Certification and Ongoing Responsibilities

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Archive Date:07/01/2011

Certification and Ongoing Responsibilities:Certification

Topic #3411

Provider Qualifications

Express Enrollment for Pregnant Women

Providers who are qualified to make EE (Express Enrollment) determinations for pregnant women may also make EE determinations for members to receive services and supplies immediately through Family Planning Only Services.

Topic #894

Requirements

Express Enrollment for Pregnant Women

EE (express enrollment) providers determine whether or not a woman qualifies for the EE for Pregnant Women Benefit. The following types of providers may be certified to make EE determinations:

- Clinics that provide prenatal care services.
- Family planning clinics.
- FQHCs (federally qualified health centers).
- Nurse practitioners.
- Outpatient hospitals.
- Physicians.
- Providers participating in the WIC (Special Supplemental Nutrition Program for Women, Infants and Children).
- RHCs (rural health clinics).

Providers may be certified to make EE determinations if they provide services typically provided by one of the following:

- Clinics furnished by or under direction of a physician (s. 1905[a][9] of the Social Security Act).
- Outpatient hospitals (s. 1905[a][2][A] of the Social Security Act).
- RHCs (s. 1905[a][2][B] of the Social Security Act).

In addition, providers are required to participate in a program established under one of the following:

- A state perinatal program defined as a physician, nurse practitioner, certified nurse midwife, family planning clinic, outpatient hospital, or other clinic that provides prenatal medical care to BadgerCare Plus members.
- The Indian Health Services or a health program or facility operated by a tribe or tribal organization (the Indian Self-Determination Act - Public Law 93-638).
- WIC (s.4(a) of the Agriculture and Consumer Protection Act of 1973).

Alternatively, providers can receive funds under one of the following:

- The Community Health Centers or Migrant Health Centers (s. 329 or 330 of the Public Health Act).
- The Maternal and Child Health Services Block Grant Programs (Title V of the Social Security Act).
- Title V of the Indian Health Care Improvement Act.

Providers are required to be Medicaid-certified or have submitted an application for Medicaid certification.

Express Enrollment for Children

BadgerCare Plus will allow EE for Children to be completed by qualified providers and other community partners (e.g., Head Start, WIC, faith-based organizations, child care centers, schools).

Provider Numbers

Topic #5097

ZIP Code

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

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

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

Claims

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Archive Date:07/01/2011

Claims:Good Faith Claims

Topic #518

Definition

A good faith claim may be submitted when a claim is denied due to a discrepancy between the member's enrollment information in the claims processing system and the member's actual enrollment. If a member presents a temporary card or an EE (Express Enrollment) card, BadgerCare Plus encourages providers to check the member's enrollment and, if the enrollment is not on file yet, make a photocopy of the member's temporary card or EE card. If Wisconsin's EVS (Enrollment Verification System) indicates that the member is not enrolled in BadgerCare Plus, providers should check enrollment again in two days or wait one week to submit a claim to ForwardHealth. If the EVS indicates that the member still is not enrolled after two days, or if the claim is denied with an enrollment-related EOB (Explanation of Benefits) code, providers should contact Provider Services for assistance.

Submission

Topic #892

Delaying Submission

When submitting a claim for services provided to a child or pregnant woman in the EE (Express Enrollment) for Children and Pregnant Women Benefit, the provider should delay submitting the claim for one week from the enrollment start date. This ensures that the enrollment information is transmitted to BadgerCare Plus and prevents claims from being inappropriately denied.

BadgerCare Plus accepts properly completed and submitted claims for covered services provided to children or pregnant women with an EE identification card as long as the DOS (date of service) is within the dates of enrollment as shown on the card.

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 Remittance Advice as paid but with a $0 paid amount.

The reimbursement reduction applies to the following paper claims:

- 1500 Health Insurance Claim Form.
- UB-04 (CMS 1450) Claim Form.
- Compound Drug Claim Form.
- Noncompound Drug Claim Form.

Exceptions to Paper Claim Reimbursement Reduction

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

- In-state emergency providers.
- Out-of-state providers.
- Medicare Crossover Claims.
- Any claims that ForwardHealth requires additional supporting information to be submitted on paper. For example:
    - Hysterectomy claims must be submitted along with a paper Acknowledgement of Receipt of Hysterectomy Information Form.
    - Sterilization claims must be submitted along with a paper Consent for Sterilization Form.
    - Claims submitted to Timely Filing appeals must be submitted on paper with a Timely Filing Appeals Request form.
    - In certain circumstances, drug claims must be submitted on paper with a Pharmacy Special Handling Request.

Covered and Noncovered Services

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Archive Date:07/01/2011

Covered and Noncovered Services:Codes

Topic #643

Unlisted Procedure Codes

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

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

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

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

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

For most unlisted codes, ForwardHealth requires additional documentation.

Unlisted Codes That Require Prior Authorization

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

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

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

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

Unlisted Codes That Do Not Require Prior Authorization

If an unlisted procedure code does not require PA, documentation submitted with the claim to justify use of the unlisted code and to describe the procedure/service rendered must be sufficient to allow ForwardHealth to determine the nature and scope of the

procedure and to determine whether or not the procedure is covered and was medically necessary, as defined in Wisconsin Administrative Code.

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

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

How to Submit Claims and Related Documentation

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

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

Covered Services and Requirements

Topic #891

Express Enrollment for Children and Pregnant Women

The following members can temporarily enroll in BadgerCare Plus via EE (Express Enrollment) and receive health care coverage under BadgerCare Plus while a full application is being processed by their local county/tribal office:

- Children younger than age 1 whose family income is at or below 300 percent of the FPL. (Federal Poverty Level)
- Children ages 1 through 5 whose family income is at or below 185 percent of the FPL.
- Children ages 6 through 18 whose family income is at or below 150 percent of the FPL.

Children who are temporarily enrolled in BadgerCare Plus receive services under the Standard Plan.

Pregnant women who are enrolled in BadgerCare Plus receive pregnancy-related outpatient and pharmacy services. Because EE for pregnant women is temporary and covers ***only*** pregnancy-related outpatient services, it is important for pregnant women to apply for full BadgerCare Plus coverage to receive full benefits. EE does not cover the cost of hospitalization, including costs for childbirth. If providers are unable to assist, members should be referred to their local county/tribal office to apply for full coverage.

Enrollment in EE runs from the date of application to the ***end of the following month***. If an application submitted to the local county or tribal agency is not processed before the end of the second month, the temporary enrollment period will be extended one month.

If an application is submitted to a county/tribal office and enrollment in BadgerCare Plus is denied, the temporary enrollment period ends on the same date BadgerCare Plus enrollment is denied.

The county/tribal office will determine whether the member qualifies for coverage under the Standard Plan or the Benchmark Plan.

Member Information

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Archive Date:07/01/2011

Member Information:Enrollment Categories

Topic #230

Express Enrollment for Children and Pregnant Women

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.

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

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

Fee-for-Service

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

Topic #3413

Fee-for-Service

Women and children who are temporarily enrolled in BadgerCare Plus through the EE (Express Enrollment) process are not eligible for enrollment in an HMO until they are determined eligible for full benefit BadgerCare Plus by the certifying agency.

Enrollment Verification

Topic #890

Verifying Enrollment

When BadgerCare Plus receives an application, a child or a pregnant woman who meets the requirements for the EE (Express Enrollment) for Children and Pregnant Women Benefit is established on Wisconsin's EVS (Enrollment Verification System). Each member who is enrolled through EE will receive a ForwardHealth card within three business days after the application is submitted. To ensure children and pregnant women receive needed services in a timely manner, providers should accept the printed paper EE cards for children and either the printed paper EE card or the beige identification cards for pregnant women as proof of enrollment for the dates provided on the cards.

Identification Cards

Topic #267

Temporary Express Enrollment Cards

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

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

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

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

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

Member Enrollment

Topic #887

Applying for Full-Benefit BadgerCare Plus

Because EE (Express Enrollment) is temporary it is important for members to apply for full BadgerCare Plus coverage. For pregnant women, EE only covers pregnancy-related outpatient services and pregnant women must apply for full BadgerCare Plus coverage to receive full benefits. Health care providers are encouraged to assist in this process. If providers are unable to assist, members should be referred to the local county/tribal office to apply for full coverage.

Topic #889

Duration of Benefits

EE (Express Enrollment) runs from the date of application to the ***end of the following month***. If an application that is submitted to the local county or tribal office is not processed before the end of the second month, the temporary enrollment period will be extended one month.

If an application is submitted to a county/tribal office and enrollment in BadgerCare Plus is denied, the temporary enrollment period ends on the same date BadgerCare Plus enrollment is denied.

Topic #888

Enrollment Criteria

Express Enrollment for Pregnant Women

To qualify for the EE (Express Enrollment) for Pregnant Women Benefit, a woman must meet the following criteria:

- Her pregnancy is medically verified (by a pregnancy test).
- Her household's gross income does not exceed 300 percent of the FPL (Federal Poverty Level) guidelines.

There is no asset test for the EE for Pregnant Women Benefit.

Express Enrollment for Children

Children can be temporarily enrolled in the BC+ Standard Plan through the Express Enrollment program if they meet the following financial criteria:

- If the child is younger than age 1, the family's gross income must be at or below 300 percent of the Federal Poverty Level.
- If the child is age 1 through 5, the family's gross income must be at or below 185 percent of the Federal Poverty Level.
- If the child is age 6 through 18, the family's gross income must be at or below 150 percent of the Federal Poverty Level.

Topic #4357

Express Enrollment Process

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

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

Topic #1972

Income Limits

Income limits are available for the EE (Express Enrollment) for Children and Pregnant Women Benefit, which are based on the FPL (Federal Poverty Level) income limits.

To determine eligibility for the EE for Pregnant Women Benefit, providers should use the income limits with the instructions in the Guide to Determining Presumptive Eligibility for Pregnant Women.

Reimbursement

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Archive Date:07/01/2011

Reimbursement:Amounts

Topic #8117

Electronic Funds Transfer

EFT (electronic funds transfer) allows ForwardHealth to directly deposit payments into a provider's designated bank account for a more efficient delivery of payments than the current process of mailing paper checks. EFT is secure, eliminates paper, and reduces the uncertainty of possible delays in mail delivery.

Only in-state and border-status providers who submit claims and MCOs (managed care organizations) are eligible to receive EFT payments.

Provider Exceptions

EFT payments are not available to the following providers:

- In-state emergency providers.
- Out-of-state providers.
- Out-of-country providers.
- SMV (specialized medical vehicle) providers during their provisional certification period.

Enrolling in Electronic Funds Transfer

A ForwardHealth Portal account is required to enroll into EFT as all enrollments must be completed via a secure Provider Portal account or a secure MCO Portal account. Paper enrollments are not accepted. A separate EFT enrollment is required for each financial payer a provider bills.

Providers who do not have a Portal account may Request Portal Access online. Providers may also call the Portal Helpdesk for assistance in requesting a Portal account.

The following guidelines apply to EFT enrollment:

- Only a Portal Administrator or a clerk that has been assigned the new "EFT" role on the Portal may complete the EFT enrollment information.
- Organizations cannot revert back to receiving paper checks once enrolled in EFT.
- Organizations may change their EFT information at any time.
- Organizations will continue to receive their Remittance Advice as they do currently.

Refer to the ForwardHealth Portal Electronic Funds Transfer User Guide and the Electronic Funds Transfer Fact Page for instructions and more information about EFT enrollment.

Providers will continue to receive payment via paper check until the enrollment process moves into "Active" status and the provider's ForwardHealth EFT enrollment is considered complete.

Recoupment and Reversals

Enrollment in EFT does not change the current process of recouping funds. Overpayments and recoupment of funds will continue to be conducted through the reduction of payments.

Note: Enrolling in EFT does not authorize ForwardHealth to make unauthorized debits to the provider's EFT account; however, in some instances an EFT reversal of payment may be necessary. For example, if the system generates a payment twice or the amount entered manually consists of an incorrect value (e.g., a decimal point is omitted creating a $50,000 keyed value for a $500 claim), a reversal will take place to correct the error and resend the correct transaction value. ForwardHealth will notify the designated EFT contact person of an EFT reversal if a payment is made in error due to a system processing or manual data entry error.

Problem Resolution

If payment is not deposited into the designated EFT account according to the ForwardHealth payment cycle, providers should first check with their financial institution to confirm the payment was received. If the payment was not received, providers should then call Provider Services to resolve the issue and payment by paper check will be reinstated until the matter has been resolved.

Resources

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Archive Date:07/01/2011

Resources:Electronic Data Interchange

Topic #11907

5010 Companion Guides and NCPDP Version D.0 Payer Sheet

The 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 for the following transactions:

- 270/271 Health Care Eligibility/Benefit Inquiry and Information Response.
- 276/277 Health Care Claim Status Request and Response.
- 835 Health Care Claim Payment/Advice.
- 837 Health Care Claim: Professional.
- 837 Health Care Claim: Institutional.
- 837 Health Care Claim: Dental.
- 999 Functional Acknowledgment. (*Note:* The 999 will replace the 997 Functional Acknowledgment.)
- TA1 Interchange Acknowledgment.
- NCPDP version D.0.

The 5010 companion guides and the payer sheet will completely replace the companion documents used for version 4010 and NCPDP version 5.1 and will not include the summary of changes known as the "revision log."

The companion guides and the payer sheet provide ForwardHealth-specific information that should be used with the national HIPAA Implementation Guides. Implementation Guides define the national data standards, electronic format, and values required for each data element within an electronic transaction.

To request paper copies of the companion guides or the payer sheet, providers may contact Provider Services at (800) 947-9627.

Compliance Testing

Each HIPAA covered entity (i.e., provider, payer, clearinghouse, or other vendor) is responsible for ensuring its own compliance with versions 5010 and D.0 transaction requirements. Providers who contract with billing services, clearinghouses, or other vendors are responsible for ensuring the services provided by their contractors are compliant with HIPAA and ForwardHealth requirements.

After completing internal testing, covered entities are required to complete compliance testing with ForwardHealth to ensure that they are able to submit and receive versions 5010 and D.0 transactions and have identified and resolved all issues prior to the January 1, 2012, implementation date.

Version 5010

Prior to submitting version 5010-compliant electronic transactions to the ForwardHealth production environment, trading partners are required to:

- Update their Trading Partner Profile on the Portal and agree to the revised Trading Partner Agreement.
- Complete compliance testing procedures as outlined in their 5010 Standard Testing Packet, found on the HIPAA ASC X12

Version 5010 and NCPDP Version D.0 Implementation Page on the Portal. Trading partner testing packets will be available on the Portal beginning August 1, 2011.

Trading partners may start compliance testing August 1, 2011.

Version D.0

Providers may work with their VAN (Value Added Network) to complete any testing for version D.0 transactions; there will not be any direct testing between providers and ForwardHealth. Providers should contact their VAN or switch vendor for information or questions they may have regarding version D.0 preparedness.

Dual Processing Period

There will be a dual processing or transition period between October 15 and December 31, 2011, during which ForwardHealth will accept in the production environment the current version 4010 and NCPDP version 5.1 transactions *and* the new version 5010 and NCPDP version D.0 transactions, except for the 270/271 and 276/277 transactions.

For the 270/271 and 276/277 transactions, the transition period during which ForwardHealth will accept versions 4010 and 5010 will be from November 12 to December 31, 2011.

Portal

Topic #11057

ASC X12 Version 5010 and NCPDP Version D.0 Implementation Page

ForwardHealth has established a page on the ForwardHealth Portal designed to keep providers and trading partners informed of important dates and information related to the implementation of the new HIPAA (Health Insurance Portability and Accountability Act of 1996) ASC X12 version 5010 and NCPDP (National Council for Prescription Drug Programs) telecommunication standard version D.0. Providers, trading partners, partners, MCOs (Managed Care Organizations), and other interested parties are encouraged to check the 5010 page of the Portal often, as ForwardHealth will post new information regularly.

As information becomes available, ForwardHealth plans to include the following on the version 5010 and version D.0 page of the Portal:

- Questions and answers about the transition to the new standards.
- Companion documents for the new standards.
- External compliance testing schedule and procedures.
- Links to national resources for version 5010 and version D.0 transactions.
- An e-mail address to which providers and trading partners can send their questions (*forwardhealth5010support@wi.gov*).

Topic #5157

Cost Share Reports for Long-Term Managed Care Organizations

Individual cost share reports for long-term care MCOs (managed care organizations) that provide Family Care, Family Care Partnership, and PACE (Program of All-Inclusive Care for the Elderly) services are available via the secure area of the ForwardHealth Portal and can be downloaded as an Excel file.

Topic #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).