

Certification and Ongoing Responsibilities

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Certification and Ongoing Responsibilities: Certification

Provider Qualifications

Express Enrollment for Pregnant Women

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

Documentation

1099 Miscellaneous Forms

ForwardHealth generates the 1099 Miscellaneous form in January of each year for earnings greater than \$600.00, per 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 share the same tax identification number. For example, a provider who conducts business with both Medicaid and WCDP will receive separate 1099 Miscellaneous forms for each program.

The 1099 Miscellaneous forms are sent to the address designated as the "1099 mailing address." The address formerly known as the "payee address" is used as the 1099 mailing address unless a provider has reported a separate address for the 1099 mailing address to ForwardHealth.

Claims

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Claims:Good Faith Claims

Definition

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

Responses

National Correct Coding Initiative

As part of the federal Patient Protection and Affordable Care Act of 2010, the CMS are required to promote correct coding and control improper coding leading to inappropriate payment of claims under Medicaid. The NCCI is the CMS response to this requirement. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. 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 submitted with CPT or HCPCS procedure codes for Wisconsin Medicaid, BadgerCare Plus, and Family Planning Only Services for compliance with the following NCCI edits:

- MUE, or units-of-service detail edits, for claims submitted on and after March 21, 2011, regardless of DOS.
- Procedure-to-procedure detail edits for claims submitted on and after April 1, 2011, regardless of DOS.

The NCCI editing will occur in addition to/along with current procedure code review and editing completed by McKesson ClaimCheck[®] and in ForwardHealth interChange.

Medically Unlikely Detail Edits

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

An example of an MUE would be procedure code 11100 (i.e., biopsy of skin lesion). 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/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 procedure code 11451 (i.e., removal of a sweat gland lesion). This is a more complex service than procedure code 93000 (i.e., electrocardiogram) and, therefore, the secondary procedure would be denied.

Quarterly Code List Updates

The CMS will issue quarterly revisions to the table of codes subject to NCCI edits that ForwardHealth will adopt and implement. Refer to the [CMS Web site](#) 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 about 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](#) 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.

Submission

An Overview

When submitting claims to ForwardHealth, providers are required to indicate, by use of an appropriate ICD-9-CM diagnosis code in either the first or second position, those services that are related to family planning (Element 21 of the 1500 Health Insurance Claim Form). The V25 series is the core set of diagnosis codes providers must use for E&M office visits associated with contraceptive management.

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

If a provider performs services for a member enrolled under TE for Family Planning Only Services, her enrollment information may not yet be available through Wisconsin's EVS or the ForwardHealth Portal. To avoid delays in reimbursement, providers who provide TE for Family Planning Only Services to a woman before her enrollment can be verified should do the following:

- Make a photocopy of the temporary white card to be used, if necessary, for Good Faith claims processing.
- Wait until enrollment has been verified through the EVS or Portal and then submit the claim.

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, procedure code. Providers submitting claims electronically should include a description of a 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 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 and PES software when providers submit the following types of claims:

- Institutional.
- Professional.
- Dental.

On the Professional and Dental forms, a Notes field is available on each detail. On the Institutional form, the Notes field is only available on the header.

Claims Submitted Via the 837 Health Care Claim Transaction

ForwardHealth accepts and utilizes information submitted by providers about NOC procedure codes in the following loop/segments on the 837 transactions:

- Loop 2300, segment NTE for 837 Health Care Claim: Institutional.
- Loop 2400, segment NTE for 837 Health Care Claim: Professional.
- Loop 2400, segment NTE for 837 Health Care Claim: Dental.

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 transaction or on a 1500 Health Insurance Claim Form. Family planning clinics may submit claims for drugs related to the treatment of sexually transmitted diseases using an NDC on a Wisconsin Medicaid [Noncompound Drug Claim](#) form. Wisconsin Medicaid will recoup payments from providers made for noncovered drugs.

Paper Claim Form Preparation and Data Alignment Requirements

Optical Character Recognition

Paper claims submitted to ForwardHealth on the 1500 Health Insurance Claim Form and UB-04 Claim Form are processed using OCR 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](#) and the [Noncompound Drug Claim](#).

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 eight diagnosis codes in Element 21 of the 1500 Health Insurance Claim Form. To correctly add additional diagnosis codes in this element so that it can be read properly by the OCR software, providers should indicate the fifth diagnosis code between the first and third diagnosis code blanks, the sixth diagnosis code between the second and fourth diagnosis code blanks, the seventh diagnosis code to the right of the third diagnosis code blank, and the eighth diagnosis code to the right of the fourth diagnosis code blank. Providers should not number any additional diagnosis codes.

Anchor Fields

Anchor fields are areas on the 1500 Health Insurance Claim Form and the UB-04 Claim Form that the OCR software uses to identify what type of form is being processed. The following fields on the 1500 Health Insurance Claim Form are anchor fields:

- Element 2 (Patient's Name).
- Element 4 (Insured's Name).
- Element 24 (Detail 1).

The following fields on the UB-04 Claim Form are anchor fields:

- Form Locator 4 (Type of Bill).
- Form Locator 5 (Fed. Tax No.).
- Form Locator 9 (Patient Address).
- Form Locator 58A (Insured's Name).

Since ForwardHealth uses these fields to identify the form as a 1500 Health Insurance Claim Form or a UB-04 Claim Form, it is required that these fields are completed for processing.

Provider-Administered Drugs

Deficit Reduction Act of 2005

Providers are required to comply with requirements of the federal DRA of 2005 and submit NDCs with HCPCS procedure codes on claims for provider-administered drugs. Section 1927(a)(7)(B) of the Social Security Act requires NDCs to be indicated on all claims submitted to ForwardHealth, including Medicare crossover claims.

ForwardHealth requires that NDCs be indicated on claims for all provider-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 provider-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.

Radiopharmaceuticals are included in the DRA requirements. Providers will be required to indicate NDCs with HCPCS procedure codes on claims for radiopharmaceuticals.

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 provider-administered drug claims for LTE or identical, related, or similar drugs for ForwardHealth members.

Medicare Crossover Claims

To be considered for reimbursement, NDCs and a HCPCS procedure code must be indicated on Medicare crossover claims for provider-administered drugs. NDCs must be indicated on claims where Medicare is the primary payer. Medicare claims with an NDC present should automatically cross over to ForwardHealth.

ForwardHealth will deny crossover claims if an NDC was not submitted to Medicare.

340B Providers

Providers who participate in the 340B Drug Pricing Program are required to indicate an NDC on claims for provider-administered drugs. The 340B Drug Pricing Program allows certain federally funded grantees and other health care providers to purchase prescription drugs at significantly reduced prices. When submitting the 340B billed amount, they are also required to indicate the actual acquisition cost plus a reasonable dispensing fee.

Explanation of Benefits Codes on Claims for Provider-Administered Drugs

Providers will receive an [EOB code](#) on claims with a denied detail for a provider-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 provider-administered drug, he or she should correct and resubmit the claim for reimbursement.

Provider-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 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 EOB code 1309 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 form along with the Pharmacy Special Handling Request form indicating the EOB code and requesting an override.

Provider-Administered Drugs and Administration Codes Reimbursed by Managed Care Organizations

For Dates of Service On and After January 1, 2009

For DOS on and after January 1, 2009, for members enrolled in BadgerCare Plus HMOs, Medicaid SSI HMOs, and most special managed care programs, BadgerCare Plus and Medicaid fee-for-service, not the member's MCO, reimburse providers for the following if the service is covered by BadgerCare Plus and Medicaid:

- All "J" codes.
- Drug-related "Q" codes.
- A limited number of related [administration codes](#).

This policy is known as the provider-administered drugs carve out policy. For members enrolled in BadgerCare Plus HMOs, Medicaid SSI HMOs, and most special managed care programs, claims for "J" codes, drug-related "Q" codes, and administration code services should be submitted to BadgerCare Plus and Medicaid fee-for-service.

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.

Provider-administered drugs and related services for members enrolled in the PACE and the Family Care Partnership are provided and reimbursed by the special managed care program.

Exemptions

Claims for drugs included in the cost of the procedure (e.g., 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 (e.g., hydration, catheter maintenance, TPN) for DOS prior to January 1, 2009, should continue to be reimbursed by the member's MCO. Provider 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 Web sites:

- [CMS DRA information page](#).
- [NUBC](#).
- [NUCC](#).

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

- The [FDA Web site](#).
- The [Drug Search Tool](#). (Providers may verify if an NDC and its segments are valid using this Web site.)
- The [Noridian Administrative Services NDC to HCPCS crosswalk](#).

Claims from Prescribers

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

- A 1500 Health Insurance Claim Form.
- The 837P transaction.
- The DDE on ForwardHealth Portal.
- The PES software.

1500 Health Insurance Claim Form

NDCs for provider-administered drugs must be indicated in the shaded area of Elements 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], ML [Milliliter], or UN [Unit]), followed by the NDC units, with no space in between.

N412345678901 UN1234.567 is an example of what may be indicated in Elements 24A-24G of the 1500 Health Insurance Claim Form.

Providers should indicate the appropriate NDC of the drug that was dispensed that corresponds to the HCPCS procedure code on claims for provider-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 Web site](#) for information about indicating NDCs on provider-administered drug claims submitted using the 837P transaction.

Direct Data Entry on the ForwardHealth Portal

The following must be indicated on provider-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 Helpdesk](#).

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 to notify them of the payment reduction. For claims with reimbursement reductions, the EOB will state the following, "This claim is eligible for electronic submission. Up to a \$1.10 reduction has been applied to this claim payment."

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

The reimbursement reduction applies to the following paper claims:

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

Exceptions to Paper Claim Reimbursement Reduction

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

- In-state emergency providers.
- Out-of-state providers.
- Medicare Crossover Claims.
- Any claims that ForwardHealth requires additional supporting information to be submitted on paper. For example:

- Hysterectomy claims must be submitted along with a paper Acknowledgement of Receipt of Hysterectomy Information Form.
- Sterilization claims must be submitted along with a paper Consent for Sterilization Form.
- Claims submitted to Timely Filing appeals must be submitted on paper with a Timely Filing Appeals Request form.
- In certain circumstances, drug claims must be submitted on paper with a Pharmacy Special Handling Request.

Coordination of Benefits

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Coordination of Benefits:Commercial Health Insurance

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.

Covered and Noncovered Services

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Covered and Noncovered Services:Codes

Diagnosis Codes

Allowable contraceptive management diagnosis codes for Family Planning Only Services are listed below.

V25 — Encounter for contraceptive management

V25.0 — General counseling and advice

V25.01 — Prescription of oral contraceptives

V25.02 — Initiation of other contraceptive measures

Fitting of diaphragm

Prescription of foams, creams, or other agents

V25.09 — Other

Family planning advice

V25.1 — Insertion of intrauterine contraceptive device

V25.2 — Sterilization

Admission of interruption of fallopian tubes

V25.3 — Menstrual extraction

Menstrual regulation

V25.4 — Surveillance of previously prescribed contraceptive methods

Checking, reinsertion, or removal of contraceptive device

Repeat prescription for contraceptive method

Routine examination in connection with contraceptive maintenance

V25.40 — Contraceptive surveillance, unspecified

V25.41 — Contraceptive pill

V25.42 — Intrauterine contraceptive device

Checking, reinsertion, or removal of intrauterine device

V25.43 — Implantable subdermal contraceptive

V25.49 — Other contraceptive method

V25.5 — Insertion of implantable subdermal contraceptive

V25.9 — Unspecified contraceptive management

All claims for Family Planning Only Services must include a diagnosis code in the V25 series. For certain procedures and services, the V25 diagnosis code must be included as the primary diagnosis. If the V25 diagnosis code is not required to be the primary diagnosis, it should still be included on the claim, following the appropriate primary diagnosis code. Family Planning Only Services claims submitted without the V25 diagnosis code may be subject to denial or recoupment.

National Drug Codes

BadgerCare Plus and SeniorCare cover FDA-approved NDCs 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. (Repackaged drugs are covered.)
- 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](#) or refer to the [Noridian Administrative Services NDC to HCPCS crosswalk](#). (This Web site contains a crosswalk of J codes and NDCs to HCPCS and select CPT procedure codes.)

Providers are required to indicate an appropriate NDC on PA requests.

New National Drug Codes

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

Procedure Codes

Information is available for [DOS before May 1, 2010](#).

Providers who submit claims for Family Planning Only Services on the UB-04 Claim Forms and the 837I transactions are required to indicate a valid HCPCS 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.

The following two tables contain the procedure codes covered under Family Planning Only Services for women. All services must include a diagnosis code in the V25 range.

Office Visits for Females		
Procedure Code	Description	Requires Primary Diagnosis Code in the V25 Series
99201	Office or other outpatient visit for the evaluation and management of a new patient (10 min)	Yes
99202	Office or other outpatient visit for the evaluation and management of a new patient (20 min)	Yes
99203	Office or other outpatient visit for the evaluation and management of a new patient (30 min)	Yes
99204	Office or other outpatient visit for the evaluation and management of a new patient (45 min)	Yes
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: A comprehensive history; A comprehensive	Yes

	examination; Medical decision making of high complexity	
99211	Office or other outpatient visit for the evaluation and management of an established patient (5 min)	Yes
99212	Office or other outpatient visit for the evaluation and management of an established patient (10 min)	Yes
99213	Office or other outpatient visit for the evaluation and management of an established patient (15 min)	Yes
99214	Office or other outpatient visit for the evaluation and management of an established patient (25 min)	Yes
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 appropriate immunization (s), 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 appropriate immunization (s), 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

* Not covered with procedure codes 99384-99396 and 99401-99404.

Procedures and Supplies for Females		
Procedure Code	Description	Requires Primary Diagnosis Code in the V25 Series
A4261	Cervical cap for contraceptive use	Yes
A4264	Permanent implantable contraceptive intratubal occlusion device(s) and delivery	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
J0696	Injection, ceftriaxone sodium [Rocephin], per 250 mg	No
J1055	Injection, medroxyprogesterone acetate for contraceptive use, 150 mg	Yes

J1056	Injection, medroxyprogesterone acetate/estradiol cypionate, 5 mg/25 mg	Yes
J7300	Intrauterine copper contraceptive	Yes
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52mg	Yes
J7303	Contraceptive supply, hormone containing vaginal ring, each	Yes
J7304	Contraceptive supply, hormone containing patch, each	Yes
J7307	Etonogestrel implant system	Yes
S4993	Contraceptive pills for birth control	Yes
11975	Insertion, implantable contraceptive capsules	Yes
11976	Removal, implantable contraceptive capsules	Yes
11977	Removal with reinsertion, implantable contraceptive capsules	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	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 15 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
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
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*	Information is available for DOS before May 1, 2010 . 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
58670*	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)	Yes
58671*	with occlusion of oviducts by device (e.g. band, clip or Falope ring)	Yes
71010	Radiologic examination, chest; single view, frontal	Yes

71020	Radiologic examination, chest; 2 views, frontal and lateral	Yes
74740	Hysterosalpingography, radiological supervision and interpretation	Yes
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Yes
99070	Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	Yes
Colposcopy		
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 the endocervical curettage	No
57460	with loop electrode biopsy(s) of the cervix	No
57461	with loop electrode conization of the cervix	No
Laboratory Services		
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
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 agent antigen, qualitative or semiquantitative; single step method (eg, reagent strip)	Yes
83907	Molecular diagnostics; lysis of cells prior to nucleic acid extraction (eg, stool specimens, paraffin embedded tissue)	Yes
84146	Prolactin	Yes
84443	Thyroid stimulating hormone (TSH)	Yes
84450	Transferase; aspartate amino (AST) (SGOT)	Yes

84703	Gonadotropin, chorionic (hCG); 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
86701	HIV-1	Yes
86703	HIV-1 and HIV-2, single assay	Yes
86780	Antibody; Treponema pallidum	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	with isolation and presumptive identification of isolates, 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 cytopathetic 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 enzyme immunoassay technique, 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 enzyme immunoassay technique qualitative or semiquantitative; multiple step method, not otherwise specified, each organism	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	Yes
87536	HIV-1, quantification	Yes
87537	HIV-2, direct probe technique	Yes
87538	HIV-2, amplified probe technique	Yes
87539	HIV-2, quantification	Yes
87591	Neisseria gonorrhoeae, amplified probe technique	Yes
87620	papillomavirus, human, direct probe technique	Yes
87621	papillomavirus, human, amplified probe technique	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
87808	Infectious agent antigen detection by immunoassay with direct optical observation; Trichomonas vaginalis	Yes
88141	Cytopathology, cervical or vaginal (any reporting system); requiring interpretation by physician	Yes
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
99000	Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory	Yes
Anesthesia Services		
00851	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection	Yes
00952	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); hysteroscopy and/or hysterosalpingography	Yes

* This service requires completion of the [Consent for Sterilization](#) form.

The following tables contain the procedure codes covered under Family Planning Only Services for men. All services must include a diagnosis code in the V25 range.

Office Visits for Males		
Procedure Code	Description	Requires Primary Diagnosis Code in the V25 Series
99201	Office or other outpatient visit for the evaluation and management of a new patient (10 min)	Yes
99202	Office or other outpatient visit for the evaluation and management of a new patient (20 min)	Yes
99203	Office or other outpatient visit for the evaluation and management of a new patient (30 min)	Yes
99204	Office or other outpatient visit for the evaluation and management of a new patient (45 min)	Yes
99211	Office or other outpatient visit for the evaluation and management of an established patient (5 min)	Yes
99212	Office or other outpatient visit for the evaluation and management of an established patient (10 min)	Yes
99213	Office or other outpatient visit for the evaluation and management of an established patient (15 min)	Yes
99214	Office or other outpatient visit for the evaluation and management of an established patient (25 min)	Yes

Procedures and Supplies for Males		
Procedure Code	Description	Requires Primary Diagnosis Code in the V25 Series
A4267	Contraceptive supply, condom, male, each	Yes
J0580	Injection, penicillin G bezathine [Bicillin long-acting]; up to 2,400,1000 units	Yes
J0696	Injection, ceftriaxone sodium [Rocephin], per 250 mg	Yes
Q0144	Azithromycin dihydrate, oral, capsules/powder, 1 gram	Yes
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
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 legions	Yes
17111	15 or more legions	Yes
55250*	Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)	No
55450*	Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure)	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 over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided	Yes
Laboratory Services		
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
86592	Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART)	Yes
86689	Antibody; HTLV or HIV antibody, confirmatory test (eg, Western blot)	Yes
86701	HIV-1	Yes
86703	HIV-1 and HIV-2, single assay	Yes
86780	Antibody; treponema pallidum	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
87491	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique	Yes
87591	Neisseria gonorrhoeae, amplified probe technique	Yes
99000	Handling and/or conveyance of specimen for transfer from the physician's office to a	Yes

	laboratory	
Anesthesia Services		
00921	Anesthesia for procedures on male genitalia (including open urethral procedures); vasectomy, unilateral or bilateral	No

* This service requires completion of the [Consent for Sterilization](#) 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 the TB-Related Services-Only Benefit. In this instance, providers should use this attachment in conjunction with TB-Only publications. (When verifying enrollment for these women, Wisconsin's EVS indicates that they are eligible for both limited benefit categories.)

Unlisted Procedure Codes

According to the HCPCS code book, if a service is provided that is not accurately described by other HCPCS/CPT procedure codes, the service should be reported using an unlisted procedure code.

Before considering using an unlisted, or NOC, 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 request, to justify use of the unlisted procedure code and to describe the procedure or service rendered. Submitting the proper documentation, which could include a PA request, may result in more timely claims processing.

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

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

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

For most unlisted codes, ForwardHealth requires additional documentation.

Unlisted Codes That Require Prior Authorization

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

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

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

- Include all required clinical/supporting documentation.

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

Unlisted Codes That Do Not Require Prior Authorization

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

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

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

How to Submit Claims and Related Documentation

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

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

Covered Services and Requirements

An Overview

Under Family Planning Only Services, eligible members receive selected family planning services and supplies through Medicaid-certified 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, HCPCS, and FDA 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.

Colposcopies

[Colposcopies](#) are reimbursable through Family Planning Only Services under certain circumstances. A colposcopy is reimbursable by Family Planning Only Services when an abnormal pap test is obtained prior to the colposcopy, but while the member is 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 in Family Planning Only Services should be to receive contraceptive management services. Contraceptive management services are defined as those services associated with an ICD-9-CM diagnosis code of the V25 series.

Core Plan Covered Family Planning-Related Services

BadgerCare Plus Core Plan Only Members

Family planning services are not covered under the BadgerCare Plus Core Plan. However, physician services that could be considered family planning services are covered under the Core Plan. These services are subject to the same copayment and other policies as other physician services. If the member is enrolled in an HMO, services must be provided through the member's HMO network.

Members Enrolled in BadgerCare Plus Core Plan and Family Planning Only Services

Eligible Core Plan members are given the opportunity to enroll in Family Planning Only Services also. Members enrolled in both the Core Plan and Family Planning Only Services are eligible for all the services covered under each of these plans. These members may receive family planning services from a family planning clinic or from any other health care provider allowed under BadgerCare Plus. Services covered under Family Planning Only Services are reimbursed on a fee-for-service basis, regardless of HMO enrollment.

If providers submit claims to the BadgerCare Plus HMO for family planning-related physician services, the HMO is required to cover

the service as a physician service under the Core Plan. Policies applicable to physician services apply. For Core Plan members who are also enrolled in Family Planning Only Services, providers are encouraged to submit family planning-related claims to BadgerCare Plus fee-for-service to ensure they are covered under Family Planning Only Services.

Definition of Covered Services

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

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
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 Xtra 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-Q-D	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 Evra	Patch
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
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

Implanon

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

- 11975 (insertion, implantable contraceptive capsules).
- 11976 (removal, implantable contraceptive capsules).
- 11977 (removal with reinsertion, implantable contraceptive capsules).

Non-emergency Transportation Services

Non-emergency transportation services by common carrier or SMV are covered for members receiving Family Planning Only Services. Transportation services are limited to trips to receive covered family planning services.

Non-emergency transportation services must be approved by the local economic support agency or provided by Medicaid-certified SMV services providers.

To be reimbursed for transportation services provided to Family Planning Only Services members, SMV providers must meet all of ForwardHealth's policies and requirements for providing SMV services. This includes documentation requirements, such as having a completed [Certification of Need for Specialized Medical Vehicle Transportation form](#) for the Family Planning Only Services member in the provider's records. Providers should refer to the [SMV area of the Online Handbook](#) for complete policies and procedures for SMV services.

Ortho Evra Patch

The Ortho Evra Patch® is 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](#) form using an [NDC](#) or on the 1500 Health Insurance Claim Form using HCPCS procedure code J7304.

Provider-Administered Drugs

A provider-administered drug is either an oral, injectable, intravenous, or inhaled drug administered by a physician or a designee of the physician (e.g., nurse, nurse practitioner, physician assistant) or incidental to a physician service. This includes, but is not limited to, all "J" codes and drug-related "Q" codes.

Providers may refer to the [maximum allowable fee schedules](#) for the most current HCPCS and CPT procedure codes for provider-administered drugs and reimbursement rates.

For Dates of Service On and After January 1, 2009

For DOS on and after January 1, 2009, for members enrolled in BadgerCare Plus HMOs, Medicaid SSI HMOs, and most special managed care programs, BadgerCare Plus and Medicaid fee-for-service, not the member's MCO, reimburse providers for the following if the service is covered by BadgerCare Plus and Medicaid:

- All "J" codes.
- Drug-related "Q" codes.
- A limited number of related [administration codes](#).

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 provider-administered drugs, including copayment, cost sharing, diagnosis restriction, PA, and pricing policies, apply to [claims submitted](#) to fee-for-service for members enrolled in an MCO.

Provider-administered drugs and related services for members enrolled in the PACE and the Family Care Partnership are provided and reimbursed by the special managed care program.

Obtaining Provider-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. If a member is given a drug to be administered by the provider for which storage, handling, and care instructions apply and the instructions are followed incorrectly, the dose may be ineffective. Prescribers may obtain a provider-administered drug from the member's pharmacy provider if the drug is transported 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. Pharmacy providers should not dispense a drug to a member if the drug will be administered in the prescriber's office.

Resetting Service Limitations

Service limitations used by a member enrolled in the BadgerCare Plus Benchmark Plan and the BadgerCare Plus Core Plan within their continuous 12-month enrollment year will reset in the following situations:

- A fee-for-service member is enrolled in an HMO.
- A member switches from one HMO to another HMO (only allowable within the first 90 days of Core Plan enrollment).
- A member is disenrolled from an HMO and moves to fee-for-service.

Note: When a member goes from fee-for-service into an HMO and subsequently moves back to fee-for-service, service limitations will not be reset for the services that were received under the initial fee-for-service enrollment period.

PA requests for services beyond the covered service limitations will be denied.

Resetting service limitations does not change a member's [Benchmark Plan](#) enrollment year or a member's [Core Plan](#) enrollment year.

Sterilizations

Sterilizations are covered by Family Planning Only Services, provided the [Sterilization Informed Consent](#) form is properly completed.

Tubal Ligations

The following types of tubal ligations are covered by Family Planning Only Services, provided the Sterilization Informed Consent 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

Noncovered Services

Basic Plan Noncovered Services

The following are among the services that are not covered under the BadgerCare Plus Basic Plan:

- Case management.
- Certain visits over the 10-visit limit.
- Community Recovery Services.
- Enteral nutrition.
- HealthCheck.
- Health education services.
- Hearing services, including hearing instruments, cochlear implants, and bone-anchored hearing aids, hearing aid batteries, and repairs.
- Home care services (home health, personal care, PDN).
- Inpatient mental health and substance abuse treatment services.
- Non-emergency transportation (i.e., common carrier, SMV).
- Nursing home.
- Obstetrical care and delivery.
- Outpatient mental health and substance abuse services.
- PNCC.
- Provider-administered drugs.
- Routine vision examinations billed with CPT codes 92002-92014 (without a qualifying diagnosis), determination of refractive state billed with CPT code 92015; vision materials such as glasses, contact lenses, and ocular prosthetics; repairs to vision materials; and services related to the fitting of contact lenses and spectacles.
- SBS.
- Transplants and transplant-related services.

Billing Members for Noncovered Services

Basic Plan members may request noncovered services from providers. In those cases, providers may collect payment for the noncovered service from the member if the member accepts responsibility for payment and makes payment arrangements with the provider. Providers are strongly encouraged to obtain a written statement in advance documenting that the member has accepted responsibility for payment of the service.

Providers may bill members up to their usual and customary charge for noncovered services. Basic Plan members do not have appeal rights for noncovered services.

Noncovered Services

The following is a list of procedure codes and services that are not covered under Family Planning Only Services effective for DOS on and after January 1, 2008.

Noncovered Procedure Codes Effective January 1, 2008	Description
00840	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise classified

00940	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise classified
00950	culdoscopy
57500	Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)
58120	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)
58555	Hysteroscopy, diagnostic (separate procedure)
88155	Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation (eg, maturation index, karyopknotic index, estrogenic index) (List separately in addition to code(s) for other technical and interpretation services)
88346	Immunofluorescent study, each antibody; direct method
88365	In situ hybridization [eg, FISH], each probe

Member Information

5

Archive Date:04/01/2011

Member Information: Enrollment Categories

BadgerCare Plus Basic Plan

The BadgerCare Plus Basic Plan is a self-funded plan that focuses on providing BadgerCare Plus Core Plan waitlist members with access to vital, cost-effective primary and preventive care. This option will allow members to have some minimal form of coverage until space becomes available in the Core Plan and will help prevent bankruptcy due to excessive medical debt.

Member participation or non-participation in the Basic Plan does not affect an individual's status on the Core Plan waitlist.

Services for the Basic Plan are covered under fee-for-service. Basic Plan members will not be enrolled in state-contracted HMOs.

As of March 19, 2011, new enrollment into the Basic Plan ended. The Basic Plan will continue for members already enrolled in the Basic Plan.

Conditions That End Member Enrollment in the Basic Plan

A member's enrollment in the Basic Plan will end if the member:

- Becomes eligible for Medicare, Medicaid, the Standard Plan, the Benchmark Plan, or the Core Plan.
- Becomes incarcerated or becomes institutionalized in an IMD.
- Becomes pregnant. (*Note:* A Basic Plan member who becomes pregnant should be referred to [Member Services](#) for more information about enrollment in the Standard Plan or the Benchmark Plan.)
- No longer resides in the state of Wisconsin.
- Obtains health insurance coverage.
- Turns 65 years of age.
- Fails to pay the monthly premium.

Note: Enrollment in the Basic Plan does not end if the member's income increases.

Providers are reminded that the Basic Plan does not cover obstetrical services or delivery services.

Providers are required to notify ForwardHealth if they have reason to believe that a person is misusing or abusing BadgerCare Plus or Medicaid benefits or the ForwardHealth identification card.

Basic Plan Member Fact Sheets

[Fact sheets](#) providing additional member information about the Basic Plan are available.

Enrollment Certification Period for Basic Plan Members

A member's enrollment will begin on the first of the month and will continue through the end of the 12th month. For example, if the individual's enrollment in the Basic Plan begins on July 1, 2010, the enrollment certification period will continue through June 30, 2011, unless conditions occur that end enrollment.

Premium payments are due on the fifth of each month, prior to the month of coverage. Members who fail to pay the monthly premium will have their benefits terminated and will also be subject to a 12-month restrictive re-enrollment period.

Basic Plan Members Enrolled in Wisconsin Chronic Disease Program

For Basic Plan members who are also enrolled in WCDP, providers should submit claims for all covered services to the Basic Plan first and then to WCDP. For pharmacy services, if both programs deny the pharmacy claim, providers should submit the claim to BadgerRx Gold.

Basic Plan Members and HIRSP Coverage

Basic Plan members may also be enrolled in the HIRSP as long as the member meets the eligibility requirements for both the Basic Plan and HIRSP. For Basic Plan members who are also enrolled in HIRSP, providers should submit claims for all Basic Plan covered services to HIRSP first and then to the Basic Plan.

Basic Plan members may not be enrolled in the Basic Plan and the Federal Temporary High Risk Insurance Pool. Information that is being distributed to Core Plan members on the waitlist regarding HIRSP and the Federal Temporary High Risk Insurance Pool is [available](#).

BadgerCare Plus Core Plan

The BadgerCare Plus Core Plan covers basic health care services including primary care, preventive care, certain generic and OTC drugs, and a limited number of brand name drugs.

Applicant Enrollment Requirements

An applicant must meet the following enrollment requirements in order to qualify for the Core Plan:

- Is a Wisconsin resident.
- Is a United States citizen or legal immigrant.
- Is between the ages of 19 and 64.
- Does not have any children under age 19 under his or her care.
- Is not pregnant.
- Is not eligible for or enrolled in Medicaid, the BadgerCare Plus Standard Plan, or the BadgerCare Plus Benchmark Plan. This would not include benefits provided under Family Planning Only Services or those benefits provided to individuals who qualify for TB-Only.
- Is not eligible for or enrolled in Medicare.
- Has a monthly gross income that does not exceed 200 percent of the FPL.
- Is not covered by health insurance currently or in the previous 12 months.
- Has not had access to employer-sponsored insurance in the previous 12 months and does not have access to employer-subsidized insurance during the month of application or any of the three months following application.

Application Process for New Members

The Core Plan application process will be streamlined and user-friendly. Individuals who wish to enroll may apply for the Core Plan [using the Access tool online](#) or via the [ESC](#). A pre-screening tool will help determine which individuals may be eligible to enroll in the Core Plan. Applications for Core Plan members will be processed centrally by the ESC, not by county agencies.

To complete the application process, applicants must meet the following requirements:

- Complete a Health Survey.
- Pay a non-refundable, annual processing fee of \$60.00 per individual or per couple for married couples. The fee will be waived for homeless individuals. There are no monthly premiums.

Medicaid-certified providers cannot pay the \$60.00 application processing fee on behalf of Core Plan applicants. An offer by a Medicaid-certified provider to pay a fee on behalf of a prospective Medicaid member may violate federal laws against kickbacks.

These laws are federal criminal statutes that are interpreted and enforced by federal agencies such as the United States DOJ and the Department of HHS's OIG.

Conditions That End Member Enrollment in the Core Plan

A member's enrollment will end if the member:

- Becomes eligible for Medicare, Medicaid, the Standard Plan, or the Benchmark Plan.
- Becomes incarcerated or institutionalized in an IMD.
- Becomes pregnant.
- No longer resides in the state of Wisconsin.
- Obtains health insurance coverage.
- Turns 65 years of age.

Providers are reminded that the Core Plan does not cover obstetrical services, including the delivery of a child or children. A Core Plan member who becomes pregnant should be referred to the ESC for more information about enrollment in the Standard Plan or the Benchmark Plan.

Enrollment Certification Period for Core Plan Members

Once determined eligible for enrollment in the Core Plan, a member's enrollment will begin either on the first or 15th of the month, whichever is first, and will continue through the end of the 12th month. For example, if the individual submits all of his or her application materials, including the application fee, by September 17, 2009, and the DHS reviews the application and approves it on October 6, 2009, the individual is eligible for enrollment beginning on October 15, 2009, the next possible date of enrollment. The enrollment certification period will continue through October 31, 2010.

The enrollment certification period for individuals who qualify for the Core Plan is 12 months, regardless of income changes.

Core Plan Members Enrolled in Wisconsin Chronic Disease Program

For Core Plan members who are also enrolled in WCDP, providers should submit claims for all covered services to the Core Plan first and then to WCDP. For pharmacy services, if both programs deny the pharmacy claim, providers should submit claims to BadgerRx Gold.

Core Plan Members with HIRSP Coverage

Core Plan members may also be enrolled in HIRSP as long as the member meets the eligibility requirements for both the Core Plan and HIRSP. For Core Plan members who are also enrolled in HIRSP, providers should submit claims for all Core Plan covered services to the Core Plan. For services not covered by the Core Plan, providers should submit claims to HIRSP. For members enrolled in the Core Plan, HIRSP is always the payer of last resort.

Note: HIRSP will only cover noncovered Core Plan services if the services are covered under the HIRSP benefit.

Express Enrollment for Pregnant Women

BadgerCare Plus does not require applicants declaring United States citizenship to provide proof of citizenship when completing either the EE for Pregnant Women Application or the TE for Family Planning Only Services Application. However, EE applicants are required to provide documentation of citizenship when applying for full-benefit BadgerCare Plus or continuing coverage through Family Planning Only Services.

Family Planning Only Services

Family Planning Only Services is a limited benefit program that provides routine contraceptive-related services to low-income individuals who are at least 15 years of age who are otherwise not eligible for Wisconsin Medicaid or BadgerCare Plus. There is no upper age limit for Family Planning Only Services enrollment as long as the member is of childbearing age. Members receiving Family Planning Only Services must be receiving routine contraceptive-related services.

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

Members enrolled in Family Planning Only Services receive routine services to prevent or delay pregnancy and are not eligible for other services (e.g., PT 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 the Wisconsin Medicaid and BadgerCare Plus family planning benefit (e.g., mammograms and hysterectomies). If a medical condition, other than an STD, is discovered during contraceptive-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-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-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 service options and provide referrals for care not covered by Family Planning Only Services.

Temporary Enrollment for Family Planning Only Services

Members whose providers are submitting an initial Family Planning Only Services application on their behalf and who meet the enrollment criteria may receive routine contraceptive-related services immediately through TE for Family Planning Only Services for up to two months. Services covered under the TE for Family Planning Only Services are the same as those covered under Family Planning Only Services and must be related to routine contraceptive management.

To determine enrollment for Family Planning Only Services, providers should use the income limit for 300 percent of the [FPL](#).

TE for Family Planning Only Services providers may issue white paper TE for Family Planning Only Services identification cards for members to use until they receive a ForwardHealth identification card. Providers should remind members that the benefit is temporary, despite their receiving a ForwardHealth card.

Fee-for-Service

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

Identification Cards

ForwardHealth Basic Plan Identification Cards

Members enrolled in the BadgerCare Plus Basic Plan will receive a [ForwardHealth Basic Plan card](#). All identification cards include the member's name and 10-digit member identification number. The identification cards may be used to verify a member's enrollment, but possession of an identification card does not guarantee enrollment. It is possible that a member will present a card when he or she is not enrolled; therefore, it is essential that providers verify enrollment before providing services.

Providers should always check enrollment for a member who presents a ForwardHealth card to verify if the member is enrolled in the Basic Plan or in one of the other ForwardHealth programs. (Providers may use the same methods of enrollment verification under the Basic Plan as they do for other ForwardHealth programs such as Medicaid. These methods include the ForwardHealth Portal, WiCall, magnetic stripe readers, and the 270/271 transactions.) Members who present a ForwardHealth card or a ForwardHealth Basic Plan card may have been enrolled in a different plan since the card was issued. Providers should be careful to verify the plan in which the member is enrolled and know which services are covered under that plan.

Basic Plan members should call [Member Services](#) with questions about premiums and covered services. The ForwardHealth Basic Plan cards include the Member Services telephone number on the back.

Temporary Enrollment for Family Planning Only Services Identification Cards

Qualified providers may issue white paper TE for Family Planning Only Services identification cards for women to use temporarily until they receive a ForwardHealth identification card. The identification card is included with the TE for Family Planning Only Services Application.

The TE for Family Planning Only Services identification cards have the following message printed on them: "Temporary Identification Card for Temporary Enrollment for Family Planning Only Services." Providers should accept the white TE for Family Planning Only Services identification cards as proof of enrollment for the dates provided on the cards and are encouraged to keep a photocopy of the card.

Member Enrollment

Annual Enrollment Review

Under Family Planning Only Services, members may receive routine contraceptive-related services and supplies from Medicaid-certified providers for 12 months from the time they are determined enrolled (as long as they 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 her SSN, 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.

Coordination with the Wisconsin Well Woman Program -

Breast Cancer Diagnosis

Women 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 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 woman does not need to be formally disenrolled from Family Planning Only Services prior to being referred to the WWWP for enrollment. If the woman is diagnosed with breast cancer through the WWWP and meets the other non-financial criteria for Well Woman Medicaid, she may be enrolled in Well Woman Medicaid through the WWWP. She does not need to return to the Family Planning Only Services provider to enroll.

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

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 (e.g., certain colposcopies, biopsy of the cervix) but does not cover diagnostic tests (e.g., 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 woman is diagnosed with cervical cancer or a precancerous condition of the cervix and needs treatment for the cancer or precancerous condition, she is eligible for Well Woman Medicaid.

The Family Planning Only Services physician or nurse practitioner should complete a Wisconsin Well Woman Medicaid Determination Form with the member and refer the woman to her certifying agency where the woman can disenroll from Family Planning Only Services and enroll in Well Woman Medicaid. If the woman does not complete the enrollment process at the certifying agency, ForwardHealth will not cover her 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 woman can seek diagnostic tests through the WWWP, through commercial health insurance, or at her own expense. If, after receiving the necessary diagnostic tests, the woman is diagnosed with breast cancer and needs treatment for the cancer, she 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 she is at least 35 years of age - seek enrollment in the WWWP. Once enrolled in the WWWP, the woman can receive the necessary diagnostic tests through the WWWP. If, in addition to meeting the nonmedical eligibility criteria, she is diagnosed with breast cancer and needs treatment for the cancer, she is eligible for Well Woman Medicaid through the WWWP. (A woman cannot enroll in the WWWP while she is enrolled in full-benefit Wisconsin Medicaid or BadgerCare Plus.)

The local WWWP coordinating agency can help the woman enroll in the WWWP. Providers may call (608) 266-8311 or go

to the WWP Web site for WWP coordinating agencies.

- The member enrolled in Family Planning Only Services can also:
 - Seek coverage for diagnostic tests through commercial health insurance.
 - Receive diagnostic tests at her 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, she is eligible for Well Woman Medicaid.

A member diagnosed with breast cancer should notify her 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 woman to her certifying agency where the woman can disenroll from Family Planning Only Services and enroll in Well Woman Medicaid. If the woman does not complete the enrollment process at the certifying agency, ForwardHealth will not cover her treatment.

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 at least 15 years of age to be eligible. 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.
- Are not currently receiving Wisconsin Medicaid or BadgerCare Plus.

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

- Be at least 15 years of age.
- 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 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 DHS 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/Review Packet](#) mailed to the ESC at the following address:

Enrollment Services Center
PO Box 7190
Madison WI 53707-7190

Paper applications can also be submitted by fax to the following number: (888) 415-2115.

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 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, women 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 and the BadgerCare Plus Core Plan 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 the [Core Plan](#) and FoodShare at the same time that they apply for Family Planning Only Services.

The Core Plan provides many health services that complement Family Planning Only Services. For uninsured members aged 19-64, enrolling in the Core Plan allows them access to basic health care services including primary care, preventive care, certain generic and over-the-counter drugs, and a limited number of brand-name drugs not covered under Family Planning Only Services.

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-certified providers, including treatment for cancer and contraceptive-related services. Previously, only women screened by the WWWP and diagnosed with cervical cancer, precancerous conditions of the cervix, or breast cancer were eligible for Well Woman Medicaid.

New 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. Women receiving services through

TE 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 permanent Family Planning Only Services 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.

Faxing Temporary Enrollment Applications

When faxing a TE 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 privacy regulation requires providers to implement reasonable safeguards to protect the privacy of PHI.

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.

Income Limits

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

Overview of Enrollment Process for Wisconsin Well Women 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.	→	<div>The woman meets all of the following criteria:</div> <ul style="list-style-type: none">• 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 Women 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.	→	<p>The woman - who is at least 35 years of age - meets all of the following criteria:</p> <ul style="list-style-type: none"> • She disenrolls from Family Planning Only Services, enrolls in the WWWP, 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 Women Medicaid.
		OR		
	→	<p>The woman meets all of the following criteria:</p> <ul style="list-style-type: none"> • 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		
	→	<p>The woman meets all of the following criteria:</p> <ul style="list-style-type: none"> • 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. 	→	
<p>* Women receiving services through TE 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.)</p>				

Temporary Enrollment

Individuals who meet the enrollment criteria may receive family planning services immediately through TE for Family Planning Only Services. Services and supplies covered under TE for Family Planning Only Services are the same as those covered under Family Planning Only Services.

Providers are encouraged to make individuals aware of the availability of Family Planning Only Services benefits so that they may request services. When an individual requests family planning services through TE for Family Planning Only Services, they may apply through a Medicaid-certified family planning agency. A certified TE for Family Planning Only Services provider will help the applicant fill out the TE for Family Planning Only Services application and will mail or fax the application to ForwardHealth.

To receive an application to become certified to make TE for Family Planning Only Services determinations, contact [Provider Services](#).

Temporary Enrollment Determinations

Providers who are currently certified to perform EE for Pregnant Women determinations are also approved to perform TE for Family Planning Only Services determinations.

The TE for Family Planning Only Services Application may be [ordered](#) through the DHS' Web site.

The TE for Family Planning Only Services [completion instructions](#) are available to download for printing. A [sample](#) copy of the TE for Family Planning Only Services application is available for reference.

Confirming Enrollment Status

Only one period of TE is allowed within a rolling 12-month period; therefore, prior to submitting a TE application, providers are reminded to confirm that the applicant did not have a TE period at any time within the last 12 months.

Once a provider has confirmed that the applicant did not have a TE period during any time within the past 12 months, providers are required to submit TE applications *within five days of the signature date on the application*. There is no retroactive TE period; TE for Family Planning Only Services is an immediate and prospective benefit. The earliest effective date for the TE period is the signature date on the application.

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

Length of Coverage

Once a provider has confirmed that an individual has not had a TE period within the last twelve months, they may receive services for up to two months, depending on his or her application date.

For identification cards issued on and after November 1, 2010, the period of TE for Family Planning Only Services coverage ends on the earliest of either:

- The first day of the month on which the individual submits the application for Family Planning Only Services and is enrolled by the certifying agency.
- The end of the calendar month following the month in which the individual was temporarily enrolled, unless they are found ineligible prior to the end of the TE for the Family Planning Only Services period.

The TE period will be determined using the policy described above, even if the provider submits an old application form. Any other TE period determined by the provider will be corrected to meet the new policy. In addition, if the TE for Family Planning Only Services application is found to be incomplete or if the information provided does not meet the TE for the Family Planning Only Services enrollment criteria, the applicant will be sent a notice and the applicant's temporary enrollment in the Family Planning Only Services will end.

Identification Card

Included with the TE for Family Planning Only Services application is a white paper identification card that the member uses to access Family Planning Only Services until they receive their ForwardHealth Identification card. The white identification card identifies the member as enrolled in TE for Family Planning Only Services, and providers should accept it for the dates indicated on the card as proof of enrollment, even though enrollment may not be on ForwardHealth's file for 48 hours after the completed application is received. Once the member's TE for Family Planning Only Services enrollment is on the ForwardHealth system, a ForwardHealth card is issued.

Only one period of TE is allowed within a rolling 12-month period.

Submitting Claims

If a provider performs services for a member enrolled under TE for Family Planning Only Services, their enrollment information may not yet be available through the EVS or the Portal. To avoid delays in reimbursement, providers who provide TE for Family Planning Only Services to a member before her Family Planning Only Services enrollment can be verified should do the following:

- Make a photocopy of the temporary white card to be used, if necessary, for [Good Faith](#) claims processing.
- Wait until enrollment has been verified through the EVS or the Portal and then submit the claim.

Wisconsin Well Woman Medicaid Determination Form

To request paper copies of the Wisconsin Well Woman Medicaid Determination Form, call the Bureau of Health Care Financing at (608) 267-9049 or send a fax to (608) 261-6861. Faxed requests should include a return address, the name of the form, and the number of the form.

The completed Wisconsin Well Woman Medicaid Determination Form must be typed or printed clearly and signed by the Family Planning Only Services physician. The provider should fax the completed form to (608) 261-6861 or send the pink copy of the form (labeled "LOCAL COORDINATING AGENCY COPY") to:

Department of Health Care Access and Accountability
Wisconsin Well Woman Medicaid
Bureau of Health Care Eligibility Rm 365
PO Box 309
Madison WI 53701-0309

The Family Planning Only Services provider should keep the yellow copy of the form (labeled "PROVIDER COPY") as part of the member's record. The woman should keep the blue copy (labeled "APPLICANT COPY") for her records and present the white copy (labeled "ES COPY") to her local county/tribal social or human services department.

Reimbursement

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Archive Date:04/01/2011

Reimbursement:Amounts

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.

Electronic Funds Transfer

EFT 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. Electronic Funds Transfer 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 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 providers during their provisional certification period.

Enrolling in Electronic Funds Transfer

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

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

The following guidelines apply to EFT enrollment:

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

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

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

Recoupment and Reversals

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

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

Problem Resolution

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

Reimbursement

Reimbursement rates for services and supplies under Family Planning Only Services are the same as the [rates for Medicaid family planning services](#).

Reproductive Health Services

The DHCAA 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 twelve months, the reproductive health service is reimbursable by Family Planning Only Services.

Resources

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Archive Date:04/01/2011

Resources:Contact Information

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.

Electronic Data Interchange

Electronic Data Interchange Helpdesk

The [EDI 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

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 enrollment.
- Medicare enrollment.
- Limited benefits categories.
- Any other commercial health insurance coverage.
- Exemption from copayments for BadgerCare Plus members.

Copayment Information

If a member is enrolled in BadgerCare Plus and is exempted from paying copayments 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 and is required to pay copayments, providers 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.

Note: The BadgerCare Plus Core Plan may also charge different copayments for hospital services depending on the member's income level. Members identified as "BadgerCare Plus Core Plan 1" are subject to lower copayments for hospital services. Members identified as "BadgerCare Plus Core Plan 2" are subject to higher copayments for hospital services.

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 copayments (BadgerCare Plus 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.

Entering Dates of Service

Enrollment information is provided based on a "From" DOS and a "To" DOS that the provider enters when making the enrollment inquiry. For enrollment inquiries, 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 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.

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 he or she is 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 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.

Responses Are Based on Financial Payer

When making an enrollment inquiry through Wisconsin's EVS, 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.
- WWWP.

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 the BadgerCare Plus Standard Plan 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 the TB-Only Benefit and Family Planning Only Services at the same time, both of which are administered by Medicaid.)

Portal

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

ForwardHealth has established a page on the ForwardHealth Portal designed to keep providers and trading partners informed of important dates and information related to the implementation of the new HIPAA ASC X12 version 5010 and NCPDP telecommunication standard version D.0. Providers, trading partners, partners, MCOs, and other interested parties are encouraged to check the 5010 page of the Portal often, as ForwardHealth will post new information regularly.

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

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

Cost Share Reports for Long-Term Managed Care Organizations

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

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 his or her PIN is received. The administrative user is responsible for this provider account and is able to add accounts for other users (clerks) within his or her 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 or provider number.
5. Click **Setup Account**.
6. At the Account Setup screen, enter the 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.

A user's guide containing detailed instructions for performing these functions can be found on the Portal.

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

Providers must designate a trading partner to receive their 835 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:

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

Providers who are unable to use the Portal to designate a trading partner to receive 835 transactions may call the [EDI Helpdesk](#) or submit a [paper](#) form.

Electronic Communications

The secure Portal contains a one-way message center where providers can receive electronic notifications and provider publications from ForwardHealth. All new messages display on the provider's main page within the secure Portal.

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.
- 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](#).

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.

Inquiries to ForwardHealth Via the Portal

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

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](#) 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.

Logging in to the Provider Area of the Portal

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

Managed Care Organization Portal

Information and Functions Through the Portal

The [MCO area](#) of the ForwardHealth Portal allows state-contracted MCOs to conduct business with ForwardHealth. The Public MCO page offers easy access to key MCO information and Web tools. A log-in is required to access the secure area of the Portal to submit or retrieve account and member information which may be sensitive.

The following information is available through the Portal:

- Certified Provider Listing of all Medicaid-certified 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 data for long term care MCOs.
- Electronic messages.
- Enrollment verification by entering a member ID or SSN with date of birth and a "from DOS" 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 code, and managed care and Medicare information.
- Provider search function for retrieving provider information such as address, telephone number, provider ID, and taxonomy code (if applicable), and provider type and specialty.
- HealthCheck information.
- MCO contact information.
- Technical contact information. Entries may be added via the Portal.

Managed Care Organization Portal Reports

The following reports are generated to MCOs 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.

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.

Obtaining a Personal Identification Number

To establish an account on the ForwardHealth Portal, providers are required to obtain a PIN. 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 recertification on the Portal. Providers will receive a separate PIN for recertification.

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 certification. A separate PIN will be needed for each provider certification. Health care providers will need to supply their NPI and corresponding taxonomy code when requesting an account. Non-healthcare providers will need to supply their unique

provider number.

Providers may request a PIN by following these steps:

1. Go to the [Portal](#).
2. Click on the "Providers" link or button.
3. Click the "Request Portal Access" link from the Quick Links box on the right side of the screen.
4. At the Request Portal Access screen, enter the following information:
 - a. Health care providers are required to enter their NPI and click "Search" to display a listing of ForwardHealth certifications. Select the correct certification for the account. The taxonomy code, ZIP+4 code, and financial payer for that certification will be automatically populated. Enter the SSN or TIN.
 - 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.
 - WCDP.
 - The WWWP.
- 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.

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.
- Designate which trading partner is eligible to receive the provider's 835.
- 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.
- Track provider-submitted PA requests.

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 greatly assist in daily business activities with ForwardHealth programs.

Maximum Allowable Fee Schedules

Within the Portal, all [fee schedules](#) for Medicaid, BadgerCare Plus, and WCDP are interactive and searchable. Providers can enter the DOS, along with other information such as procedure code, category of supplies, or provider type, to find the maximum allowable fee. Providers can also download all fee schedules.

Online Handbook

The Online Handbook is the single source for all current policy and billing information for ForwardHealth. The Online Handbook is

designed to sort information based on user-entered criteria, such as program and provider type.

Revisions to policy information are incorporated into the Online Handbook in conjunction with published *Updates*. The Online Handbook also links to the [ForwardHealth Publications page](#), an archive section where providers can research previously published *Updates*.

ForwardHealth Publications Archive Section

The [ForwardHealth Publications page](#), available via the Quick Links box, lists *Updates*, *Update Summaries*, archives of provider Handbooks and provider guides, and monthly archives of the Online Handbook. The ForwardHealth Publications page contains both current and obsolete information for research purposes only. Providers should use the Online Handbook for current policy and procedure questions. The *Updates* are searchable by provider type or program (e.g., physician or HealthCheck "Other Services") and by year of publication.

Training

Providers can register for all scheduled trainings and view online trainings via the [Portal Training 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 (i.e., telephone call or e-mail) 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 Certification

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

Other Business Enhancements 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 provider publication summaries and other new 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.
- [E-mail subscription](#) service for *Updates*. Providers can register for e-mail subscription to receive notifications of new provider publications via e-mail. Users are able to select, by program and service area, which publication notifications they would like to receive.
- A [forms library](#).

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 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 have the ability to search for and view the status of all of their finalized claims, regardless of how they were submitted (i.e., paper, electronic, clearinghouse). If a claim contains an error, providers can correct it on the Portal and resubmit it to ForwardHealth.

Providers can submit an individual claim or adjust a claim via DDE through the secure Portal.

Submitting Prior Authorization and Amendment Requests Via the Portal

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

- Correct errors on PAs or amendment requests via the Portal, regardless of how the PA was originally submitted.
- View all recently submitted and finalized PA and amendment requests.
- View the latest provider review and decision letters.
- Receive messages about PA and amendment requests that have been adjudicated or returned for provider review.

Electronic Communications

The secure Portal contains a one-way message center where providers can receive electronic notifications and provider publications from ForwardHealth. All new messages display on the provider's main page within the secure Portal.

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.
- Whether or not the member has any third-party liability, such as Medicare or commercial health insurance.

Using the Portal to check enrollment may be more efficient than calling the AVR system or the EVS (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.
- Designate which trading partner is eligible to receive the provider's 835.
- 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.
- Track provider-submitted PA requests.

System and Browser Requirements

The following table lists the recommended system and browser requirements for using the Portal. PES 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	Microsoft Internet Explorer v. 6.0 or higher, or Firefox v. 1.5 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	Safari, or Firefox v. 1.5 or higher
Mac OS X 10.2.x or higher operating system	

Trading Partner Portal

The following information is available on the public [Trading Partner](#) area of the ForwardHealth Portal:

- Trading partner [testing packets](#).
- [Trading Partner Profile](#) submission.
- [PES](#) software and upgrade information.
- EDI [companion documents](#).

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

WiCall

Entering Letters into WiCall

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

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

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

Information Available Via WiCall

WiCall, ForwardHealth's AVR 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 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 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 program ("financial payer" option, i.e., Wisconsin Medicaid, WCDP, or WWWP by entering their provider ID, member identification number, DOS, 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. 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.

Prior Authorization Status

Except in certain instances, providers may obtain the status of PA requests for Medicaid and WCDP via WiCall by entering their provider ID and the applicable PA number. If the provider does not know the PA number, there is an option to bypass entering the PA number and the caller will be prompted to enter other PA information such as member ID and type of service (i.e., NDC/procedure code, revenue code, or ICD-9-CM diagnosis 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.