Provider Enrollment and Ongoing Responsibilities

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Provider Enrollment and Ongoing Responsibilities:Provider Enrollment

Topic #14137

Enrollment Requirements Due to the Affordable Care Act

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

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

Topic #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 #14317

Terminology to Know for Provider Enrollment

ForwardHealth adopted terminology due to the ACA (Affordable Care Act), which is included in the following table. This terminology is useful to providers during the provider enrollment and revalidation processes. Providers may refer to the Medicaid rule 42 C.F.R. § s. 455.101 for more information.

Terminology	Definition
Agent	Any person who has been delegated the authority to obligate or act on behalf of a provider.
Disclosing entity	A Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent.
Federal health care programs	Federal health care programs include Medicare, Medicaid, Title XX, and Title XXI.
Other disclosing agent	Any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVII, or XX of the Act. This includes: • Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or HMO that participates in Medicare (Title XVIII) • Any Medicare intermediary or carrier • Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or XX of the Act
Indirect ownership	An ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership in the disclosing entity.
Managing employee	A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.
Ownership interest	The possession of equity in the capital, the stock, or the profits of the disclosing entity.
Person with an ownership or control interest	A person or corporation for which one or more of the following applies: • Has an ownership interest totaling 5% or more in a disclosing entity • Has an indirect ownership interest equal to 5% or more in a disclosing entity • Has a combination of direct and indirect ownership interest equal to 5% or more in a disclosing entity • Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured

	by the disclosing entity if that interest equals at least 5% of the value of the property or asset of the disclosing entity - Is an officer or director of a disclosing entity that is organized as a corporation - Is a person in a disclosing entity that is organized as a partnership
Subcontractor	- An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or, - An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.
Re-enrollment	Re-enrollment of a provider whose Medicaid enrollment has ended for any reason other than sanctions or failure to revalidate may be re-enrolled as long as all licensure and enrollment requirements are met. Providers should note that when they re-enroll, application fees and screening activities may apply. Re-enrollment was formerly known as re-instate.
Revalidation	All enrolled providers are required to revalidate their enrollment information every three years to continue their participation with Wisconsin Medicaid. Revalidation was formerly known as recertification.

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

Ongoing Responsibilities

Topic #15157

Recovery Audit Contractor Audits

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

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

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

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

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

Affected Providers

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

Additional Information

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

Topic #13277

Reporting Suspected Waste, Fraud, and Abuse

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

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

Those who suspect fraudulent activity in Medicaid programs are required to notify the OIG if they have reason to believe that a

person is misusing or abusing any DHS health care program or the ForwardHealth identification card.

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

Reporting Suspected Fraud and Abuse

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

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

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

The following information is helpful when reporting fraud and abuse:

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

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

Documentation

Topic #6277

1099 Miscellaneous Forms

ForwardHealth generates the 1099 Miscellaneous form in January of each year for earnings greater than $600, per IRS (Internal Revenue Service) regulations. One 1099 Miscellaneous form per financial payer and per tax identification number is generated, regardless of how many provider IDs or NPIs (National Provider Identifier) share the same tax identification number. For example, a provider who conducts business with both Medicaid and WCDP (Wisconsin Chronic Disease Program) will receive separate 1099 Miscellaneous forms for each program.

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

Topic #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.

Prescription

Topic #21937

Requirements for Standing Orders

Any prescription for Medicaid enrollees, including those based on standing orders, must be documented according to Wis. Admin. Code § DHS 107.02(2m)(b). For documentation purposes, "the prescriber's MA provider number" in Wis. Admin. Code § DHS 107.02(2m)(b) refers to that of the provider who authored the standing order.

Providers must follow licensure scope of practice requirements when delegating dispensing or treatment authority per a standing order.

The member's medical record must reflect what was prescribed through the standing order and for what purpose.

Covered and Noncovered Services

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Covered and Noncovered Services:Noncovered Services

Topic #4358

Noncovered Services

Inpatient hospital services are not covered through the family planning only benefit. Services unrelated to contraceptive management are not covered.

Codes

Topic #1929

Diagnosis Codes

The following table lists all allowable diagnosis codes related to ICD (International Classification of Diseases) contraceptive management for Family Planning Only Services.

Diagnosis Code	Description
Z30.011	Encounter for initial prescription of contraceptive pills
Z30.012	Encounter for prescription of emergency contraception
Z30.013	Encounter for initial prescription of injectable contraceptive
Z30.014	Encounter for initial prescription of intrauterine contraceptive device
Z30.015	Encounter for initial prescription of vaginal ring hormonal contraceptive
Z30.016	Encounter for initial prescription of transdermal patch hormonal contraceptive device
Z30.017	Encounter for initial prescription of implantable subdermal contraceptive
Z30.018	Encounter for initial prescription of other contraceptives
Z30.019	Encounter for initial prescription of contraceptives, unspecified
Z30.02	Counseling and instruction in natural family planning to avoid pregnancy
Z30.09	Encounter for other general counseling and advice on contraception
Z30.2	Encounter for sterilization
Z30.40	Encounter for surveillance of contraceptives, unspecified
Z30.41	Encounter for surveillance of contraceptive pills
Z30.42	Encounter for surveillance of injectable contraceptive
Z30.430	Encounter for insertion of intrauterine contraceptive device
Z30.431	Encounter for routine checking of intrauterine contraceptive device
Z30.432	Encounter for removal of intrauterine contraceptive device
Z30.433	Encounter for removal and reinsertion of intrauterine contraceptive device
Z30.44	Encounter for surveillance of vaginal ring hormonal contraceptive device
Z30.45	Encounter for surveillance of transdermal patch hormonal contraceptive device
Z30.46	Encounter for surveillance of implantable subdermal contraceptive
Z30.49	Encounter for surveillance of other contraceptives
Z30.8	Encounter for other contraceptive management
Z30.9	Encounter for contraceptive management, unspecified

Topic #15077

Modifier

Providers submitting claims for members enrolled in Family Planning Only Services are required to identify the service as family planning-related by using the most appropriate allowable ICD (International Classification of Diseases) contraceptive management diagnosis code. When an ICD diagnosis code related to contraceptive management is not appropriate for the service provided, providers may instead use modifier FP associated with the allowable procedure code.

Claims for members enrolled in Family Planning Only Services that are submitted without either an allowable primary ICD contraceptive management diagnosis code or modifier FP associated with an allowable procedure code will be denied.

Topic #1943

National Drug Codes

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

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

The NDC is divided into the following segments:

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

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

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

New National Drug Codes

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

Obsolete National Drug Codes

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

Topic #2624

Procedure Codes Covered Under Family Planning Only Services

Providers who submit claims for Family Planning Only Services using the UB-04 Claim Form and the 837I (837 Health Care Claim: Institutional) transactions are required to indicate a valid HCPCS (Healthcare Common Procedure Coding System) procedure code for each revenue code on the claim. The HCPCS code should be entered in Form Locator 44 of the UB-04 Claim Form. This policy should be used in conjunction with service-specific claim submission policies.

ForwardHealth requires HCPCS procedure codes on claims to assist in monitoring reimbursement for covered services.

Procedure Codes

The following tables contain the procedure codes covered under Family Planning Only Services. In addition to indicating an appropriate covered procedure code, providers submitting claims for members enrolled in Family Planning Only Services are required to identify the service as family planning-related by associating the procedure with modifier FP (Service provided as part of Family Planning program) or the most appropriate ICD (International Classification of Diseases) diagnosis code related to contraceptive management.

The following tables indicate which procedure code requires an allowable primary diagnosis code related to contraceptive management. "No" indicates that the allowable contraceptive management diagnosis code does not have to be in the primary position. If an ICD diagnosis code related to contraceptive management is not appropriate for the service provided, providers may instead use modifier FP associated with the procedure.

Claims for members enrolled in Family Planning Only Services that are submitted without either a modifier FP associated with the procedure code or an allowable primary ICD contraceptive management diagnosis code will be denied.

Evaluation and Management Services		
Procedure Code	**Description**	**Requires Allowable Contraceptive Management Code as Primary Diagnosis Code**
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15–29 minutes of total time is spent on the date of the encounter.	Yes
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30–44 minutes of total time is spent on the date of the encounter.	Yes
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45–59 minutes of total time is spent on	Yes

	the date of the encounter.	
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60–74 minutes of total time is spent on the date of the encounter.	Yes
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.	Yes
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10–19 minutes of total time is spent on the date of the encounter.	Yes
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20–29 minutes of total time is spent on the date of the encounter.	Yes
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30–39 minutes of total time is spent on the date of the encounter.	Yes
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40–54 minutes of total time is spent on the date of the encounter.	Yes
G2212	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional	Yes

	15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT (Current Procedural Terminology) codes 99205, 99215 for office or other outpatient evaluation and management services)	
99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)	Yes
99385	18–39 years	Yes
99386	40–64 years	Yes
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)	Yes
99395	18–39 years	Yes
99396	40–64 years	Yes
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes	Yes
99402	approximately 30 minutes	Yes
99403	approximately 45 minutes	Yes
99404	approximately 60 minutes	Yes
Q3014	Telehealth originating site facility fee	No
S9445	Patient education, not otherwise classified, non-physician provider, individual, per session	Yes

Note: S9445 not covered with procedure codes 99384–99396 and 99401–99404.

Supplies and Drugs		
Procedure Code	**Description**	**Requires Allowable Contraceptive Management Code as Primary Diagnosis Code**
A4261	Cervical cap for contraceptive use	Yes
A4264	Permanent implantable contraceptive intratubal occlusion device(s) and delivery system	Yes
A4266	Diaphragm for contraceptive use	Yes
A4267	Contraceptive supply, condom, male, each	Yes

A4268	Contraceptive supply, condom, female, each	Yes
A4269	Contraceptive supply, spermicide (e.g., foam, gel), each	Yes
G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	Yes
J0561	Injection, penicillin G benzathine, 100,000 units	No
J0696	Injection, ceftriaxone sodium [Rocephin], per 250 mg	No
J7296	Levonorgestrel-releasing intrauterine contraceptive system, (Kyleena), 19.5 mg	Yes
J7297	Levonorgestrel-releasing intrauterine contraceptive system (Liletta), 52mg	Yes
J7298	Levonorgestrel-releasing intrauterine contraceptive system (Mirena), 52mg	Yes
J7300	Intrauterine copper contraceptive	Yes
J7304	Contraceptive supply, hormone containing patch, each	Yes
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies	Yes
Q0144	Azithromycin dihydrate, oral, capsules/powder, 1 gram	Yes
S4993	Contraceptive pills for birth control	Yes

Anesthesia Services		
Procedure Code	**Description**	**Requires Allowable Contraceptive Management Code as Primary Diagnosis Code**
00851	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection	Yes
00921	Anesthesia for procedures on male genitalia (including open urethral procedures); vasectomy, unilateral or bilateral	No
00952	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); hysteroscopy and/or hysterosalpingography	Yes

Surgery Services		
Procedure Code	**Description**	**Requires Allowable Contraceptive Management Code as Primary Diagnosis Code**
10060	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paraonychia); simple or single	Yes
10140	Incision and drainage of hematoma, seroma or fluid collection	Yes
11420	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less	Yes
11976	Removal, implantable contraceptive capsules	Yes

11981	Insertion, non-biodegradable drug delivery implant	Yes
11982	Removal, non-biodegradable drug delivery implant	Yes
11983	Removal with reinsertion, non-biodegradable drug delivery implant	Yes
17110	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions	No
17111	15 or more lesions	No
46900	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical	No
46924	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)	No
55250*	Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)	No
56501	Destruction of lesion(s), vulva; simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)	No
57061	Destruction of vaginal lesion(s); simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)	No
57170	Diaphragm or cervical cap fitting with instructions	Yes
57452	Colposcopy of the cervix including upper/adjacent vagina;	No
57454	with biopsy(s) of the cervix and endocervical curettage	No
57455	with biopsy(s) of the cervix	No
57456	with endocervical curettage	No
57460	with loop electrode biopsy(s) of the cervix	No
57461	with loop electrode conization of the cervix	No
58300	Insertion of intrauterine device (IUD)	Yes
58301	Removal of intrauterine device (IUD)	Yes
58340	Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography	Yes
58565*	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants [The professional service only is reimbursed under CPT procedure code 58565. The implantable device is reimbursed under HCPCS procedure code A4264.]	Yes
58600*	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	Yes
+ 58611*	Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)	Yes

58615*	Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring) vaginal or suprapubic approach	Yes
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salphingectomy)	Yes
58670*	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)	Yes
58671*	with occlusion of oviducts by device (eg, band, clip, or Falope ring)	Yes

Radiology Services		
Procedure Code	**Description**	**Requires Allowable Contraceptive Management Code as Primary Diagnosis Code**
71045	Radiologic examination, chest; single view	Yes
71046	Radiologic examination, chest; 2 views	Yes
74740	Hysterosalpingography, radiological supervision and interpretation	Yes

Medicine Services		
Procedure Code	**Description**	**Requires Allowable Contraceptive Management Code as Primary Diagnosis Code**
90636	Hepatitis A and hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use	No
90649	Human Papillomavirus vaccine, types 6, 11, 16, 18, quadrivalent (4vHPV), 3 dose schedule, for intramuscular use	No
90650	Human Papillomavirus vaccine, types 16, 18, bivalent (2vHPV), 3 dose schedule, for intramuscular use	No
90651	Human Papillomavirus vaccine, types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 2 or 3 dose schedule, for intramuscular use	No
90739	Hepatitis B vaccine (HepB), CpG-adjuvanted, adult dosage, 2 dose or 4 dose schedule, for intramuscular use	No
90740	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 3 dose schedule, for intramuscular use	No
90743	Hepatitis B vaccine (HepB), adolescent, 2 dose schedule, for intramuscular use	No
90744	Hepatitis B vaccine (HepB), pediatric/adolescent dosage, 3 dose schedule, for intramuscular use	No
90746	Hepatitis B vaccine (HepB), adult dosage, 3 dose schedule, for intramuscular use	No

90759	Hepatitis B vaccine (HepB), 3-antigen (S, Pre-S1, Pre-S2), 10 mcg dosage, 3 dose schedule, for intramuscular use	No
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Yes
99070	Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	Yes

Laboratory Services		
Procedure Code	**Description**	**Requires Allowable Contraceptive Management Code as Primary Diagnosis Code**
G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision	Yes
80048	Basic metabolic panel [see CPT for tests that must be included in the panel]	Yes
80050	General health panel [see CPT for tests that must be included in the panel]	Yes
80051	Electrolyte panel [see CPT for tests that must be included in the panel]	Yes
80053	Comprehensive metabolic panel [see CPT for tests that must be included in the panel]	Yes
80061	Lipid panel [see CPT for tests that must be included in the panel]	Yes
80074	Acute hepatitis panel [see CPT for tests that must be included in the panel]	Yes
80076	Hepatic function panel [see CPT for tests that must be included in the panel]	Yes
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy	Yes
81002	non-automated, without microscopy	Yes
81025	Urine pregnancy test, by visual color comparison methods	Yes
82565	Creatinine; blood [only used if patient is on medication for Herpes]	Yes
82728	Ferritin	Yes
82746	Folic acid; serum	Yes
82947	Glucose; quantitative, blood (except reagent strip)	Yes
82948	blood, reagent strip	Yes
83001	Gonadotropin; follicle stimulating hormone (FSH)	Yes
83020	Hemoglobin fractionation and quantitation; electrophoresis (eg, A2, S, C, and/or F)	Yes
83518	Immunoassay for analyte other than infectious agent antibody or infectious	Yes

	agent antigen; qualitative or semiquantitative, single step method (eg, reagent strip)	
84146	Prolactin	Yes
84443	Thyroid stimulating hormone (TSH)	Yes
84450	Transferase; aspartate amino (AST) (SGOT)	Yes
84702	Gonadotropin, chorionic (hCG); quantitative	Yes
84703	qualitative	Yes
85007	Blood count; blood smear, microscopic examination with manual differential WBC count	Yes
85009	manual differential WBC count, buffy coat	Yes
85013	spun microhematocrit	Yes
85014	hematocrit (Hct)	Yes
85018	hemoglobin (Hgb)	Yes
85025	complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count	Yes
85027	complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	Yes
85032	manual cell count (erythrocyte, leukocyte, or platelet) each	Yes
85041	red blood cell (RBC), automated	Yes
85048	leukocyte (WBC), automated	Yes
85651	Sedimentation rate, erythrocyte; non-automated	Yes
86592	Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART)	Yes
86689	Antibody; HTLV or HIV antibody, confirmatory test (eg, Western Blot)	Yes
86694	herpes simplex, non-specific type test	Yes
86695	herpes simplex, type 1	Yes
86696	herpes simplex, type 2	Yes
86701	HIV-1	Yes
86703	HIV-1 and HIV-2, single result	Yes
86780	Treponema pallidum	Yes
86803	Hepatitis C antibody	Yes
87070	Culture, bacterial; any other source except urine, blood or stool, aerobic, with isolation and presumptive identification of isolates	Yes
87075	any source, except blood, anaerobic with isolation and presumptive identification of isolates	Yes
87076	anaerobic isolate, additional methods required for definitive identification, each isolate	Yes
87081	Culture, presumptive, pathogenic organisms, screening only	Yes
87086	Culture, bacterial; quantitative colony count, urine	Yes

87088	Culture, bacterial; with isolation and presumptive identification of each isolate, urine	Yes
87101	Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; skin, hair, or nail	Yes
87109	Culture, mycoplasma, any source	Yes
87110	Culture, chlamydia, any source	Yes
87205	Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types	Yes
87206	fluorescent and/or acid fast stain for bacteria, fungi, parasites, viruses, or cell types	Yes
87207	special stain for inclusion bodies or parasites (eg, malaria, coccidia, microsporidia, trypanosomes, herpes viruses)	Yes
87210	wet mount for infectious agents (eg, saline, India ink, KOH preps)	Yes
87252	Virus isolation; tissue culture inoculation, observation, and presumptive identification by cytopathic effect	Yes
87254	centrifuge enhanced (shell vial) technique, includes identification with immunofluorescence stain, each virus	Yes
87270	Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis	Yes
87274	Herpes simplex virus type 1	Yes
87320	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; Chlamydia trachomatis	Yes
87340	hepatitis B surface antigen (HBsAg)	Yes
87390	HIV-1	Yes
87391	HIV-2	Yes
87449	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]), qualitative or semiquantitative; multiple-step method, not otherwise specified, each organism	Yes
87481	Infectious agent detection by nucleic acid (DNA or RNA); Candida species, amplified probe technique	Yes
87490	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique	Yes
87491	Chlamydia trachomatis, amplified probe technique	Yes
87492	Chlamydia trachomatis, quantification	Yes
87510	Gardnerella vaginalis, direct probe technique	Yes

87511	Gardnerella vaginalis, amplified probe technique	Yes
87512	Gardnerella vaginalis, quantification	Yes
87528	Herpes simplex virus, direct probe technique	Yes
87529	Herpes simplex virus, amplified probe technique	Yes
87530	Herpes simplex virus, quantification	Yes
87531	Herpes virus-6, direct probe technique	Yes
87532	Herpes virus-6, amplified probe technique	Yes
87533	Herpes virus-6, quantification	Yes
87534	HIV-1, direct probe technique	Yes
87535	HIV-1, amplified probe technique, includes reverse transcription when performed	Yes
87536	HIV-1, quantification, includes reverse transcription when performed	Yes
87537	HIV-2, direct probe technique	Yes
87538	HIV-2, amplified probe technique, includes reverse transcription when performed	Yes
87539	HIV-2, quantification, includes reverse transcription when performed	Yes
87563	Infectious agent detection by nucleic acid (DNA or RNA); mycoplasma genitalium, amplified probe technique	Yes
87591	Neisseria gonorrhoeae, amplified probe technique	Yes
87623	Human Papillomavirus (HPV), low-risk types (eg, 6, 11, 42, 43, 44)	Yes
87624	Human Papillomavirus (HPV), high-risk types (eg, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68)	Yes
87625	Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed	Yes
87797	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; direct probe technique, each organism	Yes
87798	amplified probe technique, each organism	Yes
87799	quantification, each organism	Yes
87801	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique	Yes
87806	Infectious agent antigen detection by immunoassay with direct optical observation; HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies	Yes
87808	Infectious agent antigen detection by immunoassay with direct optical observation; Trichomonas vaginalis	Yes
88141	Cytopathology, cervical or vaginal (any reporting system), requiring	Yes

	interpretation by physician	
88142	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision	Yes
88143	with manual screening and rescreening under physician supervision	Yes
88160	Cytopathology, smears, any other source; screening and interpretation	Yes
88164	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision	Yes
88165	with manual screening and rescreening under physician supervision	Yes
88166	with manual screening and computer-assisted rescreening under physician supervision	Yes
88167	with manual screening and computer-assisted rescreening using cell selection and review under physician supervision	Yes
88175	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision	Yes
88199	Unlisted cytopathology procedure	No
88300	Level I — Surgical pathology, gross examination only	Yes
88302	Level II — Surgical pathology, gross and microscopic examination	Yes
88305	Level IV — Surgical pathology, gross and microscopic examination	No
88307	Level V — Surgical pathology, gross and microscopic examination	No
+ 88341	Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (List separately in addition to code for primary procedure)	No
88342	Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure	No
99000	Handling and/or conveyance of specimen for transfer from the office to a laboratory	Yes

* This service requires completion of the Consent for Sterilization (F-01164 (10/2008)) form.

Allowable Procedure Codes for Services Provided to Members Receiving the Tuberculosis-Related Services-Only Benefit

Members may be enrolled in more than one limited benefit category. For example, a member may be enrolled in Family Planning Only Services and Tuberculosis-Related Medicaid. In this instance, providers should use the Family Planning Only Services Online Handbook in conjunction with the Tuberculosis-Related Medicaid Online Handbook. (Wisconsin's EVS (Enrollment Verification System) will indicate that these members are eligible for both limited benefit categories.)

Topic #643

Unlisted Procedure Codes

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

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

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

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

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

For most unlisted codes, ForwardHealth requires additional documentation.

Unlisted Codes That Require Prior Authorization

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

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

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

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

Unlisted Codes That Do Not Require Prior Authorization

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

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

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

How to Submit Claims and Related Documentation

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

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

Topic #830

Valid Codes Required on Claims

ForwardHealth requires that all codes indicated on claims and PA (prior authorization) requests, including diagnosis codes, revenue codes, HCPCS (Healthcare Common Procedure Coding System) codes, HIPPS (Health Insurance Prospective Payment System) codes, and CPT (Current Procedural Terminology) codes be valid codes. Claims received without valid diagnosis codes, revenue codes, and HCPCS, HIPPS, or CPT codes will be denied; PA requests received without valid codes will be returned to the provider. Providers should refer to current national coding and billing manuals for information on valid code sets.

Code Validity

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

Code Specificity for Diagnosis

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

Covered Services and Requirements

Topic #2554

An Overview

Under Family Planning Only Services, eligible members receive selected family planning services and supplies through Medicaid-enrolled providers. Services and supplies that are covered under Family Planning Only Services are reimbursed fee-for-service. There is no copayment for the services and supplies covered in this benefit.

Providers are responsible for knowing which services are covered under Family Planning Only Services. ForwardHealth reviews CPT (Current Procedural Terminology), HCPCS (Healthcare Common Procedure Coding System), and FDA (Food and Drug Administration) changes regularly. Certain changes may require federal approval before they are added to Family Planning Only Services. If changes affect Family Planning Only Services, providers will be notified.

Coverage of services and supplies under Family Planning Only Services are less inclusive than the full ForwardHealth family planning benefit. Abortions and hysterectomies are not covered benefits of Family Planning Only Services.

Facility charges incurred as a result of covered sterilizations provided to Family Planning Only Services members that are provided in outpatient hospitals and ambulatory surgery centers are reimbursable by Wisconsin Medicaid up to the Medicaid-allowed amount.

Topic #2366

Colposcopies

Colposcopies are reimbursable through Family Planning Only Services when an abnormal pap test is obtained prior to the colposcopy and while the member is enrolled in Family Planning Only Services. Therefore, if a woman has had an abnormal pap prior to becoming eligible for Family Planning Only Services, the provider must perform a follow-up pap under Family Planning Only Services in order to have the colposcopy covered.

Members receiving colposcopies under Family Planning Only Services must also be receiving contraceptive management care, as the primary reason for being enrolled in Family Planning Only Services should be to receive contraceptive management services. Contraceptive management services are defined as those services associated with an allowable primary contraceptive management ICD (International Classification of Diseases) diagnosis code. To indicate that the colposcopy was provided as part of a contraceptive management visit or as a follow-up to a contraceptive management visit, providers are required to use either an allowable primary contraceptive ICD diagnosis code or modifier FP with an appropriate procedure code on a claim. Providers may use additional ICD diagnosis codes in the secondary positions as appropriate.

Topic #2369

Contraceptive Patch

Contraceptive patches are covered for family planning clinics for services provided to members enrolled in BadgerCare Plus and Medicaid. Providers should submit claims for this item on a Noncompound Drug Claim (F-13072 (04/2017)) form using an NDC (National Drug Code) or on the 1500 Health Insurance Claim Form ((02/12)) using HCPCS (Healthcare Common Procedure Coding System) procedure code J7304.

Topic #44

Definition of Covered Services

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

Topic #3409

Drugs

Additional information about drugs and quantity limits is available on the ForwardHealth Portal.

The following drugs are covered by Family Planning Only Services.

Drug Name and Strength	Dosage
Acyclovir 200 mg (Zovirax)	Capsule
Acyclovir 400 mg	Tablet
Acyclovir 800 mg	Tablet
Acyclovir 200 mg/5 mL	Suspension
Aldara 5%	Cream
Alesse-28	Tablet
Antifungal 2%	Cream
Apri 28 day	Tablet
Aranelle 28	Tablet
Aviane-28	Tablet
Azithromycin 250 mg (Zithromax)	Tablet, Z-pak tablet
Azithromycin 500 mg	Tablet
Azithromycin 600 mg	Tablet
Baza antifungal 2%	Cream
Brevicon 28	Tablet
Camila	Tablet
Carrington antifungal 2%	Cream
Cesia 28 day	Tablet
Clindagel 1%	Gel
ClindaMax 1%	Gel, lotion
ClindaMax 2%	Vaginal cream
Clindamycin 1% (Clindets)	Pledgets
Clindamycin 2% (Cleocin)	Vaginal cream
Clindamycin phosphate 1% (Cleocin T)	Gel, lotion, pledgets, solution,

	topical lotion
Ceftriaxone 250 mg (Rocephin)	Vial
Ceftriaxone 500 mg	Vial
Ceftriaxone 1 gm	Vial
Ceftriaxone 2 gm	Vial
Ceftriaxone 10 gm	Vial
Ciprofloxacin HCL 250 mg (Cipro)	Tablet
Ciprofloxacin HCL 500 mg	Tablet
Ciprofloxacin HCL 750 mg	Tablet
Ciprofloxacin HCL 100 mg	Tablet
Ciprofloxacin 5%	Suspension
Ciprofloxacin 10%	Suspension
Clotrim 1% (Lotrimin)	Vaginal cream
Clotrimazole antifungal 1%	Cream
Clotrimazole 3 day	Cream, insert
Clotrimazole-7	Insert
Contraceptive Supply, hormone-containing patch	Patch
Cruex 1%	Cream
Cryselle-28	Tablet
Cyclessa 28 day	Tablet
Demulen 1/35-21	Tablet
Demulen 1/35-28	Tablet
Demulen 1/50-21	Tablet
Demulen 1/50-28	Tablet
Depo-Provera 400 mg/mL	Vial
Depo-subQ provera 104	Syringe
Desenex 1%	Cream
Desenex 2%	Spray powder
Desogen 28 day	Tablet
Doxycycline 50 mg (Vibramycin)	Capsule
Doxycycline 100 mg	Capsule, tablet, vial
Doxycycline monohydrate 50 mg (Monodox)	Capsule
Doxycycline monohydrate 100 mg	Capsule
Enpresse-28	Tablet
Errin	Tablet

EryPed 200 mg (E.E.S.)	Suspension
EryPed 100 mg/2.5 mL	Drops
EryPed 400 mg/5 mL	Granules, suspension
Erythromycin 250 mg (Eryc)	Capsule EC
Erythromycin 250 mg	Filmtab
Erythromycin 200 mg/5 mL	Suspension
Erythromycin 400 mg/5 mL	Suspension
Erythromycin ES 400 mg	Tablet
Erythromycin EST 125 mg/5 mL	Suspension
Erythromycin EST 250 mg/5 mL	Suspension
Erythromycin ST 250 mg	Tablet
Erythromycin ST 500 mg	Tablet
E.E.S. 400 mg	Filmtab
E.E.S. 200 mg/5 mL	Granules, oral suspension
Erythrocin 250 mg	Filmtab
Erythrocin 500 mg	Filmtab
Ery-Tab 250 mg	Tablet EC
Ery-Tab 333 mg	Tablet EC
Ery-Tab 500 mg	Tablet EC
Estrostep FE-28	Tablet
Famvir 125 mg	Tablet
Famvir 250 mg	Tablet
Famvir 500 mg	Tablet
Femcare	Insert
Flagyl ER 750 mg	Tablet SA
Fluconazole 50 mg (Diflucan)	Tablet
Fluconazole 100 mg	Tablet
Fluconazole 150 mg	Tablet
Fluconazole 200 mg	Tablet
Fluconazole 10 mg/mL	Suspension
Fluconazole 40 mg/mL	Suspension
Gyne-Lotrimin 1%	Cream
Gyne-Lotrimin	Insert
Gynazole-1	Cream
Gynol II	Jelly
Gynol II Extra Strength 3%	Jelly
Jolivette	Tablet

Junel 1/20	Tablet
Junel 1.5/30	Tablet
Junel FE 1/20	Tablet
Junel FE 1.5/30	Tablet
Kariva 28 day	Tablet
Kelnor 1/35 28	Tablet
Leena 28	Tablet
Lessina-28	Tablet
Levaquin 250 mg	Tablet
Levaquin 500 mg	Tablet
Levaquin 750 mg	Tablet
Levlen 28	Tablet
Levlite-28	Tablet
Levora-21	Tablet
Levora-28	Tablet
Loestrin 24 FE	Tablet
Lo/Ovral-21	Tablet
Lo/Ovral-28	Tablet
Low-Ogestrel-28	Tablet
Lutera-28	Tablet
Medroxyprogesterone 150 mg/mL (Depo-Provera)	Syringe
Metronidazole 250 mg (Flagyl)	Tablet
Metronidazole 375 mg	Capsule
Metronidazole 500 mg	Tablet
Metrogel 0.75%	Gel
Metronidazole 0.75% (MetroCream)	Cream
Micaderm 2%	Cream
Micatin 2%	Aerosol spray, cream
Microgestin 21 1/20 (Loestrin)	Tablet
Microgestin 21 1.5/30	Tablet
Microgestin FE 1/20	Tablet
Microgestin FE 1.5/30	Tablet
Micro-Guard 2%	Cream
Micronor	Tablet
Miconazole 7 (Monistat)	Cream
Miconazole nitrate 2%	Cream

Miconazole 7 100 mg	Vaginal suppository
Miconazole 3 200 mg	Vaginal suppository
Mircette 28 day	Tablet
Mitrazol 2%	Cream
Modicon 28	Tablet
Monistat-Derm 2%	Cream
Mononessa 28	Tablet
Mycelex 1%	Cream
Neosporin antifungal 2%	Cream, spray powder
Necon 0.5/35-21	Tablet
Necon 0.5/35-28	Tablet
Necon 1/35-21	Tablet
Necon 1/35-28	Tablet
Necon 1/50-28	Tablet
Necon 7/7/7-28	Tablet
Necon 10/11-21	Tablet
Necon 10/11-28	Tablet
Nora-BE	Tablet
Nordette-21	Tablet
Nordette-28	Tablet
Norinyl 1+35-28	Tablet
Norinyl 1+50-28	Tablet
Nor-QD	Tablet
Nortrel 0.5/35	Tablet
Nortrel 1/35	Tablet
Nortrel 7/7/7-28	Tablet
Nortrel 21	Tablet
Nortrel 28	Tablet
Noritate 1%	Cream
Nystatin	Vaginal tablet
NuvaRing	Vaginal ring
Ofloxacin 200 mg (Floxin)	Tablet
Ofloxacin 300 mg	Tablet
Ofloxacin 400 mg	Tablet
Ogestrel	Tablet
Ortho-Cept 28 day	Tablet
Ortho-Cyclen-28 0.25/35	Tablet

Ortho-Novum 1/35 28	Tablet
Ortho-Novum 1/50-28	Tablet
Ortho-Novum 7/7/7-28	Tablet
Ortho-Novum 10/11-28	Tablet
Ortho Tri-Cyclen Lo	Tablet
Ortho Tri-Cyclen 28	Tablet
Ovcon-35 21	Tablet
Ovcon-35 28	Chewable tablet, tablet
Ovcon-50 28	Tablet
Ovral-21	Tablet
Ovral-28	Tablet
Ovrette	Tablet
PCE 333 mg	Dispertab
PCE 500 mg	Dispertab
Plan B 0.75 mg	Tablet
Podactin 2%	Cream
Podofilox 0.5% (Condylox)	Gel, topical solution
Portia-28	Tablet
Previfem	Tablet
Reclipsen 28 day	Tablet
Seasonale 0.15 mg and 0.03 mg	Tablet
Seasonique 0.15/0.03-0.01	Tablet
Secura antifungal 2%	Cream
Solia	Tablet
Sprintec 28 day	Tablet
Suprax 400 mg	Tablet
Suprax 100 mg/5 mL	Suspension
Tri-Levlen 28	Tablet
Tri-Norinyl 28	Tablet
Triphasil-21	Tablet
Triphasil-28	Tablet
Trivora-28	Tablet
Terconazole 0.4% (Terazol)	Cream
Terconazole 0.8%	Cream
Terconazole 80 mg	Suppository
Terazol 7 0.4%	Cream and applicator
Tetracycline 250 mg	Capsule

Tetracycline 500 mg	Capsule
TriNessa	Tablet
Tri-Previfem	Tablet
Tri-Sprintec	Tablet
Triple care antifungal	Cream
Valtrex 500 mg	Tablet
Valtrex 1 gm	Caplet
Velivet 28 day	Tablet
Yasmin 28	Tablet
Yaz 28	Tablet
Zithromax 1 gm	Powder packet
Zithromax 100 mg/5 mL	Suspension
Zithromax 200 mg/5 mL	Suspension
Zovia 1/35-21	Tablet
Zovia 1/35-28	Tablet
Zovia 1/50-21	Tablet
Zovia 1/50-28	Tablet
Zovirax	Ointment

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.

Topic #4359

Nexplanon

Nexplanon, a contraceptive implant, is covered for females who are 12 to 60 years of age. Providers should indicate HCPCS (Healthcare Common Procedure Coding System) procedure code J7307 (Etonogestrel [contraceptive] implant system, including implants and supplies) and the appropriate administration code on claims when implanting Nexplanon. The administration codes include the following:

- 11981 (insertion, non-biodegradable drug delivery implant)
- 11982 (removal, non-biodegradable drug delivery implant)
- 11983 (removal with reinsertion, non-biodegradable drug delivery implant)

Topic #10757

Non-Emergency Transportation Services

NEMT (non-emergency medical transportation) services are covered for members receiving Family Planning Only Services and are limited to trips to receive covered family planning services. NEMT services are provided to Family Planning Only members by the NEMT manager contracted with the Wisconsin DHS (Department of Health Services). Refer to the NEMT Online Handbook for complete policies and procedures for NEMT services. Providers may be asked to verify that the member received covered services at their site on a particular date.

Topic #5697

Physician-Administered Drugs

A physician-administered drug is either an oral, injectable, intravenous, or inhaled drug administered by a physician or a medical professional within their scope of practice.

Providers may refer to the maximum allowable fee schedules for the most current HCPCS (Healthcare Common Procedure Coding System) and CPT (Current Procedural Terminology) procedure codes for physician-administered drugs and reimbursement rates.

Physician-administered drugs carve-out policy is defined to include the following procedure codes:

- Drug-related "J" codes
- Drug-related "Q" codes
- Certain drug-related "S" codes

The Physician-Administered Drugs Carve-Out Procedure Codes table indicates the status of procedure codes considered under the physician-administered drugs carve-out policy. This table provides information on Medicaid and BadgerCare Plus coverage status as well as carve-out status based on POS (place of service).

Note: The table will be revised in accordance with national annual and quarterly HCPCS code updates.

For members enrolled in BadgerCare Plus HMOs, Medicaid SSI HMOs, and most special managed care programs, claims for these services should be submitted to BadgerCare Plus and Medicaid fee-for-service.

All fee-for-service policies and procedures related to physician-administered drugs, including copay, cost sharing, diagnosis restriction, PA (prior authorization), and pricing policies, apply to claims submitted to fee-for-service for members enrolled in an MCO (managed care organization).

Physician-administered drugs and related services for members enrolled in PACE (Program of All-Inclusive Care for the Elderly) are provided and reimbursed by the special managed care program.

Note: For Family Care Partnership members who are not enrolled in Medicare (Medicaid-only members), outpatient drugs (excluding diabetic supplies), physician-administered drugs, compound drugs (including parenteral nutrition), and any other drugs requiring drug utilization review are covered by fee-for-service Medicaid. All fee-for-service policies, procedures, and requirements apply for pharmacy services provided to Medicaid-only Family Care Partnership members. Dual eligibles (enrolled in Medicare and Medicaid) receive their outpatient drugs through their Medicare Part D plans. However, if the member's Part D plan does not cover the outpatient drug, these dually eligible members may access certain Medicaid outpatient drugs that are excluded or otherwise restricted from Medicare coverage through fee-for-service Medicaid. For these drugs, fee-for-service policies would apply.

Obtaining Physician-Administered Drugs

To ensure the content and integrity of the drugs administered to members, prescribers are required to obtain all drugs that will be administered in their offices. Prescribers may obtain a physician-administered drug from a pharmacy provider if the drug is delivered directly from the pharmacy to the prescriber's office. Prescribers may also obtain a drug to be administered in the prescriber's office from a drug wholesaler or direct purchase. Pharmacy providers should not dispense a drug to a member if the drug will be administered in the prescriber's office.

Topic #8697

Sterilizations

Sterilizations are covered by Family Planning Only Services, provided the Consent for Sterilization (F-01164 (10/2008)) form is properly completed.

Topic #2536

Tubal Ligations

The following types of tubal ligations are covered by Family Planning Only Services, provided the Consent for Sterilization (F-01164 (10/2008)) form is properly completed:

Procedure Code	Description	Applicable Modifiers
58611	Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery	AA, 80
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)	AA, 80
58671	with occlusion of oviducts by device (eg, band, clip, Falope ring)	AA, 80

Claims

3

Archive Date:02/03/2025

Claims:Submission

Topic #934

An Overview

Providers submitting claims for members enrolled in Family Planning Only Services are required to indicate one of the following on the detail level of the claim:

- An appropriate allowable ICD (International Classification of Diseases) diagnosis code from the list of allowable contraceptive management codes as a primary or secondary diagnosis if the service provided was related to contraceptive management, as applicable
- Modifier FP associated with the procedure code if the service provided was related to family planning when an allowable contraceptive management diagnosis code is not appropriate, for example, when billing a colposcopy provided in follow up to a contraceptive management visit

Claims for members enrolled in Family Planning Only Services that are submitted without either an allowable primary ICD contraceptive management diagnosis code or modifier FP associated with an allowable procedure code will be denied.

Providers who submit claims using NDCs (National Drug Codes) are required to indicate the NDC from the package of the drug that is dispensed.

If a provider performs services for a member who is temporarily enrolled in Family Planning Only Services through EE (Express Enrollment), the member's enrollment information may not yet be available through Wisconsin's EVS (Enrollment Verification System) or the ForwardHealth Portal. To avoid delays in reimbursement, providers who provide Family Planning Only Services to a member who is temporarily enrolled through EE before the member's enrollment in ongoing Family Planning Only Services coverage can be verified should do the following:

- Make a photocopy of the Temporary Identification Card for Express Enrollment in Family Planning Only Services to be used, if necessary, for good faith claims processing.
- Wait until enrollment for ongoing Family Planning Only Services coverage has been verified through the EVS or Portal and then submit the claim.

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 #10837

Note Field for Most Claims Submitted Electronically

In some instances, ForwardHealth requires providers to include a description of a service identified by an unlisted, or NOC (not otherwise classified), procedure code. Providers submitting claims electronically should include a description of an NOC procedure code in a Notes field, if required. The Notes field allows providers to enter up to 80 characters. In some cases, the Notes field allows providers to submit NOC procedure code information on a claim electronically instead of on a paper claim or with a paper attachment to an electronic claim.

The Notes field should only be used for NOC procedure codes that do not require PA (prior authorization).

Claims Submitted via the ForwardHealth Portal Direct Data Entry or Provider Electronic Solutions

A notes field is available on the ForwardHealth Portal DDE (Direct Data Entry) and PES (Provider Electronic Solutions) software when providers submit the following types of claims:

- Professional
- Institutional
- Dental

On the professional form, the Notes field is available on each detail. On the institutional and dental forms, the Notes field is only available on the header.

Claims Submitted via 837 Health Care Claim Transactions

ForwardHealth accepts and utilizes information submitted by providers about NOC procedure codes in certain loops/segments on the 837 (837 Health Care Claim) transactions. Refer to the companion guides for more information.

Topic #583

Oral Contraceptives and Drugs Used to Treat Sexually Transmitted Diseases

Family planning clinics must bill for oral contraceptives using procedure code S4993 on the 837P (837 Health Care Claim: Professional) transaction or on a 1500 Health Insurance Claim Form ((02/12)). Wisconsin Medicaid will recoup payments from providers made for noncovered drugs.

Topic #561

Paper Claim Form Preparation and Data Alignment Requirements

Optical Character Recognition

Paper claims submitted to ForwardHealth on the 1500 Health Insurance Claim Form ((02/12)) and UB-04 Claim Form are processed using OCR (Optical Character Recognition) software that recognizes printed, alphanumeric text. OCR software increases efficiency by alleviating the need for keying in data from paper claims.

The data alignment requirements do not apply to the Compound Drug Claim (F-13073 (04/2017)) form and the Noncompound Drug Claim (F-13072 (04/2017)) form.

Speed and Accuracy of Claims Processing

OCR software processes claim forms by reading text within fields on claim forms. After a paper claim form is received by ForwardHealth, the claim form is scanned so that an image can be displayed electronically. The OCR software reads the electronic image on file and populates the information into the ForwardHealth interChange system. This technology increases accuracy by removing the possibility of errors being made during manual keying.

OCR software speeds paper claim processing, but only if providers prepare their claim forms correctly. In order for OCR software to read the claim form accurately, the quality of copy and the alignment of text within individual fields on the claim form need to be precise. If data are misaligned, the claim could be processed incorrectly. If data cannot be read by the OCR software, the process will stop and the electronic image of the claim form will need to be reviewed and keyed manually. This will cause an increase in processing time.

Handwritten Claims

Submitting handwritten claims should be avoided whenever possible. ForwardHealth accepts handwritten claims; however, it is very difficult for OCR software to read a handwritten claim. If a handwritten claim cannot be read by the OCR software, it will need to be keyed manually from the electronic image of the claim form. Providers should avoid submitting claims with handwritten corrections as this can also cause OCR software processing delays.

Use Original Claim Forms

Only original 1500 Health Insurance Claim Forms and UB-04 Claim Forms should be submitted. Original claim forms are printed in red ink and may be obtained from a federal forms supplier. ForwardHealth does not provide these claim forms. Claims that are submitted as photocopies cannot be read by OCR software and will need to be keyed manually from an electronic image of the claim form. This could result in processing delays.

Use Laser or Ink Jet Printers

It is recommended that claims are printed using laser or ink jet printers rather than printers that use DOT matrix. DOT matrix printers have breaks in the letters and numbers, which may cause the OCR software to misread the claim form. Use of old or worn ink cartridges should also be avoided. If the claim form is read incorrectly by the OCR software, the claim may be denied or reimbursed incorrectly. The process may also be stopped if it is unable to read the claim form, which will cause a delay while it is manually reviewed.

Alignment

Alignment within each field on the claim form needs to be accurate. If text within a field is aligned incorrectly, the OCR software may not recognize that data are present within the field or may not read the data correctly. For example, if a reimbursement amount of $300.00 is entered into a field on the claim form, but the last "0" is not aligned within the field, the OCR software may read the number as $30.00, and the claim will be reimbursed incorrectly.

To get the best alignment on the claim form, providers should center information vertically within each field, and align all information on the same horizontal plane. Avoid squeezing two lines of text into one of the six line items on the 1500 Health Insurance Claim Form.

The following sample claim forms demonstrate correct and incorrect alignment:

- Correct alignment for the 1500 Health Insurance Claim Form.
- Incorrect alignment for the 1500 Health Insurance Claim Form.
- Correct alignment for the UB-04 Claim Form.
- Incorrect alignment for the UB-04 Claim Form.

Clarity

Clarity is very important. If information on the claim form is not clear enough to be read by the OCR software, the process may stop, prompting manual review.

The following guidelines will produce the clearest image and optimize processing time:

- Use 10-point or 12-point Times New Roman or Courier New font.
- Type all claim data in uppercase letters.
- Use only black ink to complete the claim form.
- Avoid using italics, bold, or script.
- Make sure characters do not touch.
- Make sure there are no lines from the printer cartridge anywhere on the claim form.
- Avoid using special characters such as dollar signs, decimals, dashes, asterisks, or backslashes, unless it is specified that these characters should be used.
- Use Xs in check boxes. Avoid using letters such as Y for Yes, N for No, M for Male, or F for Female.
- Do not highlight any information on the claim form. Highlighted information blackens when it is imaged, and the OCR software will be unable to read it.

Note: The above guidelines will also produce the clearest image for claims that need to be keyed manually from an electronic image.

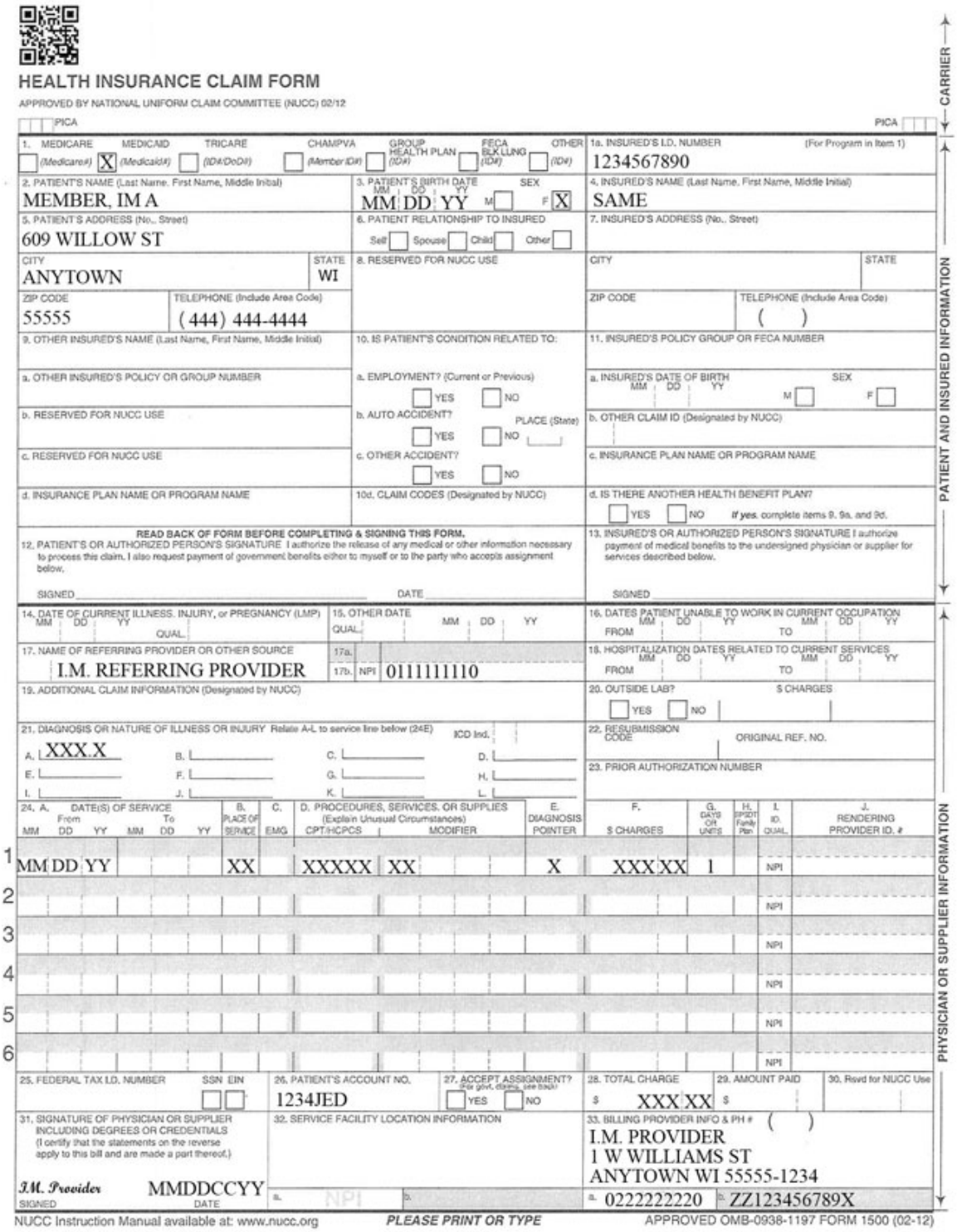
Staples, Correction Liquid, and Correction Tape

The use of staples, correction liquid, correction tape, labels, or stickers on claim forms should be avoided. Staples need to be removed from claim forms before they can be imaged, which can damage the claim and cause a delay in processing time. Correction liquid, correction tape, labels, and stickers can cause data to be read incorrectly or cause the OCR process to stop, prompting manual review. If the form cannot be read by the OCR software, it will need to be keyed manually from an electronic image.

Additional Diagnosis Codes

ForwardHealth will accept up to 12 diagnosis codes in Item Number 21 of the 1500 Health Insurance Claim Form.

Sample of a Correctly Aligned 1500 Health Insurance Claim Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MEMBER, IM A

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 609 WILLOW ST

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WI

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (444) 444-4444

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES [ ] NO [ ]

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: I.M. REFERRING PROVIDER

17a.

17b. NPI 0111111110

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. XXX.X B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 MM DD YY		XX		XXXXX	XX	X	XXX XX	1		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Provider MMDDCCYY

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

I.M. PROVIDER
1 W WILLIAMS ST
ANYTOWN WI 55555-1234

a. 0222222220 b. ZZ123456789X

CARRIER

PATIENT AND INSURED INFORMATION

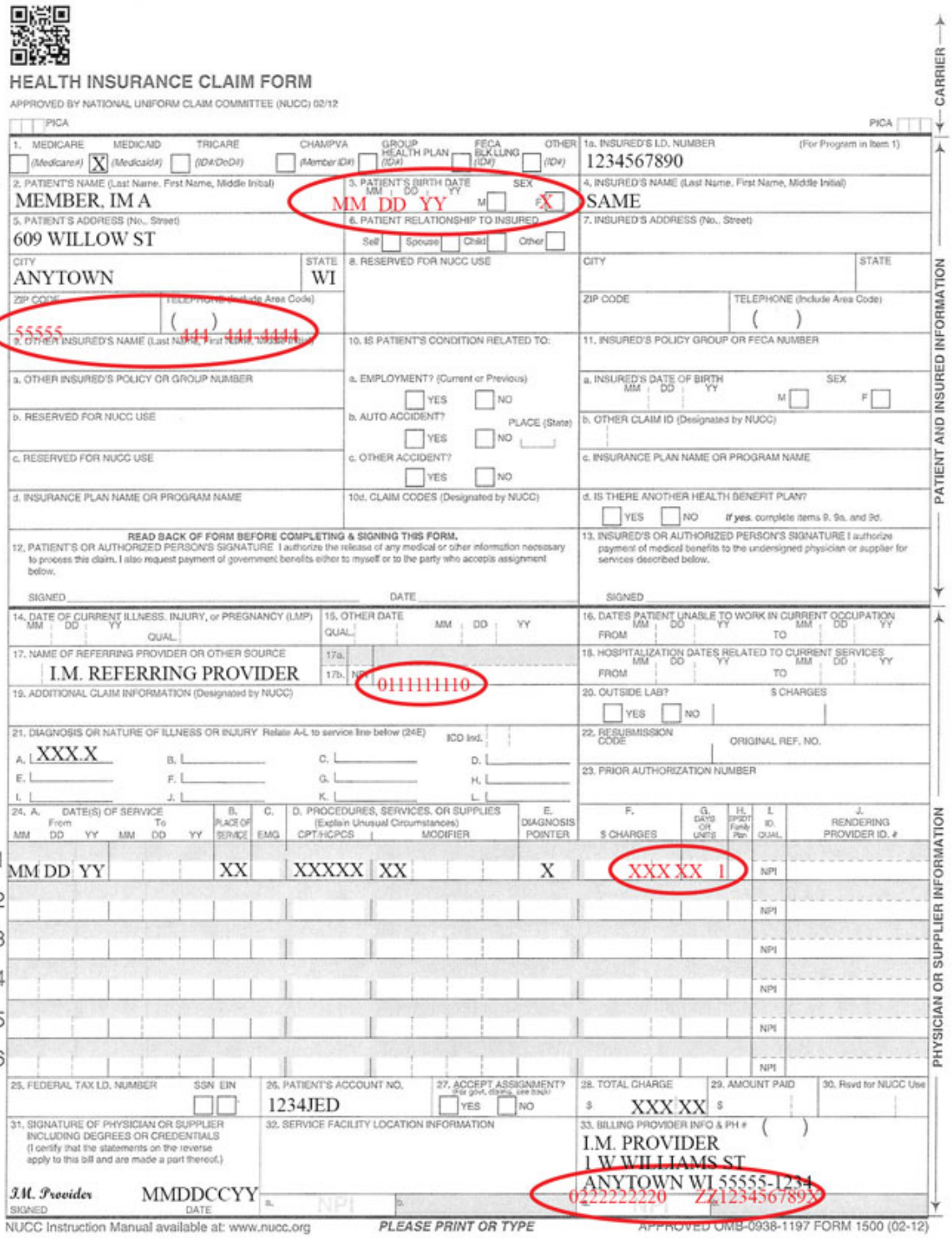
PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Sample of an Incorrectly Aligned 1500 Health Insurance Claim Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) X | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): MEMBER, IM A

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F X: MM DD YY

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 609 WILLOW ST

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY: ANYTOWN | STATE: WI

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): ( ) 111 111 1111

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: I.M. REFERRING PROVIDER

17a.

17b. NPI 0111111110

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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A. XXX.X B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 MM DD YY		XX		XXXXX	XX	X	XXX XX	1		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ XXX XX

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M. Provider MMDDCCYY

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

I.M. PROVIDER
1 W WILLIAMS ST
ANYTOWN WI 55555-1234
0222222220 ZZ123456789X

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Sample of a Correctly Aligned UB-04 Claim Form

1 IM BILLING PROVIDER
444 E CLAIREMONT
ANYTOWN WI 55555-1234
(444) 444-4444

3a PAT. CNTL #
b. MED. REC. # 11 7654321
4 TYPE OF BILL: XXX
5 FED. TAX NO.: 01-2345678
6 STATEMENT COVERS PERIOD FROM: MMDDCCYY THROUGH: MMDDCCYY

8 PATIENT NAME: b MEMBER, IM A
9 PATIENT ADDRESS: a ON FILE

10 BIRTHDATE | 11 SEX | ADMISSION 12 DATE | 13 HR | 14 TYPE: X | 15 SRC: X | 16 DHR | 17 STAT: XX | CONDITION CODES 18–28 | 29 ACDT STATE | 30

31–34 OCCURRENCE CODE / DATE | 35–36 OCCURRENCE SPAN CODE / FROM / THROUGH | 37

38 | 39–41 VALUE CODES CODE / AMOUNT (a, b, c, d)

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
XXXX		XXXXX	MMDDYY	1.0	XX XX		
XXXX		XXXXX	MMDDYY	1.0	XX XX		
XXXX		XXXXX	MMDDYY	1.0	XX XX		
	PAGE 1 OF 1	CREATION DATE		TOTALS	XXX XX		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
T19 MEDICAID						0111111110

57 OTHER PRV ID

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
SAME		1234567890		

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX: XXXX

67 A–Q | 68

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

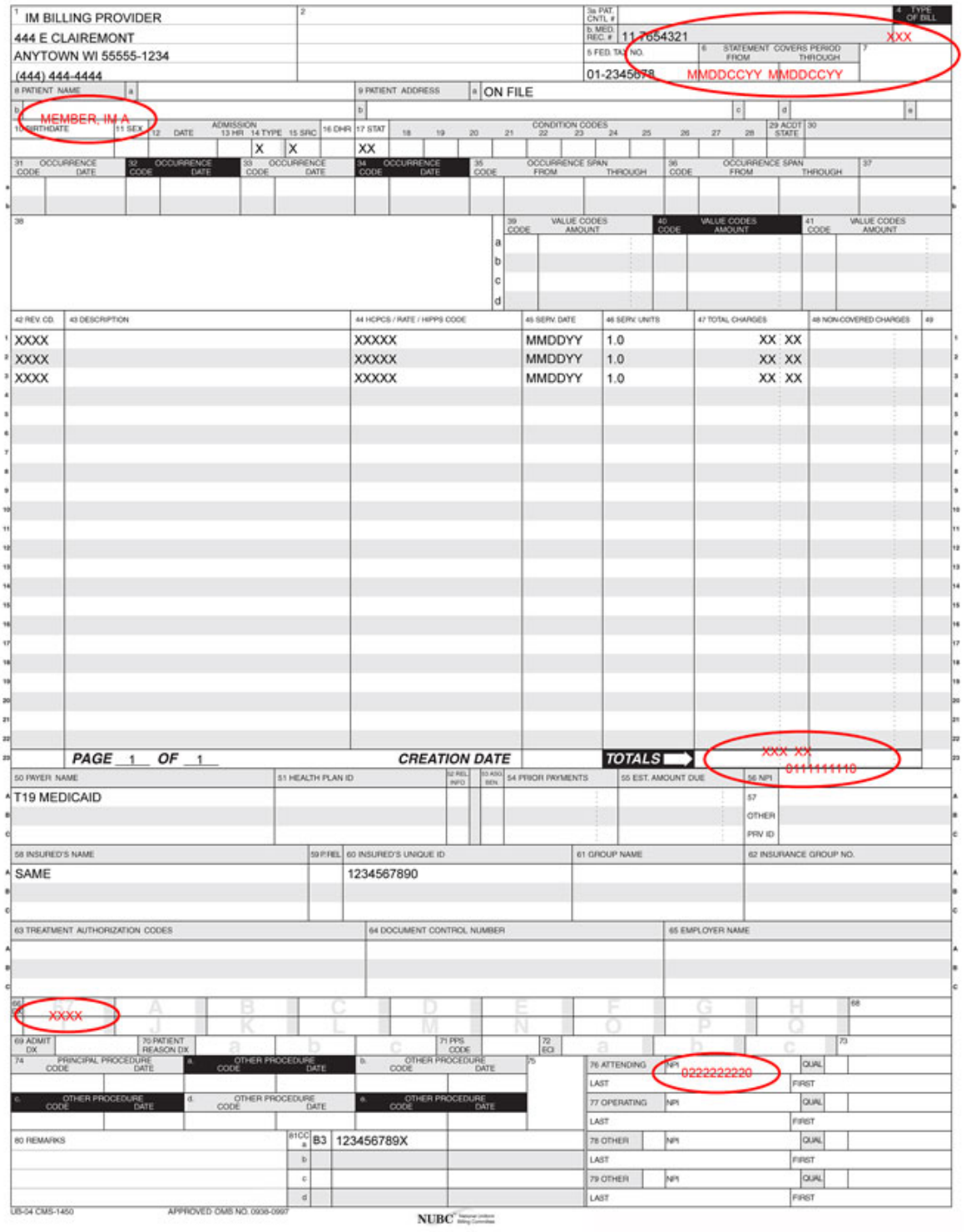
74 PRINCIPAL PROCEDURE CODE / DATE | a.–e. OTHER PROCEDURE CODE / DATE | 75

76 ATTENDING NPI 0222222220 QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

80 REMARKS | 81CC a: B3 123456789X

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee

Sample of an Incorrectly Aligned UB-04 Claim Form



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 #4382

Physician-Administered Drug Claim Requirements

Deficit Reduction Act of 2005

Providers are required to comply with requirements of the federal DRA (Deficit Reduction Act) of 2005 and submit NDCs (National Drug Codes) with HCPCS (Healthcare Common Procedure Coding System) procedure codes on claims for physician-administered drugs. Section 1927(a)(7)(C) of the Social Security Act requires NDCs to be indicated on all claims submitted to ForwardHealth for covered outpatient drugs, including Medicare crossover claims.

ForwardHealth requires that NDCs be indicated on claims for all physician-administered drugs to identify the drugs and invoice a manufacturer for rebates, track utilization, and receive federal funds. States that do not collect NDCs with HCPCS procedure codes on claims for physician-administered drugs will not receive federal funds for those claims.

ForwardHealth cannot claim a rebate or federal funds if the NDC submitted on a claim is incorrect or invalid or if an NDC is not indicated.

If an NDC is not indicated on a claim submitted to ForwardHealth, or if the NDC indicated is invalid, the claim will be denied.

Note: Vaccines are exempt from the DRA requirements. Providers who receive reimbursement under a bundled rate are not subject to the DRA requirements.

Less-Than-Effective Drugs

ForwardHealth will deny physician-administered drug claims for ForwardHealth members for LTE (less-than-effective) drugs as identified by the federal CMS (Centers for Medicare & Medicaid Services) or identical, related, or similar drugs.

Claim Submission

Institutional Claims

Providers that submit claims for services on an institutional claim also are required to submit claims for physician-administered drugs on an institutional claim.

Institutional claims that include physician-administered drugs must be submitted to ForwardHealth fee-for-service for fee-for-service members and to the HMO for managed care members.

Professional Claims

Providers that submit claims for services on a professional claim also are required to submit claims for physician-administered drugs on a professional claim.

Professional claims that include physician-administered drugs must be submitted to ForwardHealth fee-for-service for fee-for-service members.

Professional claims for physician-administered drugs must be submitted to ForwardHealth fee-for-service for managed care members. Other services submitted on a professional claim must be submitted to the HMO for managed care members.

The following POS (place of service) codes will not be accepted by Medicaid fee-for-service when submitted by a provider on a professional claim:

POS Code	Description
06	Indian Health Services Provider-Based Facility
08	Tribal 638 Provider-Based Facility
21	Inpatient Hospital
22	On Campus—Outpatient Hospital
23	Emergency Room—Hospital
51	Inpatient Psychiatric Facility
61	Comprehensive Inpatient Rehabilitation Facility
65	ESRD Treatment Facility

Medicare Crossover Claims

To be considered for reimbursement, NDCs and a HCPCS procedure code must be indicated on Medicare crossover claims.

ForwardHealth will deny crossover claims if an NDC was not submitted to Medicare with a physician-administered drug HCPCS code.

340B Providers

The 340B Program (340B Drug Pricing Program) enables covered entities to fully utilize federal resources, reaching more eligible patients and providing more comprehensive services. Providers who participate in the 340B Program are required to indicate an NDC on claims for physician-administered drugs. When submitting the 340B billed amount, they are also required to indicate the AAC (Actual Acquisition Cost) and appropriate claim level identifier(s).

Explanation of Benefits Codes on Claims for Physician-Administered Drugs

Providers will receive an EOB (Explanation of Benefits) code on claims with a denied detail for a physician-administered drug if the claim does not comply with the standards of the DRA. If a provider receives an EOB code on a claim for a physician-administered drug, he or she should correct and resubmit the claim for reimbursement.

Physician-Administered Claim Denials

If a clinic's professional claim with a HCPCS code is received by ForwardHealth and a subsequent claim for the same drug is received from a pharmacy, having a DOS (date of service) within seven days of the clinic's DOS, then the pharmacy's claim will be denied as a duplicate claim.

Reconsideration of the denied drug claim may occur if the claim was denied with an EOB code and the drug therapy was due to the treatment for an acute condition. To submit a claim that was originally denied as a duplicate, pharmacies should complete and submit the Noncompound Drug Claim (F-13072 (04/2017)) form along with the Pharmacy Special Handling Request (F-13074 (04/2014)) form indicating the EOB code and requesting an override.

Physician-Administered Drugs Carve-Out Code Sets

Physician-administered drugs carve-out policy is defined to include the following procedure codes:

- Drug-related "J" codes
- Drug-related "Q" codes
- Certain drug-related "S" codes

The Physician-Administered Drugs Carve-Out Procedure Codes table indicates the status of procedure codes considered under the physician-administered drugs carve-out policy. This table provides information on Medicaid and BadgerCare Plus coverage status as well as carve-out status based on POS.

Note: The table will be revised in accordance with national annual and quarterly HCPCS code updates.

Physician-administered drugs carve-out policy applies to certain procedure code sets, services, POS, and claim types. A service is carved-out based on the procedure code, POS, and claim type on which the service is submitted. It is important to note that physician-administered drugs may be given in many different practice settings and submitted on different claim types. Whether the service is carved in or out depends on the combination of these factors, not simply on the procedure code.

Claims for dual eligibles should be submitted to Medicare first before they are submitted to ForwardHealth. Providers should continue to submit claims for other services to the member's MCO (managed care organization).

Physician-administered drugs and related services for members enrolled in PACE (Program for All-Inclusive Care for the Elderly) are provided and reimbursed by the special managed care program.

Note: For Family Care Partnership members who are not enrolled in Medicare (Medicaid-only members), outpatient drugs (excluding diabetic supplies), physician-administered drugs, compound drugs (including parenteral nutrition), and any other drugs requiring drug utilization review are covered by fee-for-service Medicaid. All fee-for-service policies, procedures, and requirements apply for pharmacy services provided to Medicaid-only Family Care Partnership members. Dual eligibles (enrolled in Medicare and Medicaid) receive their outpatient drugs through their Medicare Part D plans. However, if the member's Part D plan does not cover the outpatient drug, these dually eligible members may access certain Medicaid outpatient drugs that are excluded or otherwise restricted from Medicare coverage through fee-for-service Medicaid. For these drugs, fee-for-service policies would apply.

Exemptions

Claims for drugs included in the cost of the procedure (for example, a claim for a dental visit where lidocaine is administered) should be submitted to the member's MCO.

Vaccines and their administration fees are reimbursed by a member's MCO.

Providers who receive reimbursement under a bundled rate are reimbursed by a member's MCO.

Providers who were reimbursed a bundled rate by the member's MCO for certain services (for example, hydration, catheter maintenance, TPN (total parenteral nutrition)) should continue to be reimbursed by the member's MCO. Providers should work with the member's MCO in these situations.

Additional Information

Additional information about the DRA and claim submission requirements can be located on the following websites:

- CMS DRA information page
- NUBC (National Uniform Billing Committee)
- NUCC (National Uniform Claim Committee)

For information about NDCs, providers may refer to the following websites:

- The FDA (Food and Drug Administration) website
- The Drug Search Tool (Providers may verify if an NDC and its segments are valid using this website.)

Topic #10237

Claims for Physician-Administered Drugs

Claims for physician-administered drugs may be submitted to ForwardHealth via the following:

- A 1500 Health Insurance Claim Form ((02/12))
- The 837P (837 Health Care Claim: Professional) transaction
- The DDE (Direct Data Entry) on ForwardHealth Portal
- The PES (Provider Electronic Solutions) software

1500 Health Insurance Claim Form

These instructions apply to claims submitted for physician-administered drugs. NDCs for physician-administered drugs must be indicated in the shaded area of Item Numbers 24A-24G on the 1500 Health Insurance Claim Form. The NDC must be accompanied by an NDC qualifier, unit qualifier, and units. To indicate an NDC, providers should do the following:

- Indicate the NDC qualifier "N4," followed by the 11-digit NDC of the drug dispensed, with no space in between
- Indicate one space between the NDC and the unit qualifier
- Indicate one unit qualifier (F2 [International unit], GR [Gram], ME [Milligram], ML [Milliliter], or UN [Unit]), followed by the NDC units, with no space in between (For further instruction on submitting a 1500 Health Insurance Claim Form with supplemental NDC information, providers may refer to the 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12 on the NUCC (National Uniform Claim Committee) website.)

Providers should indicate the appropriate NDC of the drug that was dispensed that corresponds to the HCPCS procedure code on claims for physician-administered drugs. If an NDC is not indicated on the claim, or if the NDC indicated is invalid, the claim will be denied.

837 Health Care Claim: Professional Transactions

Providers may refer to the NUCC Website for information about indicating NDCs on physician-administered drug claims submitted using the 837P transaction.

Direct Data Entry on the ForwardHealth Portal

The following must be indicated on physician-administered drug claims submitted using DDE on the Portal:

- The NDC of the drug dispensed
- Quantity unit
- Unit of measure

Note: The "N4" NDC qualifier is not required on claims submitted on the Portal.

Provider Electronic Solutions Software

ForwardHealth offers electronic billing software at no cost to providers. The PES software allows providers to submit 837P transactions, adjust claims, and check claim status. To obtain PES software, providers may download it from the ForwardHealth Portal. For assistance installing and using PES software, providers may call the EDI (Electronic Data Interchange) Helpdesk.

Topic #10637

Reimbursement Reduction for Most Paper Claims

As a result of the Medicaid Rate Reform project, ForwardHealth will reduce reimbursement on most claims submitted to ForwardHealth on paper. Most paper claims will be subject up to a $1.10 reimbursement reduction per claim.

For each claim that a reimbursement reduction was applied, providers will receive an EOB (Explanation of Benefits) to notify them of the payment reduction. For claims with reimbursement reductions, the EOB will state the following, "This claim is eligible for electronic submission. Up to a $1.10 reduction has been applied to this claim payment."

If a paid claim's total reimbursement amount is less than $1.10, ForwardHealth will reduce the payment up to a $1.10. The claim will show on the RA (Remittance Advice) as paid but with a $0 paid amount.

The reimbursement reduction applies to the following paper claims:

- 1500 Health Insurance Claim Form ((02/12))
- UB-04 (CMS 1450) Claim Form
- Compound Drug Claim (F-13073 (04/2017)) form
- Noncompound Drug Claim (F-13072 (04/2017)) form

Exceptions to Paper Claim Reimbursement Reduction

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

- In-state emergency providers
- Out-of-state providers
- Medicare crossover claims
- Any claims that ForwardHealth requires additional supporting information to be submitted on paper, such as:
  - Hysterectomy claims must be submitted along with an Acknowledgment of Receipt of Hysterectomy Information (F-

01160 (06/2013)) form.

- Sterilization claims must be submitted along with a paper Consent for Sterilization (F-01164 (10/2008)) form.
- Claims submitted to Timely Filing appeals must be submitted on paper with a Timely Filing Appeals Request (F-13047 (08/2015)) form.
- In certain circumstances, drug claims must be submitted on paper with a Pharmacy Special Handling Request (F-13074 (04/2014)) form.
- Claims submitted with four or more NDCs (National Drug Codes) for compound and noncompound drugs with specific and non-specific HCPCS (Healthcare Common Procedure Coding System) procedure codes.

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.

Topic #11537

National Correct Coding Initiative

As part of the federal PPACA (Patient Protection and Affordable Care Act) of 2010, the federal CMS (Centers for Medicare and Medicaid Services) are required to promote correct coding and control improper coding leading to inappropriate payment of claims under Medicaid. The NCCI (National Correct Coding Initiative) is the CMS response to this requirement. The NCCI includes the creation and implementation of claims processing edits to ensure correct coding on claims submitted for Medicaid reimbursement.

ForwardHealth is required to implement the NCCI in order to monitor all professional claims and outpatient hospital claims submitted with CPT (Current Procedural Terminology) or HCPCS (Healthcare Common Procedure Coding System) procedure codes for Wisconsin Medicaid, BadgerCare Plus, WCDP (Wisconsin Chronic Disease Program), and Family Planning Only Services for compliance with the following NCCI edits:

- MUE (Medically Unlikely Edits), or units-of-service detail edits
- Procedure-to-procedure detail edits

The NCCI editing will occur in addition to/along with current procedure code review and editing completed by Change Healthcare ClaimsXten and in ForwardHealth interChange.

Medically Unlikely Detail Edits

MUE, or units-of-service detail edits, define the maximum units of service that a provider would report under most circumstances for a single member on a single DOS (date of service) for each CPT or HCPCS procedure code. If a detail on a claim is denied for MUE, providers will receive an EOB (Explanation of Benefits) code on the RA (Remittance Advice) indicating that the detail was denied due to NCCI.

An example of an MUE would be if procedure code 11102 (tangential biopsy of skin [eg, shave, scoop, saucerize, curette]; single lesion) was billed by a provider on a professional claim with a quantity of two or more. This procedure is medically unlikely to occur more than once; therefore, if it is billed with units greater than one, the detail will be denied.

Procedure-to-Procedure Detail Edits

Procedure-to-procedure detail edits define pairs of CPT or HCPCS codes that should not be reported together on the same DOS for a variety of reasons. This edit applies across details on a single claim or across different claims. For example, an earlier claim that was paid may be denied and recouped if a more complete code is billed for the same DOS on a separate claim. If a detail on a claim is denied for procedure-to-procedure edit, providers will receive an EOB code on the RA indicating that the detail was denied due to NCCI.

An example of a procedure-to-procedure edit would be if procedure codes 11451 (excision of skin and subcutaneous tissue for hidradenitis, axillary; with complex repair) and 93000 (electrocardiogram, routine ECG with at least 12 leads; with interpretation and report) were billed on the same claim for the same DOS. Procedure code 11451 describes a more complex service than procedure code 93000, and therefore, the secondary procedure would be denied.

Quarterly Code List Updates

CMS will issue quarterly revisions to the table of codes subject to NCCI edits that ForwardHealth will adopt and implement. Refer to the CMS Medicaid website for downloadable code lists.

Claim Details Denied as a Result of National Correct Coding Initiative Edits

Providers should take the following steps if they are uncertain why particular services on a claim were denied:

- Review ForwardHealth remittance information for the EOB message related to the denial.
- Review the claim submitted to ensure all information is accurate and complete.
- Consult current CPT and HCPCS publications to make sure proper coding instructions were followed.
- Consult current ForwardHealth publications, including the Online Handbook, to make sure current policy and billing instructions were followed.
- Call Provider Services for further information or explanation.

If reimbursement for a claim or a detail on a claim is denied due to an MUE or procedure-to-procedure edit, providers may appeal the denial. Following are instructions for submitting an appeal:

- Complete the Adjustment/Reconsideration Request (F-13046 (08/2015)) form. In Element 16, select the "Consultant review requested" checkbox and the "Other/comments" checkbox. In the "Other/comments" text box, indicate "Reconsideration of an NCCI denial."
- Attach notes/supporting documentation.
- Submit a claim, Adjustment/Reconsideration Request, and additional notes/supporting documentation to ForwardHealth for processing.

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.

Reimbursement

4

Archive Date:02/03/2025

Reimbursement:Amounts

Topic #3364

Colposcopies

A colposcopy is reimbursable only if an abnormal result is received from a Pap test that was performed and covered by Family Planning Only Services prior to the colposcopy.

Topic #8117

Electronic Funds Transfer

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

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

Provider Exceptions

EFT payments are not available to the following providers:

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

Enrolling in Electronic Funds Transfer

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

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

The following guidelines apply to EFT enrollment:

- Only a Portal Administrator or a clerk that has been assigned the EFT role on the Portal may complete the EFT enrollment information.
- Organizations can revert back to receiving paper checks by disenrolling in EFT.
- Organizations may change their EFT information at any time.
- Organizations will continue to receive their Remittance Advice as they do currently.

Refer to the Electronic Funds Transfer User Guide on the User Guides page of the Portal for instructions and more information about EFT enrollment.

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

Recoupment and Reversals

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

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

Problem Resolution

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

Topic #2222

Reimbursement

Reimbursement rates for services and supplies under Family Planning Only Services are the same as the rates for Medicaid family planning services.

Collecting Payment From Members

Topic #227

Conditions That Must Be Met

A member may request a noncovered service, a covered service for which PA (prior authorization) was denied (or modified), or a service that is not covered under the member's limited benefit category. The charge for the service may be collected from the member if the following conditions are met **prior** to the delivery of that service:

- The member accepts responsibility for payment.
- The provider and member make payment arrangements for the service.

Providers are strongly encouraged to obtain a **written** statement in advance documenting that the member has accepted responsibility for the payment of the service.

Furthermore, the service must be separate or distinct from a related, covered service. For example, a vision provider may provide a member with eyeglasses but then, upon the member's request, provide and charge the member for anti-glare coating, which is a noncovered service. Charging the member is permissible in this situation because the anti-glare coating is a separate service and can be added to the lenses at a later time.

Amounts

Topic #3365

Reproductive Health Services

The Wisconsin DMS (Division of Medicaid Services) reserves the right to recoup payment for services from the provider if the Family Planning Only Services member has not received a contraceptive-related service within the previous 12 months.

Reproductive health services are reimbursable only if the Family Planning Only Services member has received a contraceptive-related Family Planning Only Services service within the previous 12 months. For example, if the need for a medically necessary reproductive health service is discovered, and a contraceptive-related Family Planning Only Services service has been provided within the past 12 months, the reproductive health service is reimbursable by Family Planning Only Services.

Member Information

5

Archive Date:02/03/2025

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 #226

Family Planning Only Services

Family Planning Only Services is a limited benefit program that provides routine contraceptive management or related services to low-income individuals who are of childbearing/reproductive age (typically 15 years of age or older) and who are otherwise not eligible for Wisconsin Medicaid or BadgerCare Plus. Members receiving Family Planning Only Services must be receiving routine contraceptive management or related services.

Note: Members who meet the enrollment criteria may receive routine contraceptive management or related services **immediately** by temporarily enrolling in Family Planning Only Services through EE (Express Enrollment).

The goal of Family Planning Only Services is to provide members with information and services to assist them in preventing pregnancy, making BadgerCare Plus enrollment due to pregnancy less likely. Providers should explain the purpose of Family Planning Only Services to members and encourage them to contact their certifying agency to determine their enrollment options if they are not interested in, or do not need, contraceptive services.

Members enrolled in Family Planning Only Services receive routine services to prevent or delay pregnancy and are not eligible for other services (for example, PT (physical therapy) services, dental services). Even if a medical condition is discovered during a family planning visit, treatment for the condition is not covered under Family Planning Only Services unless the treatment is identified in the list of allowable procedure codes for Family Planning Only Services.

Members are also not eligible for certain other services that are covered under Wisconsin Medicaid and BadgerCare Plus (for example, mammograms and hysterectomies). If a medical condition, other than an STD (sexually transmitted disease), is discovered during routine contraceptive management or related services, treatment for the medical condition is not covered under Family Planning Only Services.

Colposcopies and treatment for STDs are only covered through Family Planning Only Services if they are determined medically necessary during routine contraceptive management or related services. A colposcopy is a covered service when an abnormal

result is received from a pap test, prior to the colposcopy, while the member is enrolled in Family Planning Only Services and receiving contraceptive management or related services.

Family Planning Only Services members diagnosed with cervical cancer, precancerous conditions of the cervix, or breast cancer may be eligible for Wisconsin Well Woman Medicaid. Providers should assist eligible members with the enrollment process for Well Woman Medicaid.

Providers should inform members about other coverage options and provide referrals for care not covered by Family Planning Only Services.

Topic #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 ongoing BadgerCare Plus coverage by the certifying agency.

Topic #229

Limited Benefit Categories Overview

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

- BadgerCare Plus Prenatal Program
- EE (Express Enrollment) for Children
- EE for Pregnant Women
- Family Planning Only Services, including EE for individuals applying for Family Planning Only Services
- QDWI (Qualified Disabled Working Individuals)
- QI-1 (Qualifying Individuals 1)
- QMB Only (Qualified Medicare Beneficiary Only)
- SLMB (Specified Low-Income Medicare Beneficiary)
- Tuberculosis-Related Medicaid

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

Members enrolled in the BadgerCare Plus Prenatal Program, Family Planning Only Services, EE for Children, EE for Pregnant Women, or Tuberculosis-Related Medicaid cannot be enrolled in full-benefit Medicaid or BadgerCare Plus. These members receive benefits through the limited benefit category.

Providers should note that a member may be enrolled in more than one limited benefit category. For example, a member may be enrolled in Family Planning Only Services and Tuberculosis-Related Medicaid.

Providers are strongly encouraged to verify dates of enrollment and other coverage information using Wisconsin's EVS (Enrollment Verification System) to determine whether a member is in a limited benefit category, receives full-benefit Medicaid or BadgerCare Plus, or both.

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

the member if certain conditions are met.

Topic #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.

SAMPLE

Member Enrollment

Topic #2625

Annual Enrollment Review

Under Family Planning Only Services, members may receive routine contraceptive-related services and supplies from Medicaid-enrolled providers for 12 months from the time members are determined enrolled (as long as members meet all the enrollment requirements). Members covered under Family Planning Only Services receive a review notice the month before the annual enrollment review is due. The annual enrollment review allows ForwardHealth to verify that a member still meets Family Planning Only Services enrollment requirements.

Continued enrollment for Family Planning Only Services requires that a member complete an annual enrollment review in person, by telephone, or by completing a mail-in review form. Based on the information collected, a certifying agency will determine whether a member will remain enrolled in Family Planning Only Services. In addition, a member may request a determination be made for full-benefit BadgerCare Plus as well.

If a member does not complete an annual review for Family Planning Only Services coverage by the end of his or her current enrollment period, enrollment in Family Planning Only Services will be discontinued, and the member will be required to reapply. A member will receive notification of this discontinuation 10 days in advance of the date the enrollment ends.

Annual Review Notices

The Family Planning Only Services 12-month enrollment review notices are sent to the address indicated on the Family Planning Only Services application unless the member reports a change in address. The Family Planning Only Services application allows a member to choose if they would like to identify an alternate address to receive the annual review notices and ForwardHealth Identification Card. If notices are sent to an alternate address, it is imperative they receive these notices in a timely manner. If a member does not receive the annual review notice or the receipt of the notice is delayed, there may be a gap in Family Planning Only Services enrollment and coverage.

Reminders for Providers Assisting Member in Filling Out the Application/Annual Review Form

Providers are reminded of the following when assisting members in filling out the Family Planning Only Services application/annual review form:

- Certifying agencies cannot approve enrollment for a member whose application/annual review form is missing required information such as their SSN (Social Security number), Wisconsin residence address, or signature. If a member indicates incorrect or incomplete information, the certifying agency will request the information before completing the redetermination.
- Certifying agencies will use the mailing address indicated on the Family Planning Only Services application and record it as it appears on the application.
- If a member has chosen their provider's mailing address for all Family Planning Only Services correspondence, it is imperative that the provider has a reliable way of contacting the member to promptly give the member the Family Planning Only Services notices and ForwardHealth card.

Members who apply **only** for limited-benefit Family Planning Only Services will not be required to provide other insurance information. Members who apply for both full-benefit BadgerCare Plus and limited-benefit Family Planning Only Services will be required to provide information about other insurance they may have.

Topic #2626

Coordination with the Wisconsin Well Woman Program - Breast Cancer Diagnosis

Members ages 35 to 44 enrolled in Family Planning Only Services who require diagnostic services not covered by Family Planning Only Services as follow up to determine a breast cancer diagnosis may be referred to the WWWP (Wisconsin Well Woman Program) for enrollment and breast cancer diagnostic services. This usually happens after a clinical breast exam performed by the Family Planning Only Services provider indicates need for diagnostic follow up. The member does not need to be formally disenrolled from Family Planning Only Services prior to being referred to the WWWP for enrollment. If the member is diagnosed with breast cancer through the WWWP and meets the other non-financial criteria for Well Woman Medicaid, they may be enrolled in Well Woman Medicaid through the WWWP. They do not need to return to the Family Planning Only Services provider to enroll.

If the member is tested for breast cancer through the WWWP and is not diagnosed with breast cancer, they may return to Family Planning Only Services for continued contraceptive-related care.

Topic #2628

Eligibility Process for Wisconsin Well Woman Medicaid

The eligibility process for Well Woman Medicaid varies based on whether the member needs treatment for cervical conditions or breast cancer. The eligibility process varies because Family Planning Only Services covers some diagnostic tests related to cervical cancer (for example, certain colposcopies, biopsy of the cervix) but does not cover diagnostic tests (for example, mammogram, biopsy) related to breast cancer.

Process for Members with Cervical Cancer or Precancerous Conditions of the Cervix

When a member enrolled in Family Planning Only Services receives an abnormal result from a pap test during routine contraceptive-related services, some diagnostic tests — including some colposcopies with biopsy — are covered under Family Planning Only Services. If, in addition to meeting the nonmedical eligibility criteria, the member is diagnosed with cervical cancer or a precancerous condition of the cervix and needs treatment for the cancer or precancerous condition, they are eligible for Well Woman Medicaid.

The Family Planning Only Services physician or nurse practitioner should complete a Wisconsin Well Woman Medicaid Application and Renewal form (F-10075 (01/2018)) with the member and refer the member to their certifying agency where the member can disenroll from Family Planning Only Services and enroll in Well Woman Medicaid. If the member does not complete the enrollment process at the certifying agency, ForwardHealth will not cover their treatment.

Process for Members Who Need Follow-Up Related to Breast Cancer

Routine screenings and diagnostic tests related to breast cancer are not covered under Family Planning Only Services. When a member enrolled in Family Planning Only Services receives a suspicious result from a clinical breast exam during routine contraceptive-related services, the member can seek diagnostic tests through the WWWP (Wisconsin Well Woman Program), through other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans), or at their own expense. If, after receiving the necessary diagnostic tests, the member is diagnosed with breast cancer and needs treatment for the cancer, they may be eligible for Well Woman Medicaid.

A member enrolled in Family Planning Only Services who has received a clinical breast exam and needs follow-up diagnostic tests related to breast cancer has the following options:

- Prior to receiving diagnostic tests, the member — if they are at least 35 years of age — seek enrollment in the WWWP. Once enrolled in the WWWP, the member can receive the necessary diagnostic tests through the WWWP. If, in addition to meeting the nonmedical eligibility criteria, they are diagnosed with breast cancer and needs treatment for the cancer, they are eligible for Well Woman Medicaid through the WWWP. (A member cannot enroll in the WWWP while they are enrolled in full-benefit Wisconsin Medicaid or BadgerCare Plus.)

  The local WWWP coordinating agency can help the member enroll in the WWWP. Providers may call 608-266-8311 or go to the WWWP web site for WWWP coordinating agencies.

- The member enrolled in Family Planning Only Services can also:
  - Seek coverage for diagnostic tests through other health insurance.
  - Receive diagnostic tests at their own expense or check with the local Public Health Department for other funding options.

  If, in addition to meeting the nonmedical eligibility criteria, the member is diagnosed with breast cancer while enrolled in Family Planning Only Services and needs treatment for the cancer, they are eligible for Well Woman Medicaid.

  A member diagnosed with breast cancer should notify their Family Planning Only Services provider immediately. After confirming the member's diagnosis and need for treatment, the Family Planning Only Services physician should complete a Wisconsin Well Woman Medicaid Determination Form with the member. The physician should refer the member to their certifying agency where the member can disenroll from Family Planning Only Services and enroll in Well Woman Medicaid. If the member does not complete the enrollment process at the certifying agency, ForwardHealth will not cover their treatment.

Topic #2629

Enrollment

Family Planning Only Services will provide services and supplies to members who meet the program's enrollment criteria. Members who may be enrolled:

- Are of childbearing/reproductive age (typically 15 years of age or older). There is no upper age limit for Family Planning Only Services enrollment as long as the member is of childbearing age.
- Have an income that is at or below 300 percent of the FPL (Federal Poverty Level).
- Are not currently receiving Wisconsin Medicaid or BadgerCare Plus.

Applicants for Family Planning Only Services must meet all of the following requirements:

- Be of childbearing/reproductive age (typically 15 years of age or older).
- Have an income that is at or below 300 percent of the FPL.
- Provide information on health insurance coverage.
- Do not currently receive Wisconsin Medicaid or BadgerCare Plus.
- Provide an SSN (Social Security number) or be willing to apply for one.
- Be a Wisconsin resident.
- Be a U.S. citizen or qualified immigrant.
- Be in compliance with any child support judgments made through the legal system. Minors are not subject to this requirement.
- Cooperate with verification requests when information is deemed questionable.

Application and Enrollment

When an individual applies for family planning services through Family Planning Only Services, they can submit an enrollment application in the following ways:

- Online: www.access.wisconsin.gov. Providers may assist individuals with completing the application online.

  Note: The Wisconsin DHS (Department of Health Services) will work with family planning providers on ways to provide enrollment assistance to applicants and members.

- By telephone: 800-291-2002.
- On the paper BadgerCare Plus Application Packet (F-10182 (07/2020)).

The application collects the information necessary for the certifying agency to determine whether the member is eligible for coverage under Family Planning Only Services. The applicant may receive services immediately through TE (temporary enrollment) for Family Planning Only Services if they are determined eligible. Providers are encouraged to assist patients who are pregnant to apply for other ForwardHealth programs.

Members who apply for both BadgerCare Plus and Family Planning Only Services will be required to give information about other insurance they may have. However, members who apply only for Family Planning Only Services benefits will not be required to give other insurance information.

If the member is determined eligible for Family Planning Only Services, they will receive family planning services for a 12-month eligibility period, unless one of the following occurs:

- The member moves out of state.
- The member becomes eligible for Wisconsin Medicaid or BadgerCare Plus.

Once a member has been determined eligible for Family Planning Only Services, they will receive a ForwardHealth identification card within a week after they complete the application and the information is sent to ForwardHealth.

Family Planning Only Services for Adults with No Dependent Children

Providers are encouraged to assist applicants with submitting Family Planning Only Services applications online instead of on paper as doing so allows applicants ages 19 to 44 to apply for FoodShare at the same time that they apply for Family Planning Only Services.

Topic #2627

Enrollment Criteria for Wisconsin Well Woman Medicaid

Members enrolled in Family Planning Only Services diagnosed with cervical cancer, precancerous conditions of the cervix, or breast cancer may be eligible for Wisconsin Well Woman Medicaid. Women enrolled in Well Woman Medicaid are eligible to receive the full range of Medicaid benefits from Medicaid-enrolled providers, including treatment for cancer and contraceptive-related services. Previously, only women screened by the WWWP (Wisconsin Well Woman Program) and diagnosed with cervical cancer, precancerous conditions of the cervix, or breast cancer were eligible for Well Woman Medicaid.

Enrollment requirements for Well Woman Medicaid may accommodate Family Planning Only Services members who are diagnosed with cervical cancer, precancerous conditions of the cervix, or breast cancer. Treatment for cancer is not covered

under Family Planning Only Services. Therefore, female Family Planning Only Services members who are diagnosed with cervical cancer, precancerous conditions of the cervix, or breast cancer may enroll in Well Woman Medicaid to receive treatment for these conditions. Providers should assist eligible members with the enrollment process for Well Woman Medicaid.

Criteria for Eligibility

Members enrolled in Family Planning Only Services are required to meet all of the following criteria to be eligible for Well Woman Medicaid:

- The member is enrolled, through her certifying agency, in Family Planning Only Services. Members who are temporarily enrolled in Family Planning Only Services through EE (Express Enrollment) are not eligible for Well Woman Medicaid. (If a member who is temporarily enrolled in Family Planning Only Services through EE needs diagnosis or treatment for cervical cancer or breast cancer, the member should apply for ongoing Family Planning Only Services coverage or the WWWP immediately. Once enrolled in ongoing Family Planning Only Services coverage or the WWWP, the woman may become eligible for Well Woman Medicaid.)
- The member has received one of the following:
  - Screening for cervical cancer during routine contraceptive-related services and was diagnosed, by biopsy, with cervical cancer or a precancerous condition of the cervix. (Precancerous cervical conditions include a biopsy result of CIN I Mild Dysplasia, CIN II Moderate Dysplasia, CIN III Severe Dysplasia, or endocervical adenocarcinoma in situ.)
  - A clinical breast exam during routine contraceptive-related services and, after appropriate follow-up diagnostic tests (e.g., mammogram, biopsy), was diagnosed with breast cancer. (Family Planning Only Services does not cover routine screenings or diagnostic tests [e.g., mammogram, biopsy] related to breast cancer.)
- The member needs treatment for cervical cancer, a precancerous condition of the cervix, or breast cancer, as determined or confirmed by the Family Planning Only Services physician.
- The member does not have commercial health insurance coverage or Medicare to cover treatment of the cervical cancer, precancerous condition of the cervix, or breast cancer.

Topic #2630

Faxing Temporary Enrollment Applications

When faxing a TE (Temporary Enrollment) for Family Planning Only Services application to the ForwardHealth fiscal agent for processing, providers must include a cover sheet and verify that they are sending it to the correct fax number (608-221-2742) in order to protect member privacy rights. Providers are reminded that the federal HIPAA (Health Insurance Portability and Accountability Act of 1996) privacy regulation requires providers to implement reasonable safeguards to protect the privacy of PHI (protected health information).

Providers are reminded that if they fax the TE for Family Planning Only Services application to ForwardHealth, it is not necessary to also mail the application.

Topic #2631

Income Limits

Income limits are available for Family Planning Only Services, which are based on FPL (Federal Poverty Level) income limits. To determine eligibility for Family Planning Only Services, providers should use the income limit at or below 300 percent of the FPL.

Topic #2637

Overview of Enrollment Process for Wisconsin Well Woman Medicaid

Enrollment Process for a Family Planning Only Services Member* with Cervical Cancer or a Precancerous Condition of the Cervix				
The Family Planning Only Services member receives an abnormal result from a pap test.	→	The woman meets all of the following criteria: ▪ She receives a colposcopy and biopsy (or other appropriate diagnostic test) through Family Planning Only Services. ▪ She is diagnosed with cervical cancer or a precancerous condition of the cervix. ▪ She needs treatment for the cancer or precancerous condition. ▪ She does not have commercial health insurance coverage or Medicare to cover the treatment.	→	The woman is eligible, upon completion of the enrollment process, for Wisconsin Well Woman Medicaid.

Eligibility Process for a Family Planning Only Services Member* Who Needs Follow-Up Related to Breast Cancer				
The Family Planning Only Services member receives a suspicious result from a clinical breast exam.	→	The woman—who is at least 35 years of age—meets all of the following criteria: ▪ She disenrolls from Family Planning Only Services, enrolls in the WWWP (Wisconsin Well Woman Program), and receives diagnostic tests through the WWWP. ▪ She is diagnosed with breast cancer. ▪ She needs treatment for the cancer. ▪ She does not have commercial health insurance coverage or Medicare to cover the treatment.	→	The woman is eligible, upon completion of the enrollment process, for Wisconsin Well Woman Medicaid.
		OR		
	→	The woman meets all of the following criteria: ▪ She receives diagnostic tests through her commercial health insurance. ▪ She is diagnosed with breast cancer. ▪ She needs treatment for the cancer. ▪ She does not have commercial health insurance coverage or Medicare to cover the treatment.	→	
		OR		
		The woman meets all of the following criteria:		

	→	- She receives diagnostic tests at her own expense. - She is diagnosed with breast cancer. - She needs treatment for the cancer. - She does not have commercial health insurance coverage or Medicare to cover the treatment.	→	

* Women receiving services through TE (temporary enrollment) for Family Planning Only Services are not eligible for Well Woman Medicaid. (If a woman receiving services through TE for Family Planning Only Services needs diagnosis or treatment for cervical cancer or breast cancer, she should enroll in Family Planning Only Services or the WWWP immediately. Once enrolled in the permanent Family Planning Only Services or the WWWP, the woman may become eligible for Well Woman Medicaid.)

Topic #2636

Wisconsin Well Woman Medicaid Application and Renewal Form

The Wisconsin Well Woman Medicaid Application and Renewal form (F-10075 (01/2018)) is available electronically as a fillable PDF version and as a paper copy.

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.

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.
- 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 the 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

DHS has the following member resources available for more information regarding health care renewals and continuous coverage for children:

- 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

Members With Dual Coverage

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. Families applying for BadgerCare Plus or Wisconsin Medicaid with a child still enrolled in Foster Care Medicaid or SSI Medicaid solely because of 12-month continuous coverage (for example, their SSI payments ended) may still enroll their child in BadgerCare Plus or Wisconsin Medicaid. These children may have dual coverage for a period of time. A family may also choose to enroll their child in BadgerCare Plus or Wisconsin Medicaid and request to end their child's Foster Care Medicaid or SSI Medicaid.

Dual Coverage Impact on HMO Enrollment

When families are enrolling children in BadgerCare Plus while the child continues to be enrolled in Foster Care Medicaid or SSI Medicaid solely because of 12-month continuous coverage, the child can be enrolled in a BadgerCare Plus HMO.

If the child is dually enrolled in Foster Care Medicaid and BadgerCare Plus, they will not be automatically enrolled in a BadgerCare Plus HMO. If their family wants to enroll them in a BadgerCare Plus HMO, they must:

- Call the Wisconsin Department of Children and Families at 833-543-5265 and request to end their child's Foster Care Medicaid
- Then contact the HMO Enrollment Specialist and request to enroll the child in a BadgerCare Plus HMO

If the child is dually enrolled in SSI Medicaid and BadgerCare Plus, they will be automatically enrolled in a BadgerCare Plus HMO. If their family wants to end their SSI Medicaid fee-for-service coverage, they should call Member Services.

Coordination of Benefits

6

Archive Date:02/03/2025

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.

Topic #1249

Other Health Insurance Sources

Providers are not required by Wisconsin Medicaid to pursue other health insurance sources for Family Planning Only Services members. This helps guard the confidentiality of Family Planning Only Services members, thereby increasing access to reproductive health care for low-income members. If providers pursue other health insurance reimbursement for procedures not covered through Family Planning Only Services, they are required to obtain permission from the member.

Resources

7

Archive Date:02/03/2025

Resources:WiCall

Topic #6257

Entering Letters into WiCall

For some WiCall inquries, health care providers are required to enter their taxonomy code with their NPI (National Provider Identifier). Because taxonomy codes are a combination of numbers and letters, telephone key pad combinations, shown in the table below, allow providers to successfully enter taxonomy code letters for WiCall functions (for example, press *21 to enter an A, press *72 to enter an R).

Letter	Key Combination	Letter	Key Combination
A	*21	N	*62
B	*22	O	*63
C	*23	P	*71
D	*31	Q	*11
E	*32	R	*72
F	*33	S	*73
G	*41	T	*81
H	*42	U	*82
I	*43	V	*83
J	*51	W	*91
K	*52	X	*92
L	*53	Y	*93
M	*61	Z	*12

Additionally, providers may select option 9 and press # for an automated voice explanation of how to enter letters in WiCall.

Topic #466

Information Available Via WiCall

WiCall, ForwardHealth's AVR (Automated Voice Response) system, gathers inquiry information from callers through voice prompts and accesses ForwardHealth interChange to retrieve and "speak" back the following ForwardHealth information:

- Claim status
- Enrollment verification
- PA (prior authorization) status
- Provider CheckWrite information

Note: ForwardHealth releases CheckWrite information to WiCall no sooner than on the first state business day following the financial cycle.

Providers are prompted to enter NPI (National Provider Identifier) or provider ID and in some cases, NPI-related data, to retrieve query information.

In all inquiry scenarios, WiCall offers the following options after information is retrieved and reported back to the caller:

- Repeat the information.
- Make another inquiry of the same type.
- Return to the main menu.
- Repeat the options.

Claim Status

Providers may check the status of a specific claim by selecting the applicable financial payer program, (for example, Wisconsin Medicaid, WCDP (Wisconsin Chronic Disease Program), or WWWP (Wisconsin Well Woman Program)) and entering their provider ID, member identification number, DOS (date of service), and the amount billed.

Note: Claim information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

Enrollment Verification

Providers may request enrollment status for any date of eligibility the member has on file by entering their provider ID and the member ID. If the member ID is unknown, providers may enter the member's date of birth and SSN (Social Security number). Additionally, the provider is prompted to enter the From DOS and the To DOS for the inquiry. The From DOS is the earliest date the provider requires enrollment information and the To DOS must be within 365 days of the "From" DOS.

Each time a provider verifies member enrollment, the enrollment verification is saved and assigned a transaction number as transaction confirmation. Providers should note the transaction number for their records.

PA Status

Except in certain instances, providers may obtain the status of PA requests for Medicaid and WCDP via WiCall by entering their provider ID and the applicable PA number. If the provider does not know the PA number, there is an option to bypass entering the PA number and the caller will be prompted to enter other PA information such as member ID and type of service (for example, NDC (National Drug Code), procedure code, revenue code, or ICD (International Classification of Diseases) procedure code). When a match is found, WiCall reports back the PA status information, including the PA number for future reference, and the applicable program.

Information on past PAs is retained indefinitely. Paper PAs require a maximum of 20 working days from receipt to be processed and incorporated into WiCall's PA status information.

Note: PA information for BadgerCare Plus and SeniorCare is available by selecting the Medicaid option.

Electronic Data Interchange

Topic #461

Electronic Data Interchange Helpdesk

The EDI (Electronic Data Interchange) Helpdesk assists anyone interested in becoming a trading partner with getting started and provides ongoing support pertaining to electronic transactions. Providers, billing services, and clearinghouses are encouraged to contact the EDI Helpdesk for test packets and/or technical questions.

Providers with policy questions should call Provider Services.

Enrollment Verification

Topic #469

An Overview

Providers should always verify a member's enrollment before providing services, both to determine enrollment for the current date (since a member's enrollment status may change) and to discover any limitations to the member's coverage. Each enrollment verification method allows providers to verify the following prior to services being rendered:

- A member's enrollment in a ForwardHealth program(s)
- State-contracted MCO (managed care organization) enrollment
- Medicare enrollment
- Limited benefits categories
- Any other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans) coverage
- Exemption from copayments for BadgerCare Plus members

Topic #4903

Copay Information

No Copay

If a member is enrolled in BadgerCare Plus or Wisconsin Medicaid and is exempt from paying copays for services, providers will receive the following response to an enrollment query from all methods of enrollment verification:

- The name of the benefit plan
- The member's enrollment dates
- The message, No Copay

If a member is enrolled in BadgerCare Plus, Wisconsin Medicaid, or SeniorCare and is required to pay a copay, the provider will be given the name of the benefit plan in which the member is enrolled and the member's enrollment dates for the benefit plan only.

Copay

If a member is enrolled in BadgerCare Plus, Wisconsin Medicaid, or SeniorCare and is required to pay a copay, providers will receive the following response to an enrollment query from all methods of enrollment verification:

- The name of the benefit plan
- The member's enrollment dates

Non-Emergent Copay

If a member is enrolled in BadgerCare Plus and is eligible for the $8 non-emergent copay, providers will receive the following response to an enrollment query from all methods of enrollment verification:

- The name of the benefit plan

- The member's enrollment dates
- The message, Member Eligible for Non-Emergent Copay or Eligible for Non-Emergent Copay

The messages Member Eligible for Non-Emergent Copay and Eligible for Non-Emergent Copay indicate that a member is a BadgerCare Plus childless adult and they are eligible for the copay if they do not meet the prudent layperson standard and seek and receive additional post-stabilization care in the emergency department after being informed of the $8 copay and availability of alternative providers with lesser or no cost share.

Topic #4901

Enrollment Verification on the Portal

The secure ForwardHealth Portal offers real-time member enrollment verification for all ForwardHealth programs. Providers will be able to use this tool to determine:

- The benefit plan(s) in which the member is enrolled
- If the member is enrolled in a state-contracted managed care program (for Medicaid and BadgerCare Plus members)
- If the member has any other coverage, such as Medicare or commercial health insurance
- If the member is exempted from copays (BadgerCare Plus and Medicaid members only)

To access enrollment verification via the ForwardHealth Portal, providers will need to do the following:

- Go to the ForwardHealth Portal.
- Establish a provider account.
- Log into the secure Portal.
- Click on the menu item for enrollment verification.

Providers will receive a unique transaction number for each enrollment verification inquiry. Providers may access a history of their enrollment inquiries using the Portal, which will list the date the inquiry was made and the enrollment information that was given on the date that the inquiry was made. For a more permanent record of inquiries, providers are advised to use the print screen function to save a paper copy of enrollment verification inquiries for their records or document the transaction number at the beginning of the response, for tracking or research purposes. This feature allows providers to access enrollment verification history when researching claim denials due to enrollment issues.

The Provider Portal is available 24 hours a day, seven days a week.

Topic #4900

Entering Dates of Service

Enrollment information is provided based on a From DOS (date of service) and a To DOS that the provider enters when making the enrollment inquiry. For enrollment inquires, a From DOS is the earliest date for which the provider is requesting enrollment information and the To DOS is the latest date for which the provider is requesting enrollment information.

Providers should use the following guidelines for entering DOS when verifying enrollment for Wisconsin Medicaid, BadgerCare Plus, SeniorCare, or WCDP (Wisconsin Chronic Disease Program) members:

- The From DOS is the earliest date the provider requires enrollment information.
- The To DOS must be within 365 days of the From DOS.
- If the date of the request is prior to the 20th of the current month, then providers may enter a From DOS and To DOS up to the end of the current calendar month.

- If the date of the request is on or after the 20th of the current month, then providers may enter a From DOS and To DOS up to the end of the following calendar month.

For example, if the date of the request was November 15, 2008, the provider could request dates up to and including November 30, 2008. If the date of the request was November 25, 2008, the provider could request dates up to and including December 31, 2008.

Topic #4899

Member Identification Card Does Not Guarantee Enrollment

Most members receive a member identification card, but possession of a program identification card does not guarantee enrollment. Periodically, members may become ineligible for enrollment, only to re-enroll at a later date. Members are told to keep their cards even though they may have gaps in enrollment periods. It is possible that a member will present a card when they are not enrolled; therefore, it is essential that providers verify enrollment before providing services. To reduce claim denials, it is important that providers verify the following information prior to each DOS (date of service) that services are provided:

- If a member is enrolled in any ForwardHealth program, including benefit plan limitations.
- If a member is enrolled in a managed care organization.
- If a member is in primary provider lock-in status.
- If a member has Medicare or other insurance coverage.

Topic #4898

Responses Are Based on Financial Payer

When making an enrollment inquiry through Wisconsin's EVS (Enrollment Verification System), the returned response will provide information on the member's enrollment in benefit plans based on financial payers.

There are three financial payers under ForwardHealth:

- Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and SeniorCare).
- WCDP (Wisconsin Chronic Disease Program).
- WWWP (Wisconsin Well Woman Program).

Within each financial payer are benefit plans. Each member is enrolled under at least one of the three financial payers, and under each financial payer, is enrolled in at least one benefit plan. An individual member may be enrolled under more than one financial payer. (For instance, a member with chronic renal disease may have health care coverage under BadgerCare Plus and the WCDP chronic renal disease program. The member is enrolled under two financial payers, Medicaid and WCDP.) Alternatively, a member may have multiple benefits under a single financial payer. (For example, a member may be covered by Tuberculosis-Related Medicaid and Family Planning Only Services at the same time, both of which are administered by Medicaid.)

Contact Information

Topic #4456

Resources Reference Guide

The Provider Services and Resources Reference Guide lists services and resources available to providers and members with contact information and hours of availability.

ForwardHealth Portal	**www.forwardhealth.wi.gov/**	**24 hours a day, seven days a week**
Public and secure access to ForwardHealth information with direct link to contact Provider Services for up-to-date access to ForwardHealth programs information, including publications, fee schedules, and forms.		
WiCall Automated Voice Response System	**800-947-3544**	**24 hours a day, seven days a week**
WiCall, the ForwardHealth AVR (Automated Voice Response) system, provides responses to the following inquiries: - Checkwrite - Claim status - PA (prior authorization) - Member enrollment		
ForwardHealth Provider Services Call Center	**800-947-9627**	**Call center representatives: Monday through Friday, 7 a.m. to 6 p.m. (Central time)* Virtual agent: 24 hours a day, seven days a week**
To assist providers in the following programs: - BadgerCare Plus - Medicaid - SeniorCare - Family Care - Family Care Partnership - IRIS (Include, Respect, I Self-Direct) - PACE (Program of All-Inclusive Care for the Elderly) - ADAP (Wisconsin AIDS Drug Assistance Program) - WCDP (Wisconsin Chronic Disease Program) - Wisconsin Medicaid and BadgerCare Plus Managed Care Programs - Wisconsin Well Woman Medicaid - WWWP (Wisconsin Well Woman Program)		

ForwardHealth Portal Helpdesk	**866-908-1363**	**Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central time)***
To assist providers and trading partners with technical questions regarding Portal functions and capabilities, including Portal accounts, registrations, passwords, and submissions through the Portal.		
Electronic Data Interchange Helpdesk	**866-416-4979**	**Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central time)***
For providers, including trading partners, billing services, and clearinghouses with technical questions about the following: - Electronic transactions - Companion documents - PES (Provider Electronic Solutions) software		
Managed Care Provider Appeals	**800-760-0001, Option 1**	**Monday through Friday, 7 a.m. to 6 p.m. (Central time)***
To assist BadgerCare Plus/Medicaid SSI (Supplemental Security Income) HMO or Children's Specialty Managed Care PIHP (Prepaid Inpatient Health Plan) providers with questions regarding their appeal status and other general managed care provider appeal information.		
Managed Care Ombudsman Program	**800-760-0001**	**Monday through Friday, 7 a.m. to 6 p.m. (Central time)***
To assist managed care enrollees with questions about enrollment, rights, responsibilities, and general managed care information.		
Member Services	**800-362-3002**	**Monday through Friday, 8 a.m. to 6 p.m. (Central time)***
To assist ForwardHealth members, or persons calling on behalf of members, with program information and requirements, enrollment, finding enrolled providers, and resolving concerns.		
Wisconsin AIDS Drug Assistance Program	**800-991-5532**	**Monday through Friday, 8 a.m. to 4:30 p.m. (Central time)***
To assist ADAP providers and members, or persons calling on behalf of members, with program information and requirements, enrollment, finding enrolled providers, and resolving concerns.		

*With the exception of state-observed holidays.

Portal

Topic #4743

Acute and Primary Managed Care Portal

Information and Functions Through the Portal

The acute and primary managed care area of the ForwardHealth Portal allows state-contracted HMOs to conduct business with ForwardHealth. The public HMO page offers easy access to key HMO information and web tools. A login is required to access the secure area of the Portal to submit or retrieve account and member information that may be sensitive.

The following information is available through the Portal:

- Listing of all Medicaid-enrolled providers
- Coordination of Benefits Extract/Insurance Carrier Master List information updated quarterly
- Data Warehouse, which is linked from the Portal to Business Objects. The Business Objects function allows for access to MCO (managed care organization) data for long-term care MCOs.
- Electronic messages
- Enrollment verification by entering a member ID or SSN (Social Security number) with date of birth and a From DOS (date of service) and a To DOS range. A transaction number is assigned to track the request.
- Member search function for retrieving member information such as medical status codes and managed care and Medicare information
- Provider search function for retrieving provider information such as the address, phone number, provider ID, taxonomy code (if applicable), and provider type and specialty
- HealthCheck information
- MCO contact information
- Technical contact information (Entries may be added via the Portal.)

Topic #4345

Creating a Provider Account

Each provider needs to designate one individual as an administrator of the ForwardHealth Portal account. This user establishes the administrative account once their PIN (personal identification number) is received. The administrative user is responsible for this provider account and can add accounts for other users (clerks) within their organization and assign security roles to clerks that have been established. To establish an administrative account after receiving a PIN, the administrative user is required to follow these steps:

1. Go to the ForwardHealth Portal.
2. Click the **Providers** button.
3. Click **Logging in for the first time?**.
4. Enter the Login ID and PIN. The Login ID is the provider's NPI (National Provider Identifier) or provider number.
5. Click **Setup Account**.
6. At the Account Setup screen, enter the user's information in the required fields. Enter a backup user's information in the required fields.
7. Read the security agreement and click the checkbox to indicate agreement with its contents.
8. Click **Submit** when complete.

Once in the secure Provider area of the Portal, the provider may conduct business online with ForwardHealth via a secure connection. Providers may also perform the following administrative functions from the Provider area of the Portal:

- Establish accounts and define access levels for clerks
- Add other organizations to the account
- Switch organizations

Refer to the Account User Guide on the User Guides page of the Portal for more detailed instructions on performing these functions.

Topic #4340

Designating a Trading Partner to Receive 835 Health Care Claim Payment/Advice Transactions

Providers must designate a trading partner to receive their 835 (835 Health Care Claim Payment/Advice) transaction for ForwardHealth interChange.

Providers who wish to submit their 835 designation via the Portal are required to create and establish a provider account to have access to the secure area of the Portal.

To designate a trading partner to receive 835 transactions, providers must first complete the following steps:

1. Access the Portal and log into their secure account by clicking the Provider link/button.
2. Click on the Designate 835 Receiver link on the right-hand side of the secure home page.
3. Enter the identification number of the trading partner that is to receive the 835 in the Trading Partner ID field.
4. Click Save.

Providers who are unable to use the Portal to designate a trading partner to receive 835 transactions may call the EDI (Electronic Data Interchange) Helpdesk or submit a paper (Trading Partner 835 Designation, F-13393 (07/12)) form.

Topic #4338

ForwardHealth Portal

Providers, members, trading partners, managed care programs, and partners have access to public **and** secure information through the ForwardHealth Portal.

The Portal has the following areas:

- Providers (public and secure)
- Trading Partners
- Members
- MCO (managed care organization)
- Partners

The secure Portal allows providers to conduct business and exchange electronic transactions with ForwardHealth. The public Portal contains general information accessible to all users. Members can access general health care program information and apply for benefits online.

Topic #4441

ForwardHealth Portal Helpdesk

Providers and trading partners may call the ForwardHealth Portal Helpdesk with technical questions on Portal functions, including their Portal accounts, registrations, passwords, and submissions through the Portal.

Topic #4451

Inquiries to ForwardHealth Via the Portal

Providers are able to contact Provider Services through the ForwardHealth Portal by clicking the Contact link and entering the relevant inquiry information, including selecting the preferred method of response (for example, telephone call or email). Provider Services will respond to the inquiry by the preferred method of response indicated within five business days.

Topic #4400

Internet Connection Speed

ForwardHealth recommends providers have an internet connection that will provide an upload speed of at least 768 Kbps and a download speed of at least 128 Kbps in order to efficiently conduct business with ForwardHealth via the Portal.

For PES (Provider Electronic Solutions) users, ForwardHealth recommends an internet connection that will provide a download speed of at least 128 Kbps for downloading PES software and software updates from the Portal.

These download speeds are generally not available through a dial-up connection.

Topic #4351

Logging in to the Provider Area of the Portal

Once an administrative user's or other user's account is set up, they may log in to the Provider area of the ForwardHealth Portal to conduct business. To log in, the user is required to click the Provider link or button, then enter their username and password and click Go in the Login to Secure Site box at the right side of the screen.

If a user has forgotten their username, they can recover their username by choosing from the following options:

- Ask the Portal Helpdesk to do one of the following:
  - Send the Portal account username to the email account on record.
  - Verify the request with the designated account backup.
- Ask the Portal Helpdesk to remove the Portal account's current credentials and create a new account.

Topic #5158

Managed Care Organization Portal Reports

The following reports are generated to MCOs (managed care organizations) through their account on the ForwardHealth MCO

Portal:

- Capitation Payment Listing Report
- Cost Share Report (long-term MCOs only)
- Enrollment Reports

MCOs are required to establish a Portal account in order to receive reports from ForwardHealth.

Capitation Payment Listing Report

The Capitation Payment Listing Report provides payee MCOs with a detailed listing of the members for whom they receive capitation payments. ForwardHealth interChange creates adjustment transaction information weekly and regular capitation transaction information monthly. The weekly batch report includes regular and adjustment capitation transactions. MCOs have the option of receiving both the Capitation Payment Listing Report and the 820 Payroll Deducted and Other Group Premium Payment for Insurance Products transactions.

Initial Enrollment Roster Report

The Initial Enrollment Roster Report is generated according to the annual schedules detailing the number of new and continuing members enrolled in the MCO and those disenrolled before the next enrollment month.

Final Enrollment Roster Report

The Final Enrollment Roster Report is generated the last business day of each month and includes members who have had a change in status since the initial report and new members who were enrolled after the Initial Enrollment Roster Report was generated.

Other Reports

Additional reports are available for BadgerCare Plus HMOs, SSI HMOs, and long-term MCOs. Some are available via the Portal and some in the secure FTP (file transfer protocol).

Topic #4744

Members ForwardHealth Portal

Members can access ForwardHealth information by going to the ForwardHealth Portal. Members can search through a directory of providers by entering a ZIP code, city, or county. Members can also access all member-related ForwardHealth applications and forms. Members can use ACCESS to check availability, apply for benefits, check current benefits, and report any changes.

Topic #4344

Obtaining a Personal Identification Number

To establish an account on the ForwardHealth Portal, providers are required to obtain a PIN (personal identification number). The PIN is a unique, nine-digit number assigned by ForwardHealth interChange for the sole purpose of allowing a provider to establish a Portal account. It is used in conjunction with the provider's login ID. Once the Portal account is established, the provider will be prompted to create a username and password for the account, which will subsequently be used to log in to the Portal.

Note: The PIN used to create the provider's Portal account is not the same PIN used for revalidation. Providers will receive a separate PIN for revalidation.

A provider may need to request more than one PIN if he or she is a provider for more than one program or has more than one type of provider enrollment. A separate PIN will be needed for each provider enrollment. Health care providers will need to supply their NPI (National Provider Identifier) and corresponding taxonomy code when requesting an account. Non-healthcare providers will need to supply their unique provider number.

Providers may request a PIN by following these steps:

1. Go to the Portal.
2. Click the Providers link or button.
3. Click the Request Portal Access link from the Quick Links box on the right side of the screen.
4. At the Request Portal Access screen, enter the following information:
    a. Health care providers are required to enter their NPI and click Search to display a listing of ForwardHealth enrollments. Select the correct enrollment for the account. The taxonomy code, ZIP+4 code, and financial payer for that enrollment will be automatically populated. Enter the SSN (Social Security number) or TIN (Tax Identification Number).
    b. Non-healthcare providers are required to enter their provider number, financial payer, and SSN or TIN. (This option should only be used by non-healthcare providers who are exempt from NPI requirements).

        The financial payer is one of the following:
        - Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and Senior Care.)
        - SSI (Supplemental Security Income)
        - WCDP (Wisconsin Chronic Disease Program)
        - The WWWP (Wisconsin Well Woman Program)

    c. Click **Submit**.
    d. Once the Portal Access Request is successfully completed, ForwardHealth will send a letter with the provider's PIN to the address on file.

Topic #5089

Other Business Enhancements Available on the Portal

The secure Provider area of the ForwardHealth Portal enables providers to do the following:

- Verify member enrollment.
- View RAs (Remittance Advice).
- Designate which trading partner is eligible to receive the provider's 835 (835 Health Care Claim Payment/Advice).
- Update and maintain provider file information. Providers have the choice to indicate separate addresses for different business functions.
- Receive electronic notifications and provider publications from ForwardHealth.
- Enroll in EFT (electronic funds transfer).
- Track provider-submitted PA (prior authorization) requests.

Topic #4740

Public Area of the Provider Portal

The public Provider area of the ForwardHealth Portal offers a variety of important business features and functions that will assist

in daily business activities with ForwardHealth programs.

Interactive Maximum Allowable Fee Schedule

Within the Portal, are maximum allowable fee schedules for most services. Providers can search the interactive maximum allowable fee schedule by a single procedure code, multiple codes, a code range, or by a service area to find the maximum allowable fee. Through the interactive fee schedule, providers also can export their search results for a single code, multiple codes, a code range, or by service area. The downloadable fee schedules, which are updated monthly, are downloadable only by service area as TXT (text) or CSV (comma separated value) files.

ForwardHealth Communications

ForwardHealth Updates announce changes in policy and coverage, PA (prior authorization) requirements, and claim submission requirements. They communicate new initiatives from the Wisconsin DHS (Department of Health Services) or new requirements from the federal CMS (Centers for Medicare & Medicaid Services) and the Wisconsin state legislature.

Updates reflect current policy at the time of publication; this information may change over time and be revised by a subsequent Update. Update information is added to the ForwardHealth Online Handbook after the Update is posted, unless otherwise noted.

Providers should refer to the Online Handbook for current information. The Online Handbook is the source for current ForwardHealth policy and contains provider-specific information for various services and benefits.

Trainings

Providers can register for all scheduled trainings and view online trainings via the Trainings page, which contains an up-to-date calendar of all available training. Additionally, providers can view webcasts of select trainings.

Contacting Provider Services

Providers and other Portal users will have an additional option for contacting Provider Services through the Contact link on the Portal. Providers can enter the relevant inquiry information, including selecting the preferred method of response (for example, a phone call or email) the provider wishes to receive back from Provider Services. Provider Services will respond to the inquiry within five business days. Information will be submitted via a secure connection.

Online Enrollment

Providers can speed up the enrollment process for Medicaid by completing a provider enrollment application via the Portal. Providers can then track their application by entering their ATN (application tracking number) given to them on completion of the application.

Other Resources Available on the Portal

The public Provider area of the Portal also includes the following features:

- A What's New? section for providers that links to the latest information posted to the Provider area of the Portal.
- Home page for the provider. (Providers have administrative control over their Portal homepage and can grant other employees access to specified areas of the Portal, such as claims and PA.)
- Email subscription service for Updates. (Providers can register for email subscription to receive notifications of new provider publications via email. Users are able to select, by program and service area, which publication notifications they would like to receive.)
- A forms library.

Topic #4741

Secure Area of the Provider Portal

Providers can accomplish many processes via the ForwardHealth Portal, including submitting, adjusting, and correcting claims, submitting and amending PA (prior authorization) requests, and verifying enrollment.

Claims and Adjustments Using the Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, and determine what claims are in pay status on the Portal. Providers can search for and view the status of all of their finalized claims, regardless of how they were submitted (for example, paper, electronic, clearinghouse). If a claim contains an error, providers can correct it on the Portal and resubmit it to ForwardHealth.

Providers can submit an individual claim or adjust a claim via DDE (Direct Data Entry) through the secure Portal.

Submitting PA and Amendment Requests Via the Portal

Nearly all service areas can submit PA requests via the Portal. Providers can do the following:

- Correct errors on PA or amendment requests via the Portal, regardless of how the PA request was originally submitted
- View all recently submitted and finalized PA and amendment requests
- Save a partially completed PA request and finish completing it at a later time (Note: providers are required to submit or re-save a PA request within 30 calendar days of the date the PA request was last saved)
- View all saved PA requests and select any to continue completing or delete
- View the latest provider review and decision letters
- Receive messages about PA and amendment requests that have been adjudicated or returned for provider review

Electronic Communications

The secure Portal contains a two-way message center where providers can send and receive electronic notifications as well as receive links to ForwardHealth provider publications. Providers will be able to send secure messages to select Wisconsin DHS (Department of Health Services) groups/staff by selecting a recipient from a drop-down menu; options in the drop-down menu will differ based on the provider's security role. All new messages will be displayed on the provider's secure Portal messages inbox.

Providers can sign up to receive notifications about the availability of new ForwardHealth messages through email, text, or both. After signing up, the user will receive a verification email to register their device. Once registered, providers will receive notifications by the requested method(s).

Enrollment Verification

The secure Portal offers real-time member enrollment verification for all ForwardHealth programs. Providers are able to use this tool to determine:

- The health care program(s) in which the member is enrolled
- Whether or not the member is enrolled in a state-contracted MCO (managed care organization)
- Whether or not the member has other health insurance (for example, commercial health insurance, Medicare, Medicare Advantage Plans), such as Medicare or commercial health insurance

Using the Portal to check enrollment may be more efficient than calling the AVR (Automated Voice Response) system or the EVS (Enrollment Verification System) (although both are available).

Providers will be assigned a unique enrollment verification number for each inquiry. Providers can also use the print screen function to print a paper copy of enrollment verification inquiries for their records.

Other Business Enhancements Available on the Portal

The secure Provider area of the Portal enables providers to do the following:

- Verify member enrollment.
- View RAs (Remittance Advices).
- Designate which trading partner is eligible to receive the provider's 835 (835 Health Care Claim Payment/Advice) transaction.
- Update and maintain provider file information; providers will have the choice to indicate separate addresses for different business functions.
- Receive electronic notifications and provider publications from ForwardHealth.
- Enroll in EFT (electronic funds transfer).
- Track provider-submitted PA requests.

Topic #4401

System and Browser Requirements

The following table lists the recommended system and browser requirements for using the ForwardHealth Portal. PES (Provider Electronic Solutions) users should note that the Windows-based requirements noted in the table apply; PES cannot be run on Apple-based systems.

Recommended System Requirements	Recommended Browser Requirements
Windows-Based Systems	
Computer with at least a 500Mhz processor, 256 MB of RAM, and 100MB of free disk space	Chrome v. 73 or higher, Edge v. 19 or higher, Firefox v. 38 or higher
Windows XP or higher operating system	
Apple-Based Systems	
Computer running a PowerPC G4 or Intel processor, 512 MB of RAM, and 150MB of free disk space	Chrome v. 73 or higher, Edge v. 19 or higher, Safari v. 14 or higher, Firefox v. 38 or higher
Mac OS X 10.2 or higher operating system	

Topic #4742

Trading Partner Portal

The following information is available on the public Trading Partners area of the ForwardHealth Portal:

- Trading partner testing packets
- Trading partner profile submission
- PES (Provider Electronic Solutions) software and upgrade information
- EDI (Electronic Data Interchange) companion guides

In the secure Trading Partners area of the Portal, trading partners can exchange electronic transactions with ForwardHealth.

Trading partners using PES should be sure to enter the web logon and web password associated with the ForwardHealth Trading Partner ID that will be used on PES transactions. Prior to submitting transactions through PES, trading partners must also make sure their trading partner account is entered as the Default Provider ID on the Switch Organization page of the secure trading partner account on the Portal.

Training Opportunities

Topic #12757

Training Opportunities

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

On-Site Sessions

On-site training sessions are offered at various locations (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

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Archive Date:02/03/2025

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.