Provider Enrollment and Ongoing Responsibilities

1

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Provider Enrollment and Ongoing Responsibilities:Provider Enrollment

Topic #3969

Categories of Enrollment

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

- Billing/rendering provider
- Rendering-only provider
- Billing-only provider (including group billing)

Providers should refer to the service-specific information in the Online Handbook or the Information for Specific Provider Types page on the Provider Enrollment Information home page to identify which category of enrollment is applicable.

Billing/Rendering Provider

Enrollment as a billing/rendering provider allows providers to identify themselves on claims (and other forms) as either the provider billing for the services or the provider rendering the services.

Rendering-Only Provider

Enrollment as a rendering-only provider is given to those providers who practice under the professional supervision of another provider (e.g., physician assistants). Providers with a rendering provider enrollment cannot submit claims to ForwardHealth directly, but they have reimbursement rates established for their provider type. Claims for services provided by a rendering provider must include the supervising provider or group provider as the billing provider.

Billing-Only Provider (Including Group Billing)

Enrollment as a billing-only provider is given to certain provider types when a separate rendering provider is required on claims.

Group Billing

Groups of individual practitioners are enrolled as billing-only providers as an accounting convenience. This allows the group to receive one reimbursement, one RA (Remittance Advice), and the 835 (835 Health Care Claim Payment/Advice) transaction for covered services rendered by individual practitioners within the group.

Providers may not have more than one group practice enrolled in Wisconsin Medicaid with the same ZIP+4 code address, NPI (National Provider Identifier), and taxonomy code combination. Provider group practices located at the same ZIP+4 code address are required to differentiate their enrollment using an NPI or taxonomy code that uniquely identifies each group practice.

Individual practitioners within group practices are required to be Medicaid-enrolled because these groups are required to identify the provider who rendered the service on claims. Claims indicating these group billing providers that are submitted without a rendering provider are denied.

Topic #14137

Enrollment Requirements Due to the Affordable Care Act

In 2010, the federal government signed into law the ACA (Affordable Care Act), also known as federal health care reform, which affects several aspects of Wisconsin health care. ForwardHealth has been working toward ACA compliance by implementing some new requirements for providers and provider screening processes. To meet federally mandated requirements, ForwardHealth is implementing changes in phases, the first of which began in 2012. A high-level list of the changes included under ACA is as follows:

- Providers are assigned a risk level of limited, moderate, or high. Most of the risk levels have been established by the federal CMS (Centers for Medicare and Medicaid Services) based on an assessment of potential fraud, waste, and abuse for each provider type.
- Providers are screened according to their assigned risk level. Screenings are conducted during enrollment, reenrollment, and revalidation.
- Certain provider types are subject to an application fee. This fee has been federally mandated and may be adjusted annually. The fee is used to offset the cost of conducting screening activities.
- Providers are required to undergo revalidation every three years.
- All physicians and other professionals who prescribe, refer, or order services are required to be enrolled as a participating Medicaid provider.
- Payment suspensions are imposed on providers based on a credible allegation of fraud.
- Providers are required to submit personal information about all persons with an ownership or controlling interest, agents, and managing employees at the time of enrollment, re-enrollment, and revalidation.

Topic #194

In-State Emergency Providers and Out-of-State Providers

ForwardHealth requires all in-state emergency providers and out-of-state providers who render services to BadgerCare Plus, Medicaid, or SeniorCare members to be enrolled in Wisconsin Medicaid. Information is available regarding the enrollment options for in-state emergency providers and out-of-state providers.

In-state emergency providers and out-of-state providers who dispense covered outpatient drugs will be assigned a professional dispensing fee reimbursement rate of $10.51.

Topic #193

Materials for New Providers

On an ongoing basis, providers should refer to the Online Handbook for the most current BadgerCare Plus, Medicaid, and ADAP (Wisconsin AIDS Drug Assistance Program) information. Future changes to policies and procedures are published in *ForwardHealth Updates*.

Topic #11937

Durable Medical Equipment Providers with Multiple Locations

Each DME (durable medical equipment) provider, with the exception of individuals and sole proprietors, is required to do the following:

- Ensure that each practice location, if there is more than one, has its own unique NPI (National Provider Identifier). To obtain an NPI, providers may request one online.
- Apply for Medicaid (or WCDP (Wisconsin Chronic Disease Program), if applicable) enrollment for each practice location.

Sole proprietors and individual providers are an exception to this requirement. A DME provider who is a sole proprietor needs only one NPI as they are assigned to an Entity Type 1, or individual, NPI. As a sole proprietor or an individual, a provider may not receive or designate more than one NPI.

Topic #4457

Provider Addresses

ForwardHealth has the capability to store the following types of addresses and contact information:

- **Practice location address and related information.** This address is where the provider's office is physically located and where records are normally kept. Additional information for the practice location includes the provider's office telephone number and the telephone number for members' use. With limited exceptions, the practice location and telephone number for members' use are published in a provider directory made available to the public.

- **Mailing address.** This address is where ForwardHealth will mail general information and correspondence. Providers should indicate accurate address information to aid in proper mail delivery.
- **PA (prior authorization) address.** This address is where ForwardHealth will mail PA information.
- **Financial addresses.** Two separate financial addresses are stored for ForwardHealth. The checks address is where ForwardHealth will mail paper checks. The 1099 mailing address is where ForwardHealth will mail IRS Form 1099.

Providers may submit additional address information or modify their current information using the demographic maintenance tool.

Note: Providers are cautioned that any changes to their practice location on file with Wisconsin Medicaid may alter their ZIP+4 code information required on transactions. Providers may verify the ZIP+4 code for their address on the U.S. Postal Service website.

Topic #1722

Provider Eligibility and Enrollment

Any individual, corporation, business, or organization that sells or rents medical equipment, supplies, oxygen supplies, prosthetic, or orthotic devices may be Wisconsin Medicaid enrolled. Any DME (durable medical equipment) provider may furnish DME, enteral nutrition formula, and DMS (disposable medical supplies). Refer to the Enteral Nutrition Formula service area and the DMS service area for policy, PA (prior authorization), and claim submission information.

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

Orthotic and Prosthetic Provider Enrollment

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

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

- Be certified by the ABC (American Board for Certification) 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.

Complex Rehabilitation Technology Provider Enrollment

To receive reimbursement for CRT services from ForwardHealth, providers must enroll under the provider specialty: complex rehabilitation technology supplier.

To be eligible for Wisconsin Medicaid enrollment as a CRT supplier, per Wis. Admin. Code ? DHS 105.54, providers must meet the following criteria:

- Have an Entity Type 2 NPI (National Provider Identifier).
- Meet the criteria per Wis. Admin. Code § DHS 105.40.
- Be accredited by a Wisconsin Department of Health Services-recognized accredited organization. For a current list of Wisconsin Department of Health Services-recognized accredited organizations, refer to the Accreditation of Medicare Certified Providers & Suppliers webpage on the Centers of Medicare & Medicaid Services website.
- Upload certificates of individual(s) employed by the provider and certified as an assistive technology professional by the RESNA (Rehabilitation Engineering and Assistive Technology Society of North America).
- Provide attestation to the statement: "The organization has the capability to service and repair all complex rehabilitation technology provided."

Topic #14157

Provider Enrollment Information Home Page

ForwardHealth has consolidated all information providers will need for the enrollment process in one location on the ForwardHealth Portal. For information related to enrollment criteria and to complete online provider enrollment applications, providers should refer to the Provider Enrollment Information home page.

The Provider Enrollment Information home page includes enrollment applications for each provider type and specialty eligible for enrollment with Wisconsin Medicaid. Prior to enrolling, providers may consult a provider enrollment criteria menu, which is a reference for each individual provider type detailing the information the provider may need to gather before beginning the enrollment process, including:

- Links to enrollment criteria for each provider type
- Provider terms of reimbursement
- Disclosure information
- Category of enrollment
- Additional documents needed (when applicable)

Providers will also have access to a list of links related to the enrollment process, including:

- General enrollment information
- Regulations and forms
- Provider type-specific enrollment information
- In-state and out-of-state emergency enrollment information
- Contact information

Information regarding enrollment policy and billing instructions may still be found in the Online Handbook.

Topic #1931

Provider Type and Specialty Changes

Provider Type

Providers who want to add a provider type or change their current provider type are required to complete a new enrollment application for each provider type they want to add or change to because they need to meet the enrollment criteria for each provider type.

Provider Specialty

Providers who have the option to add or change a provider specialty can do so using the demographic maintenance tool. After adding or changing a specialty, providers may be required to submit documentation to ForwardHealth, either by uploading through the demographic maintenance tool or by mail, supporting the addition or change.

Providers should contact Provider Services with any questions about adding or changing a specialty.

Topic #1721

Providers Providing Durable Medical Equipment Services

Medicaid-enrolled nursing homes, pharmacies, and other types of providers may be reimbursed for providing DME (durable medical equipment) services without obtaining enrollment as a DME provider. The DME 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.

Topic #22257

Providers Have 35 Days to Report a Change in Ownership

Medicaid-enrolled providers are required to notify ForwardHealth of a change in ownership within 35 calendar days after the effective date of the change, in accordance with the Centers for Medicare & Medicaid Services Final Rule 42 C.F.R. § 455.104(c)(1)(iv).

Failure to report a change in ownership within 35 calendar days may result in denial of payment, per 42 C.F.R. § 455.104(e).

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

Written Notification and a New Enrollment Application Are Required

Any time a change in ownership occurs, providers are required to do **one** of the following:

- Mail a change in ownership notification to ForwardHealth. After mailing the notification, providers are required to complete a new Medicaid provider enrollment application on the Portal.
- Upload a change in ownership notification as an attachment when completing a new Medicaid provider enrollment application on the Portal.

ForwardHealth must receive the change in ownership notification, which must include the affected provider number (NPI (National Provider Identifier) or provider ID), within 35 calendar days **after** the effective date of the change in ownership.

Providers will receive written notification of their new Medicaid enrollment effective date in the mail once their provider file is updated with the change in ownership.

Special Requirements for Specific Provider Types

The following provider types require Medicare enrollment and/or Wisconsin DQA (Division of Quality Assurance) certification with current provider information before submitting a Medicaid enrollment change in ownership:

- Ambulatory surgery centers
- CHCs (Community Health Centers)
- ESRD (End Stage Renal Disease) services providers
- Home health agencies
- Hospice providers
- Hospitals (inpatient and outpatient)
- Nursing homes
- Outpatient rehabilitation facilities
- Rehabilitation agencies
- RHCs (Rural Health Clinics)
- Tribal FQHCs (Federally Qualified Health Centers)

Events That ForwardHealth Considers a Change in Ownership

ForwardHealth defines a change in ownership as an event where a different party purchases (buys out) or otherwise obtains ownership or effective control over a practice or facility.

The following events are considered a change in ownership and require the completion of a new provider enrollment application:

- Change from one type of business structure to another type of business structure. Business structures include the following:
  - Sole proprietorships
  - Corporations
  - Partnerships
  - Limited Liability Companies
- Change of name and TIN (Tax Identification Number) associated with the provider's submitted enrollment application (for example, EIN (Employer Identification Number))
- Change (addition or removal) of names identified as owners of the provider

Examples of a Change in Ownership

Examples of a change in ownership include the following:

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

End Date of Previous Owner's Enrollment

The end date of the previous owner's enrollment will be one day prior to the effective date for the change in ownership. When the Wisconsin DHS (Department of Health Services) is notified of a change in ownership, the original owner's enrollment will automatically be end-dated.

Repayment Following a Change in Ownership

Medicaid-enrolled providers who sell or otherwise transfer their business or business assets are required to repay ForwardHealth for any erroneous payments or overpayments made to them. If the previous owner does not repay ForwardHealth for any erroneous payments or overpayments, the new owner's application will be denied.

If necessary, ForwardHealth will hold responsible for repayment the provider to whom a transfer of ownership is made prior to the final transfer of ownership. The provider acquiring the business is responsible for contacting ForwardHealth to ascertain if they are liable under this provision.

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

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

Office of the Inspector General
PO Box 309
Madison WI 53701-0309

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

Automatic Recoupment Following a Change in Ownership

ForwardHealth will automatically recover payments made to providers whose enrollment has ended in the ForwardHealth system due to a change in ownership. This automatic recoupment for previous owners occurs about 45 days after DHS is notified of the change in ownership. The recoupment will apply to all claims processed with DOS (Dates of Service) after the provider's new end date.

New Prior Authorization Requests Must Be Submitted After a Change in Ownership

Medicaid-enrolled providers are required to submit new PA (Prior Authorization) requests when there is a change in billing providers. New PA requests must be submitted with the new billing provider's name and billing provider number. The expiration date of the new PA request will remain the same as the original PA request.

The provider is required to send the following to ForwardHealth with the new PA request:

- A copy of the original PA request, if possible
- The new PA request, including the required attachments and supporting documentation indicating the new billing provider's name, address, and billing provider number
- A letter requesting to enddate the original PA request (may be a photocopy), which should include the following information:
  - The previous billing provider's name and billing provider number, if known
  - The new billing provider's name and billing provider number
  - The reason for the change of billing provider (The new billing provider may want to verify with the member that the services from the previous billing provider have ended. The new billing provider may include this verification in the letter).
  - The requested effective date of the change

Submitting Claims After a Change in Ownership

The provider acquiring the business may submit claims with DOS on and after the change in ownership effective date.

Additional information on submission of timely filing requests or adjustment reconsideration requests is available.

How to Bill for a Hospital Stay That Spans a Change in Ownership

When a change in hospital ownership occurs, use the NPI that is current on the date of discharge. For example: A change in ownership occurs on July 1. A patient stay has DOS from June 26 to July 2. The hospital submits the claim using the NPI effective July 1.

How to Bill for a Nursing Home Stay That Spans a Change in Ownership

When a change in nursing home ownership occurs, use the NPI that is current on the date of discharge. For example: A change in ownership occurs on July 1. A nursing home patient stay has DOS from June 26 to July 2. The nursing home submits the claim using the NPI effective July 1.

For Further Questions

Providers with questions about changes in ownership may call Provider Services.

Topic #14317

Terminology to Know for Provider Enrollment

Due to the ACA (Affordable Care Act), ForwardHealth has adopted new terminology. The following table includes new terminology that will be useful to providers during the provider enrollment and revalidation processes. Providers may refer to the Medicaid rule 42 C.F.R. s. 455.101 for more information.

New Terminology	Definition
Agent	Any person who has been delegated the authority to obligate or act on behalf of a provider.
Disclosing entity	A Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent.
Federal health care programs	Federal health care programs include Medicare, Medicaid, Title XX, and Title XXI.
Other disclosing agent	Any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVII, or XX of the Act. This includes: - Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or HMO that participates in Medicare (Title XVIII) - Any Medicare intermediary or carrier - Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or XX of the Act
Indirect ownership	An ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership in the disclosing entity.
Managing employee	A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization,

	or agency.
Ownership interest	The possession of equity in the capital, the stock, or the profits of the disclosing entity.
Person with an ownership or control interest	A person or corporation for which one or more of the following applies: • Has an ownership interest totaling five percent or more in a disclosing entity • Has an indirect ownership interest equal to five percent or more in a disclosing entity • Has a combination of direct and indirect ownership interest equal to five percent or more in a disclosing entity • Owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or asset of the disclosing entity • Is an officer or director of a disclosing entity that is organized as a corporation • Is a person in a disclosing entity that is organized as a partnership
Subcontractor	• An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or, • An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.
Re-enrollment	Re-enrollment of a provider whose Medicaid enrollment has ended for any reason other than sanctions or failure to revalidate may be re-enrolled as long as all licensure and enrollment requirements are met. Providers should note that when they re-enroll, application fees and screening activities may apply. Re-enrollment was formerly known as re-instate.
Revalidation	All enrolled providers are required to revalidate their enrollment information every three years to continue their participation with Wisconsin Medicaid. Revalidation was formerly known as recertification.

Note: Providers should note that the federal CMS (Centers for Medicare and Medicaid Services) requires revalidation at least every five years. However, Wisconsin Medicaid will continue to revalidate providers every three years.

Ongoing Responsibilities

Topic #220

Accommodating Members With Disabilities

All providers, including ForwardHealth providers, operating an existing public accommodation have requirements under Title III of the Americans with Disabilities Act of 1990 (nondiscrimination).

Topic #219

Civil Rights Compliance (Nondiscrimination)

Providers are required to comply with all federal laws relating to Title XIX of the Social Security Act and state laws pertinent to ForwardHealth, including the following:

- Title VI and VII of the Civil Rights Act of 1964
- The Age Discrimination Act of 1975
- Section 504 of the Rehabilitation Act of 1973
- The ADA (Americans With Disabilities Act) of 1990

The previously listed laws require that all health care benefits under ForwardHealth be provided on a nondiscriminatory basis. No applicant or member can be denied participation in ForwardHealth or be denied benefits or otherwise subjected to discrimination in any manner under ForwardHealth on the basis of race, color, national origin or ancestry, sex, religion, age, disability, or association with a person with a disability.

Any of the following actions may be considered discriminatory treatment when based on race, color, national origin, disability, or association with a person with a disability:

- Denial of aid, care, services, or other benefits
- Segregation or separate treatment
- Restriction in any way of any advantage or privilege received by others (There are some program restrictions based on eligibility classifications.)
- Treatment different from that given to others in the determination of eligibility
- Refusing to provide an oral language interpreter to persons who are considered LEP (limited English proficient) at no cost to the LEP individual in order to provide meaningful access
- Not providing translation of vital documents to the LEP groups who represent 5 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 C.F.R. 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 Wisconsin DHS (Department of Health Services) Affirmative Action and Civil Rights Compliance Plan requirements. Providers that employ less than 25 employees and receive less than $25,000 annually in Medicaid reimbursement are required to comply by submitting a Letter of Assurance and other appropriate forms.

Providers without internet access may obtain copies of the DHS Affirmative Action and Civil Rights Compliance Plan (including the Letter of Assurance and other forms) and instructions by calling the Affirmative Action and Civil Rights Compliance Officer at 608-266-9372. Providers may also write to the following address:

AA/CRC Office
1 W Wilson St Rm 561
PO Box 7850

Madison WI 53707-7850

For more information on the acts protecting members from discrimination, refer to the civil rights compliance information in the Enrollment and Benefits booklet. The booklet is given to new ForwardHealth members by local county or tribal agencies. Potential ForwardHealth members can request the booklet by calling Member Services.

Title VI of the Civil Rights Act of 1964

This act requires that all benefits be provided on a nondiscriminatory basis and that decisions regarding the provision of services be made without regard to race, color, or national origin. Under this act, the following actions are prohibited, if made on the basis of race, color, or national origin:

- Denying services, financial aid, or other benefits that are provided as a part of a provider's program
- Providing services in a manner different from those provided to others under the program
- Aggregating or separately treating clients
- Treating individuals differently in eligibility determination or application for services
- Selecting a site that has the effect of excluding individuals
- Denying an individual's participation as a member of a planning or advisory board
- Any other method or criteria of administering a program that has the effect of treating or affecting individuals in a discriminatory manner

Title VII of the Civil Rights Act of 1964

This act prohibits differential treatment, based solely on a person's race, color, sex, national origin, or religion, in the terms and conditions of employment. These conditions or terms of employment are failure or refusal to hire or discharge compensation and benefits, privileges of employment, segregation, classification, and the establishment of artificial or arbitrary barriers to employment.

Federal Rehabilitation Act of 1973, Section 504

This act prohibits discrimination in both employment and service delivery based solely on a person's disability.

This act requires the provision of reasonable accommodations where the employer or service provider cannot show that the accommodation would impose an undue hardship in the delivery of the services. A reasonable accommodation is a device or service modification that will allow the disabled person to receive a provider's benefits. An undue hardship is a burden on the program that is not equal to the benefits of allowing that handicapped person's participation.

A handicapped person means any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

In addition, Section 504 requires "program accessibility," which may mean building accessibility, outreach, or other measures that allow for full participation of the handicapped individual. In determining program accessibility, the program or activity will be viewed in its entirety. In choosing a method of meeting accessibility requirements, the provider shall give priority to those methods that offer a person who is disabled services that are provided in the most integrated setting appropriate.

Americans With Disabilities Act of 1990

Under Title III of the ADA of 1990, any provider that operates an existing public accommodation has four specific requirements:

1. Remove barriers to make their goods and services available to and usable by people with disabilities to the extent that it is readily achievable to do so (i.e., to the extent that needed changes can be accomplished without much difficulty or expense)
2. Provide auxiliary aids and services so that people with sensory or cognitive disabilities have access to effective means of communication, unless doing so would fundamentally alter the operation or result in undue burdens
3. Modify any policies, practices, or procedures that may be discriminatory or have a discriminatory effect, unless doing so would fundamentally alter the nature of the goods, services, facilities, or accommodations
4. Ensure that there are no unnecessary eligibility criteria that tend to screen out or segregate individuals with disabilities or limit their full and equal enjoyment of the place of public accommodation

Age Discrimination Act of 1975

The Age Discrimination Act of 1975 prohibits discrimination on the basis of age in programs and activities receiving federal financial assistance. The Act, which applies to all ages, permits the use of certain age distinctions and factors other than age that meet the Act's requirements.

Topic #198

Contracted Staff

Under a few circumstances (e.g., personal care, case management services), providers may contract with non-Medicaid-enrolled agencies for services. Providers are legally, programmatically, and fiscally responsible for the services provided by their contractors and their contractors' services.

When contracting services, providers are required to ensure contracted agencies are qualified to provide services, meet all ForwardHealth and program requirements, and maintain records in accordance with the requirements for the provision of services.

Medicaid requirements do not relieve contracted agencies of their own regulatory requirements. Contracted agencies are required to continue to meet their own regulatory requirements, in addition to ForwardHealth requirements.

Providers are also responsible for informing a contracted agency of ForwardHealth requirements. Providers should refer those with whom they contract for services to ForwardHealth publications for program policies and procedures. ForwardHealth references and publications include, but are not limited to, the following:

- Wisconsin Administrative Code
- *ForwardHealth Updates*
- The Online Handbook

Providers should encourage contracted agencies to visit the ForwardHealth Portal regularly for the most current information.

Topic #216

Examples of Ongoing Responsibilities

Responsibilities for which providers are held accountable are described throughout the Online Handbook. Medicaid-enrolled providers have responsibilities that include, but are not limited to, the following:

- Providing the same level and quality of care to ForwardHealth members as private-pay patients
- Complying with all state and federal laws related to ForwardHealth
- Obtaining PA (prior authorization) for services, when required
- Notifying members in advance if a service is not covered by ForwardHealth and the provider intends to collect payment from the member for the service
- Maintaining accurate medical and billing records
- Retaining preparation, maintenance, medical, and financial records, along with other documentation, for a period of not less than five years from the date of payment, except rural health clinic providers who are required to retain records for a minimum of six years from the date of payment
- Billing only for services that were actually provided
- Allowing a member access to their records
- Monitoring contracted staff
- Accepting Medicaid reimbursement as payment in full for covered services
- Keeping provider information (i.e., address, business name) current
- Notifying ForwardHealth of changes in ownership
- Responding to Medicaid revalidation notifications
- Safeguarding member confidentiality
- Verifying member enrollment
- Keeping up-to-date with changes in program requirements as announced in ForwardHealth publications

Topic #217

Keeping Information Current

Changes That Require ForwardHealth Notification

Providers are required to notify ForwardHealth of any changes to their demographic information, including the following, as they occur:

- Address(es) — practice location and related information, mailing, PA (prior authorization), and/or financial

  Note: Health care providers who are federally required to have an NPI (National Provider Identifier) are cautioned that changes to their practice location address on file with ForwardHealth may alter their ZIP+4 code information that is required on transactions.

- Business name
- Contact name
- Federal Tax ID number (IRS (Internal Revenue Service) number)
- Group affiliation
- Licensure
- NPI
- Ownership
- Professional certification
- Provider specialty
- Supervisor of nonbilling providers
- Taxonomy code
- Telephone number, including area code

Failure to notify ForwardHealth of changes may result in the following:

- Incorrect reimbursement
- Misdirected payment
- Claim denial
- Suspension of payments or cancellation of provider file if provider mail is returned to ForwardHealth for lack of a current address

Entering new information on a claim form or PA request is **not** adequate notification of change.

Notifying ForwardHealth of Changes

Providers can notify ForwardHealth of changes using the demographic maintenance tool.

Providers Enrolled in Multiple Programs

If demographic information changes, providers enrolled in multiple programs (e.g., Wisconsin Medicaid and WCDP (Wisconsin Chronic Disease Program)) will need to change the demographic information for each program. By toggling between accounts using the Switch Organization function of the Portal, providers who have a Portal account for each program can change their information for each program using the demographic maintenance tool. The Account User Guide provides specific information about switching organizations.

Providers Licensed or Certified by the Division of Quality Assurance

Providers licensed or certified by the DQA (Division of Quality Assurance) are required to notify the DQA of changes to physical address, changes of ownership, and facility closures by emailing Lisa.Imhof@dhs.wisconsin.gov.

Topic #577

Legal Framework

The following laws and regulations provide the legal framework for BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid:

- Federal Law and Regulation:
  - Law — United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI
  - Regulation — Title 42 C.F.R. Parts 430-498 and Parts 1000-1008 (Public Health)
- Wisconsin Law and Regulation:
  - Law — Wis. Stat. §§ 49.43-49.499, 49.665, and 49.473
  - Regulation — Wis. Admin. Code chs. 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 Wisconsin DHS (Department of Health Services). Within DHS, DMS (Division of Medicaid Services) is directly responsible for managing these programs.

Topic #17097

Licensure Information

Licensed providers are required to keep all licensure information, including license number, grant and expiration dates, and physical location as applicable (e.g., hospital providers), current with ForwardHealth.

If providers do not keep their licensure information, including their license number, current with ForwardHealth, any of the following may occur:

- Providers' enrollment may be deactivated. As a result, providers would not be able to submit claims or PA (prior authorization) requests or be able to function as prescribing/referring/ordering providers, if applicable, until they update their licensure information.
- Providers may experience a lapse in enrollment. If a lapse occurs, providers may need to re-enroll, which may result in another application fee being assessed.

Providers may change the grant and expiration dates for their current license(s) and enter information for a new license(s), such as the license number, licensing state, and grant and expiration dates, using the demographic maintenance tool. After entering information for their new license (s), some providers (e.g., out-of-state providers) will also be required to upload a copy of their license using the demographic maintenance tool. Provided licensure information must correspond with the information on file with the applicable licensing authority.

In some cases, ForwardHealth will need to verify licensure information with the applicable licensing authority, which may take up to 10 business days after submission. Providers updating their license information should plan accordingly so that they do not experience any of the indicated interruptions in enrollment. If provided licensure information (e.g., grant and expiration dates) does not correspond with the licensing authority's information, the licensing authority's information will be retained and will display in the demographic maintenance tool once verified by ForwardHealth.

Topic #15157

Recovery Audit Contractor Audits

The ACA (Affordable Care Act) requires states to establish an RAC (Recovery Audit Contractor) program to enable the auditing of Medicaid claim payments to providers. In Wisconsin, the RAC will audit claim payments from Wisconsin Medicaid and BadgerCare Plus. The Wisconsin DHS (Department of Health Services) has awarded the contract to HMS (Health Management Systems, Inc.) as the RAC for the state of Wisconsin.

Note: The RAC will not audit claims submitted for Family Planning Only Services, SeniorCare, WCDP (Wisconsin Chronic Disease Program), the WWWP (Wisconsin Well Woman Program), and ADAP (Wisconsin AIDS Drug Assistance Program).

The overall goal of the RAC program is to identify and decrease improper payments. The audits will ensure that payments are for services covered under the programs in which the member was enrolled and that the services were actually provided and properly billed and documented. The audits are being conducted under Generally Accepted Government Auditing Standards.

Providers will be selected for audits based on data analysis by the RAC and referrals by state agencies. The RAC will ensure that its audits neither duplicate state audits of the same providers nor interfere with potential law enforcement investigations.

Providers who receive a notification regarding an audit should follow the instructions as outlined in the notification within the requested time frames.

Affected Providers

Any provider may be audited, including, but not limited to, fee-for-service providers, institutional and non-institutional providers, as well as managed care entities.

Additional Information

Any questions regarding the RAC program should be directed to HMS at 855-699-6289. Refer to the RAC website for additional information regarding HMS RAC activities.

Topic #13277

Reporting Suspected Waste, Fraud, and Abuse

The Wisconsin DHS (Department of Health Services) OIG (Office of Inspector General) investigates fraud and abuses including, but not limited to, the following:

- Billing Medicaid for services or equipment that were not provided
- Submitting false applications for a DHS-funded assistance program such as Medicaid, BadgerCare Plus, WIC (Special Supplemental Nutrition Program for Women, Infants, and Children), or FoodShare
- Trafficking FoodShare benefits
- Crime, misconduct, and/or mismanagement by a DHS employee, official, or contractor

Those who suspect fraudulent activity in Medicaid programs are required to notify the OIG if they have reason to believe that a person is misusing or abusing any DHS health care program or the ForwardHealth identification card.

Wisconsin Stat. § 49.49 defines actions that represent member misuse or abuse of benefits and the resulting sanctions that may be imposed. Providers are under no obligation to inform the member that they are misusing or abusing their benefits. A provider may not confiscate a ForwardHealth card from a member in question.

Reporting Suspected Fraud and Abuse

Those who suspect any form of fraud, waste, or abuse of a program by providers, trading partners, billing services, agencies, or recipients of any government assistance program are required to report it. Those reporting allegations of fraud and abuse may remain anonymous. However, not providing contact information may prevent OIG from fully investigating the complaint if questions arise during the review process.

If a provider suspects that someone is committing fraudulent activities or is misusing his or her ForwardHealth card, the provider is required to notify ForwardHealth by one of the following methods:

- Going to the OIG fraud and abuse reporting website
- Calling the DHS fraud and abuse hotline at 877-865-3432

The following information is helpful when reporting fraud and abuse:

- A description of the fraud, waste, and/or abuse, including the nature, scope, and timeframe of the activity in question (The description should include sufficient detail for the complaint to be evaluated.)
- The names and dates of birth (or approximate ages) of the people involved, as well as the number of occurrences and length of the suspected activity
- The names and date(s) of other people or agencies to which the activity may have been reported

After the allegation is received, DHS OIG will evaluate it and take appropriate action. If the name and contact information of the person reporting the allegation was provided, the OIG may be in contact to verify details or ask for additional information.

Documentation

Topic #6277

1099 Miscellaneous Forms

ForwardHealth generates the 1099 Miscellaneous form in January of each year for earnings greater than $600.00, per IRS (Internal Revenue Service) regulations. One 1099 Miscellaneous form per financial payer and per tax identification number is generated, regardless of how many provider IDs or NPIs (National Provider Identifier) share the same tax identification number. For example, a provider who conducts business with both Medicaid and WCDP (Wisconsin Chronic Disease Program) will receive separate 1099 Miscellaneous forms for each program.

The 1099 Miscellaneous forms are sent to the address designated as the "1099 mailing address."

Topic #1640

Availability of Records to Authorized Personnel

The Wisconsin DHS (Department of Health Services) has the right to inspect, review, audit, and reproduce provider records pursuant to Wis. Admin. Code § DHS 106.02(9)(e). The DHS periodically requests provider records for compliance audits to match information against ForwardHealth's information on paid claims, PA (prior authorization) requests, and enrollment. These records include, but are not limited to, medical/clinical and financial documents. Providers are obligated to ensure that the records are released to an authorized DHS staff member(s).

Wisconsin Medicaid reimburses providers $0.06 per page for the cost of reproducing records requested by the DHS to conduct a compliance audit. A letter of request for records from the DHS will be sent to a provider when records are required.

Reimbursement is not made for other reproduction costs included in the provider agreement between the DHS and a provider, such as reproduction costs for submitting PA requests and claims.

Also, state-contracted MCOs (managed care organizations), including HMOs and SSI HMOs, are not reimbursed for the reproduction costs covered in their contract with the DHS.

The reproduction of records requested by the PRO (Peer Review Organization) under contract with the DHS is reimbursed at a rate established by the PRO.

Topic #200

Confidentiality and Proper Disposal of Records

ForwardHealth supports member rights regarding the confidentiality of health care and other related records, including an applicant or member's billing information or medical claim records. An applicant or member has a right to have this information safeguarded, and the provider is obligated to protect that right. Use or disclosure of any information concerning an applicant or member (including an applicant or member's billing information or medical claim records) for any purpose not connected with program administration is prohibited unless authorized by the applicant or member (program administration includes contacts with third-party payers that are necessary for pursuing third-party payment and the release of information as ordered by the court).

Federal HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy and Security regulations establish requirements regarding the confidentiality and proper disposal of health care and related records containing PHI (protected health information). These requirements apply to all providers (who are considered "covered entities") and their business associates who create, retain, and dispose of such records.

For providers and their business partners who are not subject to HIPAA, Wisconsin confidentiality laws have similar requirements pertaining to proper disposal of health care and related records.

HIPAA Privacy and Security Regulations

Definition of Protected Health Information

As defined in the HIPAA privacy and security regulations, PHI is protected health information (including demographic information) that:

- Is created, received, maintained, or transmitted in any form or media.
- Relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the payment for the provision of health care to an individual.
- Identifies the individual or provides a reasonable basis to believe that it can be used to identify the individual.

A member's name combined with their member identification number or Social Security number is an example of PHI.

Requirements Regarding "Unsecured" Protected Health Information

Title XIII of the American Recovery and Reinvestment Act of 2009 (also known as the HITECH (Health Information Technology for Economic and Clinical Health) Act) included a provision that significantly expanded the scope, penalties, and compliance challenges of HIPAA. This provision imposes new requirements on covered entities and their business associates to notify patients, the federal government, and the media of breaches of "unsecured" PHI (refer to 45 C.F.R. Parts 160 and 164 and § 13402 of the HITECH Act).

Unsecured PHI is PHI that has not been rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of physical destruction approved by the U.S. HHS (Department of Health and Human Services). According to HHS, destruction is the only acceptable method for rendering PHI unusable, unreadable, or indecipherable.

As defined by federal law, unsecured PHI includes information in **any** medium, not just electronic data.

Actions Required for Proper Disposal of Records

Under the HIPAA privacy and security regulations, health care and related records containing PHI must be disposed of in such a manner that they cannot be reconstructed. This includes ensuring that the PHI is secured (i.e., rendered unusable, unreadable, or indecipherable) prior to disposal of the records.

To secure PHI, providers and their business associates are required to use one of the following destruction methods approved by the HHS:

- Paper, film, labels, or other hard copy media should be shredded or destroyed such that the PHI cannot be read or otherwise reconstructed.
- Electronic media should be cleared, purged, or destroyed such that the PHI cannot be retrieved according to National Institute of Standards and Technology Special Publication 800-88, Guidelines for Media Sanitization, which can be found on the NIST (National Institute of Standards and Technology) website.

For more information regarding securing PHI, providers may refer to Health Information Privacy on the HHS website.

Wisconsin Confidentiality Laws

Wis. Stat. § 134.97 requires providers and their business partners who are not subject to HIPAA regulations to comply with Wisconsin confidentiality laws pertaining to the disposal of health care and related records containing PHI.

Wis. Stat. § 146.836 specifies that the requirements apply to "all patient health care records, including those on which written, drawn, printed, spoken, visual, electromagnetic or digital information is recorded or preserved, regardless of physical form or characteristics." Paper **and** electronic records are subject to Wisconsin confidentiality laws.

"Personally Identifiable Data" Protected

According to Wis. Stat. § 134.97(1)(e), the types of records protected are those containing "personally identifiable data."

As defined by the law, personally identifiable data is information about an individual's medical condition that is not considered to be public knowledge. This may include account numbers, customer numbers, and account balances.

Actions Required for Proper Disposal of Records

Health care and related records containing personally identifiable data must be disposed of in such a manner that no unauthorized person can access the personal information. For the period of time between a record's disposal and its destruction, providers and their business partners are required to take actions that they reasonably believe will ensure that no unauthorized person will have access to the personally identifiable data contained in the record.

Businesses Affected

Wis. Stat.§§ 134.97 and 134.98, governing the proper disposal of health care and related records, apply to medical businesses as well as financial institutions and tax preparation businesses. For the purposes of these requirements, a medical business is any for-profit or nonprofit organization or enterprise that possesses information — other than personnel records — relating to a person's physical or mental health, medical history, or medical treatment. Medical businesses include sole proprietorships, partnerships, firms, business trusts, joint ventures, syndicates, corporations, limited liability companies, or associates.

Continuing Responsibilities for All Providers After Ending Participation

Ending participation in a ForwardHealth program does not end a provider's responsibility to protect the confidentiality of health care and related records containing PHI.

Providers who no longer participate in a ForwardHealth program are responsible for ensuring that they and their business associates/partners continue to comply with all federal and state laws regarding protecting the confidentiality of members' PHI. Once record retention requirements expire, records must be disposed of in such a manner that they cannot be reconstructed — according to federal and state regulations — in order to avoid penalties.

All ForwardHealth providers and their business associates/partners who cease practice or go out of business should ensure that they have policies and procedures in place to protect all health care and related records from any unauthorized disclosure and use.

Penalties for Violations

Any covered entity provider or provider's business associate who violates federal HIPAA regulations regarding the confidentiality and proper disposal of health care and related records may be subject to criminal and/or civil penalties, including any or all of the following:

- Fines up to $1.5 million per calendar year
- Jail time
- Federal HHS Office of Civil Rights enforcement actions

For entities not subject to HIPAA, Wis. Stat. § 34.97(4) imposes penalties for violations of confidentiality laws. Any provider or provider's business partner who violates Wisconsin confidentiality laws may be subject to fines up to $1,000 per incident or occurrence.

For more specific information on the penalties for violations related to members' health care records, providers should refer to § 13410(d) of the HITECH Act, which amends 42 USC § 1320d-5, and Wis. Stat. §§ 134.97(3), (4) and 146.84.

Topic #201

Financial Records

According to Wis. Admin. Code § DHS 106.02(9)(c), a provider is required to maintain certain financial records in written or electronic form.

Topic #202

Medical Records

A dated clinician's signature must be included in all medical notes. According to Wis. Admin. Code § DHS (Department of Health Services) 106.02(9)(b), a provider is required to include certain written documentation in a member's medical record.

Topic #1723

Documentation for Disposable Medical Supplies and 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 (durable medical equipment)/DMS (disposable medical supplies) services as stated in Wis. Admin. Code § DHS 106.02(9)(a). A current, signed, and dated physician prescription is required for each DME/DMS for each DOS (date of service) when requesting Medicaid reimbursement. Per Wis. Admin. Code § DHS 105.02(4), providers are required to maintain medical records for no less than five years from the date of reimbursement.

For DME/DMS requiring a face-to-face visit, documentation of the face-to-face visit is required. Providers are required to produce and/or submit the documentation to ForwardHealth upon request. ForwardHealth may deny or recoup payment for services that fail to meet this requirement.

The documentation of the face-to-face visit must be clearly titled and be a separate and distinct section of (or a clearly titled addendum to) the prescription and must include:

- Date of the face-to-face visit
- Name and credentials of the physician or NPP who conducted the face-to-face visit
- The clinical findings that support the member's need for the impacted DME/DMS
- Signature of the prescribing physician or NPP who conducted the face-to-face visit for impacted DME/DMS

Topic #19238

Dates of Service

ForwardHealth defines the DOS as follows:

- The date on which the DME was dispensed to the member or the member's caregiver by the provider
- The date on which the DME was shipped or mailed to the member or the member's caregiver if the provider used a shipping service or mail order

Topic #19257

Documentation Requirements for Date of Delivery

The billing provider's record must adhere to all of the following documentation requirements related to the date of delivery of DME.

When Dispensed Directly to the Member or the Member's Caregiver

The billing provider's record must include all of the following documentation related to the date of delivery when the provider dispenses DME to the member or the member's caregiver:

- Written confirmation of delivery of the product/service to the member, which includes the following:
  - Date of delivery
  - Member's printed name
  - Member's acknowledgment of receipt with member's signature and date signed
  - If member is not able to sign, the printed name of the person accepting delivery, that person's signature, date signed, and relationship to the member
  - Brand, model, and sizes issued to the member
  - Quantity dispensed

When Mailed or Shipped to the Member or the Member's Caregiver

The billing provider's record must include all of the following documentation related to the date of delivery when the provider mails or ships DME to the member or the member's caregiver:

- Written confirmation of delivery of the product/service to the member, which includes the following:
  - Member's printed name
  - Delivery address
  - Delivery service's package identification number, supplier invoice number, or alternative method that links the supplier's delivery documents with the delivery service's records (this information should be printed out and kept on file or in the member's medical record)
  - Brand, model, and sizes issued to the member
  - Quantity delivered
  - Date delivered

Any claim for DME that does not include complete proof of delivery from the provider may be subject to recoupment during a provider audit.

Topic #19297

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
- 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 (prior authorization) request
- Documentation submitted with a claim

Additional Requirements for Diabetic Shoes and Inserts

The billing provider is required to document and maintain the following information in the member's medical record:

- A physician's prescription for diabetic shoes and/or inserts
- The member's ICD (International Classification of Diseases) diagnosis (or diagnoses) and any other co-morbid conditions that support the condition for the requested services
- The objective measurement of specific foot deformity, if applicable
- The member's height and weight
- The shoe brand, model number, and size(s)
- Medical records from the prescribing provider that support the claim
- The written report of the member's podiatry exam and results
- The member's ambulatory status and/or transfer abilities
- The member's use of any ambulation aids for mobility, if applicable
- Information regarding the member's functional daily routine (e.g., place of residence, caregiver type, and level of assistance, if applicable)
- Specific reason for the requested service, date of initial issue of the requested service to the member, or the reason for replacement and the last DOS to member, if known
- If mismatched shoes are requested, documentation of the foot size discrepancy

In addition to the above, the medical record for custom molded shoes using HCPCS (Healthcare Common Procedure Coding System) procedure code A5501 (For diabetics only, fitting [including follow-up], custom preparation and supply of shoe molded from cast[s] of patient's foot [custom molded shoe], per shoe) must include the following:

- Documentation that the member has a foot deformity that cannot be accommodated by a depth shoe

- A detailed description of the nature of the severity of the deformity
- Documentation from the visit that included taking impressions, making cases, or obtaining CAD/CAM (Computer-Aided Design/Computer-Aided Manufacturing) images of the member's feet in order to create models of the feet

In addition to the above, the medical record for custom molded inserts using HCPCS procedure code A5513 (For diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer [or higher], includes arch filler and other shaping material, custom fabricated, each) must include the following:

- A list of materials that were used
- A description of the custom fabrication process

Additional Requirements for Facial Prosthetics

ForwardHealth requires that the billing provider maintains the following documentation in the member's medical record for coverage of facial prosthetics:

- A written prescription for the facial prosthetic or repair
- Documentation of the loss or absence of facial tissue due to disease, trauma, surgery, or congenital defect
- Documentation of member visits to take impressions and make molds
- A copy of written instructions for the member regarding how to wear and care for the prosthetic
- Date-of-delivery documentation

Additional Requirements for Orthopedic or Corrective Shoes and Foot Orthotics

The billing provider's record of service for orthopedic or corrective shoes or foot orthotics must include all of the following:

- A prescription for orthopedic or corrective shoes or foot orthotics, and for all related services (modifications, repair, etc.), that meets the requirements stated in Wis. Admin. Code § DHS 107.02(2m)(b) and includes the following:
  - An ICD diagnosis that supports the medical need for the requested orthopedic or corrective shoes or foot orthotics
  - If present, an ICD diagnosis of any other co-morbid conditions of the member that support the medical need for the requested orthopedic or corrective shoes or foot orthotics
  - If present, an ICD diagnosis of the member's gross foot deformity and/or other conditions that justify the medical need for the orthopedic or corrective shoes or foot orthotics
  - The quantity to be dispensed and the length of need
  - The member's ICD diagnosis (or diagnoses) and any other co-morbid conditions that support the condition for the requested services
- If present, the objective measurement of specific foot deformity
- The member's height and weight
- The shoe brand, model number, and size(s)
- Medical records from the prescribing provider that support the PA request
- The written report of the member's podiatry exam and results
- The member's ambulatory status and/or transfer abilities
- The member's use of any ambulation aids for mobility, if applicable
- Information regarding the member's functional daily routine (e.g., place of residence, caregiver type, and level of assistance, if applicable)
- Specific reason for the requested service, date of initial issue of the requested service to the member, or the reason for replacement and the last DOS to member, if known
- If new equipment is requested to replace current items, the estimate of charges to repair the member's current equipment and/or the reason repair is not possible or cost-effective
- If mismatched shoes are requested, documentation of the foot size discrepancy
- If custom services are requested, documentation of the services or equipment that have been tried by the member and results indicating what specific medical needs of the member were not met
- A copy of the completed PA request and all records submitted for the service
- Written instruction to the member for the use and care of the items dispensed
- All information to support both PA requests and claims

Additional Requirements for Speech Generating Devices, Digitized

ForwardHealth requires that billing providers maintain the following documentation in their medical records:

- Prescription for the device
- Date-of-Delivery documentation
- A formal evaluation of the member's communication abilities by a SLP (Speech Language Pathologist). The SLP must document and confirm all of the following:
  - The member has a severe expressive speech impairment, and alternative natural communication methods are not feasible or are inadequate for that individual's daily functional communication needs.
  - The member's speech impairment will benefit from the device.
  - The member has the prerequisite skills to utilize the devices.
  - The member possesses a treatment plan that includes a training schedule for the selected device.
  - The rational for a specific device, including how its features match the member's communication needs and skills.

Topic #199

Member Access to Records

Providers are required to allow members access to their health care records, including those related to ForwardHealth services, maintained by a provider in accordance with Wisconsin Statutes, excluding billing statements.

Fees for Health Care Records

Per Wis. Stat. § 146.83, providers may charge a fee for providing one set of copies of health care records to members who are enrolled in Wisconsin Medicaid or BadgerCare Plus programs on the date of the records request. This applies regardless of the member's enrollment status on the DOS (dates of service) contained within the health care records.

Per Wis. Stat. § 146.81(4), health care records are all records related to the health of a patient prepared by, or under the supervision of, a health care provider.

Providers are limited to charging members enrolled in state-funded health care programs 25 percent of the applicable fees for providing one set of copies of the member's health care records.

Note: A provider may charge members 100 percent of the applicable fees for providing a second or additional set of copies of the member's health care records.

The Wisconsin DHS (Department of Health Services) adjusts the amounts a provider may charge for providing copies of a member's health care records yearly per Wis. Stat. § 146.83(3f)(c).

Topic #16157

Policy Requirements for Use of Electronic Signatures on Electronic Health Records

For ForwardHealth policy areas where a signature is required, electronic signatures are acceptable as long as the signature meets the requirements. When ForwardHealth policy specifically states that a handwritten signature is required, an electronic signature will not be accepted. When ForwardHealth policy specifically states that a written signature is required, an electronic signature will be accepted.

Reimbursement for services paid to providers who do not meet all electronic signature requirements may be subject to recoupment.

Electronic Signature Definition

An electronic signature, as stated in Wis. Stats. § 137.11(8), is "an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record."

Some examples include:

- Typed name (performer may type their complete name)
- Number (performer may type a number unique to them)
- Initials (performer may type initials unique to them)

All examples above must also meet all of the electronic signature requirements.

Benefits of Using Electronic Signatures

The use of electronic signatures will allow providers to:

- Save time by streamlining the document signing process.
- Reduce the costs of postage and mailing materials.
- Maintain the integrity of the data submitted.
- Increase security to aid in non-repudiation.

Electronic Signature Requirements

By following the general electronic signature requirements below, the use of electronic signatures provides a secure alternative to written signatures. These requirements align with HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rule guidelines.

General Requirements

When using an electronic signature, all of the following requirements must be met:

- The electronic signature must be under the sole control of the rendering provider. Only the rendering provider or designee has the authority to use the rendering provider's electronic signature. Providers are required to maintain documentation that shows the electronic signature that belongs to each rendering provider if a numbering or initial system is used (e.g., what number is assigned to a specific rendering provider). This documentation must be kept confidential.
- The provider is required to have current policies and procedures regarding the use of electronic signatures. The Wisconsin DHS (Department of Health Services) recommends the provider conduct an annual review of policies and procedures with those using electronic signatures to promote ongoing compliance and to address any changes in the policies and procedures.
- The provider is required to conduct or review a security risk analysis in accordance with the requirements under 45 CFR s. 164.308(a)(1).
- The provider is required to implement security updates as necessary and correct identified security deficiencies as part of its risk management process.
- The provider is required to establish administrative, technical, and physical safeguards in compliance with the HIPAA Security Rule.

Electronic Health Record Signature Requirements

An EHR (electronic health record) that utilizes electronic signatures must meet the following requirements:

- The certification and standard criteria defined in the Health Information Technology Initial Set of Standards, Implementation Specifications, Certification Criteria for Electronic Health Record Technology Final Rule (45 CFR Part 170) and any revisions including, but not limited to, the following:
  - Assign a unique name and/or number for identifying, tracking user identity, and establishing controls that permit only authorized users to access electronic health information.
  - Record actions related to electronic health information according to the standard set forth in 45 CFR s. 170.210.
  - Enable a user to generate an audit log for a specific time period. The audit log must also have the ability to sort entries according to any of the elements specified in the standard 45 CFR s. 170.210.
  - Verify that a person or entity seeking access to electronic health information is the one claimed and is authorized to access such information.
  - Record the date, time, patient identification, and user identification when electronic health information is created, modified, accessed, or deleted. An indication of which action(s) occurred and by whom must also be recorded.
  - Use a hashing algorithm with a security strength equal to or greater than SHA-1 (Secure Hash Algorithm 1) as specified by the NIST (National Institute of Standards and Technology) in FIPS PUB 180-3 (October 2008) to verify that electronic health information has not been altered. (Providers unsure whether or not they meet this guideline should contact their IT (Information

Technology) and/or security/privacy analyst.)
- Ensure the EHR provides:
  - Nonrepudiation — assurance that the signer cannot deny signing the document in the future
  - User authentication — verification of the signer's identity at the time the signature was generated
  - Integrity of electronically signed documents — retention of data so that each record can be authenticated and attributed to the signer
  - Message integrity — certainty that the document has not been altered since it was signed
  - Capability to convert electronic documents to paper copy — the paper copy must indicate the name of the individual who electronically signed the form as well as the date electronically signed
- Ensure electronically signed records created by the EHR have the same back-up and record retention requirements as paper records.

Topic #203

Preparation and Maintenance of Records

All providers who receive payment from Wisconsin Medicaid, including state-contracted MCOs (managed care organizations), are required to maintain records that fully document the basis of charges upon which all claims for payment are made, according to Wis. Admin. Code § DHS 106.02(9)(a). This required maintenance of records is typically required by any third-party insurance company and is not unique to ForwardHealth.

Topic #1724

Prescriptions

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

Topic #204

Record Retention

Providers are required to retain documentation, including medical and financial records, for a period of not less than five years from the date of payment, except RHCs (rural health clinics), which are required to retain records for a minimum of six years from the date of payment.

According to Wis. Admin. Code § DHS 106.02(9)(d), providers are required to retain all evidence of billing information.

Ending participation as a provider does not end a provider's responsibility to retain and provide access to fully maintained records unless an alternative arrangement of record retention and maintenance has been established.

Maintaining Confidentiality of Records

Ending participation in a ForwardHealth program does not end a provider's responsibility to protect the confidentiality of health care and related records containing PHI (protected health information).

Providers who no longer participate in a ForwardHealth program are responsible for ensuring that they and their business associates/partners continue to comply with all federal and state laws regarding protecting the confidentiality of members' PHI. Once record retention requirements expire, records must be disposed of in such a manner that they cannot be reconstructed — according to federal and state regulations — in order to avoid penalties. For more information on the proper disposal of records, refer to Confidentiality and Proper Disposal of Records.

All ForwardHealth providers and their business associates/partners who cease practice or go out of business should ensure that they have policies and procedures in place to protect all health care and related records from any unauthorized disclosure and use.

Reviews and Audits

The Wisconsin DHS (Department of Health Services) periodically reviews provider records. DHS has the right to inspect, review, audit, and

photocopy the records. Providers are required to permit access to any requested record(s), whether in written, electronic, or micrographic form.

Topic #205

Records Requests

Requests for billing or medical claim information regarding services reimbursed by Wisconsin Medicaid may come from a variety of individuals including attorneys, insurance adjusters, and members. Providers are required to notify ForwardHealth when releasing billing information or medical claim records relating to charges for covered services except in the following instances:

- When the member is a dual eligible (i.e., member is eligible for both Medicare and Wisconsin Medicaid or BadgerCare Plus) and is requesting materials pursuant to **Medicare** regulations.
- When the provider is attempting to exhaust all existing health insurance sources prior to submitting claims to ForwardHealth.

Request From a Member or Authorized Person

If the request for a member's billing information or medical claim records is from a member or authorized person acting on behalf of a member, the provider is required to do the following:

1. Send a copy of the requested billing information or medical claim records to the requestor.
2. Send a letter containing the following information to ForwardHealth:
    - Member's name
    - Member's ForwardHealth identification number or SSN (Social Security number), if available
    - Member's DOB (date of birth)
    - DOS (date of service)
    - Entity requesting the records, including name, address, and telephone number

    The letter must be sent to the following address:

    Wisconsin Casualty Recovery — HMS
    Ste 100
    5615 Highpoint Dr
    Irving TX 75038-9984

Request From an Attorney, Insurance Company, or Power of Attorney

If the request for a member's billing information or medical claim records is from an attorney, insurance company, or power of attorney, the provider is required to do the following:

1. Obtain a release signed by the member or authorized representative.
2. Furnish the requested material to the requester, marked "BILLED TO FORWARDHEALTH" or "TO BE BILLED TO FORWARDHEALTH," with a copy of the release signed by the member or authorized representative. Approval from ForwardHealth is not necessary.
3. Send a copy of the material furnished to the requestor, along with a copy of their original request and medical authorization release to:

    Wisconsin Casualty Recovery — HMS
    Ste 100
    5615 Highpoint Dr
    Irving TX 75038-9984

Request for Information About a Member Enrolled in a State-Contracted Managed Care Organization

If the request for a member's billing information or medical claim records is for a member enrolled in a state-contracted MCO (managed care organization), the provider is required to do the following:

1. Obtain a release signed by the member or authorized representative.
2. Send a copy of the letter requesting the information, along with the release signed by the member or authorized representative, directly to the MCO.

The MCO makes most benefit payments and is entitled to any recovery that may be available.

Request for a Statement From a Dual Eligible

If the request is for an itemized statement from a dual eligible, pursuant to HR 2015 (Balanced Budget Act of 1997) § 4311, a dual eligible has the right to request and receive an itemized statement from their Medicare-enrolled health care provider. The Act requires the provider to furnish the requested information to the member. The Act does **not** require the provider to notify ForwardHealth.

Topic #1646

Release of Billing Information to Government Agencies

Providers are permitted to release member information without informed consent when a written request is made by Wisconsin DHS (Department of Health Services) or the federal HHS (Department of Health and Human Services) to perform any function related to program administration, such as auditing, program monitoring, and evaluation.

Providers are authorized under Wisconsin Medicaid confidentiality regulations to report suspected misuse or abuse of program benefits to the DHS, as well as to provide copies of the corresponding patient health care records.

Provider Rights

Topic #208

A Comprehensive Overview of Provider Rights

Medicaid-enrolled providers have certain rights including, but not limited to, the following:

- Limiting the number of members they serve in a nondiscriminatory way.
- Ending participation in Wisconsin Medicaid.
- Applying for a discretionary waiver or variance of certain rules identified in Wisconsin Administrative Code.
- Collecting payment from a member under limited circumstances.
- Refusing services to a member if the member refuses or fails to present a ForwardHealth identification card. However, possession of a ForwardHealth card does not guarantee enrollment (e.g., the member may not be enrolled, may be enrolled only for limited benefits, or the ForwardHealth card may be invalid). Providers may confirm the current enrollment of the member by using one of the EVS (Enrollment Verification System) methods, including calling Provider Services.

Topic #207

Ending Participation

Providers other than home health agencies and nursing facilities may terminate participation in ForwardHealth according to Wis. Admin. Code § DHS 106.05.

Providers choosing to withdraw should promptly notify their members to give them ample time to find another provider.

When withdrawing, the provider is required to do the following:

- Provide a written notice of the decision at least 30 days in advance of the termination.
- Indicate the effective date of termination.

Providers will not receive reimbursement for nonemergency services provided on and after the effective date of termination. Voluntary termination notices can be sent to the following address:

Wisconsin Medicaid
Provider Enrollment
313 Blettner Blvd
Madison WI 53784

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

Topic #209

Hearing Requests

A provider who wishes to contest a Wisconsin DHS (Department of Health Services) action or inaction for which due process is required under Wis. Stat. ch. 227, may request a hearing by writing to the DHA (Division of Hearings and Appeals).

A provider who wishes to contest the DMS (Division of Medicaid Services)'s notice of intent to recover payment (e.g., to recoup for overpayments discovered in an audit by DMS) is required to request a hearing on the matter within the time period specified in the notice. The request, which must be in writing, should briefly summarize the provider's basis for contesting the DHS decision to withhold payment.

Refer to Wis. Admin. Code ch. DHS 106 for detailed instructions on how to file an appeal.

If a timely request for a hearing is not received, DHS may recover those amounts specified in its original notice from future amounts owed to the provider.

Note: Providers are not entitled to administrative hearings for billing disputes.

Topic #210

Limiting the Number of Members

If providers choose to limit the number of members they see, they cannot accept a member as a private-pay patient. Providers should instead refer the member to another ForwardHealth provider.

Persons applying for or receiving benefits are protected against discrimination based on race, color, national origin, sex, religion, age, disability, or association with a person with a disability.

Topic #206

Requesting Discretionary Waivers and Variances

In rare instances, a provider or member may apply for, and the DMS (Division of Medicaid Services) will consider applications for, a discretionary waiver or variance of certain rules in Wis. Admin. Code chs. DHS 102, 103, 104, 105, 107, and 108. Rules that are not considered for a discretionary waiver or variance are included in Wis. Admin. Code § DHS 106.13.

Waivers and variances are not available to permit coverage of services that are either expressly identified as noncovered or are not expressly mentioned in Wis. Admin. Code ch. DHS 107.

Requirements

A request for a waiver or variance may be made at any time; however, all applications must be made in writing to the DMS. All applications are required to specify the following:

- The rule from which the waiver or variance is requested.
- The time period for which the waiver or variance is requested.
- If the request is for a variance, the specific alternative action proposed by the provider.
- The reasons for the request.
- Justification that all requirements for a discretionary waiver or variance would be satisfied.

The DMS may also require additional information from the provider or the member prior to acting on the request.

Application

The DMS may grant a discretionary waiver or variance if it finds that all of the following requirements are met:

- The waiver or variance will not adversely affect the health, safety, or welfare of any member.
- Either the strict enforcement of a requirement would result in unreasonable hardship on the provider or on a member, or an alternative to a rule is in the interests of better care or management. An alternative to a rule would include a new concept, method, procedure or technique, new equipment, new personnel qualifications, or the implementation of a pilot project.
- The waiver or variance is consistent with all applicable state and federal statutes and federal regulations.
- Federal financial participation is available for all services under the waiver or variance, consistent with the Medicaid state plan, the federal CMS (Centers for Medicare and Medicaid Services), and other applicable federal program requirements.
- Services relating to the waiver or variance are medically necessary.

To apply for a discretionary waiver or variance, providers are required to send their application to the following address:

Division of Medicaid Services
Waivers and Variances
PO Box 309
Madison WI 53701-0309

Sanctions

Topic #211

Intermediate Sanctions

According to Wis. Admin. Code § DHS 106.08(3), the Wisconsin DHS (Department of Health Services) may impose intermediate sanctions on providers who violate certain requirements. Common examples of sanctions that 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, DHS will issue a written notice to the provider in accordance with Wis. Admin. Code § DHS 106.12.

Any sanction imposed by DHS may be appealed by the provider under Wis. Admin. Code § DHS 106.12. Providers may appeal a sanction by writing to the DHA (Division of Hearings and Appeals).

Topic #212

Involuntary Termination

The Wisconsin DHS (Department of Health Services) may suspend or terminate the Medicaid enrollment of any provider according to Wis. Admin. Code § DHS 106.06.

The suspension or termination may occur if both of the following apply:

- DHS finds that any of the grounds for provider termination are applicable.
- The suspension or termination will not deny members access to services.

Reasonable notice and an opportunity for a hearing within 15 days will be given to each provider whose enrollment is terminated by DHS. Refer to Wis. Admin. Code § DHS 106.07 for detailed information regarding possible sanctions.

In cases where Medicare enrollment is required as a condition of enrollment with Wisconsin Medicaid, termination from Medicare results in automatic termination from Wisconsin Medicaid.

Topic #213

Sanctions for Collecting Payment From Members

Under state and federal laws, if a provider inappropriately collects payment from an enrolled member, or authorized person acting on behalf of the member, that provider may be subject to program sanctions including termination of Medicaid enrollment. In addition, the provider may also be fined not more than $25,000, or imprisoned not more than five years, or both, pursuant to 42 USC § 1320a-7b(d) or Wis. Stat. § 49.49 (3m).

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

Topic #214

Withholding Payments

The Wisconsin DHS (Department of Health Services) may withhold full or partial Medicaid provider payments without prior notification if, as the result of any review or audit, 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.

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.

Provider Numbers

Topic #3421

Provider Identification

Health Care Providers

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

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

Providers should ensure that they have obtained an appropriate NPI prior to beginning their enrollment application. There are two kinds of NPIs:

- Entity Type 1 NPIs are for individuals who provide health care, such as physicians, dentists, and chiropractors.
- Entity Type 2 NPIs are for organizations that provide health care, such as hospitals, group practices, pharmacies, and home health agencies.

It is possible for a provider to qualify for both Entity Type 1 and Entity Type 2 NPIs. For example, an individual physical therapist may also be the owner of a therapy group that is a corporation and have two Wisconsin Medicaid enrollments — one enrollment as an individual physical therapist and the other enrollment as the physical therapy group. A Type 1 NPI for the individual enrollment and a Type 2 NPI for the group enrollment are required.

NPIs and classifications may be viewed on the NPPES website. The federal CMS (Centers for Medicare and Medicaid Services) website includes more information on Type 1 and Type 2 NPIs.

Health care providers who are federally required to have an NPI are responsible for obtaining the appropriate certification for their NPI.

Non-healthcare Providers

Non-healthcare providers, such as SMV (specialized medical vehicle) providers, personal care agencies, and blood banks, are exempt from federal NPI requirements. Providers exempt from federal NPI requirements are assigned a Medicaid provider number once their enrollment application is accepted; they are required to indicate this Medicaid provider number on electronic and paper transactions submitted to ForwardHealth.

Topic #5096

Taxonomy Codes

Taxonomy codes are standard code sets used to provide information about provider type and specialty for the provider's enrollment. ForwardHealth uses taxonomy codes as additional data for correctly matching the NPI (National Provider Identifier) to the provider file.

Providers are required to use a taxonomy code when the NPI reported to ForwardHealth corresponds to multiple enrollments and the provider's practice location ZIP+4 code does not uniquely identify the provider.

Providers are allowed to report multiple taxonomy codes to ForwardHealth as long as the codes accurately describe the provider type and specialty for the provider's enrollment. When doing business with ForwardHealth, providers may use any one of the reported codes. Providers who report multiple taxonomy codes will be required to designate one of the codes as the primary taxonomy code; ForwardHealth will use this primary code for identification purposes.

Providers who wish to change their taxonomy code or add additional taxonomy codes may do so using the demographic maintenance tool.

Most taxonomy code changes entered through the demographic maintenance tool will take effect in real time; providers may use the new codes immediately on transactions.

Omission of a taxonomy code when it is required as additional data to identify the provider will cause claims and other transactions to be denied or delayed in processing.

Note: Taxonomy codes do not change provider enrollment or affect reimbursement terms.

Topic #5097

ZIP Code

The ZIP code of a provider's practice location address on file with ForwardHealth must be a ZIP+4 code. The ZIP+4 code helps to identify a provider when the NPI (National Provider Identifier) reported to ForwardHealth corresponds to multiple enrollments and the reported taxonomy code does not uniquely identify the provider.

When a ZIP+4 code is required to identify a provider, omission of it will cause claims and other transactions to be denied or delayed in processing.

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

Covered and Noncovered Services

2

Archive Date:04/01/2024

Covered and Noncovered Services:Noncovered Services

Topic #10917

"Not for Retail Sale" Products

ForwardHealth does not reimburse for diabetic supplies considered "not for retail sale" by the manufacturer. "Not for retail sale" products are considered noncovered.

Topic #68

Definition of Noncovered Services

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

Topic #3164

Noncovered Durable Medical Equipment and Services

Providers must use the PA (Prior Authorization) process to determine the medical necessity of any medical equipment requests based on the member's individual circumstances and needs. Information regarding HealthCheck "Other Services" can be found in the Definition of HealthCheck "Other Services" and the Prior Authorization for HealthCheck "Other Services" topics of the Online Handbook.

ForwardHealth will continue to not cover the following:

- Equipment and services that are excluded from coverage under Wis. Admin. Code § DHS 107.03
- Noncovered equipment according to federal law:
  - Medical equipment and appliances not useful to an individual in the absence of a disability, per 42 C.F.R. § 440.70(b)(3)(ii)
  - Environmental or structural housing modifications and vehicle modifications, per Federal Register, volume 81(21), Feb 2, 2016, p 5538, 5539, 5542

Topic #104

Member Payment for Noncovered Services

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

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

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

Missed Appointments

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

Avoiding Missed Appointments

ForwardHealth offers the following suggestions to help avoid missed appointments:

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

Translation Services

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

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

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

Topic #18557

Orthotics

Diabetic Shoes and Inserts

ForwardHealth does not cover the following items:

- Diabetic shoes and/or inserts for members without a diagnosis of diabetes and who do not meet general coverage criteria
- Shoes and/or inserts that do not meet the definition of DME (durable medical equipment), per Wis. Admin. Code § DHS 101.03 (50)
- Shoes and/or inserts to accommodate weather or seasonal needs

ForwardHealth does not cover diabetic shoes in any of the following situations, and, if provided, the member may be responsible for any associated costs:

- Diabetic shoes were ordered for a member who does not have a diagnosis of diabetes.
- Diabetic shoes were ordered for a member with a primary diagnosis of gestational diabetes.
- Diabetic shoes were ordered for a member without complications of one or both feet.
- Diabetic shoes were ordered for member without a diabetes care plan.
- Diabetic shoes were ordered for a member for style change or weather change.

Although members may not qualify for diabetic shoes, members may qualify for orthopedic or corrective shoes and/or foot orthotics if they meet the corresponding coverage criteria.

Orthopedic or Corrective Shoes and Foot Orthotics

Per Wis. Admin. Code § DHS 107.24(5), ForwardHealth does not cover the following:

- Orthopedic or corrective shoes or foot orthotics 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
- Delivery or set-up charges for equipment as a separate service
- Fitting, adapting, adjusting, or modifying a prosthetic or orthotic device or corrective or orthopedic shoes as a separate service

Per Wis. Admin. Code § DHS 101.03(50), DME is defined as equipment which can withstand repeated use, is primarily used for medical services, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the home. ForwardHealth does not cover the following models, types, and styles of orthopedic or corrective shoes:

- Sandals or other open-toed models
- Models requested to accommodate seasonal or weather conditions
- Models to accommodate work situations or recreational purposes
- Athletic shoes

HealthCheck "Other Services"

Topic #22

Definition of HealthCheck "Other Services"

HealthCheck is the term used for EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) in Wisconsin. The HealthCheck benefit provides periodic, comprehensive health screening exams (also known as "well child checks"), as well as interperiodic screens, outreach and case management, and additional medically necessary services (referred to as HealthCheck "Other Services") for members under 21 years of age.

Wisconsin Medicaid covers most diagnostic and intervention services a member may need. However, federal law requires that states provide any additional health care services that are coverable under the federal Medicaid program and found to be medically necessary to treat, correct, or reduce illnesses and conditions discovered regardless of whether or not the service is covered in a state's Medicaid program. HealthCheck "Other Services" is Wisconsin's term for this federal requirement.

The requested service must be allowable under federal Medicaid law, per § 1905(a) of the Social Security Act, and must be medically necessary and reasonable for the member to be covered by Wisconsin Medicaid, per Wis. Admin. Code § DHS 107.02(3)(e). Most HealthCheck "Other Services" require PA (prior authorization) per Wis. Admin. Code § DHS 107.02.

Topic #1

Prior Authorization for HealthCheck "Other Services"

Providers submitting PA (prior authorization) requests for HealthCheck "Other Services" should review the two types of PA requests. The following types of PA requests have their own submission requirements:

- Requests for exceptions to coverage limitations
- Requests for federally allowable Medicaid services not routinely covered by Wisconsin Medicaid

PA Submission Requirements for Exceptions to Coverage Limitations

HealthCheck "Other Services" may additionally cover established Medicaid health care services that are limited in coverage for members under 21 years of age.

If a PA request is submitted requesting additional coverage for a benefit where there is established policy, the request is automatically processed under the HealthCheck "Other Services" benefit to evaluate whether the requested service is likely to correct or ameliorate the member's condition, including maintaining current status or preventing regression.

Examples of coverage limitations include service amounts that are prohibited by policy, or the requested service is not expected to result in a favorable improvement in the member's condition or diagnosis.

Every PA request for a member under age 21 is first processed according to standard Medicaid guidelines and then reviewed under HealthCheck "Other Services" guidelines. For these reasons, providers do **not** need to take additional action to identify the PA request as a HealthCheck "Other Services" request.

If an established benefit will be requested at a level that exceeds Wisconsin Medicaid coverage limits, in addition to the required PA documentation detailed in the appropriate service area of the Online Handbook, the request should provide:

- The rationale detailing why standard coverage is not considered acceptable to address the identified condition.
- The rationale detailing why the requested service is needed to correct or ameliorate the member's condition.

PA Submission Requirements for Services Not Routinely Covered by Wisconsin

Medicaid

HealthCheck "Other Services" allows coverage of health care services that are not routinely covered by Wisconsin Medicaid, but are federally allowable and medically necessary to maintain, improve, or correct the member's physical and mental health, per § 1905(a) of the Social Security Act. These HealthCheck "Other Services" require PA since the determination of medical necessity is made on a case-by-case basis depending on the needs of the member.

If a PA request is submitted requesting coverage for a service that does not have established policy and is not an exception to coverage limitations, the provider is required to identify the PA as a HealthCheck "Other Services" request by **checking the HealthCheck "Other Services" box** and submit the following information:

- A current, valid order or prescription for the service being requested:
  - Prescriptions are valid for 12 or fewer months from the date of the signature (depending on the service area).
  - Updated prescriptions may be required more frequently for some benefits.
- A completed PA/RF (Prior Authorization Request Form, F-11018 (05/2013)), for most service areas, including the following:
  - For Element 1, **check the HealthCheck "Other Services" box.**
  - For Element 19, enter the procedure code that most accurately describes the service, even if the code is not ordinarily covered by Wisconsin Medicaid. Unlisted procedure codes can be requested if the service is not accurately described by existing procedure codes.
  - For Element 20, enter informational procedure code modifier EP (Service provided as part of Medicaid early periodic screening diagnosis and treatment [EPSDT] program) to indicate that the service is requested as a HealthCheck "Other Services" benefit.
  - For Element 22, include the description of the service.
- A completed PA/DRF (Prior Authorization/Dental Request Form, F-11035 (07/2012)), or PA/HIAS1 (Prior Authorization Request for Hearing Instrument and Audiological Services, F-11020 (05/2013)) when the PA/RF is not applicable
- A PA attachment form(s) for the related service area, if known, or clinical documentation substantiating the medical necessity of the requested procedure code and:
  - The rationale detailing why services typically covered by Wisconsin Medicaid are not considered acceptable to address the identified condition or why services were discontinued.
  - The rationale detailing why the requested service is needed to correct or ameliorate the member's condition.

  Note: Providers may call Provider Services to determine the appropriate PA attachment.

- Evidence the requested service is clinically effective and not harmful (If the requested service is new to Wisconsin Medicaid, additional documentation regarding current research and/or safety of the intervention may be submitted.)
- The MSRP (manufacturer's suggested retail price) for requested equipment or supplies
- The 11-digit NDC (National Drug Code) for any dispensed OTC (over-the-counter) drugs on pharmacy PA requests

Providers may call Provider Services for more information about HealthCheck "Other Services."

If the PA request is incomplete or additional information is needed to substantiate the necessity of the requested service, the PA request will be returned to the provider. **A return for more information is not a denial.**

Topic #41

Requirements

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

- The service is provided to a member who is under 21 years of age.
- The service is coverable under federal Medicaid law.
- The service is medically necessary and reasonable.
- The service is prior authorized before it is provided.
- Services currently available are not considered acceptable to treat the identified condition.

ForwardHealth 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 the authorized amount is reasonable and maintains the preventive intent of the HealthCheck benefit.

HealthCheck "Other Services" does not include reimbursement in excess of ForwardHealth published maximum allowable fees.

All PA (prior authorization) requests must follow NCCI (National Correct Coding Initiative) guidelines.

Codes

Topic #471

Bone-Anchored Hearing Devices

The following are allowable HCPCS (Healthcare Common Procedure Coding System) procedure codes for bone-anchored hearing devices or bone-anchored hearing device repairs or replacement parts. These procedure codes are separately reimbursable for members residing in a nursing home.

The DME (Durable Medical Equipment) and DMS (Disposable Medical Supply) indices list the maximum allowable fees for the following procedure codes, as applicable.

Bone-Anchored Hearing Devices	
Procedure Code	**Description**
L8690	Auditory osseointegrated device, includes all internal and external components
L8692	Auditory osseointegrated device, external sound processor, used without osseointegration, body worn, includ headband or other means of attachment

Bone-Anchored Hearing Device Repairs or Replacement Parts	
Procedure Code	**Description**
L7510	Repair of prosthetic device, repair or replace minor parts
L8691	Auditory osseointegrated device, external sound processor, excludes transducer/actuator, replacement only, e
L8694	Auditory osseointegrated device transducer/actuator, replacement only, each
V5266	Battery for use in hearing device

Topic #4012

Cochlear Implants

The following are allowable procedure codes for cochlear implant devices and cochlear implant device repairs and replacements. These procedure codes are separately reimbursable for members residing in a nursing home.

The DME (Durable Medical Equipment) Index lists the maximum allowable fees for the following procedure codes.

Cochlear Implant 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 or auditory osseointegrated device, replacement
L8618	Transmitter cable for use with cochlear implant device, replacement
L8619	Cochlear implant, external speech processor and controller, integrated system, 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,
L8624	Lithium ion battery for use with cochlear implant or auditory osseointegrated device speech processor, ear lev replacement, each
L8625	External recharging system for battery for use with cochlear implant or auditory osseointegrated device, replacement only, each
L8627	Cochlear implant, external speech processor, component, replacement
L8628	Cochlear implant, external controller component, replacement
L8629	Transmitting coil and cable, integrated for use with cochlear implant device, replacement

Replacement Parts for Cochlear Implants

The following cochlear implant 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**
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

Topic #18618

Cranial Remolding Orthosis

Providers are required to use HCPCS (Healthcare Common Procedure Coding System) procedure code S1040 (Cranial remolding orthosis, pediatric, rigid, with soft interface material, custom fabricated, includes fitting and adjustment[s]) when submitting PA (prior authorization) requests and claims for CRO (Cranial Remolding Orthosis). Separate claims should not be submitted for fitting and adjustments.

Topic #1735

Modifiers

Modifiers for Durable Medical Equipment

Refer to the DME (Durable Medical Equipment) Index for allowable modifiers by procedure code.

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 (prior authorization) 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

Topic #1943

National Drug Codes

BadgerCare Plus, Medicaid, SeniorCare, and WCDP (Wisconsin Chronic Disease Program) cover FDA (Food and Drug Administration)-approved NDCs (National Drug Codes) for drugs in which the manufacturer has signed a rebate agreement.

The FDA assigns NDCs for drugs that have received FDA approval. The NDC is an 11-digit, three-segment number for a drug.

The NDC is divided into the following segments:

- The first segment, a five-digit labeler code that identifies any firm that manufactures, repacks, or distributes the drug.
- The second segment, a four-digit code that identifies the drug's strength, dose, and formulation.
- The third segment, a two-digit code that identifies the package size.

In most cases, if an NDC is 10 digits or less, providers are required to indicate a preceding zero in the segment(s) with less than the required number of digits. If the labeler code begins with a number that is greater than or equal to one, the preceding zero may need to be indicated in the second or third segment. In other cases, providers may need to indicate a zero at the end of a segment.

Providers may use the Drug Search Tool to verify the arrangement of the segments of a specific NDC. Providers may also contact Provider Services.

New National Drug Codes

BadgerCare Plus, Medicaid, and SeniorCare automatically add an NDC of a new drug to the drug file if it meets program guidelines and is produced by a manufacturer participating in the drug rebate program.

Obsolete National Drug Codes

ForwardHealth will no longer reimburse NDCs with an obsolete date of two or more years. The obsolete date is reported by the manufacturer or by the FDA and provides the date the product is not available to the marketplace due to the cessation of marketing, production, or distribution of the product. The obsolete date provided to First DataBank is used to automatically update ForwardHealth.

Topic #1736

Place of Service Codes

Allowable POS (place of service) codes for DME (durable medical equipment) services are listed in the following table.

POS Code	Description
01	Pharmacy
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
13	Assisted Living Facility
14	Group Home
19	Off Campus—Outpatient Hospital
22	On Campus—Outpatient Hospital
23	Emergency Room—Hospital
24	Ambulatory Surgical Center
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
49	Independent Clinic
50	Federally Qualified Health Center
54	Intermediate Care Facility/Individuals with Intellectual Disabilities
71	State or Local Public Health Clinic
72	Rural Health Clinic

Note: Not all POS codes listed are applicable for all DME services. When providing DME items to members residing in an ICF/IID (Intermediate Care Facility for Individuals with Intellectual Disabilities), providers are required to use POS code 54.

Topic #1733

Portable Document Format Version of the Durable Medical Equipment Index

A PDF (Portable Document Format) version of the DME (Durable Medical Equipment) Index is available. This user-friendly PDF version is updated periodically (changes will be highlighted in yellow) and includes a comprehensive list of allowable DME procedure codes and modifiers, along with associated quantity limits and maximum allowable fee information.

Note: Maximum allowable fees are subject to change. Refer to the interactive maximum allowable fee schedule for the most current reimbursement rates.

The DME Index is divided into separate categories of DME to make the information easier to access. For information about these categories as well as field descriptions and policy notes, refer to the Key to DME Index PDF.

Topic #19697

Positioning Seats

The following HCPCS (Healthcare Common Procedure Coding System) procedure codes for positioning seats for motor vehicle use and for home use are covered by ForwardHealth with an approved PA (prior authorization) request.

Claims and PA requests submitted for repairs and replacement parts of positioning seats must include modifier RA to indicate repair or replacement parts of DME (durable medical equipment) for proper consideration.

Note: The information in the following tables is subject to change. The interactive maximum fee schedule contains the most current information on covered codes.

Positioning Seats for Motor Vehicle Use				
	Procedure Code	**Description**	**Required Modifier**	**Use**
Purchase	T5001	Positioning seat for persons with special orthopedic needs, supply, not otherwise specified		Purchase of positioning seat for motor vehicle. An approved PA request is required.
Rental	T5001	Positioning seat for persons with special orthopedic needs, supply, not otherwise specified	RR (Rental)	Rental of positioning seat, tether anchor kit, and accessories; for motor vehicle only. (Rental is not available for positioning seat used in home.) An appr PA request is required after the initial 60 days.
Replacement	T5999	Supply, not otherwise specified	RA (Replacement of a DME, orthotic or prosthetic item)	Purchase of replacement part(s) for positioning seats. approved PA request is required.
	E0190	Positioning cushion/pillow/wedge, any shape or size, includes all components and accessories	RA (Replacement of a DME, orthotic or prosthetic item)	Replacement of cushion/pillow/wedge, any shape or s An approved PA request is required. *Note:* E0190 may be billed only with the RA modifie **and** only when replacing pads/cushion/pillow/wedge T5001.

Positioning Seats for Home Use				
	Procedure Code	**Description**	**Required Modifier**	**Use**

Purchase	T5001	Positioning seat for persons with special orthopedic needs, supply, not otherwise specified		Purchase of positioning seat for home. (Rental i not available for positioning seat used in home.) approved PA request is required.
Replacement	T5999	Supply, not otherwise specified	RA (Replacement of a DME, orthotic or prosthetic item)	Purchase of replacement part(s) for positioning seats. An approved PA request is required.
	E0190	Positioning cushion/pillow/wedge, any shape or size, includes all components and accessories	RA (Replacement of a DME, orthotic or prosthetic item)	Replacement of cushion/pillow/wedge, any sha or size. An approved PA request is required. *Note:* E0190 may be billed only with the RA modifier **and** only when replacing pads/cushion/pillow/wedge on T5001.

Topic #2047

Procedure Codes

As stated in Wis. Admin. Code § DHS 107.24(2)(b), covered services are limited to those items contained in the DME (Durable Medical Equipment) Index. Covered DME services are identified by HCPCS (Healthcare Common Procedure Coding System) procedure codes. HCPCS procedure codes are required on all DME PA (prior authorization) requests, claims, and adjustment requests. Providers are required to indicate procedure codes that are allowable for the DOS (date of service) and that most accurately identify the DME on PA requests, claims, and adjustment requests. DME PA requests, claims, and adjustment requests received without HCPCS procedure codes are denied.

Most procedure codes listed in the DME Index include all the components of the DME item. Billing additionally or separately for these components, when provided at the same time or when a more inclusive code exists, could result in PA denials or claim adjustments and/or recoupments from ForwardHealth.

Topic #643

Unlisted Procedure Codes

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

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

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

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

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

For most unlisted codes, ForwardHealth requires additional documentation.

Unlisted Codes That Require Prior Authorization

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

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

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

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

Unlisted Codes That Do Not Require Prior Authorization

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

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

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

How to Submit Claims and Related Documentation

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

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

Topic #830

Valid Codes Required on Claims

ForwardHealth requires that all codes indicated on claims and PA (prior authorization) requests, including diagnosis codes, revenue codes, HCPCS (Healthcare Common Procedure Coding System) codes, HIPPS (Health Insurance Prospective Payment System)

codes, and CPT (Current Procedural Terminology) codes be valid codes. Claims received without valid diagnosis codes, revenue codes, and HCPCS, HIPPS, or CPT codes will be denied; PA requests received without valid codes will be returned to the provider. Providers should refer to current national coding and billing manuals for information on valid code sets.

Code Validity

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

Code Specificity for Diagnosis

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

Topic #18657

Wearable Cardioverter Defibrillator

DME (Durable medical equipment) providers are required to indicate HCPCS (Healthcare Common Procedure Coding System) procedure code K0606 (Automatic external defibrillator, with integrated electrocardiogram analysis, garment type) and modifier RR (Rental) on PA (prior authorization) requests and claims for the rental of a WCD (wearable cardioverter defibrillator).

The DME Index includes additional coverage information.

Topic #22317

Electrical Stimulation Devices

HCPCS (Healthcare Common Procedure Coding System) procedure code E0766 (Electrical stimulation device used for cancer treatment, includes all accessories, any type) is allowable with modifier RR (Rental) for the treatment of the brain cancer GBM (glioblastoma multiforme) (grade IV astrocytoma).

For reimbursement rates for the electrical stimulation device, refer to the maximum allowable fee schedule.

Covered Services and Requirements

Topic #18117

Bone Growth Stimulators

Bone growth stimulators are covered with PA (prior authorization) and are considered Class III medical devices by the FDA (Food and Drug Administration). PA requests for these devices may be approved if they are medically necessary and are employed for a qualifying FDA-approved use.

The DME (Durable Medical Equipment) Index contains additional information regarding POS (place of service) codes, device life expectancies, and maximum allowable fees.

Bone growth stimulators are not covered for any of the following conditions:

- Nonunion of skull, vertebrae, or tumor-related fracture
- Delayed union fractures

Topic #13717

Bone-Anchored Hearing Devices

ForwardHealth covers unilateral bone-anchored hearing device implant surgeries, bilateral bone-anchored hearing device implant surgeries, and bone-anchored hearing device implant surgeries for profound unilateral sensorineural hearing loss with normal hearing in the opposite ear when the following criteria for coverage are met.

Note: Providers (such as bone-anchored hearing device manufacturers, outpatient hospitals, ASCs (ambulatory surgery centers), or rendering surgeons) are required to obtain separate Medicaid enrollment as a DME (durable medical equipment) provider before submitting claims for bone-anchored hearing devices.

Coverage Criteria for Unilateral Bone-Anchored Hearing Device Implant Surgeries

ForwardHealth covers unilateral bone-anchored hearing device implant surgeries if all of the following criteria are met:

- The member is 5 years of age or older at the time of surgery.
- The member has sufficient bone volume and bone quality to support successful fixture placement as determined by the surgeon AND the surgeon determines that the implant can safely be done in a one-step procedure.
- The member has a conductive and/or mixed hearing loss (unilateral or bilateral) with pure-tone average bone-conduction thresholds (measured at 0.5, 1, 2, and 3 kHz) less than or equal to 65 dB HL. The threshold range is intended to accommodate different degrees of hearing loss and corresponding output power of the bone-anchored hearing device.
- The member demonstrates an air-bone gap of at least 30 dB in the proposed implant ear.
- The member demonstrates a word recognition score greater than 60 percent via conventional air-conduction speech audiometry using single-syllable words.
- The member has one or more of the following conditions:
  - Severe chronic external otitis or otitis media
  - Chronic draining ear through a tympanic membrane perforation
  - Malformation of the external auditory canal or middle ear
  - Stenosis of the external auditory canal
  - Ossicular discontinuity or erosion that cannot be repaired
  - Chronic dermatologic conditions such as psoriasis of the ear canal
  - Tumors of the external canal and/or tympanic cavity
  - Other conditions in which an air-conduction hearing aid is contraindicated for the ear to be implanted, or where the

condition prevents restoration of hearing using a conventional air-conduction hearing aid

Coverage Criteria for Bilateral Bone-Anchored Hearing Device Implant Surgeries

ForwardHealth covers bilateral bone-anchored hearing device implant surgeries if the following criteria are met:

- The member meets the unilateral bone-anchored hearing device criteria noted above for both ears and has symmetrical bone-conduction thresholds between ears. Symmetrical bone-conduction thresholds are defined as less than a 10 dB average difference between ears (measured at 0.5, 1, 2, and 3 kHz), or less than a 15 dB difference at individual frequencies.
- The member presents lifestyle needs that justify the need for binaural hearing via bone conduction.

Coverage Criteria for Bone-Anchored Hearing Device Implant Surgeries for Profound Unilateral Sensorineural Hearing Loss With Normal Hearing in the Opposite Ear

Note: Profound unilateral sensorineural hearing loss with normal hearing in the opposite ear is sometimes referred to as unilateral sensorineural deafness or SSD.

ForwardHealth covers bone-anchored hearing device implant surgeries for profound unilateral sensorineural hearing loss if the following criteria are met:

- The member has normal hearing in one ear, defined as a pure-tone average air-conduction threshold measured at 0.5, 1, 2, and 3 kHz of 20 dB HL or better.
- The member has average air-conduction thresholds measured at 0.5, 1, 2, and 3 kHz in the ear with the sensorineural hearing loss of 90 dB HL or poorer.
- The member is 5 years of age or older at the time of surgery.
- The member has sufficient bone volume and bone quality to support successful fixture placement as determined by the surgeon AND the surgeon determines that the implant can safely be done in a one-step procedure.
- The member is mature enough and otherwise able to give accurate feedback on the effectiveness of the intervention during a trial period.

Non-Implant Bone-Anchored Hearing Devices

ForwardHealth covers non-implant bone-anchored hearing devices; however, PA (prior authorization) is required.

Topic #573

Cochlear Implant Surgeries

Cochlear implant surgery to improve sensorineural hearing loss is covered by ForwardHealth when the following coverage criteria are met.

Coverage Criteria

General Coverage Criteria

ForwardHealth covers unilateral and bilateral cochlear implant surgery if **all** of the following criteria are met:

- Cochlear implant surgery is medically necessary and used to treat bilateral sensorineural hearing loss in adults or unilateral or bilateral sensorineural hearing loss in children under age 21.
- The member is cognitively and psychologically suitable for the implant.
- The member's hearing loss is not due to problems with the auditory nerve or with the central auditory nervous system.
- There are no medical contraindications to implantation, as determined by the cochlear implant team. Contraindications include, but are not limited to:

- Deafness due to lesions of the eighth cranial (acoustic) nerve, central auditory pathway, or brain stem
- Active or chronic infections of the external or middle ear and mastoid cavity
- Tympanic membrane perforation
- Cochlear ossification that prevents adequate electrode insertion as determined by the treating physician
- Absence of cochlear development as demonstrated by CT (computed tomography) scans

- There is radiographic evidence of cochlear development as demonstrated by a CT and/or MRI (magnetic resonance imaging) scan.
- The member's state of health permits the surgical procedure, as determined by a physician.
- The ear (right or left) is specified.

Coverage Criteria for Children

ForwardHealth covers unilateral or bilateral cochlear implant surgery under the following circumstances for children under age 21:

- The family has been properly informed about all aspects of the cochlear implant, including evaluation, surgical, and rehabilitation procedures.
- The member is scheduled to attend a concentrated oral and/or aural rehabilitation program recommended by the cochlear implant team through the Birth to 3 Program, local school, rehabilitation site, etc.
- For children under 12 months of age, a cochlear implant team has documented the medical necessity of implantation, and implantation is not medically contraindicated by current evidence-based research or anatomy development.
- For children 12 to 24 months of age, a cochlear implant team has documented the following:
  - Unilateral or bilateral severe to profound pre- or post-lingual sensorineural hearing loss, defined as a hearing threshold of pure-tone average of 70 dB (decibels) hearing loss or greater at 500 Hz (hertz), 1000 Hz, and 2000 Hz.
  - A lack of progress in the development of auditory skills in conjunction with appropriate binaural amplification and participation in intensive auditory rehabilitation over a three-to-six-month period. Limited benefit from amplification may be quantified by measures including, but not limited to, the Meaningful Auditory Integration Scale or the Early Speech Perception Test.
- For children 24 months of age and older, a cochlear implant team has documented the following:
  - Unilateral or bilateral severe to profound pre- or post-lingual sensorineural hearing loss, defined as a hearing threshold of pure-tone average of 70 dB hearing loss or greater at 500 Hz, 1000 Hz, and 2000 Hz.
  - A lack of progress in the development of auditory skills in conjunction with appropriate binaural amplification and participation in intensive auditory rehabilitation over a three-to-six-month period. Limited benefit from amplification is defined and may be quantified as demonstrated by the following:
    - An aided score of 30 percent or less on the Multisyllabic Lexical Neighborhood Test (MLNT) for children 24 months of age.
    - An aided score of 30 percent or less on the Lexical Neighborhood Test (LNT) for children 25 months to 5 years of age.
    - A test that may vary depending upon the child's cognitive and linguistic skills for children 5 years of age and older.

Coverage Criteria for Adults

ForwardHealth covers unilateral or bilateral cochlear implantation under the following circumstances for adults ages 21 and older:

- The member has a moderate to profound bilateral sensorineural hearing loss (50 dB or poorer averaged over 500-2000 Hz in the better ear).
- The member demonstrates limited benefit from amplification as defined by test scores of less than 50 percent correct in the best aided listening condition on recorded open-set sentence tests.

Documentation Requirements

The rendering surgeon must document **all** of the following in the member's medical record:

- Documentation that fully supports the coverage criteria
- Preliminary evaluations, diagnoses, and recommendations from a licensed otologist/otolaryngologist and audiologist that must occur within six months of the proposed implant date, prior to the cochlear implant team evaluation
- A pre-surgical team evaluation by a cochlear implant team, which may include otologists, otolaryngologists, audiologists, and experts from the speech-language pathology, psychology, social work, or deaf education disciplines
- Documentation of the cochlear implant team's current experience with cochlear implantation and with rehabilitation strategies

- Documentation of a post-surgical follow-up plan
- For simultaneous or sequential bilateral cochlear implantation, documentation that a unilateral cochlear implant plus a hearing aid in the other ear will **not** result in a sufficient bilateral hearing benefit (for those members, the hearing loss is to a degree that a hearing aid will not produce the required amplification)
- For placement of a second cochlear implant in the opposite ear requested more than 17 months after the initial implantation, documentation from the cochlear implant team supporting the evidenced-based clinical rationale

Facilities Must Be Medicaid-Enrolled Durable Medical Equipment Providers

Cochlear implant manufacturers, outpatient hospitals, and ASCs (ambulatory surgery centers) are required to obtain separate Medicaid enrollment as a DME (durable medical equipment) provider before submitting claims for the cochlear implants.

Topic #17897

Continuous Glucose Monitoring

Professional Continuous Glucose Monitoring (Provider-Owned Equipment)

Professional continuous glucose monitoring utilizing provider-owned equipment is covered for BadgerCare Plus and Medicaid members as a supplement to standard care for diabetes when the primary care provider or attending provider determines such monitoring is medically necessary to establish an optimal insulin regimen. Results must be monitored and interpreted under physician supervision.

Professional continuous glucose monitoring is a diagnostic measurement of glucose levels received throughout the day and night. This type of glucose monitoring is done as a 3-5 day test to evaluate diabetes control.

The following CPT (Current Procedural Terminology) procedure codes are covered for members receiving professional continuous glucose monitoring:

- 95250 (Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician or other qualified health care professional [office] provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording).
- 95251 (Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report).

Procedure codes 95250 and 95251 require a minimum of 72 hours of data and may be reimbursed up to four times per year but may not be reimbursed more than once per month. PA (prior authorization) is not required.

Supplies and equipment are not separately reimbursable as they are included in the reimbursement for procedure code 95250.

Allowable provider types and POS (places of service) are listed on the interactive maximum allowable fee schedule.

Note: Procedure code 99091 (Collection and interpretation of physiologic data [eg, ECG, blood pressure, glucose monitoring] digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation [when applicable] requiring a minimum of 30 minutes of time, each 30 days) should not be used with professional continuous glucose monitoring and cannot be reported in conjunction with procedure code 95250 or 95251. Procedure code 95251 does not require a face-to-face visit.

Documentation Requirements

The member's medical record must include documentation supporting the medical necessity of professional continuous glucose monitoring to establish an optimal insulin regimen for a member with insulin-requiring diabetes and documented inadequate glycemic control. The documentation must also include monitor calibration, member training, sensor removal, and recording printout, as well as the physician report with interpretation and findings based on information obtained during monitoring.

Personal Continuous Glucose Monitoring (Purchased for Individual Member)

Personal continuous glucose monitoring devices, transmitters, and sensors are covered in certain circumstances. PA is required for coverage of monitoring devices and transmitters, but it is not required for sensors.

Allowable Procedure Codes

The following HCPCS (Healthcare Common Procedure Coding System) procedure codes are allowable for personal continuous glucose monitoring devices and accessories:

- A9276 (Sensor; invasive [e.g., subcutaneous], disposable, for use with interstitial continuous glucose monitoring system, one unit = 1 day supply)
- A9277 (Transmitter; external, for use with interstitial continuous glucose monitoring system)
- A9278 (Receiver [monitor]; external, for use with interstitial continuous glucose monitoring system)

Topic #1738

Definition

DME (durable medical equipment) 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.

Topic #44

Definition of Covered Services

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

Topic #85

Emergencies

Certain program requirements and reimbursement procedures are modified in emergency situations. Emergency services are defined in Wis. Admin. Code § DHS 101.03(52), 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 (prior authorization) or other program requirements may be waived in emergency situations.
- Non-U.S. citizens may be eligible for covered services in emergency situations.

Topic #19577

Gait Trainers

Gait trainer purchases and rentals for longer than 60 days are covered by ForwardHealth with PA (prior authorization). PA is not required for the first 60 days of gait trainer rental.

Topic #22917

Interpretive Services

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

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

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

Covered Interpretive Services

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

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

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

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

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

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

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

Documentation

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

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

Third-Party Vendors and In-House Interpreters

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

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

Limitations

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

Claims Submission

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

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

Noncovered Services

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

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

Cancellations or No Shows

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

Procedure Code and Modifiers

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

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

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

Time (Minutes)	Number of Interpretation Units Billed
8–22 minutes	1.0 unit
23–37 minutes	2.0 units
38–52 minutes	3.0 units
53–67 minutes	4.0 units
68–82 minutes	5.0 units

83–97 minutes	6.0 units

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

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

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

Delivery Method of Interpretive Services	Definition for Sign Language and Foreign Language Interpreters		Modif
In person (foreign language and sign language)	When the interpreter is physically present with the member and provider		U1 or
Telehealth* (foreign language and sign language)	When the member is located at an originating site and the interpreter is available remotely (via audio-visual or audio only) at a distant site		U1 or **and** GT or
	Phone (foreign language only)	When the interpreter is not physically present with the member and the provider and interprets via audio-only through the phone	U1 **and** 93
	Interactive video (foreign language and sign language)	When the interpreter is not physically present with the member and the provider and interprets on interactive video	U1 or **and** GT

*Any telehealth service must be provided using HIPAA-compliant software or delivered via an app or service that includes all the necessary privacy and security safeguards to meet the requirements of HIPAA.

Dental Providers

Dental providers submitting claims for interpretive services are not required to include a modifier with procedure code T1013. Dental providers should retain documentation of the interpretive service in the member's records.

Allowable Places of Service

Claims for interpretive services must include a valid POS (place of service) code where the interpretive services are being provided.

Federally Qualified Health Centers

Non-tribal FQHCs (federally qualified health centers), also known as CHCs (community health centers), (POS code 50), will not receive direct reimbursement for interpretive services as these are indirect services assumed to be already included in the FQHC's bundled PPS (prospective payment system) rate. However, CHCs can still bill the T1013 code as an indirect procedure code when providing interpretive services. This billing process is similar to that of other indirect services provided by non-tribal FQHCs. This will enable DHS (Wisconsin Department of Health Services) to better track how FQHCs provide these services and process any future

change in scope adjustment to increase their PPS rate that includes providing interpretive services.

Rural Health Clinics

RHCs (rural health clinics) (POS code 72) receives direct reimbursement for interpretive services. Procedure code T1013 should be billed when providing interpretive services.

Interpreter Qualifications

The two types of allowable interpreters include:

- Sign language interpreters—Professionals who facilitate the communication between a hearing individual and a person who is deaf or hard of hearing and uses sign language to communicate.
- Foreign language interpreters—Professionals who are fluent in both English and another language and listen to a communication in one language and convert it to another language while retaining the same meaning.

Qualifications for Sign Language Interpreters

For Medicaid-enrolled providers to receive reimbursement, sign language interpreters must be licensed in Wisconsin under Wis. Stat. § 440.032 and must follow the specific requirements regarding education, training, and locations where they are able to interpret. The billing provider is responsible for determining the sign language interpreter's licensure and must retain all documentation supporting it.

Qualifications for Foreign Language Interpreters

There is not a licensing process in Wisconsin for foreign language interpreters. However, Wisconsin Medicaid strongly recommends that providers work through professional agencies that can verify the qualifications and skills of their foreign language interpreters.

A competent foreign language interpreter should:

- Be at least 18 years of age.
- Be able to interpret effectively, accurately, and impartially, both receptively and expressively, using necessary specialized vocabulary.
- Demonstrate proficiency in English and another language and have knowledge of the relevant specialized terms and concepts in both languages.
- Be guided by the standards developed by the National Council on Interpreting Health Care.
- Demonstrate cultural responsiveness regarding the LEP language group being served including values, beliefs, practices, languages, and terminology.

Topic #84

Medical Necessity

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

Topic #86

Member Payment for Covered Services

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

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

Topic #18537

Orthotics

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.

The DME (Durable Medical Equipment) Index includes a list of allowable procedure codes and related limitations.

Cranial Remolding Orthoses

CRO (Cranial Remolding Orthosis) is covered by ForwardHealth with PA (prior authorization).

Diabetic Shoes and Inserts

Diabetic shoes and inserts are covered by ForwardHealth for members who meet **all** of the following criteria:

- Have been diagnosed with diabetes (other than gestational diabetes) by a physician
- Have at least one of the following conditions in one or both feet:
  - Foot deformity
  - History of foot ulcers
  - History of calluses that could lead to foot ulcers
  - Nerve damage due to diabetes, with signs of problems with calluses
  - Partial or complete foot amputation
  - Poor circulation
- Have a comprehensive diabetes care plan and require therapeutic shoes and/or inserts because of diabetes as documented by the physician in the member's medical record.

Life Expectancy

ForwardHealth covers medically necessary diabetic shoes and/or inserts without PA at a frequency of one pair of shoes and three inserts per foot per 12 months.

Note: Reimbursement of diabetic shoes and inserts that are needed in excess of the life expectancy listed above require PA.

Diagnosis Restrictions

Reimbursement of diabetic shoes and/or inserts is covered for members who have a primary diagnosis of diabetes, with the exception of gestational diabetes. Shoes and/or inserts are not covered for members with a primary diagnosis of gestational diabetes.

Physician Prescription Requirements

A prescription for diabetic shoes and/or inserts must include:

- An ICD (International Classification of Diseases) diagnosis that supports the medical need for the requested diabetic shoes and/or inserts
- If present, an ICD diagnosis of any other co-morbid conditions of the member that support the medical need for the requested diabetic shoes and/or inserts
- If present, an ICD diagnosis of the member's gross foot deformity and/or other conditions that justify the medical need for requested diabetic shoes and/or inserts
- The quantity to be dispensed and the length of need

If a billing provider receives an initial prescription for a service, but after assessing the member, the physician's prescription does not completely and accurately represent all of the services and items that will be issued to the member, the billing provider is responsible for obtaining a new prescription. A prescription that indicates only "refill" or "verbal order" or the phrase "orthopedic shoes," even if signed by a physician, does not meet this requirement. Wisconsin Medicaid does not accept verbal orders for diabetic shoes and/or inserts. A billing provider is required to have a current, valid, written prescription on file before the service may be issued to the member. These prescription requirements must be present on every prescription used to support the billing provider's submission of a claim or PA request.

Off-The-Shelf Orthotic Devices

CMS (Centers for Medicare and Medicaid Services) recognizes three distinct categories of orthotic devices: customized items, fabricated items, and off-the-shelf items. Customized and fabricated items are only reimbursable for ABC (American Board for Certification in Orthotics and Prosthetics)-certified orthotists, prosthetists, licensed PTs (physical therapists), licensed OTs (occupational therapists), and for spinal orthotics, licensed chiropractors. Off-the-shelf items, which do not require specific provider training or expertise to dispense, are reimbursable for a broader range of provider types; however, provision of off-the-shelf orthotics must be within the provider's legal scope of practice in order to be reimbursed. Fittings for orthotic devices are not separately reimbursable.

Providers may be reimbursed for one spinal and one lower extremity off-the-shelf orthotic device per member per year without submitting a PA request. PA is required for additional spinal and lower extremity off-the-shelf orthotic devices of the same type when the life expectancy of the device has been exceeded.

Orthopedic or Corrective Shoes and Foot Orthotics

Orthopedic or corrective shoes and foot orthotics are covered with PA. Additionally, they are covered in the following situations, per Wis. Admin. Code § DHS 107.24(4)(f):

- Postsurgery conditions
- Gross deformities
- When attached to a bar or brace

Per Wis. Admin. Code § DHS 107.24(2)(c)2, the following shoes are covered:

- Mismatched shoes involving a difference of a full size or more
- Modified shoes to take into account discrepancy in limb length

Orthopedic or corrective shoes and foot orthotics are covered when medically necessary, as defined in Wis. Admin. Code § DHS 101.03(96m). Orthopedic or corrective shoes and foot orthotics are considered medically necessary by ForwardHealth when the member is ambulatory and/or routinely and consistently performs standing pivot transfers.

Physician Prescription Requirements

A prescription for orthopedic or corrective shoes or foot orthotics, and for all related services (modifications, repair, etc.), must meet the requirements stated in Wis. Admin. Code § DHS 107.02(2m)(b) and include the following:

- An ICD diagnosis that supports the medical need for the requested orthopedic or corrective shoes or foot orthotics
- If present, an ICD diagnosis of any other co-morbid conditions of the member that support the medical need for the requested orthopedic or corrective shoes or foot orthotics
- If present, an ICD diagnosis of the member's gross foot deformity and/or other conditions that justify the medical need for the orthopedic or corrective shoes or foot orthotics
- The quantity to be dispensed and the length of need

If a billing provider receives an initial prescription for a service, but after assessing the member, the physician's prescription does not completely and accurately represent all of the services and items that will be issued to the member, the billing provider is responsible for obtaining a new prescription. A prescription that indicates only "refill," "verbal order," or "orthopedic shoes," even if signed by a physician, does not meet this requirement. Wisconsin Medicaid does not accept verbal orders for orthopedic or corrective shoes or foot orthotics. A billing provider is required to have a current and valid written prescription on file before the service may be issued to the member. These prescription requirements must be present on every prescription used to support the billing provider's submission of a

claim.

Topic #1766

Prescriptions

Medicaid Home Health Final Rule (CMS-2348-F) requires a physician to write the initial prescription for certain DME (durable medical equipment) as defined by the federal CMS (Centers for Medicare and Medicaid Services). The list of impacted DME is maintained by CMS, and providers should regularly check it for changes.

For non-impacted DME purchases and all DME repairs or service of equipment, or rental or purchase of ancillary equipment, physicians, 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 any setting in which normal life activities take place.

Prescription Requirements for Diabetic Supplies

Except as otherwise indicated in federal or state law, a prescriber is required to write a prescription or a pharmacist is required to accept a prescription verbally or electronically from the prescriber. The prescription must include the following:

- The name, strength, and quantity of the drug or item prescribed
- The date of issue of the prescription
- The prescriber's name and address
- The member's name and address
- The prescriber's signature (if the prescriber writes the prescription)
- The directions for use of the prescribed drug or item

If the pharmacist takes the prescription verbally from the prescriber, the pharmacist is required to generate a hard copy. BadgerCare Plus and SeniorCare prescription orders, including prescriber-limited refill prescriptions, are valid for no more than one year from the date of the prescription. Controlled substance and prescriber-limited prescriptions are valid for periods of less than one year.

According to Wis. Admin. Code §§ DHS 105.02(4) and 105.02(7), and Wis. Stat. § 450.11(2), pharmacy providers are required to retain hard copies of prescriptions for five years from the DOS (date of service). Prescriptions transmitted electronically may be filed and preserved in electronic format, per Wis. Stat. § 961.38(2). If a pharmacist takes a prescription verbally from the prescriber, the pharmacist is required to generate a hard copy.

Topic #21017

Face-to-Face Requirements Durable Medical Equipment

A member is required to have a face-to-face visit with a physician or authorized NPP (non-physician practitioner) for the initial prescription of certain DME/DMS (disposable medical supplies) as defined by CMS. The list is maintained by CMS and providers should regularly check it for changes.

The following NPPs are allowed to provide the face-to-face visit:

- Clinical nurse specialist
- Nurse practitioner
- Physician assistant

Documentation of the face-to-face visit must explain how the individual's observed health status relates to the primary reason that the member requires home health service or impacted DME or DMS.

A face-to-face visit is not required for DME or DMS refills, repairs or service of equipment, or rental or purchase of ancillary equipment.

Timeframe Requirements

The face-to-face visit must occur no more than six months before the signature date of the initial prescription.

Second Face-to-Face Visit Not Required

If an individual has a documented face-to-face visit with a physician or NPP for the initial prescription, and the individual subsequently enrolls in Wisconsin Medicaid, a new face-to-face visit is not required.

Providers are required to maintain the original physician prescription and documentation of a face-to-face visit in the member's medical record and submit them with the PA request if a PA is applicable.

Topic #1739

Product Life Expectancy

The federal CMS (Centers for Medicare and Medicaid Services) has established that the reasonable useful lifetime of most DME (durable medical equipment) is five years. The DME Index indicates the life expectancy for each DME item. Product life expectancy is measured based on when the item is delivered to the member, not the age of the item itself.

Mobility Devices

The documentation submitted with the PA (prior authorization) request must meet the approval criteria for a mobility device, including an adaptive stroller, and demonstrate either a replacement mobility device is medically necessary to meet the member's functional needs or the member has outgrown their current mobility device.

Speech Generating Device, Synthesized

The documentation submitted with the PA request is required to meet the approval criteria for a synthesized SGD (Speech-Generating Device). In addition, the documentation must support that the current SGD meets one of the following criteria:

- Cannot be repaired based on documented attempts to repair the device
- Does not meet the current or changing needs of the member
- Does not provide features that are necessary for the member's communication

Topic #66

Program Requirements

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

Topic #1836

Purchase or Rental

ForwardHealth reserves the right to determine whether an item will be purchased or rented for the member. In most cases, the item is purchased. If the item is only needed for short-term use, or the member's prognosis is poor, equipment rental is approved.

Certain DME (durable medical equipment) must be used for a trial period before PA (prior authorization) is required. Providers may be reimbursed for the trial rental period without PA. The following items must be used for a trial period of at least two months before PA is requested:

- TENS (transcutaneous electrical nerve stimulation) units
- Neuromuscular stimulators
- Lymphedema pumps
- Dynasplints

After the trial period, PA is required for any ongoing rental or purchase of the device. ForwardHealth determines if the DME is medically necessary to the member based on results of the rental period.

The documentation of trial results must be noted on the PA request.

Mobile arm supports also require a trial period prior to the submission of a PA request; however, ForwardHealth does not allow reimbursement for rental of this equipment. If reimbursement for the rental of a mobile arm support system is necessary to complete the trial period, a PA request should be submitted using HCPCS (Healthcare Common Procedure Coding System) procedure code E1399 (Durable medical equipment, miscellaneous).

Refer to the DME Index for additional purchase and rental information.

Topic #824

Services That Do Not Meet Program Requirements

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

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

- Services for which records or other documentation were not prepared or maintained
- Services for which the provider fails to meet any or all of the requirements of Wis. Admin. Code § DHS 106.03, 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 Wisconsin DHS (Department of Health Services), the PRO (Peer Review Organization) review process, or BadgerCare Plus determines to be inappropriate, in excess of accepted standards of reasonableness or less costly alternative services, or of excessive frequency or duration
- Services provided by a provider who fails or refuses to meet and maintain any of the enrollment requirements under Wis. Admin. Code ch. DHS 105
- 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 DHS

Topic #1857

Speech Generating Device Repairs

ForwardHealth covers repairs after the manufacturer's warranty expires. PA (Prior Authorization) is required for repairs when the billed amount is more than $300. Extended warranties are not covered.

Providers are reminded that delivery or set-up charges for equipment as a separate service are noncovered per Wis. Admin. Code § DHS 107.24(5)(h).

Topic #20157

Digitized Speech Generating Devices

Purchase and repair of digitized speech generating devices are covered by BadgerCare Plus and Medicaid for members with severe expressive speech impairment when alternative natural communication methods are not feasible or are inadequate for an individual's daily functional communication needs. Digitized speech generating devices use recorded speech output instead of synthesized or computerized

speech output. There is a three-year life expectancy for these digitized speech generating devices.

Note: ForwardHealth does **not** reimburse for rental of digitized speech generating devices.

PA (Prior Authorization) is not required for purchase of digitized speech generating devices except in limited circumstances.

Topic #12717

Wearable Cardioverter Defibrillator

Rental of a WCD (wearable cardioverter defibrillator) is a covered service with PA (prior authorization) and is supplied by a DME (durable medical equipment) vendor. The WCD is indicated for members 19 years of age or older who are at high risk for sudden cardiac death. A WCD is used on an outpatient basis and is intended for short-term use under medical supervision.

DME providers are required to request PA. The DME provider is responsible for obtaining the required clinical information from the member's cardiologist to complete the PA.

Reimbursement Policy and Claims

Rental of a WCD includes delivery, setup, and training. Wisconsin Medicaid does not separately reimburse for cables, alarms, electrodes, belts, holsters, lead wires, battery packs, battery charger, monitor, the garment, and other supplies since those items are included in the total rental charge.

Equipment rental is covered only as long as medical necessity exists. Once an ICD (implantable cardioverter defibrillator) is implanted or a heart transplant takes place, the WCD is no longer needed. Providers may not bill for DOS (dates of service) when medical necessity no longer exists.

Topic #22318

Electrical Stimulation Devices

ForwardHealth covers the rental of an electrical stimulation device for the treatment of the brain cancer GBM (glioblastoma multiforme) (grade IV astrocytoma). An electrical stimulation device, such as Optune, is a device that uses TTFields (Tumor Treating Fields) therapy to treat GBM. TTFields are electric fields that disrupt cancer cell division.

ForwardHealth covers the rental of an electrical stimulation device for the treatment of the brain cancer GBM for members 22 years old and older.

Electrical stimulation device coverage includes:

- The electric field generator device
- Four transducer arrays
- A connecting cable
- A power source of either a battery or electrical outlet cord
- A carrying case

Individual components are not separately reimbursable. The electrical stimulation device is covered for monthly rental only and is not covered for purchase.

PA (prior authorization) is **not** required for the first three calendar months of rental. After the first three calendar months, PA is required for continued coverage. On PA requests and claims, one unit represents one calendar month of rental.

Back-up or Secondary Durable Medical Equipment

Topic #1730

Back-up or Secondary Durable Medical Equipment

Back-up or secondary DME (durable medical equipment) 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 (prior authorization) 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 DME Index lists the procedure codes for which Wisconsin Medicaid allows reimbursement. Please refer to the DME Index for complete coverage information.

Home Health Equipment

Topic #1745

Adaptive Equipment

Covered adaptive equipment is limited to basic items for independence in self-care tasks. Selected adaptive equipment is 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 Wis. Admin. Code § DHS 107.24(2)(c), adaptive equipment is the category of DME (durable medical equipment) used in the home to assist a person with a disability to achieve independence in performing daily self-care tasks.

Noncovered Adaptive Equipment

The following adaptive equipment items are not covered:

- Items determined not to be medically necessary, such as the following:
  - 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.

Topic #1746

An Overview

Home health equipment is DME (durable medical equipment) 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.

Topic #1842

Blood Pressure Monitor

A sphygmomanometer is a device for measuring blood pressure. At least daily monitoring of blood pressure must be documented as medically necessary by a primary care provider for a blood pressure cuff, automatic blood pressure monitor, or sphygmomanometer. For more information about required documentation, refer to the Medical Records topic.

Topic #1748

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.

- 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 (for example, 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 order 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 HCPCS (Healthcare Common Procedure Coding System) 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.

PA is required for certain breast pump purchases.

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.

PA is required if rental of a breast pump (E0604) exceeds 60 days.

Breast Pump Order Form

Providers are recommended to use the Breast Pump Order (F-01153 (10/2022)) 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 Wis. Admin. Code § DHS 106.02(9).

Topic #1750

Long-Term Rentals for Certain Infusion Pumps

The following table outlines specific rental guidelines for certain infusion pumps:

Procedure code	Description	Initial rental period modifier*	Extended rental period
B9002	Enteral nutrition infusion pump, any type	RR	During the extended rental period for equipment liste this table, providers will be reimbursed only for repa and nonroutine service using the appropriate proced codes.
B9004	Parenteral nutrition infusion pump, portable	RR	
B9006	Parenteral nutrition infusion pump, stationary	RR	
E0781	Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient	RR	
E0791	Parenteral infusion pump, stationary, single or multichannel	RR	

* RR = Rental.

Initial Rental Period

The daily rental maximum allowable fee rate is payable monthly to providers until the purchase price max fee listed in the DME (durable medical equipment) Index is reached. Use HCPCS (Healthcare Common Procedure Coding System) 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 (prior authorization) 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.

Topic #11137

Negative Pressure Wound Therapy Pumps

The rental of negative pressure wound therapy pumps and purchase of related accessories and supplies is covered for services provided in the home when used for the treatment of ulcers and wounds that have not responded to traditional wound treatment methods.

A negative pressure wound therapy pump is the controlled application of subatmospheric pressure to a wound using an electrical pump to intermittently or continuously convey atmospheric pressure through connecting tubing of a specialized wound dressing that is meant to contain the subatmospheric pressure at the wound site and thereby promote healing. The subatmospheric pressure conveyed to the wound is in a range of 100 to greater than or equal to 200 mm Hg. The pump sounds an alarm when desired pressures are not being achieved (e.g., when there is a leak in the dressing seal) and when the canister to collect drainage from the wound is full.

Before supplying negative pressure wound therapy pumps, providers are required to document in the member's medical record that the following treatments have been tried and have failed to achieve wound healing in the previous 30 days:

- For all ulcers and wounds:
  - Application of dressings to maintain a moist wound environment.
  - Debridement of necrotic tissue and treatment of osteomyelitis or wound infection, if present.
- For stage III or IV pressure ulcers:
  - The member has been appropriately turned and positioned, has used a group 2 or 3 support surface for pressure ulcers on the posterior trunk or pelvis, (a group 2 or 3 support surface is not required if the ulcer is not on the trunk or pelvis) and the member's moisture and incontinence have been appropriately managed.
- For neuropathic ulcers:
  - The member has been on a comprehensive diabetic management program and reduction in pressure on a foot or leg ulcer has been accomplished with appropriate modalities.
- For venous insufficiency ulcers:
  - Leg elevation and ambulation have been encouraged.
- For surgical wounds:
  - The member has complications of a surgically created wound or a traumatic wound where there is documentation of the medical necessity for accelerated formation of granulation tissue which cannot be achieved by other available topical wound treatments.

If traditional wound treatment methods have not resulted in improvement, a negative pressure wound therapy pump may be ordered.

More than one negative pressure wound therapy pump billed per member, per day for the same time period is not covered. The negative pressure wound therapy pump must accommodate more than one wound dressing set for multiple wounds on a member.

Detailed documentation showing medical necessity of the negative pressure wound therapy pump is required to be kept by the supplying provider. A written physician's order for the use of negative pressure wound therapy pumps and supplies must be signed and dated by the treating physician and obtained by the provider before supplying the pump. The order is required to be kept on file by the provider.

If detailed documentation in the member's medical record is incomplete or does not show the medical necessity of the negative pressure wound therapy pump and supplies, payments may be subject to recoupment.

Documentation showing medical necessity is required to be recorded and maintained in a member's medical record and must include the following:

- Signed and dated physician order obtained prior to the application of the negative pressure wound therapy pump.
- Wound origin and history, including date wound first occurred.
- Evaluation and treatment plan.
- Weekly wound measurements (including length, width, and depth) and description (including type and amount of drainage) by a licensed health care professional.
- Evaluation and provision for adequate nutritional status, including required lab work for recent albumin and total protein levels. If lab work is not within normal range (albumin 3.4-5.4 g/dl and total protein 5.6-8.4 g/dl) dietary assessment and additional

intervention measures to improve levels must be documented.
- Type of diet, appetite, height, weight, and notation of recent weight loss, if applicable.
- Dates and number of hours per day that negative pressure wound therapy pump is in use. The device should only be used by qualified, trained, and authorized personnel.

Use of the negative pressure wound therapy pump is no longer covered when the treating physician determines wound healing has occurred to the degree that the negative pressure wound therapy pump is no longer needed or when any measureable degree of wound healing has failed to occur over the course of a month.

Information about negative pressure wound therapy pumps for nursing home members is available.

Definition of Lack of Improvement of a Wound

Lack of improvement of a wound is defined as a lack of improvement in the quantitative measurements of wound characteristics including wound length and width (surface area) or depth measured serially and documented over a specific interval of time. Wound healing is defined as improvement (smaller size) in either surface area or depth of the wound.

Inappropriate and Noncovered Use

The use of negative pressure wound therapy pumps is not appropriate and therefore not covered in the following situations:

- Presence of necrotic tissue with eschar, if debridement is not attempted.
- The presence of a fistula to an organ or body cavity within the vicinity of the wound.
- When cancer is present near or in the wound.
- If untreated infection or osteomyelitis is noted in the wound.

Topic #1751

Passive Motion Exercise Device

Rental of passive motion devices is covered with PA (prior authorization) 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.

Topic #19717

Positioning Seats

Positioning Seats for Motor Vehicle Use

The purchase or rental of a positioning seat for motor vehicle use is covered by ForwardHealth with an approved PA (prior authorization) request for a member with **all** of the following attributes:

- The member is at least 4 years of age and weighs at least 40 pounds.
- The member has a moderate to severe impairment in trunk control and/or head control that is caused by a medical condition.
- The member needs adaptive positioning for safe transportation.

Accessories

Wisconsin Medicaid does not separately reimburse for positioning seat accessories.

Positioning Seats for Home Use

ForwardHealth covers the purchase of a positioning seat for use in a member's home if the member has a medical condition resulting in an inability to independently maintain an unsupported sitting position, and the member does not require mobility equipment. The purchase of a positioning seat for home use requires PA.

ForwardHealth does not cover the rental of a positioning seat for home use.

Accessories

Wisconsin Medicaid does not separately reimburse for positioning seat accessories.

Replacement Parts for Positioning Seats for Motor Vehicle Use and for Home Use

Cushions, Pillows, and/or Wedges

ForwardHealth covers replacement of positioning seat cushions, pillows, and/or wedges with PA.

Other Replacement Parts

ForwardHealth covers other replacement parts for positioning seats with PA.

Topic #1747

Speech Generating Devices, Synthesized

Purchase, rental, and repair of dedicated synthesized SGDs (Speech Generating Device) are covered when PA (Prior Authorization) criteria are met. The device must improve a member's communication ability when alternative natural communication methods are not feasible or are inadequate for their daily functional communication.

ForwardHealth recommends that members undergo an up to 90 day trial period with the synthesized SGD before a PA request for purchase is submitted. This trial period is not required prior to submitting a PA for the purchase; however, the trial period allows the member to demonstrate progress related to targeted SGD communication skills during and outside of treatment sessions and within targeted interactions (for example, with a caregiver or other team members). Documented progress during the trial period can help substantiate the medical necessity of the SGD purchase request.

Note: In limited circumstances, such as a member with amyotrophic lateral sclerosis, if the member demonstrated proficiency with the device at the end of the initial evaluation, the provider should consider submission of a PA to purchase the SGD without further trial of the device or additional therapy data.

Accessories

The following accessories are included in the purchase of a SGD, and are not separately reimbursable at the time of initial purchase:

- AC adapters
- All applicable software programs
- Batteries
- Battery chargers
- Nonintegrated keyboards
- Protective case or covers

Implants

Topic #1752

Vagus Nerve and Dorsal Column/Spinal Stimulators

Enrolled medical equipment vendors are separately reimbursed for vagus nerve stimulators and dorsal column or spinal stimulators when the implant surgery is performed in an ASC (ambulatory surgery center) or outpatient hospital and when the performing surgeon has an approved PA (prior authorization) for the surgery. The POS (place of service) codes for these facilities are as follows:

- 22 (On Campus — 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 or dorsal column/spinal 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)

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

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

Nursing Home Members and Durable Medical Equipment

Topic #1755

An Overview

The DME (Durable Medical Equipment) 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. ForwardHealth will automatically adjust claims when a LOC (level of care) is found for a member and the item is included in the nursing home rate.

Topic #11019

Negative Pressure Wound Therapy Pumps

The rental of negative pressure wound therapy pumps and the purchase of related accessories and supplies is covered for members residing in a nursing home when used for the treatment of ulcers and wounds that have not responded to traditional wound treatment methods.

Reimbursement for the rental of a negative pressure wound therapy pump and the purchase of related accessories and supplies are not part of the nursing home daily rate and cannot be included as part of a nursing home's cost reports.

Allowable POS (place of services) codes for negative pressure wound therapy services provided by DME (durable medical equipment) providers are 11 (Office), 12 (Home), and 19 (Off Campus — Outpatient Hospital). Durable medical equipment providers cannot be directly reimbursed for negative pressure wound therapy pump services to members residing in a nursing home.

Information about negative pressure wound therapy pumps for home health is available.

Topic #1757

Respiratory Equipment

The DME (Durable Medical Equipment) 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.

Topic #1758

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.

Complex Rehabilitation Technology Not Included in Nursing Home Daily Rate

CRT (complex rehabilitation technology) is not included in the nursing home daily rate. CRT items are separately reimbursable when medically necessary and used by the member to do any of the following:

- Contribute to the member's independent completion of activities of daily living
- Support the member's occupational, vocational, or psychosocial activities
- Support the member's ability to independently move around the facility, or to attain or retain self-care

Prior Authorization Requests for Complex Rehabilitation Technology

PA (prior authorization) is required for the purchase or rental of CRT.

Non-Complex Rehabilitation Technology Wheelchair Rentals

Non-CRT wheelchair rentals for members residing in a nursing home are not separately reimbursable.

A non-CRT 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.

Complex Rehabilitation Technology Custom Seating Systems

Wisconsin Medicaid separately reimburses providers for CRT custom seating systems that are distinct from the wheelchair base, or used in conjunction with the CRT mobility base, for nursing home residents when all of the following apply:

- The CRT seating system is prescribed by a physician.
- The CRT seating system is custom-made to fit one member only and is used only by that member.
- The CRT seating system is medically necessary per the diagnosis, prognosis, and the occupational or vocational activities of the member.

Repairs

Wisconsin Medicaid separately reimburses providers for repairs to member-owned wheelchairs only when the repairs are for CRT items.

The nursing home is responsible for providing a non-CRT wheelchair as needed. Repair of a member-owned non-CRT wheelchair in a nursing home is not covered by Wisconsin Medicaid. However, consideration of Medicaid coverage of a non-CRT wheelchair will be taken if the member is in the process of transferring to a more independent setting.

Prosthetic Procedures

Topic #1762

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.

Topic #20137

Facial Prosthetics

ForwardHealth covers facial prosthetics and facial prosthetic repairs for members who have a loss or absence of facial tissue due to disease, trauma, surgery, or congenital defect. PA (prior authorization) is not required for coverage of facial prosthetics and facial prosthetic repairs with the exception of facial prosthetics and repairs identified by unlisted procedure codes. There is a one-year life expectancy for facial prosthetics.

Repair of Durable Medical Equipment

Topic #1763

General Policy

All DME (durable medical equipment) 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 (date of service).

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 (prior authorization). If the provider is unsure whether the total cost of providing the service will exceed the dollar threshold amount in the DME 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.

Topic #1764

Labor Costs for Repairs

Use procedure code K0739 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 (prior authorization) 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 K0739 is all-inclusive, so it includes reimbursement for expenses such as overhead, travel, and delivery.

Topic #1765

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 a procedure code matching the specific part in the DME (Durable Medical Equipment) Index.
2. If no procedure code has been found, use E1399 for the part. Procedure code E1399 always requires PA (prior authorization).

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 mattres
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, withou mattress
E0260	Hospital bed, semi-electric (head and foot adjustment), with any ty side rails, with mattress
E0261	Hospital bed, semi-electric (head and foot adjustment), with any ty side rails, without mattress
E0265	Hospital bed, total electric (head, foot, and height adjustments), wi any type side rails, with mattress
E0266	Hospital bed, total electric (head, foot, and height adjustments), wi 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 mattres
E0293	Hospital bed, variable height, hi-lo, without side rails, without matt
E0294	Hospital bed, semi-electric (head and foot adjustment), without sic rails, with mattress
E0295	Hospital bed, semi-electric (head and foot adjustment), without sic 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 ty 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 ty 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
E0168	Commode chair, extra wide and/or heavy duty, stationary or mobi 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 a procedure code matching the specific part in the DME Index.
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	Lightweight portable motorized/power wheelchair
K0014	Other motorized/power wheelchair base
K0800	Power operated vehicle, group 1 standard, patient weight capacity to and including 300 pounds
K0801	Power operated vehicle, group 1 heavy duty, patient weight capac 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 to and including 300 pounds
K0807	Power operated vehicle, group 2 heavy duty, patient weight capac 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 a procedure code matching the specific part in the DME Index.
2. If no procedure code has been found, use E1399 for the part. Procedure code E1399 always requires PA.

Oxygen and Respiratory Equipment

Topic #3507

Chest Wall Oscillation Systems

Wisconsin Medicaid reimburses providers for HCPCS (Healthcare Common Procedure Coding System) 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, the equipment is considered purchased. Ownership of the equipment remains with the provider. Providers will no longer receive reimbursement from Wisconsin Medicaid for this equipment and are responsible for the long-term support of the equipment, including the lifetime warranty and all services covered under the warranty, such as repairs, any necessary supplies, and replacement, until the equipment is no longer medically necessary.

Topic #1767

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 (Durable Medical Equipment) Index lists all covered respiratory equipment.

Topic #20017

Home Ventilator Rental Coverage

Primary Home Ventilator

ForwardHealth covers primary home ventilator rental for members who have a documented medical need for mechanical ventilation for acute or chronic respiratory failure, insufficient oxygenation, insufficient alveolar ventilation, or a combination of these, depending on severity.

Note: Information regarding home ventilator rental reimbursement is available.

Back-Up or Secondary Home Ventilator

When medically necessary, ForwardHealth may cover the rental of up to two home ventilators.

ForwardHealth will cover a back-up or secondary home ventilator rental with PA (prior authorization) in limited circumstances.

Note: Back-up or secondary home ventilator rental is not covered when provided to members in a nursing home or skilled nursing home setting.

Documentation Requirements for Home Ventilators

ForwardHealth requires that a provider maintain the following documentation in the member's medical record for coverage of primary and back-up or secondary home ventilator rental:

- A diagnosis or clinical condition and respiratory assessments from the physician that substantiate the medical necessity for ventilatory support
- A physician prescription

- Ventilator settings
- Documentation of weaning attempts and/or the potential for weaning
- Regular (monthly) running hours reports that show daily (and/or hourly) member use of mechanical ventilation
- The mechanical mode of ventilation (invasive or non-invasive)
- The amount of family or skilled care needed
- Pulmonary progress notes
- Indication of whether or not the primary ventilator is portable
- Home environment assessment results to confirm that the residence will safely accommodate the home ventilator and auxiliary equipment
- Documentation of the training on equipment use that has occurred with family and caregivers
- Records on maintenance and repair of equipment, including DOS (date of service) and descriptions of what was done
- Emergency plan in case of improper function of equipment
- Date-of-delivery documentation

Topic #1770

Medical Necessity for Oxygen Services

Whether a member resides in a SNF (skilled nursing facility) 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.

Topic #1771

Oxygen Contents

Oxygen contents may only be purchased. 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 (Healthcare Common Procedure Coding System) code descriptions. PA (Prior authorization) is required for oxygen contents after 30 days.

Topic #1772

Oxygen Delivery Systems

Purchased Oxygen Delivery Systems

Oxygen delivery systems may be purchased with PA (prior authorization). 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 (Durable Medical Equipment) 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 the other health insurance (for example, commercial health insurance,

Medicare, Medicare Advantage Plans) source's 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 other health insurance.

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 stationary oxygen while at rest 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 stationary oxygen while at rest 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 (date of service) as long as the appropriate physician prescription and documentation to support medical necessity and actual oxygen use is maintained.

Topic #1773

Prescriptions for Oxygen Services

The FDA (Food and Drug Administration) 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., O_2 @ 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 (prior authorization) 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 (F-11042 (07/2012)).

Exception

For the initial prescription of certain DME (durable medical equipment)/DMS (disposable medical supplies) as defined by the federal CMS (Centers for Medicare and Medicaid Services), a physician is required to write the initial prescription. The list is maintained by CMS, and providers should regularly check it for changes. The written prescription must be received prior to dispensing impacted DME.

Topic #1740

Rental Guidelines for Respiratory Equipment Excluding Home Ventilators

The following guidelines apply to certain respiratory equipment excluding home ventilators.

Initial Rental Period

The daily rental max fee rate is payable monthly to providers until the purchase price max fee listed in the DME (Durable Medical Equipment) Index is reached. Use HCPCS (Healthcare Common Procedure Coding System) modifier RR (Rental) with the equipment procedure code on the PA (prior authorization) request and claim form.

Extended Rental Period

Once the purchase price max fee has been reached for certain DME, 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. Temporary replacement equipment is not reimbursed separately. 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.

The federal CMS (Centers for Medicare and Medicaid Services) has established that the reasonable useful lifetime of most DME is five years.

For each piece of equipment for which repair or nonroutine service is performed, indicate one of the following HCPCS procedure codes on the PA request or claim form:

- K0739 (Repair or nonroutine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes)
- E1399 (Durable medical equipment, miscellaneous)

Providers should use the procedure code that best describes the exact replacement part or service before submitting PA requests and claims with procedure code E1399.

For specific repair and service guidelines for respiratory equipment, refer to the DME Index.

Topic #12017

Respiratory Assist Device Coverage

ForwardHealth will approve PA (prior authorization) requests for the appropriate RAD (Respiratory Assist Device) procedure code based on the physician-ordered settings. Pulmonary progress notes and respiratory assessments from the physician must also be included and match the physician orders.

Due to new technology, most RADs have the capability of multiple settings and are interchangeable. They can be utilized for both invasive and non-invasive use, and since they are portable, they can be used in any setting ranging from hospital to home use.

Initial Rental Period

The daily rental maximum allowable fee rate is payable monthly to providers until the purchase price max fee listed in the DME (Durable Medical Equipment) Index is reached. Use HCPCS (Healthcare Common Procedure Coding System) 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.

Extended Rental for Respiratory Assist Devices

During the extended rental period for procedure code E0472, 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. Extended rental status carries from one provider to the next provider.

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 the following:

- AC/DC chargers
- Adapters
- Air/oxygen mixers
- Auto adapters
- Backpacks
- Battery boxes
- Battery packs
- Clamps
- Circuits
- Filters, both HEPA and bacteria type
- Fittings
- Generators
- Internal and additional batteries for back-up use
- Manifolds
- Power cables/cords
- Power centers

- Power inverters
- Pressure alarms
- Pressure hoses
- Transport packs
- Valves

Usual and necessary accessories and supplies remain included even if a current PA for a RAD is not on file.

Additional payment is not made for repair, maintenance, or replacement during the rental of this equipment. It is the provider's responsibility to ensure there is an emergency plan in place to address mechanical failure of the equipment.

Disposable medical supplies for the member, such as face masks or tracheostomy suction catheters, continue to be covered and reimbursed separately.

The following table outlines service guidelines for RADs:

Procedure code	Description	Initial rental period modifier*	Extended rental peri modifiers*
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	RR and 52

*The following are the modifiers and their definitions for the table above:

- RR = Rental.
- 52 = Reduced services. Modifier 52 must be billed with modifier RR during the extended rental period.

Mobility Devices and Accessories

Topic #21137

Adaptive Strollers, Manual Wheelchairs, and Power Wheelchairs

Adaptive Strollers

ForwardHealth covers adaptive strollers for members who require seating, trunk, and/or head positional supports that are unavailable on a commercial stroller.

ForwardHealth will cover adaptive strollers as the primary mobility device if **all** of the following are met:

- The request is medically necessary.
- The member meets the mobility device coverage criteria.
- The member's weight, height, and positioning needs cannot be adequately met with a commercially available stroller.
- A manual wheelchair does not meet **or** exceeds the member's needs.
- The functionality and size of the requested adaptive stroller are the most appropriate for the environment in which it will be used most frequently.

Adaptive Stroller Accessories

Options and accessories are included in the reimbursement of the adaptive stroller and are not separately reimbursable.

Manual Wheelchairs

ForwardHealth covers manual wheelchairs for members who require a mobility base to accomplish medically necessary activities of daily living.

ForwardHealth will cover medically necessary manual wheelchairs as the primary mobility device if all the following are met:

- The request is medically necessary.
- The member meets the mobility device coverage criteria.
- The requested manual wheelchair or a comparable product has been trialed with enough time to determine its utility for the member.
- The request addresses one of the following:
  - The member demonstrates the ability to self-propel and navigate a functional distance while utilizing a manual wheelchair.
  - The positioning available on adaptive strollers/transport chairs is insufficient to meet the member's positioning needs. Member is unable to self-propel a manual wheelchair.

Manual Wheelchair Accessories

In addition to the base requirements for manual wheelchairs, accessory requests require detailed documentation of member medical needs or caregiver impact.

Power Wheelchairs

ForwardHealth covers power wheelchairs for members who require a mobility base to accomplish medically necessary activities of daily living that cannot otherwise be accomplished with a power-operated vehicle (scooter), manual wheelchair, adaptive stroller, walkers, crutches, or canes.

In addition to the PA (prior authorization) submission requirements and the mobility device requirements outline in the Overview topic, all of the following are required:

- The inability to self-propel a properly equipped scooter/manual wheelchair to meet medically necessary mobility-related needs has been documented.
- Assistance for adaptive stroller/transport chair/manual wheelchair propulsion is medically necessary but unavailable and/or age inappropriate.
- The positioning available on adaptive strollers, transport chairs, or manual wheelchairs is insufficient to meet the member's positioning needs.
- A detailed safety assessment has been performed that includes operational safety and the member's cognitive ability to operate the machine.
- The requested power wheelchair or a comparable product has been trialed with adequate time to determine its utility for the member.

Power Wheelchair Accessories

In addition to the base requirements for power wheelchairs, each power wheelchair accessory requires documentation of the accomplishment of member-specific medically necessary tasks and how the accessory will help the member complete the medically necessary task.

Power Wheelchairs with Seat Elevator Function

In addition to the base requirements for power wheelchair and power wheelchair accessories, requests for seat elevator function require additional member-specific documentation as follows:

- Reasonable adaptation/modification of the task or environment cannot alone meet the member's needs. Examples of reasonable adaptation/modification include equipment listed in the Adaptive Equipment topic, adjustable height bed/table, dresser/cabinet re-organization, or a grab bar for transfer assistance.
- Use of a power seat elevation system will allow the member to independently perform activities of daily living and significantly reduce caregiver dependency.

Power Wheelchairs with Standing Function

In addition to the base requirements for power wheelchair and power wheelchair accessories, PA requests for power wheelchairs with standing function also require documentation of either functional needs or physiological needs, based on which is more appropriate. Documentation requirements for both functional needs and physiological needs for standing wheelchairs are outlined below.

When submitting the required documentation of the **functional** need for a standing wheelchair, providers must include all of the following:

- A description of reasonable adaptation or modification of the task or environment that alone cannot meet the member's needs. Examples of reasonable adaptation or modification include:
  - Adjustable height bed/table
  - Dresser/cabinet re-organization
  - Grab bar for transfer assistance
- A list of any special adaptive equipment or items owned or used by the member in any environment (for example, specialized seating/positioning equipment, seat elevator feature, standing frames, and/or mobility aids).
- Documentation of the member's participation in therapy services, including an applicable POC (plan of care) within an appropriate timeframe, and an assessment of the member's range of motion, strength, muscle tone, sensation, coordination, balance, ambulatory status, cognitive status, functional status, and ADL (activities of daily living) status.

When submitting the required documentation of the **physiological** need for a standing wheelchair, providers must include all of the following:

- Documentation that the standing feature is an integral part of a rehabilitative or maintenance therapy program with specific and measurable outcomes unique to the member to address at least one of the following areas:
  - Maintain or improve bladder function
  - Maintain or promote bone/joint health

    - Maintain or improve bowel function
    - Maintain or improve digestive process
    - Maintain or promote cardiac function
    - Manage contractures and range of motion in the lower extremities
    - Manage pain associated with spasticity or tone
- Documentation that the member is willing to use the standing feature as indicated in the rehabilitative or maintenance therapy program.
- Documentation that caregivers are willing and able to assist with the standing program, as applicable. This documentation should include trials and outcomes with the utilization of a static standing frame, or other standing program, and clinical justification for why a static standing frame would not meet the member's medical needs.
- A description of reasonable adaptation or modification of the task or environment alone cannot meet the member's needs. Examples of reasonable adaptation or modification include:
    - Adjustable height bed/table
    - Dresser/cabinet re-organization
    - Grab bar for transfer assistance
- A list of any special adaptive equipment or items owned or used by the member in any environment (for example, specialized seating/positioning equipment, seat elevator feature, standing frames, and/or mobility aids).
- Documentation of the member's participation in therapy services, including an applicable POC within an appropriate timeframe; and an assessment of the member's range of motion, strength, muscle tone, sensation, coordination, gait, balance, cognitive status, functional status, and ADL status.

Topic #6737

Mobility Device Definitions

Adaptive Stroller

Adaptive strollers are for members who require seating, trunk, and/or head positional supports that are unavailable on a commercial stroller. An adaptive stroller is a dependent mobility base that is not designed to be propelled by the user.

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.

Wheelchair, Pediatric-Size

The seat has a width or depth of 15 inches or less. A complete manual wheelchair, pediatric-size base includes:

- A complete frame
- A sling back; other seat back support, which can accommodate a wheelchair back cushion; or a back frame structured in such a way as to be capable of accepting a back system
- A sling seat; a seat pan, which can accommodate a wheelchair seat cushion; or a seat frame structured in such a way as to be capable of accepting a seating system
- Brakes
- Casters
- Medically necessary transport options
- Propulsion wheels
- Standard armrests
- Standard leg and footrests

Custom Wheelchair

A wheelchair that is uniquely designed, from 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. The following are examples of standard wheelchairs:

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

Topic #1774

Overview

ForwardHealth defines mobility devices as adaptive strollers, manual/power wheelchairs, and power scooters. Purchase of these devices requires PA (prior authorization). Rental of these devices requires PA after specified lengths of time. Providers should refer to the DME Index (Durable Medical Equipment) for PA requirements for rental.

ForwardHealth will cover medically necessary mobility devices if **all** the following criteria are met:

- The request is for an adaptive stroller, manual/power wheelchair, or power scooter.
- The member is unable to ambulate functional distances due to a physical disability and/or a medical condition that significantly reduces their ability to participate in medically necessary MRADL (mobility-related activities of daily living), such as toileting, feeding, dressing, grooming, bathing, and vocational activities.
- The member's medically necessary MRADL needs cannot be practically and safely met by the utilization of less restricting mobility devices, such as canes, crutches, or walkers.
- The member and/or caregiver demonstrates a competence and willingness to operate the requested mobility device.
- The functionality and size of the requested mobility device are the most appropriate for the environment in which it will be used most frequently.

Topic #11997

Power Wheelchair Batteries Limited to Two

ForwardHealth limits coverage of batteries for power wheelchairs to a maximum quantity of two batteries. A third battery used on a power wheelchair as an external power source (power center, third battery, portable power, etc.) is not considered medically necessary, and therefore is not covered.

Topic #1775

Power-Operated Vehicles (Scooters)

Providers are required to indicate HCPCS (Healthcare Common Procedure Coding System) procedure codes K0800-K0812 for power-operated vehicles (scooters). All power-operated vehicles require PA (prior authorization).

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 Wis. Admin. Code §DHS 101.03(96m), for medical necessity. Wisconsin Medicaid does not cover certain accessories such as baskets, lights, horns, or flags.

Topic #3464

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 (durable medical equipment) 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.

Topic #1776

Second Mobility Device

ForwardHealth will cover the purchase of medically necessary second mobility devices when the primary mobility device (i.e., adaptive stroller, manual/power wheelchair or power scooter) is unable to be utilized safely or practically for a reoccurring medically or functionally necessary task/environment and is not duplicative in function.

ForwardHealth will cover the rental of a second wheelchair while a member's primary wheelchair is being repaired. PA (prior authorization) is required for all power mobility device rentals. After 60 days, PA is required for the rental of manual wheelchairs.

Topic #1777

Wheelchair Evaluations

According to Wis. Admin. Code § DHS 101.03(96m)(b)7., medical services cannot be provided solely for the convenience of the member, the member's family, or a provider. When a DME (durable medical equipment) 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.

Topic #1778

Wheelchair Seating and Positioning

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 (prior authorization) 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 Index (Durable Medical Equipment) 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.

Seating Width

ForwardHealth does not separately reimburse for width or depth adjustments at the time of purchase. If the member requires width or depth seating adjustments for a member-owned mobility device, the provider is required to submit a PA.

Diabetic Supplies

Topic #1749

Diabetic Equipment

Blood glucose monitoring equipment and supplies are covered when the medically necessary requirements according to Wis. Admin. Code § DHS 101.03(96m), 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 (Department of Health Services) on request, per Wis. Admin. Code § DHS 106.02(9).

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.
- The member's 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.

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 (International Classification of Diseases) code or narrative) of diabetes. The provider is also responsible for documenting the source of this information, for example, 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 follow these procedures:

- Enter one of the following modifiers in Item Number 24D of the 1500 Health Insurance Claim Form ((02/12)) 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 diagnosis code describing the condition that necessitates glucose testing in Item Number 24E of the 1500 Health Insurance Claim Form for **each** procedure code indicated.

Topic #8937

Preferred Products

Certain diabetic supplies have preferred products and non-preferred products. Non-preferred products require PA (prior authorization) for members enrolled in BadgerCare Plus and Wisconsin Medicaid. The following preferred and non-preferred diabetic supplies also have quantity limits:

- Blood glucose meters
- Blood glucose test strips

Not all blood glucose meters and blood glucose test strips provided by a preferred manufacturer are preferred products. For a complete list of preferred and non-preferred diabetic supplies, providers may refer to the Diabetic Supply List Quick Reference.

The following diabetic supplies are reimbursable by NDC (National Drug Code):

- Blood glucose calibrator solutions and chips
- Blood glucose meters
- Blood glucose test strips
- Insulin syringes
- Lancets
- Lancet devices
- Pen needles

Topic #9037

Quantity Limits

Certain diabetic supplies have quantity limits.

Providers may dispense up to the allowed quantity to members but may not exceed the quantity limit without requesting a quantity limit override. To request an override of quantity limits for diabetic supplies, providers may contact the DAPO (Drug Authorization and Policy Override) Center.

For type I diabetics, the following are examples of when providers may request a quantity limit policy override for diabetic supplies:

- If the member is an uncontrolled type 1 diabetic with episodes of hypoglycemia and is being treated by an endocrinologist or has been referred to the primary care provider by an endocrinologist
- If the member is using an insulin pump

For type II diabetics, providers may request a quantity limit policy override for diabetic supplies, for example, when the member is using sliding scale insulin and the override is medically warranted. Requests for quantity limit policy overrides for type II diabetics will not be granted unless there is sufficient medical evidence to warrant the override.

Providers may request a quantity limit policy override for members, regardless of their benefit plan. If a quantity limit exception is not approved, the service is considered noncovered, and there are no appeal rights due to service limitation policy.

Telehealth

Topic #22837

Telehealth Definitions

General Telehealth Definitions

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

"Synchronous" telehealth services are two-way, real-time, interactive communications. They may include audio-only (telephone) or audio-visual communications.

"Asynchronous" telehealth services are defined as telehealth that is used to transmit medical data about a patient to a provider when the transmission is not a two-way, real-time, interactive communication.

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

Telehealth Service Definitions

The following are definitions to clarify the meaning of existing terms that describe different modes of telehealth service delivery in telehealth policy.

"In-person" refers to when the provider rendering a service and the member receiving that service are located together physically in the same space. In-person services are not considered to be delivered through telehealth, including audio-visual telehealth, unless there are applicable supervision components and requirements that are rendered through telehealth outside of the direct patient contact by the provider.

"Face-to-face" refers to requirements that can be met either in-person or through real-time, interactive audio-visual telehealth. An interactive telehealth service with face-to-face components must be functionally equivalent to an in-person service. It is delivered from outside the physical presence of a Medicaid member by using audio-visual technology, and there is no reduction in quality, safety, or effectiveness. ForwardHealth does not consider a "face-to-face" requirement to be met by audio-only or asynchronous delivery of services.

Under telehealth policy, "direct" refers to an in-person contact between a member and a provider. Direct services often require a provider to physically touch or examine the recipient and delegation is not appropriate.

Topic #510

Telehealth Policy

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

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

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

email, text, or fax transmission.

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

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

Telehealth Policy Requirements

The following requirements apply to the use of telehealth:

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

Allowable Services

Providers should refer to the Max Fee Schedules page for a complete list of services allowed under permanent telehealth policy. Effective for dates of service on and after April 1, 2022, procedure codes for services allowed under permanent telehealth policy have POS codes 02 and 10 listed as an allowable POS in the fee schedule. Complete descriptions of these POS codes are as follows:

- POS code 02: Telehealth Provided Other Than in Patient's Home–The location where health services and health related services are provided or received through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.
- POS code 10: Telehealth Provided in Patient's Home–The location where health services and health related services are provided or received through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.

Claims for services delivered via telehealth must include all modifiers required by the existing benefit coverage policy in order to reimburse the claim correctly. Telehealth delivery of the service is shown on the claim by indicating POS code 02 or 10 and including either the GQ, GT, FQ, or 93 modifier in addition to any other required benefit-specific modifiers.

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

Note: The GT, FQ or 93 modifiers may not be listed on the fee schedule, but it is still required on all claim submissions that use POS code 02 or 10 to indicate the telehealth service was performed synchronously. The GQ modifier is required to indicate the telehealth service was performed asynchronously.

Services Not Appropriate Via Telehealth

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

- Services that are not covered when provided in-person.
- Services that do not meet applicable laws, regulations, licensure requirements, or procedure code definitions if delivered via telehealth.
- Services where a provider is required to physically touch or examine the recipient and delegation is not appropriate.
- Services the provider declines to deliver via telehealth.
- Services the recipient declines to receive via telehealth.
- Transportation services.

- Services provided by personal care workers, home health aides, private duty nurses, or school-based service care attendants.

Reimbursement for Covered Services

The health care provider at the distant site must determine the following:

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

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

Documentation Requirements

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

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

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

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

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

Audio-Only Guidelines

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

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

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

Member Consent Guidelines for Telehealth

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

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

Privacy and Security

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

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

Group Treatment

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

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

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

Costs Member Cannot Be Billed For

The following cannot be billed to the member:

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

Allowable Providers

There is no restriction on the location of a distant site provider. In addition, there are no limitations on what provider types may be reimbursed for telehealth services.

Requirements and Restrictions

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

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

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

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

Noncovered Services

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

Additional Policy for Certain Types of Providers

Out-of-State Providers

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

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

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

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

Compression Garments

Topic #11697

Burn and Gradient Compression Garments

In this topic, the term "compression garments" is used to refer to both gradient compression garments and compression burn garments, unless otherwise stated.

Types of Compression Garments

For ForwardHealth reimbursement purposes, the following types of compression garments are defined below:

- Non-custom compression garments
- Custom compression garments
- Non-elastic binders
- Compression burn garments
- Over-the-counter garments

Non-Custom Gradient Compression Garments

Non-custom gradient compression garments (for example, Jobst, SigVarus, Venes) are defined as any garment that meets the definition of a valid HCPCS (Healthcare Common Procedure Coding System) procedure code and has a gradient pressure of 18 mmHg or more. Circumferential and length measurements are required for fitting. A signed and dated physician's prescription is required prior to dispensing the garment; see the Prescription Requirements section below for more information.

Allowable HCPCS procedure codes for non-custom gradient compression garments include the following: A6530–A6541, A6545, S8421, S8424, S8427, and S8428. The provider is required to use the specific code that meets the definition of the HCPCS code. For example, if a below-knee 18–30 mmHg garment is being ordered, the correct code to use is A6530.

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

- Consideration for small to extra-large and short to tall sizes
- The addition of liners, zippers, and reinforced areas when medically necessary

Custom Gradient Compression Garments

Custom 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 (when the body part or segment is an atypical shape) or are fabricated with a unique fabric or material, and provide accurate and consistent gradient compression to manage the member's symptoms. Providers are reminded to review the definition of non-custom gradient compression garments to determine which procedure code is allowable for reimbursement. The process of taking measurements does not in itself justify the use of a "custom" or "not otherwise specified" procedure code, as measurements are required to order any compression garment described with procedure codes A6501–A6549 and S8420–S8429. When a garment meets the description of a specific code, the provider is required to use the specific code.

Circumferential and length measurements are required for fitting. Garments with liners, zippers, or reinforced areas alone are not considered as meeting the definition of a custom gradient compression garment.

A signed and dated physician's prescription is required prior to dispensing the garment; see the Prescription Requirements section below for more information.

The following are examples of custom gradient compression garments:

- A garment requiring a unique fit due to the size and/or shape of the member's limb (when the body part or segment is an atypical shape).

- A garment requiring the application of unique fabric (for example, Elvarex).

Allowable HCPCS procedure codes for custom gradient compression garments include the following: A6549, S8420, S8422, S8423, S8425, and S8426.

A "custom" or "not otherwise specified" compression garment procedure code cannot be billed for any of the following alone:

- Compression garments incorporating zippers, reinforced areas, or liners
- The process of taking measurements
- Compression garments to accommodate a large, small, tall, or short size

Non-Elastic Binders

Non-elastic binders (for example, CircAid, LegAssist, Reid Sleeve) are defined as garments that provide continuous compression using adjustable hook and loop or buckle straps. Circumferential and length measurements are required for fitting. A signed and dated physician's prescription is required prior to dispensing the garment; see the Prescription Requirements section below for more information.

HCPCS procedure code S8429 is allowed for non-elastic binder compression garments for upper and lower extremities.

Compression Burn Garments

Compression burn garments are custom compression garments that are uniquely sized and/or shaped and custom made to fit the exact dimensions of the affected extremity and provide accurate and consistent compression to manage the member's burn symptoms. Circumferential and length measurements are required for fitting. A signed and dated physician's prescription is required prior to dispensing the garment; see the Prescription Requirements section below for more information.

Providers submitting claims for compression burn garments should use the same claim instructions and follow the same claim attachment requirements as when submitting claims for not otherwise specified gradient compression garments (such as those for procedure code A6549).

Allowable HCPCS procedure codes for compression burn garments include A6501–A6513.

Over-the-Counter Garments

Over-the-counter garments are defined as any garments with a pressure less than 18 mmHg. ForwardHealth does not cover over-the-counter garments purchased with or without a prescription (for example, elastic stockings, surgical leggings, anti-embolism stockings T.E.D. hose, support hose) or garments with 15–20 mmHg or 12–15 mmHg gradient compression. If certain conditions are met, a provider may collect payment from a member for these noncovered services.

Bandages and dressings are not covered as a separately reimbursable DME (durable medical equipment) service.

Medical Necessity Requirements

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

- Varicose veins of the lower extremities
- Postmastectomy lymphedma syndrome
- Other lymphedema
- Postphlebetic syndrome
- Venous (peripheral) insufficiency
- Edema or excessive weight gain in pregnancy, without mention of hypertension
- Ulcers of the lower limbs, except pressure ulcer
- Ulcers of other parts of the lower limbs
- Hereditary edema of the legs (Milroy's disease)
- Scrotal, pelvic, or vulval varices

Individually fitted prescription burn compression garments are generally considered medically necessary and, unless the established life

expectancy has been exceeded, do not require PA for members who have any of the following medical conditions:

- Burns of multiple specified sites
- Burns of the face, head, and neck
- Burns of the trunk
- Burns of the upper limbs, except wrists and hands
- Burns of the wrists and hands
- Burns of the lower limbs

If a member has a diagnosis not included in the lists above, providers may submit a PA request to ForwardHealth. Refer to Prior Authorization for Burn and Gradient Compression Garments for more information on PA requirements.

Additional Requirements for Non-Elastic Binders

In addition to the medical necessity requirements for gradient compression garments, non-elastic binders (for example, 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

ForwardHealth has established a life expectancy of three garments per rolling 12-month period for all covered compression garments except compression burn garments. 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 for these garments until greater than three garments per procedure code, per rolling 12-month period, is medically necessary.

Eight compression burn garments (per body segment) are allowed without PA per rolling 12-month period when medically necessary. Coverage for a series of compression burn garments will end two years from the first DOS (date of service). If a member requires two different compression burn garments per body segment, the provider should submit both compression burn garment procedure codes on one claim with the required supporting documentation. PA is not required for these garments until greater than eight garments per procedure code, per rolling 12 months, is medically necessary.

Compression Garments Certification or Licensure

Compression garments are reimbursable to allowable provider types when fit, ordered, and dispensed by one of the following:

- A certified fitter
- A licensed physical therapist or occupational therapist
- An ABC (American Board for Certification in Orthotics and Prosthetics)-certified orthotist or prosthetist (per Wis. Admin. Code § DHS 105.40[2])

Prescription Requirements

A written prescription must be signed and dated by the physician and completed prior to the dispensing DOS. The physician prescription must include the following:

- The member's diagnosis
- The specific type of garment prescribed, including the body part, type of material, and the measurement of prescribed compression

(mmHg for gradient compression garments)
- The quantity needed
- The date and signature of the prescribing physician

A verbal order is not acceptable unless it is reduced to writing, includes the elements stated above, and is valid for the DOS. A prescription is considered valid for one year from the signed date unless otherwise specified in the prescription.

A claim submitted with a physician's prescription that does not include all of the required elements may be denied or, if payment has been made, it may be recouped. The following are examples in which a claim may be denied or a payment subsequently reduced or recouped:

- A physician prescription reads "Non-custom compression knee-hi's" but is submitted with a claim using procedure code A6549 (Gradient compression stocking/sleeve, not otherwise specified).
- A prescription for thigh-high garments, 30–40 mmHg, is signed and dated by the physician on June 1, 2010, but is used with a claim submitted for a DOS of May 15, 2010.
- A claim for custom Elvarex garments is accompanied by a prescription that does not specifically identify "Elvarex."

Providers are reminded that all claims submitted must be supported by records maintained by the provider in accordance with Wis. Admin. Code § DHS 106.02(9)(e)1. In addition, the provider record must include confirmation of delivery of the service or item to the member. For DME, the DOS is the date the item is delivered to the member.

Place of Service Codes for Compression Garments

The following POS (place of service) codes are allowable for providers billing for compression garments.

POS Code	Description
01	Pharmacy
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
13	Assisted Living Facility
14	Group Home
19	Off Campus—Outpatient Hospital
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
49	Independent Clinic
50	Federally Qualified Health Center
54	Intermediate Care Facility/Individuals with Intellectual Disabilities
72	Rural Health Clinic
99	Other Place of Service

Prior Authorization

3

Archive Date:04/01/2024

Prior Authorization:Services Requiring Prior Authorization

Topic #1881

An Overview

PA (prior authorization) is required for the following situations:

- DME (durable medical equipment) 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"

PA Guidelines

Complete PA guidelines are available upon written request from the following address:

Division of Medicaid Services
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.

Topic #18137

Bone Growth Stimulators

Bone growth stimulators are covered by ForwardHealth with PA (prior authorization). Bone growth stimulators are considered Class III medical devices by the FDA (Food and Drug Administration). PA requests for these devices may be approved if they are medically necessary and are employed for a qualifying FDA-approved use.

Approval Criteria for Electrical Bone Growth Stimulators

Documentation of at least one of the following clinical criteria must be submitted for PA approval of an electrical bone growth stimulator using HCPCS (Healthcare Common Procedure Coding System) procedure code E0747 (Osteogenesis stimulator, electrical, non-invasive, other than spinal applications):

- A nonunion fracture of bones of the appendicular skeleton (clavicle, humerus, radius, ulna, femur, fibula, tibia, carpal, metacarpal, tarsal, or metatarsal) demonstrating three or more months of ceased healing. Serial radiographs must include two sets of radiographs, each with multiple views of the fracture site and separated by a minimum of 90 days.
- A failed fusion of a joint where a minimum of nine months has lapsed since the last surgery.
- Congenital pseudarthrosis.

Documentation of at least one of the following clinical criteria must be submitted for PA approval of an electrical bone growth stimulator using HCPCS procedure code E0748 (Osteogenesis stimulator, electrical, non-invasive, spinal applications):

- Spinal fusion surgery for members with a history of previously failed spinal fusion at the same site
- Multiple level fusion surgery involving three or more vertebrae (for example, L3-L5, L4-S1)

- A failed fusion where a minimum of nine months has lapsed since the last surgery

Approval Criteria for Ultrasonic Bone Growth Stimulator

Documentation supporting the use of an ultrasonic bone growth stimulator for the treatment of nonunion fracture of bones of the appendicular skeleton (clavicle, humerus, radius, ulna, femur, fibula, tibia, carpal, metacarpal, tarsal, or metatarsal) must be submitted for PA approval of an ultrasonic bone growth stimulator using HCPCS procedure code E0760 (Osteogenesis stimulator, low intensity ultrasound, non-invasive). Nonunion fractures must be documented by a minimum of two sets of radiographs (with multiple views) obtained prior to starting treatment and separated by a minimum of 90 days.

Prior Authorization Documentation

All of the following must be included as part of a PA request for a bone growth stimulator:

- A PA/RF (Prior Authorization Request Form, F-11018 (05/2013)), completed by the DME vendor
- A PA/DMEA (Prior Authorization/Durable Medical Equipment Attachment, F-11030 (02/2024)), completed by the physician
- Documentation supporting the clinical criteria indicated above
- A physician's prescription

Topic #18057

Bone-Anchored Hearing Device Repairs and Replacements

HCPCS (Healthcare Common Procedure Coding System) procedure codes L7510 (Repair of prosthetic device, repair or replace minor parts) and L8691 (Auditory osseointegrated device, external sound processor excludes transducer/actuator; replacement only, each) are allowable for repairs and replacements of bone-anchored hearing devices.

PA (prior authorization) is required for procedure code L7510 if the total repair of the bone-anchored hearing device exceeds $150.00 or if the replacement parts of the bone-anchored hearing device have not exceeded their life expectancy.

PA is not required for procedure code L8691.

Note: ForwardHealth assigns "U" modifiers to multiple items listed on PA requests to indicate separate approval of DME (durable medical equipment) items (i.e., accessories).

Topic #691

Cochlear Implants Repairs and Replacements

PA (prior authorization) is required is required in the following circumstances:

- External speech processor needs to be replaced within three years of the implant surgery or a previous replacement
- Total cost for repair of the cochlear implant or parts of the implant (procedure code L7510) exceeds $150.00
- Replacement parts exceed life expectancy

ForwardHealth assigns "U" modifiers to multiple items listed on PA requests to indicate separate approval of DME (durable medical equipment) items (i.e., accessories).

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

Topic #22319

Electrical Stimulation Devices

PA (prior authorization) requests for electrical stimulation devices may be approved for up to six months.

PA Request Approval Criteria Following Initial Glioblastoma Multiforme Diagnosis

After the first three calendar months of use of the electrical stimulation device, PA is required for continued coverage. A PA request for an electrical stimulation device may be approved if the member meets **all** of the following criteria for GBM (glioblastoma multiforme) treatment for an **initial diagnosis** of GBM:

- The member is at least 22 years old.
- The member has histologically confirmed (World Health Organization grade IV astrocytoma), newly diagnosed, supratentorial GBM.
- The member had initial treatment with maximal debulking surgery (when feasible), followed by chemotherapy and radiotherapy.
- TTFields (Tumor Treating Fields) therapy is initiated within seven weeks from the last dose of concomitant chemotherapy and radiotherapy, whichever is later.
- The member has no evidence of progression by Response Assessment in Neuro-Oncology criteria.
- The member has a Karnofsky Performance Status score of ≥ 60 or Eastern Cooperative Oncology Group Performance Status of ≤ 2.
- All of the following are documented in the clinical record:
  - The member had a clinical reevaluation by the treating provider following initiation of treatment.
  - The treating provider verified that the member has adhered to therapy for an average of 18 hours per day.
  - The member is benefiting from TTFields therapy.

PA Request Approval Criteria Following Recurrent Glioblastoma Multiforme Diagnosis

After the first three calendar months of use of the electrical stimulation device, PA is required for continued coverage. A PA request for an electrical stimulation device may be approved if the member meets **all** of the following criteria for GBM treatment for **recurrent** GBM:

- The member is at least 22 years old.
- The member has a diagnosis of histologically confirmed (World Health Organization grade IV astrocytoma) or radiologically confirmed, recurrent GBM limited to the supratentorial region following treatment with chemotherapy after surgical and radiation treatments have been exhausted.
- The electrical stimulation device is used as the only treatment (monotherapy).
- The member has a Karnofsky Performance Status score of ≥ 60 or Eastern Cooperative Oncology Group Performance Status of ≤ 2.
- All of the following are documented in the clinical record:
  - The member had a clinical reevaluation by the treating provider following initiation of treatment.
  - The treating provider verified that the member has adhered to therapy for an average of 18 hours per day.
  - The member is benefiting from TTFields therapy.

PA Request Denial Criteria

PA requests for an electrical stimulation device will be denied for any of the following situations:

- The member is less than 22 years old (per current FDA (Food and Drug Administration) approval criteria).
- The member has an active implanted medical device (deep brain stimulator, spinal cord stimulator, vagus nerve stimulator, pacemaker, defibrillator, or programmable shunt).
- The member has a skull defect, such as missing bones or bullet fragments.
- The member has a known sensitivity to conductive hydrogels.
- The member does not meet the PA approval criteria.

PA Request Renewal Criteria

A renewal PA request for an electrical stimulation device must meet the same criteria as the initial PA request. Renewal PA requests may be approved for up to six months.

PA Documentation

PA requests for an electrical stimulation device should include the following:

- PA/RF (Prior Authorization Request Form, F-11018 (05/2013))
- PA/DMEA (Prior Authorization/Durable Medical Equipment Attachment, F-11030 (02/2024)) form
- Prescription
- Documentation that meets PA request approval criteria

On PA requests and claims, one unit represents one calendar month of rental.

Topic #1882

Equipment With a Dollar Threshold

For certain procedures, PA (prior authorization) is required only when the cost of providing the entire service exceeds the specified dollar amount listed in the DME (durable medical equipment) Index. The dollar threshold in the Index is for the complete service, not per DOS (date of service).

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.

Topic #21037

Face-to-Face Prior Authorization Requirement

DME (durable medical equipment)/DMS (disposable medical supplies) providers are required to include the initial physician prescription and physician documentation of the face-to-face visit when submitting PA (prior authorization) for the initial prescription of certain DME/DMS as defined by CMS (Centers for Medicare and Medicaid Services).

Initial PA requests for impacted DME/DMS that require PA but do not include documentation of the face-to-face visit will be returned to the provider.

Topic #19557

Gait Trainers and Posterior Walkers

PA (Prior authorization) is required to purchase or rent gait trainers or posterior walkers for longer than 60 days.

Prior Authorization Approval Criteria

PA requests for gait trainers or posterior walkers may be approved if **all** of the following criteria are met:

- The member's diagnoses and/or clinical conditions support the need for a gait trainer or posterior walker.
- There is sufficient clinical documentation to support that the member has demonstrated improved functional ambulation during a trial period. A trial period is defined as **one** of the following:
  - A time period adequate to document the member's ability to functionally use a facility-owned (for example, school or outpatient clinic) gait trainer or posterior walker and necessary accessories.
  - A rental period of four to eight weeks in circumstances where the therapist is unable to document functional gains or the ability to use the gait trainer or posterior walker beyond the therapy setting or when the member's caregivers would like to try the device prior to purchase.
- The member can stand upright in the device and demonstrates adequate head control, ROM (range of motion), and lower extremity and trunk strength to be supported by the gait trainer or posterior walker for functional ambulation.
- There is sufficient clinical documentation to support that the member requires greater structural and balance assistance than can be provided by a walker or other less restrictive device, and the anticipated functional benefits of walking are not attainable with the use of a walker or other less restrictive device.
- There is a written home therapy plan outlining the use of the requested gait trainer or posterior walker.

- There is documentation that caregiver education has and will be supplied to monitor for safe and appropriate use of the gait trainer or posterior walker.
- If the request is for replacement of an existing gait trainer, there is sufficient clinical documentation to support that the member has maintained functional ambulation with the use of the gait trainer or posterior walker.

Prior Authorization Submission

The providers are required to submit the following to ForwardHealth when requesting PA for gait trainer or posterior walker rentals or purchases:

- A completed PA/RF (Prior Authorization Request Form, F-11018 (05/2013)).
- A completed PA/DMEA (Prior Authorization/Durable Medical Equipment Attachment, F-11030 (07/2012)).
- A written and valid prescription per Wis. Admin. Code § DHS 107.02(2m)(b)
- Valid face-to-face documentation, if required (For more information, refer to the Face-to-Face Prior Authorization Requirement topic and the Face-to-Face Requirements Durable Medical Equipment topic.)
- A complete qualified health care professional evaluation that meets the following criteria:
  - Is performed by a licensed physician, physician's assistant, occupational therapist, physical therapist, or chiropractor
  - Includes detailed assessments in the relevant areas that pertains to the specific CRT (complex rehabilitation technology) service requested (Refer to the Services Requiring Prior Authorization chapter in the Prior Authorization section of the Durable Medical Equipment service area of the Online Handbook for more information about assessments.)
  - Uses body structure and function and/or activity components of the International Classification of Functioning model to provide justification for member specific needs for each requested line item.
  - Includes a signed statement from the qualified health care professional who is writing the evaluation indicating that they do not have a financial relationship with the CRT supplier requesting the durable medical equipment.
- A complete CRT professional evaluation that meets the following criteria:
  - Is performed by a qualified CRT professional
  - Includes a copy of the certification as defined in § DHS 101.03 (28m)
  - Indicates the qualified CRT professional performing the CRT evaluation was present at the member's CRT clinical evaluation or indicates that documentation of coordination has been submitted with the CRT clinical evaluation performed by the qualified health care professional
- Assessments that are completed in-person, signed and dated, and include details of the following areas:
  - Current equipment the member may be using (such as the equipment's make, model, and age)
  - Projected life expectancy of the current and proposed CRT service
  - Member's home or setting for accessibility using the Durable Medical Equipment Home Accessibility Report, F-02891 (08/2022)
  - Transportation method, including the make and model of vehicle, if applicable
  - Cost-effectiveness of the requested service compared to a similar service and the reason the comparable service would not meet the member's needs, if applicable
- Signed and dated statement asserting that the qualified CRT professional will provide appropriate training to the member and will maintain adequate documentation of the training provided
- Documentation supporting the approval criteria
- Manufacturer gait trainer product information, including the make, model, and size of item, any additionally required prompts or accessories to be dispensed, and height and/or weight user limits
- The member's age, weight, and height (recorded within the last six months)
- An evaluation of the member's gait. The gait evaluation must document the member's ability to use the device, including, but not limited to, the following:
  - Gait pattern
  - Distance ambulated
  - Level of assistance required, including specific verbal and/or manual cues and any other assistance required
  - Any required prompts and/or accessories and the reasons they are required
- Documentation of the member's participation in therapy services (if applicable), including the current POC (plan of care) and an assessment of the member's ROM, strength, muscle tone, sensation, coordination, gait, balance, cognitive status, functional status, and ADL (activities of daily living) status
- The results of the trial period for each setting of the requested gait trainer
- A written plan for treatment in the home that outlines when, how, and in what environments the requested gait trainer will be used
- If supervision is required, documentation that there is a caretaker who can appropriately supervise the use of the gait trainer
- A description of any special adaptive equipment or items owned or used by the member in any environment, including any specialized seating/positioning equipment, standing frames, and/or ambulation aides. If the member has an existing ambulation aide, the provider is required to document the following:

    - The make, model, and size of previous equipment
    - The date that the previous equipment was dispensed
    - The reason that existing equipment no longer meets the member's medical needs

Additionally, providers are required to submit documentation of the following when requesting PA for gait trainer rentals:

- The change in condition or functional status that prompted the need for the requested device (for example, the surgical procedure performed and the date of surgery)
- The member's previous functional status, including ambulation abilities and any ambulation aides used
- Anticipated length of need

Topic #4516

Non-implant Bone-Anchored Hearing Devices

Non-implant bone-anchored hearing devices (HCPCS (Healthcare Common Procedure Coding System) procedure code L8692) require PA (prior authorization). All of the following criteria must be met before PA requests for non-implant bone-anchored hearing devices can be approved:

- The member has a conductive and/or mixed hearing loss (unilateral or bilateral) with pure-tone average bone-conduction thresholds (measured at 0.5, 1, 2, and 3 kHz) less than or equal to 65 dB HL. The threshold range is intended to accommodate different degrees of hearing loss and corresponding output power of the bone-anchored hearing device.
- The member demonstrates an air-bone gap of at least 30 dB.
- The member demonstrates a word recognition score greater than 60 percent via conventional air-conduction speech audiometry using single-syllable words.
- The member has one or more of the following conditions:
    - Severe chronic external otitis or otitis media
    - Chronic draining ear through a tympanic membrane perforation
    - Malformation of the external auditory canal or middle ear
    - Stenosis of the external auditory canal
    - Ossicular discontinuity or erosion that cannot be repaired
    - Chronic dermatologic conditions such as psoriasis of the ear canal
    - Tumors of the external canal and/or tympanic cavity
    - Other conditions that prevent restoration of hearing using a conventional air-conduction hearing aid

When requesting PA for non-implant bone-anchored hearing devices, providers are required to submit the following:

- A completed PA/HIAS1 (Prior Authorization Request for Hearing Instrument and Audiological Services, F-11020 (05/2013)).
- A completed PA/HIAS2 (Prior Authorization Request for Hearing Instrument and Audiological Services, F-11021 (07/2012)) documenting the medical necessity of the non-implant bone-anchored hearing device.

Topic #18517

Orthotics

Ankle Foot Orthotics

Most ankle foot orthotic devices do not require PA (prior authorization) unless the frequency limitation is exceeded. The DME (Durable Medical Equipment) Index includes allowable procedure codes and associated life expectancy.

A PA request is required if a new ankle foot orthotic is needed before the life expectancy ends for the following reasons:

- A change in the member's medical needs, such as growth (the specific amount of growth must be documented in the provider's record and on the PA request), a changed foot/ankle position, or loss or gain of significant weight or height (provider must be specific in records and on the PA request).
- To replace a broken orthotic. The provider's records and the PA request must document the specific broken part or the reasons for

replacement or for a different orthotic (post-surgical, etc.).

The PA request must indicate that the member will receive maximal stability in a specified area or that the orthotic device will prevent an increase in severity of a deformity.

Note: If a provider replaces an ankle foot orthotic for a fully grown adult after the one-year life expectancy has ended, PA is not required, but the provider is required to document the member's medical needs specifically in their records as listed above.

Cranial Remolding Orthoses

CRO (Cranial Remolding Orthosis) is covered by ForwardHealth with PA.

Prior Authorization Requirements

PA requests for CRO may be approved if it is medically necessary and will be used to correct skull deformity under the following circumstances:

- The member has had surgery to treat craniosynostosis.
- The member has not had surgery to treat craniosynostosis and all of the following criteria are true:
  - The member is at least 3 months old and no more than 12 months old.
  - The member underwent at least two months of documented failed conservative therapy including home management, mechanical adjustments, and repositioning.
  - A pediatric neurosurgeon with expertise in craniofacial malformations or a craniofacial surgeon has indicated that the condition is likely to compromise normal bodily function.
  - The CRO is prescribed by a pediatric neurosurgeon with expertise in craniofacial malformations or by a craniofacial surgeon that completed an assessment and developed a treatment plan.

Prior Authorization Documentation

All of the following must be included as part of a PA request for CRO:

- A completed PA/RF (Prior Authorization Request Form, F-11018 (05/2013)).
- A completed PA/DMEA (Prior Authorization/Durable Medical Equipment Attachment, F-11030 (02/2024)).
- Documentation that fully supports PA requirements.
- An assessment of outcome following a trial of at least two months of mechanical adjustments, home management, and repositioning. Documentation must include information on the frequency and type of conservative therapy.
- A signed and dated order from a pediatric neurosurgeon with expertise in craniofacial malformations or by a craniofacial surgeon indicating the deformity is likely to compromise normal bodily functions. The order must be dated following completion of the two-month trial.

Grant and Expiration Dates

PA will be granted for three months. If CRO is not dispensed within three months, a new PA request will need to be submitted.

Diabetic Shoes and Inserts

PA is required to exceed life expectancy for diabetic shoes and inserts. The DME Index includes allowable procedure codes and associated life expectancy.

PA requests for diabetic shoes and inserts must include the following:

- A completed PA/RF
- A completed PA/DMEA
- Documentation that fully supports the coverage criteria for diabetic shoes and inserts
- Documentation that meets the documentation requirements for diabetic shoes and inserts
- A physician prescription that meets the physician prescription requirements for diabetic shoes and inserts

Mobile Arm Supports

Mobile arm supports must be used for a trial period before a PA request is submitted.

The PA request is required to be submitted with documentation of the trial period that includes the following:

- The length of time the equipment was used on a trial basis.
- Report of the trial period to identify where it was used and the individual(s) involved in training the member how to properly use the equipment, including the credentials of the individual(s).
- Report of the member's specific functional abilities without the equipment.
- Report of the member's specific functional abilities with the use of the equipment.

If the member is involved in a therapy program to increase functional abilities, and the record of the therapy service includes the documentation required, the therapy reports may be included in the PA request.

This report of the equipment trial period is required in addition to the documentation required for all DME to support the medical necessity of the requested equipment for the specific clinical condition of the member. The PA request for the mobile arm support equipment must include the following:

- The setting(s) in which the equipment will be used.
- The transportation method that will be used, if the equipment will be transported.
- The method that will be used to store the equipment.
- The individual(s) responsible for care and maintenance of the equipment.

ForwardHealth does not allow reimbursement for rental of mobile arm supports. If reimbursement for rental of a mobile arm support system is necessary to complete the trial period, a PA request should be submitted using HCPCS (Healthcare Common Procedure Coding System) procedure code E1399 (Durable medical equipment, miscellaneous).

Off-The-Shelf Orthotic Devices

Providers may be reimbursed for one spinal and one lower extremity off-the-shelf orthotic device per member per year without submitting a PA request. PA is required for additional spinal and lower extremity off-the-shelf orthotic devices of the same type when the life expectancy of the device has been exceeded.

This PA requirement is monitored through the claims processing system. Providers should not submit a PA request if they are unsure whether the life expectancy of the device has been exceeded, unless instructed to do so through the claims processing system. Instead, providers should submit the claim for the spinal or lower extremity off-the-shelf device after the delivery of the device. If the life expectancy of the device has been exceeded, the claim will be denied and providers will be notified through an EOB (explanation of benefits) code that PA is required. When notified through an EOB code that PA is required, providers should submit a PA request that includes the EOB code indicated on the claim. The PA request must be submitted within two weeks of receiving the EOB code. Providers are required to document the DOS (date of service) on the PA request so that the PA can be processed correctly for reimbursement. Once the PA request is approved, the claim must be resubmitted.

Orthopedic or Corrective Shoes and Foot Orthotics

Orthopedic or corrective shoes and foot orthotics are covered by ForwardHealth with PA.

Prior Authorization Requirements

PA requirements are listed in the DME Index.

Note: PA is not always required for some procedure codes (for example, minor repairs or additions to orthopedic shoes).

Prior Authorization Documentation

The following documentation must be submitted with PA requests for orthopedic or corrective shoes or foot orthotics:

- A completed PA/RF.
- A completed PA/DMEA.
- A physician's prescription for orthopedic or corrective shoes and/or foot orthotics.
- The member's ICD (International Classification of Diseases) diagnosis (or diagnoses) and any other co-morbid conditions that support the condition for the requested services.
- If present, the objective measurement of specific foot deformity.
- The member's height and weight.
- The shoe brand, model number, and size(s).
- Medical records from the prescribing provider that support the PA request.
- The written report of the member's podiatry exam and results.
- The member's ambulatory status and/or transfer abilities.
- The member's use of any ambulation aids for mobility, if applicable.
- Information regarding the member's functional daily routine (that is, place of residence, caregiver type, and level of assistance, if applicable).
- Specific reason for the requested service, date of initial issue of the requested service to the member, or the reason for replacement and the last DOS to member, if known.
- If new equipment is requested to replace current items, the estimate of charges to repair the member's current equipment and/or the reason repair is not possible or cost-effective.
- If mismatched shoes are requested, documentation of the foot size discrepancy.
- If custom services are requested, documentation of the services or equipment that have been tried by the member and results indicating what specific medical needs of the member were not met.

Topic #19817

Personal Continuous Glucose Monitoring Devices and Accessories

PA (prior authorization) is required for coverage of personal continuous glucose monitoring devices and transmitters, but it is not required for sensors.

Prior Authorization Approval Criteria

PA requests for personal continuous glucose monitoring devices and transmitters may be approved for members who meet all of the following criteria:

- The member has Type 1 and/or Type 2 diabetes mellitus.
- The member is 21 years of age or older.
- The member is insulin-treated with multiple daily administrations of insulin or a continuous subcutaneous insulin infusion pump.
- The member has the motivation to use a personal continuous glucose monitoring device on a near-daily basis and has the ability and readiness, as assessed by their medical team, to make appropriate adjustments to their treatment regimen from the trending information obtained from the continuous glucose monitoring device.
- The member is receiving in-depth diabetes education and is in regular close contact with their diabetes management team.

For members who do not have Type 1 and/or Type 2 diabetes, coverage of personal continuous glucose monitoring devices will be considered on a case-by-case basis and reviewed for medical necessity.

ForwardHealth will consider coverage of a personal continuous glucose monitoring device on a case-by-case basis for members under 21 years old who meet the above criteria despite appropriate modifications in insulin regimen. Success of a personal continuous glucose monitoring device is highly dependent on compliance, especially for members under 21 years old. Documentation for members under 21 years old must include an assessment by an endocrinologist or diabetes educator of readiness of the member to use the device on a near-daily basis, as well as clear documentation that the member or the member's caregiver is compliant with self-monitoring as described above.

ForwardHealth does not cover personal continuous glucose monitoring devices for conditions that do not have sufficient evidence of the efficacy of continuous glucose monitoring (for example, gestational diabetes).

Prior Authorization Documentation

All of the following must be included as part of a PA request for personal continuous glucose monitoring devices and/or accessories:

- A completed PA/RF (Prior Authorization Request Form, F-11018 (05/2013))
- A completed PA/DMEA (Prior Authorization/Durable Medical Equipment Attachment, F-11030 (02/2024))
- Documentation of the member's diagnosis of Type 1 and/or Type 2 diabetes mellitus
- A written prescription from a licensed medical professional on the member's medical team
- The following information about the continuous glucose monitoring device:
  - Name of the manufacturer of the device
  - Make of the device
  - Statement regarding whether or not the device is FDA (Food and Drug Administration)-approved
- A description of the member's compliance with a physician-ordered diabetic treatment plan, including regular self-monitoring and insulin-treated with multiple daily administrations of insulin or a continuous subcutaneous insulin infusion pump
- Documentation of member and/or caregiver in-person training and available ongoing support in sensor placement, transmitter hookup, and monitor calibration, and an assessment from a licensed medical professional on the member's medical team of the member's ability to self-manage treatment according to information obtained from the monitor

Topic #12697

Wearable Cardioverter Defibrillator

Rental of a WCD (wearable cardioverter defibrillator) is a covered service with PA (prior authorization), subject to certain claims submission requirements. The WCD is indicated for members 19 years of age or older who are at high risk for sudden cardiac death. A WCD is used on an outpatient basis and is intended for short-term use under medical supervision.

Approval Criteria

According to Wis. Admin Code § DHS 107.02(3), ForwardHealth has the authority to require and define the terms of PA for DME (durable medical equipment). The following criteria must be met in order for a PA request for the rental of a WCD to be approved:

- The rental of the WCD is medically necessary for a member at high risk of sudden cardiac arrest and meets the American College of Cardiology guidelines for an implantable cardioverter.
- One of the following is true:
  - The member is on the waiting list for a medically necessary heart transplant.
  - The member has an ICD (implantable cardioverter defibrillator) that requires removal due to an infection and is waiting for a new ICD to be inserted.
  - The member has an infectious process or other temporary condition preventing the initial insertion of an ICD.
  - The member has a familial or inherited condition with a high risk of life-threatening ventricular tachyarrhythmia (for example, long QT syndrome or hypertrophic cardiomyopathy).
  - The member has a documented episode of ventricular fibrillation or a sustained (lasting 30 seconds or longer) ventricular tachyarrhythmia that is not during the first 48 hours after an acute myocardial infarction and is either:
    - Spontaneous.
    - Induced during an electrophysiologic study.

Denial Criteria

ForwardHealth will not cover the rental of a WCD in any of the following circumstances:

- The WCD is not medically necessary (for example, the member received an ICD or heart transplant).
- The member is 18 years of age or younger.
- The member has a vision, hearing, or developmental problem that may interfere with the perception of alarms or messages from the WCD.
- The member is taking medications that would interfere with his or her ability to respond to alarms or messages from the WCD.
- The member is pregnant, breastfeeding, or of childbearing age and is not attempting to prevent pregnancy.
- The member will be exposed to high levels of electromagnetic interference that may prevent the WCD from operating.
- The member is unable or unwilling to wear the device continuously (except when bathing).

- The member has drug-refractory class IV congestive heart failure and is not a candidate for a heart transplant.
- The member has a history of psychiatric disorders that interfere with necessary care and follow-up.
- The member has a reversible triggering factor for ventricular tachycardia or ventricular fibrillation that can be definitely identified, such as ventricular tachyarrhythmia in evolving acute myocardial infarction or an electrolyte abnormality.
- The member has a terminal illness.

Submitting a Prior Authorization Request

DME providers are required to submit the following when requesting PA for the rental of a WCD:

- A completed PA/RF (Prior Authorization Request Form, F-11018 (05/2013))
- A completed PA/DMEA (Prior Authorization/Durable Medical Equipment Attachment, F-11030 (02/2024)) (The DME provider is responsible for obtaining the required clinical information from the member's cardiologist to complete the PA/DMEA.)
- A prescription from the member's cardiologist for the WCD
- Documentation supporting the approval criteria indicated in this topic (The DME provider is responsible for obtaining this documentation from the member's cardiologist.)

Note: The cardiologist must be certified by the American Board of Cardiology.

Forms and Attachments

Topic #960

An Overview

Depending on the service being requested, most PA (prior authorization) requests must be comprised of the following:

- The PA/RF (Prior Authorization Request Form, F-11018 (05/2013)), PA/DRF (Prior Authorization/Dental Request Form, F-11035 (07/2012)), or PA/HIAS1 (Prior Authorization Request for Hearing Instrument and Audiological Services, F-11020 (05/2013))
- A service-specific PA attachment(s)
- Additional supporting clinical documentation (Typical PA requirements regarding attachments may not apply for some HealthCheck "Other Services" PA requests.)

Topic #13137

Enteral Nutrition Formula

The following must be submitted for PA requests for enteral nutrition formula:

- A PA/RF
- A PA/ENFA (Prior Authorization/Enteral Nutrition Formula Attachment, F-11054 (04/2020))
- A copy of the original prescription or order that is not greater than one year old
- Supporting clinical documentation that cannot be sufficiently indicated on the PA/ENFA

Billing providers or authorized representatives acting on behalf of billing providers are responsible for the following:

- Obtaining clinical documentation and information from prescribers necessary to submit PA requests (Billing providers may have prescribers complete sections of the PA/ENFA if needed.)
- Signing the PA/RF and PA/ENFA
- The truthfulness, accuracy, timeliness, and completeness of PA requests and submission of PA requests to ForwardHealth

Enteral Nutrition Supplies

ForwardHealth covers enteral feeding supplies up to a maximum quantity per month without PA. Providers may refer to the DMS (disposable medical supply) Index for quantity limits.

Topic #446

Attachments

In addition to the PA/RF (Prior Authorization Request Form, F-11018 (05/2013)), PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (05/2013)), or PA/DRF (Prior Authorization/Dental Request Form, F-11035 (07/2012)), a service-specific PA (prior authorization) 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.

Topic #1831

Prior Authorization/Durable Medical Equipment Attachment

The purpose of the PA/DMEA (Prior Authorization/Durable Medical Equipment Attachment, F-11030 (02/2024)) is to document the medical necessity of DME (durable medical equipment) requiring PA.

Prior Authorization/Oxygen Attachment

The purpose of the PA/OA (Prior Authorization/Oxygen Attachment, F-11066 (07/2012)) 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 (F-11067 (07/2012)) must be submitted with the PA/RF and the PA/OA for respiratory equipment requiring PA when the member resides in a nursing home.

Prior Authorization/Speech Generating Device, Synthesized

At the time that the speech-language pathologist recommends an SGD (speech-generating device) and relevant accessories for rental or purchase for a member, they will complete a report(s) with required content or the two optional forms:

- PA/SGD Skills and Needs Profile Attachment (Prior Authorization/Speech-Generating Device Skills and Needs Profile Attachment, F-02494 (07/2019))
- PA/SGD Purchase Recommendation Attachment (Prior Authorization/Speech-Generating Device Purchase Recommendation Attachment, F-02493 (07/2019))

Speech-language pathologists can alternatively complete report(s) in a format of their choosing with the required content found on the optional forms.

The billing provider is required to submit these forms to ForwardHealth when requesting PA for rental of synthesized SGDs or purchase of synthesized SGDs, accessories, mounting systems, or software.

Topic #9157

Prior Authorization Drug Attachment for Blood Glucose Meters and Test Strips

The purpose of the Prior Authorization Drug Attachment for Blood Glucose Meters and Test Strips (F-00239 (12/2013)) form is to document the medical necessity of non-preferred Blood Glucose Meters and Test Strips.

Topic #447

Obtaining Forms and Attachments

Providers may obtain paper versions of all PA (prior authorization) 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
313 Blettner Blvd
Madison WI 53784

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 (Portable Document Format) and fillable Microsoft Word formats.

Web PA Via the Portal

Certain providers may complete the PA/RF (Prior Authorization Request Form, F-11018 (05/2013)) 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.

Topic #448

Prior Authorization Request Form

The PA/RF (Prior Authorization Request Form, F-11018 (05/2013)) is used by ForwardHealth and is mandatory for most providers when requesting PA (prior authorization). 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 the claim for prior authorized services.

Topic #1832

Prior Authorization Request Form Completion Instructions for Durable Medical Equipment

A sample PA/RF (Prior Authorization Request Form) for DME (durable medical equipment) is available.

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 (Wis. Admin. Code § DHS 104.02[4]).

Under Wis. Stat. § 49.45(4), 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 (prior authorization) requests, or processing provider claims for reimbursement. The use of the PA/RF (Prior Authorization Request Form, F-11018 (05/2013)) 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 (Prior Authorization/Durable Medical Equipment Attachment, F-11030 (02/2024)) by fax to ForwardHealth at 608-221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

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 (Wisconsin Chronic Disease Program) 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)
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 (National Provider Identifier) 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.

Element 6a — Name — Prescribing / Referring / Ordering Provider
Enter the prescribing provider's name.

Element 6b — National Provider Identifier — Prescribing / Referring / Ordering Provider
Enter the prescribing provider's 10-digit NPI.

SECTION II — MEMBER INFORMATION

Element 7 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth identification card or Wisconsin's EVS (Enrollment

Verification System) to obtain the correct number.

Element 8 — Date of Birth — Member
Enter the member's date of birth in MM/DD/CCYY format.

Element 9 — 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 10 — Name — Member
Enter the member's last name, followed by their 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 11 — Gender — Member
Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 12 — Diagnosis — Primary Code and Description
Enter the appropriate ICD (International Classification of Diseases) diagnosis code and description with the highest level of specificity most relevant to the service/procedure requested. The ICD diagnosis code must correspond with the ICD description.

Element 13 — Start Date — SOI (not required)

Element 14 — First Date of Treatment — SOI (not required)

Element 15 — Diagnosis — Secondary Code and Description
Enter the appropriate secondary ICD diagnosis code and description with the highest level of specificity most relevant to the service/procedure requested, if applicable. The ICD diagnosis code must correspond with the ICD description.

Element 16 — Requested PA Start Date (not required)

Element 17 — Rendering Provider Number (not required)

Element 18 — Rendering Provider Taxonomy Code (not required)

Element 19 — Service Code
Enter the appropriate HCPCS (Healthcare Common Procedure Coding System) code for each service/procedure/item requested.

Element 20 — Modifiers
Enter the modifier(s) corresponding to the procedure code listed if a modifier is required.

Element 21 — POS
Enter the appropriate POS (place of service) code designating where the requested service/procedure/item would be provided/performed/dispensed.

Element 22 — Description of Service
Enter a written description corresponding to the appropriate HCPCS code for each service/procedure/item requested.

Element 23 — QR
Enter the appropriate quantity (for example, number of services) requested for the procedure code listed.

Element 24 — 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 Wisconsin DHS (Department

of Health Services).

Element 25 — Total Charges
Enter the anticipated total charges for this request.

Element 26 — Signature — Requesting Provider
The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

Element 27 — Date Signed
Enter the month, day, and year the PA/RF was signed (in MM/DD/CCYY format).

Sample PA/RF for Durable Medical Equipment

DEPARTMENT OF HEALTH SERVICES
ForwardHealth
F-11018 (05/13)

STATE OF WISCONSIN
DHS 106.03(4), Wis. Admin. Code
DHS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to ForwardHealth at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 313 Blettner Boulevard, Madison, WI 53784. **Instructions:** Type or print clearly. Before completing this form, read the service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

SECTION I — PROVIDER INFORMATION

1. Check only if applicable	2. Process Type	3. Telephone Number — Billing Provider
❑ HealthCheck "Other Services" ❑ Wisconsin Chronic Disease Program (WCDP)	139	(555) 555-5555

4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code)	5a. Billing Provider Number
I.M. BILLING PROVIDER 609 WILLOW ST ANYTOWN WI 55555-1234	0222222220
	5b. Billing Provider Taxonomy Code 123456789X

6a. Name — Prescribing / Referring / Ordering Provider	6b. National Provider Identifier — Prescribing / Referring / Ordering Provider
I.M. PRESCRIBING PROVIDER	0111111110

SECTION II — MEMBER INFORMATION

7. Member Identification Number	8. Date of Birth — Member	9. Address — Member (Street, City, State, ZIP Code)
1234567890	MM/DD/CCYY	322 RIDGE ST ANYTOWN WI 55555

10. Name — Member (Last, First, Middle Initial)	11. Gender — Member
MEMBER, IM A	❑ Male ☒ Female

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

12. Diagnosis — Primary Code and Description	13. Start Date — SOI	14. First Date of Treatment — SOI
Z93.0 — Tracheostomy status		

15. Diagnosis — Secondary Code and Description	16. Requested PA Start Date

17. Rendering Provider Number	18. Rendering Provider Taxonomy Code	19. Service Code	20. Modifiers 1	2	3	4	21. POS	22. Description of Service	23. QR	24. Charge
		E0600	RR				12	Respiratory suction pump, home model	30	XXX.XX

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.

25. Total Charges	XXX.XX

26. **SIGNATURE** — Requesting Provider	27. Date Signed
I.M. Requesting Provider	MM/DD/CCYY

Topic #4619

Prior Authorization Request Form Completion Instructions for Pharmacy Services and Diabetic Supplies

A sample PA/RF for pharmacy services is available.

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 (Wis. Admin. Code § DHS 104.02[4]).

Under Wis. Stat. § 49.45(4), 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 (prior authorization) requests, or processing provider claims for reimbursement. The use of the PA/RF (Prior Authorization Request Form, F-11018 (05/2013)) 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 all applicable service-specific attachments, via the ForwardHealth Portal, by fax to ForwardHealth at 608-221-8616, or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
313 Blettner Blvd
Madison WI 53784

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 (Wisconsin Chronic Disease Program) if the services requested on the PA/RF are for a WCDP member.

Element 2 — Process Type
Enter the process type 131 — Drugs. The process type is a three-digit code used to identify a category of service requested.

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 the 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 (National Provider Identifier) 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 of the billing provider in Element 5a.

Element 6a — Name — Prescribing / Referring / Ordering Provider
Enter the prescribing provider's name.

Element 6b — National Provider Identifier — Prescribing / Referring / Ordering Provider
Enter the prescribing provider's 10-digit NPI.

SECTION II — MEMBER INFORMATION

Element 7 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth identification card or Wisconsin's EVS (Enrollment Verification System) to obtain the correct number.

Element 8 — Date of Birth — Member
Enter the member's date of birth in MM/DD/CCYY format.

Element 9 — 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 10 — Name — Member
Enter the member's last name, followed by their 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 11 — Gender — Member
Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 12 — Diagnosis — Primary Code and Description
Enter the appropriate ICD (International Classification of Diseases) diagnosis code and description with the highest level of specificity most relevant to the service/procedure requested. The ICD diagnosis code must correspond with the ICD description.

Element 13 — Start Date — SOI (spell of illness) (not required)

Element 14 — First Date of Treatment — SOI (not required)

Element 15 — Diagnosis — Secondary Code and Description
Enter the appropriate secondary ICD diagnosis code and description with the highest level of specificity most relevant to the service/procedure requested, if applicable. The ICD diagnosis code must correspond with the ICD description.

Element 16 — Requested PA Start Date
Enter the requested start DOS (date of service) in MM/DD/CCYY format, if a specific start date is requested.

Element 17 — Rendering Provider Number
Enter the provider ID of the provider who will be performing the service, only if this number is different from the billing provider ID listed in Element 5a.

Element 18 — Rendering Provider Taxonomy Code
Enter the national 10-digit alphanumeric taxonomy code that corresponds to the provider who will be performing the service, only if this code is different from the taxonomy code listed for the billing provider in Element 5b.

Element 19 — Service Code
Enter the appropriate NDC (National Drug Code) for each service/procedure/item requested.

Element 20 — Modifiers
Enter the modifier(s) corresponding to the service code listed if a modifier is required.

Element 21 — POS
Enter the appropriate place of service code designating where the requested item would be provided/performed/dispensed.

Element 22 — Description of Service

Enter a written description corresponding to the appropriate NDC for each item requested.

Element 23 — QR
Enter the appropriate quantity (for example, days' supply) requested for the procedure code listed.

Element 24 — 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 Wisconsin DHS (Department of Health Services).

Element 25 — Total Charges
Enter the anticipated total charges for this request.

Element 26 — Signature — Requesting Provider
The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

Element 27 — Date Signed
Enter the month, day, and year the PA/RF was signed (in MM/DD/CCYY format).

Sample PA/RF for Pharmacy Services

DEPARTMENT OF HEALTH SERVICES
ForwardHealth
F-11018 (05/13)

STATE OF WISCONSIN
DHS 106.03(4), Wis. Admin. Code
DHS 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

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SECTION I — PROVIDER INFORMATION

1. Check only if applicable	2. Process Type	3. Telephone Number — Billing Provider
❑ HealthCheck "Other Services" ❑ Wisconsin Chronic Disease Program (WCDP)	131	(555) 555-5555

4. Name and Address — Billing Provider (Street, City, State, ZIP+4 Code)	5a. Billing Provider Number
I.M. BILLING PROVIDER 609 WILLOW ST ANYTOWN WI 55555-1234	0222222220
	5b. Billing Provider Taxonomy Code 123456789X

6a. Name — Prescribing / Referring / Ordering Provider	6b. National Provider Identifier — Prescribing / Referring / Ordering Provider
I.M. PRESCRIBING PROVIDER	0111111110

SECTION II — MEMBER INFORMATION

7. Member Identification Number	8. Date of Birth — Member	9. Address — Member (Street, City, State, ZIP Code)
1234567890	MM/DD/CCYY	322 RIDGE ST ANYTOWN WI 55555

10. Name — Member (Last, First, Middle Initial)	11. Gender — Member
MEMBER, IM A	❑ Male ☒ Female

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

12. Diagnosis — Primary Code and Description	13. Start Date — SOI	14. First Date of Treatment — SOI
I48.91 — Unspecified atrial fibrillation		

15. Diagnosis — Secondary Code and Description	16. Requested PA Start Date
	MM/DD/CCYY

17. Rendering Provider Number	18. Rendering Provider Taxonomy Code	19. Service Code	20. Modifiers 1	2	3	4	21. POS	22. Description of Service	23. QR	24. Charge
		00056-0172-70					01	Coumadin 5mg tablet	365	XXX.XX

An approved authorization does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus Managed Care Program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the Managed Care Program.

25. Total Charges	XXX.XX

26. **SIGNATURE** — Requesting Provider	27. Date Signed
I.M. Requesting Provider	MM/DD/CCYY

Topic #449

Supporting Clinical Documentation

Certain PA (prior authorization) 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 dental models will be returned to providers.

Photographs submitted to ForwardHealth as additional supporting clinical documentation for PA requests will not be returned to providers and will be disposed of securely.

Review Process

Topic #450

Clerical Review

The first step of the PA (prior authorization) request review process is the clerical review. The provider, member, diagnosis, and treatment information indicated on the PA/RF (Prior Authorization Request Form, F-11018 (05/2013)), PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (05/2013)), and PA/DRF (Prior Authorization/Dental Request Form, F-11035 (07/2012)) 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-enrolled.
- 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.

Topic #451

Clinical Review

Upon verifying the completeness and accuracy of clerical items, the PA (prior authorization) 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 Wis. Admin. Code § DHS 107.02(3)(e).

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 Wis. Admin Code § DHS 101.03(96m), "medically necessary" is a service under Wis. Admin. Code ch. DHS 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 Wisconsin DHS (Department of Health Services)
- Standards of practice
- Professional knowledge
- Scientific literature

Decisions

Topic #424

Approved Requests

PA (prior authorization) 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.

Topic #4724

Communicating Prior Authorization Decisions

ForwardHealth will make a decision regarding a provider's PA (prior authorization) 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 their 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.

Topic #5038

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, they 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 (prior authorization) request or amendment request via the Portal to ForwardHealth for processing. When correcting errors, providers only need to address the items identified in the returned provider review letter or the amendment provider review letter. Providers are not required to resubmit PA information already submitted to ForwardHealth.

Topic #5037

Decision Notice Letters and Returned Provider Review Letters on the Portal

Providers can view PA (prior authorization) 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.

Topic #425

Denied Requests

When a PA (prior authorization) 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 their 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 (Prior Authorization Request Form, F-11018 (05/2013)), PA/DRF (Prior Authorization/Dental Request Form, F-11035 (07/2012)), or PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (05/2013)).
- 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.

Sample Notice of Appeal Rights Letter

<Month DD, CCYY>
<sequence number>
<RecipName>
<RecipAddressLine1>
<RecipAddressLine2>
<RecipCity> <RecipStateZip>

Member Identification Number:
<XXX-XX-XXXXX>
Local County or Tribal Agency
Telephone Number: <AgencyPhone>

<PROGRAM NAME> Notice of Appeal Rights

Appeal Date: <AppealDate>

In <PROGRAM NAME>, certain services and products must be reviewed and approved before payment can be made for them. This review process is called prior authorization (PA). The purposes of this letter are to notify you that <PROGRAM NAME> has either denied or modified a request for prior authorization of a service or product that was submitted on your behalf and to inform you of your right to appeal that decision.

Your provider <ProviderName> requested prior authorization for the following service(s):

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ServiceNN>

That prior authorization request, PA number <PANumber>, was reviewed by <PROGRAM NAME> medical consultants. Based on that review, the following services have been denied or modified as follows.

Denied Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<DeniedServiceNN>

Modified Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ModifiedServiceNN>

<PROGRAM NAME>'s denial or modification of the services requested was made for the following reasons:

(Denial/modify code(s) will be inserted here)

<PROGRAM NAME> bases its decisions on criteria found in the Wisconsin Administrative Code. <PROGRAM NAME> may modify or deny a prior authorization request if one or more of the criteria are not supported by documentation submitted by your provider. The specific regulation(s) that supports the reason for the denial/modification of your provider's request for services is found in the following Wisconsin Administrative Code:

(Wis. Admin. Code Regulation(s) will be inserted here)

We have sent your provider the denied/modified prior authorization request. We encourage you to contact <Provider Name> to review the prior authorization request and the reasons for the decision.

Your Rights and Responsibilities

You or your designated representative may appeal this decision in accordance with state and federal law within <RecipientDays> days. To file an appeal, you may do one of the following:

1) Call your local county or tribal agency at the telephone number listed on the first page of this letter for an appeal form and/or assistance in completing it.

2) Write a letter requesting an appeal to the Division of Hearings and Appeals at the following address:

   Division of Hearings and Appeals
   Department of Administration
   PO Box 7875
   Madison WI 53707-7875

The appeal form or letter should include all of the following:

- The name, address, and telephone number of the <PROGRAM NAME> member for whom the appeal is being made.
- The member identification number.
- The prior authorization number <PANumber> of the denied/modified request.
- The reason you think the denial or modification of the prior authorization is wrong.

REMEMBER: You must mail or deliver your appeal to your local county or tribal agency or the Division of Hearings and Appeals so it is received by the <RecipientDays>-day deadline, which is <AppealDate>.

You will lose your right to an appeal if your request to appeal is not received by the local county or tribal agency or the Division of Hearings and Appeals by <AppealDate>.

If you file an appeal, you may expect the following to occur:

- The state Division of Health Care Access and Accountability will be required to explain, in writing, the reason(s) for the denial or modification of the services your provider requested. This explanation will be mailed to you.
- The Division of Hearings and Appeals will schedule a hearing to consider your appeal and will notify you of the time and place by mail. Hearings are generally held at your local county or tribal agency. You may want to ask your local county or tribal agency if there is free legal help available in your area.
- At that hearing, you (or you may choose a friend, relative, attorney, provider, etc., to represent you) will have an opportunity to explain your need for the service to a hearing officer. Division of Health Care Access and Accountability staff may also appear in person or participate by telephone.
- Based on all the information available, the hearing officer will make a decision on your appeal, notify you of the decision by mail, and advise you of any additional appeal rights.

Whether or not you appeal, <PROGRAM NAME> will pay for any services it has approved. After the hearing officer makes a decision on your appeal, <PROGRAM NAME> will continue to pay for the approved services plus any additional services the hearing officer directs <PROGRAM NAME> to pay.

If you need information about accommodation for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (TTY) immediately so arrangements can be made. The staff at these numbers will not be able to provide you with information about the reasons for Wisconsin <PROGRAM NAME>'s decision to deny or modify the prior authorization request. These telephone numbers at the Division of Hearings and Appeals should only be used for questions about the hearing process.

F-11194 (10/08)

Topic #426

Modified Requests

Modification is a change in the services originally requested on a PA (prior authorization) 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 their 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.

Sample Notice of Appeal Rights Letter

<Month DD, CCYY>
<sequence number>
<RecipName>
<RecipAddressLine1>
<RecipAddressLine2>
<RecipCity> <RecipStateZip>

Member Identification Number:
<XXX-XX-XXXXX>
Local County or Tribal Agency
Telephone Number: <AgencyPhone>

<PROGRAM NAME> Notice of Appeal Rights

<PROGRAM NAME> Notice of Appeal Rights

Appeal Date: <AppealDate>

In <PROGRAM NAME>, certain services and products must be reviewed and approved before payment can be made for them. This review process is called prior authorization (PA). The purposes of this letter are to notify you that <PROGRAM NAME> has either denied or modified a request for prior authorization of a service or product that was submitted on your behalf and to inform you of your right to appeal that decision.

Your provider <ProviderName> requested prior authorization for the following service(s):

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ServiceNN>

That prior authorization request, PA number <PANumber>, was reviewed by <PROGRAM NAME> medical consultants. Based on that review, the following services have been denied or modified as follows.

Denied Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<DeniedServiceNN>

Modified Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ModifiedServiceNN>

<PROGRAM NAME>'s denial or modification of the services requested was made for the following reasons:

(Denial/modify code(s) will be inserted here)

<PROGRAM NAME> bases its decisions on criteria found in the Wisconsin Administrative Code. <PROGRAM NAME> may modify or deny a prior authorization request if one or more of the criteria are not supported by documentation submitted by your provider. The specific regulation(s) that supports the reason for the denial/modification of your provider's request for services is found in the following Wisconsin Administrative Code:

services is found in the following Wisconsin Administrative Code:

(Wis. Admin. Code Regulation(s) will be inserted here)

We have sent your provider the denied/modified prior authorization request. We encourage you to contact <Provider Name> to review the prior authorization request and the reasons for the decision.

Your Rights and Responsibilities

You or your designated representative may appeal this decision in accordance with state and federal law within <RecipientDays> days. To file an appeal, you may do one of the following:

1) Call your local county or tribal agency at the telephone number listed on the first page of this letter for an appeal form and/or assistance in completing it.

2) Write a letter requesting an appeal to the Division of Hearings and Appeals at the following address:

    Division of Hearings and Appeals
    Department of Administration
    PO Box 7875
    Madison WI 53707-7875

The appeal form or letter should include all of the following:

- The name, address, and telephone number of the <PROGRAM NAME> member for whom the appeal is being made.
- The member identification number.
- The prior authorization number <PANumber> of the denied/modified request.
- The reason you think the denial or modification of the prior authorization is wrong.

REMEMBER: You must mail or deliver your appeal to your local county or tribal agency or the Division of Hearings and Appeals so it is received by the <RecipientDays>-day deadline, which is <AppealDate>.

You will lose your right to an appeal if your request to appeal is not received by the local county or tribal agency or the Division of Hearings and Appeals by <AppealDate>.

If you file an appeal, you may expect the following to occur:

- The state Division of Health Care Access and Accountability will be required to explain, in writing, the reason(s) for the denial or modification of the services your provider requested. This explanation will be mailed to you.
- The Division of Hearings and Appeals will schedule a hearing to consider your appeal and will notify you of the time and place by mail. Hearings are generally held at your local county or tribal agency. You may want to ask your local county or tribal agency if there is free legal help available in your area.
- At that hearing, you (or you may choose a friend, relative, attorney, provider, etc., to represent you) will have an opportunity to explain your need for the service to a hearing officer. Division of Health Care Access and Accountability staff may also appear in person or participate by telephone.
- Based on all the information available, the hearing officer will make a decision on your appeal, notify you of the decision by mail, and advise you of any additional appeal rights.

Whether or not you appeal, <PROGRAM NAME> will pay for any services it has approved. After the hearing officer makes a decision on your appeal, <PROGRAM NAME> will continue to pay for the approved services plus any additional services the hearing officer directs <PROGRAM NAME> to pay.

If you need information about accommodation for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (TTY) immediately so arrangements can be made. The staff at these numbers will not be able to provide you with information about the reasons for Wisconsin <PROGRAM NAME>'s decision to deny or modify the prior authorization request. These telephone numbers at the Division of Hearings and Appeals should only be used for questions about the hearing process.

F-11194 (10/08)

Topic #21657

Prior Authorization Requests for Denial

PA (Prior authorization) requests will be returned to providers who specifically request denial of a PA request, because the provider has an alternative funding source. PA determinations for all members are reviewed for medical necessity of the request.

ForwardHealth will not deny PAs due to coverage or lack of coverage from another funding source.

Topic #4737

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 (prior authorization) 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.

Topic #427

Returned Requests

A PA (prior authorization) 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 and dental models will be returned once the PA is finalized.

Photographs submitted to ForwardHealth as additional supporting clinical documentation for PA requests will not be returned to providers and will be disposed of securely.

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.

Follow-Up to Decisions

Topic #4738

Amendment Decisions

ForwardHealth will make a decision regarding a provider's amendment request within 20 working days from the receipt of all the necessary information. The method ForwardHealth will use to communicate decisions regarding PA (prior authorization) amendment requests will depend on how the **PA request** was originally submitted (not how the amendment request was submitted) and whether the provider has a ForwardHealth Portal account:

- If the PA request was originally submitted via the Portal, the decision notice letter or returned amendment provider review letter will be sent to the provider via the Portal.
- If the PA request was originally submitted 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 PA request was originally submitted via mail or fax and the provider does **not** have a Portal account, the decision notice letter or returned amendment provider review letter will be sent by mail to the address indicated in the provider's file as their 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 or amendment request.

Topic #431

Amendments

Providers are required to use the Prior Authorization Amendment Request (F-11042 (07/2012)) to amend an approved or modified PA (prior authorization) 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 their medical condition
- To change the rendering provider information when the billing provider remains the same
- To change the member's ForwardHealth 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.

Topic #432

Appeals

If a PA (prior authorization) 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 (Division of Hearings and Appeals). 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.

To file an appeal, members may complete and submit a Request for Fair Hearing (DHA-28 (08/09)) 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 their 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 and the member. 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 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
313 Blettner Blvd
Madison WI 53784

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
313 Blettner Blvd
Madison WI 53784

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 members.

Sample Notice of Appeal Rights Letter

<Month DD, CCYY>
<sequence number>
<RecipName>
<RecipAddressLine1>
<RecipAddressLine2>
<RecipCity> <RecipStateZip>

Member Identification Number:
<XXX-XX-XXXXX>
Local County or Tribal Agency
Telephone Number: <AgencyPhone>

<PROGRAM NAME> Notice of Appeal Rights

Appeal Date: <AppealDate>

In <PROGRAM NAME>, certain services and products must be reviewed and approved before payment can be made for them. This review process is called prior authorization (PA). The purposes of this letter are to notify you that <PROGRAM NAME> has either denied or modified a request for prior authorization of a service or product that was submitted on your behalf and to inform you of your right to appeal that decision.

Your provider <ProviderName> requested prior authorization for the following service(s):

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ServiceNN>

That prior authorization request, PA number <PANumber>, was reviewed by <PROGRAM NAME> medical consultants. Based on that review, the following services have been denied or modified as follows.

Denied Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<DeniedServiceNN>

Modified Services

Service Code	Modifier	Service Description	Unit	Dollar
XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

XXXXXXXXXXX	XX XX XX XX	XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXX	XXXXX.XX	XXXXX.XX

<ModifiedServiceNN>

<PROGRAM NAME>'s denial or modification of the services requested was made for the following reasons:

(Denial/modify code(s) will be inserted here)

<PROGRAM NAME> bases its decisions on criteria found in the Wisconsin Administrative Code. <PROGRAM NAME> may modify or deny a prior authorization request if one or more of the criteria are not supported by documentation submitted by your provider. The specific regulation(s) that supports the reason for the denial/modification of your provider's request for services is found in the following Wisconsin Administrative Code:

(Wis. Admin. Code Regulation(s) will be inserted here)

We have sent your provider the denied/modified prior authorization request. We encourage you to contact <Provider Name> to review the prior authorization request and the reasons for the decision.

Your Rights and Responsibilities

You or your designated representative may appeal this decision in accordance with state and federal law within <RecipientDays> days. To file an appeal, you may do one of the following:

1) Call your local county or tribal agency at the telephone number listed on the first page of this letter for an appeal form and/or assistance in completing it.

2) Write a letter requesting an appeal to the Division of Hearings and Appeals at the following address:

    Division of Hearings and Appeals
    Department of Administration
    PO Box 7875
    Madison WI 53707-7875

The appeal form or letter should include all of the following:
- The name, address, and telephone number of the <PROGRAM NAME> member for whom the appeal is being made.
- The member identification number.
- The prior authorization number <PANumber> of the denied/modified request.
- The reason you think the denial or modification of the prior authorization is wrong.

REMEMBER: You must mail or deliver your appeal to your local county or tribal agency or the Division of Hearings and Appeals so it is received by the <RecipientDays>-day deadline, which is <AppealDate>.

You will lose your right to an appeal if your request to appeal is not received by the local county or tribal agency or the Division of Hearings and Appeals by <AppealDate>.

If you file an appeal, you may expect the following to occur:
- The state Division of Health Care Access and Accountability will be required to explain, in writing, the reason(s) for the denial or modification of the services your provider requested. This explanation will be mailed to you.
- The Division of Hearings and Appeals will schedule a hearing to consider your appeal and will notify you of the time and place by mail. Hearings are generally held at your local county or tribal agency. You may want to ask your local county or tribal agency if there is free legal help available in your area.
- At that hearing, you (or you may choose a friend, relative, attorney, provider, etc., to represent you) will have an opportunity to explain your need for the service to a hearing officer. Division of Health Care Access and Accountability staff may also appear in person or participate by telephone.

or participate by telephone.
- Based on all the information available, the hearing officer will make a decision on your appeal, notify you of the decision by mail, and advise you of any additional appeal rights.

Whether or not you appeal, <PROGRAM NAME> will pay for any services it has approved. After the hearing officer makes a decision on your appeal, <PROGRAM NAME> will continue to pay for the approved services plus any additional services the hearing officer directs <PROGRAM NAME> to pay.

If you need information about accommodation for a disability or for language translation, please call 1-608-266-3096 (voice) or 1-608-264-9853 (TTY) immediately so arrangements can be made. The staff at these numbers will not be able to provide you with information about the reasons for Wisconsin <PROGRAM NAME>'s decision to deny or modify the prior authorization request. These telephone numbers at the Division of Hearings and Appeals should only be used for questions about the hearing process.

F-11194 (10/08)

Topic #1106

Enddating

Providers are required to use the Prior Authorization Amendment Request (F-11042 (07/2012)) to enddate most PA (prior authorization) 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 (Specialized Transmission Approval Technology-Prior Authorization) 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.

Topic #4739

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 (prior authorization) 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 and dental models will be returned once the amendment request is finalized.

Photographs submitted to ForwardHealth as additional supporting clinical documentation for PA requests will not be returned to providers and will be disposed of securely.

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.

Topic #5039

Searching for Previously Submitted Prior Authorization Requests on the Portal

Providers will be able to search for all previously submitted PA (prior authorization) requests, regardless of how the PA was initially submitted. If the provider knows the PA number, they can enter the number to retrieve the PA information. If the provider does not know the PA number, they 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.

Situations Requiring New Requests

Topic #452

Change in Billing Providers

Providers are required to submit a new PA (prior authorization) 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

Topic #9138

Prior Authorizations for Diabetic Supplies

When a PA request is approved for diabetic supplies, the member may go to any Medicaid-enrolled provider to obtain the prior authorized supplies. As a result, the member's PA does not need to be enddated when the member changes providers.

Topic #453

Examples

Examples of when a new PA (prior authorization) 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, 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.

Topic #454

Services Not Performed Before Expiration Date

Generally, a new PA (prior authorization) 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.

Member Eligibility Changes

Topic #443

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 (Enrollment Verification System) before the services are provided at each visit.
- When the PA (prior authorization) 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.

Topic #444

Retroactive Disenrollment From State-Contracted MCOs

Occasionally, a service requiring fee-for-service PA (prior authorization) is performed during a member's enrollment period in a state-contracted MCO (managed care organization). 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 (date of service). 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.

Topic #445

Retroactive Enrollment

If a service(s) that requires PA (prior authorization) 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.

Emergent and Urgent Situations

Topic #429

Emergency Services

In emergency situations, the PA (prior authorization) requirement may be waived for services that normally require PA. Emergency services are defined in Wis. Admin. Code DHS 101.03(52) 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.

Topic #430

Urgent Services

Telephone consultations with DMS (Division of Medicaid Services) staff regarding a prospective PA (prior authorization) 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 DMS. All telephone consultations for urgent services should be directed to the Service Authorization section at 608-267-9311. Providers should have the following information ready when calling:

- Member's name
- Member ID 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.

General Information

Topic #4402

An Overview

The PA (prior authorization) review process includes 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.

Topic #434

Communication With Members

ForwardHealth recommends that providers inform members that PA (prior authorization) 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.

Topic #435

Definition

PA (prior authorization) 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.

Topic #5098

Designating an Address for Prior Authorization

Correspondence

Correspondence related to PA (prior authorization) 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 dental models.

Photographs submitted to ForwardHealth as additional supporting clinical documentation for PA requests will not be returned to providers and will be disposed of securely.

Providers may designate a separate address for PA correspondence using the demographic maintenance tool.

Topic #1834

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 (prior authorization); 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.

Topic #1835

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 (prior authorization) for services requiring PA. Failure to do so results in non-payment of the remaining otherwise allowable cost by Wisconsin Medicaid.

Topic #4383

Prior Authorization Numbers

Upon receipt of the PA/RF (Prior Authorization Request Form, F-11018 (05/2013)), ForwardHealth will assign a PA (prior authorization) number to each PA request.

The PA number consists of 10 digits, containing valuable information about the PA (for example, 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 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 (Specialized Transmission Approval Technology-Prior Authorization); 4 = STAT-PA; 5 = Portal; 6 = Portal; 7 = NCPDP (National Council for Prescription Drug Programs) transaction or 278 (278 Health Care Services

	Review—Request for Review and Response) transaction; 9 = eviCore healthcare
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.

Topic #436

Reasons for Prior Authorization

Only about 4 percent of all services covered by Wisconsin Medicaid require PA (prior authorization). PA requirements vary for different types of services. Refer to ForwardHealth publications and Wis. Admin. Code ch. DHS 107 for information regarding services that require PA. According to Wis. Admin. Code § DHS 107.02(3)(b), 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 Wisconsin DHS (Department of Health Services).

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.

Topic #437

Referrals to Out-of-State Providers

PA (prior authorization) may be granted to out-of-state providers when nonemergency services are necessary to help a member attain or regain their 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 ForwardHealth'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 provider, the referring provider should instruct the out-of-state provider to go to the Provider Enrollment Information home page on the ForwardHealth Portal to complete a Medicaid Out-of-State Provider Enrollment Application.

All out-of-state nursing homes, regardless of location, are required to obtain PA for all services. All other out-of-state nonborder-status providers are required to obtain PA for all nonemergency services except for home dialysis supplies and equipment.

Topic #438

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 (prior authorization) 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 enrolled in Wisconsin Medicaid on the date the service is provided.
- The service is billed according to service-specific claim instructions.
- The provider meets 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.

Topic #1268

Sources of Information

Providers should verify that they have the most current sources of information regarding PA (prior authorization). 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.

Topic #812

Status Inquiries

Providers may inquire about the status of a PA (prior authorization) request through one of the following methods:

- Accessing WiCall, ForwardHealth's AVR (Automated Voice Response) system
- Calling Provider Services

Providers should have the 10-digit PA number available when making inquiries.

Topic #1837

Two Providers Requesting the Same Equipment for One Member

A second PA (prior authorization) 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

Topic #439

Backdating

Backdating an initial PA (prior authorization) request or SOI (spell of illness) 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 or SOI request.
- The request includes clinical justification for beginning the service before PA or SOI was granted.
- The request is received by ForwardHealth within 14 calendar days of the start of the provision of services.

Topic #440

Expiration Date

The expiration (end) date of an approved or modified PA (prior authorization) 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.

Topic #441

Grant Date

The grant (start) date of an approved or modified PA (prior authorization) 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.

Topic #442

Renewal Requests

To prevent a lapse in coverage or reimbursement for ongoing services, all renewal PA (prior authorization) requests (that is, 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.

Submission Options

Topic #12597

278 Health Care Services Review — Request for Review and Response Transaction

Providers may request PA (prior authorization) electronically using the 278 (278 Health Care Services Review — Request for Review and Response) transaction, the standard electronic format for health care service PA requests.

Compliance Testing

Trading partners may conduct compliance testing for the 278 transaction.

After receiving an "accepted" 999 (999 Functional Acknowledgment) for a test 278 transaction, trading partners are required to call the EDI (Electronic Data Interchange) Helpdesk to request the production 278 transaction set be assigned to them.

Submitting Prior Authorization Requests

Submitting an initial PA request using the 278 transaction does not result in a real-time approval and cannot be used to request PA for drugs and diabetic supplies.

After submitting a PA request via a 278 transaction, providers will receive a real-time response indicating whether the transaction is valid or invalid. If the transaction is invalid, the response will indicate the reject reason(s), and providers can correct and submit a new PA request using the 278 transaction. A real-time response indicating a valid 278 transaction will include a PA number and a pending status. The PA request will be placed in a status of "Pending - Fiscal Agent Review."

The 278 transaction does not allow providers to submit supporting clinical information as required to adjudicate the PA request.

Trading partners cannot submit the 278 transaction through PES (Provider Electronic Solutions). In order to submit the 278 transaction, trading partners will need to use their own software or contract with a software vendor.

Topic #7857

Drug Authorization and Policy Override Center

The DAPO (Drug Authorization and Policy Override) Center is a specialized drug help desk for prescribers, their designees, and pharmacy providers to submit PA (prior authorization) requests for anti-obesity drugs and to request policy overrides for other drugs or diabetic supplies over the phone. After business hours, providers may leave a voicemail message for DAPO Center staff to return the next business day.

The DAPO Center is staffed by certified pharmacy technicians.

Prior Authorization Requests and Policy Override Decisions

Providers who call the DAPO Center to request a PA for anti-obesity drugs or a policy override for other drugs or diabetic supplies are given an immediate decision about the PA or policy override, allowing members to receive drugs or diabetic supplies in a timely manner. The DAPO Center reviews PA requests and policy overrides for members enrolled in BadgerCare Plus, Wisconsin Medicaid, and SeniorCare.

Prior Authorization Requests

Prescribers or their billing providers are required to be enrolled in Wisconsin Medicaid to submit PA requests to ForwardHealth. Prescribers who are enrolled in Wisconsin Medicaid should indicate their name and NPI (National Provider Identifier) as the billing provider on PA

requests. Providers who are not enrolled in Wisconsin Medicaid should indicate the name and NPI of the Wisconsin Medicaid-enrolled billing provider (for example, clinic) with which they are affiliated on PA requests.

When a prescriber, or their designee, calls the DAPO Center, a pharmacy technician will ask them a series of questions based on the Prior Authorization Drug Attachment for Anti-Obesity Drugs (F-00163 (04/2023)) form. The prescriber, or their designee, should have all PA information completed on the appropriate PA drug attachment form before calling the DAPO Center to obtain PA. DAPO Center staff will ask for the name of the caller and the caller's credentials. (Is the caller an RN (registered nurse), physician assistant, physician, certified medical assistant, or nurse practitioner?)

Generally by the end of the call, if clinical PA criteria are met, DAPO Center staff will approve the PA request based on the information provided by the caller. If the PA request for an anti-obesity drug is approved, a decision notice letter will be mailed to the prescribing provider. After a PA for an anti-obesity drug has been approved, the prescriber should send the prescription to the pharmacy and the member can pick up the drug. The member does not need to wait for the prescriber to receive the decision notice to pick up the drug at the pharmacy.

Note: If the provider receives a decision notice letter for a drug for which they did not request PA, the provider should notify the DAPO Center within 14 days of receiving the letter to inactivate the PA.

If a prescriber or their designee calls the DAPO Center to request PA and the clinical criteria for the PA are not met, the caller will be informed that the PA request is not approved because it does not meet the clinical criteria. If the prescriber chooses to submit additional medical documentation for consideration, they may submit the PA request to ForwardHealth for review by a pharmacist. The prescriber is required to submit a PA/RF (Prior Authorization Request Form, F-11018 (05/2013)) and the applicable PA drug attachment form with the additional medical documentation. Documentation may be submitted to ForwardHealth through the Portal or by fax or mail.

Providers with questions about pharmacy policies and procedures may continue to call Provider Services.

Policy Override Decisions

When calling the DAPO Center to request a policy override, the following information must be provided:

- Member information
- Provider information
- Prescription information
- The reason for the override request

Topic #455

Fax

Faxing of all PA (prior authorization) requests to ForwardHealth may eliminate one to three days of mail time. The following are recommendations to avoid delays when faxing PA requests:

- Providers should 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 (F-01176 (09/2022)) 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 at 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.

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 (Prior Authorization Request Form, F-11018 (05/2013)) or the PA/HIAS1 (Prior Authorization for Hearing Instrument and Audiological Services 1, F-11020 (05/13)) 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 608-224-6124, 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 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.

Topic #458

ForwardHealth Portal Prior Authorization

Providers can use the PA (prior authorization) features on the ForwardHealth Portal to do the following:

- Submit PA requests and amendments for all services that require PA.
- View or maintain a PA collaboration (for certain services only).
- Save a partially completed PA request and return at a later time to finish completing it.
- Upload PA attachments and additional supporting clinical documentation for PA requests.
- Receive decision notice letters and returned provider review letters.
- Correct returned PA requests and PA amendment requests.
- Change the status of a PA request from "Suspended" to "Pending."
- Submit additional supporting documentation for a PA request that is in "Suspended" or "Pending" status.
- Search and view previously submitted PA requests or saved PA requests.
- Print a PA cover sheet.

Submitting PA 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 (National Provider Identifier) requirements, NPI and related data are required on PA requests 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 PA requests with a status of "Approved" or "Approved with Modifications."

View or Maintain a PA Collaboration (for Certain Services Only)

A **PA collaborative** will link two or more PA requests for the same member together so providers can easily see and maintain them. Providers may collaborate on PA request submissions and amendments that are submitted for certain services through the Portal.

Any of the following provider types may initiate or add a PA request to a collaborative:

- Physical therapists
- Occupational therapists
- Speech-language pathologists
- Home health agencies
- Personal care agencies

PA requests and amendments will continue to be reviewed individually, regardless of whether they are part of a PA collaborative or not. The denial or modification of one PA request will **not** impact other PA requests in the same collaborative.

Saving Partially Completed PA Requests

Providers do not have to complete PA requests in one session; they can save partially completed PA requests at any point after the Member Information page has been completed by clicking on the Save and Complete Later button, which is at the bottom of each page. There is no limit to how many times PA requests can be saved.

Providers can complete partially saved PA requests at a later time by logging in to the secure Provider area of the Portal, navigating to the Prior Authorization home page, and clicking on the Complete a Saved PA Request link. This link takes the provider to a Saved PA Requests page containing all of the provider's PA requests that have been saved.

Once on the Saved PA Requests page, providers can select a specific PA request and choose to either continue completing it or delete it.

Note: The ability to save partially completed PA requests is only applicable to new PA requests. Providers cannot save partially completed PA amendments or corrections to returned PA requests or amendments.

30 Calendar Days to Submit or Re-Save PA Requests

Providers must submit or re-save PA requests within 30 calendar days of the date the PA request was last saved. After 30 calendar days of inactivity, a PA request is automatically deleted, and the provider has to re-enter the entire PA request.

The Saved PA Requests page includes a list of deleted PA requests. This list is for information purposes only and includes saved PA requests that have been deleted due to inactivity (it does **not** include PA requests deleted by the provider). Neither providers nor ForwardHealth are able to retrieve PA requests that have been deleted.

Submitting Completed PA Requests

ForwardHealth's initial receipt of a PA request occurs when the PA request is submitted on the Portal. Normal backdating policy applies based on the date of initial receipt, not on the last saved date. Providers receive a confirmation of receipt along with a PA number once a PA request is submitted on the Portal.

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/PAD (Prior Authorization/Physician-Administered Drug Attachment, F-11034 (07/2022)) and display the form for the provider to complete. Certain PA attachments cannot be completed online or uploaded.

Providers may also upload an electronically completed version of the paper PA attachment form. However, when submitting a PA attachment electronically, ForwardHealth recommends completing the PA attachment online as opposed to uploading an electronically completed version of the paper attachment form to reduce the chances of the PA request being returned for clerical errors.

All PA request attachment forms are available on the Portal to download and print to submit by fax or mail.

Providers may also choose 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 (F-11159 (07/12)) must be printed and sent with the attachment to ForwardHealth for processing. Providers must list the attachment(s) on the Portal PA Cover Sheet. When ForwardHealth receives the PA attachment(s) by mail or fax, they will be matched up with the PA/RF (Prior Authorization Request Form, F-11018 (05/2013)) that was completed on the Portal.

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 request 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 providers.

Additional Supporting Clinical Documentation

ForwardHealth accepts additional supporting clinical documentation when the information cannot be indicated on the required PA request forms and is pertinent for processing the PA request or PA amendment request. Providers have the following options for submitting additional supporting clinical information for PA requests or PA amendment requests:

- Upload electronically
- Mail
- Fax

Providers can choose to upload electronic supporting information through the Portal in the following formats:

- JPEG (Joint Photographic Experts Group) (.jpg or .jpeg)
- PDF (.pdf)
- Rich Text Format (.rtf)
- Text File (.txt)
- OrthoCAD (.3dm) (for dental providers)

JPEG files must be stored with a ".jpg" or ".jpeg" extension; text files must be stored with a ".txt" extension; rich text format files must be stored with an ".rtf" extension; and PDF files must be stored with a ".pdf" extension. Dental OrthoCAD files are stored with a ".3dm" extension.

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

In addition, providers can also upload additional supporting clinical documentation via the Portal when:

- Correcting a PA request or PA amendment request that is in a "Returned — Provider Review" status.
- Submitting a PA amendment request.

If submitting supporting clinical information via mail or fax, 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.

ForwardHealth will return PA requests and PA amendments requests when the additional documentation could have been indicated on the PA/RF and PA attachments or when the pertinent information is difficult to find.

"Suspended" PA Requests

For PA requests in a "Suspended" status, the provider has the option to:

- Change a PA request status from "Suspended" to "Pending."
- Submit additional documentation for a PA request that is in "Suspended" or "Pending" status.

Changing a PA Request From "Suspended" to "Pending"

The provider has the option of changing a PA request status from "Suspended — Provider Sending Info" to "Pending" if the provider determines that additional information will not be submitted. Changing the status from "Suspended — Provider Sending Info" to "Pending" will allow the PA request to be processed without waiting for additional information to be submitted. The provider can change the status by searching for the suspended PA request, checking the box indicating that the PA request is ready for processing without additional documentation, and clicking the Submit button to allow the PA request to be processed by ForwardHealth. There is an optional free form text box, which allows providers to explain or comment on why the PA request can be processed.

Submitting Additional Supporting Clinical Documentation for a PA Request in "Suspended" or "Pending" Status

There is an Upload Documents for a PA link on the PA home page in the provider secured Home Page. By selecting that link, providers have the option of submitting additional supporting clinical documentation for a PA request that is in "Suspended" or "Pending" status. When submitting additional supporting clinical documentation for a PA request that is in "Suspended" status, providers can choose to have ForwardHealth begin processing the PA request or to keep the PA request suspended. PA requests in a "Pending" status are processed regardless.

Note: When the PA request is in a "Pending" status and the provider uploads additional supporting clinical documentation, there may be up to a four-hour delay before the documentation is available to ForwardHealth in the system. If the uploaded information was received after the PA request was processed and the PA request was returned for missing information, the provider may resubmit the PA request stating that the missing information was already uploaded.

Topic #456

Mail

Any type of PA (prior authorization) 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
313 Blettner Blvd
Madison WI 53784

Providers are encouraged to retain copies of all PA requests and supporting documentation before submitting them to ForwardHealth.

Back-up or Secondary Durable Medical Equipment

Topic #1780

Back-up or Secondary Durable Medical Equipment

For back-up or secondary DME (durable medical equipment), the following PA (prior authorization) 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.

Home Health Equipment

Topic #1839

Adaptive Equipment

PA (prior authorization) 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
- Adaptive hygiene aids, such as a long-handled sponge

PA is required for other adaptive equipment not listed above. Use HCPCS (Healthcare Common Procedure Coding System) procedure code E1399 (Durable medical equipment, miscellaneous) when submitting PA requests for these items.

Providers are required to complete a PA/RF (Prior Authorization Request Form, F-11018 (05/2013)) and a PA/DMEA (Prior Authorization/Durable Medical Equipment Attachment, F-11030 (07/2012)). The PA request must adequately describe the DME (durable medical equipment) item.

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 (activities of daily living) independently, with a caregiver, or with adaptive equipment
- Caregiver information (for example, availability, duties, and whether the caregiver is a spouse, other family member, home health aide)
- Specific results of trial use of the adaptive equipment or report of therapy service, if available

Topic #1841

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 (prior authorization) 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.

Topic #1843

Breast Pumps

Prior Authorization for Rentals

PA (prior authorization) 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").

PA for Purchases

ForwardHealth covers the purchase of a maximum of three breast pumps per member with up to one breast pump per year from the date of equipment delivery without PA for HCPCS (Healthcare Common Procedure Coding System) procedure codes E0602 and E0603.

Note: The member's initial and subsequent breast pumps do not need to be the same type of breast pump; they may be a combination of manual and electric breast pumps.

PA is required for reimbursement of additional breast pumps.

An exception is that PA is required for HCPCS procedure codes E0602 and E0603 for the following places of service for the purchase of one or more breast pumps:

- 31 (Skilled Nursing Facility)
- 32 (Nursing Facility)
- 54 (Intermediate Care Facility/Individuals with Intellectual Disabilities)

Topic #1844

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 (prior authorization). 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.

Topic #1845

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 (prior authorization) 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.

Topic #1846

Extra-Uterine Monitor

An extra-uterine monitor is a device used to monitor the presence of significant uterine contractions. A PA (prior authorization) 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.

Topic #1847

Hospital Beds

An ordinary bed is one that 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.

PA (prior authorization) requests for all hospital beds must document **one** of the following base requirements:

- 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 than 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 the base requirements for all hospital beds noted previously, PA 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. In addition to the base requirements for all hospital beds noted previously, documentation for a semi-electric hospital bed must indicate 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 **and** one of the following:

- The member is alone for extended periods of time, requires frequent and immediate changes in body position, and can operate the bed controls independently.
- The caregiver has a documented medical condition that requires a bed with variable height or a bed with electric head and foot adjustments.

Hospital Bed, Total Electric

A total electric hospital bed is one with electric height adjustment and electric head and leg elevation adjustments. In addition to the base

requirements for all hospital beds noted previously, documentation for a total electric hospital bed must indicate one or both of the following:

- The member has tried multiple means of transfer, including setting the bed at an optimal height for transfers, and can only transfer with a total electric bed.
- The caregiver has a documented medical condition that requires a bed with electric height adjustment.

Hospital Bed, Institutional Type, Includes: Oscillating, Circulating, and Stryker Frame

Oscillating beds are never covered, according to Wis. Admin. Code § 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.

PA requests for a six-way hospital bed must document the medical need for Trendelenburg positioning. This includes documentation on why reverse Trendelenburg positioning using a semi-electric bed would not meet the member's needs.

Topic #1848

Needle-Free Injection Device

A needle-free injection device delivers multiple pressurized injections without the use of needles and without skin trauma. A PA (prior authorization) 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.

Topic #1849

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 (prior authorization) 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

Topic #19718

Positioning Seats

Prior Authorization

Approval Criteria for Positioning Seats for Motor Vehicle Use

An approved PA (prior authorization) request is required for the purchase or rental of a positioning seat for motor vehicle use, with the exception of the first 60 days of a rental, which does not require PA.

All the following criteria is required for PA requests for all positioning seats, whether they are for home use or motor vehicle use:

- The member's diagnosis(es)/clinical condition(s) support the need for a specialized vehicle positioning seat due to decreased seated postural control that would immediately result in an adverse medical outcome.
- A commercially available vehicle positioning seat has been trialed and demonstrated to not meet member's medical needs.
- The member can only be safely transported in a specialized vehicle positioning seat.
- If the member has a mobility base, the member cannot be transported in a motor vehicle in the mobility base (for example, the member's primary caregiver does not drive an adaptive van equipped to transport the member in the mobility base).
- The growth capacity of the positioning seat will accommodate the member's growth.
- The positioning seat and components and/or accessories (if necessary) comply with federal safety standards.

Approval Criteria for Positioning Seats for Home Use

An approved PA request is required for the purchase of a positioning seat for home use.

ForwardHealth may approve a PA request for a positioning seat for home use if **all** of the following criteria are met:

- The member's diagnosis(es)/clinical condition(s) support that the member has demonstrated impaired gross motor skills needed to independently maintain sitting balance and sitting endurance.
- The provider has collected the following documentation for activity chairs:
  - The activity chair will let the member complete medically necessary tasks that cannot be completed with other positioning devices (such as, adaptive strollers, manual wheelchairs, power wheelchairs, or floor sitters) also available to the member.
  - Commercially available products with more cost-effective modifications (such as the use of bolsters, pillows, or wedges) have been trialed and will not meet the member's needs.
- The provider has the following documentation for floor sitters:
  - The activity chair is age-appropriate or developmentally appropriate
  - Clinical documentation on functional task performance with floor sitter use
  - Commercially available products with more cost-effective modifications (such as the use of bolsters, pillows, or wedges) have been trialed and will not meet the member's needs.

Prior Authorization Documentation

Providers are required to indicate the following information in Element 22 (Description of Service) on the PA/RF (Prior Authorization Request Form, F-11018 (05/2013)) when requesting purchase or rental of a positioning seat for motor vehicle use or purchase of a positioning seat for home use:

- The name of the product being requested
- Whether the requested equipment is for motor vehicle use or home use

Information Required on All Prior Authorization Requests for Positioning Seats

Providers are required to submit **all** of the following information with a PA request for a positioning seat:

- A completed PA/RF
- A completed PA/DMEA (Prior Authorization/Durable Medical Equipment Attachment, F-11030 (02/2024))
- A written and valid prescription per Wis. Admin. Code § DHS 107.02(2m)(b)
- Valid face-to-face documentation, if required
- A complete qualified health care professional evaluation that meets the following criteria:
  - Is performed by a licensed physician, physician's assistant, occupational therapist, physical therapist, or chiropractor
  - Includes detailed assessments in the relevant areas that pertains to the specific CRT (complex rehabilitation technology) service requested (Refer to the Services Requiring Prior Authorization chapter in the Prior Authorization section of the Durable Medical Equipment service area of the Online Handbook for more information about assessments.)
  - Uses body structure and function and/or activity components of the International Classification of Functioning model to provide justification for member specific needs for each requested line item.

    - Includes a signed statement from the qualified health care professional who is writing the evaluation indicating that they do not have a financial relationship with the CRT supplier requesting the durable medical equipment.
- A complete CRT professional evaluation that meets the following criteria:
    - Is performed by a qualified CRT professional
    - Includes a copy of the certification as defined in § DHS 101.03 (28m)
    - Indicates the qualified CRT professional performing the CRT evaluation was present at the member's CRT clinical evaluation or indicates that documentation of coordination has been submitted with the CRT clinical evaluation performed by the qualified health care professional
- Assessments that are completed in-person, signed and dated, and include details of the following areas:
    - Current equipment the member may be using (such as the equipment's make, model, and age)
    - Projected life expectancy of the current and proposed CRT service
    - Member's home or setting for accessibility using the Durable Medical Equipment Home Accessibility Report, F-02891 (08/2022)
    - Transportation method, including the make and model of vehicle, if applicable
    - Cost-effectiveness of the requested service compared to a similar service and the reason the comparable service would not meet the member's needs, if applicable
- Signed and dated statement asserting that the qualified CRT professional will provide appropriate training to the member and will maintain adequate documentation of the training provided
- The member's current age, height, and weight, as well as the source and date of the height and weight record
- Clinical documentation of the member's functional status that includes the following:
    - Ambulation status, including what ambulation aids are used (if any)
    - Transfer performance
    - Head and trunk stability
    - Sitting and standing balance
    - Sitting and standing endurance
- Clinical documentation of the member's diagnosis(es) and/or all other medical conditions, including complications of the following:
    - Airway
    - Skin integrity
    - Circulation
    - Behavior, if applicable
- Description of the member's current equipment and the reason the existing equipment no longer meets the member's medical needs, including adaptations or modifications to commercially available items
- Manufacturer product information, including the make, model, size, height and weight user limits, and growth capacity of the positioning seat

Additional Information Required for Positioning Seats for Motor Vehicle Use

In addition to submitting the information required with all PA requests for positioning seats, providers are required to also submit **all** of the following information with a PA request for a positioning seat for motor vehicle use:

- Description of how the member is currently transported in a motor vehicle
- Accessibility of the member's primary caregiver's vehicle

Additional Information Required for Positioning Seats for Home Use

In addition to submitting the information required with all PA requests for positioning seats, providers are required to also submit **all** of the following information with a PA request for a positioning seat for home use:

- Accessibility of the member's residence
- All commercially available or special adaptive equipment or items owned and/or used by the member in all environments regardless of the pay source of that equipment
- The member's current or anticipated use of a mobility base

Topic #1850

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 (prior authorization) 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.

Topic #1840

Speech Generating Device

PA (prior authorization) is required in the following situations:

- A synthesized SGD (speech-generating device) is purchased.
- More than 90 days of rental are required during a 365-day period for the following procedure codes:
  - 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 SGD to the member.
- For the following procedure codes, PA is required beginning on the first day of rental or purchase:
  - 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).
- Repairs of the SGD are performed when the billed amount is more than $300.
- The SGD is replaced within the life expectancy.

When submitting a PA request for procedure codes E2511, E2512, and 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.

Approval Criteria for Synthesized Speech-Generating Devices

PA requests for rental or purchase of a synthesized SGD, accessories, mounting systems, and software may be approved if all the following criteria are met:

- The member has a functional communication need as a result of a congenital, acquired, or progressive neurologic disorder(s) or condition (s).
- The member's current functional speech and/or language status is inadequate for expressing needs and supporting age-appropriate participation within daily situations.
- The SGD is intended to be solely dedicated for communication, following relevant standards for DME (Durable Medical Equipment).
- The SLP (Speech Language Pathology) documentation reflects at least one of the following three criteria:
  - The member demonstrates improvement in multiple skills targeted during ongoing treatment and/or during the rental/trial period. Targeted skills may include language skills (for example, vocabulary, syntax), social and relevant interaction skills (for example, communicative functions), operational skills (for example, on/off, page navigation), context requirements (for example, frequency or types of cues), and communicating ability with communication partners and situations.
  - The member uses the recommended SGD to re-establish communication skills demonstrated with a previous or current SGD that is not working, is unreliable, or no longer meets their needs, without requiring treatment or a trial period.
  - The member's history demonstrates age-appropriate receptive and expressive language skills, but an acquired disability has reduced or eliminated speech as a means of expression. The member demonstrates proficiency using the recommended SGD without requiring treatment or a trial period.

- The features of the requested SGD are documented to match the member's skills and needs and a less costly SGD would not equally support communication success, opportunities for communication development, and/or communication efficiency.
- The recommended accessories, mounting system, access adaptations, and software are documented to match the member's skills and needs and maximize access to the SGD in different situations. (Documentation from an occupational or physical therapist participating in the SGD evaluation may be included.)

Requesting Prior Authorization

The billing provider is required to submit the following documentation to ForwardHealth when requesting PA for rental of synthesized SGD or purchase of synthesized SGDs, accessories, mounting systems or software:

- A completed PA/RF (Prior Authorization Request Form, F-11018 (05/2013))
- A completed PA/DMEA (Prior Authorization/Durable Medical Equipment Attachment, F-11030 (07/2012))
- A written prescription
- If applicable, documentation of face-to-face visits
- Manufacturer name and product name for the device, accessories, and mounting system
- MSRP (manufacturer suggested retail price) or invoice for SGD accessories and hardware (not required for procedure codes E2508 or E2510)
- A formal initial evaluation of the member's communication abilities documented by a speech-language pathologist on the PA/SGD Skills and Needs Profile Attachment (Prior Authorization/Speech Generating Device Skills and Needs Profile Attachment, F-02494 (07/2019)) or their own report that includes all of the following:
  - Background information/history
  - Confirmation of need for synthesized SGD
  - Member receptive language skills
  - Member speech and expressive language skills, including linguistic and non-linguistic skills
  - Member cognitive skills
  - Member physical skills related to use of synthesized SGD
  - SGD feature matches the member's skills and needs
- Recommendation by a speech-language pathologist for the requested device (This information may be recorded on the PA/SGD Purchase Recommendation Attachment (Prior Authorization/Speech Generating Device Purchase Recommendation, F-02493 (07/2019)) or equivalent.)
- Recommendations for skilled treatment following the purchase of the SGD or rationale explaining why skilled treatment is not required following purchase of the SGD
- A copy of the member's IEP (individualized education plan) when a purchase is being requested for a school age child (ages 3-21) or the member's IFSP (individual family service plan) when a purchase is being requested for children under 3 who are participating in the Birth to 3 Program.

Topic #1851

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, prosthetics, various transfer devices, or wheelchairs.

Standing frame purchase and rental are covered by ForwardHealth with PA (prior authorization). Standing frame rentals do not require PA for the first 90 days. An extension of the rental beyond 90 days requires PA.

Allowable Procedure Codes

The DME (durable medical equipment) Index contains information regarding modifiers associated with allowable procedure codes.

PA Approval Criteria

Single Position Standing Frame

PA requests for rental or purchase of a single-position standing frame using HCPCS (Healthcare Common Procedure Coding System) code

E0638 (Standing frame/table system, one position [e.g., upright, supine or prone stander], any size including pediatric, with or without wheels) may be approved if **all** of the following criteria are met:

- The standing frame is an integral part of a rehabilitative or maintenance therapy program with specific and measurable outcomes unique to the member to address at least **one** of the following areas:
  - Maintain or improve bladder function
  - Maintain or promote bone/joint health
  - Maintain or improve bowel function
  - Maintain or improve digestive process
  - Maintain or promote cardiac function
  - Management of contractures and range of motion in the lower extremities
  - Management of pain associated with spasticity or tone
  - Reduced respiratory function secondary to inability to independently achieve an upright posture
- The standing frame fits in the environment for which it is being requested.
- The member is willing to use the standing frame in the environment for which it is being requested.
- Caregivers are willing and able to assist with the standing program.

Combination Standing Frame

PA requests for rental or purchase of a combination standing frame using HCPCS code E0637 (Combination sit to stand frame/table system, any size including pediatric, with seat lift feature, with or without wheels) may be approved if the **all** of the following criteria are met:

- The standing frame is an integral part of a rehabilitative or maintenance therapy program with specific and measurable outcomes unique to the member to address at least **one** of the following areas:
  - Maintain or improve bladder function
  - Maintain or promote bone/joint health
  - Maintain or improve bowel function
  - Maintain or improve digestive process
  - Maintain or promote cardiac function
  - Management of contractures and range of motion in the lower extremities
  - Management of pain associated with spasticity or tone
  - Reduced respiratory function secondary to inability to independently achieve an upright posture
- The standing frame fits in the environment for which it is being requested.
- The member is willing to use the standing frame in the environment for which it is being requested.
- Caregivers are willing and able to assist with the standing program.
- One of the following is true:
  - Variable sit-to-stand positions are necessary to support the member in a more upright standing position because the member's knee and/or hip range of motion prevents the use of a prone, supine, or upright standing frame (E0638).
  - The member requires assistance of one person or more for standing pivot transfers with or without an assistive device.

Multi-Position Standing Frame

PA requests for rental or purchase of a multi-position standing frame using HCPCS code E0641 (Standing frame/table system, multi-position [e.g., three-way stander], any size including pediatric, with or without wheels) may be approved if **all** of the following criteria are met:

- The standing frame is an integral part of a rehabilitative or maintenance therapy program with specific and measurable outcomes unique to the member to address at least **one** of the following areas:
  - Maintain or improve bladder function
  - Maintain or promote bone/joint health
  - Maintain or improve bowel function
  - Maintain or improve digestive process
  - Maintain or promote cardiac function
  - Management of contractures and range of motion in the lower extremities
  - Management of pain associated with spasticity or tone
  - Reduced respiratory function secondary to inability to independently achieve an upright posture
- The standing frame fits in the environment for which it is being requested.
- The member is willing to use the standing frame in the environment for which it is being requested.
- Caregivers are willing and able to assist with the standing program.

- One of the following is true:
  - Variable sit-to-stand positions are necessary to support the member in a more upright standing position because the member's knee and/or hip range of motion prevents the use of a prone, supine, or upright standing frame (E0638).
  - The member requires assistance of one person or more for standing pivot transfers with or without an assistive device.
- Clinical documentation that standing frames represented by E0637 and/or E0638 cannot meet the medical needs of the member.

PA Submission

Providers are required to submit the following to ForwardHealth when requesting PA for standing frame rental or purchase and accessories purchase:

- A completed PA/RF (Prior Authorization Request Forms, F-11018 (05/2013))
- A completed PA/DMEA (Prior Authorization/Durable Medical Equipment Attachment, F-11030 (02/2024))
- A written and valid prescription per Wis. Admin. Code § DHS 107.02(2m)(b)
- Valid face-to-face documentation, if required
- A complete qualified health care professional evaluation that meets the following criteria:
  - Is performed by a licensed physician, physician's assistant, occupational therapist, physical therapist, or chiropractor
  - Includes detailed assessments in the relevant areas that pertains to the specific CRT service requested (Refer to the Services Requiring Prior Authorization chapter in the Prior Authorization section of the Durable Medical Equipment service area of the Online Handbook for more information about assessments.)
  - Uses body structure and function and/or activity components of the International Classification of Functioning model to provide justification for member specific needs for each requested line item.
  - Includes a signed statement from the qualified health care professional who is writing the evaluation indicating that they do not have a financial relationship with the CRT supplier requesting the durable medical equipment.
- A complete CRT professional evaluation that meets the following criteria:
  - Is performed by a qualified CRT professional
  - Includes a copy of the certification as defined in § DHS 101.03 (28m)
  - Indicates the qualified CRT professional performing the CRT evaluation was present at the member's CRT clinical evaluation or indicates that documentation of coordination has been submitted with the CRT clinical evaluation performed by the qualified health care professional
- Assessments that are completed in-person, signed and dated, and include details of the following areas:
  - Current equipment the member may be using (such as the equipment's make, model, and age)
  - Projected life expectancy of the current and proposed CRT service
  - Member's home or setting for accessibility using the Durable Medical Equipment Home Accessibility Report, F-02891 (08/2022)
  - Transportation method, including the make and model of vehicle, if applicable
  - Cost-effectiveness of the requested service compared to a similar service and the reason the comparable service would not meet the member's needs, if applicable
- Signed and dated statement asserting that the qualified CRT professional will provide appropriate training to the member and will maintain adequate documentation of the training provided
- Documentation supporting the approval criteria
- Manufacturer standing frame product information (including the make, model, and size of item, any additionally required prompts or accessories to be dispensed, and height and/or weight user limits)
- Documentation of the member's participation in therapy services, including the current POC (plan of care) and an assessment of the member's range of motion, strength, muscle tone, sensation, coordination, gait, balance, cognitive status, functional status, and ADL (activities of daily living) status
- Documentation of the proposed standing frame utilization plan including:
  - Methods of utilization
  - Frequency/duration of utilization
  - Therapy goals attempting to address
- A description of any special adaptive equipment or items owned or used by the member in any environment, including specialized seating/positioning equipment, standing frames, and/or mobility aids
- Documentation of MSRP (Manufacturer's Suggested Retail Price)
- If the member has an existing standing frame, documentation of the following:
  - Make, model, and size of equipment
  - Date the equipment was dispensed
  - Reason that existing equipment no longer meets the member's medical need

Oxygen and Respiratory Equipment

Topic #1877

Airway Clearance Devices

An airway clearance device is a self-administered chest PT (physical therapy) system, consisting of a mechanical device that promotes airway clearance by HFCC (high frequency chest compression).

Key elements for the approval of PA (prior authorization) 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 their 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.

Topic #1860

An Overview of Oxygen Services Requiring Prior Authorization

According to the DME (durable medical equipment) Index, PA (prior authorization) 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 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 (Prior Authorization Request Form, F-11018 (05/2013)) and the PA/OA (Prior Authorization/Oxygen Attachment, F-11066 (07/2012)) 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 (F-11067 (07/2012)) 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 (skilled nursing facility), 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 (for example, 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, flowmeter, 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, single delivery port, 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.

Topic #1861

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 (prior authorization) 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 (sudden infant death syndrome), 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.

Topic #1880

Back-Up or Secondary Home Ventilator Rental

ForwardHealth will cover a back-up or secondary home ventilator rental with PA (prior authorization) in limited circumstances.

Prior Authorization Submission Criteria

Providers are required to submit all of the following when submitting a PA request for coverage of back-up or secondary home ventilator rental:

- A completed PA/RF (Prior Authorization Request Form, F-11018 (05/2013))
- A completed PA/DMEA (Prior Authorization/Durable Medical Equipment Attachment, F-11030 (02/2024))
- A diagnosis or clinical condition and respiratory assessments from the physician that substantiate the medical necessity for ventilatory support
- Physician prescription
- Ventilator settings
- Documentation of weaning attempts and/or the potential for weaning
- Number of hours per day that the member requires mechanical ventilation
- The mechanical mode of ventilation (invasive or non-invasive)
- The amount of family or skilled care needed
- Pulmonary progress notes
- Documentation of the training on equipment use that has occurred or will occur with family and caregivers
- Documentation of the member's circumstance requiring a back-up or secondary piece of equipment
- Indication of whether or not the primary ventilator is portable

Note: Back-up or secondary home ventilator rental is not covered when provided to members in a nursing home or skilled nursing home setting.

Topic #1863

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 (prior authorization) 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 facility-based or home-based sleep study is required.

Topic #1862

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 (prior authorization) 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.

Topic #1864

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 (intermittent

positive pressure breathing) treatments, oxygen delivery, or as part of a ventilation/oxygen system.

Topic #1865

Intermittent Positive Pressure Breathing Device

An IPPB (intermittent positive pressure breathing) 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

Topic #1866

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 (prior authorization) requests for nebulizers with compressors are as follows:

- The compressor is covered when prescribed for use with oxygen or IPPB (intermittent positive pressure breathing) 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.

Topic #1867

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 (prior authorization) 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.

Topic #1868

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 (prior authorization) 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.

Topic #1869

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 (prior authorization) requests for oxygen conservers are as follows:

- A physician prescription dated within 30 days of the first DOS (date of service) 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 (arterial blood gases) 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.

Topic #1870

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 their 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 (prior authorization) 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 (skilled nursing facilities) 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.

Topic #1871

Oxygen Tents

An oxygen tent is a protective canopy used for inhalation therapy.

Key elements for the approval of PA (prior authorization) 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 (arterial blood gases) 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.

Topic #1872

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 (prior authorization) 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.

Topic #1873

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 (prior authorization) approval, medical documentation must include the purpose of the test and how the results will be used in treatment of the member.

Topic #1876

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 (prior authorization) 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.

Topic #1879

Vaporizer

A vaporizer is a device that converts medicated liquids to vapors for inhalation.

Key elements for the approval of PA (prior authorization) 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.

Mobility Devices and Accessories

Topic #1884

Complex Rehabilitation Technology Mobility Devices and Accessories

Providers are required to submit **all** of the following to ForwardHealth when requesting PA (prior authorization) for purchase or rental of a CRT (complex rehabilitation technology) mobility device or the purchase of CRT mobility device accessories:

- A completed PA/RF (Prior Authorization Request Form, F-11018 (05/2013))
- A completed PA/DMEA (Prior Authorization/Durable Medical Equipment Attachment, F-11030 (02/2024))
- A written and valid prescription per Wis. Admin. Code § DHS 107.02(2m)(b)
- Valid face-to-face documentation, if required
- A complete qualified health care professional evaluation that meets the following criteria:
  - Is performed by a licensed physician, physician's assistant, occupational therapist, physical therapist, or chiropractor
  - Includes detailed assessments in the relevant areas that pertains to the specific CRT service requested
  - Uses body structure and function and/or activity components of the International Classification of Functioning model to provide justification for member specific needs for each requested line item
  - Includes a signed statement from the qualified health care professional who is writing the evaluation indicating that they do not have a financial relationship with the CRT supplier requesting the durable medical equipment
- A complete CRT professional evaluation that meets the following criteria:
  - Is performed by a qualified CRT professional
  - Includes a copy of the certification as defined in Wis. Admin. Code § DHS 101.03(28m)
  - Indicates the qualified CRT professional performing the CRT evaluation was present at the member's CRT clinical evaluation or indicates that documentation of coordination has been submitted with the CRT clinical evaluation performed by the qualified health care professional
- Assessments that are completed in-person, signed and dated, and include details of the following areas:
  - Current equipment the member may be using (such as the equipment's make, model, and age)
  - Projected life expectancy of the current and proposed CRT service
  - Member's home or setting for accessibility using the Durable Medical Equipment Home Accessibility Report (F-02891 (08/2022))
  - Transportation method, including the make and model of vehicle, if applicable
  - Cost-effectiveness of the requested service compared to a similar service and the reason the comparable service would not meet the member's needs, if applicable
- Signed and dated statement asserting that the qualified CRT professional will provide appropriate training to the member and will maintain adequate documentation of the training provided

Additional Wheelchair Accessories Instead of Secondary Mobility Devices

ForwardHealth will cover additional medically necessary wheelchair accessories instead of a secondary mobility device if **all** of the following are met:

- The wheelchair accessory is more cost effective than a second mobility base (for example, the purchase of a second set of specialized wheels to help the member navigate within the home, work, or outdoor terrain instead of purchasing a second mobility base).
- The wheelchair accessory most appropriately meets the member's MRADL (mobility-related activities of daily living) needs in lieu of additional mobility equipment.
- The wheelchair accessory is necessary on a routine basis to allow the primary mobility device to be utilized safely or practically for a reoccurring medical or functional need.

Complex Rehabilitation Technology for Nursing Home Residents

Requirements for CRT in nursing homes are available.

PA amendment requests to backdate the POS (place of service) for CRT items are not permitted.

Topic #1883

Power-Operated Vehicles (Scooters)

All power-operated vehicles require PA (prior authorization). PA requests for power-operated vehicles with procedure codes K0801, K0802, K0807, and K0808 will be considered when the member has exceptional needs (for example, 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 (for example, 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 (Prior Authorization Request Form, F-11018 (05/2013))
- A completed PA/DMEA (Prior Authorization/Durable Medical Equipment Attachment, F-11030 (02/2024))
- 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 (for example, 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

"Not Otherwise Classified" Procedure Codes

Topic #1781

"Not Otherwise Classified" Procedure Codes

PA (prior authorization) is required for "not otherwise classified" procedure codes. Requests must be submitted on the PA/RF (Prior Authorization Request Form, F-11018 (05/2013)). 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.

Repairs

Topic #1858

General Guidelines for Repairs

PA (prior authorization) 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 (Durable Medical Equipment) 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.

Topic #1859

Modifier RB for Miscellaneous Repair Parts

Procedures codes with the "RB" modifier do not require PA (prior authorization) if all of the following are true:

- The charge is for repair parts for equipment that have been identified for use with the "RB" modifier and is one of the following:
  - $50 or less for home health DME (durable medical equipment) indicated in the DME (Durable Medical Equipment) Index.
  - $150.00 or less for manual wheelchairs.
  - $150.00 or less for power operated vehicles.
  - $300.00 or less for power wheelchairs.
- The DME is more than one year old.
- Wisconsin Medicaid and BadgerCare Plus purchased the equipment.

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 DME Index for 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 "RB" modifier.
3. If the part needing repair isn't described by a procedure code in the fee schedule, providers can submit a claim with procedure code E1399. PA is needed for this procedure code.

Home Health Equipment (i.e., Hospital Beds, Lifts, and Commode Chairs)

Providers may use the "RB" 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
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. Look in the DME Index for 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	Lightweight 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. Look in the DME Index for 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.

Compression Garments

Topic #11717

Prior Authorization for Burn and Gradient Compression Garments

In this topic, the term "compression garments" is used to refer to both gradient compression garments and compression burn garments, unless otherwise stated.

ForwardHealth requires PA (prior authorization) for compression garments in the following situations:

- When life expectancy has been exceeded (that is, when greater than three garments per procedure code, per rolling 12 months for gradient compression garments or greater than eight garments per rolling 12 months for compression burn garments are medically necessary)
- When the member's diagnosis is other than a diagnosis for which billing is allowed without PA

When submitting a PA request for compression garments, providers are required to include the following:

- PA/RF (Prior Authorization Request Form, F-11018 (05/2013))
- PA/DMEA (Prior Authorization/Durable Medical Equipment Attachment, F-11030 (02/2024))
- Member's diagnosis or medical condition
- Copy of the signed and dated physician's prescription
- Description of the service to be provided
- Type of compression garment
- Modifier RT, LT, or RA, 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 (for example, centimeters used at every measurement).
  - Reasons why life expectancy has been exceeded
  - Reasons related to diagnosis (that is, for diagnoses other than those for which billing is allowed without PA and those for which compression garments are contraindicated or should be used with caution)

Modifiers

Providers are required to include modifier RT and/or LT on PA requests submitted for procedure codes A6504 to A6508, A6530 to A6538, A6545, A6549, and S8420 to S8429. These procedure codes are incomplete without modifier RT or LT.

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.

If a provider is replacing a member's compression garment using measurements currently on file, the provider is required to use the RA modifier. However, if the garment is being replaced based on new measurements, even if there is no change to the measurements currently on file, the providers should not use the RA modifier.

Claims

4

Archive Date:04/01/2024

Claims:Submission

Topic #17797

1500 Health Insurance Claim Form Completion Instructions

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

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

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

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

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

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

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

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

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

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

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

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

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

Note: When submitting paper claims to ForwardHealth, if the member has any other health insurance sources (for example, commercial health insurance, Medicare, Medicare Advantage Plans), providers are required to complete and submit a separate Explanation of Medical Benefits

form for each other payer as an attachment(s) to their completed paper claim.

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

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

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

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

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

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

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

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

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

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

For additional information about submitting a 1500 Health Insurance Claim Form with supplemental NDC information, refer to the completion instructions located under "Section 24" in the Field Specific Instructions section of the NUCC's 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12.

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

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

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

Topic #542

Attached Documentation

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

Topic #19677

Bone-Anchored Hearing Devices and Cochlear Implants

Wisconsin Medicaid separately reimburses DME (durable medical equipment) providers for bone-anchored hearing devices and cochlear implants when the implant surgery is performed in an ASC (ambulatory surgery center) or outpatient hospital and the rendering surgeon has submitted a claim for the surgery. The POS (place of service) codes for these facilities are as follows:

- "11" (Office)
- "19" (Off Campus — Outpatient Hospital)
- "22" (On Campus — Outpatient Hospital)
- "24" (Ambulatory Surgical Center)

Claims for bone-anchored hearing devices and bone-anchored hearing device surgery and cochlear implants and cochlear implant surgery are required to be submitted in a professional claim format (e.g., electronically using and 837 transaction, Direct Data Entry on the Portal, or Provider Electronic Solutions claims submission software, or on paper using the 1500 Health Insurance Claim Form).

The rendering surgeon is required to submit the claim for the surgery; the DME provider is required to submit the claim for the device.

Note: ForwardHealth will confirm that a claim for the bone-anchored hearing device surgery or cochlear implant surgery has been submitted prior to processing the DME provider's claim for the device. The DME provider is required to coordinate with the surgeon to ensure that the surgical claim is submitted first.

Topic #15737

Claims for Services Prescribed, Referred, or Ordered

Claims for services that are prescribed, referred, or ordered must include the NPI (National Provider Identifier) of the Medicaid-enrolled provider who prescribed, referred, or ordered the service. Claims that do not include the NPI of a Medicaid-enrolled provider will be denied. (However, providers should **not** include the NPI of a provider who prescribes, refers, or orders services on claims for services that are not prescribed, referred, or ordered, as those claims will also deny if the provider is not Medicaid-enrolled.)

Note: Claims submitted for ESRD (end-stage renal disease) services do not require **referring** provider information; however, **prescribing** and **ordering** provider information will still be required on claims.

Contacting Prescribing/Referring/Ordering Provider After a Claim Denial

If a claim for services prescribed, referred, or ordered is denied because the prescribing/referring/ordering provider was not Medicaid-enrolled, the rendering provider should contact the prescribing/referring/ordering provider and do the following:

- Communicate that the prescribing/referring/ordering provider is required to be Medicaid-enrolled
- Inform the prescribing/referring/ordering provider of the limited enrollment available for prescribing/referring/ordering providers
- Resubmit the claim once the prescribing/referring/ordering provider has enrolled in Wisconsin Medicaid

Exception for Services Prescribed, Referred, or Ordered Prior to a Member's Medicaid Enrollment

Providers may submit claims for services prescribed, referred, or ordered by a non-Medicaid-enrolled provider if the member was not yet enrolled in Wisconsin Medicaid at the time the prescription, referral, or order was written (and the member has since enrolled in Wisconsin Medicaid). However, once the prescription, referral, or order expires, the prescribing/referring/ordering provider is required to enroll in Wisconsin Medicaid if they continue to prescribe, refer, or order services for the member.

The procedures for submitting claims for this exception depend on the type of claim submitted:

- Institutional, professional, and dental claims for this exception must be sent to the following address:

  ForwardHealth
  P.R.O. Exception Requests
  Ste 50
  313 Blettner Blvd
  Madison WI 53784

  A copy of the prescription, referral, or order must be included with the claim.

- Pharmacy and compound claims for this exception do **not** require any special handling. These claims include a prescription date, so they can be processed to bypass the prescriber Medicaid enrollment requirement in situations where the provider prescribed services before the member was Medicaid-enrolled.

Topic #6957

Copy Claims on the ForwardHealth Portal

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

Topic #5017

Correct Errors on Claims and Resubmit to ForwardHealth on the Portal

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

Topic #10137

Compound and Noncompound Drug Claims

For example, the provider might see on his or her RA (Remittance Advice) the detail for a noncompound drug claim was denied with the EOB code indicating that the detail on the claim was not processed due to an error. The provider may then correct the error on the claim via the Portal online screen application and resubmit the claim to ForwardHealth.

Topic #1729

Dates of Service

ForwardHealth defines the DOS (date of service) as follows:

- The date on which the DME (durable medical equipment) was dispensed to the member or the member's caregiver by the provider
- The date on which the DME was shipped or mailed to the member or the member's caregiver if the provider used a shipping service or mail order

Rental items billed to ForwardHealth must have "from" and "to" DOS. If the item 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. The number of days indicated must equal the number of days within the range. Rental items must be ranged within the same calendar month per detail line.

The "to" DOS requirement does not apply to Medicare crossover claims.

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.

Topic #4997

Direct Data Entry of Professional and Institutional Claims on the Portal

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

- Professional claims
- Institutional claims
- Dental claims
- Compound drug claims
- Noncompound drug claims

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

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

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

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

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

- Type of bill
- Patient status
- Visit point of origin
- Visit priority
- Diagnosis codes
- Revenue codes
- Procedure codes
- HIPPS (Health Insurance Prospective Payment System) codes
- Modifiers

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

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

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

- Diagnosis codes
- NDCs (National Drug Codes)

- Place of service codes
- Professional service codes
- Reason for service codes
- Result of service codes

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

Topic #344

Electronic Claim Submission

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

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

Topic #2045

Electronic Claim Submission for Durable Medical Equipment

Electronic claims for DME (durable medical equipment) must be submitted using the 837P (837 Health Care Claim: Professional) transaction. Electronic claims for DME submitted using any transaction other than the 837P will be denied.

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

Provider Electronic Solutions Software

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

Topic #2333

Point-of-Sale Claims

BadgerCare Plus, Medicaid, and SeniorCare use a voluntary pharmacy POS (Point-of-Sale) electronic claims management system. The POS system enables providers to submit electronic pharmacy claims for legend and OTC (over-the-counter) drugs in an online, real-time environment.

The pharmacy system verifies member enrollment and monitors pharmacy policy. Within seconds of submitting a real-time claim, these processes are completed and the provider receives an electronic response indicating payment or denial.

National Council for Prescription Drug Programs D.0 Telecommunications Standard Claims

BadgerCare Plus, Medicaid, and SeniorCare use the NCPDP (National Council for Prescription Drug Programs) Telecommunication Standard Format Version D.0. Using this format, providers are able to complete the following:

- Initiate new claims and reverse and resubmit previously paid real-time claims

- Submit individual claims or a batch of claims for the same member within one electronic transmission
- Submit claims for compound drugs

Cardholder ID

If the member identification number submitted on a claim is not the most current member ID on file with ForwardHealth, the claim will be denied and the Cardholder ID (302-C2) field on the claim response will include the current member ID.

Other Amount Claimed Submitted

Wisconsin Medicaid does not reimburse for charges (i.e., postage, shipping, administrative costs) indicated in the Other Amount Claimed Submitted (480-H9) field. Claims will be denied if a provider indicates a charge in the Other Amount Claimed Submitted field.

National Provider Identifier On Compound and Noncompound Claims

Billing Providers

An NPI (National Provider Identifier) is required on compound and noncompound claims. Providers who do not have a unique NPI for each enrollment are required to select one Medicaid enrollment as the "default" enrollment. Claims will be processed using the provider file information from the default enrollment.

Prescriber ID and Prescriber ID Qualifier

An NPI is the only identifier accepted on compound and noncompound claims, including paper claims. Billing providers are required to make every effort possible to obtain the prescribing provider's NPI. Only in instances when the billing provider is unable to obtain the prescriber's NPI may the billing provider indicate their own NPI in the Prescriber ID field. DEA (Drug Enforcement Agency) numbers, including "default" DEA numbers, are not accepted for the Prescriber ID on pharmacy claims.

Direct Data Entry of Claims on the Portal

Claims for compound drugs and noncompound drugs may be submitted to ForwardHealth using DDE (Direct Data Entry) on the ForwardHealth Portal. DDE is an online application that allows providers to submit claims directly to ForwardHealth.

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

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

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

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

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. PES (Provider Electronic Solutions) software allows providers to submit NCPDP 1.1 batch format pharmacy transactions, reverse claims, and check claim status. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI (Electronic Data Interchange) Helpdesk.

Topic #16937

Electronic Claims and Claim Adjustments With Other Commercial Health Insurance Information

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

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

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

Adjustments to Claims Submitted Prior to June 16, 2014

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

Topic #365

Extraordinary Claims

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

Topic #4837

HIPAA-Compliant Data Requirements

Procedure Codes

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

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

Provider Numbers

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

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

Topic #20057

Home Ventilator Rental

When submitting claims for primary and back-up or secondary home ventilator rental, providers are required to indicate one of the following allowable HCPCS (Healthcare Common Procedure Coding System) procedure codes, as applicable:

- E0465 (Home ventilator; any type, used with invasive interface, [e.g., tracheostomy tube])
- E0466 (Home ventilator; any type, used with non-invasive interface, [e.g., mask, chest shell])

Note: Due to advances in technology, some devices have multiple capabilities, including functioning as a BiPap, C-Pap, or RAD (Respiratory Assist Device). These devices should not be submitted on a claim using the above procedure codes for a home ventilator.

Modifiers

Providers are required to include the following modifiers, as appropriate on claims and PA (prior authorization) requests for primary and back-up or secondary home ventilator rental:

- RR (Rental)
- TW (Back-up or secondary home ventilator)

Unit Measure

One unit represents one **calendar month** of rental. Providers are required to indicate a unit of 1 on claims and PA requests to represent one **calendar month** of rental.

Date of Service

Providers should only indicate a single DOS (date of service)on claims for primary and back-up or secondary home ventilator rental. The DOS can be any one date within the calendar month. Claims with span billing will be denied.

Topic #562

Managed Care Organizations

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

Topic #10837

Note Field for Most Claims Submitted Electronically

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

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

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

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

- Professional
- Institutional
- Dental

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

Claims Submitted via 837 Health Care Claim Transactions

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

Topic #17757

Providers are reminded to submit claims for services with the most accurate procedure codes for all services and equipment. The DME (Durable Medical Equipment) Index includes allowable procedure codes, associated maximum allowable fees, and POS (place of service) information.

Diabetic Shoes or Inserts

When submitting claims for diabetic shoes or inserts, providers are required to do the following:

- Record each procedure code representing the shoe or unit as a separate line item. Refer to the specific procedure code description to determine the number of units.
- Indicate the RT (right side) or LT (left side) modifier, as appropriate, on separate line items of the claim.

Orthopedic or Corrective Shoes and Foot Orthotics

When submitting claims for orthopedic or corrective shoes and foot orthotics, providers are required to record each procedure code representing the shoe or unit as a separate line item. Refer to the specific procedure code description to determine the number of units:

- If code description indicates "each," indicate the RT (right side) or LT (left side) modifier, as appropriate, on separate line items of the claim or PA (prior authorization) request.
- If the code description indicates "pair," indicate no modifier. Submit as one line item as a unit of one on the claim or PA request.

Topic #561

Paper Claim Form Preparation and Data Alignment Requirements

Optical Character Recognition

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

The data alignment requirements do not apply to the Compound Drug Claim (F-13073 (04/2017)) form and the Noncompound Drug Claim (F-13072 (04/2017)) form.

Speed and Accuracy of Claims Processing

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

OCR software speeds paper claim processing, but only if providers prepare their claim forms correctly. In order for OCR software to read the

claim form accurately, the quality of copy and the alignment of text within individual fields on the claim form need to be precise. If data are misaligned, the claim could be processed incorrectly. If data cannot be read by the OCR software, the process will stop and the electronic image of the claim form will need to be reviewed and keyed manually. This will cause an increase in processing time.

Handwritten Claims

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

Use Original Claim Forms

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

Use Laser or Ink Jet Printers

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

Alignment

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

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

The following sample claim forms demonstrate correct and incorrect alignment:

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

Clarity

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

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

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

- Do not highlight any information on the claim form. Highlighted information blackens when it is imaged, and the OCR software will be unable to read it.

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

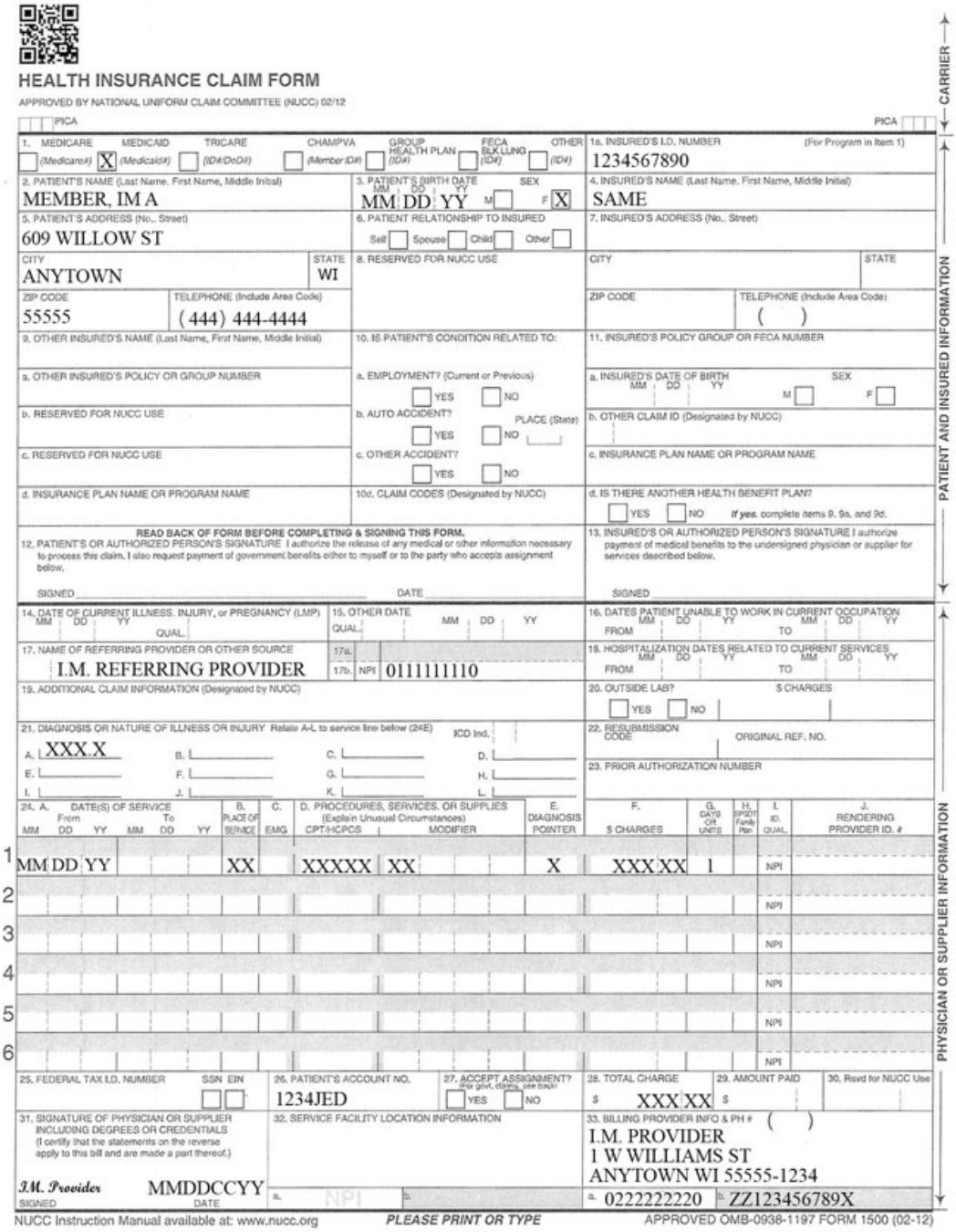
Staples, Correction Liquid, and Correction Tape

The use of staples, correction liquid, correction tape, labels, or stickers on claim forms should be avoided. Staples need to be removed from claim forms before they can be imaged, which can damage the claim and cause a delay in processing time. Correction liquid, correction tape, labels, and stickers can cause data to be read incorrectly or cause the OCR process to stop, prompting manual review. If the form cannot be read by the OCR software, it will need to be keyed manually from an electronic image.

Additional Diagnosis Codes

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

Sample of a Correctly Aligned 1500 Health Insurance Claim Form



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
MEMBER, IM A	MM DD YY M [ ] F [X]	SAME
5. PATIENT'S ADDRESS (No., Street): 609 WILLOW ST	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street)
CITY: ANYTOWN / STATE: WI	8. RESERVED FOR NUCC USE	CITY / STATE
ZIP CODE: 55555 / TELEPHONE (Include Area Code): (444) 444-4444		ZIP CODE / TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [ ]	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY / QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: I.M. REFERRING PROVIDER	17a. / 17b. NPI 0111111110	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / MM DD YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES [ ] NO [ ] / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.		22. RESUBMISSION CODE / ORIGINAL REF. NO.
A. XXX.X B. C. D. / E. F. G. H. / I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]	28. TOTAL CHARGE $ XXX XX	29. AMOUNT PAID $	30. Rsvd for NUCC Use
	1234JED				

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
I.M. Provider MMDDCCYY SIGNED DATE	a. NPI b.	I.M. PROVIDER 1 W WILLIAMS ST ANYTOWN WI 55555-1234 a. 0222222220 b. ZZ123456789X

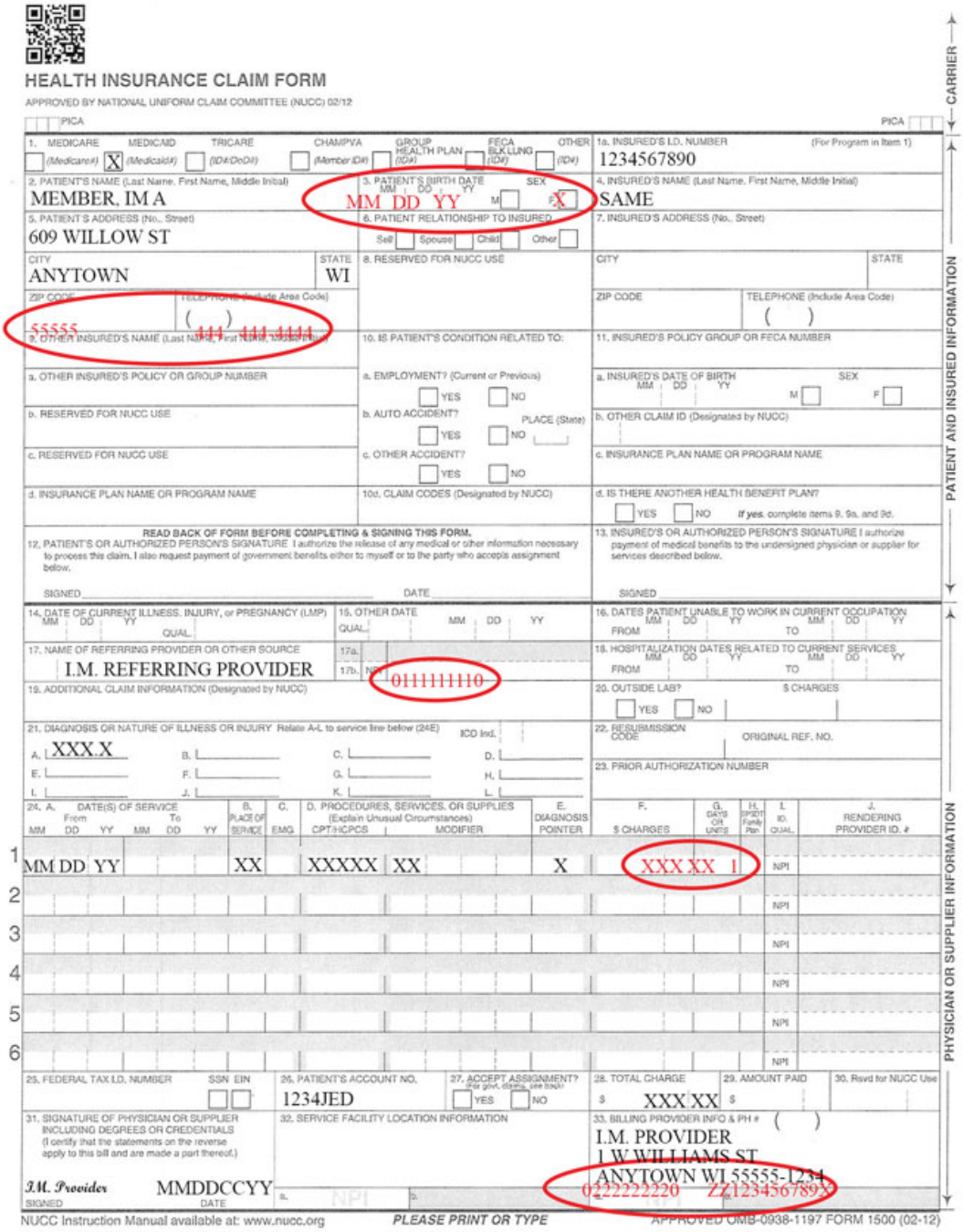
NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample of an Incorrectly Aligned 1500 Health Insurance Claim Form



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

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

CITY: ANYTOWN | STATE: WI

8. RESERVED FOR NUCC USE

CITY | STATE

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

ZIP CODE | TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES | NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

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

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

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

17a.

17b. NPI 0111111110

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO $ CHARGES

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

A. XXX.X B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. 1234JED

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

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

I.M. Provider MMDDCCYY

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

I.M. PROVIDER
1 W WILLIAMS ST
ANYTOWN WI 55555-1234
0222222220 ZZ1234567893

CARRIER

PATIENT AND INSURED INFORMATION

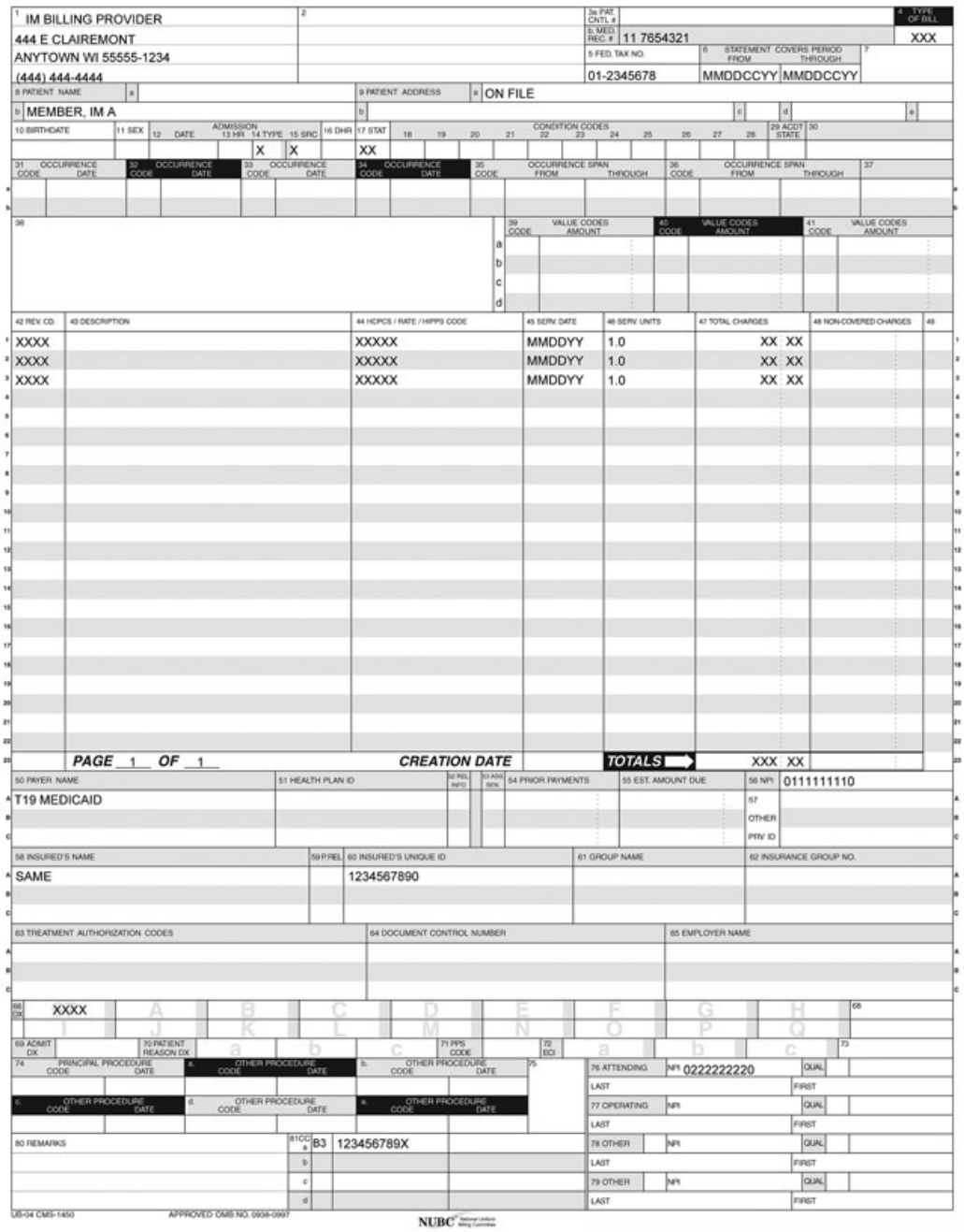
PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Sample of a Correctly Aligned UB-04 Claim Form



1 IM BILLING PROVIDER 444 E CLAIREMONT ANYTOWN WI 55555-1234 (444) 444-4444	3a PAT. CNTL #
	3b MED. REC. # 11 7654321
	4 TYPE OF BILL XXX
	5 FED. TAX NO. 01-2345678
	6 STATEMENT COVERS PERIOD FROM MMDDCCYY THROUGH MMDDCCYY
8 PATIENT NAME b MEMBER, IM A	9 PATIENT ADDRESS a ON FILE
10 BIRTHDATE	11 SEX
	12 ADMISSION DATE
	13 HR
	14 TYPE X
	15 SRC X
	16 DHR
	17 STAT XX
	18–28 CONDITION CODES
	29 ACDT STATE
	30
31–34 OCCURRENCE CODE / DATE	
35–36 OCCURRENCE SPAN CODE / FROM / THROUGH	
37	
38	39 VALUE CODES CODE / AMOUNT
	40 VALUE CODES CODE / AMOUNT
	41 VALUE CODES CODE / AMOUNT

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

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
T19 MEDICAID					

56 NPI 0111111110; 57 OTHER; PRV ID

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

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX XXXX; A–Q; 68

69 ADMIT DX; 70 PATIENT REASON DX; a b c; 71 PPS CODE; 72 ECI; a b c; 73

74 PRINCIPAL PROCEDURE CODE / DATE; a. OTHER PROCEDURE CODE / DATE; b. OTHER PROCEDURE CODE / DATE; 75

c. OTHER PROCEDURE CODE / DATE; d. OTHER PROCEDURE CODE / DATE; e. OTHER PROCEDURE CODE / DATE

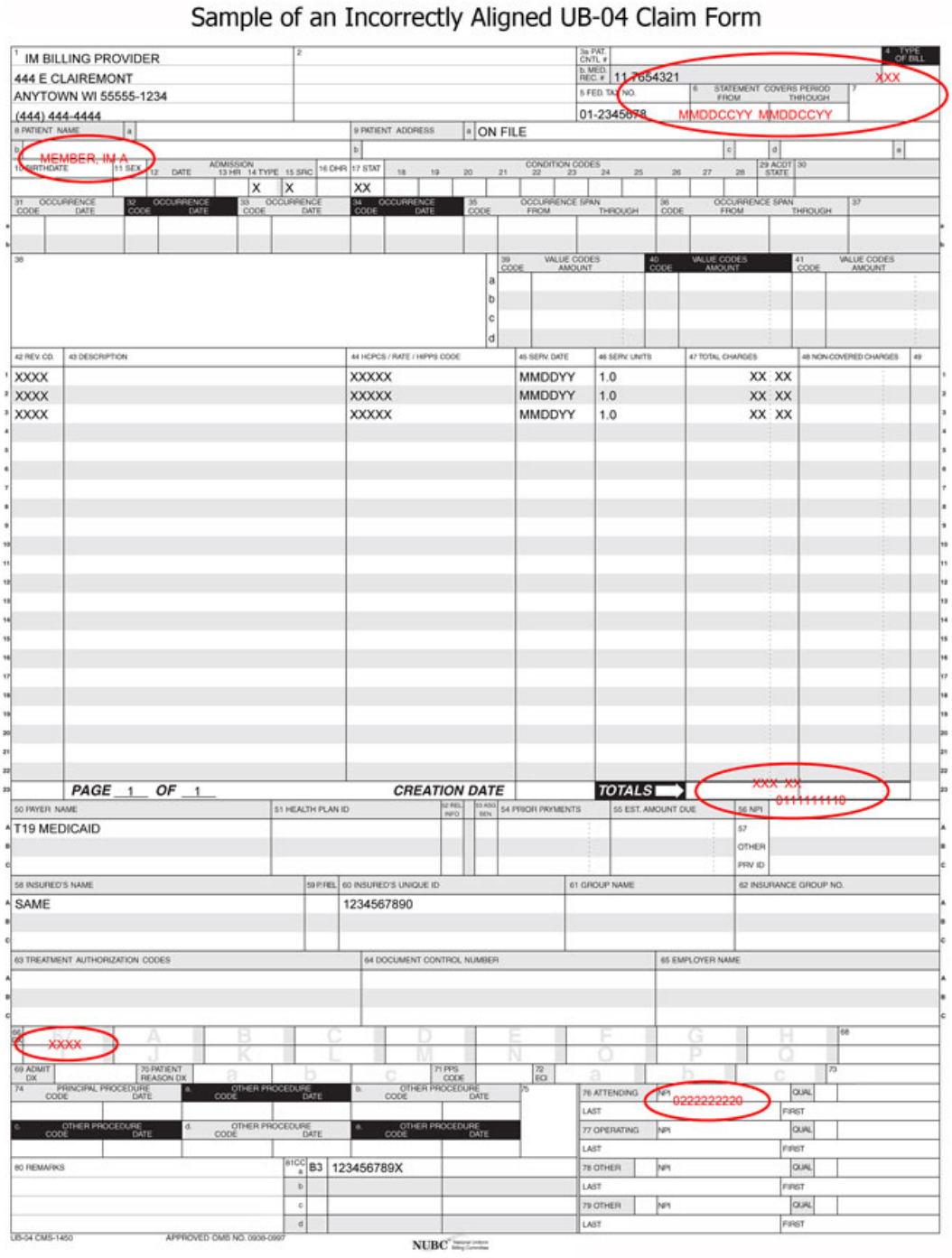
76 ATTENDING	NPI 0222222220	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS

81CC a B3 123456789X; b; c; d

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

Sample of an Incorrectly Aligned UB-04 Claim Form



Topic #2046

Paper Claim Submission

Paper claims for DME (durable medical equipment), except for diabetic supplies, must be submitted using the 1500 Health Insurance Claim Form ((02/12)).

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.

Topic #9117

Paper Claim Submission for Diabetic Supplies

Paper claims for diabetic supplies must be submitted on a Noncompound Drug Claim (F-13072 (04/2017)) form with two exceptions:

- There is an approved PA (prior authorization) on file.
- The claim is a Medicare Part B crossover claim.

Submit completed paper claim forms for payment to the following address:

ForwardHealth
313 Blettner Blvd
Madison WI 53784

To order paper claim forms, providers may call Provider Services, or write to the following address:

ForwardHealth
Form Reorder
313 Blettner Blvd
Madison, WI 53784

Providers should indicate the number of forms needed in their written request.

Topic #22797

Payment Integrity Review Supporting Documentation

Providers are notified that an individual claim is subject to PIR (payment integrity review) through a message on the Portal when submitting claims. When this occurs, providers have seven calendar days to submit the supporting documentation that must be retained in the member's record for the specific service billed. This documentation must be attached to the claim. The following are examples of documentation providers may attach to the claim; however, this list is not exhaustive, and providers may submit any documentation available to substantiate payment:

- Case management or consultation notes
- Durable medical equipment or supply delivery receipts or proof of delivery and itemized invoices or bills
- Face-to-face encounter documentation
- Individualized plans of care and updates
- Initial or program assessments and questionnaires to indicate the start DOS (date of service)
- Office visit documentation
- Operative reports
- Prescriptions or test orders
- Session or service notice for each DOS
- Testing and lab results
- Transportation logs
- Treatment notes

Providers must attach this documentation to the claim at the time of, or up to seven days following, submission of the claim. A claim may be denied if the supporting documentation is not submitted. If a claim is denied, providers may submit a new claim with the required documentation for reconsideration. To reduce provider impact, claims reviewed by the OIG (Office of the Inspector General) will be processed as quickly as possible, with an expected average adjudication of 30 days.

Topic #10177

Prior Authorization Numbers on Claims

Providers are not required to indicate a PA (prior authorization) number on claims. ForwardHealth interChange matches the claim with the appropriate approved PA request. ForwardHealth's RA (Remittance Advice) and the 835 (835 Health Care Claim Payment/Advice) report to the provider the PA number used to process a claim. If a PA number is indicated on a claim, it will not be used and it will have no effect on processing the claim.

When a PA requirement is added to the list of drugs requiring PA and the effective date of a PA falls in the middle of a billing period, two separate claims that coincide with the presence of PA for the drug must be submitted to ForwardHealth.

Topic #3868

Referring Providers

Claims for DME (durable medical equipment) require the referring provider's name and NPI (National Provider Identifier).

Topic #10637

Reimbursement Reduction for Most Paper Claims

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

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

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

The reimbursement reduction applies to the following paper claims:

- 1500 Health Insurance Claim Form ((02/12))
- UB-04 (CMS 1450) Claim Form
- Compound Drug Claim (F-13073 (04/2017)) form
- Noncompound Drug Claim (F-13072 (04/2017)) form

Exceptions to Paper Claim Reimbursement Reduction

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

- In-state emergency providers
- Out-of-state providers
- Medicare crossover claims
- Any claims that ForwardHealth requires additional supporting information to be submitted on paper, such as:
  - Hysterectomy claims must be submitted along with an Acknowledgment of Receipt of Hysterectomy Information (F-01160 (06/2013)) form
  - Sterilization claims must be submitted along with a paper Consent for Sterilization (F-01164 (10/2008)) form.
  - Claims submitted to Timely Filing appeals must be submitted on paper with a Timely Filing Appeals Request (F-13047 (08/2015)) form.
  - In certain circumstances, drug claims must be submitted on paper with a Pharmacy Special Handling Request (F-13074 (04/2014)) form.
  - Claims submitted with four or more NDCs (National Drug Codes) for compound and noncompound drugs with specific and non-specific HCPCS (Healthcare Common Procedure Coding System) procedure codes.

Topic #3504

Requirements for Compression Garments

In this topic, the term "compression garments" is used to refer to both gradient compression garments **and** compression burn garments, unless otherwise stated.

The following table contains information required on claims submissions for compression garments.

Procedure Code	Claim Attachment?[1]	RT and/or LT Modifier Required?	Reorder (RA) Modifier?[2]	Allowable ICD (International Classification of Diseases) Diagnosis Codes Without Prior Authorization[3]
A6501	Yes	No	Yes	T30.0, T30.4
A6502	No	No	Yes	T20.00XA*–T20.79XS* (Excluding codes with "9" as the sixth character), T26.21XA*–T26.22XS*, T26.41XA*–T26.42XS*
A6503	No	No	Yes	T20.00XA*–T20.79XS* (Excluding codes with "9" as the sixth character), T26.21XA*–T26.22XS*, T26.41XA*–T26.42XS*, T26.51XA*–T26.52XS*
A6504	No	Yes	Yes	T23.001A*–T23.792S* (Excluding codes with "9" as the sixth character)
A6505	No	Yes	Yes	T22.00XA*–T22.092S* (Excluding codes with "9" as the sixth character), T22.111A*–T22.192S* (Excluding codes with "9" as the sixth character), T22.211A*–T22.493S* (Excluding codes with "9" as the sixth character), T22.511A*–T22.592S* (Excluding codes with "9" as the sixth character), T22.611A*–T23.792S* (Excluding codes with "9" as the sixth character)
A6506	No	Yes	Yes	T22.00XA*–T22.092S* (Excluding codes with "9" as the sixth character), T22.111A*–T22.192S* (Excluding codes with "9" as the sixth character), T22.211A*–T22.493S* (Excluding codes with "9" as the sixth character), T22.511A*–T22.592S* (Excluding codes with "9" as the sixth character), T22.611A*–T23.792S* (Excluding codes with "9" as the sixth character)
A6507	No	Yes	Yes	T24.001A*–T25.792S* (Excluding codes with "9" as the sixth character)
A6508	No	Yes	Yes	T24.001A*–T25.792S* (Excluding codes with "9" as the sixth character)
A6509	No	No	Yes	T21.00XA*–T21.79XS*
A6510	No	No	Yes	T21.00XA*–T22.099S*, T22.10XA*–T22.392S* (Excluding codes with "9" as the sixth character), T22.40XA*–T22.499S*, T22.50XA*–T22.792S* (Excluding codes with "9" as the sixth character)
A6511	No	No	Yes	T21.30XA*–T21.39XS*, T21.70XA*–T21.79XS*
A6512	Yes	No	Yes	T30.0, T30.4
A6513	No	No	Yes	T20.00XA*–T20.79XS* (Excluding codes with "9" as the sixth

				character), T26.01XA*–T26.02XS*, T26.21XA*–T26.22XS*, T26.41XA*–T26.42XS*, T26.51XA*–T26.52XS*
A6530	No	Yes	No	I70.231–I70.249, I70.331–I70.349, I70.431–I70.449, I70.531–I70.549, I70.631–I70.649, I70.731–I70.749, I83.011–I83.029, I83.11–I83.12, I83.211–I83.813, I83.891–I83.893, I83.91–I83.93, I87.001–I87.093 (Excluding codes with "9" as the sixth character), I87.2, I89.0, L97.111–L97.129, L97.211–L97.229, L97.311–L97.329, L97.411–L97.429, L97.511–L97.529, L97.811–L97.829, L97.911–L97.929, O12.00, O12.04, O12.05, O12.20, O12.24. O12.25, O26.00, Q82.0
A6531	No	Yes	No	I70.231–I70.249, I70.331–I70.349, I70.431–I70.449, I70.531–I70.549, I70.631–I70.649, I70.731–I70.749, I83.011–I83.029, I83.11–I83.12, I83.211–I83.813, I83.891–I83.893, I83.91–I83.93, I87.001–I87.093 (Excluding codes with "9" as the sixth character), I87.2, I89.0, L97.111–L97.129, L97.211–L97.229, L97.311–L97.329, L97.411–L97.429, L97.511–L97.529, L97.811–L97.829, L97.911–L97.929, O12.00, O12.04, O12.05, O12.20, O12.24. O12.25, O26.00, Q82.0
A6532	No	Yes	No	I70.231–I70.249, I70.331–I70.349, I70.431–I70.449, I70.531–I70.549, I70.631–I70.649, I70.731–I70.749, I83.011–I83.029, I83.11–I83.12, I83.211–I83.813, I83.891–I83.893, I83.91–I83.93, I87.001–I87.093 (Excluding codes with "9" as the sixth character), I87.2, I89.0, L97.111–L97.129, L97.211–L97.229, L97.311–L97.329, L97.411–L97.429, L97.511–L97.529, L97.811–L97.829, L97.911–L97.929, O12.00, O12.04, O12.05, O12.20, O12.24. O12.25, O26.00, Q82.0
A6533	No	Yes	No	I70.231–I70.249, I70.331–I70.349, I70.431–I70.449, I70.531–I70.549, I70.631–I70.649, I70.731–I70.749, I83.011–I83.029, I83.11–I83.12, I83.211–I83.813, I83.891–I83.893, I83.91–I83.93, I87.001–I87.093 (Excluding codes with "9" as the sixth character), I87.2, I89.0, L97.111–L97.129, L97.211–L97.229, L97.311–L97.329, L97.411–L97.429, L97.511–L97.529, L97.811–L97.829, L97.911–L97.929, O12.00, O12.04, O12.05, O12.20, O12.24. O12.25, O26.00, Q82.0
A6534	No	Yes	No	I70.231–I70.249, I70.331–I70.349, I70.431–I70.449, I70.531–I70.549, I70.631–I70.649, I70.731–I70.749, I83.011–I83.029, I83.11–I83.12, I83.211–I83.813, I83.891–I83.893, I83.91–I83.93, I87.001–I87.093 (Excluding codes with "9" as the sixth character), I87.2, I89.0, L97.111–L97.129, L97.211–L97.229, L97.311–L97.329, L97.411–L97.429, L97.511–L97.529, L97.811–L97.829, L97.911–L97.929, O12.00, O12.04, O12.05, O12.20, O12.24, O12.25, O26.00, Q82.0

A6535	No	Yes	No	I70.231–I70.249, I70.331–I70.349, I70.431–I70.449, I70.531–I70.549, I70.631–I70.649, I70.731–I70.749, I83.011–I83.029, I83.11–I83.12, I83.211–I83.813, I83.891–I83.893, I83.91–I83.93, I87.001–I87.093 (Excluding codes with "9" as the sixth character), I87.2, I89.0, L97.111–L97.129, L97.211–L97.229, L97.311–L97.329, L97.411–L97.429, L97.511–L97.529, L97.811–L97.829, L97.911–L97.929, O12.00, O12.04, O12.05, O12.20, O12.24, O12.25, O26.00, Q82.0
A6536	No	Yes	No	I70.231–I70.249, I70.331–I70.349, I70.431–I70.449, I70.531–I70.549, I70.631–I70.649, I70.731–I70.749, I83.011–I83.029, I83.11–I83.12, I83.211–I83.813, I83.891–I83.893, I83.91–I83.93, I87.001–I87.093 (Excluding codes with "9" as the sixth character), I87.2, I89.0, L97.111–L97.129, L97.211–L97.229, L97.311–L97.329, L97.411–L97.429, L97.511–L97.529, L97.811–L97.829, L97.911–L97.929, O12.00, O12.04, O12.05, O12.20, O12.24, O12.25, O26.00, Q82.0
A6537	No	Yes	No	I70.231–I70.249, I70.331–I70.349, I70.431–I70.449, I70.531–I70.549, I70.631–I70.649, I70.731–I70.749, I83.011–I83.029, I83.11–I83.12, I83.211–I83.813, I83.891–I83.893, I83.91–I83.93, I87.001–I87.093 (Excluding codes with "9" as the sixth character), I87.2, I89.0, L97.111–L97.129, L97.211–L97.229, L97.311–L97.329, L97.411–L97.429, L97.511–L97.529, L97.811–L97.829, L97.911–L97.929, O12.00, O12.04, O12.05, O12.20, O12.24, O12.25, O26.00, Q82.0
A6538	No	Yes	No	I70.231–I70.249, I70.331–I70.349, I70.431–I70.449, I70.531–I70.549, I70.631–I70.649, I70.731–I70.749, I83.011–I83.029, I83.11–I83.12, I83.211–I83.813, I83.891–I83.893, I83.91–I83.93, I87.001–I87.093 (Excluding codes with "9" as the sixth character), I87.2, I89.0, L97.111–L97.129, L97.211–L97.229, L97.311–L97.329, L97.411–L97.429, L97.511–L97.529, L97.811–L97.829, L97.911–L97.929, O12.00, O12.04, O12.05, O12.20, O12.24, O12.25, O26.00, Q82.0
A6539	No	No	No	I83.019, I83.029, I86.1–I86.3, I87.2, I89.0, O12.01–O12.03, O12.04, O12.05, O12.21–O12.23, O12.24, O12.25, O26.01–O26.03, Q82.0
A6540	No	No	No	I83.019, I83.029, I86.1–I86.3, I87.2, I89.0, O12.01–O12.03, O12.04, O12.05, O12.21–O12.23, O12.24, O12.25, O26.01–O26.03, Q82.0
A6541	No	No	No	I83.019, I83.029, I86.1–I86.3, I87.2, I89.0, O12.01–O12.03, O12.04, O12.05, O12.21–O12.23, O12.24, O12.25, O26.01–O26.03, Q82.0
A6545	No	Yes	Yes	I83.019, I83.029, I86.1–I86.3, I87.2, I89.0, O12.01–O12.03,

				O12.04, O12.05, O12.21–O12.23, O12.24, O12.25, O26.01–O26.03, Q82.0
A6549	Yes	Yes	Yes	I83.019, I83.029, I86.1–I86.3, I87.2, I89.0, O12.01–O12.03, O12.04, O12.05, O12.21–O12.23, O12.24, O12.25, O26.01–O26.03, Q82.0
S8420	Yes	Yes	Yes	I97.2
S8421	No	Yes	No	I97.2
S8422	Yes	Yes	Yes	I97.2
S8423	Yes	Yes	Yes	I97.2
S8424	No	Yes	No	I97.2
S8425	Yes	Yes	Yes	I97.2
S8426	Yes	Yes	Yes	I97.2
S8427	No	Yes	No	I97.2
S8428	No	Yes	No	I97.2
S8429	Yes	Yes	Yes	I83.011–I83.029, I83.11, I83.12, I83.211–I83.812, I83.891–I83.893, I83.91–I83.93, I86.1–I86.3, I87.001–I87.093 (Excluding codes with "9" as the sixth character), I87.2, I87.9, I89.0, I97.2, O12.01–O12.03, O12.04, O12.05, O12.21–O12.23, O12.24, O12.25, O26.01–O26.03, Q82.0

[1]A "Yes" in this column indicates claim attachments are required with this procedure code. Refer to the Claim Attachment Requirements section below for more information.

[2]A "Yes" in this column indicates the compression garment must be billed with an RA modifier if the provider is replacing the member's compression garment using measurements currently on file.

[3]When a member has one of the allowable diagnoses listed for the procedure code, PA (prior authorization) is required only if the life expectancy has been exceeded. If the member has an allowable diagnosis for the requested procedure code, the diagnosis code must be entered in the claim's primary diagnosis field. If the member has a diagnosis not included in the listed allowable diagnoses, providers may submit a PA request.

*This code range requires a seventh character. These characters can be "A" for initial encounter, "D" for subsequent encounter, or "S" for sequela. This seventh character must always be preceded by six characters. If more characters are needed for the code to contain seven, an "X" should be used as a placeholder (e.g., T20.00XA).

Claim Attachment Requirements

The use of a "custom" or "not otherwise specified" procedure code for a gradient compression garment on a claim should only be used in exceptional cases. For "custom" or "not otherwise specified" gradient compression garments, each attachment must document why a "custom" or "not otherwise specified" procedure code was used instead of a non-custom compression garment procedure code. All compression burn garments are considered custom and therefore also require attachments to be submitted with the claim.

When using procedure codes marked with a "Yes" under "Claim Attachment" in the table above, ForwardHealth requires the following attachments when submitting claims:

- The physician prescription. Refer to Prescription Requirements for more information.
- The form or document used to record the measurements used for the garment order/fabrication, which includes:
  - The date the measurements were taken or date(s) the measurements were re-affirmed, if applicable. If a provider re-affirms the previous measurements, ForwardHealth recommends the provider sign and date the same form used in the previous order if the previous measurements remain accurate.

- The name and credentials of the individual taking or affirming the measurements (i.e., the certified fitter, ABC (American Board for Certification in Orthotics and Prosthetics)-certified orthotist or prosthetist, or licensed physical therapist or occupational therapist).
- The provider's justification for the use of a "custom" or "not otherwise specified" procedure code. To justify use of a custom or not otherwise specified procedure code, ForwardHealth recommends identifying the extremity's circumferential measurement that did not allow fitting the member with a garment represented by a specified code by circling the measurement on the form, adding a notation in the margin of the measurement or order form, and/or including a narrative as an additional record. One example of when a custom compression garment may be justified is when the body part or segment is an atypical shape. However, a body part or segment that is simply larger than average would not justify a custom or not otherwise specified compression garment and a specified procedure code should be used on the claim (and attachments should not be submitted).

- The provider invoice with the specific garment(s) clearly identified.

For those claims submitted without PA, the allowable diagnosis code (listed in the table above) and any required modifiers must be on the claim.

Modifiers RT and LT Required on Claims

Providers are required to include modifier RT and/or LT on claims submitted for the procedure codes marked with "Yes" under "RT and/or LT Modifier Required?" in the table (A6504–A6508, A6530–A6538, A6549, and S8420–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 A6504–A6508, A6530–A6538, A6549, and S8420–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 line and modifier LT on a second detail line. ForwardHealth will not accept modifier 50 (Bilateral) for processing claims for compression garments.

Claims for pantyhose, waist-high garments, vests, panties, or facial masks should **not** include the RT and LT modifiers.

Modifier RA for Custom Compression Garment Reorders

If a provider is replacing a member's compression garment using measurements currently on file, the provider is required to use the RA modifier. However, if the garment is being replaced based on new measurements, even if there is no change to the measurements currently on file, the providers should not use the RA modifier.

The use of the RA modifier does not change the requirement to submit supporting documentation with the claim for custom and not otherwise specified procedure codes. Refer to Claim Attachment Requirements for more information.

Providers are reminded that all claims submitted must be supported by records maintained by the provider in accordance with Wis. Admin. Code § DHS 106.02(9)(e)1. In addition, the provider record must include confirmation of delivery of the service or item to the member. For DME (durable medical equipment), the DOS (date of service) is the date the item is delivered to the member.

Provider records that do not support the procedure codes listed on the claim are subject to claim denial, reduction in reimbursement, or recoupment.

Claim Submittal Recommendations

If a member requires two different compression garments per body segment, the provider should submit both compression garment procedure codes on one claim with the required supporting documentation.

If a member requires more than one compression garment (e.g., one arm, two legs, and a non-elastic wrap), the provider is urged to submit all the member's required compression garments on one claim, rather than submitting one claim for each garment. While ForwardHealth supports a provider's flexibility in submitting claims, submitting claims as suggested may reduce denials for insufficient documentation (i.e., insufficient to either support the claim or to refute the apparent duplication of services).

Refer to Prior Authorization for Burn and Gradient Compression Garments for information on PA.

Topic #4817

Submitting Paper Attachments With Electronic Claims

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

Paper attachments that go with electronic claim transactions must be submitted with the Claim Form Attachment Cover Page (F-13470 (03/2023)). Providers are required to indicate an ACN (attachment control number) for paper attachment(s) submitted with electronic claims. (The ACN is an alphanumeric entry between 2 and 80 digits assigned by the provider to identify the attachment.) The ACN must be indicated on the cover page so that ForwardHealth can match the paper attachment(s) to the correct electronic claim.

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

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

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

This does not apply to compound and noncompound claims.

Topic #11677

Uploading Claim Attachments Via the Portal

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

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

Claim Types

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

- Professional.
- Institutional.
- Dental.

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

Document Formats

Providers are able to upload documents in the following formats:

- JPEG (Joint Photographic Experts Group) (.jpg or .jpeg).
- PDF (Portable Document Format) (.pdf).
- Rich Text Format (.rtf).
- Text File (.txt).

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

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

Uploading Claim Attachments

Claims Submitted by Direct Data Entry

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

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

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

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

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

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

Responsibilities

Topic #516

Accuracy of Claims

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

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

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

Topic #3144

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.

Topic #366

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.

Topic #22798

Payment Integrity Review Program

The PIR (Payment Integrity Review) program:

- Allows the OIG (Office of the Inspector General) to review claims prior to payment.
- Requires providers to submit all required documentation to support approval and payment of PIR-selected claims.

The goal of the PIR program is to further safeguard the integrity of Wisconsin DHS (Department of Health Services)-administered public assistance programs, such as BadgerCare Plus and Wisconsin Medicaid, from fraud, waste, and abuse by:

- Proactively reviewing claims prior to payment to ensure federal and state requirements are met.
- Providing enhanced, compliance-based technical assistance to meet the specific needs of providers.
- Increasing the monitoring of benefit and service areas that are at high risk for fraud, waste, and abuse.

Fraud, waste, and abuse includes the potential overutilization of services or other practices that directly or indirectly result in unnecessary

program costs, such as:

- Billing for items or services that were not rendered.
- Incorrect or excessive billing of CPT (Current Procedural Terminology) or HCPCS (Healthcare Common Procedure Coding System) procedure codes.
- Unit errors, duplicate charges, and redundant charges.
- Billing for services outside of the provider specialty.
- Insufficient documentation in the medical record to support the charges billed.
- Lack of medical necessity or noncovered services.

Note: Review of claims in the PIR process does not preclude claims from future post-payment audits or review.

Payment Integrity Review Program Overview

When a provider submits a claim electronically via the ForwardHealth Portal, the system will display a message if the claim is subject to PIR. The message will instruct providers to submit supporting documentation with the claim. Providers have seven days to attach documentation to claims. The claim will automatically be denied if documentation is not attached within seven days.

Claims that meet PIR requirements may be eligible for payment once they are accurate and complete. Claims that do not meet PIR requirements may be denied or repriced. In these cases, providers are encouraged to:

- Review the EOB (Explanation of Benefits) for billing errors.
- Refer to the Online Handbook for claims documentation and program policy requirements.
- Correct the PIR billing errors and resubmit the claim.

Types of Payment Integrity Review

There are three types of review in the PIR program:

- Claims Review
- Pre-Payment Review
- Intermediate Sanctions

For each type of review, providers must submit supporting documentation that substantiates the CPT and/or HCPCS procedure codes on the claim.

	Claims Review	Pre-Payment Review	Intermediate Sanction
How claims are selected for review	A sampling of claims is selected from providers, provider types, benefit areas, or service codes identified by the OIG.	The OIG has reasonable suspicion that a provider is violating program rules.	The OIG has established cause that a provider is violating program rules.
How providers are notified that selected claims are under review	The provider receives a message on the Portal.	The provider receives a Provider Notification letter and message on the Portal.	The provider receives a Notice of Intermediate Sanction letter and message on the Portal.
How to successfully exit the review	Claims are selected for review based on a pre-determined percentage of claim submissions of specific criteria. All providers who bill the service codes that are part of this criteria are subject to review, regardless of their compliance rates.	75 percent of a provider's reviewed claims over a three-month period must be paid as submitted. The number of claims submitted during the three-month period may not drop more than 10 percent of the provider's volume of submitted claims prior to pre-	The provider must meet parameters set during the sanction process.

		payment review.	

Claims Review

In accordance with Wis. Admin. Code § DHS 107.02(2), the OIG may identify providers, provider types, benefit areas, or procedure codes, and based on those criteria, choose a sampling of claims to review prior to payment. When a claim submitted through the Portal that meets one of these criteria is selected for review, a message will appear on the Portal to notify the provider that the claim must be submitted with all necessary supporting documentation within seven calendar days. The claim will automatically be denied if documentation is not attached within seven days.

Pre-Payment Review

In accordance with Wis. Admin Code § DHS 106.11, if the OIG has cause to suspect that a provider is prescribing or providing services that are not necessary for members, are in excess of the medical needs of members, or do not conform to applicable professional practice standards, the provider's claims may be subject to review prior to payment. Providers who are subject to this type of review will receive a Pre-Payment Review Initial Notice letter, explaining that the OIG has identified billing practice or program integrity concerns in the provider's claims that warrant the review. This notice details the steps the provider must follow to substantiate their claims and the length of time their claims will be subject to review. Additionally, a message will appear on the Portal when the provider submits claims to notify the provider that certain claims must be submitted with all necessary supporting documentation within seven calendar days. The claim will automatically be denied if documentation is not attached within seven days.

For a provider to be considered for removal from pre-payment review, both of the following conditions must be met:

- 75 percent of the provider's reviewed claims over a three-month period are approved to be paid.
- The number of claims the provider submits during that three-month period may not drop more than 10 percent from their submitted claim amount prior to pre-payment review.

The OIG reserves the right to adjust these thresholds according to the facts of the case.

Intermediate Sanction Review

In accordance with Wis. Admin. Code § DHS 106.08(3)(d), if the OIG has established cause that a provider is violating program rules, the OIG may impose an intermediate sanction that requires the provider's claims to be reviewed prior to payment. Providers who are subject to this type of review will be sent an official Intermediate Sanction Notice letter from the OIG that details the program integrity concerns that warrant the sanction, the length of time the sanction will apply, and the provider's right to appeal the sanction. The provider also will receive a message on the Portal when submitting claims that indicates certain claims must be submitted with the necessary supporting documentation within seven calendar days. The claim will automatically be denied if documentation is not attached within seven days.

For a provider to be considered for removal from an intermediate sanction, the provider must meet the parameters set during the sanction process.

Topic #547

Submission Deadline

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

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

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

Claims

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

applies to claims, corrected claims, and adjustments to claims.

Crossover Claims

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

Exceptions to the Submission Deadline

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

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

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

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

Topic #517

Usual and Customary Charges

For most services, providers are required to indicate their usual and customary charge when submitting claims. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to the program's benefits. For providers who have not established usual and customary charges, the charge should be reasonably related to the provider's cost for providing the service.

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

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

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

Responses

Topic #540

An Overview of the Remittance Advice

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

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

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

Topic #5091

National Provider Identifier on the Remittance Advice

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

Topic #4818

Calculating Totals on the Remittance Advice for Adjusted and Paid Claims

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

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

Topic #534

Claim Number

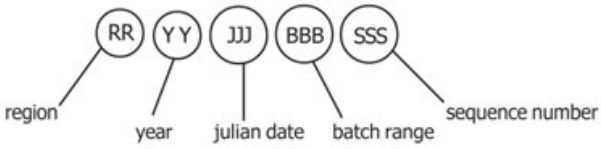
Each claim or adjustment request received by ForwardHealth is assigned a unique claim number (also known as the ICN (internal control number)). However, denied real-time compound and noncompound claims are not assigned an ICN, but receive an authorization number. Authorization numbers are not reported to the RA (Remittance Advice) or 835 (835 Health Care Claim Payment/Advice).

Interpreting Claim Numbers

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

Interpreting Claim Numbers

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



Type of Number and Description	Applicable Numbers and Description
Region — Two digits indicate the region. The region indicates how ForwardHealth received the claim or adjustment request.	10 — Paper Claims with No Attachments 11 — Paper Claims with Attachments 20 — Electronic Claims with No Attachments 21 — Electronic Claims with Attachments 22 — Internet Claims with No Attachments 23 — Internet Claims with Attachments 25 — Point-of-Service Claims 26 — Point-of-Service Claims with Attachments 40 — Claims Converted from Former Processing System 45 — Adjustments Converted from Former Processing System 50–59 — Adjustments 67 — Cash Payment Applied 80 — Claim Resubmissions 90–91 — Claims Requiring Special Handling
Year — Two digits indicate the year ForwardHealth received the claim or adjustment request.	For example, the year 2008 would appear as 08.
Julian date — Three digits indicate the day of the year, by Julian date, that ForwardHealth received the claim or adjustment request.	For example, February 3 would appear as 034.
Batch range — Three digits indicate the batch range assigned to the claim.	The batch range is used internally by ForwardHealth.
Sequence number — Three digits indicate the sequence number assigned within the batch range.	The sequence number is used internally by ForwardHealth.

Topic #535

Claim Status

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

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

Topic #4746

Cutback Fields on the Remittance Advice for Adjusted and Paid Claims

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

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

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

Topic #537

Electronic Remittance Information

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

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

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

Text File

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

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

Comma-Separated Values Downloadable File

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

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

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

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

may need to be split into smaller files when downloading using earlier versions. Microsoft Office Access can manage larger data files.

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

835

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

Provider Electronic Solutions Software

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

Topic #4822

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

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

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

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

TEXT File

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

CSV File

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

Topic #13437

ForwardHealth-Initiated Claim Adjustments

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

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

the RA (Remittance Advice).

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

Topic #4820

Identifying the Claims Reported on the Remittance Advice

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

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

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

Topic #11537

National Correct Coding Initiative

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

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

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

The NCCI editing will occur in addition to/along with current procedure code review and editing completed by Change Healthcare ClaimsXten and in ForwardHealth interChange.

Medically Unlikely Detail Edits

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

An example of an MUE would be if procedure code 11102 (tangential biopsy of skin [eg, shave, scoop, saucerize, curette]; single lesion) was billed by a provider on a professional claim with a quantity of two or more. This procedure is medically unlikely to occur more than once; therefore, if it is billed with units greater than one, the detail will be denied.

Procedure-to-Procedure Detail Edits

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

An example of a procedure-to-procedure edit would be if procedure codes 11451 (excision of skin and subcutaneous tissue for hidradenitis,

axillary; with complex repair) and 93000 (electrocardiogram, routine ECG with at least 12 leads; with interpretation and report) were billed on the same claim for the same DOS. Procedure code 11451 describes a more complex service than procedure code 93000, and therefore, the secondary procedure would be denied.

Quarterly Code List Updates

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

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

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

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

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

- Complete the Adjustment/Reconsideration Request (F-13046 (08/2015)) form. In Element 16, select the "Consultant review requested" checkbox and the "Other/comments" checkbox. In the "Other/comments" text box, indicate "Reconsideration of an NCCI denial."
- Attach notes/supporting documentation.
- Submit a claim, Adjustment/Reconsideration Request, and additional notes/supporting documentation to ForwardHealth for processing.

Topic #539

Obtaining the Remittance Advice

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

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

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

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

Topic #4745

Overview of Claims Processing Information on the Remittance Advice

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

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

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

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

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

- Adjusted claims
- Denied claims
- Paid claims

Claim Types	Provider Types
Dental claims	Dentists, dental hygienists, HealthCheck agencies that provide dental services
Inpatient claims	Inpatient hospital providers and institutes for mental disease providers
Long term care claims	Nursing homes
Medicare crossover institutional claims	Most providers who submit claims on the UB-04
Medicare crossover professional claims	Most providers who submit claims on the 1500 Health Insurance Claim Form ((02/12))
Noncompound and compound drug claims	Pharmacies and dispensing physicians
Outpatient claims	Outpatient hospital providers and hospice providers
Professional claims	Ambulance providers, ambulatory surgery centers, anesthesiologist assistants, audiologists, case management providers, certified registered nurse anesthetists, chiropractors, community care organizations, community support programs, crisis intervention providers, day treatment providers, family planning clinics, federally qualified health centers, HealthCheck providers, HealthCheck "Other Services" providers, hearing instrument specialists, home health agencies, independent labs, individual medical supply providers, medical equipment vendors, mental health/substance abuse clinics, nurses in independent practice, nurse practitioners, occupational therapists, opticians, optometrists, personal care agencies, physical therapists, physician assistants, physician clinics, physicians, podiatrists, portable X-ray providers, prenatal care coordination providers, psychologists, rehabilitation agencies, respiratory therapists, rural health clinics, school-based services providers, specialized medical vehicle providers, speech and hearing clinics, speech-language pathologists, therapy groups

Topic #4821

Prior Authorization Number on the Remittance Advice

The RA (Remittance Advice) reports PA (prior authorization) numbers used to process the claim. PA numbers appear in the detail lines of

claims processing information.

Topic #4418

Reading Non-Claims Processing Sections of the Remittance Advice

Address Page

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

Banner Messages

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

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

Explanation of Benefits Code Descriptions

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

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

Financial Transactions Page

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

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

Refunds are payments made to providers for overpayments.

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

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

For decreasing claim adjustments listed on the RA, a separate accounts receivable will be established and will be listed in the Financial Transactions section. The accounts receivable will be established for the entire amount of the original paid claim. Providers will see net difference between the claim and the adjustment reflected on the RA.

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

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

Service Code Descriptions

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

Summary

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

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

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

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

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

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

Topic #368

Reading the Claim Adjustments Section of the Remittance Advice

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

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

To adjust a claim, ForwardHealth recoups the **difference**—or pays the **difference**—between the original claim amount and the claim adjustment amount. This difference will be reflected on the RA.

In the Claim Adjustments section, the original claim information in the claim header is surrounded by parentheses. Information about the claim

adjustment appears directly below the original claim header information. Providers should check the Adjustment EOB (Explanation of Benefits) code(s) for a summary of why the claim was adjusted; other header EOBs will provide additional information.

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

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

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

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

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

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

Topic #4824

Reading the Claims Denied Section of the Remittance Advice

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

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

Sample Professional Services Claims Denied Section of the Remittance Advice

Remittance Advice — Professional Service Claims Denied Sample

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

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                  PAYEE ID      999999999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                          NPI               9999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                                                          CHECK/EFT NUMBER    999999999
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, XX  XXXXX-XXXX                                         PAYMENT DATE       MM/DD/CCYY

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

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


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


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


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

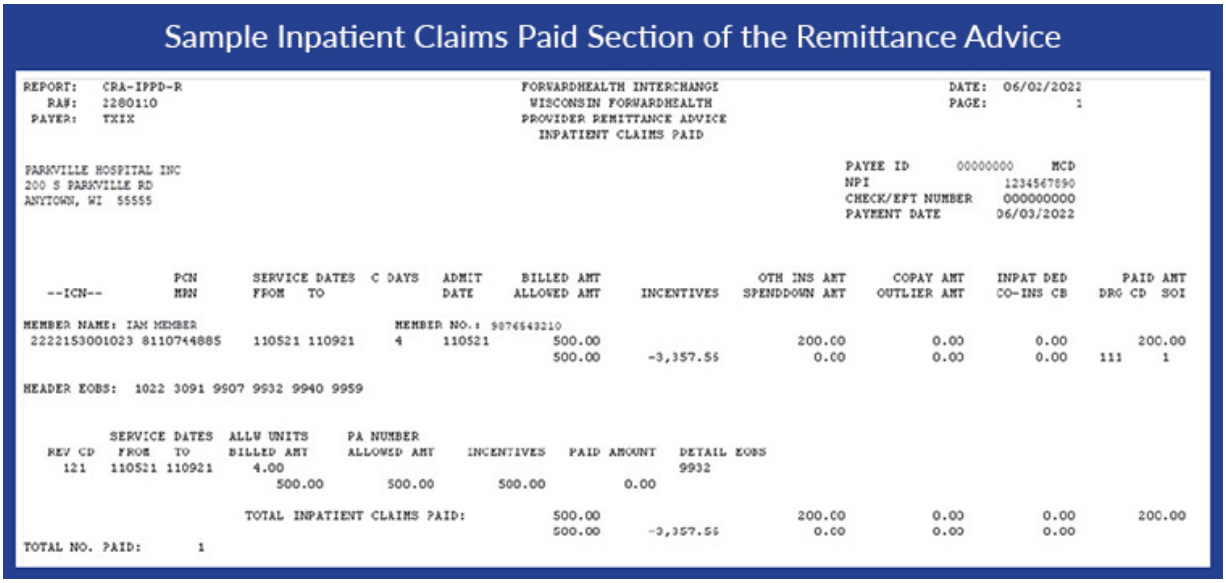
Topic #4825

Reading the Claims Paid Section of the Remittance Advice

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

In a paid claims section, providers will see the original claim information reported along with EOB (Explanation of Benefits) codes for both the header and the detail lines, if applicable. Providers should refer to the EOB Code Description section of the RA for more information about how the reimbursement amount was determined. The Incentives column is calculated in accordance with the 835 (835 Health Care Claim Payment/Advice) standards to balance between the service line, the claim, and the transaction.

Sample Inpatient Claims Paid Section of the Remittance Advice



REPORT: CRA-IPPD-R
RA#: 2280110
PAYER: TXIX

FORWARDHEALTH INTERCHANGE
WISCONSIN FORWARDHEALTH
PROVIDER REMITTANCE ADVICE
INPATIENT CLAIMS PAID

DATE: 06/02/2022
PAGE: 1

PARKVILLE HOSPITAL INC
200 S PARKVILLE RD
ANYTOWN, WI 55555

PAYEE ID 00000000 MCD
NPI 1234567890
CHECK/EFT NUMBER 000000000
PAYMENT DATE 06/03/2022

--ICN--	PCN / MRN	SERVICE DATES FROM	TO	C DAYS	ADMIT DATE	BILLED AMT / ALLOWED AMT	INCENTIVES	OTH INS AMT / SPENDDOWN AMT	COPAY AMT / OUTLIER AMT	INPAT DED / CO-INS CB	PAID AMT / DRG CD / SOI
MEMBER NAME: IAM MEMBER					MEMBER NO.: 9876543210						
2222153001023	8110744885	110521	110921	4	110521	500.00		200.00	0.00	0.00	200.00
						500.00	-3,357.56	0.00	0.00	0.00	111 1

HEADER EOBS: 1022 3091 9507 9932 9940 9959

REV CD	SERVICE DATES FROM	TO	ALLW UNITS / BILLED AMT	PA NUMBER / ALLOWED AMT	INCENTIVES	PAID AMOUNT	DETAIL EOBS
121	110521	110921	4.00				9932
			500.00	500.00	500.00	0.00	

TOTAL INPATIENT CLAIMS PAID:	500.00		200.00	0.00	0.00	200.00
	500.00	-3,357.56	0.00	0.00	0.00	

TOTAL NO. PAID: 1

Topic #4828

Remittance Advice Financial Cycles

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

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

Topic #4827

Remittance Advice Generated by Payer and by Provider Enrollment

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

- Wisconsin Medicaid (Wisconsin Medicaid is the financial payer for the Medicaid, BadgerCare Plus, and SeniorCare programs)
- ADAP (Wisconsin AIDS Drug Assistance Program)
- WCDP (Wisconsin Chronic Disease Program)
- WWWP (Wisconsin Well Woman Program)

A separate Portal account is required for each financial payer.

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

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

For instance, a hospital has obtained a single NPI. The hospital has a clinic, a lab, and a pharmacy that are all enrolled with ForwardHealth.

The clinic, the lab, and the pharmacy submit separate claims that indicate the same NPI as the hospital. Separate RAs will be generated for the hospital, the clinic, the lab, and the pharmacy.

Topic #6237

Reporting a Lost Check

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

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

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

ForwardHealth
Financial Services
313 Blettner Blvd
Madison WI 53784

Topic #5018

Searching for and Viewing All Claims on the Portal

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

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

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

Topic #4829

Sections of the Remittance Advice

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

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

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

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

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

Remittance Advice Header Information

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

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

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

The following information is in the middle of the header:

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

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

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

Topic #544

Verifying Accuracy of Claims Processing

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

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

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

Adjustment Requests

Topic #814

Allowed Claim

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

Topic #815

Denied Claim

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

Topic #512

Electronic

837 Transaction

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

Provider Electronic Solutions Software

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

Portal Claim Adjustments

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

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

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

Topic #513

Follow-Up

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

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

Topic #515

Paper

Paper adjustment requests must be submitted using the Adjustment/Reconsideration Request (F-13046 (08/2015)) form.

Topic #816

Processing

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

Topic #514

Purpose

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

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

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

Topic #4857

Submitting Paper Attachments with Electronic Claim Adjustments

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

Good Faith Claims

Topic #518

Definition of Good Faith Claims

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

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

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

Timely Filing Appeals Requests

Topic #549

Requirements

When a claim or adjustment request meets one of the exceptions to the submission deadline, the provider is required to mail ForwardHealth a Timely Filing Appeals Request (F-13047 (08/2015)) form with a paper claim or an Adjustment/Reconsideration Request (F-13046 (08/2015)) form to override the submission deadline. If claims or adjustment requests are submitted electronically, the entire amount of the claim will be recouped.

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

Topic #551

Resubmission

Decisions on Timely Filing Appeals Requests (F-13047 (08/2015)) cannot be appealed. Providers may resubmit the claim to Timely Filing if both of the following occur:

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

Topic #744

Submission

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

- A properly completed Timely Filing Appeals Request (F-13047 (08/2015)) form for each claim and each adjustment to allow for documentation of individual claims and adjustments submitted to ForwardHealth
- A legible claim or Adjustment/Reconsideration Request (F-13046 (08/2015)) form
- All required documentation as specified for the exception to the submission deadline
- A properly completed Explanation of Medical Benefits form for paper claims and paper claim adjustments where other health insurance sources are indicated

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

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

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

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

Change in Nursing Home Resident's Level of Care or Liability Amount

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

This exception occurs when a claim is initially received by the deadline but is denied due to a discrepancy between the member's enrollment information in ForwardHealth interChange and the member's actual enrollment.	To receive consideration, the request must be submitted within 455 days from the DOS. Include the following documentation as part of the request:
	• A copy of remittance information showing the claim was submitted in a timely manner and denied with a qualifying enrollment-related explanation.
	• A photocopy of **one** of the following indicating enrollment on the DOS:
	  ◦ Temporary Identification Card for Express Enrollment in BadgerCare Plus
	  ◦ Temporary Identification Card for Express Enrollment in Family Planning Only Services
	  ◦ The response received through Wisconsin's EVS (Enrollment Verification System) from a commercial eligibility vendor
	  ◦ The transaction log number received through WiCall
	  ◦ The enrollment tracking number received through the ForwardHealth Portal
		ForwardHealth
		Good Faith/Timely Filing
		Ste 50
		313 Blettner Blvd
		Madison WI 53784

ForwardHealth Reconsideration or Recoupment		

Description of the Exception	Documentation Requirements	Submission Address
This exception occurs when ForwardHealth reconsiders a previously processed claim. ForwardHealth will initiate an adjustment on a previously paid claim.	If a subsequent provider submission is required, the request must be submitted within 90 days from the date of the RA (Remittance Advice) message. Include the following documentation as part of the request: • A copy of the RA message that shows the ForwardHealth-initiated adjustment • A copy of the Explanation of Medical Benefits form, if applicable	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
Retroactive Enrollment for Persons on General Relief		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when the income maintenance or tribal agency requests a return of a GR (general relief) payment from the provider because a member has become retroactively enrolled for Wisconsin Medicaid or BadgerCare Plus.	To receive consideration, the request must be submitted within 180 days from the date the backdated enrollment was added to the member's enrollment information. Include the following documentation as part of the request: • A copy of the Explanation of Medical Benefits form, if applicable **And** • "GR retroactive enrollment" indicated on the claim **Or** • A copy of the letter received from the income maintenance or tribal agency	ForwardHealth GR Retro Eligibility Ste 50 313 Blettner Blvd Madison WI 53784
Medicare Denial Occurs After the Submission Deadline		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when claims submitted to Medicare (within 365 days of the DOS) are denied by Medicare after the 365-day submission deadline. A waiver of the submission deadline will not be granted when Medicare denies a claim for one of the following reasons: • The charges were previously submitted to Medicare. • The member name and identification number do not match. • The services were previously denied by Medicare. • The provider retroactively applied for Medicare enrollment and did not become enrolled.	To receive consideration, the request must be submitted within 90 days of the Medicare processing date. Include the following documentation as part of the request: • A copy of the Medicare remittance information • A copy of the Explanation of Medical Benefits form, if applicable	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

Refund Request from an Other Health Insurance Source		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when an other health insurance source reviews a previously paid claim and determines that reimbursement was inappropriate.	To receive consideration, the request must be submitted within 90 days from the date of recoupment notification. Include the following documentation as part of the request: - A copy of the recoupment notice - An updated Explanation of Medical Benefits form, if applicable *Note:* When the reason for resubmitting is due to Medicare recoupment, ensure that the associated Medicare disclaimer code (i.e., M-7 or M-8) is included on the updated Explanation of Medical Benefits form.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
Retroactive Member Enrollment into Medicaid		
Description of the Exception	**Documentation Requirements**	**Submission Address**
This exception occurs when a claim cannot be submitted within the 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 by selecting "Retroactive member enrollment for ForwardHealth (attach appropriate documentation for retroactive period, if available)" box on the Timely Filing Appeals Request (F-13047 (08/15)) form.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

Overpayments

Topic #528

Adjustment Request vs. Cash Refund

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

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

Topic #532

Adjustment Requests

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

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

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

Electronic Adjustment Requests

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

Paper Adjustment Requests

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

- Submit an Adjustment/Reconsideration Request (F-13046 (08/2015)) form through normal processing channels (not timely filing), regardless of the DOS
- Indicate the reason for the overpayment, such as a duplicate reimbursement or an error in the quantity indicated on the claim

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

Topic #533

Cash Refunds

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

ForwardHealth
Financial Services Cash Unit
313 Blettner Blvd
Madison WI 53784

Topic #531

ForwardHealth-Initiated Adjustments

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

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

Topic #530

Requirements

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

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

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

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

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

Topic #10138

Reversing Claims

Providers may reverse (or 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 reversed claim is a complete recoupment of that claim payment. Once a claim has been reversed, the claim can no longer be adjusted; however, the services provided and indicated on the reversed claim may be resubmitted on a new claim.

If a provider returns an overpayment by mail, reversed claims will have ICNs (internal control numbers) beginning with "67." Overpayments that are adjusted on the Portal will have ICNs that begin with "59."

Topic #8417

Voiding Claims

Providers may void claims on the ForwardHealth Portal to return overpayments. This way of returning overpayments may be a more efficient

and timely way for providers as a voided claim is a complete recoupment of the payment for the entire claim. Once a claim is voided, the claim can no longer be adjusted; however, the services indicated on the voided claim may be resubmitted on a new claim.

Reimbursement

5

Archive Date:04/01/2024

Reimbursement:Payer of Last Resort

Topic #242

Instances When Medicaid Is Not Payer of Last Resort

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

- Birth to 3
- Crime Victim Compensation Fund
- GA (General Assistance)
- HCBS (Home and Community-Based Services) waiver programs
- IDEA (Individuals with Disabilities Education Act)
- Indian Health Service
- Maternal and Child Health Services
- WCDP (Wisconsin Chronic Disease Program):
  - Adult Cystic Fibrosis
  - Chronic Renal Disease
  - Hemophilia Home Care

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

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

Topic #251

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 and Medicare Cost plans
- TriCare
- CHAMPVA (Civilian Health and Medical Plan of the Veterans Administration)
- Other governmental benefits

Topic #253

Payer of Last Resort

Except for a few instances, Wisconsin Medicaid or BadgerCare Plus is the payer of last resort for any covered services. Therefore, the provider is required to make a reasonable effort to exhaust all other existing health insurance sources before submitting claims to ForwardHealth or to a state-contracted MCO (managed care organization).

Topic #255

Primary and Secondary Payers

The terms "primary payer" and "secondary payer" indicate the relative order in which insurance sources are responsible for paying claims.

In general, commercial health insurance is primary to Medicare, and Medicare is primary to Wisconsin Medicaid and BadgerCare Plus. Therefore, Wisconsin Medicaid and BadgerCare Plus are secondary to Medicare, and Medicare is secondary to commercial health insurance.

Amounts

Topic #258

Acceptance of Payment

The amounts allowed as payment for covered services must be accepted as payment in full. Therefore, total payment for the service (i.e., any amount paid by other health insurance sources, any BadgerCare Plus or Medicaid copayment or spenddown amounts paid by the member, and any amount paid by BadgerCare Plus, Medicaid, or ADAP (Wisconsin AIDS Drug Assistance Program)) may not exceed the allowed amount. As a result, providers may not collect payment from a member, or authorized person acting on behalf of the member, for the difference between their usual and customary charge and the allowed amount for a service (i.e., balance billing).

Other health insurance payments may exceed the allowed amount if no additional payment is received from the member or BadgerCare Plus, Medicaid, or ADAP.

Topic #21217

Annual Reimbursement Changes

To comply with federal legislation, ForwardHealth will annually compare maximum allowable fees of DME (durable medical equipment) procedure codes to Medicare's annual max fee updates. ForwardHealth will reduce max fees for any impacted DME codes where ForwardHealth's max fee is above the lowest corresponding max fee for Wisconsin in that given year.

ForwardHealth will post the updated max fees for DME in the DME index and in the maximum allowable fee schedules.

Topic #694

Billing Service and Clearinghouse Contracts

According to Wis. Admin. Code § DHS 106.03(5)(c)2, contracts with outside billing services or clearinghouses may not be based on commission in which compensation for the service is dependent on reimbursement from BadgerCare Plus. This means compensation must be unrelated, directly or indirectly, to the amount of reimbursement or the number of claims and is not dependent upon the actual collection of payment.

Topic #8117

Electronic Funds Transfer

EFT (electronic funds transfer) allows ForwardHealth to directly deposit payments into a provider's designated bank account for a more efficient delivery of payments than the current process of mailing paper checks. EFT is secure, eliminates paper, and reduces the uncertainty of possible delays in mail delivery.

Only in-state and border-status providers who submit claims and MCOs (managed care organizations) are eligible to receive EFT payments.

Provider Exceptions

EFT payments are not available to the following providers:

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

- SMV (specialized medical vehicle) providers during their provisional enrollment period

Enrolling in Electronic Funds Transfer

A ForwardHealth Portal account is required to enroll into EFT as all enrollments must be completed via a secure Provider Portal account or a secure MCO Portal account. Paper enrollments are not accepted. A separate EFT enrollment is required for each financial payer a provider bills.

Providers who do not have a Portal account may Request Portal Access online. Providers may also call the Portal Helpdesk for assistance in requesting a Portal account.

The following guidelines apply to EFT enrollment:

- Only a Portal Administrator or a clerk that has been assigned the "EFT" role on the Portal may complete the EFT enrollment information.
- Organizations can revert back to receiving paper checks by disenrolling in EFT.
- Organizations may change their EFT information at any time.
- Organizations will continue to receive their Remittance Advice as they do currently.

Refer to the Electronic Funds Transfer User Guide on the User Guides page of the Portal for instructions and more information about EFT enrollment.

Providers will continue to receive payment via paper check until the enrollment process moves into "Active" status and the provider's ForwardHealth EFT enrollment is considered complete.

Recoupment and Reversals

Enrollment in EFT does not change the current process of recouping funds. Overpayments and recoupment of funds will continue to be conducted through the reduction of payments.

Note: Enrolling in EFT does not authorize ForwardHealth to make unauthorized debits to the provider's EFT account; however, in some instances an EFT reversal of payment may be necessary. For example, if the system generates a payment twice or the amount entered manually consists of an incorrect value (e.g., a decimal point is omitted creating a $50,000 keyed value for a $500 claim), a reversal will take place to correct the error and resend the correct transaction value. ForwardHealth will notify the designated EFT contact person of an EFT reversal if a payment is made in error due to a system processing or manual data entry error.

Problem Resolution

If payment is not deposited into the designated EFT account according to the ForwardHealth payment cycle, providers should first check with their financial institution to confirm the payment was received. If the payment was not received, providers should then call Provider Services to resolve the issue and payment by paper check will be reinstated until the matter has been resolved.

Topic #897

Fee Schedules

Maximum allowable fee information is available on the Max Fee Schedules page of the ForwardHealth Portal in the following forms:

- An interactive maximum allowable fee schedule
- Downloadable fee schedules by service area only in TXT (text) or CSV (comma separated value) files

Policy information is not displayed in the fee schedules. Providers should refer to their specific service area in the Online Handbook for more information about coverage policy related to a specific procedure code.

Certain fee schedules are interactive. On the interactive fee schedule, providers have more search options for looking up some coverage information, as well as the maximum allowable fees, as appropriate, for reimbursable HCPCS (Healthcare Common Procedure Coding System), CPT (Current Procedural Terminology), or CDT (Current Dental Terminology) procedure codes for most services.

Providers have the ability to independently search by:

- A single HCPCS, CPT, or CDT procedure code
- Multiple HCPCS, CPT, or CDT procedure codes
- A pre-populated code range
- A service area (Service areas listed in the interactive fee schedule more closely align with the provider service areas listed in the Online Handbook, including the WCDP (Wisconsin Chronic Disease Program) programs and WWWP (Wisconsin Well Woman Program).)

The downloadable fee schedules, which are updated monthly, provide basic maximum allowable fee information by provider service area.

Through the interactive fee schedule, providers can export their search results for a single code, multiple codes, a code range, or by service area. The export function of the interactive fee schedule will return a zip file that includes seven CSV files containing the results.

Note: The interactive fee schedule will export all associated information related to the provider's search criteria except the procedure code descriptions.

Providers may call Provider Services in the following cases:

- The ForwardHealth Portal is not available.
- There is uncertainty as to which fee schedule should be used.
- The appropriate fee schedule cannot be found on the Portal.
- To determine coverage or maximum allowable fee of procedure codes not appearing on a fee schedule.

Topic #13897

Durable Medical Equipment Index

Providers should refer to the DME Index (Durable Medical Equipment) for maximum allowable fee information specific to allowable DME procedure codes.

Topic #20037

Home Ventilator Rental

Current reimbursement rates for primary and back-up or secondary home ventilator rental are available in the maximum allowable fee schedule. Back-up or secondary home ventilator rental is reimbursed at 80 percent of the primary home ventilator reimbursement.

Note: ForwardHealth does not separately reimburse providers for delivery, set-up, repair, maintenance, or modification of rented DME (durable medical equipment), per Wis. Admin. Code §§ DHS 107.24(5)(g) and (h).

Ventilator options, accessories, and supplies are included in the reimbursement of the home ventilator rental and are not separately reimbursable. This includes, but is not limited to, the following:

- AC/DC chargers
- Adapters
- Air/oxygen mixers
- Auto adapters
- Backpacks
- Battery boxes
- Battery packs
- Clamps
- Circuits
- Filters, both HEPA and bacteria type
- Fittings
- Generators
- Humidifiers

- Internal and additional batteries for back-up use
- Masks
- Manifolds
- Power cables/cords
- Power centers
- Power inverters
- Pressure alarms
- Pressure hoses
- Transport packs
- Tubing
- Valves

Information regarding home ventilator rental coverage policy is available.

Note: It is the provider's responsibility to ensure that there is an emergency plan in place to address mechanical failure of the equipment.

Topic #260

Maximum Allowable Fees

Maximum allowable fees are established for most covered services. Maximum allowable fees are based on various factors, including a review of usual and customary charges submitted, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. Maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law.

Providers are reimbursed at the lesser of their billed amount and the maximum allowable fee for the procedure.

Topic #11157

Negative Pressure Wound Therapy Pumps

Modifier "RR" is required to be indicated with procedure code E2402.

After a lifetime 90 days, up to an additional 90 days for a rolling 12 months may be reimbursed.

The lifetime limit and the rolling 12 month limit for negative pressure wound therapy pumps will be determined regardless of POS (place of service).

Once the limit is reached for the additional 90 days for the rolling 12 months, the service is considered noncovered and may not be billed to BadgerCare Plus members or Medicaid members or to their families under any circumstances and cannot be appealed. This includes the use of negative pressure wound therapy pumps for purposes that do not qualify for reimbursement.

Allowable POS codes for negative pressure wound therapy pump services provided by DME (durable medical equipment) providers are 11 (Office), 12 (Home), and 19 (Off Campus — Outpatient Hospital). Durable medical equipment providers cannot be directly reimbursed for negative pressure wound therapy pump services to members residing in a nursing home.

Topic #1885

Reimbursement for Oxygen-Related Services

Wisconsin Medicaid reimburses DME (durable medical equipment) 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 their home or in a nursing facility.

Topic #1886

Rented Durable Medical Equipment

Rental charges for DME (durable medical equipment) are deducted from the Medicaid-allowed amount for the subsequent purchase of the item.

Note: Delivery, setup, and training are included in the reimbursement for rental equipment.

Equipment rental is covered only as long as medical necessity exists. If equipment is returned to the provider before the PA (prior authorization)'s expiration date because it is no longer needed, the provider must prorate the rental charge based on the DOS (date of service).

Collecting Payment From Members

Topic #227

Conditions That Must Be Met

A member may request a noncovered service, a covered service for which PA (prior authorization) was denied (or modified), or a service that is not covered under the member's limited benefit category. The charge for the service may be collected from the member if the following conditions are met **prior** to the delivery of that service:

- The member accepts responsibility for payment.
- The provider and member make payment arrangements for the service.

Providers are strongly encouraged to obtain a **written** statement in advance documenting that the member has accepted responsibility for the payment of the service.

Furthermore, the service must be separate or distinct from a related, covered service. For example, a vision provider may provide a member with eyeglasses but then, upon the member's request, provide and charge the member for anti-glare coating, which is a noncovered service. Charging the member is permissible in this situation because the anti-glare coating is a separate service and can be added to the lenses at a later time.

Topic #538

Cost Sharing

According to federal regulations, providers cannot hold a member responsible for any commercial or Medicare cost-sharing amount such as coinsurance, copayment, or deductible. Therefore, a provider may not collect payment from a member, or authorized person acting on behalf of the member, for copayments required by other health insurance sources. Instead, the provider should collect from the member **only** the Medicaid or BadgerCare Plus copayment amount indicated on the member's remittance information.

Topic #1887

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 (durable medical equipment).

Topic #224

Situations When Member Payment Is Allowed

Providers may not collect payment from a member, or authorized person acting on behalf of the member, **except** for the following:

- Required member copayments for certain services.
- Other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) payments made to the member.
- Spenddown.
- Charges for a private room in a nursing home if meeting the requirements stated in Wis. Admin. Code § DHS 107.09(4)(k), or in a hospital if meeting the requirements stated in Wis. Admin. Code § DHS 107.08(3)(a)2.
- Noncovered services if certain conditions are met.
- Covered services for which PA (prior authorization) was denied (or an originally requested service for which a PA request was modified) if certain conditions are met. These services are treated as noncovered services.

- Services provided to a member in a limited benefit category when the services are not covered under the limited benefit and if certain conditions are met.

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

Copayment

Topic #1888

Amounts

Allowable DME (durable medical equipment) procedure codes and their applicable copayment amounts under BadgerCare Plus and Wisconsin Medicaid can be found in the maximum allowable fee schedule.

Note: Rental items and repairs are not subject to a copayment.

Topic #9139

Copayment for Diabetic Supplies

Copayment for diabetic supplies is $0.50 per prescription for all benefit plans with no monthly or annual limits. For example, if a member has one prescription for two boxes of lancets, the copayment would be $0.50 and one prescription for one box of syringes, the copayment would be $0.50. The member's total copayment is $1.00.

Topic #231

Exemptions

Wisconsin Medicaid and BadgerCare Plus Copay Exemptions

According to Wis. Admin. Code § DHS 104.01(12)(a), and 42 C.F.R. (Code of Federal Regulations) § 447.56, providers are prohibited from collecting any copays from the following Medicaid and BadgerCare Plus members:

- Children under age 19
- American Indians or Alaskan Natives, regardless of age or income level, who are receiving or have ever received items and services either directly from an Indian health care provider or through referral under contract health services (Note: Until further notice, Wisconsin Medicaid and BadgerCare Plus will apply this exemption policy for **all** services regardless of whether a tribal health care provider or a contracted entity provides the service. Providers may not collect copay from any individual identified in the EVS (Enrollment Verification System) as an American Indian or Alaskan Native.)
- Terminally ill individuals receiving hospice care
- Nursing home residents
- Members enrolled in Wisconsin Well Woman Medicaid
- Individuals eligible through EE (Express Enrollment)

The following services do not require copays from any member enrolled in Wisconsin Medicaid or BadgerCare Plus:

- Behavioral treatment
- Care coordination services (prenatal and child care coordination)
- CRS (Community Recovery Services)
- Crisis intervention services
- CSP (community support program) services
- Comprehensive community services
- COVID-19-related care
- Emergency services for medical conditions that meet the prudent layperson standard (the prudent layperson standard is defined by 42 C.F.R. (Code of Federal Regulations) § 438.114, and may be expanded to include a psychiatric emergency involving a significant risk or serious harm to oneself or others, a substance abuse emergency in which there is significant risk of serious harm to a member or others or there is likelihood of return to substance abuse without immediate treatment, or emergency dental care, which is defined as an

immediate service needed to relieve the patient from pain, an acute infection, swelling, trismus, fever, or trauma)
- EMTALA (Emergency Medical Treatment and Labor Act)-required medical screening exam and stabilization services
- Family planning services and supplies, including sterilizations
- HealthCheck services
- Home care services (home health, personal care, and PDN (private duty nurse) services)
- Hospice care services
- Immunizations, including approved vaccines recommended to adults by the ACIP (Advisory Committee on Immunization Practices)
- Independent laboratory services
- Injections
- Pregnancy-related services
- Preventive services with an A or B rating* from the USPSTF (U.S. Preventive Services Task Force)**, including tobacco cessation services
- SBS (school-based services)
- Substance abuse day treatment services
- Surgical assistance
- Targeted case management services

Note: Providers may not impose cost sharing for health-care acquired conditions or other provider-preventable services as defined in federal law under 42 C.F.R. § 447.26(b).

* Providers are required to add CPT (Current Procedural Terminology) modifier 33 to identify USPSTF services that are not specifically identified as preventive in nature. The definition for modifier 33 reads as follows:

> When the primary purpose of the service is the delivery of an evidence based service in accordance with a U.S. Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.

Since many of the USPSTF recommendations are provided as part of a regular preventive medicine visit, ForwardHealth will not deduct a copayment for these services (CPT procedure codes 99381–99387 and 99391–99397).

** The USPSTF recommendations include screening tests, counseling, immunizations, and preventive medications for targeted populations. These services must be provided or recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice.

Topic #233

Limitations

Providers should verify that they are collecting the correct copay for services as some services have monthly or annual copay limits. Providers may not collect member copays in amounts that exceed copay limits.

Monthly Copay Limits

Per the federal limitations on premiums and cost sharing in 42 C.F.R. § 447.56(f), the combined amount of Medicaid premiums and copays a BadgerCare Plus or Medicaid member incurs each month may not exceed 5 percent of the member's monthly household income. To comply with federal limitations on premiums and cost sharing, ForwardHealth calculates each member's monthly premium and copay limit, which is a maximum allowable copay amount based on monthly income, for individual members. Members within the same household may have different individual copay limits, and children under age 19 are exempt from copays.

Providers must determine whether or not a BadgerCare Plus or Medicaid member is exempt from paying copays or has reached their monthly copay limit by accessing the Enrollment Verification System and receiving the message "No Copay" in response to an enrollment query.

Member Notification

Each member receives a letter in the mail that states their individual monthly copay limit. If a member has a change, such as a change in income

or marital status, they will receive a letter with the updated individual monthly copay limit.

When a member reaches their monthly copay limit before the end of the month, they will receive a letter that informs them that they have met their copay limit for that month, and copays will resume on the first day of the following month.

Copay Collection

Once a member meets their individual monthly copay limit, copays will no longer be deducted from the provider's reimbursement. This is true even if subsequent claim adjustments reduce the member's incurred copay amount to below their monthly limit. **Providers may not collect copays from members who have met their individual monthly copay limit.**

Topic #237

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.

Topic #239

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 member who fails to make a copayment.

Wis. Stat. § 49.45(18) 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.

Reimbursement Not Available

Topic #21038

Face-to-Face Visit Does not Occur

Reimbursement is not available for services when a face-to-face visit does not occur or does not occur within the specified timeframes for impacted DME (durable medical equipment).

For impacted services that do not require PA (prior authorization), the reimbursement will be subject to recovery during a provider audit.

Topic #695

Reimbursement Not Available Through a Factor

BadgerCare Plus will not reimburse providers through a factor, either directly or by virtue of a power of attorney given to the factor by the provider. A factor is an organization (e.g., a collection agency) or person who advances money to a provider for the purchase or transferal of the provider's accounts receivable. The term "factor" does not include business representatives, such as billing services, clearinghouses, or accounting firms, which render statements and receive payments in the name of the provider.

Topic #51

Services Not Separately Reimbursable

If reimbursement for a service is included in the reimbursement for the primary procedure or service, it is not separately reimbursable. For example, routine venipuncture is not separately reimbursable, but it is included in the reimbursement for the laboratory procedure or the laboratory test preparation and handling fee. Also, DME (durable medical equipment) delivery charges are included in the reimbursement for DME items.

Member Information

6

Archive Date:04/01/2024

Member Information:Enrollment Categories

Topic #225

BadgerCare Plus

Populations Eligible for BadgerCare Plus

The following populations are eligible for BadgerCare Plus:

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

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

Premiums

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

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

Topic #16677

BadgerCare Plus Benefit Plan Changes

Effective April 1, 2014, all members eligible for BadgerCare Plus were enrolled in the BadgerCare Plus Standard Plan. As a result of this change, the following benefit plans were discontinued:

- BadgerCare Plus Benchmark Plan
- BadgerCare Plus Core Plan
- BadgerCare Plus Basic Plan

Members who are enrolled in the Benchmark Plan or the Core Plan who met new income limits for BadgerCare Plus eligibility were automatically transitioned into the BadgerCare Plus Standard Plan on April 1, 2014. In addition, the last day of BadgerRx Gold program coverage for all existing members was March 31, 2014.

Providers should refer to the March 2014 Online Handbook archive of the appropriate service area for policy information pertaining to these discontinued benefit plans.

Topic #785

BadgerCare Plus Prenatal Program

As a result of 2005 Wisconsin Act 25, BadgerCare has expanded coverage to the following individuals:

- Pregnant non-U.S. citizens who are not qualified aliens but meet other eligibility criteria for BadgerCare.
- Pregnant individuals detained by legal process who meet other eligibility criteria for BadgerCare.

The BadgerCare Plus Prenatal Program is designed to provide better birth outcomes.

Women are eligible for all covered services from the first of the month in which their pregnancy is verified or the first of the month in which the application for BadgerCare Plus is filed, whichever is later. Members are enrolled through the last day of the month in which they deliver or the pregnancy ends. Postpartum care is reimbursable **only** if provided as part of global obstetric care. Even though enrollment is based on pregnancy, these women are eligible for **all** covered services. (They are not limited to pregnancy-related services.)

These women are not presumptively eligible. Providers should refer them to the appropriate income maintenance or tribal agency where they can apply for this coverage.

Fee-for-Service

Pregnant non-U.S. citizens who are not qualified aliens and pregnant individuals detained by legal process receive care only on a fee-for-service basis. Providers are required to follow all program requirements (e.g., claim submission procedures, PA (prior authorization) requirements) when providing services to these women.

Emergency Services for Non-U.S. Citizens

When BadgerCare Plus enrollment ends for pregnant non-U.S. citizens who are not qualified aliens, they receive coverage for emergency services. These women receive emergency coverage for 60 days after the pregnancy ends; this coverage continues through the end of the month in which the 60th day falls (e.g., a woman who delivers on June 20, 2006, would be enrolled through the end of August 2006).

Topic #230

Express Enrollment for Children and Pregnant Women

The EE (Express Enrollment) 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.

The EE for Children Benefit allows certain members through 18 years of age to receive BadgerCare Plus benefits 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 income maintenance or tribal agency.

Topic #226

Family Planning Only Services

Family Planning Only Services is a limited benefit program that provides routine contraceptive management or related services to low-income individuals who are of childbearing/reproductive age (typically 15 years of age or older) and who are otherwise not eligible for Wisconsin Medicaid or BadgerCare Plus. Members receiving Family Planning Only Services must be receiving routine contraceptive management or related services.

Note: Members who meet the enrollment criteria may receive routine contraceptive management or related services **immediately** by temporarily enrolling in Family Planning Only Services through EE (Express Enrollment).

The goal of Family Planning Only Services is to provide members with information and services to assist them in preventing pregnancy, making BadgerCare Plus enrollment due to pregnancy less likely. Providers should explain the purpose of Family Planning Only Services to members

and encourage them to contact their certifying agency to determine their enrollment options if they are not interested in, or do not need, contraceptive services.

Members enrolled in Family Planning Only Services receive routine services to prevent or delay pregnancy and are not eligible for other services (e.g., PT (physical therapy) services, dental services). Even if a medical condition is discovered during a family planning visit, treatment for the condition is not covered under Family Planning Only Services unless the treatment is identified in the list of allowable procedure codes for Family Planning Only Services.

Members are also not eligible for certain other services that are covered under Wisconsin Medicaid and BadgerCare Plus (e.g., mammograms and hysterectomies). If a medical condition, other than an STD (sexually transmitted disease), is discovered during routine contraceptive management or related services, treatment for the medical condition is not covered under Family Planning Only Services.

Colposcopies and treatment for STDs are only covered through Family Planning Only Services if they are determined medically necessary during routine contraceptive management or related services. A colposcopy is a covered service when an abnormal result is received from a pap test, prior to the colposcopy, while the member is enrolled in Family Planning Only Services and receiving contraceptive management or related services.

Family Planning Only Services members diagnosed with cervical cancer, precancerous conditions of the cervix, or breast cancer may be eligible for Wisconsin Well Woman Medicaid. Providers should assist eligible members with the enrollment process for Well Woman Medicaid.

Providers should inform members about other coverage options and provide referrals for care not covered by Family Planning Only Services.

Topic #4757

ForwardHealth and ForwardHealth interChange

ForwardHealth brings together many Wisconsin DHS (Department of Health Services) health care programs with the goal to create efficiencies for providers and to improve health outcomes for members. ForwardHealth interChange is the DHS claims processing system that supports multiple state health care programs and web services, including:

- BadgerCare Plus
- BadgerCare Plus and Medicaid managed care programs
- SeniorCare
- ADAP (Wisconsin AIDS Drug Assistance Program)
- WCDP (Wisconsin Chronic Disease Program)
- WIR (Wisconsin Immunization Registry)
- Wisconsin Medicaid
- Wisconsin Well Woman Medicaid
- WWWP (Wisconsin Well Woman Program)

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

Topic #229

Limited Benefit Categories Overview

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

- BadgerCare Plus Prenatal Program
- EE (Express Enrollment) for Children
- EE for Pregnant Women
- Family Planning Only Services, including EE for individuals applying for Family Planning Only Services
- QDWI (Qualified Disabled Working Individuals)
- QI-1 (Qualifying Individuals 1)
- QMB Only (Qualified Medicare Beneficiary Only)
- SLMB (Specified Low-Income Medicare Beneficiary)

- Tuberculosis-Related Medicaid

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 the BadgerCare Plus Prenatal Program, Family Planning Only Services, EE for Children, EE for Pregnant Women, or Tuberculosis-Related Medicaid 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 Family Planning Only Services and Tuberculosis-Related Medicaid.

Providers are strongly encouraged to verify dates of enrollment and other coverage information using Wisconsin's EVS (Enrollment Verification System) 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.

Topic #228

Medicaid

Medicaid is a joint federal/state program established in 1965 under Title XIX of the Social Security Act to pay for medical services for selected groups of people who meet the program's financial requirements.

The purpose of Medicaid is to provide reimbursement for and assure the availability of appropriate medical care to persons who meet the criteria for Medicaid. Wisconsin Medicaid is also known as the Medical Assistance Program, WMAP (Wisconsin Medical Assistance Program), MA (Medical Assistance), Title XIX, or T19.

A Medicaid member is any individual entitled to benefits under Title XIX of the Social Security Act and under the Medical Assistance State Plan as defined in Wis. Stat. ch. 49.

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 they are 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
- Foster care or adoption assistance programs
- SSI (Supplemental Security Income)
- WWWP (Wisconsin Well Woman Program)

Providers may advise these individuals or their representatives to contact their certifying agency for more information. The following agencies certify people for Wisconsin Medicaid enrollment:

- Income maintenance or tribal agencies
- Medicaid outstation sites
- SSA (Social Security Administration) offices

In limited circumstances, some state agencies also certify individuals for Wisconsin Medicaid.

Medicaid fee-for-service members receive services through the traditional health care payment system under which providers receive a payment for each unit of service provided. Some Medicaid members receive services through state-contracted MCOs (managed care organizations).

Topic #232

Qualified Disabled Working Individual Members

QDWI (Qualified Disabled Working Individual) 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 income maintenance or tribal agency. To qualify, QDWI members are required to meet the following qualifications:

- Have income under 200 percent of the FPL (Federal Poverty Level)
- Be entitled to, but not necessarily enrolled in, Medicare Part A
- Have income or assets too high to qualify for QMB-Only (Qualified Medicare Beneficiary-Only) and SLMB (Specified Low-Income Medicare Beneficiary)

Topic #234

Qualified Medicare Beneficiary-Only Members

QMB-Only (Qualified Medicare Beneficiary-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 income maintenance or tribal agency. QMB-Only members are required to meet the following qualifications:

- Have an income under 100 percent of the FPL (Federal Poverty Level)
- Be entitled to, but not necessarily enrolled in, Medicare Part A

Topic #235

Qualifying Individual 1 Members

QI-1 (Qualifying Individual 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 income maintenance 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 (Federal Poverty Level)
- Be entitled to, but not necessarily enrolled in, Medicare Part A

Topic #18777

Real-Time Eligibility Determinations

ForwardHealth may complete real-time eligibility determinations for BadgerCare Plus and/or Family Planning Only Services applicants who meet pre-screening criteria and whose reported information can be verified in real time while applying in ACCESS Apply for Benefits. Once an

applicant is determined eligible through the real-time eligibility process, they are considered eligible for BadgerCare Plus and/or Family Planning Only Services and will be enrolled for 12 months, unless changes affecting eligibility occur before the 12-month period ends.

A member determined eligible through the real-time eligibility process will receive a temporary ID (identification) card for BadgerCare Plus and/or Family Planning Only Services. Each member will get their own card, and each card will include the member's ForwardHealth ID number. The temporary ID card will be valid for the dates listed on the card and will allow the member to get immediate health care or pharmacy services.

Eligibility Verification

When a member is determined eligible for BadgerCare Plus and/or Family Planning Only Services through the real-time eligibility process, providers are able to see the member's eligibility information in Wisconsin's EVS (Enrollment Verification System) in real time. Providers should always verify eligibility through EVS prior to providing services.

On rare occasions, it may take up to 48 hours for eligibility information to be available through interChange. In such instances, if a member presents a valid temporary ID card, **the provider is still required to provide services**, even if eligibility cannot be verified through EVS.

Sample Temporary Identification Card for Badger Care Plus

To the Provider

The individual listed on this card has been enrolled in BadgerCare Plus. This card entitles the listed individual to receive health care services, including pharmacy services, through BadgerCare Plus from any Medicaid-enrolled provider. For additional information, call Provider Services at 800-947-9627 or refer to the ForwardHealth Online Handbook at *www.forwardhealth.wi.gov*.

NOTE:

It is important to provide services when this card is presented. Providers who render services based on the enrollment dates on this card will receive payment for those services, as long as other reimbursement requirements are met. All policies regarding covered services apply for this individual, including the prohibition against billing members. If "Pending Assignment" is indicated after the name on this card, the member identification (ID) number will be assigned within one business day; the card is still valid. Refer to the ForwardHealth Online Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card.

WISCONSIN DEPARTMENT OF HEALTH SERVICES

TEMPORARY IDENTIFICATION CARD FOR BADGERCARE PLUS

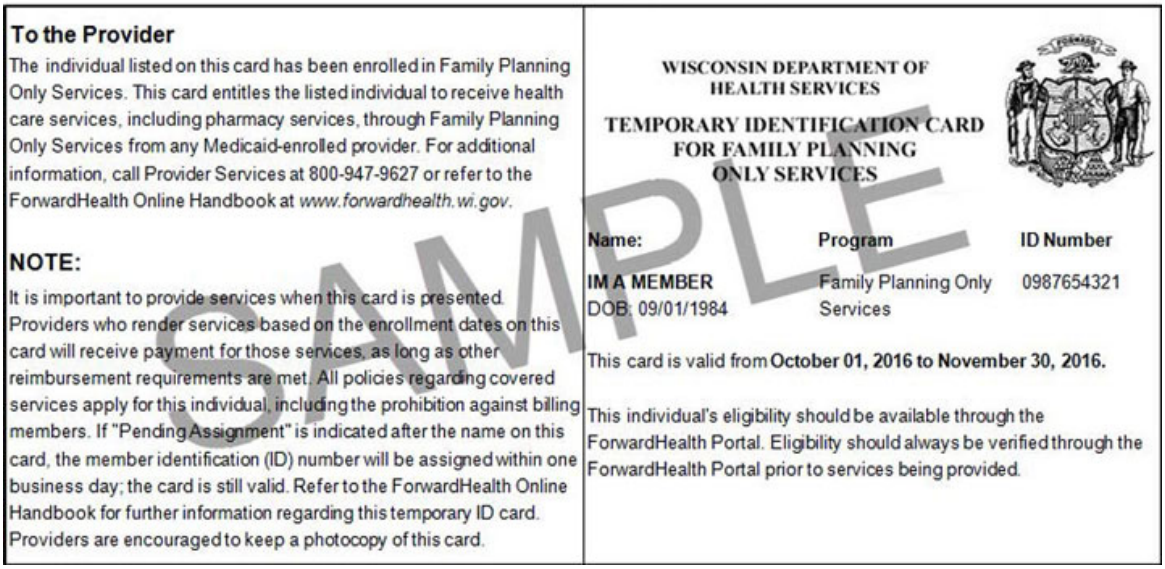
Name:	Program	ID Number
IM A MEMBER DOB: 09/01/1984	BadgerCare Plus	0987654321

This card is valid from **October 01, 2016 to November 30, 2016.**

This individual's eligibility should be available through the ForwardHealth Portal. Eligibility should always be verified through the ForwardHealth Portal prior to services being provided.

SAMPLE

Sample Temporary Identification Card for Family Planning Only Services



To the Provider

The individual listed on this card has been enrolled in Family Planning Only Services. This card entitles the listed individual to receive health care services, including pharmacy services, through Family Planning Only Services from any Medicaid-enrolled provider. For additional information, call Provider Services at 800-947-9627 or refer to the ForwardHealth Online Handbook at *www.forwardhealth.wi.gov*.

NOTE:

It is important to provide services when this card is presented. Providers who render services based on the enrollment dates on this card will receive payment for those services, as long as other reimbursement requirements are met. All policies regarding covered services apply for this individual, including the prohibition against billing members. If "Pending Assignment" is indicated after the name on this card, the member identification (ID) number will be assigned within one business day; the card is still valid. Refer to the ForwardHealth Online Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card.

WISCONSIN DEPARTMENT OF HEALTH SERVICES

TEMPORARY IDENTIFICATION CARD FOR FAMILY PLANNING ONLY SERVICES

Name:	Program	ID Number
IM A MEMBER DOB: 09/01/1984	Family Planning Only Services	0987654321

This card is valid from **October 01, 2016 to November 30, 2016.**

This individual's eligibility should be available through the ForwardHealth Portal. Eligibility should always be verified through the ForwardHealth Portal prior to services being provided.

SAMPLE

Topic #236

Specified Low-Income Medicare Beneficiaries

SLMB (Specified Low-Income Medicare Beneficiary) 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 income maintenance or tribal agency. To qualify, SLMB members are required to meet the following qualifications:

- Have an income under 120 percent of the FPL (Federal Poverty Level)
- Be entitled to, but not necessarily enrolled in, Medicare Part A

Topic #262

Tuberculosis-Related Medicaid

Tuberculosis-Related Medicaid is a limited benefit category that allows individuals with TB (tuberculosis) infection or disease to receive covered TB-related outpatient services.

Topic #240

Wisconsin Well Woman Medicaid

Wisconsin Well Woman Medicaid provides full Medicaid benefits to underinsured or uninsured women ages 35 to 64 who have been screened and diagnosed by WWWP (Wisconsin Well Woman Program) or Family Planning Only Services, meet all other enrollment requirements, and are in need of treatment for any of the following:

- Breast cancer
- Cervical cancer

- Precancerous conditions of the cervix

Services provided to women who are enrolled in WWWMA (Wisconsin Well Woman Medicaid) are reimbursed through Medicaid fee-for-service.

Identification Cards

Topic #266

ForwardHealth Identification Cards

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

ForwardHealth Identification Card Features

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

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

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

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

Digital ForwardHealth Identification Cards

Members can access digital versions of their ForwardHealth cards on the MyACCESS mobile app. Members are able to save PDFs and print out paper copies of their cards from the app. The digital and paper printout versions of the cards are identical to the physical cards for the purposes of accessing Medicaid-covered services. All policies that apply to the physical cards mailed by ForwardHealth to the member also apply to the digital or printed versions that members may present.

A member may still access their digital ForwardHealth card on the MyACCESS app when they are no longer enrolled. The MyACCESS app will display a banner message noting that the member is not currently enrolled in a ForwardHealth program. Providers should always 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 their 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 they do not know the member. After the member's identity has been verified, providers may verify a member's enrollment by using one of the EVS methods such as AVR (Automated Voice Response).

Defective Cards

If a provider uses a card reader for a ForwardHealth card and the magnetic stripe is defective, the provider should encourage the member to call Member Services at the number listed on the back of the member's card to request a new card.

If a member presents a ForwardHealth card with a defective magnetic stripe, providers may verify the member's enrollment by using an alternate enrollment verification method. Providers may also verify a member's enrollment by entering the member ID or 16-digit card number on a touch pad, if available, or by calling WiCall or Provider Services.

Lost Cards

If a member needs a replacement ForwardHealth card, they may call Member Services to request a new one.

If a member lost their ForwardHealth card or never received one, the member may call Member Services to request a new one.

Managed Care Organization Enrollment Changes

Members do not receive a new ForwardHealth card if they are enrolled in a state-contracted MCO (managed care organization) or change from one MCO to another. Providers should verify enrollment with the EVS every time they see a member to ensure they have the most current managed care enrollment information.

Topic #1435

Types of Identification Cards

ForwardHealth members receive an identification card upon initial eligibility determination. Identification cards may be presented in different formats (e.g., white plastic cards, paper cards, or paper printouts), depending on the program and the method used to enroll (i.e., paper application or online application). Members who are temporarily enrolled in BadgerCare Plus or Family Planning Only Services receive temporary identification cards.

Enrollment Rights

Topic #246

Appealing Enrollment Determinations

Applicants and members have the right to appeal certain decisions relating to BadgerCare Plus, Medicaid, or ADAP (Wisconsin AIDS Drug Assistance Program) enrollment. An applicant, a member, or authorized person acting on behalf of the applicant or member, or former member may file the appeal with the DHA (Division of Hearings and Appeals).

Pursuant to Wis. Admin. Code § HA 3.03, an applicant, member, or former member may appeal any adverse action or decision by an agency or department that affects their benefits. Examples of decisions that may be appealed include, but are not limited to, the following:

- Individual was denied the right to apply.
- Application for BadgerCare Plus, ADAP, or Wisconsin Medicaid was denied.
- Application for BadgerCare Plus, ADAP, or Wisconsin Medicaid was not acted upon promptly.
- Enrollment was unfairly discontinued, terminated, suspended, or reduced.

In the case when enrollment is cancelled or terminated, the date the member, or authorized person acting on behalf of the member, files an appeal with the DHA determines what continuing coverage, if any, the member will receive until the hearing decision is made. The following scenarios describe the coverage allowed for a member who files an appeal:

- If a member files an appeal before his or her enrollment ends, coverage will continue pending the hearing decision.
- If a member files an appeal within 45 days after his or her enrollment ends, a hearing is allowed but coverage is not reinstated.

If the member files an appeal more than 45 days after his or her enrollment ends, a hearing is not allowed. Members may file an appeal by submitting a Request for Fair Hearing (DHA-28 (08/09)) form.

Claims for Appeal Reversals

Claim Denial Due to Termination of BadgerCare Plus or Wisconsin Medicaid Enrollment

If a claim is denied due to termination of BadgerCare Plus or Wisconsin Medicaid enrollment, a hearing decision that reverses that determination will allow the claim to be resubmitted and paid. The provider is required to obtain a copy of the appeal decision from the member, attach the copy to the previously denied claim, and submit both to ForwardHealth at the following address:

ForwardHealth
Specialized Research
Ste 50
313 Blettner Blvd
Madison WI 53784

If a provider has not yet submitted a claim, the provider is required to submit a copy of the hearing decision along with a paper claim to Specialized Research.

As a reminder, claims submission deadlines still apply even to those claims with hearing decisions.

Claim Denial Due to Termination of ADAP Enrollment

If a claim is denied due to termination of ADAP enrollment, a hearing decision that reverses that determination will allow the claim to be resubmitted and paid. The provider is required to obtain a copy of the appeal decision from the member, attach the copy to the previously denied claim, and submit both to ForwardHealth at the following address:

ForwardHealth

ADAP Claims and Adjustments
PO Box 8758
Madison WI 53708

If a provider has not yet submitted a claim, the provider is required to submit a copy of the hearing decision along with a paper claim to ADAP Claims and Adjustments.

As a reminder, claims submission deadlines still apply even to those claims with hearing decisions.

Topic #247

Freedom of Choice

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

Topic #248

General Information

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

Topic #250

Notification of Discontinued Benefits

When DHS (Department of Health Services) intends to discontinue, suspend, or reduce a member's benefits, or reduce or eliminate coverage of services for a general class of members, DHS sends a written notice to members. This notice is required to be provided at least 10 days before the effective date of the action.

Topic #252

Prompt Decisions on Enrollment

Individuals applying for BadgerCare Plus or Wisconsin Medicaid have the right to prompt decisions on their applications. Enrollment decisions are made within 60 days of the date the application was signed for those with disabilities and within 30 days for all other applicants.

Topic #254

Requesting Retroactive Enrollment

An applicant has the right to request retroactive enrollment when applying for BadgerCare Plus or Wisconsin Medicaid. Enrollment may be backdated to the first of the month three months prior to the date of application for eligible members. Retroactive enrollment does not apply to QMB-Only (Qualified Medicare Beneficiary-Only) members.

Enrollment Responsibilities

Topic #241

General Information

Members have certain responsibilities per Wis. Admin. Code § DHS 104.02 and the ForwardHealth Enrollment and Benefits (P-00079 (07/14)) booklet.

Topic #243

Loss of Enrollment — Financial Liability

Some covered services consist of a series of sequential treatment steps, meaning more than one office visit is required to complete treatment.

In most cases, if a member loses enrollment midway through treatment, BadgerCare Plus and Medicaid will **not** reimburse services (including prior authorized services) after enrollment has lapsed.

Members are financially responsible for any services received after their enrollment has been terminated. If the member wishes to continue treatment, it is a decision between the provider and the member whether the service should be given and how the services will be paid. The provider may collect payment from the member if the member accepts responsibility for payment of a service and certain conditions are met.

To avoid misunderstandings, it is recommended that providers remind members that they are financially responsible for any continued care after enrollment ends.

To avoid potential reimbursement problems that can arise when a member loses enrollment midway through treatment, the provider is encouraged to verify the member's enrollment using the EVS (Enrollment Verification System) or the ForwardHealth Portal prior to providing each service, even if an approved PA (prior authorization) request is obtained for the service.

Topic #707

Member Cooperation

Members are responsible for giving providers full and accurate information necessary for the correct submission of claims. If a member has other health insurance, it is the member's obligation to give full and accurate information to providers regarding the insurance.

Topic #269

Members Should Present Card

It is important that providers determine a member's enrollment and other insurance coverage **prior to** each DOS (date of service) that services are provided. Pursuant to Wis. Admin. Code § DHS 104.02(2), a member should inform providers that they are enrolled in BadgerCare Plus or Wisconsin Medicaid and should present a current ForwardHealth identification card before receiving services.

Note: Due to the nature of their specialty, certain providers — such as anesthesiologists, radiologists, DME (durable medical equipment) suppliers, independent laboratories, and ambulances — are not always able to see a member's ForwardHealth identification card because they might not have direct contact with the member prior to providing the service. In these circumstances, it is still the provider's responsibility to obtain member enrollment information.

Topic #244

Prior Identification of Enrollment

Except in emergencies that preclude prior identification, members are required to inform providers that they are receiving benefits and must present their ForwardHealth identification card before receiving care. If a member forgets their ForwardHealth card, providers may verify enrollment without it.

Topic #245

Reporting Changes to Caseworkers

Members are required to report certain changes to their caseworker at their certifying agency. These changes include, but are not limited to, the following:

- A new address or a move out of state
- A change in income
- A change in family size, including pregnancy
- A change in other health insurance coverage
- Employment status
- A change in assets for members who are over 65 years of age, blind, or disabled

Special Enrollment Circumstances

Topic #276

Medicaid Members from Other States

Wisconsin Medicaid does not pay for services provided to members enrolled in other state Medicaid programs. Providers are advised to contact other state Medicaid programs to determine whether the service sought is a covered service under that state's Medicaid program.

Topic #279

Members Traveling Out of State

When a member travels out of state but is within the United States (including its territories), Canada, or Mexico, BadgerCare Plus and Wisconsin Medicaid cover medical services in any of the following circumstances:

- An emergency illness or accident
- When the member's health would be endangered if treatment were postponed
- When the member's health would be endangered if travel to Wisconsin were undertaken
- When PA (prior authorization) has been granted to the out-of-state provider for provision of a nonemergency service
- When there are coinsurance, copayment, or deductible amounts remaining after Medicare payment or approval for dual eligibles

Note: Some providers located in a state that borders Wisconsin may be Wisconsin Medicaid enrolled as a border-status provider if the provider notifies ForwardHealth in writing that it is common practice for members in a particular area of Wisconsin to seek their medical services. Border-status providers follow the same policies as Wisconsin providers.

Topic #277

Non-U.S. Citizens — Emergency Services

Certain non-U.S. citizens who are not qualified aliens are eligible for services only in cases of acute emergency medical conditions. Providers should use the appropriate diagnosis code to document the nature of the emergency.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of such severity that one could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the person's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Due to federal regulations, BadgerCare Plus and Wisconsin Medicaid do not cover services for non-U.S. citizens who are not qualified aliens related to routine prenatal or postpartum care, major organ transplants (for example, heart, liver), or ongoing treatment for chronic conditions where there is no evidence of an acute emergent state. For the purposes of this policy, services for ESRD (end-stage renal disease) and all labor and delivery are considered emergency services.

Note: Babies born to certain non-qualifying immigrants are eligible for Medicaid enrollment under the CEN (continuously eligible newborn) option. However, babies born to women with incomes over 300 percent of the FPL (Federal Poverty Level) are not eligible for CEN status. The baby may still qualify for BadgerCare Plus. These mothers should report the birth to the local agencies within ten calendar days.

A provider who gives emergency care to a non-U.S. citizen should refer them to the income maintenance or tribal agency or ForwardHealth outstation site for a determination of BadgerCare Plus enrollment. Providers may complete the Certification of Emergency for Non-U.S. Citizens (F-01162 (02/2009)) form for clients to take to the income maintenance or tribal agency in their county of residence where the BadgerCare Plus enrollment decision is made.

Providers should be aware that a client's enrollment does not guarantee that the services provided will be reimbursed by BadgerCare Plus.

Topic #278

Persons Detained by Legal Process

Most individuals detained by legal process who are eligible for BadgerCare Plus or Wisconsin Medicaid benefits will have their eligibility suspended during their detention period. During the suspension, ForwardHealth will only cover inpatient services received while the member is outside of jail or prison for 24 hours or more.

Note: "Detained by legal process" means a person who is incarcerated because of law violation or alleged law violation, which includes misdemeanors, felonies, delinquent acts, and day-release prisoners. Inmates who are released from jail under the Huber Program to return home to care for their minor children may be eligible for full benefit BadgerCare Plus or Wisconsin Medicaid without suspension.

Pregnant women detained by legal process who qualify for the BadgerCare Plus Prenatal Program and state prison inmates who qualify for Wisconsin Medicaid or BadgerCare Plus during inpatient hospital stays may receive certain benefits and are not subject to eligibility suspension. Additionally, inmates of county jails admitted to a hospital for inpatient services who are expected to remain in the hospital for 24 hours or more will be eligible for PE (presumptive eligibility) determinations for BadgerCare Plus by qualified hospitals. Refer to the Presumptive Eligibility chapter of either the Inpatient or Outpatient Hospital service area for more information on the PE determination process.

The DOC (Department of Corrections) or county jail oversee health care-related needs for individuals detained by legal process who do not qualify for the BadgerCare Plus Prenatal Program or for state prison inmates who do not qualify for Wisconsin Medicaid or BadgerCare Plus during an inpatient hospital stay.

Topic #16657

State Prison Inmates May Qualify for BadgerCare Plus or Wisconsin Medicaid During Inpatient Hospital Stays

As a result of 2013 Wisconsin Act 20, state prison inmates may qualify for BadgerCare Plus or Wisconsin Medicaid during inpatient hospital stays.

Eligibility

Most individuals detained by legal process who are eligible for BadgerCare Plus or Wisconsin Medicaid benefits will have their eligibility suspended during their detention period. During the suspension, ForwardHealth will only cover inpatient services received while the member is outside of jail or prison for 24 hours or more.

To qualify for BadgerCare Plus or Wisconsin Medicaid, prison or jail inmates must meet all applicable eligibility criteria. The DOC coordinates and reimburses inpatient hospital services for state prison inmates who do not qualify for BadgerCare Plus or Wisconsin Medicaid.

Inmates whose BadgerCare Plus or Wisconsin Medicaid eligibility has been suspended will have coverage of inpatient services for the duration of a hospital stay of 24 hours or more. This coverage begins on their date of admission and ends on their date of discharge.

Inmates are not eligible for outpatient hospital services, including observations, under BadgerCare Plus and Wisconsin Medicaid. Inmates may only be eligible for ER (emergency room) services if they are admitted to the hospital directly from the ER and are counted in the midnight census; otherwise, ER services are considered outpatient services. Outpatient hospital services approved by the DOC are reimbursed by the DOC.

Inmates are not presumptively eligible. Retroactive eligibility will only apply to dates of admission on and after April 1, 2014.

Enrollment

The DOC coordinates the submission of enrollment applications on behalf of state prison inmates.

Covered Services

The only services allowable by BadgerCare Plus or Wisconsin Medicaid for inmates are inpatient hospital services and professional services provided during the inpatient hospital stay that are covered under BadgerCare Plus and Wisconsin Medicaid. Providers with questions regarding services covered by BadgerCare Plus and Wisconsin Medicaid may refer to the applicable service area or contact Provider Services.

Fee-for-Service

Inmates receive services on a fee-for-service basis; they are not enrolled in HMOs.

Prior Authorization

The DOC will assist inpatient hospital providers with their submission of PA (prior authorization) requests for any services requiring PA. If PA is denied, the DOC is responsible for reimbursement of the services.

Enrollment Verification

Inmates are only enrolled for the duration of their hospital stay. Providers should always verify an inmate's enrollment in BadgerCare Plus or Wisconsin Medicaid before submitting a claim.

Claim Submission

When submitting a claim for an inmate's inpatient hospital stay, providers should follow the current claim submission procedures for each applicable service area.

Reimbursement

Acute care hospitals that provide services to inmates are reimbursed at a percentage of their usual and customary charge.

Critical access hospitals that provide services to inmates are reimbursed according to their existing Wisconsin Medicaid reimbursement methodology.

Wisconsin Medicaid reimburses professional services related to an inmate's inpatient hospital stay (e.g., laboratory services, physician services, radiology services, or DME (durable medical equipment)) at the current maximum allowable fee.

Contact Information

Providers may contact the DOC at 608-240-5139 or 608-240-5190 with questions regarding enrollment or PA for inmate inpatient hospital stays.

Topic #280

Retroactive Enrollment

Retroactive enrollment occurs when an individual has applied for BadgerCare Plus or Medicaid and enrollment is granted with an effective date prior to the date the enrollment determination was made. A member's enrollment may be backdated to allow retroactive coverage for medical bills incurred prior to the date of application.

The retroactive enrollment period may be backdated up to three months prior to the month of application if all enrollment requirements were met during the period. Enrollment may be backdated more than three months if there were delays in determining enrollment or if court orders, fair hearings, or appeals were involved.

Reimbursing Members in Cases of Retroactive Enrollment

When a member receives retroactive enrollment, he or she has the right to request the return of payments made to a Medicaid-enrolled provider for a covered service during the period of retroactive enrollment, according to Wis. Admin. Code § DHS 104.01(11). A Medicaid-

enrolled provider is required to submit claims to ForwardHealth for covered services provided to a member during periods of retroactive enrollment. Medicaid cannot directly refund the member.

If a service(s) that requires PA (prior authorization) was performed during the member's period of retroactive enrollment, the provider is required to submit a PA request and receive approval from ForwardHealth **before** submitting a claim.

If a provider receives reimbursement from Medicaid for services provided to a retroactively enrolled member and the member has paid for the service, the provider is required to reimburse the member or authorized person acting on behalf of the member (for example, local General Relief agency) the full amount that the member paid for the service.

If a claim cannot be filed within 365 days of the DOS (date of service) due to a delay in the determination of a member's retroactive enrollment, the provider is required to submit the claim to Timely Filing within 180 days of the date the retroactive enrollment is entered into Wisconsin's EVS (Enrollment Verification System) (if the services provided during the period of retroactive enrollment were covered).

Topic #281

Spenddown to Meet Financial Enrollment Requirements

Occasionally, an individual with significant medical bills meets all enrollment requirements except those pertaining to income. These individuals are required to "spenddown" their income to meet financial enrollment requirements.

The certifying agency calculates the individual's spenddown (or deductible) amount, tracks all medical costs the individual incurs, and determines when the medical costs have satisfied the spenddown amount. (A payment for a medical service does not have to be made by the individual to be counted toward satisfying the spenddown amount.)

When the individual meets the spenddown amount, the certifying agency notifies ForwardHealth and the provider of the last service that the individual is eligible beginning on the date that the spenddown amount was satisfied.

If the individual's last medical bill is greater than the amount needed to satisfy the spenddown amount, the certifying agency notifies the affected provider by indicating the following:

- The individual is eligible for benefits as of the DOS (date of service) on the last bill.
- A claim for the service(s) on the last bill should be submitted to ForwardHealth. (The claim should indicate the full cost of the service.)
- The portion of the last bill that the individual must pay to the provider.

The certifying agency also informs ForwardHealth of the individual's enrollment and identifies the following:

- The DOS of the final charges counted toward satisfying the spenddown amount
- The provider number of the provider of the last service
- The spenddown amount remaining to be satisfied

When the provider submits the claim, the spenddown amount will automatically be deducted from the provider's reimbursement for the claim. The spenddown amount is indicated in the Member's Share element on the Medicaid Remaining Deductible Update (F-10109 (02/2014)) 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.

Misuse and Abuse of Benefits

Topic #271

Examples of Member Abuse or Misuse

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

Topic #274

Pharmacy Services Lock-In Program

Overview of the Pharmacy Services Lock-In Program

The purpose of the Pharmacy Services Lock-In Program is to coordinate the provision of health care services for members who abuse or misuse Medicaid, BadgerCare Plus, or SeniorCare benefits by seeking duplicate or medically unnecessary services, particularly for controlled substances. The Pharmacy Services Lock-In Program focuses on the abuse or misuse of prescription benefits for controlled substances. Abuse or misuse is defined under Recipient Duties in Wis. Admin. Code § DHS 104.02.

Coordination of member health care services is intended to:

- Curb the abuse or misuse of controlled substance medications.
- Improve the quality of care for a member.
- Reduce unnecessary physician utilization.

The Pharmacy Services Lock-In Program focuses on the abuse or misuse of prescription benefits for controlled substances. Abuse or misuse is defined under Recipient Duties in Wis. Admin. Code § DHS 104.02. The abuse and misuse definition includes:

- Not duplicating or altering prescriptions
- Not feigning illness, using false pretense, providing incorrect enrollment status, or providing false information to obtain service
- Not seeking duplicate care from more than one provider for the same or similar condition
- Not seeking medical care that is excessive or not medically necessary

The Pharmacy Services Lock-In Program applies to members in fee-for-service as well as members enrolled in Medicaid SSI HMOs and BadgerCare Plus HMOs. Members remain enrolled in the Pharmacy Services Lock-In Program for two years and are continuously monitored for their prescription drug usage. At the end of the two-year enrollment period, an assessment is made to determine if the member should continue enrollment in the Pharmacy Services Lock-In Program.

Members enrolled in the Pharmacy Services Lock-In Program will be locked into one pharmacy where prescriptions for restricted medications must be filled and one prescriber who will prescribe restricted medications. Restricted medications are most controlled substances, carisoprodol, and tramadol. Referrals will be required only for restricted medication services.

Fee-for-service members enrolled in the Pharmacy Services Lock-In Program may choose physicians and pharmacy providers from whom to receive prescriptions and medical services not related to restricted medications. Members enrolled in an HMO must comply with the HMO's policies regarding care that is not related to restricted medications.

Referrals of members as candidates for lock-in are received from retrospective DUR (Drug Utilization Review), physicians, pharmacists, other providers, and through automated surveillance methods. Once a referral is received, six months of pharmacy claims and diagnoses data are reviewed. A recommendation for one of the following courses of action is then made:

- No further action.
- Send an intervention letter to the physician.
- Send a warning letter to the member.

- Enroll the member in the Pharmacy Services Lock-In Program.

Medicaid, BadgerCare Plus, and SeniorCare members who are candidates for enrollment in the Pharmacy Services Lock-In Program are sent a letter of intent, which explains the restriction that will be applied, how to designate a primary prescriber and a pharmacy, and how to request a hearing if they wish to contest the decision for enrollment (that is, due process). If a member fails to designate providers, the Pharmacy Services Lock-In Program may assign providers based on claims' history. In the letter of intent, members are also informed that access to emergency care is not restricted.

Letters of notification are sent to the member and to the lock-in primary prescriber and pharmacy. Providers may designate alternate prescribers or pharmacies for restricted medications, as appropriate. Members remain in the Pharmacy Services Lock-In Program for two years. The primary lock-in prescriber and pharmacy may make referrals for specialist care or for care that they are otherwise unable to provide (for example, home infusion services). The member's utilization of services is reviewed prior to release from the Pharmacy Services Lock-In Program, and lock-in providers are notified of the member's release date.

Excluded Drugs

The following scheduled drugs will be excluded from monitoring by the Pharmacy Services Lock-In Program:

- Anabolic steroids
- Barbiturates used for seizure control
- Lyrica
- Provigil and Nuvigil
- Weight loss drugs

Pharmacy Services Lock-In Program Administrator

The Pharmacy Services Lock-In Program is administered by Kepro. Kepro may be contacted by phone at 877-719-3123, by fax at 800-881-5573, or by mail at the following address:

Pharmacy Services Lock-In Program
c/o Kepro
PO Box 3570
Auburn AL 36831-3570

Pharmacy Services Lock-In Prescribers Are Required to Be Enrolled in Wisconsin Medicaid

To prescribe restricted medications for Pharmacy Services Lock-In Program members, prescribers are required to be enrolled in Wisconsin Medicaid. Enrollment for the Pharmacy Services Lock-In Program is not separate from enrollment in Wisconsin Medicaid.

Role of the Lock-In Prescriber and Pharmacy Provider

The lock-in prescriber determines what restricted medications are medically necessary for the member, prescribes those medications using their professional discretion, and designates an alternate prescriber if needed. If the member requires an alternate prescriber to prescribe restricted medications, the primary prescriber should complete the Pharmacy Services Lock-In Program Designation of Alternate Prescriber for Restricted Medication Services (F-11183 (03/2023)) form and return it to the Pharmacy Services Lock-In Program and to the member's HMO, if applicable.

To coordinate the provision of medications, the lock-in prescriber may also contact the lock-in pharmacy to give the pharmacist(s) guidelines as to which medications should be filled for the member and from whom. The primary lock-in prescriber should also coordinate the provision of medications with any other prescribers they have designated for the member.

The lock-in pharmacy fills prescriptions for restricted medications that have been written by the member's lock-in prescriber(s) and works with the lock-in prescriber(s) to ensure the member's drug regimen is consistent with the overall care plan. The lock-in pharmacy may fill prescriptions for medications from prescribers other than the lock-in prescriber only for medications not on the list of restricted medications. If a pharmacy claim for a restricted medication is submitted from a provider who is not a designated lock-in prescriber, the claim will be denied.

Designated Lock-In Pharmacies

The Pharmacy Services Lock-In Program pharmacy fills prescriptions for restricted medications that have been written by the member's lock-in prescriber(s) and works with the lock-in prescriber(s) to ensure the member's drug regimen is consistent with the overall care plan. The lock-in pharmacy may fill prescriptions for medications from prescribers other than the lock-in prescriber only for medications not on the list of restricted medications. If a pharmacy claim for a restricted medication is submitted from a provider who is not a designated lock-in prescriber, the claim will be denied.

Alternate Providers for Members Enrolled in the Pharmacy Services Lock-In Program

Members enrolled in the Pharmacy Services Lock-In Program do not have to visit their lock-in prescriber to receive medical services unless an HMO requires a primary care visit. Members may see other providers to receive medical services; however, other providers cannot prescribe restricted medications for Pharmacy Services Lock-In Program members unless specifically designated to do so by the primary lock-in prescriber. For example, if a member sees a cardiologist, the cardiologist may prescribe a statin for the member, but the cardiologist may not prescribe restricted medications unless they have been designated by the lock-in prescriber as an alternate provider.

A referral to an alternate provider for a Pharmacy Services Lock-In Program member is necessary only when the member needs to obtain a prescription for a restricted medication from a provider other than their lock-in prescriber or lock-in pharmacy.

If the member requires alternate prescribers to prescribe restricted medications, the primary lock-in prescriber is required to complete the Pharmacy Services Lock-In Program Designation of Alternate Prescriber for Restricted Medication Services form. Referrals for fee-for-service members must be on file with the Pharmacy Services Lock-In Program. Referrals for HMO members must be on file with the Pharmacy Service Lock-In Program and the member's HMO.

Designated alternate prescribers are required to be enrolled in Wisconsin Medicaid.

Claims from Providers Who Are Not Designated Pharmacy Services Lock-In Providers

If the member brings a prescription for a restricted medication from a non-lock-in prescriber to the designated lock-in pharmacy, the pharmacy provider cannot fill the prescription.

If a pharmacy claim for a restricted medication is submitted from a provider who is not the designated lock-in prescriber, alternate prescriber, lock-in pharmacy, or alternate pharmacy, the claim will be denied. If a claim is denied because the prescription is not from a designated lock-in prescriber, the lock-in pharmacy provider cannot dispense the drug or collect a cash payment from the member because the service is a nonreimbursable service. However, the lock-in pharmacy provider may contact the lock-in prescriber to request a new prescription for the drug, if appropriate.

To determine if a provider is on file with the Pharmacy Services Lock-In Program, the lock-in pharmacy provider may do one of the following:

- Speak to the member.
- Call Kepro.
- Call Provider Services.
- Use the ForwardHealth Portal.

Claims are not reimbursable if the designated lock-in prescriber, alternate lock-in prescriber, lock-in pharmacy, or alternate lock-in pharmacy provider is not on file with the Pharmacy Services Lock-In Program.

For More Information

Providers may call Kepro with questions about the Pharmacy Services Lock-In Program. Pharmacy providers may also refer to the list of restricted medications data table or call Provider Services with questions about the following:

- Drugs that are restricted for Pharmacy Services Lock-In Program members
- A member's enrollment in the Pharmacy Services Lock-In Program

- A member's designated lock-in prescriber or lock-in pharmacy

Topic #273

Providers May Refuse to Provide Services

Providers may refuse to provide services to a BadgerCare Plus or Medicaid member in situations when there is reason to believe that the person presenting the ForwardHealth identification card is misusing or abusing it.

Members who abuse or misuse BadgerCare Plus or Wisconsin Medicaid benefits or their ForwardHealth card may have their benefits terminated or be subject to limitations under the Pharmacy Services Lock-In Program or to criminal prosecution.

Topic #275

Requesting Additional Proof of Identity

Providers may request additional proof of identity from a member if they suspect fraudulent use of a ForwardHealth identification card. If another form of identification is not available, providers can compare a person's signature with the signature on the back of the ForwardHealth identification card if it is signed. (Adult members are encouraged to sign the back of their cards; however, it is not mandatory for members to do so.)

Verifying member identity, as well as enrollment, can help providers detect instances of fraudulent ForwardHealth card use.

Coordination of Benefits

7

Archive Date:04/01/2024

Coordination of Benefits:Other Coverage Information

Topic #4940

After Reporting Discrepancies

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

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

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

Topic #4941

Coverage Discrepancies

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

Topic #609

Insurance Disclosure Program

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

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

Topic #610

Maintaining Accurate and Current Records

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

- Insurance Disclosure program
- Providers who submit an Commercial Other Coverage Discrepancy Report (F-01159 (04/2017)) form or Medicare Other Coverage Discrepancy Report (F-02074 (04/2018)) form
- Member certifying agencies
- Members

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

Topic #4942

Reporting Discrepancies

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

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

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

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

Commercial Health Insurance

Topic #595

Assignment of Insurance Benefits

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

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

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

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

Topic #844

Claims for Services Denied by Commercial Health Insurance

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

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

Topic #598

Commercial Fee-for-Service

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

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

Topic #601

Definition of Commercial Health Insurance

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

Common types of commercial health insurance include HMOs, PPOs (preferred provider organizations), POS (point-of-service) plans,

Medicare Advantage plans, Medicare supplemental plans, dental plans, vision plans, HRAs (health reimbursement accounts), and LTC (long term care) plans. Some commercial health insurance providers restrict coverage to a specified group of providers in a particular service area.

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

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

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

Topic #602

Discounted Rates

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

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

Topic #596

Exhausting Commercial Health Insurance Sources

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

Step 1. Determine if the Member Has Commercial Health Insurance

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

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

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

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

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

- The provider is encouraged to bill commercial health insurance if they believe that benefits are available. Reimbursement from commercial health insurance may be greater than the Medicaid-allowed amount. If billing commercial health insurance first, the provider should proceed to Step 3.

- The provider may submit a claim without indicating an other insurance indicator on the claim or on the Explanation of Medical Benefits form, as applicable.

The provider may not bill Wisconsin Medicaid and commercial health insurance simultaneously. Simultaneous billing may constitute fraud and interferes with Wisconsin Medicaid's ability to recover prior payments.

Step 3. Identify Assignment of Commercial Health Insurance Benefits

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

The provider should proceed in one of the following ways:

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

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

Step 4. Bill Commercial Health Insurance and Follow Up

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

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

Step 5. Submit Claim to ForwardHealth

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

Topic #18497

Explanation of Medical Benefits Form Requirement

An Explanation of Medical Benefits (F-01234 (04/2018)) form must be included for each other payer when other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) sources are indicated on a paper claim or paper adjustment.

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

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

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

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

The Explanation of Medical Benefits form requirement applies to paper claims and paper adjustments submitted to Wisconsin Medicaid,

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

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

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

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

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

Topic #263

Members Unable to Obtain Services Under Managed Care Plan

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

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

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

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

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

Topic #604

Non-Reimbursable Commercial Health Insurance Services

Providers are not reimbursed for the following:

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

Topic #605

Other Insurance Indicators

Other insurance indicators are used to report results of commercial health insurance billing and to report when existing insurance was not billed

according to Wisconsin Medicaid expectations. Providers are required to use these indicators as applicable on professional, institutional, or dental claims or on the Explanation of Medical Benefits form, as applicable, submitted for members with commercial health insurance. The intentional misuse of other insurance indicators to obtain inappropriate reimbursement constitutes fraud.

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

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

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

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

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

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

Documentation Requirements

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

Topic #603

Services Not Requiring Commercial Health Insurance Billing

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

- Case management services

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

Topic #769

Services Requiring Commercial Health Insurance Billing

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

- Ambulance services, if provided as emergency services
- Anesthetist services
- Audiology services, unless provided in a nursing home or SNF (skilled nursing facility)
- Behavioral treatment
- Blood bank services
- Chiropractic services
- Dental services
- DME (durable medical equipment) (rental or purchase), prosthetics, and hearing aids if the billed amount is over $10.00 per item
- Home health services (excluding PC (personal care) services)
- Hospice services
- Hospital services, including inpatient or outpatient
- Independent nurse, nurse practitioner, or nurse midwife services
- Laboratory services
- Medicare-covered services for members who have Medicare and commercial health insurance
- In-home mental health/substance abuse treatment services for children (HealthCheck "Other Services") rendered by providers at the master's degree level, doctoral level, and psychiatrist level
- Outpatient mental health/substance abuse services
- Mental health/substance abuse day treatment services, including child and adolescent day treatment
- Narcotic treatment services
- PT (physical therapy), OT (occupational therapy), and SLP (speech and language pathology) services, unless provided in a nursing home or SNF
- Physician assistant services
- Physician services, including surgery, surgical assistance, anesthesiology, or any service to a hospital inpatient (however, physician services provided to a woman whose primary diagnosis indicates a high-risk pregnancy do not require commercial health insurance billing)
- Pharmacy services for members with verified drug coverage
- Podiatry services
- PDN (private duty nursing) services
- Radiology services
- RHC (rural health clinic) services
- Skilled nursing home care, if any DOS (date of service) is within 120 days of the date of admission; if benefits greater than 120 days are available, the nursing home is required to continue to bill for them until those benefits are exhausted
- Vision services over $50, unless provided in a home, nursing home, or SNF

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

- Ophthalmology services

- Optometrist services

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

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

ForwardHealth has identified services requiring Medicare Advantage billing.

Medicare

Topic #664

Acceptance of Assignment

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

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

Topic #666

Claims Denied for Errors

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

Topic #668

Claims Processed by Commercial Health Insurance That Is Secondary to Medicare

If a crossover claim is also processed by commercial health insurance that is secondary to Medicare (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 or Explanation of Medical Benefits form, as applicable.

Topic #670

Claims That Do Not Require Medicare Billing

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

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

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

Topic #704

Claims That Fail to Cross Over

ForwardHealth must be able to identify the billing provider in order to report paid or denied Medicare crossover claims information on the RA

(Remittance Advice). Claims with an NPI (National Provider Identifier) that fails to appear on the provider's RA are an indication that there is a problem with the matching and identification of the billing provider and the claims were denied.

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

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

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

Topic #667

Claims for Services Denied by Medicare

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

Topic #671

Crossover Claims

A Medicare crossover claim is a Medicare-allowed claim for a dual eligible or QMB-Only (Qualified Medicare Beneficiary-Only) member sent to ForwardHealth for payment of coinsurance, 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 (durable medical equipment) regional carrier
- Medicare Advantage Plan or Medicare Cost Plan
- Railroad Retirement Board carrier (also known as the Railroad Medicare carrier)

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

- Automatic crossover claims
- Provider-submitted crossover claims

Automatic Crossover Claims

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

Claims will be forwarded if the following occur:

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

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

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

Provider-Submitted Crossover Claims

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

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

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

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

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

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

Topic #9077

Crossover Claims for Diabetic Supplies

Medicare Part B

Claims for dual eligibles enrolled in BadgerCare Plus and Medicaid should first be submitted to Medicare Part B. Claims that are reimbursed by Medicare Part B should automatically cross over to ForwardHealth. Claims that are reimbursed by Medicare Part B that fail to cross over to ForwardHealth must be submitted on the 1500 Health Insurance Claim Form ((02/12)) with the appropriate HCPCS (Healthcare Common Procedure Coding System) procedure code.

As a reminder, if Medicare Part B denies a claim for diabetic supplies provided to a member who is covered by BadgerCare Plus or Medicaid, the provider may submit a claim for those services to ForwardHealth. Medicare Part B-denied crossover claims must be submitted to ForwardHealth electronically, on a Compound Drug Claim (F-13073 (04/2017)) form, or a Noncompound Drug Claim (F-13072 (04/2017)) form with an NDC (National Drug Code) and the appropriate other coverage code.

Medicare Part D

Diabetic supplies associated with the administration of insulin may be covered for members with Medicare Part D. Providers should contact the member's Medicare Part D PDP (Prescription Drug Plan) for information about the PDP's diabetic supply policy.

Topic #672

Definition of Medicare

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

Medicare coverage is divided into four parts:

- Part A (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 (physical therapy) services, OT (occupational therapy) services, and some home health services).
- Part C (i.e., Medicare Advantage). A commercial health plan that acts for Medicare Parts A and B, and sometimes Medicare Part D, for all Medicare covered services except hospice. Medicare Part A continues to provide coverage for hospice services. There are limitations on coverage outside of the carrier's provider network.
- Part D (i.e., drug benefit).

Topic #684

Dual Eligibles

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

Dual eligibles may receive coverage for the following:

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

Topic #669

Exhausting Medicare Coverage

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

Adjustment Request for Crossover Claim

The provider may submit a paper or electronic adjustment request. If submitting a paper Adjustment/Reconsideration Request (F-13046 (08/2015)) form, the provider should complete and submit the Explanation of Medical Benefits form, as applicable.

Provider-Submitted Crossover Claim

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

- The automatic crossover claim is not processed by ForwardHealth within 30 days of the Medicare processing date.
- ForwardHealth denied the automatic crossover claim, and additional information may allow payment.

- The claim is for a member who is enrolled in a Medicare Advantage Plan.
- The claim is for a member who is enrolled in Medicare and commercial health insurance that is secondary to Medicare (**for example**, Medicare Supplemental).
- The claim is for a member who was not enrolled in BadgerCare Plus at the time the service was submitted to Medicare for payment, but the member was retroactively enrolled.*

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

- For electronic claims, indicate the Medicare payment.
- For paper claims, complete the Explanation of Medical Benefits form.

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

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

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

Claim for Services Denied by Medicare

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

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

Crossover Claim Previously Reimbursed

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

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

In these situations, the provider should proceed as follows:

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

Topic #687

Medicare Advantage

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

ForwardHealth has identified services requiring Medicare Advantage billing.

Paper Crossover Claims

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

Reimbursement Limits

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

Topic #20677

Medicare Cost

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

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

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

Topic #688

Medicare Disclaimer Codes

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

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

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

Code	Description
M-7	Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the member's lifetime benefit, SOI (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 enrolled in Medicare Part A.

	▪ The member is eligible for Medicare Part A. ▪ The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or exhausted benefits. **For Medicare Part B, use M-7 in the following instances (all three criteria must be met):** ▪ The provider is identified in ForwardHealth files as enrolled in Medicare Part B. ▪ The member is eligible for Medicare Part B. ▪ The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or exhausted benefits.
M-8	Noncovered Medicare service. This code may be used when Medicare was not billed because the service is not covered in this circumstance. **For Medicare Part A, use M-8 in the following instances (all three criteria must be met):** ▪ The provider is identified in ForwardHealth files as enrolled in Medicare Part A. ▪ The member is eligible for Medicare Part A. ▪ The service is usually covered by Medicare Part A but not in this circumstance (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 enrolled in Medicare Part B. ▪ The member is eligible for Medicare Part B. ▪ The service is usually covered by Medicare Part B but not in this circumstance (e.g., member's diagnosis).

Documentation Requirements

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

Topic #8457

Medicare Late Fees

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

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

Resubmitting Medicare Crossover Claims with Late Fees

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

Paper Claim Submissions

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

Electronic Claim Submissions

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

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

- Billed Amount: $110.00
- 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.

Topic #689

Medicare Provider Enrollment

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

Services for Dual Eligibles

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

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

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

Services for Qualified Medicare Beneficiary-Only Members

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

Topic #690

Medicare Retroactive Eligibility — Member

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

Topic #895

Modifier for Catastrophe/Disaster-Related Crossover Claims

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

Topic #4957

Provider-Submitted Crossover Claims

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

Electronic Professional Crossover Claims

Providers submitting crossover claims electronically must indicate all Medicare coinsurance, 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 (Explanation of Medicare Benefits) as an attachment. Providers should, however, be sure to complete Medicare CAS segments when submitting 837 (837 Health Care Claim) transactions.

Paper Professional Crossover Claims

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

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

Topic #692

Qualified Medicare Beneficiary-Only Members

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

- Medicare monthly premiums for Part A, Part B, or both
- Coinsurance, 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.

Topic #686

Reimbursement for Crossover Claims

Professional Crossover Claims

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

Total payment for a Medicare Part B-covered service (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- covered 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 three examples of how the limitations are applied.

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

Outpatient Hospital Crossover Claims

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

Inpatient Hospital Services

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

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

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

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

Reimbursement for Medicare Part A-Covered Inpatient Hospital Services Provided To Dual Eligibles			
Explanation	**Example**		
	1	**2**	**3**
Provider's billed amount	$1,200	$1,200	$1,200
Medicare-allowed amount	$1,000	$1,000	$1,000

Medicaid-allowed amount (e.g., diagnosis-related group or per diem)	$1,200	$750	$750
Medicare-paid amount	$1,000	$800	$500
Difference between Medicaid-allowed amount and Medicare-paid amount	$200	($-50)	$250
Medicare coinsurance, copayment and deductible	$0	$200	$500
Medicaid payment	$0	$0	$250

Nursing Home Crossover Claims

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

Topic #770

Services Requiring Medicare Advantage Billing

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

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

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

ForwardHealth has identified services requiring commercial health insurance billing.

Provider-Based Billing

Topic #660

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 or Wisconsin Medicaid. For example, a provider-based billing claim is created when BadgerCare Plus or Wisconsin Medicaid pays a claim and later discovers that other coverage exists or was made retroactive. Since BadgerCare Plus and Wisconsin Medicaid 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 Wis. Admin. Code § DHS 106.03(7).

Topic #658

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 608-243-0676. 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.

Topic #661

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 and necessary information for providers to review and handle each claim.

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.

Accessing Provider-Based Billing Summary Reports

Providers can retrieve provider-based billing summary reports through the Portal by logging in to their secure provider Portal account. Once logged in, providers can click the Provider Based Bills (PBB) link located in the Quick Links box of the Providers area of the Portal to access the Provider Based Billing page. This page has links for the provider to download provider-based summary reports in .csv or .pdf format.

Refer to the Provider-Based Billing Retrieval User Guide for step-by-step instructions on how to access the Provider Based Billing page and download provider-based summary reports.

Note: ForwardHealth also sends the paper provider-based billing summary report to the provider's "mail to" address on file in the Portal.

The provider-based billing process runs monthly on the first full weekend of every month and files are available once the process is completed.

Topic #659

Responding to ForwardHealth After 120 Days

If a response is not received within 120 days, the amount originally paid by BadgerCare Plus or Wisconsin Medicaid 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 (dates of service) 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 (Enrollment Verification System) 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 provider-based billing summary).	ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784
The provider discovers that the member's other coverage information (that is, enrollment dates) reported by the EVS is invalid.	• A Commercial Other Coverage Discrepancy Report (F-01159 (04/2017)) form or Medicare Other Coverage Discrepancy Report (F-02074 (04/2018)) form. • 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 provider-based billing summary).	Send the Commercial Other Coverage Discrepancy Report form or Medicare Other Coverage Discrepancy Report form to the address indicated on the form. Send the claim to the following address: ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784
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 provider-based billing summary). • The appropriate other insurance indicator on the claim or complete and submit the Explanation of Medical Benefits form, as applicable. • The amount received from the other health insurance source on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.	ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784
The other health insurance source denies the provider-based billing claim.	• A claim according to normal claims submission procedures (do **not** use the provider-based billing summary). • The appropriate other insurance indicator or Medicare disclaimer code on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.	ForwardHealth Claims and Adjustments 313 Blettner Blvd Madison WI 53784
The commercial health insurance carrier does	• A claim according to normal claims submission	ForwardHealth

not respond to an initial **and** follow-up provider-based billing claim.	procedures (do **not** use the provider-based billing summary). The appropriate other insurance indicator on the claim or complete and submit the Explanation of Medical Benefits form, as applicable.	Claims and Adjustments 313 Blettner Blvd Madison WI 53784

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 provider-based billing summary). A Timely Filing Appeals Request (F-13047 (08/2015)) form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
The provider discovers that the member's other coverage information (that is, enrollment dates) reported by the EVS is invalid.	A Commercial Other Coverage Discrepancy Report form or Medicare 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 provider-based billing summary.) A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	Send the Commercial Other Coverage Discrepancy Report form or Medicare 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 50 313 Blettner Blvd Madison WI 53784
The commercial health insurance carrier reimburses or partially reimburses the provider-based billing claim.	A claim (do **not** use the provider-based billing summary). Indicate the amount received from the commercial health insurance on the claim or complete and submit the Explanation of Medical Benefits form, as applicable. A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784
The other health insurance source denies the provider-based billing claim.	A claim. The appropriate other insurance indicator or Medicare disclaimer code on the claim or complete and submit the Explanation of Medical Benefits form, as applicable. A Timely Filing Appeals Request form according to normal timely filing appeals procedures. The Provider-Based Billing Summary.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

	◦ 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.	
The commercial health insurance carrier does not respond to an initial and follow-up provider-based billing claim.	◦ A claim (do **not** use the provider-based billing summary). ◦ The appropriate other insurance indicator on the claim or complete and submit the Explanation of Medical Benefits form, as applicable. ◦ A Timely Filing Appeals Request form according to normal timely filing appeals procedures.	ForwardHealth Timely Filing Ste 50 313 Blettner Blvd Madison WI 53784

Topic #662

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 (Enrollment Verification System) 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 website 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 (date of service), 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. • A copy of the Explanation of Medical Benefits form, as applicable. *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
		ForwardHealth
		Provider-Based Billing
		PO Box 6220
		Madison WI 53716-0220
		Fax 608-221-4567

	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. ¡ A copy of the Explanation of Medical Benefits form, as applicable. l 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.	
The other health insurance source fails to respond to the initial **and** follow-up provider-based billing claim.	l The Provider-Based Billing Summary. l Indication that no response was received by the other health insurance source. l Indication of the dates that the initial and follow-up provider-based billing claims were submitted to the other health insurance source.	ForwardHealth Provider-Based Billing PO Box 6220 Madison WI 53716-0220 Fax 608-221-4567

Topic #663

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 should add all information required by the other health insurance source 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

Topic #657

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 Wis. Admin. Code § DHS 106.03(8), BadgerCare Plus and Wisconsin Medicaid will not reimburse providers if they receive payment from either of these sources.

The provider may choose a different option for each DOS (date of service). 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.

Topic #829

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 or Wisconsin Medicaid, 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.

Topic #826

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.

Topic #827

Submitting Claims to ForwardHealth

If the provider chooses to submit a claim to ForwardHealth, they 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 an accident-related diagnosis code on claims when services are provided to an accident victim. 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.

Resources

8

Archive Date:04/01/2024

Resources:WiCall

Topic #257

Enrollment Inquiries

WiCall is an AVR (Automated Voice Response) system that allows providers with touch-tone telephones direct access to enrollment information.

Information from WiCall will be returned in the following order if applicable to the member's current enrollment:

- Transaction number: A number will be given as a transaction confirmation that providers should keep for their records.
- Benefit enrollment: All benefit plans the member is enrolled in on the DOS (date of service) or within the DOS range selected for the financial payer.
- County code: The member's county code will be provided if available. The county code is a two-digit code between 01 and 72 that represents the county in which member resides. If the enrollment response reflects that the member resides in a designated HPSA (Health Personnel Shortage Area) on the DOS or within the DOS range selected, HPSA information will be given.
- MCO (managed care organization): All information about state-contracted MCO enrollment, including MCO names and telephone numbers, that exists on the DOS or within the DOS range selected will be listed. This information is applicable to Medicaid and BadgerCare Plus members only.
- Hospice: If the member is enrolled in the hospice benefit on the DOS or within the DOS range that the provider selected, the hospice information will be given. This information is applicable to Medicaid and BadgerCare Plus members only.
- Lock-in: Information about the Pharmacy Services Lock-In Program that exists on the DOS or within the DOS range selected will be provided. This information is applicable to Medicaid, BadgerCare Plus, and SeniorCare members only.
- Medicare: All information about Medicare coverage, including type of coverage and Medicare member ID, if available, that exists on the DOS or within the DOS range selected will be listed.
- Commercial health insurance coverage: All information about commercial coverage, including carrier names and telephone numbers, if available, that exists on the DOS or within the DOS range selected will be listed.
- Transaction completed: After the member's enrollment information has been given using the financial payer that was selected, providers will be given the following options to:
  - Hear the information again
  - Request enrollment information for the same member using a different financial payer
  - Hear another member's enrollment information using the same financial payer
  - Hear another member's enrollment information using a different financial payer
  - Return to the main menu

WiCall is available 24 hours a day, seven days a week. If for some reason the system is unavailable, providers may call Provider Services.

Transaction Number

The AVR system issues a transaction number every time a provider verifies enrollment, even when an individual is *not* enrolled in BadgerCare Plus or Wisconsin Medicaid. The provider should retain this transaction number. It is proof that an inquiry was made about the member's enrollment. If a provider thinks a claim was denied in error, the provider can reference the transaction number to ForwardHealth to confirm the enrollment response that was actually given.

Topic #6257

Entering Letters into WiCall

For some WiCall inquries, health care providers are required to enter their taxonomy code with their NPI (National Provider Identifier). Because taxonomy codes are a combination of numbers and letters, telephone key pad combinations, shown in the table below, allow providers to successfully enter taxonomy code letters for WiCall functions (e.g., press *21 to enter an "A," press *72 to enter an "R").

Letter	Key Combination	Letter	Key Combination
A	*21	N	*62
B	*22	O	*63
C	*23	P	*71
D	*31	Q	*11
E	*32	R	*72
F	*33	S	*73
G	*41	T	*81
H	*42	U	*82
I	*43	V	*83
J	*51	W	*91
K	*52	X	*92
L	*53	Y	*93
M	*61	Z	*12

Additionally, providers may select option 9 and press "#" for an automated voice explanation of how to enter letters in WiCall.

Topic #466

Information Available Via WiCall

WiCall, ForwardHealth's AVR (Automated Voice Response) system, gathers inquiry information from callers through voice prompts and accesses ForwardHealth interChange to retrieve and "speak" back the following ForwardHealth information:

- Claim status
- Enrollment verification
- PA (prior authorization) status
- Provider CheckWrite information

Note: ForwardHealth releases CheckWrite information to WiCall no sooner than on the first state business day following the financial cycle.

Providers are prompted to enter NPI (National Provider Identifier) or provider ID and in some cases, NPI-related data, to retrieve query information.

In all inquiry scenarios, WiCall offers the following options after information is retrieved and reported back to the caller:

- Repeat the information.
- Make another inquiry of the same type.
- Return to the main menu.
- Repeat the options.

Claim Status

Providers may check the status of a specific claim by selecting the applicable financial payer (program, i.e., Wisconsin Medicaid, WCDP (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program)) and entering their provider ID, member identification number, DOS (date of service), and the amount billed.

Note: Claim information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

Enrollment Verification

Providers may request enrollment status for any date of eligibility the member has on file by entering their provider ID and the member ID. If the member ID is unknown, providers may enter the member's date of birth and SSN (Social Security number). Additionally, the provider is prompted to enter the "From DOS" and the "To DOS" for the inquiry. The "From" DOS is the earliest date the provider requires enrollment information and the "To" DOS must be within 365 days of the "From" DOS.

Each time a provider verifies member enrollment, the enrollment verification is saved and assigned a transaction number as transaction confirmation. Providers should note the transaction number for their records.

PA Status

Except in certain instances, providers may obtain the status of PA requests for Medicaid and WCDP via WiCall by entering their provider ID and the applicable PA number. If the provider does not know the PA number, there is an option to bypass entering the PA number and the caller will be prompted to enter other PA information such as member ID and type of service (i.e., NDC (National Drug Code), procedure code, revenue code, or ICD (International Classification of Diseases) procedure code). When a match is found, WiCall reports back the PA status information, including the PA number for future reference, and the applicable program.

Information on past PAs is retained indefinitely. Paper PAs require a maximum of 20 working days from receipt to be processed and incorporated into WiCall's PA status information.

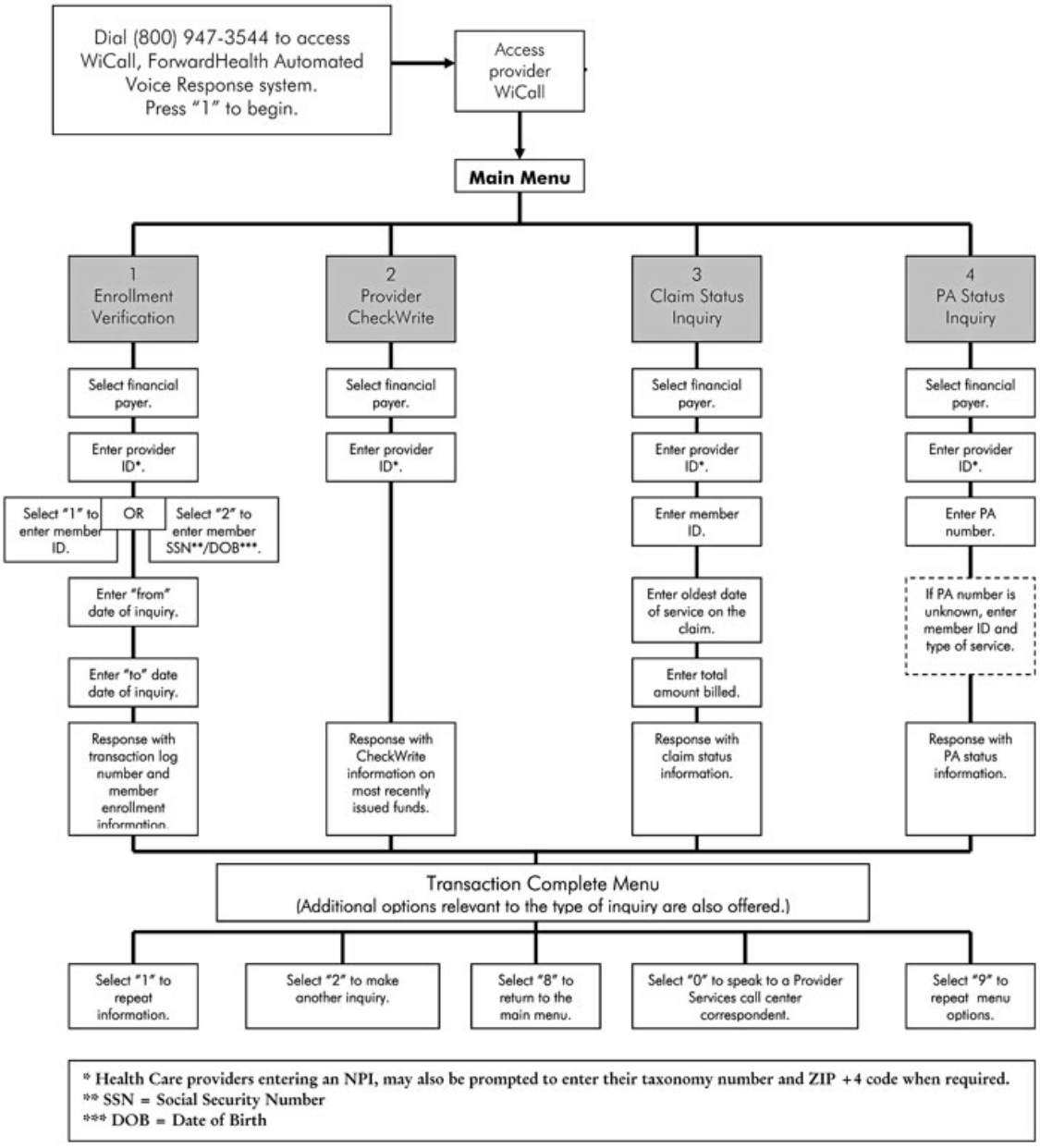
Note: PA information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

Topic #765

Quick Reference Guide

The WiCall AVR (Automated Voice Response) Quick Reference Guide displays the information available for WiCall inquiries.

Automated Voice Response Quick Reference Guide



* Health Care providers entering an NPI, may also be prompted to enter their taxonomy number and ZIP +4 code when required.
** SSN = Social Security Number
*** DOB = Date of Birth

Electronic Data Interchange

Topic #459

Companion Guides and NCPDP Version D.0 Payer Sheet

Companion guides and the NCPDP (National Council for Prescription Drug Programs) version D.0 payer sheet are available for download on the ForwardHealth Portal.

Purpose of Companion Guides

ForwardHealth companion guides and payer sheet provide trading partners with useful technical information on ForwardHealth's standards for nationally recognized electronic transactions.

The information in companion guides and payer sheet applies to BadgerCare Plus, Medicaid, SeniorCare, ADAP (Wisconsin AIDS Drug Assistance Program), WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program). Companion guides and payer sheet are intended for information technology and systems staff who code billing systems or software.

The companion guides and payer sheet complement the federal HIPAA (Health Insurance Portability and Accountability Act of 1996) implementation guides and highlight information that trading partners need to successfully exchange electronic transactions with ForwardHealth, including general topics such as the following:

- Methods of exchanging electronic information (e.g., exchange interfaces, transaction administration, and data preparation)
- Instructions for constructing the technical component of submitting or receiving electronic transactions (e.g., claims, RA (Remittance Advice), and enrollment inquiries)

Companion guides and payer sheet do **not** include program requirements, but help those who create the electronic formats for electronic data exchange.

Companion guides and payer sheet cover the following specific subjects:

- Getting started (e.g., identification information, testing, and exchange preparation)
- Transaction administration (e.g., tracking claims submissions, contacting the EDI (Electronic Data Interchange) Helpdesk)
- Transaction formats

Revisions to Companion Guides and Payer Sheet

Companion guides and payer sheet may be updated as a result of changes to federal requirements. When this occurs, ForwardHealth will do the following:

- Post the revised companion guides and payer sheet on the ForwardHealth Portal.
- Post a message on the banner page of the RA.
- Send an email to trading partners.

Trading partners are encouraged to periodically check for revised companion guides and payer sheet on the Portal. If trading partners do not follow the revisions identified in the companion guides or payer sheet, transactions may not process successfully (e.g., claims may deny or process incorrectly).

A change summary located at the end of the revised companion guide lists the changes that have been made. The date on the companion guide reflects the date the revised companion guide was posted to the Portal. In addition, the version number located in the footer of the first page is changed with each revision.

Revisions to the payer sheet are listed in Appendix A. The date on the payer sheet reflects the date the revised payer sheet was posted to the Portal.

Topic #460

Data Exchange Methods

The following data exchange methods are supported by the EDI (Electronic Data Interchange) Helpdesk:

- Remote access server dial-up, using a personal computer with a modem, browser, and encryption software
- Secure web, using an internet service provider and a personal computer with a modem, browser, and encryption software
- Real-time, by which trading partners exchange the NCPDP (National Council for Prescription Drug Programs) D.0, 270/271 (270/271 Eligibility & Benefit Inquiry and Response), 276/277 (276/277 Health Care Claim Status Request and Response), or 278 (278 Health Care Services Review — Request for Review and Response) transactions via an approved clearinghouse

The EDI Helpdesk supports the exchange of the transactions for BadgerCare Plus, Medicaid, SeniorCare, ADAP (Wisconsin AIDS Drug Assistance Program), WCDP (Wisconsin Chronic Disease Program), and WWWP (Wisconsin Well Woman Program).

Topic #461

Electronic Data Interchange Helpdesk

The EDI (Electronic Data Interchange) Helpdesk assists anyone interested in becoming a trading partner with getting started and provides ongoing support pertaining to electronic transactions. Providers, billing services, and clearinghouses are encouraged to contact the EDI Helpdesk for test packets and/or technical questions.

Providers with policy questions should call Provider Services.

Topic #462

Electronic Transactions

HIPAA (Health Insurance Portability and Accountability Act of 1996) ASC (Accredited Standards Committee) X12 Version 5010 Companion Guides and the NCPDP (National Council for Prescription Drug Programs) Version D.0 Payer Sheet are available for download on the HIPAA Version 5010 Companion Guides and NCPDP Version D.0 Payer Sheet page of the ForwardHealth Portal.

Trading partners may submit claims and adjustment requests, inquire about member enrollment, claim status, and ForwardHealth payment advice by exchanging electronic transactions.

Through the EDI (Electronic Data Interchange) Helpdesk, trading partners may exchange the following electronic transactions:

- 270/271 (270/271 Eligibility & Benefit Inquiry and Response). The 270 is the electronic transaction for inquiring about a member's enrollment. The 271 is received in response to the inquiry.
- 276/277 (276/277 Health Care Claim Status Request and Response). The 276 is the electronic transaction for checking claim status. The 277 is received in response.
- 278 (278 Health Care Services Review — Request for Review and Response). The electronic transaction for health care service PA (prior authorization) requests.
- 835 (835 Health Care Claim Payment/Advice). The electronic transaction for receiving remittance information.
- 837 (837 Health Care Claim). The electronic transaction for submitting claims and adjustment requests.
- 999 (999 Acknowledgment for Health Care Insurance). The electronic transaction for reporting whether a transaction is accepted or rejected.
- TA1 interChange Acknowledgment. The electronic transaction for reporting a transaction that is rejected for interChange-level errors.
- NCPDP D.0 Telecommunication Standard for Retail Pharmacy claims. The real-time POS (Point-of-Sale) electronic transaction for submitting pharmacy claims.

Topic #9177

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. The PES (Provider Electronic Solutions) software allows providers to submit NCPDP (National Council for Prescription Drug Programs) transactions, reverse claims, and check claim status. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI (Electronic Data Interchange) Helpdesk.

Topic #464

Trading Partner Profile

A Trading Partner Profile must be completed and signed for each billing provider number that will be used to exchange electronic transactions.

In addition, billing providers who do not use a third party to exchange electronic transactions, billing services, and clearinghouses are required to complete a Trading Partner Profile.

To determine whether a Trading Partner Profile is required, providers should refer to the following:

- Billing providers who do not use a third party to exchange electronic transactions, including providers who use the PES (Provider Electronic Solutions) software, are required to complete the Trading Partner Profile.
- Billing providers who use a third party (billing services and clearinghouses) to exchange electronic transactions are required to submit a Trading Partner Profile.
- Billing services and clearinghouses, including those that use PES software, that are authorized by providers to exchange electronic transactions on a provider's behalf, are required to submit a Trading Partner Profile.

Providers who change billing services and clearinghouses or become a trading partner should keep their information updated by contacting the EDI (Electronic Data Interchange) Helpdesk.

Topic #465

Trading Partners

ForwardHealth exchanges nationally recognized electronic transactions with trading partners. A "trading partner" is defined as a covered entity that exchanges electronic health care transactions. The following covered entities are considered trading partners:

- Providers who exchange electronic transactions directly with ForwardHealth
- Billing services and clearinghouses that exchange electronic transactions directly with ForwardHealth on behalf of a billing provider

Enrollment Verification

Topic #256

270/271 Transactions

The 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Information Response) transactions allow for batch enrollment verification, including information for the current benefit month or for any date of eligibility the member has on file, through a secure internet connection. The 270 is the electronic transaction for inquiring about a member's enrollment. The 271 is received in response to the inquiry.

For those providers who are federally required to have an NPI (National Provider Identifier), an NPI is required on the 270/271 transactions. The NPI indicated on the 270 is verified to ensure it is associated with a valid enrollment on file with ForwardHealth. The 271 response will report the NPI that was indicated on the 270.

For those providers exempt from NPI, a provider ID is required on the 270/271 transactions. The provider ID indicated on the 270 is verified to ensure it is associated with a valid enrollment on file with ForwardHealth. The 271 response will report the provider ID that was indicated on the 270.

Topic #469

An Overview

Providers should always verify a member's enrollment before providing services, both to determine enrollment for the current date (since a member's enrollment status may change) and to discover any limitations to the member's coverage. Each enrollment verification method allows providers to verify the following prior to services being rendered:

- A member's enrollment in a ForwardHealth program(s)
- State-contracted MCO (managed care organization) enrollment
- Medicare enrollment
- Limited benefits categories
- Any other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) coverage
- Exemption from copayments for BadgerCare Plus members

Topic #259

Commercial Enrollment Verification Vendors

ForwardHealth has agreements with several commercial enrollment verification vendors to offer enrollment verification technology to ForwardHealth providers. Commercial enrollment verification vendors have up-to-date access to the ForwardHealth enrollment files to ensure that providers have access to the most current enrollment information. Providers may access Wisconsin's EVS (Enrollment Verification System) to verify member enrollment through one or more of the following methods available from commercial enrollment verification vendors:

- Magnetic stripe card readers
- Personal computer software
- Internet

Vendors sell magnetic stripe card readers, personal computer software, internet access, and other services. They also provide ongoing maintenance, operations, and upgrades of their systems. Providers are responsible for the costs of using these enrollment verification methods.

Note: Providers are *not* required to purchase services from a commercial enrollment verification vendor. For more information on other ways to verify member enrollment or for questions about ForwardHealth identification cards, contact Provider Services.

The real-time enrollment verification methods allow providers to print a paper copy of the member's enrollment information, including a

transaction number, for their records. Providers should retain this number or the printout as proof that an inquiry was made.

Magnetic Stripe Card Readers

The magnetic stripe card readers resemble credit card readers. Some ForwardHealth identification cards have a magnetic stripe and signature panel on the back, and a unique, 16-digit card number on the front. The 16-digit card number is valid only for use with a magnetic card reader.

Providers receive current member enrollment information after passing the ForwardHealth card through the reader or entering the member identification number or card number into a keypad and entering the DOS (date of service) about which they are inquiring.

Personal Computer Software

Personal computer software can be integrated into a provider's current computer system by using a modem and can access the same information as the magnetic stripe card readers.

Internet Access

Some enrollment verification vendors provide real-time access to enrollment from the EVS through the internet.

Topic #4903

Copay Information

No Copay

If a member is enrolled in BadgerCare Plus or Wisconsin Medicaid and is exempt from paying copays 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, Wisconsin Medicaid, or SeniorCare and is required to pay a copay, the provider will be given the name of the benefit plan in which the member is enrolled and the member's enrollment dates for the benefit plan only.

Copay

If a member is enrolled in BadgerCare Plus, Wisconsin Medicaid, or SeniorCare and is required to pay a copay, 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

Non-Emergent Copay

If a member is enrolled in BadgerCare Plus and is eligible for the $8 non-emergent copay, 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, "Member Eligible for Non-Emergent Copay" or "Eligible for Non-Emergent Copay"

The messages "Member Eligible for Non-Emergent Copay" and "Eligible for Non-Emergent Copay" indicate that a member is a BadgerCare Plus childless adult and they are eligible for the copay if they do not meet the prudent layperson standard and seek and receive additional post-stabilization care in the emergency department after being informed of the $8 copay and availability of alternative providers with lesser or no

cost share.

Topic #264

Enrollment Verification System

Member enrollment issues are the primary reason claims are denied. To reduce claim denials, providers should **always** verify a member's enrollment before providing services, both to determine enrollment for the current date (since a member's enrollment status may change) and to discover any limitations to the member's coverage. Providers may want to verify the member's enrollment a second time before submitting a claim to find out whether the member's enrollment information has changed since the appointment.

Providers can access Wisconsin's EVS (Enrollment Verification System) to receive the most current enrollment information through the following methods:

- ForwardHealth Portal
- WiCall, Wisconsin's AVR (Automated Voice Response) system
- Commercial enrollment verification vendors
- 270/271 (270/271 Health Care Eligibility/Benefit Inquiry and Response) transactions
- Provider Services

Providers cannot charge a member, or authorized person acting on behalf of the member, for verifying their enrollment.

The EVS does not indicate other government programs that are secondary to Wisconsin Medicaid.

Topic #4901

Enrollment Verification on the Portal

The secure ForwardHealth Portal offers real-time member enrollment verification for all ForwardHealth programs. Providers will be able to use this tool to determine:

- The benefit plan(s) in which the member is enrolled
- If the member is enrolled in a state-contracted managed care program (for Medicaid and BadgerCare Plus members)
- If the member has any other coverage, such as Medicare or commercial health insurance
- If the member is exempted from copays (BadgerCare Plus and Medicaid members only)

To access enrollment verification via the ForwardHealth Portal, providers will need to do the following:

- Go to the ForwardHealth Portal.
- Establish a provider account.
- Log into the secure Portal.
- Click on the menu item for enrollment verification.

Providers will receive a unique transaction number for each enrollment verification inquiry. Providers may access a history of their enrollment inquiries using the Portal, which will list the date the inquiry was made and the enrollment information that was given on the date that the inquiry was made. For a more permanent record of inquiries, providers are advised to use the "print screen" function to save a paper copy of enrollment verification inquiries for their records or document the transaction number at the beginning of the response, for tracking or research purposes. This feature allows providers to access enrollment verification history when researching claim denials due to enrollment issues.

The Provider Portal is available 24 hours a day, seven days a week.

Topic #4900

Entering Dates of Service

Enrollment information is provided based on a "From" DOS (date of service) and a "To" DOS that the provider enters when making the enrollment inquiry. For enrollment inquires, a "From" DOS is the earliest date for which the provider is requesting enrollment information and the "To" DOS is the latest date for which the provider is requesting enrollment information.

Providers should use the following guidelines for entering DOS when verifying enrollment for Wisconsin Medicaid, BadgerCare Plus, SeniorCare, or WCDP (Wisconsin Chronic Disease Program) members:

- The "From" DOS is the earliest date the provider requires enrollment information.
- The "To" DOS must be within 365 days of the "From" DOS.
- If the date of the request is prior to the 20th of the current month, then providers may enter a "From" DOS and "To" DOS up to the end of the current calendar month.
- If the date of the request is on or after the 20th of the current month, then providers may enter a "From" DOS and "To" DOS up to the end of the following calendar month.

For example, if the date of the request was November 15, 2008, the provider could request dates up to and including November 30, 2008. If the date of the request was November 25, 2008, the provider could request dates up to and including December 31, 2008.

Topic #265

Member Forgets ForwardHealth Identification Card

Even if a member does not present a ForwardHealth identification card, a provider can use Wisconsin's EVS (Enrollment Verification System) to verify enrollment; otherwise, the provider may choose not to provide the service(s) until a member brings in a ForwardHealth card or displays a digital ForwardHealth Card on the MyACCESS app.

A provider may use a combination of the member's name, date of birth, ForwardHealth identification number, or SSN (Social Security number) with a "0" at the end to access enrollment information through the EVS.

A provider may call Provider Services with the member's full name and date of birth to obtain the member's enrollment information if the member's identification number or SSN is not known.

Topic #4899

Member Identification Card Does Not Guarantee Enrollment

Most members receive a member identification card, but possession of a program identification card does not guarantee enrollment. Periodically, members may become ineligible for enrollment, only to re-enroll at a later date. Members are told to keep their cards even though they may have gaps in enrollment periods. It is possible that a member will present a card when they are not enrolled; therefore, it is essential that providers verify enrollment before providing services. To reduce claim denials, it is important that providers verify the following information prior to each DOS (date of service) that services are provided:

- If a member is enrolled in any ForwardHealth program, including benefit plan limitations
- If a member is enrolled in a managed care organization
- If a member is in primary provider lock-in status
- If a member has Medicare or other insurance coverage

Topic #4898

Responses Are Based on Financial Payer

When making an enrollment inquiry through Wisconsin's EVS (Enrollment Verification System), the returned response will provide information on the member's enrollment in benefit plans based on financial payers.

There are three financial payers under ForwardHealth:

- Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and SeniorCare).
- WCDP (Wisconsin Chronic Disease Program).
- WWWP (Wisconsin Well Woman Program).

Within each financial payer are benefit plans. Each member is enrolled under at least one of the three financial payers, and under each financial payer, is enrolled in at least one benefit plan. An individual member may be enrolled under more than one financial payer. (For instance, a member with chronic renal disease may have health care coverage under BadgerCare Plus and the WCDP chronic renal disease program. The member is enrolled under two financial payers, Medicaid and WCDP.) Alternatively, a member may have multiple benefits under a single financial payer. (For example, a member may be covered by Tuberculosis-Related Medicaid and Family Planning Only Services at the same time, both of which are administered by Medicaid.)

Forms

Topic #767

An Overview

ForwardHealth requires providers to use a variety of forms for PA (prior authorization), claims processing, and documenting special circumstances.

Topic #470

Fillable Forms

Most forms may be obtained from the Forms page of the ForwardHealth Portal.

Forms on the Portal are available as fillable PDF (Portable Document Format) files, which can be viewed with Adobe Reader computer software. Providers may also complete and print fillable PDF files using Adobe Reader.

To complete a fillable PDF, follow these steps:

- Select a specific form.
- Save the form to the computer.
- Use the "Tab" key to move from field to field.

Note: The Portal provides instructions on how to obtain Adobe Reader at no charge from the Adobe website. 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 website for more information about fillable PDFs.

Selected forms are also available in fillable Microsoft Word format on the Portal. The fillable Microsoft Word format allows providers to complete and print the form using Microsoft Word. To complete a fillable Microsoft Word form, follow these steps:

- Select a specific form.
- Save the form to the computer.
- Use the "Tab" key to move from field to field.

Note: Providers may save fillable Microsoft Word documents to their computer by choosing "Save As" from the "File" menu, creating a file name, and selecting "Save" on their desktop.

Topic #766

Telephone or Mail Requests

Providers who do not have internet access or who need forms that are not available on the ForwardHealth Portal may obtain them by doing either of the following:

- Requesting a paper copy of the form by calling Provider Services. Questions about forms may also be directed to Provider Services.
- Submitting a written request and mailing it to ForwardHealth. Include a return address, the name of the form, and the form number and send the request to the following address:

    ForwardHealth
    Form Reorder
    313 Blettner Blvd

Madison WI 53784

Updates

Topic #478

Accessing ForwardHealth Communications

ForwardHealth Updates announce changes in policy and coverage, prior authorization requirements, and claim submission requirements. They communicate new initiatives from the Wisconsin Department of Health Services or new requirements from the federal Centers for Medicare and Medicaid Services and the Wisconsin state legislature.

Updates reflect current policy at the time of publication; this information may change over time and be revised by a subsequent *Update*. *Update* information is added to the Online Handbook after the *Update* is posted, unless otherwise noted.

Providers should refer to the *ForwardHealth Online Handbook* for current information. The Online Handbook is the source for current ForwardHealth policy and contains provider-specific information for various services and benefits.

Topic #4458

Electronic Notifications from ForwardHealth

ForwardHealth sends electronic messaging using both email subscription and secure Portal messaging to notify providers of newly released ForwardHealth Updates. ForwardHealth also uses electronic messaging to communicate training opportunities and other timely information.

Secure Portal Messages

Providers who have established a secure ForwardHealth Portal account automatically receive messages from ForwardHealth in their secure Portal Messages inbox.

E-mail Subscription Messages

Providers and other interested parties may register to receive e-mail subscription notifications. When registering for e-mail subscription, providers and other interested parties are able to select, by program (for example, Wisconsin Medicaid, BadgerCare Plus, ADAP (Wisconsin AIDS Drug Assistance Program), or WCDP (Wisconsin Chronic Disease Program)), provider type (for example, physician, hospital, DME (durable medical equipment) vendor), and/or specific area of interest, (Trading Partner and ICD-10 (International Classification of Diseases, 10th Revision) Project Information) to designate what information they would like to receive. Any number of staff or other interested parties from an organization may sign up for an e-mail subscription and may select multiple subscription options.

Registering for E-mail Subscription

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

1. Click the Register for E-mail Subscription link on the ForwardHealth Portal home page.
2. The Subscriptions page will be displayed. In the E-Mail field in the New Subscriber section, enter the e-mail address to which messages should be sent.
3. Enter the e-mail address again in the Confirm E-Mail field.
4. Click Register. A message will be displayed at the top of the Subscriptions page indicating the registration was successful. If there are any problems with the registration, an error message will be displayed instead.
5. Once registration is complete, click the program for which you want to receive messages in the Available Subscriptions section of the Subscriptions page. The selected program will expand and a list of service areas will be displayed.
6. Select the service area(s) for which you want to receive messages. Click Select All if you want to receive messages for all service areas.
7. When service area selection is complete, click Save at the bottom of the page.

The selected subscriptions will load and a confirmation message will appear at the top of the page.

Topic #4460

Full Text Publications Available

Providers without internet access may call Provider Services to request that a paper copy of a *ForwardHealth Update* be mailed to them. To expedite the call, correspondents will ask providers for the *Update* number. Providers should allow seven to 10 business days for delivery.

Contact Information

Topic #476

Member Services

Providers should refer ForwardHealth members with questions to Member Services. The telephone number for Member Services is for member use only.

Topic #473

Professional Field Representatives

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

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

- Dental providers
- Milwaukee County

Provider Education

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

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

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

Additional Inquiries

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

- Claims, including discrepancies regarding enrollment verification and claim processing
- PES (Provider Electronic Solutions) claims submission software
- Claims processing problems that have not been resolved through other channels (for example, phone or written correspondence)
- Referrals by a Provider Services phone correspondent
- Complex issues that require extensive explanation

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

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

representative to ensure secure transmission of information.

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

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

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

- Member's name
- Member ID number
- Claim number
- DOS (date of service)

Topic #474

Provider Services

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

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

Ways Provider Services Can Help

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

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

Information to Have Ready

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

- Provider name and NPI or provider ID
- Member name and ID
- Claim ICN (internal control number)
- PA number
- DOS (date of service)
- Amount billed

- RA (Remittance Advice)
- Procedure code of the service in question
- Reference to any provider publications that address the inquiry

Call Center Representatives

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

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

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

Walk-in Appointments

Walk-in appointments offer face-to-face assistance for providers at the Provider Services office. Providers must schedule an appointment in advance by contacting Provider Services at 800-947-9627. Appointments for in-person provider assistance are available Monday through Friday, 7:30 a.m.-4:00 p.m. (CST), except for state-observed holidays. Providers without an appointment may not receive in-person assistance and may have to schedule an appointment for a later date.

Written Inquiries

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

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

ForwardHealth
Provider Services Written Correspondence
313 Blettner Blvd
Madison WI 53784

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

Topic #4456

Resources Reference Guide

The Provider Services and Resources Reference Guide lists services and resources available to providers and members with contact information and hours of availability.

ForwardHealth Portal	**www.forwardhealth.wi.gov/**	**24 hours a day, seven days a week**
Public and secure access to ForwardHealth information with direct link to contact Provider Services for up-to-date access to ForwardHealth programs information, including publications, fee schedules, and forms.		
WiCall Automated Voice Response System	**800-947-3544**	**24 hours a day, seven days a week**

WiCall, the ForwardHealth AVR (Automated Voice Response) system, provides responses to the following inquiries: - Checkwrite - Claim status - PA (prior authorization) - Member enrollment		
ForwardHealth Provider Services Call Center	**800-947-9627**	**Call center representatives: Monday through Friday, 7 a.m. to 6 p.m. (Central time)* Virtual agent: 24 hours a day, seven days a week**
To assist providers in the following programs: - BadgerCare Plus - Medicaid - SeniorCare - ADAP (Wisconsin AIDS Drug Assistance Program) - WCDP (Wisconsin Chronic Disease Program) - Wisconsin Medicaid and BadgerCare Plus Managed Care Programs - Wisconsin Well Woman Medicaid - WWWP (Wisconsin Well Woman Program)		
ForwardHealth Portal Helpdesk	**866-908-1363**	**Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central time)***
To assist providers and trading partners with technical questions regarding Portal functions and capabilities, including Portal accounts, registrations, passwords, and submissions through the Portal.		
Electronic Data Interchange Helpdesk	**866-416-4979**	**Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central time)***
For providers, including trading partners, billing services, and clearinghouses with technical questions about the following: - Electronic transactions - Companion documents - PES (Provider Electronic Solutions) software		
Managed Care Provider Appeals	**800-760-0001, Option 1**	**Monday through Friday, 7 a.m. to 6 p.m. (Central time)***
To assist BadgerCare Plus/Medicaid SSI (Supplemental Security Income) HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) providers with questions regarding their appeal status and other general managed care provider appeal information.		
Managed Care Ombudsman Program	**800-760-0001**	**Monday through Friday, 7 a.m. to 6 p.m. (Central time)***
To assist managed care enrollees with questions about enrollment, rights, responsibilities, and general managed care information.		
Member Services	**800-362-3002**	**Monday through Friday, 8 a.m. to 6 p.m. (Central time)***
To assist ForwardHealth members, or persons calling on behalf of members, with program information and requirements, enrollment, finding enrolled providers, and resolving concerns.		

Wisconsin AIDS Drug Assistance Program	**800-991-5532**	**Monday through Friday, 8 a.m. to 4:30 p.m. (Central time)***
To assist ADAP providers and members, or persons calling on behalf of members, with program information and requirements, enrollment, finding enrolled providers, and resolving concerns.		

*With the exception of state-observed holidays.

Portal

Topic #4743

Acute and Primary Managed Care Portal

Information and Functions Through the Portal

The acute and primary managed care area of the ForwardHealth Portal allows state-contracted HMOs to conduct business with ForwardHealth. The public HMO page offers easy access to key HMO information and web tools. A login is required to access the secure area of the Portal to submit or retrieve account and member information that may be sensitive.

The following information is available through the Portal:

- Listing of all Medicaid-enrolled providers
- Coordination of Benefits Extract/Insurance Carrier Master List information updated quarterly
- Data Warehouse, which is linked from the Portal to Business Objects. The Business Objects function allows for access to MCO (managed care organization) data for long-term care MCOs.
- Electronic messages
- Enrollment verification by entering a member ID or SSN (Social Security number) with date of birth and a "from DOS (date of service)" and a "to DOS" range. A transaction number is assigned to track the request.
- Member search function for retrieving member information such as medical status codes and managed care and Medicare information
- Provider search function for retrieving provider information such as the address, phone number, provider ID, taxonomy code (if applicable), and provider type and specialty
- HealthCheck information
- MCO contact information
- Technical contact information (Entries may be added via the Portal.)

Topic #4904

Claims and Adjustments Using the ForwardHealth Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, copy claims, and determine what claims are in "pay" status on the ForwardHealth Portal. Providers have the ability to search for and view the status of all their finalized claims, regardless of how they were submitted (i.e., paper, electronic, clearinghouse). If a claim contains an error, providers can correct it on the Portal and resubmit it to ForwardHealth.

Providers can submit an individual claim or adjust a claim through DDE (Direct Data Entry) through the secure Portal.

Topic #8524

Conducting Revalidation Via the ForwardHealth Portal

Providers can conduct revalidation online via a secure revalidation area of the ForwardHealth Portal.

Topic #4345

Creating a Provider Account

Each provider needs to designate one individual as an administrator of the ForwardHealth Portal account. This user establishes the administrative account once their PIN (personal identification number) is received. The administrative user is responsible for this provider

account and can add accounts for other users (clerks) within their organization and assign security roles to clerks that have been established. To establish an administrative account after receiving a PIN, the administrative user is required to follow these steps:

1. Go to the ForwardHealth Portal.
2. Click the **Providers** button.
3. Click **Logging in for the first time?**.
4. Enter the Login ID and PIN. The Login ID is the provider's NPI (National Provider Identifier) or provider number.
5. Click **Setup Account**.
6. At the Account Setup screen, enter the user's information in the required fields. Enter a backup user's information in the required fields.
7. Read the security agreement and click the checkbox to indicate agreement with its contents.
8. Click **Submit** when complete.

Once in the secure Provider area of the Portal, the provider may conduct business online with ForwardHealth via a secure connection. Providers may also perform the following administrative functions from the Provider area of the Portal:

- Establish accounts and define access levels for clerks
- Add other organizations to the account
- Switch organizations

Refer to the Account User Guide on the User Guides page of the Portal for more detailed instructions on performing these functions.

Topic #16737

Demographic Maintenance Tool

The demographic maintenance tool allows providers to update information online that they are required to keep current with ForwardHealth. To access the demographic maintenance tool, providers need a ForwardHealth Portal account. After logging into their Portal account, providers should select the Demographic Maintenance link located in the Home Page box on the right side of the secure Provider home page.

Note: The Demographic Maintenance link will only display for administrative accounts or for clerk accounts that have been assigned the Demographic Maintenance role. The Account User Guide provides specific information about assigning roles.

The demographic maintenance tool contains general panels which are available to all or most providers as well as specific panels which are only available to certain provider types and specialties. The Demographic Maintenance Tool User Guide provides further information about general and provider-specific panels.

Uploading Supporting Documentation

Providers can upload enrollment-related supporting documentation (e.g., licenses, certifications) using the demographic maintenance tool. Documents in the following formats can be uploaded:

- JPEG (Joint Photographic Experts Group) (.jpg or .jpeg)
- PDF (Portable Document Format) (.pdf)

To avoid delays in processing, ForwardHealth strongly encourages providers to upload their documents.

Submitting Information

After making **all** their changes, providers are required to submit their information in order to save it. After submitting information, providers will receive one of the following messages:

- "Your information was **updated** successfully." This message indicates that providers' files were immediately updated with the changed information.
- "Your information was **uploaded** successfully." This message indicates that ForwardHealth needs to verify the information before providers' files can be updated. Additionally, an Application Submitted panel will display and indicate next steps.

Verification

ForwardHealth will verify changes within 10 business days of submission. If the changes can be verified, ForwardHealth will update providers' files. In some cases, providers may receive a Change Notification letter indicating what information ForwardHealth updated. Providers should carefully review the Provider File Information Change Summary included with the letter to verify the accuracy of the changes. If any of the changes are inaccurate, providers can correct the information using the demographic maintenance tool. Providers may contact Provider Services if they have questions regarding the letter.

Regardless of whether or not providers are notified that their provider files were updated, changed information is not considered approved until 10 business days after the information was changed. If the changes cannot be verified within 10 business days, ForwardHealth will notify providers by mail that their provider files were not updated, and providers will need to make corrections using the demographic maintenance tool.

Topic #4340

Designating a Trading Partner to Receive 835 Health Care Claim Payment/Advice Transactions

Providers must designate a trading partner to receive their 835 (835 Health Care Claim Payment/Advice) transaction for ForwardHealth interChange.

Providers who wish to submit their 835 designation via the Portal are required to create and establish a provider account to have access to the secure area of the Portal.

To designate a trading partner to receive 835 transactions, providers must first complete the following steps:

1. Access the Portal and log into their secure account by clicking the Provider link/button.
2. Click on the Designate 835 Receiver link on the right-hand side of the secure home page.
3. Enter the identification number of the trading partner that is to receive the 835 in the Trading Partner ID field.
4. Click Save.

Providers who are unable to use the Portal to designate a trading partner to receive 835 transactions may call the EDI (Electronic Data Interchange) Helpdesk or submit a paper (Trading Partner 835 Designation, F-13393 (07/12)) form.

Topic #5088

Enrollment Verification

The secure ForwardHealth Portal offers real time member enrollment verification for all ForwardHealth programs. Providers are able to use this tool to determine:

- The health care program(s) in which the member is enrolled
- Whether or not the member is enrolled in a state-contracted MCO (managed care organization)
- Whether or not the member has any third-party liability, such as Medicare or commercial health insurance
- Whether or not the member is enrolled in the Pharmacy Services Lock-In Program and the member's Lock-In pharmacy, primary care provider, and referral providers (if applicable)

Using the Portal to check enrollment may be more effective than calling WiCall or the EVS (Enrollment Verification System) (although both are available).

Providers are assigned a unique enrollment verification number for each inquiry. Providers can also use the "print screen" function to print a paper copy of enrollment verification inquiries for their records.

Topic #4338

ForwardHealth Portal

Providers, members, trading partners, managed care programs, and partners have access to public **and** secure information through the ForwardHealth Portal.

The Portal has the following areas:

- Providers (public and secure)
- Trading Partners
- Members
- MCO (managed care organization)
- Partners

The secure Portal allows providers to conduct business and exchange electronic transactions with ForwardHealth. The public Portal contains general information accessible to all users. Members can access general health care program information and apply for benefits online.

Topic #4441

ForwardHealth Portal Helpdesk

Providers and trading partners may call the ForwardHealth Portal Helpdesk with technical questions on Portal functions, including their Portal accounts, registrations, passwords, and submissions through the Portal.

Topic #4451

Inquiries to ForwardHealth Via the Portal

Providers are able to contact Provider Services through the ForwardHealth Portal by clicking the Contact link and entering the relevant inquiry information, including selecting the preferred method of response (i.e., telephone call or email). Provider Services will respond to the inquiry by the preferred method of response indicated within five business days.

Topic #4400

Internet Connection Speed

ForwardHealth recommends providers have an internet connection that will provide an upload speed of at least 768 Kbps and a download speed of at least 128 Kbps in order to efficiently conduct business with ForwardHealth via the Portal.

For PES (Provider Electronic Solutions) users, ForwardHealth recommends an internet connection that will provide a download speed of at least 128 Kbps for downloading PES software and software updates from the Portal.

These download speeds are generally not available through a dial-up connection.

Topic #4351

Logging in to the Provider Area of the Portal

Once an administrative user's or other user's account is set up, they may log in to the Provider area of the ForwardHealth Portal to conduct business. To log in, the user is required to click the "Provider" link or button, then enter their username and password and click "Go" in the Login to Secure Site box at the right side of the screen.

If a user has forgotten their username, they can recover their username by choosing from the following options:

- Ask the Portal Helpdesk to do one of the following:
  - Send the Portal account username to the email account on record.
  - Verify the request with the designated account backup.
- Ask the Portal Helpdesk to remove the Portal account's current credentials and create a new account.

Topic #5158

Managed Care Organization Portal Reports

The following reports are generated to MCOs (managed care organizations) through their account on the ForwardHealth MCO Portal:

- Capitation Payment Listing Report
- Cost Share Report (long-term MCOs only)
- Enrollment Reports

MCOs are required to establish a Portal account in order to receive reports from ForwardHealth.

Capitation Payment Listing Report

The Capitation Payment Listing Report provides "payee" MCOs with a detailed listing of the members for whom they receive capitation payments. ForwardHealth interChange creates adjustment transaction information weekly and regular capitation transaction information monthly. The weekly batch report includes regular and adjustment capitation transactions. MCOs have the option of receiving both the Capitation Payment Listing Report and the 820 Payroll Deducted and Other Group Premium Payment for Insurance Products transactions.

Initial Enrollment Roster Report

The Initial Enrollment Roster Report is generated according to the annual schedules detailing the number of new and continuing members enrolled in the MCO and those disenrolled before the next enrollment month.

Final Enrollment Roster Report

The Final Enrollment Roster Report is generated the last business day of each month and includes members who have had a change in status since the initial report and new members who were enrolled after the Initial Enrollment Roster Report was generated.

Other Reports

Additional reports are available for BadgerCare Plus HMOs, SSI HMOs, and long-term MCOs. Some are available via the Portal and some in the secure FTP (file transfer protocol).

Topic #4744

Members ForwardHealth Portal

Members can access ForwardHealth information by going to the ForwardHealth Portal. Members can search through a directory of providers by entering a ZIP code, city, or county. Members can also access all member-related ForwardHealth applications and forms. Members can use ACCESS to check availability, apply for benefits, check current benefits, and report any changes.

Topic #4344

Obtaining a Personal Identification Number

To establish an account on the ForwardHealth Portal, providers are required to obtain a PIN (personal identification number). The PIN is a unique, nine-digit number assigned by ForwardHealth interChange for the sole purpose of allowing a provider to establish a Portal account. It is used in conjunction with the provider's login ID. Once the Portal account is established, the provider will be prompted to create a username

and password for the account, which will subsequently be used to log in to the Portal.

Note: The PIN used to create the provider's Portal account is not the same PIN used for revalidation. Providers will receive a separate PIN for revalidation.

A provider may need to request more than one PIN if he or she is a provider for more than one program or has more than one type of provider enrollment. A separate PIN will be needed for each provider enrollment. Health care providers will need to supply their NPI (National Provider Identifier) and corresponding taxonomy code when requesting an account. Non-healthcare providers will need to supply their unique provider number.

Providers may request a PIN by following these steps:

1. Go to the Portal.
2. Click on the "Providers" link or button.
3. Click the "Request Portal Access" link from the Quick Links box on the right side of the screen.
4. At the Request Portal Access screen, enter the following information:
    a. Health care providers are required to enter their NPI and click "Search" to display a listing of ForwardHealth enrollments. Select the correct enrollment for the account. The taxonomy code, ZIP+4 code, and financial payer for that enrollment will be automatically populated. Enter the SSN (Social Security number) or TIN (Tax Identification Number).
    b. Non-healthcare providers are required to enter their provider number, financial payer, and SSN or TIN. (This option should only be used by non-healthcare providers who are exempt from NPI requirements).

       The financial payer is one of the following:
        - Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and Senior Care.)
        - SSI (Supplemental Security Income)
        - WCDP (Wisconsin Chronic Disease Program)
        - The WWWP (Wisconsin Well Woman Program)

    c. Click **Submit**.
    d. Once the Portal Access Request is successfully completed, ForwardHealth will send a letter with the provider's PIN to the address on file.

Topic #4459

Online Handbook

The Online Handbook gives providers access to all policy and billing information for Wisconsin Medicaid, BadgerCare Plus, ADAP (Wisconsin AIDS Drug Assistance Program), and WCDP (Wisconsin Chronic Disease Program). A secure ForwardHealth Portal account is not required to use the Online Handbook, as it is available to all Portal visitors.

Revisions to Online Handbook information are incorporated after policy changes have been issued in *ForwardHealth Updates*, typically on the policy effective date. The Online Handbook also links to the Communication Home page, which takes users to ForwardHealth Updates, user guides, and other communication pages.

The Online Handbook is designed to sort information based on user-entered criteria, such as program and provider type. It is organized into sections, chapters, and topics. Sections within each handbook may include the following:

- Claims
- Coordination of Benefits
- Covered and Noncovered Services
- Managed Care
- Member Information
- Prior Authorization
- Provider Enrollment and Ongoing Responsibilities
- Reimbursement
- Resources

Each section consists of separate chapters (for example, claims submission, procedure codes), which contain further detailed information in individual topics.

Search Function

The Online Handbook has a search function that allows providers to search for a specific word, phrase, or topic number within a user type, program, service area, or throughout the entire Online Handbook.

Providers can access the search function by following these steps:

1. Go to the Portal.
2. Click **Online Handbooks** under the Policy and Communication heading.
3. Complete the two drop-down selections at the left to narrow the search by program and service area, if applicable. This is not needed if searching the entire Online Handbook.
4. Enter the word, phrase, or topic number you would like to search.
5. Select **Search within the options selected above** or **Search all handbooks, programs and service areas; or Search by Topic Number.**
6. Click **Search**.

Saving Preferences

Providers can select Save Preferences when performing a search (by service area, section, chapter, topic number) and will receive confirmation that their preferences have been saved. This will save the program (for example, BadgerCare Plus and Medicaid) and service area (for example, Anesthesiologist) combinations that are selected from the drop-down menus. The next time the provider accesses the Online Handbook, they will be taken to their default preferences page. The provider can also click the Preferences Home link, which returns the provider to the saved area of the Online Handbook with their default preferences.

ForwardHealth Publications Archive Area

The Handbook Archives page allows providers to view 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 **Communication Home** link under the Policy and Communication heading.
3. Click the **Online Handbooks** link on the left sidebar menu.
4. Click on the **ForwardHealth Handbook Archives** link at the bottom of the page.

Topic #5089

Other Business Enhancements Available on the Portal

The secure Provider area of the ForwardHealth Portal enables providers to do the following:

- Verify member enrollment.
- View RAs (Remittance Advice).
- Designate which trading partner is eligible to receive the provider's 835 (835 Health Care Claim Payment/Advice).
- Update and maintain provider file information. Providers have the choice to indicate separate addresses for different business functions.
- Receive electronic notifications and provider publications from ForwardHealth.
- Enroll in EFT (electronic funds transfer).
- Track provider-submitted PA (prior authorization) requests.

Topic #4911

Portal Account Administrators

Portal administrators are responsible for requesting, creating, and managing accounts to access these features for their organization.

There must be one administrator assigned for each Portal account and all users established for that account. The responsibilities of the Portal administrator include:

- Ensuring the security and integrity of all user accounts (clerk administrators and clerks) created and associated with their Portal account.
- Ensuring clerks or clerk administrators are given the appropriate authorizations they need to perform their functions for the provider, trading partner, or MCO (managed care organization).
- Ensuring that clerks or clerk administrator accounts are removed/deleted promptly when the user leaves the organization.
- Ensuring that the transactions submitted are valid and recognized by ForwardHealth.
- Ensuring that all users they establish know and follow security and guidelines as required by HIPAA (Health Insurance Portability Accountability Act of 1996). As Portal administrators establish their Portal account and create accounts for others to access private information, administrators are reminded that all users must comply with HIPAA. The HIPAA privacy and security rules require that the confidentiality, integrity, and availability of PHI (protected health information) are maintained at all times. The HIPAA Privacy Rule provides guidelines governing the disclosure of PHI. The HIPAA Security Rule delineates the security measures to be implemented for the protection of electronic PHI. If Portal administrators have any questions concerning the protection of PHI, visit the Portal for additional information.

Portal administrators have access to all secure functions for their Portal account.

Establish an Administrator Account

All Portal accounts require an administrator account. The administrator is a selected individual who has overall responsibility for management of the account. Therefore, they have complete access to all functions within the specific secure area of their Portal and are permitted to add, remove, and manage other individual roles.

Add Backup Contact Information for Provider Administrator Accounts

Provider administrators must set up a backup contact for their Portal accounts to ensure that requests and changes can be verified as legitimate. Provider administrators will not be able to use the same contact information for both the administrator account and the backup contact.

Topic #4912

Portal Clerk Administrators

A Portal administrator may choose to delegate some of the authority and responsibility for setting up and managing the users within their ForwardHealth Portal account. If so, the Portal administrator may establish a clerk administrator. An administrator or clerk administrator can create, modify, manage or remove clerks for a Portal account. When a clerk is created, the administrator or clerk administrator must grant permissions to the clerks to ensure they have the appropriate access to the functions they will perform. A clerk administrator can only grant permissions that they themselves have. For example, if an administrator gives a clerk administrator permission only for enrollment verification, then the clerk administrator can only establish clerks with enrollment verification permissions.

Even if a Portal administrator chooses to create a clerk administrator and delegate the ability to add, modify, and remove users from the same account, the Portal administrator is still responsible for ensuring the integrity and security of the Portal account.

Topic #4913

Portal Clerks

The administrator (or the clerk administrator if the administrator has granted them authorization) may set up clerks within their ForwardHealth Portal account. Clerks may be assigned one or many roles (i.e., claims, PA (prior authorization), member enrollment verification). Clerks do not have the ability to establish, modify, or remove other accounts.

Once a clerk account is set up, the clerk account does not have to be established again for a separate Portal account. Clerks can easily be assigned a role for different Portal accounts (i.e., different ForwardHealth enrollments). To perform work under a different Portal account for which they have been granted authorization, a clerk can use the "switch org" function and toggle between the Portal accounts to which they

have access. Clerks may be granted different authorization in each Portal account (i.e., they may do member enrollment verification for one Portal account, and HealthCheck inquires for another).

Topic #4740

Public Area of the Provider Portal

The public Provider area of the ForwardHealth Portal offers a variety of important business features and functions that will assist in daily business activities with ForwardHealth programs.

Interactive Maximum Allowable Fee Schedule

Within the Portal, are maximum allowable fee schedules for most services. Providers can search the interactive maximum allowable fee schedule by a single procedure code, multiple codes, a code range, or by a service area to find the maximum allowable fee. Through the interactive fee schedule, providers also can export their search results for a single code, multiple codes, a code range, or by service area. The downloadable fee schedules, which are updated monthly, are downloadable only by service area as TXT (text) or CSV (comma separated value) files.

ForwardHealth Communications

ForwardHealth Updates announce changes in policy and coverage, PA (prior authorization) requirements, and claim submission requirements. They communicate new initiatives from the Wisconsin DHS (Department of Health Services) or new requirements from the federal CMS (Centers for Medicare & Medicaid Services) and the Wisconsin state legislature.

Updates reflect current policy at the time of publication; this information may change over time and be revised by a subsequent Update. Update information is added to the ForwardHealth Online Handbook after the Update is posted, unless otherwise noted.

Providers should refer to the Online Handbook for current information. The Online Handbook is the source for current ForwardHealth policy and contains provider-specific information for various services and benefits.

Trainings

Providers can register for all scheduled trainings and view online trainings via the Trainings 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 (that is, a phone call or email) the provider wishes to receive back from Provider Services. Provider Services will respond to the inquiry within five business days. Information will be submitted via a secure connection.

Online Enrollment

Providers can speed up the enrollment process for Medicaid by completing a provider enrollment application via the Portal. Providers can then track their application by entering their ATN (application tracking number) given to them on completion of the application.

Other Resources 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 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.)
- Email subscription service for Updates (Providers can register for email subscription to receive notifications of new provider publications

via email. Users are able to select, by program and service area, which publication notifications they would like to receive.)
- A forms library

Topic #4741

Secure Area of the Provider Portal

Providers can accomplish many processes via the ForwardHealth Portal, including submitting, adjusting, and correcting claims, submitting and amending PA (prior authorization) requests, and verifying enrollment.

Claims and Adjustments Using the Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, and determine what claims are in "pay" status on the Portal. Providers can search for and view the status of all of their finalized claims, regardless of how they were submitted (i.e., paper, electronic, clearinghouse). If a claim contains an error, providers can correct it on the Portal and resubmit it to ForwardHealth.

Providers can submit an individual claim or adjust a claim via DDE (Direct Data Entry) through the secure Portal.

Submitting PA and Amendment Requests Via the Portal

Nearly all service areas can submit PA requests via the Portal. Providers can do the following:

- Correct errors on PA or amendment requests via the Portal, regardless of how the PA request was originally submitted
- View all recently submitted and finalized PA and amendment requests
- Save a partially completed PA request and finish completing it at a later time (*Note:* providers are required to submit or re-save a PA request within 30 calendar days of the date the PA request was last saved)
- View all saved PA requests and select any to continue completing or delete
- View the latest provider review and decision letters
- Receive messages about PA and amendment requests that have been adjudicated or returned for provider review

Electronic Communications

The secure Portal contains a two-way message center where providers can send and receive electronic notifications as well as receive links to ForwardHealth provider publications. Providers will be able to send secure messages to select Wisconsin DHS (Department of Health Services) groups/staff by selecting a recipient from a drop-down menu; options in the drop-down menu will differ based on the provider's security role. All new messages will be displayed on the provider's secure Portal messages inbox.

Providers can sign up to receive notifications about the availability of new ForwardHealth messages through email, text, or both. After signing up, the user will receive a verification email to register their device. Once registered, providers will receive notifications by the requested method(s).

Enrollment Verification

The secure Portal offers real-time member enrollment verification for all ForwardHealth programs. Providers are able to use this tool to determine:

- The health care program(s) in which the member is enrolled
- Whether or not the member is enrolled in a state-contracted MCO (managed care organization)
- Whether or not the member has other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans), such as Medicare or commercial health insurance

Using the Portal to check enrollment may be more efficient than calling the AVR (Automated Voice Response) system or the EVS (Enrollment Verification System) (although both are available).

Providers will be assigned a unique enrollment verification number for each inquiry. Providers can also use the "print screen" function to print a paper copy of enrollment verification inquiries for their records.

Other Business Enhancements Available on the Portal

The secure Provider area of the Portal enables providers to do the following:

- Verify member enrollment.
- View RAs (Remittance Advices).
- Designate which trading partner is eligible to receive the provider's 835 (835 Health Care Claim Payment/Advice) transaction.
- Update and maintain provider file information; providers will have the choice to indicate separate addresses for different business functions.
- Receive electronic notifications and provider publications from ForwardHealth.
- Enroll in EFT (electronic funds transfer).
- Track provider-submitted PA requests.

Topic #4905

Submitting Prior Authorization and Amendment Requests Via the Portal

Nearly all service areas can submit PA (prior authorization) requests 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 PAs 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.

Topic #4401

System and Browser Requirements

The following table lists the recommended system and browser requirements for using the ForwardHealth Portal. PES (Provider Electronic Solutions) users should note that the Windows-based requirements noted in the table apply; PES cannot be run on Apple-based systems.

Recommended System Requirements	Recommended Browser Requirements
Windows-Based Systems	
Computer with at least a 500Mhz processor, 256 MB of RAM, and 100MB of free disk space	Chrome v. 73 or higher, Edge v. 19 or higher, Firefox v. 38 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	Chrome v. 73 or higher, Edge v. 19 or higher, Safari v. 14 or higher, Firefox v. 38 or higher
Mac OS X 10.2 or higher operating system	

Topic #4742

Trading Partner Portal

The following information is available on the public Trading Partners area of the ForwardHealth Portal:

- Trading partner testing packets
- Trading partner profile submission

- PES (Provider Electronic Solutions) software and upgrade information
- EDI (Electronic Data Interchange) companion guides

In the secure Trading Partners area of the Portal, trading partners can exchange electronic transactions with ForwardHealth.

Trading partners using PES should be sure to enter the web logon and web password associated with the ForwardHealth Trading Partner ID that will be used on PES transactions. Prior to submitting transactions through PES, trading partners must also make sure their trading partner account is entered as the "Default Provider ID" on the Switch Organization page of the secure trading partner account on the Portal.

Training Opportunities

Topic #12757

Training Opportunities

The Provider Relations representatives conduct training sessions in a variety of formats on both program-specific and topic-specific subjects. There is no fee for attending/accessing these training sessions.

On-Site Sessions

On-site training sessions are offered at various locations (e.g., hotel conference rooms, provider facilities) throughout the state. These training sessions include general all-provider sessions, service-specific and/or topic-specific sessions, and program-specific (such as WCDP (Wisconsin Chronic Disease Program) or the WWWP (Wisconsin Well Woman Program)) sessions.

Registration is required to attend on-site sessions. Online registration is available on the Trainings page of the Providers area of the Portal.

Online (Real-Time, Web-Based) Sessions

Online (real-time, web-based) training sessions are available and are facilitated through HPE MyRoom. MyRoom sessions are offered on many of the same topics as on-site sessions, but online sessions offer the following advantages:

- Participants can attend training at their own computers without leaving the office.
- Sessions are interactive as participants can ask questions during the session.
- If requested or needed, a session can be quickly organized to cover a specific topic for a small group or office.

For some larger training topics (such as ForwardHealth Portal Fundamentals), the training may be divided into individual modules, with each module focused on a particular subject. This allows participants to customize their training experience.

Registration, including an e-mail address, is required to attend Virtual Room sessions, so important session information can be sent to participants prior to the start of the session. Online registration is available on the Trainings page of the Portal.

Recorded Webcasts

Recorded Webcasts are available on a variety of topics, including some of the same topics as on-site and online sessions. Like Virtual Room sessions, some recorded Webcasts on larger training topics may be divided into individual Webcast modules, allowing participants to customize their training experience. Recorded Webcasts allow providers to view the training at their convenience on their own computers.

Registration is not required to view a recorded Webcast. Related training materials are available to download and print from the specific Webcast training session page on the Portal.

Notification of Training Opportunities

In addition to information on the Trainings page of the Portal, upcoming training session information is distributed directly through messages to providers who have secure Portal accounts and to providers who have registered for the ForwardHealth e-mail subscription service.

To sign up for a secure Portal account, click the "Request Portal Access" link in the Quick Links box on the Provider page of the Portal. To sign up for e-mail subscription, click "Register for E-mail Subscription" in the Quick Links box on the Provider page of the Portal.

Managed Care

9

Archive Date:04/01/2024

Managed Care:Managed Care Information

Topic #401

BadgerCare Plus HMO Program

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

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

Topic #16177

Care4Kids Program Overview

Care4Kids is a health care program for children and youth in out-of-home care in Wisconsin. The Care4Kids program will offer comprehensive, coordinated services that are intended to improve the quality and timeliness of and access to health services for these children.

The Care4Kids program will serve children in out-of-home care placements (other than residential care centers) in Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha counties. Member participation will be voluntary and enrollment will be allowed to continue for up to 12 months after the child leaves the out-of-home care system, as long as the child remains Medicaid-eligible and resides within one of the six counties.

Care4Kids is required to provide at least the same benefits as those provided under fee-for-service arrangements.

Program Administration

Children's Hospital of Wisconsin is currently the only integrated health system certified by ForwardHealth to administer the Care4Kids program. Children's Hospital of Wisconsin will be responsible for providing or arranging for the provision of all services covered under Medicaid, with a small number of exceptions. The services not included in the Care4Kids program will be reimbursed as fee-for-service benefits. Children's Hospital of Wisconsin's integrated network of health care providers, which includes specialty and primary care physicians and clinics within the Children's Hospital System as well as providers who are participating in CCHP (Children's Community Health Plan), is intended to provide coordinated care and services to meet the individualized needs of each of the children enrolled across multiple disciplines, including physical, behavioral health, and dental care.

Care4Kids will be responsible for providing or arranging for the provision of all medically necessary services covered by Wisconsin Medicaid to enrollees. Providers are required to be part of the CCHP network to get reimbursed by Care4Kids. Providers interested in being a part of the network should contact CCHP. Out-of-network providers are required to call Care4Kids prior to providing services to a Care4Kids enrollee. In situations where emergency medical services are needed, out-of-network providers are required to contact Care4Kids within 24 hours of providing services.

Member Enrollment Verification

Providers should verify a member's enrollment before providing services to determine if the member is enrolled in Care4Kids. Members enrolled in Care4Kids will present a ForwardHealth member identification card.

Providers verifying enrollment on the ForwardHealth Portal will see Care4Kids under the MC Program heading in the Managed Care Enrollment panel.

For 271 response transactions, Care4Kids enrollment will be identified in the EB segment of the 2110C loop. Identified by "MC" in the EB01, "HM" in the EB04, and "Care4Kids" in the EB05. The MC provider contact information will be reported in the NM1 (name info), N3 (address info), and PER (telephone numbers) segments within the 2120C loop.

The WiCall AVR (automated voice response) system will identify Care4Kids as the state-contracted managed care program in which the member is enrolled.

Contact Information

Providers can contact CCHP at 800-482-8010 for the following:

- To become part of the CCHP network
- For coverage policy and procedure information, including PA (prior authorization) and claim submission guidelines, if they are already a Care4Kids network provider

Topic #405

Managed Care

Managed Care refers to the BadgerCare Plus HMO program, the Medicaid SSI HMO program, and the following MLTC (managed long-term care) programs available: Family Care, Family Care Partnership, and PACE (Program of All-Inclusive Care for the Elderly).

The primary goals of the managed care programs are:

- To improve the quality of member care by providing continuity of care and improved access
- To reduce the cost of health care through better care management

Topic #402

Managed Care Contracts

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

Topic #403

Managed Long-Term Care Programs

Wisconsin Medicaid has several MLTC (managed long-term care) programs that provide services to individuals who are elderly and/or who have disabilities. These members may be eligible to enroll in voluntary regional managed care programs such as Family Care, PACE (Program of All-Inclusive Care for the Elderly), and the Family Care Partnership Program. Additional information about these MLTC programs may be obtained from the Managed Care Organization area of the ForwardHealth Portal.

Topic #404

SSI HMO Program

Medicaid SSI HMOs provide the same benefits as Medicaid fee-for-service (e.g., medical, dental [in certain counties only], mental health/substance abuse, and vision) at no cost to their members through a care management model. Medicaid SSI members and SSI-related

Medicaid members may be eligible to enroll in an SSI HMO.

SSI-related Medicaid members receive coverage from Wisconsin Medicaid because of a disability determined by the Disability Determination Bureau.

Member Enrollment

Certain eligible SSI members and SSI-related Medicaid adult members are required to enroll in an SSI HMO. The following groups are excluded from the requirement to enroll in an SSI HMO:

- Members under 19 years of age
- Members of a federally recognized tribe
- Dual eligible members
- MAPP (Medicaid Purchase Plan) eligible members
- Members enrolled in a LTC (long-term care) MCO (managed care organization) or waiver program

Continuity of Care

Special provisions are included in the contract for SSI HMOs for continuity of care for SSI members and SSI-related Medicaid members. These provisions include the following:

- Coverage of services provided by the member's current provider for the first 90 days of enrollment in the SSI program or until the first of the month following completion of an assessment and care plan, whichever comes later. The contracted provider should get a referral from the member's HMO after this.
- Honoring a PA (prior authorization) that is currently approved by ForwardHealth. The PA must be honored for 90 days or until the month following the HMO's completion of the assessment and care plan, whichever comes later.

To assure payment, non-contracted providers should contact the SSI HMO to confirm claim submission and reimbursement processes. If an SSI HMO is not honoring a PA that is currently approved by ForwardHealth, the provider should first contact the HMO. If the provider is not able to resolve their issue with the HMO, the provider should contact ForwardHealth Provider Services.

For new authorizations during the member's first 90 days of enrollment, the provider is required to follow the SSI HMO's PA process. SSI HMOs may use PA guidelines that differ from fee-for-service guidelines; however, these guidelines may not result in less coverage than fee-for-service.

Care Management

SSI HMO health plans employ a care management model to ensure high-quality care to members. The care management model provides each enrollee with the following:

- An initial health assessment
- A comprehensive care plan
- Assistance in choosing providers and identifying a primary care provider
- Assistance in accessing social and community services
- Information about health education programs, treatment options, and follow-up procedures
- Advocates on staff to assist members in choosing providers and accessing needed care

ForwardHealth requires all SSI HMO health plans to have dedicated care managers to assist providers in meeting the medical care needs of members. SSI HMOs, through their care management teams, will serve as single points of contact for providers who need assistance addressing the health care needs of members, especially those who have multiple points of contact within the health care system.

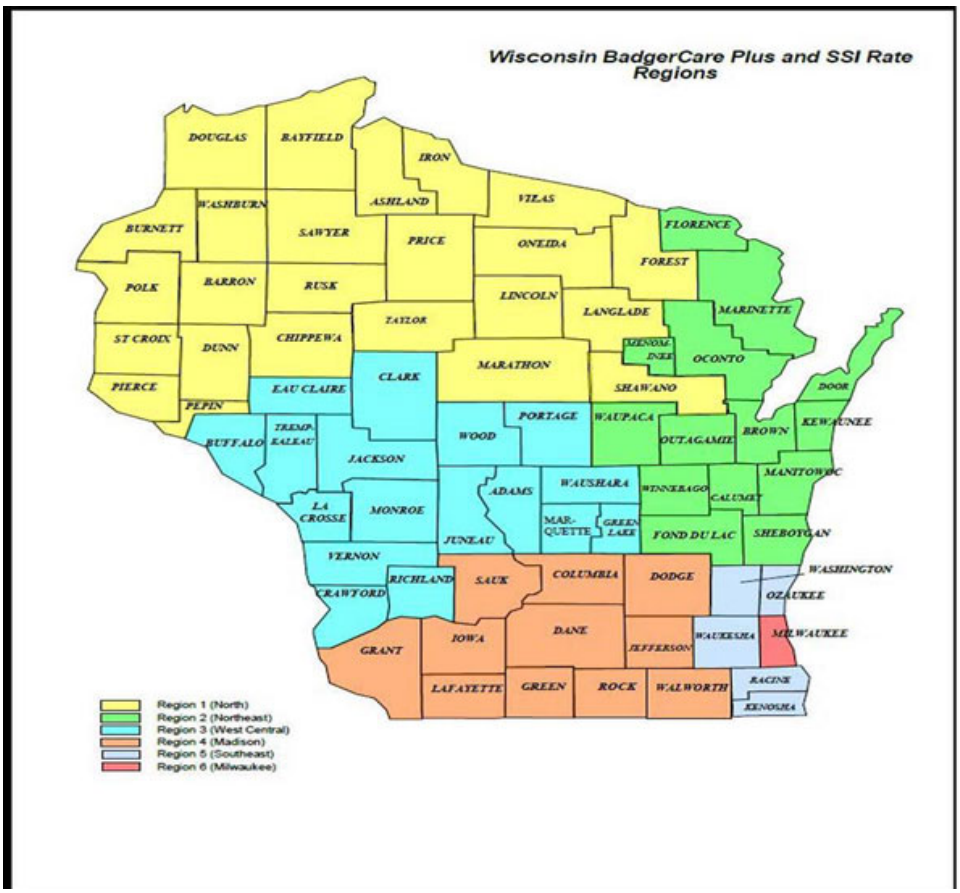
The SSI HMO care management teams will be responsible, when it is deemed appropriate, for notifying primary care providers of members' emergency room visits, hospital discharges, and other major medical events, as well as sharing patient-specific care management plans with appropriate providers to reduce hospital admissions and readmission, to reduce appointment no-shows, and to improve compliance with health care recommendations such as medication regimens.

Topic #20697

SSI Rate Regions

The map below shows the Wisconsin BadgerCare Plus and SSI (Supplemental Security Income) Rate Regions for the SSI HMO Program.

SSI Rate Regions


Wisconsin BadgerCare Plus and SSI Rate Regions
DOUGLAS
BAYFIELD
IRON
ASHLAND
VILAS
FLORENCE
WASHBURN
BURNETT
SAWYER
PRICE
ONEIDA
FOREST
POLK
BARRON
RUSK
LINCOLN
LANGLADE
MARINETTE
TAYLOR
ST CROIX
DUNN
CHIPPEWA
MARATHON
OCONTO
PIERCE
EAU CLAIRE
CLARK
SHAWANO
DOOR
PEPIN
PORTAGE
WAUPACA
KEWAUNEE
BUFFALO
TREMPEALEAU
WOOD
OUTAGAMIE
BROWN
JACKSON
MANITOWOC
ADAMS
WAUSHARA
WINNEBAGO
CALUMET
LA CROSSE
MONROE
MARQUETTE
GREEN LAKE
FOND DU LAC
SHEBOYGAN
JUNEAU
VERNON
WASHINGTON
RICHLAND
SAUK
COLUMBIA
DODGE
CRAWFORD
OZAUKEE
GRANT
IOWA
DANE
JEFFERSON
WAUKESHA
MILWAUKEE
LAFAYETTE
GREEN
ROCK
WALWORTH
RACINE
KENOSHA
Region 1 (North)
Region 2 (Northeast)
Region 3 (West Central)
Region 4 (Madison)
Region 5 (Southeast)
Region 6 (Milwaukee)

Enrollment

Topic #392

Disenrollment and Exemptions

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

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

Topic #393

Enrollee Grievances

Enrollees have the right to file grievances about services or benefits provided by a BadgerCare Plus HMO 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 Wisconsin DHS (Department of Health Services) and the HMO or SSI HMO describes the responsibilities of the HMO or SSI HMO and the DHS regarding enrollee grievances.

Topic #397

Enrollment Eligibility

BadgerCare Plus HMOs

Members enrolled in BadgerCare Plus are eligible for enrollment in a BadgerCare Plus HMO.

An individual who receives Tuberculosis-Related Medicaid, SeniorCare, or Wisconsin Well Woman Medicaid cannot be enrolled in a BadgerCare Plus HMO.

Information about a member's HMO enrollment status and other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) coverage may be verified by using Wisconsin's EVS (Enrollment Verification System) or the ForwardHealth Portal.

SSI HMOs

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

Topic #394

Enrollment Periods

BadgerCare Plus HMOs

Eligible enrollees are sent enrollment packets that explain the BadgerCare Plus HMOs and the enrollment process and provide contact information. Once enrolled in a BadgerCare Plus HMO, members may change their HMO assignment within the first 90 days of enrollment in an HMO (whether they chose the HMO or were auto-assigned). If an enrollee no longer meets the criteria, they will be disenrolled from the HMO.

SSI HMOs

Eligible enrollees are sent enrollment packets that explain the Medicaid SSI HMO enrollment process and provide contact information. Once enrolled in an SSI HMO, members may change their HMO assignment within the first 90 days of enrollment in an HMO (whether they chose the HMO or were auto-assigned).

Topic #395

Enrollment Specialist

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

Topic #398

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.

Topic #396

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.

Ombuds can be contacted at the following address:

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

Topic #399

Release of Billing or Medical Information

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

Provider Information

Topic #406

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. However, even in these cases, providers are prohibited from collecting copayment from members who are exempt from the copayment requirement.

When services are provided through fee-for-service or to members enrolled in a BadgerCare Plus HMO, copayments will apply, except when the member or the service is exempt from the copayment requirement.

Topic #407

Emergencies

Non-network providers may provide services to BadgerCare Plus HMO 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 Wisconsin DHS (Department of Health Services) and the HMO or SSI HMO defines an emergency situation and includes general payment requirements.

Unless the HMO or SSI HMO has a written agreement with the non-network provider, the HMO or SSI HMO is only liable to the extent fee-for-service would be liable for an emergency situation, as defined in 42 C.F.R. § 438.114. Billing procedures for emergencies may vary depending on the HMO or SSI HMO. For specific billing instructions, non-network providers should always contact the enrollee's HMO or SSI HMO.

Topic #408

Non-network Providers

Providers who do not have a contract with the enrollee's BadgerCare Plus HMO 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 Wisconsin DHS (Department of Health Services) and the HMO or SSI HMO
- When the HMO or SSI HMO has authorized (in writing) an out-of-plan referral to a non-network provider
- When the service is not provided under the HMO's or SSI HMO's contract with the DHS (such as dental, chiropractic, and pharmacy services)

Non-network providers may not serve BadgerCare Plus HMO or Medicaid SSI HMO enrollees as private-pay patients.

Topic #409

Out-of-Area Care

BadgerCare Plus HMOs 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.

Topic #410

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 but must provide access to Medicaid-covered, medically-necessary services under the scope of their contract for enrolled members. Each HMO may have policies and procedures specific to their provider credentialing and contracting process that providers are required to meet prior to becoming an in-network provider for that HMO.

Topic #411

Referrals

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

Topic #412

Services Not Provided by HMOs or SSI HMOs

If an enrollee's BadgerCare Plus HMO or Medicaid SSI HMO benefit package does not include a covered service, such as chiropractic or dental services, any Medicaid-enrolled provider may provide the service to the enrollee and submit claims to fee-for-service.

Covered and Noncovered Services

Topic #16197

Care4Kids Program Benefit Package

Covered Services

Members enrolled in the Care4Kids program are eligible to receive all medically necessary services covered under Wisconsin Medicaid; however, Care4Kids will have the flexibility to provide services in a manner that best meets the unique needs of children in out-of-home care, including streamlining PA (prior authorization) requirements and offering select services in home settings. Members will also be allowed to go to any Medicaid-enrolled provider for emergency medical services or family planning services.

Noncovered Services

The following services are not provided as covered benefits through the Care4Kids program, but can be reimbursed for eligible Medicaid members on a fee-for-service basis:

- Behavioral treatment
- Chiropractic services
- CRS (Community Recovery Services)
- CSP (Community Support Programs)
- CCS (Comprehensive Community Services)
- Crisis intervention services
- Directly observed therapy for individuals with tuberculosis
- MTM (Medication therapy management)
- NEMT (Non-emergency medical transportation) services
- Prescription and over-the-counter drugs and diabetic supplies dispensed by the pharmacy
- Physician-administered drugs and their administration, and the administration of Synagis
- SBS (School-based services)
- Targeted case management

Children's Hospital of Wisconsin will establish working relationships, defined in writing through a memorandum of understanding, with providers of the following services:

- CSP
- CCS
- Crisis intervention services
- SBS
- Targeted case management services

Providers of these services must coordinate with Care4Kids to help assure continuity of care, eliminate duplication, and reduce fragmentation of services.

Topic #390

Covered Services

HMOs

HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements. Although ForwardHealth requires contracted HMOs and Medicaid SSI HMOs to provide all medically necessary covered services, the following services may be provided by BadgerCare Plus HMOs at their discretion:

- Dental
- Chiropractic

If the HMO does not include these services in their benefit package, the enrollee receives the services on a fee-for-service basis.

Topic #391

Noncovered Services

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

- Behavioral treatment
- County-based mental health programs, including CRS (Community Recovery Services), CSP (Community Support Program) benefits, and crisis intervention services
- Environmental lead investigation services provided through local health departments
- CCC (child care coordination) services provided through county-based programs
- Pharmacy services and diabetic supplies
- PNCC (prenatal care coordination) services
- Physician-administered drugs

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

- SBS (school-based services)
- Targeted case management services
- NEMT (non-emergency medical transportation) services
- DOT (directly observed therapy) and monitoring for TB (tuberculosis)-Only Services

Providers that render these services to an SSI HMO member are required to submit claims directly to ForwardHealth on a fee-for-service basis.

Note: Members enrolled in an SSI HMO are not eligible for targeted case management services.

Prior Authorization

Topic #1779

Enrollment Changes

A PA (prior authorization) granted by BadgerCare Plus fee-for-service for DME (durable medical equipment) 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 (care management organization), or special managed care program) for DME is not applicable once a BadgerCare Plus enrollee disenrolls and enters BadgerCare Plus fee-for-service. The reimbursement system, either fee-for-service or a managed care program, in which the member is enrolled on the DOS (date of service) 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 fee-for-service for a DME item, enrolls in a managed care program:

- The BadgerCare Plus fee-for-service 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 fee-for-service, 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 Wisconsin DHS (Department of Health Services) has the final determination on whether the MCO (managed care organization) is responsible for providing and paying for the DME item. If the MCO is required to pay for the item that was authorized under fee-for-service, 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 fee-for-service:

- Follow BadgerCare Plus fee-for-service policies and procedures, including PA requirements, before delivering the equipment.
- If the DME item requires a fee-for-service PA and fee-for-service 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-enrolled 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 fee-for-service or from fee-for-service to managed care since the DME was

authorized, the DME provider should request approval and payment from whatever system (i.e., managed care or fee-for-service) the member is enrolled in at the time of the provider's request.

- Members have the right to appeal the BadgerCare Plus fee-for-service 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 fee-for-service.

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.

Topic #400

Prior Authorization Procedures

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

Claims

Topic #384

Appeals to BadgerCare Plus/Medicaid SSI HMOs and Children's Specialty Managed Care PIHPs

BadgerCare Plus/Medicaid SSI HMO and Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) contracted and non-contracted providers are required to first file an appeal directly with the HMO/PIHP after the initial payment denial or reduction. Providers should refer to their signed contract with the HMO/PIHP or the HMO's/PIHP's website for specific filing timelines and responsibilities (for example, PA (prior authorization), claim filing timelines, and coordination of benefits requirements) pertaining to filing a claim reconsideration and/or filing a formal appeal. The provider's signed contract with the HMO/PIHP may dictate the final decision. Filing a claim reconsideration is not the same as filing a formal appeal.

Appeal documents must reach the HMO/PIHP within the time frame established by the HMO/PIHP. Special care should be taken to ensure the documents reach the HMO/PIHP by the timely filing deadline by allowing enough time for U.S. Postal Service mail handling or by using a verifiable delivery method (for example, secure Portal, fax, certified mail, or secure email).

The HMO/PIHP has 45 calendar days to respond in writing to a formal appeal. The HMO/PIHP decides whether or not to pay the claim and sends a letter stating this decision. If the HMO/PIHP does not respond in writing within 45 calendar days or the provider is dissatisfied with the HMO's/PIHP's response, the provider may submit an appeal to ForwardHealth through the Provider Appeals portal within 60 calendar days from the end of the 45 calendar day timeline or the date of the HMO/PIHP response.

Topic #385

Appeals to ForwardHealth

ForwardHealth **will not review** appeals that were not first made to the BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan). If a provider sends an appeal directly to ForwardHealth without first filing it with the HMO/PIHP, the appeal will be returned to the provider., and the payment denial or reduction will be upheld.

The provider has 60 calendar days to file an appeal with ForwardHealth after the HMO/PIHP either does not respond in writing within 45 calendar days or if the provider is dissatisfied with the HMO/PIHP response.

Appeals will only be reviewed for enrollees who were eligible for and who were enrolled in an HMO/PIHP on the DOS (date of service) in question.

Once all pertinent information is received, ForwardHealth has 45 calendar days to make a final decision. The provider and the HMO/PIHP will be notified by ForwardHealth of the final decision. If the decision is in the provider's favor, the HMO/PIHP is required to pay the provider within 45 calendar days of the final decision. The decision is final, and all parties are required to abide by the decision.

Providers are required to submit an appeal to ForwardHealth through the Provider Appeals portal.

How to Begin Using the Provider Appeals Portal

Providers who contract with a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP and who need to appeal a claim decision will be required to register and set up a Provider Appeals portal account. Note: This portal account is separate from a provider's secure ForwardHealth Portal account.

To register for a Provider Appeals portal account, providers and HMOs/PIHPs can access the Provider Appeals portal. Providers are required to complete and submit the registration form, available by clicking either the HMO Registration or Provider Registration button (as applicable) on the Provider Appeals portal home page. Examples of information required to complete the registration process include the

following:

- The provider's Medicaid ID or both their NPI (National Provider Identifier) and taxonomy code
- Provider ZIP+4 code
- Date of service for the appeal
- Contact information (name, email, phone number) for the person registering

Once ForwardHealth receives and processes the registration form, an account login ID and associated PIN (provider identification number) will be created. Providers will receive an email message with their Provider Appeals portal login ID and will receive their PIN information in a mailed letter.

Note: Third party administrators and out-of-state providers must call the EDI (Electronic Data Interchange) Helpdesk at 866-417-4979 or send an email to vedswiedi@wisconsin.gov to begin registration.

More information on registering for and using the Provider Appeals portal and additional portal resources, including the Provider Appeals Portal User Guide, is available.

Portal Functionality

Providers can use the ForwardHealth appeals process through the Provider Appeals portal after exhausting the HMO/PIHP payment dispute process. Providers are required to use the Provider Appeals portal to:

- Submit an appeal to ForwardHealth for a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP claim payment denial or reduced payment.
- Submit documentation.
- Check the status of an appeal.
- Respond to requests for additional information.
- View decision notices.

For assistance regarding submission of an appeal through the ForwardHealth Portal, providers can call the ForwardHealth Managed Care Unit at 800-760-0001, option 1.

Required Documentation

When submitting an appeal to ForwardHealth through the Provider Appeals portal, the following documentation must be submitted/attached in required fields:

- The original claim submitted to the HMO/PIHP and all corrected claims submitted to the HMO/PIHP
- All of the HMO's/PIHP's payment denial remittances showing the dates of denial and reason codes with descriptions of the exact reasons for the claim denial
- The provider's written appeal to the HMO/PIHP
- The HMO's/PIHP's response to the appeal
- Relevant medical documentation for appeals regarding coding issues or emergency determination that supports the appeal (Providers should only submit relevant documentation that supports the appeal. Large medical records submitted with no indication of where supporting information is found will not be reviewed.)
- Any contract language that supports the provider's appeal with the exact language that supports overturning the payment denial indicated (Contract language submitted with no indication of where supporting information is found will not be reviewed, and the denial will be upheld.)
- Any other documentation that supports the appeal (for example, commercial insurance Explanation of Benefits/Explanation of Payment to support Wisconsin Medicaid as the payer of last resort)

Only relevant documentation should be included.

Appeal Decisions

A decision to uphold the HMO's/PIHP's original payment denial or to overturn the denial will be made based on the documentation submitted to ForwardHealth for review. Failure to submit the required documentation or submitting incomplete, insufficient, or illegible documentation may

lead to the original denial being upheld. The decision to overturn an HMO's/PIHP's denial must be clearly supported by the documentation.

If the HMO/PIHP subsequently overturns their original denial and reprocesses and pays the claim for which an appeal has been submitted, providers must contact the ForwardHealth Managed Care Unit at 800-760-0001, option 1, and request that the appeal be withdrawn.

To check on the status of an appeal submitted to ForwardHealth, providers can:

- Access the Provider Appeals portal.
- Call the ForwardHealth Managed Care Unit at 800-760-0001, option 1.

Topic #386

Claims Submission

BadgerCare Plus/Medicaid SSI HMOs and Children's Specialty Managed Care PIHPs (Prepaid Inpatient Health Plans) have requirements for timely filing of claims, and providers are required to follow the HMO/PIHP claims submission guidelines for each organization. Providers should contact the enrollee's HMO/PIHP for organization-specific submission deadlines.

Topic #387

Extraordinary Claims

Extraordinary claims are BadgerCare Plus or Medicaid claims for a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) enrollee that have been denied by an HMO/PIHP 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/PIHP at the time they were admitted to an inpatient hospital, but then they enrolled in an HMO/PIHP during the hospital stay. In this case, all claims related to the stay (including physician claims) should be submitted to fee-for-service. For the physician claims associated with the inpatient hospital stay, the provider is required to include the date of admittance and date of discharge in Item Number 18 of the paper 1500 Health Insurance Claim Form ((02/12)).
- The claims are for orthodontia/prosthodontia services that began before HMO/PIHP coverage. The provider must include a record with the claim indicating when the bands were placed.

Submitting Extraordinary Claims

When submitting an extraordinary claim, providers must include the following:

- A legible copy of the completed claim form in accordance with billing guidelines
- A letter detailing the problem, any claim denials, and any steps taken to correct the situation
- A copy of the Explanation of Medical Benefits form as applicable

Submit extraordinary claims to:

ForwardHealth
Managed Care Extraordinary Claims
PO Box 6470
Madison WI 53716-0470

Topic #388

Medicaid as Payer of Last Resort

Wisconsin Medicaid is the payer of last resort for most covered services, even when a member is enrolled in a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan). Before submitting claims to HMOs/PIHPs, providers are

required to submit claims to other health insurance sources. Providers should contact the enrollee's HMO/PIHP for more information about billing other health insurance sources.

Topic #389

Provider Appeals

When a BadgerCare Plus/Medicaid SSI HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) denies a provider's claim, the HMO/PIHP is required to send the provider a notice informing them of the right to file an appeal.

An HMO/PIHP network or non-network provider may file an appeal to the HMO/PIHP when:

- A claim submitted to the HMO/PIHP is denied payment.
- The full amount of a submitted claim is not paid.

Providers are required to file an appeal with the HMO/PIHP **before** filing an appeal with ForwardHealth.