Provider Enrollment and Ongoing Responsibilities

1

Archive Date:08/01/2025

Provider Enrollment and Ongoing Responsibilities: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 #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 #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.

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% 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 HDAP (Wisconsin HIV 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.

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 Wis. Stat. § 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 (for example, 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. 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 C.F.R. 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 C.F.R. 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 C.F.R. 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 C.F.R. 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.

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 website.

Covered and Noncovered Services

2

Archive Date:08/01/2025

Covered and Noncovered Services: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 their certifying agency to apply for ongoing coverage.

Covered Services and Requirements

Topic #891

Covered Services During Temporary Enrollment

Effective with the date of determination (for example, 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** (for example, 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).

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		Modifiers
In person (foreign language and sign language)	When the interpreter is physically present with the member and provider		U1 or U3
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 U3 **and** GT or 93
	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 U3 **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.

Claims

3

Archive Date:08/01/2025

Claims: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 #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 #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.

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.

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.

Responsibilities

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% 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% of the provider's volume of submitted claims prior to pre-payment review.	The provider must meet parameters set during the sanction process.

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% 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% 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.

Member Information

4

Archive Date:08/01/2025

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 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 #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 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.

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 their 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 (for example, 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 they turned 18.

Topic #888

Enrollment Criteria

Express Enrollment of Pregnant Women in BadgerCare Plus

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

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

Certain pregnant members who are qualifying non-U.S. citizens may be temporarily enrolled in BadgerCare Plus through Express Enrollment. The paper BadgerCare Plus Express Enrollment for Pregnant Women Application Instructions and the web-based Express Enrollment tool provide information on the qualifying non-U.S. citizens who are eligible for temporary enrollment in BadgerCare Plus.

There is no asset test for Express Enrollment of pregnant members in BadgerCare Plus.

Express Enrollment of Children in BadgerCare Plus

Children can be temporarily enrolled in BadgerCare Plus through Express Enrollment 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% 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% 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% of the FPL.

Children are limited to one temporary enrollment period in a 12-month rolling period.

Certain children who are qualifying non-U.S. citizens may be temporarily enrolled in BadgerCare Plus through Express Enrollment. The web-based Express Enrollment tool provides information on the qualifying non-U.S. citizens who are eligible for temporary enrollment in BadgerCare Plus.

Express Enrollment of Adults in BadgerCare Plus

The following individuals can be temporarily enrolled in BadgerCare Plus through Express Enrollment:

- Parents and other caretakers, including qualifying non-U.S. citizens, with incomes at or below 100% of the FPL.
- Childless adults age 19 through 64, including qualifying non-U.S. citizens, with incomes at or below 100% of the FPL.

These individuals can apply for Express Enrollment in BadgerCare Plus using the web-based Express Enrollment tool.

Express Enrollment of Individuals Applying for Family Planning Other Services

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

Certain qualifying non-U.S. citizens may be temporarily enrolled in Family Planning Only Services through Express Enrollment. The web-based Express Enrollment application tool and the paper Temporary Enrollment for Family Planning Only Services Application Instructions provide information on the qualifying non-U.S. citizens who are eligible for temporary enrollment in Family Planning Only Services.

Express Enrollment for Wisconsin Well Woman Medicaid

Women under age 65 with breast or cervical cancer with incomes at or below 250% of the FPL may be temporarily eligible for Wisconsin Well Woman Medicaid.

Topic #4357

Enrollment Process

Qualified providers can make 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 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 Express Enrollment tool in ACCESS to make presumptive eligibility determinations; using the online tool allows providers to make faster, more secure presumptive eligibility determinations. Chapter 12 of the ACCESS Handbook provides detailed information about using ACCESS to make presumptive eligibility determinations.

Process for Express Enrollment in BadgerCare Plus

Qualified providers can use the web-based Express Enrollment tool to temporarily enroll pregnant women and children in BadgerCare Plus. Community partners can use the web-based Express Enrollment tool to temporarily enroll children in BadgerCare Plus.

For Express Enrollment of pregnant women, a paper application is also available and may be ordered. In addition, the Instructions for the paper BadgerCare Plus Express Enrollment for Pregnant Women Application Instructions are available.

Once an application is submitted through Express Enrollment, 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 Express Enrollment application tool in ACCESS to temporarily enroll individuals applying for Family Planning Only Services.

A paper application is also available and may be ordered. In addition, paper Temporary Enrollment for Family Planning Only Services Application Instructions are available.

Once an application is submitted through Express Enrollment, 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, they are certified until August 31. However, if their mother completes an application for ongoing BadgerCare Plus coverage for them on July 5 and on August 6 they are 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

Members who are temporarily enrolled in BadgerCare Plus or Family Planning Only Services through Express Enrollment will receive a temporary identification card:

- For members who are temporarily enrolled using the web-based Express Enrollment application tool, identification cards are included in 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 Express Enrollment application, an identification card is attached to the bottom portion 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 Express Enrollment, they will be included on the same temporary identification card; however, each member will receive their own ForwardHealth identification card. A permanent ForwardHealth identification card will be mailed to the member within three to five business days if the member has not already been issued a ForwardHealth identification card. If the member has been issued a ForwardHealth identification card in the past, a new one will not be mailed. The member can use their previously issued ForwardHealth identification card or contact Member Services to request a new one.

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 Express Enrollment 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 the dates printed on the temporary identification card.

To the Provider

The individuals listed on this card have been temporarily enrolled in BadgerCare Plus through Express Enrollment, in accordance with Wis. Stat. s. 49.471. This card is valid for the dates specified and entitles the listed individual to receive health care services including pharmacy services through BadgerCare Plus from any certified BadgerCare Plus provider. Pregnant women may only receive pregnancy-related outpatient care. For additional information, call Provider Services at 800-947-9627 or see the ForwardHealth 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 during the temporary enrollment period, including the prohibition against billing members. Refer to the ForwardHealth Online Provider Handbook for further information regarding this temporary identification 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 EXPRESS ENROLLMENT IN BADGERCARE PLUS

Name:	ID Number:
IM A MEMBER	0123456789

Temporary Card Valid From: 09/26/2016 - 10/09/2016

For services provided after the dates above, a ForwardHealth card should be presented or eligibility verified through ForwardHealth.

To the Provider

The individual listed has been temporarily enrolled in Family Planning Only Services through Express Enrollment, in accordance with Wis. Stat. s. 49.471. This card is valid for the dates specified and entitles the listed individual to receive certain family planning services including certain family planning-related pharmacy services from any certified family planning provider. For additional information, call Provider Services at (800) 947-9627 or see the ForwardHealth 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 during the temporary enrollment period, including the prohibition against billing members. Refer to the ForwardHealth Online Provider Handbook for further information regarding this temporary identification 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 EXPRESS ENROLLMENT IN FAMILY PLANNING ONLY SERVICES

Name:	ID Number:
IM A MEMBER	0123456789

Temporary Card Valid From: 09/26/2016 - 10/09/2016

For services provided after the dates above, a ForwardHealth card should be presented or eligibility verified through ForwardHealth.

Special Enrollment Circumstances

Topic #23277

12-Month Continuous Health Care Coverage for Children

Most children enrolled in BadgerCare Plus or Medicaid programs will keep their health insurance coverage for 12 months. Even if their family has a change in income or other circumstances, children under age 19 will have coverage at least until their next renewal. This policy is required by the federal Consolidated Appropriations Act, 2023.

Children enrolled in Foster Care Medicaid or SSI Medicaid will have 12-months of continuous coverage even if their out-of-home placement, subsidized guardianship, court-ordered kinship care, adoption assistance agreement, or SSI payment ends.

Qualifying Programs

Members under age 19 in the following programs qualify for continuous coverage:

- BadgerCare Plus
- Emergency Services Medicaid
- Family Planning Only Services
- Foster Care Medicaid
- HCBW (Home and Community-Based Waiver) Medicaid
- Institutional Medicaid
- Katie Beckett Medicaid
- MAPP (Medicaid Purchase Plan)
- Medicare Savings Programs
- Special Status Medicaid
- SSI (Supplemental Security Income)-Related Medicaid
- SSI Medicaid
- Tuberculosis-Related Medicaid
- Wisconsin Well Woman Medicaid

Exceptions to Continuous Coverage

Continuous coverage does not apply to children:

- Enrolled under presumptive eligibility, also known as Express Enrollment.
- Enrolled by meeting a deductible. These are members who become eligible for up to a six-month period based on their medical expenses.

Children remain eligible for the 12 months until their next renewal unless:

- They turn 19.
- They move out of Wisconsin.
- Their citizenship or immigration status is not verified.
- Their eligibility was based on inaccurate information or agency error.
- The family asks to end their coverage.

Assisting Members Through Enrollment Renewals

Helping families through the health care renewal process remains vital to keeping children covered. Providers are asked to remind BadgerCare Plus and other Wisconsin Medicaid program members to renew their coverage, even if they think their situation will change in the future. Members should also be reminded to tell their agency about any changes to their address, phone number, or email to ensure they continue to receive important information about their health care coverage from Wisconsin DHS (Department of Health Services).

Member Resources

Free Health Insurance Application and Renewal Assistance

Members who need help with applying for or renewing health care coverage can access the following resources:

- Covering Wisconsin (free expert help with health insurance), available at the WisCovered website
- 211 Wisconsin at 211 or 877-947-2211

Continuous Coverage and Health Care Renewal Information

Additional member resources regarding health care renewals and continuous coverage for children are available:

- Medicaid: Programs for Children web page
- Health Care Renewals web page
- "Keeping Kids Covered" 12-Month Continuous Coverage for Children fact sheet
- BadgerCare Plus: Frequently Asked Questions

Additional policy information on continuous coverage for children is available in the BadgerCare Plus Handbook.

Coordination of Benefits

5

Archive Date:08/01/2025

Coordination of Benefits:Commercial Health Insurance

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 (for example, 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.

Resources

6

Archive Date:08/01/2025

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 (for example, 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 email 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 email 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 email subscription, click Register for Email Subscription in the Quick Links box on the Provider page of the Portal.

Managed Care

7

Archive Date:08/01/2025

Managed Care: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

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.