

Claims

1

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Claims:Overpayments

Topic #8417

Voiding Claims

Providers may void claims on the ForwardHealth Portal to return overpayments. This way of returning overpayments may be a more efficient and timely way for providers as a voided claim is a complete recoupment of the payment for the entire claim. Once a claim is voided, the claim can no longer be adjusted; however, the services indicated on the voided claim may be resubmitted on a new claim.

Responses

Topic #13437

ForwardHealth-Initiated Claim Adjustments

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

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

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

Topic #11537

National Correct Coding Initiative

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

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

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

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

Medically Unlikely Detail Edits

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

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

Procedure-to-Procedure Detail Edits

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

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

Quarterly Code List Updates

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

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

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

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

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

- Complete the [Adjustment/Reconsideration Request \(F-13046 \(07/12\)\)](#) form. In Element 16, select the "Consultant review requested" checkbox and the "Other/comments" checkbox. In the "Other/comments" text box, indicate "Reconsideration of an NCCI denial."
- Attach notes/supporting documentation.
- Submit a claim, Adjustment/Reconsideration Request, and additional notes/supporting documentation to ForwardHealth for processing.

Topic #5018

Searching for and Viewing All Claims on the Portal

All claims, including compound, noncompound, and dental claims, are available for viewing on the ForwardHealth Portal.

To search and view claims on the Portal, providers may do the following:

- Go to the Portal.
- Log in to the secure Provider area of the Portal.
- The most recent claims processed by ForwardHealth will be viewable on the provider's home page or the provider may select "claim search" and enter the applicable information to search for additional claims.
- Select the claim the provider wants to view.

Submission

Topic #17797

1500 Health Insurance Claim Form Completion Instructions

These instructions are for the completion of the 1500 Health Insurance Claim Form ((02/12)) for ForwardHealth. Refer to the [1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12](#), prepared by the NUCC (National Uniform Claim Committee) and available on their Web site, to view instructions for all item numbers not listed below.

Use the following claim form completion instructions, in conjunction with the 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12, prepared by the NUCC, to avoid denial or inaccurate claim payment. Be advised that every code used is required to be a valid code, even if it is entered in a non-required field. Do not include attachments unless instructed to do so.

Members enrolled in BadgerCare Plus or Medicaid receive a ForwardHealth member identification card. Always verify a member's enrollment before providing nonemergency services to determine if there are any limitations to covered services and to obtain the correct spelling of the member's name.

When submitting a claim with multiple pages, providers are required to indicate page numbers using the format "Page X of X" in the upper right corner of the claim form.

Other health insurance sources (e.g., commercial insurance, Medicare, Medicare Advantage Plans) must be billed prior to submitting claims to ForwardHealth, unless the service does not require commercial insurance billing as determined by ForwardHealth.

Submit completed paper claims to the following address:

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

Item Number 6 — Patient Relationship to Insured

Enter "X" in the "Self" box to indicate the member's relationship to insured when Item Number 4 is completed. Only one box can be marked.

Item Number 9 — Other Insured's Name

When applicable, commercial health insurance must be billed prior to submitting claims to ForwardHealth, unless the service [does not require commercial health insurance billing](#) as determined by ForwardHealth.

If the EVS indicates that the member has dental ("DEN") insurance only, is enrolled in a Medicare Advantage Plan only, or has no commercial health insurance, leave Item Number 9 blank.

If the EVS indicates that the member has any other commercial health insurance, and the service requires other insurance billing, one of the following three OI (other insurance) explanation codes must be indicated in the first box of Item Number 9. If submitting a multiple-page claim, providers are required to indicate OI explanation codes on the *first page* of the claim.

The description is not required, nor is the policyholder, plan name, group number, etc. Item Numbers 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part or in full by commercial health insurance or commercial HMO. In Item Number 29 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer.
OI-Y	YES, the member has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to, the following: <ul style="list-style-type: none"> • The member denied coverage or will not cooperate. • The provider knows the service in question is not covered by the carrier. • The member's commercial health insurance failed to respond to initial and follow-up claims. • Benefits are not assignable or cannot get assignment. • Benefits are exhausted.

Note: The provider may not use OI-D or OI-Y if the member is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by ForwardHealth except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not bill ForwardHealth for services that are included in the capitation payment.

Item Number 9a — Other Insured's Policy or Group Number

This field is not used for processing by ForwardHealth.

Item Number 9d — Insurance Plan Name or Program Name

This field is not used for processing by ForwardHealth.

Item Number 10d — Claim Codes (Designated by NUCC)

When applicable, enter the Condition Code. The Condition Codes approved for use on the 1500 Health Insurance Claim Form are available on the [NUCC Web Site under Code Sets](#).

Item Number 11 — Insured's Policy Group or FECA Number

When applicable, if an EOMB (Explanation of Medicare Benefits) indicates that the member is enrolled in a Medicare Advantage Plan and the claim is being billed as a crossover, enter "MMC" in the upper right corner of the claim, indicating that the other insurance is a Medicare Advantage Plan and the claim should be processed as a crossover claim.

Use the first box of this Item Number only. (Item Numbers 11a, 11b, 11c, and 11d are not required.) Item Number 11 should be left blank when one or more of the following statements are true:

- Medicare never covers the procedure in any circumstance.
- ForwardHealth indicates the member does *not* have any Medicare coverage, including a Medicare Advantage Plan, for the service provided. For example, the service is covered by Medicare Part A, but the member does not have Medicare Part A.
- ForwardHealth indicates that the provider is not Medicare enrolled.
- Medicare has allowed the charges. In this case, attach the EOMB, but do not indicate on the claim form the amount Medicare paid.

If none of the previous statements are true, a Medicare disclaimer code is necessary. If submitting a multiple-page claim, indicate

Medicare disclaimer codes on the *first page* of the claim. The following Medicare disclaimer codes may be used when appropriate.

Code	Description
M-7	<p>Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the member's lifetime benefit, SOI (spell of illness), or yearly allotment of available benefits is exhausted.</p> <p><i>For Medicare Part A, use M-7 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as enrolled in Medicare Part A. • The member is eligible for Medicare Part A. • The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or exhausted benefits. <p><i>For Medicare Part B, use M-7 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as enrolled in Medicare Part B. • The member is eligible for Medicare Part B. • The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or exhausted benefits.
M-8	<p>Noncovered Medicare service. This code may be used when Medicare was not billed because the service is not covered in this circumstance.</p> <p><i>For Medicare Part A, use M-8 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as enrolled in Medicare Part A. • The member is eligible for Medicare Part A. • The service is usually covered by Medicare Part A but not in this circumstance (e.g., member's diagnosis). <p><i>For Medicare Part B, use M-8 in the following instances (all three criteria must be met):</i></p> <ul style="list-style-type: none"> • The provider is identified in ForwardHealth files as enrolled in Medicare Part B. • The member is eligible for Medicare Part B. • The service is usually covered by Medicare Part B but not in this circumstance (e.g., member's diagnosis).

Item Number 11d — Is There Another Health Benefit Plan?

This field is not used for processing by ForwardHealth.

Item Number 19 — Additional Claim Information (Designated by NUCC)

When applicable, enter provider identifiers or taxonomy codes. A list of applicable qualifiers are defined by the NUCC and can be found in the NUCC 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12, prepared by the NUCC.

If a provider bills an [unlisted \(or not otherwise classified\) procedure code](#), a description of the procedure must be indicated in this field. If a more specific code is not available, the provider is required to submit the appropriate documentation, which could include a PA (prior authorization) request, to justify use of the unlisted procedure code and to describe the procedure or service rendered.

Item Number 22 — Resubmission Code and/or Original Reference Number

This field is not used for processing by ForwardHealth.

Section 24

The six service lines in section 24 have been divided horizontally. Enter service information in the bottom, unshaded area of the six service lines. The horizontal division of each service line is not intended to allow the billing of 12 lines of service.

For provider-administered drugs: NDCs (National Drug Codes) must be indicated in the shaded area of Item Numbers 24A-24G. Each NDC must be accompanied by an NDC qualifier, unit qualifier, and units. To indicate an NDC, providers should do the following:

- Indicate the NDC qualifier N4, followed by the 11-digit NDC, with no space in between.
- Indicate one space between the NDC and the unit qualifier.
- Indicate one unit qualifier (F2 [International unit], GR [Gram], ME [Milligram], ML [Milliliter], or UN [Unit]), followed by the NDC units, with no space in between.

For additional information about submitting a 1500 Health Insurance Claim Form with supplemental NDC information, refer to the completion instructions located under "Section 24" in the Field Specific Instructions section of the NUCC's 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12.

Item Number 24C — EMG

Enter a "Y" in the unshaded area for each procedure performed as an emergency. If the procedure was not an emergency, leave this field blank.

Item Number 29 — Amount Paid

When applicable, enter the actual amount paid by commercial health insurance. If submitting a multiple-page claim, indicate the amount paid by commercial health insurance only on the *first page* of the claim.

Enter the dollar amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter "00" in the cents area if the amount is a whole number.

If a dollar amount indicated in Item Number 29 is greater than zero, "OI-P" must be indicated in Item Number 9. If the commercial health insurance denied the claim, enter "000." Do not enter Medicare-paid amounts in this field.

Topic #10677

Advanced Imaging Services

Claims for advanced imaging services should be submitted to ForwardHealth using normal procedures and claim completion instructions. When PA (prior authorization) is required, providers should always wait two full business days from the date on which [MedSolutions](#) approved the PA request before submitting a claim for an advanced imaging service that requires PA. This will ensure that ForwardHealth has the PA on file when the claim is received.

Submitting Claims for Situations Exempt from the Prior Authorization Requirement

In the following situations, PA is not required for advanced imaging services:

- The service is provided during a member's inpatient hospital stay.
- The service is provided when a member is in observation status at a hospital.
- The service is provided as part of an emergency room visit.
- The service is provided as an emergency service.

- The ordering provider is exempt from the PA requirement.

Service Provided During an Inpatient Stay

Advanced imaging services provided during a member's inpatient hospital stay are exempt from PA requirements.

Institutional claims for advanced imaging services provided during a member's inpatient hospital stay are automatically exempt from PA requirements. Providers submitting a professional claim for advanced imaging services provided during a member's inpatient hospital stay should indicate POS (place of service) code 21 (Inpatient Hospital) on the claim.

Service Provided for Observation Status

Advanced imaging services provided when a member is in observation status at a hospital are exempt from PA requirements.

Providers using a paper institutional claim form should include modifier UA in Form Locator 44 (HCPCS (Healthcare Common Procedure Coding System)/Rate/HIPPS Code) with the procedure code for the advanced imaging service. To indicate a modifier on an institutional claim, enter the appropriate five-digit procedure code in Form Locator 44, followed by the two-digit modifier. Providers submitting claims electronically using the 837I (837 Health Care Claim: Institutional) should refer to the appropriate companion guide for instructions on including a modifier.

Providers using a professional claim form should indicate modifier UA with the advanced imaging procedure code.

Service Provided as Part of Emergency Room Visit

Advanced imaging services provided as part of an emergency room visit are exempt from the PA requirements.

Providers using an institutional claim form should include modifier UA in Form Locator 44 with the procedure code for the advanced imaging service. Providers submitting claims electronically using the 837I should refer to the appropriate companion guide for instructions on including a modifier.

Providers using a professional claim form should indicate POS code 23 (Emergency Room — Hospital) on the claim.

Service Provided as Emergency Service

Advanced imaging services provided as emergency services are exempt from the PA requirements.

Providers using an institutional claim form should include modifier UA in Form Locator 44 with the procedure code for the advanced imaging service. Providers submitting claims electronically using the 837I should refer to the appropriate companion guide for instructions on including a modifier.

Providers using a professional claim form should submit a claim with an emergency indicator.

Ordering Provider Is Exempt from Prior Authorization Requirement

Health systems, groups, and individual providers (requesting providers) that order CT (computed tomography) and MR (magnetic resonance) imaging services and have implemented advanced imaging decision support tools may [request an exemption from PA requirements](#) for these services from ForwardHealth. Upon approval, ForwardHealth will recognize the requesting provider's advanced imaging decision support tool (e.g., ACR Select, Medicalis) as an alternative to current PA requirements for CT and MR imaging services. Requesting providers with an approved tool will not be required to obtain PA through MedSolutions for these services when ordered for Medicaid and BadgerCare Plus fee-for-service members.

Providers rendering advanced imaging services for an ordering provider who is exempt from PA requirements are required to include modifier Q4 (Service for ordering/referring physician qualifies as a service exemption) on the claim detail for the CT or MR imaging service. This modifier, which may be used in addition to the TC (Technical component) or 26 (Professional component) modifiers on advanced imaging claims, indicates to ForwardHealth that the referring provider is exempt from PA requirements for these services.

Topic #6957

Copy Claims on the ForwardHealth Portal

Providers can copy institutional, professional, and dental paid claims on the ForwardHealth Portal. Providers can open any paid claim, click the "Copy" button, and all of the information on the claim will be copied over to a new claim form. Providers can then make any desired changes to the claim form and click "Submit" to submit as a new claim. After submission, ForwardHealth will issue a response with a new ICN (internal control number) along with the claim status.

Topic #5017

Correct Errors on Claims and Resubmit to ForwardHealth on the Portal

Providers can view [EOB \(Explanation of Benefits\) codes](#) and descriptions for any claim submitted to ForwardHealth on the ForwardHealth Portal. The EOBs help providers determine why a claim did not process successfully, so providers may correct the error online and resubmit the claim. The EOB appears on the bottom of the screen and references the applicable claim header or detail.

Topic #4997

Direct Data Entry of Professional and Institutional Claims on the Portal

Providers can submit the following claims to ForwardHealth via DDE (Direct Data Entry) on the ForwardHealth Portal:

- Professional claims.
- Institutional claims.
- Dental claims.
- Compound drug claims.
- Noncompound drug claims.

DDE is an online application that allows providers to submit claims directly to ForwardHealth.

When submitting claims via DDE, required fields are indicated with an asterisk next to the field. If a required field is left blank, the claim will not be submitted and a message will appear prompting the provider to complete the specific required field(s). Portal help is available for each online application screen. In addition, search functions accompany certain fields so providers do not need to look up the following information in secondary resources.

On professional claim forms, providers may search for and select the following:

- Procedure codes.

- Modifiers.
- Diagnosis codes.
- Place of service codes.

On institutional claim forms, providers may search for and select the following:

- Type of bill.
- Patient status.
- Visit point of origin.
- Visit priority.
- Diagnosis codes.
- Revenue codes.
- Procedure codes.
- Modifiers.

On dental claims, providers may search for and select the following:

- Procedure codes.
- Rendering providers.
- Area of the oral cavity.
- Place of service codes.

On compound and noncompound drug claims, providers may search for and select the following:

- Diagnosis codes.
- NDCs (National Drug Codes).
- Place of service codes.
- Professional service codes.
- Reason for service codes.
- Result of service codes.

Using DDE, providers may submit claims for compound drugs and single-entity drugs. Any provider, including a provider of DME (durable medical equipment) or of DMS (disposable medical supplies) who submits noncompound drug claims, may submit these claims via DDE. All claims, including POS (Point-of-Sale) claims, are viewable via DDE.

Topic #15957

Documenting and Billing the Appropriate National Drug Code

Providers are required to use the NDC (National Drug Code) of the administered drug and not the NDC of another manufacturer's product, even if the chemical name is the same. Providers should not preprogram their billing systems to automatically default to NDCs that do not accurately reflect the product that was administered to the member.

Per [DHS \(Department of Health Services\) 106.03\(3\)](#) and [107.10](#), Wis. Admin. Code, submitting a claim with an NDC other than the NDC on the package from which the drug was dispensed is considered an unacceptable practice.

Upon retrospective review, ForwardHealth can seek recoupment for the payment of a claim from the provider if the NDC(s) submitted does not accurately reflect the product that was administered to the member.

Topic #16937

Electronic Claims and Claim Adjustments with Other Commercial Health Insurance Information

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

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

Under HIPAA (Health Insurance Portability and Accountability Act of 1996), claims and adjustments submitted using an 837 (837 Health Care Claim) transaction must include detail-level information for other insurance if they were processed at the detail level by the primary insurance.

Adjustments to Claims Submitted Prior to June 16, 2014

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

Topic #10837

Note Field for Most Claims Submitted Electronically

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

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

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

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

- Professional.
- Institutional.
- Dental.

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

Claims Submitted Via 837 Health Care Claim Transactions

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

Topic #561

Paper Claim Form Preparation and Data Alignment Requirements

Optical Character Recognition

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

The data alignment requirements do not apply to the [Compound Drug Claim \(F-13073 \(07/12\)\)](#) and the [Noncompound Drug Claim \(F-13072 \(07/12\)\)](#).

Speed and Accuracy of Claims Processing

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

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

Handwritten Claims

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

Use Original Claim Forms

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

Use Laser or Ink Jet Printers

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

manually reviewed.

Alignment

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

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

The following sample claim forms demonstrate correct and incorrect alignment:

- [Correct alignment](#) for the 1500 Health Insurance Claim Form.
- [Incorrect alignment](#) for the 1500 Health Insurance Claim Form.
- [Correct alignment](#) for the UB-04 Claim Form.
- [Incorrect alignment](#) for the UB-04 Claim Form.

Clarity

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

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

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

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

Staples, Correction Liquid, and Correction Tape

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

Additional Diagnosis Codes

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

Sample of a Correctly Aligned 1500 Health Insurance Claim Form



HEALTH INSURANCE CLAIM FORM

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

PICA										PICA									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare) (Medicaid) (IDA/DoDI) (Member ID#) (ID#) (ID#)</small>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MEMBER, IM A										4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME									
3. PATIENT'S BIRTH DATE MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) 609 WILLOW ST										7. INSURED'S ADDRESS (No., Street)									
CITY ANYTOWN					STATE WI					CITY					STATE				
ZIP CODE 55555					TELEPHONE (Include Area Code) (444) 444-4444					ZIP CODE					TELEPHONE (Include Area Code) ()				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										11. INSURED'S POLICY GROUP OR FECA NUMBER									
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____										a. INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL _____										b. OTHER CLAIM ID (Designated by NUCC)									
15. OTHER DATE MM DD YY QUAL _____										c. INSURANCE PLAN NAME OR PROGRAM NAME									
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9c.</i>									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE I.M. REFERRING PROVIDER										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
17a. _____										17b. NPI 0111111110									
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____									
A. XXX.X B. _____ C. _____ D. _____										23. PRIOR AUTHORIZATION NUMBER _____									
E. _____ F. _____ G. _____ H. _____										24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE XX C. EMG XXXXX D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) XX E. DIAGNOSIS POINTER X F. \$ CHARGES XXX.XX G. GATE OUT UNITS 1 H. SPDT (Punk) Pen _____ I. ID. QUAL _____ J. RENDERING PROVIDER ID. # _____									
I. _____ J. _____ K. _____ L. _____										25. FEDERAL TAX I.D. NUMBER SSN EIN 1234JED 26. PATIENT'S ACCOUNT NO. 1234JED 27. ACCEPT ASSIGNMENT? (For govt. disca, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO 28. TOTAL CHARGE \$ XXX.XX 29. AMOUNT PAID \$ _____ 30. Rev'd for NUCC Use _____									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) I.M. Provider MMDDCCYY SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION									
33. BILLING PROVIDER INFO & PH # I.M. PROVIDER 1 W WILLIAMS ST ANYTOWN WI 55555-1234										34. 022222220 35. ZZ123456789X									

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Sample of an Incorrectly Aligned 1500 Health Insurance Claim Form



HEALTH INSURANCE CLAIM FORM

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

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

<input type="checkbox"/> PICA <input type="checkbox"/> PICA																													
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare) (Medicaid) (IDA/DoDI) (Member ID#) (ID#) (ID#) (ID#)					1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890																								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) MEMBER, IM A					3. PATIENT'S BIRTH DATE MM DD YY					4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME																			
5. PATIENT'S ADDRESS (No., Street) 609 WILLOW ST					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)																			
CITY ANYTOWN					STATE WI					8. RESERVED FOR NUCC USE																			
ZIP CODE 55555					TELEPHONE (Include Area Code) () 444 444 4444					9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)																			
10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER																								
a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY					SEX <input type="checkbox"/> M <input type="checkbox"/> F																			
b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					b. OTHER CLAIM ID (Designated by NUCC)					c. INSURANCE PLAN NAME OR PROGRAM NAME																			
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9c.</i>																			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
SIGNED _____ DATE _____										SIGNED _____																			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL					15. OTHER DATE MM DD YY QUAL					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE I.M. REFERRING PROVIDER					17a. NPI 011111110					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO					\$ CHARGES														
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD 9rd.										22. RESUBMISSION CODE ORIGINAL REF. NO.					23. PRIOR AUTHORIZATION NUMBER														
A. XXX.X		B. _____		C. _____		D. _____		E. _____		F. _____		G. _____		H. _____		I. _____		J. _____											
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT+CPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. GAT9 OUT UNITS		H. SPDT (Rank) Per		I. ID. DUAL		J. RENDERING PROVIDER ID. #											
1 MM DD YY		XX		XXXXX		XX		X		XXXXX		1		NPI		NPI		NPI											
2		3		4		5		6		NPI		NPI		NPI		NPI		NPI											
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (By govt. docs, see 15a)					28. TOTAL CHARGE \$					29. AMOUNT PAID \$					30. Rsvd for NUCC Use				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)					32. SERVICE FACILITY LOCATION INFORMATION					33. BILLING PROVIDER INFO & PH # ()					\$ XXX XX														
I.M. Provider					MMDDCCYY					ANYTOWN WI 55555-1234					022222220 ZZ123456789X														
SIGNED _____ DATE _____					NPI					NPI					NPI														

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Sample of a Correctly Aligned UB-04 Claim Form

1 IM BILLING PROVIDER 444 E CLAIREMONT ANYTOWN WI 55555-1234 (444) 444-4444	2	3a PAT CNTL #	4 TYPE OF BILL XXX
5 MED REC # 11 7654321	6 STATEMENT COVERS PERIOD FROM	7 THROUGH	
8 FED TAX NO. 01-2345678	9 PATIENT NAME	10 PATIENT ADDRESS	11 ON FILE
12 MEMBER, IM A	13	14	15
16 BIRTHDATE	17 SEX	18 DATE	19 ADMISSION 13 NR 14 TYPE 15 SRC 16 DHR 17 STAT
20	21	22	23
24	25	26	27
28	29 ACCT STATE	30	31
32 OCCURRENCE DATE	33 OCCURRENCE DATE	34 OCCURRENCE DATE	35 OCCURRENCE DATE
36 OCCURRENCE SPAN FROM	37 THROUGH	38 OCCURRENCE SPAN FROM	39 THROUGH
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848	849	850	851
852	853	854	855
856	857	858	859
860	861	862	863
864	865	866	867
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876	877	878	879
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884	885	886	

Sample of an Incorrectly Aligned UB-04 Claim Form

1 IM BILLING PROVIDER 444 E CLAIREMONT ANYTOWN WI 55555-1234 (444) 444-4444		2		3a PAT CNTL #		4 TYPE OF BILL XXX	
8 PATIENT NAME MEMBER, IM A		9 PATIENT ADDRESS ON FILE		5 MED REC # 117654321		6 STATEMENT COVERS PERIOD FROM THROUGH 01-2345678 MMDDCCYY MMDDCCYY	
10 BIRTHDATE		11 SEX		12 DATE		13 HR	
14 TYPE		15 SRC		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACUT STATE	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 OCCURRENCE DATE		36 OCCURRENCE DATE		37 OCCURRENCE DATE		38 OCCURRENCE DATE	
39 CODE		40 CODE		41 CODE		42 CODE	
43 DESCRIPTION		44 HCPCS / RATE / HPPS CODE		45 SERV DATE		46 SERV UNITS	
47 TOTAL CHARGES		48 NON-COVERED CHARGES		49		50	
XXXX		XXXXX		MMDDYY		1.0	
XXXX		XXXXX		MMDDYY		1.0	
XXXX		XXXXX		MMDDYY		1.0	
PAGE 1 OF 1		CREATION DATE		TOTALS		XXX XX 0111111110	
50 PAYER NAME T19 MEDICAID		51 HEALTH PLAN ID		52 REL NPI		53 ADJ SER	
54 FROTH PAYMENTS		55 EST. AMOUNT DUE		56 NPI		57 OTHER PRV ID	
58 INSURED'S NAME SAME		59 PHEL		60 INSURED'S UNIQUE ID 1234567890		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66		67		68		69	
70		71		72		73	
74 PRINCIPAL PROCEDURE CODE		75 OTHER PROCEDURE CODE		76 OTHER PROCEDURE CODE		77 OTHER PROCEDURE CODE	
78 ATTENDING NPI		79 OPERATING NPI		80 OTHER NPI		81 OTHER NPI	
LAST		FIRST		LAST		FIRST	
82		83		84		85	
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Topic #1402

Provider Numbers

Providers are required to indicate their FQHC (federally qualified health center) NPI (National Provider Identifier) on all claims submitted to ForwardHealth for FQHC services. The FQHC NPI is used to report FQHC services to the federal government. Claims that are submitted under an FQHC group/clinic NPI must include an appropriate rendering provider NPI.

FQHCs may also have separate provider numbers to provide the following services:

- Case management.
- Community support.
- Day treatment.
- Mental health.
- Personal care.
- Prenatal care.
- Substance abuse.

Services provided by these provider types may be considered FQHC services. Claims for services that are *not* FQHC services must be submitted under a separate NPI.

Topic #10637

Reimbursement Reduction for Most Paper Claims

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

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

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

The reimbursement reduction applies to the following paper claims:

- 1500 Health Insurance Claim Form ((02/12)).
- UB-04 (CMS 1450) Claim Form.
- [Compound Drug Claim \(F-13073 \(07/12\)\)](#) form.
- [Noncompound Drug Claim \(F-13072 \(07/12\)\)](#) form.

Exceptions to Paper Claim Reimbursement Reduction

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

- In-state emergency providers.
- Out-of-state providers.
- Medicare crossover claims.
- Any claims that ForwardHealth requires additional supporting information to be submitted on paper. For example:
 - Hysterectomy claims must be submitted along with an [Acknowledgment of Receipt of Hysterectomy Information \(F-01160 \(06/13\)\)](#) form.
 - Sterilization claims must be submitted along with a paper [Consent for Sterilization \(F-01164 \(10/08\)\)](#) form.
 - Claims submitted to Timely Filing appeals must be submitted on paper with a [Timely Filing Appeals Request \(F-13047 \(07/12\)\)](#) form.
 - In certain circumstances, drug claims must be submitted on paper with a [Pharmacy Special Handling Request \(F-](#)

[13074 \(07/12\)](#) form.

- o Claims submitted with four or more NDCs (National Drug Codes) for compound and noncompound drugs with specific and non-specific HCPCS (Healthcare Common Procedure Coding System) procedure codes.

Topic #15977

Submitting Multiple National Drug Codes per Procedure Code

If two or more NDCs (National Drug Codes) are submitted for a single procedure code, the procedure code is required to be repeated on separate details for each unique NDC. Whether billing a compound or noncompound drug, the procedures for billing multiple components (NDCs) with a single HCPCS (Healthcare Common Procedure Coding System) code are the same.

Claim Submission Instructions for Claims with Two or Three National Drug Codes

When two NDCs are submitted on a claim, a KP modifier (first drug of a multiple drug unit dose formulation) is required on the first detail and a KQ modifier (second or subsequent drug of a multiple drug unit dose formulation) is required on the second detail.

For example, if a provider administers 150 mg of Synagis[®], and a 100 mg vial and a 50 mg vial were used, then the NDC from each vial must be submitted on the claim. Although the vials have different NDCs, the drug has one procedure code, 90378 (Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each). In this example, the same procedure code would be reported on two details of the claim and paired with different NDCs.

Procedure Code	NDC	NDC Description
90378	60574-4111-01	Synagis [®] — 100 mg
90378	60574-4112-01	Synagis [®] — 50 mg

Example 1500 Health Insurance Claim Form for Submitting Two National Drug Codes per Procedure Code

	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER	F. S CHARGES	G. DAYS OR UNITS	H. FIRST Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
	MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER							
1	N460574411101	ME100	11					90378	KP			AC	500.00	2	N	NPI	0123456789
2	N460574411201	ME50	11					90378	KQ			AC	500.00	1	N	NPI	0123456789

When three NDCs are submitted on a claim, a KP modifier is required on the first detail, a KQ modifier on the second detail, and the modifier should be left blank on the third detail.

For example, if a provider administers a mixture of 1 mg of hydromorphone HCl powder, 125 mg of bupivacaine HCl powder, and 50 ml of sodium chloride 0.9 percent solution, each NDC is required on a separate detail. However, this compound drug formulation is required to be billed under one procedure code, J3490 (Unclassified drugs), and the same procedure code must be reported on three separate details on the claim and paired with different NDCs.

Procedure Code	NDC	NDC Description
J3490	00406-3245-57	Hydromorphone HCl Powder — 1 mg

J3490	38779-0524-03	Bupivacaine HCl Powder — 125 mg
J3490	00409-7984-13	Sodium Chloride 0.9% Solution — 50 ml

Example 1500 Health Insurance Claim Form for Submitting Three National Drug Codes per Procedure Code

	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSON Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #			
	From	To	MM	DD	YY	MM			DD	YY	CPT/HCPCS							MODIFIER		
1	N400406324557	ME1	11	13	14	11	13	14	11		J3490	KP			AC	500.00	1	N	NPI	0123456789
2	N438779052403	ME125	11	13	14	11	13	14	11		J3490	KQ			AC	500.00	1	N	NPI	0123456789
3	N400409798413	ML50	11	13	14	11	13	14	11		J3490				AC	500.00	1	N	NPI	0123456789

Claims for provider-administered drugs with two or three NDCs may be submitted to ForwardHealth via the following methods:

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

Claim Submission Instructions for Claims with Four or More National Drug Codes

When four or more components are reported, each component is required to be listed separately in a statement of ingredients on an attachment that must be appended to a paper 1500 Health Insurance Claim Form.

Note: The reimbursement reduction for paper claims will not affect claims submitted on paper with four or more NDCs, as described above.

Covered and Noncovered Services

2

Archive Date:02/02/2015

Covered and Noncovered Services:Codes

Topic #1889

Allowable Codes

FQHCs (federally qualified health centers) are required to indicate procedure codes, POS (place of service) codes, diagnosis codes, etc., that are allowable for the DOS (date of service) and that most accurately identify the service on PA (prior authorization) requests, claims, and adjustments. Allowable codes are identified in each service area of the ForwardHealth Portal.

Topic #17537

Skin Substitute Products Procedure Codes

The following table lists allowable procedure codes, corresponding application codes, and related diagnosis codes for CTPs (cellular/tissue-based products). Providers are required to follow CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) coding guidelines for reporting application procedure codes and product codes when submitting claims to ForwardHealth. Application procedure codes will not be covered when associated with noncovered CTPs.

No PA (prior authorization) is required for CTP products. All non-indicated conditions are considered noncovered.

HCPCS Code	Description	Covered Conditions	CPT Application Code	Diagnosis Code(s)	Description
Q4101	Apligraf, per square centimeter	Venous leg ulcers	15271-15278	454.0	Varicose veins of Lower Extremities with ulcer
				454.2	Varicose veins of lower extremities with ulcer and inflammation
				459.81	Venous (peripheral) insufficiency, unspecified
				707.12*	Ulcer of calf
				707.13*	Ulcer of ankle
				707.14*	Ulcer of heel and midfoot
				707.15*	Ulcer of other part of foot (toe)
				707.19*	Ulcer of other part of lower limb
		Full-thickness neuropathic diabetic foot ulcers	15275-15278	249.60-249.71	Secondary diabetes mellitus with neurologic manifestations or peripheral disorders
				250.60-250.83	Diabetes with neurologic, peripheral or other specified disorders
				707.13	Ulcer of ankle
				707.14	Ulcer of heel and midfoot

				707.15	Ulcer of other part of foot (toe)
Q4106	Dermagraft, per square centimeter	Full-thickness neuropathic diabetic foot ulcers	15275-15278	249.60-249.83	Secondary diabetes mellitus with neurologic manifestations or peripheral disorders
				250.60-250.83	Diabetes with neurologic, peripheral, or other specified disorders
				707.13**	Ulcer of ankle
				707.14**	Ulcer of heel and midfoot
				707.15**	Ulcer of other part of foot (toe)
Q4116	Alloderm, per square centimeter	Breast reconstructive surgery	15271-15274, 15777	174.0-174.9	Malignant neoplasm of female breast
				175.0-175.9	Malignant neoplasm of male breast
				233.0	Carcinoma in situ of breast
				V10.3	Personal history of malignant neoplasm; breast
				V45.71	Acquired absence of breast and nipple

* The ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) code must be billed with ICD-9-CM code 459.81 as the primary diagnosis.

** The ICD-9-CM code must be billed with ICD-9-CM code 249.60-249.83 or 250.60-250.83 as the primary diagnosis.

Topic #643

Unlisted Procedure Codes

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

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

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

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

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

For most unlisted codes, ForwardHealth requires additional documentation.

Unlisted Codes That Require Prior Authorization

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

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

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

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

Unlisted Codes That Do Not Require Prior Authorization

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

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

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

How to Submit Claims and Related Documentation

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

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

Covered Services and Requirements

Topic #17517

Cellular/Tissue-Based Products

ForwardHealth covers CTPs (cellular/tissue-based products) in limited circumstances where evidence of efficacy is strong. ForwardHealth only covers CTPs for wound treatment for members with neuropathic diabetic foot ulcers, non-infected venous leg ulcers, or members who are undergoing breast reconstruction surgery following a breast cancer diagnosis.

CTPs are biological or biosynthetic products used to assist in the healing of open wounds. Evidence of the efficacy of this treatment varies significantly by both the patient treated and the product being used.

Product Coverage Review Policy

Currently, limited research is available on the effectiveness of CTPs. ForwardHealth uses [Hayes ratings](#) to determine the appropriateness and effectiveness of medical products such as CTPs.

Topic #17897

Continuous Glucose Monitoring

Professional Continuous Glucose Monitoring (Provider-Owned Equipment)

Professional continuous glucose monitoring utilizing provider-owned equipment is covered for BadgerCare Plus and Medicaid members as a supplement to standard care for diabetes when the primary care provider or attending provider determines such monitoring is medically necessary to establish an optimal insulin regimen. Results must be monitored and interpreted under physician supervision.

Professional continuous glucose monitoring is a diagnostic measurement of glucose levels received throughout the day and night. This type of glucose monitoring is done as a 3-5 day test to evaluate diabetes control.

The following CPT (Current Procedural Terminology) procedure codes are covered for members receiving professional continuous glucose monitoring:

- 95250 (Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording).
- 95251 (Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; interpretation and report).

Procedure codes 95250 and 95251 require a minimum of 72 hours of data and may be reimbursed up to four times per year but may not be reimbursed more than once per month. PA (prior authorization) is not required.

Supplies and equipment are not separately reimbursable as they are included in the reimbursement for procedure code 95250.

Allowable provider types and POS (places of service) are listed in the [interactive maximum allowable fee schedules](#).

Note: Procedure code 99091, which describes the collection and interpretation of physiologic data collected in digital format,

requiring a minimum of 30 minutes interpretation time, should not be used with professional continuous glucose monitoring and cannot be reported in conjunction with procedure code 95250 or 95251. Procedure code 95251 does not require a face-to-face visit.

Documentation Requirements

The member's medical record must include documentation supporting the medical necessity of professional continuous glucose monitoring to establish optimal insulin regimens for members with insulin-requiring diabetes and documented inadequate glycemic control. The documentation must also include monitor calibration, member training, sensor removal, and recording printout, as well as the physician report with interpretation and findings based on information obtained during monitoring.

Personal Continuous Glucose Monitoring (Purchased for Individual Member)

Personal continuous glucose monitoring is noncovered. This includes member-owned continuous glucose monitoring devices, meters, test strips, and other supplies directly related to personal continuous glucose monitoring.

Topic #44

Definition of Covered Services

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

Topic #17937

Low-Dose Computed Tomography Scans

ForwardHealth covers low-dose CT (computed tomography) scans (identified by HCPCS (Healthcare Common Procedure Coding System) procedure code S8032) for lung cancer screening without PA (prior authorization) for Wisconsin Medicaid and BadgerCare Plus-enrolled members who are at high risk for lung cancer and meet all of the following criteria:

- Are aged 55 to 80.
- Have a 30-pack-a-year smoking history, as indicated by the appropriate ICD (International Classification of Diseases) diagnosis code.
- Are either current smokers or have quit smoking within the past 15 years, as indicated by the appropriate ICD diagnosis code.
- Have no signs or symptoms suggestive of underlying cancer.

ForwardHealth requires PA for coverage of all other CT scans, including those that would be performed as a follow up to the initial low-dose CT screening, unless the provider has an exemption under ForwardHealth's [advanced imaging PA exemption program](#).

Topic #510

Telemedicine

Telemedicine services (also known as "Telehealth") are services provided from a remote location using a combination of interactive video, audio, and externally acquired images through a networking environment between a member (i.e., the originating

site) and a Medicaid-enrolled provider at a remote location (i.e., distant site). The services must be of sufficient audio and visual fidelity and clarity as to be functionally equivalent to a face-to-face contact. Telemedicine services do not include telephone conversations or Internet-based communication between providers or between providers and members.

All applicable HIPAA (Health Information Portability and Accountability Act of 1996) confidentiality requirements apply to telemedicine encounters.

Reimbursable Telemedicine Services

The following individual providers are reimbursed for selected telemedicine-based services:

- Physicians and physician clinics.
- RHCs (rural health clinics).
- FQHCs (federally qualified health centers).
- Physician assistants.
- Nurse practitioners.
- Nurse midwives.
- Psychiatrists in private practice.
- Ph.D. psychologists in private practice.

These providers may be reimbursed, as appropriate, for the following services provided through telemedicine:

- Office or other outpatient services (CPT (Current Procedural Terminology) procedure codes 99201-99205, 99211-99215).
- Office or other outpatient consultations (CPT codes 99241-99245).
- Initial inpatient consultations (CPT codes 99251-99255).
- Outpatient mental health services (CPT codes 90785, 90791-90792, 90832-90834, 90836-90840, 90845-90847, 90849, 90875, 90876, and 90887).
- Health and behavior assessment/intervention (CPT codes 96150-96152, 96154-96155).
- ESRD (end-stage renal disease)-related services (CPT codes 90951-90952, 90954-90958, 90960-90961).
- Outpatient substance abuse services (HCPCS (Healthcare Common Procedure Coding System) codes H0022, H0047, T1006).

Reimbursement for these services is subject to the same restrictions as face-to-face contacts (e.g., POS (place of service), allowable providers, multiple service limitations, PA (prior authorization)).

Claims for services performed via telemedicine must include HCPCS modifier "GT" (via interactive audio and video telecommunication systems) with the appropriate procedure code and must be submitted on the 837P (837 Health Care Claim: Professional) transaction or 1500 Health Insurance Claim Form ((02/12)). Reimbursement is the same for these services whether they are performed face-to-face or through telemedicine.

Only one eligible provider may be reimbursed per member per DOS (dates of service) for a service provided through telemedicine unless it is medically necessary for the participation of more than one provider. Justification for the participation of the additional provider must be included in the member's medical record.

Separate services provided by separate specialists for the same member at different times on the same DOS may be reimbursed separately.

Services Provided by Ancillary Providers

Claims for services provided through telemedicine by ancillary providers should continue to be submitted under the supervising physician's NPI (National Provider Identifier) using the lowest appropriate level office or outpatient visit procedure code or other appropriate CPT code for the service performed. These services must be provided under the direct on-site supervision of a

physician and documented in the same manner as face-to-face services. Coverage is limited to procedure codes 99211 or 99212, as appropriate.

Federally Qualified Health Centers and Rural Health Clinics

Telemedicine may be reported as an encounter on the cost settlement report for both RHCs and FQHCs when both of the following are true:

- The RHC or FQHC is the distant site.
- The member is an established patient of the RHC or FQHC at the time of the telemedicine service.

Members Located in Nursing Homes

Claims for telemedicine services where the originating site is a nursing home should be submitted with the appropriate level office visit or consultation procedure code.

Out-of-State Providers

Out-of-state providers, except border-status providers, are required to obtain PA before delivering telemedicine-based services to Wisconsin Medicaid members.

Documentation Requirements

All telemedicine services must be thoroughly documented in the member's medical record in the same way as if it were performed as a face-to-face service.

Eligible Members

All members are eligible to receive services through telemedicine. Providers may not require the use of telemedicine as a condition of treating the member. Providers should develop their own methods of informed consent verifying that the member agrees to receive services via telemedicine.

Telemedicine and Enhanced Reimbursement

Providers may receive enhanced reimbursement for pediatric services (services for members 18 years of age and under) and HPSA (Health Professional Shortage Area)-eligible services performed via telemedicine in the same manner as face-to-face contacts. As with face-to-face visits, HPSA-enhanced reimbursement is allowed when either the member resides in or the provider is located in a [HPSA-eligible ZIP code](#). Providers may submit claims for services performed through telemedicine that qualify for pediatric or HPSA-enhanced reimbursement with both modifier "GT" and the applicable pediatric or HPSA modifier.

Originating Site Facility Fee

An originating site may be reimbursed a facility fee. The originating site is a facility at which the member is located during the telemedicine-based service. It may be a physician's office, a hospital outpatient department, an inpatient facility, or any other appropriate POS with the requisite equipment and staffing necessary to facilitate a telemedicine service. The originating site may not be an emergency room.

Note: The originating site facility fee is not an RHC/FQHC service and, therefore, may not be reported as an encounter on the cost report. Any reimbursement for the originating site facility fee must be reported as a deductive value on the cost report.

Claim Submission

The originating site is required to submit claims for the facility fee with HCPCS code Q3014 (Telehealth originating site facility fee). These claims must be submitted on an 837P transaction or a 1500 Health Insurance Claim Form with a POS code appropriate to where the service was provided.

Code	Description
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Center
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Facilities for Developmental Disabilities
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Nonresidential Substance Abuse Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End-Stage Renal Disease Treatment Facility
71	Public Health Clinic
72	Rural Health Clinic

99	Other Place of Service
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Outpatient Hospital Reimbursement

Wisconsin Medicaid will reimburse outpatient hospitals only the facility fee (Q3014) for the service. Wisconsin Medicaid will separately reimburse an outpatient hospital for other covered outpatient hospital services only if they are provided beyond those included in the telemedicine service on the same DOS. Professional services provided in the outpatient hospital are separately reimbursable.

Store and Forward Services

"Store and forward" services are the asynchronous transmission of medical information to be reviewed at a later time by a physician or nurse practitioner at the distant site. These services are not separately reimbursable.

Health Professional Shortage Areas

Note: The county is listed for information purposes only. Not all ZIP codes in a county may be included in the HPSA.

Name	County	ZIP Codes
Adams County	Adams	Entire county: 53910, 53920, 53927, 53934, 53936, 53952, 53964, 53965, 54457, 54613, 54921, 54930, 54943, 54966
Augusta/Osseo	Eau Claire	54722, 54741, 54758, 54770
	Jackson	54635, 54741, 54758
	Trempealeau	54758, 54770
Baldwin	St. Croix	54002, 54013, 54015, 54017, 54026, 54027, 54028, 54749, 54767
	Dunn	54749, 54751
Bayfield	Ashland	54850
	Bayfield	54814, 54827, 54844, 54891
Beloit	Rock	53511, 53512
Boscobel	Crawford	53805, 53826, 53831, 54657
	Grant	53518, 53573, 53801, 53804, 53805, 53809, 53816, 53821, 53827
	Richland	53518, 53573
Burnett County	Burnett	Entire county: 54801, 54813, 54830, 54837, 54840, 54845, 54853, 54871, 54872, 54893
Central Trempealeau	Trempealeau	54616, 54747, 54760, 54773
Chetek/Colfax	Barron	54004, 54728, 54733, 54757, 54762, 54812, 54889, 54895
	Dunn	54005, 54725, 54730, 54734, 54749, 54751, 54757, 54763, 54772
Chilton/New Holstein/Brillion	Calumet	53014, 53042, 53049, 53061, 53062, 54110, 54129, 54130
Clark County	Clark	Entire county: 54405, 54420, 54421, 54422, 54425, 54436, 54437, 54446, 54456, 54460, 54466, 54479, 54488, 54493, 54498, 54746, 54754, 54768, 54771
Clintonville/Marion	Outagamie	54106, 54170, 54922
	Shawano	54928, 54929, 54950
	Waupaca	54922, 54929, 54949, 54950
Coon Valley/Chaseburg	La Crosse	54619, 54623, 54667
	Vernon	54621, 54623, 54667
Darlington/Schullsburg	Green	53504, 53516
	Lafayette	53504, 53516, 53530, 53541, 53565, 53586, 53587
Durand	Buffalo	54736
	Dunn	54736, 54737, 54739, 54740, 54751, 54755
	Pepin	54721, 54736, 54759, 54769
	Pierce	54740, 54750, 54761, 54767
Eastern Marinette/Southern Menomonie	Marinette	54143, 54157, 54159, 54177

Elcho	Langlade	54424, 54428, 54435, 54462, 54485
	Oneida	54435, 54463
Florence County	Florence	Entire county: 54103, 54120, 54121, 54151, 54542
Forest County	Forest	Entire county: 54103, 54104, 54465, 54511, 54520, 54541, 54542, 54562, 54566
Frederic/Luck	Polk	54829, 54837, 54853
Galesville/Trempealeau	Trempealeau	54612, 54625, 54627, 54630, 54661
Hayward/Radisson	Bayfield	54517, 54821, 54832, 54839, 54873
	Sawyer	54817, 54835, 54843, 54862, 54867, 54876, 54896
	Washburn	54843, 54875, 54876
Hillsboro	Juneau	53929, 53968
	Monroe	53929, 54638, 54648, 54651, 54670
	Richland	53924, 53941, 54634
	Sauk	53968
	Vernon	53929, 53968, 54634, 54638, 54639, 54651
Hurley/Mercer	Iron	54534, 54536, 54545, 54547, 54550, 54559
Kenosha	Kenosha	53140, 53142, 53143, 53144
Kewaunee City/Algoma	Kewaunee	54201, 54205, 54216, 54217
Lancaster/Fennimore	Grant	53569, 53802, 53804, 53806, 53809, 53810, 53813, 53820, 53825
Land O'Lakes/Presque Isle	Vilas	54540, 54547, 54557
Markesan/Kingston	Green Lake	53923, 53926, 53939, 53946, 53947, 53949
Marquette County	Marquette	Entire county: 53920, 53926, 53930, 53949, 53952, 53953, 53954, 54960, 53964, 54982
Menominee County	Menominee	Entire county: 54135, 54150, 54416
Milwaukee	Milwaukee	53203, 53204, 53205, 53206, 53208, 53209, 53210, 53212, 53215, 53216, 53218, 53233
Minong/Solon Springs	Douglas	54820, 54830, 54838, 54849, 54859, 54873
	Washburn	54859, 54875, 54888
Mondovi	Buffalo	54610, 54622, 54736, 54747, 54755
	Pepin	54755
Mountain/White Lake	Langlade	54430, 54465, 54491
	Oconto	54112, 54114, 54138, 54149, 54161, 54174, 54175, 54491
Oconto/Oconto Falls	Oconto	54101, 54124, 54139, 54141, 54153, 54154, 54171, 54174
	Shawano	54127
Platteville/Cuba City	Grant	53554, 53807, 53811, 53818, 53820
	Iowa	53554, 53580
	Lafayette	53510, 53803, 53807, 53811, 53818
Portage/Pardeeville	Columbia	53901, 53911, 53923, 53928, 53932, 53935, 53954, 53955, 53956, 53960, 53969
	Dodge	53956, 53957

Price/Mellen	Ashland	54514, 54527, 54546
	Iron	54552
	Price	Entire county: 54459, 54513, 54514, 54515, 54524, 54530, 54537, 54552, 54555, 54556, 54564
Pulaski	Brown	54162
	Shawano	54162, 54165
	Oconto	54162
Rusk County	Rusk	Entire county: 54526, 54530, 54563, 54728, 54731, 54745, 54757, 54766, 54817, 54819, 54835, 54848, 54868, 54895
Sister Bay/Washington Island	Door	54202, 54210, 54211, 54212, 54234, 54246
Sparta	Monroe	54615, 54619, 54648, 54656
Spooner/Shell Lake	Washburn	54801, 54813, 54817, 54870, 54871, 54875, 54888
Spring Green/Plain	Richland	53556
	Sauk	53556, 53577, 53578, 53583, 53588, 53937, 53943, 53951
Stanley/Cornell	Chippewa	54726, 54727, 54732, 54745, 54757, 54766, 54768
	Eau Claire	54722, 54726, 54742, 54768
Sturgeon Bay	Door	54201, 54202, 54204, 54209, 54213, 54217, 54235
Taylor County	Taylor	Entire county: 54422, 54425, 54433, 54434, 54439, 54447, 54451, 54460, 54470, 54480, 54490, 54498, 54766, 54768, 54771
Tigerton/Biramwood	Marathon	54408, 54414, 54427, 54429, 54440, 54499
	Shawano	54409, 54414, 54416, 54427, 54450, 54486, 54499
	Waupaca	54486, 54926, 54945
Tomahawk	Lincoln	54435, 54442, 54487, 54501, 54564
	Oneida	54487, 54529, 54564
Wausau, City of	Marathon	54401, 54403
Waushara	Waushara	54909, 54923, 54930, 54940, 54943, 54960, 54965, 54966, 54967, 54970, 54981, 54982, 54984
Western Marinette	Marinette	54102, 54104, 54112, 54114, 54119, 54125, 54151, 54156, 54159, 54161, 54177

Medication Therapy Management

Topic #14477

An Overview of Medication Therapy Management

ForwardHealth implemented the MTM (Medication Therapy Management) benefit in conjunction with the WPQC (Wisconsin Pharmacy Quality Collaborative). The MTM benefit consists of the following types of services:

- **Intervention-based services.** These are focused interventions between a pharmacist and a member. All Medicaid-enrolled pharmacies are eligible to provide these services to members. Certification by the WPQC is *not* required to perform and receive reimbursement for intervention-based services.
- **CMR/A (Comprehensive Medication Review and Assessment) services.** These are private consultations between a pharmacist and a member to review the member's drug regimen. The member must be approved by ForwardHealth as a patient who is at [high risk](#) of experiencing medical complications due to his or her drug regimen to receive the CMR/A. The pharmacy requests approval to perform the CMR/A by calling the DAPO (Drug Authorization and Policy Override) Center. In addition to Medicaid enrollment, WPQC certification is required to perform and receive reimbursement for CMR/A services.

Topic #14497

Federally Qualified Health Centers

Services under the MTM benefit are not eligible for an allowable encounter; therefore, FQHCs (federally qualified health centers) are required to be Medicaid enrolled as pharmacy providers in order to be reimbursed for services covered under the MTM benefit.

When submitting claims for the MTM benefit, FQHCs will be required to provide the unique taxonomy code for the pharmacy. Claims submitted for the MTM benefit with the FQHC taxonomy will be denied. FQHCs should continue to submit non-MTM pharmacy claims under their FQHC NPI (National Provider Identifier) and taxonomy code.

Topic #17297

Electronic Submission of Documentation Requirement and Submission Options

ForwardHealth requires providers to submit MTM documentation electronically using one of the following options:

- ForwardHealth-approved MTM (Medication Therapy Management) case management software.
- The ForwardHealth Portal.

This electronic submission requirement is in addition to the requirement for providers to maintain on-site MTM documentation (either on paper or electronically) in the member's file. The information required to be submitted to ForwardHealth electronically is the same information required to be maintained in the member's file. Documentation for MTM services that is submitted to ForwardHealth may be used by ForwardHealth to evaluate the MTM benefit.

For MTM services provided between September 1, 2012, and August 31, 2014, providers are encouraged to submit

documentation electronically, although it is not a requirement to do so. Providers are still required to maintain on-site documentation (either on paper or electronically) for MTM services provided during this time period.

For MTM services provided on and after September 1, 2014, providers are required to submit the associated MTM documentation electronically within 365 days of submitting the claim for MTM services. Providers are encouraged to submit associated MTM documentation electronically within 30 days of submitting the claim for MTM services provided.

A separate record is required for each MTM service provided. Providers are reminded to only submit one record for each service provided. Documentation that is stored in ForwardHealth-approved MTM case management software is automatically sent to ForwardHealth; documentation stored on the Portal is also automatically sent to ForwardHealth. In order to avoid duplication, providers should not record documentation for the same services on both the Portal and in ForwardHealth-approved MTM case management software.

ForwardHealth-Approved Case Management Software

ForwardHealth will approve MTM case management software that meets certain criteria to access ForwardHealth's claim information. Approved software will be able to do the following:

- Identify BadgerCare Plus, SeniorCare, and Wisconsin Medicaid members who are eligible for MTM services.
- Submit claims for MTM services on a pharmacy provider's behalf.
- Capture, store, and maintain clinical information, including the required documentation for CMR/A (Comprehensive Medication Review and Assessment) or intervention-based services, in a member's file.
- Exchange clinical information with ForwardHealth. ForwardHealth will use this clinical information to evaluate the MTM benefit.

A list of [ForwardHealth-approved vendors](#) and their contact information is available.

Contracting Options

Pharmacy providers may choose to do one of the following:

- Contract with a ForwardHealth-approved MTM case management software vendor. Pharmacy providers who contract with a ForwardHealth-approved MTM case management software vendor are still required to receive approval from the [DAPO \(Drug Authorization and Policy Override\)](#) Center to provide CMR/A services.
- Contract with another MTM case management software vendor. Pharmacy providers who contract with an MTM case management software vendor not approved by ForwardHealth should note that the unapproved vendor will not be able to receive claim information from or exchange documentation with ForwardHealth.
- Not contract with any MTM case management software vendor. Pharmacy providers who do not contract with any MTM case management software vendor can still submit claims for MTM services and are still required to capture, store, and maintain required documentation in a member's file and to submit required documentation electronically.

Documentation on the ForwardHealth Portal

Pharmacy providers have the option to capture, retrieve, and submit required MTM documentation on the secure Provider area of the ForwardHealth Portal. This is an optional service for providers; however, it will fulfill ForwardHealth's electronic documentation submission requirement for MTM services.

For assistance regarding the submission of MTM documentation on the Portal, call the [ForwardHealth Portal Helpdesk](#) or refer to the [Medication Therapy Management Documentation Storage User Guide](#).

EHR Incentive Program

3

Archive Date:02/02/2015

EHR Incentive Program: Adopting, Implementing, or Upgrading Certified EHR Technology

Topic #12102

Adopting EHR Technology

In order to qualify for a Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program payment under "adoption," Eligible Professionals and Eligible Hospitals must demonstrate acquisition, installation, or contractual proof of a future acquisition of CEHRT (Certified Electronic Health Record Technology) in the first payment year. All information is subject to audit at any time and must be retained by the Eligible Professional or Eligible Hospital for six years post-attestation. If selected for an audit, the applicant must be able to supply one of the following items:

- Receipt(s) for the CEHRT. The receipt must match the products associated with the CMS (Centers for Medicare and Medicaid Services) EHR certification ID the applicant received from the ONC (Office of the National Coordinator for Health Information Technology) for Health IT Certified EHR [Product List](#) and reported through the application process.
- A contract for the CEHRT. The products listed in the contract must match the products associated with the CMS EHR certification ID the applicant received from ONC's Certified Health IT Product List and reported through the application process.

Additional documentation may be considered but must, at a minimum, identify the CEHRT adopted and indicate the CEHRT acquired or purchased.

Topic #12103

Implementing EHR Technology

In order to qualify for a Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program payment under "implementation," Eligible Professionals and Eligible Hospitals must meet the criteria for adopting CEHRT (Certified Electronic Health Record Technology) and demonstrate actual implementation, installation, or utilization of CEHRT. Examples of how to demonstrate implementation of CEHRT includes completing a workflow analysis and redesign, training staff on the use of modules, and patient demographics and administrative data. All information is subject to audit at any time and must be retained by the Eligible Professional or Eligible Hospital for six years post-attestation. If selected for an audit, the applicant must be able to supply at least one document from each of the following lists:

List One:

- Receipt(s) for the CEHRT. The receipt must match the products associated with the CMS (Centers for Medicare and Medicaid Services) EHR certification ID that the applicant received from the ONC (Office of the National Coordinator for Health Information Technology) Certified Health IT [Product List](#) and reported through the application process.
- A contract for the CEHRT. The products listed in the contract must match the products associated with the CMS EHR certification ID the applicant received from ONC's Certified Health IT Product List and reported through the application process.

List Two:

- Maintenance agreement.
- Installation contract or receipts.

- System logs indentifying use of the certified technology and/or user license agreements.
- Evidence of cost, contract, or third party certification of CEHRT training.

Additional documentation may be considered but must, at a minimum, identify the CEHRT implemented and indicate the CEHRT acquired or purchased.

If attesting to "implementation," the Eligible Professional or Eligible Hospital will select from a list of implementation activities that are either "Planned" or "Completed." Some examples of these activities include workflow analysis, workflow redesigns, software installations, hardware installations, and peripheral installations.

Topic #12104

Upgrading EHR Technology

In order to qualify for a Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program payment under "upgrade," Eligible Professionals and Eligible Hospitals must meet the criteria for adopting and implementing and demonstrate expansion of the CEHRT (Certified Electronic Health Record Technology)'s functionality, such as the addition of an e-prescribing functionality or CPOE (Computerized Physician Order Entry). All information is subject to audit at any time and must be retained by the Eligible Professional or Eligible Hospitals for six years post-attestation. If selected for an audit, the applicant must be able to supply one of the following items:

- Receipt(s) for the CEHRT. The receipt must match the products associated with the CMS (Centers for Medicare and Medicaid Services) EHR certification ID the applicant received from the ONC (Office of the National Coordinator for Health Information Technology) Certified Health IT [Product List](#) and reported through the application process.
- Executed contract for the CEHRT. The products in listed in the contract must match the products associated with the CMS EHR certification ID the applicant received from ONC's Certified Health IT Product List and reported through the application process.

Additional documentation may be considered but must, at a minimum, identify the CEHRT upgraded and indicate the CEHRT acquired or purchased.

Topic #12497

Uploading Documentation for Adopting, Implementation, and Upgrading Certified EHR Technology

It is recommended, but not required, that Eligible Professionals and Hospitals provide documentation supporting adoption, implementation, or upgrading of CEHRT (Certified Electronic Health Record Technology). If attesting to adoption, implementation, or upgrade, the Eligible Professional or Hospital may upload supporting documentation at the conclusion of the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program application. Eligible Professionals and Hospitals may upload any relevant documentation to support their attestations related to adopting, implementing, or upgrading. This may include PDF (Portable Document Format) files (of no more than 2MBs) of purchase orders, vendor contracts to install the CEHRT, any other receipts, and any other auditable documentation.

All Eligible Professionals and Hospitals are reminded that they should retain supporting documentation for the Wisconsin Medicaid EHR Incentive Program application in their files for six years post-attestation.

An Overview

Topic #16897

Certified Electronic Health Record Technology

All Eligible Professionals are required to adopt CEHRT (Certified Electronic Health Record Technology) that meets the criteria outlined in the ONC (Office of the National Coordinator for Health Information Technology)'s 2014 Edition Standards & Certification Criteria Final Rule, regardless of the stage of Meaningful Use they are demonstrating. Eligible Professionals are required to have the following:

- The base EHR (electronic health record) technology outlined by the ONC.
- The EHR technology for the "core set" objectives and measures to which they are attesting for the applicable stage of Meaningful Use unless an exclusion applies.
- The EHR technology for the "menu set" objectives and measures to which they are attesting for the applicable stage of Meaningful Use.

An Eligible Professional's CEHRT must be able to support his or her ability to demonstrate the applicable stage of Meaningful Use.

Topic #17637

Flexibility in Implementing Certified Electronic Health Record Technology for Program Year 2014

Effective for Program Year 2014 only, if Eligible Professionals could not fully implement 2014 Edition CEHRT for their EHR reporting period due to delays in their EHR vendor releasing 2014 Edition CEHRT, they may use any of the following CEHRT, as appropriate:

- The 2011 Edition CEHRT.
- The 2014 Edition CEHRT.
- A combination of 2011 and 2014 Edition CEHRT.

EHR vendors must have been delayed in releasing 2014 Edition CEHRT because of insufficient time to develop, certify, and test 2014 Edition CEHRT. Eligible Professionals can only use the CEHRT flexibility options if they were then unable to train staff, test the updated edition, or establish new workflows.

If Eligible Professionals did not fully implement 2014 Edition CEHRT for financial reasons (i.e., the costs associated with implementing, upgrading, installing, or testing), then they are not eligible to use the CEHRT flexibility options.

Eligible Professionals who have fully implemented 2014 Edition CEHRT are required to attest to the original objectives and measures for their applicable stage of Meaningful Use for their EHR reporting period in Program Year 2014. For information regarding the original objectives and measures, Eligible Professionals should refer to the 2014 Stage 1 EHR Meaningful Use [Specification Sheets](#) or to the Stage 2 EHR Meaningful Use [Specification Sheets](#), as applicable.

Eligible Professionals who have fully implemented 2014 Edition CEHRT but cannot meet one or more of the original objectives and measures are not eligible to use the CEHRT flexibility options and are required to attest to their applicable stage of Meaningful Use using 2014 Edition CEHRT. The only exception would be if they are unable to meet the requirements for the Stage 2 Meaningful Use Summary of Care measure.

The CMS (Centers for Medicare and Medicaid Services) has made an exception for Eligible Professionals who could not meet the threshold for the 2014 Stage 2 Summary of Care measure, which requires the transmission of an electronic summary of care document, because the recipients of the transitions or referrals were impacted by the delays in 2014 Edition CEHRT availability, resulting in their not being able to receive the electronic summary of care document. As a result, Eligible Professionals may attest to using one of the CEHRT flexibility options. Eligible Professionals are required to retain documentation clearly demonstrating that they were unable to transmit the electronic summary of care document for more than 10 percent of transitions or referrals.

The sections below indicate available attestation options based on an Eligible Professional's originally scheduled attestation and CEHRT edition, and the table below summarizes this information. The CEHRT flexibility options are only available to qualified Eligible Professionals.

Eligible Professionals are required to attest to the CMS-established Meaningful Use objectives and measures and related CQMs (clinical quality measures) for their applicable stage of Meaningful Use and cannot switch between years. For example, Eligible Professionals who are attesting to 2013 Stage 1 Meaningful Use objectives and measures cannot attest to 2014 CQMs; they are required to attest to 2013 CQMs.

Attesting to Adopt, Implement, or Upgrade in Program Year 2014

Eligible Professionals who were originally scheduled to attest to adopting, implementing, or upgrading CEHRT in Program Year 2014 are required to attest using 2014 Edition CEHRT. Eligible Professionals who are adopting, implementing, or upgrading CEHRT in Program Year 2014 may start their application immediately.

Attesting to Stage 1 Meaningful Use in Program Year 2014

The 2011 Edition Certified Electronic Health Record Technology

Eligible Professionals who could not fully implement 2014 Edition CEHRT for their EHR reporting period in Program Year 2014 due to delays in 2014 CEHRT availability and who were originally scheduled to attest to 2014 Stage 1 Meaningful Use are able to use 2011 Edition CEHRT to attest to 2013 Stage 1 Meaningful Use objectives and measures and related CQMs. Eligible Professionals who are attesting to 2013 Stage 1 Meaningful Use objectives and measures and related CQMs in Program Year 2014 with 2011 Edition CEHRT may start their application in spring 2015 after the system has been updated to allow this option for the EHR reporting period in Program Year 2014. When completing their application, Eligible Professionals are required to attest that they were unable to fully implement 2014 Edition CEHRT due to delays in 2014 Edition CEHRT availability.

The 2014 Edition Certified Electronic Health Record Technology

Eligible Professionals who were originally scheduled to attest to 2014 Stage 1 Meaningful Use are able to use 2014 Edition CEHRT to attest to 2014 Stage 1 Meaningful Use objectives and measures and related CQMs. Eligible Professionals who are attesting to Stage 1 Meaningful Use in Program Year 2014 can start their application immediately since they are attesting to 2014 Stage 1 objectives and measures and related CQMs as originally scheduled.

Combination of the 2011 and 2014 Edition Certified Electronic Health Record Technology

Eligible Professionals who could not fully implement 2014 Edition CEHRT for their EHR reporting period in Program Year 2014 due to delays in 2014 CEHRT availability and who were originally scheduled to attest to 2014 Stage 1 Meaningful Use are able to use a combination of 2011 and 2014 Edition CEHRT to attest to one of the following:

- The 2013 Stage 1 Meaningful Use objectives and measures and related CQMs.
- The 2014 Stage 1 Meaningful Use objectives and measures and related CQMs.

Eligible Professionals who are attesting to 2013 Stage 1 or 2014 Stage 1 Meaningful Use objectives and measures and related

CQMs in Program Year 2014 with 2011 and 2014 Edition CEHRT may start their application in spring 2015 after the system has been updated to allow these options for the EHR reporting period in Program Year 2014. When completing their application, Eligible Professionals are required to attest that they were unable to fully implement 2014 Edition CEHRT due to delays in 2014 Edition CEHRT availability.

Attesting to Stage 2 Meaningful Use in Program Year 2014

The 2011 Edition Certified Electronic Health Record Technology

Eligible Professionals who could not fully implement 2014 Edition CEHRT for their EHR reporting period in Program Year 2014 due to delays in 2014 CEHRT availability (including delays affecting their ability to meet the threshold for the Stage 2 Summary of Care measure) and who were originally scheduled to attest to 2014 Stage 2 Meaningful Use are able to use 2011 Edition CEHRT to attest to 2013 Stage 1 Meaningful Use objectives and measures and related CQMs. Eligible Professionals who are attesting to 2013 Stage 1 Meaningful Use objectives and measures and related CQMs with 2011 Edition CEHRT may start their application in spring 2015 after the system has been updated to allow this option for the EHR reporting period in Program Year 2014. When completing their application, Eligible Professionals are required to attest that they were unable to fully implement 2014 Edition CEHRT due to delays in 2014 Edition CEHRT availability.

The 2014 Edition Certified Electronic Health Record Technology

Eligible Professionals who were originally scheduled to attest to 2014 Stage 2 Meaningful Use are able to use 2014 Edition CEHRT to attest to one of the following:

- The 2014 Stage 1 Meaningful Use objectives and measures and related CQMs. Only Eligible Professionals who could not fully implement 2014 Edition CEHRT for their EHR reporting period in Program Year 2014 due to delays in 2014 CEHRT availability (including delays affecting their ability to meet the threshold for the Stage 2 Summary of Care measure) may use this option. Eligible Professionals who are attesting to 2014 Stage 1 Meaningful Use objectives and measures and related CQMs with 2014 Edition CEHRT may start their application in spring 2015 after the system has been updated to allow these options for the EHR reporting period in Program Year 2014. When completing their application, Eligible Professionals are required to attest that they were unable to fully implement 2014 Edition CEHRT due to delays in 2014 Edition CEHRT availability.
- The 2014 Stage 2 Meaningful Use objectives and measures and related CQMs. Eligible Professionals who are attesting to 2014 Stage 2 Meaningful Use in Program Year 2014 can start their application immediately since they are attesting to 2014 Stage 2 objectives and measures and related CQMs as originally scheduled.

Combination of the 2011 and 2014 Edition Certified Electronic Health Record Technology

Eligible Professionals who could not fully implement 2014 Edition CEHRT for their EHR reporting period in Program Year 2014 due to delays in 2014 CEHRT availability (including delays affecting their ability to meet the threshold for the Stage 2 Summary of Care measure) and who were originally scheduled to attest to 2014 Stage 2 Meaningful Use are able to use a combination of 2011 and 2014 Edition CEHRT to attest to one of the following:

- The 2013 Stage 1 Meaningful Use objectives and measures and related CQMs.
- The 2014 Stage 1 Meaningful Use objectives and measures and related CQMs.
- The 2014 Stage 2 Meaningful Use objectives and measures and related CQMs.

Eligible Professionals who are attesting to 2013 Stage 1, 2014 Stage 1, or 2014 Stage 2 Meaningful Use objectives and measures and related CQMs in Program Year 2014 with 2011 and 2014 Edition CEHRT may start their application in spring 2015 after the system has been updated to allow these options for the EHR reporting period in Program Year 2014. When completing their application, Eligible Professionals are required to attest that they were unable to fully implement 2014 Edition CEHRT due to delays in 2014 Edition CEHRT availability.

Summary of Certified Electronic Health Record Technology Flexibility Options

The table below summarizes the options available to Eligible Professionals for using CEHRT for their applicable attestation in Program Year 2014.

Originally Scheduled Attestation Option for Program Year 2014	Meaningful Use Measures and Objectives to Which Eligible Professionals Can Attest	CEHRT Edition That Can Be Used	Date Wisconsin Medicaid EHR Incentive Program Application Can Be Started
Adopt, Implement, Upgrade	N/A	2014	Immediately
Stage 1 Meaningful Use	2013 Stage 1	2011*	Spring 2015
		Combination of 2011 and 2014*	Spring 2015
	2014 Stage 1	2014	Immediately
		Combination of 2011 and 2014*	Spring 2015
Stage 2 Meaningful Use	2013 Stage 1	2011*	Spring 2015
		Combination of 2011 and 2014*	Spring 2015
	2014 Stage 1	2014*	Spring 2015
		Combination of 2011 and 2014*	
	2014 Stage 2	2014	Immediately
		Combination of 2011 and 2014*	Spring 2015

* This option may only be used by Eligible Professionals who were unable to fully implement 2014 Edition CEHRT for their EHR reporting period in Program Year 2014 as a result of delays in 2014 Edition CEHRT availability.

Topic #12037

Overview of the EHR Incentive Program

The EHR (Electronic Health Record) Incentive Program was established under the American Recovery and Reinvestment Act of 2009, also known as the "Stimulus Bill," to encourage certain eligible health care professionals and hospitals to adopt and become meaningful users of CEHRT (Certified Electronic Health Record Technology).

Under the federal law, Medicare and Medicaid have separate EHR incentive programs. Eligible Professionals may register to participate in either the Medicare or Medicaid EHR Incentive Programs, but not both. Eligible Professionals may change their EHR Incentive Program election once, switching between Medicare and Medicaid, but the change in election must occur on or before December 31, 2014. All Eligible Professionals must be Wisconsin Medicaid-enrolled in order to participate in the Wisconsin Medicaid EHR Incentive Program. Eligible Professionals may participate in only one state's Medicaid EHR Incentive Program. Eligible Professionals should apply for EHR payments from the state with which they do most of their business.

Eligible Professionals must first register with the R&A (Medicare and Medicaid Electronic Health Record Incentive Program Registration and Attestation System). Eligible Professionals may then apply with the Wisconsin Medicaid EHR Incentive Program. All Wisconsin Medicaid EHR Incentive Program applications will be submitted through the secure Provider area of the ForwardHealth Portal.

Payments to Eligible Professionals will be made within 45 calendar days of the approval of a completed and submitted application. Eligible Professionals who meet all of the requirements may receive an incentive payment once per calendar year.

The Wisconsin Medicaid EHR Incentive Program will be available for Eligible Professionals from 2011 through 2021. The last date Eligible Professionals may register to begin receiving incentive payments for adopting, implementing, and upgrading EHR technology is December 31, 2016. Eligible Professionals may participate for a total of six years in the Wisconsin Medicaid EHR Incentive Program. Eligible Professionals are encouraged, but not required, to participate in all six allowed payment years.

The Wisconsin Medicaid EHR Incentive Program payment years are defined as calendar years and are composed in the following way:

- First payment year: Eligible Professionals are required to attest to adopting, implementing, or upgrading CEHRT.
- Second payment year: Eligible Professionals are required to demonstrate Meaningful Use of CEHRT during any 90-day, continuous period during the payment year.
- Third-sixth payment year: Eligible Professionals are required to demonstrate Meaningful Use of CEHRT for the entire payment year.

Eligible Professionals will have an additional grace period after the end of the Program Year to apply for an incentive payment for that Program Year. The Program Year for Eligible Professionals is based on the calendar year (i.e., January 1-December 31).

Eligible Professionals are not required to participate in consecutive years of the Wisconsin Medicaid EHR Incentive Program. For example, an Eligible Professional may register and complete all requirements for the first year in 2011 and receive a payment but then wait until 2013 to demonstrate Meaningful Use during a 90-day, continuous period for the second payment year.

All information submitted on the Wisconsin Medicaid EHR Incentive Program application is subject to audit at any time.

Appeals

Topic #12137

Appeals Process

To file an appeal, the Eligible Professional or Hospital should log into the secure ForwardHealth Portal and select the new quick link called the "Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program Appeal" on the secure Portal homepage.

Eligible Professionals and Hospitals (or an authorized preparer) filing a Wisconsin Medicaid EHR Incentive Program appeal should have the following information on hand when initiating an appeal:

- The NPI (National Provider Identifier) of the Eligible Hospital or Eligible Professional submitting the appeal.
- The payment year for which the appeal is being submitted.
- The name, telephone number, email address, and the preferred method of contact of the person submitting the appeal (i.e., the Eligible Hospital, Eligible Professional, or authorized preparer).

Once the Wisconsin Medicaid EHR Incentive Program has validated that the NPI matches a current application, the Eligible Professional or Hospital will then be able to select the reason to appeal from a drop-down list of reasons or will be able to provide a statement in a free-form comment box.

If the Wisconsin Medicaid EHR Incentive Program cannot match the NPI supplied with a current application, the Eligible Professional or Hospital will receive the following message: "A Wisconsin Medicaid EHR Incentive Program application that is denied or approved for payment is not found for the Eligible Hospital/Professional submitted. Please verify the information entered. If you believe this message was received in error, contact Provider Services." The Eligible Professional or Hospital should then contact Provider Services.

After selecting the reason for the appeal or providing a statement in the free-form comment box, the Eligible Professional or Hospital will then be able to upload any relevant supporting documentation in support of their appeal. This documentation may include any PDF (Portable Document Format) files up to 5 MBs each. Eligible Hospitals and Eligible Professionals should note that they must upload all relevant supporting documentation at the time of submission, as they will not be able to return to the appeal application to upload any documentation after submitting the appeal. Eligible Professionals and Eligible Hospitals will also have the option of creating a PDF of their appeal for their files.

After submission of the appeal, Eligible Professionals or Hospitals will receive a tracking number that is assigned to each appeal. Eligible Professionals and Hospitals should have this tracking number on hand to reference if they need to contact Provider Services regarding their appeal.

Once an appeal has been filed, the Eligible Professional or Hospital will receive an e-mail confirming the receipt of the appeal request and a second e-mail confirming that the appeal request has been adjudicated. The Wisconsin Medicaid EHR Incentive Program will communicate the appeal determination through a decision letter, sent to the address provided during Wisconsin Medicaid EHR Incentive Program application process, within 90 days of receipt of all information needed to make a determination. The decision letter will state whether the appeal has been denied or approved.

Topic #12477

Valid Reasons to Appeal

Eligible Professionals and Hospitals may only appeal to the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program for the following reasons:

- To dispute the payment amount.
- To appeal a denied Wisconsin Medicaid EHR Incentive Program application.

Appealing a Payment Amount

Eligible Professionals and Hospitals who wish to appeal a payment amount must do so within 45 calendar days of the RA (Remittance Advice) date of the Wisconsin Medicaid EHR Incentive Program payment.

Appealing a Denied Wisconsin Medicaid Electronic Health Record Incentive Program Application

Eligible Professionals and Hospitals who do not qualify for a Wisconsin Medicaid EHR Incentive Program payment will receive a denial letter in the mail, sent to the address provided during the Wisconsin Medicaid EHR Incentive Program application process. The letter will explain why their Wisconsin Medicaid EHR Incentive Program application was denied. Eligible Professionals and Hospitals who wish to appeal a denied Wisconsin Medicaid EHR Incentive Program application must do so within 45 calendar days from the date on the denial letter.

Eligible Professionals and Hospitals should refer to the tables below for the following information:

- A complete list of valid application denial appeal reasons.
- Additional supporting documentation that the Eligible Professional or Hospital may be required to upload based on the type of appeal, including instances when a statement is needed from the Eligible Professional or Hospital in the appeals application free-form comment box.
- Appealing the payment amount.

Denied Application Appeals	
Reason for Appeal	Documentation Needed
The patient volume required by the CMS (Centers for Medicare and Medicaid Services) have not been met, see federal rule 42 CFR 495.304.	<ul style="list-style-type: none"> • For Eligible Hospitals, provide the out-of-state patient volume for the reported 90-day period on the Wisconsin Medicaid EHR Incentive Program application. • For Eligible Professionals, provide the patient volume for the reported 90-day period on the Wisconsin Medicaid EHR Incentive Program application.
The Eligible Hospital has indicated it is not an acute care hospital with an average length of stay of 25 days or less or a children's hospital.	Acute care and children's hospitals are required to have an average length of stay for patients of 25 days or less to qualify for the Wisconsin Medicaid EHR Incentive Program. If the question was answered incorrectly when completing the original Wisconsin Medicaid EHR Incentive Program application, provide a clarifying statement indicating the reason why the Eligible Hospital meets the requirements for the program.
The Eligible Hospital did not confirm to only participate in the Wisconsin Medicaid EHR Incentive Program.	Eligible Hospitals must agree to participate in only one state's Medicaid EHR Incentive Program. If the question was answered incorrectly when completing the original Wisconsin Medicaid EHR Incentive Program application, provide a clarifying statement that the Eligible Hospital confirms to only participate in the Wisconsin Medicaid EHR Incentive Program.

The Eligible Professional has indicated that they have current or pending sanctions with Medicare or Medicaid and therefore does not qualify for the Wisconsin Medicaid EHR Incentive Program.	Upload documentation proving the Eligible Professional has been reinstated by the Office of Inspector General. If the question was answered incorrectly when completing the original Wisconsin Medicaid EHR Incentive Program application, provide a clarifying statement that the Eligible Professional has no current or pending sanctions with Medicare or Medicaid.
The Eligible Professional has indicated that he or she is hospital based.	Eligible Professionals are not eligible for the Wisconsin Medicaid EHR Incentive Program if they provide 90 percent or more of their services to eligible members in an inpatient hospital or emergency department. If the question was answered incorrectly when completing the original Wisconsin Medicaid EHR Incentive Program application, provide a clarifying statement that the Eligible Professional is not hospital based.
The Eligible Professional has indicated they are not waiving their right to a Medicare EHR Incentive Program payment for this payment year. Eligible Professionals must select to register with either Medicare or Medicaid EHR Incentive Program, but not both.	Eligible Professionals may participate in either Medicare or Medicaid EHR Incentive Programs, but not both. If the question was answered incorrectly when completing the original Wisconsin Medicaid EHR Incentive Program application, provide a clarifying statement that the Eligible Professional is waiving their right to a Medicare EHR Incentive Program payment for this year.

Payment Amount Appeals

Reason for Appeal	Documentation Needed
Eligible Professional payment amount (pediatrician only)	Provide the patient volume numbers for the reported 90-day period that should have been reported on the original Wisconsin Medicaid EHR Incentive Program application.
Eligible Hospital payment amount	Upload the Eligible Hospital's Medicare and Medicaid Cost Reports for the last four years.

Clinical Quality Measures

Topic #16879

Clinical Quality Measures Overview

CQMs (clinical quality measures) are tools that help measure or quantify health care processes, outcomes, patient perceptions, organizational structures, and systems that are associated with the ability to provide high-quality health care. Although CQMs are reported separately from Meaningful Use measures, all Eligible Professionals are still required to report CQMs in order to demonstrate Meaningful Use successfully. The reporting period for CQMs is the same as the Meaningful Use EHR (electronic health record) reporting period for that Program Year.

Starting in Program Year 2014, CMS (Centers for Medicare and Medicaid Services) has defined new CQMs to be reported and has defined recommended core sets of CQMs, one for adults and one for children, based on the analysis of several factors, including the following:

- Conditions that contribute to the morbidity and mortality of the most Medicare and Medicaid beneficiaries.
- Conditions that represent national public health priorities.
- Conditions that are common to health disparities.
- Conditions that disproportionately drive health care costs and could improve with better quality measurement.
- Measures that would enable CMS, states, and the provider community to measure quality of care in new dimensions, with a stronger focus on parsimonious measurement.
- Measures that include patient and/or caregiver engagement.

Eligible Professionals are encouraged to report on the [recommended core set of CQMs](#) that apply to their scope of practice and patient population.

Additionally, CMS selected all CQMs to align with the HHS (Department of Health and Human Services)'s National Quality Strategy priorities for health care quality improvement. These priorities have been placed into the following six domains:

- Patient and family engagement.
- Patient safety.
- Care coordination.
- Population and public health.
- Efficient use of health care resources.
- Clinical processes/effectiveness.

Of the 64 approved CQMs, Eligible Professionals are required to report on nine. The selected CQMs must cover at least three of the six domains.

Additional information on reporting clinical quality measures can be found on the [CMS Web site](#).

Topic #16880

Wisconsin Medicaid-Recommended Clinical Quality Measures

Eligible Professionals report CQMs (clinical quality measures) through attestation at an aggregate level. For Program Year 2014, Wisconsin Medicaid recommends Eligible Professionals report on the following priority CQMs. Wisconsin Medicaid highly recommends that Eligible Professionals report measures marked with an "A" in the Wisconsin Medicaid Recommendations column because those measures closely align with Medicaid's initiatives and priorities. Additionally, Wisconsin Medicaid recommends that Eligible Professionals report measures marked with a "B" in the Wisconsin Medicaid Recommendations column because those measures have been identified as potential future areas of interest for Wisconsin Medicaid.

eMeasure ID	National Quality Forum #	Measure Title	CMS (Centers for Medicare and Medicaid Services) Domain	Wisconsin Medicaid Recommendations	CMS Recommendations
CMS146v1	0002	Appropriate Testing for Children with Pharyngitis	Efficient Use of Healthcare Resources	B	Pediatric Recommended Core Measure
CMS137v1	0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Clinical Process/Effectiveness	A	
CMS165v1	0018	Controlling High Blood Pressure	Clinical Process/Effectiveness	A	Adult Recommended Core Measure
CMS156v1	0022	Use of High-Risk Medications in the Elderly	Patient Safety	B	Adult Recommended Core Measure
CMS155v1	0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Population/Public Health	A	Pediatric Recommended Core Measure
CMS138v1	0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Population/Public Health	A	Adult Recommended Core Measure
CMS125v1	0031	Breast Cancer Screening	Clinical Process/Effectiveness	A	
CMS124v1	0032	Cervical Cancer Screening	Clinical Process/Effectiveness	A	
CMS153v1	0033	Chlamydia Screening for Women	Population/Public Health	A	Pediatric Recommended Core Measure
CMS126v1	0036	Use of Appropriate Medications for Asthma	Clinical Process/Effectiveness	A	Pediatric Recommended Core Measure
CMS117v1	0038	Childhood Immunization Status	Population/Public Health	A	Pediatric Recommended Core Measure
CMS166v2	0052	Use of Imaging Studies for Low Back Pain	Efficient Use of Healthcare Resources	B	Adult Recommended Core Measure
CMS122v1	0059	Diabetes: Hemoglobin A1c Poor Control	Clinical Process/Effectiveness	A	

CMS163v1	0064	Diabetes: Low Density Lipoprotein (LDL) Management	Clinical Process/Effectiveness	A	
CMS164v1	0068	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	Clinical Process/Effectiveness	A	
CMS154v1	0069	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Efficient Use of Healthcare Resources	A	Pediatric Recommended Core Measure
CMS161v1	0104	Major Depressive Disorder (MDD): Suicide Risk Assessment	Clinical Process/Effectiveness	B	
CMS128v1	0105	Anti-depressant Medication Management	Clinical Process/Effectiveness	A	
CMS136v2	0108	ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	Clinical Process/Effectiveness	A	Pediatric Recommended Core Measure
CMS62v1	0403	HIV/AIDS: Medical Visit	Clinical Process/Effectiveness	A	
CMS52v1	0405	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	Clinical Process/Effectiveness	A	
CMS77v1	TBD (proposed as 0407)	HIV/AIDS: RNA Control for Patients with HIV	Clinical Process/Effectiveness	A	
CMS2v2	0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Population/Public Health	A	Adult Recommended Core Measure Pediatric Recommended Core Measure
CMS68v2	0419	Documentation of Current Medications in the Medical Record	Patient Safety	A	Adult Recommended Core Measure
CMS69v1	0421	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Population/Public Health	B	Adult Recommended Core Measure
CMS159v1	0710	Depression Remission at Twelve Months	Clinical Process/Effectiveness	A	
CMS160v1	0712	Depression Utilization of the PHQ-9 Tool	Clinical Process/Effectiveness	A	
CMS75v1	TBD	Children Who Have Dental Decay or Cavities	Clinical Process/Effectiveness	A	Pediatric Recommended Core Measure

CMS65v2	TBD	Hypertension: Improvement in Blood Pressure	Clinical Process/Effectiveness	A	
CMS50v1	TBD	Closing the Referral Loop: Receipt of Specialist Report	Care Coordination	A	Adult Recommended Core Measure
CMS90v2	TBD	Functional status Assessment for Complex Chronic Conditions	Patient and Family Engagement	B	Adult Recommended Core Measure

Eligibility

Topic #12038

Eligible Professionals for EHR Incentive Program

To be eligible to participate in the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program, an Eligible Professional must be enrolled in Wisconsin Medicaid as one of the following:

- Advanced practice nurse prescriber with psychiatric specialty.
- Dentist.
- Nurse midwife.
- Nurse practitioner.
- Physician.
- PAs (physician assistants). Only PAs practicing in an FQHC (federally qualified health center) or RHC (rural health clinic) are considered Eligible Professionals.

Note: Under the federal law, only PAs practicing in an FQHC or RHC that is so led by a PA are considered Eligible Professionals. "So led" is defined in the federal regulation as one of the following:

- When a PA is the primary provider in a clinic.
- When a PA is a clinical or medical director at a clinical site of practice.
- When a PA is an owner of an RHC.

Eligible Professionals who are able to demonstrate that they funded the acquisition of the CEHRT (Certified Electronic Health Record Technology) they are using without reimbursement from an Eligible Hospital and provide more than 90 percent of their services in POS (place of service) 21 (Inpatient Hospital) or 23 (Emergency Room — Hospital) are eligible to participate in the Wisconsin Medicaid EHR Incentive Program. Hospital-based Eligible Professionals are required to upload one of the following documents as part of the application process:

- Receipt or proof of purchase detailing the CEHRT, including the vendor, product, and version number.
- Contract or lease detailing the CEHRT, including the vendor, product, and version number.

Financial Information

Topic #12120

835 Health Care Claim Payment/Advice Transaction

To assist trading partners in identifying Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program payments received for an Eligible Professional or organizations on the 835 (835 Health Care Claim Payment/Advice) transaction, the NPI (National Provider Identifier) of the Eligible Professional approved to receive the Wisconsin Medicaid EHR Incentive Program payment will appear in segment PLB01 of the 2110 Loop. The PLB03-1 segment identifies the adjustment reason code. A code of LS will represent a positive incentive payment while a code of WO will represent a recovery of a previously paid incentive payment. The PLB04 segment will represent the monetary amount that is either paid or recouped based on the Adjustment Reason Code displayed in PLB03-1.

Topic #12118

Electronic Funds Transfer

Eligible Professionals who assign payments to themselves as individuals may elect to receive paper checks but are encouraged to set up an EFT (electronic funds transfer). EFTs allow ForwardHealth to directly deposit payments into the group's or Eligible Professional's designated bank account for a more efficient delivery of payments. An EFT is secure, eliminates paper, and reduces the uncertainty of possible delays in mail delivery.

Eligible Professionals that assign payments to an organization or clinic must supply the organization's EFT number. Organizations receiving payment from an Eligible Professional may only receive incentive payments through their existing EFT account.

Refer to the Electronic Funds Transfer User Guide on the [Portal User Guides page](#) of the Portal for information on EFT enrollment.

Topic #12117

Example of a Six-Year Payment Schedule for an Eligible Professional

Eligible Professionals who complete all the requirements for each applicable payment year will receive incentive payments in lump sums, as listed in the following table. Eligible Professionals may begin registering for the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program beginning in 2011 and up until 2016.

Calendar Year	Wisconsin Medicaid Eligible Professionals*					
	2011	2012	2013	2014	2015	2016
2011	\$21,250	—	—	—	—	—
2012	\$8,500	\$21,250	—	—	—	—
2013	\$8,500	\$8,500	\$21,250	—	—	—
2014	\$8,500	\$8,500	\$8,500	\$21,250	—	—

2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	—
2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
2017	—	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
2018	—	—	\$8,500	\$8,500	\$8,500	\$8,500
2019	—	—	—	\$8,500	\$8,500	\$8,500
2020	—	—	—	—	\$8,500	\$8,500
2021	—	—	—	—	—	\$8,500
Total	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

*Pediatricians with a minimum of 20 percent eligible member patient volume, but less than 30 percent eligible member patient volume will receive two-thirds of the incentive payment amounts. Eligible pediatricians will receive \$14,167 in their first payment year, \$5,667 in their second payment year, and \$42,500 in their third through sixth payment years.

Topic #12105

Incentive Payment Information

Eligible Professionals who meet all of the requirements will receive an incentive payment once per calendar year. Eligible Professionals must assign payment to either themselves or their organization's federal TIN (tax identification number).

Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program payments for Eligible Professionals may only be assigned to either the Eligible Professional themselves or the group practice assigned for the pay-to address on the Wisconsin Medicaid provider file. Eligible Professionals should ensure that the most current group practice is assigned for the pay-to address. Eligible Professionals can check this information via their ForwardHealth Portal Account in the "Demographic" section.

Topic #12119

Remittance Advice

Financial Transactions Section

Eligible Professionals and Eligible Hospitals will see the following information under the "Non-Claim Specific Payouts to Payee" section within the financial transactions page of the TXT (text) version of the RA (Remittance Advice) as well as within Section 130 of the CSV (comma-separated value) downloadable file:

- All Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program payments will appear under the "Non-Claim Specific Payouts to Payee" section of the RA.
- Amounts identified with the Reason Code 0247 will designate the amount as a Wisconsin Medicaid EHR Incentive Program payment.
- Amounts identified with the Reason Code 0248 will designate the amount as a Wisconsin Medicaid EHR Incentive Program positive adjustment.
- Payments reported in this section are processed and mean the same as any other ForwardHealth payment identified within this section.
- A new field has been added, called "Related Provider ID," to identify the NPI (National Provider Identifier) of the individual Eligible Professional approved to receive the Wisconsin Medicaid EHR Incentive Program payment.

Eligible Professionals and Eligible Hospitals will see the following information on the "Accounts Receivable" section within the Financial Transactions page of the TXT version of the RA as well as within Section 150 of the CSV downloadable file:

- If a negative adjusting entry is required to adjust the original Wisconsin Medicaid EHR Incentive Program incentive payment issued, an Accounts Receivable transaction will be generated to initiate the adjusting entry. All Wisconsin Medicaid EHR Incentive Program payment adjustments will be identified with the Reason Code 0265 (EHR Payment Adjustment). The Wisconsin Medicaid EHR Incentive Program payments are subject to recoupment as a result of any monies owed to ForwardHealth.
- The Wisconsin Medicaid EHR Incentive Program payment adjustments are processed and report on the RA as they do today under the Accounts Receivable section.

Summary Section

The Earnings Data section on the Summary section of the TXT version of the RA and the Sections 160 (Summary Net Payments) and Section 180 (Summary Net Earnings) of the CSV downloadable file will include the Wisconsin Medicaid EHR Incentive Program payments and adjustments reported on the Financial Transactions section. The process for calculating and reporting the net payments and earnings for the Summary section has not changed.

Meaningful Use of Certified EHR Technology

Topic #13357

Definition of Meaningful Use

The Medicare and Medicaid EHR (Electronic Health Record) Incentive Programs provide a financial incentive for the Meaningful Use of certified technology to achieve health and efficiency goals. By implementing and using EHR systems, Eligible Professionals can also expect benefits beyond financial incentives, such as reduction of clerical errors, immediate availability of records and data, clinical decision support, and e-prescribing and refill automation.

The American Recovery and Reinvestment Act of 2009 specifies three main components of Meaningful Use:

- The use of a certified EHR in a meaningful manner, such as e-prescribing.
- The use of CEHRT (Certified Electronic Health Record Technology) for electronic exchange of health information to improve quality of health care.
- The use of CEHRT to submit clinical quality and other measures.

In short, Meaningful Use means Eligible Professionals need to demonstrate that they are using EHR technology in ways that can be measured in quality and quantity.

Topic #13358

Electronic Health Record Reporting Period for Meaningful Use

The EHR (Electronic Health Record) Reporting Period is defined as the timeframe when Eligible Professionals report Meaningful Use to the Wisconsin Medicaid EHR Incentive Program. The EHR Reporting Period years are defined as:

- First year: The Eligible Professional must be able to show Meaningful Use for a 90-day timeframe that falls within the Calendar Year that the Eligible Professional is applying for a Wisconsin Medicaid EHR Incentive Program payment. For example, if an Eligible Professional is applying for the 2012 Wisconsin Medicaid EHR Incentive Program payment, the entire 90-day reporting period must fall in Calendar Year 2012.
- Subsequent years: The Eligible Professional must be able to show Meaningful Use for the entire Calendar Year for which the Eligible Professional is applying for the Wisconsin Medicaid EHR Incentive Program payment. For example, if an Eligible Professional is applying for the 2013 Wisconsin Medicaid EHR Incentive Program payment, the reporting period must be January 1, 2013, through December 31, 2013.

Note: In Program Year 2014, all Eligible Professionals, regardless of their stage of Meaningful Use, are only required to demonstrate Meaningful Use for a 90-day EHR reporting period of their choosing. The CMS is permitting this one-time 90-day reporting period in Program Year 2014 only.

Topic #13377

Meaningful Use Criteria Overview

CMS (Centers for Medicare and Medicaid Services) has split the Meaningful Use criteria into three stages that will be rolled out over five years. Currently, the stages are identified as follows:

- Stage 1 sets the baseline for electronic data capture and information sharing.
- Stage 2 will expand on the baseline to advance clinical practices.
- Stage 3 will use advanced clinical practices to improve outcomes. Stage 3 requirements will be determined through future rule making.

Meaningful Use Supporting Documentation

All information is subject to audit at any time and must be retained by Eligible Professionals for six years post-attestation. If selected for an audit, the applicant must be able to supply supporting documentation.

Topic #13417

Stage 1 Meaningful Use Supporting Documentation

The table below contains examples of supporting documentation an Eligible Professional (EP) would be expected to provide if selected for an audit of an application submitted for the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program under Stage 1 Meaningful Use.

Example #	Requirement	Measure	Examples of Supporting Documentation
1	Must report and meet the required threshold/answers for all General Requirements and Core Measures	EPGMU 01-02 EPCMU 01-15	<ul style="list-style-type: none"> • Meaningful Use Reports/Dashboard produced by CEHRT (Certified Electronic Health Record Technology) • Documentation on how the attestations were created, specifically how the numerator/denominators were calculated, including rationale taken into account for inclusion/exclusion of data
2	EPGMU 01: Percent of CEHRT Use	Must have 50 percent or more of their patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with CEHRT	<ul style="list-style-type: none"> • List of total encounters with detail including date, patient identifier, payer, and rendering provider • List of encounters with CEHRT, with detail on location and CEHRT used
3	EPGMU 02: Unique Patients in CEHRT	Must have 80 percent or more of their unique patient data in the certified EHR during the EHR reporting period	<ul style="list-style-type: none"> • List of all unique patients with indication of whether in CEHRT. If practicing at multiple locations, indicate which patients seen in what location
4	EPCMU 01: CPOE (computerized physician order entry)	Must have at least one medication order entered using CPOE for more than 30 percent of all unique patients with at least one medication in their medication list	<ul style="list-style-type: none"> • Access to a random sampling of patient records • Rationale for exclusion/ inclusion of patient records

		seen by the EP during the EHR reporting period	
5	EPCMU 02: Drug-drug and drug-allergy interaction checks	Must have enabled functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period	<ul style="list-style-type: none"> • Audit log showing it is enabled for this functionality with time/date stamp
6	EPCMU 03: Maintain an up-to-date problem list of current and active diagnoses	Must have at least one entry (or an indication that no problems are known for the patient) recorded as structured data for more than 80 percent of all unique patients seen by the EP during the EHR reporting period	<ul style="list-style-type: none"> • Access to a random sampling of patient records
7	EPCMU 04: E-Prescribing (eRx)	Must have used the CEHRT to transmit prescriptions electronically for more than 40 percent of all permissible prescriptions written by the EP during the EHR reporting period	<ul style="list-style-type: none"> • Access to a random sampling of patient records • Rationale for exclusion/inclusion of patient records • Rationale for exclusion/inclusion of prescriptions
8	EPCMU 05: Maintain active medication list	Must have at least one active medication entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data for more than 80 percent of all unique patients seen by the EP during the EHR reporting period	<ul style="list-style-type: none"> • Access to a random sampling of patient records • Rationale for exclusion/inclusion of patient records
9	EPCMU 06: Maintain active medication allergy list	Must have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data for more than 80 percent of all unique patients seen by the EP during the EHR reporting period	<ul style="list-style-type: none"> • Access to a random sampling of patient records
10	EPCMU 07: Record demographics	Must have demographics recorded as structured data for more than 50 percent of all unique patients seen by the EP during the EHR reporting period	<ul style="list-style-type: none"> • Access to a random sampling of patient records
11	EPCMU 08: Record and chart changes in vital signs	Must have height, weight, and blood pressure recorded as structured data for more than 50 percent of all unique patients age 2 and over seen by the EP during the EHR reporting period	<ul style="list-style-type: none"> • Access to a random sampling of patient records • Rationale for exclusion/ inclusion of patient records
12	EPCMU 09: Record smoking status for patients 13 years or older	Must have smoking status recorded as structured data for more than 50 percent of all unique patients 13 years old or older seen	<ul style="list-style-type: none"> • Access to a random sampling of patient records • Rationale for exclusion/ inclusion of patient records

		by the EP during the EHR reporting period	
13	EPCMU 10: Report ambulatory clinical quality measures to CMS (Centers for Medicare and Medicaid Services)/states	Must successfully report to Wisconsin the ambulatory clinical quality measures selected by CMS in the manner specified by Wisconsin	<ul style="list-style-type: none"> • Audit log showing the enabling of this functionality with time/date stamp
14	EPCMU 11: Implement one clinical decision support rule	Must implement one clinical decision support rule	<ul style="list-style-type: none"> • Rationale for clinical decision support rule implemented • Audit log showing the enabling of this functionality with time/date stamp
15	EPCMU 12: Provide patients with an electronic copy of their health information upon request	Provide an electronic copy of health information to more than 50 percent of patients who request it within three business days.	<ul style="list-style-type: none"> • EP Policy and Procedure documentation • Rationale for exclusion/inclusion of patient records
16	EPCMU 13: Provide clinical summaries for patients for each office visit	Must have provided clinical summaries to patients for more than 50 percent of all office visits within three business days.	<ul style="list-style-type: none"> • Rationale for exclusion/ inclusion of patient records • Sample of Clinical Summary
17	EPCMU 14: Capability to exchange key clinical information among providers of care and patient-authorized entities electronically	Must have performed at least one test of CEHRT's capacity to electronically exchange key clinical information.	<ul style="list-style-type: none"> • Detail of exchange of key clinical information including, but not limited to: date, time, entity with which exchange took place (including contact information), and method of transportation for the exchange (include information on HIE (health information exchange) used if applicable)
18	EPCMU 15: Protect electronic health information	Must conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), implement security updates as necessary, and correct identified security deficiencies as part of its risk management process.	<ul style="list-style-type: none"> • Detail on security risk analysis including, but not limited to: approach for assessment, results of the assessment, indication of who performed the assessment • Detail on security update performed as a result of the security risk analysis including, but not limited to: update made, date made
19	Must report and meet the required threshold/answers for five of the 10 Menu Measures with at least one measure being classified as a public health measure (EPMMU 09 or EPMMU 10)	EPMMU 01 -EPMMU 10	<ul style="list-style-type: none"> • Meaningful Use Reports/ Dashboard produced by CEHRT • Documentation on how the attestations were created, specifically how the numerator/denominators were calculated, including rationale taken into account for inclusion/exclusion of data

20	EPMMU 01: Drug-formulary checks	Must have enabled Drug-formulary check functionality and have access to at least one internal or external formulary for the entire EHR reporting period	<ul style="list-style-type: none"> • Audit log showing the enabling of this functionality with time/date stamp
21	EPMMU 02: Incorporate clinical lab test results as structured data	Must have incorporated in CEHRT as structured data, more than 40 percent of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format	<ul style="list-style-type: none"> • Access to a random sampling of patient records
22	EPMMU 03: Generate lists of patients by specific conditions	Must generate at least one report listing patients of the EP with a specific condition	<ul style="list-style-type: none"> • Rationale/reason for the list being generated with detail on the specific condition addressed • Rationale for exclusion/inclusion of patient records
23	EPMMU 04: Send reminders to patients per patient preference for preventive/follow up care	Must have sent an appropriate reminder during the EHR reporting period to more than 20 percent of all patients 65 years or older or 5 years old or younger.	<ul style="list-style-type: none"> • Access to a random sampling of patient records • Rationale for exclusion/ inclusion of patient records
24	EPMMU 05: Provide patients with timely electronic access to their health information	Must have provided timely (available to the patient within four business days of being updated in the CEHRT) electronic access to health information (subject to the EP's discretion to withhold certain information) for at least 10 percent of all unique patients seen by the EP during the EHR reporting period	<ul style="list-style-type: none"> • Access to a random sampling of patient records • Rationale for exclusion/ inclusion of patient records
25	EPMMU 06: Use CEHRT to identify patient-specific education resources and provide to patient, if appropriate	Must have provided patient-specific education resources to more than 10 percent of all unique patients seen by the EP during the EHR reporting period	<ul style="list-style-type: none"> • Documentation of patient-specific education resources that are provided to patients
26	EPMMU 07: Medication reconciliation	Must perform medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP during the EHR reporting period	<ul style="list-style-type: none"> • Access to a random sampling of patient records • Rationale for exclusion/inclusion of patient records
27	EPMMU 08: Summary of care record for each transition of care/ referrals	Must provide a summary of care record for more than 50 percent of transitions of care and referrals of patients to another setting of care or provider of care during the EHR reporting period	<ul style="list-style-type: none"> • Access to a random sampling of patient records • Rationale for exclusion/inclusion of patient records

28	EPMMU 09: Capability to submit electronic data to immunization registries/systems*	Must have performed at least one test of CEHRT's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically).	<ul style="list-style-type: none"> • Detail on test date and time
29	EPMMU 10: Capability to provide electronic syndromic surveillance data to public health agencies*	Performed at least one test of CEHRT's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information has the capacity to receive the information electronically).	<ul style="list-style-type: none"> • Detail on test date and time • Wisconsin Public Health Letter qualifying EP for exclusion

Topic #16877

Stage 1 of Meaningful Use

Requirements for Stage 1 Meaningful Use

The requirements for Stage 1 Meaningful Use include both a "core set" and a "menu set" of objectives that are specific to Eligible Professionals. There are a total of 23 Meaningful Use objectives. To qualify for a Wisconsin Medicaid EHR (electronic health record) Incentive Program payment, 18 of the 23 Meaningful Use objectives must be met. Of the 23 objectives, there are 13 required "core set" objectives that must be met. The remaining five "menu set" objectives may be chosen from a list of 10 menu set objectives, two of which are Public Health objectives.

Public Health Objectives

Eligible Professionals can only meet the Stage 1 Meaningful Use requirements for a public health objective by registering with the DPH and conducting at least one test with the chosen registry.

Note: Eligible Professionals who are attesting to 2013 or 2014 Stage 1 Meaningful Use for the EHR reporting period in Program Year 2014 using a [CEHRT \(Certified Electronic Health Record Technology\) flexibility option](#) and who have conducted a test with a chosen registry for an EHR reporting period in a previous Program Year are not required to conduct another test for that public health objective for the EHR reporting period in Program Year 2014.

Registration

All Eligible Professionals, regardless of their stage of Meaningful Use, are required to [register](#) with the Wisconsin DHS (Department of Health Services), DPH (Division of Public Health) to initiate the onboarding process, including testing, for any of the public health objectives.

At the start of their EHR reporting period, Eligible Professionals are required to check the current status of each DPH program's

capability to accept data on the [Public Health Meaningful Use Web site](#) because the program's capability may change.

Reporting

Two public health "menu set" objectives are available for Eligible Professionals to report on for Stage 1 Meaningful Use although they are required to report on only one. These objectives require Eligible Professionals to test electronic transmission of the following data to the DPH:

- Immunizations. The DPH's Wisconsin Immunization Program has the capacity to accept immunization data from Eligible Professionals.
- Syndromic surveillance. The DPH does not currently have a syndromic surveillance program for ambulatory clinics; however, there are some circumstances under which the DPH could accept syndromic surveillance data from Eligible Professionals. For information about these circumstances, Eligible Professionals may e-mail the DPH at ehhealth@wisconsin.gov.

To meet the requirements of a public health objective in Stage 1, Eligible Professionals are required to conduct at least one test with the chosen registry. If multiple Eligible Professionals are using the same in a shared physical setting (location), regardless of their stage of Meaningful Use, they are only required to conduct an initial test or achieve ongoing submission for their location. They are not required to conduct an initial test or achieve ongoing submission for each Eligible Professional at their location.

The Eligible Professional or location should institute ongoing data submission if the test is successful. If the test is unsuccessful, the Eligible Professional(s) at the location will still satisfy the requirements of this objective for Meaningful Use.

Eligible Professionals cannot attest to completing a public health objective if the initial test is not completed before or during their EHR reporting period. Instead, if they registered with the DPH to complete a test but are not contacted by the DPH to initiate testing, they are required to select the exclusion for the objective that indicates that the public health registry or agency does not have the capacity to electronically receive the information.

Communications

The DPH will send all communications, including acknowledgements of successful registration and successful ongoing submission, via e-mail to Eligible Professionals or their representatives. Each DPH program has its own e-mail address, which is listed on the Public Health Meaningful Use Web site.

Responses for Meaningful Use Measures

Eligible Professionals will have three different types of responses to Meaningful Use measures:

- Yes or No.
- Attest to exclusions (any measure not applicable to the Eligible Professional's practice).
- Numerators and Denominators.

Exclusions

Some Meaningful Use objectives are not applicable to every Eligible Professional's clinical practice; therefore, no patients or actions would be eligible for the measure denominator. In these cases, the Eligible Professional would be excluded from having to meet that measure. For example, core measure nine of 13 is to "Record smoking status for patients 13 years old or older." An Eligible Professional who does not see patients 13 years or older may select the exclusion to this measure.

Eligible Professionals are not able to claim an exclusion to a "menu set" objective if they are able to meet the requirements for other "menu set" objectives. Eligible Professionals may claim an exclusion to a "menu set" objective if they can claim an exclusion for all the remaining "menu set" objectives.

Numerators and Denominators

When entering percentage-based measures, the calculation to determine the Meaningful Use numerator and denominator will vary by measure. Eligible Professionals should refer to the CMS (Centers for Medicare and Medicaid Services) Stage 1 EHR Meaningful Use [Specification Sheets](#) for a clear definition of a Meaningful Use numerator and denominator prior to completing the Wisconsin Medicaid EHR Incentive Program application.

Note: Meaningful Use numerators and denominators include the number of relevant patients as defined in the Specification Sheets and not just Medicare and Medicaid patients.

Centers for Medicare and Medicaid Services Stage 1 Meaningful Use Resources

Eligible Professionals should refer to the table of contents on the [CMS Web site](#) for information regarding "core set" and "menu set" objectives. Each objective contains the following information:

- The definition of the objective.
- How to measure the objective.
- Any applicable exclusions.

Additional information, such as the following, may also be included:

- Term definitions.
- Attestation requirements.
- Any other additional information related to the objective.
- Frequently asked questions.
- Certification and standards criteria.

Topic #16898

Stage 2 Meaningful Use Supporting Documentation

The following table contains examples of supporting documentation an Eligible Professional would be expected to provide if selected for an audit of an application submitted for the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program under Stage 2 Meaningful Use.

Example #	Requirement	Measure	Examples of Supporting Documentation
1	Must report and meet the required threshold/answers for all General Requirements and Core Measures	Stage 2 EPGMU 01-02 Stage 2 EPCMU 01-17	<ul style="list-style-type: none"> • Meaningful Use Reports/Dashboard produced by CEHRT (Certified Electronic Health Record Technology). • Documentation on how the attestations were created, specifically how the numerators/denominators were calculated, including rationale taken into account for inclusion/exclusion of data.
2	Stage 2 EPGMU 01: Percent of CEHRT Use	Must have 50 percent or more of their patient encounters during the EHR reporting period at a practice/location or	<ul style="list-style-type: none"> • List of total encounters with detail including date, patient identifier, payer, and rendering provider.

		practices/locations equipped with CEHRT.	<ul style="list-style-type: none"> List of encounters with CEHRT, with detail on location and CEHRT used.
3	Stage 2 EPGMU 02: Unique Patients in CEHRT	Must have 80 percent or more of their unique patient data in the CEHRT during the EHR reporting period.	<ul style="list-style-type: none"> List of all unique patients with indication of whether they are in CEHRT; if practicing at multiple locations, indicate which patients were seen in what location.
4	Stage 2 EPCMU 01a: CPOE (computerized physician order entry) - Measure 1 - Medication Orders	Must have more than 60 percent of medication orders created by the Eligible Professional during the EHR reporting period recorded using CPOE.	<ul style="list-style-type: none"> Random sampling of patient records. Rationale for exclusion/inclusion of patient records. List of individuals who entered CPOE with their credentials. Policies and procedures on CPOE.
5	Stage 2 EPCMU 01b: CPOE - Measure 2 - Laboratory Orders	Must have more than 30 percent of laboratory orders created by the Eligible Professional during the EHR reporting period recorded using CPOE.	<ul style="list-style-type: none"> Random sampling of patient records. Rationale for exclusion/inclusion of patient records. List of individuals who entered CPOE with their credentials. Policies and procedures on CPOE.
6	Stage 2 EPCMU 01c: CPOE - Measure 3 - Radiology Orders	Must have more than 30 percent of radiology orders created by the Eligible Professional during the EHR reporting period recorded using CPOE.	<ul style="list-style-type: none"> Random sampling of patient records. Rationale for exclusion/inclusion of patient records. List of individuals who entered CPOE with their credentials. Policies and procedures on CPOE.
7	Stage 2 EPCMU 02: E-Prescribing (eRx)	More than 50 percent of all permissible prescriptions written by the Eligible Professional are queried for a drug formulary and transmitted electronically using CEHRT.	<ul style="list-style-type: none"> Random sampling of patient records. Rationale for exclusion/inclusion of patient records. Rationale for exclusion/inclusion of prescriptions. Documentation on exclusion 1 qualification — proof they wrote fewer than 100 permissible prescriptions. Documentation on exclusion 2 qualification — on lack of pharmacies that accept electronic prescriptions within 10 miles of the Eligible Professional's practice location at the start of their EHR reporting period.
8	Stage 2 EPCMU 03: Record demographics	Must have demographics recorded as structured data for more than 80 percent of all unique patients seen by the Eligible Professional during the EHR reporting period.	<ul style="list-style-type: none"> Random sampling of patient records.
9	Stage 2 EPCMU 04: Record Vital Signs	More than 80 percent of all unique patients seen by the Eligible Professional during the EHR reporting period must	<ul style="list-style-type: none"> Random sampling of patient records. Rationale for exclusion/inclusion of patient records.

		<p>have changes to the below vital signs recorded as structured data:</p> <ul style="list-style-type: none"> • Height/Length (no age limit). • Weight (no age limit). • Blood pressure (ages three and over). • Calculate and display BMI (body mass index) (no age limit). • Plot and display growth charts for children 0-20 years old, including BMI. 	<ul style="list-style-type: none"> • Rationale for exclusion 2. • Rationale for exclusion 3. • Rationale for exclusion 4.
10	Stage 2 EPCMU 05: Record Smoking Status	Must have smoking status recorded as structured data for more than 80 percent of all unique patients 13 years old or older seen by the Eligible Professional during the EHR reporting period.	<ul style="list-style-type: none"> • Random sampling of patient records. • Rationale for exclusion/inclusion of patient records.
11	Stage 2 EPCMU 06a: Clinical Decision Support Rule	Must implement five CDS (clinical decision support) interventions related to four or more CQMs (clinical quality measures) at a relevant point in patient care for the entire EHR reporting period. Absent four CQMs related to an Eligible Professional's scope of practice or patient population, the CDS interventions must be related to high-priority health conditions.	<ul style="list-style-type: none"> • Description of what CDS interventions have been implemented with explanation of how the CDS interventions are aligned to four or more CQMs (documentation should be uploaded pre-payment). • EHR audit log showing the enabling of this functionality with time/date stamp.
12	Stage 2 EPCMU 06b: Clinical Decision Support Rule	Has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.	<ul style="list-style-type: none"> • EHR audit log showing the enabling of this functionality with time/date stamp.
13	Stage 2 EPCMU 07a: Patient Electronic Access	Must provide more than 50 percent of all patients seen by the Eligible Professional during the EHR reporting period with timely (available to the patient within four business days after the information is available to the Eligible Professional) online access to their health information.	<ul style="list-style-type: none"> • Eligible Professional Policy and Procedure documentation. • Rationale for exclusion/inclusion of patient records. • Documentation on how access was granted to patients within the set timeline. • EHR audit logs of patient access processing. • Random sampling of patient records. • Rationale on how the Eligible Professional neither orders nor creates information listed for inclusion in the measure. • Proof that 50 percent or more of the Eligible Professional's patient encounters take place in a county that does not have 50 percent or more of its housing units with 3Mbps broadband availability.
14	Stage 2 EPCMU 07b: Patient	More than five percent of all unique patients seen by the Eligible Professional	<ul style="list-style-type: none"> • Eligible Professional Policy and Procedure documentation.

	Electronic Access	during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information.	<ul style="list-style-type: none"> • Rationale for exclusion/inclusion of patient records. • EHR audit log of patient access to their health information. • Random sampling of patient records. • Rationale on how the Eligible Professional neither orders nor creates information listed for inclusion in the measure. • Proof that 50 percent or more of the Eligible Professional's patient encounters take place in a county that does not have 50 percent or more of its housing units with 3Mbps broadband availability.
15	Stage 2 EPCMU 08: Clinical Summaries	Must have provided clinical summaries to patients or patient-authorized representatives within one business day for more than 50 percent of all office visits.	<ul style="list-style-type: none"> • Rationale for exclusion/inclusion of patient records. • Sample of Clinical Summary.
16	Stage 2 EPCMU 09: Protect Electronic Health Information	Must conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) a, including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of its risk management process for Eligible Professionals.	<ul style="list-style-type: none"> • Detail on security risk analysis, including, but not limited to the following: approach for the assessment, results of the assessment, indication of who performed the assessment. • Detail on security update performed as a result of the security risk analysis, including, but not limited to the following: the update made and the date made.
17	Stage 2 EPCMU 10: Clinical Lab Test Results	Must have incorporated more than 55 percent of all clinical lab test results ordered by the Eligible Professional during the EHR reporting period whose results are either in a positive/negative or numerical format as structured data in CEHRT.	<ul style="list-style-type: none"> • Random sampling of patient records. • EHR audit trail of clinical lab tests.
18	Stage 2 EPCMU 11: Patient Lists	Must generate at least one report listing patients of the Eligible Professional with a specific condition.	<ul style="list-style-type: none"> • Rationale/reason for the list being generated with detail on the specific condition addressed. • Rationale for exclusion/inclusion of patient records. • EHR audit trail of patient list creation. • Patient list example with time/date stamp.
19	Stage 2 EPCMU 12: Preventive Care	Must have sent an appropriate reminder to more than 10 percent of all unique patients who have had two or more office visits with the Eligible Professional within the 24 months before the beginning of the	<ul style="list-style-type: none"> • Random sampling of patient records. • Rationale for exclusion/inclusion of patient records.

		EHR reporting period.	
20	Stage 2 EPCMU 13: Patient-Specific Education Resources	Must have provided patient-specific education resources to more than 10 percent of all unique patients with office visits seen by the Eligible Professional during the EHR reporting period.	<ul style="list-style-type: none"> • Documentation to show use of patient education based on information stored in the system (e.g., screen shots or EHR-generated reports). • Sample of patient record indicating resources provided and the rationale for the education resource — the connection to their clinically relevant information.
21	Stage 2 EPCMU 14: Medication Reconciliation	Must perform medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the Eligible Professional during the EHR reporting period.	<ul style="list-style-type: none"> • Random sampling of patient records. • Rationale for exclusion/inclusion of patient records.
22	Stage 2 EPCMU 15a: Summary of Care	Must provide a summary of care record for more than 50 percent of transitions of care and referrals of patients to another setting of care or provider of care during the EHR reporting period.	<ul style="list-style-type: none"> • Random sampling of patient records. • Sample of a summary of care record. • Rationale for exclusion/inclusion of patient records.
23	Stage 2 EPCMU 15b: Summary of Care	The Eligible Professional who transitions or refers his or her patient to another setting of care or provider of care must provide a summary of care record for more than 10 percent of such transitions and referrals either electronically to a recipient using CEHRT or via an exchange to a recipient that is facilitated by an organization that is a NwHIN (Nationwide Health Information Network) exchange participant or that is facilitated in a manner that is consistent with the governance mechanism the Office of the ONC (National Coordinator for Health Information Technology) establishes for the NwHIN.	<ul style="list-style-type: none"> • Random sampling of patient records. • Rationale for exclusion/inclusion of patient records. • Supporting documentation that an exchange was facilitated by an organization that is an NwHIN participant or in a manner consistent with the governance mechanism ONC establishes for a NwHIN. • Log of exchange that took place during the EHR reporting period.
24	Stage 2 EPCMU 15c: Summary of Care	<p>Eligible Professionals must satisfy one of the following criteria:</p> <ul style="list-style-type: none"> • Conduct one or more successful electronic exchanges of a summary of care document, part of which is counted in Stage 2 EPCMU 15b (for Eligible Professionals the measure at §495.6[j][14][ii][B] with a recipient who has EHR technology that was developed designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314[b][2]). 	<ul style="list-style-type: none"> • Documentation of a successful electronic exchange of a summary of care document, part of which is counted in Stage 2 EPCMU 15b (for Eligible Professionals the measure at §495.6[j][14][ii][B] with a recipient who has EHR technology that was developed designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314[b][2]). (Documentation should include the date, time, recipient of the exchange, CEHRT used by the Eligible Professional, CEHRT used by the recipient, and information on any other entity involved in the exchange). • Documentation of a successful test with the

		<ul style="list-style-type: none"> Conduct one or more successful tests with the CMS (Centers for Medicare and Medicaid Services)-designated test EHR during the EHR reporting period. 	<p>CMS-designated test EHR during the EHR reporting period. (Documentation should include the date, time, CEHRT used by the Eligible Professional, and information on any other entity involved in the exchange).</p>
25	Stage 2 EPCMU 16: Immunization Registries Data Submission	Successful ongoing submission of electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period.	<ul style="list-style-type: none"> Documentation of the Eligible Professional's registration, onboarding, and ongoing submission with the DPH (Division of Public Health).
26	Stage 2 EPCMU 17: Use Secure Electronic Messaging	For more than five percent of unique patients (or their authorized representatives) seen by the Eligible Professional during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT.	<ul style="list-style-type: none"> Random sampling of patient records. Rationale for exclusion/inclusion of patient records. Documentation that a secure message was sent (e.g., EHR audit logs, random sampling of records to show the secure message functionality in use).
27	Must report and meet the required threshold/answers for three of the six "Menu Set" Measures.	Stage 2 EPMMU 01 - EPMMU 06	<ul style="list-style-type: none"> Meaningful Use Reports/Dashboard produced by CEHRT. Documentation on how the attestations were created, specifically how the numerator/denominators were calculated, including rationale taken into account for inclusion/exclusion of data.
28	Stage 2 EPMMU 01: Syndromic Surveillance Data Submission	Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period.	<ul style="list-style-type: none"> Documentation of the Eligible Professional's registration, onboarding, and ongoing submission with the DPH. Documentation on the mechanism the Eligible Professional has chosen to report syndromic surveillance data.
29	Stage 2 EPMMU 02: Electronic Notes	For more than 30 percent of unique patients with at least one office visit during the EHR reporting period, at least one electronic progress note must be created, edited, and signed by the Eligible Professional. (The text of the electronic note must be text-searchable and may contain drawings and other content.)	<ul style="list-style-type: none"> Random sampling of patient records. Rationale for exclusion/inclusion of patient records. Documentation of progress notes being created, edited, and signed by the Eligible Professional (e.g., EHR audit log, sample of patient record with progress notes).
30	Stage 2 EPMMU 03: Imaging Results	More than 10 percent of all tests whose result is one or more images ordered by the Eligible Professional during the EHR reporting period are accessible through CEHRT.	<ul style="list-style-type: none"> Random sampling of patient records. Rationale for exclusion/inclusion of patient records. Sample of patient record with imaging results accessible through CEHRT. Documentation that the Eligible Professional orders fewer than 100 tests (list of tests ordered in the EHR reporting period with their results) whose result is an image during

			<p>the EHR reporting period.</p> <ul style="list-style-type: none"> Supporting documentation that the Eligible Professional has no access to electronic imaging results at the start of the EHR reporting period.
31	Stage 2 EPMMU 04: Family Health History	More than 20 percent of all unique patients seen by the Eligible Professional during the EHR reporting period have a structured data entry for one or more first-degree relatives.	<ul style="list-style-type: none"> Random sampling of patient records. Rationale for exclusion/inclusion of patient records.
32	Stage 2 EPMMU 05: Report Cancer Cases	Successful ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period.	<ul style="list-style-type: none"> Documentation of the Eligible Professional's registration, onboarding, and ongoing submission with the DPH.
33	Stage 2 EPMMU 06: Report Specific Cases	Successful ongoing submission of specific case information from CEHRT to a specialized registry for the entire EHR reporting period.	<ul style="list-style-type: none"> Documentation of the Eligible Professional's registration, onboarding, and ongoing submission with the DPH. Documentation on how the specialized registry relates to the Eligible Professional's scope of practice.

Topic #16878

Stage 2 of Meaningful Use

Requirements for Stage 2 Meaningful Use

All Eligible Professionals are required to complete Stage 1 Meaningful Use before attesting to Stage 2 Meaningful Use. Eligible Professionals will need to meet a higher threshold for Stage 2 Meaningful Use objectives than they did for Stage 1 Meaningful Use objectives.

In Stage 2, there are a total of 23 Meaningful Use objectives. To qualify for a Wisconsin Medicaid EHR (electronic health record) Incentive Program payment, an Eligible Professional is required to meet 20 of the 23 Meaningful Use objectives. Eligible Professionals are required to meet all 17 "core set" objectives and three out of six "menu set" objectives.

Public Health Objectives

Registration

All Eligible Professionals, regardless of their stage of Meaningful Use, are required to [register](#) with the Wisconsin DHS (Department of Health Services), DPH (Division of Public Health), to initiate the onboarding process, including testing, for any of the public health objectives. Eligible Professionals are required to register with the DPH either before their EHR reporting period starts or within 60 days of their EHR reporting period starting.

At the start of their EHR reporting period, Eligible Professionals are required to check the current status of each DPH program's capability to accept data on the [Public Health Meaningful Use Web site](#) because the program's capability may change.

Reporting

The public health objectives for Stage 2 Meaningful Use build on Stage 1's specifications for public health reporting. For Stage 2 Meaningful Use, Eligible Professionals are required to report on the one public health "core set" objective. Eligible Professionals may, but are not required to, report on any of the three available public health "menu set" objectives in order to meet the "menu set" objective requirements.

The Stage 2 Meaningful Use "core set" public health objective requires Eligible Professionals to indicate ongoing submission of immunization data to DPH. The DPH's Wisconsin Immunization Program has the capacity to accept immunization data from Eligible Professionals.

The Stage 2 Meaningful Use "menu set" public health objectives require Eligible Professionals to indicate ongoing submission of the following data to DPH:

- Syndromic surveillance. The DPH does not currently have a syndromic surveillance program for ambulatory clinics; however, there are some circumstances under which DPH could accept syndromic surveillance data from Eligible Professionals. For information about these circumstances, Eligible Professionals may e-mail DPH at ehhealth@wisconsin.gov.
- Cancer. The DPH has the capacity to accept cancer data from Eligible Professionals through the Wisconsin Cancer Reporting System. Eligible Professionals are required to check the status of the Wisconsin Cancer Reporting System's capability to accept data on the Public Health Meaningful Use Web site at the start of their EHR reporting period.
- Specialized registries. Since the DPH has not currently identified specialized registries, Eligible Professionals may attest to an exclusion for specialized registries.

Ongoing submission is the ability of an Eligible Professional to regularly report data from his or her CEHRT (Certified Electronic Health Record Technology) to a DPH public health program using the Program Year 2014 standards and specifications for the entire EHR reporting period.

In addition to registering with the DPH either before their EHR reporting period starts or within 60 days of their EHR reporting period starting, Eligible Professionals are required to do the following to meet the Stage 2 Meaningful Use ongoing submission requirement:

- Achieve ongoing submission in Stage 1 Meaningful Use prior to the beginning of Stage 2 and satisfy the Stage 2 Meaningful Use technical standards and specifications for ongoing submission.
- Achieve ongoing submission during Stage 2 Meaningful Use.
- Be in the process of achieving ongoing submission.
- Be in a queue awaiting an invitation from DPH to begin the onboarding process.

If multiple Eligible Professionals are using the same CEHRT in a shared physical setting (location), regardless of their stage of Meaningful Use, they are only required to conduct an initial test or achieve ongoing submission for their location. They are not required to conduct an initial test or achieve ongoing submission for each Eligible Professional at their location.

Eligible Professionals will not meet the ongoing submission requirement if they fail to do the following:

- Register with the DPH either before their EHR reporting period starts or within 60 days of their EHR reporting period starting.
- Respond within 30 calendar days to requests by DPH for action on two separate occasions.

Communications

The DPH will send all communications, including acknowledgements of successful registration and successful ongoing submission, via e-mail to Eligible Professionals or their representatives. Each DPH program has its own e-mail address, which is listed on the Public Health Meaningful Use Web site.

Responses for Meaningful Use Measures

Eligible Professionals will have three different types of responses to Meaningful Use measures:

- Yes or No.
- Attest to exclusions (any measure not applicable to the Eligible Professional's practice).
- Numerators and Denominators.

Exclusions

Some Meaningful Use objectives are not applicable to every Eligible Professional's clinical practice; therefore, the Eligible Professional would not have any eligible patients or actions to enter for the measure. In these cases, the Eligible Professional would be excluded from having to meet that Meaningful Use measure. For example, core measure five of 17 is "Record smoking status for patients 13 years old or older." Any Eligible Professional who does not see patients 13 years or older may select the exclusion to this measure.

Eligible Professionals are not able to claim an exclusion to a "menu set" objective if they are able to meet the requirements for other "menu set" objectives. Eligible Professionals may claim an exclusion to a "menu set" objective if they can claim an exclusion for all the remaining "menu set" objectives.

Numerators and Denominators

When entering percentage-based measures, the calculation to determine the Meaningful Use numerator and denominator will vary by measure. Eligible Professionals should refer to the CMS (Centers for Medicare and Medicaid Services) Stage 2 EHR Meaningful Use [Specification Sheets](#) for a clear definition of a Meaningful Use numerator and denominator prior to completing the Wisconsin Medicaid EHR Incentive Program application.

Note: Meaningful Use numerators and denominators include the number of relevant patients as defined in the Specification Sheets and not just Medicare and Medicaid patients.

Eligible Professionals should refer to their EHR system for Meaningful Use denominators to be entered into the Wisconsin Medicaid EHR Incentive Program application. Eligible Professionals should note that each EHR system varies.

Centers for Medicare and Medicaid Services Stage 2 Meaningful Use Resources

Eligible Professionals should refer to the table of contents on the [CMS Web site](#) for information regarding "core set" and "menu set" objectives. Each objective contains the following information:

- The definition of the objective.
- How to measure the objective.
- Any applicable exclusions.

Additional information, such as the following, may also be included:

- Term definitions.
- Attestation requirements.
- Any other additional information related to the objective.
- Frequently asked questions.
- Certification and standards criteria.

Topic #13397

Stages of Meaningful Use of Certified EHR Technology

The table below demonstrates what stage of Meaningful Use must be reported based upon the first year an Eligible Professional began participating in the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program. Eligible Professionals do not need to participate in consecutive Program Years.

First Year of Participation	Stage of Meaningful Use by Program Year										
	2011	2012	2013	2014*	2015	2016	2017	2018	2019	2020	2021
2011	1	1	1	1 or 2	2	2**	3	3	TBD	TBD	TBD
2012		1	1	1 or 2	2	2**	3	3	TBD	TBD	TBD
2013			1	1	2	2	3	3	TBD	TBD	TBD
2014				1	1	2	2	3	3	TBD	TBD
2015					1	1	2	2	3	3	TBD
2016						1	1	2	2	3	3
2017							1	1	2	2	3

* In Program Year 2014 only, all Eligible Professionals, regardless of their stage of Meaningful Use, are only required to demonstrate Meaningful Use for a 90-day EHR reporting period of their choosing.

** Eligible Professionals who began attesting to Meaningful Use in Program Year 2011 or Program Year 2012 may continue to attest to Stage 2 Meaningful Use in Program Year 2016.

Patient Volume

Topic #12098

Eligible Member Patient Volume

The federal law 42 CFR s. 495.306(c)(1) stipulates that only certain services rendered to certain members who are reimbursed with Medicaid (Title XIX) funds may be counted towards eligible member patient volume requirements. The Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program defines eligible members as those members enrolled in the programs listed [here](#).

Eligible Professionals using the eligible member patient volume method must meet a minimum patient encounter volume threshold of one of the following:

- At least 30 percent of their patient volume attributed to eligible members over a continuous 90-day period in the calendar year preceding the payment year.
- Pediatricians will be considered eligible if 20 percent of their patient encounter volume is attributable to eligible members but will receive two-thirds of the incentive amounts. If a pediatrician's patient encounter volume is 30 percent or higher, the incentive payments are the same as any other Eligible Professional.

Note: Eligible Professionals should note that the Wisconsin Medicaid EHR Incentive Program will not round up to meet the minimum patient volume threshold. All patient volumes reported that are below 30 percent (including those at or below 29.99 percent) will be deemed ineligible.

An eligible member patient encounter is defined as any services rendered on any one day to an individual enrolled in a Medicaid program. The Wisconsin Medicaid EHR Incentive Program will consider a claim paid at \$0 or more for services rendered on any one day to an individual enrolled in a Medicaid program to be an eligible member patient encounter.

Multiple Eligible Professionals may count an encounter for the same individual. For example, it may be common for a PA (physician assistant) or nurse practitioner and physician to provide services to a patient during an encounter on the same DOS (date of service). It is acceptable in these and similar circumstances to count the same encounter for multiple Eligible Professionals for purposes of calculating each Eligible Professional's patient volume. The encounters must take place within the scope of practice for each of the Eligible Professionals.

Eligible Professionals may be unable to distinguish between some eligible members and some non-eligible members when determining their patient volume. The Wisconsin Medicaid EHR Incentive Program only considers services provided to members who are eligible to be reimbursed with funding directly from Medicaid (Title XIX) to be a patient encounter. Eligible Professionals may be unable to determine where funding for eligible members comes from, so in order to assist Eligible Professionals in determining their eligible patient encounters, the Wisconsin Medicaid EHR Incentive Program will calculate a standard deduction. The standard deduction for Program Year 2014 is 8.11 percent.

To figure out the eligible member patient encounters, the Eligible Professional must multiply the total eligible member encounter patient volume by a factor of $(1 - .0811)$ or 0.9189 and then divide that number by the total eligible member patient encounter volume. The final number should be rounded to the nearest whole number (i.e., .01 through .49 should be rounded down and .50 through .99 should be rounded up to the nearest number.)

Eligible Professionals using the eligible member patient volume method may elect to calculate patient volume at the individual or group practice level. If an Eligible Professional calculates his or her patient encounter volume based on a group practice level, the entire group practice's patient encounter volume must be included. This includes the services rendered by all providers within the

group practice, regardless of provider type or eligibility status for the Wisconsin Medicaid EHR Incentive Program. Additionally, all Eligible Professionals included in the group practice who register for the Wisconsin Medicaid EHR Incentive Program must also register using the group practice patient volume.

A group practice is defined by how a group practice enumerates its business using NPIs (National Provider Identifiers). When calculating a group practice patient volume, the group practice patient volume methodology can only be used if all of the following conditions are satisfied:

- The eligible members included in the group practice patient volume calculation were provided services during the 90-day period that the group practice is attesting (for the first year).
- There is an auditable data source to support a group practice's patient volume determination.
- All Eligible Professionals in the group practice use the same methodology for the payment year.
- The group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way.
- If an Eligible Professional works inside and outside the group practice, the patient volume calculation may only include those encounters associated with the group practice and not individual encounters outside the group practice.

Note: Eligible Professionals should note that whether they calculate their eligible member patient encounter volume as a group practice or as an individual will not affect how the incentive payments are distributed. For example, an Eligible Professional may calculate their eligible member patient volume at an individual level and assign payment to their group practice. Conversely, an Eligible Professional may calculate their eligible member patient volume at a group practice level and assign payment to themselves.

Eligible Professionals calculating group practice patient volume under the eligible member patient volume must meet a minimum of at least 30 percent of their patient volume attributed to eligible members. The standard deduction must be applied to the total (in-state) eligible member-only patient encounters of the group and rounded to the nearest whole number prior to entry in the Wisconsin EHR Incentive Program application.

Topic #12101

Example of Calculating Group Practice Patient Volume

Eligible Professionals must have at least 30 percent of their patient volume encounters attributed to eligible members. When electing to use group practice patient volume, the entire practice's patient volume must be included. This includes the services rendered by all Eligible Professionals within the group practice, regardless of provider type or eligibility status for the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program. Groups are defined by how their businesses are enumerated under their NPI (National Provider Identifier).

The following is an example of calculating group practice volume for the purpose of establishing eligibility for the Wisconsin Medicaid EHR Incentive Program.

Eligible Based on Provider Type	Provider Type	Total Encounters (Eligible Members/Total)	Percentage of Eligible Member Encounters
Yes	Physician	80/200	40 percent
Yes	Nurse Practitioner	50/100	50 percent
Yes	Physician	0/100	0 percent
No	Registered Nurse	150/200	75 percent
No	Pharmacist	80/100	80 percent
Yes	Physician	30/300	10 percent

Yes	Dentist	5/100	5 percent
Yes	Dentist	60/200	30 percent

In this scenario, there are 1300 encounters in the selected 90-day period. Of the 1300 encounters, 455 are attributable to eligible members, or 35 percent. The next step is to apply the standard deduction ($1 - .0811 = 0.9189$) to the number of eligible members.

$$455 * 0.9189 = 418.100$$

That number is divided by the total number of encounters in the selected 90-day period, or 1300.

$$418.100 / 1300 = 0.322 \text{ or } 32.2 \text{ percent}$$

Therefore, the group practice patient volume is 32.2 percent, which is rounded to the nearest whole number of 32 percent, and is eligible for the Wisconsin Medicaid EHR Incentive Program.

Eligible Professionals should note that even though one dentist's eligible member encounter percentage was only 5 percent and one physician's eligible member encounter percentage was 10 percent, when included in the group practice patient volume, both are eligible for the program when registering with the group practice patient volume. The physician whose eligible member encounter percentage is zero is not eligible for the program because he or she did not render services to at least one eligible member; however, if the physician is new to practicing medicine (e.g., a recent graduate of an appropriate training program), he or she would be eligible for the program because he or she does not need to provide proof of an encounter.

Topic #12100

Example of Calculating Individual Patient Volume

Eligible Professionals must have at least 30 percent (except pediatricians, who must have at least 20 percent) of their patient volume attributed to eligible members. For example, if an Eligible Professional calculates his or her total eligible member patient encounter volume of 33 out of a total patient encounter volume of 75, the eligible member patient volume is 44 percent.

Eligible Professionals may be unable to distinguish between some eligible members and some non-eligible members when determining their patient volume. The Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program only considers services provided to members who are eligible to be reimbursed with funding directly from Medicaid (Title XIX) to be a patient encounter. Eligible Professionals may be unable to determine where funding for eligible members comes from, so in order to assist Eligible Professionals in determining their eligible patient encounters, the Wisconsin Medicaid EHR Incentive Program will calculate a standard deduction. The standard deduction for Program Year 2014 is 8.11 percent.

To figure out the eligible member patient encounters, Eligible Professionals must multiply their total eligible member encounter patient volume by a factor of $(1 - 0.0811)$ or 0.9189 and then divide that number by their total eligible member patient encounter volume.

Standard Deduction Calculation

$$\begin{array}{l} \text{Total eligible member patient encounters during any 90-day continuous period} * 0.9189 \\ \text{-----} * 100 \end{array}$$

Total patient encounters, regardless of payer over that same 90-day continuous period

-Or-

$33 * 0.9189$

----- * 100 = 40.43 percent

75

So the final eligible member patient encounter volume is 30.32 encounters out of 75 total, or 40.43 percent, rounded to the nearest whole number, 40 percent.

Therefore, 40 percent of the Eligible Professional's patient volume is eligible members and the Eligible Professional fulfills the patient volume requirement for the Wisconsin Medicaid EHR Incentive Program. Eligible Professionals should note that the Wisconsin Medicaid EHR Incentive Program will not round up to meet the minimum patient volume threshold. All patient volumes reported that are below 30 percent (including those at or below 29.99 percent) will be deemed ineligible.

Topic #12097

Members Who May Be Counted When Determining Patient Volume

Most members enrolled in the programs listed below are considered eligible members and may be counted when determining patient encounters and patient volume:

- Wisconsin Medicaid.
- BadgerCare Plus Standard Plan.
- BadgerCare Plus Express Enrollment for Pregnant Women.
- Alien Emergency Service Only.
- TB-Only (Tuberculosis-Related Service Only) Benefit.
- Family Planning Only Services.

Note: There are certain members enrolled in these programs or certain services provided to eligible members that may be included in the patient volume, which is the reason for the standard deduction.

Topic #12099

Needy Individual Patient Volume

The federal law stipulates that only certain services rendered to certain individuals may be counted towards the needy individual patient volume requirements. The Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program defines needy individuals as those listed [here](#) as well as those who are provided uncompensated care by the provider, or individuals provided services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

Only Eligible Professionals, including pediatricians, practicing predominantly in an FQHC (Federally Qualified Health Center) or RHC (Rural Health Clinic) may use the Needy Individual Patient Volume method. An Eligible Professional is defined as practicing predominantly in a FQHC or RHC if more than 50 percent of the Eligible Professional's encounters occur in an FQHC or RHC during a six-month period in the most recent calendar year or in the most recent 12 months prior to attestation.

Eligible Professionals using the Needy Individual Patient Volume method must meet a minimum of 30 percent needy individual patient volume threshold. Needy Individual Patient Volume encounters consist of the following:

- Services rendered on any one day to an individual where Medicaid or BadgerCare Plus paid all or part of the service including copayments or any other cost-sharing.
- Services rendered on any one day to an individual where Children's Health Insurance Program under Title XXI paid for part or all of the service.
- Services rendered on any one day to an individual furnished by the provider as uncompensated care.
- Services rendered on any one day to an individual furnished at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

Eligible Professionals using the Needy Individual Patient Volume method may elect to calculate patient volume at an individual or a group practice level. If an Eligible Professional calculates his or her patient encounter volume based on a group practice, the entire group practice's patient volume must be included. This includes the services rendered by all providers within the group practice, regardless of provider type or eligibility status for the Wisconsin Medicaid EHR Incentive Program. Additionally, all Eligible Professionals included in the group practice who register for the Wisconsin Medicaid EHR Incentive Program must also register using the group practice patient volume.

A group practice is defined by how a group practice enumerates its business using NPIs (National Provider Identifiers). When calculating a group practice patient volume, the group practice patient volume methodology can only be used if all of the following conditions are satisfied:

- The eligible members included in the group practice patient volume calculation were provided services during the 90-day period that the organization is attesting (for the first year).
- There is an auditable data source to support a group practice's patient volume determination.
- All Eligible Professionals in the group practice use the same methodology for the payment year.
- The group practice uses the entire group practice's patient volume and does not limit patient volume in any way.
- If an Eligible Professional works inside and outside the group practice, the patient volume calculation may only include those encounters associated with the group practice and not individual encounters outside the group practice.

Note: Eligible Professionals should note that whether they calculate their needy individual patient encounter volume as a group practice or as an individual will not affect how the incentive payments are distributed. For example, an Eligible Professional may calculate his or her needy individual patient volume at an individual level and assign payment to the group practice. Conversely, an Eligible Professional may calculate his or her needy individual patient volume at a group practice level and assign payment to him- or herself.

Eligible Professionals calculating group patient volume under the needy individual patient volume must meet a minimum of at least 30 percent of their patient volume attributed to needy individuals. The standard deduction must be applied to the total (in-state) eligible member-only patient encounters of the organization and rounded to the nearest whole number prior to entry in the Wisconsin EHR Incentive Program application.

Topic #12078

Patient Volume Requirements and Calculations

In addition to other EHR (Electronic Health Record) Incentive Program requirements, Eligible Professionals must meet patient volume thresholds over the course of a 90-day period.

Eligible Professionals are required to select one of the following patient volume reporting periods:

- Calendar year preceding payment year.
- Twelve months preceding attestation date.

Note: The attestation date is defined as the day when the application is electronically signed and submitted for the first time in the Program Year or the last day of the Program Year if applying during the grace period.

An Eligible Professional cannot calculate patient volume by including patient encounters that occur during the 90-day grace period following the Program Year. For example, an Eligible Professional who applies for Program Year 2013 participation cannot include patient encounters occurring after December 31, 2013.

An Eligible Professional cannot use the same or overlapping patient volume periods for future Program Year applications. For example, an Eligible Professional uses January 1, 2013, through March 31, 2013, for Program Year 2013. In Program Year 2014, the Eligible Professional cannot use January 1, 2013, through March 31, 2013, or any overlapping period (i.e., February 1, 2013, through April 30, 2013).

When reporting patient volume, Eligible Professionals will designate which practice locations are using CEHRT (Certified Electronic Health Record Technology) and enter the relevant patient encounter data needed to determine eligibility. Patient encounter data will be entered in three parts for each practice location:

- The total (in-state) eligible member-only patient encounter volume over the previously determined continuous 90-day reporting period.
- The total (regardless of state) eligible member-only patient encounter volume over the previously determined continuous 90-day reporting period.
- The total patient encounter volume (regardless of state or payer) over the previously determined continuous 90-day reporting period.

When attesting to Wisconsin Medicaid EHR Incentive Program patient volume requirements, there are two methods by which an Eligible Professional may calculate patient volume.

- Eligible member patient volume.
- Needy individual patient volume.

Each patient volume method contains its own unique requirements; however, only Eligible Professionals practicing in an FQHC (federally qualified health center) or RHC (rural health clinic) may use the needy individual patient volume method.

Registration and Applying

Topic #12057

Individuals Applying for the EHR Incentive Program

A secure Provider account on the ForwardHealth Portal is required to apply for the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program. All applications must be completed via a secure Provider Portal account.

An Eligible Professional applying as an individual needs to follow the process below when applying for the Wisconsin Medicaid EHR Incentive Program:

- The Eligible Professional needs to first log in to the Portal. If the Eligible Professional does not have a Portal account, he or she needs to obtain one. The Eligible Professional should refer to the Account User Guide on the [Portal User Guides page](#) of the Provider area of the Portal for more information on obtaining a Portal account.
- The Eligible Professional needs to click on the Wisconsin Medicaid EHR Incentive Program link in the Quick Link box.
- The Eligible Professional will have to designate payment to either him- or herself or to the organization.

Topic #12040

Organizations Applying for the EHR Incentive Program on Behalf of Eligible Professionals

A secure Provider Portal account is required to apply for the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program. All applications must be completed via a secure Provider ForwardHealth Portal account.

Organizations applying on behalf of Eligible Professionals need to follow the process below when applying for the Wisconsin Medicaid EHR Incentive Program:

- The organization needs to first log in to the Portal. The organization only needs one Portal account to apply for all Eligible Professionals assigning payment to their organization and associated with the organization's federal TIN (tax identification number). If the organization does not have a Portal account, it needs to obtain one. Refer to the Account User Guide on the [Portal User Guides page](#) of the Provider area of the Portal for more information on obtaining a Portal account.
- Portal Administrators will automatically have access to the Wisconsin Medicaid EHR Incentive Program application. Organizations may assign the new "EHR Incentive" role to a clerk to conduct all Wisconsin Medicaid EHR Incentive Program business.
- The organization may access the EHR Incentive Program application by clicking on the Wisconsin Medicaid EHR Incentive Program link in the Quick Link box.
- The organization will see a list of all Eligible Professionals that are associated with the organization's TIN. The organization will have to submit a separate application for each Eligible Professional associated with their TIN. Organizations should note that once an application has begun for an Eligible Professional, only the Portal account used to begin the application can access that Eligible Professional's application.

Topic #12039

Registration for the EHR Incentive Program with CMS

All Eligible Professionals are required to first register at the [R&A \(Medicare and Medicaid Electronic Health Record Incentive Program Registration and Attestation System\) Web site](#). A step-by-step walkthrough of the R&A registration process for Eligible Professionals is also available [online](#).

After an Eligible Professional successfully registers on the R&A, CMS (Centers for Medicare and Medicaid Services) will process the registration and send the file to the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program. After receipt of the file, the Wisconsin Medicaid EHR Incentive Program will enter all relevant information into the ForwardHealth system. Eligible Professionals must wait two full business days before beginning the application for the Wisconsin Medicaid EHR Incentive Program to allow for this process.

Topic #12058

Required Information When Starting the EHR Incentive Program Application

Eligible Professionals will be required to supply specific information when completing the EHR (Electronic Health Record) Incentive Program application. Eligible Professionals do not have to complete the entire application in one session. The application will allow users to save the information entered and return later to complete the application.

Eligible Professionals should have the following information available when beginning the application:

- Information submitted to the R&A (Medicare and Medicaid Electronic Health Record Incentive Program Registration and Attestation System). Eligible Professionals will need to confirm all of this information during the initial application phases.
- Contact name, telephone number, and e-mail address of the authorized preparer of the Eligible Professional's application, if not the Eligible Professional.
- Information regarding whether or not the Eligible Professional applying to the Wisconsin Medicaid EHR Incentive Program has any sanctions or pending sanctions with the Medicare or Medicaid programs and is licensed to practice in all states in which services are rendered.
- The CMS (Centers for Medicare and Medicaid Services) EHR certification ID for the CEHRT (Certified Electronic Health Record Technology) the Eligible Professional already has or is contractually obligated to acquire. For more information on approved EHR technology, Eligible Professionals should refer to the ONC (Office of the National Coordinator for Health Information Technology)-certified EHR [product list](#).
- Required Patient Volume Data:
 - The total in-state eligible member patient encounter volume over the previously determined continuous 90-day reporting period.
 - The total eligible member patient encounter volume over the previously determined continuous 90-day reporting period.
 - The total patient encounter volume over the previously determined continuous 90-day reporting period.

Topic #12077

Reviewing, Confirming, and Submitting the EHR Incentive Program Application

After completing attestations for the EHR (Electronic Health Record) Incentive Program, the Eligible Professional will be asked to review all answers provided. An error-checking function will identify any errors found in the application.

Final submission will require an electronic signature by providing the preparer or the Eligible Professional's initials, the Eligible Professional's NPI (National Provider Identifier) and the Eligible Professional's personal TIN (tax identification number). If

completed through the use of an authorized preparer, that preparer will also need to include his or her name and relationship to the Eligible Professional and then electronically sign the application before submission. Once the Wisconsin Medicaid EHR Incentive Program application has been completed and submitted, an e-mail notification will be sent to confirm the application's submission. After an application is successfully submitted and approved, Eligible Professionals can expect payments within 45 days.

Resources for EHR Incentive Program

Topic #12138

Provider Services

Eligible Professionals and Eligible Hospitals should call [Provider Services](#) with all questions regarding the Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program.

Topic #12139

User Guide

Wisconsin Medicaid EHR (Electronic Health Record) Incentive Program User Guides for Eligible Professionals and Eligible Hospitals are available on the [Portal User Guides page](#) of the Provider area of the ForwardHealth Portal.

Topic #12140

Web Sites

The following Web sites provide additional information regarding the EHR (Electronic Health Record) Incentive Program.

Available Resources	Web Sites
Wisconsin Medicaid EHR Incentive Program Web Site	www.dhs.wisconsin.gov/ehrincentive/index.htm
CMS (Centers for Medicare and Medicaid Services) EHR Incentive Program	www.cms.gov/EHRIncentivePrograms/
Wisconsin Health Information Technology Extension Center Web Site	www.whitec.org/

Managed Care

4

Archive Date:02/02/2015

Managed Care: Covered and Noncovered Services

Topic #16197

Care4Kids Program Benefit Package

Covered Services

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

Noncovered Services

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

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

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

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

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

Managed Care Information

Topic #16177

Care4Kids Program Overview

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

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

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

Program Administration

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

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

Member Enrollment Verification

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

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

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

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

Contact Information

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

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

Member Information

5

Archive Date:02/02/2015

Member Information:Enrollment Categories

Topic #16677

BadgerCare Plus Benefit Plan Changes

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

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

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

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

Prior Authorization

6

Archive Date:02/02/2015

Prior Authorization:Advanced Imaging Services

Topic #15477

Exemption from Prior Authorization

Providers Ordering Computed Tomography and Magnetic Resonance Imaging Services

Health systems, groups, and individual providers (requesting providers) that order CT (computed tomography) and MR (magnetic resonance) imaging services and have implemented advanced imaging decision support tools may request an exemption from PA (prior authorization) requirements for these services. Upon approval, ForwardHealth will recognize the requesting provider's advanced imaging decision support tool (e.g., ACR Select, Medicalis) as an alternative to current PA requirements for CT and MR imaging services. Requesting providers with an approved tool will not be required to obtain PA through MedSolutions for these services when ordered for Medicaid and BadgerCare Plus fee-for-service members.

Note: It is the ordering provider's responsibility to communicate PA status (whether the provider is exempt from PA requirements or PA has been obtained through MedSolutions) to the rendering provider at the time of the request for advanced imaging services.

Exemption from Prior Authorization Requirements Not Available for Positron Emission Tomography

Decision support for PET (positron emission tomography) is not available in all advanced imaging decision support tools. Therefore, PET will not be eligible to be exempted from PA requirements at this time. ForwardHealth may review its policies and requirements in response to any future developments in decision support tools, including the addition of PET decision support tools to the PA exemption.

Process for Obtaining an Exemption from Prior Authorization Requirements

Requesting providers with advanced imaging decision support tools may request exemption from PA requirements for CT and MR imaging services using the following process:

1. Complete a [Prior Authorization Requirements Exemption Request for Computed Tomography \(CT\) and Magnetic Resonance \(MR\) Imaging Services \(F-00787 \(05/13\)\)](#) and agree to its terms.
2. Submit the completed Prior Authorization Requirements Exemption Request for CT and MR Imaging Services to the mailing or e-mail address listed on the form. Once received, ForwardHealth will review the exemption request materials, approve or deny the request, and send a decision letter to the requesting provider within 60 days after receipt of all necessary documentation. ForwardHealth will contact the requesting provider if any additional information is required for the application.
3. If the exemption request is approved, submit a list of all individual providers who order CT and MR scans using the requesting provider's decision support tool. Exemptions are verified using the NPI (National Provider Identifier) of the individual ordering provider; therefore, requesting providers should submit a complete list of all individual ordering providers within the requesting provider's group to ForwardHealth. Lists may be submitted via e-mail to DHSPAExemption@wisconsin.gov.

Process for Maintaining an Exemption from Prior Authorization

Requirements

To maintain exemption from PA requirements for advanced imaging services, the requesting provider is required to report the following outcome measures to ForwardHealth for the previous full six-month interval (January 1 through June 30 and July 1 through December 31) by July 31 and January 31 of each year:

- Aggregate score for all ordering providers that measures consistency with system recommendations based on the reporting standards described in more detail in Section III of the Prior Authorization Requirements Exemption Request for CT and MR Imaging Services form.
- Subset scores, grouped by primary and specialty care.
- Aggregate outcome measures identified in the quality improvement plan.

ForwardHealth will work with requesting providers to determine the most appropriate quality metrics. All requesting providers will need to provide similar data based on their reporting capabilities. This information should be submitted by the July 31 and January 31 deadlines to DHSPAExemption@wisconsin.gov.

Refer to the Prior Authorization Requirements Exemption Request for CT and MR Imaging Services form for more detailed information on quality improvement plans and maintaining exemption from PA requirements. Providers with questions regarding the requirements may e-mail them to DHSPAExemption@wisconsin.gov. If a requesting provider's quality improvement plan changes over time, any additional information identified in the plan must also be reported to this e-mail address.

ForwardHealth may discontinue an exemption after initial approval if it determines the requesting provider either no longer meets the requirements outlined previously or does not demonstrate meaningful use of decision support to minimize inappropriate utilization of CT and MR imaging services.

Updating the List of Eligible Providers

The requesting provider is required to maintain the list of individual ordering providers eligible for the exemption. The requesting provider will have two mechanisms for updating the list of individual ordering providers eligible for the exemption: individual entry of provider NPIs or uploading a larger, preformatted text file.

The requesting provider may enter individual NPIs using the Prior Authorization Exempted link under the Quick Links box in the secure Provider area of Portal.

For larger lists of providers eligible for exemption, requesting providers should upload a text file to the Portal that includes the individual provider NPIs, start dates for exemption, and end dates for exemption, if applicable. All submitted NPIs will be matched to the ForwardHealth provider file. ForwardHealth will notify the requesting provider monthly, using the e-mail contact indicated on the exemption application form, of any NPIs that cannot be matched.

ForwardHealth will enable the requesting provider's Portal administrator and delegated clerks to update the individual ordering providers for whom the exemption applies by July 1, 2013. Any changes that need to be made prior to that time for individual ordering providers eligible for the exemption should be sent to DHSPAExemption@wisconsin.gov.

The individual providers listed may order CT and MR imaging services without requesting PA for any DOS on and after the date the requesting provider indicates those providers are eligible to use the decision support tool, regardless of the date an individual provider's information was submitted to ForwardHealth.

For example, ABC Health Clinic is approved for an exemption from PA requirements on June 1. Dr. Smith of ABC Health Clinic orders an MR imaging service on June 15. It is discovered on June 20 that Dr. Smith was mistakenly excluded from ABC Health Clinic's exemption list. Once Dr. Smith is added to the exemption list, she is covered under the exemption going back to the date ABC Health Clinic indicated she was eligible to use the clinic's decision support tool.

Providers Rendering Advanced Imaging Services

Providers rendering advanced imaging services are encouraged to verify that either a PA request has been approved for the member (verified by contacting MedSolutions or the ordering provider), or the ordering provider is exempt from PA (verified by contacting the ordering provider) prior to rendering the service.

Claim Submission

Providers rendering advanced imaging services for an ordering provider who is exempt from PA requirements should include modifier Q4 (Service for ordering/referring physician qualifies as a service exemption) on the claim detail for the CT or MR imaging service. This modifier, which may be used in addition to the TC (Technical component) or 26 (Professional component) modifiers on advanced imaging claims, indicates to ForwardHealth that the ordering provider is exempt from PA requirements for these services.

Providers are also reminded to include the NPI of the ordering provider on the claim if the ordering provider is different from the rendering provider. If a PA request was not approved for the member and an exempt ordering provider's NPI is not included on the claim, the claim will be denied.

Topic #10678

Prior Authorization for Advanced Imaging Services

Most advanced imaging services, including CT (computed tomography), MR (magnetic resonance), and PET (positron emission tomography) imaging, require PA (prior authorization) when performed in either outpatient hospital settings or in non-hospital settings (e.g., radiology clinics). [MedSolutions](#), a private radiology benefits manager, is authorized to administer PA for advanced imaging services on behalf of ForwardHealth. Refer to the Prior Authorization section of the Radiology area of the Online Handbook for PA requirements and submission information for advanced imaging services.

Health systems, groups, and individual providers that order CT and MR imaging services and have implemented decision support tools may request an exemption from PA requirements for these services. Upon approval, ForwardHealth will recognize the requesting provider's advanced imaging decision support tool (e.g., ACR Select, Medicalis) as an alternative to current PA requirements for CT and MR imaging services.

Provider Enrollment and Ongoing Responsibilities

7

Archive Date:02/02/2015

Provider Enrollment and Ongoing Responsibilities:Documentation

Topic #6277

1099 Miscellaneous Forms

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

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

Topic #1640

Availability of Records to Authorized Personnel

The DHS (Department of Health Services) has the right to inspect, review, audit, and reproduce provider records pursuant to [DHS 106.02\(9\)\(e\)](#), Wis. Admin. Code. The DHS periodically requests provider records for compliance audits to match information against ForwardHealth's information on paid claims, PA (prior authorization) requests, and enrollment. These records include, but are not limited to, medical/clinical and financial documents. Providers are obligated to ensure that the records are released to an authorized DHS staff member(s).

Wisconsin Medicaid reimburses providers \$0.06 per page for the cost of reproducing records requested by the DHS to conduct a compliance audit. A letter of request for records from the DHS will be sent to a provider when records are required.

Reimbursement is not made for other reproduction costs included in the provider agreement between the DHS and a provider, such as reproduction costs for submitting PA requests and claims.

Also, state-contracted MCOs (managed care organizations), including HMOs and SSI (Supplemental Security Income) HMOs, are not reimbursed for the reproduction costs covered in their contract with the DHS.

The reproduction of records requested by the PRO (Peer Review Organization) under contract with the DHS is reimbursed at a rate established by the PRO.

Topic #200

Confidentiality and Proper Disposal of Records

ForwardHealth supports member rights regarding the confidentiality of health care and other related records, including an applicant or member's billing information or medical claim records. An applicant or member has a right to have this information safeguarded, and the provider is obligated to protect that right. Use or disclosure of any information concerning an applicant or member (including an applicant or member's billing information or medical claim records) for any purpose not connected with program administration is prohibited unless authorized by the applicant or member (program administration includes contacts with third-party payers that are necessary for pursuing third-party payment and the release of information as ordered by the court).

Federal HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy and Security regulations establish requirements regarding the confidentiality and proper disposal of health care and related records containing PHI (protected health information). These requirements apply to all providers (who are considered "covered entities") and their business associates who create, retain, and dispose of such records.

For providers and their business partners who are not subject to HIPAA, Wisconsin confidentiality laws have similar requirements pertaining to proper disposal of health care and related records.

HIPAA Privacy and Security Regulations

Definition of Protected Health Information

As defined in the HIPAA privacy and security regulations, PHI is protected health information (including demographic information) that:

- Is created, received, maintained, or transmitted in any form or media.
- Relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the payment for the provision of health care to an individual.
- Identifies the individual or provides a reasonable basis to believe that it can be used to identify the individual.

A member's name combined with his or her member identification number or Social Security number is an example of PHI.

Requirements Regarding "Unsecured" Protected Health Information

Title XIII of the American Recovery and Reinvestment Act of 2009 (also known as the HITECH (Health Information Technology for Economic and Clinical Health) Act) included a provision that significantly expanded the scope, penalties, and compliance challenges of HIPAA. This provision imposes new requirements on covered entities and their business associates to notify patients, the federal government, and the media of breaches of "unsecured" PHI (refer to 45 CFR Parts 160 and 164 and s. 13402 of the HITECH Act).

Unsecured PHI is PHI that has not been rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of physical destruction approved by the HHS (U.S. Department of Health and Human Services). According to the HHS, destruction is the only acceptable method for rendering PHI unusable, unreadable, or indecipherable.

As defined by federal law, unsecured PHI includes information in *any* medium, not just electronic data.

Actions Required for Proper Disposal of Records

Under the HIPAA privacy and security regulations, health care and related records containing PHI must be disposed of in such a manner that they cannot be reconstructed. This includes ensuring that the PHI is secured (i.e., rendered unusable, unreadable, or indecipherable) prior to disposal of the records.

To secure PHI, providers and their business associates are required to use one of the following destruction methods approved by the HHS:

- Paper, film, labels, or other hard copy media should be shredded or destroyed such that the PHI cannot be read or otherwise reconstructed.
- Electronic media should be cleared, purged, or destroyed such that the PHI cannot be retrieved according to National Institute of Standards and Technology Special Publication 800-88, Guidelines for Media Sanitization, which can be found on the [NIST \(National Institute of Standards and Technology\) Web site](#).

For more information regarding securing PHI, providers may refer to [Health Information Privacy](#) on the HHS Web site.

Wisconsin Confidentiality Laws

[Section 134.97](#), Wis. Stats., requires providers and their business partners who are not subject to HIPAA regulations to comply with Wisconsin confidentiality laws pertaining to the disposal of health care and related records containing PHI.

[Section 146.836](#), Wis. Stats., specifies that the requirements apply to "all patient health care records, including those on which written, drawn, printed, spoken, visual, electromagnetic or digital information is recorded or preserved, regardless of physical form or characteristics." Paper *and* electronic records are subject to Wisconsin confidentiality laws.

"Personally Identifiable Data" Protected

According to [s.134.97\(1\)\(e\)](#), Wis. Stats., the types of records protected are those containing "personally identifiable data."

As defined by the law, personally identifiable data is information about an individual's medical condition that is not considered to be public knowledge. This may include account numbers, customer numbers, and account balances.

Actions Required for Proper Disposal of Records

Health care and related records containing personally identifiable data must be disposed of in such a manner that no unauthorized person can access the personal information. For the period of time between a record's disposal and its destruction, providers and their business partners are required to take actions that they reasonably believe will ensure that no unauthorized person will have access to the personally identifiable data contained in the record.

Businesses Affected

Sections [134.97](#) and [134.98](#), Wis. Stats., governing the proper disposal of health care and related records, apply to medical businesses as well as financial institutions and tax preparation businesses. For the purposes of these requirements, a medical business is any for-profit or nonprofit organization or enterprise that possesses information — other than personnel records — relating to a person's physical or mental health, medical history, or medical treatment. Medical businesses include sole proprietorships, partnerships, firms, business trusts, joint ventures, syndicates, corporations, limited liability companies, or associates.

Continuing Responsibilities for All Providers After Ending Participation

Ending participation in a ForwardHealth program does not end a provider's responsibility to protect the confidentiality of health care and related records containing PHI.

Providers who no longer participate in a ForwardHealth program are responsible for ensuring that they and their business associates/partners continue to comply with all federal and state laws regarding protecting the confidentiality of members' PHI. Once record retention requirements expire, records must be disposed of in such a manner that they cannot be reconstructed — according to federal and state regulations — in order to avoid penalties.

All ForwardHealth providers and their business associates/partners who cease practice or go out of business should ensure that they have policies and procedures in place to protect all health care and related records from any unauthorized disclosure and use.

Penalties for Violations

Any covered entity provider or provider's business associate who violates federal HIPAA regulations regarding the confidentiality and proper disposal of health care and related records may be subject to criminal and/or civil penalties, including any or all of the following:

- Fines up to \$1.5 million per calendar year.
- Jail time.
- Federal HHS Office of Civil Rights enforcement actions.

For entities not subject to HIPAA, [s.134.97\(4\)](#), Wis. Stats., imposes penalties for violations of confidentiality laws. Any provider or provider's business partner who violates Wisconsin confidentiality laws may be subject to fines up to \$1,000 per incident or occurrence.

For more specific information on the penalties for violations related to members' health care records, providers should refer to s. 13410(d) of the HITECH Act, which amends 42 USC s. 1320d-5, and [s. 134.97\(3\)](#), [\(4\)](#) and [146.84](#), Wis. Stats.

Topic #201

Financial Records

According to [DHS 106.02\(9\)\(c\)](#), Wis. Admin. Code, a provider is required to maintain certain financial records in written or electronic form.

Topic #202

Medical Records

A dated clinician's signature must be included in all medical notes. According to [DHS \(Department of Health Services\) 106.02\(9\)\(b\)](#), Wis. Admin. Code, a provider is required to include certain written documentation in a member's medical record.

Topic #199

Member Access to Records

Providers are required to allow members access to their health care records, including those related to ForwardHealth services, maintained by a provider in accordance with Wisconsin Statutes, excluding billing statements.

Fees for Health Care Records

Per [s. 146.83](#), Wis. Stats., providers may charge a fee for providing one set of copies of health care records to members who are enrolled in Wisconsin Medicaid or BadgerCare Plus programs on the date of the records request. This applies regardless of the member's enrollment status on the DOS (dates of service) contained within the health care records.

Per [s. 146.81\(4\)](#), Wis. Stats., health care records are all records related to the health of a patient prepared by, or under the supervision of, a health care provider.

Providers are limited to charging members enrolled in state-funded health care programs 25 percent of the applicable fees for providing one set of copies of the member's health care records.

Note: A provider may charge members 100 percent of the applicable fees for providing a second or additional set of copies of the member's health care records.

The DHS (Department of Health Services) adjusts the [amounts](#) a provider may charge for providing copies of a member's health care records yearly per [s. 146.83\(3f\)\(c\)](#), Wis. Stats.

Topic #16157

Policy Requirements for Use of Electronic Signatures on Electronic Health Records

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

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

Electronic Signature Definition

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

Some examples include:

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

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

Benefits of Using Electronic Signatures

The use of electronic signatures will allow providers to:

- Save time by streamlining the document signing process.
- Reduce the costs of postage and mailing materials.
- Maintain the integrity of the data submitted.
- Increase security to aid in non-repudiation.

Electronic Signature Requirements

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

General Requirements

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

- The electronic signature must be under the sole control of the rendering provider. Only the rendering provider or designee has the authority to use the rendering provider's electronic signature. Providers are required to maintain documentation that shows the electronic signature that belongs to each rendering provider if a numbering or initial system is used (e.g., what number is assigned to a specific rendering provider). This documentation must be kept confidential.
- The provider is required to have current policies and procedures regarding the use of electronic signatures. The DHS

(Department of Health Services) recommends the provider conduct an annual review of policies and procedures with those using electronic signatures to promote ongoing compliance and to address any changes in the policies and procedures.

- The provider is required to conduct or review a security risk analysis in accordance with the requirements under 45 CFR s. 164.308(a)(1).
- The provider is required to implement security updates as necessary and correct identified security deficiencies as part of its risk management process.
- The provider is required to establish administrative, technical, and physical safeguards in compliance with the HIPAA Security Rule.

Electronic Health Record Signature Requirements

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

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

Topic #203

Preparation and Maintenance of Records

All providers who receive payment from Wisconsin Medicaid, including state-contracted MCOs (managed care organizations), are required to maintain records that fully document the basis of charges upon which all claims for payment are made, according to [DHS 106.02\(9\)\(a\)](#), Wis. Admin. Code. This required maintenance of records is typically required by any third-party insurance company and is not unique to ForwardHealth.

Topic #204

Record Retention

Providers are required to retain documentation, including medical and financial records, for a period of not less than five years from the date of payment, except RHCs (rural health clinics), which are required to retain records for a minimum of six years from the date of payment.

According to [DHS 106.02\(9\)\(d\)](#), Wis. Admin. Code, providers are required to retain all evidence of billing information.

Ending participation as a provider does not end a provider's responsibility to retain and provide access to fully maintained records unless an alternative arrangement of record retention and maintenance has been established.

Maintaining Confidentiality of Records

Ending participation in a ForwardHealth program does not end a provider's responsibility to protect the confidentiality of health care and related records containing PHI (protected health information).

Providers who no longer participate in a ForwardHealth program are responsible for ensuring that they and their business associates/partners continue to comply with all federal and state laws regarding protecting the confidentiality of members' PHI. Once record retention requirements expire, records must be disposed of in such a manner that they cannot be reconstructed — according to federal and state regulations — in order to avoid penalties. For more information on the proper disposal of records, refer to [Confidentiality and Proper Disposal of Records](#).

All ForwardHealth providers and their business associates/partners who cease practice or go out of business should ensure that they have policies and procedures in place to protect all health care and related records from any unauthorized disclosure and use.

Reviews and Audits

The DHS (Department of Health Services) periodically reviews provider records. The DHS has the right to inspect, review, audit, and photocopy the records. Providers are required to permit access to any requested record(s), whether in written, electronic, or micrographic form.

Topic #205

Records Requests

Requests for billing or medical claim information regarding services reimbursed by Wisconsin Medicaid may come from a variety of individuals including attorneys, insurance adjusters, and members. Providers are required to notify ForwardHealth when releasing billing information or medical claim records relating to charges for covered services except in the following instances:

- When the member is a dual eligible (i.e., member is eligible for both Medicare and Wisconsin Medicaid or BadgerCare Plus) and is requesting materials pursuant to *Medicare* regulations.
- When the provider is attempting to exhaust all existing health insurance sources prior to submitting claims to ForwardHealth.

Request from a Member or Authorized Person

If the request for a member's billing information or medical claim records is from a member or authorized person acting on behalf of a member, the provider is required to do the following:

1. Send a copy of the requested billing information or medical claim records to the requestor.

2. Send a letter containing the following information to ForwardHealth:
 - Member's name.
 - Member's ForwardHealth identification number or SSN (Social Security number), if available.
 - Member's DOB (date of birth).
 - DOS (date of service).
 - Entity requesting the records, including name, address, and telephone number.

The letter must be sent to the following address:

Wisconsin Casualty Recovery — HMS
 Ste 100
 5615 Highpoint Dr
 Irving TX 75038-9984

Request from an Attorney, Insurance Company, or Power of Attorney

If the request for a member's billing information or medical claim records is from an attorney, insurance company, or power of attorney, the provider is required to do the following:

1. Obtain a release signed by the member or authorized representative.
2. Furnish the requested material to the requester, marked "BILLED TO FORWARDHEALTH" or "TO BE BILLED TO FORWARDHEALTH," with a copy of the release signed by the member or authorized representative. Approval from ForwardHealth is not necessary.
3. Send a copy of the material furnished to the requestor, along with a copy of their original request and medical authorization release to:

Wisconsin Casualty Recovery — HMS
 Ste 100
 5615 Highpoint Dr
 Irving TX 75038-9984

Request for Information About a Member Enrolled in a State-Contracted Managed Care Organization

If the request for a member's billing information or medical claim records is for a member enrolled in a state-contracted MCO (managed care organization), the provider is required to do the following:

1. Obtain a release signed by the member or authorized representative.
2. Send a copy of the letter requesting the information, along with the release signed by the member or authorized representative, directly to the MCO.

The MCO makes most benefit payments and is entitled to any recovery that may be available.

Request for a Statement from a Dual Eligible

If the request is for an itemized statement from a dual eligible, pursuant to HR 2015 (Balanced Budget Act of 1997) s. 4311, a dual eligible has the right to request and receive an itemized statement from his or her Medicare-enrolled health care provider. The Act requires the provider to furnish the requested information to the member. The Act does *not* require the provider to notify ForwardHealth.

Topic #1646

Release of Billing Information to Government Agencies

Providers are permitted to release member information without informed consent when a written request is made by the DHS (Department of Health Services) or the federal HHS (Department of Health and Human Services) to perform any function related to program administration, such as auditing, program monitoring, and evaluation.

Providers are authorized under Wisconsin Medicaid confidentiality regulations to report suspected misuse or abuse of program benefits to the DHS, as well as to provide copies of the corresponding patient health care records.

Ongoing Responsibilities

Topic #220

Accommodating Members with Disabilities

All providers, including ForwardHealth providers, operating an existing public accommodation have requirements under [Title III of the Americans with Disabilities Act of 1990 \(nondiscrimination\)](#).

Topic #219

Civil Rights Compliance (Nondiscrimination)

Providers are required to comply with all federal laws relating to Title XIX of the Social Security Act and state laws pertinent to ForwardHealth, including the following:

- Title VI and VII of the Civil Rights Act of 1964.
- The Age Discrimination Act of 1975.
- Section 504 of the Rehabilitation Act of 1973.
- The ADA (Americans with Disabilities Act) of 1990.

The previously listed laws require that all health care benefits under ForwardHealth be provided on a nondiscriminatory basis. No applicant or member can be denied participation in ForwardHealth or be denied benefits or otherwise subjected to discrimination in any manner under ForwardHealth on the basis of race, color, national origin or ancestry, sex, religion, age, disability, or association with a person with a disability.

Any of the following actions may be considered discriminatory treatment when based on race, color, national origin, disability, or association with a person with a disability:

- Denial of aid, care, services, or other benefits.
- Segregation or separate treatment.
- Restriction in any way of any advantage or privilege received by others. (There are some program restrictions based on eligibility classifications.)
- Treatment different from that given to others in the determination of eligibility.
- Refusing to provide an oral language interpreter to persons who are considered LEP (limited English proficient) at no cost to the LEP individual in order to provide meaningful access.
- Not providing translation of vital documents to the LEP groups who represent five percent or 1,000, whichever is smaller, in the provider's area of service delivery.

Note: Limiting practice by age is not age discrimination and specializing in certain conditions is not disability discrimination. For further information, see 45 CFR Part 91.

Providers are required to be in compliance with the previously mentioned laws as they are currently in effect or amended. Providers who employ 25 or more employees and receive \$25,000 or more annually in Medicaid reimbursement are also required to comply with the DHS (Department of Health Services) [Affirmative Action and Civil Rights Compliance Plan](#) requirements. Providers that employ less than 25 employees and receive less than \$25,000 annually in Medicaid reimbursement are required to comply by submitting a Letter of Assurance and other appropriate forms.

Providers without Internet access may obtain copies of the DHS Affirmative Action and Civil Rights Compliance Plan (including the Letter of Assurance and other forms) and instructions by calling the Affirmative Action and Civil Rights Compliance Officer at (608) 266-9372. Providers may also write to the following address:

AA/CRC Office
1 W Wilson St Rm 561
PO Box 7850
Madison WI 53707-7850

For more information on the acts protecting members from discrimination, refer to the civil rights compliance information in the Enrollment and Benefits booklet. The booklet is given to new ForwardHealth members by local county or tribal agencies. Potential ForwardHealth members can request the booklet by calling [Member Services](#).

Title VI of the Civil Rights Act of 1964

This act requires that all benefits be provided on a nondiscriminatory basis and that decisions regarding the provision of services be made without regard to race, color, or national origin. Under this act, the following actions are prohibited, if made on the basis of race, color, or national origin:

- Denying services, financial aid, or other benefits that are provided as a part of a provider's program.
- Providing services in a manner different from those provided to others under the program.
- Aggregating or separately treating clients.
- Treating individuals differently in eligibility determination or application for services.
- Selecting a site that has the effect of excluding individuals.
- Denying an individual's participation as a member of a planning or advisory board.
- Any other method or criteria of administering a program that has the effect of treating or affecting individuals in a discriminatory manner.

Title VII of the Civil Rights Act of 1964

This act prohibits differential treatment, based solely on a person's race, color, sex, national origin, or religion, in the terms and conditions of employment. These conditions or terms of employment are failure or refusal to hire or discharge compensation and benefits, privileges of employment, segregation, classification, and the establishment of artificial or arbitrary barriers to employment.

Federal Rehabilitation Act of 1973, Section 504

This act prohibits discrimination in both employment and service delivery based solely on a person's disability.

This act requires the provision of reasonable accommodations where the employer or service provider cannot show that the accommodation would impose an undue hardship in the delivery of the services. A reasonable accommodation is a device or service modification that will allow the disabled person to receive a provider's benefits. An undue hardship is a burden on the program that is not equal to the benefits of allowing that handicapped person's participation.

A handicapped person means any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

In addition, Section 504 requires "program accessibility," which may mean building accessibility, outreach, or other measures that allow for full participation of the handicapped individual. In determining program accessibility, the program or activity will be viewed in its entirety. In choosing a method of meeting accessibility requirements, the provider shall give priority to those methods that offer a person who is disabled services that are provided in the most integrated setting appropriate.

Americans with Disabilities Act of 1990

Under Title III of the ADA (Americans with Disabilities Act) of 1990, any provider that operates an existing public accommodation has four specific requirements:

1. Remove barriers to make his or her goods and services available to and usable by people with disabilities to the extent that it is readily achievable to do so (i.e., to the extent that needed changes can be accomplished without much difficulty or expense).
2. Provide auxiliary aids and services so that people with sensory or cognitive disabilities have access to effective means of communication, unless doing so would fundamentally alter the operation or result in undue burdens.
3. Modify any policies, practices, or procedures that may be discriminatory or have a discriminatory effect, unless doing so would fundamentally alter the nature of the goods, services, facilities, or accommodations.
4. Ensure that there are no unnecessary eligibility criteria that tend to screen out or segregate individuals with disabilities or limit their full and equal enjoyment of the place of public accommodation.

Age Discrimination Act of 1975

The Age Discrimination Act of 1975 prohibits discrimination on the basis of age in programs and activities receiving federal financial assistance. The Act, which applies to all ages, permits the use of certain age distinctions and factors other than age that meet the Act's requirements.

Topic #198

Contracted Staff

Under a few circumstances (e.g., personal care, case management services), providers may contract with non-Medicaid-enrolled agencies for services. Providers are legally, programmatically, and fiscally responsible for the services provided by their contractors and their contractors' services.

When contracting services, providers are required to monitor the contracted agency to ensure that the agency is meeting member needs and adhering to ForwardHealth requirements.

Providers are also responsible for informing a contracted agency of ForwardHealth requirements. Providers should refer those with whom they contract for services to ForwardHealth publications for program policies and procedures. ForwardHealth references and publications include, but are not limited to, the following:

- Wisconsin Administrative Code.
- *ForwardHealth Updates*.
- The Online Handbook.

Providers should encourage contracted agencies to visit the ForwardHealth Portal regularly for the most current information.

Topic #216

Examples of Ongoing Responsibilities

Responsibilities for which providers are held accountable are described throughout the Online Handbook. Medicaid-enrolled providers have responsibilities that include, but are not limited to, the following:

- Providing the same level and quality of care to ForwardHealth members as private-pay patients.

- Complying with all state and federal laws related to ForwardHealth.
- Obtaining PA (prior authorization) for services, when required.
- Notifying members in advance if a service is not covered by ForwardHealth and the provider intends to collect payment from the member for the service.
- Maintaining accurate medical and billing records.
- Retaining preparation, maintenance, medical, and financial records, along with other documentation, for a period of not less than five years from the date of payment, except rural health clinic providers who are required to retain records for a minimum of six years from the date of payment.
- Billing only for services that were actually provided.
- Allowing a member access to his or her records.
- Monitoring contracted staff.
- Accepting Medicaid reimbursement as payment in full for covered services.
- Keeping provider information (i.e., address, business name) current.
- Notifying ForwardHealth of changes in ownership.
- Responding to Medicaid revalidation notifications.
- Safeguarding member confidentiality.
- Verifying member enrollment.
- Keeping up-to-date with changes in program requirements as announced in ForwardHealth publications.

Topic #217

Keeping Information Current

Changes That Require ForwardHealth Notification

Providers are required to notify ForwardHealth of any changes to their demographic information, including the following, as they occur:

- [Address\(es\)](#) — practice location and related information, mailing, PA (prior authorization), and/or financial.

Note: Health care providers who are federally required to have an NPI (National Provider Identifier) are cautioned that changes to their practice location address on file with ForwardHealth may alter their ZIP+4 code information that is required on transactions.

- Business name.
- Contact name.
- Federal Tax ID number (IRS (Internal Revenue Service) number).
- Group affiliation.
- Licensure.
- NPI.
- [Ownership](#).
- Professional certification.
- [Provider specialty](#).
- Supervisor of nonbilling providers.
- [Taxonomy code](#).
- Telephone number, including area code.

Failure to notify ForwardHealth of changes may result in the following:

- Incorrect reimbursement.
- Misdirected payment.
- Claim denial.

- Suspension of payments or cancellation of provider file if provider mail is returned to ForwardHealth for lack of a current address.

Entering new information on a claim form or PA request is *not* adequate notification of change.

Notifying ForwardHealth of Changes

Providers can notify ForwardHealth of changes using the [demographic maintenance tool](#).

Providers Enrolled in Multiple Programs

If demographic information changes, providers enrolled in multiple programs (e.g., Wisconsin Medicaid and WCDP (Wisconsin Chronic Disease Program)) will need to change the demographic information for each program. By toggling between accounts using the Switch Organization function of the Portal, providers who have a Portal account for each program can change their information for each program using the demographic maintenance tool. The [Account User Guide](#) provides specific information about switching organizations.

Providers Licensed or Certified by the Division of Quality Assurance

Providers licensed or certified by the DQA (Division of Quality Assurance) are required to notify the DQA of changes to physical address, changes of ownership, and facility closures by calling (608) 266-8481. Since the DQA will inform ForwardHealth of the changes, providers do not need to also notify ForwardHealth.

Topic #577

Legal Framework

The following laws and regulations provide the legal framework for BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid:

- Federal Law and Regulation:
 - Law — United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
 - Regulation — Title 42 CFR Parts 430-498 and Parts 1000-1008 (Public Health).
- Wisconsin Law and Regulation:
 - Law — Wisconsin Statutes: [49.43-49.499](#), [49.665](#), and [49.473](#).
 - Regulation — Wisconsin Administrative Code, Chapters [DHS 101](#), [102](#), [103](#), [104](#), [105](#), [106](#), [107](#), and [108](#).

Laws and regulations may be amended or added at any time. Program requirements may not be construed to supersede the provisions of these laws and regulations.

The information included in the ForwardHealth Portal applies to BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid. BadgerCare Plus, Medicaid, and Wisconsin Well Woman Medicaid are administered by the DHS (Department of Health Services). Within the DHS, the DHCAA (Division of Health Care Access and Accountability) is directly responsible for managing these programs.

Topic #17097

Licensure Information

Licensed providers are required to keep all licensure information, including license number, grant and expiration dates, and

physical location as applicable (e.g., hospital providers), current with ForwardHealth.

If providers do not keep their licensure information, including their license number, current with ForwardHealth, any of the following may occur:

- Providers' enrollment may be deactivated. As a result, providers would not be able to submit claims or PA (prior authorization) requests or be able to function as [prescribing/referring/ordering providers](#), if applicable, until they update their licensure information.
- Providers may experience a lapse in enrollment. If a lapse occurs, providers may need to re-enroll, which may result in another application fee being assessed.

Providers may change the grant and expiration dates for their current license(s) and enter information for a new license(s), such as the license number, licensing state, and grant and expiration dates, using the [demographic maintenance tool](#). After entering information for their new license(s), some providers (e.g., out-of-state providers) will also be required to upload a copy of their license using the demographic maintenance tool. Provided licensure information must correspond with the information on file with the applicable licensing authority.

In some cases, ForwardHealth will need to verify licensure information with the applicable licensing authority, which may take up to 10 business days after submission. Providers updating their license information should plan accordingly so that they do not experience any of the indicated interruptions in enrollment. If provided licensure information (e.g., grant and expiration dates) does not correspond with the licensing authority's information, the licensing authority's information will be retained and will display in the demographic maintenance tool once verified by ForwardHealth.

Topic #15157

Recovery Audit Contractor Audits

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

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

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

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

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

Affected Providers

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

Additional Information

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

Topic #13277

Reporting Suspected Waste, Fraud, and Abuse

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

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

Those who suspect fraudulent activity in Medicaid programs are required to notify the OIG if they have reason to believe that a person is misusing or abusing any DHS health care program or the ForwardHealth identification card.

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

Reporting Suspected Fraud and Abuse

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

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

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

The following information is helpful when reporting fraud and abuse:

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

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

Prescription

Topic #525

General Requirements

It is vital that prescribers provide adequate supporting clinical documentation for a pharmacy or other dispensing providers to fill a prescription. Except as otherwise provided in federal or state law, a prescription must be in writing or given orally and later reduced to writing by the provider filling the prescription. The prescription must include the following information:

- The name, strength, and quantity of the drug or item prescribed.
- The service required, if applicable.
- The date of issue of the prescription.
- The prescriber's name and address.
- The member's name and address.
- The prescriber's signature (if the prescriber writes the prescription) and date signed.
- The directions for use of the prescribed drug, item, or service.

Drug Enforcement Agency Number Audits

All prescriptions for controlled substances must indicate the DEA (Drug Enforcement Agency) number of the prescriber on all prescriptions. DEA numbers are not required on claims or PAs (prior authorizations).

Members in Hospitals and Nursing Homes

For hospital and nursing home members, prescriptions must be entered into the medical and nursing charts and must include the previously listed information. Prescription orders are valid for no more than one year from the date of the prescription except for controlled substances and prescriber-limited refills that are valid for shorter periods of time.

Topic #11117

Opioid Monthly Prescription Fill Limit

[Opioid drugs](#) are limited to five prescription fills per calendar month for BadgerCare Plus Standard Plan, Wisconsin Medicaid, and SeniorCare members.

These limits do not affect members who are in a nursing home or hospice care.

The following drugs will be exempt from the opioid monthly prescription fill limit:

- Suboxone film and tablet.
- Buprenorphine tablet.
- Methadone solution.
- Opioid antitussive liquid.

Prescriber Responsibilities

If a member enrolled in the Standard Plan, Medicaid, and SeniorCare require more than five opioid prescription fills in a month, the prescriber may request a policy override through the [DAPO \(Drug Authorization and Policy Override\) Center](#). An override is required for each opioid fill that exceeds the five prescription fill limit per calendar month.

When calling the DAPO Center to request a policy override for opioids, the following information must be provided:

- Prescriber's name and NPI (National Provider Identifier).
- Member's name and ID.
- Pharmacy's name and telephone number where the member attempted to have the prescription filled.
- Date the prescription was attempted to be filled.
- Drug name, strength, and quantity.
- Instructions for use.

The DAPO Center will provide information to the prescriber regarding the member's recent medication history.

If the prescriber determines an override is medically necessary, the DAPO Center will record the override, and the prescriber should contact the member and the pharmacy. When contacting the member, the prescriber should use this opportunity to discuss the appropriate use of opioids.

If the prescriber decides that it is not medically necessary to override the opioid monthly prescription fill limit, the prescriber should contact the member and discuss follow-up care. If the override is not given, the prescriber should contact the pharmacy to have the prescription canceled.

Pharmacy Responsibilities

When pharmacies are contacted by a prescriber and notified that an override is available, the pharmacy should submit the claim for the opioid. Pharmacies are responsible for submitting claims for opioids within three days of the override being obtained by the prescriber. If the pharmacy provider does not submit the claim within the three day time period, the claim will be denied.

Note: If the pharmacy provider contacts the DAPO Center to obtain an override, the DAPO Center will inform the pharmacy provider that the prescriber is responsible for obtaining the override.

If a prescriber does not override the opioid monthly prescription fill limit for members enrolled in the Standard Plan, Medicaid, or SeniorCare, the service is considered noncovered.

If a pharmacy has difficulty with claim submission related to the opioid monthly prescription limit, contact the DAPO Center.

Exceptions

Opioid prescription fill limit exceptions are covered for members enrolled in the Standard Plan, Medicaid, and SeniorCare.

Schedule III-V drugs

If the prescriber is unavailable, the DAPO Center will grant a 96-hour supply exception to exceed the opioid monthly prescription fill limit for a Schedule III-V drug if the following conditions are met:

- Member is enrolled in the Standard Plan, Medicaid, or SeniorCare.
- The pharmacy attempted to contact the prescriber (or the prescriber's agent) but the prescriber is unavailable (e.g., clinic is closed).
- The pharmacy must document on the prescription order that the prescriber is not available.
- The pharmacist confirmed that dispensing a 96-hour supply is medically necessary.
- A 96-hour supply exception was not previously granted within the current calendar month.

If the prescriber is unavailable and the DAPO Center is closed, then pharmacy providers may dispense a 96-hour supply if the following conditions are met:

- Member is enrolled in the Standard Plan, Medicaid, or SeniorCare.
- The pharmacy attempted to contact the prescriber (or the prescriber's agent), but the prescriber is unavailable (e.g., clinic is closed).
- The pharmacy must document on the prescription order that the prescriber is not available.
- The pharmacist confirmed that dispensing a 96-hour supply is medically necessary.
- A 96-hour supply exception was not previously granted within the current calendar month.

Only one 96-hour supply exception for opioid drugs is allowed per calendar month. Once the DAPO Center is open, the pharmacy must call to obtain the 96-hour supply exception.

The 96-hour supply exception may be retroactive up to five days (i.e., back dated).

If a 96-hour supply exception has already been provided in the same calendar month, the prescription is a noncovered service.

Schedule II Drugs

If the prescriber is unavailable, the DAPO Center may grant an exception for a Schedule II drug if the following conditions are met:

- Member is enrolled in the Standard Plan, Medicaid, or SeniorCare.
- The pharmacy attempted to contact the prescriber (or the physician's agent), but the prescriber is unavailable (e.g., clinic is closed).
- The pharmacy must document on the prescription order that the prescriber is not available.
- The pharmacist confirmed that it is medically necessary to dispense the drug.
- An exception for Schedule II drugs was not previously granted within the current calendar month.
- The pharmacist may dispense the full quantity indicated on the prescription order.

If the prescriber is unavailable and the DAPO Center is closed, the pharmacy may dispense an exception for a Schedule II drug if the following conditions are met:

- Member is enrolled in the Standard Plan, Medicaid, or SeniorCare.
- The pharmacy attempted to contact the prescriber (or the physician's agent), but the prescriber is unavailable (e.g., clinic is closed).
- The pharmacy documented on the prescription order that the prescriber is not available.
- The pharmacist confirmed that it is medically necessary to dispense the drug.
- The pharmacist may dispense the full quantity indicated on the prescription order.

Pharmacy providers are required to submit a [Noncompound Drug Claim \(F-13072 \(07/12\)\)](#) form, with a [Pharmacy Special Handling Request \(F-13074 \(07/12\)\)](#) form, indicating the following:

- The drug dispensed was a Schedule II drug and the opioid monthly prescription fill limit was exceeded.
- The pharmacy attempted to contact the prescriber (or the physician's agent), but the prescriber is unavailable (e.g., clinic is closed).
- The pharmacist is required to provide justification why it was medically necessary to dispense the Schedule II opioid before discussing with the prescriber an exception to the opioid monthly prescription fill limit.

Only one exception for Schedule II opioid is allowed per calendar month.

If a Schedule II opioid exception has already been provided in the same calendar month, the prescription is a noncovered service.

Topic #523

Prescriber Information for Drug Prescriptions

Most legend and certain OTC (over-the-counter) drugs are covered. (A legend drug is one whose outside package has the legend or phrase "Caution, federal law prohibits dispensing without a prescription" printed on it.)

Coverage for some drugs may be restricted by one of the following policies:

- PDL (Preferred Drug List).
- PA (prior authorization).
- Brand medically necessary drugs that require PA.
- Diagnosis-restricted drugs.
- Age-restricted and gender-restricted drugs.

Prescribers are encouraged to write prescriptions for drugs that do not have restrictions; however, processes are available to obtain reimbursement for medically necessary drugs that do have restrictions.

For the most current prescription drug information, refer to the [pharmacy data tables](#). Providers may also call [Provider Services](#) for more information.

Preferred Drug List

Most preferred drugs on the [PDL](#) do *not* require PA, although these drugs may have other restrictions (e.g., age, diagnosis); non-preferred drugs *do* require PA. Prescribers are encouraged to write prescriptions for preferred drugs; however, a PA process is available for non-preferred drugs if the drugs are medically necessary. Prescribers are encouraged to try more than one preferred drug, if medically appropriate for the member, before prescribing a non-preferred drug.

Prescriber Responsibilities for Non-preferred Drugs

Prescribers should determine the ForwardHealth benefit plan in which a member is enrolled before writing a prescription. If a member is enrolled in the BadgerCare Plus Standard Plan, Medicaid, or SeniorCare, prescribers are encouraged to write prescriptions for preferred drugs. Prescribers are encouraged to prescribe more than one preferred drug before a non-preferred drug is prescribed.

If a non-preferred drug or a preferred drug that requires clinical PA is medically necessary for a member, the prescriber is required to complete a PA request for the drug. Prescribers are required to complete the appropriate [PA form](#) and submit it to the pharmacy provider where the prescription will be filled. When completing the PA form, prescribers are reminded to provide a handwritten signature and date on the form. PA request forms may be faxed or mailed to the pharmacy provider, or the member may carry the form with the prescription to the pharmacy provider. The pharmacy provider will use the completed form to submit a PA request to ForwardHealth. The prescriber is required to attest on the form that the member meets the clinical criteria for PA approval. Prescribers should not submit PA forms to ForwardHealth.

Prescribers and pharmacy providers are required to retain a completed copy of the PA form.

Diagnosis-Restricted Drugs

Prescribers are required to include a diagnosis description on prescriptions for those [drugs that are diagnosis-restricted](#).

Prescribing Drugs Manufactured by Companies Who Have Not Signed the

Rebate Agreement

By federal law, pharmaceutical manufacturers who participate in state Medicaid programs must sign a rebate agreement with the CMS (Centers for Medicare and Medicaid Services). BadgerCare Plus, Medicaid, and SeniorCare will cover legend and specific categories of OTC products of manufacturers who have signed a rebate agreement.

Note: SeniorCare does not cover OTC drugs, except insulin.

ForwardHealth has identified [drug manufacturers who have signed the rebate agreement](#). By signing the rebate agreement, the manufacturer agrees to pay ForwardHealth a rebate equal to a percentage of its "sales" to ForwardHealth.

Drugs of companies choosing not to sign the rebate agreement, with few exceptions, are not covered. A Medicaid-enrolled pharmacy can confirm for prescribers whether or not a particular drug manufacturer has signed the agreement.

Members Enrolled in the BadgerCare Plus Standard Plan, Medicaid, or SeniorCare (Levels 1 and 2a)

BadgerCare Plus, Medicaid, and SeniorCare levels 1 and 2a may cover certain FDA (Food and Drug Administration)-approved legend drugs through the PA process even though the drug manufacturers did not sign rebate agreements.

Prescribers are required to complete the [appropriate section\(s\) of the PA/DGA \(Prior Authorization/Drug Attachment, F-11049 \(10/13\)\)](#) as it pertains to the drug being requested.

Included with the PA, the prescriber is required to submit documentation of medical necessity and cost-effectiveness that the non-rebated drug is the only available and medically appropriate product for treating the member. The documentation must include the following:

- A copy of the medical record or documentation of the medical history detailing the member's medical condition and previous treatment results.
- Documentation by the prescriber that shows why other drug products have been ruled out as ineffective or unsafe for the member's medical condition.
- Documentation by the prescriber that shows why the non-rebated drug is the most appropriate and cost-effective drug to treat the member's medical condition.

If a PA request for a drug without a signed manufacturer rebate is approved, claims for drugs without a signed rebate agreement must be submitted on paper. Providers should complete and submit the [Noncompound Drug Claim \(F-13072 \(07/12\)\)](#) indicating the actual NDC of the drug with the [Pharmacy Special Handling Request \(F-13074 \(07/12\)\)](#) form.

If a PA request for a drug without a signed manufacturer rebate is denied, the service is considered noncovered.

Members Enrolled in SeniorCare (Levels 2b and 3)

PA is not available for drugs from manufacturers without a separate, signed SeniorCare rebate agreement for members in levels 2b and 3. PA requests submitted for drugs without a separate, signed SeniorCare rebate agreement for members in levels 2b and 3 will be returned to the providers unprocessed and the service will be noncovered. Members do not have appeal rights regarding returned PA requests for noncovered drugs.

Drug Utilization Review System

The federal OBRA (Omnibus Budget Reconciliation Act of 1990) (42 CFR Parts 456.703 and 456.705) called for a DUR (Drug Utilization Review) program for all Medicaid-covered drugs to improve the quality and cost-effectiveness of member care.

ForwardHealth's prospective DUR system assists pharmacy providers in screening certain drug categories for clinically important potential drug therapy problems before the prescription is dispensed to the member. The DUR system checks the member's entire drug history regardless of where the drug was dispensed or by whom it was prescribed.

Diagnoses from medical claims are used to build a medical profile for each member. The prospective DUR system uses this profile to determine whether or not a prescribed drug may be inappropriate or harmful to the member. It is very important that prescribers provide up-to-date medical diagnosis information about members on medical claims to ensure complete and accurate member profiles, particularly in cases of disease or pregnancy.

Note: The prospective DUR system does not dictate which drugs may be dispensed; prescribers and pharmacists must exercise professional judgment.

Prospective Drug Utilization Review's Impact on Prescribers

If a pharmacist receives an alert, a response is required before the drug can be dispensed to the member. This may require the pharmacist to contact the prescriber for additional information to determine if the prescription should be filled as written, modified, or cancelled. Prescribers should respond to inquiries, such as telephone calls or faxes, related to prescribed drugs from pharmacy providers.

Drugs with Three-Month Supply Requirement

ForwardHealth has identified a [list of three-month supply drugs](#):

- Certain drugs are required to be dispensed in a three-month supply.
- Additional drugs are allowed to be dispensed in a three-month supply.

Member Benefits

When it is appropriate for the member's medical condition, a three-month supply of a drug benefits the member in the following ways:

- Aiding compliance in taking prescribed generic, maintenance medications.
- Reducing the cost of member copayments.
- Requiring fewer trips to the pharmacy.
- Allowing the member to obtain a larger quantity of generic, maintenance drugs for chronic conditions (e.g., hypertension).

Prescribers are encouraged to write prescriptions for a three-month supply when appropriate for the member.

Prescription Quantity

A prescriber is required to indicate the appropriate quantity on the prescription to allow the dispensing provider to dispense the maintenance drug in a three-month supply. For example, if the prescription is written for "Hydrochlorothiazide 25 mg, take one tablet daily," the prescriber is required to indicate a quantity of 90 or 100 tablets on the prescription so the pharmacy provider can dispense a three-month supply. In certain instances, brand name drugs (e.g., oral contraceptives) may be dispensed in a three-month supply.

Pharmacy providers are not required to contact prescribers to request a new prescription for a three-month supply if a prescription has been written as a one-month supply with multiple or as needed (i.e., PRN) refills.

ForwardHealth will not audit or recoup three-month supply claims if a pharmacy provider changes a prescription written as a one-month supply with refills as long as the total quantity dispensed per prescription does not exceed the total quantity authorized by the prescriber.

Prescription Mail Delivery

Current Wisconsin law permits Wisconsin Medicaid-enrolled retail pharmacies to deliver prescriptions to members via the mail. Wisconsin Medicaid-enrolled retail pharmacies may dispense and mail any prescription or OTC medication to a Medicaid fee-for-service member at no additional cost to the member or Wisconsin Medicaid.

Providers are encouraged to use the mail delivery option if requested by the member, particularly for prescriptions filled for a three-month supply.

Noncovered Drugs

The following drugs are not covered:

- Drugs that are identified by the FDA as LTE (less-than-effective) or identical, related, or similar to LTE drugs.
- Drugs identified on the Wisconsin Negative Formulary.
- Drugs manufactured by companies who have not signed the rebate agreement.
- Drugs to treat the condition of ED (Erectile Dysfunction). Examples of noncovered drugs for ED are Viagra® and Cialis®.

SeniorCare

[SeniorCare](#) is a prescription drug assistance program for Wisconsin residents who are 65 years of age or older and meet eligibility criteria. SeniorCare is modeled after Wisconsin Medicaid in terms of drug coverage and reimbursement, although there are a few differences. Unlike Medicaid, SeniorCare does not cover OTC drugs other than insulin.

Topic #4346

Tamper-Resistant Prescription Pad Requirement

Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 imposed a requirement on prescriptions paid for by Medicaid, SeniorCare, or BadgerCare fee-for-service. The law requires that all written or computer-generated prescriptions that are given to a patient to take to a pharmacy must be written or printed on tamper-resistant prescription pads or tamper-resistant computer paper. This requirement applies to prescriptions for both controlled and noncontrolled substances.

All other Medicaid policies and procedures regarding prescriptions continue to apply.

Required Features for Tamper-Resistant Prescription Pads or Computer Paper

To be considered tamper-resistant, federal law requires that prescription pads/paper contain all three of the following characteristics:

- One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.
- One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.
- One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

Exclusions to Tamper-Resistant Prescription Pad Requirement

The following are exclusions to the tamper-resistant prescription pad requirement:

- Prescriptions faxed directly from the prescriber to the pharmacy.
- Prescriptions electronically transmitted directly from the prescriber to the pharmacy.
- Prescriptions telephoned directly from the prescriber to the pharmacy.
- Prescriptions provided to members in nursing facilities, ICF/IIDs (Intermediate Care Facilities for Individuals with Intellectual Disabilities), and other specified institutional and clinical settings to the extent that drugs are part of their overall rate. However, written prescriptions filled by a pharmacy outside the walls of the facility are subject to the tamper-resistant requirement.

72-Hour Grace Period

Prescriptions presented by patients on non-tamper-resistant pads or paper may be dispensed and considered compliant if the pharmacy receives a compliant prescription order within 72 hours.

Coordination of Benefits

The federal law imposing these new requirements applies even when ForwardHealth is the secondary payer.

Retroactive ForwardHealth Eligibility

If a patient becomes retroactively eligible for ForwardHealth, the federal law presumes that prescriptions retroactively dispensed were compliant. However, prospective refills will require a tamper-resistant prescription.

Penalty for Noncompliance

Payment made to the pharmacy for a claim corresponding to a noncompliant order may be recouped, in full, by Wisconsin Medicaid.

Provider Enrollment

Topic #899

CLIA Certification or Waiver

Congress implemented CLIA (Clinical Laboratory Improvement Amendment) to improve the quality and safety of laboratory services. CLIA requires *all* laboratories and providers that perform tests (including waived tests) for health assessment or for the diagnosis, prevention, or treatment of disease or health impairment to comply with specific federal quality standards. This requirement applies even if only a single test is being performed.

CLIA Enrollment

The federal CMS (Centers for Medicare and Medicaid Services) sends CLIA enrollment information to ForwardHealth. The enrollment information includes CLIA identification numbers for all current laboratory sites. ForwardHealth verifies that laboratories are CLIA certified before Medicaid grants enrollment.

CLIA Regulations

ForwardHealth complies with the following federal regulations as initially published and subsequently updated:

- Public Health Service Clinical Laboratory Improvement Amendments of 1988.
- Title 42 CFR Part 493, Laboratory Requirements.

Scope of CLIA

CLIA governs all laboratory operations including the following:

- Accreditation.
- Certification.
- Fees.
- Patient test management.
- Personnel qualifications.
- Proficiency testing.
- Quality assurance.
- Quality control.
- Records and information systems.
- Sanctions.
- Test methods, equipment, instrumentation, reagents, materials, supplies.
- Tests performed.

CLIA regulations apply to *all* providers who perform CLIA-monitored laboratory services, including, but not limited to, the following:

- Clinics.
- HealthCheck providers.
- Independent clinical laboratories.
- Nurse midwives.

- Nurse practitioners.
- Osteopaths.
- Physician assistants.
- Physicians.
- Rural health clinics.

CLIA Certification Types

The CMS regulations require providers to have a CLIA certificate that indicates the laboratory is qualified to perform a category of tests.

Clinics or groups with a single group billing certification, but multiple CLIA numbers for different laboratories, may wish to contact [Provider Services](#) to discuss various certification options. There are five types of CLIA certificates as defined by CMS:

1. *Certificate of Waiver*. This certificate is issued to a laboratory to perform only waived tests. The CMS Web site identifies the most current list of [waived procedures](#). BadgerCare Plus identifies allowable waived procedures in [maximum allowable fee schedules](#).
2. *Certificate for Provider-Performed Microscopy Procedures (PPMP)*. This certificate is issued to a laboratory in which a physician, mid-level practitioner, or dentist performs no tests other than the microscopy procedures. This certificate permits the laboratory to also perform waived tests. The CMS Web site identifies the most current list of [CLIA-allowable provider-performed microscopy procedures](#). BadgerCare Plus identifies allowable provider-performed microscopy procedures in fee schedules.
3. *Certificate of Registration*. This certificate is issued to a laboratory and enables the entity to conduct moderate- or high-complexity laboratory testing, or both, until the entity is determined by survey to be in compliance with CLIA regulations.
4. *Certificate of Compliance*. This certificate is issued to a laboratory after an inspection that finds the laboratory to be in compliance with all applicable CLIA requirements.
5. *Certificate of Accreditation*. This is a certificate that is issued to a laboratory on the basis of the laboratory's accreditation by an accreditation organization approved by CMS. The six major approved accreditation organizations are:
 - The Joint Commission.
 - CAP (College of American Pathologists).
 - COLA.
 - American Osteopathic Association.
 - American Association of Blood Banks.
 - ASHI (American Society of Histocompatibility and Immunogenetics).

Applying for CLIA Certification

Use the CMS 116 CLIA application to apply for program certificates. Providers may obtain CMS 116 forms from the [CMS Web site](#) or from the following address:

Division of Quality Assurance
 Clinical Laboratory Section
 1 W Wilson St
 PO Box 2969
 Madison WI 53701-2969

Providers Required to Report Changes

Providers are required to notify Provider Enrollment within 30 days of any change(s) in ownership, name, location, or director. Also, providers are required to notify Provider Enrollment of changes in CLIA certificate types immediately and within six months when a specialty/subspecialty is added or deleted.

Providers may notify Provider Enrollment of changes by uploading supporting documentation using the [demographic maintenance tool](#) or by mailing supporting documentation to the following address:

Wisconsin Medicaid
 Provider Enrollment
 313 Blettner Blvd
 Madison WI 53784

If a provider has a new certificate type to add to its certification information on file with ForwardHealth, the provider should upload or mail a copy of the new certificate. When a provider sends ForwardHealth a copy of a new CLIA certificate, the effective date on the certificate will become the effective date for CLIA certification on file with ForwardHealth.

Topic #3969

Categories of Enrollment

Wisconsin Medicaid enrolls providers in three billing categories. Each billing category has specific designated uses and restrictions. These categories include the following:

- Billing/rendering provider.
- Rendering-only provider.
- Billing-only provider (including group billing).

Providers should refer to the service-specific information in the Online Handbook or the Information for Specific Provider Types page on the [Provider Enrollment Information home page](#) to identify which category of enrollment is applicable.

Billing/Rendering Provider

Enrollment as a billing/rendering provider allows providers to identify themselves on claims (and other forms) as either the provider billing for the services or the provider rendering the services.

Rendering-Only Provider

Enrollment as a rendering-only provider is given to those providers who practice under the professional supervision of another provider (e.g., physician assistants). Providers with a rendering provider enrollment cannot submit claims to ForwardHealth directly, but they have reimbursement rates established for their provider type. Claims for services provided by a rendering provider must include the supervising provider or group provider as the billing provider.

Billing-Only Provider (Including Group Billing)

Enrollment as a billing-only provider is given to certain provider types when a separate rendering provider is required on claims.

Group Billing

Groups of individual practitioners are enrolled as billing-only providers as an accounting convenience. This allows the group to receive one reimbursement, one RA (Remittance Advice), and the 835 (835 Health Care Claim Payment/Advice) transaction for covered services rendered by individual practitioners within the group.

Providers may not have more than one group practice enrolled in Wisconsin Medicaid with the same ZIP+4 code address, NPI (National Provider Identifier), and taxonomy code combination. Provider group practices located at the same ZIP+4 code address are required to differentiate their enrollment using an NPI or taxonomy code that uniquely identifies each group practice.

Individual practitioners within group practices are required to be Medicaid-enrolled because these groups are required to identify the provider who rendered the service on claims. Claims indicating these group billing providers that are submitted without a rendering provider are denied.

Topic #14137

Enrollment Requirements Due to the Affordable Care Act

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

- Providers are assigned a risk level of limited, moderate, or high. Most of the risk levels have been established by the CMS (Centers for Medicare and Medicaid Services) based on an assessment of potential fraud, waste, and abuse for each provider type.
- Providers are screened according to their assigned risk level. Screenings are conducted during initial enrollment and revalidation.
- Certain provider types are subject to an enrollment application fee. This fee has been federally mandated and may be adjusted annually. The fee is used to offset the cost of conducting screening activities.
- During the enrollment process, providers are required to provide additional information for persons with an ownership or controlling interest, managing employees, and agents. "Persons" in this instance may mean a person or a corporation.
- Providers are required to undergo revalidation every three to five years.
- Ordering and referring physicians or other professionals are required to be enrolled as a participating Medicaid provider.
- Payment suspensions are imposed on providers based on a credible allegation of fraud.

ForwardHealth Implementation of Affordable Care Act Requirements to Date

Provider Screenings

Wisconsin Medicaid screens all enrolling providers to accommodate the ACA limited risk level screening requirements. Limited risk level screening activities include:

- Checking federal databases, which include:
 - The SSA (Social Security Administration)'s Death Master File.
 - The NPPES (National Plan and Provider Enumeration System).
 - OIG (Office of the Inspector General) LEIE (List of Excluded Individuals/Entities).
 - EPLS (The Excluded Parties List System).
 - MED (Medicare Exclusion Database).
- Verifying licenses are appropriate in accordance with state laws and that there are no current limitations on the license.

These screening activities are conducted on applicants, providers, and any person with an ownership or controlling interest or who is an agent or managing employee of the provider at the time of enrollment, on a monthly basis for enrolled providers, and at revalidation.

ForwardHealth will deny enrollment or terminate the enrollment of any provider where any person with a five percent or greater

direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or Title XXI program in the last 10 years or if invalid licensure information is found.

Additional Information Needed During Provider Enrollment

ForwardHealth collects some personal data information from persons with an ownership or controlling interest, agents, and managing employees. ForwardHealth will only use the provided information for provider enrollment. All information provided will be protected under the HIPAA (Health Insurance Portability and Accountability Act of 1996) privacy rule.

Providers are required to submit the following information at the time of enrollment and revalidation for their individual owners with a controlling interest:

- First and last name.
- Provider's SSNs (Social Security numbers).
- Dates of birth.
- Street address, city, state, and ZIP+4 code.

Providers are required to submit the following information at the time of enrollment and revalidation for their organizational owners with controlling interest:

- Legal business name.
- Tax identification number.
- Business street address, city, state, ZIP+4 code.

Providers are required to submit the following information at the time of enrollment and revalidation for their managing employees and agents:

- First and last name.
- Employees' and agents' SSNs.
- Dates of birth.
- Street address, city, state, and ZIP+4 code.

Topic #1206

Federally Qualified Health Centers

To qualify for Medicaid FQHC (federally qualified health center) enrollment, a clinic must provide documentation that it is either designated by the federal HHS (Department of Health and Human Services) as an FQHC or that it receives funds under the Indian Self-Determination Act (Public Law 93-638).

1. A federal HHS FQHC is a community health center, migrant health center, or health care for the homeless program that meets one of the following:
 1. Receives a grant under the Public Health Services Act, Section 329, 330, or 340.
 2. Has been designated by the Secretary of the federal HHS as a facility that meets the requirements of receiving a grant (FQHC Look Alike).
 3. Has been granted a temporary waiver of the grant requirements by the Secretary of the federal HHS.
2. An Indian Self-Determination Act FQHC is an outpatient health program or facility operated by a tribe or tribal organization receiving funds under the Indian Self-Determination Act.

Physician and Dental Services

Medicaid-enrolled FQHCs may provide the following services and submit claims for these services:

- Physician.
- Dental (including dental hygienists).

The service areas for the above have information regarding covered services, PA (prior authorization) guidelines, and billing instructions.

Other Services

FQHCs may also be enrolled as the following provider types:

- Ambulance.
- Case Management.
- Community Support Programs.
- Day Treatment.
- DME (durable medical equipment).
- DMS (disposable medical supplies).
- ESRD (end-stage renal disease).
- Family Planning Clinic.
- HealthCheck.
- Hospice.
- Outpatient Mental Health.
- Outpatient Substance Abuse.
- PC (personal care).
- PNCC (prenatal care coordination).
- Rehabilitation Agency.
- RHC (rural health clinic).
- SMV (specialized medical vehicle).

Refer to the above service areas for information regarding covered services, PA guidelines, and billing instructions.

Topic #194

In-State Emergency Providers and Out-of-State Providers

ForwardHealth requires all in-state emergency providers and out-of-state providers who render services to BadgerCare Plus, Medicaid, or SeniorCare members to be [enrolled](#) in Wisconsin Medicaid. Information is available regarding the enrollment options for [in-state emergency providers](#) and [out-of-state providers](#).

Topic #193

Materials for New Providers

On an ongoing basis, providers should refer to the Online Handbook for the most current BadgerCare Plus, Medicaid, and ADAP (Wisconsin AIDS Drug Assistance Program) information. Future changes to policies and procedures are published in *ForwardHealth Updates*. Updates are available for viewing and downloading on the [ForwardHealth Publications page](#).

Topic #4457

Provider Addresses

ForwardHealth has the capability to store the following types of addresses and contact information:

- *Practice location address and related information.* This address is where the provider's office is physically located and where records are normally kept. Additional information for the practice location includes the provider's office telephone number and the telephone number for members' use. With limited exceptions, the practice location and telephone number for members' use are published in a provider directory made available to the public.
- *Mailing address.* This address is where ForwardHealth will mail general information and correspondence. Providers should indicate accurate address information to aid in proper mail delivery.
- *PA (prior authorization) address.* This address is where ForwardHealth will mail PA information.
- *Financial addresses.* Two separate financial addresses are stored for ForwardHealth. The checks address is where ForwardHealth will mail paper checks. The 1099 mailing address is where ForwardHealth will mail IRS Form 1099.

Providers may submit additional address information or modify their current information using the [demographic maintenance tool](#).

Note: Providers are cautioned that any changes to their practice location on file with Wisconsin Medicaid may alter their ZIP+4 code information required on transactions. Providers may verify the ZIP+4 code for their address on the [U.S. Postal Service Web site](#).

Topic #14157

Provider Enrollment Information Home Page

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

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

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

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

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

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

Topic #1931

Provider Type and Specialty Changes

Provider Type

Providers who want to add a provider type or change their current provider type are required to complete a new [enrollment application](#) for each provider type they want to add or change to because they need to meet the enrollment criteria for each provider type.

Provider Specialty

Providers who have the option to add or change a provider specialty can do so using the [demographic maintenance tool](#). After adding or changing a specialty, providers may be required to submit documentation to ForwardHealth, either by uploading through the demographic maintenance tool or by mail, supporting the addition or change.

Providers should contact [Provider Services](#) with any questions about adding or changing a specialty.

Topic #14317

Terminology to Know for Provider Enrollment

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

New Terminology	Definition
Agent	Any person who has been delegated the authority to obligate or act on behalf of a provider.
Disclosing entity	A Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent.
Federal health care programs	Federal health care programs include Medicare, Medicaid, Title XX, and Title XXI.
Other disclosing agent	Any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVII, or XX of the Act. This includes: <ul style="list-style-type: none"> Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or HMO that participates in Medicare (Title XVIII). Any Medicare intermediary or carrier. Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or XX of the Act.
Indirect ownership	An ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership in the disclosing entity.
Managing employee	A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.
Ownership interest	The possession of equity in the capital, the stock, or the profits of the disclosing entity.
Person with an	A person or corporation for which one or more of the following applies:

ownership or control interest	<ul style="list-style-type: none"> • Has an ownership interest totaling five percent or more in a disclosing entity. • Has an indirect ownership interest equal to five percent or more in a disclosing entity. • Has a combination of direct and indirect ownership interest equal to five percent or more in a disclosing entity. • Owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or asset of the disclosing entity. • Is an officer or director of a disclosing entity that is organized as a corporation. • Is a person in a disclosing entity that is organized as a partnership.
Subcontractor	<ul style="list-style-type: none"> • An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or, • An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.
Re-enrollment	Re-enrollment of a provider whose Medicaid enrollment has ended for any reason other than sanctions or failure to revalidate may be re-enrolled as long as all licensure and enrollment requirements are met. If a provider's enrollment with Wisconsin Medicaid lapses for longer than one year, they will have to re-enroll as a "new" provider. Providers should note that when they re-enroll, application fees and screening activities may apply. Re-enrollment was formerly known as re-instate.
Revalidation	All enrolled providers are required to revalidate their enrollment information every three years to continue their participation with Wisconsin Medicaid. Revalidation was formerly known as recertification.

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

Provider Numbers

Topic #1891

Group Billing Numbers

Claims that are submitted under an FQHC (federally qualified health center) group/clinic billing provider's NPI (National Provider Identifier) must include an appropriate rendering provider's NPI. The FQHC NPI should be included on all claims submitted for FQHC services.

Topic #3421

Provider Identification

Health Care Providers

Health care providers are required to indicate an NPI (National Provider Identifier) on enrollment applications and electronic and paper transactions submitted to ForwardHealth.

The NPI is a 10-digit number obtained through the NPPES (National Plan and Provider Enumeration System).

Providers should ensure that they have obtained an appropriate NPI prior to beginning their enrollment application. There are two kinds of NPIs:

- Entity Type 1 NPIs are for individuals who provide health care, such as physicians, dentists, and chiropractors.
- Entity Type 2 NPIs are for organizations that provide health care, such as hospitals, group practices, pharmacies, and home health agencies.

It is possible for a provider to qualify for both Entity Type 1 and Entity Type 2 NPIs. For example, an individual physical therapist may also be the owner of a therapy group that is a corporation and have two Wisconsin Medicaid enrollments — one enrollment as an individual physical therapist and the other enrollment as the physical therapy group. A Type 1 NPI for the individual enrollment and a Type 2 NPI for the group enrollment are required.

NPIs and classifications may be viewed on the [NPPES Web site](#). The [CMS \(Centers for Medicare and Medicaid Services\) Web site](#) includes more information on Type 1 and Type 2 NPIs.

Health care providers who are federally required to have an NPI are responsible for obtaining the appropriate certification for their NPI.

Non-healthcare Providers

Non-healthcare providers, such as SMV (specialized medical vehicle) providers, personal care agencies, and blood banks, are exempt from federal NPI requirements. Providers exempt from federal NPI requirements are assigned a Medicaid provider number once their enrollment application is accepted; they are required to indicate this Medicaid provider number on electronic and paper transactions submitted to ForwardHealth.

Topic #5096

Taxonomy Codes

Taxonomy codes are standard code sets used to provide information about provider type and specialty for the provider's enrollment. ForwardHealth uses taxonomy codes as additional data for correctly matching the NPI (National Provider Identifier) to the provider file.

Providers are required to use a taxonomy code when the NPI reported to ForwardHealth corresponds to multiple enrollments and the provider's practice location ZIP+4 code does not uniquely identify the provider.

Providers are allowed to report multiple taxonomy codes to ForwardHealth as long as the codes accurately describe the provider type and specialty for the provider's enrollment. When doing business with ForwardHealth, providers may use any one of the reported codes. Providers who report multiple taxonomy codes will be required to designate one of the codes as the primary taxonomy code; ForwardHealth will use this primary code for identification purposes.

Providers who wish to change their taxonomy code or add additional taxonomy codes may do so using the [demographic maintenance tool](#). Most taxonomy code changes entered through the demographic maintenance tool will take effect in real time; providers may use the new codes immediately on transactions.

Omission of a taxonomy code when it is required as additional data to identify the provider will cause claims and other transactions to be denied or delayed in processing.

Note: Taxonomy codes do not change provider enrollment or affect reimbursement terms.

Topic #14097

Taxonomy Code Requirements for FQHCs

FQHCs (federally qualified health centers) are required to indicate the specific taxonomy code that is related to the appropriate enrollment for the service provided. The taxonomy code allows ForwardHealth to determine the correct provider file and information to use when processing a claim.

For example, if an FQHC, enrolled as both an FQHC clinic provider and an ambulance provider, uses the same NPI for both FQHC and ambulance services and submits a claim for an ambulance service, the taxonomy code for the ambulance enrollment should be indicated on the claim.

Topic #5097

ZIP Code

The ZIP code of a provider's practice location address on file with ForwardHealth must be a ZIP+4 code. The ZIP+4 code helps to identify a provider when the NPI (National Provider Identifier) reported to ForwardHealth corresponds to multiple enrollments and the reported taxonomy code does not uniquely identify the provider.

When a ZIP+4 code is required to identify a provider, omission of it will cause claims and other transactions to be denied or delayed in processing.

Providers may verify the ZIP+4 code for their address on the [U.S. Postal Service Web site](#).

Provider Rights

Topic #208

A Comprehensive Overview of Provider Rights

Medicaid-enrolled providers have certain rights including, but not limited to, the following:

- Limiting the number of members they serve in a nondiscriminatory way.
- Ending participation in Wisconsin Medicaid.
- Applying for a discretionary waiver or variance of certain rules identified in Wisconsin Administrative Code.
- [Collecting payment from a member under limited circumstances.](#)
- Refusing services to a member if the member refuses or fails to present a ForwardHealth identification card. However, possession of a ForwardHealth card does not guarantee enrollment (e.g., the member may not be enrolled, may be enrolled only for limited benefits, or the ForwardHealth card may be invalid). Providers may confirm the current enrollment of the member by using one of the [EVS \(Enrollment Verification System\) methods](#), including calling [Provider Services](#).

Topic #207

Ending Participation

Providers other than home health agencies and nursing facilities may terminate participation in ForwardHealth according to [DHS 106.05](#), Wis. Admin. Code.

Providers choosing to withdraw should promptly notify their members to give them ample time to find another provider.

When withdrawing, the provider is required to do the following:

- Provide a written notice of the decision at least 30 days in advance of the termination.
- Indicate the effective date of termination.

Providers will not receive reimbursement for nonemergency services provided on and after the effective date of termination. Voluntary termination notices can be sent to the following address:

Wisconsin Medicaid
 Provider Enrollment
 313 Blettner Blvd
 Madison WI 53784

If the provider fails to specify an effective date in the notice of termination, ForwardHealth may terminate the provider on the date the notice is received.

Topic #209

Hearing Requests

A provider who wishes to contest a DHS (Department of Health Services) action or inaction for which due process is required

under [s. 227](#), Wis. Stats., may request a hearing by writing to the DHA (Division of Hearings and Appeals).

A provider who wishes to contest the DHCAA's (Division of Health Care Access and Accountability) notice of intent to recover payment (e.g., to recoup for overpayments discovered in an audit by DHCAA) is required to request a hearing on the matter within the time period specified in the notice. The request, which must be in writing, should briefly summarize the provider's basis for contesting the DHS decision to withhold payment.

Refer to [DHS 106](#), Wis. Admin. Code, for detailed instructions on how to file an appeal.

If a timely request for a hearing is not received, the DHS may recover those amounts specified in its original notice from future amounts owed to the provider.

Note: Providers are not entitled to administrative hearings for billing disputes.

Topic #210

Limiting the Number of Members

If providers choose to limit the number of members they see, they cannot accept a member as a private-pay patient. Providers should instead refer the member to another ForwardHealth provider.

Persons applying for or receiving benefits are protected against discrimination based on race, color, national origin, sex, religion, age, disability, or association with a person with a disability.

Topic #206

Requesting Discretionary Waivers and Variances

In rare instances, a provider or member may apply for, and the DHCAA (Division of Health Care Access and Accountability) will consider applications for, a discretionary waiver or variance of certain rules in [DHS 102](#), [103](#), [104](#), [105](#), [107](#), and [108](#), Wis. Admin. Code. Rules that are not considered for a discretionary waiver or variance are included in [DHS 106.13](#), Wis. Admin. Code.

Waivers and variances are not available to permit coverage of services that are either expressly identified as noncovered or are not expressly mentioned in DHS 107, Wis. Admin. Code.

Requirements

A request for a waiver or variance may be made at any time; however, all applications must be made in writing to the DHCAA. All applications are required to specify the following:

- The rule from which the waiver or variance is requested.
- The time period for which the waiver or variance is requested.
- If the request is for a variance, the specific alternative action proposed by the provider.
- The reasons for the request.
- Justification that all requirements for a discretionary waiver or variance would be satisfied.

The DHCAA may also require additional information from the provider or the member prior to acting on the request.

Application

The DHCAA may grant a discretionary waiver or variance if it finds that all of the following requirements are met:

- The waiver or variance will not adversely affect the health, safety, or welfare of any member.
- Either the strict enforcement of a requirement would result in unreasonable hardship on the provider or on a member, or an alternative to a rule is in the interests of better care or management. An alternative to a rule would include a new concept, method, procedure or technique, new equipment, new personnel qualifications, or the implementation of a pilot project.
- The waiver or variance is consistent with all applicable state and federal statutes and federal regulations.
- Federal financial participation is available for all services under the waiver or variance, consistent with the Medicaid state plan, the federal CMS (Centers for Medicare and Medicaid Services), and other applicable federal program requirements.
- Services relating to the waiver or variance are medically necessary.

To apply for a discretionary waiver or variance, providers are required to send their application to the following address:

Division of Health Care Access and Accountability
Waivers and Variances
PO Box 309
Madison WI 53701-0309

Sanctions

Topic #211

Intermediate Sanctions

According to [DHS 106.08\(3\)](#), Wis. Admin. Code, the DHS (Department of Health Services) may impose intermediate sanctions on providers who violate certain requirements. Common examples of sanctions that the DHS may apply include the following:

- Review of the provider's claims before payment.
- Referral to the appropriate peer review organization, licensing authority, or accreditation organization.
- Restricting the provider's participation in BadgerCare Plus.
- Requiring the provider to correct deficiencies identified in a DHS audit.

Prior to imposing any alternative sanction under this section, the DHS will issue a written notice to the provider in accordance with [DHS 106.12](#), Wis. Admin. Code.

Any sanction imposed by the DHS may be appealed by the provider under DHS 106.12, Wis. Admin. Code. Providers may appeal a sanction by writing to the DHA (Division of Hearings and Appeals).

Topic #212

Involuntary Termination

The DHS (Department of Health Services) may suspend or terminate the Medicaid enrollment of any provider according to [DHS 106.06](#), Wis. Admin. Code.

The suspension or termination may occur if both of the following apply:

- The DHS finds that any of the grounds for provider termination are applicable.
- The suspension or termination will not deny members access to services.

Reasonable notice and an opportunity for a hearing within 15 days will be given to each provider whose enrollment is terminated by the DHS. Refer to [DHS 106.07](#), Wis. Admin. Code, for detailed information regarding possible sanctions.

In cases where Medicare enrollment is required as a condition of enrollment with Wisconsin Medicaid, termination from Medicare results in automatic termination from Wisconsin Medicaid.

Topic #213

Sanctions for Collecting Payment from Members

Under state and federal laws, if a provider inappropriately collects payment from an enrolled member, or authorized person acting on behalf of the member, that provider may be subject to program sanctions including termination of Medicaid enrollment. In addition, the provider may also be fined not more than \$25,000, or imprisoned not more than five years, or both, pursuant to 42 USC s. 1320a-7b(d) or [s. 49.49\(3m\)](#), Wis. Stats.

There may be narrow exceptions on when providers may [collect payment from members](#).

Topic #214

Withholding Payments

The DHS (Department of Health Services) may withhold full or partial Medicaid provider payments without prior notification if, as the result of any review or audit, the DHS finds reliable evidence of fraud or willful misrepresentation.

"Reliable evidence" of fraud or willful misrepresentation includes, but is not limited to, the filing of criminal charges by a prosecuting attorney against the provider or one of the provider's agents or employees.

The DHS is required to send the provider a written notice within five days of taking this action. The notice will generally set forth the allegations without necessarily disclosing specific information about the investigation.

Reimbursement

8

Archive Date:02/02/2015

Reimbursement:Amounts

Topic #8117

Electronic Funds Transfer

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

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

Provider Exceptions

EFT payments are not available to the following providers:

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

Enrolling in Electronic Funds Transfer

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

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

The following guidelines apply to EFT enrollment:

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

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

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

Recoupment and Reversals

Enrollment in EFT does not change the current process of recouping funds. Overpayments and recoupment of funds will continue

to be conducted through the reduction of payments.

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

Problem Resolution

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

Cost Reporting

Topic #1616

Auditing

All cost reports are audited. Once a cost report has been audited, an FQHC (federally qualified health center) has 60 days to request an adjustment. After 60 days, the cost report is final and additional encounters (i.e., face-to-face visits) will not be accepted. Once a cost settlement is final, it will be reopened only when an audit requires Wisconsin Medicaid to make revisions to the settlement.

If an audited cost report determines that payment to an FQHC, including interim payments, exceeded the FQHC's actual costs for providing services to members, the difference will be recouped by Wisconsin Medicaid. All FQHCs are encouraged to submit timely cost reports so that they may receive cost settlements and avoid recoupment.

Topic #1633

Cost Report Forms

FQHCs (federally qualified health centers) are required to use the [Federally Qualified Health Center Cost Report Forms \(F-11129B-11129H \(04/09\)\)](#) for cost settlements.

The FQHC cost report forms are available to providers as a complete set in a single, fillable Microsoft[®] Excel workbook. After opening the workbook, providers may choose among the tabs at the bottom of the document to display the form or worksheet needed. These forms will accurately perform all necessary calculations for the user and may be downloaded and saved to a computer's hard drive or a computer disk.

Topic #1637

Interim Report Form

FQHCs (federally qualified health centers) interested in receiving a partial cost settlement for services rendered to members for a given fiscal year may submit an interim report to the DHCAA (Division of Health Care Access and Accountability). Interim reports may be submitted at any time within the FQHC's current fiscal year for activity occurring within that time period.

The [Federally Qualified Health Center Interim Report \(F-11130 \(04/09\)\)](#) is available in fillable Microsoft[®] Excel format.

Topic #4172

Site of Service Codes as Allowable Encounters

Site of service revenue codes received by ForwardHealth on Medicare crossover claims may be considered an allowable encounter on FQHC (federally qualified health center) cost reports.

Note: Site of service revenue code 0527 is not applicable for cost reporting purposes as there are currently no home health shortage areas in Wisconsin.

Revenue Code	Definition
0521	Clinic visit by member* to RHC (rural health clinic)/FQHC
0522	Home visit by RHC/FQHC practitioner (for home address visits to the FQHC/RHC member)
0524	Visit by RHC/FQHC practitioner to a member in a covered Part A stay at the SNF
0525	Visit by RHC/FQHC practitioner to a member in an SNF (skilled nursing facility) (not in a covered Part A stay) or NF or ICF MR or other residential facility
0528	Visit by RHC/FQHC practitioner to other non-RHC/FQHC site (e.g., scene of accident)

* A member is defined as someone who has a history of receiving medical care and whose medical record is located at a specific RHC/FQHC.

Topic #1650

Submission

FQHCs (federally qualified health centers) that obtain FQHC enrollment may submit claims to BadgerCare Plus fee-for-service and submit interim requests for FQHC reimbursement and annual cost reports to receive supplemental payments (i.e., cost settlements) that equal 100 percent of reasonable costs. Claims for FQHCs services that are *not* submitted with an FQHCs provider number may not be included on cost reports and, therefore, will not be included in the cost settlement.

Services provided to Medicaid and BadgerCare Plus Standard Plan members are eligible for inclusion on cost reports.

Deadline

Because providers are required to retain documentation for no less than five years under [DHS 106.02\(9\)\(e\)2](#), Wis. Admin. Code, cost reports will be accepted only if they are submitted within five years of the last DOS (date of service) in the fiscal year. If a cost report is not completed and sent to ForwardHealth within five years of the last DOS in a fiscal year, providers will not receive a cost settlement for that fiscal year. Settlement may be denied for a cost report if supporting documentation is not available when the FQHC is audited for that fiscal year.

Payment Methodology

According to the BIPA (Benefits Improvement and Protection Act of 2000), all states are required to implement an FQHCs payment methodology using a base rate from expenses filed in 1999 and 2000. These rates are evaluated annually based on the cost reports filed by each FQHCs. To be compliant with the BIPA requirements and for a cost settlement to be issued from ForwardHealth, cost reports must be filed with the DHCAA (Division of Health Care Access and Accountability) BPI (Bureau of Program Integrity).

Interim Payments

If ForwardHealth does not receive a cost report from an FQHCs for two fiscal years, Wisconsin Medicaid may withhold future interim FQHCs payments. If an FQHCs submits a cost report to ForwardHealth more than five years after the DOS, ForwardHealth will not accept the report and may recoup any interim payments made to the FQHCs for that reporting period.

Resources

9

Archive Date:02/02/2015

Resources:Contact Information

Topic #4456

Resources Reference Guide

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

Provider Services and Resources Reference Guide

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

ForwardHealth Portal	www.forwardhealth.wi.gov/	24 hours a day, seven days a week
Public and secure access to ForwardHealth information with direct link to contact Provider Services for up-to-date access to ForwardHealth programs information, including publications, fee schedules, and forms.		
WiCall Automated Voice Response System	(800) 947-3544	24 hours a day, seven days a week
WiCall, the ForwardHealth Automated Voice Response system, provides responses to the following inquiries:		
<ul style="list-style-type: none"> • Checkwrite. • Claim status. • Prior authorization. • Member enrollment. 		
ForwardHealth Provider Services Call Center	(800) 947-9627	Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Standard Time)*
To assist providers in the following programs:		
<ul style="list-style-type: none"> • BadgerCare Plus. • Medicaid. • SeniorCare. • Wisconsin Well Woman Medicaid. • Wisconsin Chronic Disease Program (WCDP). • Wisconsin Well Woman Program (WWWP). • Wisconsin Medicaid and BadgerCare Plus Managed Care Programs. 		
ForwardHealth Portal Helpdesk	(866) 908-1363	Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central Standard Time)*
To assist providers and trading partners with technical questions regarding Portal functions and capabilities, including Portal accounts, registrations, passwords, and submissions through the Portal.		
Electronic Data Interchange Helpdesk	(866) 416-4979	Monday through Friday, 8:30 a.m. to 4:30 p.m. (Central Standard Time)*
For providers, trading partners, billing services, and clearinghouses with technical questions about the following:		
<ul style="list-style-type: none"> • Electronic transactions. • Companion documents. • Provider Electronic Solutions (PES) software. 		
Managed Care Ombudsman Program	(800) 760-0001	Monday through Friday, 7:00 a.m. to 6:00 p.m. (Central Standard Time)*
To assist managed care enrollees with questions about enrollment, rights, responsibilities, and general managed care information.		
Member Services	(800) 362-3002	Monday through Friday, 8:00 a.m. to 6:00 p.m. (Central Standard Time)*
To assist ForwardHealth members or persons calling on behalf of members with program information and requirements, enrollment, finding certified providers, and resolving concerns.		
Wisconsin AIDS Drug Assistance Program (ADAP)	(800) 991-5532	Monday through Friday, 8:00 a.m. to 4:30 p.m. (Central Standard Time)*
To assist ADAP providers and members, or persons calling on behalf of members, with program information and requirements, enrollment, finding enrolled providers, and resolving concerns.		

*With the exception of state-observed holidays.

Electronic Data Interchange

Topic #461

Electronic Data Interchange Helpdesk

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

Providers with policy questions should call [Provider Services](#).

Enrollment Verification

Topic #469

An Overview

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

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

Topic #4903

Copayment Information

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

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

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

Topic #4901

Enrollment Verification on the Portal

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

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

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

- Go to the ForwardHealth Portal.
- Establish a provider account.

- Log into the secure Portal.
- Click on the menu item for enrollment verification.

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

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

Topic #4900

Entering Dates of Service

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

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

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

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

Topic #4899

Member Identification Card Does Not Guarantee Enrollment

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

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

Topic #4898

Responses Are Based on Financial Payer

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

There are three financial payers under ForwardHealth:

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

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

Portal

Topic #4904

Claims and Adjustments Using the ForwardHealth Portal

Providers can [track the status](#) of their submitted claims, [submit individual claims](#), correct errors on claims, copy claims, and determine what claims are in "pay" status on the ForwardHealth Portal. Providers have the ability to [search for and view](#) the status of all 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 through DDE (Direct Data Entry) through the secure Portal.

Topic #8524

Conducting Revalidation Via the ForwardHealth Portal

Providers can conduct [revalidation](#) online via a secure revalidation area of the ForwardHealth Portal.

Topic #5157

Cost Share Reports for Long-Term Managed Care Organizations

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

Topic #4345

Creating a Provider Account

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

1. Go to the ForwardHealth Portal.
2. Click the **Providers** button.
3. Click **Logging in for the first time?**.
4. Enter the Login ID and PIN. The Login ID is the provider's NPI or provider number.
5. Click **Setup Account**.
6. At the Account Setup screen, enter the user's information in the required fields.

7. Read the security agreement and click the checkbox to indicate agreement with its contents.
8. Click **Submit** when complete.

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

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

Refer to the Account User Guide on the [Portal User Guides page](#) of the Portal for more detailed instructions on performing these functions.

Topic #16737

Demographic Maintenance Tool

The demographic maintenance tool allows providers to update information online that they are required to keep [current](#) with ForwardHealth. To access the demographic maintenance tool, providers need a ForwardHealth Portal account. After logging into their Portal account, providers should select the Demographic Maintenance link located in the Home Page box on the right side of the secure Provider home page.

Note: The Demographic Maintenance link will only display for administrative accounts or for clerk accounts that have been assigned the Demographic Maintenance role. The [Account User Guide](#) provides specific information about assigning roles.

The demographic maintenance tool contains general panels which are available to all or most providers as well as specific panels which are only available to certain provider types and specialties. The [Demographic Maintenance Tool User Guide](#) provides further information about general and provider-specific panels.

Uploading Supporting Documentation

Providers can upload enrollment-related supporting documentation (e.g., licenses, certifications) using the demographic maintenance tool. Documents in the following formats can be uploaded:

- JPEG (Joint Photographic Experts Group) (.jpg or .jpeg).
- PDF (Portable Document Format) (.pdf).

To avoid delays in processing, ForwardHealth strongly encourages providers to upload their documents.

Submitting Information

After making *all* their changes, providers are required to submit their information in order to save it. After submitting information, providers will receive one of the following messages:

- "Your information was *updated* successfully." This message indicates that providers' files were immediately updated with the changed information.
- "Your information was *uploaded* successfully." This message indicates that ForwardHealth needs to verify the information before providers' files can be updated. Additionally, an Application Submitted panel will display and indicate next steps.

Verification

ForwardHealth will verify changes within 10 business days of submission. If the changes can be verified, ForwardHealth will update providers' files. In some cases, providers may receive a Change Notification letter indicating what information ForwardHealth updated. Providers should carefully review the Provider File Information Change Summary included with the letter to verify the accuracy of the changes. If any of the changes are inaccurate, providers can correct the information using the demographic maintenance tool. Providers may contact [Provider Services](#) if they have questions regarding the letter.

Regardless of whether or not providers are notified that their provider files were updated, changed information is not considered approved until 10 business days after the information was changed. If the changes cannot be verified within 10 business days, ForwardHealth will notify providers by mail that their provider files were not updated, and providers will need to make corrections using the demographic maintenance tool.

Topic #4340

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

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

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

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

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

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

Topic #5088

Enrollment Verification

The secure ForwardHealth Portal offers real time member [enrollment verification](#) for all ForwardHealth programs. Providers are able to use this tool to determine:

- The health care program(s) in which the member is enrolled.
- Whether or not the member is enrolled in a state-contracted MCO (managed care organization).
- Whether or not the member has any third-party liability, such as Medicare or commercial health insurance.
- Whether or not the member is enrolled in the [Pharmacy Services Lock-In Program](#) and the member's Lock-In pharmacy, primary care provider, and referral providers (if applicable).

Using the Portal to check enrollment may be more effective than calling [WiCall](#) or the EVS (Enrollment Verification System) (although both are available).

Providers are 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.

Topic #4338

ForwardHealth Portal

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

The Portal has the following areas:

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

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

Topic #4441

ForwardHealth Portal Helpdesk

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

Topic #16517

ForwardHealth's Transition to ICD-10-CM and ICD-10-PCS Code Sets

ICD-10 Code Set Transition Portal Page

ForwardHealth has established the [ICD-10 \(International Classification of Diseases, 10th Revision\) Code Set Transition](#) Portal page to communicate information related to the transition to ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification) and ICD-10-PCS (International Classification of Diseases, 10th Revision, Procedure Coding System) code sets. The ICD-10 Code Set Transition page is a repository of information and communications related to ForwardHealth's transition to ICD-10. All stakeholders and interested parties are encouraged to check the ICD-10 Code Set Transition page regularly for new information.

ICD-10 Project Information E-mail Subscription Messaging

ForwardHealth has introduced a new e-mail subscription option, ICD-10 Project Information, to communicate targeted ICD-10 information. All interested parties are encouraged to [register to receive information from ForwardHealth about ICD-10](#), including those with Portal account access and those already registered to receive e-mail subscription messages for other service areas. Adding ICD-10 as a subscription option will not impact existing subscriptions. The ICD-10 e-mail option will automatically be discontinued when communicating ICD-10 transition information is no longer necessary.

Frequently Asked Questions About ForwardHealth's Transition to ICD-10

ForwardHealth has developed a [Frequently Asked Questions About ForwardHealth's Transition to ICD-10](#) document to capture questions submitted from stakeholders and to share answers. The document is revised with new information as it is available.

Submit an ICD-10 Question to ForwardHealth

Stakeholders may submit ICD-10 questions to ForwardHealth directly from the ICD-10 Code Set Transition page by clicking on the [Submit an ICD-10 Question to ForwardHealth](#) link.

Topic #4451

Inquiries to ForwardHealth Via the Portal

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

Topic #4400

Internet Connection Speed

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

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

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

Topic #4351

Logging in to the Provider Area of the Portal

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

Topic #4743

Managed Care Organization Portal

Information and Functions Through the Portal

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

The following information is available through the Portal:

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

Topic #5158

Managed Care Organization Portal Reports

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

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

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

Capitation Payment Listing Report

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

Initial Enrollment Roster Report

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

Final Enrollment Roster Report

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

Other Reports

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

Topic #4744

Members ForwardHealth Portal

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

Topic #4344

Obtaining a Personal Identification Number

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

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

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

Providers may request a PIN by following these steps:

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

The financial payer is one of the following:

- Medicaid (Medicaid is the financial payer for Wisconsin Medicaid, BadgerCare Plus, and Senior Care).
 - SSI (Supplemental Security Income).
 - WCDP (Wisconsin Chronic Disease Program).
 - The WWWP (Wisconsin Well Woman Program).
- c. Click **Submit**.
 - d. Once the Portal Access Request is successfully completed, ForwardHealth will send a letter with the provider's PIN to the address on file.

Topic #5089

Other Business Enhancements Available on the Portal

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

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

Topic #4911

Portal Account Administrators

Portal administrators are responsible for requesting, creating, and managing accounts to access these features for their organization.

There must be one administrator assigned for each Portal account and all users established for that account. The responsibilities of the Portal administrator include:

- Ensuring the security and integrity of all user accounts (clerk administrators and clerks) created and associated with their Portal account.
- Ensuring clerks or clerk administrators are given the appropriate authorizations they need to perform their functions for the provider, trading partner, or MCO (managed care organization).
- Ensuring that clerks or clerk administrator accounts are removed/deleted promptly when the user leaves the organization.
- Ensuring that the transactions submitted are valid and recognized by ForwardHealth.
- Ensuring that all users they establish know and follow security and guidelines as required by HIPAA (Health Insurance Portability Accountability Act of 1996). As Portal administrators establish their Portal account and create accounts for others to access private information, administrators are reminded that all users must comply with HIPAA. The HIPAA privacy and security rules require that the confidentiality, integrity, and availability of PHI (protected health information) are maintained at all times. The HIPAA Privacy Rule provides guidelines governing the disclosure of PHI. The HIPAA Security Rule delineates the security measures to be implemented for the protection of electronic PHI. If Portal administrators have any questions concerning the protection of PHI, visit the Portal for additional information.

Portal administrators have access to all secure functions for their Portal account.

Establish an Administrator Account

All Portal accounts require an administrator account. The administrator is a selected individual who has overall responsibility for management of the account. Therefore, he or she has complete access to all functions within the specific secure area of his or her Portal and are permitted to add, remove, and manage other individual roles.

Topic #4912

Portal Clerk Administrators

A Portal administrator may choose to delegate some of the authority and responsibility for setting up and managing the users within their ForwardHealth Portal account. If so, the Portal administrator may establish a clerk administrator. An administrator or clerk administrator can create, modify, manage or remove clerks for a Portal account. When a clerk is created, the administrator or clerk administrator must grant permissions to the clerks to ensure they have the appropriate access to the functions they will perform. A clerk administrator can only grant permissions that they themselves have. For example, if an administrator gives a clerk administrator permission only for enrollment verification, then the clerk administrator can only establish clerks with enrollment verification permissions.

Even if a Portal administrator chooses to create a clerk administrator and delegate the ability to add, modify, and remove users from the same account, the Portal administrator is still responsible for ensuring the integrity and security of the Portal account.

Topic #4913

Portal Clerks

The administrator (or the clerk administrator if the administrator has granted them authorization) may set up clerks within their ForwardHealth Portal account. Clerks may be assigned one or many roles (i.e., claims, PA (prior authorization), member enrollment verification). Clerks do not have the ability to establish, modify, or remove other accounts.

Once a clerk account is set up, the clerk account does not have to be established again for a separate Portal account. Clerks can easily be assigned a role for different Portal accounts (i.e., different ForwardHealth enrollments). To perform work under a different Portal account for which they have been granted authorization, a clerk can use the "switch org" function and toggle between the Portal accounts to which they have access. Clerks may be granted different authorization in each Portal account (i.e., they may do member enrollment verification for one Portal account, and HealthCheck inquires for another).

Topic #4740

Public Area of the Provider Portal

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

Maximum Allowable Fee Schedules

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

Online Handbook

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

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

ForwardHealth Publications Archive Section

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

Training

Providers can register for all scheduled trainings and view online trainings via the [Portal Training page](#), which contains an up-to-date calendar of all available training. Additionally, providers can view [Webcasts](#) of select trainings.

Contacting Provider Services

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

Online Enrollment

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

Other Business Enhancements Available on the Portal

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

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

Topic #4741

Secure Area of the Provider Portal

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

Claims and Adjustments Using the Portal

Providers can track the status of their submitted claims, submit individual claims, correct errors on claims, and determine what

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

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

Submitting Prior Authorization and Amendment Requests Via the Portal

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

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

Electronic Communications

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

Enrollment Verification

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

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

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

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

Other Business Enhancements Available on the Portal

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

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

Topic #4401

System and Browser Requirements

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

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

Topic #4742

Trading Partner Portal

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

- Trading partner [testing packets](#).
- [Trading Partner Profile](#) submission.
- [PES \(Provider Electronic Solutions\)](#) software and upgrade information.
- EDI (Electronic Data Interchange) [companion guides](#).

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

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

Training Opportunities

Topic #12757

Training Opportunities

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

On-Site Sessions

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

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

Online (Real-Time, Web-Based) Sessions

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

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

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

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

Recorded Webcasts

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

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

Notification of Training Opportunities

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

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

WiCall

Topic #6257

Entering Letters into WiCall

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

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

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

Topic #466

Information Available Via WiCall

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

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

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

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

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

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

Claim Status

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

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

Enrollment Verification

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

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

Prior Authorization Status

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

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

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