Certification and Ongoing Responsibilities

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Archive Date:12/30/2008

Certification and Ongoing Responsibilities:Certification

Provider Qualifications

Express Enrollment for Pregnant Women

Providers who are qualified to make EE determinations for pregnant women may also make EE determinations for women to receive services and supplies immediately through the FPW.

Claims

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Claims:Good Faith Claims

Definition

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

Submission

An Overview

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

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

If a provider performs services for a woman eligible under FPW PE, her enrollment information may not yet be available through the EVS. To avoid delays in reimbursement, providers who provide FPW PE services to a woman before her Medicaid enrollment can be verified should do the following:

- Make a photocopy of the temporary white card to be used, if necessary, for Good Faith claims processing. Refer to the Claims Submission section of the All-Provider Handbook for more information on Good Faith claims.
- Wait until enrollment has been verified through the EVS and then submit the claim.

Oral Contraceptives and Drugs Used to Treat Sexually Transmitted Diseases

Family planning clinics must bill for oral contraceptives using procedure code S4993 on the 837P transaction or CMS 1500 paper claim form. Family planning clinics may submit claims for drugs related to the treatment of sexually transmitted diseases using an NDC on a Wisconsin Medicaid Noncompound Drug Claim form. Wisconsin Medicaid will recoup payments from providers made for noncovered drugs.

Paper Claim Form Preparation and Data Alignment Requirements

Optical Character Recognition

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

The data alignment requirements do not apply to the Compound Drug Claim and the Noncompound Drug Claim.

Speed and Accuracy of Claims Processing

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

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

Handwritten Claims

Submitting handwritten claims should be avoided whenever possible. ForwardHealth accepts handwritten claims; however, it is very difficult for OCR software to read a handwritten claim. If a handwritten claim cannot be read by the OCR software, it will need to be keyed manually from the

electronic image of the claim form. Providers should avoid submitting claims with handwritten corrections as this can also cause OCR software processing delays.

Use Original Claim Forms

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

Use Laser or Ink Jet Printers

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

Alignment

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

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

The following sample claim forms demonstrate correct and incorrect alignment:

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

Clarity

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

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

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

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

Staples, Correction Liquid, and Correction Tape

The use of staples, correction liquid, correction tape, labels, or stickers on claim forms should be avoided. Staples need to be removed from claim forms before they can be imaged, which can damage the claim and cause a delay in processing time. Correction liquid, correction tape, labels, and

stickers can cause data to be read incorrectly or cause the OCR process to stop, prompting manual review. If the form cannot be read by the OCR software, it will need to be keyed manually from an electronic image.

Additional Diagnosis Codes

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

Anchor Fields

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

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

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

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

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

Physician-Administered Drugs

Deficit Reduction Act of 2005

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

ForwardHealth requires that NDCs be indicated on claims for all physician-administered drugs to identify the drugs and invoice a manufacturer for rebates, track utilization, and receive federal funds. States that do not collect NDCs with HCPCS and CPT procedure codes on claims for physician-administered drugs will not receive federal funds for those claims. ForwardHealth cannot claim a rebate or federal funds if the NDC submitted on a claim is incorrect or invalid or if an NDC is not indicated.

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

National Drug Codes

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

- The first segment, a five-digit labeler code that identified any firm that manufacturers, repacks, or distributes the drug. (ForwardHealth covers repackaged drugs.)
- 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 sement(s) with less that 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.

Less-Than-Effective Drugs

ForwardHealth will deny physician-administered drug claims for LTE or identical, related, or similar drugs for ForwardHealth members.

Medicare Crossover Claims

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

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

340B Providers

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

Drugs with Signed Manufacturer Rebate Agreements

In accordance with the OBRA of 1990, also known as the Medicaid Drug Rebate Program, drug manufacturers who choose to participate in BadgerCare Plus and Medicaid are required to sign a rebate agreement with the federal government. Drug manufacturers who choose to participate in WCDP are required to sign a rebate agreement with the DHS.

BadgerCare Plus and SeniorCare will cover only the legend drugs of manufacturers who have signed rebate agreements. Non-participating manufacturers may sign rebate agreements that are effective the following quarter.

Manufacturer rebates are based on Medicaid claims data showing the quantity of each NDC dispensed to ForwardHealth members. Manufacturers may dispute the payment of drug rebates if they believe the utilization data reported to them is inaccurate. To resolve disputes, ForwardHealth verifies utilization data by having individual providers check the accuracy of claims information they submit.

Additional Information

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

- Centers for Medicare and Medicaid Services Deficit Reduction Act information page.
- National Uniform Billing Committee.
- National Uniform Claim Committee.

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

- The FDA Web site.
- The SeniorCare Drug Search Tool. (Providers may verify if an NDC and its segments are valid using this Web site.)
- The Palmetto GBA NDC crosswalk. (This Web site contains a crosswalk of J codes and NDCs to HCPCS and select CPT procedure codes.)

Coordination of Benefits

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Coordination of Benefits:Commercial Health Insurance

Other Health Insurance Sources

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

Covered and Noncovered Services

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Covered and Noncovered Services:Codes

Diagnosis Codes

Allowable contraceptive management diagnosis codes for the FPW are listed below.

V25 — Encounter for contraceptive management

- V25.0 — General counseling and advice
  - V25.01 — Prescription of oral contraceptives
  - V25.02 — Initiation of other contraceptive measures
    Fitting of diaphragm
    Prescription of foams, creams, or other agents
  - V25.09 — Other
    Family planning advice
- V25.1 — Insertion of intrauterine contraceptive device
- V25.2 — Sterilization
  Admission of interruption of fallopian tubes
- V25.3 — Menstrual extraction
  Menstrual regulation
- V25.4 — Surveillance of previously prescribed contraceptive methods
  Checking, reinsertion, or removal of contraceptive device
  Repeat prescription for contraceptive method
  Routine examination in connection with contraceptive maintenance
  - V25.40 — Contraceptive surveillance, unspecified
  - V25.41 — Contraceptive pill
  - V25.42 — Intrauterine contraceptive device
    Checking, reinsertion, or removal of intrauterine device
  - V25.43 — Implantable subdermal contraceptive
  - V25.49 — Other contraceptive method
- V25.5 — Insertion of implantable subdermal contraceptive
- V25.9 — Unspecified contraceptive management

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

Procedure Codes

Providers who submit claims for FPW services on the UB-04 Claim Forms and the 837I transactions are required to indicate a valid HCPCS procedure code for each revenue code on the claim. The HCPCS code should be entered in Form Locator 44 of the UB-04 Claim Form. This policy should be used in conjunction with service-specific claim submission policies.

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

BadgerCare Plus covers additional services under the FPW. The following table contains the procedure codes.

Office Visits		
Procedure Code	**Description**	**Requires Primary Diagnosis Code in the V25 Series**
G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	Yes
99201	Office or other outpatient visit for the evaluation and management of a new patient (10 min)	Yes
99202	Office or other outpatient visit for the evaluation and management of a new patient (20 min)	Yes
99203	Office or other outpatient visit for the evaluation and management of a new patient (30 min)	Yes
99204	Office or other outpatient visit for the evaluation and management of a new patient (45 min)	Yes
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity — **newly covered procedure/service**	Yes
99211	Office or other outpatient visit for the evaluation and management of an established patient (5 min)	Yes
99212	Office or other outpatient visit for the evaluation and management of an established patient (10 min)	Yes
99213	Office or other outpatient visit for the evaluation and management of an established patient (15 min)	Yes
99214	Office or other outpatient visit for the evaluation and management of an established patient (25 min)	Yes
99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)	Yes
99385	18-39 years	Yes
99386	40-64 years	Yes
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures established patient; adolescent (age 12 through 17 years)	Yes
99395	18-39 years	Yes
99396	40-64 years	Yes
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes — **newly covered procedure/service**	Yes
99402	approximately 30 minutes — **newly covered procedure/service**	Yes
99403	approximately 45 minutes — **newly covered procedure/service**	Yes
99404	approximately 60 minutes — **newly covered procedure/service**	Yes
Q3014	Telehealth originating site facility fee — **newly covered procedure/service**	No
S9445*	Patient education, not otherwise classified, non-physician provider, individual, per session — **newly covered procedure/service**	Yes

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

Procedures and Supplies		
Procedure Code	**Description**	**Requires Primary Diagnosis Code in the V25 Series**
A4261	Cervical cap for contraceptive use	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
J0696	Injection, ceftriaxone sodium [Rocephin], per 250 mg	No
J1055	Injection, medroxyprogesterone acetate for contraceptive use, 150 mg	Yes
J1056	Injection, medroxyprogesterone acetate/estradiol cypionate, 5 mg/25 mg	Yes
J7300	Intrauterine copper contraceptive	Yes
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52mg	Yes
J7303	Contraceptive supply, hormone containing vaginal ring, each	Yes
J7304	Contraceptive supply, hormone containing patch, each	Yes
J7307	Etonogestrel implant system (new HCPCS 010108) — **newly covered procedure/service**	Yes
S4993	Contraceptive pills for birth control	Yes
11975	Insertion, implantable contraceptive capsules	Yes
11976	Removal, implantable contraceptive capsules	Yes
11977	Removal with reinsertion, implantable contraceptive capsules	Yes
17110	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions — **newly covered procedure/service**	No
17111	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 15 lesions — **newly covered procedure/service**	No
46900	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical — **newly covered procedure/service**	No
46924	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery) — **newly covered procedure/service**	No
56501	Destruction of lesion(s), vulva; simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery) — **newly covered procedure/service**	No
57061	Destruction of vaginal lesion(s); simple (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery) — **newly covered procedure/service**	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 — **newly covered procedure/service**	Yes
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants — **newly covered procedure/service**	Yes
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	Yes
58611	Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)	Yes
58615	Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring) vaginal or suprapubic approach	Yes
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transaction)	Yes
58671	With occlusion of oviducts by device (e.g. band, clip or Falope ring)	Yes
71010	Radiologic examination, chest; single view, frontal — **newly covered procedure/service**	Yes
71020	Radiologic examination, chest; stero, frontal — **newly covered procedure/service**	Yes
74740	Hysterosalpingography, radiological supervision and interpretation — **newly covered procedure/service**	Yes
90772	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or	Yes

	intramuscular	
99070	Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)	Yes

Colposcopy		
Procedure Code	**Description**	**Requires Primary Diagnosis Code in the V25 Series**
57452	Colposcopy of the cervix including upper/adjacent vagina;	No
57454	With biopsy(s) of the cervix and endocervical curettage	No
57455	With biopsy(s) of the cervix	No
57456	With the endocervical curettage	No
57460	With loop electrode biopsy(s) of the cervix	No
57461	With loop electrode conization of the cervix	No

Laboratory Services		
Procedure Code	**Description**	**Requires Primary Diagnosis Code in the V25 Series**
G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by cytotechnologist under physician supervision — **newly covered procedure/service**	Yes
80048	Basic metabolic panel (see CPT for tests that must be included in the panel)	Yes
80050	General health panel (see CPT for tests that must be included in the panel)	Yes
80051	Electrolyte panel (see CPT for tests that must be included in the panel)	Yes
80061	Lipid panel (see CPT for tests that must be included in the panel)	Yes
80074	Acute hepatitis panel (see CPT for tests that must be included in the panel)	Yes
80076	Hepatic function panel (see CPT for tests that must be included in the panel)	Yes
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy	Yes
81002	Non-automated, without microscopy	Yes
81025	Urine pregnancy test, by visual color comparison methods	Yes
82565	Creatinine; blood [only used if patient is on medication for Herpes]	Yes
82728	Ferritin	Yes
82746	Folic acid; serum	Yes
82947	Glucose; quantitative, blood (except reagent strip)	Yes
82948	Blood, reagent strip	Yes
83001	Gonadotropin; follicle stimulating hormone (FSH)	Yes
83020	Hemoglobin fractionation and quantitation; electrophoresis (eg, A2, S, C, and/or F)	Yes
83518	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen, qualitative or semiquantitative; single step method (eg, reagent strip)	Yes
83907	Molecular diagnostics; lysis of cells prior to nucleic acid extraction (eg, stool specimens, paraffin embedded tissue) — **newly covered procedure/service**	Yes
84146	Prolactin	Yes
84443	Thyroid stimulating hormone (TSH) — newly covered procedure/service	Yes

84450	Transferase; aspartate amino (AST) (SGOT) [Only used if patient has history of Mono]	Yes
84703	Gonadotropin, chorionic (hCG); qualitative	Yes
85007	Blood count; blood smear, microscopic examination with manual differential WBC count	Yes
85009	Manual differential WBC count, buffy coat	Yes
85013	Spun microhematocrit	Yes
85014	Hematocrit (Hct)	Yes
85018	Hemoglobin (Hbg)	Yes
85025	Complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count — **newly covered procedure/service**	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; qualitative (eg, VDRL, RPR, ART)	Yes
86689	Antibody; HTLV or HIV antibody, confirmatory test (eg, Western Blot)	Yes
86694	Herpes simplex, non-specific type test	Yes
86701	HIV-1 — **newly covered procedure/service**	Yes
86703	HIV-1 and HIV-2, single assay	Yes
86781	Treponema pallidum, confirmatory test (eg, FTA-abs)	Yes
87070	Culture, bacterial; any other source except urine, blood or stool, aerobic with isolation and presumptive identification of isolates	Yes
87075	Any source, except blood, anaerobic with isolation and presumptive identification of isolates	Yes
87076	Anaerobic isolate, additional methods required for definitive identification, each isolate	Yes
87081	Culture, presumptive, pathogenic organisms, screening only;	Yes
87086	Culture, bacterial; quantitative colony count, urine	Yes
87088	With isolation and presumptive identification of isolates, urine	Yes
87101	Culture, fungi (mold or yeast) isolation, with presumptive identification of isolates; skin, hair, or nail	Yes
87109	Culture, mycoplasma, any source	Yes
87110	Culture, chlamydia, any source	Yes
87205	Smear, primary source with interpretation; Gram or Giemsa stain for bacteria, fungi, or cell types	Yes
87206	Fluorescent and/or acid fast stain for bacteria, fungi, parasites, viruses or cell types	Yes
87207	Special stain for inclusion bodies or parasites (eg, malaria, coccidia, microsporidia, trypanosomes, herpes viruses	Yes
87210	Wet mount for infectious agents (eg, saline, India ink, KOH preps)	Yes
87252	Virus isolation; tissue culture inoculation, observation, and presumptive identification by cytopathetic effect	Yes
87254	Centrifuge enhanced (shell vial) technique, includes identification with immunofluorescence stain, each virus	Yes
87270	Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis	Yes
87274	Herpes simplex virus type 1	Yes
87320	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; Chlamydia trachomatis	Yes
87340	Hepatitis B surface antigen (HBsAg)	Yes
87390	HIV-1	Yes
87391	HIV-2	Yes

87449	Infectious agent antigen detection by enzyme immunoassay technique qualitative or semiquantitative; multiple step method, not otherwise specified, each organism	Yes
87490	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique	Yes
87491	Chlamydia trachomatis, amplified probe technique	Yes
87492	Chlamydia trachomatis, quantification	Yes
87510	Gardnerella vaginalis, direct probe technique	Yes
87511	Gardnerella vaginalis, amplified probe technique	Yes
87512	Gardnerella vaginalis, quantification	Yes
87528	Herpes simplex virus, direct probe technique	Yes
87529	Herpes simplex virus, amplified probe technique — **newly covered procedure/service**	Yes
87530	Herpes simplex virus, quantification	Yes
87531	Herpes virus-6, direct probe technique	Yes
87532	Herpes virus-6, amplified probe technique	Yes
87533	Herpes virus-6, quantification	Yes
87534	HIV-1, direct probe technique	Yes
87535	HIV-1, amplified probe technique	Yes
87536	HIV-1, quantification	Yes
87537	HIV-2, direct probe technique	Yes
87538	HIV-2, amplified probe technique	Yes
87539	HIV-2, quantification	Yes
87591	Neisseria gonorrhoeae, amplified probe technique	Yes
87620	Papillomavirus, human, direct probe technique (*International Classification of Diseases, Ninth Revision, Clinical Modification* [ICD-9-CM] [to accompany human papillomavirus] 079.4)	Yes
87621	Papillomavirus, human, amplified probe technique	Yes
87797	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; direct probe technique, each organism	Yes
87798	Amplified probe technique, each organism	Yes
87799	Quantification, each organism	Yes
87808	Infectious agent antigen detection by immunoassay with direct optical observation; Trichomonas vaginalis — **newly covered procedure/service**	Yes
88141	Cytopathology, cervical or vaginal (any reporting system); requiring interpretation by physician (List separately in addition to code for technical service)	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 — **newly covered procedure/service**	No
99000	Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory	Yes

Anesthesia Services		
Procedure Code	**Description**	**Requires Primary Diagnosis Code in the V25 Series**
00851	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transaction	Yes
00952	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); hysteroscopy and/or hysterosalpingography	Yes

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 the FPW Program and the TB-Related Services-Only Benefit. In this instance, providers should use this attachment in conjunction with TB-Only publications. (When verifying enrollment for these women, the EVS indicates that they are eligible for both limited benefit categories.)

Covered Services and Requirements

An Overview

Under the FPW, eligible women receive selected family planning services and supplies through Medicaid-certified providers. Services and supplies that are covered under the FPW 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 the FPW. ForwardHealth reviews CPT, HCPCS, and FDA changes regularly. Certain changes may require federal approval before they are added to the FPW. If changes affect the FPW, providers will be notified.

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

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

Colposcopies

Colposcopies are reimbursable through the FPW under certain circumstances. A colposcopy is reimbursable by the FPW when an abnormal pap test is obtained prior to the colposcopy, but while the member is in the FPW. Therefore, if a woman has had an abnormal pap prior to becoming eligible for the FPW, the provider must perform a follow-up pap under the FPW in order to have the colposcopy covered.

Members receiving colposcopies under the FPW must also be receiving contraceptive management care, as the primary reason for being in the FPW should be to receive contraceptive management services. Contraceptive management services are defined as those services associated with an ICD-9-CM diagnosis code of the V25 series.

Definition of Covered Services

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

Drugs

The following drugs are covered by the FPW.

Drug Name and Strength	Dosage
Acyclovir 200 mg (Zovirax)	Capsule
Acyclovir 400 mg	Tablet
Acyclovir 800 mg	Tablet
Acyclovir 200 mg/5 ml	Suspension
Aldara 5%	Cream
Alesse-28	Tablet
Antifungal 2%	Cream
Apri 28 day	Tablet
Aranelle 28	Tablet
Aviane-28	Tablet
Azithromycin 250 mg (Zithromax)	Tablet, Z-pak tablet
Azithromycin 500 mg	Tablet

Azithromycin 600 mg	Tablet
Baza antifungal 2%	Cream
Brevicon 28	Tablet
Camila	Tablet
Carrington antifungal 2%	Cream
Cesia 28 day	Tablet
Clindagel 1%	Gel
Clindamax 1%	Gel, lotion
Clindamax 2%	Vaginal cream
Clindamycin 1% (Clindets)	Pledgets
Clindamycin 2% (Cleocin)	Vaginal cream
Clindamycin phosphate 1% (Cleocin T)	Gel, lotion, pledgets, solution, topical lotion
Ceftriaxone 250 mg (Rocephin)	Vial
Ceftriaxone 500 mg	Vial
Ceftriaxone 1 gm	Vial
Ceftriaxone 2 gm	Vial
Ceftriaxone 10 gm	Vial
Ciprofloxacin HCL 250 mg (Cipro)	Tablet
Ciprofloxacin HCL 500 mg	Tablet
Ciprofloxacin HCL 750 mg	Tablet
Ciprofloxacin HCL 100 mg	Tablet
Ciprofloxacin 5%	Suspension
Ciprofloxacin 10%	Suspension
Clotrim 1% (Lotrimin)	Vaginal cream
Clotrimazole antifungal 1%	Cream
Clotrimazole 3 day	Cream, insert
Clotrimazole-7	Insert
Cruex 1%	Cream
Cryselle-28	Tablet
Cyclessa 28 day	Tablet
Demulen 1/35-21	Tablet
Demulen 1/35-28	Tablet
Demulen 1/50-21	Tablet
Demulen 1/50-28	Tablet
Depo-Provera 400 mg/ml	Vial
Depo-subq provera 104	Syringe
Desenex 1%	Cream
Desenex 2%	Spray powder
Desogen 28 day	Tablet
Doxycycline 50 mg (Vibramycin)	Capsule
Doxycycline 100 mg	Capsule, tablet, vial
Doxycycline monohydrate 50 mg (Monodox)	Capsule
Doxycycline monohydrate 100 mg	Capsule
Enpresse-28	Tablet
Errin	Tablet

Eryped 200 mg (E.E.S.)	Suspension
Eryped 100 mg/2.5 ml	Drops
Eryped 400 mg/5 ml	Granules, suspension
Erythromycin 250 mg (Eryc)	Capsule EC
Erythromycin 250 mg	Filmtab
Erythromycin 200 mg/5 ml	Suspension
Erythromycin 400 mg/5 ml	Suspension
Erythromycin ES 400 mg	Tablet
Erythromycin EST 125 mg/5 ml	Suspension
Erythromycin EST 250 mg/5 ml	Suspension
Erythromycin ST 250 mg	Tablet
Erythromycin ST 500 mg	Tablet
E.E.S. 400 mg	Filmtab
E.E.S. 200 mg/5 ml	Granules, oral suspension
Erythrocin 250 mg	Filmtab
Erythrocin 500 mg	Filmtab
Ery-tab 250 mg	Tablet EC
Ery-tab 333 mg	Tablet EC
Ery-tab 500 mg	Tablet EC
Estrostep FE-28	Tablet
Famvir 125 mg	Tablet
Famvir 250 mg	Tablet
Famvir 500 mg	Tablet
Femcare	Insert
Flagyl ER 750 mg	Tablet SA
Fluconazole 50 mg (Diflucan)	Tablet
Fluconazole 100 mg	Tablet
Fluconazole 150 mg	Tablet
Fluconazole 200 mg	Tablet
Fluconazole 10 mg/ml	Suspension
Fluconazole 40 mg/ml	Suspension
Gyne-lotrimin 1%	Cream
Gyne-lotrimin	Insert
Gynazole-1	Cream
Gynol II	Jelly
Gynol II Xtra Strength 3%	Jelly
Jolivette	Tablet
Junel 1/20	Tablet
Junel 1.5/30	Tablet
Junel FE 1/20	Tablet
Junel FE 1.5/30	Tablet
Kariva 28 day	Tablet
Kelnor 1/35 28	Tablet
Leena 28	Tablet
Lessina-28	Tablet

Levaquin 250 mg	Tablet
Levaquin 500 mg	Tablet
Levaquin 750 mg	Tablet
Levlen 28	Tablet
Levlite-28	Tablet
Levora-21	Tablet
Levora-28	Tablet
Loestrin 24 FE	Tablet
Lo/ovral-21	Tablet
Lo/ovral-28	Tablet
Low-ogestrel-28	Tablet
Lutera-28	Tablet
Medroxyprogesterone 150 mg/ml (Depo-Provera)	Syringe
Metronidazole 250 mg (Flagyl)	Tablet
Metronidazole 375 mg	Capsule
Metronidazole 500 mg	Tablet
Metrogel 0.75%	Gel
Metronidazole 0.75% (Metrocream)	Cream
Micaderm 2%	Cream
Micatin 2%	Aerosol spray, cream
Microgestin 21 1/20 (Loestrin)	Tablet
Microgestin 21 1.5/30	Tablet
Microgestin FE 1/20	Tablet
Microgestin FE 1.5/30	Tablet
Micro-guard 2%	Cream
Micronor	Tablet
Miconazole 7 (Monistat)	Cream
Miconazole nitrate 2%	Cream
Miconazole 7 100 mg	Vaginal suppository
Miconazole 3 200 mg	Vaginal suppository
Mircette 28 day	Tablet
Mitrazol 2%	Cream
Modicon 28	Tablet
Monistat-derm 2%	Cream
Mononessa 28	Tablet
Mycelex 1%	Cream
Neosporin antifungal 2%	Cream, spray powder
Necon 0.5/35-21	Tablet
Necon 0.5/35-28	Tablet
Necon 1/35-21	Tablet
Necon 1/35-28	Tablet
Necon 1/50-28	Tablet
Necon 7/7/7-28	Tablet
Necon 10/11-21	Tablet
Necon 10/11-28	Tablet

Nora-be	Tablet
Nordette-21	Tablet
Nordette-28	Tablet
Norinyl 1+35-28	Tablet
Norinyl 1+50-28	Tablet
Nor-Q-D	Tablet
Nortrel 0.5/35	Tablet
Nortrel 1/35	Tablet
Nortrel 7/7/7-28	Tablet
Nortrel 21	Tablet
Nortrel 28	Tablet
Noritate 1%	Cream
Nystatin	Vaginal tablet
Nuvaring	Vaginal ring
Ofloxacin 200 mg (Floxin)	Tablet
Ofloxacin 300 mg	Tablet
Ofloxacin 400 mg	Tablet
Ogestrel	Tablet
Ortho-cept 28 day	Tablet
Ortho-cyclen-28 0.25/35	Tablet
Ortho Evra	Patch
Ortho-novum 1/35 28	Tablet
Ortho-novum 1/50-28	Tablet
Ortho-novum 7/7/7-28	Tablet
Ortho-novum 10/11-28	Tablet
Ortho tri-cyclen lo	Tablet
Ortho tri-cyclen 28	Tablet
Ovcon-35 21	Tablet
Ovcon-35 28	Chewable tablet, tablet
Ovcon-50 28	Tablet
Ovral-21	Tablet
Ovral-28	Tablet
Ovrette	Tablet
PCE 333 mg	Dispertab
PCE 500 mg	Dispertab
Plan B 0.75 mg	Tablet
Podactin 2%	Cream
Podofilox 0.5% (Condylox)	Gel, topical solution
Portia-28	Tablet
Previfem	Tablet
Reclipsen 28 day	Tablet
Seasonale 0.15 mg and 0.03 mg	Tablet
Seasonique 0.15/0.03-0.01	Tablet
Secura antifungal 2%	Cream
Solia	Tablet

Sprintec 28 day	Tablet
Suprax 400 mg	Tablet
Suprax 100 mg/5 ml	Suspension
Tri-levlen 28	Tablet
Tri-norinyl 28	Tablet
Triphasil-21	Tablet
Triphasil-28	Tablet
Trivora-28	Tablet
Terconazole 0.4% (Terazol)	Cream
Terconazole 0.8%	Cream
Terconazole 80 mg	Suppository
Terazol 7 0.4%	Cream and applicator
Trinessa	Tablet
Tri-previfem	Tablet
Tri-sprintec	Tablet
Triple care antifungal	Cream
Valtrex 500 mg	Tablet
Valtrex 1 gm	Caplet
Velivet 28 day	Tablet
Yasmin 28	Tablet
Yaz 28	Tablet
Zithromax 1 gm	Powder packet
Zithromax 100 mg/5 ml	Suspension
Zithromax 200 mg/5 ml	Suspension
Zovia 1/35-21	Tablet
Zovia 1/35-28	Tablet
Zovia 1/50-21	Tablet
Zovia 1/50-28	Tablet
Zovirax	Ointment

Implanon

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

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

Ortho Evra Patch

The Ortho Evra Patch® is covered for family planning clinics for services provided to members enrolled in BadgerCare Plus and Medicaid. Providers should submit claims for this item on a Noncompound Drug Claim form using an NDC or on the 1500 Health Insurance Claim Form using HCPCS procedure code J7304.

Tubal Ligations

The following types of tubal ligations are covered by the FPW, provided the Sterilization Informed Consent form is properly completed:

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

Noncovered Services

Noncovered Services

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

Noncovered Procedure Codes Effective January 1, 2008	Description
00840	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise classified
00940	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise classified
00950	culdoscopy
A0130	Non-emergency transportation; wheel-chair van
A0170	Transportation ancillary: parking fees, tolls, other
S0209	Wheelchair van, mileage, per mile
T2001	Non-emergency transportation; patient attendant/escort
57500	Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)
58120	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)
58555	Hysteroscopy, diagnostic (separate procedure)
88155	Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation (eg, maturation index, karyopknotic index, estrogenic index) (List separately in addition to code(s) for other technical and interpretation services)
88346	Immunofluorescent study, each antibody; direct method
88365	In situ hybridization [eg, FISH], each probe

Member Information

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Archive Date:12/30/2008

Member Information:Enrollment Categories

Express Enrollment for Pregnant Women

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

Family Planning Waiver

The FPW is a limited benefit program that provides routine contraceptive-related services to low-income women age 15 through 44 who are otherwise not eligible for Wisconsin Medicaid or BadgerCare Plus. Members receiving FPW services must be receiving routine contraceptive-related services.

The goal of the FPW is to provide women 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 the FPW program to women and encourage them to contact their local county or tribal agency to determine their enrollment options if they are not interested in receiving, or do not wish to receive, contraceptive services.

Members enrolled in the FPW program receive routine services to prevent or delay pregnancy. In addition, FPW program members may receive certain reproductive health services if the services are determined medically necessary during contraceptive-related FPW services. Only services *clearly* related to contraceptive management are covered under the FPW.

Providers should inform women about other service options and provide referrals for care not covered by the FPW program.

FPW program members are not eligible for other services that are covered under full-benefit Medicaid and BadgerCare Plus (e.g., PT services, dental services). Even if a medical condition is discovered during a contraceptive-related FPW service, treatment for the condition is not covered under the FPW unless the treatment is identified in the list of allowable procedure codes for FPW services. They are also not eligible for other family planning services that are covered under full-benefit Wisconsin Medicaid and BadgerCare Plus (e.g., mammograms and hysterectomies). If a medical condition, other than an STD, is discovered during contraceptive-related services, treatment for the medical condition is not covered under the FPW.

Colposcopies and treatment for STDs are only covered through the FPW program if they are determined medically necessary during routine contraceptive-related services. A colposcopy is a covered service when an abnormal result is received from a pap test, prior to the colposcopy, while the member is in the FPW program and receiving contraceptive-related services.

FPW 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 women about other service options and provide referrals for care not covered by FPW.

Presumptive Eligibility for the Family Planning Waiver Program

Women whose providers are submitting an initial FPW application on their behalf and who meet the enrollment criteria may receive routine contraceptive-related services immediately through PE for the FPW program for up to three months. Services covered under the PE for the FPW program are the same as those covered under the FPW program and must be clearly related to routine contraceptive management.

To determine enrollment for the FPW program, providers should use the income limit for 200 percent of the FPL.

PE for the FPW program providers may issue white paper PE for the FPW program temporary identification cards for women to use until they receive a ForwardHealth identification card. Providers should remind women that the benefit is temporary, despite their receiving a ForwardHealth card.

Fee-for-Service

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

Identification Cards

Presumptive Eligibility for the Family Planning Waiver Temporary Cards

Qualified providers may issue white paper PE for the FPW identification cards for women to use temporarily until they receive a ForwardHealth identification card. The identification card is included with the Presumptive Eligibility for the Family Planning Waiver Application.

The PE for the FPW identification cards have the following message printed on them: "Wisconsin Medicaid Presumptive Eligibility for the Family Planning Waiver Temporary Identification Card." Providers should accept the white PE for FPW identification cards as proof of enrollment for the dates provided on the cards and are encouraged to keep a photocopy of the card.

Member Enrollment

Annual Eligibility Review

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

Continued enrollment for the FPW 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 local county or tribal agency will determine whether a woman will remain enrolled in FPW coverage. In addition, a member may request a determination be made for full-benefit BadgerCare Plus as well.

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

Annual review notices

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

Reminders for providers assisting women in filling out the application/annual review form

Providers are reminded of the following when assisting women in filling out the FPW application/annual review form:

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

Women who apply *only* for the limited-benefit FPW will not be required to provide other insurance information. Women who apply for both full-benefit BadgerCare Plus and the limited-benefit FPW will be required to provide information about other insurance they may have.

Completion Instructions for the Presumptive Eligibility for the Family Planning Waiver Application

This application is only for those persons applying for PE for the FPW. The FPW provides limited services to women seeking contraceptive management. Both the FPW qualified provider and client should complete the application together.

Providing or applying for a SSN is voluntary; however, any person who wants BadgerCare Plus but does not provide an SSN or apply for one will not be eligible for benefits. SSNs and personally identifiable information will be used only for the direct administration of the ForwardHealth Program.

Once the application has been completed, provide the client a copy, retain a copy for your files and mail or fax a copy to:

Wisconsin Medicaid

Presumptive Eligibility
6406 Bridge Rd
Madison WI 53784
Fax: (608) 250-5202

SECTION I — CLIENT INFORMATION (GENERAL) (Client completes this Section)

If the client prefers information she receives in a language other than English, indicate the preferred language.

Line 1: Client name, birth date, telephone number.

Determine if the client is age 15 through 44:

- If the client will turn 45 during the presumptive eligibility period, she may be eligible up to her 45th birthday.
- The client must be at least 15 years of age on the date that the form is signed.

If the client meets the age requirement, go to Line 2.

If the client does not meet this age requirement, go to Section III and check the box indicating that the client is not eligible because she does not qualify under the age guidelines. Follow the instructions for Section III - Notice for a client who is not presumptively eligible for the FPW.

Line 2: Client's residence address and county of residence.

If the client is a resident of Wisconsin, continue to Line 3.

If the client is not a Wisconsin resident, go to Section III and check the box indicating that the client is not eligible because she does not qualify under the residency guidelines. Follow the instructions for Section III - Notice for a client who is not presumptively eligible for the FPW.

Line 3: Are you receiving full-benefit Wisconsin Medicaid/BadgerCare?

If the client answers "No" on Line 3, go to Line 4.

If the client answers "Yes" on Line 3, she is already receiving full-benefit Medicaid or BadgerCare benefits. Explain that she already has access to the same benefits through the Medicaid and/or BadgerCare programs. Go to Section III and check the box that the client is not eligible because she is eligible for full-benefits Medicaid. Follow the instructions for Section III - Notice for a client who is not presumptively eligible for the FPW.

Line 4: Are you a U. S. citizen?

If the client answers "Yes" on Line 4, go to Line 5.

If the client answers "No" on Line 4, she has indicated that she is not a U.S. citizen, go to Section III and check the box indicating that the client is not eligible because she is not a U.S. citizen. Follow the instructions for Section III - Notice for a client who is not Presumptively Eligible for the FPW.

Inform the client you cannot determine her presumptively eligible, however, she may still be eligible for the FPW or BadgerCare Plus, but she must apply through her county/tribal social or human services agency or ForwardHealth outstation site. A list of these agencies can be found on the DHS Web site, or you can contact Member Services.

Line 5: Have you been determined presumptively eligible for the FPW in the last 12 months?

If the client answers "No" on Line 5, go to Section II — Income Information.

If the client answers "Yes" on Line 5, she cannot be determined presumptively eligible. A woman is only allowed to have one period of presumptive eligibility in a 12-month period. To determine if the client has been determined presumptively eligible in the last 12 months, call Provider Services.

Go to Section III and check the box indicating that the client is not eligible because she has been presumptively eligible for FPW in the last 12 months. Follow the instructions for Section III - Notice for a client who is not presumptively eligible for the FPW.

Explain that she can only be determined presumptively eligible once in a 12 month period. Encourage the woman to apply formally for the FPW through the local county/tribal social or human services agency or ForwardHealth outstation site.

Section II — Income Information

To complete Section II, the qualified provider should work with the client to answer the questions regarding her finances. For determining presumptive eligibility the financial test is based on anticipated income. For this calculation, use the actual income expected during the month. (For example, a woman applying any time in September will use expected income for September.) Answer all the questions for the individuals counted as part of the group on Line 6, Section II.

Line 6: When determining who is in the group, the provider is required to include certain family members living with the client. Count only the client, her spouse, and any minor natural, step or adopted children that live in the household in determining the group size.

For example, if the client is a/an:

- Minor female — Include only the minor female, her spouse and her natural, step or adopted children that live in the household and unborn fetuses of any member of the household.
- Adult female without spouse — Include the adult female, her minor natural or adopted children living in the household and the number of unborn fetuses of any member of the household.
- Adult female with spouse — Include the adult female, her spouse if he is living in the household, her minor natural, step or adopted children living in the household and the number of unborn fetuses of any member of the household.

Enter the number of family members, on Line 6.

Line 7: To be determined presumptively eligible, the client must meet the income limits for the appropriate group size. Income includes the spouse's income if the client is married. Do not count the parent's income if the client is a minor.

Earned income includes:

- Wages.
- Salaries.
- Tips.
- Commissions.
- All other payments resulting from labor or personal service, excluding allowances.
- Self-employment.

Self-employment income is income earned directly from one's own business, rather than earned as an employee with a specified salary or wages from an employer. Deduct self-employment expenses when calculating income (use the monthly average for this calculation.

Do **not** count the following as monthly-earned income:

- Wages for full-time students or part-time students who are not employed full time.
- Work-study for college students.
- Earned Income Tax Credit payments.
- Allowances.

Add monthly gross-earned income (amount of money earned before any deductions) for each member of the group to monthly-earned income. Enter this amount on Line 7.

Line 8: Add all monthly unearned income. Unearned income includes, but is not limited to:

- Pensions, annuities, insurance benefits, Social Security (use gross amounts), Veterans benefits, military allotments and Workers' Compensation.
- Payments received for the rental of rooms, apartments, dwelling units, buildings or land (if not reported as self-employment income). Taxes and the expense of property maintenance may be deducted.
- Child support payments received (deduct $50 per month from total child support payments). If the applicant is a minor, list the child support payments received for the minor, even if the minor does not directly receive the payments.
- Money, including allowances provided to someone in the eligibility group by someone outside of the eligibility group.

Example: Julia is a 17 year old who applies for PE for the FPW. Julia receives $25 a week or $100 a month as an allowance from her father who no longer lives in the same household. Julia's father also pays child support directly to Julia's mother in the amount of $400. After the allowable $50 is deducted from the child support and Julia's monthly allowance is totaled ($350 child support + $100 allowance) Julia's unearned income would be $450. This is the amount that is reported on line 8.

Do not count the following as monthly-unearned income:

- SSI.
- Student loans or grants, regardless of source, including work study.
- Reimbursement for expenses which the client has incurred or paid, except for reimbursement for normal household living expenses such as rent, clothing or food eaten at home.
- Foster care or subsidized adoption payments.
- Life insurance policy dividends.
- Tax refunds, including Earned Income Tax Credits payments.
- Payments made by a third party directly to landlords or other vendors.
- Governmental (federal, state, or local) rent and housing subsidies, including payments made directly to the client for housing or utility costs (e.g., U.S. Department of HUD utility allowances).
- Nutrition-related benefits, such as a FoodShare Wisconsin (formerly the Food Stamp Program) allotment.

Enter this amount on Line 8.

Line 9: Add the total monthly gross income by adding the client's monthly gross earned income (Line 7) and total monthly unearned income (Line 8). Enter this amount on Line 9.

If the client's total monthly gross income (Line 9) exceeds 185 percent of the FPL for the appropriate group size, go to Line 10 to begin allowing deductions.

If the client's total monthly gross income (Line 9) is at or below 185 percent of the FPL for the appropriate group size and all non-financial eligibility requirements have been met, she is presumptively eligible. Check "Yes" on Line 15 and go to Section III.

The FPL Guidelines are updated annually.

Line 10: Calculate the work expense ($90 per month) for each employed household member. Enter this amount on Line 10.

Line 11: Calculate the expense deduction for dependent care, if necessary for employment. The allowable expense is the actual dependent care (child care) expenses paid for a dependent child or for an incapacitated adult (adult day care), up to:

1. $175 per month per dependent child age two or older, or incapacitated adult.
2. $200 per month per dependent child under age two.

Enter this amount on Line 11.

Line 12: When determining the eligibility of a woman who has been ordered by a court to pay child support, (i.e., support for a child not living in the same home as the parent paying child support), the amount of child support actually paid is disregarded in determining her financial eligibility. Enter amount actually paid, up to the amount ordered by the court on Line 12.

Line 13: Add the allowable work-related expense deductions (Line 10), the allowable amount of dependent care (Line 11), and the court-ordered monthly child support paid to anyone outside of the family (Line 12) and enter this amount on Line 13.

Line 14: Subtract the total allowable deductions (Line 13) from the total monthly gross income (Line 9). Enter this amount on Line 14.

Line 15: Compare total net monthly income (Line 14) to the monthly standard for the appropriate group size on FPL guidelines. Countable income must be at or below 185 percent of the FPL for the appropriate group size.

If countable monthly income is at or below 185 percent of the FPL for the appropriate group size, and all other non-financial eligibility requirements have been met, the client is presumptively eligible. Complete Section III - Notice for a client who is presumptively eligible for the FPW.

If countable monthly income exceeds 185 percent of the FPL for the appropriate group size, the client is not presumptively eligible. Complete

Section III of the application and check the appropriate box indicating that the client is not eligible because she does not qualify under the income guidelines. Follow the instructions for Section III - Notice for a client who is not presumptively eligible for the FPW.

Inform the client she may still be eligible for the FPW or BadgerCare Plus, but she must apply through her county/tribal social or human services agency or ForwardHealth outstation site.

Section III — Notice

If the Client is Presumptively Eligible for the FPW

If the client is presumptively eligible, qualified providers are required to do all of the following:

1. The qualified provider should check the appropriate box and enter the provider's name, address (street, city, state, ZIP code) and provider number information. If the provider is a large organization with a number of local sites, please use the specific local site address where the client was served. The qualified provider should then sign and date the PE for the FPW application. Do not use an agency's name. The signature must be legible.

   Inform the client that her presumptive eligibility for the FPW lasts from the date of application until the end of the second month following the month that presumptive eligibility is determined. To continue receiving family planning benefits after the PE end date, the client must apply for BadgerCare Plus or the FPW at the local agency.

   Explain to the client that a PE determination does not guarantee that her county/tribal social or human services agency or ForwardHealth outstation site will find her eligible for BadgerCare Plus or the FPW because of other requirements that may apply.

   The client may fill out a Wisconsin Family Medicaid, BadgerCare and Family Planning Waiver Application and Review Packet furnished by the qualified provider, or the qualified provider may refer her to her local county/tribal social or human services agency or ForwardHealth outstation site.

2. Inform the client that her county/tribal social or human services agency may extend her PE. This may be done only when the client files an application on or before the last day of the PE period and her eligibility cannot be determined before her PE period ends.

3. Check the appropriate box indicating that the client is presumptively eligible. Have her read the statement and sign the PE for the FPW application. Give the client a copy of the PE for the FPW application.

4. Inform the client that she is only eligible for covered family planning-related services, but she may be eligible for full-benefit BadgerCare Plus if she has minor dependent children and meets certain other eligibility requirements. Encourage her to apply for full-benefit BadgerCare Plus if she would like to receive more than family planning-related services, by mail, telephone, or in person through her county/tribal social or human services agency.

5. Inform clients that have children under age five that she and/or her children may be eligible for WIC and provide her with a copy of the WIC pamphlet.

6. Go to Section IV.

If the Client is not Presumptively Eligible for the FPW

If the client is not presumptively eligible for the FPW, qualified providers are required to do all of the following:

1. Check the appropriate box in Section III indicating the reason for the client's ineligibility.

2. Sign and date the application.

3. Have the client sign and date the application indicating that she understands that, even though the qualified provider has not found her presumptively eligible for the FPW, she may still be eligible for the FPW or BadgerCare Plus.

   Encourage the client to apply for the FPW and BadgerCare Plus by mail, telephone or in person, through her county/tribal social or human services agency or ForwardHealth outstation site.

4. Detach and destroy the temporary card on the last page of the form and provide the client with a copy of the PE for the FPW application.

This will serve as the client's notice of denial of eligibility. Give the client a copy of the application, retain a copy for your files and fax or mail a copy, within 5 days, to:

Wisconsin Medicaid
Presumptive Eligibility
6406 Bridge Rd
Madison WI 53784
Fax: (608) 250-5202

5. Inform clients that have children under age five that she and/or her children may be eligible for WIC and provide her with a copy of the WIC pamphlet.

Section IV — Temporary Identification Card

Complete the following items on the temporary card if the client is presumptively eligible:

1. Card Effective Dates: PE begins on the day eligibility is determined and continues through the last day of the second month following the month in which presumptive eligibility is determined (e.g., a woman whose PE begins June 6 is eligible through the end of August).

   Inform the client that, in order to receive FPW services beyond the PE end date, she must apply for BadgerCare Plus eligibility by mail, telephone or in person through her county/tribal social or human services agency or ForwardHealth outstation site.

2. Identification Number: Enter the client's SSN. When entering a client's SSN add a zero to the end of the number.

   If the client does not have an SSN or does not know the number, qualified providers are required to call Recipient Services to obtain a pseudo number.

   ForwardHealth will contact the qualified provider if a SSN or pseudo-number is not recorded on the presumptive eligibility application. ForwardHealth requires this number on all applications.

   Note: The client will have to provide a valid SSN or apply for one to be certified eligible for continuous FPW through her county/tribal socia human services agency.

3. Agency Code: Enter the agency code number assigned to the qualified provider.

4. Client Information: Print or type the client's full name and address in the box provided at the bottom of the card.

   If the client is concerned about other household members receiving her confidential information regarding this program, encourage her to indicate a mailing address other than her residence address and to receive FPW information in care of another person.

   If notices are sent to an alternate address, it is imperative she receive these notices in a timely manner. If a woman does not receive the annual review notice or her receipt of the notice is delayed, there may be a gap in her FPW eligibility and coverage. If a member has chosen her provider's mailing address for her FPW correspondence, it is imperative that the provider has a reliable way of contacting her to promptly give her FPW notices and ForwardHealth Identification Card.

5. Detach the bottom portion of the application for the client to use as a temporary FPW ID card. This temporary ID card entitles the client to family planning-related services provided by a Medicaid certified provider participating in the FPW.

   Inform the client that a plastic ForwardHealth card will be mailed to her. The ForwardHealth card is valid only for the PE period and will only allow the client to receive covered family planning-related services unless the client applies for full benefit BadgerCare Plus or the FPW and is found eligible. She will then continue to use the same ForwardHealth card.

Coordination with the Wisconsin Well Woman Program - Breast Cancer Diagnosis

Women ages 35 to 44 enrolled in the FPW who require diagnostic services not covered by the FPW as follow up to determine a breast cancer diagnosis may be referred to the WWWP for enrollment and breast cancer diagnostic services. This usually happens after a clinical

breast exam performed by the FPW provider indicates need for diagnostic follow up. The woman does not need to be formally disenrolled from the FPW 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 FPW 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 the FPW for continued contraceptive-related care.

Eligibility

The FPW will provide services and supplies to women who meet the program's enrollment criteria. Women who may be enrolled:

- Are at least 15 years old but not older than 44.
- Have an income that is at or below 200 percent of the FPL.
- Are not currently receiving Wisconsin Medicaid or BadgerCare Plus.

Applicants for the FPW must meet all of the following requirements:

- Be at least 15 years old but not older than 44.
- Have an income that is at or below 200 percent of the FPL.
- Provide information on health insurance coverage.
- Do not currently receive Wisconsin Medicaid or BadgerCare Plus.
- Provide an SSN or be willing to apply for one.
- Be a Wisconsin resident.
- Be a U.S. citizen or qualified immigrant.
- Be in compliance with any child support judgements 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 a woman applies for family planning services through the FPW, she can apply in person, by telephone, or by completing a mail-in application. The application collects the information necessary for a local county or tribal agency to determine whether the woman is eligible for coverage under the FPW. The applicant may receive services immediately through TE for the FPW if she is determined eligible. Providers are encouraged to assist patients who are pregnant to apply for other ForwardHealth programs.

Women who apply for both full-benefit BadgerCare Plus and the FPW will be required to give information about other insurance they may have. However, women who apply only for FPW benefits will not be required to give other insurance information.

If the woman is determined eligible for family planning waiver services, she will receive family planning services for a 12-month eligibility period, unless one of the following occurs:

- She moves out of state.
- She turns 45 years of age during the enrollment period.
- She becomes eligible for Wisconsin Medicaid or BadgerCare Plus.

Once a woman has been determined eligible for the FPW, she will receive a ForwardHealth identification card within a week after she completes the application and the information is sent to ForwardHealth.

Eligibility Criteria for Wisconsin Well Woman Medicaid

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

New eligibility requirements for Well Woman Medicaid may accommodate FPW members who are diagnosed with cervical cancer,

precancerous conditions of the cervix, or breast cancer. Treatment for cancer is not covered under the FPW program. Therefore, FPW 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

FPW members are required to meet all of the following criteria to be eligible for Well Woman Medicaid:

- The member is enrolled, through her local county/tribal social or human services department, in the FPW program. Women receiving services through FPW EE are not eligible for Well Woman Medicaid. (If a woman receiving services through FPW EE needs diagnosis or treatment for cervical cancer or breast cancer, she should enroll in the FPW program or the WWWP immediately. Once enrolled in the permanent FPW program 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. (The FPW program 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 FPW 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.

Eligibility Process for Wisconsin Well Women Medicaid

The eligibility process for Well Women Medicaid varies based on whether the member needs treatment for cervical conditions or breast cancer. The eligibility process varies because the FPW 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 an FPW member receives an abnormal result from a pap test during routine contraceptive-related services, some diagnostic tests - including some colposcopies with biopsy - are covered under the FPW. 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 Women Medicaid.

The FPW physician or nurse practitioner should complete a Wisconsin Well Woman Medicaid Determination Form with the member and refer the woman to her local county/tribal social or human services department where the woman can disenroll from the FPW and enroll in Well Woman Medicaid. If the woman does not complete the enrollment process at the local county/tribal social or human services department, 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 the FPW. When an FPW member receives a suspicious result from a clinical breast exam during routine contraceptive-related services, the woman can seek diagnostic tests through the WWWP, through commercial health insurance, Medicare, 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 Women Medicaid.

An FPW member 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 FPW member can also:
  - Seek coverage for diagnostic tests through commercial health insurance or Medicare.
  - 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 the FPW and needs treatment for the cancer, she is eligible for Well Woman Medicaid.

A member diagnosed with breast cancer should notify her FPW provider immediately. After confirming the member's diagnosis and need for treatment, the FPW physician should complete a Wisconsin Well Woman Medicaid Determination Form with the member. The physician should refer the woman to her local county/tribal social or human services department where the woman can disenroll from the FPW program and enroll in Well Woman Medicaid. If the woman does not complete the enrollment process at the local county/tribal social or human services department, ForwardHealth will not cover her treatment.

Express Enrollment Reminder

Women whose providers are submitting an initial FPW application on their behalf and who meet the eligibility criteria may receive routine contraceptive-related services and supplies immediately through FPW EE for up to three months. Services and supplies covered under the FPW EE are the same as those covered under the FPW and must be directly related to a diagnosis of routine contraceptive management. If contraceptive management services are not appropriate for a member, the provider should not submit claims under the FPW.

EE providers should advise a member to apply for the FPW at her county/tribal social or human services department to receive FPW services for the full 12-month eligibility period rather than just for the PE period.

The period of FPW EE coverage ends:

- The end of the second calendar month following the month in which the woman was determined presumptively eligible.
- The first day of the month in which the county/tribal social or human services department or W-2 agency receives a woman's application for the FPW and she is determined eligible.
- If she applies at her county/tribal social or human services department and is found ineligible prior to the end of the FPW EE period.
- If the FPW EE application is found to be incomplete or the information provided does not meet the FPW EE eligibility criteria. The applicant will then be sent a notice and she will be terminated from the FPW program.

Once ForwardHealth receives and processes an FPW EE application from the certified PE provider, the woman's eligibility is usually established on the ForwardHealth system within 48 hours. Providers may then verify the member's eligibility through the EVS.

A woman may receive FPW EE coverage only once within a 12-month period.

Faxing Applications

When faxing an FPW PE application to ForwardHealth, providers are reminded to verify that they are sending it to the correct fax number ([608] 250-5202). Providers are reminded the federal HIPAA privacy regulation requires providers to implement reasonable safeguards to protect the privacy of protected health information.

Income Limits

Income limits are available for the FPW, which are based on FPL income limits. To determine eligibility for the FPW, providers should use the income limit for 200 percent of the FPL.

Overview of Enrollment Process for Wisconsin Well Women Medicaid

Enrollment Process for a FPW Member* with Cervical Cancer or a Precancerous Condition of the Cervix				
The FPW 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 the FPW. • 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 FPW Member* Who Needs Follow-Up Related to Breast Cancer				
The FPW 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 the FPW, enrolls in the WWWP, and receives diagnostic tests through the WWWP. • She is diagnosed with breast cancer. • She needs treatment for the cancer. • She does not have commercial health insurance coverage or Medicare to cover the treatment.	→	The woman is eligible, upon completion of the enrollment process, for Wisconsin Well Women Medicaid.
		OR		
	→	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 for the FPW are not eligible for Well Woman Medicaid. (If a woman receiving services through TE for the FPW needs diagnosis or treatment for cervical cancer or breast cancer, she should enroll in the FPW or the WWWP immediately. Once enrolled in the permanent FPW or the WWWP, the woman may become eligible for Well Woman Medicaid.)

Presumptive Eligibility

Women who meet the eligibility criteria may receive family planning services immediately through FPW PE. Services and supplies covered

under FPW PE are the same as those covered under the FPW.

Providers are encouraged to make women aware of the availability of FPW benefits so that they may request services. When a woman requests family planning services through FPW PE, she may apply through a Medicaid-certified family planning agency. A certified FPW PE provider will help the applicant fill out the PE for the FPW Application and will mail in or fax the application to ForwardHealth.

Presumptive Eligibility Determinations

Providers who are currently certified to perform HealthyStart EE determinations are also approved to perform FPW PE.

To receive an application to become certified to make FPW PE determinations, contact Provider Services.

Length of Coverage

Once a woman is determined to be presumptively eligible FPW PE, she may receive services for up to three months, depending on her application date.

The period of FPW PE coverage ends on the earliest of either:

- The first day of the month on which the woman submits the application for the FPW and is determined eligible by her county/tribal social or human services department or W-2 agency.
- The end of the second calendar month following the month in which the woman was determined presumptively eligible, unless she is found ineligible prior to the end of the FPW PE period.

Once ForwardHealth receives the FPW PE application from the certified PE provider, the woman's eligibility is usually established on the ForwardHealth system within 48 hours. Providers may then verify the eligibility of a member through the EVS.

Identification Card

Included with the FPW PE application is a white paper identification card that the woman uses to access family planning waiver services until she receives her Forward Identification card. The white identification card identifies the woman as eligible for FPW PE, and providers should accept it for the dates indicated on the card as proof of eligibility, even though eligibility may not be on ForwardHealth's file for 48 hours after the completed application is received. Once the woman's FPW PE eligibility is on the ForwardHealth system, a Forward card is issued.

A woman is allowed to receive only one FPW PE determination within a twelve-month period.

Submitting Claims

If a provider performs services for a woman enrolled under FPW PE, her eligibility information may not yet be available through the EVS. To avoid delays in reimbursement, providers who provide FPW PE services to a woman before her FPW eligibility can be verified should do the following:

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

Presumptive Eligibility Fax Number

ForwardHealth has a new fax number devoted to FPW PE applications. Providers should fax FPW PE applications to (608) 250-5202. If a provider has faxed an application, it is not necessary to also mail the application.

Wisconsin Well Woman Medicaid Determination Form

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

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

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

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

Reimbursement

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Archive Date:12/30/2008

Reimbursement:Amounts

Colposcopies

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

Reimbursement

Reimbursement rates for services and supplies under the FPW are the same as the rates for Medicaid family planning services.

Reproductive Health Services

The DHCAA reserves the right to recoup payment for services from the provider if the FPW member has not received a contraceptive-related service within the previous 12 months.

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

Resources

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Archive Date:12/30/2008

Resources:Contact Information

Resources Reference Guide

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

Electronic Data Interchange

Electronic Data Interchange Helpdesk

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

Providers with policy questions should call Provider Services.

Enrollment Verification

An Overview

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

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

Copayment Information

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

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

If a member is enrolled in BadgerCare Plus and is required to pay copayments, providers will be given the name of the benefit plan in which the member is enrolled and the member's enrollment dates for the benefit plan only.

Enrollment Verification on the Portal

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

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

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

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

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

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

Entering Dates of Service

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

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

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

Member Identification Card Does Not Guarantee Enrollment

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

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

Responses Are Based on Financial Payer

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

There are three financial payers under ForwardHealth:

- Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and SeniorCare).
- WCDP.
- WWWP.

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

Portal

Cost Share Reports for Long-Term Managed Care Organizations

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

Creating a Provider Account

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

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

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

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

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

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

Providers must designate a trading partner to receive their 835 transaction for ForwardHealth interChange.

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

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

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

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

Electronic Communications

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

ForwardHealth Portal

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

The Portal has the following areas:

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

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

ForwardHealth Portal Helpdesk

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

Inquiries to ForwardHealth Via the Portal

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

Internet Connection Speed

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

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

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

Logging in to the Provider Area of the Portal

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

Managed Care Organization Portal

Information and Functions Through the Portal

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

The following information is available through the Portal:

6. Certified Provider Listing of all Medicaid-certified providers.
7. Coordination of Benefits Extract/Insurance Carrier Master List information updated quarterly.
8. 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.
9. Electronic messages.
10. Enrollment verification by entering a member ID or SSN with date of birth and a "from DOS" and a "to DOS" range. A transaction number is assigned to track the request.
11. Member search function for retrieving member information such as medical status code, and managed care and Medicare information.
12. Provider search function for retrieving provider information such as address, telephone number, provider ID, and taxonomy code (if applicable), and provider type and specialty.
13. HealthCheck information.
14. MCO contact information.
15. Technical contact information. Entries may be added via the Portal.

Managed Care Organization Portal Reports

The following reports will be generated to MCOs through their account on the ForwardHealth MCO Portal:

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

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

Capitation Payment Listing Report

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

Initial Enrollment Roster Report

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

Final Enrollment Roster Report

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

Other Reports

Additional reports are available for BadgerCare Plus HMOs, SSI HMOs, and long-term MCOs, some available via the Portal and some in the secure FTP.

Members ForwardHealth Portal

Members can access ForwardHealth information by going to the ForwardHealth Portal. Members will be able to search through a directory of providers by entering a ZIP code, city, or county. Members can also access all member-related ForwardHealth applications and forms.

Members can use ACCESS to check availability, apply for benefits, check current benefits, and report any changes.

Obtaining a Personal Identification Number

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

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

Providers may request a PIN by following these steps:

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

        The financial payer is one of the following:
        - Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and Senior Care).
        - SSI.
        - WCDP.
        - The WWWP.

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

Public Area of the Provider Portal

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

Maximum Allowable Fee Schedules

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

Online Handbook

The Online Handbook is the single source for *all* policy and billing information for ForwardHealth located in one centralized place. The Online Handbook is designed to sort information based on user-entered criteria, such as program and provider type.

Revisions to information are incorporated immediately after policy changes have been issued in *Updates*. The Online Handbook also includes an archive section, so providers can research past policy changes.

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 Us" link on the Portal. Providers can enter the relevant inquiry information, including selecting the preferred method of response (i.e., telephone call or e-mail) the provider wishes to receive back from Provider Services. Provider Services will respond to the inquiry within five business days. Information will be submitted via a secure connection.

Online Certification

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

Other Business Enhancements Available on the Portal

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

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

Secure Area of the Provider Portal

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

Claims and Adjustments Using the Portal

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

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

Submitting Prior Authorization and Amendment Requests Via the Portal

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

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

Electronic Communications

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

Enrollment Verification

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

- The health care program(s) in which the member is enrolled.
- Whether or not the member is enrolled in a state-contracted MCO.
- Whether or not the member has any third-party liability, such as Medicare or commercial health insurance.

Using the Portal to check enrollment may be more efficient than calling the AVR system or the EVS (although both will still be 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 also enables providers to do the following:

- View RAs.
- Designate which trading partner is eligible to receive the provider's 835.
- Update and maintain provider file information. Providers will have the choice to indicate separate addresses for different business functions.

System and Browser Requirements

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

Recommended System Requirements	Recommended Browser Requirements
Windows-Based Systems	
Computer with at least a 500Mhz processor, 256 MB of RAM, and 100MB of free disk space	Microsoft Internet Explorer v. 6.0 or higher, or Firefox v. 1.5 or higher
Windows XP or higher operating system	
Apple-Based Systems	
Computer running a PowerPC G4 or Intel processor, 512 MB of RAM, and 150MB of free disk space	Safari, or Firefox v. 1.5 or higher
Mac OS X 10.2.x or higher operating system	

Trading Partner Portal

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

- Trading partner testing packets.
- Trading Partner Profile submission.
- PES software and upgrade information.
- EDI companion documents.

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

WiCall

Information Available Via WiCall

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

16. Claim status.
17. Enrollment verification.
18. PA status.
19. Provider CheckWrite information.

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

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.

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

20. Repeat the information.
21. Make another inquiry of the same type.
22. Return to the main menu.
23. Repeat the options.

Claim Status

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

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

Enrollment Verification

Providers may request enrollment status by entering their provider ID and the member ID. If the member ID is unknown, providers may enter the member's date of birth and SSN. Additionally, the provider is prompted to enter the "From DOS" and the "To DOS" for the inquiry. The "From DOS" information is available up to one year back from the current date. The provider is also informed if the member is not subject to copayments.

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

Prior Authorization Status

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

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