Claims

1

Topic #518

Definition of Good Faith Claims

A good faith claim may be submitted when a claim is denied due to a discrepancy between the member's enrollment information in the claims processing system and the member's actual enrollment. If a member presents a temporary identification card for BadgerCare Plus or Family Planning Only Services, the provider should check the member's enrollment via Wisconsin's EVS (Enrollment Verification System) and, if the enrollment is not on file yet, make a photocopy of the member's temporary identification card.

When a member presents a temporary ID card for EE (Express Enrollment) in BadgerCare Plus or Family Planning Only Services but the member's enrollment is not on file yet in the EVS, the provider should check enrollment again in two days or wait one week to submit a claim to ForwardHealth. If, after two days, the EVS indicates that the member still is not enrolled or the claim is denied with an enrollment-related EOB (Explanation of Benefits) code, the provider should contact Provider Services for assistance.

When a member who received a real-time eligibility determination presents a temporary ID card but the member's enrollment is not on file yet in the EVS, the provider should wait up to one week to submit a claim to ForwardHealth. If the claim is denied with an enrollment-related EOB code, the provider should contact Provider Services for assistance.

Responses

Topic #13437

ForwardHealth-Initiated Claim Adjustments

There are times when ForwardHealth must initiate a claim adjustment to address claim issues that do not require provider action and do not affect reimbursement.

Claims that are subject to this type of ForwardHealth-initiated claim adjustment will have EOB (Explanation of Benefits) code 8234 noted on the RA (Remittance Advice).

The adjusted claim will be assigned a new claim number, known as an ICN (internal control number). The new ICN will begin with "58." If the provider adjusts this claim in the future, the new ICN will be required when resubmitting the claim.

Topic #11537

National Correct Coding Initiative

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

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

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

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

Medically Unlikely Detail Edits

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

An example of an MUE would be if procedure code 11100 (i.e., biopsy of skin lesion) was billed with a quantity of two or more. This procedure is medically unlikely to occur more than once; therefore, if it is billed with units greater than one, the detail will be denied.

Procedure-to-Procedure Detail Edits

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

An example of a procedure-to-procedure edit would be if procedure codes 11451 (i.e., removal of a sweat gland lesion) and 93000 (i.e., electrocardiogram) were billed on the same claim for the same DOS. Procedure code 11451 describes a more complex service than procedure code 93000, and therefore, the secondary procedure would be denied.

Quarterly Code List Updates

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 Medicaid website for downloadable code lists.

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

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

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

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

- Complete the Adjustment/Reconsideration Request (F-13046 (08/15)) 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

Topic #934

An Overview

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

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

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

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

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

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

Topic #16937

Electronic Claims and Claim Adjustments with Other Commercial Health Insurance Information

Effective for claims and claim adjustments submitted electronically via the Portal or PES software on and after June 16, 2014, other insurance information must be submitted at the detail level on professional, institutional, and dental claims and adjustments if it was processed at the detail level by the primary insurance. Except for a few instances, Wisconsin Medicaid or BadgerCare Plus is the payer of last resort for any covered services; therefore, providers are required to make a reasonable effort to exhaust all existing other health insurance sources before submitting claims to ForwardHealth or to a state-contracted MCO (managed care organization).

Other insurance information that is submitted at the detail level via the Portal or PES software will be processed at the detail level by ForwardHealth.

Under HIPAA (Health Insurance Portability and Accountability Act of 1996), claims and adjustments submitted using an 837

transaction must include detail-level information for other insurance if they were processed at the detail level by the primary insurance.

Adjustments to Claims Submitted Prior to June 16, 2014

Providers who submit professional, institutional, or dental claim adjustments electronically on and after June 16, 2014, for claims originally submitted prior to June 16, 2014, are required to submit other insurance information at the detail level on the adjustment if it was processed at the detail level by the primary insurance.

Topic #10837

Note Field for Most Claims Submitted Electronically

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

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

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

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

- Professional.
- Institutional.
- Dental.

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

Claims Submitted via 837 Health Care Claim Transactions

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

Topic #583

Oral Contraceptives and Drugs Used to Treat Sexually Transmitted Diseases

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

Topic #561

Paper Claim Form Preparation and Data Alignment Requirements

Optical Character Recognition

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

The data alignment requirements do not apply to the Compound Drug Claim (F-13073 (04/17)) and the Noncompound Drug Claim (F-13072 (04/17)).

Speed and Accuracy of Claims Processing

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

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

Handwritten Claims

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

Use Original Claim Forms

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

Use Laser or Ink Jet Printers

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

Alignment

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

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

The following sample claim forms demonstrate correct and incorrect alignment:

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

Clarity

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

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

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

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

Staples, Correction Liquid, and Correction Tape

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

Additional Diagnosis Codes

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

Sample of a Correctly Aligned 1500 Health Insurance Claim Form

HEALTH INSURANCE CLAIM FORM

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

☐ PICA

PICA ☐☐

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

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

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

3. PATIENT'S BIRTH DATE   SEX
MM DD YY   M ☐   F ☒
MM DD YY

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

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

6. PATIENT RELATIONSHIP TO INSURED
Self ☐ Spouse ☐ Child ☐ Other ☐

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

CITY **ANYTOWN**   STATE **WI**

8. RESERVED FOR NUCC USE

CITY   STATE

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

ZIP CODE   TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous)
☐ YES ☐ NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT?   PLACE (State)
☐ YES ☐ NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT?
☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

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

SIGNED _____   DATE _____

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

SIGNED _____

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

15. OTHER DATE   MM DD YY
QUAL.

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

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

17a.
17b. NPI **0111111110**

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? $ CHARGES
☐ YES ☐ NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)   ICD Ind.
A. **XXX.X**   B. ____   C. ____   D. ____
E. ____   F. ____   G. ____   H. ____
I. ____   J. ____   K. ____   L. ____

22. RESUBMISSION CODE   ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER   SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.
1234JED

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

28. TOTAL CHARGE $ **XXX XX**

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI   b.

33. BILLING PROVIDER INFO & PH # ( )
I.M. PROVIDER
1 W WILLIAMS ST
ANYTOWN WI 55555-1234
a. **0222222220**   b. **ZZ123456789X**

NUCC Instruction Manual available at: www.nucc.org   **PLEASE PRINT OR TYPE**   APPROVED OMB-0938-1197 FORM 1500 (02-12)

Sample of an Incorrectly Aligned 1500 Health Insurance Claim Form

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

□ PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare#) [X] (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#) (ID#)	1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M □ F [X]	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
MEMBER, IM A	MM DD YY	SAME

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
609 WILLOW ST	Self □ Spouse □ Child □ Other □	

CITY ANYTOWN	STATE WI	8. RESERVED FOR NUCC USE	CITY	STATE

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

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) □ YES □ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M □ F □
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State) □ YES □ NO	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? □ YES □ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? □ YES □ NO If yes, complete items 9, 9a, and 9d.

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

SIGNED_____ DATE_____

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

SIGNED_____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE MM DD YY QUAL.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE I.M. REFERRING PROVIDER	17a. 17b. NPI 0111111110	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? □ YES □ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.	22. RESUBMISSION CODE ORIGINAL REF. NO.
A. XXX.X B. C. D. E. F. G. H. I. J. K. L.	23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER □ SSN □ EIN	26. PATIENT'S ACCOUNT NO. 1234JED	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) □ YES □ NO	28. TOTAL CHARGE $ XXX XX	29. AMOUNT PAID $	30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) I.M. Provider MMDDCCYY SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.	33. BILLING PROVIDER INFO & PH # ( ) I.M. PROVIDER 1 W WILLIAMS ST ANYTOWN WI 55555-1234 0222222220 ZZ123456789X

NUCC Instruction Manual available at: www.nucc.org   PLEASE PRINT OR TYPE   APPROVED OMB-0938-1197 FORM 1500 (02-12)

Sample of a Correctly Aligned UB-04 Claim Form

1 IM BILLING PROVIDER	2		3a PAT. CNTL #		4 TYPE OF BILL
444 E CLAIREMONT			b. MED. REC. # 11 7654321		XXX
ANYTOWN WI 55555-1234			5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7
(444) 444-4444			01-2345678	MMDDCCYY MMDDCCYY	

8 PATIENT NAME	a		9 PATIENT ADDRESS	a ON FILE					
b MEMBER, IM A						c	d		e

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR 14 TYPE 15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22 23 24 25	26	27	28	29 ACDT STATE	30
			X	X	XX										

31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 CODE	OCCURRENCE SPAN FROM THROUGH	36 CODE	OCCURRENCE SPAN FROM THROUGH	37

38		39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
		a					
		b					
		c					
		d					

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

PAGE 1 OF 1   CREATION DATE   **TOTALS** →   XXX XX

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 0111111110
T19 MEDICAID						57 OTHER PRV ID

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

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX XXXX	A B C D E F G H	67
	I J K L M N O P Q	

69 ADMIT DX	70 PATIENT REASON DX a b c	71 PPS CODE	72 ECI a b c	73

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75	76 ATTENDING NPI 0222222220 QUAL
				LAST FIRST
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE		77 OPERATING NPI QUAL
				LAST FIRST

80 REMARKS	81CC a B3 123456789X	78 OTHER NPI QUAL
	b	LAST FIRST
	c	79 OTHER NPI QUAL
	d	LAST FIRST

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

Sample of an Incorrectly Aligned UB-04 Claim Form

Topic #4382

Provider-Administered Drugs

Deficit Reduction Act of 2005

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

ForwardHealth requires that NDCs be indicated on claims for all 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.

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 ForwardHealth members for LTE (less-than-effective) drugs as identified by CMS (Centers for Medicare and Medicaid Services) or identical, related, or similar drugs.

Claim Submission

Institutional Claims

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

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

Professional Claims

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

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

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

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

POS Code	Description
06	Indian Health Services Provider-Based Facility
08	Tribal 638 Provider-Based Facility

21	Inpatient Hospital
22	On Campus — Outpatient Hospital
23	Emergency Room — Hospital
51	Inpatient Psychiatric Facility
61	Comprehensive Inpatient Rehabilitation Facility
65	ESRD Treatment Facility

Medicare Crossover Claims

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

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

340B Providers

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

Explanation of Benefits Codes on Claims for Provider-Administered Drugs

Providers will receive an EOB (Explanation of Benefits) 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 (date of service) within seven days of the clinic's DOS, then the pharmacy's claim will be denied as a duplicate claim.

Reconsideration of the denied drug claim may occur if the claim was denied with an EOB code and the drug therapy was due to the treatment for an acute condition. To submit a claim that was originally denied as a duplicate, pharmacies should complete and submit the Noncompound Drug Claim (F-13072 (04/17)) form along with the Pharmacy Special Handling Request (F-13074 (07/12)) form indicating the EOB code and requesting an override.

Provider-Administered Drugs Carve-Out Code Sets

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

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

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

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

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

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

Provider-administered drugs and related services for members enrolled in the PACE (Program for All-Inclusive Care for the Elderly) 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 (total parenteral nutrition)) should continue to be reimbursed by the member's MCO. Providers should work with the member's MCO in these situations.

Additional Information

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

- CMS (Centers for Medicare and Medicaid Services) DRA information page
- NUBC (National Uniform Billing Committee)
- NUCC (National Uniform Claim Committee)

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

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

Topic #10237

Claims for Provider-Administered Drugs

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

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

- The PES (Provider Electronic Solutions) software

1500 Health Insurance Claim Form

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

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

Providers should indicate the appropriate NDC of the drug that was dispensed that corresponds to the HCPCS procedure code on claims for 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 (Electronic Data Interchange) Helpdesk.

Topic #10637

Reimbursement Reduction for Most Paper Claims

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

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

If a paid claim's total reimbursement amount is less than $1.10, ForwardHealth will reduce the payment up to a $1.10. The claim

will show on the RA (Remittance Advice) as paid but with a $0 paid amount.

The reimbursement reduction applies to the following paper claims:

- 1500 Health Insurance Claim Form ((02/12)).
- UB-04 (CMS 1450) Claim Form.
- Compound Drug Claim (F-13073 (04/17)) form.
- Noncompound Drug Claim (F-13072 (04/17)) 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 an Acknowledgment of Receipt of Hysterectomy Information (F-01160 (06/13)) form.
  - Sterilization claims must be submitted along with a paper Consent for Sterilization (F-01164 (10/08)) form.
  - Claims submitted to Timely Filing appeals must be submitted on paper with a Timely Filing Appeals Request (F-13047 (08/15)) form.
  - In certain circumstances, drug claims must be submitted on paper with a Pharmacy Special Handling Request (F-13074 (07/12)) form.
  - Claims submitted with four or more NDCs (National Drug Codes) for compound and noncompound drugs with specific and non-specific HCPCS (Healthcare Common Procedure Coding System) procedure codes.

Coordination of Benefits

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Archive Date:04/02/2018

Coordination of Benefits:Commercial Health Insurance

Topic #18497

Explanation of Medical Benefits Form Requirement

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

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

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

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

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

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

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

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

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

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

Topic #1249

Other Health Insurance Sources

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

Covered and Noncovered Services

3

Covered and Noncovered Services:Codes

Topic #1929

Diagnosis Codes

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

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

Z30.45	Encounter for surveillance of transdermal patch hormonal contraceptive device
Z30.46	Encounter for surveillance of implantable subdermal contraceptive
Z30.49	Encounter for surveillance of other contraceptives
Z30.8	Encounter for other contraceptive management
Z30.9	Encounter for contraceptive management, unspecified

Topic #15077

Modifier

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

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

Topic #1943

National Drug Codes

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

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

The NDC is divided into the following segments:

- The first segment, a five-digit labeler code that identifies any firm that manufactures, repacks, or distributes the drug. (Repackaged drugs are not 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 (Healthcare Common Procedure Coding System) crosswalk for a crosswalk of J codes and NDCs to HCPCS and select CPT (Current Procedural Terminology) procedure codes and the ASP (Average Sales Price) Drug Pricing Files.

New National Drug Codes

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

Obsolete National Drug Codes

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

Topic #18677

Procedure Codes Covered Under Family Planning Only Services for Men

Information is available for DOS (dates of service) before January 1, 2018.

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

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

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

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

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

Office Visits for Males		
Procedure Code	Description	Requires Allowable Contraceptive Management Code as Primary Diagnosis Code
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making	Yes
	Office or other outpatient visit for the evaluation and management	

99202	of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making	Yes
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity	Yes
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity	Yes
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional	Yes
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making	Yes
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity	Yes
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity	Yes

Procedures and Supplies for Males		
Procedure Code	Description	Requires Allowable Contraceptive Management Code as Primary Diagnosis Code
A4267	Contraceptive supply, condom, male, each	Yes
J0561	Injection, penicillin G benzathine, 100,000 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 lesions	Yes
17111	15 or more lesions	Yes
55250*	Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)	No
90649	Human papillomavirus vaccine, types 6, 11, 16, 18, quadrivalent (4vHPV), 3 dose schedule, for intramuscular use	No
90650	Human papillomavirus vaccine, types 16, 18, bivalent (2vHPV), 3 dose schedule, for intramuscular use	No
90651	Human papillomavirus vaccine, types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 2 or 3 dose schedule, for intramuscular use	No
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Yes
99070	Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	Yes
Laboratory Services		
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	HTLV or HIV antibody, confirmatory test (eg, Western blot)	Yes
86701	HIV-1	Yes
86703	HIV-1 and HIV-2, single result	Yes
86780	Treponema pallidum	Yes
87205	Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types	Yes
87206	flourescent 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
87806	HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies	Yes
99000	Handling and/or conveyance of specimen for transfer from the office to a laboratory	Yes
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 (F-01164 (10/08)) 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 (Tuberculosis)-Related Services-Only Benefit. In this instance, providers should use the Family Planning Only Services Online Handbook in conjunction with the TB-Related Services-Only Online Handbook. (Wisconsin's EVS (Enrollment Verification System) will indicate that these members are eligible for both limited benefit categories.)

Topic #2624

Procedure Codes Covered Under Family Planning Only Services for Women

Information is available for [DOS (dates of service) before January 1, 2018](#).

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

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

Procedure Codes

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

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

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

Office Visits for Females		
Procedure Code	**Description**	**Requires Allowable Contraceptive Management Code as Primary Diagnosis Code**
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making	Yes
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making	Yes
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity	Yes
	Office or other outpatient visit for the evaluation and management	

99204	of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity	Yes
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity	Yes
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional	Yes
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making	Yes
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity	Yes
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity	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 laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)	Yes
99385	18-39 years	Yes
99386	40-64 years	Yes
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures established patient; adolescent (age 12 through 17 years)	Yes

99395	18-39 years	Yes
99396	40-64 years	Yes
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes	Yes
99402	approximately 30 minutes	Yes
99403	approximately 45 minutes	Yes
99404	approximately 60 minutes	Yes
Q3014	Telehealth originating site facility fee	No
S9445	Patient education, not otherwise classified, non-physician provider, individual, per session	Yes

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

Procedures and Supplies for Females		
Procedure Code	**Description**	**Requires Allowable Contraceptive Management Code as Primary Diagnosis Code**
A4261	Cervical cap for contraceptive use	Yes
A4264	Permanent implantable contraceptive intratubal occlusion device(s) and delivery system	Yes
A4266	Diaphragm for contraceptive use	Yes
A4267	Contraceptive supply, condom, male, each	Yes
A4268	Contraceptive supply, condom, female, each	Yes
A4269	Contraceptive supply, spermicide (e.g., foam, gel), each	Yes
G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	Yes
J0561	Injection, penicillin G benzathine, 100,000 units	No
J0696	Injection, ceftriaxone sodium [Rocephin], per 250 mg	No
J7296	Levonorgestrel-releasing intrauterine contraceptive system, (Kyleena), 19.5 mg	Yes
J7297	Levonorgestrel-releasing intrauterine contraceptive system (Liletta), 52mg	Yes

J7298	Levonorgestrel-releasing intrauterine contraceptive system (Mirena), 52mg	Yes
J7300	Intrauterine copper contraceptive	Yes
J7303	Contraceptive supply, hormone containing vaginal ring, each	Yes
J7304	Contraceptive supply, hormone containing patch, each	Yes
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies	Yes
S4993	Contraceptive pills for birth control	Yes
11976	Removal, implantable contraceptive capsules	Yes
11981	Insertion, non-biodegradable drug delivery implant	Yes
11982	Removal, non-biodegradable drug delivery implant	Yes
11983	Removal with reinsertion, non-biodegradable drug delivery implant	Yes
17110	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions	No
17111	15 or more lesions	No
46900	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical	No
46924	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)	No
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[*]	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants (The professional service only is reimbursed under CPT (Current	Yes

	Procedural Terminology) procedure code 58565. The implantable device is reimbursed under HCPCS procedure code A4264.)	
58600*	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	Yes
58611*	Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)	Yes
58615*	Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring) vaginal or suprapubic approach	Yes
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salphingectomy)	Yes
58670*	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)	Yes
58671*	with occlusion of oviducts by device (e.g. band, clip or Falope ring)	Yes
71045	Radiological examination, chest; single view	Yes
71046	Radiological examination, chest; 2 views	Yes
74740	Hysterosalpingography, radiological supervision and interpretation	Yes
90649	Human papillomavirus vaccine, types 6, 11, 16, 18, quadrivalent (4vHPV), 3 dose schedule, for intramuscular use	No
90650	Human papillomavirus vaccine, types 16, 18, bivalent (2vHPV), 3 dose schedule, for intramuscular use	No
90651	Human papillomavirus vaccine, types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 2 or 3 dose schedule, for intramuscular use	No
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Yes
99070	Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	Yes
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 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
84146	Prolactin	Yes
84443	Thyroid stimulating hormone (TSH)	Yes
84450	Transferase; aspartate amino (AST) (SGOT)	Yes
84702	Gonadotropin, chorionic (hCG); quantitative	Yes
84703	qualitative	Yes
85007	Blood count; blood smear, microscopic examination with manual differential WBC count	Yes
85009	manual differential WBC count, buffy coat	Yes
85013	spun microhematocrit	Yes
85014	hematocrit (Hct)	Yes
85018	hemoglobin (Hbg)	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	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 result	Yes
86780	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 each isolate, urine	Yes
87101	Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; skin, hair, or nail	Yes
87109	Culture, mycoplasma, any source	Yes
87110	Culture, chlamydia, any source	Yes
87205	Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types	Yes
87206	fluorescent and/or acid fast stain for bacteria, fungi, parasites, viruses or cell types	Yes
87207	special stain for inclusion bodies or parasites (eg, malaria, coccidia, microsporidia, trypanosomes, herpes viruses)	Yes
87210	wet mount for infectious agents (eg, saline, India ink, KOH preps)	Yes
87252	Virus isolation; tissue culture inoculation, observation, and presumptive identification by cytopathic effect	Yes
87254	centrifuge enhanced (shell vial) technique, includes identification with immunofluorescence stain, each virus	Yes
87270	Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis	Yes
87274	Herpes simplex virus type 1	Yes
87320	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; Chlamydia trachomatis	Yes
87340	hepatitis B surface antigen (HBsAg)	Yes
87390	HIV-1	Yes
87391	HIV-2	Yes
87449	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]), qualitative or semiquantitative; multiple-step method, not otherwise specified,	Yes

	each organism	
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, reverse transcription and amplified probe technique	Yes
87536	HIV-1, reverse transcription and quantification	Yes
87537	HIV-2, direct probe technique	Yes
87538	HIV-2, reverse transcription and amplified probe technique	Yes
87539	HIV-2, reverse transcription and quantification	Yes
87591	Neisseria gonorrhoeae, amplified probe technique	Yes
87623	Human Papillomavirus (HPV), low-risk types (eg, 6, 11, 42, 43, 44)	Yes
87624	Human Papillomavirus (HPV), high-risk types (eg, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68)	Yes
87625	Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed	Yes
87797	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; direct probe technique, each organism	Yes
87798	amplified probe technique, each organism	Yes
87799	quantification, each organism	Yes
87806	HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies	Yes

87808	Infectious agent antigen detection by immunoassay with direct optical observation; Trichomonas vaginalis	Yes
88141	Cytopathology, cervical or vaginal (any reporting system); requiring 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 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	Yes

	hysterosalpingography		

* This service requires completion of the [Consent for Sterilization (F-01164 (10/08))](#) 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 (Tuberculosis)-Related Services-Only Benefit. In this instance, providers should use the Family Planning Only Services Online Handbook in conjunction with the [TB-Related Services-Only Online Handbook](#). (Wisconsin's EVS (Enrollment Verification System) will indicate that these members are eligible for both limited benefit categories.)

Topic #643

Unlisted Procedure Codes

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

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

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

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

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

For most unlisted codes, ForwardHealth requires additional documentation.

Unlisted Codes That Require Prior Authorization

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

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

Topic #830

Valid Codes Required on Claims

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

Code Validity

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

Code Specificity for Diagnosis

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

Covered Services and Requirements

Topic #2554

An Overview

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

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

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

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

Topic #2366

Colposcopies

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

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

Topic #2369

Contraceptive Patch

Contraceptive patches are covered for family planning clinics for services provided to members enrolled in BadgerCare Plus and Medicaid. Providers should submit claims for this item on a Noncompound Drug Claim (F-13072 (04/17)) form using an NDC (National Drug Code) or on the 1500 Health Insurance Claim Form ((02/12)) using HCPCS (Healthcare Common Procedure Coding System) procedure code J7304.

Topic #44

Definition of Covered Services

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

Topic #3409

Drugs

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

The following drugs are covered by Family Planning Only Services.

Drug Name and Strength	Dosage
Acyclovir 200 mg (Zovirax)	Capsule
Acyclovir 400 mg	Tablet
Acyclovir 800 mg	Tablet
Acyclovir 200 mg/5 ml	Suspension
Aldara 5%	Cream
Alesse-28	Tablet
Antifungal 2%	Cream
Apri 28 day	Tablet
Aranelle 28	Tablet
Aviane-28	Tablet
Azithromycin 250 mg (Zithromax)	Tablet, Z-pak tablet
Azithromycin 500 mg	Tablet
Azithromycin 600 mg	Tablet
Baza antifungal 2%	Cream
Brevicon 28	Tablet
Camila	Tablet
Carrington antifungal 2%	Cream
Cesia 28 day	Tablet
Clindagel 1%	Gel
Clindamax 1%	Gel, lotion

Clindamax 2%	Vaginal cream
Clindamycin 1% (Clindets)	Pledgets
Clindamycin 2% (Cleocin)	Vaginal cream
Clindamycin phosphate 1% (Cleocin T)	Gel, lotion, pledgets, solution, topical lotion
Ceftriaxone 250 mg (Rocephin)	Vial
Ceftriaxone 500 mg	Vial
Ceftriaxone 1 gm	Vial
Ceftriaxone 2 gm	Vial
Ceftriaxone 10 gm	Vial
Ciprofloxacin HCL 250 mg (Cipro)	Tablet
Ciprofloxacin HCL 500 mg	Tablet
Ciprofloxacin HCL 750 mg	Tablet
Ciprofloxacin HCL 100 mg	Tablet
Ciprofloxacin 5%	Suspension
Ciprofloxacin 10%	Suspension
Clotrim 1% (Lotrimin)	Vaginal cream
Clotrimazole antifungal 1%	Cream
Clotrimazole 3 day	Cream, insert
Clotrimazole-7	Insert
Contraceptive Supply, hormone containing patch	Patch
Cruex 1%	Cream
Cryselle-28	Tablet
Cyclessa 28 day	Tablet
Demulen 1/35-21	Tablet
Demulen 1/35-28	Tablet
Demulen 1/50-21	Tablet
Demulen 1/50-28	Tablet
Depo-Provera 400 mg/ml	Vial
Depo-subq provera 104	Syringe
Desenex 1%	Cream
Desenex 2%	Spray powder

Desogen 28 day	Tablet
Doxycycline 50 mg (Vibramycin)	Capsule
Doxycycline 100 mg	Capsule, tablet, vial
Doxycycline monohydrate 50 mg (Monodox)	Capsule
Doxycycline monohydrate 100 mg	Capsule
Enpresse-28	Tablet
Errin	Tablet
Eryped 200 mg (E.E.S.)	Suspension
Eryped 100 mg/2.5 ml	Drops
Eryped 400 mg/5 ml	Granules, suspension
Erythromycin 250 mg (Eryc)	Capsule EC
Erythromycin 250 mg	Filmtab
Erythromycin 200 mg/5 ml	Suspension
Erythromycin 400 mg/5 ml	Suspension
Erythromycin ES 400 mg	Tablet
Erythromycin EST 125 mg/5 ml	Suspension
Erythromycin EST 250 mg/5 ml	Suspension
Erythromycin ST 250 mg	Tablet
Erythromycin ST 500 mg	Tablet
E.E.S. 400 mg	Filmtab
E.E.S. 200 mg/5 ml	Granules, oral suspension
Erythrocin 250 mg	Filmtab
Erythrocin 500 mg	Filmtab
Ery-tab 250 mg	Tablet EC
Ery-tab 333 mg	Tablet EC
Ery-tab 500 mg	Tablet EC
Estrostep FE-28	Tablet
Famvir 125 mg	Tablet
Famvir 250 mg	Tablet
Famvir 500 mg	Tablet
Femcare	Insert

Flagyl ER 750 mg	Tablet SA
Fluconazole 50 mg (Diflucan)	Tablet
Fluconazole 100 mg	Tablet
Fluconazole 150 mg	Tablet
Fluconazole 200 mg	Tablet
Fluconazole 10 mg/ml	Suspension
Fluconazole 40 mg/ml	Suspension
Gyne-lotrimin 1%	Cream
Gyne-lotrimin	Insert
Gynazole-1	Cream
Gynol II	Jelly
Gynol II 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-novum 1/35 28	Tablet
Ortho-novum 1/50-28	Tablet
Ortho-novum 7/7/7-28	Tablet
Ortho-novum 10/11-28	Tablet
Ortho tri-cyclen lo	Tablet
Ortho tri-cyclen 28	Tablet
Ovcon-35 21	Tablet

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

Trinessa	Tablet
Tri-previfem	Tablet
Tri-sprintec	Tablet
Triple care antifungal	Cream
Valtrex 500 mg	Tablet
Valtrex 1 gm	Caplet
Velivet 28 day	Tablet
Yasmin 28	Tablet
Yaz 28	Tablet
Zithromax 1 gm	Powder packet
Zithromax 100 mg/5 ml	Suspension
Zithromax 200 mg/5 ml	Suspension
Zovia 1/35-21	Tablet
Zovia 1/35-28	Tablet
Zovia 1/50-21	Tablet
Zovia 1/50-28	Tablet
Zovirax	Ointment

Topic #4359

Implanon

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

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

Topic #10757

Non-emergency Transportation Services

NEMT (non-emergency medical transportation) services are covered for members receiving Family Planning Only Services and are limited to trips to receive covered family planning services. NEMT services are provided to Family Planning Only members by MTM, Inc. (Medical Transportation Management, Inc.) Refer to the NEMT Online Handbook for complete policies and procedures for NEMT services. Providers may be asked to verify that the member received covered services at their site on a

particular date.

Topic #5697

Provider-Administered Drugs

A provider-administered drug is either an oral, injectible, intravenous, or inhaled drug administered by a physician or a designee of the physician (e.g., nurse, nurse practitioner, physician assistant).

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

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

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

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

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

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

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

Provider-administered drugs and related services for members enrolled in the PACE (Program of All-Inclusive Care for the Elderly) 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. Prescribers may obtain a provider-administered drug from a pharmacy provider if the drug is delivered directly from the pharmacy to the prescriber's office. Prescribers may also obtain a drug to be administered in the prescriber's office from a drug wholesaler or direct purchase. Pharmacy providers should not dispense a drug to a member if the drug will be administered in the prescriber's office.

Topic #8697

Sterilizations

Sterilizations are covered by Family Planning Only Services, provided the [Consent for Sterilization (F-01164 (10/08))](#) form is properly completed.

Topic #2536

Wisconsin Medicaid

Tubal Ligations

The following types of tubal ligations are covered by Family Planning Only Services, provided the Consent for Sterilization (F-01164 (10/08)) 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

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Noncovered Services

Topic #4358

Noncovered Services

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

Managed Care

4

Topic #16197

Care4Kids Program Benefit Package

Covered Services

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

Noncovered Services

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

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

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

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

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

Managed Care Information

Topic #16177

Care4Kids Program Overview

Care4Kids is a health care program for children and youth in out-of-home care in Wisconsin. The Care4Kids program will offer comprehensive, coordinated services that are intended to improve the quality and timeliness of and access to health services for these children.

The Care4Kids program will serve children in out-of-home care placements (other than residential care centers) in Kenosha, Milwaukee, Ozaukee, Racine, Washington, and Waukesha counties. Member participation will be voluntary and enrollment will be allowed to continue for up to 12 months after the child leaves the out-of-home care system, as long as the child remains Medicaid-eligible and resides within one of the six counties.

Care4Kids is required to provide at least the same benefits as those provided under fee-for-service arrangements.

Program Administration

Children's Hospital of Wisconsin is currently the only integrated health system certified by ForwardHealth to administer the Care4Kids program. Children's Hospital of Wisconsin will be responsible for providing or arranging for the provision of all services covered under Medicaid, with a small number of exceptions. The services not included in the Care4Kids program will be reimbursed as fee-for-service benefits. Children's Hospital of Wisconsin's integrated network of health care providers, which includes specialty and primary care physicians and clinics within the Children's Hospital System as well as providers who are participating in CCHP (Children's Community Health Plan), is intended to provide coordinated care and services to meet the individualized needs of each of the children enrolled across multiple disciplines, including physical, behavioral health, and dental care.

Care4Kids will be responsible for providing or arranging for the provision of all medically necessary services covered by Wisconsin Medicaid to enrollees. Providers are required to be part of the CCHP network to get reimbursed by Care4Kids. Providers interested in being a part of the network should contact CCHP. Out-of-network providers are required to call Care4Kids prior to providing services to a Care4Kids enrollee. In situations where emergency medical services are needed, out-of-network providers are required to contact Care4Kids within 24 hours of providing services.

Member Enrollment Verification

Providers should verify a member's enrollment before providing services to determine if the member is enrolled in Care4Kids. Members enrolled in Care4Kids will present a ForwardHealth member identification card.

Providers verifying enrollment on the ForwardHealth Portal will see Care4Kids under the MC Program heading in the Managed Care Enrollment panel.

For 271 response transactions, Care4Kids enrollment will be identified in the EB segment of the 2110C loop. Identified by "MC" in the EB01, "HM" in the EB04, and "Care4Kids" in the EB05. The MC provider contact information will be reported in the NM1 (name info), N3 (address info), and PER (telephone numbers) segments within the 2120C loop.

The WiCall AVR (automated voice response) system will identify Care4Kids as the state-contracted managed care program in which the member is enrolled.

Contact Information

Providers can contact CCHP at (800) 482-8010 for the following:

- To become part of the CCHP network.
- For coverage policy and procedure information, including PA (prior authorization) and claim submission guidelines, if they are already a Care4Kids network provider.

Member Information

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Topic #16677

BadgerCare Plus Benefit Plan Changes

Effective April 1, 2014, all members eligible for BadgerCare Plus were enrolled in the BadgerCare Plus Standard Plan. As a result of this change, the following benefit plans were discontinued:

- BadgerCare Plus Benchmark Plan.
- BadgerCare Plus Core Plan.
- BadgerCare Plus Basic Plan.

Members who are enrolled in the Benchmark Plan or the Core Plan who met new income limits for BadgerCare Plus eligibility were automatically transitioned into the BadgerCare Plus Standard Plan on April 1, 2014. In addition, the last day of BadgerRx Gold program coverage for all existing members was March 31, 2014.

Providers should refer to the March 2014 Online Handbook archive of the appropriate service area for policy information pertaining to these discontinued benefit plans.

Topic #226

Family Planning Only Services

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

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

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

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

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

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

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

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

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

Topic #3413

Fee-for-Service

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

Topic #18777

Real-Time Eligibility Determinations

ForwardHealth may complete real-time eligibility determinations for BadgerCare Plus and/or Family Planning Only Services applicants who meet pre-screening criteria and whose reported information can be verified in real time while applying in ACCESS Apply for Benefits. Once an applicant is determined eligible through the real-time eligibility process, he or she is considered eligible for BadgerCare Plus and/or Family Planning Only Services and will be enrolled for 12 months, unless changes affecting eligibility occur before the 12-month period ends.

A member determined eligible through the real-time eligibility process will receive a temporary ID (identification) card for BadgerCare Plus and/or Family Planning Only Services. Each member will get his or her own card, and each card will include the member's ForwardHealth ID number. The temporary ID card will be valid for the dates listed on the card and will allow the member to get immediate health care or pharmacy services.

Eligibility Verification

When a member is determined eligible for BadgerCare Plus and/or Family Planning Only Services through the real-time eligibility process, providers are able to see the member's eligibility information in Wisconsin's EVS (Enrollment Verification System) in real time. Providers should always verify eligibility through EVS prior to providing services.

On rare occasions, it may take up to 48 hours for eligibility information to be available through interChange. In such instances, if a member presents a valid temporary ID card, **the provider is still required to provide services**, even if eligibility cannot be verified through EVS.

Sample Temporary Identification Card
for Badger Care Plus

To the Provider

The individual listed on this card has been enrolled in BadgerCare Plus. This card entitles the listed individual to receive health care services, including pharmacy services, through BadgerCare Plus from any Medicaid-enrolled provider. For additional information, call Provider Services at 800-947-9627 or refer to the ForwardHealth Online Handbook at *www.forwardhealth.wi.gov*.

NOTE:

It is important to provide services when this card is presented. Providers who render services based on the enrollment dates on this card will receive payment for those services, as long as other reimbursement requirements are met. All policies regarding covered services apply for this individual, including the prohibition against billing members. If "Pending Assignment" is indicated after the name on this card, the member identification (ID) number will be assigned within one business day; the card is still valid. Refer to the ForwardHealth Online Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card.

WISCONSIN DEPARTMENT OF HEALTH SERVICES

TEMPORARY IDENTIFICATION CARD FOR BADGERCARE PLUS

Name:	Program	ID Number
IM A MEMBER	BadgerCare Plus	0987654321
DOB: 09/01/1984		

This card is valid from October 01, 2016 to November 30, 2016.

This individual's eligibility should be available through the ForwardHealth Portal. Eligibility should always be verified through the ForwardHealth Portal prior to services being provided.

SAMPLE

Sample Temporary Identification Card
for Family Planning Only Services

To the Provider

The individual listed on this card has been enrolled in Family Planning Only Services. This card entitles the listed individual to receive health care services, including pharmacy services, through Family Planning Only Services from any Medicaid-enrolled provider. For additional information, call Provider Services at 800-947-9627 or refer to the ForwardHealth Online Handbook at www.forwardhealth.wi.gov.

NOTE:

It is important to provide services when this card is presented. Providers who render services based on the enrollment dates on this card will receive payment for those services, as long as other reimbursement requirements are met. All policies regarding covered services apply for this individual, including the prohibition against billing members. If "Pending Assignment" is indicated after the name on this card, the member identification (ID) number will be assigned within one business day; the card is still valid. Refer to the ForwardHealth Online Handbook for further information regarding this temporary ID card. Providers are encouraged to keep a photocopy of this card.

WISCONSIN DEPARTMENT OF HEALTH SERVICES

TEMPORARY IDENTIFICATION CARD FOR FAMILY PLANNING ONLY SERVICES

SAMPLE

Name:	Program	ID Number
IM A MEMBER	Family Planning Only	0987654321
DOB: 09/01/1984	Services	

This card is valid from October 01, 2016 to November 30, 2016.

This individual's eligibility should be available through the ForwardHealth Portal. Eligibility should always be verified through the ForwardHealth Portal prior to services being provided.

Member Enrollment

Topic #2625

Annual Enrollment Review

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

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

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

Annual Review Notices

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

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

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

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

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

Topic #2626

Coordination with the Wisconsin Well Woman Program - Breast Cancer Diagnosis

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 (Wisconsin Well Woman Program) for enrollment and breast cancer diagnostic services. This usually happens after a clinical breast exam performed by the Family Planning Only Services provider indicates need for diagnostic follow up. The 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.

Topic #2628

Eligibility Process for Wisconsin Well Woman Medicaid

The eligibility process for Well Woman Medicaid varies based on whether the member needs treatment for cervical conditions or breast cancer. The eligibility process varies because Family Planning Only Services covers some diagnostic tests related to cervical cancer (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 Application and Renewal form (F-10075 (01/2018)) 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 (Wisconsin Well Woman Program), 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 WWWP Web site for WWWP 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.

Topic #2629

Enrollment

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

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

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

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

Application and Enrollment

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

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

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

- By telephone: (800) 291-2002.
- On the paper BadgerCare Plus Application/Review Packet (BadgerCare Plus Application/Review Packet, F-10182 (11/13)).

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

Members who apply for both BadgerCare Plus and Family Planning Only Services will be required to give information about other insurance they may have. However, 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 for Adults with No Dependent Children

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

Topic #2627

Enrollment Criteria for Wisconsin Well Woman Medicaid

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

Enrollment requirements for Well Woman Medicaid may accommodate Family Planning Only Services members who are

diagnosed with cervical cancer, precancerous conditions of the cervix, or breast cancer. Treatment for cancer is not covered under Family Planning Only Services. Therefore, female Family Planning Only Services members who are diagnosed with cervical cancer, precancerous conditions of the cervix, or breast cancer may enroll in Well Woman Medicaid to receive treatment for these conditions. Providers should assist eligible members with the enrollment process for Well Woman Medicaid.

Criteria for Eligibility

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

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

Topic #2630

Faxing Temporary Enrollment Applications

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

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

Topic #2631

Income Limits

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

Topic #2637

Overview of Enrollment Process for Wisconsin Well 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.	→	The woman meets all of the following criteria: • She receives a colposcopy and biopsy (or other appropriate diagnostic test) through Family Planning Only Services. • She is diagnosed with cervical cancer or a precancerous condition of the cervix. • She needs treatment for the cancer or precancerous condition. • She does not have commercial health insurance coverage or Medicare to cover the treatment.	→	The woman is eligible, upon completion of the enrollment process, for Wisconsin Well 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.	→	The woman - who is at least 35 years of age - meets all of the following criteria: • She disenrolls from Family Planning Only Services, enrolls in the WWWP (Wisconsin Well Woman Program), and receives diagnostic tests through the WWWP. • She is diagnosed with breast cancer. • She needs treatment for the cancer. • She does not have commercial health insurance coverage or Medicare to cover the treatment.	→	The woman is eligible, upon completion of the enrollment process, for Wisconsin Well Women Medicaid.
		OR		
	→	The woman meets all of the following criteria: • She receives diagnostic tests through her commercial health insurance. • She is diagnosed with breast cancer. • She needs treatment for the cancer. • She does not have commercial health insurance coverage or Medicare to cover the treatment.	→	

	OR		
→	The woman meets all of the following criteria: • She receives diagnostic tests at her own expense. • She is diagnosed with breast cancer. • She needs treatment for the cancer. • She does not have commercial health insurance coverage or Medicare to cover the treatment.	→	

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

Topic #2636

Wisconsin Well Woman Medicaid Application and Renewal Form

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

Provider Enrollment and Ongoing Responsibilities

6

Topic #6277

1099 Miscellaneous Forms

ForwardHealth generates the 1099 Miscellaneous form in January of each year for earnings greater than $600.00, per IRS (Internal Revenue Service) regulations. One 1099 Miscellaneous form per financial payer and per tax identification number is generated, regardless of how many provider IDs or NPIs (National Provider Identifier) share the same tax identification number. For example, a provider who conducts business with both Medicaid and WCDP (Wisconsin Chronic Disease Program) will receive separate 1099 Miscellaneous forms for each program.

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

Topic #16157

Policy Requirements for Use of Electronic Signatures on Electronic Health Records

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

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

Electronic Signature Definition

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

Some examples include:

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

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

Benefits of Using Electronic Signatures

The use of electronic signatures will allow providers to:

- Save time by streamlining the document signing process.

- Reduce the costs of postage and mailing materials.
- Maintain the integrity of the data submitted.
- Increase security to aid in non-repudiation.

Electronic Signature Requirements

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

General Requirements

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

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

Electronic Health Record Signature Requirements

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

- The certification and standard criteria defined in the Health Information Technology Initial Set of Standards, Implementation Specifications, Certification Criteria for Electronic Health Record Technology Final Rule (45 CFR Part 170) and any revisions including, but not limited to, the following:
  - Assign a unique name and/or number for identifying, tracking user identity, and establishing controls that permit only authorized users to access electronic health information.
  - Record actions related to electronic health information according to the standard set forth in 45 CFR s. 170.210.
  - Enable a user to generate an audit log for a specific time period. The audit log must also have the ability to sort entries according to any of the elements specified in the standard 45 CFR s. 170.210.
  - Verify that a person or entity seeking access to electronic health information is the one claimed and is authorized to access such information.
  - Record the date, time, patient identification, and user identification when electronic health information is created, modified, accessed, or deleted. An indication of which action(s) occurred and by whom must also be recorded.
  - Use a hashing algorithm with a security strength equal to or greater than SHA-1 (Secure Hash Algorithm 1) as specified by the NIST (National Institute of Standards and Technology) in FIPS PUB 180-3 (October 2008) to verify that electronic health information has not been altered. (Providers unsure whether or not they meet this guideline should contact their IT (Information Technology) and/or security/privacy analyst.)
- Ensure the EHR provides:
  - Nonrepudiation — assurance that the signer cannot deny signing the document in the future.
  - User authentication — verification of the signer's identity at the time the signature was generated.
  - Integrity of electronically signed documents — retention of data so that each record can be authenticated and attributed to the signer.

- ○ Message integrity — certainty that the document has not been altered since it was signed.
- ○ Capability to convert electronic documents to paper copy — the paper copy must indicate the name of the individual who electronically signed the form as well as the date electronically signed.
- Ensure electronically signed records created by the EHR have the same back-up and record retention requirements as paper records.

Ongoing Responsibilities

Topic #15157

Recovery Audit Contractor Audits

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

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

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

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

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

Affected Providers

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

Additional Information

Any questions regarding the RAC program should be directed to HMS at (800) 310-0865. Refer to the RAC Web site for additional information regarding HMS RAC activities.

Topic #13277

Reporting Suspected Waste, Fraud, and Abuse

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

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

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

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

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

Reporting Suspected Fraud and Abuse

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

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

- Going to the OIG fraud and abuse reporting Web site.
- Calling the DHS fraud and abuse hotline at (877) 865-3432.

The following information is helpful when reporting fraud and abuse:

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

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

Provider Enrollment

Topic #14137

Enrollment Requirements Due to the Affordable Care Act

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

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

Topic #14157

Provider Enrollment Information Home Page

ForwardHealth has consolidated all information providers will need for the enrollment process in one location on the ForwardHealth Portal. For information related to enrollment criteria and to complete online provider enrollment applications, providers should refer to the Provider Enrollment Information home page.

The Provider Enrollment Information home page includes enrollment applications for each provider type and specialty eligible for enrollment with Wisconsin Medicaid. Prior to enrolling, providers may consult a provider enrollment criteria menu, which is a reference for each individual provider type detailing the information the provider may need to gather before beginning the enrollment process, including:

- Links to enrollment criteria for each provider type.
- Provider terms of reimbursement.
- Disclosure information.
- Category of enrollment.
- Additional documents needed (when applicable).

Providers will also have access to a list of links related to the enrollment process, including:

- General enrollment information.
- Regulations and forms.
- Provider type-specific enrollment information.
- In-state and out-of-state emergency enrollment information.
- Contact information.

Information regarding enrollment policy and billing instructions may still be found in the Online Handbook.

Topic #14317

Terminology to Know for Provider Enrollment

Due to the ACA (Affordable Care Act), ForwardHealth has adopted new terminology. The following table includes new terminology that will be useful to providers during the provider enrollment and revalidation processes. Providers may refer to the Medicaid rule 42 CFR s. 455.101 for more information.

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

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

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

Reimbursement

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Reimbursement:Amounts

Topic #3364

Colposcopies

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

Topic #8117

Electronic Funds Transfer

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

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

Provider Exceptions

EFT payments are not available to the following providers:

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

Enrolling in Electronic Funds Transfer

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

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

The following guidelines apply to EFT enrollment:

- Only a Portal Administrator or a clerk that has been assigned the "EFT" role on the Portal may complete the EFT enrollment information.
- Organizations 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 Electronic Funds Transfer User Guide on the Portal User Guides page of the Portal for instructions and more information about EFT enrollment.

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

Recoupment and Reversals

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

Note: Enrolling in EFT does not authorize ForwardHealth to make unauthorized debits to the provider's EFT account; however, in some instances an EFT reversal of payment may be necessary. For example, if the system generates a payment twice or the amount entered manually consists of an incorrect value (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.

Topic #2222

Reimbursement

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

Topic #3365

Reproductive Health Services

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

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

Resources

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Resources:Contact Information

Topic #4456

Resources Reference Guide

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

Provider Services and Resources Reference Guide

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

ForwardHealth Portal	www.forwardhealth.wi.gov/	24 hours a day, seven days a week
Public and secure access to ForwardHealth information with direct link to contact Provider Services for up-to-date access to ForwardHealth programs information, including publications, fee schedules, and forms.		
WiCall Automated Voice Response System	**(800) 947-3544**	24 hours a day, seven days a week
WiCall, the ForwardHealth Automated Voice Response system, provides responses to the following inquiries: • Checkwrite. • Claim status. • Prior authorization. • Member enrollment.		
ForwardHealth Provider Services Call Center	**(800) 947-9627**	Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Standard Time)*
To assist providers in the following programs: • BadgerCare Plus. • Medicaid. • SeniorCare. • Wisconsin Well Woman Medicaid. • Wisconsin Chronic Disease Program (WCDP). • Wisconsin Well Woman Program (WWWP). • Wisconsin Medicaid and BadgerCare Plus Managed Care Programs.		
ForwardHealth Portal Helpdesk	**(866) 908-1363**	Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central Standard Time)*
To assist providers and trading partners with technical questions regarding Portal functions and capabilities, including Portal accounts, registrations, passwords, and submissions through the Portal.		
Electronic Data Interchange Helpdesk	**(866) 416-4979**	Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central Standard Time)*
For providers, trading partners, billing services, and clearinghouses with technical questions about the following: • Electronic transactions. • Companion documents. • Provider Electronic Solutions (PES) software.		
Managed Care Provider Appeals	**(800) 760-0001, Option 1**	Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Standard Time)*
To assist BagderCare Plus and Medicaid Supplemental Security Income (SSI) managed care providers with questions regarding their appeal status and other general managed care provider appeal information.		
Managed Care Ombudsman Program	**(800) 760-0001**	Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Standard Time)*
To assist managed care enrollees with questions about enrollment, rights, responsibilities, and general managed care information.		
Member Services	**(800) 362-3002**	Monday through Friday, 8:00 a.m. to 6:00 p.m. (Central Standard Time)*
To assist ForwardHealth members or persons calling on behalf of members with program information and requirements, enrollment, finding certified providers, and resolving concerns.		
Wisconsin AIDS Drug Assistance Program (ADAP)	**(800) 991-5532**	Monday through Friday, 8:00 a.m. to 4:30 p.m.

		(Central Standard Time)*
To assist ADAP providers and members, or persons calling on behalf of members, with program information and requirements, enrollment, finding enrolled providers, and resolving concerns.		

*With the exception of state-observed holidays.

Electronic Data Interchange

Topic #461

Electronic Data Interchange Helpdesk

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

Providers with policy questions should call Provider Services.

Enrollment Verification

Topic #469

An Overview

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

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

Topic #4903

Copayment Information

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

Topic #4901

Enrollment Verification on the Portal

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

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

Topic #4900

Entering Dates of Service

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

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

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

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

Topic #4899

Member Identification Card Does Not Guarantee Enrollment

Most members receive a member identification card, but possession of a program identification card does not guarantee enrollment. Periodically, members may become ineligible for enrollment, only to re-enroll at a later date. Members are told to keep their cards even though they may have gaps in enrollment periods. It is possible that a member will present a card when 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 (date of service) that services are provided:

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

Topic #4898

Responses Are Based on Financial Payer

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

There are three financial payers under ForwardHealth:

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

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

Portal

Topic #5157

Cost Share Reports for Long-Term Managed Care Organizations

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

Topic #4345

Creating a Provider Account

Each provider needs to designate one individual as an administrator of the ForwardHealth Portal account. This user establishes the administrative account once his or her PIN (personal identification number) 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 (National Provider Identifier) or provider number.
5. Click **Setup Account**.
6. At the Account Setup screen, enter the user's information in the required fields.
7. Read the security agreement and click the checkbox to indicate agreement with its contents.
8. Click **Submit** when complete.

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

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

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

Topic #4340

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

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

ForwardHealth interChange.

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

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

- 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 (Electronic Data Interchange) Helpdesk](#) or submit a [paper (Trading Partner 835 Designation, F-13393 (07/12))](#) form.

Topic #5087

Electronic Communications

The secure ForwardHealth 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.

Topic #4338

ForwardHealth Portal

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

The Portal has the following areas:

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

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

Topic #4441

ForwardHealth Portal Helpdesk

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

Topic #4451

Inquiries to ForwardHealth Via the Portal

Providers are able to contact Provider Services through the ForwardHealth Portal by clicking the Contact link and entering the relevant inquiry information, including selecting the preferred method of response (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.

Topic #4400

Internet Connection Speed

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

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

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

Topic #4351

Logging in to the Provider Area of the Portal

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

Topic #4743

Managed Care Organization Portal

Information and Functions Through the Portal

The MCO (managed care organization) 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 that may be sensitive.

The following information is available through the Portal:

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

- HealthCheck information
- MCO contact information
- Technical contact information (Entries may be added via the Portal.)

Topic #5158

Managed Care Organization Portal Reports

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

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

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

Capitation Payment Listing Report

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

Initial Enrollment Roster Report

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

Final Enrollment Roster Report

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

Other Reports

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

Topic #4744

Members ForwardHealth Portal

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

Topic #4344

Obtaining a Personal Identification Number

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

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

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

Providers may request a PIN by following these steps:

1. Go to the Portal.
2. Click 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 enrollments. Select the correct enrollment for the account. The taxonomy code, ZIP+4 code, and financial payer for that enrollment will be automatically populated. Enter the SSN (Social Security number) or TIN (Tax Identification Number).
   b. Non-healthcare providers are required to enter their provider number, financial payer, and SSN or TIN. (This option should only be used by non-healthcare providers who are exempt from NPI requirements).

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

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

Topic #5089

Other Business Enhancements Available on the Portal

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

- Verify member enrollment.
- View RAs (Remittance Advice).
- Designate which trading partner is eligible to receive the provider's 835 (835 Health Care Claim Payment/Advice).
- Update and maintain provider file information. Providers have the choice to indicate separate addresses for different

business functions.
- Receive electronic notifications and provider publications from ForwardHealth.
- Enroll in EFT (electronic funds transfer).
- Track provider-submitted PA (prior authorization) requests.

Topic #4740

Public Area of the Provider Portal

The public Provider area of the ForwardHealth Portal offers a variety of important business features and functions that will greatly assist in daily business activities with ForwardHealth programs.

Maximum Allowable Fee Schedules

Within the Portal, all maximum allowable fee schedules for Medicaid, BadgerCare Plus, and WCDP (Wisconsin Chronic Disease Program) are interactive and searchable. Providers can enter the DOS (date of service), 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 Enrollment

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

Other 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 (prior authorization).
- 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.

Topic #4741

Secure Area of the Provider Portal

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

Claims and Adjustments Using the Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, and determine what claims are in "pay" status on the Portal. Providers 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 (Direct Data Entry) through the secure Portal.

Submitting Prior Authorization and Amendment Requests Via the Portal

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

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

Electronic Communications

The secure Portal contains a 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 (managed care organization).
- 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 (Automated Voice Response) system or the EVS (Enrollment Verification System) (although both are available).

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

Other Business Enhancements Available on the Portal

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

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

Topic #4401

System and Browser Requirements

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

Recommended System Requirements	Recommended Browser Requirements
Windows-Based Systems	
Computer with at least a 500Mhz processor, 256 MB of RAM, and 100MB of free disk space	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

Mac OS X 10.2.x or higher operating system	Firefox v. 1.5 or higher

Topic #4742

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 (Provider Electronic Solutions)](#) software and upgrade information.
- EDI (Electronic Data Interchange) [companion guides](#).

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

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

Training Opportunities

Topic #12757

Training Opportunities

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

On-Site Sessions

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

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

Online (Real-Time, Web-Based) Sessions

Online (real-time, web-based) training sessions are available and are facilitated through [HPE® MyRoom](#). MyRoom sessions are offered on many of the same topics as on-site sessions, but online sessions offer the following advantages:

- Participants can attend training at their own computers without leaving the office.
- Sessions are interactive as participants can ask questions during the session.
- If requested or needed, a session can be quickly organized to cover a specific topic for a small group or office.

For some larger training topics (such as ForwardHealth Portal Fundamentals), the training may be divided into individual modules, with each module focused on a particular subject. This allows participants to customize their training experience.

Registration, including an e-mail address, is required to attend Virtual Room sessions, so important session information can be sent to participants prior to the start of the session. Online registration is available on the [Trainings](#) page of the Portal.

Recorded Webcasts

Recorded Webcasts are available on a variety of topics, including some of the same topics as on-site and online sessions. Like Virtual Room sessions, some recorded Webcasts on larger training topics may be divided into individual Webcast modules, allowing participants to customize their training experience. Recorded Webcasts allow providers to view the training at their convenience on their own computers.

Registration is not required to view a recorded Webcast. Related training materials are available to download and print from the specific [Webcast training session page](#) on the Portal.

Notification of Training Opportunities

In addition to information on the Trainings page of the Portal, upcoming training session information is distributed directly through messages to providers who have secure Portal accounts and to providers who have registered for the ForwardHealth e-mail subscription service.

To sign up for a secure Portal account, click the "Request Portal Access" link in the Quick Links box on the Provider page of the Portal. To sign up for e-mail subscription, click "Register for E-mail Subscription" in the Quick Links box on the Provider page of the Portal.

WiCall

Topic #6257

Entering Letters into WiCall

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

Topic #466

Information Available Via WiCall

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

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

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

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

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

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

Claim Status

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

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

Enrollment Verification

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

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

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 (National Drug Code), procedure code, revenue code, or ICD (International Classification of Diseases) procedure code.) When a match is found, WiCall reports back the PA status information, including the PA number for future reference, and the applicable program.

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

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