Claims

1

Archive Date:05/02/2016

Claims: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.

For a temporary identification card for EE (Express Enrollment) in BadgerCare Plus or Family Planning Only Services, 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.

For a temporary identification card from members who received a real-time eligibility determination, the provider should check enrollment again after the date and time indicated on the ID card, or wait one week to submit a claim to ForwardHealth. If, after the date and time indicated on the ID card, the EVS indicates that the member is still not enrolled, or the claim is denied with an enrollment-related EOB code, the provider should contact Provider Services for assistance.

Responses

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.

Submission

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 #892

Submitting Claims During Temporary Enrollment Period

To avoid delays in reimbursement and prevent claims from being inappropriately denied, providers who render services to a member applying for EE (Express Enrollment) in BadgerCare Plus or Family Planning Only Services should wait until the member's temporary enrollment has been verified through Wisconsin's EVS (Enrollment Verification System) or the ForwardHealth Portal before submitting a claim for the services. Providers should make a photocopy of the temporary identification card to be used, if necessary, for good faith claims processing.

BadgerCare Plus and Wisconsin Medicaid accept properly completed and submitted claims for covered services provided to individuals with a temporary identification card as long as the DOS (date of service) is within the dates of enrollment as shown on the card.

Providers may refer to the service area appropriate to their provider type for more information about claim submissions.

Coordination of Benefits

2

Archive Date:05/02/2016

Coordination of Benefits:Commercial Health Insurance

Topic #18497

Explanation of Medical Benefits Form Requirement

An Explanation of Medical Benefits (F-01234 (11/14)) form must be included for each other payer when other health insurance sources (e.g., commercial insurance, Medicare) are indicated on a paper claim or paper adjustment.

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

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

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

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

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

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

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

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

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

Covered and Noncovered Services

3

Archive Date:05/02/2016

Covered and Noncovered Services:Covered Services and Requirements

Topic #891

Covered Services During Temporary Enrollment

Effective with the date of determination (i.e., the date an application that meets the PE (presumptive eligibility) criteria is submitted), individuals will be eligible to receive coverage under Wisconsin Medicaid and BadgerCare Plus as indicated below. Services provided during the temporary enrollment period are covered on a fee-for-service basis. Individuals are not enrolled in an HMO during this period.

Pregnant Women

Pregnant women are eligible for *ambulatory* (i.e., non-institutional) pregnancy-related care. Ambulatory pregnancy-related care includes pharmacy services. The member is required to be fully enrolled for coverage of inpatient services, including the delivery.

Providers may refer to the service area appropriate to their provider type for more information about policy requirements.

Family Planning Only Services

Individuals who are determined eligible for the Family Planning Only Services benefit will be eligible for family planning and family planning-related services only. Services must be related to contraceptive management.

Providers may refer to the Family Planning Only Services area for a listing of covered services and for more information about policy requirements.

All Other Populations

All other populations indicated below will be eligible for full Medicaid and BadgerCare Plus benefits:

- Children.
- Parents and caretakers.
- Childless adults.
- Women with breast or cervical cancer.

Providers may refer to the service area appropriate to their provider type for more information about policy requirements.

Topic #17597

Definition of Express Enrollment

State and federal laws allow qualified entities to temporarily enroll children, pregnant women, and certain adults in BadgerCare Plus and individuals in Family Planning Only Services when these individuals are determined to be "presumptively eligible" based on preliminary information about family size and income. In Wisconsin, the process of making PE (presumptive eligibility) determinations and temporarily enrolling individuals in these programs is known as EE (Express Enrollment).

Noncovered Services

Topic #17617

Noncovered Services During Temporary Enrollment Period

Pregnant women who are temporarily enrolled in BadgerCare Plus through EE (Express Enrollment) are not eligible for coverage of hospitalization and other costs associated with childbirth. It is important for pregnant women to apply for ongoing BadgerCare Plus coverage in order to receive full BadgerCare Plus benefits. If providers are unable to assist a member, the member should be referred to her certifying agency to apply for ongoing coverage.

Managed Care

4

Archive Date:05/02/2016

Managed Care:Covered and Noncovered Services

Topic #16197

Care4Kids Program Benefit Package

Covered Services

Members enrolled in the Care4Kids program are eligible to receive all medically necessary services covered under Wisconsin Medicaid; however, Care4Kids will have the flexibility to provide services in a manner that best meets the unique needs of children in out-of-home care, including streamlining PA (prior authorization) requirements and offering select services in home settings. Members will also be allowed to go to any Medicaid-enrolled provider for emergency medical services or family planning services.

Noncovered Services

The following services are not provided as covered benefits through the Care4Kids program, but can be reimbursed for eligible Medicaid members on a fee-for-service basis:

- Behavioral treatment.
- Chiropractic services.
- CRS (Community Recovery Services).
- CSP (Community Support Programs).
- CCS (Comprehensive Community Services).
- Crisis intervention services.
- Directly observed therapy for individuals with tuberculosis.
- MTM (Medication therapy management).
- NEMT (Non-emergency medical transportation) services.
- Prescription and over-the-counter drugs and diabetic supplies dispensed by the pharmacy.
- Provider-administered drugs and their administration, and the administration of Synagis.
- SBS (School-based services).
- Targeted case management.

Children's Hospital of Wisconsin will establish working relationships, defined in writing through a memorandum of understanding, with providers of the following services:

- CSP.
- CCS.
- Crisis intervention services.
- SBS.
- Targeted case management services.

Providers of these services must coordinate with Care4Kids to help assure continuity of care, eliminate duplication, and reduce fragmentation of services.

Managed Care Information

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.

Member Information

5

Archive Date:05/02/2016

Member Information:Enrollment Categories

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 #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 under the BadgerCare Plus Standard Plan while an application for BadgerCare Plus is processed.

Fee-for-Service

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

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, the member is considered eligible for BadgerCare Plus and/or Family Planning Only Services and will be enrolled for 12 months, unless changes affecting eligibility occur before the 12-month period ends.

Members will receive a temporary ID card for BadgerCare Plus and/or Family Planning Only Services. The temporary ID card will be valid for the dates listed on the card and will allow the applicant and/or household members to get immediate health care or pharmacy services. Each approved applicant will get his or her own card, and each card will include the member's ForwardHealth ID number.

Enrollment Verification

Providers should note that while the temporary ID card can be printed immediately and used for ForwardHealth-covered services, providers will not be able to check eligibility information via Wisconsin's EVS (Enrollment Verification System) immediately. It will take up to 72 hours for providers to check a member's eligibility via the EVS. The temporary ID card will include the date and time by which providers will be able to verify eligibility using the EVS. If a member presents a temporary ID card prior to that date and time, **the provider is still required to provide services**, even if eligibility cannot be verified. If a member presents a temporary ID card after that date and time, the provider should verify eligibility using the EVS. Samples of the Temporary Identification Card for BadgerCare Plus and Temporary Identification Card for Family Planning Only Services are available.

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(s) to receive health care services, including pharmacy services, through BadgerCare Plus from any enrolled BadgerCare Plus / Medicaid provider. For additional information, call Provider Services at (800) 947-9627 or see the online Provider Handbook.

Note:

It is important to provide services when this card is presented. Providers who render services based on the enrollment dates on this card will receive payment for those services, as long as other reimbursement requirements are met. All policies regarding covered services apply for these individuals, including the prohibition against billing members. Refer to the online Provider Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card. If the name on this card is followed by the words "Pending Assignment", the Member ID will be assigned within one business day; the card is still valid.

WISCONSIN DEPARTMENT OF HEALTH SERVICES

TEMPORARY IDENTIFICATION CARD FOR BADGERCARE PLUS

Name	Program	ID Number
Ima Member DOB: 09/01/1984	BadgerCare Plus	0987654321

This card is valid from **September 01, 2015 to September 30, 2015.**

This individual's eligibility may not appear in the ForwardHealth Portal before 8 a.m. on **09/08/2015**. If this card is presented prior to this date, the provider should honor the individuals coverage and provide services based on good faith policies outlined in the Provider Handbook.

For services provided as of 8 a.m. on 09/08/2015, eligiblity should be verified through the ForwardHealth Portal prior to providing services.

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(s) to receive health care services, including pharmacy services, through Family Planning Only Services from any enrolled Family Planning Only Services provider. For additional information, call Provider Services at (800) 947-9627 or see the online Provider Handbook.

Note:

It is important to provide services when this card is presented. Providers who render services based on the enrollment dates on this card will receive payment for those services, as long as other reimbursement requirements are met. All policies regarding covered services apply for these individuals, including the prohibition against billing members. Refer to the online Provider Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card. If the name on this card is followed by the words "Pending Assignment", the Member ID will be assigned within one business day; the card is still valid.

WISCONSIN DEPARTMENT OF HEALTH SERVICES

TEMPORARY IDENTIFICATION CARD FOR FAMILY PLANNING ONLY SERVICES

Name:	Program	ID Number
Ima Member DOB: 09/01/1984	Family Planning Only Services	0987654321

This card is valid from **September 01, 2015 to September 30, 2015.**

This individual's eligibility may not appear in the ForwardHealth Portal before 8 a.m. on **09/08/2015**. If this card is presented prior to this date, the provider should honor the individuals coverage and provide services based on good faith policies outlined in the Provider Handbook.

For services provided as of 8 a.m. on 09/08/2015, eligibility should be verified through the ForwardHealth Portal prior to providing services.

Enrollment Verification

Topic #890

Verifying Enrollment

With the exception of pregnant women, one temporary enrollment period is allowed within a rolling 12-month period; therefore, prior to submitting an application for EE (Express Enrollment), the provider should confirm that the applicant did not have a temporary enrollment period any time within the previous 12 months.

For paper applications, once a provider has confirmed that the applicant did not have a temporary enrollment period any time within the previous 12 months, the provider is required to submit the EE application *within five calendar days of the signature date on the application.* There is no retroactive temporary enrollment period; EE is an immediate and prospective benefit. The earliest effective date for the temporary enrollment period is the signature date on the application.

EE applications that are not submitted to ForwardHealth before the last date of the temporary enrollment period will not be accepted for processing, and claims for services provided during periods of ineligibility will not be reimbursed.

Wisconsin's EVS (Enrollment Verification System) includes eligibility information for members who are temporarily enrolled in BadgerCare Plus or Family Planning Only Services. Each member who is temporarily enrolled receives a temporary identification card. To ensure individuals receive needed services in a timely manner, providers should accept temporary identification cards as proof of enrollment for the dates provided on the cards.

Member Enrollment

Topic #887

Applying for Ongoing BadgerCare Plus or Family Planning Only Services Coverage

Because enrollment in BadgerCare Plus or Family Planning Only Services through the EE (Express Enrollment) process is temporary, it is important for members to apply for ongoing BadgerCare Plus or Family Planning Only Services coverage. Providers are encouraged to assist members with this process. If the member does not want or need assistance with the application for ongoing coverage, the provider should refer the member to ACCESS Apply for Benefits or to his or her certifying agency to apply for ongoing coverage.

Topic #16777

Eligible Populations

The following populations are eligible for EE (Express Enrollment) if the applicable enrollment criteria are met:

- Pregnant women.
- Children under age 19.
- Former Foster Care Youth.*
- Individuals applying for Family Planning Only Services.
- Adults age 19 through 64.
- Parents and other caretakers.
- Women under age 65 with breast or cervical cancer.

Note: 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 ongoing BadgerCare Plus coverage by their certifying agency.

The ACCESS Handbook, Chapter 12, includes a step-by-step PE (presumptive eligibility) application process for each of these groups.

Eligible Populations Who Are Inmates of Public Correctional Facilities

Qualified hospitals are allowed to make PE determinations for patients who are inmates of certain public correctional institutions (e.g., county jails) as long as those patients are expected to remain in the hospital for 24 hours or more. The PE determination process for these patients will be the same as for other patients. Patients who are inmates of a state correctional facility are not eligible for Medicaid or BadgerCare Plus through the hospital PE process.

Proof of Citizenship Not Required

BadgerCare Plus does not require applicants declaring United States citizenship or a qualifying immigration status to provide proof of citizenship or qualifying immigration status when applying for temporary enrollment in BadgerCare Plus or Family Planning Only Services through the EE process. However, applicants are required to provide documentation of citizenship or qualifying immigration status when applying for ongoing BadgerCare Plus or Family Planning Only Services coverage.

Qualifying Non-U.S. Citizens

Certain qualifying non-U.S. citizens are eligible for EE. Providers may refer to the Web-based EE tool in ACCESS for information on the qualifying non-U.S. citizens who are eligible for EE.

*Individuals who are Former Foster Care Youth have no income limit for PE, but must still meet all other non-financial eligibility requirements, including residency and citizenship criteria. A Former Foster Care Youth is an individual age 18 through 25 who was receiving foster care, subsidized guardianship, or court-ordered kinship care on the date that he or she turned 18.

Topic #888

Enrollment Criteria

Express Enrollment of Pregnant Women in BadgerCare Plus

In order for a pregnant woman to be temporarily enrolled in BadgerCare Plus through EE (Express Enrollment), her assistance group's taxable income may not exceed 306 percent of the FPL (Federal Poverty Level) guidelines.

Pregnant women are limited to one temporary enrollment period per pregnancy.

Certain pregnant women who are qualifying non-U.S. citizens are also eligible for EE in BadgerCare Plus. The paper EE application instructions and the Web-based EE (Express Enrollment) tool provide information on the qualifying non-U.S. citizens who are eligible for EE.

There is no asset test for EE of pregnant women in BadgerCare Plus.

Express Enrollment of Children in BadgerCare Plus

Children can be temporarily enrolled in BadgerCare Plus through EE if they meet the following financial criteria:

- If the child is younger than age 1, the taxable income of the child's assistance group must be at or below 306 percent of the FPL.
- If the child is age 1 through 5, the taxable income of the child's assistance group must be at or below 191 percent of the FPL.
- If the child is age 6 through 18, the taxable income of the child's assistance group must be at or below 156 percent of the FPL.

Children are limited to one temporary enrollment period per year.

Certain children who are qualifying non-U.S. citizens are eligible for temporary enrollment in BadgerCare Plus through EE. The Web-based EE tool provides information on the qualifying non-U.S. citizens who are eligible for EE.

Express Enrollment of Individuals Applying for Family Planning Other Services

Individuals with incomes at or below 306 percent of the FPL may receive Family Planning Only Services immediately through EE for Family Planning Only Services.

Certain qualifying non-U.S. citizens are eligible for EE for Family Planning Only Services. The Web-based EE application tool and the paper application instructions provide information on the qualifying non-U.S. citizens who are eligible for EE for Family

Planning Only Services.

Express Enrollment of All Other Populations

The following individuals can be temporarily enrolled in BadgerCare Plus through EE if they meet the following financial criteria:

- Parents and other caretakers with incomes at or below 100 percent of the FPL.
- Childless adults age 19 through 64 with incomes at or below 100 percent of the FPL.
- Women under age 65 with breast or cervical cancer with incomes at or below 250 percent of the FPL.

Topic #4357

Enrollment Process

Qualified providers can make PE (presumptive eligibility) determinations and temporarily enroll pregnant women and children in BadgerCare Plus or individuals in Family Planning Only Services by using the Web-based EE (Express Enrollment) tool in ACCESS. For temporary enrollment of pregnant women in BadgerCare Plus or individuals applying for Family Planning Only Services, a separate paper application is also available. To the extent possible, providers are strongly encouraged to use the EE tool in ACCESS to make PE determinations; using the online tool allows providers to make faster, more secure PE determinations. Chapter 12 of the ACCESS Handbook on the DHS Web site provides detailed information about using ACCESS to make PE determinations.

Process for Express Enrollment in BadgerCare Plus

Qualified providers (and community partners) can use the Web-based EE tool to temporarily enroll pregnant women and children in BadgerCare Plus.

For EE of pregnant women, a paper application is also available and may be ordered through the DHS Web site. Instructions for the paper application are available to download for printing.

Once an application is submitted through EE, providers and partners are encouraged to assist the applicant or the applicant's parent or guardian in completing and submitting the online application in ACCESS for ongoing BadgerCare Plus coverage. This will help ensure that there is no break in coverage.

Process for Express Enrollment in Family Planning Only Services

Qualified providers are encouraged to use the Web-based EE application tool in ACCESS to temporarily enroll individuals applying for Family Planning Only Services.

A paper application is also available and may be ordered through the DHS Web site. Instructions for the paper application are available to download for printing.

Once an application is submitted through EE, providers are encouraged to assist the applicant or the applicant's parent or guardian in completing and submitting the online application in ACCESS for ongoing Family Planning Only Services coverage. This will help ensure that there is no break in coverage.

Topic #16798

Temporary Enrollment Period

The temporary enrollment period begins on the date of application. For all eligibility categories, the temporary enrollment period ends on the earlier of the following:

- The last day of the month following the month in which the PE determination was made if no application for ongoing Medicaid or BadgerCare Plus coverage is filed by that date.
- The date an eligibility determination for ongoing Medicaid or BadgerCare Plus coverage is made, regardless of the outcome of the determination.

For example, if a child is found presumptively eligible for BadgerCare Plus on July 3, he is certified until August 31. However, if his mother completes an application for ongoing BadgerCare Plus coverage for him on July 5 and on August 6 he is found ineligible for BadgerCare Plus for some reason (such as excess income), the child's temporary enrollment period would end on August 6. The provider will not be required to amend the end date of the temporary enrollment period.

Limits on Number of Temporary Enrollment Periods

There are limits on the number of temporary enrollment periods for all eligibility groups. Pregnant women are eligible for one temporary enrollment period per pregnancy. All other populations are limited to one temporary enrollment period within a rolling 12-month period, starting with the effective date of the initial temporary enrollment period. Since multiple temporary enrollment periods are not allowed, providers are encouraged to assist applicants with the completion of an application for ongoing Medicaid or BadgerCare Plus coverage.

Note: Hospitals are required to assist applicants with the completion of an application for ongoing Medicaid or BadgerCare Plus coverage.

Topic #267

Temporary Identification Cards for Express Enrollment

Each member who is temporarily enrolled in BadgerCare Plus or Family Planning Only Services through EE (Express Enrollment) receives a temporary identification card:

- For members who are temporarily enrolled using the Web-based EE application tool, identification cards are included on the bottom portion of the enrollment notice that is printed out and provided to the member after the online enrollment process is completed.
- For members who are temporarily enrolled using a paper EE application, an identification card is attached to the last page of the application and is provided to the member after completion of the application.

Note: If multiple individuals in one household are temporarily enrolled in BadgerCare Plus through EE, they will be included on the same temporary identification card; however, each individual will receive his or her own ForwardHealth identification card if the individual is found eligible for ongoing BadgerCare Plus coverage.

Temporary identification cards are valid for 14 days.

Samples of the Temporary Identification Card for Express Enrollment in BadgerCare Plus and Temporary Identification Card for Express Enrollment in Family Planning Only Services are available.

To ensure that members who are temporarily enrolled in BadgerCare Plus or Family Planning Only Services through EE receive needed services in a timely manner, providers should accept temporary identification cards as proof of enrollment for the dates provided on the cards. Providers are encouraged to keep a photocopy of the temporary identification card.

Providers may use Wisconsin's EVS (Enrollment Verification System) to verify enrollment for DOS (dates of service) after those printed on the temporary identification card.

Provider Enrollment and Ongoing Responsibilities

6

Archive Date:05/02/2016

Provider Enrollment and Ongoing Responsibilities:Documentation

Topic #16157

Policy Requirements for Use of Electronic Signatures on Electronic Health Records

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

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

Electronic Signature Definition

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

Some examples include:

- Typed name (performer may type his or her complete name).
- Number (performer may type a number unique to him or her).
- Initials (performer may type initials unique to him or her).

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

Benefits of Using Electronic Signatures

The use of electronic signatures will allow providers to:

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

Electronic Signature Requirements

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

General Requirements

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

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

Electronic Health Record Signature Requirements

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

- The certification and standard criteria defined in the Health Information Technology Initial Set of Standards, Implementation Specifications, Certification Criteria for Electronic Health Record Technology Final Rule (45 CFR Part 170) and any revisions including, but not limited to, the following:
    - Assign a unique name and/or number for identifying, tracking user identity, and establishing controls that permit only authorized users to access electronic health information.
    - Record actions related to electronic health information according to the standard set forth in 45 CFR s. 170.210(b).
    - 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(b).
    - 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.

Ongoing Responsibilities

Topic #16797

Performance Reviews and Reasons for Disqualification for Qualified Hospitals

ForwardHealth monitors PE (presumptive eligibility) submissions and conducts periodic, random reviews of the hospital EE (Express Enrollment) process. Reviews could include on-site visits. ForwardHealth provides technical assistance to hospitals if a need is indicated. However, ForwardHealth will make immediate referrals to the state's OIG (Office of the Inspector General) if internal monitoring or random reviews lead to a suspicion of inappropriate PE submissions. ForwardHealth may immediately suspend the hospital's ability to submit applications pending the outcome of OIG's investigation. If an allegation of fraud is substantiated, ForwardHealth will pursue recovery of payments made to the hospital during the temporary enrollment period if submissions do not meet ForwardHealth requirements.

ForwardHealth monitors, on a hospital-by-hospital basis, the number of presumptively eligible members who are subsequently found eligible for Medicaid or BadgerCare Plus. ForwardHealth may require additional training for hospitals with resulting Medicaid or BadgerCare Plus enrollment levels that fall below 90 percent of the number of PE determinations made in a 12-month period.

On an annual basis, ForwardHealth monitors each hospital to ensure that the hospital is following the stated policies and procedures. ForwardHealth uses the criteria outlined below to disqualify hospitals:

- Hospitals delegating their PE determination authority to an outside entity will immediately have PE submissions suspended by ForwardHealth. Hospitals will be disqualified for two years if this practice is not corrected as requested by ForwardHealth.
- Hospitals committing fraudulent violations of the PE policies will be disqualified for five years by ForwardHealth if such violations are verified.
- Starting in calendar year 2015, hospitals that fall short of an established submission rate for a completed Medicaid and BadgerCare Plus application may be subject to corrective action and ultimate disqualification for up to two years. The performance expectation for this measure will be established in 2015, based on the ratio of PE applications to full Medicaid and BadgerCare Plus submissions.

ForwardHealth will send a written notification to hospitals stating the reason for the disqualification. ForwardHealth will not accept PE determinations from hospitals during the period of disqualification.

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 (800) 310-0865. Refer to the RAC Web site for additional information regarding HMS RAC activities.

Provider Enrollment

Topic #17577

Applicants for Whom Qualified Providers May Make Presumptive Eligibility Determinations

Qualified *hospitals* may make PE (presumptive eligibility) determinations for children, pregnant women, and certain adults for BadgerCare Plus; they may also make PE determinations for individuals applying for Family Planning Only Services.

Qualified *providers* may make PE determinations for children and pregnant women for BadgerCare Plus; they may also make PE determinations for individuals applying for Family Planning Only Services.

Qualified *partners* may only make PE determinations for children.

The Express Enrollment page in the Provider Enrollment Information area of the ForwardHealth Portal provides information on applying to become a qualified provider (or partner) for making PE determinations.

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 #16778

Provider Qualifications and Application

Becoming a qualified provider for making PE (presumptive eligibility) determinations is a straightforward process, and there is no fee for applying. The Express Enrollment page in the Provider Enrollment Information area of the ForwardHealth Portal outlines the enrollment criteria and provides information on completing the provider enrollment application.

Provider Numbers

Topic #5097

ZIP Code

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

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

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

Resources

7

Archive Date:05/02/2016

Resources:Training Opportunities

Topic #12757

Training Opportunities

The Provider Relations representatives conduct training sessions in a variety of formats on both program-specific and topic-specific subjects. There is no fee for attending/accessing these training sessions.

On-Site Sessions

On-site training sessions are offered at various locations (e.g., hotel conference rooms, provider facilities) throughout the state. These training sessions include general all-provider sessions, service-specific and/or topic-specific sessions, and program-specific (such as WCDP (Wisconsin Chronic Disease Program) or the WWWP (Wisconsin Well Woman Program)) sessions.

Registration is required to attend on-site sessions. Online registration is available on the Trainings page of the Providers area of the Portal.

Online (Real-Time, Web-Based) Sessions

Online (real-time, Web-based) training sessions are available and are facilitated through HP® 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.