidifiers are reimbursable only for supplemental humidification during IPPB treatments, oxygen delivery, or as part of a ventilation/oxygen system.

Intermittent Positive Pressure Breathing Device

An IPPB device is medically appropriate for the following indications:

- Members at risk of respiratory failure because of decreased respiratory function secondary to kyphoscoliosis or neuromuscular disorders.
- Members with severe bronchospasm or exacerbated chronic obstructive pulmonary disease who fail to respond to standard therapy.
- Management of atelectasis that has not improved with simple therapy.

Nebulizer, with Compressor

A nebulizer is used to convert liquid into a fine spray; the compressor distributes the mist.

Key elements for the approval of PA requests for nebulizers with compressors are as follows:

- The compressor is covered when prescribed for use with oxygen or IPPB treatments.
- The nebulizer is covered when the member requires aerosol medication therapy due to a respiratory condition. The type and dose of medication must be specified.

Oximeter Device

The oximeter is a device that measures the oxygen saturation of the blood in a non-invasive manner.

Key elements for the approval of PA requests for pulse oximeters are as follows:

- Documentation must include:
  - Oxygen saturation levels dated no more than 30 days prior to the date the PA request is received by ForwardHealth.
  - The frequency of monitoring oxygen saturation levels as ordered by the physician.
  - The frequency of low oxygen saturation and the actions and treatments used to treat the low oxygen level.
- For pediatric members (under age 18), the documented oxygen saturation level must be consistently 92 percent or below on room air.
- For adult members (age 18 and older), the documented oxygen saturation level must be 88 percent or below on room air.

Oxygen Analyzer

The oxygen analyzer is a device used to determine oxygen levels delivered in respirators, incubators, and other medical equipment.

Key elements for the approval of PA requests for oxygen analyzers are as follows:

- The diagnosis and clinical circumstances, such as use in conjunction with a tracheostomy, a compressor, and a ventilator, must be described.
- Analyzers are most often used for pediatric (under age 18) members.

Oxygen Conserver

An oxygen conserver is a device that allows the flow of oxygen only during inspiration resulting in reduced oxygen use.

Key elements for the approval of PA requests for oxygen conservers are as follows:

- A physician prescription dated within 30 days of the first DOS being requested must include all of the following:
  - Diagnosis and degree of impairment.
  - Oxygen flow rate and hours per day of use.
  - An estimate of the duration of need.
- The request must include a laboratory report with ABG or pulse oximetry values dated within 60 days of the date the request is received. Values must be consistent with the values currently required by Medicare. For children (under age 18) pulse oximetry would be required, not an ABG. The provider of oxygen services may not perform the laboratory studies.
- This equipment is most appropriate for persons who have a need for portable oxygen for extended periods of time.

Oxygen Saturation Levels

Medical necessity is established by the measurement of arterial oxygen saturation by arterial blood gas studies or pulse oximetry. Blood gas studies and pulse oximetry readings are acceptable when ordered and evaluated by the attending physician and performed under his or her supervision or when performed by a qualified provider or a supplier of laboratory services. The provider of the oxygen services or its entities may not perform these readings.

Providers should keep the following in mind when obtaining oxygen saturation level readings:

- Room air oxygen saturation levels should be taken when the member is in a stable, chronic state. Documentation must indicate the specific oxygen saturation level at the time the level was taken; ranges are not acceptable.
- If a member's condition dictates, it is acceptable to perform an oxygen saturation level while the member is receiving oxygen if the member's blood oxygen saturation level is equal to or less than 88 percent (on oxygen).
- Room air oxygen saturation level readings must be performed any time the member's medical condition changes resulting in an oxygen usage change. In addition, Wisconsin Medicaid and BadgerCare Plus may request that oxygen saturation levels be indicated on PA request renewals to ensure medical necessity for continued oxygen services.

Documenting Representative

The credentials of the documenting representative are not specified, but the documenting representative is required to have direct knowledge or factual information of the oxygen use they are documenting for the member. Additional information may be requested concerning the source of oxygen use documentation. (SNFs should follow their policies, which must comply with Wisconsin nursing home rules and regulations.)

Documentation of Oxygen Services in a Member's Home

When a drug (oxygen) is prescribed for self-administration in the member's home, daily documentation is not feasible. However, documentation of hours of concentrator use and maintenance of equipment are required to show the level of service that is provided in the member's home.

Oxygen Tents

An oxygen tent is a protective canopy used for inhalation therapy.

Key elements for the approval of PA requests for oxygen tents are as follows:

- The documentation must include a physician prescription dated within 30 days of the date the initial request is received. The prescription or attached certification of medical necessity must specify all of the following:
  - The diagnosis and degree of impairment.
  - Oxygen liter flow rate and hours per day of use.
  - An estimate of the duration of need.
- Laboratory reports of ABG or pulse oximetry values must be included with the request. Values must be consistent with the values currently required by Medicare. For children (under age 18) pulse oximetry would be required, not an ABG. The date of the laboratory test may be no more than 60 days from the date the request is received. The provider of the oxygen services may not perform the laboratory studies.

Percussor

A percussor is a device used to perform chest physical therapy with the purpose of assisting in removing excess secretions from the bronchial tubes.

Key elements for the approval of PA requests for percussors are as follows:

- The member must require, as a daily activity, cupping therapy of the chest in order to facilitate the removal of lung secretions.
- The member does not have a primary caregiver or receive routine home health care services.
- The member can self-administer the equipment.

Respiratory Tests

Respiratory tests, such as oximetry tests, oximetry trending sleep studies, pneumogram/pediscan tests, and oxicario/respirograms, measure respiratory functioning to determine appropriate therapy. For PA approval, medical documentation must include the purpose of the test and how the results will be used in treatment of the member.

Suction Pump

A suction pump is a device used to remove excess oropharyngeal, upper respiratory, tracheal, or other secretions by suction.

Key elements for the approval of PA requests for suction pumps are as follows:

- Suction pumps are covered for members who have difficulty raising and clearing secretions.
- Portable suction pumps are covered for members who may need suctioning while away from home.

Therapeutic Ventilator (BiPap-ST)

A therapeutic ventilator is a non-continuous mechanical ventilation system used for 12 hours or less per day.

Key elements for the approval of PA requests for therapeutic ventilators are as follows:

- Documentation from the provider must include: ventilator settings, weaning attempts or reasons why weaning is not an option, and the number of hours per day that mechanical ventilation is required.
- The need for mechanical ventilation does not exceed 12 hours per day.

Vaporizer

A vaporizer is a device that converts medicated liquids to vapors for inhalation.

Key elements for the approval of PA requests for vaporizers are as follows:

- Vaporizers are authorized for home use only in conjunction with an oxygen delivery system.
- The member has an established need for humidification due to respiratory problems.
- The request indicates that the vaporizer is necessary to loosen secretions that may be thick and the member is unable to expectorate.

Volume Ventilator

A volume ventilator is a device that delivers a preset volume and frequency of respiratory gases, as determined by the physician, with each inspiration. It is used for continuous mechanical ventilation.

Key elements for the approval of PA requests for volume ventilators are as follows:

- Information from the provider must include:
  - Ventilator settings.
  - Weaning attempts and/or the potential and number of hours per day that the member requires mechanical ventilation.
- The member has a documented need for mechanical ventilation for more than 12 hours per day.

Review Process

Clerical Review

The first step of the PA request review process is the clerical review. The provider, member, diagnosis, and treatment information indicated on the PA/RF, PA/HIAS1, and PA/DRF forms is reviewed during the clerical review of the PA request review process. The following are examples of information verified during the clerical review:

- Billing and/or rendering provider number is correct and corresponds with the provider's name.
- Provider's name is spelled correctly.
- Provider is Medicaid certified.
- Procedure codes with appropriate modifiers, if required, are covered services.
- Member's name is spelled correctly.
- Member's identification number is correct and corresponds with the member's name.
- Member enrollment is verified.
- All required elements are complete.
- Forms, attachments, and additional supporting clinical documentation are signed and dated.
- A current physician's prescription for the service is attached, if required.

Clerical errors and omissions are responsible for the majority of PA requests that are returned to providers for correction or additional information. Since having to return a PA request for corrections or additional information can delay approval and delivery of services to a member, providers should ensure that all clerical information is correctly and completely entered on the PA/RF, PA/DRF, or PA/HIAS1.

If clerical errors are identified, the PA request is returned to the provider for corrections before undergoing a clinical review. One way to reduce the number of clerical errors is to complete and submit PA/RFs through Web PA.

Clinical Review

Upon verifying the completeness and accuracy of clerical items, the PA request is reviewed to evaluate whether or not each service being requested meets Wisconsin Medicaid's definition of "medically necessary" as well as other criteria.

The PA attachment allows a provider to document the clinical information used to determine whether the standards of medical necessity are met for the requested service. Wisconsin Medicaid considers certain factors when determining whether to approve or deny a PA request pursuant to DHS 107.02(3)(e), Wis. Admin. Code.

It is crucial that a provider include adequate information on the PA attachment so that the ForwardHealth consultant performing the clinical review can determine that the service(s) being requested meets all the elements of Wisconsin Medicaid's definition of "medically necessary", including elements that are not strictly medical in nature. Documentation must provide the justification for the service requested specific to the member's current condition and needs. Pursuant to DHS 101.03(96m), Wis. Admin. Code, "medically necessary" is a service under ch. HFS 107 that meets certain criteria.

Determination of Medical Necessity

The definition of "medically necessary" is a legal definition identifying the standards that must be met for approval of the service. The definition imposes parameters and restrictions that are both medical and nonmedical.

The determination of medical necessity is based on the documentation submitted by the provider. For this reason, it is essential that documentation is submitted completely and accurately and that it provides the justification for the service requested, specific to the

member's current condition and needs. To be approved, a PA request must meet all of the standards of medical necessity including those that are not strictly medical in nature.

To determine if a requested service is medically necessary, ForwardHealth consultants obtain direction and/or guidance from multiple resources including:

- Federal and state statutes.
- Wisconsin Administrative Code.
- PA guidelines set forth by the DHS.
- Standards of practice.
- Professional knowledge.
- Scientific literature.

Services Requiring Prior Authorization

An Overview

PA is required for the following situations:

- DME items that list a PA requirement in the DME Index.
- Rental or purchase of DME beyond the limits in the DME Index.
- Replacement of DME prior to the end of its designated life expectancy from the DME Index. (This must be noted on the PA request.)
- DME item and repair costs beyond the dollar amount threshold listed in the DME Index.
- DME items that are not listed in the DME Index.
- DME items that have no specific procedure codes in the DME Index.
- Some DME items for nursing home residents that are not covered in the nursing home daily rate.
- HealthCheck "Other Services."

Prior Authorization Guidelines

Complete PA guidelines are available upon written request from the following address:

Division of Health Care Access and Accountability
1 West Wilson St
PO Box 309
Madison WI 53701-0309

Providers are required to specify the procedure code or description of the item for which guidelines are being requested.

Equipment with a Dollar Threshold

For certain procedures, PA is required only when the cost of providing the entire service exceeds the specified dollar amount listed in the DME Index. The dollar threshold in the Index is for the complete service, not per DOS.

The provider should estimate the cost of providing the complete service before the service is initiated. Since Wisconsin Medicaid does not reimburse for shipping and handling, do not include these charges in the estimate. If the provider is uncertain whether the total cost will exceed the dollar threshold, the provider should submit a PA request for the service.

Situations Requiring New Requests

Change in Billing Providers

Providers are required to submit a new PA request when there is a change in billing providers. A new PA request must be submitted with the new billing provider's name and billing provider number. The expiration date of the PA request will remain the same as the original PA request.

Typically, as no more than one PA request is allowed for the same member, the same service(s), and the same dates, the new billing provider is required to send the following to ForwardHealth's PA Unit:

- A copy of the existing PA request, if possible.
- A new PA request, including the required attachments and supporting documentation indicating the new billing provider's name and address and billing provider number.
- A letter requesting the enddating of the existing PA request (may be a photocopy) attached to each PA request with the following information:
    - The previous billing provider's name and billing provider number, if known.
    - The new billing provider's name and billing provider number.
    - The reason for the change of billing provider. (The provider may want to confer with the member to verify that the services by the previous provider have ended. The new billing provider may include this verification in the letter.)
    - The requested effective date of the change.

Changes to Member Enrollment Status

Changes to a member's enrollment status may affect PA determinations. In the following cases, providers are required to obtain valid, approved PA for those services that require PA:

- A member enrolled in the BadgerCare Plus Standard Plan has a change in income level and becomes eligible for the BadgerCare Plus Benchmark Plan. The member's enrollment status changes to Benchmark Plan.
- A member enrolled in the Benchmark Plan has a change in income level or medical condition and becomes eligible for the Standard Plan or Medicaid. The member's enrollment status changes to Standard Plan or Medicaid accordingly.

Some changes in a member's enrollment status do not affect PA determinations. In the following cases, providers are not required to obtain separate PA because PA will continue to be valid:

- A member enrolled in the Standard Plan becomes eligible for Medicaid coverage. PA granted under the Standard Plan will be valid for Medicaid.
- A member switches from the Standard Plan to the Benchmark Plan and there is already a valid PA on file for the member under the Benchmark Plan.
- A member switches from the Benchmark Plan to the Standard Plan or Medicaid and there is already a valid PA on file for the member under the Standard Plan or Medicaid.

Providers are encouraged to verify enrollment before every office visit or service rendered. Verifying enrollment will help providers identify changes in member enrollment status and take appropriate actions to obtain PA for services when necessary.

The first time a member switches plans, the provider is required to submit a new PA request, including all required PA forms and attachments. If a member switches back into either of the plans and there is a valid, approved PA on file under that plan, the provider does not need to submit a new PA request.

Providers who have a provider account on the ForwardHealth Portal may use the Portal to check if a valid PA is on file for the

service.

Calculating Limits for Services Requiring Prior Authorization

Any limits that pertain to services requiring PA will accumulate separately under each plan.

Examples

Examples of when a new PA request must be submitted include the following:

- A provider's billing provider changes.
- A member requests a provider change that results in a change in billing providers.
- A member's enrollment status changes and there is not a valid PA on file for the member's current plan (i.e., BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, Medicaid).

If the *rendering* provider indicated on the PA request changes but the *billing* provider remains the same, the PA request remains valid and a new PA request does *not* need to be submitted.

Services Not Performed Before Expiration Date

Generally, a new PA request with a new requested start date must be submitted to ForwardHealth if the amount or quantity of prior authorized services is not used by the expiration date of the PA request and the service is still medically necessary.

Submission Options

Fax

Faxing of all PA requests to ForwardHealth may eliminate one to three days of mail time. The following are recommendations to avoid delays when faxing PA requests:

- Follow the PA fax procedures.
- Providers should *not* fax the same PA request more than once.
- Providers should *not* fax *and* mail the same PA request. This causes delays in processing.

PA requests containing X-rays, dental molds, or photos as documentation must be mailed; they may not be faxed.

To help safeguard the confidentiality of member health care records, providers should include a fax transmittal form containing a confidentiality statement as a cover sheet to all faxed PA requests. The Prior Authorization Fax Cover Sheet includes a confidentiality statement and may be photocopied.

Providers are encouraged to retain copies of all PA requests and supporting documentation before submitting them to ForwardHealth.

Prior Authorization Fax Procedures

Providers may fax PA requests to ForwardHealth at (608) 221-8616. PA requests sent to any fax number other than (608) 221-8616 may result in processing delays.

When faxing PA requests to ForwardHealth, providers should follow the guidelines/procedures listed below.

Fax Transmittal Cover Sheet

The completed fax transmittal cover sheet must include the following:

- Date of the fax transmission.
- Number of pages, including the cover sheet. The ForwardHealth fax clerk will contact the provider by fax or telephone if all the pages do not transmit.
- Provider contact person and telephone number. The ForwardHealth fax clerk may contact the provider with any questions about the fax transmission.
- Provider number.
- Fax telephone number to which ForwardHealth may send its adjudication decision.
- To: "ForwardHealth Prior Authorization."
- ForwardHealth's fax number ([608] 221-8616). PA requests sent to any other fax number may result in processing delays.
- ForwardHealth's telephone numbers. For specific PA questions, providers should call Provider Services. For faxing questions, providers should call (608) 221-4746, extension 80118.

Incomplete Fax Transmissions

If the pages listed on the initial cover sheet do not all transmit (i.e., pages stuck together, the fax machine has jammed, or some other error has stopped the fax transmission), or if the PA request is missing information, providers will receive the following by fax from the ForwardHealth fax clerk:

- A cover sheet explaining why the PA request is being returned.
- Part or all of the original incomplete fax that ForwardHealth received.

If a PA request is returned to the provider due to faxing problems, providers should do the following:

- Attach a completed cover sheet with the number of pages of the fax.
- Resend the entire original fax transmission and the additional information requested by the fax clerk to (608) 221-8616.

General Guidelines

When faxing information to ForwardHealth, providers should not reduce the size of the PA/RF or the PA/HIAS1 to fit on the bottom half of the cover page. This makes the PA request difficult to read and leaves no space for consultants to write a response if needed or to sign the request.

If a photocopy of the original PA request and attachments is faxed, the provider should make sure these copies are clear and legible. If the information is not clear, it will be returned to the provider.

If the provider does not indicate his or her fax number, ForwardHealth will mail the decision back to the provider.

ForwardHealth will attempt to fax a response to the PA request to a provider three times. If unsuccessful, the PA request will be mailed to the provider.

If providers are not sure if an entire fax was sent, they should call ForwardHealth's fax clerk at (608) 221-4746, extension 80118, to inquire about the status of the fax.

Prior Authorization Request Deadlines

Faxing a PA request eliminates one to three days of mail time. However, the adjudication time of the PA request has not changed. All actions regarding PA requests are made within the predetermined time frames.

Faxed PA requests received after 1:00 p.m. will be considered as received the following business day. Faxed PA requests received on a Saturday, Sunday, or holiday will be processed on the next business day.

Avoid Duplicating Prior Authorization Requests

After faxing a PA request, providers should not send the original paperwork, such as the carbon PA/RF, by mail. Mailing the original paperwork after faxing the PA request will create duplicate PA requests in the system and may result in a delay of several days to process the faxed PA request.

Refaxing a PA request before the previous PA request has been returned will also create duplicate PA requests and may result in delays.

Response Back from ForwardHealth

Once ForwardHealth reviews a PA request, ForwardHealth will fax one of three responses back to the provider:

- "Your approved, modified, or denied PA request(s) is attached."
- "Your PA request(s) requires additional information (see attached). Resubmit the entire PA request, including the attachments, with the requested additional information."
- "Your PA request(s) has missing pages and/or is illegible (see attached). Resubmit the entire PA request, including the attachments."

Resubmitting Prior Authorization Requests

When resubmitting a faxed PA request, providers are required to resubmit the faxed copy of the PA request, including attachments. This will allow the provider to obtain the earliest possible grant date for the PA request (apart from backdating for retroactive

enrollment). If any attachments or additional information that was requested is received without the rest of the PA request, the information will be returned to the provider.

ForwardHealth Portal Prior Authorization

Providers can use the following PA features on the ForwardHealth Portal to do the following:

- Submit PA requests and amendments for all services that require PA.
- Receive decision notice letters and returned provider review letters.
- Correct returned PA requests and PA amendment requests.
- Search and view previously submitted PA requests.
- Print a PA cover sheet.

Submitting Prior Authorization Requests and Amendment Requests

Providers can submit PA requests for all services that require PA to ForwardHealth via the secure Provider area of the Portal. To save time, providers can copy and paste information from plans of care and other medical documentation into the appropriate fields on the PA request. Except for those providers exempt from NPI requirements, NPI and related data are required on PAs submitted via the Portal.

When completing PA attachments on the Portal, providers can take advantage of an Additional Information field at the end of the PA attachment that holds up to five pages of text that may be needed.

Providers may also submit amendment requests via the Portal for PAs with a status of "Approved" or "Approved with Modifications."

PA Attachments on the Portal

Almost all PA request attachments can be completed and submitted on the Portal. When providers are completing PA requests, the Portal presents the necessary attachments needed for that PA request. For example, if a physician is completing a PA request for physician-administered drugs, the Portal will prompt a PA/JCA, and display the form for the provider to complete.

All PA request attachment forms are available on the Portal to download and print to submit by fax or mail.

Providers may also chose to submit their PA request on the Portal and mail or fax the PA attachment(s) and/or additional supporting documentation to ForwardHealth. If the PA attachment(s) are mailed or faxed, a system-generated Portal PA Cover Sheet, must be printed and sent with the attachment to ForwardHealth for processing. Providers must list the attachments on the Portal PA Cover Sheet. When ForwardHealth receives the PA attachments by mail or fax, they will be matched up with the PA/RF that was completed on the Portal.

*Please note: If the cover sheet could not be generated while submitting the PA request due to technical difficulties, providers can print the cover sheet from the main Portal PA page.

Before submitting any PA documents, providers should save or print a copy for their records. Once the PA request is submitted, it cannot be retrieved for further editing.

As a reminder, ForwardHealth does not mail back any PA request documents submitted by the providers.

Additional Supporting Information

Providers may choose to submit additional supporting information via mail or fax. If additional supporting information is needed, providers are prompted to print a system-generated Portal PA Cover Sheet to be sent with the information to ForwardHealth for processing. Providers must list the additional supporting information on the Portal PA Cover Sheet.

For certain PA process types, providers can choose to upload electronic supporting information through the Portal. Files can be uploaded if the user selects a process type of 117 (Physician services), 124 (Dental services), or 125 (Orthodontic services). Photographs, X-rays and dental models may be uploaded through the Portal if the images are in a JPEG format or created with OrthoCad software (available free on the Web). Dental model OrthoCad files must be uploaded with an extension of ".3dm." JPEG files must be uploaded with an extension of ".jpg" or ".jpeg."

Mail

Any type of PA request may be submitted on paper. Providers may mail completed PA requests, amendments to PA requests, and requests to enddate a PA request to ForwardHealth at the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

Providers are encouraged to retain copies of all PA requests and supporting documentation before submitting them to ForwardHealth.

STAT-PA

Providers can submit STAT-PA requests for a limited number of services (e.g., certain drugs, selected orthopedic shoes, lead inspections for HealthCheck). The STAT-PA system is an automated system accessed by providers by touch-tone telephone that allows them to receive an immediate decision for certain PA requests.

NPI and related data are required when using the STAT-PA system.

Providers are encouraged to retain copies of all PA requests and supporting documentation before submitting them to ForwardHealth.

Note: A PA request cannot be submitted through STAT-PA for members enrolled in the BadgerCare Plus Benchmark Plan or the BadgerCare Plus Core Plan for Adults with No Dependent Children. PA requests for members enrolled in the Benchmark Plan and the Core Plan may be submitted online via the ForwardHealth Portal or on paper.

To request PA for selected orthopedic shoes using the STAT-PA system, access STAT-PA in one of the following ways:

- Touch-tone telephone.
- STAT-PA help desk correspondent.

Wisconsin STAT-PA is available from 8:00 a.m. to 11:45 p.m., seven days a week. The STAT-PA help desk is available from 8 a.m. to 6 p.m., Monday through Friday, excluding holidays. Providers are allowed to submit up to five PA requests per connection for touch-tone telephone and help desk queries.

The STAT-PA System Instructions and the STAT-PA Quick Reference Guide include more information about STAT-PA inquiries.

Responses to a STAT-PA Request

A STAT-PA request will be approved or returned. Providers will receive a STAT-PA confirmation notice both during the transaction and by mail for any STAT-PA request submitted, whether it was approved or returned. The STAT-PA system will assign a PA number to the transaction only when all of the questions in the STAT-PA Required Information section have been appropriately answered.

When a STAT-PA request is *approved*:

- A PA number is assigned at the end of the transaction.
- The approved procedure code(s) is indicated.
- The grant and expiration dates are indicated.
- The provider records the assigned PA number on the STAT-PA Orthopedic Shoes Worksheet.
- Providers are required to maintain a copy of the worksheet in their records for documentation purposes.

When a STAT-PA request is *returned*:

- A PA number is assigned at the end of the transaction.
- The STAT-PA system indicates that more clinical documentation is required and the provider may submit a paper PA request for reconsideration.
- If the provider chooses to resubmit the PA request on paper, the provider is required to include:
  - A PA/RF with the STAT-PA-assigned PA number in the description field. (This allows for backdating to the grant date originally requested. It is also important for adjudication of the paper PA request.)
  - The PA/DMEA.
  - A signed and dated prescription.
  - A copy of the completed STAT-PA Orthopedic Shoes Worksheet.
- Providers are required to maintain a copy of the completed STAT-PA Orthopedic Shoes Worksheet in their records for documentation purposes. Providers are required to maintain all documentation that supports medical necessity, claim information, and delivery of equipment in their records for a period not less than five years.
- A request for reconsideration may be faxed or mailed to ForwardHealth.

Wheelchairs and Wheelchair Accessories

Power-Operated Vehicles (Scooters)

All power-operated vehicles require PA. PA requests for power-operated vehicles with procedure codes K0801, K0802, K0807, and K0808 will be considered when the member has exceptional needs (e.g., greater weight capacity or heavy-duty needs). Providers are required to document on the PA request the member's medical need and any exceptional circumstances (e.g., member's weight) for consideration of the use of these procedure codes.

Documentation for Power-Operated Vehicles

PA requests for power-operated vehicles must include the following:

- A completed PA/RF.
- A completed PA/DMEA.
- Brand/model of requested equipment.
- A photocopy of the manufacturer's suggested retail price list when requesting a power-operated vehicle with procedure codes K0801, K0802, K0807, and K0808 or any accessories listed under procedure code E1399 (Durable medical equipment, miscellaneous).
- A prescription signed and dated by a physician within six months of the date ForwardHealth receives the PA request.

Providers are reminded that PA requests for power-operated vehicles must include, at a minimum, the following supporting clinical documentation:

- Member's height and weight.
- Member's diagnosis and date of onset and any associated condition(s) necessitating the equipment.
- Member's ambulation skills.
- Member's ability to transfer on and off the power-operated vehicle.
- Member's demonstrated ability to use the power-operated vehicle in all necessary environments.
- How and where the scooter will be used in the member's daily routine (e.g., indoors versus outdoors, city versus rural).
- Location of power-operated vehicle when not in use.
- Accessibility of rooms used in member's residence.
- Method of transporting the power-operated vehicle.
- Therapy evaluation, if available and/or if requested.
- List of reasons the requested power-operated vehicle was selected over other brands/models as the most appropriate and cost effective. Indicate other brands/ models considered or tried but not selected.

This documentation, along with the serial number of the power-operated vehicle that is being requested, must be maintained in the member's medical record.

Documentation for Replacement Equipment

A PA request for a power-operated vehicle that is replacing existing equipment must include the following supporting documentation:

- Age and condition of existing equipment.
- Reason for replacement.
- Whether repair to existing equipment is possible, and if so, the total estimated cost to repair the existing equipment.

Wheelchairs and Accessories

Rental of manual wheelchairs after 60 days requires PA. The PA request must indicate that the need is of short-term duration. Rental of a wheelchair may be approved for a time period.

The following guidelines are used for requesting PA for a non-nursing home manual wheelchair and a non-nursing home power\motorized wheelchair:

- Document the specific brand and type with the components.
- Have a physician prescription.
- Documents the following (be as specific as possible):
  - Medical necessity.
  - Therapist evaluation and justification (if available).
  - Independent use or description of abilities.
  - Caregiver involvement.
  - Accessibility of the home (e.g., ramps, door ways, bathroom, halls, kitchen).
  - Means of transporting the wheelchair.
  - Specific activity involvement.

Wheelchairs for Nursing Home Residents

Justification on the PA request for nursing home wheelchairs must include specific and measurable goals for functional ADL. Functional ADL include eating, dressing, hygiene, grooming, and vocational activities of the member. The therapy evaluation typically includes this information and should be attached to the PA request. The following are not considered medically necessary justifications for obtaining PA:

- Independent mobilization of a wheelchair to social activities.
- Therapy consisting of a range of motion program.
- General strengthening program.
- Positioning program or prevocational skills.

Reimbursement

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Archive Date:03/01/2010

Reimbursement:Amounts

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) may not exceed the BadgerCare Plus-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 BadgerCare Plus-allowed amount for a service (i.e., balance billing).

Other health insurance payments may exceed the BadgerCare Plus-allowed amount if no additional payment is received from the member or BadgerCare Plus.

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.

Electronic Funds Transfer

EFT 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. Electronic Funds Transfer 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 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 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 new "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 ForwardHealth Portal Electronic Funds Transfer User Guide and the Electronic Funds Transfer Fact Page 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 ForwardHealth Provider Services to resolve the issue and payment by paper check will be reinstated until the matter has been resolved.

Fee Schedules

Maximum allowable fee information is available on the ForwardHealth Portal in the following forms:

- Interactive fee schedule.
- Downloadable fee schedule in TXT 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.

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.

Reimbursement for Oxygen-Related Services

Wisconsin Medicaid reimburses DME providers for oxygen equipment rental and accessories at a single daily rate. Reimbursement for rented systems (including portable systems) procedure codes include oxygen contents and the reimbursement amount is based on the prescribed flow rate. The flow rate is indicated on the claim using a modifier.

Providers are reimbursed for oxygen contents at a monthly rate only for member-owned or nursing home-owned systems.

Providers are reminded that reimbursement for oxygen services can be made only for the days the member actually uses it, whether the member is using oxygen in his or her home or in a nursing facility.

Rented Durable Medical Equipment

Rental charges for DME are deducted from the Medicaid-allowed amount for the subsequent purchase of the item.

Equipment rental is covered only as long as medical necessity exists. If equipment is returned to the provider before the PA's expiration date because it is no longer needed, the provider must prorate the rental charge based on the DOS.

Collecting Payment From Members

Benchmark Plan Service Limitations

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

Services with Visit Limitations per Enrollment Year

Under the Benchmark Plan, some services are covered until a member reaches a specified number of visits or days of service per enrollment year. These services include:

- Inpatient hospital stays for substance abuse and mental health treatment.
- Home health visits.
- Nursing home stays.
- Routine eye exams.
- Therapy visits (PT, OT, and SLP).

Note: Hospice services are subject to a lifetime limit under the Benchmark Plan.

Visits and days of service that exceed the service limitations established under the Benchmark Plan are considered noncovered. Services provided during a noncovered visit will not be reimbursed by BadgerCare Plus. 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.

Services with Dollar Amount Limits per Enrollment Year

Under the Benchmark Plan, some services are subject to a specified dollar amount service limitation per member per enrollment year. Any products or services that exceed the dollar amount limit are considered noncovered.

If BadgerCare Plus reimburses any portion of the charges for the service, providers are required to accept the BadgerCare Plus allowed reimbursement, which is the lesser of the provider's usual and customary charges or the maximum allowable fee, as payment in full. If BadgerCare Plus pays a portion of the claim and the claim exceeds the member's dollar amount service limitation, providers can balance bill the member for the difference between the allowed reimbursement and the dollar amount actually paid by BadgerCare Plus.

For example, the Benchmark Plan reimburses up to $2,500.00 for DME per member per enrollment year. Suppose a member has expended $2,200.00 of her DME coverage and requires a new DME item. The BadgerCare Plus-allowed reimbursement for this DME item is $500.00. BadgerCare Plus will reimburse only $300.00 before the member has exhausted his or her coverage. The member is responsible for the additional $200.00. The provider must still accept $500.00 as payment in full because BadgerCare Plus reimbursed a portion of the charges. The provider must not bill the member for more than $200.00.

If a member has already met or exceeded his or her dollar limit, BadgerCare Plus will not reimburse providers for services provided to that member. Providers can bill members up to their usual and customary charges for noncovered services.

Conditions That Must Be Met

A member may request a noncovered service, a covered service for which PA 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.

Core Plan Service Limitations

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

Services with Visit Limitations per Enrollment Year

Under the Core Plan, certain services (i.e., outpatient hospital visits and therapy visits) are covered until a member reaches a specified number of visits or days of service per enrollment year. Visits that exceed the service limitations established under the Core Plan are considered noncovered. Services provided during a noncovered visit will not be reimbursed by the Core Plan. 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 are strongly encouraged to make payment arrangements with the member in advance.

Services with Dollar Amount Limits per Enrollment Year

Under the Core Plan, some services are subject to a specified dollar amount service limitation per member per enrollment year. Any products or services that exceed the dollar amount limit are considered noncovered. If BadgerCare Plus reimburses any portion of the charges for the service, providers are required to accept the Core Plan allowed reimbursement, which is the lesser of the provider?s usual and customary charges or the maximum allowable fee, as payment in full. If BadgerCare Plus pays a portion of the claim and the claim exceeds the member's dollar amount service limitation, providers can balance bill the member for the difference between the allowed reimbursement and the dollar amount paid by BadgerCare Plus. For example, the Core Plan reimburses up to $2,500.00 for durable medical equipment (DME) per member per enrollment year. Suppose a member has expended $2,200.00 of his or her DME coverage and requires a new DME item. The allowed reimbursement for this DME item is $500.00. BadgerCare Plus will reimburse only $300.00 before the member has exhausted his or her coverage. The member is responsible for the additional $200.00. The provider must still accept $500.00 as payment in full because BadgerCare Plus reimbursed a portion of the charges. The provider must not bill the member for more than $200.00. If a member has already met or exceeded his or her dollar limit, BadgerCare Plus will not reimburse providers for services provided to that member. Providers can bill members up to their usual and customary charges for noncovered services.

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 *only* the copayment amount from the member.

Deposit Fees and Delivery Charges Prohibited

Providers are prohibited from charging members a deposit fee, delivery charge, or any amount other than copayment for DME.

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 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

Amounts

Standard Plan, Core Plan, and Medicaid

Allowable DME procedure codes and their applicable copayment amounts under the BadgerCare Plus Standard Plan, the BadgerCare Plus Core Plan, and Medicaid can be found in the maximum allowable fee schedule. There is no copayment for rentals.

Benchmark Plan

Copayment for purchased DME is up to $5.00 per item under the Benchmark Plan. If reimbursement for the DME is less than $5.00, the member must be charged the lesser amount.

Nursing home residents who are members of the BadgerCare Plus Benchmark Plan are subject to copayment for DME that is not covered in the nursing home daily rate, such as exceptional supplies.

Exemptions

Wisconsin Medicaid Exemptions

According to DHS 104.01(12), Wis. Admin. Code, providers are prohibited from collecting copayment from the following Wisconsin Medicaid members:

- Members under 18 years of age with incomes at or below 100 percent of the FPL. (For HealthCheck services, members under 19 years old are exempt.)
- Members under 18 years of age who are members of a federally recognized tribe regardless of income.
- Members enrolled in Medicaid because they are in foster care regardless of age.
- Members enrolled in Medicaid through subsidized adoption regardless of age.
- Members enrolled in Medicaid through the Katie Beckett program regardless of age.
- Nursing home residents.
- Members enrolled in Medicaid SSI HMOs or Medicaid special managed care programs receiving managed care-covered services.
- Pregnant women.

The following services do not require copayment:

- Case management services.
- Crisis intervention services.
- CSP services.
- Emergency services.
- Family planning services, including sterilizations.
- Home care services.
- Hospice care services.
- Immunizations.
- Independent laboratory services.
- Injections.
- PDN and PDN services for ventilator-dependent members.

- SBS.
- Substance abuse day treatment services.
- Surgical assistance.

BadgerCare Plus Standard Plan Exemptions

Providers are prohibited from collecting copayment from the following BadgerCare Plus Standard Plan members:

- Members in nursing homes.
- Members under 18 years old who are members of a federally recognized tribe regardless of income.
- Members under 18 years old with incomes at or below 100 percent of the FPL.
- Pregnant women.

The following services do not require copayment:

- Case management services.
- Crisis intervention services.
- CSP services.
- Emergency services.
- Family planning services, including sterilizations.
- Home care services.
- Hospice care services.
- Immunizations.
- Independent laboratory services.
- Injections.
- PDN and PDN services for ventilator-dependent members.
- SBS.
- Substance abuse day treatment services.
- Surgical assistance.

Wisconsin Well Woman Medicaid Exemptions

Providers are prohibited from collecting copayment from members who have been enrolled into Wisconsin Well Woman Medicaid from the BadgerCare Plus Benchmark Plan or Core Plan for any Medicaid covered service.

Benchmark Plan Exemptions

Certain BadgerCare Plus Benchmark Plan members are exempt from copayment requirements, including the following:

- Members under 18 years old who are members of a federally recognized tribe.
- Pregnant women.

Providers should always use Wisconsin's EVS to verify member enrollment and to check if the member is subject to a copayment.

The following services do not require copayment under the Benchmark Plan:

- Family planning services.
- Preventive services, including HealthCheck screenings.

Limitations

Providers should verify that they are collecting the correct copayment for services as some services have monthly or annual copayment

limits. Providers may not collect member copayments in amounts that exceed copayment limits.

Resetting Copayment Limitations

Copayment amounts paid 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.
- 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, copayments will not be reset for the services that were received under the initial fee-for-service enrollment period.

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

Refund/Collection

If a provider collects a copayment before providing a service and BadgerCare Plus does not reimburse the provider for any part of the service, the provider is required to return or credit the entire copayment amount to the member.

If BadgerCare Plus deducts less copayment than the member paid, the provider is required to return or credit the remainder to the member. If BadgerCare Plus deducts more copayment than the member paid, the provider may collect the remaining amount from the member.

Requirements

Federal law permits states to charge members a copayment for certain covered services. Providers are required to request copayments from members. Providers may not deny services to a Wisconsin Medicaid or BadgerCare Plus Standard Plan member who fails to make a copayment; however, providers may deny services to a BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, or aBadgeCare Plus Core Plan member who fails to make a copayment.

Chapter 49.45(18), Wis. Stats., requires providers to make a reasonable attempt to collect copayment from the member unless the provider determines that the cost of collecting the copayment exceeds the amount to be collected.

Payer of Last Resort

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:

- B-3.
- Crime Victim Compensation Fund.
- GA.
- HCBS waiver programs.
- IDEA.
- Indian Health Service.
- Maternal and Child Health Services.
- WCDP.
    - 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.

Other Health Insurance Sources

BadgerCare Plus reimburses only that portion of the allowed cost remaining after a member's other health insurance sources have been exhausted. Other health insurance sources include the following:

- Commercial fee-for-service plans..
- Commercial managed care plans.
- Medicare supplements (e.g., Medigap).
- Medicare.
- Medicare Advantage.
- TriCare.
- CHAMPVA.
- Other governmental benefits.

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.

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

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.

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 delivery charges are included in the reimbursement for DME items.

Resources

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Archive Date:03/01/2010

Resources:Contact Information

Member Services

Providers should refer ForwardHealth members with questions to Member Services. The telephone number for Member Services is for member use only.

Provider Relations Representatives

The Provider Relations representatives, also known as field representatives, conduct training sessions on various ForwardHealth topics for both large and small groups of providers and billers. In addition to provider education, field representatives are available to assist providers with complex billing and claims processing questions. Field representatives are located throughout the state to offer detailed assistance to all ForwardHealth providers and all ForwardHealth programs.

Field Representative Specialization

The field representatives are assigned to specific regions of the state. In addition, the field representatives have specialized in a group of provider types. This specialization allows the field representatives to most efficiently and effectively address provider inquiries. To better direct inquiries, providers should contact the field representative in their region who specializes in their provider type.

Provider Education

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

- Conducting provider training sessions throughout the state.
- Providing training and information for newly 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 requests on the Portal). Refer to the Providers Trainings page for the latest information on training opportunities.

Additional Inquiries

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

- Claims, including discrepancies regarding enrollment verification and claim processing.
- PES 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 at (800) 362-3002.

If contacting a field representative by e-mail, providers should ensure that no individually identifiable health information, known as PHI,

is included in the message. PHI can include things such as the member's name combined with his/her identification number or 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 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.

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, and WWWP 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 (e.g., verifying a member's other health insurance coverage).
- Assistance with completing forms.
- Assistance with remittance information and claim denials.
- Policy clarification.
- PA 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 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.
- Amount billed.
- RA.
- 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 for STAT-PA inquiries, including inquiries from pharmacies, DME 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, and hospice services or NIP).
- 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 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
6406 Bridge Rd
Madison WI 53784-0005

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.

Provider Suggestions

The DHCAA 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 form.

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.

Electronic Data Interchange

Companion Documents

Purpose of Companion Documents

ForwardHealth companion documents provide trading partners with useful technical information on ForwardHealth's standards for nationally recognized electronic transactions.

The information in companion documents applies to BadgerCare Plus, Medicaid, SeniorCare, WCDP, and WWWP. Companion documents are intended for information technology and systems staff who code billing systems or software.

The companion documents complement the federal HIPAA 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, and enrollment inquiries).

Companion documents do *not* include program requirements, but help those who create the electronic formats for electronic data exchange.

Companion documents 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 Helpdesk).
- Transaction formats.

Revisions to Companion Documents

Companion documents may be updated as a result of changes to federal requirements. When this occurs, ForwardHealth will do the following:

- Post the revised companion document 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 the revised companion documents on the Portal. If trading partners do not follow the revisions identified in the companion document, transactions may not process successfully (e.g., claims may deny or process incorrectly).

A revision log located at the front of the revised companion document lists the changes that have been made. The date on the companion document reflects the last date the companion document was revised. In addition, the version number located in the footer of the first page is changed with each revision.

Data Exchange Methods

The following data exchange methods are supported by the EDI Department:

- 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 5.1 (pharmacies only), 270/271, or 276/277 transactions via an approved clearinghouse.

The EDI Department supports the exchange of the transactions for BadgerCare Plus, Medicaid, SeniorCare, WCDP, and WWWP.

Electronic Data Interchange Helpdesk

The EDI 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.

Electronic Transactions

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 Department, trading partners may exchange the following electronic transactions:

- 270/271. The 270 is the electronic transaction for inquiring about a member's enrollment. The 271 is received in response to the inquiry.
- 276/277. The 276 is the electronic transaction for checking claim status. The 277 is received in response.
- 835. The electronic transaction for receiving remittance information.
- 837. The electronic transaction for submitting claims and adjustment requests.
- 997. 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 5.1 Telecommunication Standard for Retail Pharmacy Claims. The real-time POS electronic transaction for submitting pharmacy claims.

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. The PES software allows providers to submit 837 transactions and download the 997 and the 835 transactions. To obtain PES software, providers may download it from the ForwardHealth Portal or may request it from the EDI Helpdesk.

Trading Partner Profile

A TPP 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 TPP.

To determine whether a TPP 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 software, are required to complete the TPP.

- Billing providers who use a third party (billing services and clearinghouses) to exchange electronic transactions are required to submit a TPP.
- 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 TPP.

Providers who change billing services and clearinghouses or become a trading partner should keep their information updated by contacting the EDI Helpdesk.

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

270/271 Transactions

The 270/271 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, 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.

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 enrollment.
- Medicare enrollment.
- Limited benefits categories.
- Any other commercial health insurance coverage.
- Exemption from copayments for BadgerCare Plus members.

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 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 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.

Copayment Information

If a member is enrolled in BadgerCare Plus and is exempted 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 and is required to pay copayments, providers 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.

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 to receive the most current enrollment information through the following methods:

- ForwardHealth Portal.
- WiCall, Wisconsin's AVR system.
- Commercial enrollment verification vendors.
- 270/271 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.

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.

Entering Dates of Service

Enrollment information is provided based on a "From" DOS 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 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.

Member Forgets ForwardHealth Identification Card

Even if a member does not present a ForwardHealth identification card, a provider can use Wisconsin's EVS 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 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.

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 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.

Responses Are Based on Financial Payer

When making an enrollment inquiry through Wisconsin's EVS, 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.
- WWWP.

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 Benefit and the FPW at the same time, both of which are administered by Medicaid.)

Forms

An Overview

ForwardHealth requires providers to use a variety of forms for PA, claims processing, and documenting special circumstances.

Fillable Forms

Most forms may be obtained from the Forms page of the ForwardHealth Portal.

Forms on the Portal are available as fillable PDF 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.

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
  6406 Bridge Rd
  Madison WI 53784-0003

Portal

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 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 through the secure Portal.

Cost Share Reports for Long-Term Managed Care Organizations

Individual cost share reports for long-term care MCOs that provide Family Care, Family Care Partnership, and PACE services are available via the secure area of the ForwardHealth Portal and can be downloaded as an Excel file.

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 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 ForeardHealth 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.

A user's guide containing detailed instructions for performing these functions can be found on the Portal.

Designating a Trading Partner to Receive 835 Health Care Claim Payment/Advice Transactions

Providers must designate a trading partner to receive their 835 transaction for ForwardHealth interChange.

Providers who wish to submit their 835 designation via the Portal are required to create and establish a provider account to have access to the secure area of the Portal.

To designate a trading partner to receive 835 transactions, providers must first complete the following steps:

- Access the Portal and log into their secure account by clicking the Provider link/button.
- Click on the Designate 835 Receiver link on the right-hand side of the secure home page.
- Enter the identification number of the trading partner that is to receive the 835 in the Trading Partner ID field.
- Click Save.

Providers who are unable to use the Portal to designate a trading partner to receive 835 transactions may call the EDI Helpdesk or submit a paper form.

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.
- 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 effective than calling WiCall or the EVS (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.

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.
- 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.

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.

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.

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 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.

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 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.

Managed Care Organization Portal

Information and Functions Through the Portal

The MCO 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 with date of birth and a "from DOS" 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, and taxonomy code (if applicable), and provider type and specialty.
- HealthCheck information.
- MCO contact information.
- Technical contact information. Entries may be added via the Portal.

Managed Care Organization Portal Reports

The following reports are generated to MCOs 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.

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.

Obtaining a Personal Identification Number

To establish an account on the Portal, providers are required to obtain a PIN. 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.

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 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 or TIN.
    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.
        - WCDP.
        - The WWWP.

    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.

Online Handbook

The Online Handbook allows providers access to all policy and billing information for Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and WCDP 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.)

Other Business Enhancements on the Portal

The secure Provider area of the Portal enables providers to do the following:

- View RAs.
- Designate which trading partner is eligible to receive the provider's 835.
- Update and maintain provider file information. Providers will have the choice to indicate separate addresses for different business functions.

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.
- 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. 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 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.

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 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.

Portal Clerks

The administrator (or the clerk administrator if the administrator has granted them authorization) may set up clerks within their 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).

Submitting Prior Authorization and Amendment Requests Via the Portal

Nearly all service areas can submit PAs via the ForwardHealth 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 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.

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 fee schedules for Medicaid, BadgerCare Plus, and WCDP are interactive and searchable. Providers can enter the DOS, 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 information are incorporated immediately after policy changes have been issued in *Updates*. The Online Handbook also links to the ForwardHealth Publications page, an archive section where providers can research past policy changes.

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 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.
- E-mail subscription service for *Updates*. Providers can sign up 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.

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 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 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.
- 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 system or the EVS (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 also enables providers to do the following:

- View RAs.
- Designate which trading partner is eligible to receive the provider's 835.
- Update and maintain provider file information. Providers will have the choice to indicate separate addresses for different business functions.

System and Browser Requirements

The following table lists the recommended system and browser requirements for using the Portal. PES 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	

Trading Partner Portal

The following information is available on the public Trading Partner area of the Portal:

- Trading partner testing packets.
- Trading Partner Profile submission.
- PES software and upgrade information.
- EDI companion documents.

In the secure Trading Partner area of the Portal, trading partners can exchange electronic transactions with ForwardHealth.

Updates

Full-Text Publications Available

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

General Information

ForwardHealth Updates are the first source of provider information. *Updates* announce the latest information on policy and coverage changes, PA submission requirements, claims submission requirements, and training announcements.

The *ForwardHealth Update Summary* is distributed on a monthly basis and contains an overview of *Updates* published that month. Providers with a ForwardHealth Portal account will be notified through their Portal mailbox when the *Update Summary* is available on the Portal. Providers without a Portal account will receive a paper copy of the *Update Summary* unless they have opted out of receiving paper publications.

Providers may obtain copies of *Updates* listed in the *Update Summary* from the Portal. A Web address that directly links providers to a list of each month's *Updates* is listed in the *Update Summary*. Providers may then print specific articles to keep on paper as well as navigate to other Medicaid information 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 immediately after policy changes have been issued in *Updates*. The Online Handbook also includes a link to the ForwardHealth Publications page, an archive section where providers can research past changes.

Multiple Ways to Access ForwardHealth Publications

Providers may choose to receive notification on paper via U.S. mail or through a new 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 much sooner than on paper. Certain providers may choose not to receive *Updates* and the monthly *Update Summary*.

ForwardHealth Portal Account

Providers who establish a Portal account will not receive the *Update Summary* on paper through the U.S. mail. Providers are still bound to the program's rules, policies, and regulations even if they do not receive the *Update Summary* through the mail.

Mail

ForwardHealth will mail the monthly *Update Summary* to providers who do not have a Portal account.

E-mail Subscription Service

Providers and other interested parties may sign up 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) and provider type (e.g., physician, hospital, DME 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. Providers who sign up for an e-mail subscription will continue to receive paper copies of the monthly *Update Summary* unless they have a Portal account or have opted out of receiving paper publications.

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

1. Go to the Portal.
2. Click on the "Providers" link or button.
3. Click the "Subscribe to Provider Notifications" link from the Quick Links box on the right side of the screen.
4. Register by supplying e-mail address.

Users may register for additional electronic subscriptions by adding service areas listed under "Available Subscriptions" on the right side of the subscriptions page.

WiCall

Enrollment Inquiries

WiCall is an AVR system that allows providers with touch-tone telephones direct access to enrollment information. A WiCall Quick Reference Guide for Enrollment Inquiries is available.

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 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 on the DOS or within the DOS range selected, HPSA information will be given.
- MCO: 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 member lock-in 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.

Entering Letters into WiCall

For some WiCall inquries, health care providers are required to enter their taxonomy code with their NPI. 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.

Information Available Via WiCall

WiCall, ForwardHealth's AVR 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 status.
- Provider CheckWrite information.

Providers are prompted to enter NPI or provider ID and in some cases, NPI-related data, to retrieve query information.

In all inquiry scenarios, WiCall offers the following options after information is retrieved and reported back to the caller:

- Repeat the information.
- Make another inquiry of the same type.
- Return to the main menu.
- Repeat the options.

Claim Status

Providers may check the status of a specific claim by selecting the applicable program ("financial payer" option, i.e., Wisconsin Medicaid, WCDP, or WWWP by entering their provider ID, member identification number, DOS, 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. 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/procedure code, revenue code, or ICD-9-CM 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.

Quick Reference Guide

The WiCall AVR Quick Reference Guide displays the information available for WiCall inquiries.